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CHILDREN'S ACCESS TO HEALTH COVERAGE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

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CHILDREN'S ACCESS TO HEALTH COVERAGE

TUESDAY, APRIL 8, 1997

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

The Subcommittee met, pursuant to call, at 10:10 a.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
March 20, 1997
No. HL–8

CONTACT: (202) 225–3943

Thomas Announces Hearing on Children's Access to Health Coverage

Congressman Bill Thomas (R–CA), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on children's access to health coverage. The hearing will take place on Tuesday, April 8, 1997, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m.

In view of the limited time available to hear witnesses, oral testimony at this hearing will be heard from invited witnesses only. 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:

The percentage of uninsured children has remained relatively stable since 1988. During that period, however, Medicaid coverage has increased as private coverage has declined. From 1988 through 1995, the percentage of uninsured children increased from 13 percent to 13.6 percent, while the percentage of children covered by private insurance dropped from 73.5 percent to 66.4 percent, and Medicaid coverage increased from 15.5 percent to 23.1 percent. Approximately one in four uninsured Americans are children. Of the 71 million children in the United Sates under age 18, 9.6 million are uninsured.

Under current law, there is a large and growing public health care safety net for children. The Federal Government shares the cost of providing comprehensive health coverage to over 16 million children through the Medicaid program. Medicaid currently covers one in four American children and pays for over one-third of all births in the United States. About 3 million of the 9.6 million uninsured children are currently eligible for Medicaid, but their parents or guardians have not enrolled them in the program. In addition to Medicaid, the Health Insurance Portability and Accountability Act (P.L. 104–191) enacted in the 104th Congress, limits preexisting conditions and provides significant new protections to pregnant women and children.

There is no clear explanation why children are uninsured, not lending itself to an easy solution. For example, children in families with incomes below 100 percent of poverty are more than twice as likely to be uninsured as children in families with incomes above 200 percent of poverty. However, nearly 14 percent of children without health insurance—1.4 million children—live in families with incomes above 300 percent of poverty. Moreover, while the majority of insured Americans get health coverage through their employer, over 80 percent of uninsured children have parents who work part-time, and nearly 60 percent have parents who work full-time for the entire year. In addition, because of the prevalence of school-based clinics, public health programs and various public and private initiatives, some children without health insurance may in fact have access to health coverage.

In announcing the hearing, Chairman Thomas stated: "So far, the issue of children without health insurance coverage has generated a significant amount of heat, but very little light. We need to begin this discussion with a better understanding of the scope of the problem before we advocate solutions. This hearing will provide the first comprehensive Congressional overview of information available on uninsured kids."

FOCUS OF THE HEARING:

The hearing will try to more clearly identify the reasons that children in the United States do not have access to health insurance coverage and the impact that lack of access has on access to health coverage and health status.

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 at least six (6) copies of their statement and a 3.5-inch diskette in WordPerfect or ASCII format, with their address and date of hearing noted, by the close of business, Tuesday, April 22, 1997, to A.L. Singleton, 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, at least one hour before the hearing begins.

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 typed in single space on legal-size paper and may not exceed a total of 10 pages including attachments. At the same time written statements are submitted to the Committee, witnesses are now requested to submit their statements on a 3.5-inch diskette in WordPerfect or ASCII format.

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, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. 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://WWW.HOUSE.GOV/WAYS__MEANS/'.

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 202–225–1904 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.

Chairman THOMAS. The Subcommittee will come to order.

I am looking for a public service announcement. I am pleased to announce, the Medicare and the Health Care Chart Book compiled by the Congressional Research Service and published in February by the Committee on Ways and Means is now widely available to the public on the Internet. The information can be assessed through the House Ways and Means Committee home page. Somebody wrote it in and then crossed it out—apparently they didn't think I could read—www.access.gpo.gov.

I think the press and the public will find that the Chart Book contains a wealth of extremely useful, timely information, and so forth, and so forth. It really is the best compilation that we have seen of charts that help you graphically understand the concerns, the problems, the timeliness of decisions in the area of Medicare, private health spending, and other issues that are before us encompassing today's topic.

I am pleased to announce that the Subcommittee today is holding the first comprehensive hearing of the 105th on children's access to health coverage. There are a number of pieces of legislation that have been introduced, and I am very anxious to begin listening to folk about the problems associated and the possible advances accompanying children's access to health coverage.

Initiatives to increase health coverage for uninsured children have not only been proposed by Members of Congress but also by President Clinton. There is significant interest in making this a priority for congressional action in health care. However, the issue has generated significantly more interest than solutions, and I believe the facts about uninsured children are much more complex—and I believe today's testimony will bear that out—than many have appreciated or understood.

I think before we can intelligently evaluate the myriad of legislative proposals and possibly then not get into some pitfalls which would create unanticipated problems, or, even worse, pass legislation when we have already anticipated the resulting problems in the health care system, we need to understand the interaction of various decisions that we may very well make; and that is the goal of today's hearing.

Before we go to our first distinguished panel of analysts, researchers, and economists, the gentleman from California, Mr. Stark, who I know has an interest in this area, would like to make an opening statement.

[The opening statement follows:]

Opening Statement of Hon. Bill Thomas, a Representative in Congress from the State of California

Today, the Subcommittee is holding the first comprehensive hearing of the 105th Congress on children's access to health coverage.

Initiatives to increase health coverage for uninsured children have been proposed by President Clinton and members of Congress from both parties. Clearly, there is significant interest in making this a priority for congressional action in health care.

However, so far the issue has generated significantly more interest than solutions. I believe the facts about uninsured children are much more complex than we have yet appreciated or understood.

Before we can intelligently evaluate the myriad of legislative proposals and sidestep pitfalls which may create unanticipated problems in the health care system, we must examine and better understand the interaction of these facts.

That is the goal of today's hearing.

We have asked a group of distinguished analysts, researchers and economists from both the private and public sector to help us get a better picture of the landscape. I look forward to today's testimony.

Mr. STARK. Thank you, Mr. Chairman.

As you were speaking, I was reviewing my opening statement. It doesn't offer a solution, unfortunately, and I guess that is what we are here to find out a little about. What I am asking people to do is think about the magnitude of the problem and put a face on it.

You are going to hear a variety of figures, but something like one in seven kids do not have health insurance. And you say, so they don't have insurance. I think, and I would like the witnesses or my colleagues to challenge my assumption here, that an uninsured child, by definition, does not get proper medical care. Some may, but on balance, if a child is uninsured, he or she is not getting the proper care at the proper time.

And worse than the one in seven—and it is numbers we used years ago in discussing the health insurance of adults; where there may be some 40 million uninsured, there are about 10 million uninsured kids, 9.8 million I guess—is that there are many more, perhaps double, that number, if you take those children who at any point in a year or two go uninsured for 1 month or more, because those uninsured months pick up the preexisting condition restrictions. If they get back in the system in 30 or 60 days, they are apt to have 6 months of waiting if they have diabetes or if they have some childhood disease which goes on and the new insurance won't pick them up.

Now, I am not suggesting that that means there are 20 million uninsured, but there could be over a period of time. Think of it this way: If New York City—suddenly, through a lot of vitamin E, if everybody in New York City became under 18, they all drank from the fountain of youth, and everybody in New York City would be uninsured.

I have a map; I just picked the States, and these are all the mountain States; but that is as if every person, every child, in that State was uninsured. That is a lot of kids.

And now the solution: Some children have it through their workplace, and the parents basically pay nothing for it. If you force other parents to pay something, the parents who are getting it free won't want to kick in. We have had that argument in schools, in parochial schools versus private schools. Some people say, Well, if we provide it through the Federal Government, the employers will stop paying their share, and therefore we will pick up a burden that is not needed.

But again, a general figure that I have in my mind—and I would like to be corrected from the witnesses today—is that if we required, through whatever means, that every child be insured, even if it were privately—I am not suggesting that this has to be a social problem—that the cost of that coverage would be about $500 a kid a year.

I am further told that if we don't require it but make it available on sort of a voluntary basis, the cost goes up to $1,500 a year because of the adverse selection. Only the parents that think their kids, or know their kids, are sick or have health problems will sign up, and the rest go uninsured, and that puts an unfair burden on whichever insurance company is doing it.

I don't know how we get from here to there. The President suggested a $500 tax credit, but that does not go to every kid because it is not refundable. I have looked at that and think it is a good place to start.

I would not mind a tobacco tax. I happen to think that would stop kids from smoking and pay for the cost, but there are a lot of political problems in how you pay for it.

So maybe today from all these witnesses we will get some idea of how—and I don't think realistically we are going to get the whole 10 million in any bill we do, but I would like to see us come together and get as many of the 10 million as we can and get it unpolitically in the next year or so. I look forward to the witnesses helping us through this maze.

Thank you for indulging me, Mr. Chairman.

Chairman THOMAS. No, thank you. And I want to underscore a couple points that you made, because although the testimony is good, it is not, frankly, as helpful as we are looking for.

And I want to let you folks anticipate the direction of the questions, because although we have talked about the public versus the private and subsidy versus tax credits and the driving out of private dollars, it concerns me a bit that not as many people as I would have liked focused on the 135-plus billion dollars of tax benefit on the private side and how that might be utilized on the margin of the subsidy driving out "private insurance."

The other thing I found somewhat interesting was, apparently some folk, based upon income, make decisions on health care from an economic basis, and others from more of a health insurance protection basis—because at the high end you have got folks who don't have the insurance because it doesn't make economic sense to them; they are, in essence, self-insured.

And I understand that at the bottom end, if you are going to provide a publicly subsidized health program that is better than anything they can buy, they are going to opt out of the private one and go to the public one. But I have some concern on a margin where taxpayers are subsidizing a far better quality health care than people in the private sector can afford to pay for themselves.

So I guess, as the gentleman from California indicated, we understand the parameters, we understand the tradeoffs; and, frankly, most of the testimony was trying to get us to understand the parameters and the tradeoffs; and at some point we have to grapple with the solutions.

You are about as good as we have got in terms of advising us on solutions. So, as you look at your testimony, if you wish to give us the parameters and the dilemmas and the tradeoffs, fine; but we are still going to have to push you on. For example, Why didn't you take a look at the tax subsidy today in terms of certain types of employers being able to deduct 100 percent, and how much of that could go into a larger pot in rethinking the way in which the dis-

tribution of health insurance that is currently present in the country could be restructured to produce a fairer and more equitable system, since it doesn't make a lot of sense to me that somebody gets 100 percent of their health care deducted and somebody else gets nothing by virtue of their place of employment. That doesn't make a lot of sense from a larger health care policy.

That is where we are today, and, as I said, I felt that that was largely ignored as you grappled with this problem of how high the subsidy versus the tradeoff or the backing out of private dollars.

I have said enough. I am anxious to listen to you. Thank you very much.

Today's first panel: Linda Bilheimer, who is the Deputy Assistant Director for Health, Health and Human Resources Division of the Congressional Budget Office—Dr. Ross is with her today—Patrick J. Purcell, who is the Congressional Research Service Analyst; and once again, Dr. Bill Scanlon, Director, Health Systems Issues, General Accounting Office.

Thank you all for coming. And I do know that perhaps some of you have done some examination of that larger question of tax subsidies on health care; and if you care to say anything during your testimony, fine. Otherwise, I will ask you questions afterward.

Why don't we begin with Dr. Bilheimer and move across the panel.

STATEMENT OF LINDA T. BILHEIMER, DEPUTY ASSISTANT DIRECTOR FOR HEALTH, HEALTH AND HUMAN RESOURCES DIVISION, CONGRESSIONAL BUDGET OFFICE; ACCOMPANIED BY MURRAY ROSS, CHIEF, HEALTH COST ESTIMATES UNIT, BUDGET ANALYSIS DIVISION

Ms. BILHEIMER. Mr. Chairman and Members of the Subommittee, I am happy to be here today to discuss issues that CBO would consider in evaluating health proposals for children.

I would like to introduce my colleague, Murray Ross, who will join me in answering any questions you may have. With your permission, I will summarize my remarks and submit my full statement for the record.

Policymakers are considering three types of proposals for expanding health insurance coverage for children: Enrolling more children in Medicaid by expanding eligibility and by extending outreach to uninsured children who are eligible but not enrolled; providing refundable tax credits to low-income families who purchase health insurance for their children——

Mr. STARK. Doctor, would you pull the mike up.

Ms. BILHEIMER. Sorry—and providing direct subsidies to low-income families with uninsured children to help them pay for insurance.

Some of those proposals would provide grants to the States to enable them to develop their own subsidy programs.

The cost of any proposal will depend on the number of uninsured children, the extent of participation by both uninsured children and children who would otherwise have another source of coverage, and the cost per child receiving assistance.

Most proposals for expanding health insurance for children have been developed in the context that about 10½ million children

through the age of 18 are uninsured, of whom 3 million are eligible for Medicaid.

The underlying situation is far more complex, however, than those numbers suggest. The estimate of 10½ million most closely corresponds to the number of children who are uninsured at any point in time. Thus, it represents neither the number of children who are uninsured for long periods of time, such as 1 year or more which would be considerably less than 10½ million, nor the number of children who are ever uninsured during the year, which would be considerably more than 10½ million. Those numbers differ because some children, especially those in low-income families, move in and out of insurance coverage. So, depending on a policy's focus, the potential target population of uninsured children could be significantly more or less than 10½ million.

Low-income children, who account for the majority of uninsured children, differ in the types of coverage they have when insured. Most children in families below the poverty level qualify for Medicaid, and relatively few of them have employer-sponsored coverage. But at any point in time, more than one-half the children in families with income between 100 and 200 percent of the poverty level have employer-sponsored coverage, and a much lower proportion of them are eligible for Medicaid.

The variability of low-income children's health insurance status, plus the fact that many of those above poverty have private coverage at least some of the time, makes designing an expansion policy difficult. Research indicates that subsidies or tax credits to encourage families to purchase coverage for their children would have to provide generous amounts of financial assistance to reduce the number of uninsured children significantly. It would be difficult to prevent low-income children who would otherwise have private coverage from participating.

States might also seek to shift Medicaid-eligible children into a program that was fully subsidized by the Federal Government. Likewise, expanding Medicaid to cover higher income children would result in the participation of some children who would otherwise have private coverage. Thus, the cost of proposals to expand coverage—whether through direct subsidies, tax credits, or Medicaid—could be considerably greater than just the costs of covering children who would otherwise be uninsured.

Although some proposals include measures to limit the participation of children who would otherwise have coverage, those measures would be difficult to enforce.

In addition to participation by different groups of children, the cost of a program to expand coverage would depend on the covered benefits, the average health status of children participating in the program, and marketing and administrative costs, all of which would vary by proposal. I discuss those issues at some length in my written testimony.

That concludes my statement, Mr. Chairman. I would be happy to answer any questions you may have, including questions relating to the tax credit and tax issues.

[The prepared statement follows:]

Statement of Linda T. Bilheimer, Deputy Assistant Director for Health, Health and Human Resources Division, Congressional Budget Office

Mr. Chairman and Members of the Committee, I appreciate the opportunity to discuss issues that the Congressional Budget Office (CBO) would consider in evaluating proposals to expand health insurance coverage for children. Despite recent expansions of the Medicaid program, about 14 percent of U.S. children are uninsured at any point in time. Many more low-income children are uninsured at some time during the year, because shifts between insured and uninsured status are constantly occurring. Because of the number of children involved and the changing composition of the insured population, a policy that would substantially reduce the number of uninsured children could be both expensive and complicated to design.

Policymakers are considering three broad approaches to increase health insurance coverage for children:

- Enrolling more children in Medicaid, both by expanding eligibility and by extending outreach to uninsured children who are eligible but not enrolled;
- Providing direct subsidies to low-income families with uninsured children to help them pay for insurance; and
- Providing refundable tax credits to low-income families who purchase health insurance for their children.

The costs of such proposals would depend on the number of children who are uninsured, the extent to which they and children who would otherwise have private insurance would participate in a subsidized program, and the average cost per child.

How Many Children Are Uninsured?

According to widely quoted estimates, about 10.5 million children through the age of 18, or 14 percent, are uninsured. At least 3 million of them are thought to be eligible for Medicaid. Most proposals to expand health insurance for children have been developed in the context of those numbers, and they assume that those figures would form the basis for determining the potential costs and coverage effects of alternative options. But the underlying situation is actually far more complex than those numbers suggest.

Although some children remain uninsured for the entire year, many more lack coverage for only part of the year. An estimate made at a point in time—which the 10.5 million figure most closely represents—counts all of the first group but only part of the second.[1] But policymakers may be primarily concerned with children who are uninsured for a year or more, which would be a smaller number than the point-in-time estimate. Alternatively, policies might focus on all children who are ever uninsured, which would be a considerably larger number than the point-in-time estimate. For example, a preliminary analysis conducted by CBO indicates that in 1993, about 13.5 percent of children were uninsured at any one point during the year, but 6.5 percent were uninsured for the entire year, while a further 15.5 percent were uninsured for part of the year. Those estimates indicate how children's insurance status can change over time.

Changes in insurance status are especially prevalent among children in low-income families (those with family income less than 200 percent of the poverty level). Such children are much more likely than others to be uninsured. CBO's estimates suggest that at any point in time, more than one-fifth of low-income children lack coverage, and they account for almost three-quarters of all uninsured children.

Moreover, in tracking children for more than a year, the probability that a child will experience a spell without health insurance rises considerably. For example, more than 40 percent of children in low-income families at the end of 1993 lacked insurance coverage at some time in the preceding two years.[2] However, some of them were uninsured for relatively short periods (four months or less). The situation may well have improved with the expansions of Medicaid coverage for poor children under age 19 that are being phased in through 2002. Those expansions may have reduced both the likelihood that poor children will become uninsured and the length of time that those uninsured children lack coverage.

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[1] CBO analysts believe that the estimate of 10.5 million children, which comes from the March 1996 Current Population Survey, is closer to a point-in-time estimate than an estimate of all children who were uninsured for the whole of 1995. For a discussion of methodological issues, see the appendix to this testimony.

[2] Those estimates should be interpreted carefully because the family income, as well as the insurance status, of those children probably fluctuated over the two-year period. In addition, unemployment rates were high in 1993, probably resulting in more children being uninsured than in a more typical year.

Within the low-income population, children in poor families (with family income less than the poverty level) and in near-poor families (with family income between 100 percent and 200 percent of the poverty level) have similar probabilities of being uninsured, but they have different patterns of insurance coverage. Relatively few poor children have employment-based insurance at any point in time, but more than 80 percent are eligible for Medicaid. (That proportion will rise even higher as Medicaid coverage for poor children under age 19 continues to be phased in.) By contrast, more than half of all near-poor children have employment-based coverage, and a much lower proportion are eligible for Medicaid.

Because they account for the large majority of uninsured children, low-income families are the focus of efforts to expand insurance coverage for children. But the volatility of their insurance status and the fact that many children above the poverty level have private coverage at least some of the time raise difficult questions about how best to design an expansion policy.

How Many Children Would Participate in a Subsidized Program?

Participation in any form of subsidized health insurance program for children would come from three groups of children: those who would otherwise be uninsured, the target group of the expansion; those who would otherwise have private coverage; and, in the case of subsidy or tax credit proposals, those who are eligible for Medicaid. The amount of federal assistance that low-income families would be eligible to receive would affect the amount of participation by each group.

Eligibility for Federal Assistance

In designing a proposal to increase children's health insurance, policymakers would have to decide who would be eligible for different levels of financial support and how long they could remain eligible without a reassessment of their financial status. Eligibility criteria might include recent health insurance status and current Medicaid eligibility, as well as family income.

Many proposals call for subsidizing uninsured children in families with income below a specified level and using a sliding scale of financial assistance for higher-income families. Proposals that would expand Medicaid, however, would probably be fully subsidized for all new participants, although they might include small premium contributions or cost-sharing requirements.

Designing a sliding scale of financial assistance to help families buy insurance for their children would involve several policy trade-offs. On the one hand, the higher the income level at which families could receive full subsidies, and the more slowly that assistance decreased as income rose, the more costly the subsidies would be. On the other hand, low subsidy rates would reduce the cost of the proposal, but they would also discourage participation. Moreover, if families who earned too much for full subsidies lost assistance quickly as their income rose, they would face high marginal tax rates (the tax rate on each additional dollar of income).

Some proposals would guarantee that low-income children remained eligible for assistance for up to one year once they enrolled in the program, regardless of whether their family's income or access to employer-sponsored coverage changed. Such a policy could stabilize insurance coverage for low-income children and help them enroll in managed care plans. But extended eligibility could also prove costly given the large number of children who are uninsured at some time during a year. It would mean that some low-income children who would otherwise experience a relatively short spell without insurance could enroll in the program and receive federal support for a full year. To avoid that outcome, proposals could restrict eligibility only to children who had been uninsured for some minimum period of time. Such a restriction could reduce the number of eligible children significantly, at least in the short run. But as discussed later, such a policy would be difficult to enforce, and its effectiveness would probably erode over time.

Participation by Children Who Would Otherwise Be Uninsured

The rate of participation in a new health insurance program by low-income families with uninsured children would depend in part on whether the program involved Medicaid expansions, subsidies, or tax credits. Both families' attitudes toward the program and the costs they would face would affect their participation.

Expansions of Medicaid. Efforts to use the Medicaid program to increase insurance coverage would probably focus on enrolling uninsured children who are already eligible, although some proposals would also broaden eligibility. Enrolling more children who are now eligible would require major new outreach efforts. Some families choose not to participate in Medicaid in part because of the perceived stigma associated with the program. Others may not participate because they know they have

conditional coverage: if their children become sick, they can enroll in Medicaid immediately. Both of those perceptions could be difficult for an outreach program to overcome. Still other families may not enroll because they do not know they are eligible, which is more likely to be the case if they do not receive cash welfare benefits.

The combination of attitudes toward Medicaid and lack of awareness of eligibility produces surprisingly low Medicaid participation rates among eligible children who do not receive cash welfare benefits. CBO estimates that at any time during the year fewer than 60 percent of children who do not receive cash benefits, do not have private insurance, and are eligible for Medicaid are enrolled in the program. However, short periods of Medicaid eligibility may also contribute to that result. Most uninsured children who qualify for Medicaid but do not participate appear to be eligible for only a few months. Proposals that would allow a one-year minimum period of eligibility, although costly, would increase participation by such children.

Subsidies or Tax Credits. Subsidies or tax credits for the purchase of health insurance would probably have to be large to increase children's coverage substantially. Uninsured children are usually in low-income families, and such families appear to be less responsive to subsidies than are higher-income families. A recent study by researchers at RAND, for example, suggests that subsidies of as much as 60 percent of the premium would cause only one-quarter of uninsured working families to buy insurance.[3]

Assuming that families had to pay only a small portion of the premium, subsidies to purchase private insurance might overcome any perceived stigma of Medicaid and thus produce higher participation rates. But extensive outreach would still be needed to inform low-income families of their options. Participation in subsidy programs might also be higher than otherwise if the procedures for determining eligibility and enrolling in health plans were streamlined and coordinated.

Although tax credits would also be free of stigma, they would probably produce lower participation rates than direct subsidies that had the same monetary value. Low-income families could experience cash flow problems if they had to pay insurance premiums during the year but only received the tax credit at the end of the tax year. Moreover, even if the credit was made available at the time a family purchased a health plan, the family would still face the possibility of having to repay part of the credit amount at the end of the tax year if its income rose during the year. Such uncertainty might discourage some families from participating. Having to deal with the tax system could also pose a challenge for some low-income families, many of whom would not ordinarily file a tax return.

Participation by Children Who Would Otherwise Have Private Insurance

In the case of higher-income children, Medicaid expansions, subsidies, and tax credits would all probably result in a significant share of federal payments going to children who would otherwise have private health insurance for at least part of the subsidy period. The participation of such children would raise federal costs beyond what was necessary to cover the uninsured.

Medicaid Expansions. Many researchers have looked at how the Medicaid expansions for children and pregnant women in the late 1980s and the 1990s have affected employment-based health insurance coverage. Private coverage of dependents has fallen as the number of children and pregnant women enrolled in Medicaid has soared. But that fact does not necessarily indicate that families have dropped private coverage to enroll in Medicaid; higher Medicaid enrollment may have resulted because families were losing private coverage.

Studies have reached various conclusions about whether Medicaid "crowds out" private insurance. However, most researchers agree that little crowding out occurs in families with income below the poverty level, although it increases higher up the income scale. Researchers at the Urban Institute, for example, estimated that over the 1988–1992 period, less than 30 percent of the increase in Medicaid coverage for pregnant women with income between 100 percent and 133 percent of the poverty level resulted from the crowding out of employment-based insurance. But the estimate was almost 60 percent for pregnant women with income between 134 percent and 185 percent of the poverty level.[4]

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[3] M. Susan Marquis and Stephen H. Long, "Worker Demand for Health Insurance in the Non-Group Market," *Journal of Health Economics,* vol. 14, no. 1 (May 1995), pp. 47–63.

[4] Lisa Dubay and Genevieve Kenney, "Did Medicaid Expansions for Pregnant Women Crowd Out Private Coverage?" *Health Affairs,* vol. 16, no. 1 (January/February 1997), pp. 185–193. Also see David M. Cutler and Jonathan Gruber, "Medicaid and Private Insurance: Evidence and Implications," *Health Affairs,* vol. 16, no. 1 (January/February 1997), pp. 194–200; and John Holohan, "Crowding Out: How Big a Problem?" *Health Affairs,* vol. 16, no. 1 (January/February 1997), pp. 204–206.

Subsidies or Tax Credits. As noted earlier, any system of subsidies or tax credits would have to be generous to have much impact on coverage. As a result, a large share of subsidy payments would probably go to children who would have been insured in the absence of the program, which could increase costs considerably. The probability of that outcome would rise, the higher the income level at which families were eligible for subsidies. But the probability would be significant even for families with income between 100 percent and 200 percent of the poverty level, who would be among the primary targets of a program to expand insurance; more than half of such families have employer-sponsored coverage.

Low-income workers would have an incentive to drop employment-based coverage for their family and obtain children's coverage through a federally subsidized program if, by so doing, they could increase their money wages. Employers with many low-income workers might be willing to adjust the composition of their workers' compensation packages accordingly.

To avoid such a response, most proposals would prohibit people from claiming subsidies or tax credits for insurance if they had been enrolled in an employer-sponsored plan within the previous year (or some other recent period) or if they were eligible for such coverage. But such provisions could be both costly and difficult to enforce, because verifying eligibility would be problematic. They would also raise questions of fairness. Some families who had chosen not to enroll in an employer-sponsored plan would be eligible for subsidies, whereas families with comparable income who had enrolled in their employer's plan would be ineligible.

Moreover, even if such "firewalls" could be successfully imposed in the short run, in the long run employers and low-income workers would change their behavior in response to the availability of federal funds in ways that the requirements could not prevent. For example, firms might transfer the jobs done by low-income employees to contractual workers who did not receive fringe benefits, and over time, increasing numbers might no longer offer family coverage.

Experience during the short existence of the health insurance tax credit (HITC), established by the Omnibus Budget Reconciliation Act of 1990, provides some insight into the way that families with insurance would probably respond to tax credits or subsidies. The HITC, which existed between 1991 and 1993, allowed taxpayers who qualified for the earned income tax credit (EITC) to claim an additional tax credit if they bought health insurance coverage for their children. The credit was 6 percent for earned income up to $7,125. Taxpayers with earned income between $7,125 and $11,275 could claim the maximum credit of $428, and the credit phased down to zero by an earned income of $21,250.

The credit was small, on average, paying for less than one-quarter of the taxpayer's share of a family health insurance premium. Hence, it was unlikely to provide much incentive for uninsured families to obtain coverage. The income of taxpayers who claimed the credit was 30 percent higher, on average, than that of other EITC recipients. Thus, claimants were primarily in the phaseout range of the credit, and their credit amounts were sufficiently small that it seems likely they would have purchased health insurance anyway.

Interactions Between a Subsidy or Tax Credit Program and Medicaid

The existence of a federally subsidized program of health insurance for children would give states an incentive to shift children out of Medicaid—for which they share responsibility with the federal government—into the new program. For example, states that provide Medicaid coverage to children in higher-income families than required by federal law might lower their income standards. To limit such responses, federal policymakers could consider requiring financial contributions from the states or maintenance of effort with respect to the existing Medicaid program in any proposal to expand health insurance coverage for children through a mechanism other than Medicaid.

Despite possible shifting by the states, however, the net effect of a subsidy or tax credit program would probably be to increase rather than decrease Medicaid enrollment. The reason is that many children applying for a new program would probably be among the 3 million uninsured children who are eligible for Medicaid at any point in time. Proposals would generally bar such children from participating in any new federally subsidized option, requiring them to obtain coverage from Medicaid instead. That requirement would mean that the states and the federal government would share the costs of covering those children.

How Much Would a Program Cost Per Participant?

The cost per child of expanding health insurance coverage would depend on which services were covered, the extent to which newly covered children used them, and

the cost of administering the program. Because proposals for expanding children's coverage would be voluntary, parents with less healthy children would be more likely to participate. Premiums are generally higher, however, the less healthy the population that is enrolled in a health plan. So if a policy goal is to keep premiums low in order to encourage parents to buy insurance for their children, limiting that type of adverse selection would be a priority in designing the program. Administrative costs would also vary according to the design of the program.

Costs per Child Under a Medicaid Expansion

If Medicaid expansions focused primarily on enrolling uninsured children who were already eligible, those children might actually cost less to insure than current enrollees. Because most poor children who are sick can enroll in Medicaid at any time, those who are eligible but are not enrolled may be healthier and use fewer health services than the ones who are enrolled. If that is indeed the case, states might be able to negotiate lower rates for such children with managed care plans. Whether children who enrolled under expanded eligibility requirements would be less costly than current enrollees is uncertain, however.

Expanding Medicaid to cover more children would entail relatively low administrative costs because the eligibility, enrollment, and provider contracting systems are already in place. But the additional outreach services that would be needed to enroll children who are now eligible could be costly.

Premiums Under Subsidy or Tax Credit Programs

Premiums for insurance purchased with subsidies or tax credits would depend on the covered benefits and on whether coverage was provided through individual policies or group plans.

Covered Benefits. Depending on the proposal, benefits for children might range from relatively costly packages, offering services similar to Medicaid's, to much leaner benefits, perhaps not even covering hospitalization. Benefit packages with higher cost-sharing requirements would generally be less costly than those with lower ones. But higher cost-sharing requirements would make health care less affordable for low-income families. Alternatively, a proposal that would expand coverage primarily through health maintenance organizations and other strictly managed health plans could provide comprehensive benefits more affordably.

Coverage Through Individual Policies or Group Plans. Proposals vary with regard to the type of coverage that would be eligible for subsidies or tax credits. Some proposals would subsidize only the purchase of special insurance policies for children. Others would allow families with access to employer-sponsored coverage to use subsidies or tax credits to help pay for that coverage.

The costs of special children's policies would depend on a variety of factors. Premiums might vary, for example, according to the age of the child. In addition, they would vary if policies covering more than one child were permitted. Allowing only single policies would increase the risk of adverse selection because families might choose to enroll only their less healthy children. How children's policies were marketed and purchased would also affect the probabilities of healthier or less healthy children enrolling, as well as the administrative costs of the program. Possibilities for marketing and purchasing include establishing a nonprofit or government organization to coordinate those functions, using the schools to group children together to buy insurance, or requiring insurance companies to sell children's policies in the individual market.

Selling policies through schools would provide a way to group mostly healthy children together to purchase health insurance, thereby reducing adverse selection and helping to keep premiums low. In effect, schools could serve the same grouping function for children that employers do for workers. Moreover, the costs of marketing the program through schools could be relatively low. The disadvantage of a school-based program, however, would be the fragmentation of a family's health insurance coverage that could result; not only parents but, presumably, preschool children would be ineligible, and those children might have to enroll in a different program.

By contrast, requiring families to buy insurance coverage for children in the individual market would reduce the probability that a generally healthy mix of children would enroll, and premiums would be correspondingly higher. Marketing costs would also be high because each family would be negotiating for health insurance on its own. Costs could be reduced, however, if a nonprofit or government organization existed to provide standardized information about health plans and to coordinate their purchase.

If families could use subsidies or tax credits to buy employment-based coverage, they would become part of their employer's group, and the employer would generally cover part of the insurance cost. But because many employers pay 60 percent or less

of a family premium, the employee's share might still be more than the cost of purchasing children's policies for one or two children. The advantage would be that parents as well as children would gain coverage, and they could all enroll in the same health plan.

Administrative Costs Under Subsidy or Tax Credit Programs

The costs of proposals using subsidies or tax credits would also depend on how complex they were to administer. All such proposals would have to develop mechanisms for establishing eligibility, determining subsidy or credit amounts, and giving those subsidies or credits directly to low-income families (perhaps in the form of vouchers) or to health plans and employers. The costs of those functions would vary among proposals.

Proposals that used the schools to administer subsidies, for example, could achieve considerable efficiencies by tying eligibility for the subsidies, as well as their amounts, to eligibility for subsidized meals (as occurs in Florida's Healthy Kids program). Parents could make payments directly to the school system, which could negotiate with health plans. By contrast, if families were able to use subsidies or tax credits to buy employment-based coverage, the agency administering those subsidies or credits might have to deal with thousands of employers, to verify both eligibility and the amount of the premium.

Any proposal using tax credits would have the advantage that the tax system provides a ready means for verifying income. But tax credits would also require low-income families who do not usually file tax returns to do so in order to obtain a credit. Moreover, experience with the EITC suggests that establishing a mechanism that would enable low-income families to receive a tax credit when they purchased health insurance would be difficult; very few families take advantage of the present option to receive their earned income credit in advance.

Conclusion

Most uninsured children live in families whose income is below 200 percent of the poverty level. Such children tend to have sporadic health insurance coverage, causing many of them to experience spells without coverage during the year. Thus, the potential target population of uninsured children could be significantly greater than the 10.5 million who lack coverage at any point in time.

Reducing the number of uninsured children significantly would require generous levels of direct subsidies or tax credits, and it would be difficult to prevent low-income children who would otherwise have private coverage from participating in such a generous program. The likelihood of their participation would increase as the income level at which families could qualify for federal assistance rose. As a result, the cost of a program to expand health insurance coverage for children would probably be considerably higher than the cost of covering only those children who would otherwise be uninsured.

An alternative approach to direct subsidies or tax credits would be to expand Medicaid to cover higher-income children, although that approach would also cause some children who would otherwise have private coverage to enroll in the program. Another way to lower the number of uninsured children would be to induce more children who were already eligible for Medicaid to enroll. However, achieving that outcome would require making major outreach efforts and, possibly, modifying the program to guarantee a minimum period of eligibility.

Appendix: Estimating How Many Children Are Uninsured

Because the health insurance status of many children, especially those in low-income families, is so volatile, the question of how many children are uninsured is not easy to answer. The number of children who are uninsured at any point in time, the number who are uninsured for the entire year, and the number who are uninsured sometime during the year differ considerably. Understanding what different estimates of the number of uninsured children actually measure is important in evaluating the costs and effects of proposals to expand coverage for children. But unfortunately, people who respond to the national sample surveys from which analysts derive estimates of insurance status appear to interpret questions about their health insurance in ways that make distinguishing among the different measures difficult. Determining people's potential eligibility for such programs as Medicaid is also difficult, because family incomes fluctuate over time in ways that surveys may not be designed to track.

Analysts at CBO use two national sample surveys from the Bureau of the Census to estimate rates of health coverage: the annual March supplement to the Current

Population Survey (CPS) and the Survey of Income and Program Participation (SIPP). Data from the CPS present a relatively current snapshot of children's health insurance status, whereas the SIPP data illuminate the transitions in insurance status that children experience over time. Because of underreporting of health insurance coverage, especially of Medicaid, both surveys probably underestimate health insurance coverage to some degree.

The CPS produces timely estimates of insurance coverage each year. The current widely quoted estimates of 10.5 million uninsured children under age 19, of whom at least 3 million are eligible for Medicaid, come from the March 1996 CPS. But analysts disagree on how to interpret those estimates. Some believe that they refer to children who were uninsured throughout 1995, which is the information that the survey intends to obtain. Other analysts, including those at CBO, believe that people's responses to the CPS questions produce estimates that reflect the number of children who were uninsured at a point in time, rather than for the full year.

The SIPP data support that interpretation. Although the SIPP is less timely than the CPS, it is a longitudinal survey that tracks the insurance status of a sample of children over time. Thus, analysts can determine how many children were uninsured for the whole year and how many were uninsured for part of the year. The most recent survey to track respondents for up to 33 months covered 1992 through part of 1994. CBO's preliminary analysis of that survey indicates that in 1993, about 13.5 percent of children were uninsured at any point in time. That estimate corresponds closely to the March 1993 CPS estimate of 13.1 percent. The SIPP data also indicate that 6.5 percent of children were insured throughout 1993 and a further 15.5 percent were uninsured for some part of the year.

Chairman THOMAS. Thank you very much, Dr. Bilheimer.

Mr. Purcell.

STATEMENT OF PATRICK J. PURCELL, ANALYST, EDUCATION AND PUBLIC WELFARE DIVISION, CONGRESSIONAL RESEARCH SERVICE

Mr. PURCELL. Good morning, Mr. Chairman and Members of the Subcommittee.

My name is Patrick Purcell. I am an Analyst in the Education and Public Welfare Division of the Congressional Research Service.

In the copies of my written testimony, you will find some charts illustrating the points I will be discussing, but in the interest of brevity, I will not refer directly to these charts in my remarks this morning.

Chairman THOMAS. The same request would be made, if you would talk directly into the microphone. They are very unidirectional, and it is hard to pick it up.

Mr. PURCELL. Surely.

In announcing today's hearing, Mr. Chairman, you stated that the Subcommittee would focus on identifying the reasons why some children do not have health insurance coverage and the impact that lack of insurance has on their access to health care services.

As you know, most of the 70 million children in the United States are covered by some form of health insurance, either public or private. More than 6 out of 10 are covered by private health insurance plans, and almost one-quarter are covered by the Medicaid Program. In any given month, however, between 9 and 10 million children have no health coverage.

I would like to use my time before the Health Subcommittee today to describe some of the employment and income characteristics of the families of uninsured children, which may explain in

part why they do not have access to the private health insurance system that covers the majority of Americans.

First, however, it is important to note that an estimated 3 million uninsured children are eligible for coverage under the Medicaid Program but are not enrolled. The reasons that some parents or guardians do not enroll their eligible and otherwise uninsured children in the Medicaid Program are not yet well understood, but anecdotal evidence suggests that lack of knowledge about their children's eligibility for Medicaid, failure of the parent or guardian to supply required information during the enrollment process, and a welfare stigma that some families associate with the Medicaid Program may all contribute to eligible children remaining uninsured.

Although one-third of uninsured children may be eligible for Medicaid, most are not. Data from the Census Bureau, however, indicate that nearly 60 percent of uninsured children are members of families in which one parent is employed year round full time. Another 20 percent are in families with a parent who is employed part time.

That so many uninsured children are members of working families is significant because employers are the predominant source of health insurance coverage in the United States today. In 1995 more than 70 percent of the U.S. population under the age of 65 was covered by private health insurance, and most of those who were covered by these plans were insured through their own employer or that of a family member.

To understand why nearly 10 million children lack health insurance when most of them are the children of working parents, we need to ask why these workers are themselves unemployed. To address this question, the Congressional Research Service has been examining data collected by the Bureau of the Census and the National Center for Health Statistics.

We used data from two national household surveys, the Current Population Survey and Health Interview Survey, to find some of the key employment, income, and demographic characteristics that distinguish working heads of families who are uninsured from working family heads who are covered by private health insurance.

In an average month during 1994, an estimated 6.3 million heads of families were employed either full time or part time but had no health insurance coverage. About three-fourths of these families included children. These family heads were predominantly young, working for small firms in the service sector or in retail or wholesale trade, and had family incomes that were lower than the national average.

For example, in 1994 nearly half of employed, uninsured family heads were under the age of 35, compared with just one-quarter of employed family heads that were covered by private health insurance. Half of all employed, uninsured family heads worked in firms with fewer than 25 employees, while just 21 percent of employed and privately insured family heads worked for firms of this size. And finally, 60 percent of employed, uninsured family heads had family incomes of less than $30,000. In contrast, among those that were employed and privately insured, only 16 percent had family incomes below $30,000.

Most of the working family heads who are without health insurance during any given month have been uninsured for a significant period of time. In 1994 more than half of the working family heads who were without health insurance in a given month reported that they either had been last insured more than 3 years ago, or that they had never been insured. Just 15 percent said they had been covered by health insurance within the past year.

Among working but uninsured family heads who had lost health insurance coverage some time within the last 3 years, one-half said that the reason they had stopped being covered was either because they had lost a job or had changed jobs. The recently enacted Health Insurance Portability and Accountability Act may help reduce loss of insurance coverage caused by changing jobs, but those that lost insurance as a result of a job change still represented only one-sixth of employed, uninsured family heads in 1994.

Although most Americans have health insurance coverage through their own employment or that of a relative, acquiring health insurance through employment is possible only when this benefit is offered as part of the compensation package. It is important to note, therefore, that in the 1994 Health Interview Survey, 70 percent of working, uninsured family heads reported that health insurance coverage was not offered at their place of employment.

Nevertheless, even though most employed but uninsured family heads reported that health insurance coverage was not available through their employers, only 1 in 10 cited the lack of an employment-based plan as the main reason they were uninsured. More than 60 percent, on the other hand, said it was the high cost of health insurance that was the primary reason they were not covered.

Finally, data from the Health Interview Survey also show that 1.3 million working, uninsured family heads were offered health insurance at their place of employment but declined that coverage. Of this number, two-thirds said that the cost of the insurance was at least one of the reasons they did not accept it.

In 1994 almost one out of every six families with a working but uninsured head reported they had spent nothing for medical care in the previous 12 months. Among working families with private health insurance, only 1 in 12 reported no spending for medical care. Moreover, this disparity in the proportion of families with no medical expenditures is not explained by differences in either family size or the age of the family head.

While working uninsured family heads were more likely to have zero medical expenses, families in both groups were about equally likely to have reported medical expenses exceeding $500. In both cases, about one-third of the families had expenses in this amount.

One possible explanation for uninsured families having a greater likelihood of zero expenditures than insured families but an equal likelihood of expenditures exceeding $500 is that they are more price sensitive than insured families with respect to small medical expenses that they might consider discretionary. When serious illness or injury occur, however, medical expenses are not easily avoided, so that relatively large expenses occur among both insured and uninsured families with similar frequency.

Because of the disparity in family incomes, however, a given medical expense would account for about twice the share of average family income among employed but uninsured family heads as it would among those covered by private health insurance.

In summary, most uninsured children are the dependents of working parents, but their parents tend to be employed in small firms that do not offer health insurance coverage. Moreover, the average income of these families is substantially lower than that of families that are covered by private health insurance.

Finally, about one-third of all uninsured children are eligible for, but not enrolled in, the Medicaid Program. While Medicaid would pay most of the medical expenses of these children if they were to become seriously ill, failure to enroll may diminish their access to primary and preventive health care services.

That concludes my remarks, Mr. Chairman. I would be happy to answer any questions.

[The prepared statement and attachments follow:]

Statement of Patrick J. Purcell, Analyst, Education and Public Welfare Division, Congressional Research Service

In announcing today's hearing, Mr. Chairman, you stated that the Subcommittee would focus on trying to identify the reasons why some children do not have access to health insurance coverage, and the impact that this lack of insurance has on their access to health care. As you know, most of the 70 million children in the United States are covered by some form of health insurance, either public or private. More than 6 out of 10 are covered by private health insurance plans, and almost a quarter are covered by the Medicaid program. In any given month, however, between 9 and 10 million children have no health insurance coverage. I would like to use my time before the Subcommittee today to describe some of the employment and income characteristics of the families of uninsured children, which may explain in part why they do not have access to the private health insurance system that covers the majority of Americans.

Before addressing the issue of access to private health insurance coverage, I would like to note that, according to information from the Census Bureau's Current Population Survey, an estimated 3 million uninsured children are eligible for coverage under the Medicaid program but are not enrolled. The reasons that some parents or guardians do not enroll their eligible and otherwise uninsured children in the Medicaid program are not yet well understood, but anecdotal evidence suggests that lack of knowledge about their children's eligibility for Medicaid, inability of the parent or guardian to supply required information during the enrollment process, and a "welfare stigma" that some families associate with the Medicaid program may all contribute to eligible children remaining uninsured.

While up to a third of uninsured children may be eligible for Medicaid, data from the Census Bureau indicate that nearly 60% of uninsured children are members of families in which at least one parent is employed year-round, full-time, and another 20% are in families with a parent who is employed part-time. That so many uninsured children are members of working families is significant because employers are the predominant source of health insurance coverage in the United States. In 1995, more than 70% of the U.S. population under age 65 was covered by private health insurance, and more than 90% of those who were covered by these plans were insured through their own employer or that of a family member.

To understand why nearly 10 million children lack health insurance when most of them are the children of working parents, we need to ask why these workers are themselves uninsured. To address this question, the Congressional Research Service has been examining data collected by the Bureau of the Census and the National Center for Health Statistics. We used data from two national household surveys—the Current Population Survey and the National Health Interview Survey—to find some of the key employment, income, and demographic characteristics that distinguish working heads of families who are uninsured from working family heads who are covered by private health insurance.

AGE, INDUSTRY OF EMPLOYMENT, AND FAMILY INCOME OF EMPLOYED, UNINSURED FAMILY HEADS

In an average month during 1994, an estimated 6.3 million heads of families were employed either full-time or part-time but had no health insurance coverage, either public or private.[1] These family heads were predominantly young, working for small firms in the service sector or in retail or wholesale trade, and their families had incomes that were lower than the national average. For example, in 1994:

- 48% of employed, uninsured family heads were under age 35. (Figure 1)
- 51% of employed, uninsured family heads worked in firms with fewer than 25 employees. (Figure 2)
- 56% of employed, uninsured family heads worked in wholesale or retail trade or in business, personal, or professional services. (Figure 3)
- 39% of employed, uninsured family heads had family incomes of less than $20,000, and 60% had incomes below $30,000. (Figure 4)

Figure 1: Age Distribution of Employed, Uninsured Family Heads

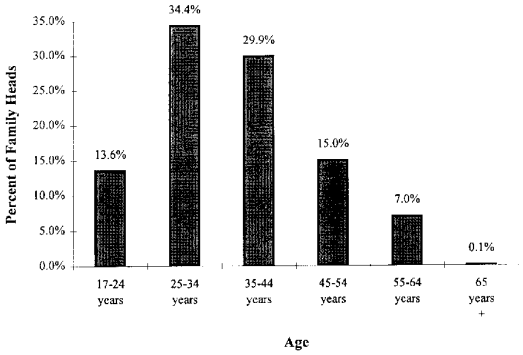
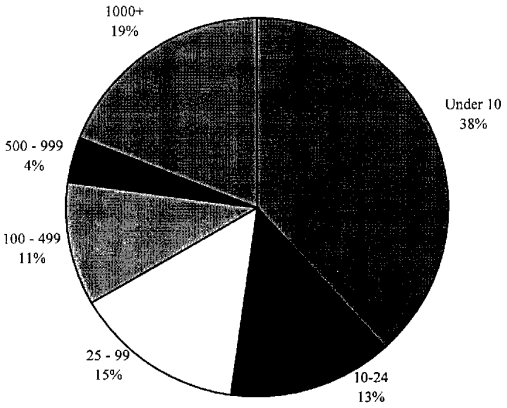


Figure 2. Size of Firm (Number of Employees) Employed, Uninsured Family Heads



Source: Bureau of the Census and National Center for Health Statistics.

Total = 6.3 million family heads.

[1] This figure includes 4.5 million employed, uninsured heads of families with children and 1.8 million employed, uninsured persons with a spouse but without children. (CRS analysis of data from the Current Population Survey).

Figure 3: Industry of Employed, Uninsured Family Heads

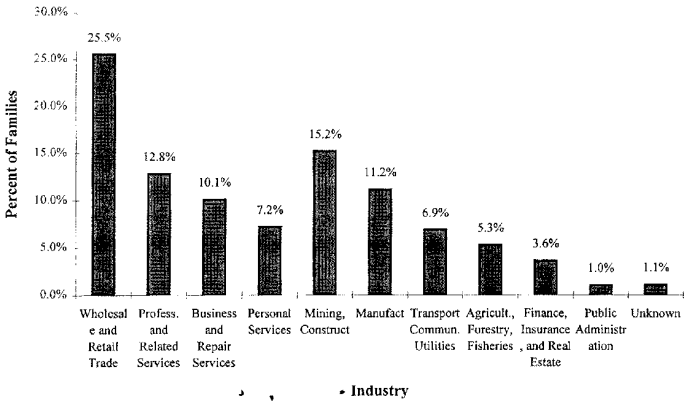
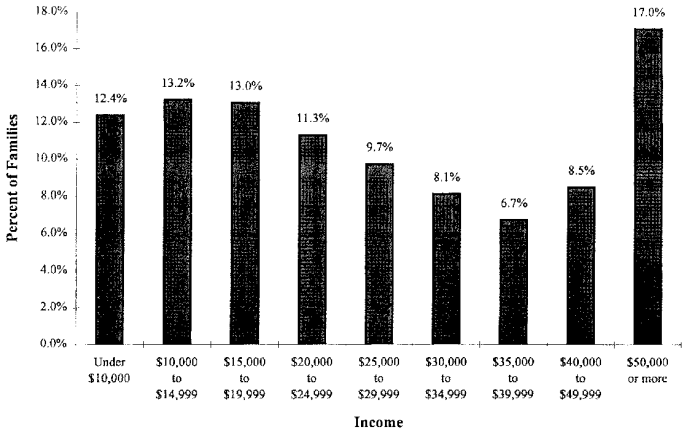


Figure 4: Family Income of Employed, Uninsured Family Heads



Source: Bureau of the Census and National Center for Health Statistics.

Total = 6.3 million family heads.

Length of Time Since Last Insured (Figure 5)

Most of the working family heads who are without health insurance coverage *during any given month* have been uninsured for a significant length of time. In 1994, 55% of the working family heads who were without health insurance in an average month reported that they had either last been insured more than 3 years ago or that they had never been insured. Only one-third reported that they had been insured some time in the last 3 years, and just 15% said that it had been less than a year since they were last covered by health insurance.

REASONS THAT PREVIOUS INSURANCE COVERAGE STOPPED (FIGURE 6)

Among working but uninsured family heads who had lost their health insurance coverage some time within the last 3 years, half said that the reason they stopped being covered by insurance was either because they had lost a job or because they changed jobs. No other single reason cited for loss of health insurance coverage accounted for as much as 10% of all responses to this question. The recently enacted Health Insurance Portability and Accountability Act (P.L. 104–191) may help reduce loss of insurance coverage caused by changing jobs, but those who lost insurance as a result of changing or losing a job still represented only one-sixth of all employed, uninsured family heads in 1994.

Figure 5: Length of Time Since Last Covered by Insurance

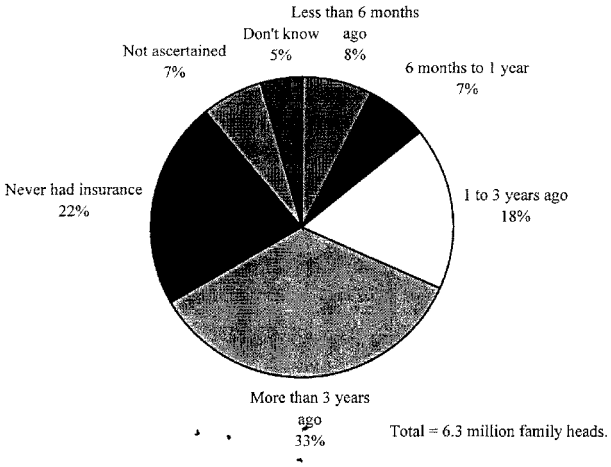
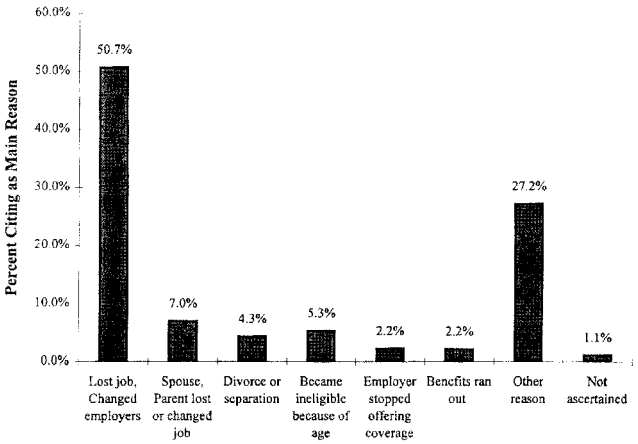


Figure 6: Main Reason Health Insurance Stopped



Source: National Center for Health Statistics 1994 Health Interview Survey.

Total = 2 million family heads who lost health insurance.

Reasons Unable to Find Insurance Coverage (Figure 7)

About one-third of the 2 million working but uninsured family heads who had lost their health insurance coverage within the last 3 years reported that they subsequently sought an alternative source of health insurance but were unable obtain coverage. By far the most commonly cited reason for being unable to regain health insurance coverage—mentioned by more than four-fifths of those responding to this question—was that they could not afford to purchase it. Seven percent of those who sought alternative coverage reported that they were turned down due to ill health or other risk factors.

Reasons Cited for Being Currently Uninsured

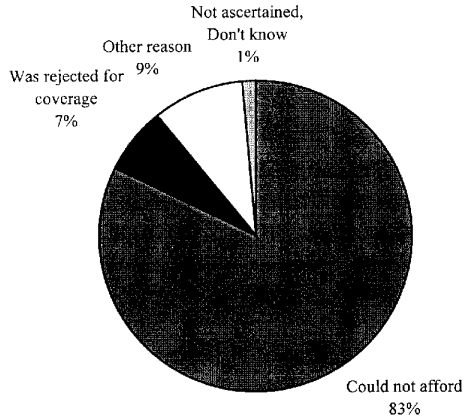
Although most Americans have health insurance coverage through their own employment or that of a relative, acquiring health insurance through one's employer is possible only when this benefit is offered as part of an employee's compensation package. It is important to note, therefore, that in the 1994 National Health Interview Survey, 70% of working, uninsured family heads reported that health insurance coverage was not offered at their place of employment. (Figure 8)

Even though 7 out of 10 employed but uninsured family heads reported that health insurance coverage was not available through their employers, only 11% cited the lack of an employment-based plan as the main reason that they were uninsured. More than 60%, on the other hand, said that the high cost of health insurance was the primary reason that they were not covered by health insurance, which may indicate that they would have purchased health insurance on their own if they had considered it worthwhile to do so. (Figure 9)

Even among uninsured family heads who said that they were not offered health insurance at their place of employment, more than twice as many cited the high cost of insurance as the main reason they were uninsured as said that it was because they could not get coverage where they worked.

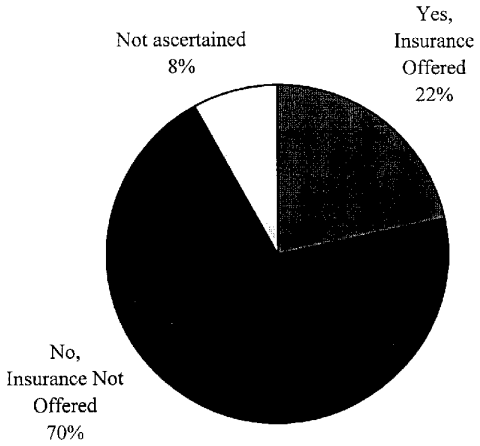
Finally, out of 1.3 million working, uninsured family heads who were offered health insurance at their place of employment but who declined that coverage, two-thirds said that the cost of this insurance was among the reasons that they declined to be covered. (Figure 10)

Figure 7: Reason Unable to Find Health Insurance



Total = 6.3 million employed, uninsured family heads.

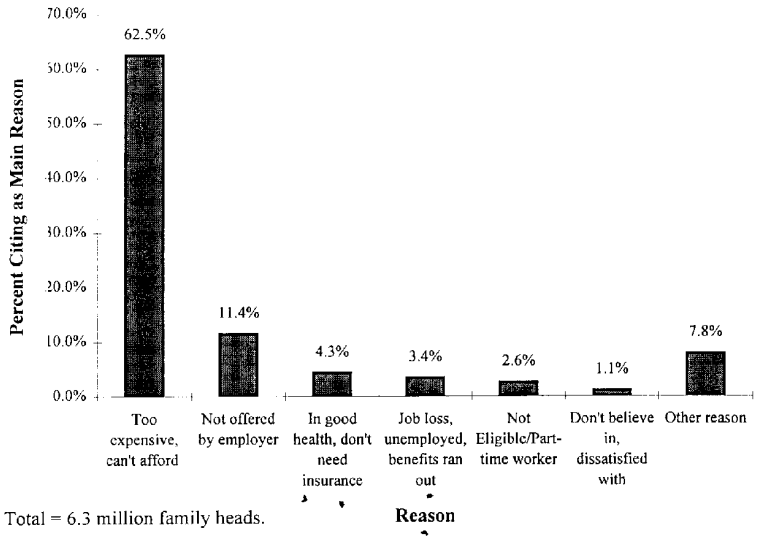
Figure 8: Is Health Insurance Offered by Employer?



Total = 740,000 employed family heads who lost health insurance coverage in last 2 years and sought other coverage.

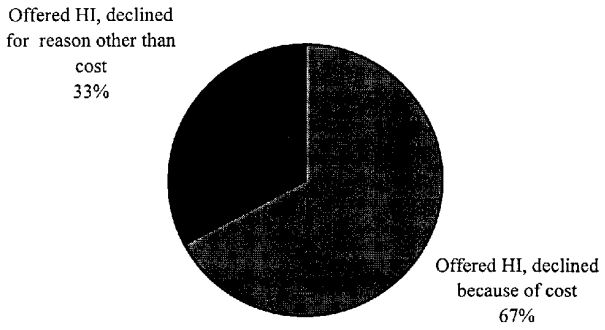
Source: National Center for Health Statistics
1994 Health Interview Survey.

Figure 9: Main Reason Not Covered by Health Insurance



Total = 6.3 million family heads.

Figure 10: Percent of Family Heads Offered HI at Work Who Said They Declined it Because of Cost



Total = 1.3 million employed, uninsured family heads who were offered HI at work.

Source: National Center for Health Statistics
1994 Health Interview Survey.

AMOUNT SPENT ON HEALTH CARE IN PREVIOUS 12 MONTHS (FIGURE 11)

Fifteen percent of families in which the head was employed but uninsured reported zero expenditures for medical care in 1994. This is twice the rate at which families where the head was both employed and insured reported no expenditures for medical care. If the higher proportion of uninsured family heads with no medical expenses had been due to the uninsured family heads being younger than their privately insured counterparts or from having fewer children than the family heads who were privately insured, then we would expect the difference in these proportions to diminish significantly once we controlled for the effects of age and family size. In fact, however, even when we adjust for size of family and age of the family head, families with an employed but uninsured head were still about twice as likely as those in which the head was employed and privately insured to have reported no medical expenses during the previous year.[2]

While working uninsured family heads were more likely than family heads who were working and privately insured to have reported zero medical expenses, they were almost as likely as privately insured family heads to have had incurred medical expenses of $500 or more. In both groups, about one-third of the families reported out-of-pocket medical expenses of $500 or more in the preceding 12 months. One possible reason for uninsured family heads to have a greater likelihood of zero expenditures than insured family heads, but an almost equal likelihood of an expenditure exceeding $500 is that they are more price-sensitive than insured family heads with respect to small medical expenses that might be considered discretionary. When serious, illness or injury occur, however, medical expenses are not easily avoided, so that relatively large expenses occur in insured and uninsured families with similar frequency.

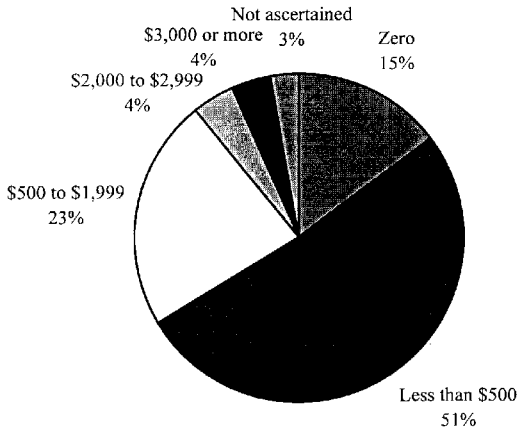
Because of the disparity in family income between the uninsured and the insured, however, medical expenses account for about twice the share of income for families with an employed but uninsured head as they do in families where the head is both employed and covered by private health insurance.

This concludes my presentation, Mr. Chairman. I would be happy to answer questions.

[2] Adjusted for age, the ratio of employed uninsured family heads to employed privately insured family heads who reported zero medical expenditures in the previous twelve months was 1.83/1. Adjusted for family size, the ratio was 1.95/1. In these tabulations, medical expenditures exclude spending for nonprescription drugs and insurance premiums for those with insurance.

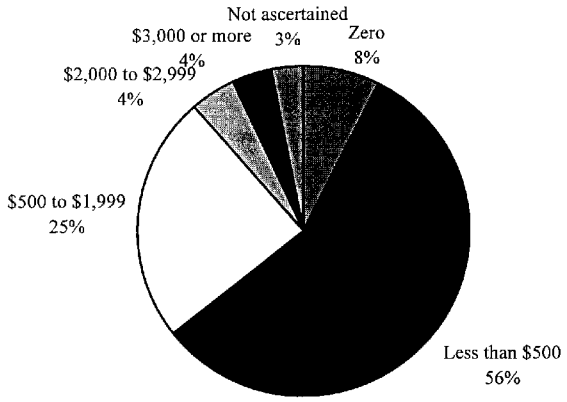
Figure 11: Amount Spent on Medical Care in Last 12 Months

Families with Employed, Uninsured Head



Total = 6.3 million employed, uninsured family heads.

Families with Employed, Privately Insured Head



Total = 37 million employed, privately insured family heads.

Source: National Center for Health Statistics
1994 Health Interview Survey.

Chairman THOMAS. Thank you, Patrick.
Dr. Scanlon.

STATEMENT OF WILLIAM J. SCANLON, DIRECTOR, HEALTH FINANCING AND SYSTEMS ISSUES, HEALTH, EDUCATION AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE

Mr. SCANLON. Thank you, Mr. Chairman and Members of the Subcommittee. I am pleased to be here today as you consider the question of health insurance coverage for children.

My remarks are drawn from a number of recently issued GAO reports on trends in the private sector and Medicaid coverage for children, including shifts in employers' commitments to family coverage and the experiences of innovative State and local programs to insure children.

Over the last several years, we have seen a continuing deterioration in the extent of private coverage accompanied by a sharp rise in the number of children on Medicaid.

Between 1989 and 1995, the percentage of children covered by private plans fell 11 percent. Without that decline, an additional 5 million children would have been privately insured at some time during 1995. Declines in private insurance coverage have been widespread, affecting both adults and children. However, children have been affected more, as 70 to 90 percent of the decline involved dependent coverage.

Many employers, responding to several years of double-digit increases in health insurance costs, have restructured their health plans to gain more control over costs. Workers, on average, are required to pay higher shares of premium costs, and workers' costs for family coverage have increased more sharply than costs of single coverage.

Other steps taken by employers to limit costs may also discourage acquisition or retention of family coverage. They include: Providing alternative benefits or incentives to workers who choose employee-only coverage or who obtain family coverage through their spouse; refusing to cover a spouse if the spouse has other health insurance; imposing a surcharge for working spouses covered as dependents; refusing to provide dependent coverage unless the employee is the family's primary wage earner.

Mr. Chairman, I would note that in our testimony we did not address the issue of tax preferences for health insurance, but in this context, employers are clearly acting in terms of appealing to employees' rationale in trying to maximize their benefits at minimum cost.

Given that our tax preferences are neutral in terms of whether or not they encourage family coverage, it may be possible to restructure them in a way that would encourage employers to maintain more support for family coverage. That would deal with the potential 5 million employees who currently work for firms who offer no family coverage, as well as some of these firms that have reduced their support for family coverage. It does not, though, ad-

dress the 18 million workers who are working for firms that offer no health insurance.

While we have seen these deteriorations in private coverage and expanded Medicaid eligibility, States, localities, and private organizations have all developed innovative programs to offer subsidized coverage to uninsured children that would not qualify for Medicaid.

In 1996 9 States had State and locally funded programs and 24 States had privately funded programs. In reviewing six of these State or privately funded programs, we found they could provide potentially useful lessons for future efforts to insure children. For example, unlike State Medicaid Programs which operate as open-ended entitlements, the programs cap enrollments and, if necessary, maintain waiting lists to stay within their fixed budgets that were provided by revenues from taxes, grants, and donations. These waiting lists generally operated, however, on a first-come, first-served basis without establishing priorities based on service needs.

All six programs we reviewed required at least some of the families to share in the cost through premiums, and some programs also required copayments for certain services such as prescription drugs and eyeglasses. The family's premium share increased as their income increased. In all programs, the lowest income children paid no premium or a very heavily subsidized premium. Two of the programs allowed children of any income to join, but families with higher incomes were responsible for paying the full premium costs.

While all six programs covered basic preventive and outpatient services, some limited other services such as hearing, vision, dental, and mental health care. Some, particularly the private funded programs, also limited inpatient care. They sometimes did so anticipating that children would qualify for Medicaid if they needed more extensive care.

All of the programs worked extensively to reach families of uninsured children. One program worked through the schools, which allowed them to most easily reach their target group, school-aged children.

Other outreach efforts included dedicated hotlines, television and radio ads, bus billboards, fast-food restaurant tray liners, and presentations provided at churches and other community locations. To encourage enrollment, two of the programs used sports and television personalities as spokespersons.

These outreach efforts served not only to identify children eligible for their programs, they also identified children eligible for Medicaid and channeled them into that program.

The programs were also developed to be easily administered. Most operated at least partially through nonprofit or private insurers, which enabled the programs to use existing provider payment systems and physician networks, guaranteeing patient access to providers. Each of the six programs developed simplified enrollment procedures and took specific steps to avoid the appearance of a welfare program.

In conclusion, let me say that the recent erosion in private coverage has left many children without insurance and has created interest in expanding coverage. However, efforts to expand coverage for children need to be developed in ways that do not supplant ex-

isting private insurance. In addition, Medicaid's potential should not be ignored, as many uninsured children are eligible for Medicaid but do not enroll. Outreach strategies developed by State and private programs could guide State efforts to reach such children.

Other innovative elements in the State and private programs, such as sliding-scale premiums and cost sharing for program enrollees, should be considered in efforts to cover more uninsured children while controlling costs. However, adopting strategies like limiting inpatient care, on the premise that other funding may be available, may not provide the range of coverage children need.

Mr. Chairman, that concludes my statement. I would be happy to answer any questions you have or Members of the Subcommittee have.

Thank you.

[The prepared statement and attachments follow:]

Statement of William J. Scanlon, Director, Health Financing and Systems Issues, Health, Education, and Human Services Division, U.S. General Accounting Office

Mr. Chairman and Members of the Committee:

I am pleased to be here today to discuss recent changes in health insurance coverage and the effect of these changes on children. Without health insurance, many families face difficulties getting preventive and basic health care for their children. Children without health insurance are less likely to have routine medical and dental care, establish a relationship with a primary care physician, and receive immunizations or treatment for injuries and chronic illnesses. Recognizing the importance of health insurance for children, Members of the House and Senate and the administration have proposed expanding children's health insurance coverage—either through grants to the states, refundable tax credits, vouchers, or other means.

My remarks today will focus on three points: (1) recent trends in children's health insurance coverage, particularly in employment-based coverage; (2) the increasing role of Medicaid in insuring children and possible interactions with private insurance; and (3) some small-scale but innovative state and private efforts to provide coverage for uninsured children. These remarks summarize findings from previous GAO work, based on our analysis of the Bureau of the Census March Current Population Surveys for health insurance coverage in 1989 and 1995 and information from the Census on trends in coverage from 1987 through 1995; other public and private surveys, such as a survey conducted by KPMG Peat Marwick on employer health insurance; interviews with experts, insurance company executives, and benefits consultants; current research on health insurance issues; and case studies of state and private programs that insure children. (A list of GAO products related to this issue appears at the end of this statement.)

In summary, we found that while most children have health insurance, almost 10 million children lack insurance. Between 1989 and 1995, the percentage of children with private coverage declined significantly—part of an overall decline in coverage of dependents through family health insurance policies. Increases in the cost of providing health insurance have prompted many employers to take steps that discourage or limit dependent coverage, such as raising premiums or providing incentive payments to employees who refuse family coverage. This erosion in employer support for health insurance has contributed to the increasing number of children in working families without private health insurance.

As these reductions in private coverage were occurring, Medicaid eligibility for children expanded. These expansions helped to cushion the effect of the loss of private coverage, but they also may have contributed to some further reductions in private coverage. Families respond to the availability of public coverage differently. While some families may have been induced to drop private coverage to gain Medicaid for their children, others may not have taken advantage of the program. Indeed, almost 3 million Medicaid-eligible children remain uninsured.

A number of states, in conjunction with local governments, and private entities have developed children's insurance programs that differ significantly from Medicaid. Some of these public/private efforts may prove instructive in developing future strategies for insuring children. For example, by targeting their outreach efforts, the programs have been able to identify uninsured children—some of whom are eligible for Medicaid. In addition, the programs have developed service packages based on preventive care and required parents to assume some of the insurance cost through premium contributions and copayments for specific services. Such strategies have helped to stretch program dollars and provide needed health care to more children.

THE DECLINE IN PRIVATE HEALTH INSURANCE COVERAGE HIT CHILDREN HARDER AS EMPLOYER FINANCIAL SUPPORT DECREASED

Between 1989 and 1995, private family insurance coverage declined for both children and working-age adults. Most of the decline was for the dependents of workers—most dramatically for children. During this period, the percentage of children with private health insurance dropped from 74 percent to 66 percent. Had this decrease not occurred, nearly 5 million more children would have had private health insurance.

Eroding employer financial support for providing health insurance to employees' families has contributed to the overall decline in private insurance coverage. The vast majority of privately insured children are covered under their parents' employment-based health care plans.[1] But as health insurance premiums reached 10 percent of employers' payroll costs, many employers began to reconsider the amount of employee insurance—particularly family coverage—that they would support. The health insurance cost to employers for a worker who does not elect family coverage is less than half the cost of family coverage. As a result, firms are considering a variety of ways to control the cost of coverage—particularly family coverage.

There was a slight decrease in the proportion of workers whose employers sponsored health insurance between 1988 and 1993. The decrease was more pronounced among those working in small firms—13 percent fewer people working for firms with fewer than 10 employees had employers who sponsored coverage. Even if an employer sponsors a plan, it may not cover family members. In 1993, almost one-quarter of the workforce could not get family coverage at work. Over 18 million workers were employed by firms that did not sponsor coverage at all, and more than 5 million workers worked for firms that sponsored coverage for workers, but not family members.

Most employers that offered coverage raised employee premium contributions significantly—especially for family coverage. In large firms with 100 or more employees, average monthly premium contributions increased 79 percent for family coverage compared with 64 percent for single coverage between 1988 and 1993. A Hewitt Associates analysis of benefits offered by a group of major firms with 1,000 or more employees showed that median monthly premium contributions for family indemnity coverage increased 64 percent between 1990 and 1995, whereas median monthly premium contributions for employee-only indemnity coverage increased 47 percent.

In addition to increasing premium contributions, employers are increasingly turning to other options in their benefit design to limit their costs. These options may discourage family coverage but may also result in employers of two-income families sharing in the cost of coverage and avoiding the cost of duplicate coverage. These options include

—providing alternative benefits or incentives to workers who choose employee-only coverage,

—providing financial incentives to employees who obtain family coverage through their spouse,

—refusing to cover a spouse if the spouse has other health insurance,

—imposing a surcharge for working spouses covered as dependents,

—refusing to provide dependent coverage unless the employee is the family's primary wage earner, and

—changing premium structures so that larger families pay higher premiums.

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[1] For information on the structure of the private market for individual coverage, see *Private Health Insurance: Millions Relying on the Individual Market Face Cost and Coverage Trade-Offs* (GAO/HEHS–97–8, Nov. 25, 1996).

EXPANDED MEDICAID COVERAGE OFFSET MUCH OF THE DECLINE IN PRIVATE COVERAGE FOR CHILDREN

Between 1989 and 1995, the number of children in the United States increased by almost 7 million, but the number of children with private health insurance coverage remained virtually unchanged. During this same period, Medicaid eligibility for children expanded so that poor and near-poor children under age 12 became eligible,[2] and enrollment increased by 6 million children. Despite the growth in Medicaid, the number of uninsured children grew by more than 1 million—reaching almost 10 million uninsured children by 1995.

There is considerable debate about the extent to which expanding Medicaid eligibility contributed to the decline in the percentage of children who had private coverage. For example, one study suggests that as much as one-sixth of the overall decline in the proportion of people with private coverage may have occurred because families dropped their insurance to enroll children and pregnant women in Medicaid.[3] However, other studies found a lesser effect or no effect at all.[4]

Regardless, the studies indicate that, at most, one-sixth of the loss in private coverage stems from families' choosing to substitute Medicaid for private coverage. Consequently, had Medicaid eligibility not been expanded, the number of uninsured children would probably have been even greater.

Moreover, Medicaid expansions could have reduced the number of uninsured children even more, but many uninsured children who are eligible for Medicaid do not enroll. In 1994, almost 3 million Medicaid-eligible children lacked health insurance. Our previous work and that of other researchers points out several reasons families do not enroll their eligible children in the Medicaid program. Some low-income families are unaware that their children may be eligible for Medicaid, and some are stymied by the complexity of the enrollment process. Moreover, some families may not consider health coverage necessary until a child experiences a medical crisis. The stigma associated with participation in a publicly funded health insurance program can also deter some families.

While states have developed Medicaid outreach programs, their past outreach efforts focused more on encouraging use of preventive care by current participants than on encouraging new enrollment. The Health Care Financing Administration and the Health Resources and Services Administration are in the preliminary stages of developing a more aggressive outreach program for potential Medicaid beneficiaries.

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[2] Beginning in 1986, the Congress passed a series of laws that expanded Medicaid eligibility for pregnant women on the basis of family income and eligibility for children on the basis of family income and age. Before these eligibility expansions, most children received Medicaid because they were enrolled in Aid to Families with Dependent Children. Starting in July 1989, states were required to expand coverage for pregnant women and infants with family incomes at or below 75 percent of the federal poverty level. Two subsequent federal laws further expanded mandated eligibility for pregnant women and children. By July 1991, states were required to cover (1) pregnant women, infants, and children up to age 6 with family income at or below 133 percent of the federal poverty level and (2) children 6 years old and older born after September 30, 1983, with family income at or below 100 percent of the federal poverty level.

[3] See David M. Cutler and Jonathan Gruber, *Does Public Insurance Crowd Out Private Insurance*? Working Paper No. 5082 (Cambridge, Mass.: National Bureau of Economic Research, Apr. 1995).

[4] See Lisa Dubay and Genevieve Kenney, *Revisiting the Issues: The Effects of Medicaid Expansions on Insurance Coverage of Children* (Washington, D.C.: The Urban Institute, Oct. 1995); Lara D. Shore-Sheppard, "Stemming the Tide? The Effect of Expanding Medicaid Eligibility on Health Insurance Coverage," unpublished draft, Nov. 1995; Lara D. Shore-Sheppard, "The Effect of Expanding Medicaid Eligibility on the Distribution of Children's Health Insurance Coverage," paper presented at the Cornell/Princeton Conference on Reforming Social Insurance Programs, May 1996; and Esel Y. Yazici, "Medicaid Expansions and the Crowding Out of Private Health Insurance," paper presented at the 18th Annual Research Conference of the Association for Public Policy Analysis and Management, Pittsburgh, Pa., Nov. 2, 1996.

States, Localities, and Private Organizations Have Created New Strategies To Insure Children

While many states expanded Medicaid beyond federal requirements to cover more uninsured children, a few developed innovative programs to offer subsidized coverage apart from Medicaid. By 1996, 9 states had state-and locally funded programs, and 24 states had privately funded programs. While most of these programs are small in scale, they do provide important lessons regarding program design characteristics.

In earlier work that we conducted on six of these state-funded or privately funded programs in five states,[5] we found that while the programs' approaches varied significantly, they shared some common characteristics. In some ways, they differed strikingly from Medicaid.

—Unlike state Medicaid programs, which operate as open-ended entitlements, all the programs capped enrollment to stay within their fixed budgets. The state programs' funding came from state general revenues; dedicated shares of specialized taxes, such as tobacco taxes or health care provider taxes; local tax revenue; and grants and donations from foundations and other private-sector entities. The private programs raised money through private donations, many with considerable support from Blue Cross/Blue Shield organizations.

—All of the programs we visited were designed to augment the existing range of coverage options by covering uninsured children not eligible for Medicaid. Two of the programs allowed children of any income to join, but families with higher incomes were responsible for paying full premium costs.

—All six programs required at least some of the families to share in the costs of coverage through premiums and copayments—with the families' share increasing as income increased. For example, Pennsylvania's Children's Health Insurance Program charged nothing for children in families with income below 185 percent of the federal poverty level and charged $29 to $34 per month per child for children in families with income between 185 and 235 percent of the federal poverty level. All programs heavily subsidized premiums for the lowest-income children—ranging from charging families nothing to charging $10 per child per month for children with family income at or below 130 percent of the federal poverty level. In every program, most children received the maximum subsidy. (See app. I.)

[5] We visited the Alabama Caring Program for Children, the Western Pennsylvania Caring Program for Children, Pennsylvania's Children's Health Insurance Program, New York's Child Health Plus Program, the Florida Healthy Kids Program, and MinnesotaCare. MinnesotaCare began as a state-funded program, but Medicaid began to fund children participating in the program as of July 1995 through Minnesota's Medicaid 1115 waiver. The children's portion of MinnesotaCare is still distinct from its Medicaid program, however.

COMPARISON OF FAMILY COST-SHARING PROVISIONS, OCTOBER 1996

Program	Income range, as a percentage of federal poverty level	Family premium contribution per month per child by income range	Percentage enrolled by income range	Copay-ments	Service and amount of copayment
Alabama Caring Program for Children	$0-12,000[a]	$0	100	Yes[b]	Outpatient services-$5
Florida Healthy Kids Program	0-130 131-185 over 185	5-10[c] 13-30[c] 45-60[c]	68 15 17	Yes	Prescription drugs-$3, eyeglass lenses-$10, refractions-$3, nonauthorized emergency room visits-$25
MinnesotaCare	0-150 151-275	4 4-98[e]	66[d] 34[d]	No	None for children or pregnant women; for other adults, prescription drugs-$3, eyeglasses-$25, inpatient hospital charges-10%
New York's Child Health Plus Program	0-159 160-222 over 222	0 2.08 35-66.50[c]	86 13 1	Yes	Prescription drugs-$1-3, inappropriate emergency room use-$35
Pennsylvania's Children's Health Insurance Program	0-184 185-235	0 28.74-34.39[c]	95[f] 5[f]	Yes	Prescription drugs-$5
Western Pennsylvania Caring Program for Children	0-184 185-235	0 20/up to 50 per family	96 4	Yes	Prescription drugs-$5

Note: This appendix corresponds with enclosure IV in GAO/HEHS-97-40R and updates table 2 in GAO/HEHS-96-35.

[a]Alabama uses absolute dollar amounts for income eligibility determination.

[b]Preferred doctors may require a $5 copayment for some services; however, most doctors waive the copayment.

[c]Premium contribution varies by locale or insurer.

[d]Estimated by program officials for 1995.

[e]Premium contribution varies by income level within specified range and family size.

[f]Estimated by program officials for 1996.

—While all six programs covered basic preventive and outpatient services, some limited other services, such as vision, hearing, dental, and mental health care. Some also limited inpatient care, particularly the privately funded programs. The programs that limited inpatient services sometimes did so anticipating that the children would qualify for Medicaid if they needed more extensive care.

—The programs were developed to be easily administered. Most operated, at least partially, through nonprofit or private insurers, which enabled the programs to use existing provider payment systems and physician networks, guaranteeing patient access to providers.

—Each of the six programs worked extensively to reach families of uninsured children and to promote their knowledge of the program. One program worked through the schools, which allowed it to most easily reach its target group: school-aged children. Other outreach efforts included dedicated hot lines, television and radio ads, bus billboards, posters in local discount stores, fast-food restaurant tray liners, and presentations provided at churches and other community locations. To encourage enrollment, three programs used sports and television personalities as program spokespersons. These outreach efforts served to identify not only children eligible for the six programs but also children eligible for Medicaid, who were then channeled into that program.

—Each of the six programs developed simplified enrollment procedures and took specific steps to avoid the appearance of a welfare program.

CONCLUSIONS

Although most children are still covered by private employment-based insurance, recent erosion of private coverage has left many children without coverage. The Medicaid expansion has cushioned the effect of this erosion on children. However, efforts to expand coverage for children need to be developed in ways that do not supplant existing private coverage. Despite the Medicaid expansion, many uninsured children who are eligible for Medicaid do not enroll. Outreach strategies developed by state and private programs could guide state efforts to reach uninsured children who are eligible for Medicaid but not enrolled. Other innovative state and private strategies, such as sliding-scale premiums and cost sharing for program enrollees, could provide a model for enrolling more uninsured children while controlling costs. However, adopting other strategies, such as limiting services like inpatient care on the premise that other funding may be available, may not provide the range of coverage that children need.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions you or Members of the Committee may have.

AVERAGE COST PER CHILD PER MONTH FOR SERVICES COVERED BY PROGRAMS, OCTOBER 1996

Costs/services	Alabama Caring Program for Children	Florida Healthy Kids Program	Minnesota-Care	New York's Child Health Plus Program	Pennsylvania's Children's Health Insurance Program	Western Pennsylvania Caring Program for Children
Average cost per child per month[a]	$20.00	$49.00	$60.00	$56.45[b]	$52.00[c] $63.00	$70.62
Services						
Primary and preventive care[d]	▪	▪	▪	▪	▪	▪
Emergency and accident care	▪	▪	▪	▪	▪	▪
Speech therapy		▪[e]	▪		▪	▪
Physical and occupational therapy		▪[e]	▪	▪	▪	▪
Prescription drugs		▪	▪	▪	▪	▪
Hospitalization and inpatient physician services		▪	▪	[b]	▪[e]	▪[e]
Mental health care		▪[e]	▪		▪[e]	▪[e]
Substance abuse care		▪[e]	▪	▪[e]		
Vision care		▪[e]	▪		▪[e]	▪[e]
Hearing care		▪	▪		▪	▪
Dental care			▪		▪	▪
Home health care		▪	▪		▪	▪
Ambulance services		▪	▪			▪
Durable medical equipment and prosthetic devices		▪	▪			▪
Podiatry		▪[e]	▪			
Chiropractic services		▪[e]	▪			▪[f]
Family planning		▪	▪			
Other services	▪	▪[g]	▪	▪	▪	▪

Note: This appendix corresponds with enclosure III in HEHS-97-40R and updates figure 3 in GAO/HEHS-96-35.

[a]Average cost reflects the total premium cost, regardless of the funding source, but excludes program administrative costs.

[b]New York planned to add inpatient services and reset premiums to cover these additional services in 1997.

[c]Average cost for fully subsidized children aged 1 through 17 is $52 per child per month and for partially subsidized children birth through age 5 is $63 per month.

[d]Primary and preventive care services include well-child visits, immunizations, diagnostic testing, outpatient physician services, and outpatient surgery.

[e]These services have specific limitations.

[f]Chiropractic services are covered if ordered by the primary care physician.

[g]Preventive dental care is offered in some counties.

RELATED GAO PRODUCTS

Employment-Based Health Insurance: Costs Increase and Family Coverage Decreases (GAO/HEHS–97–35, Feb. 24, 1997).

Private Health Insurance: Millions Relying on Individual Market Face Cost and Coverage Trade-Offs (GAO/HEHS–97–8, Nov. 25, 1996).

Medicaid and Uninsured Children, 1994 (GAO/HEHS–96–174R, July 9, 1996).

Health Insurance for Children: Private Insurance Coverage Continues to Deteriorate (GAO/HEHS–96–129, June 17, 1996).

Medicaid: Spending Pressures Spur States Toward Program Restructuring (GAO/T–HEHS–96–75, Jan. 18, 1996).

Health Insurance for Children: State and Private Programs Create New Strategies to Insure Children (GAO/HEHS–96–35, Jan. 18, 1996).

Medicaid and Children's Insurance (GAO/HEHS–96–50R, Oct. 20, 1995).

Health Insurance for Children: Many Remain Uninsured Despite Medicaid Expansion (GAO/HEHS–95–175, July 19, 1995).

Medicaid: Spending Pressures Drive States Toward Program Reinvention (GAO/HEHS–95–122, Apr. 4, 1995).

Medicaid: Experience With State Waivers to Promote Cost Control and Access Care (GAO/HEHS–95–115, Mar. 23, 1995).

Uninsured and Children on Medicaid (GAO/HEHS–95–83R, Feb. 14, 1995).

Tax Policy: Health Insurance Tax Credit Participation Rate Was Low (GAO/GGD–94–99, May 2, 1994).

Employer-Based Health Insurance: High Costs, Wide Variation Threaten System (GAO/HRD–92–125, Sept. 22, 1992).

Access to Health Insurance: State Efforts to Assist Small Businesses (GAO/HRD–92–90, May 14, 1992).

Chairman THOMAS. Thank all of you very much.

I am fully cognizant that we are looking for answers when perhaps the basic charge was to try to review the area, because as we have moved forward in our knowledge in this area, there are certain frustrations that have begun to develop.

And I guess the first question I would ask all of you is that we are now focusing, as I indicated in my opening remarks, on children's insurance. It is kind of like an age bracket, and we are normally used to looking at age brackets in terms of the 65 and above for Medicare. And when I look at some of the States that have been pulled together and listen to some people who are talking about employer retirement programs, we had a panel several weeks ago in which—I believe it was GTE in terms of telecommunications—and more and more are having folks retire at 55. Now there is this concern between 55 and 65 of an age group who are uninsured, which is a relatively large number.

But when we were looking at the general universe of those who were uninsured, I was not surprised to know that it was the 25 to 34 age group that was above the poverty level, employed, who did not have insurance. I have had two in that category.

A lot of it is a mental set about the fact that they do not need it because nothing is going to happen to them, and there is no package out there that fits their needs, and a whole series of issues. But they are the single largest group. And now we have children, and, as Pete said, maybe one in seven; somebody else used the statistic, five out of six children are insured.

I guess my first question would be, If we were looking for a segment from a societal point of view, is this the segment that we would focus on vis-a-vis the other groups?

And yes, I understand the payoff in terms of dealing with health care early over the life of the child, but what has happened recently that has had us focus on this particular segment? Because when you break out children, you have concerns about family income, how you tie them in to various programs, and the consequence of perhaps somebody in the family being insured and someone else not from the poverty end.

So why this age segment? Why are we looking at this question? Anybody.

Ms. BILHEIMER. I guess, Mr. Chairman——

Chairman THOMAS. From a priority point of view when we have limited dollars.

Ms. BILHEIMER [continuing]. I think three issues have really focused attention on children. First, we have undertaken extensive expansions of the Medicaid Program for children. I think some peo-

ple viewed those expansions as ways to provide coverage for children, and they are now looking and seeing that the problem of uninsured children has not, in fact, been solved, that we still have very large numbers of uninsured children in spite of large expansions of Medicaid.

Second, the issue that you addressed—that children do not appear, if they are uninsured, to gain access to basic preventive health services—has caused concern.

Third, if coverage for children focuses on the broader child population, that is a relatively inexpensive group of the population to insure.

I think all three of those issues have caused people to focus on children as a group that we could perhaps expand coverage to relatively inexpensively. But I think you are correct in saying that it is not necessarily the group in which the highest rates of uninsurance are likely to be found.

Chairman THOMAS. My concern is about reaching them inexpensively. We have testimony, and we will get it later, and it is fairly obvious, that children that are covered have better health profiles. That makes sense.

But when you look at some of the efforts that have been made, as Mr. Scanlon indicated, in the States, it makes sense, if you are focusing on uninsured children, to use groupings where children are, like schools, which may in fact fracture to a certain extent the way we have looked at offering insurance historically. If you are going to deal with it from a Medicaid point of view or subsidy point of view, you have to get at the family income.

And we have experienced from our EITC changes and the others that it is very difficult incrementally to get people to change behavior, and administratively it is relatively expensive to look at those groups. I don't completely understand your statement that we can do it inexpensively.

I understand the group, and if we can get them into the insurance and their health care needs are not that great so that they would be good to add to the insurance pool and would not be expensive when they are covered with the insurance. If that is what you meant, I understand it.

Ms. BILHEIMER. That is what I meant. And your point is well taken on the administrative costs of doing anything like this.

Chairman THOMAS. Any other reaction?

Mr. PURCELL. I would like to add a fourth point, and that is a fairly dramatic change in the source of health insurance among children since the late eighties.

Between 1988 and 1995, the proportion of children covered by private health insurance has declined from about 73½ percent to about 66½ percent. Simultaneously, the proportion of children covered by Medicaid went from about 15 to 23 percent.

There is a lot changing in the health insurance field among children, and we don't know for sure yet whether the trend of declining private health insurance coverage among children is going to continue or not. While these changes have occurred——

Chairman THOMAS. But when you make that statement, then, I come back to you and say, Why? And I think the answer is obvious, but why have we had this switch? The uninsured have remained

relatively stable among the population, but who insures them has switched from private to public. Why?

Mr. PURCELL. I don't know. But I do know——

Chairman THOMAS. Is the answer marketplace, the cost of the insurance in the private sector?

Mr. PURCELL. I think that probably is a large part of the answer. A lot of employers are finding that they simply cannot afford to offer this fringe benefit to their workers, and so they are cutting back. The next panel will discuss whether there was a cause and effect going on here, if expansion of Medicaid caused families to consciously drop family coverage to pick up Medicaid. There is some evidence of that occurring too. But I think the bulk of the evidence is that it is the employers that are deciding that this is something that a lot of them can't afford.

Ms. BILHEIMER. Picking up on that, Mr. Chairman, a recent study that was undertaken by a firm here in Washington surveyed employers to look at their attitudes toward coverage of families, and I think a majority of the firms that were interviewed stated they didn't think that employers should pay more than 50 percent of family coverage. Some thought that employers should be paying less, and some thought that employers should not be paying for family coverage at all.

I think the attitudes of employers are changing quite rapidly.

Chairman THOMAS. Thank you.

One other question I wanted to—we have got a lot of questions, and we can try to weave them together.

Mr. Stark, in his opening statement, talked about the concern of how long children have been uninsured. And you have a chart, Mr. Purcell, which shows about one-third of them have been uninsured in terms of family heads for more than 3 years, which means the children clearly have been uninsured for more than 3 years, 18 percent from 1 to 3 years, and 22 percent never had insurance.

When you look at the distribution of who has it and the length at which they don't have it, you have the vast majority from 1 year to never having had it before.

But one of the focuses of the President's proposal is to spend almost $10 billion in the area of subsidies to low-income workers on a temporarily unemployed window. And I guess my question would be, If we have limited bucks and we are trying to get the most bang for the buck, is this where you folks would spend that money?

Mr. PURCELL. I would say that part of that distribution is caused by the fact that this survey asks people about their health insurance coverage at a point in time, and at a point in time people without health insurance for a long period are heavily represented.

There is this other group of people which is substantial which sort of churned in and out of insurance coverage because of job changes. And if you follow a sample of families through the course of 1 year, you would see that a larger proportion of people who are ever uninsured, are uninsured for a short period.

Chairman THOMAS. And if we could get at some of the problems of not picking up insurance through those short-term problems, which are definitional problems as to who is eligible in a pool, we can resolve a number of those problems, in my opinion, for a whole

lot less money. And if I have limited dollars to spend, I would like to think about spending them in perhaps a slightly different way.

You all received this sheet. I believe CRS helped us. And I don't think it is available to the general audience, but we will make it available if anyone shows an interest. All it tried to do was take a look at how many people we were using to subsidize the number of folks covered under primarily government programs—Medicare, Medicaid, veterans' health care, FEHBP, Department of Defense, consolidated health centers, Indian health care. It came to about 110 million people, at a cost of $332 billion. We were looking at the exclusion and deduction side of it, and there are about 150 million people covered roughly, with 135 billion dollars' worth.

This just underscores everybody's comment that if it is in the private sector, you wouldn't want to drive out private sector dollars currently paying for insurance and substitute them with public dollars, because clearly the tradeoff is a very expensive one, leading to the trend of a very, very heavy price tag added to the already very heavy price tag in terms of public subsidy.

Dr. Bilheimer, you folks did a study, though, about the employer contribution; and the concern that I have, historically, I have dealt with a lot of things like salaries and the rest, and when you deal with income variations and you apply a 100-percent deduction to it and it is tied percentagewise to income, there is a clear skewing of benefits to the higher income. If you used fixed dollar amounts that would be available, obviously the lower end would be a percentagewise higher benefit.

I understand you looked at the employer benefit picture. Can you give us some feel for the distribution of benefits?

Ms. BILHEIMER. Yes. CBO's Tax Analysis Division conducted a study back in 1994 of the tax subsidy for employment-based health insurance. As you know, the subsidy from the tax exclusion increases with the size of the premium, the share of the premium paid by an employer, and the marginal tax rate of the employee, all of which tend to increase with income.

Premiums are likely to be higher at higher income levels, both because workers are more likely to have insurance year-round and to be covered by more than one policy, and because they are more likely to have family rather than individual coverage.

So when we looked at where the subsidy goes by income level, we looked at the average tax subsidy for tax units—that is sort of the equivalent of families—between 100 and 200 percent of the poverty level, versus those with incomes at 400 percent of the poverty level and above. And in 1994, that average tax subsidy was about $250 for families between 100 and 200 percent of the poverty level, versus about $1,160 for families at 400 percent the poverty level and above. A major reason for that outcome was that many of the taxpayers between 100 and 200 percent of the poverty level didn't actually have employment-based coverage at all.

If we looked just at people in that income bracket who had employer-sponsored coverage, their tax subsidy averaged about $730, compared with about $1,340 for families at 400 percent of the poverty level and above who had employment-based coverage.

But before one draws too many conclusions from that, remember that although higher income people benefit more than lower income

people from the tax subsidy, the net distributional effect depends on how it is financed. The benefits accruing to higher income families may be offset by other taxes that must be raised to make up for the lost tax revenues.

Chairman THOMAS. I appreciate that last point, which is a universal one that folks often do not look at when they look at the various particular areas. But I still see in the overall, including those who do not have insurance, a 4- to 5-time benefit and then more realistically, a 2-to-1 benefit. But anything approaching a 2-to-1 benefit by virtue of what is supposed to be available to all is, I think, a significant emphasis.

Mr. Purcell, there is a chart in figure 2 in your testimony which talked about the uninsured family heads vis-a-vis size of the firm, number of employees, and although you break it down between 10 and 24 and 25 and 99, if you grouped it from 10 to 100, since your next group is 100 to 500 and then 500 to 1,000 and above 1,000, what you would get would be a percentage reduction, which I think most people would find rather intuitive, up to a point that, under 10, the smaller firms, you had 38 percent of them who did not have the insurance and somewhere around 15 percent for the 10 to 100 and then 11 percent for the 100 to 500, and 4 percent for the 500 to 1,000. That is a clear, reduced percentage of uninsured as the size of the company gets larger. And then you go to the 1,000 plus, and you have 19 percent.

My assumption has to be that that includes a number of people who, by choice, don't make, to them, an economic decision to have insurance. Or do you have other evidence to the contrary?

Mr. PURCELL. I believe that some of it is what you pointed out, and some of it may be that the large—not all large firms are like GM or IBM. There are fairly high-wage people there. Some of these are large firms with low-wage work forces and low benefits as well. But predominantly, I think your interpretation is accurate.

Chairman THOMAS. And then another chart, figure 3, which I find interesting and, again, almost self-evident to most people who have looked at the area, and that is, clearly, far and away the type of employment that does not provide insurance is the wholesale and retail trade area, and historically such has been the case.

One of the areas I did not see represented in any examination is one that is of concern to me—and I will end on this, and anybody can respond to it—is that we have had the first of what I consider consolidation in terms of health cost changing the industry on the delivery of health care with the movement toward managed care.

What we have not seen completely yet, although it is beginning to occur, in the area of simply offering insurance itself, is to begin to examine the households with two earners and the reconciling of insurance between those two earners, because it has historically been the choice of the earners to determine which insurance they will go with and which employer.

More and more, the second employer is a government entity either at the State, local, or Federal level. And what we have seen is more and more a richer package offered at that level, and we have not seen the full movement of employers requiring identification of what else is out there in terms of insurance, so that you don't get duplication of insurance costs through employers, but that

you get everybody covered with one dollar coverage in a way that creates a seamless but not duplicative structure.

And I don't think we fully appreciated the transfer of what used to be private insurance costs to the public sector by virtue of the employee opting for the spousal insurance covered by a government entity rather than the private sector.

Any comment by anybody on that?

Mr. SCANLON. I think you are very right, Mr. Chairman, in terms of the slowness, but the start of developments in this area as employers are recognizing that there are savings available through better coordination of insurance for dual working couples.

As we have noted in our testimony, there have been a number of different steps that employers have taken. And with respect to that first chart you referred to of Mr. Purcell's, the major firms, firms of over 1,000 employees, very frequently will make use of flexible spending accounts, which make it easy for an employee to make a rational choice in terms of foregoing health insurance coverage sort of with their firm if their spouse is able to provide them with comprehensive coverage through other employment.

I think we don't have good numbers on the fraction of employers that are doing this, but it appears to be a growing trend that employers are seeking better coordination of coverage in order to reduce their costs, and they are offering incentives to their employees to make it attractive to them as well.

Chairman THOMAS. It just seems to me, if in fact this is going to be something, we could examine the way in which we allow the cost of insurance to be written off by corporations and the growing percentage for those who are self-employed between dependents only or dependents with family deductions that would allow us to resolve at least a portion of the dilemma that we see between the subsidy, the tax credit, and the driving out of private insurance versus public. And I didn't see anybody in any of the testimony focusing on the full use of all of the tax structure that currently provides support in the purchase of insurance.

And then just finally, this one chart which compares the uninsured head of family and the privately insured head and the cost of health care, I guess my reaction was, I was amazed at how similar the two charts look in that with just about a 4-percent adjustment on the zero and 2 percent on that first $500, the expenses are the same between the insured and the uninsured. And I found that more remarkable than the marginal comment you made about the charts.

Mr. PURCELL. Actually, I put them side by side for that reason because, for the most part, the charts look——

Chairman THOMAS. I want to assure you that had they been on separate pages, I would have still noticed how similar they look. But I appreciate you putting them on one page.

Mr. PURCELL [continuing]. They are similar, but the one difference I think that stands out is that about twice as many of the families with an employed uninsured head reported zero expenditures. So the only difference is——

Chairman THOMAS. Well, I understand. But that is 8 percent versus 15 percent when you say double the amount.

But in terms of high cost, no cost, and intermediate cost, I think that is striking, how similar they are.

Mr. PURCELL. I think that may be because, as I said in my testimony, if illness or injury occur, it doesn't happen with respect to whether or not you have insurance.

Chairman THOMAS. Precisely. I thank you.

Mr. STARK. Thank you, Mr. Chairman.

I would like to review with the panel this issue of what was referred to as crowding out. I guess the major concern is that if we, in fact, subsidize kids' insurance, then employers will not pay for it themselves. It makes good sense. And I would like to just discuss this a little bit in terms of not the emotional issue of, should we insure kiddies, but what happens to the cost.

If private companies drop dependent coverage, they will save about 15 to 20 percent. Does anybody want to disagree with that?

In the ballpark? OK.

They are dropping coverage or increasing cost sharing to the employees, which is about the same thing, I guess, at an increasing rate. Does anybody want to disagree with that?

Mr. SCANLON. That is correct.

Mr. STARK. We are in an area of high employment, so there is some competition certainly for skilled workers. But at the low end of the scale—if you were going to offer any health insurance, you would offer it to workers first, it seems intuitive, because you might have some single workers and you are mostly concerned about attracting the worker. So the incentive for the employer who is going to do the right thing or is going to try to make a more attractive workplace is at least to start with workers coverage and not necessarily dependent coverage. Still OK?

Ms. BILHEIMER. I would like to make one comment, Mr. Stark. With regard to the 15- or 20-percent reduction in premium payments by employers, that would depend on whether they were dropping coverage for all dependents or were still offering policies that covered the spouse.

Mr. STARK. So, 15 to 20 percent is the kiddies' cost, not necessarily the spouse?

Ms. BILHEIMER. Not necessarily the spouse.

Mr. STARK. All of that kind of smushes together, doesn't it? Because, generally, I don't know of any policies that are not all dependents, spouse, and children.

Ms. BILHEIMER. Employers are beginning to develop alternative policies now.

Mr. STARK. It is worker plus spouse, or worker plus spouse and kids? You are getting three levels rather than the traditional two?

Ms. BILHEIMER. In some cases, even more than that. Some employers may offer a one-parent-with-a-child policy.

Mr. STARK. OK. Tradition is no longer serving me to keep current on this stuff. So you are saying they are cutting these decisions more narrowly.

Well, what I am having trouble seeing, then, if my $500 figure is right—and it may or may not be, but let's use it because I can do the math with my shoes and socks on—and it is $500 for a kid, we are talking 25 cents an hour.

John Hallahan at Urban Institute basically says that if we have substantial coverage expansion—that is picking up kids—we are going to crowd out private coverage and that the only way to avoid crowding out private coverage is to do little or nothing and accept a large number of uninsured.

I guess what I am getting at is, Do any of you see an in between? Mr. Thomas suggests some various tax incentives to give employers less of a tax credit or deduction for only the worker and then increase the percentage of the deduction if they insure more members of the family. But that is, in effect, giving them some money—that is federally buying it one way or the other.

Is there any alternative to either requiring or sitting with and watching the crowding out? That is where I am stuck. Does anybody have a solution?

Mr. SCANLON. Well, I don't think employers are acting unilaterally in this situation.

Mr. STARK. But it is the trend; am I not correct?

Mr. SCANLON. Well, except that much of the research has indicated that employees' choice plays a big role here, too, that when given an opportunity to have less cost to them for insurance, they may opt to choose Medicaid as opposed to choosing their employer-based insurance.

Mr. STARK. To choosing what?

Mr. SCANLON. Choosing Medicaid rather than employer-based insurance.

Mr. STARK. Oh, OK. But I am going to assume that is your 3 million or so, and it still leaves 7 million for whom Medicaid is not an option.

Mr. SCANLON. That is true. But in terms of behavior, the employee has——

Mr. STARK. If we do universal coverage, Medicaid wouldn't be an issue anyway, then, if everybody paid two bits an hour, they would have the choice to go public or private.

But I just want to see how we get this crowding out for the people that would otherwise buy the insurance.

Mr. Purcell. Dr. Bilheimer. Anybody.

Mr. PURCELL. I think one possibility might be, for instance, in the decision whether or not to enroll a child in Medicaid, since there is this large number of uninsured above the poverty line, for whom currently Medicaid is basically free.

There is always the possibility of transitioning from a full subsidy to a partial subsidy. If you have some income, you can buy in at a partially subsidized premium. And that way, if the family does have some alternative choice of insurance, at least it is not a comparison of, this one costs and this one is free; there is at least some cost to either choice.

Mr. STARK. So you are saying we might expand the Medicaid coverage as an option?

Mr. PURCELL. With some sort of income-related premium.

Mr. STARK. Yes. But I am just saying expand the Medicaid coverage income eligibility and requirement, because now we no longer are doing that quite as extensively as we did.

Mr. PURCELL. Exactly.

Ms. BILHEIMER. I think as you get higher up the income scale with some form of subsidy or tax credit, some amount of replacement is almost inevitable. That is something that has to be considered as part of a policy.

Having said that, the design of a particular policy may affect the extent to which that occurs. If you are dealing with subsidies or tax credits for family coverage versus individual policies that you are selling through the schools, you are going to get different types of response.

Mr. STARK. Wouldn't it make sense if someplace up the income scale, you had individual insurance, whereas the higher up the income scale, the more likely it is that you have individual insurance at your place of employment. The convenience factor of just adding your spouse or kiddies to the policy as opposed to—the marginal difference for a person at a relatively high income of going out and shopping the kids' insurance on the cheap, as opposed to including it in one deduction from your paycheck, sounds to me like——

Ms. BILHEIMER. I think the convenience factor is very important, and it is not just from the financial side.

Mr. STARK. It is being in the same health plan?

Ms. BILHEIMER. It is being in the same health plan. I talked to some people in the Florida Healthy Kids Program, for example, and they said they didn't think there was a big issue with higher income families enrolling in the program, even though they couldn't really police it. They said the convenience factor was a considerable one because the children would have had to have been in a separate health plan from younger children who were not eligible and from the parents, and that was a big issue for them.

Mr. STARK. My time is over. But in a sense I guess what I am trying to ask the panel is, If we are going to subsidize for kids, we are going have to put up with some crowding out. Is that fair?

Ms. BILHEIMER. Yes.

Mr. SCANLON. Right. And in addition to charging a premium to families as incomes increase, the other technique that has been used by States is to establish less easy access to their Medicaid Programs by requiring that people be uninsured for a period of time so that you cannot just simply drop private coverage and join the Medicaid Program immediately. If you are going to be in one of the optional groups, you would have to have a waiting period of some period of uninsurance.

Mr. STARK. And our problem, in January the NFIB said they oppose any legislation to expand coverage for uninsured children because it would just be another mandate that undermines the ability of small businessowners to manage their health care costs and voluntarily provide health benefits to their employees. So there you sort of set up the argument.

If we talk about crowding out, we have a very substantial lobbying effort to stop it. We need some help.

Thank you, Mr. Chairman.

Chairman THOMAS. Thank you.

And just to add a couple of other factors to it, as long as some of our witnesses will be talking, they are dealing with the 150, 185, or maximum 200 percent of poverty. We can talk about it as a marginal crowding out, but some of these proposals are 300 percent of

poverty, and there is going to be a bidding war on the Senate side which may go higher.

I think you have a serious problem regarding crowding out, and my problem is, when you look at the government-provided programs with no cost, no payment, no deductibles for prescription as well, versus what an employer might be able to offer, you can get fairly high up in the income level in terms of the attractiveness of going public versus private, so that, on the margin, not only do you have to deal with the phasing out, I believe, but you also are going to have to deal with some copays and deductibles or some other kinds of packages to create a number of smaller stairs rather than this relatively high income cliff.

Does the gentleman from New York wish to inquire?

Mr. HOUGHTON. Yes. Thank you, Mr. Chairman.

I am trying to put my arms around what are the critical issues here. We have got a problem. The uninsured children have remained relatively stable in number since 1988, and Medicaid has gone up, and the uninsured children, I guess, have gone from 13 to 13.6 percent. Medicaid coverage has increased.

What is the answer to this thing in terms of the States? For example, New York State has a program, and you have listed these things in terms of some of the coverage which has been extended to them. It has been quite successful. Is this an answer to our problem? Or must we go to a Federal expensive, complicated system to solve some of these issues?

So that is the number one question.

Question number two is, Why are the uninsured families increasing in some of the larger companies rather than the smaller companies? And does the concept of self-insurance, which some firms are going to, make any sense?

So I throw those two questions out to anybody in the panel who would like to answer.

Mr. SCANLON. I think the New York program and the other State programs that we have reported on have been quite successful in terms of covering children, covering them relatively efficiently, and by keeping costs down.

These programs have operated on very limited scales. They have relied on some State revenues. They have relied on donations and other fundraising, and, as a result, they have had to limit their enrollments.

In some programs there have been waiting lists, and sometimes the time on the waiting list can be considerable. So the issue, in part, is the benefit of these programs. If we want to make them more available, we have to find additional revenue sources.

The States feel pressure and would tell you that they would feel hard pressed to substantially add their contributions to this.

In terms of private donations, it is always hard to raise money privately in large amounts, and that is what I think these programs have encountered, but they have done a remarkable job in terms of operating very effectively with the limited dollars they have had.

The major firms, I think, are recognizing, as Mr. Purcell indicated, that they have a heterogeneous work force, and they are offering that work force a set of options in terms of benefits. And

lower income workers, we have found, tend to forgo insurance because they have other priorities they would like to spend their incomes on, so that when they are given a choice of benefits, they may more frequently forgo insurance, particularly for children, because we talked about children being less expensive to insure. It is in part because most children are healthy. They need important preventive and routine care on a periodic basis, but generally most children are healthy, and therefore, parents may feel they can forgo the insurance.

Mr. HOUGHTON. What about the self-insurance concept?

Mr. SCANLON. Most of the major firms are engaged in self-insurance. Therefore, they are very sensitive to the costs of the services that their employees are going to be using and are seeking ways to minimize those costs.

The coordination of coverage between a worker and that worker's spouse is one of the techniques that is available to them.

There is also concern from employers with respect to these costs in regard to fairness to all their workers. As you provide coverage for a family, it costs more to cover a larger family, and why would an employer subsidize one worker more than another by paying more for their benefits? Employees are taking actions with respect to that as well.

I think the issue of self-insurance versus purchased insurance from an outside firm comes back to the issue of cost, though. The firm feels sensitive to the cost in both situations and may have somewhat more control when they self-insure in terms of how they structure their benefits, but still their decisions may be motivated or affected primarily by the cost issue.

Mr. HOUGHTON. Yes, but with the number of children covered by private insurance dropping quite substantially, does that include the self-insurance?

Mr. SCANLON. That included the self-insured, yes.

Mr. HOUGHTON. And that will be a further goal to reduce the cost and eliminate the insurance for children in those people who are self-insured?

Mr. SCANLON. I am sorry?

Mr. HOUGHTON. Well, will the movement toward self-insurance accelerate the reduction in coverage for children?

Mr. SCANLON. I don't think it should have a major impact on it, except to the extent that it gives the employer more flexibility in designing their plans in ways that coordinate coverage for working spouses better.

Mr. HOUGHTON. Thank you very much.

Chairman THOMAS. Does the gentleman from Nevada wish to inquire?

Mr. ENSIGN. Thank you, Mr. Chairman.

I would, first of all, like to try to identify a few of the problems out there. We have heard a lot about uninsured children, and certainly from an emotional standpoint and from a press standpoint, that grabs headlines and that stirs a lot of people's emotions.

What percentage of the children that are uninsured are getting improper health care?

Mr. SCANLON. We have seen in evaluations, some of the programs that we looked at, that as many as one-third of the parents

reported they delayed getting necessary care for their children when they were sick and they did not have insurance.

Mr. ENSIGN. And was that simply because they did not have insurance?

Mr. SCANLON. Concern over the cost was the primary reason as to why they delayed the obtaining of services.

Mr. ENSIGN. The reason I ask that is that in the State of Nevada, at least in Clark County, which is the Las Vegas metropolitan area, we provide free vaccinations for children, and yet we still have a fairly high number of unvaccinated children simply because the parents, even though it does not cost them anything, they don't do it, and the schools require vaccinations. Even with all of that, you still have a fairly high number of children that don't get vaccinated.

I guess that is one of the reasons I ask the question, is that, if a lot of these people were insured, would their children still be getting proper health care?

Mr. SCANLON. Insurance and costs are not the only barrier to the proper use of services. There is clearly a role for education and outreach to parents and families to ensure that they do receive proper services, that they recognize when they need particular services. The efforts need to be done in combination, if we are going to be effective in delivering services to children.

Mr. ENSIGN. How much of it do you think is education? How much of it do you think is just pure laziness and pure irresponsibility?

I think it is totally irresponsible for parents not to get their children vaccinated. But is that because people don't realize that they need vaccinations? Do you think the people are that ignorant to know, growing up in America, that vaccination is a good thing for children?

Mr. SCANLON. I am afraid that we have never looked into it. I think it is a tough question in terms of what is motivating or what is deterring people from seeking health services. I recognize it is a very important question, because if we are going to overcome these nonfinancial barriers, we need to understand their causes. But it is not something we have looked at or I am aware that others have looked at as well.

Mr. ENSIGN. Dr. Bilheimer, maybe I can ask you a question, because I have read proposals that had to do with taking the EITC arm, making that a place where you could provide a tax credit, directing that portion of the EITC for families with lower incomes to require them if they are going to get the EITC to buy private health insurance.

Could you comment on that?

Ms. BILHEIMER. I have not looked at those proposals at any length, but I am certainly aware they are out there.

For some families, supposing health insurance cost $500, $700, $800 a child; that would make a significant dent in their income. It would take a significant part out of their EITC. But for those who were in the range of the maximum EITC credit, if they had one or two children, it would probably be worth their while to do that.

As you get up into the upper end of the phaseout range of the EITC, which for families with more than one child, would be income of around $25,000 to $29,000—the EITC would be less than the cost of the insurance for two children. So, it probably would not be in their interest to participate.

The other question you have to ask is, What type of insurance would be available if you established a $500 tax credit that would be taken out of a family's EITC? Experience with the HITC, health insurance tax credit, that existed between 1991 and 1993 suggests that if there were credits available for small amounts, insurance companies might emerge that would offer very bare-bones policies or, in some cases, policies that provided very little coverage at all, and they would convince people that this was coverage and would the EITC requirement.

I think this would have to be very carefully monitored so that we didn't go through some of the experience we went through with the HITC.

Mr. ENSIGN. Thank you, Mr. Chairman.

Chairman THOMAS. Does the gentleman from Georgia wish to inquire?

Mr. LEWIS. Thank you, Mr. Chairman. Thank you, Mr. Chairman, for holding this hearing. I think this is an urgent concern.

I must first say that I think our country is too rich and too great to have children who do not have health insurance. This is a problem we can fix, and I think, through the help of our Chairman and our colleagues, we can fix it. We must fix it. This hearing is a good first step, and I look forward to working with you toward the completion of this process.

I missed the testimony of members of this panel, but I have had an opportunity to read most of the statements, and so I would like to raise a question. Is it true that many parents working at jobs—put it simple—are not offered health insurance? If that is true, then is the question whether public action will replace private action, known as the crowding out effect, so serious?

Ms. BILHEIMER. If you take families below 100 percent of the poverty level, I think most researchers who have looked at the issue conclude that the probability of much crowding out is very small.

For families between 100 and 200 percent of the poverty level, especially once you get up above 150 percent of the poverty level, at any point in time about 50 percent of the children do have employment-based coverage.

So, much above 150 percent of the poverty level, some crowding out is part of the price that you would pay for expanding coverage. Some of the other panelists may want to comment.

Mr. PURCELL. Yes, I would just like to say that although a large percentage of employed, uninsured family heads work at firms that do not offer insurance, there are many other people who work at firms that are similar that do offer health insurance. It is a question of targeting.

If you were to somehow make insurance available to those who work at firms that don't offer it, you don't want to create an incentive for those firms that do offer it to drop it.

Mr. SCANLON. I would agree, and I think one of the things we face in how to minimize the crowding out effect is that solutions such as charging premiums and making insurance less readily available to encourage employers to maintain their insurance are not going to be perfect. There is still going to be an impact when there is public insurance available.

However, we need to recognize whether the tradeoff in terms of the expanded coverage we may obtain is commensurate with the amount of crowding out that we are willing to tolerate.

Mr. LEWIS. Dr. Scanlon, let me ask you: It seems to me everyone agrees that quite a few children, maybe around 10 million, are uninsured. There is debate and sometimes conflict or maybe a little controversy about the actual number, but everyone agrees that some of our children are uninsured, have it as debate whether Medicaid expansion encourages families to drop private health insurance. Is it fair to say there is no agreement even in the academic community on whether that is true?

Mr. SCANLON. I think in the academic community there is agreement that there has been a crowding out effect. There is disagreement in terms of the magnitude of that effect. It is a difficult issue to study.

One of the ways of looking at it that would be most ideal is to be able to follow large groups of people through time and observe their behavior. We don't very often get an opportunity to do that, we have to work with more fragmentary evidence, and the researchers in this area have done excellent work in terms of trying to use that evidence to identify the extent of the crowding out effect. They have come up with varying estimates. I think we all recognize it is real, and we are not quite sure of its magnitude.

Mr. LEWIS. Would other members of the panel like to respond about this controversy, this debate over the number of children that are actually uninsured?

Ms. BILHEIMER. I think, Mr. Lewis, that the next panel is going to include experts on this issue.

Mr. LEWIS. So, I should be patient and wait.

Mr. Chairman, could I just take another 30 seconds?

According to the testimony from the Congressional Research Service, the uninsured are employed at all sizes of firms, not just small firms. Would it be a good guess that the main reason for this is that they cannot afford health insurance even if the firm offers it?

Mr. PURCELL. I think there is one of the tables that shows that among employed, uninsured family heads, there are about 1.3 million who were offered insurance at their place of employment but declined it, and about two-thirds of them said the reason they declined it was at least partly because of the cost.

Mr. LEWIS. Would you be prepared, any member, to tell Members of this Subcommittee that we have hundreds, thousands, and maybe millions of our citizens that are working every day, and the working poor, but they cannot provide or be part of an effort to provide or pay part of the health insurance for their children or for themselves?

Ms. BILHEIMER. I don't know that we have a specific number that we can give you. But to add to Mr. Purcell's comment, there are

two issues involved here. The first is whether people can afford what their employer offers. The second is that in some cases, particularly among poor families, people are not eligible even though their employer offers coverage, because they are part-time workers or because they are in a probationary period prior to being eligible to enroll. Surveys suggest that a significant number of low-income people do work for employers that offer insurance, but in fact, they are not eligible to participate.

Mr. LEWIS. Thank you.

Thank you, Mr. Chairman.

Chairman THOMAS. I thank the gentleman.

Does the gentleman from Nebraska wish to inquire?

Mr. CHRISTENSEN. Mr. Chairman, this may have already been asked, and it might not be the right panel, so I will ask it, and if it has already been asked, we will just go on.

Has there been any discussion about the number of participants in the 10 million figure who are illegal aliens or who are legal aliens?

Chairman THOMAS. That has not been asked.

Mr. CHRISTENSEN. Would anyone have a comment on that or know that figure, or should we save that for the next panel?

Ms. BILHEIMER. I do not have any number on that. I don't know whether anybody else on the panel does.

Mr. PURCELL. Actually, the CRS was asked that question recently, I think, by the Senate Finance Committee; and we looked at the CPS. The problem is there are not a lot of people in-household surveys who are going to willingly admit that they are illegal aliens. There is data, though, on citizenship and birthplace of both parents; and a small fraction of those children who were reported to be uninsured were either noncitizens or born in another country. It was about 9 percent.

Mr. SCANLON. We don't have any additional information.

Mr. CHRISTENSEN. Mr. Purcell, you were commenting earlier—before I had to leave, you were talking about free health care and free this and free that; and I would just remind you there is nothing free in this country.

Mr. PURCELL. I agree, there is no free lunch. That is what they taught us in Economics 101. I was speaking to the issue of who pays; and in this case, for instance, Medicaid, that it is the other people who are paying.

Mr. CHRISTENSEN. I know.

Also, during your testimony, you talked about the stigma that may be identified with people not participating in the Medicaid Program and taking the opportunity of getting their health care. How big a problem do you think that really is? Did your study or did your findings show anything in terms of the actual stigma of participating in a welfare-type program?

Mr. PURCELL. It is not something that anyone can quantify. And I also believe, it is just my opinion, having looked at the data over a number of years, that it may decline over time because I think fewer and fewer people automatically associate Medicaid with welfare. That is partly because the eligibility requirements are now very distinct for the two, and it is possible over time more and

more people will have a view of Medicaid as just a public insurance program and not necessarily as welfare.

Mr. SCANLON. I would note that in the State programs that we looked at there was a sensitivity on the part of the program officials to avoid welfare stigma with their programs. They wanted to clearly identify them as insurance programs and make them more mainstream. They were very proud of the fact that to a provider it may be invisible as to what the source of insurance was. For an individual, program managers thought that making their coverage more like mainstream insurance provided better access to providers for their beneficiaries, and I think that is an important distinction in their minds.

Mr. CHRISTENSEN. Have any of you examined the issue that Senator Trent Lott talked about this past week concerning the expansion of the MSA proposal to cover the temporary lapse of parents in between-job situations and coverage for their children?

Ms. BILHEIMER. That is a very recent proposal, and we really haven't had an opportunity to look at it, so we don't know any of the specifics. It would depend on whether the proposal was designed to provide more coverage for families or whether it was specifically targeted at children. It is not clear right now how a medical savings account specifically for children might work; so, until we see more details, I don't think we can comment on that.

Mr. CHRISTENSEN. OK. My time is running out. I do want to make a quick comment, Mr. Chairman.

At a time when we do have a system that is available as far as Medicaid that is not being utilized by a lot of those that need to use it, we have free immunizations—and, frankly, in my district, there are very few kids that are ever denied access to health care when they truly need emergency health care. But, we also want to be cognizant of the fact that we want to make sure that we take care of the children. In terms of compassion, I think that is the right thing that we focus on.

But I also don't want to move too quickly and create a problem where there may or may not be a problem and not fully utilizing the current system that is in place, and so I appreciate the panel and their testimony and look forward to learning more about this issue.

Chairman THOMAS. I thank the gentleman for his comments. You will find that most everybody is focusing on, as we use limited tax resources, how we can get the most bang for the buck; and clearly, some alternative insurance programs like medical savings accounts might actually provide us more bang for the buck in honor of our colleague from Louisiana, who is not here, and who is fond of saying that people will consume as much health care as other people are willing to pay for.

There is a clear understanding of this transitionary period where, if I have to pay for it and I get less and I have an option of not paying for it and getting more, that it is a simple choice for them to make.

My concern is that, as we look at the bang-for-the-buck question, we not only look at this crowding-out concept but also alternatives in what government might offer rather than a standard, one-size-fits-all Medicaid approach.

Does the gentlewoman from Connecticut wish to inquire?

Mrs. JOHNSON of Connecticut. Thank you, Mr. Chairman, and thank you for holding this hearing. I think it is extremely important we get a better grasp of what is happening for children in America with regard to health services; and, in that regard, I would like to pursue a slightly different line of questioning.

What do we know about where the uninsured children live?

Ms. BILHEIMER. In terms of the States where they live?

Mrs. JOHNSON of Connecticut. And the locations. In other words, what percentage of uninsured children live in New York, Chicago, and Los Angeles? What percentage live in the top 2 percent of the largest cities? In other words, does knowing about where these children are located have any—can that help us look at how we might meet their needs? What do we know about where they live?

Mr. PURCELL. CRS just put out a report on the number of uninsured children by State. In terms of regional distributions, there is a slightly higher likelihood of being uninsured for children who live in the South and the West, compared to the Midwest or Northeast. I am not sure, I have not looked at data that breaks out urban rural, so I can't really tell you whether a child is more likely to be uninsured if they live in a rural area or an urban area. But, we can certainly look at that.

Mrs. JOHNSON of Connecticut. We are likely to know that the 3 million of the 10 million who are Medicaid eligible but not participating probably do live in the cities. But it would be interesting.

Anyway, what I need to know is, Can you analyze this for me? Can you find this out? And can you find out if the majority of the uninsured children do live in urban areas, what percentage of those urban areas have community health centers?

Mr. PURCELL. We can certainly address the first of those questions fairly easily, which is the percentage that live in cities versus rural areas. And the data are even accurate to look at some——

Mrs. JOHNSON of Connecticut. Well, can you look at where the community health centers are located?

Mr. PURCELL. We can do that, yes.

Mrs. JOHNSON of Connecticut. The reason this is important, the community health centers provide dental, vision, health, mental health, and prenatal on a sliding-scale fee; and this is a great underutilized resource in America. And when you look at the chart that the Chairman was referring to, 8 million people are helped by the community health centers for $8 million, I think.

But I have long worked with community health centers, and people don't think about them. And when we had big layoffs and steep and sudden layoffs in Connecticut, I referred a lot of families to the community health centers which are in our area. There is a brandnew one in my hometown, state of the art, beautiful; and because they have doctors who are reducing their loan costs, often extremely capable and qualified doctors.

So this is not second-tier health care, and it is available very cheap. People don't know about it. The new one in my district has been going door to door. So we need to know before we jump into this who lives within what kind of radius of our community health centers and whether or not more money going into our community health care system will reach better.

We also need to know, Are any of the States that are into this issue, are they finding a way to add a hospital component to the community health center plan? Now, Connecticut has had community health centers develop their only network alternative to compete for Medicaid family business; and we need to look at what in addition to community health care center dollar expansion it would cost us to also add in hospital components. That is one of the questions I would like your help on.

I assume you have no immediate information. If not, I will just go on to the other information we also need. We also need to know how many of these children live in cities where there is a well-developed series of school-based health clinics, and this goes to this issue of the fact that we actually fund free vaccines for all the children in America. They just don't get them. We have known that for a long time.

Remember, President Clinton proposed a free vaccine program; and we said, we already have it; and we went on about how they don't deliver it. So we need to look at that and then what health care are these children getting now? What percentage of the 10 million are seen in emergency rooms and we are paying through uncompensated care. Do we know about all the money we are pouring into uncompensated care costs? How much of that is going to these children?

A kid breaks his arm, he is uninsured, he goes to the emergency room, he gets all the care he needs. Well, once he is in the emergency room system, if he has no insurance, if the family is low income or even if not, minimum amounts are paid by the children.

So we need a better understanding of how we are paying for essential services for these children now, where is that money. Because we might be better off pulling that money out of the system and using it in a different way. And maybe insurance premium isn't the best way.

And the last thing I would like to say ask you, Mr. Scanlon, what is Tenn-Care doing? What does that tell us? Also, in your very interesting chart, which we thank you very much, they were very helpful, the States that do have children programs, what are the experiences in those States with displacement? So Tenn-Care and the States' displacement you might actually answer.

Then, Mr. Purcell, a similar kind of question. You have a couple charts that show 17 percent of families that are uninsured heads of household but working full time and then your other chart, 19 percent of upper income. On one chart, 17 percent earn more than 50,000. The other 19 percent of employers, over a thousand employees don't choose it. Where is our potential to at least get some percentage of the children through that group?

So, if you would take off on some of those questions, I would appreciate it.

Mr. SCANLON. Sure. Tenn-Care was a program that very effectively reduced the number of uninsured. It was introduced in 1994. It employed one of the methods that we have talked about here today, which is to require that individuals who wish to enroll in Tenn-Care have a period of no insurance before they would be eligible so that people would not drop their private coverage in favor of the subsidized coverage available through Tenn-Care.

There was a very dramatic increase in the number of insured in Tennessee immediately following the introduction of the program. Now, Tennessee was able to reduce the per person cost of coverage in moving from their fee-for-service system to the managed care model that they are using for Tenn-Care. They were, frankly, surprised by the number of people that were enrolling and have not reopened enrollment for a considerable period of time. So after having enrollment open for the first year of operation, newly uninsured have not had the opportunity to join the Tenn-Care Program as Tenn-Care faces other financial demands that they have been struggling to meet.

Mrs. JOHNSON of Connecticut. And what does your experience say about do they have any uninsured children in Tennessee anymore and are the uninsured children amongst those who have been post the open enrollment period?

Mr. SCANLON. We have not looked at recent data on Tennessee, but I would expect, with the passage of time, that there has been an increase in the number of uninsured children. We can find out more information about that for you.

Mrs. JOHNSON of Connecticut. We need to know in that first year if they went down to zero uninsured children or zero cared-for children—I don't want to use the wrong language and get the wrong answer. I want to know if there were people that didn't get care in that first year because they were out of the system and what they did, in the sense, was reach a zero tolerance for uncared-for children.

Mr. SCANLON. They were very effective in terms of expanding eligibility. I think zero is a hard thing to reach, and so there were undoubtedly small numbers that were not getting the care they required. But Tennessee was effective in expanding their eligibility in that period. We can find out for you how that has changed since the introduction of the program in 1994.

Mrs. JOHNSON of Connecticut. Given all the questions we have been asking, if you would take a look at the Tenn-Care Program and see what indication it gives us, I would appreciate it.

Mr. SCANLON. We would be happy to.

[The information was subsequently received:]

This responds to Mrs. Johnson's question on the impact of TennCare on the number of uninsured children in Tennessee, including current policy on enrolling children. Since the beginning of TennCare, in January 1994, the estimated percentage of uninsured Tennesseans declined. (See Table 1.) When it first opened enrollment, TennCare provided coverage not only to people eligible for Medicaid, but also to people who had been uninsured as of March 31, 1993. Researchers estimate that TennCare reduced the uninsured population by about 47 percent between 1993 and 1994. However, the percentage of uninsured Tennesseans has crept up since 1994, likely in part because TennCare began to limit new uninsured enrollees and remove some enrollees from its program due to nonpayment of premiums. Because TennCare's funding was limited and enrollment had grown more than expected, TennCare closed enrollment in January, 1995 for persons who had been uninsured—unless they were Medicaid-eligible or uninsurable due to preexisting conditions.

Table 1.—Estimated Number and Percentage of Uninsured Persons in Tennessee, 1993–1996

	1993	1994	1995	1996
Number	452,232	298,653	303,785	333,268
Percent	8.9	5.7	5.8	6.3

Source: William F. Fox and William Lyons. Health Care and TennCare: A Survey of Tennesseans. (Knoxville: Tennessee: Center for Business and Economic Research and Social Science Research Institute, the University of Tennessee at Knoxville: February, 1997), p. 2.

TennCare currently covers about 550,000 children under 18 years old. Most of these children come from the Medicaid-eligible population, but about 75,000 were previously uninsured and would not have been Medicaid eligible. An estimated 67,430 children were uninsured in Tennessee in 1996.

Due to concern about the number of children still uninsured, in April, 1997 TennCare opened enrollment to uninsured children under 18 years old. To encourage enrollment, the program also dropped three potential barriers to care. TennCare disregarded any potential COBRA coverage, waived any back premiums owed to TennCare from previous enrollment, and waived any requirement about the length of time children had to be uninsured prior to TennCare enrollment. It is too early to tell what impact these changes will have on the number and percentage of uninsured children in Tennessee.

Mrs. JOHNSON of Connecticut. Mr. Purcell, How do you respond to the issue of over 50,000 people who don't carry insurance? Do they have children?

Mr. PURCELL. If you will note, in that group of tables I think it says about three-fourths of the families included have children. The reason I did the table with that particular group is because I was under time constraints preparing for the hearing. We are going to reproduce that whole table focusing particularly on families with uninsured children.

Mrs. JOHNSON of Connecticut. Thank you, Mr. Chairman.

Chairman THOMAS. Does the gentleman from California, Mr. Becerra, wish to inquire?

Mr. BECERRA. Thank you, Mr. Chairman.

I note in an Urban Institute report recently the Institute found that, regardless of industry, employer-sponsored coverage is falling for all groups. According to the Institute's report, from 1988 to 1993 employers provided coverage for employees between the ages of 18 to 34 in all sectors at a rate that was 7 percent less. For children zero to 10, during that same period, coverage fell by 8 percent.

Question to the panelists, whether any of you believe this is a trend that will continue and what is it about service industry employment which seems to be the trend, especially in the areas like the West, that leads to lower rates of coverage?

Ms. BILHEIMER. In terms of whether it will continue, surveys of employers show an increasing unwillingness to pay for much more than 50 percent of family coverage—and, in some cases, less. So I don't think anyone is very sanguine about the trend slowing.

In terms of service occupations, these are low-compensation jobs. But one of the reasons they provide little coverage is they are often part-time work; they are often contract companies. These new types of employment arrangements or part-time arrangements are much less likely to provide fringe benefits, and we are seeing more low-income workers in those types of jobs.

Mr. BECERRA. What about those working for a computer company? That is service in many respects as well. If you work for America On-Line doing some service work, that is fairly high paid but oftentimes without the benefits as well.

Ms. BILHEIMER. I don't know what to say on that. I don't know whether anybody else on the panel has any insight on that.

Mr. PURCELL. There is some anecdotal evidence I recently discussed with another analyst at CRS. In that particular industry, there is an increasing trend, for instance, among programmers to hire people under contract rather than full-time employees. One of the reasons being they do not offer any benefits, it is strictly a wage deal.

Mr. SCANLON. I think another factor is that this is also a group of people who are in an age range where they sometimes choose to forgo insurance. When offered a flexible spending contract, what they do is choose other kinds of benefits rather than health insurance. And you may see, in terms of looking at a particular company, that a portion of their employees do not have insurance from their company but they are actually insured because they also have a working spouse that provides them coverage.

Mr. BECERRA. I don't know if any study shows this, but it seems to me if you take a look at where you find those industries that are most successful in providing coverage to their employees, it seems to be the northeastern manufacturing industries which seem to be the most unionized; and where you find the least amount of coverage is in the newer industries, the service-sector industries, that seem to be least unionized. Would that be a fair or unfair assessment to make?

Ms. BILHEIMER. If you look at industries in general, that seems to be the case, yes.

Mr. BECERRA. Any comment of the panelists on whether the cost of not insuring the children is real or speculative? If every day we do not insure the 10 million children in this country, is there a real cost or are we just speculating?

Ms. BILHEIMER. One of the questions Mrs. Johnson asked was, Do we know where children are actually receiving health services? And, do we know what health services they are actually getting? Insofar as children are not receiving preventive health services, that obviously affects their health status as children and maybe later in life. But we don't know the extent to which uninsured children do receive some services from local health departments, community health centers, or school clinics. So your question is a very difficult one to answer.

Mr. SCANLON. I think we also have a concern that as we want to think about better management of care, greater continuity of care, both in terms of controlling cost and ensuring quality of service, that is, if children do not have a regular source of care and regular source of financing for care, there will be a tendency to use services only when they are needed on an emergency basis or on some more urgent basis. And you end up spending more in those situations than you would have if the person had continuous care.

I know that managed care firms are very concerned that if they are going to participate in the Medicaid Program, they would rather not have the emergency room be the point of entry to Medicaid eligibility. They would like to engage in provision of primary preventive care so that they can better control the cost of care.

Mr. BECERRA. Mr. Chairman, if I could continue for just a moment longer.

If I could get both Dr. Scanlon and Dr. Bilheimer to attempt to respond to the question, to give me a more direct response to the fact that we have children in this country that are not insured, a cost associated with that. In our ultimately providing health services nationwide, do we save more money by seeing these kids remain uninsured? Because, obviously, we don't have to federally or through private insurance provide premium coverage for that individual child. Or are we incurring a cost because the child not having health insurance may not be receiving health benefits which ultimately may be received at a later date at a higher cost?

Ms. BILHEIMER. I don't think we know how the total costs net out. We do know that uninsured children use fewer health services of a preventive nature. But they do still receive a lot of health services, some of them in the emergency room, when they are sicker. But I don't think anybody has done a study of what the net costs are of children remaining uninsured.

Mr. SCANLON. I would agree completely. I think our problem is that, while we can identify the source of higher costs, namely the use of more expensive services, the exacerbation of certain conditions, we have not been able to weigh that against what the cost would be of an effective strategy to expand the insurance coverage to the majority of these uninsured children.

Mr. BECERRA. Isn't it true, though, that the CDC and other research institutes have actually done some studies that show, for example, that providing a woman with prenatal services—a low-income woman with prenatal services probably would save us at least $3 for every $1 spent on prenatal services?

I know there is another study that shows that the outcome—the death outcome or death rate of a similar-situated patient who is going into a hospital is much different for the insured white patient versus the uninsured white patient or the uninsured minority patient, so that what we see is that people go in for the same problem and a lot fewer of the minority or poor—or the white poor come out than do the insured, especially the insured white.

Mr. SCANLON. I think those situations are exactly what you are pointing to, exactly the kind of situation where we can demonstrate that in those instances there is cost effectiveness in terms of providing more timely services.

I think what Dr. Bilheimer and I were referring to, though, was to weigh that against insuring a large population that may not have as intensive a need for services as either pregnant women or some persons that are hospitalized. The larger population will gain some benefits. What we don't know in terms of the cost savings associated with those benefits is whether we are going to have a net effect or not.

Mr. BECERRA. Thank you, Mr. Chairman.

Mr. ENSIGN [presiding]. Before I go to the gentleman from Texas, just one comment on the line of questioning from the gentleman from California. That is, from what I understand, the two areas where we know for sure there are cost savings, one is more children and coverage, one is with vaccinations, the other is with prenatal care.

With all the other services, I don't know that there is a cost savings. As a matter of fact, from what I understand, there is probably

a cost increase for covering all children. But for those two areas, that are the cheapest areas, by the way, to provide care, those are the areas that we know that there are cost savings.

Mr. SCANLON. I think for very prevalent conditions, those are two of the most prominent in terms of cost savings. For more rare or sort of less frequent conditions, there is also potential for cost savings. Good management of conditions like asthma and diabetes can be effective in terms of reducing health utilization and also having better outcomes, but the number of children that suffer from those types of conditions is small compared to the overall child population.

Mr. ENSIGN. The gentleman from Texas.

Mr. JOHNSON of Texas. I would like to follow up on Mr. Ensign's question earlier about people who have access to health care but don't get it, and back to the EITC.

Do you think penalizing people by deducting an amount from their EITC would motivate them to enroll? We have already tried to increase their deduction, and it hasn't worked according to you. And you say three-fourths of all the uninsured children are below the poverty level, so I would presume they would be almost eligible for Medicaid anyway.

Ms. BILHEIMER. With regard to deductions from the EITC, I think it really depends on what tax credit people get. For people who are getting the maximum of about $3,000, which is for families with income between $9,000 and $12,000, obviously it would still be well worth their while to participate in the EITC, even if an amount were deducted to pay for health insurance.

I think the concerns would be, first of all, that it would take a significant amount out of their total income. Second, if it were known you were going to get $500 taken out for each child who was not insured, insurance companies would start offering packages for around $500 to cover children. And as I said earlier, when we had the health insurance tax credit earlier in this decade, some not very good insurance policies got sold to low-income people under the guise of the EITC.

And then, for people who were higher up in the phaseout ranges of the EITC, you would reach a point at which the cost of insurance would exceed the amount they would get from the tax credit anyway. So, this would probably not be worth their while to participate in.

Mr. JOHNSON of Texas. The bulk of those are eligible for Medicaid anyway, aren't they?

Ms. BILHEIMER. A significant percentage of families who get the EITC would have children who were eligible for Medicaid, but by no means all of them. I think about one-third of EITC recipients currently do not have health insurance, something like that.

Mr. JOHNSON of Texas. One-third of them?

Ms. BILHEIMER. I think that is correct, yes.

Mr. JOHNSON of Texas. Are those one-third also eligible for Medicaid?

Ms. BILHEIMER. We have not looked into that. We can certainly see what we can find out on that issue.

[The information follows:]

We have looked into the question of how many uninsured children in families receiving the EITC are eligible for Medicaid. Unfortunately, we do not have reliable data that allow us to determine who is jointly eligible for those two programs. Over time, however, as the states continue to expand their Medicaid coverage of children, a growing proportion of children in families receiving the EITC will become eligible for Medicaid.

Mr. JOHNSON of Texas. On a different subject, following up on Mrs. Johnson's questioning, the percentage of uninsured vary so much from State to State. There is a bigger burden. I think you indicated that, Mr. Purcell, in your study when you said the South and Southwest had more, at least from your statistics, than the rest of the country.

And she was asking about cities. You also made the comment that New York City had a large percentage of them, too. So it would follow, I think, that some of the major metropolitan areas also would fall into that category, if they have low-income people as part of their population. Would you agree with that?

Mr. PURCELL. In general, I think that is true.

I was surprised yesterday to look at some statistics for a city in the Midwest and found that its rate of uninsured for the whole metropolitan area was actually lower than the national average. I think it varies a great deal from State to State, and whether you are looking at the center city or the whole metro area, which includes the suburbs.

Mr. JOHNSON of Texas. Yes. Well, most States have already implemented some form of program to provide children with health insurance. Do you think we are in danger of preempting the States before we know what the States have done and what works best?

Mr. SCANLON. I think the States have been both innovative and have responded very well to the problem of the uninsured. I think we need to be careful in terms of crafting a Federal response, that we do something that will be compatible with the variation that goes on within the States. They are using different combinations of Medicaid and non-Medicaid sources for insurance; and given the amount of innovation and some of the successes they have had, it would be regrettable to do something that dramatically hampered some of those activities. I think you are right, that we need to be careful about that.

Mr. JOHNSON of Texas. Thank you.

Also, Mrs. Johnson made the point that in the case of Tennessee, I guess, they have a program which, according to her, and you agreed, Tennessee does not have the problem; and yet you list 11.9 percent as the uninsured rate in Tennessee. Can you explain that?

Mr. SCANLON. Tennessee was able to reduce their uninsured rate to about 5 percent when the program was initially introduced, when they had an open enrollment period and were allowing anyone who had no insurance for a period of time to enroll. Since then, they have not been able to have open enrollment periods. Therefore, as we note there, the number of uninsured has increased; and the proportion of uninsured has increased as well.

Mr. JOHNSON of Texas. Are you all going to investigate those States that have done programs like that with an attempt to try to get us some statistics on it, as she requested?

Mr. SCANLON. We certainly will, yes.

Mr. JOHNSON of Texas. Thank you very much.

Thank you, Mr. Chairman.

Mr. ENSIGN. I would like to thank the panel very much. Very informative. And you are dismissed.

I would like to call the next panel up, which includes Jonathan Gruber, associate professor of economics, Massachusetts Institute of Technology, faculty research fellow, the National Bureau of Economic Research; Lisa Dubay, senior research associate with the Urban Institute; and Richard Curtis, president, Institute for Health Policy Solutions.

Chairman THOMAS [presiding]. Let me tell each of the panel members that any written testimony you have will be made a part of the record, and you may address it in any way you see fit in the time that you have.

Mr. Curtis, why don't you, notwithstanding the list of the panel in a different order, just begin—no, let's do it the way it is listed. Because, in reading the material, you really do an overview of the literature and include Dr. Gruber and Ms. Dubay's testimony. Let's do it that way and keep it the way it is structured.

We will start with Dr. Gruber, go to Ms. Dubay; and Mr. Curtis, you come back and clean up.

STATEMENT OF JONATHAN GRUBER, ASSOCIATE PROFESSOR OF ECONOMICS, MASSACHUSETTS INSTITUTE OF TECHNOLOGY FACULTY RESEARCH FELLOW, NATIONAL BUREAU OF ECONOMIC RESEARCH

Mr. GRUBER. Thank you. Thank you for allowing me to speak to you today about the problems of uninsured children in the United States.

There are currently 10 million children in the United States without health insurance. This figure has risen relatively slowly over the past decade, but this slow rise in the number of uninsured children masks two important trends, a rapidly declining rate of public insurance coverage and a correspondingly rising rate—a rapidly declining rate of private insurance coverage and a corresponding rising rate of public insurance coverage.

These trends correspond to a dramatic expansion of the Medicaid Program, which provides insurance for low-income children. Traditionally limited to very poor children living in single female-headed families, this program has been expanded to cover all children under age 6 in families below 133 percent of the poverty line and all children under age 13 in families below the poverty line.

By my estimates, fully one-third of all children in the United States today are eligible for the Medicaid Program. In fact, the expansion of the Medicaid Program may be part of the root cause of these trends in private and public insurance coverage, through the crowdout mechanism we have been discussing.

The typical privately insured family pays roughly one-third of their medical costs between copayments, deductibles, premiums, and uncovered costs such as prescription drugs. But Medicaid is to-

tally free. There are no copayments, no deductibles, and many extras such as prescription drugs are covered in all or almost all States. As a result, upon eligibility for Medicaid, many privately insured families may find it attractive to drop their insurance and sign up for the public program.

In recent research with David Cutler of Harvard University, I investigated the magnitude of this crowdout phenomenon. Our results are striking. We find that for every two persons that joined the Medicaid Program due to these expansions, one person dropped private health insurance coverage, for a crowdout of 50 percent.

The mechanism for this crowdout does not appear to be employers dropping their insurance coverage when their employees become eligible for the program, however. Rather, it looks like it is employees not taking up insurance where they must pay a share of the cost, preferring instead to join the public program.

Now the existence of this crowdout does not mean that expanding Medicaid was a bad idea. In fact, in other research with Janet Currie of UCLA, I found enormous health benefits to low-income populations from expansion of this program. We found that the Medicaid expansions dramatically increase health care utilization among low-income populations. For example, becoming eligible for Medicaid lowered the odds that a child went 1 year without a doctor's visit by over 50 percent.

Correspondingly, we found striking health benefits from this expansion in insurance coverage. We found that the Medicaid expansions lowered the infant mortality rate by 8.5 percent, averting nearly 4,000 infant deaths per year; and we found that it lowered the child mortality rate by 4.5 percent, averting over 1,400 child deaths per year.

Thus, despite the crowdout, expanded Medicaid yielded impressive benefits in terms of improved health of the low-income population.

The key point is that crowdout determines the cost at which these benefits are achieved. Any expansion in Medicaid will provide insurance to some insured children and, as a result, will have health benefits. Crowd-out does not negate these accomplishments. It just simply dictates how much they will cost. Thus, crowdout acts to reduce Medicaid's bang for the buck, the health benefits to children per dollar of spending.

This concept is obviously an important one for thinking about the future direction for policy in this area. Policy initiatives will have the highest bang for the buck, if they can focus their action on the populations that are likely to be uninsured as opposed to privately insured.

This insight suggests that, clearly, the priority for Medicaid policy should be to increase takeup among existing eligibles, not near-eligible populations. Currently, there are 10 million children living below 133 percent of the poverty line who are not on the Medicaid Program. Among those children, over one-half, or 5.4 million, are uninsured. This is a population for which the bang for the buck is likely to be quite high.

Contrast this with another population of interest, those living between 133 and 200 percent of the poverty line. There are currently 8.3 million children living in this income range that are not on the

Medicaid Program. Among these children, only 27 percent, or 2.2 million, are uninsured. This is a group for which the bang for the buck will be much lower. That is, among the poorest children who are not on Medicaid already, for every uninsured child you make eligible, you make one insured child eligible. But among the higher income group, for every uninsured child you make eligible, you make three insured children eligible. This will increase crowdout and lower the bang for the buck.

This implies that the first priority for the policy in this area has to be to increase utilization of the Medicaid Program by those poor children who are eligible but not currently enrolled. Policy initiatives in this area are relatively straight forward and involve outreach potentially through school-based programs.

But this discussion should not be taken to imply that we should ignore families further up the income scale. In fact, I would argue that the second priority for policy in this area should be a limited expansion of the Medicaid Program up to 200 percent of poverty. But expansions in this range face a larger crowdout problem, so the goal here should be to minimize crowdout.

The core of the crowdout problem, if you think about it, is that the Government is offering insurance that is free to people who are paying for their insurance now. This problem can be mitigated by reducing the generosity of Medicaid that is offered to higher income families.

For example, a typical government policy in this area could be to introduce income-related premiums. The program could be free below 133 percent of the poverty, with a subsidy that phases out up to 200 percent of the poverty line. This would impose a relatively limited cost on families but would likely minimize the crowdout.

Let me just sort of conclude my comments by just highlighting two points. First, insurance among children in the United States is an important problem with real health consequences. Discussions of crowdout should not miss the essential point that, because of the Medicaid Program, there are 4,000 fewer infants and 1,400 fewer children dying in the United States.

Nevertheless, combating uninsurance in a cost-effective manner requires focusing on those populations where the bang for the buck is likely to be highest, groups with a high rate of uninsurance. This suggests the first priority for policymakers is to focus on eligibles who are not taking up and then to worry about expanding up the income scale.

Thank you very much. I am happy to answer any questions.

[The prepared statement follows:]

Statement of Jonathan Gruber, Associate Professor of Economics, Massachusetts Institute of Technology Faculty Research Fellow, National Bureau of Economic Research

Thank you for allowing me to speak to you today about the problem of uninsured children in the U.S. There are currently 10 million children in the U.S. without health insurance. This figure has risen relatively slowly over the past decade, But this slow rise in the number of uninsured children masks two important trends: a rapidly declining rate of private insurance coverage and a corresponding rising rate of public insurance coverage. The share of children with private coverage has fallen by 8 percentage points over the past decade, while public coverage has grown by an offsetting 7 percentage points.

These trends correspond to a dramatic expansion of the Medicaid program, which provides insurance for low income children. Traditionally limited to very poor children living in single female headed families, this program has been expanded to cover all children under age 6 in families below 133% of the Federal poverty line, and all children under age 13 below 100% of the Federal poverty line. By my estimates, fully one-third of all children in the U.S. today are eligible for the Medicaid program.

In fact, the expansion of the Medicaid program may be part of the root cause of these trends in private and public insurance coverage, through the "crowdout" mechanism. Privately insured individuals who become eligible for Medicaid may find it attractive to drop their private coverage and join the Medicaid program. The typical privately insured family pays roughly one-third of their medical costs, between copayments, deductibles, premiums, and uncovered costs such as prescription drugs. But Medicaid is totally free: there are no copayments or deductibles, and many extras such as prescriptions are covered. As a result, upon eligibility for Medicaid, privately insured families may find it attractive to drop their private coverage and sign up for the public program.

In recent research with David Cutler of Harvard University, I have investigated the magnitude of this crowdout phenomenon. Our results are striking: *for every two persons who joined the Medicaid program due to these expansions, one person lost private insurance coverage, for a "crowdout" of 50%.* The mechanism for this crowdout does not appear to be employers dropping their insurance coverage when their employees become eligible for the program. Rather, it is employees not taking up insurance where they must pay some share of the costs, preferring instead to join the public program.

The existence of crowdout does not mean that expanding Medicaid was a bad idea. In fact, in other research with Janet Currie of UCLA, I have found enormous health benefits to low income populations from the expansion of the Medicaid program. We found that the Medicaid expansions dramatically increased health care utilization among the low income population: *becoming eligible for Medicaid lowered the odds that a child went a year without a doctor's visit by over 50%.* Correspondingly, we found striking health benefits from this expansion in insurance access: *the Medicaid expansions lowered the infant mortality rate by 8.5%, averting nearly 4000 infant deaths per year.* And they *lowered the child mortality rate by 4.5% as well, averting over 1400 child deaths per year.* Thus, despite crowdout, expanding Medicaid yielded impressive benefits for the health of children in the U.S.

The key point is that crowdout determines the cost at which these successes are achieved. Any expansion in the Medicaid program will provide insurance to some uninsured children, and as a result have health benefits; crowdout does not negate those health benefits. What crowdout does is to raise the costs of these accomplishments, since along with these previously uninsured children who see improved health, we also cover some previously insured children who see no health benefit. That is, crowdout reduces Medicaid's *"bang for the buck": the health benefits to children per dollar of spending.*

This concept is an important one for thinking about future direction for policy in this area. Policy initiatives will have the highest bang for the buck if they focus on populations which are likely to be uninsured, as opposed to populations that are primarily privately insured.

This insight suggests that the priority for Medicaid policy should be to increase takeup among existing eligibles, rather than expanding the program up the income scale. Currently, *there are 10 million children living below 133% of the Federal poverty line who are not on the Medicaid program. Among these children, 53%, or 5.4 million, are uninsured.* This is a population in which the bang for the buck is likely to be quite high: there is relatively little private insurance coverage to be crowded out.

Contrast this with another population of interest: those between 133% and 200% of poverty. There are currently *8.3 million children living between 133% and 200% of the Federal poverty line who are not on the Medicaid program. Among these children, 27%, or 2.2 million are uninsured.* This is a group for which the bang for the buck will be much lower. That is, among the poorest children who are not already on Medicaid, for every uninsured child made eligible, you make one insured child eligible. But among this higher income group, for every uninsured child made eligible, you make three insured children eligible. This will increase crowdout and lower the bang for the buck.

This implies that *the first priority for policy in this area should be to increase utilization of the Medicaid program by those poor children who are eligible but not currently enrolled.* Policy initiatives in this area should include extensive outreach programs. A natural locus of such outreach would be schools. America has had fantastic

success with immunization among school age children, since almost all children come in contact with our public and private school systems. Similar success could perhaps be achieved with Medicaid takeup if we ensured that families of school children were informed of their eligibility for this valuable benefit.

This discussion should not be taken to imply, however, that we should ignore families further up the income scale. Indeed, the *second priority for policy in this area should be a limited expansion of the Medicaid program up to 200% of poverty.* Expansions of the program in this range do face a larger crowdout problem, but crowdout can be minimized by reducing the generosity of the program. The core of the crowdout problem is that the government is offering insurance that is both more generous than the typical private insurance policy, and cheaper, to a population that is largely privately insured. This problem could be mitigated by reducing the generosity of the Medicaid policy that is offered to higher income families.

For example, the government could introduce income related premiums: *the program could be free below 133% of poverty, with the subsidy then phasing out up to 200% of poverty, reaching (for example) a cost of $500 per child at 200% of poverty.* For a family with two children living at 200% of poverty, this would amount to less than 3% of their family income. But a cost of $1000 would likely be enough to deter privately insured families from dropping their coverage to join the program.

Income-related premiums are only one alternative for reducing generosity. Alternatives include introducing copayments or deductibles at the point of utilization, or a continued shift to managed care; both of these policies would have the added virtue of increasing the efficiency with which medical care is delivered to the poor. The key point is that policies such as these decrease the attractiveness of the program to the privately insured, while maintaining its essential insurance features for those who truly need coverage.

This discussion also has implications for non-Medicaid alternatives for covering uninsured children. One popular alternative is tax credits for children's insurance. But tax credits are likely to have a particularly low bang for the buck, since most children have private insurance coverage. Indeed, there are *five insured children for every uninsured child in the U.S.* Thus, an unlimited tax credit would largely serve to subsidize the insurance purchase of children who are already privately insured.

Moreover, it is doubtful that such a credit would have much impact on the current set of uninsured children. There is currently no market for purchasing insurance for children only. As a result, a subsidy to the insurance coverage of children would probably only impact those families where the parent is already insured. *But children in these families with at least one insured parent represent only 22% of uninsured children.* The impact of this credit would also be limited unless it was refundable, as 40% *of uninsured children live in families with no taxable income.*

This discussion suggests that, should the tax credit approach be pursued, the credit should be very tightly focused on the potentially uninsured population. For example, *a refundable credit for those with incomes up to $20,000 would apply to 8.3 million of the currently uninsured children, which is 78% of the total number of uninsured children. But it would only apply to 16.9 million of currently insured children, which is 33% of the total number of privately insured children.*

In conclusion, I want to highlight two points. First, uninsurance among children in the U.S. is an important problem with real health consequences, as witnessed by the striking health benefits of the Medicaid expansions. Discussions of crowdout should not miss the essential point that, because of Medicaid policy over the 1980s and 1990s, there are 4,000 fewer infants and 1400 fewer children dying each year in the U.S.

Nevertheless, combatting uninsurance in a cost effective manner requires focusing on those populations where the bang for the buck is likely to be highest: groups with a high rate of uninsurance. This suggests that the first priority for policy makers is to increase enrollment in the Medicaid program among those low income children who are already eligible. Additional steps, such as further expansions to higher income children or tax credits, should be limited in a manner which focuses their impact on the uninsured. This could be accomplished through income related premiums for Medicaid, and through relatively low income cutoffs for tax credits.

Chairman THOMAS. Well, thank you, Dr. Gruber.

Ms. Dubay.

STATEMENT OF LISA DUBAY, SENIOR RESEARCH ASSOCIATE, URBAN INSTITUTE

Ms. DUBAY. I want to thank the Members of the Subcommittee on Health for providing me with this opportunity to comment on the issue of health insurance coverage for children.

Today, I am going to talk about the lessons we have learned from the Medicaid expansions for pregnant women and children that have been unfolding over the past decade and how these lessons are relevant for today's policy debate. In particular, I will be addressing the issue of crowdout, that is the substitution of public coverage for private coverage that may occur when new public programs are implemented.

I am going to organize my talk around four main questions and draw on research that I conducted with Genevieve Kenney at the Urban Institute, and I should say that the opinions I will be expressing today are my own, and they do not represent the views of the Urban Institute or its sponsors.

The first question is, Can programs that subsidize health insurance coverage for children reduce the number of uninsured? And the answer is, Yes, they can.

In our research, we examined the impact of the Medicaid expansions on changes in insurance coverage of low-income children and pregnant women using the current population survey. We found that without the Medicaid Program, more than 3 million more children would have been uninsured. However, we found that the program participation rates were low, even though Medicaid offered coverage at a 100-percent subsidy. We found that only 69 percent of the children and 44 percent of the pregnant women eligible under the expansions and without employer-sponsored coverage enrolled in the Medicaid Program.

The second question is, Will the new programs that provide subsidies for health insurance coverage displace private coverage?

The answer is, Yes, they will; but the magnitude of this effect depends on, among other things, the income eligibility threshold of the program.

We estimated the amount of crowding out that occurred with the expansions and found that only 17 percent of the increase in Medicaid enrollment of young children and 14 percent of the increase in enrollment of pregnant women was attributable to crowdout. And I should note that these effects are much lower than those just presented by Jonathan Gruber, but they are much higher than the two other studies that have found no displacement effect.

But the insight that comes out of our work is that we found there is no evidence of crowding out for pregnant women below poverty and very little crowding out for children below poverty. We did find crowdout effects above poverty, and these effects were higher for pregnant women than for children because pregnant women are covered up to 185 percent of poverty and children were only covered up to 133 percent of poverty.

Based on these findings, we conclude that programs that limit coverage to lower income groups will find that a relatively small percentage of new public dollars will be replacing employer and individual contributions; and programs that offer coverage to children

at higher incomes could potentially see a large share of public dollars replacing private dollars.

The third question is, What can be done about crowding out?

Well, we really don't know; and, unfortunately, many of the solutions may create new equity problems.

Given current Federal budget constraints, it is important that new public programs that subsidize health insurance coverage of children be appropriately targeted. What can be done to prevent crowdout? We can limit eligibility to individuals who have been uninsured for a period of time or to those who do not have an offer of employer-sponsored coverage.

The problem is that we don't know how effective these strategies would be at minimizing crowdout. Moreover, these types of initiatives might also mean that families that lost their employer-sponsored coverage for reasons beyond their control or who face premium contributions that represent a large financial burden, could not participate, thus creating new equity issues.

Sliding-scale premium contributions could also reduce such substitution. However, smaller subsidies are also likely to deter uninsured families from participating in the program.

The fourth and final question is, What should policymakers do? And the answer depends on how much we are willing to spend to reduce the number of uninsured children.

The conundrum facing policymakers today is how to cover a substantial number of uninsured children without also covering children who would otherwise be insured. On the one hand, other research indicates that subsidies will have to be large in order to achieve significant reductions in the number of uninsured children. At the same time, concern about the substitution of public coverage for private coverage is a real issue from a budget perspective; and it is not clear how to prevent it.

The fact that uninsured children are not concentrated at the low end of the income distribution makes this a very challenging problem. Covering children under poverty is a win-win option—there will be almost no crowding out—but these children do not constitute a large percentage of the uninsured. New programs that subsidize coverage for children in families with incomes up to 185 percent of poverty may produce acceptably low levels of crowdout but will still leave 46 percent of uninsured children uncovered, and the majority of new dollars will go to covering children who are uninsured.

In contrast, programs that include children in families with incomes up to 300 percent of poverty would make more than 80 percent of all uninsured children eligible. Yet, under such programs, the share of participants that previously had private coverage will likely be large unless mechanisms to limit the substitution of public for private coverage are effective.

But even if a significant number of working families do drop their private coverage and take advantage of the new program, this may have important benefits to children, such as providing them with greater insurance security and more comprehensive coverage and offering financial relief to their families.

Therefore, in order to ensure that more children in this country have health insurance coverage, it may be necessary to accept a

greater public role in financing health insurance coverage for children.

[The prepared statement and attachments follow:]

Statement of Lisa Dubay,* Senior Research Associate, Urban Institute; and Genevieve Kenney,* Senior Research Associate, Urban Institute

I. Introduction

Extending health insurance coverage to more children is currently of considerable policy interest as evidenced by the number of bills so far introduced in the 105th Congress.[1] These legislative initiatives propose a range of mechanisms for reducing the number of uninsured children including: tax credits and vouchers for families to assist them in purchasing insurance coverage for their children, grants to states to design and finance new health insurance coverage programs, and a new entitlement program. The motivation behind these initiatives is the belief that providing health insurance coverage to uninsured children will improve access to and use of health care which will in turn lead to improved health. In addition, these initiatives seek to provide some financial relief to working uninsured families.

While only one of the legislative initiatives on child health insurance coverage proposes expansions of the Medicaid program, the experience of the Medicaid expansions for children and pregnant women is relevant for today's policy debate. The Medicaid expansions provided full subsidies for the health insurance coverage of certain low-income children. Many of the proposed initiatives would provide full or partial subsidies of health insurance coverage for children who live in families with incomes that exceed current Medicaid eligibility thresholds, with the more generous including families up to 300 percent of poverty. The expansions provide important lessons regarding the ability of programs that provide health insurance coverage to reach their target population and reduce the number of uninsured children. In addition, they can shed light on the amount of "crowding-out" that can be anticipated.

Crowding-out is a phenomenon whereby new public programs or expansion of existing public programs designed to extend coverage to the uninsured prompt some privately insured persons to drop their private coverage and take advantage of the expanded public subsidy. The issue of crowding out can be important because it may lead to fewer improvements in access to care and greater program costs than expected.

Our testimony today will provide information on the extent and nature of the population of children without health insurance and describe the lessons learned from the expansions in Medicaid coverage for children and pregnant women that occurred over the last decade. We will also identify areas where more information is needed in order to make informed policy choices.

Our testimony can be summarized by the following six conclusions:

- Policy solutions aimed at reducing the number of uninsured children must take a multi-pronged approach. This type of approach is necessary because about a quarter of uninsured children are currently eligible for Medicaid but not enrolled, older children living in poverty will not all be covered by Medicaid until 2002, and the remainder, almost three quarters of all uninsured children, live in families with incomes above poverty.
- New programs that provide public subsidies for health insurance coverage will result in some crowding out of private coverage. The magnitude of this effect will depend on the income eligibility level of the program, the success of the attempts made to minimize the substitution of public coverage for private coverage, the magnitude of premium cost-sharing for employer-sponsored coverage faced by those eligible for the new program, and the generosity of the benefit package under the new program relative to under employer-sponsored coverage.

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[1] These bills include: the Children's Health Coverage Act (S. 13, Daschle, D–SD); the Health Assurance Act (S. 24, Spector, R–PA); the Healthy Children's Pilot Program Act (S. 435, Spector, R–PA); the Healthy Start Act (H.R. 560, Stark, D–CA): the Children's Health Insurance Act (H.R. 561, Stark, D–CA); the Child Health Insurance and Lower Deficit Act (Hatch, R–UT, Kennedy, D–MA). In addition the Family and Child Health Assurance Act (Gramm, R–TX and Coverdell, R–GA) will be introduced and the President's FY 1998 budget addresses health insurance coverage for children.

• Programs that limit coverage to lower income groups will find that a relatively small percentage of new public dollars will be replacing private employer and individual payments. Programs that offer coverage to children at higher incomes could potentially see a large share of public dollars replacing employer and individual contributions thus affecting the distribution of who pays for health insurance coverage.

• In an era of scarce resources, it is important to reduce the incentives to substitute public dollars for private dollars. While mechanisms to reduce this crowdout effect are important, it is difficult to prevent substitution without creating inequities in access to coverage.

• While programs that phase out subsidies as income increases will discourage the substitution of public coverage for private coverage, they may also discourage families with uninsured children from purchasing insurance for their children. Without large subsidies, the ability of a new program to reduce the number of uninsured children may be compromised.

• In order to assure that most uninsured children receive health insurance coverage, we may need to accept a shifting of the distribution of who pays for such coverage from the private to the public sector as part of the cost of this coverage.

II. The Problem

According to 1994 estimates from the Current Population Survey (CPS), more than seven million children lack health insurance coverage. Uninsured children come from all income and age groups (see Table 1). Altogether 54 percent of uninsured children live in households with income less than 185 percent of the federal poverty line and almost 23 percent of uninsured children live in households below the federal poverty line.

Table 1.—The Composition of uninsured Children, 1994

[By Income]

Percentage of Poverty	Total (Millions)	0–5	6–12	13–18	All
0–99%	1.67	20.55%	21.51%	25.78%	22.73%
100–133%	0.88	9.83%	13.52%	12.31%	12.07%
134–185%	1.46	18.94%	20.85%	19.51%	19.85%
186–299%	2.02	29.88%	27.21%	25.95%	27.52%
300%+	1.31	20.81%	16.91%	16.44%	17.84%
All	7.35	28.05%	37.20%	34.75%	100.00%

[By Age]

Age	Total (Millions)	0–99%	100–133%	134–185%	186–299%	300%+	All
0 to 5	2.06	25.36%	22.85%	26.77%	30.46%	32.73%	28.05%
6 to 12	2.73	35.21%	41.69%	39.07%	36.77%	35.25%	37.20%
13 to 18	2.55	39.42%	35.46%	34.16%	32.77%	32.02%	34.75%
All	7.35	22.73%	12.07%	19.85%	27.52%	17.84%	100.00%

Source: Urban Institute tabulations from the TRIM2 edited version of the March Current Population Survey, 1995.

Note: Percentages may not sum to 100 because of rounding. The population excludes the elderly, the institutionalized and families with an active military member. "Other" coverage covered through groups include the non-elderly Medicare, VA, CHAMPUS, and military health.

The distribution of insurance coverage for children varies by household income and age of child (Table 2). The risk of being uninsured increases with the age of the child, particularly in poorer families. Overall, children age 13 to 18 are a third more likely than those under 6 to lack health insurance. In households with incomes below the federal poverty line, older children were three times as likely to lack health coverage relative to the younger children. For children of all ages, lower rates of uninsurance occurred at the very bottom and top of the income ranges; living in households with incomes between 133 and 185 percent of the federal poverty level puts children at the greatest risk of not having health insurance coverage.

Table 2.—Insurance Coverage of Children, 1994

[All Children through Age 18]

Poverty Level	Total (millions)	Employer Sponsored	Medicaid	Private and Other	Uninsured
0–99%	16.33	15.96%	72.09%	1.73%	10.23%
100–133%	5:51	39.06%	41.37%	3.49%	16.09%
134–185%	7.72	58.83%	17.21%	5.07%	18.89%
186–299%	15.36	76.13%	4.92%	5.78%	13.17%
300%+	71.85	62.69%	22.95%	4.14%	10.23%
All	71.85	62.69%	22.95%	4.14%	10.23%

[0 to 5]

Poverty Level	Total (millions)	Employer Sponsored	Medicaid	Private and Other	Uninsured
0–99%	6.76	13.68%	78.76%	1.30%	6.27%
100–133%	2.01	38.15%	50.04%	1.74%	10.07%
134–185%	2.64	56.04%	25.75	3.43%	14.78%
186–299%	4.86	74.70%	7.33%	5.31%	12.67%
300%+	7.67	87.55%	1.81%	5.50%	5.59%
All	23.95	56.46%	31.34%	3.59%	8.61%

[Children Age 6 to 12 Years]

Poverty Level	Total (millions)	Employer Sponsored	Medicaid	Private and Other	Uninsured
0–99%	5.96	17.50%	71.27%	1.35%	9.87%
100–133%	2.07	41.22%	38.28%	2.68%	17.83%
134–185%	2.94	61.45%	13.84%	5.35%	19.36%
186–299%	6.05	78.17%	4.21%	5.32%	12.30%
300%+	9.78	90.11%	1.17%	3.99%	4.73%
All	26.80	64.34%	21.70%	3.75%	10.20%

[Children Age 13 to 18 Years]

Poverty Level	Total (millions)	Employer Sponsored	Medicaid	Private and Other	Uninsured
99%	3.62	17.70%	60.94	3.14%	18.21%
100–133%	1.43	37.20%	33.62%	7.14%	22.04%
134–185%	2.14	58.69%	11.31%	6.70%	23.30%
186–299%	4.45	74.94%	3.23%	6.93%	14.90%
300%+	9.48	89.88%	1.04%	4.65%	4.43%
All	21.10	67.65%	15.01%	5.25%	12.10%

Source: Urban Institute tabulations from the TRIM2 edited version of the March Current Population Survey, 1995.

Note: percentages may not sum to 100 because of rounding. The population excludes the elderly, the institutionalized and families with an active military member. "Other" coverage groups include the nonelderly covered through Medicare, VA, CHAMPUS, and military health.

Patterns of insurance coverage are influenced by Medicaid eligibility policies which offer protection to all poor children under 14 years of age. In response to evidence indicating declining health status for low-income children and growing disparities in access to health care between the insured and the uninsured, Medicaid coverage for children was expanded in the late 1980s. Congress permitted and eventually mandated states to provide phased-in Medicaid coverage for children up to age six in families with incomes up to 133 percent of the federal poverty level and to all children born after September 30, 1983, in families with incomes at the poverty line or below. Under the phase-in, all children under age 18 living in households beneath the federal poverty line will be eligible for Medicaid by the year 2002.

States were also given the option to cover infants with family incomes up to 185 percent of poverty.[2] These expansions represented a dramatic change from the past, when children qualified for Medicaid only if their families' incomes were below AFDC thresholds (which had averaged only about 50 percent of the poverty level prior to the expansions).

III. What Did We Learn From the Medicaid Expansions for Pregnant Women and Children?

The expansions in Medicaid coverage for pregnant women and children that took place in the late 1980s and early 1990s provide important lessons regarding the ability of programs that subsidize health insurance coverage to enroll eligible children and reduce the number of uninsured children, as well as the amount of crowding-out that can be anticipated under such programs.

The intent of the Medicaid expansions was to reduce the number of uninsured children and pregnant women, increase access to health care, and thus, improve children's health. Between 1988 and 1993, the number of children receiving Medicaid-covered services grew by 10.7 to 16.5 million a 54 percent increase (unpublished tabulations of HCFA Form 2082 data). The number of births financed by Medicaid also increased substantially (Sing, Gold, and Frost, 1994).

Over the same period, which also witnessed an economic recession, employer-sponsored insurance coverage was declining (Holahan, Winterbottom, and Rajan, 1996; Peat Marwick, 1994), and the number of uninsured children grew (Dubay and Kenney, 1996). The simultaneous decline in employer-sponsored coverage and increase in Medicaid coverage of children, coupled with the increase in uninsured children has led some observers to suspect that the Medicaid expansions for children and pregnant women "crowded-out" employer-sponsored coverage. To try to identify whether, and if so how much, the expansions crowded out private coverage, researchers at the Urban Institute conducted the following analysis.

The Dubay-Kenney Study

In the this study, we examined changes in health insurance coverage for children and pregnant women using CPS data edited by the Urban Institute's Transfer Income Model (TRIM2) and representing 1988 and 1991/1992.[3] We focused our analysis on the target population of poor and near poor pregnant women and children ages 10 and under. Our overall approach in assessing the impact of the expansions on insurance coverage was to examine aggregate changes in health insurance coverage separately for pregnant women and children 10 years old and younger by income group.

We first assessed the extent to which the expansions were covering the target population. We found participation rates for expansion eligible children and pregnant women to be less than that under the traditional Medicaid program where over 90 percent of those eligible enroll. Only 44 percent of pregnant women eligible for the expansions who did not have employer-sponsored insurance enrolled in Medicaid. Sixty-nine percent of the children eligible under the expansions who did not have employer-sponsored coverage enrolled in the Medicaid program. Whether the lower participation rates for the expansion population are due to lack of knowledge about the new eligibility rules, unwillingness to enroll in Medicaid, or persisting problems with the Medicaid eligibility determination process is unclear. The fact that such a large percentage of uninsured children are Medicaid eligible suggests that large inroads into the problem could be made by increasing Medicaid participation rates and illustrates the importance of understanding why the participation rate is so low.

We then estimated the extent to which the expansions crowded out employer-sponsored insurance. We compared the declines in employer-sponsored coverage for children and pregnant women to the declines for men ages 18–44—a group unlikely to be affected by the expansions. We did this to control for the portion of the decline in employer-sponsored coverage for children and pregnant women that would have occurred in the absence of the expansion. The difference between the decline in employer-sponsored coverage for children and pregnant women and that for men is the amount of the decline in employer-sponsored coverage for children and pregnant women attributable to crowdout. We then divided this decline by the increase in

[2] In addition, using other provisions of Medicaid law (Section 1902(r)(2) and Section 1115), some states have chosen to offer coverage to children in households with higher income levels than specified in the expansions.

[3] Dubay and Kenney use 1991 data for their analysis of pregnant women and 1992 data for their analysis of children as their post-expansion period.

Medicaid enrollment. This provides our estimate of how much of the Medicaid enrollment increase resulted from crowdout.

About 14 percent of the increase in Medicaid enrollment of pregnant women and 17 percent of the increase in enrollment of young children was attributable to crowdout, according to our estimates. These estimates represent the degree to which public funds substituted for private funds over the period. We find no evidence of crowding out for poor (that is, below the poverty line) pregnant women and very little crowding out for poor children. For pregnant women and children with household incomes above the poverty line (that is, 100–185 percent of poverty for pregnant women and 100–133 percent of poverty for children) we find the crowdout effect to be 45 and 21 percent respectively. The higher crowdout estimate for pregnant women suggests that more crowding out occurs as income eligibility thresholds increase.

We also found that more than 75 percent of the increase in Medicaid enrollment over the expansion period was for children and pregnant women who would otherwise have been uninsured or would have lost their insurance as a result of secular declines in employer-sponsored coverage. This means that, without the Medicaid program, an additional 3 million children would have been uninsured in 1992.

Study Limitations. Using men ages 18–44 is not a perfect control for how the health insurance coverage of children and pregnant women would have changed in the absense of the expansions. For example, if the secular declines in coverage were greater for children and pregnant women than for men, we may over-estimate the extent of crowding out. In fact, there is evidence to suggest that this is the case: between 1989 and 1993, *employee* health insurance contributions rose by twice as much for family coverage as for individual coverage, providing a much more substantial disincentive to continue employer-sponsored coverage of dependents.[4]

It has also been claimed (Culter and Gruber 1997) that we underestimate the Medicaid crowdout effect by failing to count the spillover effect within families. This effect comes about when a family drops employer-sponsored coverage because some of the family members (pregnant mother and younger children) are eligible for, and choose to take advantage of, the Medicaid expansion—leaving the ineligible family members (older children) without insurance. Since these family members are ineligible for Medicaid, we do not consider this a crowdout effect. However, even with a broader interpretation of crowdout, the spillover effect is likely to be small. In work that we are currently doing, we find that less than 3 percent of the children living in families with Medicaid-covered children are uninsured. This 3 percent estimate is an upper bound on the spillover effect since some of these uninsured children would have been uninsured even in the absence of the expansions.

This research, and much of the other literature on crowdout, uses the Current Population Survey which is a *cross-sectional* database. A definitive analysis of the crowdout issue requires the use of a *longitudinal* database to shed light on the dynamic nature of health insurance coverage. In other words, in order to understand changes in insurance coverage over time, we want to be able to observe the transitions between one type of insurance coverage and another. When cross-sectional data are used, the movement of one group out of employer-sponsored coverage and into the uninsured category combined with another group moving from the ranks of the uninsured into Medicaid might appear to be a movement from employer-sponsored coverage into Medicaid.

In order to eliminate this problem, a new Urban Institute study by Blumberg, Dubay and Norton, is using the 1990 panel of the Survey of Income and Program Participation—a data base that follows the same households over a 2 and a half year period—to examine health insurance coverage transitions for poor and near poor children over the expansion period. The results of this analysis will be released in the near future.

IV. What Lessons Are Relevant for Today's Policy World?

As mentioned previously, some of the legislative initiatives currently in Congress propose to provide full or close to full subsidies to purchase health insurance coverage for children in families with incomes up to some specified level. In this way, the initiatives are similar to the Medicaid expansions and some lessons can be easily applied. At the same time, there are aspects of the initiatives that are unlike the expansions. For example, income eligibilty for many of the proposed programs

[4] Authors' computations of the percentage change in average monthly employee contributions towards health insurance premiums between 1989 and 1993 in medium and large firms. From the Bureau of Labor Statistics' Employer Benefits Survey, U.S. Department of Labor, Bulletins 2363 and 2456.

would be substantially higher than under the Medicaid expansions and those with higher incomes would receive only partial subsidies.

Four lessons stand out as important for today's policy discussion regarding federal programs to subsidize the costs of health insurance coverage for children.

• Programs that subsidize health insurance coverage for children will reduce the number of uninsured children.

• Even when the entire cost of health insurance coverage for children is subsidized, some eligible children will remain uninsured.

• Subsidizing insurance coverage for children in poor households will result in very little substitution of employer-sponsored coverage, in large part because this population has very little insurance coverage to begin with.

• The higher the income-eligibility cutoff, the greater will be the crowdout effect. This is because as income increases, the prevalence of employer-sponsored coverage increases and the proportion of households without insurance decreases. Therefore, even if only a small percentage of families substitute private for public coverage and participation by the otherwise uninsured is relatively high, as the income eligibility cutoff for a new program increases, the percentage of entrants into that program will increasingly come from those who previously had private coverage.

These are important lessons. There are also a number of limitations in the applicability of these analyses to the types of health insurance programs currently being considered by Congress.

1. Since the expansions were limited to children and pregnant women with incomes below 133 and 185 percent of poverty respectively, there is no evidence on how much public coverage would substitute for private coverage in programs with higher income eligibility levels.

2. Since the expansions fully subsidized the costs of health insurance coverage, there is also no evidence from this literature regarding how premium cost-sharing would affect either participation in the program or the dropping of employer-sponsored coverage.

3. The dynamics of family participation in a health insurance programs other than Medicaid may be quite different from those driving Medicaid participation, particularly if the stigma associated with the program is lower, the eligibility determination process is different, or the benefit package under the program is less comprehensive.

4. There is little evidence that employers responded to the expansions by reducing their offers of and contributions to health insurance coverage (Cutler and Gruber 1996). The proposed initiatives that cover children up to 300 percent of poverty would make 60 percent of all children eligible for the program. Such large-scale initiatives could alter employer behavior, potentially further reducing employer contributions for dependent health insurance coverage.

5. Finally, none of the studies tells us why those individuals who dropped their private insurance over this period did so. For example, it may be that the families who substituted Medicaid for private coverage were those with policies that had high deductibles and co-payments, covered only catastrophic illness, or did not cover preventive services. For some low-income families, the movement into the Medicaid program may have represented access to coverage that they did not previously have. Similarly, those families that dropped their private coverage may have faced premium contributions that represented large financial burdens.

V. What Can be Done to Appropriately Target New Programs and Limit the Extent of Crowding Out?

Given the current federal budget constraints, it is important that new public programs that subsidize health insurance coverage of children be appropriately targeted in order to get the most "bang for the buck." What do we know about the effectiveness of strategies to reduce the substitution effect? States have implemented a number of strategies designed to prevent crowding-out when they expanded insurance coverage (either through their Medicaid Section 1115 waivers or though their state-only health insurance programs). These strategies have included limiting eligibility to individuals a) who have been uninsured for a period of time, b) who do not have an offer of employer-sponsored coverage, or c) who face premium cost-sharing greater than 50 percent for their employer-sponsored coverage. However, these programs are relatively new and the effectiveness of these mechanisms at reducing crowdout has not been assessed. States have also found these types of mechanisms administratively complex (Wooldridge et al 1997) making them difficult to implement.

Moreover, these types of initiatives could also prevent families who lost their employer-sponsored coverage for reasons beyond their control, such as job loss or reduc-

tions in employer contributions to premiums, from taking up the new program. Thus, they potentially create inequities in who is eligible for the subsidy.

Each of the bills introduced in Congress this year would require that some families contribute to the costs of health insurance coverage under the new program and would vary the subsidy based on family income. Families for which the offered subsidy is less than the cost sharing they currently face (including differences in benefit packages, co-payments, deductibles, and premium contributions) will be unlikely to substitute public coverage for private. Thus lower subsidies would tend to reduce the crowdout effect. However, the subsidy schedule will also affect the extent to which families with uninsured children will participate in the program. According to research by Marquis and Long (1995), in order for low-income working families to purchase insurance, subsidies must be quite high.

VI. Conclusions

The conundrum facing policy makers today is how to cover a substantial number of uninsured children without also covering children who would otherwise be insured. On the one hand, evidence suggests that subsidies will have to be large in order to achieve significant reductions in the number of uninsured children. At the same time, concern about substitution of public coverage for private coverage is a real issue from a budget perspective and it is not clear how to prevent it.

The fact that uninsured children are not concentrated at the low end of the income distribution makes this a very challenging problem. Covering children under poverty is win-win option—there will be almost no crowding out—but these children do not constitute a large percentage of the uninsured. New programs that subsidize coverage for children in families with incomes up to 185 percent of poverty may produce acceptably low levels of crowdout, but will still leave 46 percent of uninsured children uncovered.[5] And, the majority of new dollars would go to covering children who are uninsured.

In contrast, programs that include children in families with incomes up to 300 percent of poverty would make more than 80 percent of all uninsured children eligible. Yet, under such programs the share of participants that previously had private coverage will likely be large unless mechanisms to limit the substitution of public for private coverage are effective. But even if a significant number of working families drop their private coverage and take advantage of the new program, this may have important benefits to children, such as providing them with greater insurance security and more comprehensive coverage, and offering financial relief for their families.

Therefore, in order to assure that more children in this country have health insurance coverage, it may be necessary to accept a greater public role in financing health insurance coverage for children.

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[5] Assuming full participation.

Chairman THOMAS. Mr. Curtis.

STATEMENT OF RICHARD E. CURTIS, PRESIDENT, INSTITUTE FOR HEALTH POLICY SOLUTIONS

Mr. CURTIS. Mr. Chairman, I appreciate the opportunity to summarize findings of our study.

As the two previous speakers' testimony has indicated, their findings, while the magnitude is different, are consistent in the following way: Both found that above poverty, especially, there was crowdout of private coverage due to Medicaid expansions, and that the farther you go up the income stream the higher the degree of crowdout.

This might be viewed as somewhat ironic since, in 1990, Congress enacted a provision that was intended to prevent this by requiring State Medicaid Programs to, when it is cost effective to do so, pay the employee's share of coverage when employer coverage is available to the Medicaid applicant.

I want to emphasize, as have the other panelists, that many modest-income working families need assistance to afford coverage, and that we should do what we can to help them get it. In fact, do what we can to cover uninsured children. But we need to do it cost effectively.

Medicaid expansions in 1988 and 1989 seemed very sensible because only 7.6 percent of uninsured poor and near-poor children at that time had a parent with employer-based coverage. I might note that today it is similarly emphasized that four out of five parents of uninsured kids are themselves uninsured. But we need avoid the same mistake we made then and be careful to look at how many of these children in the target income ranges are actually already covered under employment-based coverage.

In 1995, 77 percent of children with family incomes between 200 and 399 percent of poverty had employer-sponsored coverage. I believe between 150 and 200 percent, the number is 55 percent. Dr. Gruber's and Dr. Dubay's findings do confirm that unless we are very careful in how we craft further expansions, there will be further crowdout, given these numbers.

Now, why was it that at the State level, we did not succeed in avoiding crowdout? Well, unfortunately, the reasons are very, very complex. They do relate to the basic nature of Medicaid, as Dr. Gruber indicated, as an all-or-nothing program. So, very often people have been faced with a choice of free Medicaid or an employee contribution to obtain coverage. And, most States only were looking at high-cost diagnostic categories, a very limited number of people, for instance, with AIDS, and pursuing employer coverage only for those people. This meant that the vast majority of children with available employer coverage were really pursued.

But where States attempted to do so, it got to be extraordinarily difficult. It was very difficult for them to get basic information on the availability of employer coverage, the benefit structure of that coverage, the employer contributions, and so forth. And there are a range of reasons that that is true. Our report goes into some of that.

When States were able to get that information, eligibility period restrictions for private employer coverage often meant they could not avail the Medicaid eligible populations of that coverage. Then, further—and this is not a small item—it is very burdensome administratively, too, to get information for each individual applicant on whatever the benefit structure happens to be for that particular individual's employer, and then look at the employer's contribution policy and try to determine whether or not it is cost effective to pay the employee's share versus cover them under Medicaid. And in many States, as you know, just as at the Federal level, the dollars to expand administrative staff just are not there.

So, for all of those reasons, it has not really worked very well. But as we move up the income stream and consider further expansions of uninsured children, certainly we can do better. And while I think it is true to say there will be some degree of crowdout no matter what we do, certainly what you do specifically will have a large influence on how much crowdout there is and, as Dr. Gruber indicated, how good the bang for the buck is.

Some proposals before Congress basically would exclude children who are or have recently been eligible for sizable employer contributions. Our analysis is that that kind of approach would be both unfair and counterproductive in the longer run. It would be unfair because many of these children's parents are faced with very sizable contribution requirements. In fact, 30 percent of low-wage employees working for firms offering coverage in 1993 faced $2,400 or more in contribution requirements; and people in that income range simply cannot afford such outlays in most cases.

It would further be counterproductive because it would basically place firms who offer coverage at a disadvantage relative to competing firms that pay the same wages but whose workers' coverage is financed by the public sector. The net result would be that over time more and more businesses would not finance family coverage. The population eligible for and receiving public subsidies under the new program would grow.

In short, I think we all have to anticipate and certainly the Medicaid experience suggests this, that people in the market will respond to the incentives established by large national programs. This would also suggest that it would be better to structure financial incentives as a way to encourage continued private contributions while providing evenhanded assistance to individuals in families who require it whether or not they have employer-based coverage available to them. And your notions of looking at current tax policy and redistributions of current tax expenditures certainly have as much potential to do that as any other I have heard of.

The one other point I would like to make—and several of the Members of your Subcommittee have made a similar point—is that families are not well served by programs which force them to have different family members in different health plans and to change health plans every time their job status or income changes. And the degree to which we can avoid that and allow families to easily access one plan—they only have to learn one set of rules and only have to learn how to access one network of providers—will certainly be better for them. I think, more importantly, create better

incentives for health plans to provide cost-effective, preventive, and primary care service.

It is a well-known problem in Medicaid that often HMOs do not have those incentives because of the high degree of turnover in the enrolled population. They never realize the benefits of preventive care because the patient has moved on to another plan or to become uninsured.

Thank you.

[The prepared statement follows:]

Statement of Richard E. Curtis, President, Institute for Health Policy Solutions

Mr. Chairman and members of the committee, I am Richard E. Curtis, President of the Institute for Health Policy Solutions, a not-for-profit, non-partisan education and research organization that does not advocate specific legislation. The Institute was established to objectively analyze and develop approaches to solve health system problems, and brings special expertise and interest to policy approaches that complement or harness private sector roles to achieve goals that are in the public interest.

We appreciate the opportunity to present our observations and findings regarding children's access to health coverage. These findings are presented in our report entitled *Extending Health Care Coverage for Modest-Income Children and Pregnant Women: Public & Employer-Financed Coverage Lessons.*

While the details and methodologies vary, the research findings of Lisa Dubay and Genevieve Kenney as well as of David Cutler and Jonathan Graber both indicate that of the children and women above poverty who were newly brought into Medicaid coverage, a sizable portion would otherwise have been covered through employer plans.

The possibility of this outcome was not entirely unanticipated. In fact, in 1990 Congress enacted a requirement that state Medicaid programs pay the employee share of costs for group coverage for a Medicaid-eligible worker or a worker with Medicaid-eligible dependents when it would be cost-effective to do so—that is, when the cost of buying into the employer coverage is less than the expected cost of providing equivalent Medicaid benefits.

But this provision has clearly not had its intended effect of preventing the "crowdout" of private coverage that has been reported. For a variety of reasons, most states have not aggressively pursued implementation of this provision, and those states which have face a number of hurdles that impede effective implementation.

Many modest-income working families need assistance to afford coverage for their children. But the experience with Medicaid indicates that better approaches for coordinating low-income subsidies with employer-financed private coverage are needed if available public dollars are to be efficiently used to cover additional children in need. Lessons can also be drawn to design policies which better afford access and continuity of care for children.

As we note in the report, Medicaid expansions were a sensible strategy to reach uninsured low-income children at the time of their adoption. Only 7.6% of poor and near poor children in 1989 had a parent with employer-based insurance. Similarly, it is often noted today that 4 out of 5 parents of uninsured kids are themselves uninsured.

But it is also critically important to observe that as one ascends the income scale to 150% of poverty and beyond, an increasing majority of children are eligible for employer coverage. In 1995 over 77% of children with family incomes between 200% and 399% of poverty had employer-sponsored coverage.

Research findings such as those by Dubay and Kenny confirm that unless carefully crafted, public coverage expansions will increasingly substitute for existing private employer coverage as groups with somewhat higher incomes are targeted. For example, their estimates for the share of pregnant women covered under Medicaid enrollment increases who would otherwise be covered under employer plans are 0% for those beneath poverty, 27% for those from 100 to 133% of poverty, and 59% for those from 134% to 185% of poverty. It is interesting to note that for the 100% to 133% of poverty range, they found a similar "crowdout" percentage for children (22%) and pregnant women (27%). This may suggest that if Medicaid income thresholds were increased to 185% of poverty for children, it could similarly cause a much higher rate of "crowdout" of employer financed coverage for children.

The reasons this occurred (despite a general federal policy to the contrary) are varied and complex. Our report identifies and assesses a number of these factors. They include a lack of clarity regarding cost-effectiveness across applicable populations, states' difficulty in identifying and getting information on employer plans, eligibility period restrictions even when such coverage was identified, and agencies' reluctance or inability to undertake the administrative burden of assessing such individual applicant's unique employment situation and verifying benefit plans.

And the basic "all or nothing" structure of Medicaid makes it particularly difficult for states to design a sensible and efficient interface with employer-financed coverage. Many modest-income working parents (of Medicaid eligible children) and pregnant women are faced with a choice of free Medicaid or substantial contributions to obtain employer-sponsored coverage. Even when employer-sponsored benefits are generous and states pay the employee share of premium, states are faced with requirements to also enroll recipients in traditional Medicaid to obtain coverage for Medicaid benefits which are often broader than those offered under their employer's plan. States are also faced with administrative difficulty of coordinating Medicaid benefits with myriad different employer benefit plan variations. The Medicaid policies behind these requirements are clearly sensible, and to many of us desirable, for poor and near-poor persons. However, as we move up the income stream to reach more uninsured children, it will be important to consider alternative approaches that can better create a complementary relationship between public and private financing of coverage.

In response to the Medicaid "crowdout" experience, some have suggested that any new expansions of children's coverage should simply exclude children who are, or have recently been, eligible for sizable employer contributions. Our analysis is that such an approach would be both unfair and counterproductive in the longer run. As the data in our report show, 30% of low-wage employees who work for firms that offer coverage would, if eligible, face $2,400 or more in annual employee contribution requirements to obtain family coverage. Without subsidies, most low-income families simply cannot afford such outlays, at least not without sacrificing other necessities. And subsidy policies that strongly favored families without access to employer coverage would also indirectly favor businesses who don't offer coverage.

On the most basic and obvious level, government would be sending a message that it does not support employer contributions to dependent coverage, and in fact favors employers who do not. But beyond the obvious sentinel effect, such policies could create counterproductive economic incentives. Firms offering coverage could be placed at a disadvantage relative to competing firms that pay the same wages but whose workers' coverage is financed by the public sector. Such firms could afford to pay higher wages while firms that have traditionally offered coverage to employees would be incented to move to the use of contractual arrangements for workers without health coverage in lieu of direct employment. The net result would be that profits, jobs and employees would shift toward businesses that do not finance family coverage. And the population eligible for and receiving public subsidies would grow.

Effects of this kind may seem merely hypothetical: outside the abstract realm where economists dwell, would millions of people immediately change their employment for a relatively small economic benefit? Would many businesses offering coverage fail while competing firms and start-ups that did not finance coverage grow quickly? Would a number of employers drop coverage and offer temporary wage increases to offset employee costs during any "waiting period" required between employer coverage and eligibility for public subsidies? Possibly not, at least in the short term. Over time, however, people do change jobs, and businesses do thrive or fail based on their response to economic incentives. In short, it must be expected that the market will respond to the incentives established by large national programs. If there is no advantage to workers who receive part of their compensation in the form of health benefits, the structure of compensation will change and public outlays for such programs would escalate.

If the intent is to rely and build on parallel public and private financing and systems, erecting a wall between them will not work. People are going to shift from one kind of coverage to another as their circumstances change. And both employers and employees will find ways to respond to economic advantages given to some businesses and employee groups over others. The Medicaid "crowdout" experience would suggest that it would be better to structure financial incentives in such a way as to encourage continued private contributions while providing even-handed assistance to individuals and families who require it. But if a related goal is to optimize the use of public subsidies to achieve access to needed medical care, it will also be important to encourage the use of health coverage vehicles that have relatively low administrative costs and that do not magnify average per person or total public costs through risk selection. Simply subsidizing purchases through the traditional

individual health insurance market could easily see a high proportion of public outlays going to insurance overhead while leaving those needing it the most unable to afford coverage.

In addition, children and their families would be well served by policies which facilitated their ability to retain coverage through one health plan over time, rather than forcing a change in coverage source when their financial status changes. Shifts from employer to publicly sponsored plans often force a change in providers as well as a change in myriad benefit details and access rules. Further, health plans do not have positive incentives for the provision of even cost-effective preventive care if turnover rates mean they usually won't realize the benefits. We are hopeful that lessons drawn from the Medicaid "crowdout" experience can lead to coverage expansions for children that are more cost-effective for government, and are better for children and their families.

Chairman THOMAS. I want to thank all of you.

Frankly, one of the reasons—your last comment, Mr. Curtis, that some of the managed care programs for the Medicaid group I think holds such great promise is if you can set up a structure which allows for an ongoing preventive care structure and try to deal with the product in a nonstigmatized way.

You folk heard some of our earlier comments, and it carries through on your information. I guess I am less interested Dr. Gruber, Ms. Dubay, as to who is right, whether it is a 50-percent crowdout or a 25-percent crowdout. I can't believe literature was initially adopted that said there was no crowdout. That, to me, is illogical.

I noticed also that the focus was in the 185- to 200-percent level. I guess if I said, What is your opinion of legislation that deals with a 300-percent poverty level, Ms. Dubay notwithstanding, the benefit of having the public program, that you would agree it begins to get fairly significant in terms of a public payment access question versus the private. Or would you like the 300 percent?

Ms. DUBAY. What I would say is that we have no evidence of what would happen above 185 percent of poverty. I would also say that I think the potential for crowdout above 185 percent of poverty there is enormous because such a large percentage of that population has private coverage. And so if a small percentage of those that have private coverage drop it and participation rates by the uninsured that are high, we may get a program where more dollars are going toward substitution of coverage than to new coverage.

Chairman THOMAS. And whether we like it or not, there is a clear relationship in terms of moving up the income level to people who pay attention to what programs they have, what benefits they get, the dollar amounts they are paying, the budgeting in terms of their family at that level, I begin to get concerned about the public policy of providing to a group of people a subsidized health care package that is clearly a better package than what is available to those folks who are trying to pay for it themselves and pay taxes to provide that package to others.

So the crowdout becomes important to me because that is the area in which we have to be most creative in terms of providing options for people that either does not wind up in terms of a subsidy for some which draws them toward that subsidy that would otherwise not be the case or go back to some of the older tax credit

approaches which, frankly, I don't think get you much for your money, and we have seen in the past don't work as well.

But I am also concerned that the subsidy-nonsubsidy tends to be a government employer access debate. If it is a subsidy, it is government, if it is done out in the private sector, you get it from your employer.

Have you looked at the question of purchasing pools? Now, schools were mentioned, but that creates the problem of separating the children from the parents in an insurance structure. But some States are offering insurance purchasing pools for small employers. I am wondering if you had any examination of alternate insurance packaging structures that might get us off of this employer-government access?

Mr. GRUBER. I think some States have tried voluntary pools. I think voluntary small business pools have not been very successful, if anything on a very, very limited scale, because of the adverse selection problems that were mentioned. It is difficult but a voluntary skill to make them work. So I think, at least my sense, maybe the other panelists know more about this, my sense is voluntary pools have not really gotten very far in terms of——

Chairman THOMAS. My problem is when we talk about adverse risk selection, I can't think of which is a worse one which does not necessarily do it in a traditional insurance sense but in which the people choose the public insurance versus the private because it is free versus expenses in the other. That is a very perverse structure.

Mr. GRUBER. I agree. In fact, I think the important point you brought out is not to forget the tax subsidy, which is a large public expenditure that certainly shouldn't fall out of this debate.

Chairman THOMAS. I do want to focus on that. Mr. Curtis mentioned it in his paper only as a concern; as we move forward that wouldn't be an academic one. But I am wondering why it couldn't be part of the policy decisionmaking, because I think that is where the current incentives create a maldistribution on the exclusions and deductions, and everybody just assumes that is a given and that is the way the world works. So, we have got to adjust it between the crowdout range that you are looking at. I am wondering why we don't look at the total public expenditure and talk about a redistribution.

Interestingly enough, Senator Kennedy and the labor unions do this when they talk about income, and they want a progressive income tax for redistribution of wealth. But I have not heard them talk about a redistribution of the benefits in terms of the Tax Code, and that is because in large part unions get a significant benefit dealing with corporations, in my opinion, as to why they have not laid that in front of us.

But I think, from a public policy point of view, to take a look at who currently is getting benefits on a percentage basis of income shows there is an enormous maldistribution. And we are arguing in an area in which there are clear, as you indicated, Mr. Gruber—notwithstanding your crowdout argument, there are clear benefits to make sure people have this insurance and utilize it. But I have a very difficult time looking at the current maldistribution and say-

ing we will not look at that as part of the solution as we try to figure out how to deal with the people on the margin.

Mr. GRUBER. I mean—I very much agree. I think there are a number of problems with the tax subsidy. I think the only resolved questions the academics are still struggling with is that if you limited the tax subsidy, what would that do to employment-based pools? Would that break down employment-based pools? Which employment-based pools have a number of advantages?

And what we don't know is to what extent is the tax subsidy the glue that holds them together and to what extent would they hold together otherwise because of other pooling benefits. Absent that issue, I think you are exactly right. There is no reason why we should be subsidizing at an increasing rate as taxes go up health insurance for high-income purchasers and worrying about crowding at the bottom.

Chairman THOMAS. Well, I would like to eventually get to your question. My problem is that with current cafeteria plans and others where you have more and more two-income households, that the decision of which spouse carries the insurance and what kind of an insurance program is offered by the employer and how you can up the other benefits under an open-ended fringe benefit package, to me are games that are being played at the higher income levels which get a disproportionate share of the writeoff in the first place.

Again, that kind of a policy decision ought to be looked at by folks who are concerned about it in other areas; and I am just amazed that that seems to be a given without discussion on it.

That is part of my concern about moving public dollars. If you are talking about bang for the buck, we have a lot of restructuring to do to make sure that the people at the lower end get a fair share. And it is not just looking at new public programs to move new public dollars into, but to reassess how our current public dollars are being spent to create a fair and equitable system.

Thank you very much.

Mr. Stark.

Mr. STARK. Thank you, Mr. Chairman.

I want to thank the witnesses for an interesting presentation. It seems to me, Dr. Gruber, that you have testified before us at some point in the past.

Mr. GRUBER. Yes.

Mr. STARK. So, I probably told you then that even though MIT flunked me out before you were born, I hold no grudge. But I would like to know——

Mr. GRUBER. Toward him personally?

Mr. STARK. Or the rest. Because I later got a degree out of them. But there is a battle between Lester Thurow and whom?

Mr. GRUBER. Paul Krugman.

Mr. STARK. Who do you sign up with?

Mr. GRUBER. I am with Paul Krugman.

Mr. STARK. All right. I don't know what difference that makes, but I just read that article recently. Is that destroying the program?

Mr. GRUBER. Is that what?

Mr. STARK. Is that really causing real problems?

Mr. GRUBER. No, not really.

Mr. STARK. OK. I am really going to ask each of the three of you, do you know—whatever we call it——

Mr. GRUBER. Crowd-out.

Mr. STARK. Crowd-out and the fact that we might have to tax somebody or might have to do a variety of things notwithstanding. If, in fact, each of you today had to figure out a way to insure the 10 million kids by the end of the year, what would you do? And nothing is not acceptable.

But then, before we do that, I wanted to ask Dr. Gruber if he ever included Jonathan Swift in his research?

Mr. GRUBER. I don't understand that context.

Mr. STARK. Well, you did a paper; and you discussed the value of saving an adult life; but you say that for kids it ain't so clear because we have not invested a lot in the children. So, therefore, little children might not be worth as much. And I would commend to you Jonathan Swift's modest proposal. You haven't read it?

Mr. GRUBER. No, I have not. I must admit I am impressed you have read my research so carefully.

Mr. STARK. Well, please do; and you will see why I suggested it, and you may get a chuckle out of it. But I just wanted to add that. Jonathan Swift's modest proposal.

Mr. GRUBER. I will take a look.

Mr. STARK. I would like to know if that figures into your proposal.

And then, also for my colleagues, what you are saying is that if we expand health insurance for poor women and children, that this is going to expand marriage. Is that right? Didn't you say that?

Mr. GRUBER. Yes.

Mr. STARK. OK. What I am saying is that not only will we insure these kids, but we are going to decrease the level of illegitimacy, because so many people will not stay unmarried to keep the benefits of Medicaid.

MR. GRUBER. This is something that has not come up in the hearing, but one thing that economic researchers paid a lot of attention to in the last couple of years, expanding Medicaid to other benefits besides health, it gets people off the welfare program because now they don't have to stay on welfare to get their health insurance.

Mr. STARK. We are going to need all the help we can get, and that might get us a vote or two.

Now the real question for each of you—Ms. Dubay, Dr. Gruber, Dr. Curtis—if we were to do it tomorrow, real quick, how would you expand? How would you do it? Expand Medicaid? Subsume Medicaid into Medicare? Do it all through private health insurance and have a tax credit? What would you do? Ms. Dubay—in 25 words or less.

Ms. DUBAY. I think, obviously, there are a lot of options. I would start by making some real efforts to increase Medicaid participation rates. I would phase in the coverage of older kids up to 100 percent of poverty immediately, and I would extend Medicaid up to 133 percent of poverty for those kids that are 6 to 18, and that would cover 61 percent of uninsured children.

Mr. STARK. How would we deal with the other 39 percent?

Ms. DUBAY. There are a range of options. There are certainly six or seven plans that have been introduced in Congress. I think there are many ways to cover the remaining uninsured children. What the different plans deal with are different mechanisms for financing and administration; and I think all of them have their pluses and minuses.

Mr. STARK. Which one has the least minuses? Income relating to subsidy?

Ms. DUBAY. I think income related subsidies are essential, if we want to ensure children have health insurance coverage.

Mr. STARK. Dr. Gruber.

Mr. GRUBER. I would do three things. I would make every effort to sign up the eligibles who aren't taking up, particularly focusing in schools. I would extend Medicaid to all children below 133 percent of poverty up to age 18, and I would make it available to up to 200 percent of poverty but increase premiums so that by 200 percent of poverty, they pay the actual average per child premium, which I think is still—if you look at—if you call that $500 per kid, a family of twice poverty, that is less than 3 percent of their family income. If they have two kids, they can insure two kids for less than 3 percent of their family income and pay the average cost.

Mr. STARK. I think we can only get the cost that low if the program were mandated to do so and there was no adverse selection.

Mr. Curtis, how would you do it?

Mr. CURTIS. I, too, would probably expand Medicaid up to 133 percent of poverty. Beyond that I would go with a program with somewhat less generous benefit structure, with sliding scale contributions that made it affordable to people who do not have employer coverage available and that benefited people who do have employer contributions available. That is, the more the employer contribution is, the less the net amount the individual would pay; and, therefore, you would be encouraging employer contributions.

In addition, and we have been doing this over the last couple months, I would work with small employer purchasing pools and with States on a more elegant interface between private and public coverage. And I also believe these kind of purchasing pool approaches have substantial potential as a vehicle to combine multiple employer contributions where you have a two-worker family with contributions available from both employers but not adequate enough from either to make coverage affordable.

Mr. STARK. One final question. Maybe you could each comment on this.

In the past, we have had some agreement on both sides of the aisle about the idea of subsuming Medicaid into a Medicare or Medicare Program for kid care, and keep the trust funds and everything separate from the seniors' Medicare. And with the changes in block grants and all the implications that welfare reform might have on eligibility, would any of you answer any differently if we, in effect, did away with Medicaid for kids and made it a Medicare? Because then, basically, what we are getting almost all children into it?

Ms. DUBAY. I think there are some advantages to that concept. Medicare is a program that is very well received, very well liked in this country.

Mr. STARK. And can you buy private insurance with it or go into managed care?

Ms. DUBAY. As much as the Medicaid Program provides an important safety net for poor children, there are clear access problems within the program; and I think a Medicare Program—a Medicare-like program could potentially solve some of these access issues.

Mr. STARK. Since Chairman Thomas gets jurisdiction, that is not a significant factor in this.

Anybody else?

Mr. GRUBER. I think if you were going to do that, it would be a great opportunity to fix the things that are wrong with Medicare, that are hard to deal with for the existing Medicare Program, do things like increasing use of managed care and other beneficial things. It might be a good—starting fresh might be a good time to fix those things if you are going to deal with kids. With that, I sort of agree with what Lisa said.

Mr. CURTIS. I would leave the children's population with expanded Federal financing, whether it is redistributed tax dollars or others at the State level, for the following reasons: For the children without a connection to the work force, approaches through school systems make sense. Those are State and local. Children's families are often changing job status and income; and it just makes sense, if we are interrelated with the private sector employer-based coverage, that it is just far easier to do that at the State and local level.

If we are going to expand Medicare to cover some populations now under Medicaid, I would pick up the SSI supplemental population, the elderly and disabled. I always felt that is screwy to operate that program at the State level rather than the Federal level.

Mr. STARK. Thank you. Thank you, Mr. Chairman.

Chairman THOMAS. The gentlewoman from Connecticut.

Mrs. JOHNSON of Connecticut. How much do you know about where the uninsured live?

Ms. DUBAY. I personally have not looked at that. My impression is that they live everywhere.

Mrs. JOHNSON of Connecticut. Well, certainly they do live everywhere to some extent, no question about that. But, obviously, any information you can give us I think would be very important. Because just as the Medicaid population is concentrated, there may be concentrations that would help us at looking at where the answers lie in this issue.

I would like to have your best effort on where these kids are and also what they are getting now. How many of them actually do participate in the school-based health care plans? How many are in community health centers, community health center programs? How many are emergency room care people? You must be able to find out something about the care that the uninsured children are currently getting. Because unless we know that, we don't know what funds to redivert.

Mr. GRUBER. I don't have the facts on the geographical distribution, but your comments actually raise a very important point which I think is largely ignored in this debate. The debate is focused on what economists call the demand side. Let's get these people insurance. There is a supply side out there which is a lot of doc-

tors won't see Medicaid patients. One-third of doctors will not see Medicaid patients, and one-third only see a very limited subset. Only about one-third of doctors will see Medicaid patients.

Mrs. JOHNSON of Connecticut. And why is that, Dr. Gruber?

Mr. GRUBER. One main reason is the low fees. Medicaid pays typically one-half or less what private insurance pays, and in some research I have done we actually found there is a lot——

Mrs. JOHNSON of Connecticut. But we are also beginning to go down that track with Medicare as well.

Mr. GRUBER. True.

Mrs. JOHNSON of Connecticut. I think it is important to see where they are being seen now. Why are voluntary vaccine programs not working? We need to know why what we are doing now to reach these kids is not working, because otherwise we—the crowding out problem is real; but I think it is only going to get bigger. Because I think once you get into there and small employers figure out, Hey, I don't have to cover these guys, that you are going to get massive reaction.

But, more importantly, even if you cover them, if physicians won't treat them—we had the discussion with the preventive panel—if you drop the reimbursement for some of the preventive studies so low and it is only a certain kind of office physicians that provides that preventive study, then you catch that physician between giving millions of preventive tests for which he essentially gets no reimbursement or seeing a person that really has a serious disease, needs a lot of attention, and for which he will get reimbursement.

So I think you have got to be careful about—there are a number of aspects about the crowding out issue that we are not looking at when we just look at the data about small employers versus Medicaid.

But Mr. Curtis, you made a very interesting comment. You said you would recommend a stripped-down Medicaid package. This is an aspect of the crowding out issue that reverses the role we have not talked about, and that is that the Medicaid benefit package is far richer than most small employers offer. So what impact—if we really go at this, what impact is that going to have on crowding out in a sense for legitimate reasons because you can get better health care for your children?

Mr. CURTIS. Well, actually, it relates to crowding out in another important way; and that is, under current law, even where a State identifies and buys into employer-sponsored coverage, they also have to enroll them in traditional Medicaid for any service covered to any degree beyond what the employer package covers, even if it is a high option HMO package. That is very, very difficult administratively, as you can imagine, doing that benefit package by benefit package with myriad employers' plans; and it has been a big impediment to States even trying to coordinate.

So beyond the obvious incentives of a more generous benefit package here versus a somewhat less generous benefit package over there, there is that administrative impact as well.

I believe Medicaid's coverage policies are very well structured for poor and near poor children. I think as you move up the income stream, parents can afford modest cost-sharing requirements and

the other kinds of modest limitations in a typical HMO benefit package from a typical employer, and that they would not be impediments to children's access to preventive and primary care.

Mrs. JOHNSON of Connecticut. Do you think we should amend the 1990 law to make it far easier to administer at the same time that we look at the issue that you pointed to with the need to help small employer groups and States integrate those Medicaid and small employer options?

Mr. CURTIS. In retrospect, we certainly could have done much better in designing the 1990 law.

Mrs. JOHNSON of Connecticut. I read your testimony as if it is basically nonfunctional.

Mr. CURTIS. There are a few States that are doing everything they can; but even those only get, for example, responses back from a small minority of employers they inquire of.

Mrs. JOHNSON of Connecticut. For national law, if a few States do it to a limited degree, I don't consider that success.

Mr. CURTIS. No, it is clearly not a success.

Mrs. JOHNSON of Connecticut. But this was an idea that you are saying has some merit, and I would like to have your help in looking at that. Because I think small employer groups are very important, and I think this interface with Medicaid and small employer groups has got to be looked at much more realistically.

But I would ask you—see, community health centers can offer that whole package of Medicaid benefits, which is a broader package. Are you aware of any effort to use that as a delivery vehicle because it is also a setting in which managed care and the benefits of managed care can be offered?

Mr. CURTIS. I am not familiar with that, but I would point out a couple of related factors. Most children with employer-sponsored coverage available through their working parent have a parent working for a larger employer, not a smaller employer, first.

Second, as we are looking at extending coverage to children moving up to, let's say, 200 or 300 percent of poverty, many of these working families do not live in areas that most traditional Medicaid clients reside in; and I have to imagine that they are in many cases not proximate to a community health center for similar reasons. These are modest income, working, middle-class families.

Mrs. JOHNSON of Connecticut. I agree, Mr. Curtis. That is why I want to understand who lives where and what. Because we have no idea, really, what percentage of these could be served by a modest expansion of the community health centers.

In Hartford, Connecticut, in working with the community health centers a few years ago, with two community health centers, they felt they could cover the whole low-income population of Hartford. Now, we didn't allow that, so they have not done that.

But I think we have to look at what kind of infrastructure investment would we have to make to make that available, and then how do we get employers involved in helping their employees participate in that, which isn't as expensive as insurance. So I think there is some—we need to know where people live, because we need to know what access they are going to have. Because you can give them insurance, and if there is nobody that takes Medicaid, they still have no access.

Mr. CURTIS. That sounds reasonable. The only hesitation I have—and it is a significant one—is, again, I believe we should find ways for families to be in the same access and coverage vehicle so that they do not have to figure out a different way of accessing needed care for every member of the family. I think that is unnecessarily burdensome.

Mrs. JOHNSON of Connecticut. I think that is a very good point. Thank you.

Thank you, Mr. Chairman.

Chairman THOMAS. Gentleman from Georgia wish to inquire?

Mr. LEWIS. Thank you, Mr. Chairman. Mr. Chairman, I will be very brief.

I want to thank the members of the panel for being here. I know between the three of you there is not any debate or conflict about the number of uninsured children. I think you tend to agree that the number is about 10 million. Is there any conflict, any debate there?

And I know something about your background and your history. You are very smart. You spend a great deal of time looking at the whole issue of health care for children, the question of providing insurance for children.

I guess where I am at this point, this is 1997; and we are moving toward the 21st century in our country, on this world, on this little planet; and I guess I want to see a revolution in this whole area. I don't want to be patient. And I guess the question I want to ask here, What else can we do as a nation, as a Congress, in a short time, in a very dramatic fashion, to bring in the children that have been left out, left behind into Medicaid? What can we do?

Mr. GRUBER. Well, I think one place that we can all get behind that, presumably it will be quick and presumably not that expensive, is we have these 3 million kids out there that are eligible for this program and who, for some reason we don't quite understand, are not taking it up. And the experience of some States like New York and I think to some extent Florida to take effective advertising, effective use of schools, something we can do in a relatively short time that is not that expensive and presumably not that controversial, that can have a dramatic impact. After all, we are talking about 30 percent of the number of uninsured kids that can have a dramatic impact in a very short time. I think that has obviously got to be the first step.

Ms. DUBAY. Part of the problem is that we do not know why they are not enrolling. We don't know if it is because the Medicaid eligibility determination process is very difficult. We don't know if they don't know about the program. It is really the parents of these children acting as agents for the children; and we don't really know why they are not enrolling their children in Medicare. Until we figure that out, we can't find a solution to the problem. And I think that is probably the first step, trying to figure out why children are not enrolling.

And I think Jonathan's point is good, there are some States working through the schools to make eligibility determinations there for Medicaid coverage, and I think that that is an important way to reach many of these kids.

Mr. CURTIS. My understanding is that in Florida their program—piggybacks eligibility on the school lunch programs. So it is very simple. People know if they are eligible or not. And, of course, they are reaching them through the schools rather than the welfare offices, which is a good way to reach most of these people, we think.

Mr. LEWIS. Is there something you would recommend to the Congress that we can do that would not cost a lot of money in terms of involving the private sector in a major media-type campaign in an effort to educate and to open the lines of communication to the American people to enroll their children, saying to the American people that if we don't take care of our children on the front end we are going to pay more on the back end?

Ms. DUBAY. I think that in some local areas, particularly with the Medicaid expansions for pregnant women, there were some public-private partnerships where private dollars were leveraged to do that sort of outreach campaign; and in some places they were very effective.

Mr. LEWIS. Thank you.

Thank you, Mr. Chairman.

Chairman THOMAS. Thank you.

Does the gentleman from California wish to inquire?

Mr. Becerra.

Mr. BECERRA. Let me ask the panel the same question I asked the first panel, and that is the trend of seeing employers providing less options of health coverage to their employees. Do you believe that the trend will continue where we see fewer and fewer employers providing health insurance—meaningful health insurance coverage to their employees?

Mr. GRUBER. I think there are two points.

First of all, one place that both Lisa and I agree is that the majority of that trend is not due to Medicaid. Even though crowdout is large, by my estimation over 830 percent of that trend is not due to Medicaid. Over 830 percent of that trend is due to other factors in the economy, and I see no reason for those factors to reverse. It has been going on a decade or more. Now we see this rapid deadline, and I see no reason for those—regardless of what government policy is on Medicaid, I see no reason for those other factors to reverse.

Ms. DUBAY. One thing I would like to mention——

Mr. BECERRA. If I could followup with Dr. Gruber before I get to you, Ms. Dubay.

We see both employers reducing coverage and we see employees through this crowdout phenomena also perhaps leaving their employers to try to go to the public sector?

Mr. GRUBER. Yes, I think both are going on. I think if you look at the time series that the majority is not Medicaid, the majority is—both employers and also employees are not taking it up. It can be very expensive, particularly for dependents, even if they don't move on to public programs, just choose to not have their kids insured rather than paying the cost.

Ms. DUBAY. The point I was going to make—and I think it really illustrates what was going on over the period of Medicaid expansions—was that between 1989 and then 1992—employee contributions for individual policies rose by 25 percent, while employee con-

tributions for family policies rose by 50 percent. So we were seeing a much faster decline in the dependent coverage.

I think that is part of what was going on with the displacement we are seeing, was that individuals were dropping their employer-sponsored coverage in response to these increased employee shares of premiums. And there is no evidence that suggests that this increase in premium contributions is going to decline or stop.

Mr. CURTIS. I feel compelled to point out that the erosion in employer contributions to family coverage which was dramatic in the late eighties and very early nineties has not continued. At least there is not consistent evidence from the employer surveys from, say, 1991 to the present.

In fact, the Foster-Higgins survey shows virtually no erosion in employer contributions to family coverage during that period; and it makes some intuitive sense because, of course, health plan premiums stabilized. Employers weren't facing rising premiums. There is evidence now that premiums are rising again, and I expect we will see some of that erosion again.

But in addition to responses to rising health care costs, we have seen far more aggressive action by employers to avoid cross-subsidizing other employers. And there has been some understandable but unfortunate gaming going on by either reducing contributions to family coverage or—and this is the kind of thing that does not show up in any of the surveys—making it beneficial to the employees to not take advantage of employer coverage when other coverage is available, either through flexible spending accounts or through things like a smaller firm increasing a person's wages who doesn't take the health benefits. Large employers became painfully aware that a lot of small employers that do not offer coverage were doing so at the expense of the larger employers who employed their spouse, and a number larger employers decided that was not fair and responded accordingly.

Frankly, my guess would be what we see in the way of erosion in family contributions over the next 5 or 6 years will directly reflect what happens with health insurance premium prices. I think those other factors have probably played out now.

Mr. BECERRA. Let me ask you then this question. Unless we get a total grip on the cost of health care, we are going to continue to see employers brought to the margin in terms of being able to provide coverage to the employees and employees' families; and so we will probably see some diminished capacity by the employers in the Nation to provide good coverage.

We have that pool of poor individuals, and even if we take into account the three or so million children that we already know are eligible for Medicaid, say we get them all covered, we still have a pool of poor or fairly poor individuals who don't have coverage.

The more we make an effort to try to cover those very poor, in other words, go up the ladder to provide coverage for the very poor, the more we end up with this dynamic where folks are going to be pulled by that magnet of having public health care to stay away from the employer type of coverage, or the employer deciding it is better for me not to provide it. So that there will be a constant pull to have the public sector do it.

But you are always going to seem to have that in between population of people that do not qualify as poor, can't afford the employer based. And every time policymakers are going to be asked to try to resolve the problems for that in between population, we are going to have to constantly drive up the public sector cost.

It seems to me, from everything I keep hearing, that means the private sector is going to be pushed away from trying to meet that need itself as well, which means ultimately we are going to have to go toward a public sector solution to try to get some form of universal coverage for all these folks out there, whether poor, modestly poor, middle income, or otherwise. Ultimately, doesn't it just boil down to the whole issue of how do we get to universal health care?

Mr. GRUBER. I think ultimately it comes down to whether health care costs can just continue to rise at the rate they are. Many, in some instances, for some reason, will stop, because we cannot imagine spending one-third of our economy on health care. But ultimately it depends on what happens there.

I think that, incrementally, the first step is to try to fix the inefficiencies that we know are wrong with the private market, like the employer tax subsidy, which leads to inefficiently high, generous health insurance coverage and potentially contributes to rising health care costs. I think that is the first step you would want to think about taking.

Mr. BECERRA. But everything we have been saying—crowdout, cost for employers to provide coverage to competition, where some employers are financing their costs and others are not and they have that competitive advantage, those that do not provide it—in essence, what we are talking about is the fact that some people have coverage, whether it is employer financed or public sector financed or private pocket financed, ultimately, that means employers providing enough for them to privately pay for it, or it is publicly financed totally by government.

But we have a gap, and the reason we have a problem is because there is this disparity, someone is paying for someone else. And whether it is crowdout or other issues, you are not going to resolve crowdout or anything else until you get to the point where someone wouldn't be put at an imbalance compared to someone else, whether it is the employer or employee. Which means until you provide everyone with access to the coverage, you are always going to have that competition.

Should an employer provide health care coverage, which means more cost to the employer when another employer is not doing it? Ultimately, it seems to me you get to that point where you have to resolve that issue. We have got a middle population that does not have coverage because it can't afford it, but we are not willing to provide it.

Ms. DUBAY. In a lot of ways I think you do make a really good point. And in terms of thinking about this problem, I really have struggled with this. Because if you really want to get these children covered, to get them insurance coverage, you are ultimately going to commit more public dollars to do it. And if your goal is to get these children covered, that is probably what you are going to end up having to do.

Mr. BECERRA. At someone's expense though.

Ms. DUBAY. At someone's expense.

Mr. BECERRA. If you continue to have the population that won't get the coverage.

Ms. DUBAY. There are people that will drop their private coverage. However, they may drop for good reasons. The dropping may not be just the substitution of coverage. It may be obtaining coverage that they do not have access to now—for instance, if they have plans that are catastrophic or that don't offer preventive coverage. So that shifting from private to public coverage may not be a bad thing, and it may get children the kind of coverage that we really care about them having. But it will cost us money.

Mr. BECERRA. Mr. Chairman, you have been gracious with the time. I appreciate it.

Chairman THOMAS. The gentleman's point is precisely the one that we have to grapple with. Because if we do not have an appropriate phaseout, you will be chasing the public subsidy right up to the top of those people who don't take insurance because they are, in essence, self-insured by the basis of their own wealth.

That is why we have been trying to put the focus on the nexus of how you create a phaseout, an increased contribution, a mix of options at that phase point to allow for the private sector to continue to pay. Because it is simply an enormous amount of money that we are talking about. We already are putting in enormous amounts of money. I think people who pay are willing to put in a bit more to get those below the poverty level covered. But as we move toward managing better health care plans in the public sector than those who can pay for it themselves who are also paying for the public sector, you have got a very, very serious problem.

Mr. BECERRA. If I could almost ask the Chairman a question to pose to the panel as well. Won't there still—even in that scenario, if we are able to find some fantastic way to provide a phaseout scheme, won't we still have the same thing in play, people balancing the interest?

Chairman THOMAS. Of course, but our concern now is at the margin rather than at the bulk, as the gentleman from Georgia has indicated the concern. That is why I think our first priority here is to get the three million children who are supposed to be covered covered.

I think we may learn some lessons about how we package a product and how we communicate a product which will serve us well as we move forward. Because it is just hard for some of us, as the gentleman from Nevada indicated, to understand why, when this is available, people don't utilize it. It is obviously a question about education, the way in which it is packaged, where and how it is packaged. And those lessons, I think, will serve us well at minimum dollars, or most bang for the buck, as Mr. Gruber says, those lessons, and then those lessons we can apply.

That is why I am concerned about these all-in-one solutions before we have really looked at and fully understand who the folk are, where they are, and how we might best serve their needs. So, in this sense, I do believe in the long run we will be serving everyone's interest if we move incrementally. It doesn't mean we can't make some real big jumps fairly quickly at the low end of the scale and then be a bit more precise as we move forward.

So I guess I would ask just a final question. In terms of the President's plan, where he is willing to spend $20 billion, more than half of it is in this short-term coverage of temporarily unemployed. I guess I will start with Dr. Gruber, who is most concerned about bang for the buck. Is this where you would spend 50 percent of your available dollars to meet the children's insurance needs?

Mr. GRUBER. I am not particularly familiar with the details of the plan. I think clearly the unemployed, some of them had access to health insurance through COBRA, so those people do have access to purchasing health insurance. I think there is a need among those people to maintain their children's coverage.

But I think for most of what we are worried about with kids is preventive care. If you go a month or two without preventive care, it is not the end of the world. What we are really worried about is these kids who go a year or two without preventive care. So I guess I share your concern. The real problem with kids especially is going long stretches of time where they are not getting the preventive care that they need.

I do not know whether one-half or less than one-half is the right amount to spend in the short-term groups, but clearly you want to worry about—with kids especially where it is less acute and more preventive, we want to focus our energies, I agree, on the longer term population.

Chairman THOMAS. Any other reactions?

Mr. CURTIS. Well, if the question is, Is that the lowest cost way to cover uninsured kids, I think the clear answer is, no, if the focus is solely kids.

One advantage of the approach is it does keep families together in terms of coverage. But $20 billion a year would be at least double or maybe triple what you need to finance coverage for all 10 million uninsured kids.

Chairman THOMAS. And that probably brings to a conclusion this Subcommittee, because it is a dilemma. We do want to provide coverage. How you cover it, I believe, is the current debate, not whether or not, especially those below the poverty level or somewhere between 100 and 200 percent of poverty should be covered.

I want to thank the panel for its testimony. I am sure we will get back to you as we move forward on this issue.

I want to thank the Members.

The Subcommittee is adjourned.

[Whereupon, at 1:10 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

Statement of American Academy of Child and Adolescent Psychiatry, Lawrence A. Stone, M.D., President

The American Academy of Child and Adolescent Psychiatry (AACAP) thanks you for holding hearings on access to health care for children. Many of the 10 million American children currently without health insurance are children with mental illnesses. These are children who suffer from childhood schizophrenia, depression, attention-deficit/hyperactivity disorder, obsessive compulsive disorder and conduct disorder.

The Academy, representing over 6,000 child and adolescent psychiatrist, urges you to support non-discriminatory coverage for mental illness treatment in any related legislation. The treatment of childhood disorders represents a major public health concern. Chronic mental illnesses respond well to treatment but lifelong access to the health care system is necessary. Successful diagnosis and treatment is a wise investment, given the pain, long-term disadvantages, and financial costs associated with untreated childhood behavioral and emotional disorders.

Health care reform proposals directed toward universal access for children and adolescents can result in a comprehensive change to a new benefit and payment system, or it can reform the existing system of public and private insurers. Whether there is a move to an expanded Medicaid program, a tax-based incentive program for employers or a subsidy program for parents and guardians, we ask that children and adolescents with mental illnesses be assured nondiscriminatory coverage.

RECOMMENDATIONS FOR HEALTH CARE REFORM 1997: CHILD AND ADOLESCENT PSYCHIATRIC SERVICES

The following three recommendations will support appropriate, quality care under any health care reform system:

Access and Nondiscrimination

1) Children and adolescents have no access to insurance on their own. Provision should be made to include access for all children and adolescents, regardless of their family's status or income level. Access to psychiatric services should be provided on a nondiscriminatory basis integrated with other necessary medical services.

• Child and adolescent psychiatrists are the most highly trained professionals in the service-delivery team.

Trained to assess the biopsychosocial dimensions of most childhood disorders, they should not be excluded because of their unique training nor should it be assumed that other, lesser-trained physicians or health care providers, can treat serious psychiatric illnesses and have the same outcomes at a lower cost.

• Services provided by child and adolescent psychiatrists should not be discriminated against because of misperceptions regarding cost or length of treatment. Excluding physicians who have acquired special training in order to treat children and adolescents is counter productive and not cost effective. Managed care contracts for medical services should not discriminate against physicians or hospitals by forcing unrealistic limits on reimbursement and skewing patients to less skilled persons. Errors in diagnosis and treatment are costly. For children this can mean developmental delays. Appropriate, quality care will be cost effective; artificial limits on who can treat or where and for how long treatment can take place raise questions of liability and quality of care.

• Diagnoses included in the DSM–IV should be reimbursable. Discrimination by insurers against select diagnoses is unacceptable, especially when illnesses are

excluded for cost-containment reasons. Numerous insurers across the country have decided that conduct disorders, Tourette's disorder, or attention-deficit/hyperactivity disorder are not reimbursable. There is no reason for denying treatment for these serious illnesses except to control costs or because of a lack of understanding about the seriousness of these illnesses.

Range of Services

2) Services provided should include a wide range of treatment options—including but not limited to preventive interventions, early identification, assessment and diagnosis, case management, outpatient treatment, partial hospitalization, home-based services, detoxification and inpatient treatment. Treatment for children requires that services involve both the child or adolescent and family as well as appropriate collaboration with other significant care givers, teachers, physicians or providers of other needed services.

• Reimbursement for a range of services to treat psychiatric illnesses has increased slowly. Innovations in treatment are inhibited by some reimbursement limitations. The system has tended to favor the most expensive treatment, such as hos-

pitalization and not to include partial hospitalization, or, in the case of residential treatment, shift from including to excluding it with no explanation and no addition of other services.

• The use of inpatient services, like hospitalization and residential care, should not be discriminated against or unfairly capped because of misperceptions about cost or effectiveness. These are necessary treatments for children and adolescents with severe disorders. Community resources are often limited to inpatient services, which has contributed to inappropriate care. A reform proposal must support expansion of community services and adequate reimbursement for providing those services.

• Medicaid is designed to provide mental health services (to eligible children and adolescents). Medicaid's mandatory services for children and adolescents with psychiatric illnesses cover outpatient hospital services, including partial hospitalization, inpatient hospital and physician services, and services under the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program. In 1989, Medicaid was amended to require the provision of treatment and follow-up services for problems identified through EPSDT screening even if the state does not normally cover such services through Medicaid.

Most states have not been able to comply with the expanded Medicaid requirements, primarily for economic reasons that impede the training of screening personnel, the establishment of referral protocols, and the inability to reimburse for professional services at any more than a minimal level; however, the language of the law reflects a reliable model for both prevention and treatment of serious emotional disorders.

Cost containment

3) Incentives should encourage the use of the earliest of interventions, the level of treatment necessary, treatment and management by an appropriately trained physician, and the most appropriate treatment setting possible, all of which would best serve the child's clinical goals in an economically prudent manner.

• Managed care, when used for cost containment, should not be equated with minimum care. Competition for contracts can lead to mental health benefit packages that discriminate solely because of the stigma of the illnesses involved. Children and adolescents with psychiatric illnesses often require complex diagnostic processes. Comorbidity is high in diagnoses such as conduct disorder or attention-deficit/hyperactivity disorder, and adjustments in the treatment plan may be necessary. Inflexible packages obstruct even standard treatment plans for children and adolescents. Diagnoses of comorbidity require trained child and adolescent psychiatrists. To miss a diagnosis and leave it untreated, lengthens the treatment and adds to the cost of the illness.

• The use of managed care to control medical services must be regulated. The managed care industry's practices vary widely in organizational structure and quality. Reform measures will be compromised if regulation and oversight are not included. Improper utilization review can grossly compromise the treatment and significant psychiatric or physical harm may result. Too often, child and adolescent psychiatrists find that reviewers do not have enough knowledge about treating young patients. Even medical directors, unless trained in child and adolescent psychiatry, make treatment plan review recommendations based on adult practice guidelines.

• Case management is essential to mental health care reform. Negotiating with agencies, resources, providers, and specialists is difficult and frustrating, and delays in treatment can result. Case managers must be trained to access a wide range of services and be appropriate in referring to those services.

Child and adolescent psychiatrists are physicians who are trained to treat the psychiatric illnesses of children, adolescents and adults. Their skills incorporate the broadest range of treatment skills available for treating the biopsychosocial facets of mental illnesses. Access to care by a child and adolescent psychiatrist should not be excluded or limited because of discrimination, stigma or misperceptions about cost and effectiveness.

Conclusion

The American Academy of Child and Adolescent Psychiatry thanks you for your consideration of children and adolescents with mental illnesses. Child and adolescent psychiatrists treat youngsters with serious mental illnesses and understand the problems of inadequate health insurance. When treatment is delayed, families suffer, financial burdens expand, and social services are overwhelmed. AACAP urges you to support health insurance coverage for all children and adolescents with mental and physical illnesses. Children must have access to the appropriate treatment and services needed to develop into productive and independent adults.

Statement of American Academy of Pediatric Dentistry, Chicago, Illinois

To the surprise of many policy maker's, America's low-income children continue to experience high levels of dental disease and disability, and restricted access to dental services while their counterparts in middle-and upper-income households enjoy unparalleled dental health.

• Afflicted children experience pain, infection, distraction from learning, and over 1.1 million days sick-in-bed and nearly 500,000 missed school days from acute dental conditions each year.

• In spite of repeated evidence from national surveys demonstrating that low-income children continue to experience significant levels of dental caries (tooth decay), a recent report from the DHHS Office of the Inspector General (OIG) indicates that only 1 in 5 Medicaid-eligible children receive required dental services annually.

• HCFA data demonstrate a wide disparity between utilization of EPSDT services provided by dentists (18%) for Medicaid-eligible children and those provided by physicians (67%).

Medicaid has mandated pediatric dental coverage for nearly 30 years but has universally failed to make good on legislated assurances that children can access care.

• Currently HCFA expends only about 1/2 of 1 percent of Medicaid dollars on children's dental care.

• 42USC 1396r–7 enacted in 1989 assured access to care for children and specifically directed HCFA to assure access for medical but not dental services. As a result nearly 4 in 5 children obtain medical care while only 1 in 5 obtains any dental care.

Existing federal programs designed to meet the dental care needs of low-income children fail to do so because of inadequate Congressional oversight. Newly proposed federal programs to extend health coverage to additional low-income children must incorporate provisions that will ensure essential basic and preventive dental services to address this highly prevalent and most common of childhood diseases.

• Provisions that were enacted as part of P.L. 101–239 (42USC, Chapter 7, Subchapter XIX, 1396r–7) to promote access to pediatric services must be extended to include providers of EPSDT dental services.

• Adequately funded and properly structured commercial health care coverage, in conjunction with adequate consumer protection measures, can be an effective mechanism for expanding access to pediatric dental services, and should be considered as an adjunct or alternative to traditional Medicaid programs.

ACCESS AND UTILIZATION OF DENTAL SERVICES BY LOW-INCOME CHILDREN

Access to dental services remains a common and serious problem for millions of low-income American children. In spite of repeated evidence from national surveys[1 2] demonstrating that low-income children continue to experience significant levels of dental caries (tooth decay), several sources including a recent report from the DHHS Office of the Inspector General[3] (OIG) and data from the Health Care Financing Administration[4] (HCFA) indicate that only 1 in 5 Medicaid-eligible children receive required dental services annually (Appendix I). HCFA data demonstrate a wide disparity between utilization of EPSDT services provided by dentists (18%) for Medicaid-eligible children and those provided by physicians (66–71%) (Appendix II).

EXTENT OF DENTAL CARIES IN LOW-INCOME CHILDREN

Dental caries remains a common, significant childhood problem in the United States, especially for low-income infants, children and adolescents. Recent national survey findings[1] demonstrate that approximately 13–32% of 2-to 4-year-old children, depending on race and ethnicity, experience caries. Prevalence rates increase with age such that nearly 50% of non-Hispanic White and Black children between the ages of 5 and 9 years, and 65% of Mexican-American 5–9 year olds experience caries in their primary dentition. Overall, rates of untreated decay in 2–9 year olds range from slightly over 40% for non-Hispanic Whites to roughly 60% for non-Hispanic Blacks and Mexican Americans.

Caries affecting permanent teeth also is a common problem for school-age children. Nearly 70% of 12–17 year olds examined in the Third National Health and Nutrition Examination Survey[1] (NHANES III) had active caries or dental restorations (fillings), with non-Hispanic Blacks and Mexican-Americans having higher rates of unfilled decayed teeth. A quarter of the children and adolescents aged 5–17 with at least one permanent tooth accounted for approximately 80% of the caries

found in permanent teeth. Previous national surveys have demonstrated similar disproportionate levels of disease burden in low-income children and adolescents.[2] Afflicted children experience pain, infection, distraction from learning, and over 1.1 million days sick-in-bed and nearly 500,000 missed school days from acute dental conditions each year.[5]

OIG Findings Concerning Children's Access to Dental Services under Medicaid

A recent inspection conducted by the DHHS Office of the Inspector General[3] confirmed HCFA data[4] demonstrating that only 1 in 5 (4.2 million out of 21.2 million) eligible Medicaid children received preventive dental services in 1993. This was a slight decrease from the 1992 data as shown in the following table:

Percent of EPSDT Children Who Received Preventive Dental Services by Age Group, 1992 and 1993

Year	All Ages	<1 Year	1–5 Years	6–14 Years	15–20 Years
1992	22.0	0.3	18.1	33.7	22.2
1993	19.7	0.4	16.0	30.0	19.5

The extent of the problem varies significantly from State to State. (See Appendix I for a State-by-State breakdown of 1993 data). The OIG report noted that in 1993, three-fourths of the States provided preventive services to fewer than 30 percent, and none of the States provided them to more than 50 percent of all eligible children.

The OIG report found that 80% of the States attribute the low utilization rates to a shortage of dentists who are willing to accept Medicaid patients. In many communities, families and EPSDT staff have difficulty getting timely dental appointments for Medicaid children. They often have to wait 6 to 8 weeks or travel long distances. Even among the 9 States reporting an adequate supply of dentists, 5 provided preventive services for fewer than 20% of eligible children. Although shortages are usually more severe in rural areas or isolated locations, 13 States report statewide shortages.

Dental Services Omitted from OBRA '89 Changes to Improve Children's Access to Medicaid Services

Section 1905(r) of the Social Security Act, created by the Omnibus Budget Reconciliation Act of 1989 (OBRA '89), details the basic requirements for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. It specifies that, in addition to mandated screening by a dental professional according to professionally developed periodicity schedules and as medically necessary, dental services must include those for "the relief of pain, infections, restoration of teeth, and maintenance of dental health." These services include diagnostic, preventive, therapeutic and emergency services for dental disease.[6]

OBRA '89 (P.L. 101–239; 42USC 1396r–7[7]) also mandated several changes aimed at improving problems concerning access to pediatric services under Medicaid. Included in the general provisions concerning Medicaid were requirements for States to submit annually proposed Medicaid payment rates for pediatric services and other such data that would assist the Secretary of DHHS in determining whether such rates are sufficient to ensure that pediatric services are at least as available to Medicaid beneficiaries as they are to the general population. The legislation also required States to immediately revise rates determined to be insufficient. However, instead of specifying the scope of services to be covered by this legislation according to Early and Periodic Screening, Diagnosis and Treatment guidelines for mandated services, the legislative language defined "pediatric services" by categories of providers. Dentists were not included, thereby effectively eliminating the requirement that States reimburse dentists for mandated services at rates comparable to those found in local markets. The impact of that omission undoubtedly is reflected in the fact that nearly 4 out of 5 Medicaid-eligible children now obtain medical care while only 1 in 5 obtains any dental care.

Effect of Payment Rates on Access to Services for Low-Income Children

Numerous examples of the effect of reimbursement rates on access to health care services exist. A recent study published by the Agency for Health Care Policy and Research[8] examined the effects of physician fees on children's use of preventive and

illness-related ambulatory physician services under the Medicaid program. Using data from the 1987 National Medical Expenditure Survey, the authors examined the effects of Medicaid fee generosity on physician service use and overall ambulatory physician spending. The results indicated that more generous fees are associated with a greater likelihood of having a doctor's office as a usual source of care and a higher number of preventive visits at office-based sites of care. Interestingly, having a doctor's office as a usual source of care was associated with lower overall ambulatory physician expenditures.

Relative fees also have been shown to be a major determinant of overall Medicaid provider supply and of dentists' participation in Medicaid.[9 10 11] A recent evaluation of a public-private partnership program which provided commercially available health care coverage (including dental benefits) to low-income children in Western Pennsylvania found that within 12 months of enrollment, the percentage of children with unmet dental needs was reduced from 43% to 10%.12 The same study demonstrated a 25% increase in the number of children with a regular source of dental care 12 months after enrollment in the program.[12]

Summary and Recommendations

Children covered by the Medicaid program continue to experience high levels of dental disease and restricted access to dental services compared to their counterparts in the general population. Failure to enact policies that ensure reimbursement for dental services based on prevailing market rates undoubtedly contributes to the gap between coverage and access to much-needed dental services under Medicaid.

- Provisions that were enacted as part of P.L. 101–239 (42USC, Chapter 7, Subchapter XIX, 1396r) to promote access to pediatric services need to be extended to include providers of EPSDT dental services.
- Adequately funded and properly structured commercial health care coverage, in conjunction with adequate consumer protection measures, can be an effective mechanism for expanding access to pediatric dental services, and should be considered as an alternative to traditional Medicaid programs.

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Appendix I—Number and Percent of Children Who Received EPSDT Preventive Dental Services in 1993, by State*

State	No. of EPSDT Eligible Children	No. Who Received Preventive Services	Percent of Eligibles
Connecticut	193094	52543	27.2
Maine	106828	36819	34.5
Massachusetts	404857	139414	34.4
Rhode Island	66136	21003	31.8
New Hampshire	40011	17905	44.8
Vermont	52251	17636	33.8
Region I Total	863177	28532	33.1
New Jersey	447272	101410	22.7
New York	1585786	283453	17.9
Region II Total	2033058	384863	18.9
Delaware	50585	6283	12.4
Maryland	229146	33129	14.5
Pennsylvania	880017	185289	21.1
Virginia	328090	64718	19.7
District of Columbia	73837	11800	16.0
West Virginia	135594	41452	30.6
Region III Total	1697269	342671	20.2
Alabama	279138	31369	11.2
Florida	1355013	222493	16.4
Georgia	643424	161496	25.1
Mississippi	470032	56843	12.1
Kentucky	293083	27604	9.4
North Carolina	550567	75794	13.8
South Carolina	302471	37876	12.5
Tennessee	534231	129886	24.3
Region IV Total	4427959	743361	16.8
Illinois	1027303	214810	20.9
Indiana	345751	144005	41.6
Michigan	823052	215885	26.2
Minnesota	291466	73539	25.2
Ohio	948612	216584	22.8
Wisconsin	342664	77103	22.5
Region V Total	3778848	941926	24.9
Arkansas	207085	35062	6.9
Louisiana	498389	128199	25.7
New Mexico	133524	8290	6.2
Oklahoma	162598	30949	19.0
Texas	1330465	160284	12.0
Region VI Total	2332061	362784	15.6
Iowa	169516	56210	33.2
Kansas	113286	40106	35.4
Missouri	403702	86619	21.5
Nebraska	102285	34267	33.5
Region VII Total	788789	217202	27.5
Colorado	210749	44305	21.0
Montana	57019	5119	9.0
North Dakota	32799	2625	8.0
South Dakota	47702	8543	17.9
Utah	123966	19186	15.5
Wyoming	34976	15157	43.3
Region VIII Total	507211	94935	18.7
Arizona	413100	1153	0.3
California	3583936	601451	16.8
Hawaii	68008	503	0.7
Nevada	34845	5010	14.4

Appendix I—Number and Percent of Children Who Received EPSDT Preventive Dental Services in 1993, by State *—Continued

State	No. of EPSDT Eligible Children	No. Who Received Preventive Services	Percent of Eligibles
Region IX Total	4099889	608117	14.8
Alaska	51691	14468	28.0
Idaho	71269	14967	21.0
Oregon	206524	71661	34.7
Washington	304257	89128	29.3
Region X Total	633741	190224	30.0
TOTAL	21162002	4171403	19.7

*This table is based on data from the HCFA–416 performance report on EPSDT program indicators for fiscal year 1993.

Source: Department of Health and Human Services, Office of the Inspector General. Children's dental services under Medicaid: access and utilization. OEI–09–93–00240, April, 1996.

Appendix II—Table 4.—Medicaid Recipients by Type of Service [3]

Type of Service	Recipients (Millions)			% of Recipients Receiving		
	1993	1994	1995	1993	1994	1995
TOTAL	33.4	35.1	36.3	.....	.....	.....
GENERAL HOSPITAL	5.9	5.9	5.6	18%	17%	15%
MENTAL HOSPITAL	0.1	0.1	0.1	0%	0%	0%
NURSING FACILITIES	1.6	1.6	1.7	5%	5%	5%
ICF MENTALLY RETARDED	0.1	0.2	0.2	0%	0%	0%
PHYSICIAN SERVICES	23.7	24.3	23.8	71%	69%	66%
DENTAL SERVICES	6.2	6.4	6.4	18%	18%	18%
OTHER PRACTITIONER	5.2	5.4	5.5	16%	15%	15%
OUTPATIENT HOSPITAL	16.4	16.6	16.7	49%	47%	46%
CLINIC SERVICES	4.8	5.3	5.3	14%	15%	15%
LAB & X–RAY	13.0	13.4	13.1	39%	38%	36%
HOME HEALTH	1.1	1.3	1.6	3%	4%	5%
PRESCRIBED DRUGS	23.9	24.5	23.7	71%	70%	65%
FAMILY PLANNING	2.5	2.6	2.5	8%	7%	7%
EPSDT	5.9	6.5	6.6	18%	18%	18%
RURAL CLINIC HEALTH	1.0	0.9	1.2	3%	3%	3%
OTHER CARE	8.1	9.9	11.4	24%	28%	31%
UNKNOWN	0.0	0.0	0.0	0%	0%	0%

SOURCE: HCFA, BDMS, OSM, DIVISION OF PROGRAM SYSTEMS

STATEMENT ON CHILDREN'S DENTAL HEALTH

The American Academy of Pediatric Dentistry believes that all children have a right to quality health care and that oral health is an integral part of total health. The majority of U.S. children have access to highly effective services for the prevention, early diagnosis and treatment of major dental diseases. Tragically, however, we and others continue to observe a sizable and growing disparity between the oral health of children who have access to quality dental care and the millions of American children who do not. The failure to provide adequate access to dental services through federal and state programs is viewed as a major contributor to the high levels of dental disease, pain and dysfunction that persist in low-income children and children with special health care needs.

We endorse the following principles:

1. Assuring access to quality basic health care, including dental care, for all U.S. children.

• We support retaining EPSDT oral health care standards for all Medicaid-eligible children and children with special health care needs.

2. Including oral health as a component in all programs that seek to improve general health.

3. Maintaining access to quality dental care for children who now have it.

• Deductibility of dental benefits by employers is a key to maintaining access for middle class children.

• Coverage for medically necessary adjunctive services, including anesthesia and hospital charges, that enable the timely delivery of appropriate dental care must be assured.

4. Including provisions for children with special health care needs in all program planning.

5. Assuring an adequate supply of pediatric dentists by providing educational support through primary care training programs.

We invite comment as we work to fulfill this agenda.

The vision of the AAPD is optimal oral health for all children!

Statement of Stanley B. Peck, Executive Director, on Behalf of American Dental Hygienists' Association

The American Dental Hygienists' Association (ADHA) is the largest national organization representing the professional interests of the approximately 100,000 dental hygienists across the country. Dental hygienists are preventive oral health professionals, licensed in dental hygiene, who provide educational, clinical and therapeutic services that support total health through the promotion of optimal oral health.

ADHA is pleased to share its views with regard to children's access to health coverage. In particular, we urge that any children's health legislation include measures to improve access to oral health care services. This is important because the Institute of Medicine estimates that fifty percent of Americans do not receive regular dental care. This figure is likely far higher for the population that children's health initiatives seek to cover.

ANY CHILDREN'S HEALTH INITIATIVE SHOULD INCLUDE MEASURES TO PREVENT ORAL DISEASE

Because ADHA feels strongly that all Americans should have access to affordable quality health care services, including oral health care services, ADHA is pleased with the significant level of interest and commitment in the 105th Congress to increase health insurance coverage among our nation's 10 million uninsured children. We are committed to participating in this process to ensure improved access to cost-effective quality health care coverage, including, at a minimum, preventive oral health services. Oral health is a part of total health; therefore oral health must be included in any children's health care initiative.

THE NATION'S ORAL HEALTH

Oral health is fundamental to total health. As former Surgeon General C. Everett Koop noted, "if you don't have oral health, you're not healthy." Despite recent advances in preventing oral disease and maintaining oral health, oral diseases still afflict 95% of all Americans. Oral Health America/America's Fund for Dental Health reports that 9 million school days are lost annually because of oral health problems.

COST-SAVINGS ASSOCIATED WITH PREVENTIVE ORAL HEALTH CARE

In contrast to most medical conditions, the three most common oral diseases—dental caries (tooth decay), gingivitis and periodontitis (gum and bone disease)—are proven to be preventable with the provision of regular oral health care. This proven ability translates into huge cost savings. Each $1 spent on preventive oral health care yields $8–$50 in savings. Because of this, increased access to preventive oral health services will likely result in decreased oral health care costs per capita and, more importantly, improvements in children's oral and total health.

Preventable oral diseases currently afflict the majority of our nation's children. Dental caries (tooth decay), gingivitis and periodontitis (gum and bone disorders) are the most common oral diseases. In fact, the Public Health Service reports that fifty percent of all children in the United States experience dental caries in their permanent teeth and two-thirds experience gingivitis. If untreated, gum disease causes bone deterioration and eventual loss of teeth, pain, bleeding, loss of function, diminished appearance, and possible systemic infections. *Each of these oral health*

disorders—dental caries, gingivitis and periodontitis—can be prevented through regular preventive care.

All American children should have access to oral health coverage as one way to support total health. Ideally, every child should have access to diagnostic, preventive, restorative and periodontal care, as well as emergency care to treat pain. At a minimum, however, preventive services should be available as an investment for long-term savings.

Additionally, any effort to revamp the present Medicaid and Medicare health care delivery systems or to advance incremental health care reform legislation should embody as one of its goals increased access to preventive oral health care services.

A 1996 U.S. Department of Health and Human Services (HHS) report on Children's Dental Services Under Medicaid indicated that, despite the provision for oral health benefits under Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, only 1 in 5 (4.2 million out of 21.2 million) eligible Medicaid children actually received preventive oral health services in 1993.[1] This represents a slight decrease from 1992 data. The 1996 HHS report attributes the low utilization rate for preventive oral health services to "the shortage of dentists who are willing to accept Medicaid patients."[2] Clearly, this trendline must be reversed. Dental hygienists can, and should, play a larger role in the delivery of oral health services to underserved populations, including Medicaid-eligible children. The nation's health care system must be reoriented to focus on preventive and primary care services including those provided by dental hygienists.

Childhood Immunizations Should Include Measures To Prevent Dental Disease

ADHA urges that any children's health initiative improve access to the known benefits of preventive oral health care services. The increased access to oral health care for children that ADHA advocates can be achieved through the inclusion of dental sealants and fluoride in any definition of childhood immunizations. While research to develop a vaccine against dental caries (tooth decay) continues, we can today effectively guard against tooth decay—which is an infectious, transmissible disease—with the combined use of dental sealants and fluoride.[3] These services protect children against tooth decay just as vaccines immunize against certain medical diseases.

Dental Sealants

Pit and fissure adhesive sealant protection for the eight permanent molars (6-year and 12-year molars) is needed when the crevices in these teeth are deep. Sealants are thin plastic coatings that seal crevices in the teeth and act as a physical barrier to prevent oral bacteria from collecting and creating the acid environment essential to the initiation of oral disease. No discomfort is involved in sealant applications, which cost approximately $20–35 in private settings, and even less in public health settings. When properly applied, sealants are virtually 100 percent effective in preventing tooth decay in the pits and fissures of molars.

The National Institutes of Health (NIH) and former Surgeon General C. Everett Koop endorse the use of sealants. One of the objectives in Health People 2000, the national health promotion and prevention agenda, is to increase to at least 50 percent the proportion of children who have received protective sealants.

Fluoride

Appropriate use of fluoride can reduce smooth surface tooth decay in children. Optimal availability of fluoride from multiple sources, such as community water fluoridation, self-applied fluorides, and professionally applied fluorides, are effective in preventing dental decay.

Effectiveness

Together, dental sealants and fluoride are virtually 100 percent effective in protecting children against tooth decay and its physical, financial, academic, emotional,

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[1] *Children's Dental Services Under Medicaid: Access and Utilization,* U.S. Department of Health and Human Services, Office of the inspector General, April 1996, (OEI–09–93–00240) at page 6.

[2] *Id.* at page 7.

[3] Research shows that the presence of bacteria known as mutans streptococci leads to dental caries in children. This decay causing bacteria is typically transferred from primary caregivers to young children between 22–26 months of age.

and social consequences. Accordingly, ADHA urges that any definition of immunization include dental sealants and fluoride.

CONCLUSION

Preventable oral diseases still afflict most of our nation's children, compromising their health and unnecessarily adding to health care costs. ADHA urges this Subcommittee—and all Members of Congress—to ensure that any children's health initiative promote access to quality, cost-effective preventive oral health care services. Ideally, all American children should have access to diagnostic, preventive, restorative and periodontal care, as well as emergency care to treat pain. But, at a very minimum, children need access to basic preventive oral health care, including education in self care, routine teeth cleaning, provision of fluorides and sealants, periodontal maintenance and routine x-rays.

ADHA stands ready to work with the nation's policymakers to improve children's access to preventive oral health services, which will achieve savings of billions of health care dollars and improve children's oral health, a fundamental part of total health.

ADHA appreciates this opportunity to submit its views. For further information, please contact our Washington Counsel Karen S. Sealander of McDermott, Will & Emery (202–778–8024).

Statement of Donald G. Dressler, CAE, on Behalf of Association Healthcare Coalition

My name is Don Dressler, and I am President of Insurance Services for Western Growers Association, headquartered in Newport Beach, California. I am submitting this statement for the record on behalf of The Association Healthcare Coalition (TAHC), of which I am immediate past president and current chairman of the legislative committee. TAHC is a nationwide coalition of over 75 trade and professional associations formed for the purpose of maintaining and improving the ability of associations to provide health care benefits to their members.

TAHC greatly appreciates the opportunity to submit a written statement with regard to the problem of children in the United States who do not have health insurance, and possible federal policy responses to this issue. I propose that the most effective method of expanding health insurance to children who are currently uninsured is to strengthen existing Association Health Plans ("AHPs"), operated by bona fide trade and professional associations. Moreover, I believe that strengthening associations, which have been providing affordable health insurance for over 50 years, will prove to be far more effective in reducing the problem of uninsured children than by creating new government programs or spending initiatives at either the federal or state level.

AFFORDABILITY IS THE KEY TO THE PROBLEM OF UNINSURED CHILDREN

First, I want to commend Chairman Thomas for calling this timely hearing. The problem of the uninsured in America, and especially that of our children who do not have health coverage, is one of the great social issues facing our nation today. Congress and the Clinton Administration took the first step towards addressing health insurance concerns by enacting the Health Insurance Portability and Accountability Act last year. This new law will be beneficial to millions of American workers, and Chairman Thomas and the members of the Subcommittee are to be commended for their leadership in enacting this legislation.

Unfortunately, the final version of the portability legislation did *not* address the issue of affordability in health insurance, despite the passage of provisions by the House to accomplish this objective. In order to reduce the number of uninsured children in America, the issue of affordability must be addressed in a comprehensive manner. TAHC urges Congress to pass legislation which addresses the affordability issue in 1997.

THE PROBLEM OF UNINSURED CHILDREN IS A SMALL BUSINESS ISSUE

If one looks closely at the problem of uninsured children, it becomes clear that conventional health insurance is just too expensive for many working Americans with families. The Subcommittee's press release announcing this hearing states that "over 80% of uninsured children have parents who work at least part-time, and nearly 60% have parents who work full time." Moreover, the majority of working

families with uninsured children are employed by small businesses or are self-employed. The percentage of uninsured persons working in companies with less than 100 employees increased from 24% in 1993 to 27% in 1995, a 12.5% increase in just two years. The reason for this is the continuing trend of rapidly rising health costs for small businesses.

In contrast, workers employed by large corporations, and their families, enjoy nearly universal health coverage today. Thus, it is apparent that workers employed in small businesses are much more likely to be uninsured themselves, or to be able to insure their families, than those who work for large and medium-sized organizations. As such, any effort to extend health insurance to uninsured children must address the underlying cause of why small businesses have greater difficulty in providing health insurance than do larger companies.

Why this disparity between workers employed in large and small businesses? One reason is that larger employers enjoy economies if scale which allow them to reduce administrative costs, obtain volume discounts, and take other measures which dramatically reduce the cost of health insurance per person. In addition, many of the larger organizations operate under ERISA, which allows them to self-insure their employees. Under ERISA, companies which self-insure avoid the costs imposed by state government mandated benefits, insurance premium taxes, and vastly different regulatory requirements from state to state. Indeed, administrative costs for larger employers operating under ERISA can be 30% lower than for small businesses, and health insurance premiums for large employers can also be 30% lower than those for small businesses.

THE SMALL BUSINESS RELATIONSHIP TO UNINSURED FAMILIES MUST BE ADDRESSED

TAHC believes that any legislation to make health insurance more affordable for children *must* strengthen the role of Association Health Plans ("AHPs"). AHPs are the key to providing access to affordable health coverage for small businesses.

AHP's already have begun to fill the niche represented by small business in the health insurance market. At Western Growers Association, we provide coverage to over 90,000 individuals, including approximately 40,000 children. Thousands of these children would not have any health coverage now without WGA's health plans. At WGA, we are able to provide coverage to families because we offer a wide variety of health plan options that are specifically designed to meet the health and financial needs of our members, their workers, and their worker's families.

For example, WGA's basic family plan for agricultural workers costs about $220 per month. In contrast, the least expensive alternative, the California State small-group plan, is well over $300 per month. Moreover, there is no traditional insurance company in the nation with any interest in serving the workers and children covered by WGA. Indeed, WGA and similar AHP's across the nation exist because they are meeting the needs, at an *affordable* price, of the small business market niche. If it were not for AHP's like WGA and others across the nation, the problem of uninsured children would be far worse than it is today.

Unfortunately, AHP's currently face challenges which are making it more difficult to provide affordable health coverage to working families. As such, Congress should pass legislation which would: (a) prevent the erosion of the ability of AHP's to continue providing affordable health coverage; and (b) enhance and expand the ability of AHP's to offer affordable coverage. Such legislation would ultimately enable millions of currently uninsured children to obtain the health coverage they so desperately need.

A LEGISLATIVE PROPOSAL TO EXPAND AFFORDABLE COVERAGE TO WORKING FAMILIES

TAHC is working with Members of Congress on legislation to achieve these objectives. This legislation would establish a regulatory framework that further facilitates the ability of small businesses to obtain affordable health coverage through AHP's. By taking a market-oriented approach, this legislation ultimately would reduce the numbers of uninsured children without any new federal spending or taxes.

More specifically, this legislation would ensure that current AHP's are not jeopardized by future regulatory actions at the state level. For example, the health coverage of thousands of families covered by WGA could be threatened by new mandates imposed on businesses or AHPs by state governments. While WGA currently abides by a California law setting requirements for AHP's, this law sunsets in 2001. Depending on the political climate of the future, it is difficult to discern what type of regulatory structure may take the current law's place, or what types of new government mandates may be imposed. By providing greater certainty through uniform regulation at the federal level, Congress would eliminate the current uncertainty,

thus protecting and enhancing the ability of AHP's to provide affordable coverage to families.

Providing a more certain, uniform regulatory environment would also allow greater numbers of bona fide trade and professional associations to offer AHP's. This would expand access to affordable coverage for low-and medium-income workers employed in small businesses. Ultimately, the resulting expansion of AHP's to serve this market niche would result in hundreds of thousands of children obtaining health coverage.

THE ERISA APPROACH HAS PROVEN TO BE SUCCESSFUL

How can we be so sure that legislation to strengthen AHPs would be successful in expanding health coverage to children? Because this approach has already been tested, and it has been proven to work. Since its inception in the early 1970s, ERISA has become the foundation of employer-sponsored health insurance, enabling large corporations to provide working families with affordable health coverage. TAHC believes strongly that it makes perfect sense to extend the successful ERISA framework to that portion of the population which has not enjoyed its benefits. Moreover, it is our view that this is absolutely necessary if we are to be successful in extending affordable coverage to uninsured children over the long run.

UNFOUNDED CRITICISMS

I would like to address several criticisms which have been leveled at our market-oriented approach to the health insurance market. First, some critics contend that our approach does not respect the role played by state governments in regulating health insurance. As such, our legislation will contain a number of provisions to ensure that many state regulatory functions remain intact. However, we acknowledge that our approach protects small businesses from government mandates imposed by states, the chief cause of escalating health insurance costs. We believe that state government mandates are no better than President Clinton's ill-fated employer mandate for health insurance proposed at the federal level. The choice for Congress in how to expand health coverage to the uninsured is clear in this regard; market forces or state government mandates.

With respect to the issue of state mandates, I would note the recent comments of Bill Gradison, president of the Health Insurance Association of America, an organization which has been one of the most strident critics of associations. In a recent interview, Gradison indicated that the current trend towards federal regulation of health insurance is likely to continue, and he also noted that the continued need for insurance companies to comply with 50 different sets of regulations increases the cost of insurance.

In this context, it is also interesting to note the comments of Kansas Insurance Commissioner Kathleen Sebelius, speaking on behalf of the National Association of Insurance Commissioners, another vocal critic of Association Health Plans. In a recent statement before the Senate Labor Committee on March 6th, Ms. Sebelius stated that the NAIC would favor "federal standards" if they were based on the NAIC's five model acts and included federal enforcement resources. It appears that even the NAIC recognizes the need for effective federal standards for AHPs.

Another criticism that AHP's have endured is that they avoid bad risks, thus leaving out less healthy individuals and driving up their insurance costs. This criticism also is completely without merit, and I urge the Subcommittee members to reject it. First, I am not aware of any reputable, empirical evidence which supports this claim. Second, a study by the respected healthcare consulting firm Lewin-VHI found no significant difference between the risk characteristics of fully-insured and self-insured populations. Finally, in an effort to "go the extra mile" to assure critics on this issue, our legislation will contain a number of requirements that will prevent any so-called "anti-selection" among AHP's in the healthcare marketplace.

Finally, it should be pointed out that our proposal would implement effective consumer protections against fraud and abuse which currently do not exist in many states. By enacting a uniform federal system of solvency standards and other safeguards, in contrast to dozens of different sets of state regulations, Congress would be taking immediate action to protect those currently covered by AHPs, and at the same time enhance the ability of bona fide associations to continue providing affordable health coverage to working families.

CONCLUSION

TAHC believes that any legislation considered by Congress to extend coverage to children must strengthen the role of AHP's in providing affordable health coverage

to small businesses. Associations are already a vital source of health care coverage for American workers, and have been serving their members in this manner for over 50 years. We look forward to working with Chairman Thomas and the Subcommittee Members towards this objective.

Statement of Susan Erickson, President, Council of Women's and Infants' Specialty Hospitals

The Council of Women's and Infants' Specialty Hospitals (CWISH) is a group of eight of the largest freestanding subspecialty perinatal hospitals dedicated to the delivery of high risk obstetrical and neonatal care to mothers and their infants.[1] CWISH is pleased to present its views with regard to children's access to health coverage.

Because access to risk-appropriate prenatal care is known to improve the outcome of pregnancy, inclusion of health insurance coverage for pregnant women in any children's health initiative will contribute to the goal of improved health for the nation's children. Accordingly, CWISH urges that health insurance coverage for pregnant women be included in any children's health initiative.

Further, children's health legislation must specifically assure access to quality, cost-effective high risk obstetrical and neonatal care for both pregnant women and infants. Access to high risk obstetrical and neonatal services is critical because studies show that premature and low-birthweight infants born in large Level III subspecialty hospitals—such as CWISH hospitals—fare better than high risk deliveries in other settings without increased cost.[2] Moreover, a healthy pregnancy and delivery bolsters the chances for a healthy childhood and can avert expensive acute and/or long-term care.

CWISH SUPPORTS EXPANDED MEDICAID OUTREACH

CWISH is pleased with the significant level of interest and commitment in this Congress to increase health insurance coverage among our nation's ten million uninsured children, including the three million children eligible for, but not receiving, Medicaid benefits. CWISH is well aware of Medicaid's importance to the health of pregnant women and infants. Indeed, CWISH is a significant participant in the federal Medicaid program, with Medicaid payments constituting up to sixty-five percent of the care provided by our hospitals.

As Congress undertakes to reform the Medicaid program, we urge this Subcommittee—and all Members of Congress—to facilitate outreach and other programs to ensure health care coverage of all Medicaid eligible pregnant women and infants and to ensure that CWISH and other subspecialty perinatal hospitals will be able to provide quality cost-effective high risk obstetrical and neonatal services to pregnant women and infants in their communities, regardless of economic need.

IMPORTANCE OF RISK-APPROPRIATE CARE FOR PREGNANT MOTHERS AND INFANTS

Lack of health insurance often results in lack of timely care, which too often results in costly acute and/or long-term care. U.S. Census Bureau data reveals that one of three children lacked health insurance for one or more months during 1995–1996.[3] Many of these uninsured children are members of families where one or both parents are working, but simply cannot afford insurance. Clearly, we must do better.

Appropriate prenatal care for expectant mothers is a major determinant of good pregnancy outcome. In fact, prenatal care, especially among poor, minority and other high-risk women, reduces the risk of low-birthweight threefold and results in lower infant mortality rates and healthier infants. Numerous studies have also shown that women who receive no prenatal care are far more likely to have babies with health problems that could have been prevented or reduced had they received the appropriate perinatal care.[4] According to the American Hospital Association,

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[1] Perinatal services include material and infant care beginning before conception and continuing through the first year of an infant's life.

[2] *The Effects of Patient Volume and Level of Care at the Hospital of Birth on Neonatal Mortality,* Journal of the American Medical Association, Volume 276, No. 13, october 2, 1996, p. 1054.

[3] *One Out of Three: Kids Without Health Insurance 1995–1996, Families USA Foundation, Washington, D.C. 1997, p. 1.*

[4] *Infants At Risk: Solutions Within Our Reach,* Greater new York March of Dimes/United Hospital Fund of New York, 1991, p. 28.

leading the list of barriers to this important care is inadequate or total lack of health insurance.

Identification of high risk pregnancies and subsequent referral and appropriate treatment by specialists is critical. As cited earlier, the recent study reported in the *Journal of the American Medical Association* confirms that high risk deliveries in large level III neonatal intensive care units (NICUs)—such as those in CWISH hospitals—fare better than high risk deliveries in other settings without increased cost. Because the major decline in infant mortality over the past 25 years is largely attributable to better access to the subspecialty services provided at hospitals such as ours, access to these high risk obstetrical and neonatal services must be included in any children's health initiative. Indeed, the Finance Committee expressly recognized the importance of access to specialty perinatal care in its fiscal year 1997 reconciliation recommendations.

In conclusion, CWISH strongly advocates access for all pregnant women and infants to cost-effective quality risk-appropriate health care. Such care should specifically include high risk obstetrical and neonatal services provided in Level III regional specialty hospitals.

CWISH appreciates this opportunity to submit its views. For further information, please contact our Washington Counsel Karen S. Sealander of McDermott, Will & Emery (202–778–8024).

Statement of Vencor, Inc., Louisville, Kentucky

Vencor is the nation's largest network of long term health care services. It owns and operates 38 long term hospitals and 325 nursing centers in 41 states and provides a complete spectrum of therapy and diagnostic services to an additional 2,000 nursing homes. It also provides home health and hospice services in some markets.

The Vencor mission is to provide essential medical services to the elderly population at the highest level of quality, with documented outcomes, and at the lowest cost to the nation's Medicare, Medicaid, and private insurance programs. Vencor believes the challenges of fiscal integrity and budgetary restraint present health providers with opportunities for developing and implementing new ways to deliver medical care.

Overview

Vencor believes that the Health Care Financing Administration has not been as accountable to Congressional directive nor as responsive to marketplace changes as it needs to be in the face of obvious demographic and financial trends. Much of our concern about the Administration's Medicare PPS-exempt proposals is based on the belief that HCFA has used neither its statutory authority to control program costs nor its intellectual and policy resources to redesign reimbursement systems that were considered "temporary" more than a decade ago.

Vencor also believes that many of the current proposals affecting PPS-exempt facilities are ill-conceived and punitive quick fixes meant to compensate for years of HCFA's inaction. Some of the proposals will create more problems than they solve, while others will exacerbate existing ones. If adopted, they will encourage HCFA to continue its reluctance to make the changes to the reimbursement system which are needed to reduce costs and ensure efficiencies.

Vencor will comment on specific proposals found in the Clinton Administration's Medicare savings plan and reference the proposals by section and number.

Section 11208 Payments to Hospitals Excluded from PPS

This section proposes radical rebasing of PPS-exempt hospital target amounts utilizing a national average, floors and ceilings to account for variability, and elimination of the incentive payment. This proposal transforms the TEFRA system without replacing it. The scheme reflects a set of values and beliefs short on facts and long on ideology. It ignores the 1996 recommendations of the Prospective Payment Advisory Commission and the advice of every provider in the PPS-exempt sector.

The current system is designed to reimburse a hospital or unit for its actual costs and reward it with an incentive payment if, over time, the hospital reduces its costs below its historic level established in the base year. When this occurs, the Medicare program obtains savings in its baseline and shares a fraction of the target amount with the hospital in the form of an incentive payment.

Congress gave the Secretary broad authority to adjust individual hospital target amounts whenever patient acuity, numbers of discharges, or changes in hospital services warranted a revision. It also provided for an exceptions process that enables hospitals to request full costs if operating conditions have changed since the base year target was established.

Vencor believes HCFA historically has not used its authority to manage this system and has taken few steps to control the formulaic calculation of targets for skilled nursing and rehabilitation units and long term hospitals. HCFA has also allowed an interim system to last for years without completing the work needed to replace it with a more efficient one.

The current Administration proposals are a mirror of what it recommended two years ago. However, in those two years, HCFA has done little to constrain costs or develop a new reimbursement system. And the industry remains vehemently opposed to HCFA's proposal because it is such a clumsy effort to cut costs without consideration of the consequences for beneficiaries and providers.

This Committee's staff has received other payment reform proposals which should be scored by the CBO and the results shared with industry providers. These approaches utilize differentiated updates, targeted emphasis on the spread between an individual hospital's costs and its target amount, and an improved process for determining how new or newer hospitals are reimbursed.

Vencor recommends that Congress reject the current rebasing proposal and preserve the incentive payment at least until a new post-acute payment system is fully implemented. Any rebasing proposal should account for variations in patient acuity and reduce the spread between hospital costs and target amounts.

Section 11207 Moratorium on New Long Term Care Hospital Exclusions

This proposal could be a reasonably effective control on unrestrained future growth in program costs for the transition period until a new payment system is devised as proposed in Section 11297. However, most providers do not have confidence in HCFA's ability to develop a new system in a timely manner and worry that the temporary restraint will become a permanent ban.

The proposal also allows HCFA to continue certifying long term "hospitals within hospitals". Vencor does not believe current statutory authority exists for HCFA to recognize these anomalies. The current HCFA regulations have not restrained their growth nor assured the integrity of their operations. HCFA has not demonstrated its ability to enforce these regulations. There is no evidence that "hospitals within hospitals" are needed for networking, managed care, or beneficiary convenience, as some providers and policymakers have asserted.

"Hospitals within hospitals", like Skilled Nursing and Rehabilitation units before them, have been established more to take advantage of inconsistencies and distortions in the Medicare reimbursement system (which HCFA was to have corrected 10 years ago) rather than improve patient outcomes or better serve beneficiaries.

Vencor recommends that Congress prohibit the certification of any future "hospitals within hospitals".

Section 11209 Reductions to Capital Payments for PPS-exempt Hospitals

Reductions in capital payments will impact PPS-exempt hospitals differently than PPS hospitals. The opportunities for accommodating these reductions with more private pay patients, updated DRG payments, or new hospital services is severely limited and fails to acknowledge their reliance on Medicare for all or most of its cost-based reimbursement.

Vencor recommends that the 15% reduction be phased in over three years at annual increments of five per cent.

Section 11206 Treatment of Transfer Cases

Vencor supports this provision as long as the discharging hospital payment is based on a formula that recognizes disproportionately higher front end costs during the hospital stay. Again, HCFA's reluctance to "level the playing field" or reduce the discontinuities between reimbursement systems and the provider facilities that bridge

them, has become a costly problem and we support this effort to mitigate it until a new post-acute reimbursement system is designed per Section 11297.

Vencor recommends that discharges of patients from PPS hospitals to PPS-exempt facilities be treated as transfers for the purpose of adjusted per-diem reimbursement.

Section 11222 Prospective Payment for Skilled Nursing Facility Services

Vencor supports the development of a PPS system for skilled nursing care and believes the 1998 implementation is realistic and should be mandated by Congress. The system should be based on patient needs and adjusted for acuity.

A phase-in period, in which the move to a national rate is accomplished, should be accompanied by a freeze on Routine Cost Limits for new providers , a transition to regional rates, and collection of sufficient data to make the new payment system equitable for all providers, simple to administer, and cost efficient for the Medicare Trust Fund.

Vencor recommends that current limitations on the provision of therapeutic and diagnostic services in skilled nursing facilities remain in place until the new Prospective Payment System is implemented.