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IMPACT OF GAPS IN HEALTH COVERAGE ON INCOME SECURITY

HEARING

BEFORE THE

SUBCOMMITTEE ON
INCOME SECURITY AND FAMILY SUPPORT

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

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IMPACT OF GAPS IN HEALTH COVERAGE ON INCOME SECURITY

WEDNESDAY, NOVEMBER 14, 2007

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON INCOME SECURITY AND FAMILY SUPPORT,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:02 a.m., in room B–318, Rayburn House Office Building, Hon. Jim McDermott (Chairman of the Subcommittee), presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON INCOME SECURITY AND FAMILY SUPPORT

FOR IMMEDIATE RELEASE
November 07, 2007

CONTACT: (202) 225–1025

McDermott Announces Hearing on Impact of Gaps in Health Coverage on Income Security

Congressman Jim McDermott (D–WA), Chairman of the Subcommittee on Income Security and Family Support, today announced a hearing on the impact of gaps in health coverage on income security. **The hearing will take place on Wednesday, November 14, 2007, at 10:00 a.m. in room B–318 Rayburn House Office Building.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND:

The Census Bureau has found that, in 2006 (the most recent year in which data is available) roughly 47 million people did not have health insurance in this nation, an increase of nearly 2.2 million over the previous year. After falling modestly in the late 1990s, the number of people without health insurance has increased by approximately 8.6 million since 2000.

Research suggests that the combination of declining share of employees being covered by employers and rising health costs have placed more moderate- and middle-income families at risk of becoming uninsured. Between 2000 and 2004, the share of non-elderly working-age adults covered by employer-sponsored insurance declined by five percentage points, from 66 percent to 61 percent, according to the Kaiser Family Foundation. While government programs, such as Medicaid, provide health coverage to certain low-income individuals, many other low- and middle-income individuals and families do not have a health safety-net available to them. As a result, many are completely without health insurance or experience gaps in coverage.

Studies have found that those who are uninsured face difficulty managing chronic conditions, are much less likely to get preventative care, and experience an overall decline in their health. The uninsured are three times more likely than those with coverage to cut back on basic needs to pay for care and, among low-income uninsured parents, are more likely to report a loss of time at work because of an illness. The absence of health insurance and gaps in coverage undermine the ability of these families to increase their overall economic well-being.

In announcing the hearing, Chairman McDermott stated, **"We know it's increasingly difficult for the middle class to obtain quality, affordable health care. The Subcommittee will explore the growing challenges facing the American people, especially the unemployed, the disabled, and vulnerable youth. There is much we can learn by examining the leadership role the federal government currently plays in the provision of health care to find ways to fill the widening gaps in our health care system."**

FOCUS OF THE HEARING:

The hearing will focus on how gaps in health care coverage affect the income security of Americans.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "*110th Congress*" from the menu entitled, "*Hearing Archives*" (*http://waysandmeans.house.gov/Hearings.asp?congress=18*). Select the hearing for which you would like to submit, and click on the link entitled, "*Click here to provide a submission for the record*." Once you have followed the online instructions, completing all informational forms and clicking "submit" on the final page, an email will be sent to the address which you supply confirming your interest in providing a submission for the record. You ***MUST REPLY*** to the email and ***ATTACH*** your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business **November 28, 2007**. **Finally**, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item 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 submissions and supplementary materials must be provided in Word or WordPerfect format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

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

3. All submissions must include a list of all clients, persons, and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone and fax numbers of each witness.

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

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

Chairman MCDERMOTT. The Subcommittee will come to order. You want me to put my microphone on?

Mr. Herger is here and we will begin. Unfortunately, family problems for Mr. Weller have kept him away today, so we will start. The number of Americans that go without health insurance is growing. We all know it. I am not giving you any big news here. It is now up to 47 million who are without health insurance. Presumably, these numbers are by the Census Bureau, this reflects the people who are uninsured for an entire year. It comes as no surprise that medical bills are also the leading cause of bankruptcy.

People, when they get a big medical bill that tips them over very often in this society, because everybody is so stretched out financially anyway. We're involved because the gaps in the provision of affordable health care impact populations that concern this Subcommittee. I am really not looking at the whole thing, but I am looking at this thing because we have some very specific groups that are affected. I will talk both about them and about the larger issue.

The disabled, the unemployed, the low and moderate-income families, and youth who are aging out of foster care are groups that are affected by this lack of health insurance.

A recent CBO report found that after becoming unemployed, nearly 40 percent of workers lacked health insurance. Applicants for SSI could wait as long as two and a half years for a final determination by the Social Security Administration that they qualify for SSI. What happens to them in that two and a half years?

What do the disabled people do to obtain health care during this period, how did they pay for it, and what impact does any delay have on their mental status, and their health status and long-term medical costs? Forty percent of uninsured Americans with medical burdens are unable to pay for necessities such as food, heat and rent.

How does the living standard of these families with these challenges compare with families who receive TANF, food stamps or housing assistance? When a foster child becomes 18, he or she loses their entitlement to Medicaid.

How does an 18-year-old obtain health insurance in today's economy, and what impact does that have on their long-term health status? This spring, this Subcommittee learned about the disproportionate number of homeless youth that were coming from the child welfare system. We then passed a resolution declaring November as National Homeless Youth Awareness month. But we really need to do more to raise consciousness in this society.

Why should we make an 18-year-old choose between housing, continuing education and health care? It really is an unfortunate set of questions to be asking. The problems confronting our health care system reach beyond this Subcommittee's jurisdiction. There is a slide which shows something I think we need to talk about.

Why does the Federal Government impose an income tax on health benefits received by a domestic partner, is a question for the full Committee. Another one concerns globalization. We have a system where almost 65 percent of non-elderly individuals obtained health insurance through employment, but this Subcommittee learned in a March hearing that globalization means that workers should expect to change jobs and careers more often than in the past. Without health care reform, we can expect globalization to translate into larger gaps in health care and more vulnerable families.

As we consider ways to fill the gaps of our current health care system, it is important to understand what we have today and the role the government already plays in the purchase of health care. We have heard recently around the debates on "SCHIP", the term "if we do any more for children in this country, we will somehow have socialized medicine", as though that were some kind of shib-

boleth that we couldn't deal with. Now, I put that chart up for you. The government already spends—50 percent of the dollars on health care come from the Federal Government, when you talk about spending and the tax breaks involved.

This vital role may impact the price and quality of health care purchased privately. Most private insurance plans operate off of what the government pays, some relationship to what is paid by Medicare or Medicaid.

I thank today's witnesses for being with us and sharing their knowledge. They bring a commitment to this issue that is very important in the coming months. I know some of you from the past, and I know where you have been and what you have been doing. Some of you are new, but nevertheless you all have a long-term stake in what happens in this issue. I expect this issue will be the number one domestic issue in the 2009 session of the U.S. Congress. I think we are going to have to do something about it. Whether we get it done or not, and how we get it done remains to be seen. I will now yield to Mr. Herger, who will make an opening statement.

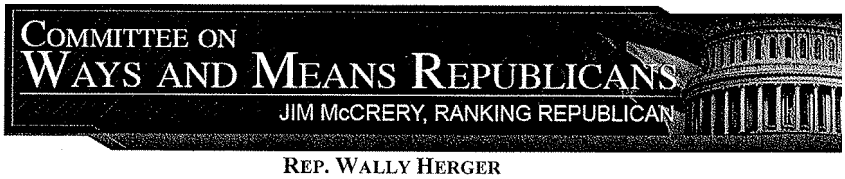
Mr. HERGER. Thank you Mr. Chairman. Unfortunately, ranking member Jerry Weller is not able to attend the hearing today. On his behalf, I would like to thank all the witnesses for being here today, and I ask that Mr. Weller's opening statement be inserted in the record. The goal of ensuring that all Americans have adequate health care is one that we all share. Just how we reach that goal has been an issue in hearings before many Committees for quite some time here in Congress.

Today's hearing will add to that list. Mr. Weller's statement explores how dropping out of high school leads to low wages, or unemployment for too many young adults. For purposes of today's hearing, dropping out of high school leads to far higher chances that adults, and their families, will lack health insurance coverage. That is despite the fact that many are covered under Medicaid, and other public programs.

I certainly agree with Mr. Weller that this is one of many reasons why this Congress, and the nation, should be doing everything we can to improve the chances that young people finish at least high school. That is the only way they can obtain the skills needed to hold down good jobs that either offer workers health coverage, or that pay enough for them to purchase coverage on their own.

I look forward to the hearing, and the witness testimony today, and I yield back the balance of my time.

[The prepared statements of Mr. Herger and Mr. Weller follow:]



REP. WALLY HERGER
SUBCOMMITTEE HEARING ON HEALTH AND INCOME SECURITY
HEARING ON GAPS IN HEALTH INSURANCE COVERAGE
NOVEMBER 14, 2007
(REMARKS AS PREPARED FOR DELIVERY)

Good morning.

Unfortunately, Ranking Member Jerry Weller is not able to attend the hearing today.

On his behalf, I would like to thank all of the witnesses for being here today and I ask that Mr. Weller's opening statement be inserted in the record.

The goal of ensuring that all Americans have adequate health care is one that we all share.

Just how we reach that goal has been an issue in hearings before many Committees for quite some time here in Congress. Today's hearing will add to that list.

Mr. Weller's statement explores how dropping out of high school leads to low wages or unemployment for too many young adults.

And for purposes of today's hearing, dropping out of high school leads to far higher chances that adults and their families will lack health insurance coverage; that is despite the fact that many are covered under Medicaid and other public programs.

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That is the only way they can obtain the skills needed to hold down good jobs that either offer workers health coverage or that pay enough for them to purchase coverage on their own.

I look forward to the hearing and the witness testimony today and I yield back the balance of my time.

STATEMENT OF REP. JERRY WELLER
INCOME SECURITY AND FAMILY SUPPORT SUBCOMMITTEE
HEARING ON GAPS IN HEALTH INSURANCE COVERAGE
NOVEMBER 14, 2007
(REMARKS AS SUBMITTED FOR THE RECORD)

Today's hearing reviews issues that aren't often considered by this subcommittee. But no one can dispute that helping more Americans receive appropriate and affordable health care is an important goal, and one we should all support.

So the question becomes what to do. Chairman Rangel, in his years working to reduce drug abuse, often talked about the "root causes" of drug use. For example, in 1989 he said "We need to focus on the problems that bring people to the desire for illicit drugs - homelessness, unemployment, lack of education, lack of health care, lack of family and, above all, poverty."

Today's hearing offers a similar opportunity to focus on the root causes that result in so many American families having low incomes, living in poverty, experiencing unemployment, and lacking health coverage. This is a complex picture, but a close look at the data shows one factor that tremendously increases the chances families will experience those problems, including lacking health coverage. That factor is not finishing high school.

Consider the following data.

First, every year 1.2 million students fail to graduate from high school on time. Many will never finish high school, and thus will join the 22 million other working age adults without high school degrees. The data also shows that African Americans and Hispanics have even higher dropout rates than others.

Figure 1

Too Many Drop Out of High School...

- "Each year, approximately 1.2 million students failed to graduate from high school."
- "Nationally, approximately 70 percent of students graduate from high school, but African-American and Hispanic students have a 55 percent or less chance of finishing high school with a regular diploma."

Source: Alliance for Excellent Education, Fact Sheet on Graduation Rates, August 2006.

Second, high school dropouts have far lower annual and lifetime incomes than others. The average high school graduate earns about 40 percent more per year than the average dropout. Over the course of a lifetime, the average high school dropout will earn about $300,000 less than his or her peer who gets a high school diploma; average college graduates will earn more than twice as much as dropouts – a total of $1.4 million more over their lifetimes.

Figure 2

...Leading to Far Lower Income

More Learning Translates Into Higher Earnings

Education	Average Annual Earnings	Average Lifetime Earnings
High school drop out	$22,000	$1.1 million
High school diploma	$31,000	$1.4 million
Associate's degree	$38,000	$1.8 million
Bachelor's Degree	$50,000	$2.5 million

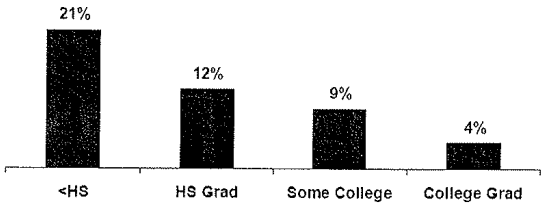
Source: Cited in "Preparing Today's High School Students for Tomorrow's Opportunities," American Diploma Project Network

Third, and not surprisingly given these income figures, high school dropouts are far more likely to be poor. Across all ages and both genders, dropouts are 75 percent more likely than high school graduates to be poor.

Figure 3

...Far Greater Poverty Overall

Percentage in Poverty by Educational Attainment, Both Sexes and All Ages (2006)

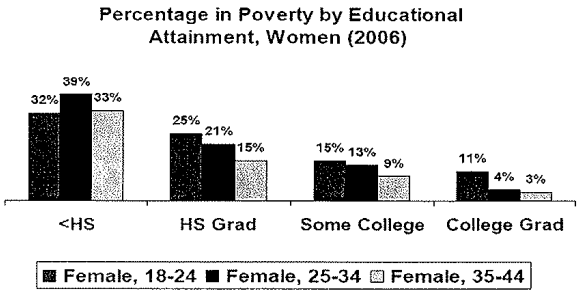


Source: Census Bureau, Current Population Survey, Table POV29.

As the fourth figure shows, for women the picture is even bleaker. Women between ages 25 and 34 who don't complete high school are almost twice as likely as high school graduates to be poor, and about 10 times as likely as college graduates to be poor – 39 percent versus 4 percent.

Figure 4

...Far Greater Poverty Among Women

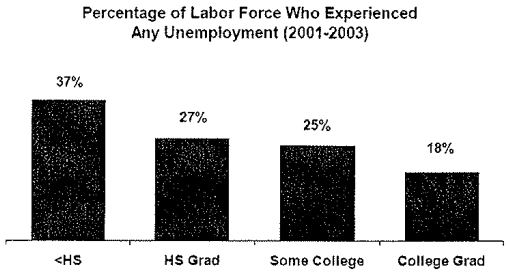


Source: Census Bureau, Current Population Survey, Table POV29.

Fifth, as a Congressional Budget Office report requested by Chairman Rangel recently displayed, following the most recent recession the chances were far greater that working age adults who hadn't finished high school would be unemployed than other workers. Dropouts were twice as likely to experience unemployment as college graduates during this period, for example.

Figure 5

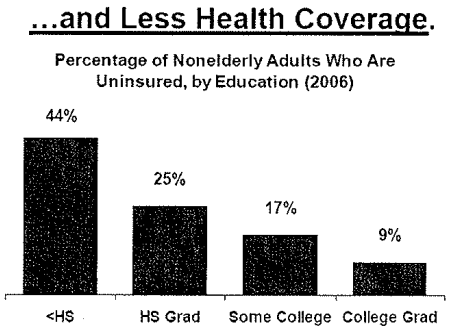
...More Unemployment



Source: CBO report requested by Chairman Rangel et al, "Long-Term Unemployment," October 2007

Finally, and back to our topic today, the lack of health coverage is rampant among high school dropouts, even with many getting coverage under the Medicaid program. According to the Kaiser Commission on Medicaid and the Uninsured, despite being twice as likely as high school graduates and nine times as likely as college graduates to be on Medicaid, working age high school dropouts are still five times as likely to be uninsured as college graduates.

Figure 6



Source: Kaiser Commission on Medicaid and the Uninsured, "The Uninsured: A Primer," October 2007

There are many reasons why Americans lack health coverage. But the above data suggests one key reason is because too many lack the basic credential needed to succeed in the workplace, which is a high school diploma. The sad fact is that people who don't finish high school are far too likely to be poor, to be unemployed, and despite existing programs to be without health coverage.

In the long run, all families will be better off if our country can improve high school completion rates. There are a number of positive proposals to do that, which like the issue of health coverage in general extend beyond the jurisdiction of this subcommittee. But taking such steps will help more workers gain the skills they need to successfully compete and win in today's global workplace, and gain health coverage for themselves and their families in the process. That is something we should all support.

Chairman MCDERMOTT. Thank you very much. We have before us today——

Mr. CAMP. Mr. Chairman, if I could just for the record.

Chairman MCDERMOTT. Sure.

Mr. CAMP. I wanted to put in that this hearing covers issues normally not under the jurisdiction of this Committee. I am ranking member of the Health Subcommittee, and there are a couple of non-partisan reports that I wanted to put in the record with unanimous consent.

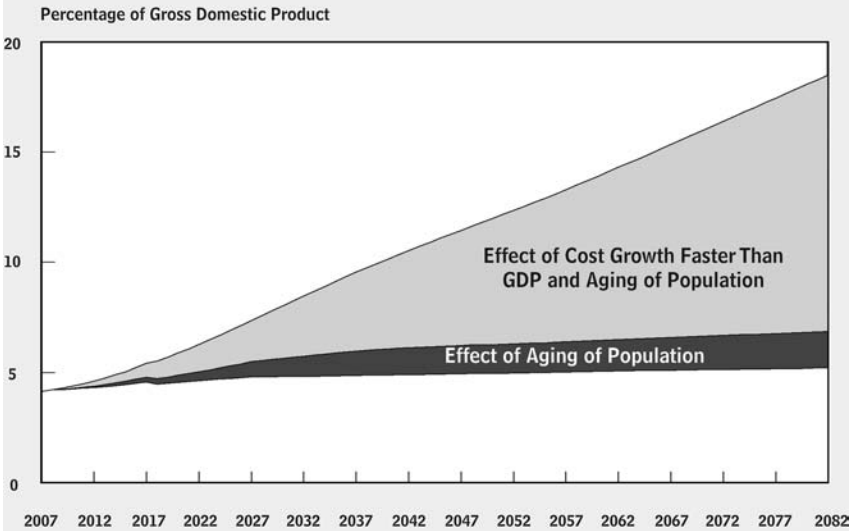
One is the Congressional Budget Office report called, "The Long-Term Outlook for Health Care Spending Sources of Growth and Projected Federal Spending on Medicare and Medicaid." The second one is one of a series of reports from the Congressional Research Service on health insurance coverage, on health insurance coverage of children and spending by employers on health insurance.

With unanimous consent, if these reports could become part of the hearing record.

[The information follows:]

CONGRESS OF THE UNITED STATES
CONGRESSIONAL BUDGET OFFICE

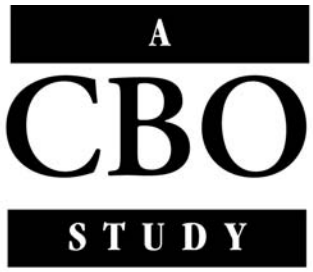
The Long-Term Outlook for Health Care Spending



Sources of Growth in Projected Federal Spending on Medicare and Medicaid

NOVEMBER 2007

12



The Long-Term Outlook for Health Care Spending

November 2007

The Congress of the United States ■ Congressional Budget Office

Notes

Numbers in the text and tables may not add up to totals because of rounding.

The figure on the cover, explained in detail in Box 2, shows that the aging of the population accounts for only a modest fraction of the projected growth in federal spending on Medicare and Medicaid. The main factor is excess cost growth—or the extent to which the increase in health care spending exceeds the growth of the economy.

Preface

Spending on health care has been growing faster than the economy for many years, representing a challenge both for the government's two major health insurance programs, Medicare and Medicaid, and for the private sector. A prologue to the Congressional Budget Office's (CBO's) upcoming long-term budget outlook, to be released next month, this study presents the agency's projections of federal spending on Medicare and Medicaid and national spending on health care over the next 75 years. The goal of the projections is to examine the implications of a continuation of current federal law, rather than to make a prediction of the future. In reality, federal law will change; nevertheless, the projections provide a useful measure of the scope of the problem facing the nation under current law.

Noah Meyerson, Lyle Nelson, Michael Simpson, and Julie Topoleski of CBO's Health and Human Resources Division prepared the study, with valuable contributions from Ignez Tristao. The study benefited from comments by Colin Baker, James Baumgardner, Thomas Bradley, Philip Ellis, Keith Fontenot, Matthew Goldberg, Arlene Holen, Joyce Manchester, William Randolph, Jonathan Schwabish, Sven Sinclair, Robert Sunshine, and Bruce Vavrichek of CBO. Members of CBO's Panel of Health Advisers also provided useful comments. (The assistance of external reviewers implies no responsibility for the final product, which rests solely with CBO.)

John Skeen edited the study, and Christine Bogusz proofread it. Maureen Costantino prepared it for publication and designed the cover. Lenny Skutnik printed the initial copies, Linda Schimmel handled the print distribution, and Simone Thomas prepared the electronic version for CBO's Web site (www.cbo.gov).

Peter R. Orszag
Director

November 2007

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The Long-Term Outlook for Health Care Spending

Introduction and Summary

Spending on health care in the United States has been growing faster than the economy for many years, representing a challenge not only for the government's two major health insurance programs—Medicare and Medicaid—but also for the private sector. As health care spending consumes a greater and greater share of the nation's economic output in the future, Americans will be faced with increasingly difficult choices between health care and other priorities. However, a variety of evidence suggests that opportunities exist to constrain health care costs without adverse health consequences.[1]

In December 2007, the Congressional Budget Office (CBO) will release new long-term budget projections, and spending on health care will play a central role in the fiscal outlook to be described in that report. This study presents CBO's projections of federal spending on Medicare and Medicaid and health care spending generally over the next 75 years. Despite the substantial uncertainties surrounding projections over that long a period, particularly ones involving the growth of health care costs, such a horizon is useful for illustrating the long-term fiscal challenges that this country faces.

The goal of the projections in this study is to examine the implications of a continuation of current federal law, rather than to make a prediction of the future. Under that assumption, however, federal spending on health care would eventually reach unsustainable levels. In reality, federal law will change in the future, ensuring that the basis for the projections will not turn out to be correct, but the projections nevertheless provide a useful measure of the scope of the problem facing the nation.

A simple extrapolation of historical growth rates in Medicare and Medicaid expenditures can illustrate paths for future spending on those programs.[2] That approach, however, implicitly allows the economic impossibility of having health care spending eventually exceed total national income and fails to allow the nonfederal components of the health system to respond to rising costs (as they probably would do even without a change in federal law). Those shortcomings are magnified as the projection period lengthens. This study describes an alternative approach in which the rising share of national income devoted to health care creates pressure on households and employers to take potentially painful steps to reduce the growth in health care spending.

Various plausible paths exist for how spending in the rest of the health care system would evolve over time in the absence of changes in federal law, and one innovation in the methodology presented here is to incorporate a specific metric for determining how that spending will grow. Many such metrics could be applied; the premise that CBO chose was that Americans will ultimately demand changes to the system to prevent their consumption of other goods and services from declining in real (inflation-adjusted) terms. In other words, CBO's projections assume that to avoid a reduction in real consumption of items besides health care, employers, households, and insurance firms will change their behavior in a variety of ways (potentially including higher cost sharing, increased utilization management, reduced insurance coverage by employers, and greater scrutiny of new technologies based on evidence of their comparative effectiveness) to slow the rate of growth of spending in the nonfederal part of the health system. The projections also assume that, even in the absence of changes in federal law, some of the measures adopted to slow growth in the rest of the health care system will moderate spending growth in Medicare

1. Statement of Peter R. Orszag, Director, Congressional Budget Office, *Health Care and the Budget: Issues and Challenges for Reform,* before the Senate Committee on the Budget (June 21, 2007).

2. Ibid.

and Medicaid and that regulatory changes at the federal level and policy changes at the state level will help to slow cost growth in those programs.[3]

The results of CBO's projections suggest that in the absence of changes in federal law:

- Total spending on health care would rise from 16 percent of gross domestic product (GDP) in 2007 to 25 percent in 2025, 37 percent in 2050, and 49 percent in 2082.
- Federal spending on Medicare (net of beneficiaries' premiums) and Medicaid would rise from 4 percent of GDP in 2007 to 7 percent in 2025, 12 percent in 2050, and 19 percent in 2082.

Those results show significantly higher federal spending on Medicare and Medicaid under current law than other official projections do, which typically assume that spending on those programs grows much more slowly in the future than it has in the past. For example, although the projections by CBO and by the trustees of the Medicare program (under their intermediate assumptions) track each other relatively closely for the next two or three decades, by the end of 75 years, Medicare spending under CBO's projections is about 50 percent higher.

To be sure, significant uncertainty surrounds such projections, and the growth of spending on health care could turn out to be substantially higher or lower over the next 75 years than projected here. Like overall budget projections that show an exploding ratio of federal debt to GDP over the long term (which could not in all likelihood actually occur because, at some point, the government would not be able to sell additional debt to investors), the projections here of significant increases in health care spending and a sustained differential in the growth rates of Medicare and Medicaid relative to that of the rest of the health care system will almost certainly not occur, because current law will be changed to help prevent such outcomes. Nonetheless, the projections are useful in illustrating the implications of current law. The main message of this study is that, without changes in federal law, federal spending on Medicare and Medicaid is on a path that cannot be sustained.

3. Such changes that would also affect federal programs could include less rapid development and adoption of costly new technologies and changes in physicians' practice patterns.

In itself, higher spending on health care is not necessarily a "problem." Indeed, there might be less concern about increasing costs if they yielded commensurate gains in health. But the degree to which the system promotes the population's health remains unclear. Indeed, substantial evidence exists that more expensive care does not always mean higher-quality care. Consequently, embedded in the country's fiscal challenge is the opportunity to reduce costs without impairing health outcomes overall (see Box 1).

Overview of the U.S. Health Care System

Spending on health care in the United States is financed through a combination of private and public sources. Most Americans under the age of 65 have private health insurance obtained through an employer. According to CBO's estimates, about 63 percent of that population (161 million people) had employment-based coverage in 2006, while about 4 percent (10 million people) purchased private coverage directly from an insurer.[4] The two main sources of public financing for health care are Medicare and Medicaid. Nearly 43 million elderly or disabled individuals were enrolled in Medicare in 2006, and nearly 61 million low-income individuals were enrolled in Medicaid for at least part of the year.[5] About 43 million people (constituting 17 percent of the nonelderly population) were uninsured. (For more details on the Medicare and Medicaid programs, see Appendix A.)

In 2005, the most recent year for which data are available, national spending on health care totaled nearly $1.9 trillion, or 14.9 percent of the nation's GDP.[6] Some 55 percent of the total was financed privately, and the rest came from public sources (see Table 1). Payments by private

4. Those estimates are from CBO's health insurance simulation model. For a description of the model, see Congressional Budget Office, *CBO's Health Insurance Simulation Model: A Technical Description* (October 2007).

5. Sixteen percent of Medicare beneficiaries were also enrolled in Medicaid.

6. This study defines national spending on health care as total spending on health services and supplies, as defined in the national health expenditure accounts, maintained by the Centers for Medicare and Medicaid Services. The figure cited is equal to total national health expenditures minus spending on research and development and construction.

Box 1.

What Policy Options Can Help Reduce Spending on Medicare and Medicaid?

The analysis underlying the projections in this study, by design, keeps federal law unchanged. A result of that constraint is that Medicare and Medicaid grow more rapidly than the rest of the health system, which is unlikely to occur because federal law will change in the future. In other words, it is certain to change to prevent the scenarios presented here from being realized. So what types of federal policy options would help to reduce future spending on Medicare and Medicaid?

One type of change involves reducing payment rates in the two programs. For example, some analysts have proposed reducing payments to Medicare Advantage plans. Those private insurance plans, according to the Congressional Budget Office's estimates, are paid roughly 12 percent more than the cost of enrolling their beneficiaries in the traditional fee-for-service component of Medicare. Other proposals have involved reductions in reimbursement rates for specific types of services or providers.

A more fundamental set of federal policy changes may help to reduce not only federal spending but also health care spending overall. Indeed, given the interactions between federal programs and the rest of the health system, many analysts believe that significantly constraining the growth of costs for Medicare and Medicaid over long periods of time, while maintaining broad access to health providers under those programs, can occur only in conjunction with slowing cost growth in the health care sector as a whole.

Two potentially complementary approaches to reducing spending on Medicare, Medicaid, and health care generally—rather than simply reallocating spending among different sectors of the economy—involve generating more information about the relative effectiveness of medical treatments and changing the incentives for providers and consumers in the supply and demand of health care. The current financial incentives facing both providers and patients tend to encourage or at least facilitate the adoption of expensive treatments and procedures, even if the evidence about their effectiveness relative to other therapies is limited. For doctors and hospitals, those incentives stem from fee-for-service reimbursement. Such payments can encourage health care providers to deliver a given service in an efficient manner but also provide an incentive to supply additional services—as long as the payments exceed the costs. For their part, insured individuals generally face only a portion of the costs of their care and thus have only limited financial incentives to seek lower-cost treatments. Private health insurers have incentives to limit the use of ineffective care but are also constrained by a lack of information about what treatments work best for which patients.

Many analysts believe that expanded research on "comparative effectiveness" offers a promising mechanism to address some of those concerns. Analysis of comparative effectiveness is simply a comparison of the impact of different options that are available for treating a given medical condition for a particular set of patients. Such studies may compare similar treatments, such as competing drugs, or they may analyze very different approaches, such as surgery in comparison to drug therapy. The analysis may focus only on the relative medical benefits and risks of each option, or it may go on to weigh both the costs and the benefits of those options. In some cases, a given treatment may be found more effective for all types of patients, but more commonly a key issue is determining which specific types would benefit most from it.

To affect medical treatment and reduce health care spending, the results of comparative effectiveness analyses would ultimately have to change the behavior of doctors and patients—that is, to get them to use fewer services or less intensive and less expensive services than are currently projected, which, for Medicare, would require changes to current law. The program has not taken costs into account in

Box 1.

Continued

determining what services are covered and has made only limited use of data on comparative effectiveness in its payment policies. But if statutory changes permitted doing so, the program could use information about comparative effectiveness to promote higher-value care. For example, Medicare could tie its payment to providers to the cost of the most effective or most efficient treatment. If that payment was less than the cost of providing a more expensive service, then doctors and hospitals would probably elect not to provide it—so the change in Medicare's payment policy would have the same practical effect as a coverage decision. Alternatively, enrollees could be required to pay for the additional costs of less effective procedures (although the impact on incentives for patients and their use of care would depend on whether and to what extent they had supplemental insurance coverage that paid some or all of Medicare's cost-sharing requirements).

More modest steps that Medicare could be authorized to take would include smaller-scale financial inducements to doctors and patients to encourage the use of cost-effective care. Doctors and hospitals could receive modest bonuses for practicing effective care or modest cuts in their payments for using less effective treatments. Likewise, enrollees could be required to pay a portion of the additional costs of less efficient procedures (rather than the full difference in costs). Or Medicare could provide information to doctors and their patients about doctors' use of various treatments, which would create some pressure for them to use more-efficient approaches. Adopting more modest measures to incorporate the findings of comparative effectiveness research, however, would probably yield smaller savings for the program.

Even in the absence of more information about comparative effectiveness, changes in incentives could help to control health care costs—but such measures would be more likely to maximize the health gains obtained for a given level of spending if they were combined with improved information. On the provider side, greater bundling of payments to cover all of the services associated with a treatment, disease, or patient could reduce or eliminate incentives to provide additional services that might be of low value. Such approaches, however, can raise concerns about the financial risk that providers face and about incentives for them to provide too little care. On the consumer side, a landmark health insurance experiment by RAND showed that higher cost sharing reduced spending—particularly when compared with a plan offering free care—with little or no adverse effects on health.

The broad options of generating more information and of changing incentives do not represent an exhaustive list of proposals intended to reduce costs in Medicare and Medicaid. In addition, some analysts have advocated significant expansions of disease management and care coordination as mechanisms for reducing costs—proposals that reflect the increasing prevalence of many chronic conditions, the large share of health care spending attributable to those conditions, and the lack of systems to coordinate care in many public and private health insurance plans. For example, 25 percent of Medicare beneficiaries accounted for 85 percent of the program's costs in 2001; more than three-quarters of those expensive beneficiaries had one or more of seven prominent chronic conditions (including coronary artery disease, diabetes, and congestive heart failure). However, the evidence to date—including the findings of several demonstration projects conducted under Medicare—suggests that disease management and care coordination may raise the quality of the health care provided but do not significantly reduce costs among a broad array of patients. As more evidence on the approaches is developed, identifying specific ways to reduce costs, especially for targeted subsets of beneficiaries, may become possible; for now, the possibility and scope of savings remain unclear.

Table 1.

National Spending on Health Care by Source of Funds, 2005

	Billions of Dollars	Percent
Private Spending	1,013.5	54.5
Private health insurance	694.4	37.3
Out-of-pocket payments	249.4	13.4
Other private spending	69.8	3.7
Public Spending	847.3	45.5
Medicare	342.0	18.4
Medicaid[a]	311.0	16.7
Other public spending	194.3	10.4
Total	**1,860.9**	**100.0**

Source: Congressional Budget Office based on data on spending on health services and supplies, as defined in the national health expenditure accounts, maintained by the Centers for Medicare and Medicaid Services.

a. Spending on Medicaid includes amounts spent by the federal government as well as by the states.

health insurers were the largest component of private spending, accounting for 37 percent of national health expenditures. Consumers' out-of-pocket expenses, which include payments for deductibles and copayments for services covered by insurance as well as payments for services not covered by insurance, accounted for 13 percent of national health expenditures.[7] Other sources of private funds, from philanthropy and on-site clinics that some employers maintain for their workers, accounted for 4 percent of the total.

Federal spending on Medicare accounted for 18 percent of national health expenditures in 2005, while federal and state spending on Medicaid accounted for 17 percent. A variety of other public programs accounted for 10 percent of national health expenditures, including ones by state and local health departments, the Department of Veterans Affairs, and the Department of Defense; workers' compensation programs; and the State Children's Health Insurance Program.

7. Out-of-pocket payments do not include the premiums that people pay for health insurance. Premiums fund the payments by insurers, which are already included in the measure of private spending.

The American health care system also consists of a broad array of health care providers, manufacturers, and suppliers. Although 45 percent of the spending on medical care is financed publicly, most services are furnished by private providers. For example, Medicare and Medicaid beneficiaries receive most of their care from physicians, hospitals, and other providers that deliver services to the general population.

From 1975 to 2005, the share of national health expenditures that was financed privately fell slightly, from 59 percent to 55 percent, while the share that was financed publicly rose correspondingly, from 41 percent to 45 percent (see Figure 1). During that period, out-of-pocket payments fell from 31 percent of national health expenditures to 13 percent, while payments by private insurers rose from 25 percent to 37 percent. Although the share of national health expenditures that is financed by out-of-pocket payments has fallen substantially, such payments are still a significant burden for many families. According to one study, 4.3 percent of the nonelderly population (nearly 11 million people) lived in families that spent more than 20 percent of their after-tax income on out-of-pocket payments for medical care in 2003.[8]

Historical Growth of Health Care Spending

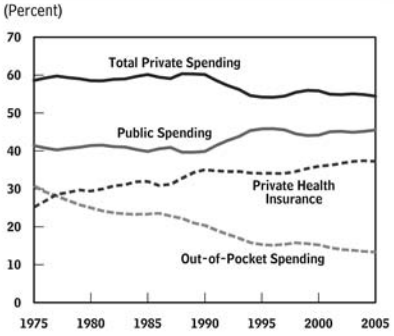
Total spending on health care in the United States, including both private and public spending, increased from 4.7 percent of GDP in 1960 to 14.9 percent in 2005, the most recent year for which data are available, rising steadily throughout most of that period (see Figure 2). A notable exception was the period from 1993 to 2000, when the share remained relatively stable. Many analysts have attributed that lull to a substantial increase in the number of people who were enrolled in managed care plans as well as to excess capacity among some types of providers, which increased health plans' negotiating leverage.[9]

8. Jessica S. Banthin and Didem M. Bernard, "Changes in Financial Burdens for Health Care: National Estimates for the Population Younger Than 65 Years, 1996 to 2003," *Journal of the American Medical Association*, vol. 296, no. 22 (December 13, 2006), pp. 2712–2719.

9. See, for example, Katharine Levit and others, "National Health Expenditures in 1997: More Slow Growth," *Health Affairs*, vol. 17, no. 6 (1998), pp. 99–110.

Figure 1.

National Spending on Health Care by Source of Funds, 1975 to 2005



Source: Congressional Budget Office based on data on spending on health services and supplies, as defined in the national health expenditure accounts, maintained by the Centers for Medicare and Medicaid Services.

Factors Underlying the Historical Growth in Health Care Spending

Most analysts agree that the most important factor contributing to the growth in health care spending in recent decades has been the emergence, adoption, and widespread diffusion of new medical technologies and services.[10] Major advances in medical science allow providers to diagnose and treat illnesses in ways that were previously impossible. Many of those innovations rely on costly new drugs, equipment, and skills. Other innovations are relatively inexpensive but add up quickly as growing numbers of patients make use of them. Although technological innovation can sometimes reduce spending, in medicine such advances and the resulting changes in clinical practice have generally increased it.

Other factors that have contributed to the growth of health care spending include increases in personal income and the growth of insurance coverage. Demand for medical care tends to rise as real family income increases. Moreover, the growth of insurance coverage in recent decades, as evidenced by the substantial reduction in the percentage of health care spending that is paid out of pocket, has also increased the demand for medical care, because coverage reduces consumers' cost of care. However, according to the best available evidence, increasing income and insurance coverage cannot explain much of the growth in health care spending in recent decades.[11]

Another source of spending growth has been the aging of the population. Among adults, average medical spending generally increases with age, so as the population becomes older, health care spending per capita rises. However, over the past three decades, the effect of aging on health care spending has been relatively modest. The demographic effect will become more pronounced with the aging of the baby-boom generation, but it will continue to have a modest effect not only on national health care spending but also on federal spending on Medicare and Medicaid.[12]

Historical Trends

When analyzing historical trends in the growth of health care spending, it is useful to disaggregate the various components. Factors that affect spending on health care include general inflation; growth in the size of the population; and, to a lesser extent, changes in the age distribution of the population. Removing their effects reveals the amount of spending growth that is attributable to factors beyond inflation and demographics. There are at least two ways to measure such additional spending growth: as the increase in real annual health care spending for an average individual ("real per capita cost growth") or as the increase in health care spending for an average individual relative to the growth of per capita GDP.[13] The latter measure is commonly referred to as "excess cost growth,"

10. See Joseph P. Newhouse, "Medical Care Costs: How Much Welfare Loss?" *Journal of Economic Perspectives*, vol. 6, no. 2 (Summer 1992), pp. 3–21; David M. Cutler, "Technology, Health Costs, and the NIH" (paper presented at the National Institutes of Health Economics Roundtable on Biomedical Research, Cambridge, Mass., September 1995); and Technical Review Panel on the Medicare Trustees' Reports, *Review of Assumptions and Methods of the Medicare Trustees' Financial Projections* (December 2000).

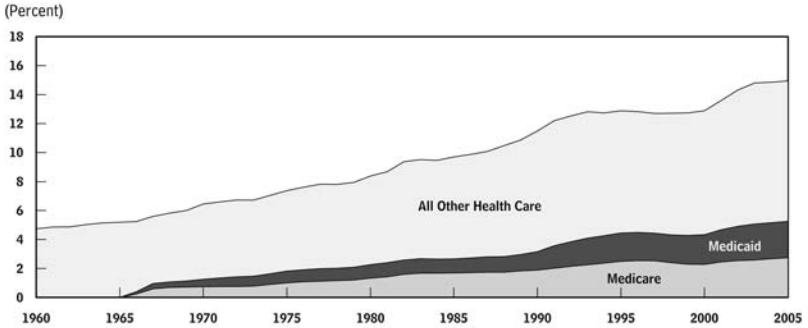
11. Ibid.

12. For the effect on Medicare, see Micah Hartman and others, "U.S. Health Spending By Age, Selected Years Through 2004," *Health Affairs*, Web Exclusive (November 6, 2007), available at www.healthaffairs.org.

13. The effect of general inflation is removed from the second measure because growth in spending on health care is measured relative to growth in per capita GDP, both of which are affected by general inflation.

Figure 2.

Spending on Health Care as a Percentage of Gross Domestic Product, 1960 to 2005



Source: Congressional Budget Office based on data on spending on health services and supplies, as defined in the national health expenditure accounts, maintained by the Centers for Medicare and Medicaid Services.

Note: Amounts for Medicare are gross federal spending on the program. Amounts for Medicaid include spending by the federal government and the states.

signifying that it measures the extent to which growth in per capita spending on health care exceeds the growth in per capita GDP, after adjustments for changes in the age distribution of the population. (The phrase is not intended to imply that growth in per capita spending on health care is necessarily excessive. It simply measures that growth relative to the growth of the economy.) If per capita health care spending grows faster than per capita GDP, the share of the economy devoted to health care will rise.

Although real per capita cost growth is useful for short-term projections, excess cost growth is a more useful concept for long-term projections. From one year to the next, real per capita cost growth is the more reliable measure, because health care spending does not closely track annual economic trends. (Per capita health care spending does not usually fall in a recession or sharply accelerate during years of strong economic growth.) As a result, excess cost growth is often unusually low during periods of strong economic growth and unusually high during periods of slow growth. Over longer periods, though, growth in per capita health care spending is likely to reflect changes in overall economic growth. As the baby-boom generation retires and the growth of the labor force slows, per capita GDP growth will probably slow from the rate experienced over the past 30 years, and growth in per capita spending on health care will probably slow as well. Because the projections contained in this study are long term, they are based on assumptions about future excess cost growth rather than real per capita cost growth.

In part, the projections are based on historical trends since 1975. The purpose of beginning in 1975 is to exclude the start-up period for Medicare and Medicaid; by that year, both programs had been in effect for nearly 10 years, and Medicare benefits had been available to nonelderly disabled people for two years.

The historical rates of cost growth that CBO used for Medicare and Medicaid remove the effect of growth in the number of beneficiaries. The calculation for Medicare also removes the effect of changes in the age composition of the population. For Medicaid, the computation removes the effect of changes in the composition of the

Table 2.

Real per Capita Cost Growth in Medicare, Medicaid, and All Other Spending on Health Care

(Percent)

	Medicare	Medicaid[a]	All Other	Total
1975 to 1990	5.4	5.4	4.8	5.1
1990 to 2005	3.8	3.3	3.1	3.4
1975 to 2005	4.6	4.4	4.1	4.2

Source: Congressional Budget Office.

Note: Figures are annual averages.

a. For Medicaid, data are available through 2004.

caseload: the portion of beneficiaries who are children, disabled people, elderly people, and other adults.[14]

From 1975 to 2005, real per capita spending on health care grew an average of 4.2 percent annually (see Table 2). During that period, per capita GDP grew at 2.2 percent, and excess cost growth amounted to 2.1 percentage points (see Table 3).[15] Those measures capture the growth in total spending on health care, including payments from all private and public sources. Excess cost growth was somewhat higher during that period for Medicare (2.4 percentage points) and Medicaid (2.2 percentage points) and somewhat lower for all other health care spending (2.0 percentage points). Included in other health care spending are payments by private insurers, payments by people who lacked health insurance coverage, all other out-of-pocket payments by consumers, and health care spending by government programs other than Medicare and Medicaid. Consequently, the differences in excess cost growth between Medicare, Medicaid, and other health care spending should not be interpreted as meaning that Medicare or Medicaid is less able to control spending than private insurers.

14. That methodology is consistent with CBO's projections of future spending, which separately account for projected changes in the composition of the caseload.

15. Excess cost growth is not computed simply by subtracting per capita growth in GDP from per capita growth in health care spending but involves a more complex formula (see Appendix B).

Excess cost growth was higher during the earlier part of that period and slower during the second half. The slower growth in overall spending during the 1990s, though, may have reflected one-time changes (for instance, the spread of managed care) rather than a change in the underlying trend. In addition, rates of excess cost growth in Medicare and Medicaid are partly driven by changes in law and policy. Changes have included expansions of the programs as well as efforts to limit cost growth. Most notably, in 1983, Medicare introduced a prospective payment system, under which hospitals are paid a predetermined rate for each admission. The system reduced costs. Whether such changes will ultimately constitute one-time shifts or more permanent changes in cost growth rates is uncertain. As with other spending on health care, the rates of real per capita cost growth and excess cost growth for Medicare and Medicaid were lower from 1990 to 2005 than they were in the preceding 15 years. Because it is unclear whether the experience from the 1990s represented a one-time shift in the level of costs or a change in the underlying trend and because the entire 30-year period was marked by substantial year-to-year volatility without any apparent trend (as shown in Figure 3), CBO uses the average from 1975 onward as the starting point for the projections of the future.

Table 3.

Excess Cost Growth in Medicare, Medicaid, and All Other Spending on Health Care

(Percentage points)

	Medicare	Medicaid[a]	All Other	Total
1975 to 1990	2.9	2.9	2.4	2.6
1990 to 2005	1.8	1.3	1.4	1.5
1975 to 2005	2.4	2.2	2.0	2.1

Source: Congressional Budget Office.

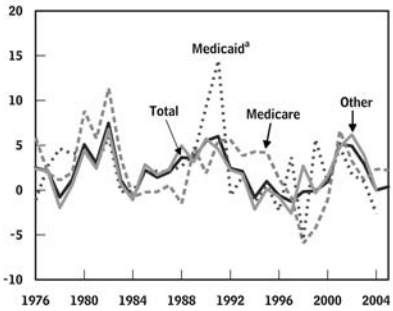
Note: Excess cost growth refers to the number of percentage points by which the growth of spending on Medicare, Medicaid, or health care generally (per beneficiary or per capita) exceeded the growth of nominal gross domestic product (per capita). Figures are annual averages.

a. For Medicaid, data are available through 2004.

Figure 3.

Excess Cost Growth in Medicare, Medicaid, and All Other Spending on Health Care

(Percentage points)



Source: Congressional Budget Office based on data on spending on health services and supplies, as defined in the national health expenditure accounts, maintained by the Centers for Medicare and Medicaid Services.

Note: Excess cost growth refers to the number of percentage points by which the growth of annual spending on Medicare, Medicaid, or all other health care (per beneficiary or per capita) exceeded the growth of nominal gross domestic product (per capita).

a. For Medicaid, data are available through 2004.

Projections of Health Care Spending

In the absence of an unprecedented change in the long-term trends, national spending on health care will grow substantially over the coming decades. The magnitude of that growth is highly uncertain, even over short periods, let alone a period as long as 75 years. CBO's projections show health care spending assuming no change in federal law affecting Medicare or Medicaid.[16] Thus, they provide a measure of the scope of the potential problem posed by the rising costs but are not a forecast of future developments because the magnitude of the problem will ultimately necessitate changes in the government's programs. They are also subject to the inherent uncertainty surrounding any long-term predictions, especially regarding health care.[17] Nevertheless, they provide a useful reference in showing the consequences of current law and assessing the impact of changes in law.

CBO's Assumptions About Future Spending on Health Care

In CBO's projections, spending for Medicare and Medicaid over the next 10 years is based on the agency's March 2007 budget outlook.[18] The projections for those programs in 2018 and later, as well as the projections for other health care spending, are based on the growth and aging of the population, growth in per capita GDP, and assumed rates of excess cost growth.

Short-Term Projections. For federal spending on Medicare and Medicaid, this study uses CBO's baseline budget projections for 2008 to 2017, which assume no change in current federal law.[19] CBO's baseline budget projections do not include projections of total national spending on health care. Therefore, short-term projections of all other (non-Medicare and non-Medicaid) health care spending

16. The projections for Medicare assume that the program will continue to pay for benefits as currently scheduled, notwithstanding the projected insolvency of the Medicare Hospital Insurance trust fund. Moreover, CBO assumes that future Medicare spending will not be affected by the provision of current law that requires the Medicare trustees to issue a "Medicare funding warning" if projected outlays for the program exceed 45 percent of "dedicated financing sources," because the law does not require the Congress to respond to such a warning by enacting legislation that would reduce Medicare spending.

17. For simplicity, the projections assume that the projected growth in health care spending has no effect on the future growth of GDP.

18. Congressional Budget Office, *An Analysis of the President's Budgetary Proposals for Fiscal Year 2008* (March 2007) and *Detailed Projections for Medicare, Medicaid, and State Children's Health Insurance Program* (March 2007).

19. Appendix C presents projections under an alternative scenario that assumes a change in federal law to prevent the reductions that would otherwise occur in the fees that Medicare allows for physicians' services. That scenario assumes that those fees will be updated to account for inflation in the inputs used for physicians' services. In both that scenario and the one presented in the main text, projected outlays for Medicare over the next 75 years are similar because the assumption that Medicare's physician fees will be updated to account for inflation has a minor effect over the long term.

were made using the same methods as those used for the long-term projections, as described below.

The Structure of Long-Term Projections. In its long-term projections, CBO combines an assumption about excess cost growth in the spending on health care with projections of the growth and aging of the population and of the growth in per capita GDP.

The agency develops separate projections for three categories:

- Federal spending on Medicare;
- Federal spending on Medicaid; and
- All other spending on health care, which includes private, state and local, and other federal health spending. (This category includes Medicare premiums, Medicare beneficiaries' cost sharing, and the states' share of Medicaid spending.)

CBO constrained Medicare premiums and cost sharing to grow at the same rate as federal spending on Medicare and constrained state Medicaid spending to grow at the same rate as federal Medicaid spending.[20]

Assumptions About Initial Rates of Excess Cost Growth. Although all long-term economic and demographic trends are difficult to forecast, future excess cost growth in health spending during the next century may be particularly uncertain. Systems of health care and health care financing have existed in their current forms for only a few decades, and medical technology continues to evolve rapidly.

One simple projection methodology is to base excess cost growth in the future on the average rate in the past. CBO adopts that approach when selecting *initial* rates of excess cost growth. Specifically, the excess cost growth rate for each of the three categories (Medicare spending, Medicaid spending, and all other spending on health care) in 2018 is assumed to equal the average of the rates from 1975 to 2005 (as presented in Table 3). (As mentioned, for all other spending on health care, the same rate is also used for 2008 through 2017.)

Assumptions About Long-Term Rates of Excess Cost Growth. For later years, one option would be to adopt the historical averages indefinitely. Although that approach is attractive for its simplicity (the results from such an extrapolation are presented in Appendix D), it has significant shortcomings. For example, simply extrapolating prior growth rates would result in total spending on health care eventually exceeding 100 percent of GDP. Furthermore, even in the absence of changes in federal law, spending growth would probably slow eventually as health care expenditures continued to rise and displaced increasing amounts of consumption of goods and services besides health care. In other words, pressure to slow cost growth will mount as health care accounts for a larger share of the American economy.

In response to rising health care costs, various policy changes in the private sector and by state governments would be likely. Employers would probably intensify their efforts to reduce their own costs, by, for example, working with insurers to make health care more efficient or by reducing insurance coverage. They would also probably raise premiums and out-of-pocket charges. Employees would then react to the higher charges either by shifting to plans with lower premiums—and more restrictive coverage—or by limiting their consumption directly in response to the higher out-of-pocket charges.[21]

It is impossible to predict with certainty precisely how such a process would unfold and how much cost growth could slow. Among various plausible approaches, a simple and transparent one is to assume that within the projection period, households would not be willing to spend so much more on health care that, from one year to the next, the increase in such spending alone was greater than the total increase in productivity. Therefore, under the assumption that the consumption of items besides health care does not decline, at the end point of CBO's projec-

20. To apply those constraints, CBO initially projected total Medicare spending, gross of beneficiaries' premiums and including cost sharing by beneficiaries, and total Medicaid spending, including both state and federal spending. To separate out federal spending on Medicare and Medicaid, CBO then reclassified the projected Medicare premiums and cost sharing and state spending on Medicaid into the category that includes all other spending on health care.

21. In its projections, CBO assumes that the share of health care spending that will be in the form of premiums in employment-based plans—and thus is tax preferred—will remain at approximately 58 percent of non-Medicare, non-Medicaid spending on health care.

tion period, in 2082, per capita consumption would continue to grow because of increased productivity, but the additional economic resources would be devoted entirely to health care. That assumption, to be sure, is not the only reasonable one, and other assumptions could generate higher or lower amounts of spending on health care in the long term. The approach, though, has the virtue of considering future levels of spending on both health care and other goods and services.[22]

Under the scenario that CBO presents, the slowdown in excess cost growth would not be painless and would not occur simply through improved efficiencies given the current structure of the health sector. Households would probably face increased cost sharing; new and potentially useful health technologies would be introduced more slowly or utilized at lower levels than would occur without a slowdown in excess cost growth; and more treatments or interventions might simply not be covered by insurance. Nevertheless, Americans would still face steadily increasing health costs. In other words, even though the growth rate might decline, the real level of health care costs would continue to rise—to the point of accounting for all of the increase in productivity. Therefore, real average consumption of goods and services other than health care would stagnate.

Such a slowdown in non-Medicare, non-Medicaid spending on health care may be particularly difficult to achieve in the absence of changes in federal law (as assumed in the projections). But at some point, the pressure on that portion of the system would probably become so severe that measures to slow growth would be taken. State governments and the private sector would almost certainly have more flexibility to respond to that pressure than the federal government would have without a change in federal law. The steps taken to slow growth in the non-Medicare, non-Medicaid sectors of the health system, in turn, would probably exert some downward pressure on growth rates in the public programs because they are integrated to a significant degree with the rest of the health care system. To the extent that actions by individuals and businesses resulted in lower-cost "practice patterns" by physicians, slower development and diffusion of new technologies, and cost-reducing changes to the structure of the health care system, Medicare and Medicaid would experience some reduction in their own growth—but the extent of that spillover is uncertain.

Moreover, CBO assumes that under current law, the federal government would make regulatory changes aimed at slowing spending growth on federal health programs and that Medicare beneficiaries' demand for health care services would decline as Medicare premiums and cost-sharing amounts consumed a growing share of their income. On the basis of discussions with health and policy experts, CBO assumes that—without changes in law—the combined effects of those factors would be to reduce Medicare's excess cost growth by one-fourth of the reduction in the growth of non-Medicare, non-Medicaid spending on health care. In other words, in a scenario in which the growth rate of spending on health care outside Medicare and Medicaid declined from 2 percent to 1 percent per year, Medicare spending growth would decline from 2 percent to 1.75 percent per year. (As discussed below, it is perhaps unlikely that Medicare and Medicaid would actually experience a significantly higher growth rate than the rest of the health sector over an extended period of time, but changes in federal law would be necessary to avoid that outcome.)

CBO assumes that excess cost growth will decline more rapidly for Medicaid, which is a joint federal–state program, than for Medicare. In addition to the spillover effects and possible federal regulatory changes noted above, states are likely to take actions to reduce the growth of Medicaid spending even without changes in federal law. State governments would probably respond to growing fiscal pressures by limiting the services they chose to cover or by reducing their number of beneficiaries by tightening eligibility. In its projections, CBO assumes that the rate of decline in Medicaid's excess cost growth will be 75 percent of the reduction in the growth of non-Medicare, non-Medicaid spending on health care. CBO's projection methodology for excess cost growth from 2019 through 2082 is thus based on the following set of assumptions:

- Excess cost growth in 2018 for Medicare, Medicaid, and all other health care will equal the historical averages;

22. For related discussions, see Michael E. Chernew, Richard A. Hirth, and David M. Cutler, "Increased Spending on Health Care: How Much Can the United States Afford?" *Health Affairs*, vol. 22, no. 4 (2003), pp. 15–25; and Glenn Follette and Louise Sheiner, "The Sustainability of Health Spending Growth," Finance and Economics Discussion Series No. 2005-60 (Washington, D.C.: Board of Governors of the Federal Reserve System, 2005).

Table 4.

Assumptions About Excess Cost Growth Over the Long Term

(Percentage points)

	2018 Rate (Historical Average)	Annual Decline in Rate, 2018–2082 (Percent)	Average Rate, 2018–2082	Rate in 2082
Medicare	2.4	1.1	1.7	1.1
Medicaid	2.2	3.4	0.9	0.2
All Other Spending on Health Care	2.0	4.6	0.6	0.1

Source: Congressional Budget Office.

Note: Excess cost growth refers to the number of percentage points by which the growth of spending on Medicare, Medicaid, or health care generally (per beneficiary or per capita) is assumed to exceed the growth of nominal gross domestic product (per capita).

- Total real per capita consumption of goods and services besides health care will not decline during the 75-year projection period; and
- The annual reduction in excess cost growth in Medicare and Medicaid will be, respectively, one-fourth and three-fourths of that for all other health care.

Under those assumptions, the excess cost growth rate for non-Medicare, non-Medicaid spending on health care declines by 4.6 percent annually (see Table 4).[23] By 2082, that rate drops to 0.1 percentage point. For Medicare, excess cost growth declines to 1.1 percentage points that year, and for Medicaid, to 0.2 percentage points. The average rates for excess cost growth between 2018 and 2082 are 0.6 percentage points for non-Medicare, non-Medicaid spending, 1.7 percentage points for Medicare, and 0.9 percentage points for Medicaid.

It may be difficult to envision how per capita Medicare and Medicaid spending could continue to grow more rapidly than other health care spending over such a long period, but changes in federal law are probably necessary to avoid that outcome. Furthermore, actions to reduce spending growth in the private sector could attenuate the incentives for the development and diffusion of new medical technologies for nonelderly people while having little effect on new technologies focused on diseases principally affecting the elderly.

That aspect of the projections may appear unrealistic, but it highlights the core problem—the unsustainability of current federal law. (The inherent tension in making long-term projections for a federal health care system that cannot be sustained in its current form must manifest itself in some way.) In reality, it is likely that changes in federal law as well as in practices in the private sector will slow the growth of health care spending such that growth in per capita Medicare and Medicaid spending does not diverge greatly from other spending on health care.

Projections of Health Spending

Over the past 30 years, total national spending on health care has more than doubled as a share of GDP. Under the assumptions described above, according to CBO's projections, that share will double again by 2035, to 31 percent of GDP. Thereafter, health care costs continue to account for a steadily growing share of GDP, reaching 41 percent by 2060 and 49 percent by the end of the 75-year projection period (see Figure 4).

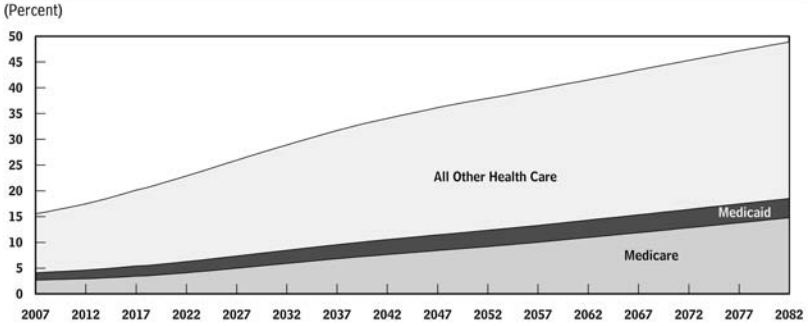
Although the *rate* of cost growth slows over the projection period, the annual increase in the *level* would remain high. For example, for the five years beginning in 2007, CBO projects health care spending, measured as a share of GDP, to grow by 12 percent—from 15.5 percent of GDP to 17.4 percent. From 2070 to 2075, CBO projects, it will grow by only 4 percent, from 44.4 percent of GDP to 46.2 percent. From one perspective, the growth during the latter period is much slower. But in both periods, health care spending rises by about 2 percent of GDP.

Spending on Medicare and Medicaid is projected to grow as a share of total spending on health care—as the assumed rates of excess cost growth for those programs under current federal law slow less quickly than does the rate for other spending on health care and as

23. Specifically, $ECG_y = ECG_{y-1} \bullet 0.954$.

Figure 4.

Projected Spending on Health Care as a Percentage of Gross Domestic Product



Source: Congressional Budget Office.

Note: Amounts for Medicare are net of beneficiaries' premiums. Amounts for Medicaid are federal spending only.

the population ages. Net federal spending on those programs now accounts for about 4 percent of GDP, or 26 percent of total spending on health care. By 2035, those figures grow to 9 percent of GDP, or 30 percent of total spending on health care, and by 2082, to 19 percent of GDP, or 38 percent of total spending.

Excess cost growth is the main factor responsible for the projected increase in both national spending on health care and federal spending on Medicare and Medicaid. By itself, the projected change in the age composition of the population has a modest effect on the future path of health care spending (see Box 2).

Consumption of Health Care and of Other Goods and Services

Historically, economic growth has been driven primarily by improved productivity. As the average worker is able to produce more, the average citizen can consume more. As the population ages and a smaller portion is employed, per capita GDP is likely to grow more slowly, but, on average, future generations will be substantially richer than Americans are today. In 2007, total per capita consumption averages about $27,000, of which about $6,000 is for health care. Under CBO's projections, by 2035, per capita consumption would grow by over $15,000 (in 2007 dollars), but more than three-quarters of that extra money would be spent on health care. While the consumption of other goods and services would grow by just 12 percent, the consumption of health care would triple.

In addition, although the consumption of goods and services besides health care would, on average, be stable at the end of the projection period, the effect would vary for different individuals. Lower-income people tend to spend fewer dollars on health care than average, but that spending represents a larger portion of their earnings than it does for others. Also, people generally have less flexibility about their spending on health care than on other things. For example, even in companies that offer multiple options for health insurance, premiums do not vary substantially. As a result, as costs for health care increased, higher-income people would generally still be able to increase their consumption of other goods and services,

Box 2.

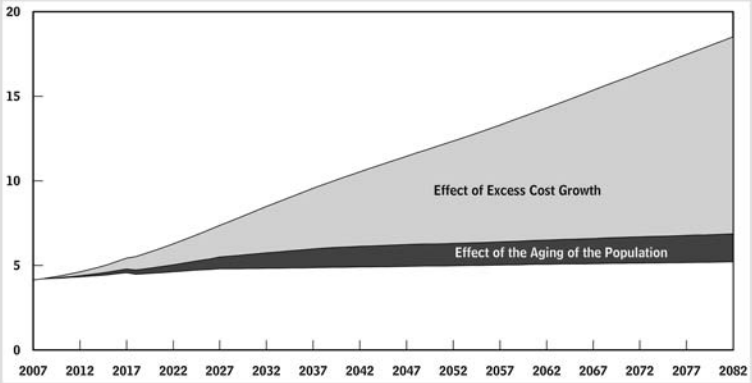
The Effect of the Aging of the Population on Spending on Medicare and Medicaid

In coming decades, the share of the population that is covered by Medicare will expand rapidly as members of the baby-boom generation become eligible for the program, and the share that uses long-term care services financed by Medicaid will also probably increase. Although the aging of the population is frequently cited as a major factor contributing to the large projected increase in federal spending on those two programs, it accounts for a modest fraction of the growth that the Congressional Budget Office (CBO) projects. The main factor is excess cost growth—or the extent to which the increase in health care spending for an average individual exceeds the growth in per capita gross domestic product (GDP).

As shown in the figure, if the age distribution of the population were fixed—so that the average age did not increase over time—and there were no excess cost growth, spending on Medicare and Medicaid as a share of GDP would remain essentially constant. That scenario is represented by the bottom line in the figure. The next line shows projected spending on Medicare and Medicaid if the age distribution of the population changes as expected—so that the average age of the population increases—but excess cost growth remains at zero. The difference between that line and the bottom line captures the effect of the aging of the population on projected federal spending on Medicare and Medicaid. The top line in the figure shows CBO's projection of spending on those programs, which includes the effects of the aging of the population and of excess cost growth. By itself, aging accounts for about one-quarter of the projected growth in federal Medicare and Medicaid spending through 2030. By 2050, that share has fallen to under 20 percent, and by 2082, to only about 10 percent.

Sources of Growth in Projected Federal Spending on Medicare and Medicaid

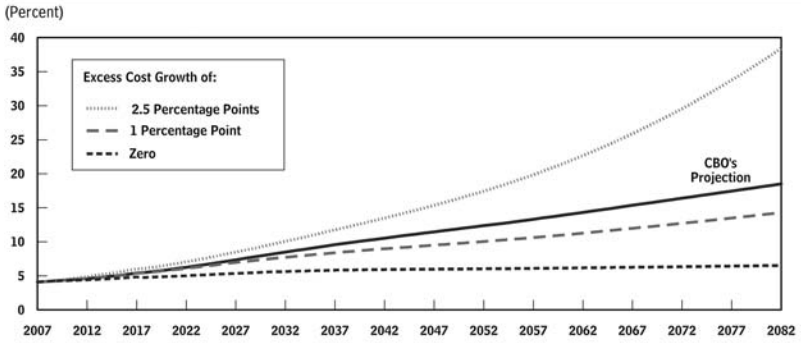
(Percentage of gross domestic product)



Source: Congressional Budget Office.

Figure 5.

Federal Spending for Medicare and Medicaid as a Percentage of Gross Domestic Product Under Different Assumptions About Excess Cost Growth



Source: Congressional Budget Office.

Note: Excess cost growth refers to the number of percentage points by which the growth of annual health care spending per beneficiary is assumed to exceed the growth of nominal gross domestic product per capita.

whereas poorer people would probably see their consumption of those items decline.[24]

Projections Under Alternative Assumptions

Analysts working 75 years ago, in 1932, would have been extremely unlikely to correctly project the current share of the economy devoted to health care, and the projections in this study will undoubtedly prove to be inaccurate in one direction or another. It will be difficult to judge their accuracy even after the fact, because they assume no changes in federal law, and such changes are virtually certain to occur.

Even without those changes, though, actual spending on health care could be much lower or much higher. Past technological developments have generally resulted in expanded treatment and higher total spending. Future innovations could accelerate that trend. Alternatively, if future research results in the development of inexpensive curative therapies, growth could slow.

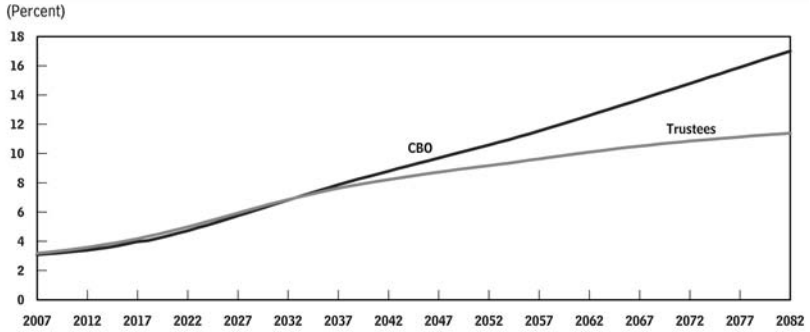
Among simple alternative scenarios for excess cost growth, one in which it is held constant at zero, while implausible, is useful because it isolates the effect of the aging of the population (see Figure 5). Aging alone is projected to increase federal spending on Medicare and Medicaid. Under that scenario, projected net federal outlays on the two programs would increase from 4 percent of GDP in 2007 to 6 percent of GDP by 2040 and then rise gradually to 7 percent by 2082.

Under a scenario in which excess cost growth for Medicare and Medicaid is 2.5 percentage points, which could be roughly interpreted as what would occur with no slowing of growth rates whatsoever, net federal spending on the two programs would grow to 13 percent of GDP in 2040 and 38 percent of GDP by 2082. (Appendix D shows a set of projections in which spending on Medicare, Medicaid, and other health care grows at their historical average excess growth rates from 1975 through 2005.)

24. For example, consider the simplified example of two coworkers with incomes of $20,000 and $80,000 who both get a 10 percent salary increase and devote their extra income to an increase of $5,000 in health insurance premiums. The lower earner's income would increase by $2,000, but his or her health care costs would be $3,000 higher than that, forcing a real reduction in his or her consumption of other goods and services. The higher earner's income would increase by $8,000, more than enough to cover the additional $5,000 in health care expenses.

Figure 6.

CBO's and the Trustees' Projections of Spending on Medicare as a Percentage of Gross Domestic Product



Source: Congressional Budget Office.

Note: Projections are of gross federal spending.

The projections presented in this study can also be compared to the Medicare trustees' projections of spending on the program.[25] For that comparison, CBO adjusted its projections to measure Medicare spending gross of the premiums paid by beneficiaries, which is the measure used by the trustees. (All of CBO's other projections of Medicare spending in this study are net of beneficiaries' premiums.) Both CBO and the trustees project that gross Medicare outlays will more than double from their current level of 3 percent of GDP to more than 7 percent of GDP in 2035 (see Figure 6). Under their intermediate scenario, the trustees assume that excess cost growth will decline gradually from the 25th to the 75th year of the projection period but constrain total spending over the 75-year period to the result obtained by assuming excess cost growth to be a constant 1 percentage point in the 25th year and later. CBO's methodology does not impose that type of constraint. Consequently, the two sets of projections track each other relatively closely over the next two to three decades but then diverge significantly; the trustees project gross Medicare outlays to reach 11 percent of GDP by the end of the projection period, compared with CBO's 17 percent. In both sets of projections, however, the main message is that health care spending is projected to rise significantly and that changes in federal law will be necessary to avoid or mitigate a substantial increase in federal spending on Medicare and Medicaid.

25. See Department of Health and Human Services, Centers for Medicare and Medicaid Services, Office of the Actuary, *2007 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (April 23, 2007), pp. 160–162.

APPENDIX

A

Medicare and Medicaid: An Overview

Medicare and Medicaid are the nation's main public health insurance programs and, after Social Security, are the largest federal entitlement programs. Together, they provide federally funded health insurance coverage to millions of low-income, disabled, or elderly beneficiaries.

The Medicare Program

The Medicare program was enacted in 1965 to provide health insurance coverage to Americans age 65 and over, and eligibility for the program was expanded in 1972 to include individuals under age 65 who qualify for Social Security disability benefits. People who are under 65 and disabled become eligible for Medicare 24 months after they become entitled to Social Security benefits. When Medicare was enacted, only about half of the elderly had any private health insurance, which generally covered only inpatient hospital costs, and even that coverage was often quite limited.[1] Much of the health care spending incurred by the elderly was paid out of pocket by the individual or family members.

Part A of Medicare, or Hospital Insurance, covers inpatient services provided by hospitals and skilled nursing facilities as well as hospice care. Part B, or Supplementary Medical Insurance, covers services provided by physicians and other practitioners, hospitals' outpatient departments, laboratories, and suppliers of medical equipment. Part B also covers a limited number of drugs, most of which must be administered by injection in a physician's office.[2] Depending on the circumstances, home health care may be covered by either Part A or Part B. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 added a prescription drug benefit that became available in 2006 under a newly created Part D.

Part A benefits are financed primarily from a payroll tax. Premiums paid by beneficiaries cover about one-quarter of the cost of the Part B program, and the rest comes from general revenues.[3] Enrollees' premiums under Part D are set at a level to cover about one-quarter of the cost of the basic prescription drug benefit, but receipts from premiums cover less than one-quarter of the total cost of the Part D program because some of the outlays for that program (such as subsidies for low-income beneficiaries and for employers that maintain drug coverage for their retirees) are not included in the calculation of premiums.

In 2006, Medicare spending totaled an estimated $381.9 billion, of which $374.9 billion (or 98 percent) covered benefits for enrollees. About 32 percent of the spending on benefits paid for inpatient hospital care, and 26 percent paid for services provided by physicians and other professionals as well as outpatient ancillary services (see Table A-1).[4] About 15 percent of Medicare expenditures were for the Medicare Advantage program (discussed

1. See Amy Finkelstein, "The Aggregate Effects of Health Insurance: Evidence from the Introduction of Medicare," Working Paper 11619 (Cambridge, Mass.: National Bureau of Economic Research, September 2005).

2. Certain other drugs are also covered under Part B, including oral cancer drugs if injectable forms are also available, oral antinausea drugs that are used as part of a cancer treatment, and oral immunosuppressive drugs used after an organ transplant.

3. The standard Part B premiums are established each year to cover 25 percent of projected average expenditures in the Part B program. In 2007, the standard monthly Part B premium is $93.50. Beginning in 2007, higher premiums are required of single beneficiaries with an annual income over $80,000 and couples with an annual income over $160,000. Those income thresholds will be indexed to inflation in future years. CBO estimates that about 4 percent of beneficiaries are paying the higher premiums in 2007.

4. Other professionals include physician assistants, nurse practitioners, psychologists, clinical social workers, and physical, occupational, and speech therapists. Outpatient ancillary items or services include durable medical equipment, Part B drugs, laboratory services, and ambulance services.

Table A-1.

Medicare Spending by Type of Service, 2006

	Billions of Dollars	Percent
Inpatient Hospital Services	120.7	32
Physicians' and Suppliers' Services	86.1	23
Medicare Advantage Plans	55.9	15
Prescription Drug Benefits	32.0	9
Hospital Outpatient Services	20.1	5
Care in Skilled Nursing Facilities	19.5	5
Home Health Services	13.2	4
Hospice Services	8.6	2
Other Services	18.8	5
Total	**374.9**	**100**

Source: Congressional Budget Office.

below), and 9 percent paid for prescription drug benefits under Part D.

The Fee-for-Service Program

Most Medicare beneficiaries receive their Part A and Part B benefits in the traditional fee-for-service program, which pays providers for each covered service (or bundle of services) they provide. Beneficiaries must pay a portion of the costs of their care through deductibles and coinsurance. Unlike many private insurance plans, Medicare does not include an annual cap on beneficiaries' cost sharing. Nearly 90 percent of beneficiaries who receive care in the fee-for-service program, however, have supplemental insurance that covers many or all of Medicare's cost-sharing requirements. The most common sources of supplemental coverage are plans for retirees offered by former employers (held by 37 percent of beneficiaries in the fee-for-service program), individually purchased medigap policies (34 percent), and Medicaid (16 percent).[5] The percentage of Medicare beneficiaries who have coverage as retirees, as well as the generosity of that coverage, is expected to decline in the future as employers respond to the financial stresses of rising health care costs. The evidence on trends in such coverage over the past decade is mixed: Some studies have found that the percentage of employers that offer the coverage has fallen during that period, while other studies have found that that percentage has remained stable. However, in recent years, some employers have sought to reduce their future costs for health coverage for retirees by increasing premiums and cost-sharing requirements and eliminating coverage for future retirees.[6]

The Medicare Advantage Program

As of June 2007, 18 percent of Medicare beneficiaries were enrolled in private health plans under the Medicare Advantage program (also known as Part C of Medicare). Such plans submit bids indicating the per capita payment for which they are willing to provide Medicare Part A and Part B benefits, and the government compares those bids with county-level benchmarks that are determined in advance through statutory rules. Plans are paid their bids (up to the benchmark) plus 75 percent of the amount by which the benchmark exceeds their bids. Plans must return that 75 percent to beneficiaries as additional benefits (such as reduced cost sharing on Medicare services) or as a rebate on their Part B or Part D premiums.

Under current law, benchmarks are required to be at least as great as per capita expenditures in every county that are incurred in the fee-for-service portion of Medicare and are higher than those expenditures in many counties. For 2007, the Congressional Budget Office (CBO) calculates that benchmarks are 17 percent higher, on average, than projected per capita fee-for-service expenditures nationwide, and that payments to plans will be about 12 percent higher than per capita spending in the fee-for-service portion of the program.

The Medicaid Program

Medicaid is a joint federal–state program that pays for health care services for a variety of low-income individuals. The program was created in 1965 by the same legislation that created Medicare, replacing an earlier program of federal grants to states to provide medical care to people with low income. In 2006, federal spending for the program was an estimated $180.6 billion, of which $160.9 billion covered benefits for enrollees. (In addition to benefits, Medicaid's spending includes payments to

5. Medicare Payment Advisory Commission, *A Data Book: Healthcare Spending and the Medicare Program* (June 2007), p. 61.

6. The Henry J. Kaiser Family Foundation and Hewitt Associates, *Retiree Health Benefits Examined: Findings from the Kaiser/Hewitt 2006 Survey on Retiree Health Benefits* (December 2006), available at www.kff.org.

Table A-2.

Medicaid Enrollees and Federal Benefit Payments, by Category of Enrollee, 2006

	Enrollees		Federal Benefit Payments		Percentage of Benefit Payments for Long-Term Care
	Number (Millions)	Percent	Billions of Dollars	Percent	
Aged	5.5	9.0	36.7	22.8	70.6
Disabled	9.8	16.1	72.2	44.9	36.0
Children	29.5	48.4	31.1	19.3	7.7
Adults	16.0	26.3	20.8	12.9	1.9
Total	**60.9**	**100.0**	**160.9**	**100.0**	**34.0**

Source: Congressional Budget Office.

Note: Disabled enrollees include some people who are over age 65 or under age 18. Adult enrollees are adults who are not aged or disabled; they are primarily poor parents and pregnant women.

hospitals that treat a "disproportionate share" of low-income patients as well as costs for the Vaccines for Children program and administrative costs.) The federal government's share of Medicaid's spending for benefits varies among the states but currently averages 57 percent.

States administer their Medicaid programs under federal guidelines that specify a minimum set of services that must be provided to certain poor individuals. Mandatory benefits include inpatient and outpatient hospital services, services by physicians and laboratories, and nursing home and home health care. Groups that must be eligible (according to federal requirements) include poor children and families who would have qualified for the former Aid to Families with Dependent Children program, certain other poor children and pregnant women, and elderly and disabled individuals who qualify for the Supplemental Security Income program. In general, a Medicaid enrollee must have both a low income and a low level of assets, although the minimum financial thresholds vary depending on the basis for an enrollee's eligibility.

Within broad statutory limits, states have the flexibility to administer the Medicaid program and determine its scope. Partly as a result, the program's rules are complex, and it can be difficult to generalize about the types of enrollees who are covered, the benefits that are offered, and the cost sharing that is required. States may choose to make additional groups of people eligible (such as individuals with high medical expenses who have "spent down" their assets) or to provide additional benefits (such as coverage for prescription drugs and dental services) and have exercised those options to varying degrees. Moreover, states often seek and receive federal waivers that allow them to provide benefits and cover groups that would otherwise be excluded under Medicaid. By one estimate, total spending on optional populations and benefits accounted for about 60 percent of the program's expenditures in 2001.[7]

On the basis of administrative data, CBO estimates that about half of Medicaid's 61 million enrollees in 2006 were poor children and that another one-quarter were either the parents of those children or poor pregnant women.[8] Per capita costs for those groups are relatively low, though, while expenses are higher for elderly and disabled beneficiaries, many of whom require long-term care. Although the elderly and disabled constitute about one-quarter of Medicaid's enrollees, they account for two-thirds of the program's spending (see Table A-2). Overall, one-third of Medicaid's spending in 2006 was for long-term care, which includes nursing home services, home health care, and other medical and social services for people whose disabilities prevent them from living independently.

7. See Kaiser Commission on Medicaid and the Uninsured, *Medicaid Enrollment and Spending by "Mandatory" and "Optional" Eligibility and Benefit Categories* (Washington, D.C.: Henry J. Kaiser Family Foundation, June 2005), p. 11.

8. The enrollment figure of 61 million includes all people who were enrolled in Medicaid at any time during 2006. About 46 million people were enrolled in the program in June of that year.

About 45 percent of Medicaid beneficiaries are enrolled in managed care plans that accept a capitated payment (a fixed amount per enrollee) for providing a comprehensive set of benefits. Those arrangements are more common for families and children, although some states also enroll the elderly and the disabled. About 15 percent of beneficiaries are enrolled in an arrangement that provides what is termed primary care case management, in which enrollees select (or are assigned) a primary care physician or group practice that is paid an additional fee for overseeing and coordinating their care. Many states also use "carve-out" arrangements, in which the states contract with organizations that assume the responsibility and financial risk for providing a subset of Medicaid benefits, such as dental services or mental health care.

APPENDIX

B

Computing Historical Excess Cost Growth

To compute historical excess cost growth for Medicare, Medicaid, and total national spending on health care, the Congressional Budget Office (CBO) adjusted historical aggregate growth rates to remove the effects of changes in the population and per capita growth of gross domestic product (GDP).

The national health expenditure accounts, maintained by the Centers for Medicare and Medicaid Services, provide detailed historical data by both source of funds and type of expenditure. Total national health expenditures represent aggregate health care spending in the United States. The analysis in this study focuses on the consumption of health care, so instead of using those totals, it uses spending on health services and supplies, which includes all spending on personal health care, governments' administrative costs and public health activities, and the net costs of private health insurance.[1] That measure captures spending on all medical care provided in a given year. Spending on health services and supplies equals total national health expenditures minus amounts invested in research and in structures and equipment.

For this anaylsis, spending on health services and supplies is divided into three categories by source of funds: Medicare, Medicaid, and other. For the total and each category, CBO estimated historical excess cost growth, which measures the increase in per capita health care spending relative to the increase in per capita GDP, after removing the changes in spending that are associated with changes in the age composition of the population. The analysis uses data from the national health expenditure accounts from 1975 through 2005.

Future health care costs are projected using the same general formula:

$$HealthCostPerCapita_t = HealthCostPerCapita_{t-1} \times \frac{GDPperCapita_t}{GDPperCapita_{t-1}} \times \frac{AgeCompIndex_t}{AgeCompIndex_{t-1}} \times (1 + x_t),$$

where x_t is excess cost growth in year t; *HealthCostPerCapita* is nominal health expenditures per capita, *GDPperCapita* is nominal GDP per capita, and *AgeCompIndex* is an age-weighted health care cost index that is included in the formula to remove changes in health care spending attributable to changes in the age distribution of the population. Both *HealthCostPerCapita* and *AgeCompIndex* vary depending on which of the measures of excess cost growth is being calculated. Historical excess cost growth (x_t) is calculated as follows:

$$x_t = \frac{HealthCostPerCapita_t}{HealthCostPerCapita_{t-1}} \times \frac{GDPperCapita_{t-1}}{GDPperCapita_t} \times \frac{AgeCompIndex_{t-1}}{AgeCompIndex_t} - 1$$

The approach for Medicaid is similar, but rather than an age composition index, an adjustment for type of beneficiary—children, disabled, aged, or other adult—is used.

Data on the total population and nominal GDP are available within the data on national health expenditures.

1. For a detailed description of national health accounts data, see Department of Health and Human Services, Centers for Medicare and Medicaid Services, *National Health Expenditures Accounts: Definitions, Sources, and Methods Used in the NHEA 2005*, available at www.cms.hhs.gov/NationalHealthExpendData/downloads/dsm-05.pdf.

Medicare

HealthCostPerCapita
For the equation to determine excess cost growth in Medicare, health costs per capita are nominal Medicare spending per beneficiary, available within the data on national health expenditures. The number of Medicare beneficiaries is from Medicare Enrollment Reports by the Centers for Medicare and Medicaid Services.[2]

AgeCompIndex
For Medicare, the age composition index in year t is:[3]

$$y_t = \left(\frac{N_{65-74}}{N_{65+}}\right) \times P_{65-74} + \left(\frac{N_{75-84}}{N_{65+}}\right) \times P_{75-84} + \left(\frac{N_{85+}}{N_{65+}}\right) \times P_{85+},$$

where N_a is the population in a given age group a in year t, and P_a is per capita personal health care expenditures in 1999 for age group a. Those expenditures are derived using the 1999 Medical Expenditure Panel Survey (MEPS), administered by the Agency for Healthcare Research and Quality within the Department of Health and Human Services.[4]

2. See www.cms.hhs.gov/MedicareEnRpts/Downloads/HISMI05.pdf.

3. The Medicare population also includes people who are under age 65 and have been collecting Social Security disability benefits for at least two years as well as nonelderly people with end-stage renal disease. Those groups are not included in the age composition index because of limitations in the available data.

4. See www.cms.hhs.gov/NationalHealthExpendData/downloads/agetables.pdf

Medicaid

HealthCostPerCapita
For the equation to determine excess cost growth in Medicaid, health costs per capita are nominal Medicaid spending per beneficiary.[5]

AgeCompIndex
For Medicaid, the age composition index in year t is:

$$y_t = \left(\frac{N_{Children}}{N_{Total}}\right) \times P_{Children} + \left(\frac{N_{Adult}}{N_{Total}}\right) \times P_{Adult} + \left(\frac{N_{Elderly}}{N_{Total}}\right) \times P_{Elderly} + \left(\frac{N_{Disabled}}{N_{Total}}\right) \times P_{Disabled},$$

where N is the number of beneficiaries of a given type in year t. The *Adult* category includes only nonelderly, nondisabled adults.[6] P is per capita Medicaid expenditures in 1999 for the given type of beneficiary.

Overall Excess Cost Growth

HealthCostPerCapita
For the equation to determine overall excess cost growth, health costs per capita are nominal spending on health services and supplies divided by the total population.

5. Spending data are within the data on national health expenditures. Data on the number of beneficiaries by category and average per capita expenditures for each beneficiary type are from Centers for Medicare and Medicaid Services, *Health Care Financing Review, Medicare and Medicaid Statistical Supplement* (2005).

6. Counts of beneficiaries by type are available only through 2004, so all calculations for Medicaid are for 1975 through that year.

AgeCompIndex

The age composition index in year t is:

$$y_t = \left(\frac{N_{0-18}}{N_{Total}}\right) \times P_{0-18} + \left(\frac{N_{19-44}}{N_{Total}}\right) \times P_{19-44} + \left(\frac{N_{45-54}}{N_{Total}}\right) \times P_{45-54} + \left(\frac{N_{55-64}}{N_{Total}}\right) \times P_{55-64} + \left(\frac{N_{65-74}}{N_{Total}}\right) \times P_{65-74} + \left(\frac{N_{75-84}}{N_{Total}}\right) \times P_{75-84} + \left(\frac{N_{85+}}{N_{Total}}\right) \times P_{85+},$$

where N_a is the number of individuals in a given age group a in year t, and P_a is per capita personal health care expenditures in 1999 for age group a derived using MEPS data.[7]

Non-Medicare, Non-Medicaid Excess Cost Growth

Excess cost growth for non-Medicare, non-Medicaid spending is calculated as a dollar-weighted average of the cost growth rates for Medicare, Medicaid, and overall. Specifically,

$$a = x_t^{Overall} \times Cost_t^{Overall}$$

$$b = x_t^{Medicare} \times Cost_t^{Medicare}$$

$$c = x_t^{Medicaid} \times Cost_t^{Medicaid}$$

$$x_t^{NMNM} = \frac{a - b - c}{Cost_t^{NMNM}},$$

where x_t is annual excess cost growth for the indicated category, *NMNM* is non-Medicare and non-Medicaid, and $Cost_t$ is the nominal dollars accounted for by that category.

7. See www.cms.hhs.gov/NationalHealthExpendData/downloads/agetables.pdf.

APPENDIX

C

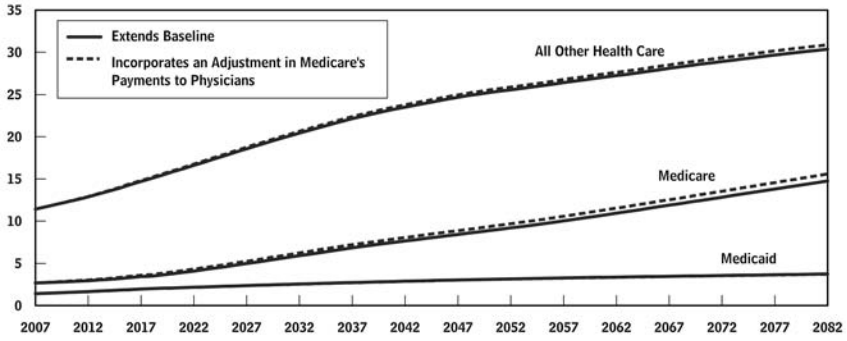
Projected Health Care Spending Under an Alternative Fiscal Scenario

For the projections of federal Medicare spending in the main text, this study uses the Congressional Budget Office's (CBO's) baseline budget projections for 2008 to 2017, which assume no change in current federal law. Based on current law, CBO's baseline assumes that the sustainable growth rate (SGR) mechanism for updating Medicare's payment rates for physicians will reduce those rates by about 4 percent or 5 percent annually for at least the next several years. However, since 2003, the Congress has taken action to prevent the reductions in physician payment rates that would have occurred under the SGR. Therefore, CBO developed an alternative set of long-term projections that assume that similar action will be taken for the next 10 years. Specifically, under that alternative scenario, Medicare's physician payment rates are assumed to grow with the Medicare economic index, which measures inflation in the inputs used for physicians' services. Projected outlays for Medicare over the next 75 years are similar in both that scenario and the one presented in the main text because the assumption that Medicare's physician fees will be updated to account for inflation has only a minor effect over the long term (see Figure C-1).

Figure C-1.

Comparison of CBO's Projections of Spending on Health Care: Extending the Baseline vs. Incorporating an Adjustment in Physician Fees Under Medicare

(Percentage of gross domestic product)



Source: Congressional Budget Office.

Note: Currently, a mechanism in federal law would reduce Medicare's fees for physicians' services. For its alternative scenario, CBO assumes that those fees are updated to account for inflation in the inputs used for physicians' services.

APPENDIX

D

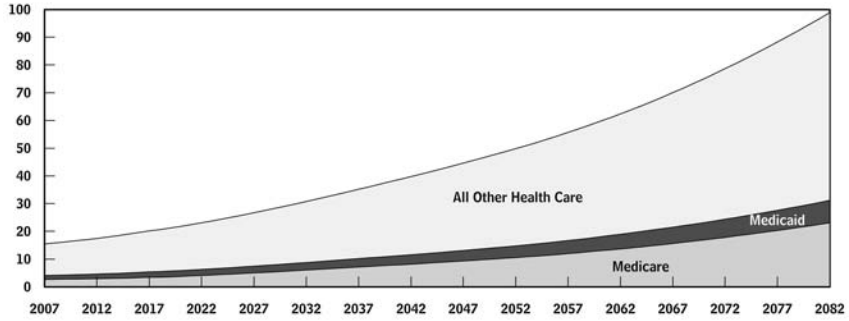
Projected Health Care Spending When Excess Cost Growth Is Assumed to Continue at Historical Averages

This appendix presents projections of health care spending under the assumption that the excess cost growth rates for spending on Medicare, Medicaid, and all other health care continue indefinitely at their average values from 1975 to 2005: 2.4 percentage points for Medicare, 2.2 percentage points for Medicaid, and 2.0 percentage points for other health care. Under that assumption, federal spending on Medicare and Medicaid would reach 8 percent of gross domestic product (GDP) by 2030, 14 percent of GDP by 2050, and 31 percent of GDP by 2082 (see Figure D-1). Total national spending on health care would reach 29 percent of GDP by 2030, 48 percent of GDP by 2050, and 99 percent of GDP by 2082.

Figure D-1.

Projected Spending on Health Care Under an Assumption That Excess Cost Growth Continues at Historical Averages

(Percentage of gross domestic product)



Source: Congressional Budget Office.

Notes: Excess cost growth refers to the number of percentage points by which the growth of spending on Medicare, Medicaid, or health care generally (per beneficiary or per capita) is assumed to exceed the growth of nominal gross domestic product (per capita).

Amounts for Medicare are net of beneficiaries' premiums. Amounts for Medicaid are federal spending only.

[The CRS reports follow:]

Order Code 96-891 EPW
Updated September 4, 2007

CRS Report for Congress

Health Insurance Coverage: Characteristics of the Insured and Uninsured Populations in 2006

Chris L. Peterson and April Grady
Domestic Social Policy Division

Summary

Based on data from the Census Bureau's Current Population Survey (CPS), 47.0 million people in the United States had no health insurance in 2006 — an increase of approximately 2.2 million people when compared with 2005. The percentage of people covered by job-based coverage has dropped annually since 2000. Whether the uninsured rate rose in response depended on how much of the job-based decrease was offset by increases in public coverage. Unlike in recent years, the overall public coverage rate declined in 2006; at the same time, rates for the Medicare and Medicaid categories of public coverage remained statistically unchanged. The uninsured rate rose from 15.3% in 2005 to 15.8% in 2006. Mostly because of Medicare, 1.5% of those 65 and older were uninsured in 2006; among the nonelderly, 17.8% were uninsured. More than half of the nonelderly uninsured were in families with a full-time, full-year worker. Young adults were more likely to be uninsured than any other age group. More than one-third of Hispanic individuals were uninsured, the highest rate among race/ethnicity groups. In 2007, the Census Bureau released revised data for 1996-2005 showing slightly fewer uninsured individuals.[1] This report focuses primarily on health insurance coverage in 2006 and will be updated when 2007 data are released (late summer 2008).

Health Insurance Coverage by Population Characteristics

Age. **Table 1** provides a breakdown of health insurance coverage by type of insurance and age. In 2006, compared to other age groups, those under age 5 had the highest rates of coverage in Medicaid, the State Children's Health Insurance Program (SCHIP), or some other program for low-income individuals (33%). Young adults ages 19 to 24 were the most likely to have gone without health insurance in 2006. While most in this age group (55%) were covered under an employment-based plan, 31% had no health insurance. Young adults are often too old to be covered as dependents on their

[1] The revision was attributed to a Census Bureau programming error that caused some people who reported private coverage to be coded as uninsured. For 2005, the revision reduced the U.S. uninsured rate by 0.6 percentage points (from 15.9% to 15.3%); for 2004, it reduced the uninsured rate by 0.7 percentage points (from 15.6% to 14.9%). For more information, see [http://www.census.gov/hhes/www/hlthins/usernote/schedule.html].

parents' policies and, as entry-level workers, do not have strong ties to the work force. Some may also feel that they are in good health and choose to remain uninsured, spending their money on other items. Of those 65 and over, 94% were covered by Medicare, and less than 2% were uninsured. The remainder of this report focuses on the nonelderly population.

Table 1. Health Insurance Coverage by Type of Insurance and Age, 2006

Age	Population (millions)	Type of Insurance[a]						
		Employment-Based[b]	Private Nongroup	Medicare	Medicaid or Other Public[c]	Military/ Veterans' Coverage	Uninsured (percent)	Uninsured (millions)
Under 5	20.5	56.4%	4.6%	0.7%	32.6%	2.8%	11.4%	2.3
5-18	57.7	62.6%	5.5%	0.5%	24.4%	2.8%	12.3%	7.1
19-24	24.3	54.6%	6.2%	0.6%	10.6%	2.5%	31.0%	7.5
25-34	39.9	60.9%	5.4%	1.2%	8.5%	2.2%	26.9%	10.7
35-54	86.2	70.5%	7.1%	3.0%	6.8%	2.7%	17.0%	14.7
55-61	24.3	69.9%	9.1%	7.3%	6.8%	5.5%	13.0%	3.2
62-64	7.9	62.2%	13.4%	14.9%	9.0%	6.3%	11.8%	0.9
65+	36.0	37.1%	27.5%	93.8%	9.3%	7.4%	1.5%	0.5
Total	**296.8**	**61.1%**	**9.1%**	**13.6%**	**12.9%**	**3.6%**	**15.8%**	**47.0**

Source: CRS analysis of data from the March 2007 Current Population Survey (CPS).

a. People may have more than one source of coverage; percentages may total to more than 100.
b. Includes group health insurance through current or former employer or union and all coverage from outside the home (published Census Bureau figures are slightly lower due to the exclusion of certain people with outside coverage). Excludes military and veterans' coverage.
c. Includes State Children's Health Insurance Program (SCHIP) and other state programs for low-income individuals. Excludes military and veterans' coverage.

Other Demographic Characteristics. **Table 2** shows the rate of health insurance coverage by type of insurance and selected demographic characteristics — race/ethnicity, family type, region, poverty status, and citizenship — *for people under age 65*. In 2006, whites were least likely to be uninsured (13%), while Hispanics were most likely (36%). The rate of employment-based health coverage was highest among whites (73%), and the rate of public coverage was highest among blacks (25%).[2]

People residing in two-parent families were most likely to have employment-based health insurance (72%) and least likely to be uninsured (13%). People in a family headed by a single mother were most likely to have public coverage (39%) compared to other family types, and people in a family headed by a single father were most likely to be uninsured (28%).

[2] "Public coverage" includes Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and any other health insurance program for low-income individuals, but excludes military and veterans' coverage. Hispanics may be of any race. In this report, whites, blacks, and Asians are those who are non-Hispanic and report only one race. Among non-Hispanics, individuals who report any other single race (e.g., American Indian) or multiple races are categorized as "other."

People were less likely to be uninsured if they lived in the Midwest (13%) or the Northeast (14%) than if they lived in the South (21%) or West (20%). Employment-based health insurance covered 71% of people in the Midwest and 69% in the Northeast, compared to 61% in the South and 60% in the West.

Among individuals with family incomes at least two times the poverty threshold, 12% went without health insurance compared to 34% of the poor (i.e., those with family incomes below the poverty threshold). Only 18% of the poor received health coverage through employment, and 46% had public coverage. Of people with family incomes at least two times the poverty threshold, 79% were covered through an employer, and only 6% had public coverage.

Noncitizens were more likely to be uninsured than people born with U.S. citizenship (i.e., "native") — 47% versus 15%, respectively. Noncitizens accounted for 8% of the population under 65 but were 22% of the under-65 uninsured. Forty percent of noncitizens were covered through employment, compared to 67% of native citizens.

Table 2. Health Insurance Coverage by Type of Insurance and Demographic Characteristics for People Under Age 65, 2006

		Type of Insurance[a]				
	Population (millions)	Employment-Based[b]	Public[c]	Other[d]	Uninsured (percent)	Uninsured (millions)
Race/ethnicity						
White	167.3	72.5%	11.3%	10.9%	12.5%	21.0
Black	33.0	53.1%	24.8%	7.2%	21.7%	7.2
Hispanic	42.4	41.7%	22.3%	4.8%	35.6%	15.1
Asian	11.8	66.7%	10.8%	12.0%	16.4%	1.9
Other	6.3	56.1%	22.8%	8.8%	20.4%	1.3
Family type						
Two parents	114.5	71.9%	12.3%	9.4%	13.1%	15.0
Single dad with children	8.0	49.5%	21.3%	6.2%	28.0%	2.2
Single mom with children	32.6	41.0%	39.4%	5.0%	21.4%	7.0
No children	105.7	64.6%	9.9%	11.1%	21.0%	22.2
Region						
Northeast	46.9	69.3%	16.0%	6.8%	14.0%	6.6
Midwest	57.4	70.7%	14.6%	8.4%	12.9%	7.4
South	94.7	60.9%	14.6%	10.2%	21.4%	20.3
West	61.7	60.1%	15.4%	11.3%	19.9%	12.2
Family income-to-poverty ratio[e]						
Less than 100%	33.1	18.4%	46.2%	6.4%	34.3%	11.4
100%-149%	22.0	33.0%	34.3%	6.8%	32.1%	7.1
150%-199%	22.6	46.8%	22.4%	9.2%	28.9%	6.5
200%+	182.7	78.8%	6.1%	10.4%	11.7%	21.4
Citizenship						
Native	227.5	66.7%	15.6%	9.8%	15.0%	34.1
Naturalized	11.7	64.8%	10.8%	9.9%	19.8%	2.3
Noncitizen	21.5	40.0%	11.3%	5.4%	46.6%	10.0
Total	**260.8**	**64.4%**	**15.0%**	**9.4%**	**17.8%**	**46.5**

Source: CRS analysis of data from the March 2007 CPS.

a. People may have more than one source of coverage; percentages may total to more than 100.
b. Includes group health insurance through current or former employer or union and all coverage from outside the home (published Census Bureau figures are slightly lower due to the exclusion of certain people with outside coverage). Excludes military and veterans' coverage.

c. Includes Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and other state programs for low-income individuals. Excludes military and veterans' coverage.
d. Includes private nongroup health insurance, military and veterans' coverage.
e. In 2006, the poverty threshold (which is used mainly for statistical purposes and differs slightly from the poverty guideline used for program eligibility and other administrative purposes) for a family with two adults and two children was $20,444. Approximately 374,000 children are excluded from CPS-based poverty analyses because they are living with a family to which they are unrelated.

Employment Characteristics. For the sixth year in a row, the employment-based coverage rate fell, to 64% among the nonelderly in 2006. **Table 3** shows the rate of health insurance coverage for people under age 65 by employment characteristics of the primary worker in the family. In 2006, only 9% of workers in large firms (1,000 or more employees) and their dependents were uninsured, compared to 35% in small firms (less than 10 employees). People who reported working in small firms and their dependents accounted for 14% of the under-65 population but 28% of the under-65 uninsured. Insurance coverage also varied by industry. The category of agriculture, forestry, fishing, and hunting had the highest proportion of uninsured workers and dependents (34%). Four percent of those associated with employment in public administration were uninsured, and no one associated with employment in the armed forces was uninsured.

Table 3. Health Insurance Coverage by Employment Characteristics[a] for People Under Age 65, 2006

		Type of Insurance[b]				
		Employment-Based[c]				
	Population (millions)	From Own Job	From Other's Job	Public or Other[d]	Uninsured (percent)	Uninsured (millions)
People in families with a worker[e]	**224.0**	**35.2%**	**37.3%**	**19.6%**	**16.9%**	**38.0**
Firm size[a, e]						
Under 10	37.6	18.9%	19.6%	32.4%	34.8%	13.1
10-24	19.8	27.7%	25.8%	23.6%	28.8%	5.7
25-99	27.9	35.6%	34.4%	19.2%	19.2%	5.4
100-499	32.0	39.3%	41.1%	15.3%	13.9%	4.5
500-999	13.2	41.3%	45.0%	13.8%	9.7%	1.3
1,000 +	93.5	41.0%	45.2%	15.9%	8.6%	8.1
Industry[a, e]						
Agriculture, forestry, fishing, and hunting	2.9	16.1%	17.5%	39.2%	33.8%	1.0
Leisure and hospitality	14.8	23.4%	20.1%	29.1%	33.5%	5.0
Construction	20.6	24.5%	27.8%	20.9%	33.0%	6.8
Other services	8.5	24.6%	23.9%	27.9%	30.1%	2.6
Wholesale and retail trade	28.9	34.4%	33.3%	21.2%	19.4%	5.6
Professional and business services	22.9	33.7%	35.4%	20.8%	18.3%	4.2
Transportation, utilities	13.3	35.5%	41.9%	15.6%	15.7%	2.1
Mining	1.6	35.9%	48.5%	8.4%	14.0%	0.2
Manufacturing	30.5	38.8%	45.6%	13.7%	11.0%	3.4
Education and health services	43.8	41.9%	40.5%	17.8%	10.3%	4.5
Financial activities	16.0	40.2%	42.8%	15.9%	9.9%	1.6
Information	6.1	40.2%	45.6%	13.1%	9.3%	0.6
Public administration	12.3	44.6%	51.3%	12.6%	4.0%	0.5
Armed forces	1.7	16.5%	32.4%	99.9%	0.0%	0.0
Labor force attachment[a, e]						
Full time, full year	181.6	37.1%	40.5%	16.5%	14.7%	26.6
Full time, part year	23.1	30.7%	26.5%	28.7%	25.5%	5.9
Part time, full year	11.3	26.0%	23.4%	32.6%	26.4%	3.0
Part time, part year	8.0	19.1%	14.1%	44.3%	30.7%	2.4

	Population (millions)	Type of Insurance[b]				
		Employment-Based[c]		Public or Other[d]	Uninsured	
		From Own Job	From Other's Job		(percent)	(millions)
People in families with no worker or policyholder does not work[e]	29.9	12.6%	9.3%	56.6%	28.4%	8.5
People with coverage outside the home	6.9	8.2%	100.0%	18.5%	0.0%	0.0
Total	260.8	31.9%	35.7%	23.8%	17.8%	46.5

Source: CRS analysis of data from the March 2007 CPS.

a. Firm size, industry and labor force attachment reflect the employment characteristics of the primary worker in families where someone is working. Those characteristics were applied to those individuals' "dependents" — their spouse and children.
b. People may have more than one source of coverage; percentages may total to more than 100.
c. Includes group health insurance through current or former employer or union and all coverage from outside the home (published Census Bureau figures are slightly lower due to the exclusion of certain people with outside coverage). Excludes military and veterans' coverage.
d. Includes Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), other state programs for low-income individuals, nongroup health insurance, and military and veterans' coverage.
e. Excluding those persons with health insurance coverage from outside the home.
f. Nearly 90% of these policyholders (i.e., those who did not work during the year but had employment-based coverage in their name) were retirees, were ill or disabled, or were at home with the family and probably received coverage through their former employer.

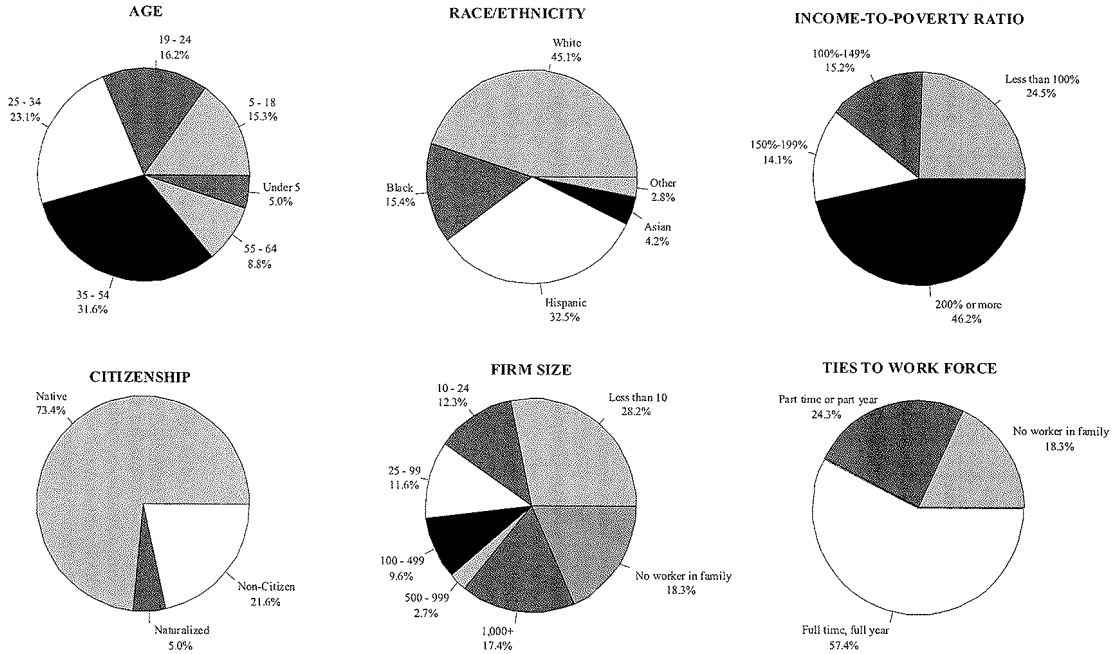
Characteristics of the Uninsured Population Under Age 65

People who lack health insurance differ from the population as a whole: they are more likely to be young adults, poor, Hispanic, or employees in small firms. **Figure 1** illustrates selected characteristics of those under age 65 who were uninsured in 2006. Approximately 16% of the under-65 uninsured were 19 to 24 years old, even though this age group represents only 9% of the under-65 population.

Hispanics represented 33% of the under-65 uninsured, but only 16% of the under-65 population. Whites (non-Hispanics who report being only white) were the most numerous racial or ethnic group among the under-65 uninsured (45%). More than a quarter of the under-65 uninsured were not native-born citizens (that is, they were either noncitizens or naturalized citizens). More than half (57%) of the under-65 uninsured were full time, full year workers or their spouses and children. Approximately 18% had no attachment to the labor force.

Three-quarters of the under-65 uninsured had family incomes above the poverty threshold. Even though the poor accounted for only 13% of the under-65 population, they represented almost 25% of the under-65 uninsured. To show money income among the uninsured, the Census Bureau provides estimates of household income (everyone in the household) and family income (all related people in the household). Many health policy analysts also create "health insurance unit" (HIU) income, which is lower than household or family income, based on people who could be covered under one health insurance policy (an adult plus spouse and dependents in the household). By this measure of HIU income, 57% of the under-65 uninsured had income below $25,000 in 2006; 26% had income between $25,000 and $49,999; 9% had income between $50,000 and $74,999; 4% had income between $75,000 and $99,999; and 4% had income of $100,000 or more.

Figure 1. Characteristics of the Uninsured U.S. Population Under Age 65, 2006 (46.5 million)



Source: Congressional Research Service analysis of data from the March 2007 Current Population Survey.

Note: Totals may not sum to 100 percent due to rounding. Hispanics may be of any race. In this chart, whites, blacks and Asians are those who are non-Hispanic and report only one race. Among non-Hispanics, individuals who report any other single race (e.g., American Indian) or multiple races are categorized as "other." "Firm size" and "ties to work force" reflect the employment characteristics of the primary worker in families where someone is working. Those characteristics were applied to those individuals' "dependents" — their spouses and children. Employed policyholders of private coverage are first to be assigned as primary workers. For those in families without private coverage, persons' employment characteristics are those of the family head or, if the head is not employed and the spouse is, the spouse.

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CRS Report for Congress

Health Insurance Coverage of Children, 2006

Chris L. Peterson and April Grady
Domestic Social Policy Division

Summary

Based on data from the Census Bureau's Current Population Survey (CPS), 9.4 million children under age 19[1] were uninsured in 2006 (12.1%), compared with 8.7 million in 2005 (11.2%). In 2006, 61% of children had employment-based health insurance and 27% had publicly provided health insurance.

Only 8% of non-Hispanic white children were uninsured in 2006, compared with 23% of Hispanic children. Children in poor or near-poor families were more likely to be uninsured than those in higher-income families. Children whose parents worked in a small firm were much more likely to be uninsured (23% in firms with less than 10 workers) than those whose parents worked in a large firm (5% in firms with 1,000 or more workers). Among uninsured children, 63% lived in a household with a parent where at least one adult worked full-time for the entire year.

In 2007, the Census Bureau released revised data for 1996-2005 showing slightly fewer uninsured individuals.[2] This report focuses primarily on health insurance coverage in 2006 and will be updated when 2007 data are released (late summer 2008).

Health Insurance Coverage by Population Characteristics

Demographic and Family Characteristics. As shown in **Table 1**, children aged 13 to 18 had higher rates of job-based coverage than younger children, but were more likely to be uninsured because they were less likely to have public coverage. Uninsured rates were highest among black and Hispanic children, who had the lowest employment-based coverage rates but were more than twice as likely as non-Hispanic

[1] Census Bureau estimates for children generally refer to individuals under age 18. Most estimates in this report refer to individuals under age 19, which corresponds with the cutoff used for Medicaid poverty-related child eligibility and the State Children's Health Insurance Program (SCHIP) allotment formula.

[2] The revision was attributed to a Census Bureau programming error that caused some people who reported private coverage to be coded as uninsured. For 2005, the revision reduced the U.S. uninsured rate by 0.6 percentage points (from 15.9% to 15.3%); for 2004, it reduced the uninsured rate by 0.7 percentage points (from 15.6% to 14.9%). For more information, see [http://www.census.gov/hhes/www/hlthins/usernote/schedule.html].

white children to have coverage through Medicaid or some other public program. Children in the South and West were more likely to be uninsured than children in the Northeast and Midwest.

Table 1. Health Insurance Coverage and Demographic and Family Characteristics of Children Under Age 19, 2006

	Population (thousands)	Type of insurance[a]				
		Employment-based[b]	Private nongroup	Public[c]	Military or veterans'	Uninsured
All children under age 19	**78,207**	**61.0%**	**5.3%**	**26.8%**	**2.8%**	**12.1%**
Age						
Under 6	24,558	57.1%	4.5%	32.4%	2.7%	11.3%
6 to 12	27,916	61.4%	5.7%	27.1%	2.8%	11.1%
13 to 18	25,733	64.2%	5.6%	21.2%	2.8%	13.9%
Race/ethnicity						
White	44,899	72.1%	6.6%	18.8%	3.1%	7.6%
Black	11,517	47.2%	3.6%	40.4%	2.9%	14.6%
Hispanic	15,950	38.9%	2.7%	40.0%	1.6%	22.8%
Asian	3,082	68.8%	7.3%	17.5%	2.4%	12.0%
Other	2,759	55.7%	3.6%	33.8%	4.2%	12.3%
Region						
Northeast	13,352	68.1%	3.8%	25.7%	0.9%	8.7%
Midwest	17,058	68.5%	5.0%	25.6%	1.5%	7.5%
South	28,786	55.9%	5.0%	27.6%	4.1%	15.4%
West	19,010	56.9%	6.9%	27.4%	3.1%	13.5%
Children not living with parent	**3,156**	**27.3%**	**2.6%**	**40.1%**	**1.3%**	**33.1%**
Children living with parent	**75,051**	**62.4%**	**5.4%**	**26.2%**	**2.8%**	**11.2%**
Family type						
Two parents	52,878	71.0%	6.2%	18.1%	3.3%	9.4%
Single dad	4,083	49.8%	4.4%	29.9%	2.0%	20.6%
Single mom	18,090	40.1%	3.3%	49.1%	1.6%	14.3%
Family income-to-poverty ratio						
Under 100%	12,502	17.3%	3.0%	66.5%	1.6%	18.7%
100% to 149%	8,243	34.4%	3.5%	50.7%	1.9%	18.0%
150% to 199%	7,744	51.1%	4.6%	34.1%	3.8%	16.1%
200% to 299%	13,705	69.3%	6.1%	18.6%	3.9%	11.9%
300%+	32,858	86.4%	6.6%	6.1%	2.9%	5.2%
Parents' health insurance coverage						
Employment-based	49,809	**91.1%**	2.9%	11.1%	2.4%	2.9%
Private nongroup	3,051	5.3%	**82.5%**	15.7%	2.3%	3.7%
Public	8,039	4.0%	0.1%	**96.5%**	0.9%	2.8%
Military or veterans'	773	3.8%	0.0%	7.7%	**97.6%**	1.5%
Uninsured	13,379	7.1%	0.4%	43.8%	0.3%	**49.5%**

Source: Congressional Research Service analysis of data from the March 2007 Current Population Survey.

a. People may have more than one source of coverage; percentages may total to more than 100.
b. Includes group health insurance through current or former employer or union and all coverage from outside the home (Census Bureau figures are slightly lower because of the exclusion of certain people with outside coverage). Excludes military and veterans' coverage.
c. Includes Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and other state programs for low-income individuals. Excludes military and veterans' coverage.
d Includes stepparent.

Insurance coverage among children under age 19 also differs by family structure. As shown in **Table 1**, 33% of children not living with a parent lacked health insurance, compared with 11% of children living with at least one parent. Among children living with a parent, family structure still had an impact on health insurance coverage. Nine percent of children living in a two-parent family were uninsured in 2006. Although children living with a single father were more likely to have employment-based health insurance than those living with a single mother, children living with a single father were more likely to be uninsured because they were less likely to have public coverage.

Among children in poverty,[3] 17% had employment-based coverage, two-thirds had Medicaid or other public coverage, and 19% were uninsured. As the family income-to-poverty ratio increases, the likelihood of children having employment-based coverage increases and the likelihood of having public coverage or being uninsured decreases. Among children in families with family incomes at least three times the poverty threshold, 86% had job-based coverage and 5% were uninsured.

A child's source of health insurance is strongly associated with his or her parents' coverage. Approximately 91% of children who lived with a parent who had employment-based coverage in 2006 also had employment-based coverage.[4] Likewise, 97% of children who lived with a parent who had Medicaid or other public coverage also had public coverage. Among children who lived with at least one parent who was uninsured in 2006, 50% were uninsured and 44% had Medicaid or other public coverage.

Parents' Employment Characteristics. As shown in **Table 2**, among children under age 19 who lived with at least one parent who worked full-time for the entire year, 72% had job-based coverage, almost 18% had Medicaid or other public coverage, and 10% were uninsured in 2006. Among children who lived with at least one parent who worked, but only part-time or part-year, 37% had job-based coverage, 52% were covered by public coverage, and 14% were uninsured. In cases where no parent worked, 71% of children had public coverage and 18% were uninsured.

Employment-based health insurance coverage is less common for workers in small firms than in larger ones. Job-based coverage rates were lowest and uninsured rates were highest in 2006 among children living with a parent where the primary worker was employed by a firm with less than 10 employees. Health insurance coverage rates also varied substantially by industry. Less than half of children living with a parent where the primary worker was in one of four industries (agriculture, construction, other services, leisure and hospitality) had employment-based coverage. However, more than three-quarters of children living with a parent where the primary worker was in one of five (six,

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[3] Among children living with at least one parent. In 2006, the poverty threshold (which is used mainly for statistical purposes and differs slightly from the poverty guideline used for program eligibility and other administrative purposes) for a family with two adults and two children was $20,444.

[4] When a parent had more than one source of coverage, the following hierarchy was used to determine "primary" coverage: employment-based, private, Medicaid/Medicare, CHAMPUS or VA, and other public. Then the parent with the "highest" coverage was used to classify both parents' insurance coverage. Thus, if one parent had employment-based coverage and the other had private insurance, the parents' coverage was classified as employment-based.

including the armed forces) industries (mining, financial activities, manufacturing, information, public administration) had such coverage.

Table 2. Health Insurance Coverage and Parents' Employment Characteristics of Children Under Age 19 Living with at Least One Parent, 2006

	Population (thousands)	Type of insurance[a]				
		Employment-based[b]	Private nongroup	Public[c]	Military or veterans'	Uninsured
Children under age 19 living with parent	**75,051**	**62.4%**	**5.4%**	**26.2%**	**2.8%**	**11.2%**
Custodial parents' work status						
At least one parent worked full-time and full-year	59,194	71.7%	5.6%	17.5%	2.9%	10.0%
None full-time and full-year, at least one part-time or part-year	10,143	36.5%	5.3%	52.3%	2.3%	14.3%
Did not work[d]	5,715	11.8%	2.8%	70.5%	2.6%	18.1%
Firm size						
Under 10	10,904	33.6%	15.1%	32.6%	1.3%	22.8%
10-24	5,864	45.1%	5.8%	34.2%	1.2%	18.4%
25-99	8,171	60.6%	4.6%	27.3%	1.3%	12.9%
100-499	9,484	70.9%	3.6%	21.1%	1.2%	10.9%
500-999	3,922	77.9%	2.5%	19.1%	1.0%	6.7%
1,000+	27,511	79.3%	3.0%	16.8%	4.9%	5.3%
Not applicable[e]	9,195	43.1%	4.5%	49.3%	3.3%	11.2%
Industry						
Agriculture, forestry, fishing, and hunting	963	27.3%	16.5%	41.6%	0.9%	20.7%
Construction	6,241	48.4%	8.3%	28.1%	1.0%	19.9%
Other services	2,411	41.6%	8.7%	35.1%	2.0%	18.6%
Leisure and hospitality	4,261	37.4%	4.9%	44.4%	1.5%	18.1%
Wholesale and retail trade	8,355	59.7%	4.6%	28.1%	1.6%	12.8%
Professional and business services	6,770	62.9%	7.5%	22.1%	2.0%	12.4%
Transportation, utilities	3,914	71.6%	3.3%	19.4%	1.7%	10.6%
Mining	475	78.4%	1.7%	13.0%	1.3%	10.4%
Financial activities	4,654	75.9%	8.4%	11.3%	1.6%	8.5%
Education and health services	12,586	70.8%	4.9%	22.5%	1.8%	8.1%
Manufacturing	9,108	77.8%	3.1%	18.2%	1.0%	7.7%
Information	1,826	81.3%	5.6%	13.6%	1.3%	6.5%
Public administration	3,598	89.3%	2.4%	9.0%	5.2%	2.8%
Armed forces	693	48.7%	1.8%	3.1%	99.8%	0.0%
Not applicable[e]	9,195	43.1%	4.5%	49.3%	3.3%	11.2%

Source: Congressional Research Service analysis of data from the March 2007 Current Population Survey.

a. People may have more than one source of coverage; percentages may total to more than 100.

b. Includes group health insurance through current or former employer or union and all coverage from outside the home (Census Bureau figures are slightly lower because of the exclusion of certain people with outside coverage). Excludes military and veterans' coverage.

c. Includes Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and other state programs for low-income individuals. Excludes military and veterans' coverage.

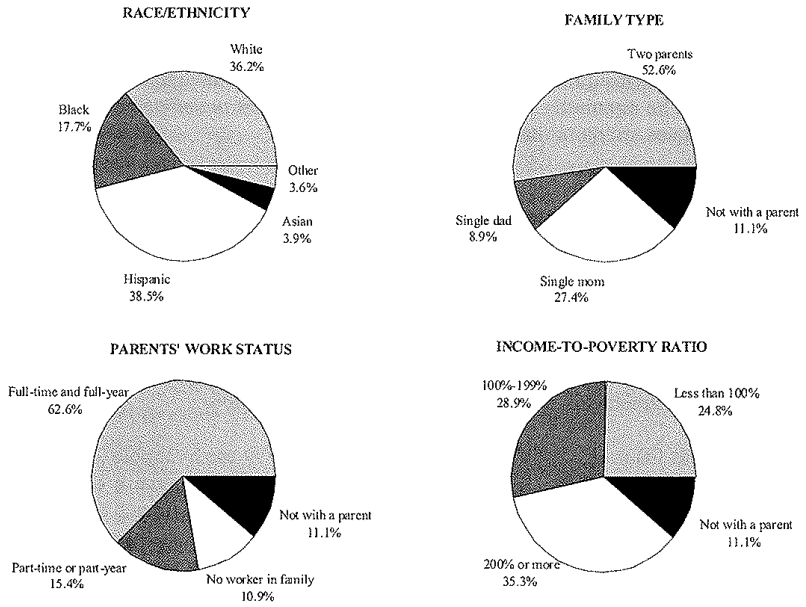
d. Child's employment-based coverage may be through a parent's former employer, from someone outside the household (e.g., noncustodial parent), or in the child's name (e.g., from his or her own job).

e. No firm-size or industry information is provided because the parent did not work or because coverage is from outside the household or in the child's name.

Characteristics of Uninsured Children

In the preceding discussion, health insurance coverage *rates* among different groups of children under age 19 were compared. For example, 8% of non-Hispanic white children were uninsured in 2006, compared with 23% of Hispanic children. However, because the United States has many more non-Hispanic white children (45 million) than Hispanic children (16 million), the *number* of uninsured in each group is similar, as shown in **Figure 1**.

Figure 1. Characteristics of Uninsured Children Under Age 19, 2006 (9.4 million)



Source: Congressional Research Service analysis of data from the March 2007 Current Population Survey.

Note: Totals may not sum to 100% due to rounding. "Full-time and full-year" means at least one parent living with the child was a full-time, full-year worker. "Part-time or part-year" means that at least one parent living with the child worked, but not full-time and full-year. Whites, blacks, and Asians are those who are non-Hispanic and report only one race. Among non-Hispanics, individuals who report any other single race (e.g., American Indian) or multiple races are categorized as "other."

This apparent paradox — that the group least likely to be uninsured makes up a large portion of the uninsured — exists when looking at other characteristics as well. Children who lived with at least one parent who worked full-time for the entire year were least likely to be uninsured (10%) compared with other children, but still composed 63% of all uninsured children in 2006. Similarly, children in two-parent families were least likely to be uninsured (9%) compared with others, yet made up more than half of the population of uninsured children. This raises difficult issues for policy makers who might wish to help uninsured children. For example, should proposals be targeted at those in two-parent families because they are more numerous, or at other uninsured children because they are more likely to be uninsured?

Health Insurance Coverage of Children Over Time

Thus far, health insurance estimates presented in this report have referred to children *under age 19*. The remainder of this report refers to children *under age 18*, for whom historical estimates are more readily available.[5]

The number and percentage of children under age 18 covered by employment-based health insurance has dropped annually since 2000. However, increases in public coverage more than offset the job-based declines between 2000 and 2004. As a result, the number and percentage of uninsured children under age 18 declined significantly — from 8.4 million (11.6%) in 2000 to 7.7 million (10.5%) in 2004.[6] Between 2004 and 2006, this downward trend in the uninsured was reversed, and the number and percentage of children under age 18 without health insurance rose significantly — from 7.7 million (10.5%) in 2004 to 8.7 million (11.7%) in 2006. Public coverage among children under age 18 remained statistically unchanged between 2004 and 2006.

CPS health insurance estimates for years prior to 1999 are available[7] but are not directly comparable to those for later years because of a questionnaire change that increased the number and percentage of people covered by health insurance beginning in 1999, as well as the absence of revised data for years prior to 1996 that would correct a Census Bureau programming error discovered in 2007.[8] Based on unrevised estimates produced using the old questionnaire, the number and percentage of uninsured children under age 18 showed year-to-year fluctuations but grew significantly between 1987 and 1998. As employment-based coverage rates declined in the late 1980s and early 1990s, public coverage rates rose. As employment-based coverage rates rebounded in the mid-1990s, public coverage rates declined.

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[5] As noted earlier, revised data for 1996-2005 showing slightly fewer uninsured individuals were released in 2007. New historical tables with revised estimates for 1999 forward are available at [http://www.census.gov/hhes/www/hlthins/historic/index.html]. Although the underlying data files were made available, the Census Bureau did not include revised estimates for 1996-1998 in its new historical tables.

[6] Statistical significance was tested at the 95% confidence level (5% significance level). This means that one can be 95% certain that the difference between years is not zero.

[7] Old historical tables are available at [http://www.census.gov/hhes/www/hlthins/historic/index_old.html].

[8] See earlier footnotes for information on the programming error and revised data.

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CRS Report for Congress

Spending by Employers on Health Insurance: A Data Brief

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Summary

To attract and maintain a skilled workforce, many businesses provide health insurance and other benefits for their employees. As the cost of health insurance rises, employers face a growing challenge paying for benefits while managing labor costs to succeed in a competitive market. All types of businesses report problems, including both small businesses and firms with thousands of employees and retirees.

Despite concerns about the cost of benefits, small and large employers together provide health coverage for most Americans, about 60% of the population in 2006.[1] But as the amount that employers pay for health insurance has been increasing — both absolutely and as a share of labor costs — the percent of the population covered has been decreasing.

To describe employer contributions for health insurance, this report presents data from two employer surveys. The first, conducted by the Kaiser Family Foundation and the Health Research and Educational Trust, provides information on premiums for employer-sponsored health insurance. The second, from the Department of Labor, provides information on employer costs for employee compensation, including costs for wages and salaries, health insurance, and other benefits.

Premiums for Employer-Sponsored Health Insurance

Although not all employers provide work-based health coverage, those that do pay most of the premium. As shown in **Table 1**, in 2007, employers paid 84.5% of the cost for single coverage and 72.9% for family coverage. Employers paid a smaller share of health insurance premiums in 2007, compared with 2006.

[1] U.S. Census Bureau, *Income Poverty, and Health Insurance Coverage in the United States: 2006*, Current Population Report no. P60-233, August 2007, p. 58. The actual estimate for 2006 was 59.7%, down from 60.2% in 2005, and from 64.2% in 2000 (the 20-year high).

Table 1. Employer and Worker Contributions for Employer-Sponsored Health Insurance, 2001-2007

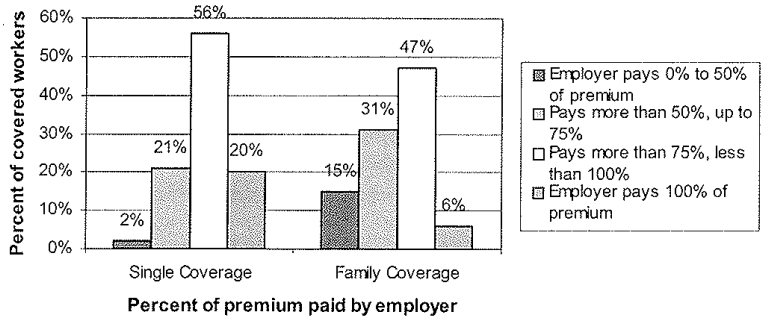
	2001	2002	2003	2004	2005	2006	2007
Employers' share of premium							
Single policy	86.4%	85.2%	85.0%	84.9%	84.8%	85.2%	84.5%
Family policy	74.5%	73.8%	73.4%	73.3%	75.1%	74.1%	72.9%
Workers' share of premium							
Single policy	13.6%	14.8%	15.0%	15.1%	15.2%	14.8%	15.5%
Family policy	25.5%	26.2%	26.6%	26.7%	24.9%	25.9%	27.1%

Source: CRS calculations based on data from the Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2007 Annual Survey, 2006 Annual Survey, 2005 Annual Survey, 2004 Annual Survey, 2003 Annual Survey, 2002 Annual Survey, and 2001 Annual Survey.*

Note: Data are based on a national sample of public and private employers with three or more workers.

The above shares are average contributions by employers, but different firms pay different shares, and even the same firm may pay different shares for different workers.[2] As shown in **Figure 1**, in 2007, employers paid 100% of the premium for health insurance for 20% of workers with single coverage and 6% of workers with family coverage. They paid 50% or less of the premium for only 2% of workers with single coverage.

Figure 1. Distribution of Percentage of Premium Paid by Employers for Single and Family Health Insurance Coverage, 2005



Source: CRS calculations based on data from the Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2007 Annual Survey.*

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[2] In addition, as mentioned already, not all employers offer insurance. According to the KFF/HRET survey, in 2007, 99% of firms with 200 or more workers offered health benefits. Offer rates for smaller firms were: 45% (3-9 workers), 76% (10-24 workers), 83% (25-49 workers), and 94% (50-199 workers).

Although the average *share* that employers contribute for premiums has been relatively stable over the 2001-2007 period (**Table 1**), the average *amount* has increased substantially. As shown in **Table 2**, employer payments for single and family coverage both increased by about two-thirds between 2001 and 2007, from $2,292 to $3,785 for single coverage, and from $5,256 to $8,824 for a family of four.

Growth in health insurance premiums has varied year-to-year, always exceeding growth in prices for all goods and services, as measured by the Consumer Price Index. Over the 2001-2006 period, premiums for single coverage in an employer-sponsored health plan grew at an average annual rate of 9.8%; average growth for family coverage was 10.2%. Over the same period, average annual growth in consumer prices was 2.6%.

Table 2. Premiums for Employer-Sponsored Health Insurance, and Growth in Prices for All Goods and Services, 2001-2007

	2001	2002	2003	2004	2005	2006	2007	Avg. Growth 2001-06
Average annual premium for single coverage								
Employer contribution	$2,292	$2,606	$2,875	$3,137	$3,413	$3,615	$3,785	
Worker contribution	$360	$454	$508	$558	$610	$627	$694	
Total premium	$2,652	$3,060	$3,383	$3,695	$4,024	$4,242	$4,479	
Growth in premium[a]	9.4%	15.4%	10.6%	9.2%	8.9%	5.4%	5.6%	9.8%
Average annual premium for a family of four								
Employer contribution	$5,256	$5,870	$6,656	$7,289	$8,167	$8,508	$8,824	
Worker contribution	$1,800	$2,084	$2,412	$2,661	$2,713	$2,973	$3,281	
Total premium	$7,056	$7,954	$9,068	$9,950	$10,880	$11,480	$12,106	
Growth in premium[a]	11.2%	12.7%	14.0%	9.7%	9.3%	5.5%	5.5%	10.2%
Average growth in prices for all goods and services								
CPI-U	2.8%	1.6%	2.3%	2.7%	3.4%	3.2%	NA	2.6%

Source: KFF/HRET employer health benefit surveys (see **Table 1**). Data on growth in prices are from the U.S. Department of Labor, Bureau of Labor Statistics, at [http://www.bls.gov].

Notes: CPI-U = Consumer Price Index-All Urban Consumers. NA = not available. Data are based on a national sample of public and private employers with three or more workers. Components may not add to totals because of rounding.

a. Growth in premium from previous year.

Health Insurance and Labor Costs

Employer contributions for health insurance are an important component of labor costs. Firms use health and other benefits to attract and retain workers, and workers value access to subsidized health coverage. As shown in **Table 3**, in March 2007, health insurance accounted for 7.9% of employee compensation; other benefits, including paid leave, pensions, and required contributions for Social Security and Medicare, accounted for 22.1%.[3] Wages and salaries made up the remaining 70% of total compensation.[4]

Table 3. Wages and Salaries, Benefits, and Health Insurance as a Percentage of Total Compensation, 2001-2007

	2001	2002	2003	2004	2005	2006	2007
Wages and salaries	72.6%	72.4%	71.8%	71.0%	70.4%	70.1%	70.0%
Total benefits	27.4%	27.6%	28.2%	29.0%	29.6%	29.9%	30.0%
Health insurance	6.1%	6.5%	6.9%	7.2%	7.5%	7.6%	7.9%
All other benefits	21.3%	21.1%	21.3%	21.8%	22.1%	22.3%	22.1%

Source: U.S. Bureau of Labor Statistics, Office of Compensation and Working Conditions, *Employer Costs for Employee Compensation (ECEC), Historical Listing, 1991-2001, 2002-2003, and 2004-2007*, at [http://www.bls.gov/ncs/ect/home.htm].

Notes: Data are for civilian workers. Percentages are based on data reported in March of each year. (Through 2001, estimates were published annually in March; since 2002, estimates have been published quarterly.) In June 2007, the share of compensation for health insurance was 7.9% (most recent data).

The 7.9% share of compensation represents average spending on health insurance for civilian workers: individual employers may devote a higher or lower share, or nothing at all. Contributions also vary by broad industry group. For example, in June 2007, spending by state and local governments on health insurance was 11.0% of total compensation, while the share for private industry was 7.1%.[5] Differences in employer

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[3] In addition to the benefits listed above, the 22% share includes overtime and other supplemental pay, life and disability insurance, and required contributions for unemployment insurance and workers' compensation.

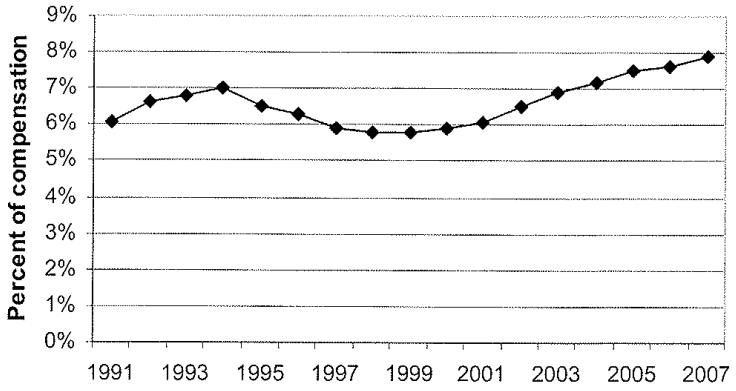
[4] Data on employer costs for employee compensation are based on a national sample of different occupations in private establishments and state and local governments. Several groups are excluded from the sample for private industry: the self-employed, farm workers, and private household workers. Federal government workers are excluded from the sample for the public sector. The data measure the average cost *per employee hour worked* that employers pay for wages and salaries and benefits. Wages and salaries are defined as the hourly straight-time wage rate or, for workers not paid on an hourly basis, straight-time earnings divided by the corresponding hours. For more information, see BLS *News*, pp. 24-26 (technical notes), released September 20, 2007, at [http://www.bls.gov/news.release/pdf/ecec.pdf].

[5] BLS *News*, September 20, 2007, p. 3.

spending may be explained by differences in health insurance coverage rates, differences in the generosity of benefits, and differences in the other components of compensation.

The 2007 share for civilian workers is high compared with the late 1990's, when employer contributions for health insurance accounted for less than 6% of compensation. As shown in **Figure 2**, over the 1999-2007 period, the share of spending for health insurance grew steadily, from 5.8% in 1999 to 7.9% in 2007. A previous upward trend occurred between 1991 and 1994, when spending grew from 6.1% of compensation to a peak of 7.0%, coinciding in time with President Clinton's health reform effort. Between 1994 and 1998, spending fell from 7.0% of compensation to 5.8%, in part because of growth in managed care plans that had some success in controlling health care costs.

Figure 2. Health Insurance as a Percentage of Total Compensation, 1991-2007

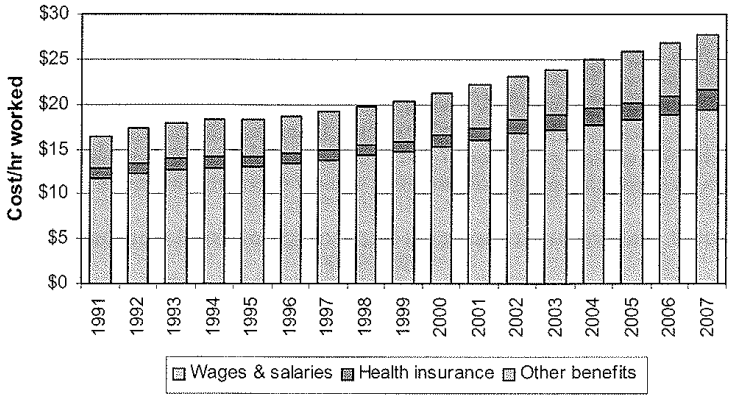


Source: U.S. Bureau of Labor Statistics, Office of Compensation and Working Conditions, *Employer Costs for Employee Compensation (ECEC), Historical Listing, 1991-2001, 2002-2003, and 2004-2007*, at [http://www.bls.gov/ncs/ect/home.htm].
Notes: Data are for civilian workers. Percentages are based on data reported in March of each year.

Growth in health insurance as a share of total compensation does not itself provide information on whether labor costs are increasing for employers. Labor costs change with changes in all of the components of compensation, including wages and salaries, health insurance, and other benefits. As shown in **Figure 3**, labor costs per hour worked grew from an average of $16.45 in 1991 to $27.82 in 2007. Over the same period, costs for wages and salaries grew from $11.81 to $19.47 per hour worked, health insurance costs grew from $1.01 to $2.19, and costs for other benefits grew from $3.63 to $6.16.

Change in the components of labor costs varies year-to-year. As shown in **Figure 4**, over the 1991-2007 period, the change in employer costs per hour worked for health insurance ranged from an increase of 11.9% in 1992 to a decrease of 6.3% in 1995; the average annual increase in costs per hour was 5.0%. Over the same period, the average annual increase in costs per hour worked was 3.2% for wages and salaries and 3.4% for other benefits.

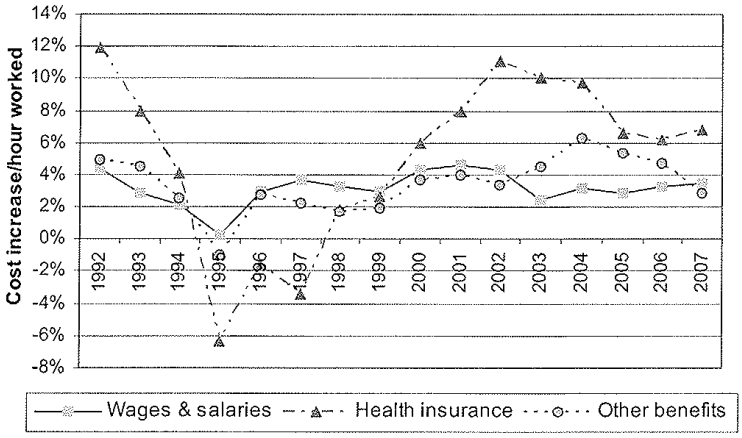
Figure 3. Employer Costs per Hour Worked for Employee Compensation, 1991-2007



Source: U.S. Bureau of Labor Statistics, Office of Compensation and Working Conditions, *Employer Costs for Employee Compensation (ECEC), Historical Listing, 1991-2001, 2002-2003, and 2004-2007*, at [http://www.bls.gov/ncs/ect/home.htm].

Notes: Data are for civilian workers. Amounts are based on data reported in March of each year. Other benefits include paid leave; overtime and other supplemental pay; life and disability insurance; pensions; and required contributions for Social Security, Medicare, unemployment insurance, and workers' compensation.

Figure 4. Growth in Employer Costs per Hour Worked for Employee Compensation, 1991-2007



Source: CRS analysis, based on data from the Bureau of Labor Statistics (see **Figure 3**).
Notes: See **Figure 3**.

Chairman MCDERMOTT. I appreciate your comments. The fact is that I talked with Pete Stark about this and when you look at the health care issue, one of the problems we have in dealing with it as a Congress, is it is fractured into a thousand pieces. I think part of our effort in Congress, to deal with this ultimately, is we are going to have to bring some of these pieces together.

The Subcommittee on Social Security has part of this issue. The health Subcommittee has part of this issue. We have part of this issue. The Commerce and Energy Committee has part of the issue. So, it really is very hard to talk about it. I appreciate your being here, and being on both Subcommittees will help us in the long run. Our witnesses today, the first witness is Sherena Johnson. She is from Georgia. Mr. Lewis, would you like to introduce her?

Mr. LEWIS. Thank you very much, Mr. Chairman and good morning. Mr. Chairman, thank you so much for holding this important hearing, I am so proud to introduce an extraordinary young woman from the State of Georgia, who is testifying before our Subcommittee today. Ms. Sherena Johnson lives in Morrow, Georgia, and has an associate's degree in social work.

She is currently attending Clayton State University, majoring in psychology and human services, and is an intern at the State Department on Human Resources in downtown Atlanta. She plans to become a licensed clinical social worker, and to work with organizations that help young people transition from foster care after graduation. She is a member of the Georgia Empowerment Group, a statewide youth leadership and advocacy group, for current and former foster youth. She was a member of the 2006 Jim Casey Youth Opportunities Initiative Leadership Institute Class.

Most recently, Sherena completed a 12-week internship with the National All Star Foster Club, making her the youngest person from Georgia to earn this honor. She is highly sought after as a youth speaker, and is an active member of the Metropolitan Atlanta Youth Opportunity Initiative. Ms. Johnson has bravely come before us today to share her difficult story, and I commend her for being here as a voice for other children in foster care, and those aging out of foster care. Ms. Johnson, thank you for being here, and we all look forward to your testimony, welcome.

Chairman MCDERMOTT. We welcome you to the Subcommittee, and I would say to you and to all the members of the panel, we have received your testimony and it will all be entered in the record in its completeness. So, we would like you to try and stay within 5 minutes of the presentation that you make here today.

So, Ms. Johnson.

STATEMENT OF SHERENA JOHNSON,
FORMER FOSTER YOUTH FROM MORROW, GEORGIA

Ms. JOHNSON. Good morning Chairman McDermott, ranking member Weller and members of your Subcommittee, I would first like to thank you for giving me this opportunity to appear before you on behalf of my brothers and sisters that are currently aging out of the foster care system today.

Mr. Lewis just gave a great introduction of myself, and I would like to start off by saying that a lot of people would consider my

story to be a success story, given my background and where I came from.

To add on to what Mr. Lewis said, my mother deceased when I was 5 months old, and she was 21 at the time. I went on to live with my grandmother, and I was taken away from her and put in foster care, because she didn't have the necessary resources to care for me at the time. I spent about 8 years in foster care, only to age out at age 18, with limited to no resources. The most significant resource that I lost was my health care insurance. I didn't know at the time, how important it would be to lose health care, because I was currently an athlete and hardly ever sick. So, I didn't know the impact that it would make on my life.

In my sophomore year of college, I was diagnosed with an illness that could cause infertility if it continued to be undetected or fixed. As a young woman, it is very significant to be able to get yearly exams. Because I didn't have health care insurance, I couldn't go to the doctor regularly to receive those exams.

So, the condition continued and I didn't really have anybody to go to, or talk about it to, and I just got really depressed. As the illness began to grow, I began to be very nauseated, depressed. I would get sick to my stomach. It got to the point where I didn't even want to get out of bed at times.

Because I didn't go to class, because I was depressed and really sick, I ended up getting suspended because my GPA dropped. As you can imagine, it just started this ripple effect. When my GPA dropped, I was suspended from school and I had to sit out for two semesters. I was originally supposed to graduate this semester, but because I was suspended back in last spring, I would be graduating in spring 2008.

It was hard for me, because living in the Atlanta Metro area, it is a very busy area, and the health clinics there were difficult to treat me at the time, because they would have a limited number that they could see, due to them not having the appropriate number of staff.

So, I would get up at 6 a.m. in the morning to try to beat the line and get there at 8. When I would get there, because they didn't have enough nurses on staff, they would tell me that they could only see the first five people with my condition.

Of course, with the line being so long even though I arrived there at 6:15 a.m., I was not one of the five people. I had to drive an hour and a half outside of the area that I was residing to finally seek medical attention at a health clinic that I attended when I was getting my associate's degree. Even though I went to that health clinic, because it is a health clinic, there is only certain procedures that they can do. So, they would still continue to send me on to other places for lab work.

As you can see, this just was an ongoing condition. It was a lot for me to have to deal with, aging out of foster care at 18 with no parents, nowhere to live. I was struggling during school, because staying at the dormitories you had to leave around the Thanksgiving and Christmas holidays. So, I was already dealing with enough, and on top of that to not be able to get my medical condition treated, I sort of lost hope.

To be honest, I stopped going to class, because the medical condition was so bad that I thought it was going to end up being cancerous. I just really thought I wasn't going to be able to make it through the semester anyway. So, I though why continue to go to class.

To this day I still do not have health care, and I am 22 years old. With me being 22, I am not standing here for myself, because despite the odds I was still able to make it. But there is a lot of youth in foster care right now today that are aging out of foster care with no insurance. I thought this was just an issue in the State of Georgia, but this is a national issue for youth and foster care.

For one thing, we are considered to suffer post-traumatic stress disorder at twice the rate of U.S. war veterans. If you think about it, they are getting shot at and everything else, and if you don't have medical insurance, you can't even go see a counselor or a licensed psychologist to get those problems taken care of.

My recommendation to this Committee would be for Congress to mandate States to exercise the Medicaid option of the Chafee Act, to allow you to have medical coverage until age 21 as we transition from foster care. The State of Georgia was my parent for many years. Consequently, it would help youth transition from foster care so much if my parents, the State of Georgia, stepped up to the plate and assumed its parental role.

Medicaid until age 21 will be the first step to helping former youth and foster care, young people like me become healthy, self-sufficient, productive individuals as we receive help we need for physical and emotional problems. Still, a more comprehensive approach is also needed to address the health care needs of young adults who remain uninsured.

So, with that being said, I would just like to thank you guys once again, for allowing me to be able to share my story with you.

[The prepared statement of Ms. Johnson follows:]

Prepared Statement of Sherena Johnson,
Former Foster Youth From Morrow, Georgia

Chairman McDermott, Ranking Member Weller, and members of this Subcommittee, thank you for allowing me to appear before you today on behalf of my brothers and sisters in foster care who need your help to make health care available for youth in foster care so they can make a successful transition to adulthood.

My name is Sherena Johnson. I am 22 years old and live in Morrow, Georgia, a suburb of Atlanta. I am a senior at Clayton State University, majoring in Psychology and Human Services. I've been very involved with the Metropolitan Atlanta Youth Opportunities Initiative, which is a site of the Jim Casey Youth Opportunities Initiative, a national foundation that helps States and communities assist youth in foster care make successful transitions to adulthood. I've served on the youth advisory board, and I'm an Opportunity Passport? participant. After my mother died and my grandmother no longer could care for me, I spent eight years in the Georgia Foster Care system only to be emancipated at age 18 with limited to no resources. The most significant resource that I lost was Medicaid.

When I left foster care, I did not realize the impact that not having health insurance would have on my life. During my sophomore year of college, I was diagnosed with a serious medical condition that left untreated could have caused infertility. As a young woman, it is critical that you receive yearly physical exams. In my case, because I had no medical insurance coverage, I was not able to afford the cost of yearly exams. During the time that my condition went undetected, I experienced nausea, pain in my stomach, and high fevers often due to my undetected medical condition. I became so depressed because of my condition and not knowing who to ask for help, I stopped going to college regularly. I was not focused in school any-

more because I was very much preoccupied with my medical condition. I imagined that the condition would ultimately be diagnosed as cancerous or worse. If this was the case, I concluded (in my fearful state of mind) that I might not be around at the end of the semester.

As expected, my negative state of mind started a ripple effect. My GPA dropped below a 2.0. I was suspended for a semester and placed on academic probation. It was not until I finally broke down and told some very special people at the Georgia Department of Human Resources (where I worked as an intern at the time) that I finally had the courage to divulge exactly what was going on. The journey to find help was difficult. Some of the members of this team of dedicated social workers drove me across numerous different counties in an attempt to find a doctor's office that would see me at an affordable rate. But all attempts proved to be unsuccessful. We tried the local health department but were unsuccessful in obtaining an immediate appointment and were told that I would have to be placed on a waiting list. We attempted to be seen at another health department in a surrounding county. In order to be seen there, I would need to arrive at the clinic no later than 7:00 a.m. due to limited availability of appointments. This clinic had a limited number of staff and because of this could only take the first five people in line. There were so many people in line when I arrived at 6:15 a.m. that I immediately became discouraged. ***I was not one of the five.***

I finally received medical attention from a health clinic that was an hour and thirty minutes outside of the county where I resided. Even still there was only so much that could be done for me because I had waited so long to get medical attention for my condition. I had to yet again be referred to another clinic for lab work. Though I was still frustrated, I did schedule an appointment for the lab work. After numerous clinic visits, help from many concerned, supportive adults in my corner, to this day I continue to have a medical condition that needs to be treated. There is a possibility that this condition may indeed require surgery. So, here I am back at the beginning, right where I started from two years ago. I have no health insurance, no means of affording insurance, no parent's insurance that will cover me.

My recommendation to this Subcommittee would be for Congress to mandate States to exercise the Medicaid option of the Chafee Act to allow youth to have medical coverage to age 21 as we transition from foster care.

The State of Georgia was my parent for many years. Consequently, it would help youth transitioning from foster care so much if my parent—the State of Georgia—stepped up to the plate and assume its parental role. Medicaid until age 21 would be a first step to helping former youth in foster care, young people like me, become healthy, self-sufficient, productive individuals as we receive the help we need for physical and emotional problems. Still, a more comprehensive approach is also needed to address the health care needs of young adults who remain uninsured.

Thank you.

Chairman MCDERMOTT. Thank you very much for coming and telling us your story. Your giving of details really made it live, so thank you very much.

Mr. Lesley is the president of First Focus from Alexandria, VA. First Focus is an organization, as I understand it, that focuses on children and families, which try to be our first focus. Mr. Lesley.

STATEMENT OF BRUCE LESLEY, PRESIDENT, FIRST FOCUS, ALEXANDRIA, VIRGINIA

Mr. LESLEY. Thank you, Mr. Chairman. Good morning Mr. Chairman, and Congressman Herger, Camp and Lewis. I am Bruce Lesley, as the Chairman noted, president of First Focus, a bipartisan organization dedicated to making children and families a priority in Federal policy and budget decisions. I would like to thank the Subcommittee, and its members, for bringing the important voice of children and foster care youth to this discussion and also for your recent hearings on the health care needs of children in the foster care system, and child welfare system.

I appreciate the opportunity to testify today about the financial problems confronting children and families in the health care system and to suggest possible policy solutions to help these families. Nowhere are families more vulnerable, than when it comes to access to health care. Unfortunately, the trends are alarming on this front.

First, the number of uninsured children in this country is on the rise, after almost a decade-long reduction in the number of uninsured children due to the passage of SCHIP. The Census Bureau found that in 2006, the number of uninsured has risen to 8.7 million, or 11.7 percent of the nation's children are now without health insurance.

The number of uninsured children had declined by a third since the creation of SCHIP a decade ago, but has in the past 2 years reversed course and has increased by one million children. While the national trend is certainly alarming, a State by State look at the insurance status of children reveals trends that are, perhaps even of more concern.

In 39 States and the District of Columbia, the percentage of children without insurance was higher in 2006 than it was in 2004, and in 29 States the rate increased by a full percentage point or more.

Second, middle class families are not able to afford the rising cost of health care. The drop in employer-sponsored insurance for children suggest that dependent coverage is declining more rapidly than the individual employee coverage. According to data from the Kaiser Family Foundation Health Research and Education Trust survey of employer sponsored health benefits, the average annual cost for single and family coverage in 2007, is $4,479 for the individual and $12,106 for a family.

Thus, the average cost for family coverage is 2.7 times the cost for individual coverage. However, employers subsidize individual workers for coverage to a much greater extent than they subsidize family coverage. As a result, the average premium cost paid by workers for family coverage is 4.7 times the cost of individual coverage.

Thus, family coverage is far more expensive, and it is becoming harder for families to absorb. Rising health care costs lead to financial instability, and the underinsured account for the majority of bankruptcy filings. Between 2001 and 2007, health care premiums have increased 78 percent, while inflation increased by 17 percent and worker wages increased by 19 percent.

Health care premiums have therefore, increased at four times the rate of worker wages. Consequently, families are increasingly faced with a triple threat to their financial security in the form of a limited family budget confronted with large annual increases in premiums, increases in other forms of cost sharing such as copayments, deductibles and health benefit limitations.

With fewer employers offering coverage, families are facing the ultimate threat to financial security, having no insurance at all, or being forced to pay out of pocket for exorbitant health care costs. It is estimated that 16 percent of families spend more than 5 percent of their income on health care, and between eight and 21 per-

cent of American families are contacted by collection agencies about their medical bills on an annual basis.

Of the 3.9 million people involved in personal bankruptcy filings in 2001, it is estimated that 1.3 million, or one-third of them were children.

To assess the impact of rising health care costs to middle-class families across America, First Focus analyzed the 12 communities that are closest to the districts represented by members of this Subcommittee. Analysis is in Appendix B of my testimony, and shows that families who are in the median income in 11 of the 12 communities are left with no money, after taking into account the average cost of housing, food, child care, transportation, other necessities, taxes and health care cost.

Health care, which is unaffordable for families with special needs children and unavailable for mental health services. I would like to highlight the particular problems facing families with children with special health care needs. These children, by definition, have health care costs that are three times greater than the costs of children without special health care needs. These children face problems including discontinuity of coverage, inadequate coverage of needed services, inability to obtain referrals through appropriate specialists because of insurance plan limitations and inadequate provider payment levels and thereby, access to care.

Doctor's Alex Chen and Paul Newacheck have found that the proportion of families with children with special health care needs who reported parents needing to stop work, or cut back on work, in order to care for their children was 30 percent. The overall proportion of families who reported having financial problems due to their child's care was 21 percent. A large percentage of families in this country are having huge financial difficulties with respect to health care costs.

With respect to mental health, I think that issue is highlighted by the very fact that the National Alliance for Mental Health did a survey, and found that 23 percent of parents with children exhibiting behavioral disorders reported being instructed to relinquish custody of their children, in order to ensure they receive appropriate mental health care treatment. No family should face such a decision.

I know I am out of time, so I will quickly say that I also think that issues that have been raised by the previous panel member really speak to the need to pass legislation like H.R. 2188, the Kinship Care giver Support Act. Sherena was in the care of her grandmother, and her grandmother could not take care of her financially. The Kinship Care giver Support Act would help families of kinship care be provided in this country, so that is not a situation that occurs.

In conclusion, First Focus would like to make the following recommendations. We believe that the solution to health care is going to require a lot of different efforts, including expansion of public programs like Medicaid and SCHIP, premium support, tax credits and personal responsibility; it is going to take all those things to really tackle this problem.

Congress should take no action that would limit or restrict the ability of States to address their uninsured or under-insurance

problems, and if nothing else, we hope that Congress will not take negative actions to roll back that coverage. Congress should also take leadership in a variety of areas involving children, particularly children with special health care needs, by passing mental health parity laws that I know the Chairman has been very strongly supportive of, and legislation such as the Keeping Families Together.

In addition, since 62 percent of all children in this country who are uninsured are eligible but un-enrolled for Medicaid or SCHIP, Congress should take up the President's challenge when he ran for reelection to cover millions of these children by working with States to conduct extensive outreach and enrollment efforts, streamlining application and enrollment procedures and making more extensive use of other needs-based public programs to enroll children. This is legislation called "Express Lane Eligibility."

Finally, Congress should focus on the most disadvantaged youth in our Nation and address gaps in coverage, health care coverage for foster care children including access to care, the needs of youth aging out of the child welfare system and kinship care issues. Thank you very much.

[The prepared statement of Mr. Lesley follows:]

TESTIMONY OF
BRUCE LESLEY, PRESIDENT, FIRST FOCUS

HOUSE WAYS AND MEANS COMMITTEE

SUBCOMMITTEE ON
INCOME SECURITY AND FAMILY SUPPORT

"IMPACT OF GAPS IN HEALTH COVERAGE ON INCOME SECURITY"

NOVEMBER 14, 2007

Good morning Chairman McDermott, Ranking Member Weller, and members and staff of the Subcommittee on Income Security and Family Support. I am Bruce Lesley, President of First Focus, a bipartisan organization dedicated to making children and families a priority in federal policy and budget decisions. I have worked in federal, state, and local policymaking for 20 years, and most recently spent six years working for Senator Jeff Bingaman on the Senate Finance and Health, Education, Labor, and Pensions Committees.

I would like to thank the subcommittee and its members for bringing the important voice of children to this discussion, and also for your recent hearings on the health care needs of children in the child welfare system. I appreciate the opportunity to testify today about the financial problems confronting children and families in the health care system and to suggest possible policy solutions to help these families.

First Focus would like to make the following recommendations to help address the needs of uninsured or underinsured children and their families:

1) Congress and the President need to set aside ideological differences and, absent a national consensus, support state efforts to expand health coverage to Americans by a variety of means, including Medicaid and SCHIP, premium support, tax credits, and personal responsibility.
2) Congress should not take actions that would limit or restrict the ability of states to address their uninsured or underinsured problems.
3) Congress should provide leadership in a variety of areas for children, particularly for children with special health care needs, by passing mental health parity laws (H.R. 1424, S. 558) and legislation such as the "Keeping Families Together Act" (H.R. 687, S. 382).
4) Congress should make it a priority to gather better information, especially at the state and local level, regarding the health and well-being of America's children, by passing legislation like the State Children Well-Being Research Act (H.R. 2477).
5) Since 62-75 percent of all uninsured children are eligible for but unenrolled in Medicaid and SCHIP, Congress should take up the President's challenge when he ran for re-election to cover millions of these children by working with states to conduct extensive outreach and enrollment efforts, streamlining application and enrollment procedures, and making more extensive use of other needs-based public programs, such as school lunch programs, the food stamps program, Women, Infants, and Children (WIC), etc., to help identify and enroll children in Medicaid and State Children's Health Insurance Program (SCHIP) through what is referred to as Express Lane Eligibility (ELE).
6) Congress should focus on the most disadvantaged youth in our nation and address gaps in health coverage for foster care children, including access to care, the needs of youth aging out of the child welfare system, and kinship care issues.

Recent Growth in Rate of Uninsured Children

According to the U.S. Census Bureau, 8.7 million or 11.7 percent of our nation's children were without health coverage in 2006. The number of uninsured children had declined by about one-third since the creation of SCHIP a decade ago, but has in the past two years reversed course and increased by one million children. While the national trend is certainly alarming, a state-by-state look at the insurance status of children reveals trends that are, perhaps, of even greater concern. In 39 states and the District of Columbia, the percentage of children without insurance was higher in 2006 than it was in 2004 and in 29 states the rate increased by a full percentage point or more. I have included an analysis of these trends by First Focus as **Appendix A.**

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While employer-sponsored insurance remains the predominate means of coverage for all non-elderly Americans, including children, the recent spike in the number of uninsured children is largely due to a drop of 1.2 percentage points in employer-sponsored coverage for children, from 60.9 percent to 59.7 percent. This decline is almost four times the rate of the drop in adult coverage of 0.3 percentage points, from 64.7 percent to 64.4 percent between 2005 and 2006.[1]

The decline in employer-sponsored health coverage has been driven by three trends. First, more and more employers are simply deciding not to offer health insurance as a benefit. Second, the economy has been shifting such that more workers are employed by firms in industries that do not, generally, offer coverage. And finally, more employees have been declining an offer of coverage from their employers because of a variety of factors, including rising costs. These three trends have combined to produce a significant decline in employer-sponsored coverage, especially of children, at all income levels.

Rising Health Care costs leads to financial instability

Children in middle-income families between 200 percent and 399 percent of the federal poverty level (approximately $40,000 to $80,000 for a family of four in 2006) account for 48 percent of the increase in the number of uninsured children, which is a population that largely does not have access to either Medicaid or SCHIP coverage.[2]

This drop in employer-sponsored insurance coverage for children suggests that dependent coverage is declining more rapidly than individual employee coverage. According to data from the Kaiser Family Foundation/Health Research and Education Trust (Kaiser/HRET) survey of employer-sponsored health benefits, the average annual cost for single and family coverage in 2007 is $4,479 and $12,106, respectively. Thus, the average cost for family coverage is 2.7 times the cost of individual coverage.

However, employers subsidize individual workers for coverage to a much greater extent than they subsidize family coverage. As a result, the annual premium contributions paid by individual workers average $694, or 16 percent of the cost, compared to $3,281, or 28 percent of the cost for family coverage. As a result, the average premium cost paid by workers for family coverage is 4.7 times the cost of individual coverage.[3]

Thus, family coverage is far more expensive than the cost of individual coverage. This is particularly true for smaller firms and businesses with a disproportionate share of low-wage workers where employees pay, on average, an even greater share of the cost of family coverage. For these workers, coverage costs are increasing even more rapidly than inflation or workers' wages.

In fact, according to data published in *Health Affairs,* between 2001 and 2007, health care premiums have increased 78 percent, while inflation increased by 17 percent and workers' wages increased by 19 percent.[4]

With both the employer- and employee-share of health care costs increasing by over four times the rate of general inflation, employers are increasingly passing on even a greater share of the costs to their employees, particularly for dependent coverage. For the four years between 2001 and 2004, health care premiums increased at more than 10 percent a year while worker earnings increased by only an average of three percent.

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Can Middle-Class Families Afford the RISING Cost of Health Insurance?

Middle-class families across America are struggling for financial security. Each day they are faced with the prospect of being unable to afford basic necessities essential to their health and well-being. For many families, serious scrutiny is given to the costs of food, housing, transportation, and a host of other necessities, in order to balance their budgets. But, after providing for all of these necessities, the average family often has very little left over to afford the costs of even the most basic health care plan.

To more closely study this problem, First Focus recently conducted an analysis to illustrate the hardships that many of these families face on a monthly basis. The analysis below breaks down the budget for a family of two parents and two children living in various areas across the nation, at three different income levels:

1. Families earning 225 percent of the Federal Poverty Level (FPL), or approximately $46,500;
2. Families earning 250 percent of FPL, or approximately $51,625; and,
3. Families earning the median income for a particular area.

The analysis (see **Appendix B**) looked at 12 communities across the nation, including Chicago, Oakland, Atlanta, Las Vegas, Miami, and Washington, D.C. Expenses for the family budget were generated by the Economic Policy Institute's Family Budget Calculator.[5] The monthly cost of private insurance was generated using the cheapest rate on www.ehealthinsurance.com for any health plan with a $1,000 deductible and less than 20 percent coinsurance rate.

After taking into account expenses for a family's budget as well as the monthly cost of health insurance, the results indicate that families in a large majority of these 12 communities experience serious financial shortfalls each month even before attempting to pay premiums for a health care policy. In 11 out of 12 communities, those families earning the median income level are left with no money remaining, with some facing over $1,500 in debts each month.

At 225 percent of FPL, in 8 out of 10 communities, families trying to afford the cost of health insurance also face serious debts each month. When earning 250 percent of FPL, only families in 3 out of 12 communities are in the red after purchasing health insurance. Even for those communities whose families would experience a surplus of funds the reality is that they would have very little left over, some as little as $18.30, and most well under $1,000. This small amount leaves very little cushion for medical expenses such as deductibles, prescriptions, and other costs incidental to medical care. Therefore, if anyone in a family gets sick, many are forced to cut costs from somewhere else within their budget, possibly from the cost of food, childcare, transportation, or rent.

Indeed, the data paint a rather bleak picture for today's middle-class, working Americans. In a significant majority of the income scenarios created in this analysis, working families are left with a negative amount of money after paying health insurance premiums each month.

This brief, snapshot analysis is indicative of an urgent problem facing every region in America – a growing population of working-class families who do not qualify for public health programs, but cannot afford coverage in the private sector, and lack access to private health insurance. This

coverage gap is becoming an even more serious problem, and it is where many of America's children are falling through the cracks.

The result is that families are increasingly faced with a "triple threat" to their financial security in the form of a limited family budget confronted with large annual increases in premiums, increases in other forms of cost-sharing such as co-payments and deductibles, and health benefit limitations. And with fewer employers offering coverage, families are facing the "ultimate threat" to financial and income security – having no insurance at all or being forced to pay out of pocket for exorbitant health care costs.

Due to the greater health and financial insecurity faced by many Americans, the latest poll by Kaiser Health Tracking found that health care is the top domestic issue and second only to Iraq as the issue that the American public wants the President and Congress to address. In that poll, the cost of health care and health insurance and expanding health insurance coverage for the uninsured were identified by the public as the top two issues that Presidential candidates need to address.[6]

As for the issue of children's health, Republican pollster Frank Luntz reported similar results in a poll that he conducted for First Focus in July that found that 90 percent of Americans support the notion that every child in America has a right to basic health care, with 76 percent of Americans strongly supporting the idea. Furthermore, by a 77-16 percent margin, Americans were supportive of legislation aimed at reducing the number of uninsured children, with nearly 60 percent strongly supporting this proposal.[7]

Threats to Income Security for the Uninsured and Underinsured

Health care coverage and income security often work in tandem either to improve the physical and financial well-being of individuals or by contributing to a downward spiral that threatens both physical health and income security.

In a *Health Affairs* article, it is noted that 16 percent of families spend more than 5 percent of their income on health care and between 8 and 21 percent of American families are contacted by collection agencies about their medical bills on an annual basis.

Moreover, of the 3.9 million people involved in personal bankruptcy filings in 2001, it was estimated that 1.3 million, or one-third, of them were children. The authors estimate that medical problems contributed to about half of all the bankruptcies and cited that "illness begot financial problems both directly (because of medical costs) and through lost income."[8]

The authors found that "a second common theme was sounded by parents of premature infants or chronically ill children; many took time from work or incurred large bills for home care while they were at their jobs." It is significant to add the point that, "among those whose illnesses led to bankruptcy, out-of-pocket costs averaged $11,854 since the start of illness" and that "75.7 percent had insurance at the onset of illness."[9]

Thus, it is not just the uninsured who are threatened with financial ruin. Those who have insurance but are underinsured represent more than three-quarters of the filed bankruptcies related to medical reasons.

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Affordability of Health Coverage for Children with Special Needs

Affordable and comprehensive health insurance is clearly an important factor in protecting both the health and well-being of families but also their financial security. Unfortunately, an accident, catastrophic or chronic illness, or a job loss can quickly threaten the health and financial security of a family. This is often the everyday story for children with special health care needs.

Children with special health care needs are, by definition, those children who have health problems that result in greater needs and services than other children. They have health care costs that are three times greater than the costs for children without special health care needs. These children face problems including discontinuity of coverage, inadequate coverage of needed services, inability to obtain referrals to appropriate specialists because of insurance plan limitations, and inadequate provider payment levels and thereby access to care.[10]

As Alex Chen and Paul Newacheck note, "more so than other children, [children with special health care needs] require services that may or may not be covered under commercial health insurance plans, as well as out-of-network services that require higher copayments. Furthermore, children with special health care needs by definition utilize those services at greater frequencies than other children, thus incurring greater out-of-pocket expenses. These cost-sharing responsibilities and out-of-pocket expenses can result in significant financial burden, particularly for poor families."[11]

Chen and Newacheck s found a close association between a child's poor health and reduced parental employment. According to the two California doctors, "…these families are often faced with the reality of one or both parents cutting back work. Cutting back or stopping work can also lead to a significant decrease in family income level as the result of lost wages, thus placing these families in a downward financial spiral."

Chen and Newacheck added, "the proportion of families with children with special health care needs who reported parents needing to stop work or cut back on work in order to care for their child was 29.9 percent. The overall proportion of families who reported having financial problems due to their child's care was 20.9 percent."[12] The result is a downward trend as a child's health care needs create increasing financial problems or, even worse, parents are forced to quit work or work part-time to care for a child, thereby increasing both the gaps in health coverage and financial hardship simultaneously.

As Amy Davidoff of the Urban Institute points out, private non-group insurance coverage is difficult to obtain for children with any major chronic condition or disability due to medical underwriting and preexisting condition exclusions that are often allowed by state regulation.[13] Furthermore, as parents attempt to deal with increased medical costs and workforce instability due to having a child with a chronic health care condition, they also find themselves struggling with health care problems, including poorer mental health and increased stress.[14]

In addition, parents of children with special health care needs face other challenges. In the workforce, "…parents indicated that they were reticent about disclosing family circumstances to their employer….," according to Dr. James Perrin and other researchers. "Parents feared reprisal – loss of their job, a promotion, or career opportunities or being perceived as a 'problem' employee. Some were reluctant to appeal a claim or make their health insurance coverage needs known, for these same reasons."[15]

Case in Point: Children with Mental Health Care Needs

Families often have so few resources to turn to for help that, in the case of children with mental health problems, a survey by the National Alliance for the Mentally Ill (NAMI) reported that 23 percent of parents with children exhibiting behavioral disorders reported being instructed to relinquish custody of their children in order to ensure they receive appropriate mental health care treatment.

As Darcy Gruttadaro of NAMI explains, "Theoretically, families should be able to access services for children with serious mental illnesses through existing systems -- private health insurance, Medicaid, special education, and/or the child welfare system. The reality is that these systems have repeatedly failed families and their children with severe mental illnesses. Private health insurance is often not an option for families with a seriously mentally ill child because policies place severe restrictions on benefits for the treatment of mental illnesses. Medicaid, the Individuals with Disabilities Education Act (IDEA) and other programs designed to provide and/or finance services for children with serious mental illnesses have also fallen well short of the mark. The unfortunate result is that parents and caregivers, who are repeatedly denied services for a child with a mental illness, may be forced to enter the juvenile justice or child welfare system just to access critically needed services. These families may ultimately face custody relinquishment."[16]

The General Accounting Office adds, "Multiple factors influence parents' decisions to place their children in the child welfare or juvenile justice systems so that they can obtain mental health services for them. Private health insurance plans often have gaps and limitations in the mental health coverage they provide…and not all children covered by Medicaid received needed services."[17]

No family should ever face such a decision. While insurance coverage is clearly very important in helping to prevent this tragic decision, insurance must be adequate to truly provide children and their families the health care they need. For these reasons, First Focus supports legislation to improve the adequacy of both private and public health care coverage, such as mental health parity for private health plans, the "Keeping Family Together Act" (H.R. 687) (sponsored by Congressman Ramstad, Stark and Kennedy) intended to ensure that parents have access to treatment for their severely emotionally disturbed children, and mental health parity within the public programs, including Medicare, Medicaid, and SCHIP.

How Do Children Fare in Your State?

That's an excellent question, and one to which we cannot have very specific answers. For a variety of reasons, when it comes to children's well-being, the data can be quite spotty. There are plenty of studies, public and private, that focus on the health care needs of adults, but children are often overlooked. Furthermore, even in the several studies that do cover children, the results can rarely be broken down by state, and we know very well that national trends often do not reflect what is happening in regions or states.

As we move forward in trying to improve the well-being of children, it is crucial to recognize that each state has its own needs. Unfortunately, when it comes to the needs of children, we are woefully uninformed. Any effort to improve the well-being of children should start with gathering better information on how our kids are faring right now. H.R. 2477 (co-sponsored by Congressman Camp and Congressman Stark), which is before this very subcommittee right now, would accomplish this

important goal. The State Child Well-Being Research Act would direct the Department of Health and Human services to conduct an annual state level survey of dozens of child-well being indicators. This crucial survey would yield a treasure trove of information about our nation's children which will prove invaluable to state and federal policymakers. This survey will offer a far better understanding of how differences in health access can impact the overall well-being of children and families and how these effects vary across states.

Good policy requires good information, and right now, sadly, we are without a lot of good information on the state level. This committee would be taking an important step forward for the health and welfare of America's children by passing the State Child Well-Being Research Act.

Crossing the Ideological Divide

To address the problems of being uninsured or underinsured in America, it will take a combination of all approaches – government-purchased private coverage, premium subsidies, sliding-scale subsidies or income-related tax credits, health insurance market reforms, purchasing pools, high-risk pools, individual responsibility, and improved access to safety net providers – to improve coverage and access to care for children.

Government-purchased private coverage could be improved by addressing problems with continuity, access to care, and enrollment. On this latter point, economists Julie Hudson and Tom Selden at the Agency for Healthcare Research and Quality (AHRQ) note that, as of 2005, 62 percent of all uninsured children are eligible for but unenrolled in either Medicaid or SCHIP. The authors write, "Of these [children], 36.1 percent were in families with incomes below poverty, and another 41.1 percent were in families with incomes of 100-200 percent of poverty…Clearly, this group includes some of the most disadvantaged children in the United States."[18]

Therefore, the uninsured rate for children could be significantly reduced if the federal government and states would work together to conduct extensive outreach and enrollment efforts[19], streamline applications and enrollment procedures, and make more extensive use of other public programs, such as school lunch programs, the food stamps program, Women, Infants, and Children (WIC), etc., to help identify and enroll children in Medicaid and SCHIP. This is called Express Lane Eligibility and is bipartisan legislation sponsored by Senators Richard Lugar (R-IN) and Jeff Bingaman (D-NM) in the Senate and is included in the various SCHIP reauthorization bills that have been debated before Congress.[20]

The other 38 percent of children need some sort of financial assistance to help make employer-sponsored or non-group health insurance coverage more affordable. For these children, states should be provided a variety of tools to expand SCHIP coverage, increase premium assistance programs, and to encourage personal responsibility for health coverage. With federal financial support, the State of Massachusetts expanded SCHIP coverage for children, increased their premium assistance program, reorganized their health insurance pooling and purchasing arrangements, and imposed an individual mandate for those that can afford to purchase coverage on their own.

The federal government should encourage such innovation by other states rather than restricting options for states to embark on coverage expansions or imposing their own one-size-fits-all solution on the country. Both the David and Lucille Packard Foundation and the Robert Wood Johnson Foundation have embarked on multi-million dollar initiatives at the state level to reduce the number of uninsured children or uninsured Americans, respectively. In the absence of consensus at the

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national level, the federal government should support initiatives like these at the state and local levels and, at the very least, not restrict or foreclose options available to the states.

Furthermore, the federal government should also provide families with the option of tax credits to help purchase non-group coverage directly. In formulating such a tax credit, the federal government should not impose the credit in lieu of other options, such as SCHIP coverage or premium assistance. The credit should be another option available to families. However, the credit should address problems with current health care tax credit proposals that provide an amount for families that is only two times the amount for individuals. In light of the fact that coverage for a spouse alone doubles the cost of health insurance, such tax credit proposals fail to recognize that family coverage is 2.7 times the cost of individual coverage in the private marketplace. As a result, children are completely left out of the credit and that must be addressed.[21]

Addressing the Health Care Needs of Children in Foster Care

And finally, this Subcommittee has had several outstanding hearings in the last few months regarding the health care problems facing foster care children that I would like to underscore today. These children have very unique health care needs that are far greater than even those experienced by other children living in poverty. In fact, nearly half of children in foster care experience a chronic medical condition and close to 80 percent suffer from a serious emotional disorder. As Dr. David Rubin of the American Academy of Pediatrics noted in his testimony before this subcommittee, these conditions are often "under-identified and under-treated."

Addressing the health care needs of foster children is a priority for First Focus and we welcome the opportunity to work with the subcommittee to address these issues, including the promotion of kinship care in a manner that helps the 2.5 million grandparents and other relatives who are responsible for meeting the basic needs, including the health care needs, of these children.

Kinship care is the fastest growing form of placement for children in foster care, and we are especially concerned with ensuring access to coverage for children living with relative caregivers. Kinship caregivers typically live in poverty, and struggle to support themselves and the children they care for. They are often older, retired and living on fixed incomes. In fact, an Urban Institute study found that nearly two-thirds of children in kinship care live in families with incomes below 200 percent of FPL. One-third of children live in families with incomes below 100 percent of FPL.[22]

Children living with relatives are also less likely to access health care. A 2001 Urban Institute report found that only 49 percent of children in informal kinship care arrangements actually received the Medicaid health insurance coverage they were entitled to, which is why outreach is critical for this population.[23] Often, kinship caregivers are unaware that there are free and affordable children's health insurance programs available through Medicaid and SCHIP, or that they can apply for the programs on behalf of the children in their care. Enhancing services, training, federal financial assistance, and outreach to kinship care are critical to ensuring that our system of care adequately meets the needs of our most vulnerable children.

We support efforts to expand and improve resources for relative caregivers, which is why we support the Kinship Caregiver Support Act (H.R. 2188, S. 661). We are especially pleased that the bill establishes a Kinship Guardianship Assistance Program that will help ensure permanent homes for some children living with relatives by providing states the option to use federal funds for subsidized guardianship payments to relative caregivers on behalf of children they have cared for in foster homes

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and are committed to caring for permanently outside of the formal child welfare system. We look forward to working with you on this critical issue and others to improve the health of our nation's children.

Thank you Mr. Chairman and members of the subcommittee for the opportunity to testify before you today.

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NOTES

[1] John Holahan and Allison Cook, "What Happened to the Insurance Coverage of Children and Adults in 2006?", Kaiser Commission on Medicaid and the Uninsured, September 2007.

[2] Ibid.

[3] Ibid.; Gary Freed and Kathryn Fant, "The Impact of the 'Aging Of America" On Children," Health Affairs, Vol. 23, No. 2, March/April 2004; and, Gary Claxton, et al, "Health Benefits in 2007: Premium Increases Fall To An Eight-Year Low, While Offer Rates and Enrollment Remain Stable," Health Affairs, Vol. 26, No. 5, September/October 2007.

[4] Claxton, et al.

[5] For specific methodology, please visit http://www.epi.org/content.cfm/bp165.

[6] Kaiser Health Tracking Poll: Election 2008, "Iraq Remains Top Issue for Public; Health Care Now Ranks Second Overall, Including Among Republicans," Issue 4, October 2007.

[7] Luntz, Maslansky Strategic Research, "Making Children a Priority: Survey 2007" for First Focus, July 2007 (see at www.firstfocus.net/Download/CHIPPoll.pdf).

[8] David Himmelstein, et al, "Illness and Injury As Contributors to Bankruptcy," Health Affairs, Web Exclusive, February 2005.

[9] Ibid.

[10] Alex Chen and Paul Newacheck, "Insurance Coverage and Financial Burden for Families of Children with Special Health Care Needs," Ambulatory Pediatrics, Vol. 6, No. 4, 2006; and, Michael Kogan, Paul Newacheck, et al, "Association Between Underinsurance and Access to Care Among Children With Special Health Care Needs in the United States," Pediatrics, Vol. 116, No. 5, November 2005.

[11] Chen and Newacheck.

[12] Ibid.

[13] Amy Davidoff, "Insurance for Children with Special Health Care Needs: Patterns of Coverage and Burden on Families to Provide Adequate Insurance," Pediatrics, Vol. 114, No. 2, August 2004.

[14] James Perrin, et al, "Benefits for Employees with Children with Special Needs: Findings From the Collaborative Employee Benefit Study," Health Affairs, Vol. 26, No. 4, July/August 2007.

[15] Ibid.

[16] Darcy Gruttadaro, National Alliance for the Mentally Ill, "The Tragedy of Custody Relinquishment," NAMI website, http://www.nami.org/Content/ContentGroups/Legal/The_Tragedy_of_Custody_Relinquishment_-_NAMI_Legal_Center.htm

[17] General Accounting Office, "Child Welfare and Juvenile Justice: Federal Agencies Could Play a Stronger Role in Helping States Reduce the Number of Children Placed Solely to Obtain Mental Health Services," GAO-03-397, April 2003.

[18] Julie Hudson and Thomas Selden, "Children's Eligibility and Coverage: Recent Trends and a Look Ahead," Health Affairs, Web Exclusive, August 16, 2007.

[19] President George W. Bush, "President's Remarks at the 2004 Republican National Convention," Madison Square Garden, New York, NY, September 2, 2004 (from transcript on White House website at http://www.whitehouse.gov/news/releases/2004/09/20040902-2.html). According to the President, "America's children must also have a healthy start in life. In a new term, we will lead an aggressive effort to enroll millions of poor children

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who are eligible but not signed up for the government's health insurance programs. We will not allow a lack of attention, or information, to stand between those children and the health care they need." This promise was included as part of the President's FY 2006 budget "Cover the Kids" proposal, which would have provided $1 billion in grants over two years in "a new campaign to enroll millions of more low-income children in Medicaid and the State Children's Health Insurance Program" (see www.whitehouse.gov/omb/budget/fy2006/hhs.html).

[20] To address this issue, Senators Lugar (R-IN) and Bingaman (D-NM) have introduced S. 1213, the "Children's Express Lane to Health Coverage Act of 2007." Additional information can be found at http://www.firstfocus.net/pages/3137/.

[21] Stan Dorn, "A Brief Analysis of the Bush Administration's Tax Propsals in the Context of SCHIP Reauthorization," August 1, 2007 (see http://firstfocus.net/pages/3248/); and, James Capretta, "Effective Healthcare Reform States with a Tax Fix," Tax Notes, May 21, 2007.

[22] Jennifer Ehrle and Rob Geen, *Children Cared for by Relatives: What Services Do They Need?* (Washington, DC: The Urban Institute, June 2002, Series B, No. B-47),

[23] Jennifer Ehrle, Rob Geen, and Rebecca Clark, *Children Cared for By Relatives: Who Are They and How are They Faring* (Washington, DC: The Urban Institute, February 2001).

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Chairman MCDERMOTT. Thank you very much.

Sara Collins is here with the Commonwealth Fund. As vice president in charge of future health insurance, Commonwealth Fund

has been at the table here, and in many places in the 20 years that I have been in Congress. We welcome your testimony.

STATEMENT OF SARA COLLINS, ASSISTANT VICE PRESIDENT, PROGRAM ON THE FUTURE OF HEALTH INSURANCE, THE COMMONWEALTH FUND

Ms. COLLINS. Thank you Mr. Chairman, and Members of the Committee, for this invitation to testify on the impact of gaps in health coverage on income security. As rising health care costs and premiums are making it more difficult for employers, particularly small firms, to provide affordable health insurance to their workers, increasing numbers of people under age 65 are finding themselves without access to employer-based coverage, and ineligible for enrollment in public insurance programs like Medicaid, and the State Children's Health Insurance Program. Or Medicare, in the case of those too disabled to work. With its high premiums and underwriting, the individual insurance market, which covers just 6 percent of the under 65 population, has proven to be an inadequate substitute for employer or public coverage.

Who is most at risk for lacking coverage? Low and moderate income families. More than 60 percent of uninsured people under age 65 are in families with incomes of under 200 percent of poverty. The majority of people without coverage are families where someone works full-time, but the likelihood of low and moderate-income families having coverage through an employer has always been lower than that of higher-income families, and has declined over the past 6 years. Small firm and low wage workers, workers who are employed in firms with fewer than 15 employees are less likely to have coverage through an employer.

Lower wage workers in small firms are at a particularly high risk for not having benefits. Non-standard workers, those who are self-employed, or in temporary part-time or contract positions, are at high risk of not having coverage, about 24 percent are uninsured. More than 13 million young adults, ages 19 to 29 are uninsured. Employer health plans often do not cover young adults as dependents after 18 or 19 if they don't go on to college.

Medicaid and the State Children's Health Insurance Program, as we've just heard, we classify all teenagers as adults on their 19th birthday. Consequently, there is a dramatic increase, an actual doubling of uninsured rates after age 19, children turning 18 to 19, particularly among young adults and low-income families.

Minorities are also at very high risk of lacking health insurance, as are people who are unemployed. Despite the availability of COBRA coverage, over half of unemployed adults under age 65 are uninsured. Lower wage workers are far less likely to be eligible for COBRA than higher wage workers. Even COBRA eligible low-income workers who leave their jobs are much more likely to be uninsured than our higher wage workers who are COBRA eligible.

There are an estimated 1.7 million people with disabilities in the waiting period for Medicare. In a Commonwealth Fund survey of older adults, more than two of five disabled Medicare beneficiaries between the ages of 50 and 64, said that they had been uninsured just prior to entering Medicare.

What are the consequences of gaps of health insurance coverage? Significantly higher rates of cost related problems getting needed health care, and problems paying medical bills. People without coverage confront profound spending tradeoffs in their budgets, as Chairman McDermott pointed out. A Commonwealth Fund survey found that 40 percent of uninsured adults with medical bill problems were unable to pay for basic necessities, and nearly 50 percent had used up all their savings to pay their bills.

The Institute of Medicine estimates that uninsured people collectively lose between $65 billion to $130 billion each year, in lost capital and earnings from poor health and shorter lifespans. It is essential on both moral and economic grounds that the United States move forward to guarantee affordable, comprehensive and continuous health insurance coverage for everyone.

In the absence of universal coverage, there are several policies that would help fill the gaps in the existing system, by building on existing public and private group insurance, and also create an essential foundation for universal coverage as we move forward.

We should build on, for example public and private group insurance, to extend coverage to vulnerable age groups and the disabled. For example, we should allow States to extend eligibility for Medicaid and SCHIP coverage beyond age 18. The Foster Care and Dependence Act, which allows States to extend Medicaid to children in foster care up to age 21, should be taken up by all States and could be expanded to all children in the Medicaid program.

Seventeen states have already redefined the age at which a young adult is no longer a dependent for purposes of insurance. Other states should follow their lead. We should allow older adults to buy into the Medicare Program, and Medicare's 2-year waiting period for coverage of the disabled.

We should also build on public and private group to extend coverage to low income workers and families, expand Medicaid to cover everyone under 150 percent of poverty and consider providing Federal matching funds for sliding scale premiums at higher income levels. We could require employers to finance COBRA coverage for up to 2 months or longer, for employees who lose their jobs, and the Federal Government could provide COBRA premium assistance for COBRA premiums.

Finally, we could connect public and private group insurance to realize efficiencies from pooling large groups of people, create a national health insurance connector, as Massachusetts has led the way on. Based on the Federal employees health benefits program, or Medicare with sliding scale premium subsidies, restrictions against risk selection on the part of carriers, and Federal reinsurance. Thank you.

[The prepared statement of Ms. Collins follows:]

WIDENING GAPS IN HEALTH INSURANCE COVERAGE IN THE UNITED STATES: THE NEED FOR UNIVERSAL COVERAGE

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Committee on Ways and Means
United States House of Representatives
Hearing on
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WIDENING GAPS IN HEALTH INSURANCE COVERAGE IN THE UNITED STATES: THE NEED FOR UNIVERSAL COVERAGE

Sara R. Collins, Ph.D.

Executive Summary

Thank you, Mr. Chairman, for this invitation to testify on the impact of gaps in health coverage on income security. As rising health care costs and premiums are making it more difficult for many employers, particularly small firms, to provide affordable health insurance to their workers, increasing numbers of people under age 65 are finding themselves without access to employer-based coverage and ineligible for enrollment in public insurance programs. The number of uninsured people climbed to 47 million in 2006, and an estimated 16 million adults are inadequately insured. Health insurance coverage is the most important determinant of access to health care. People who lack coverage have fundamentally different life experiences than those who have it; many die prematurely, and many suffer lost productivity and earnings.

With so many people left outside the health care system, it is no wonder that the U.S. system performs poorly compared with systems in industrialized nations that have universal health insurance. It is critical on moral and economic grounds that the nation move affirmatively to guarantee affordable, comprehensive and continuous health insurance for everyone.

The Gap Between Employer-Based and Public Coverage Is Widening

- Employer-based coverage forms the backbone of the United States's voluntary, mixed private–public health insurance system; more than 160 million workers and their dependents, or 62 percent of the under-65 population, has job-based coverage.
- Medicaid and the State Children's Health Insurance Program (SCHIP) play a critical supporting role, covering an additional 28 million adults and children, or 11 percent of the under-65 population. Medicare covers 39 million people, mostly those over age 65.
- The most gaping hole in the current system is evident when people under age 65 do not have access to employer coverage and are not eligible for Medicaid, SCHIP, or Medicare, as in the case of those too disabled to work.

- With their high premiums and underwriting, individual insurance plans—which cover just 6 percent of the under-65 population—have proven to be an inadequate substitute for employer group coverage.

Who Is Most at Risk for Lacking Coverage?

- **Low- and Moderate-Income Families**
  - More than two-thirds (67%) of adults under age 65 who do not have health insurance are in families where at least one member works full time.
  - The likelihood of low- and moderate-income families having coverage through an employer has always been lower than that of higher-income families and has declined over the last six years.
  - In 2005, 53 percent of people with incomes less than $20,000, and 41 percent of people in households with incomes between $20,000 and $40,000, reported a time when they were uninsured in the prior year.
- **Small-Firm and Low-Wage Workers**
  - Workers who are employed in firms with fewer than 50 employees are less likely to have coverage through an employer than are those employed by larger companies.
  - Lower-wage workers in small firms are at particularly high risk for not being offered health benefits, not being eligible for such benefits, or not having the financial means to "take up" coverage. Nearly two of five lower-wage workers in small firms are uninsured—more than twice the rate of higher-wage workers in small firms.
- **Nonstandard Workers**
  - An estimated 34 million workers are in nonstandard jobs, meaning they are either self-employed or in temporary, part-time, or contract positions.
  - Just one of five nonstandard workers has health insurance through his or her employer, compared with three-quarters of regular, full-time employees.
  - About one-quarter (24%) of nonstandard workers are uninsured, versus 12 percent of regular full-time workers.
- **Young Adults**
  - More than 13 million young adults ages 19 to 29 are uninsured, the fastest growing age group among the uninsured population.

- Turning 19 is a critical milestone. Employer health plans often do not cover young adults as dependents after age 18 or 19 if they do not go on to college. Medicaid and SCHIP reclassify all teenagers as adults on their 19th birthday.
- The loss of employer coverage, Medicaid coverage, and SCHIP coverage shows up dramatically in uninsured rates of young adults, particularly those in low-income families. Among 19-to-29-year-olds in families with incomes below the poverty level, more than half are uninsured, compared with about one of five low-income children age 18 and under. About 42 percent of young adults in families with incomes between 100 percent and 199 percent of poverty are uninsured.

- **Minorities**
  - Sixty-two percent of working-age Hispanics and 33 percent of African Americans were uninsured for some time during 2005, compared with 20 percent of whites in the same age group.
  - Eighty percent of Hispanics in households with incomes under 200 percent of poverty experienced a time when they were uninsured over a four-year period, compared with 66 percent of African Americans and 63 percent of whites in that income group. This is in spite of the fact that Hispanics in lower-income households were more likely than either African-Americans or whites in the same income group to have been continuously employed full-time over that period.

- **Unemployed**
  - Despite the availability of COBRA coverage, over half of unemployed adults under age 65 are uninsured, more than three times the rate for employed adults.
  - Just as they are less likely to be offered employer-based coverage in general, lower-wage workers are far less likely to be eligible for COBRA. Many who leave their jobs were uninsured while they were working.
  - Even when lower-wage workers are eligible for COBRA benefits, the full cost of the premium is often unaffordable, particularly as a share of an unemployment benefit. COBRA-eligible low-income workers who leave their jobs are much more likely to be uninsured than higher-wage workers. They have fewer options than higher-wage workers have for coverage through a new job or through a spouse.

- **People with Disabilities in Two-Year Waiting Period for Medicare**
    - There are an estimated 1.7 million disabled people in the waiting period for Medicare. Of those, about one-third have coverage through a former employer or though a spouse's employer, just over a third are covered by Medicaid, 9 percent purchase coverage through the individual insurance market, and 15 percent, or nearly 265,000 people, are without health insurance.
    - More than two of five disabled Medicare beneficiaries ages 50 to 64 said that they had been uninsured just prior to entering Medicare

Consequences of Gaps in Health Insurance Coverage for the Health and Economic Security of Families

- **Poor Access to Care**
    - People who spend any time without coverage report significantly higher rates of cost-related access problems, are significantly less likely to have a regular doctor or medical home, and less likely to say that they always or often receive the health care they need when they need it.
    - Poor-quality health care is particularly devastating and can have long-term implications for uninsured adults with chronic health problems.
- **Health and Economic Implications for Families and the Nation**
    - More than half of working-age adults who had been uninsured during 2005 reported problems paying medical bills during that time or were paying off accrued medical debt, compared with 26 percent of those who had been insured all year.
    - Medical debt forces families to make stark tradeoffs. For example, 40 percent of uninsured adults with medical bill problems were unable to pay for basic necessities like food, heat, or rent, and nearly 50 percent had used all their savings to pay their bills.
    - The Institute of Medicine estimates that 18,000 avoidable deaths occur each year in the U.S. as a direct result of individuals being uninsured
    - The aggregate, annualized cost of uninsured people's lost capital and earnings from poor health and shorter lifespans falls between $65 billion and $130 billion for each year without coverage.

- Gaps in coverage for uninsured people with chronic health conditions may have long-run cost implications for the health system, and the Medicare program in particular.

Health Care Reform Is Necessary to Fill the Gaps

It is essential on both moral and economic grounds that the United States move forward to guarantee affordable, comprehensive, and continuous health insurance for everyone. Without universal coverage, our health system will not be able to provide more effective, higher-quality, and more efficiently delivered care, and it will not be able to ensure longer, healthier, and more productive lives. It is unacceptable that people without health insurance collectively lose between $65 billion and $130 billion a year in lost productivity and earnings, and are greater risk of dying prematurely. Several proposals for universal coverage have been put forth—or implemented, as in the case of Massachusetts—by governors, members of Congress, and the 2008 presidential candidates. This is a welcome development, and highly promising for reversing the inexorable climb in the uninsured population over the past several years.

In the absence of universal coverage, there are several policies that would help fill the gaps in the existing system by building on existing public and private group insurance and also create an essential foundation for universal coverage.

- **Build on Public and Private Group Insurance to Extend Coverage to Vulnerable Age Groups and the Disabled**
  - Allow states to extend eligibility for Medicaid and SCHIP coverage beyond age 18. The Foster Care Independence Act of 1999, which allows states to extend Medicaid coverage to children in foster care beyond age 18, could be expanded to cover all children in Medicaid. Depending on the income eligibility levels, extending coverage up to age 25 would cover 3.3 million uninsured young adults 19 to 25 in families with incomes under 100 percent of poverty and 5.7 million with incomes under 200 percent of poverty.
  - Seventeen states have already redefined the age at which a young adult is no longer a dependent for purposes of insurance, ranging from 24 to 30. Other states should follow their lead to ensure that young adults can remain on their parents' plans while they make the transition to college, graduate school, or work.
  - Allow older adults ages 55 to 64 to "buy in" to Medicare.
  - End Medicare's two-year waiting period for coverage of the disabled.

- **Build on Public and Private Group Insurance to Extend Coverage to Low-Income Workers and Families**
    - Expand Medicaid to cover everyone under 150 percent of poverty; consider providing federal matching funds for sliding-scale premiums at higher income levels.
    - Require employers to finance COBRA coverage for up to two months for employees who lose their jobs. The federal government could provide premium assistance for 70 percent of COBRA premiums for unemployed workers.
- **Connect Public and Private Group Insurance to Realize Efficiencies from Pooling Large Groups of People**
    - Create a national health insurance "connector" based on the Federal Employees Health Benefits Program or Medicare, with sliding-scale premium subsidies, restrictions against risk selection on the part of carriers, and federal reinsurance.

We are at a crossroads. A majority of the public is asking its leaders to address our health insurance problem through comprehensive reform, even if it requires a substantial investment of public and private funds. States like Massachusetts are leading the nation in this effort, and national policy leaders are responding with well-thought-out proposals. We are a wealthy and innovative country, and we have the resources and the technology to move affirmatively toward universal coverage in a way that improves quality and controls costs. The time is upon us to resolve ideological differences over strategies and find consensus based on pragmatism and fact.

Thank you.

WIDENING GAPS IN HEALTH INSURANCE COVERAGE IN THE UNITED STATES: THE NEED FOR UNIVERSAL COVERAGE

Sara R. Collins, Ph.D.

Thank you, Mr. Chairman, for this invitation to testify on the impact of gaps in health coverage on income security. Increasing numbers of people under age 65 are finding themselves without access to employer-based coverage and ineligible for enrollment in public insurance programs. The number of uninsured people climbed to 47 million in 2006 and an estimated 16 million adults are inadequately insured. Those most affected are low and moderate income families, people who are self-employed or who work for companies of fewer than 50 employees, those employed in non-standard jobs, young adults, those who are unemployed, minorities, and people too disabled to work who are in the two-year waiting period for Medicare. Health insurance coverage is the most important determinant of access to health care. People who lack health insurance have fundamentally different life experiences than do those who are insured, suffering premature death and lost productivity and earnings. Leaving so many people effectively outside the health care system contributes to the poor overall performance of the U.S. health care system compared to that of other industrialized nations with universal health insurance.[1] It is critical on moral and economic grounds that the nation move affirmatively forward to guarantee affordable, comprehensive and continuous health insurance for everyone.

The Gap Between Employer-Based and Public Coverage Is Widening

Employer-based coverage forms the backbone of the United States's voluntary, mixed private–public health insurance system, insuring more than 160 million workers and their dependents, or 62 percent of the under 65 population (Figure 1). Medicaid and the State Children's Health Insurance Program (SCHIP) play a critical supporting role, covering an additional 28 million adults and children, or 11 percent of the under-65 population. Medicare covers 39 million people, mostly over age 65.

The most gaping hole in the current system occurs when people under age 65 do not have access to employer coverage and are not eligible for Medicaid, SCHIP, or Medicare, in the case of those too disabled to work. Rising health care costs and

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[1] C. Schoen, R. Osborn, M. M. Doty, M. Bishop, J. Peugh, and N. Murukutla, "Toward Higher-Performance Health Systems: Adults' Health Care Experiences in Seven Countries, 2007," *Health Affairs* Web Exclusive (Oct. 31, 2007):w717–w734; C. Schoen, K. Davis, S. K. H. How, and S. C. Schoenbaum, "U.S. Health System Performance: A National Scorecard," *Health Affairs* Web Exclusive (Sept. 20, 2006):w457–w475; and Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from a National Scorecard on U.S. Health System Performance* (New York: The Commonwealth Fund, Sept. 2006).

premiums have made it increasingly difficult for many employers, particularly small companies, to continue offering affordable health insurance to their employees. The individual insurance market—where just 6 percent of the under 65 population buys coverage—has proven an inadequate substitute. In 2006 the number of uninsured people in the United States climbed to 47 million, an increase of 8.6 million since 2000. Sixteen million more adults under age 65 are estimated to be underinsured, with high out-of-pocket costs relative to income.[2]

The individual insurance market presents significant challenges for families seeking coverage due to high premiums and the difficulty of gaining coverage when individuals have pre-existing health problems. The Commonwealth Fund Biennial Health Insurance Survey found that of 58 million adults under age 65 who sought coverage in the individual insurance market over a three year period, 90 percent never purchased a plan (Figure 2).[3] More than 70 percent of people with health problems or incomes under 200 percent of poverty said that it was very difficult or impossible to find a plan they could afford. Enrollment is also far more transitional than that in employer based plans. Klein and colleagues found that just 53 percent of people under age 65 with individual market coverage were still enrolled in the plan two years later, compared to 86 percent of people in employer-based health plans (Figure 3). Although increasing numbers of adults lost access to employer-based coverage over 2000–2006, there has been virtually no change in the number of people covered by individual market insurance. Loss of employer coverage has led to higher levels of uninsured individuals, not to higher levels of individual coverage.[4]

If not for state expansions in eligibility in Medicaid and the State Children's Health Insurance Program (SCHIP) over the last decade, this trend would have also extended to children. The number of states where 16 percent or more of children under age 18 were uninsured fell from nine in 1999–2000 to five in 2005–2006 (Figure 4). In contrast, the number of states where 23 percent or more of the adult population under age 65 was uninsured jumped from two in 1999–2000 to nine in 2005–2006 (Figure 5).

Coverage eligibility for parents and adults without children in Medicaid and SCHIP varies greatly across states: 14 states cover parents with incomes up to 50 percent of poverty, which is approximately equivalent to an annual income of just over $10,000

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[2] C. Schoen , M. M. Doty, S. R. Collins, and A. L. Holmgren, "Insured But Not Protected: How Many Adults Are Underinsured?" *Health Affairs* Web Exclusive (June 14, 2005):w5-289–w5-302.

[3] S. R. Collins, J. L. Kriss, K. Davis, M. M Doty, and A. L. Holmgren, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Well-Being of American Families* (New York: The Commonwealth Fund, Sept. 2006).

[4] C. DeNavas-Walt, B. D. Proctor, and J. Smith, *Income, Poverty, and Health Insurance Coverage in the United States: 2006* (Washington, D.C.: U.S. Census Bureau, Aug. 2007).

for a family of four.[5] Thirty-four states provide no Medicaid coverage at all for adults who do not have children. Increasing the income eligibility levels in Medicaid for parents and adults without children would help counteract the erosion in access to employer-based health insurance that is disproportionately affecting low and moderate income families.

Who Is Most At Risk of Lacking Coverage?

Who is most at risk of lacking access to employer based health insurance and public insurance coverage? Families with have low and moderate incomes, people who are self-employed or who work for companies of fewer than 50 employees, those employed in non-standard jobs, young adults, those who are unemployed, minorities, and people too disabled to work who are in the two-year waiting period for Medicare.

Low and Moderate Income Families. More than two-thirds (67%) of adults under age 65 without health insurance are in families where at least one member works full time (Figure 6).[6] Compared to those with high incomes, people in families with low and moderate incomes are most at risk of lacking coverage through an employer and are the most at risk of being uninsured. Indeed, the likelihood of low and moderate income families having coverage through an employer has declined over the last six years. Only 22 percent of adults under age 65 in families with incomes of $20,000 or less had coverage through an employer in 2006, down from 29 percent in 2000 (Figure 7). Employer-based coverage in the next higher income category—under $37,800 annually—declined from 62 percent in 2000 to 53 percent in 2006. Nearly 90 percent of people in the highest income households have coverage through employers, and this has remained relatively constant over time.

Uninsured rates for moderate-income families are rising rapidly, so much that the margin between reported rates of instability in these families and that of the lowest-income households has narrowed significantly. According to the Commonwealth Fund Biennial Health Insurance Surveys, in 2001, 28 percent of people with incomes between $20,000 and $35,000 experienced a time uninsured compared with 49 percent of people with incomes less than $20,000—a difference of 21 percentage points (Figure 8).[7] In

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[5] Kaiser Family Foundation, "Income Eligibility Levels for Children's Separate SCHIP Programs, 2006" and "Income Eligibility for Parents applying for Medicaid, 2006" (Washington, D.C.: KFF). Available at http://www.statehealthfactsonline.org.

[6] S. R. Collins, K. Davis, M. M. Doty, J. L. Kriss, and A. L. Holmgren, *Gaps in Health Insurance: An All-American Problem* (New York: The Commonwealth Fund, Apr. 2006).

[7] L. Duchon, C. Schoen, M. M. Doty, K. Davis, E. Strumpf, and S. Bruegman, *Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk—Findings from the 2001 Health Insurance Survey* (New York: The Commonwealth Fund, Dec. 2001); S. R. Collins, M. M. Doty, K. Davis, C. Schoen, A. L. Holmgren, and A. Ho, *The Affordability Crisis in U.S. Health Care: Findings from the Commonwealth Fund Biennial Health Insurance Survey* (New York: The Commonwealth Fund, Mar. 2004); and Collins, Davis, Doty, Kriss, Holmgren, *Gaps in Health Insurance,* 2006.

2005, 41 percent of people in households with incomes between $20,000 and $40,000 reported a time uninsured, compared with 53 percent of families with incomes less than $20,000—a difference of 12 percentage points.[8] The lowest-income workers have always been most at risk of not being offered job-based coverage. Now, more moderate income earners and their families are also in jeopardy.[9]

Most people who experience gaps in their insurance coverage are uninsured for long periods of time. In the 2005 Commonwealth Fund Biennial Health Insurance Survey, of those adults who were uninsured at the time of the survey, 82 percent had been uninsured for one year or more.[10] Of those who had coverage when surveyed but had experienced a time uninsured in the past year, one-quarter (26%) were without coverage for a year or longer. One-third (34%) had been uninsured for three months or less.

Small Firm and Low Wage Workers. Workers who are employed in firms of fewer than 50 employees are less likely to have coverage through an employer than are those employed in larger companies. Small employers face higher premium and administrative costs per worker than large firms and thus are less likely to offer coverage. Gabel found that employees in companies with fewer than 10 employees pay an average of 18 percent more in health insurance premiums than those in the largest firms, after taking into account the actuarial value of their plans. He also found that premiums varied widely across the country.[11] Rapid growth in health care costs and premiums over the last several years has exacerbated the problem. The average annual cost of family coverage in employer-based health plans, including employer and employee contributions, topped $12,106 in 2007—more than the average yearly earnings of a full-time worker earning the minimum wage.[12] From 2000 to 2007, the share of business with fewer than 10 employees that offer coverage dropped from 57 percent to 45 percent.[13]

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[8] In 2001, 2003, and 2005, the Commonwealth Fund health insurance surveys asked respondents what their approximate annual incomes were by offering them income ranges to select from. In 2001 and 2003, the midpoint of the income ranges offered was $35,000. In 2005, the midpoint was increased to $40,000 to account for inflation and increases in poverty thresholds defined by the U.S. Census Bureau. In 2005, an income of $40,000 for a family of four was 200 percent of poverty (poverty was $20,000 for a family of four); in 2003 an income of $37,000 was 200 percent of poverty; and in 2001 $36,000 was 200 percent of poverty. See http://www.census.gov/hhes/www/poverty/threshld/thresh01.html.

[9] See S. R. Collins, K. Davis, C. Schoen, M. M. Doty, and J. L. Kriss, *Health Coverage for Aging Baby Boomers: Findings from the Commonwealth Fund Survey of Older Adults* (New York: The Commonwealth Fund, Jan. 2006); J. Holahan and A. Cook, "Changes in Economic Conditions and Health Insurance Coverage, 2000–2004," *Health Affairs* Web Exclusive (Nov. 1, 2005):w5-498–w5-508; S. R. Collins, K. Davis, M. M. Doty, and A. Ho, *Wages, Health Benefits, and Workers' Health* (New York: The Commonwealth Fund, Oct. 2004); and S. R. Collins, C. Schoen, D. Colasanto, and D. A. Downey, *On the Edge: Low-Wage Workers and Their Health Insurance Coverage* (New York: The Commonwealth Fund, Apr. 2003).

[10] Collins, Davis, Doty et al., *Gaps in Health Insurance,* 2006.

[11] J. Gabel, R. McDevitt, L. Gandolfo et al., "Generosity and Adjusted Premiums In Job-Based Insurance: Hawaii Is Up, Wyoming Is Down," *Health Affairs,* May/June 2006 25(3):832–43.

[12] G. Claxton, J. Gabel, B. DiJulio et al., "Health Benefits in 2007: Premium Increases Fall to An Eight-Year Low, While Offer Rates and Enrollment Remain Stable," *Health Affairs,* Sept./Oct. 2007 26(5):1407–16; Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health*

Lower-wage workers in small firms are at particularly high risk of not being offered health benefits, not being eligible for such benefits, or not having the financial means to "take up" coverage. The Commonwealth Fund Biennial Health Insurance Survey found that in 2005, two of five workers in firms with fewer than 50 employees who earned less than $15 an hour worked for an employer that offered coverage. Moreover, only one-third were eligible for that coverage, and just one of five actually enrolled in a plan (Figure 9). In contrast, half of higher-wage workers in small firms worked for companies that offered coverage, half were eligible and 45 percent enrolled in coverage. While lower-wage workers in larger companies are much better off than their lower-wage counterparts in small firms, they are still less likely than higher-wage workers to be employed by firms that offer coverage, to be eligible for that coverage, and to enroll. Nearly two of five lower-wage workers in small firms are uninsured—more than twice the rate of higher-wage workers in small firms (Figure 10). Seventeen percent of lower-wage workers in large firms are uninsured.

Non-Standard Workers. An estimated 34 million workers are in non-standard jobs- either self-employed or in temporary, part-time or contract positions. Ditsler and colleagues found that of those, just one of five has health insurance through his or her employer, compared with three-quarters of regular full-time employees (Figure 11).[14] About one-quarter (24%) of non-standard workers are uninsured, compared with 12 percent of regular full-time workers. Eighteen percent of the children and 16 percent of the spouses of nonstandard workers are uninsured. Nonstandard workers are far more likely than standard workers to rely on government health insurance coverage - five percent of nonstandard workers are covered by Medicaid or Medicare, compared to 1 percent of standard workers. Ten percent of the children and 6 percent of the spouses of nonstandard workers rely on public health insurance for coverage.

Young Adults. New entrants to the labor force are at high risk of not having insurance through their jobs. Young adults ages 19–29 are the fastest-growing age group among the uninsured population. The number of uninsured young adults ages 19–29 climbed to 13.3 million in 2005, from 12.9 million in 2004.[15] Even though they comprise just 17 percent of the under-65 population, young adults account for 30 percent of the nonelderly uninsured.

Benefits, 2007 Annual Survey (Washington, D.C.: KFF/HRET, 2007). Available at http://www.kff.org/insurance/7672/upload/EHBS-2007-Full-Report-PDF.pdf.

[13] Ibid.

[14] E. Ditsler, P. Fisher, and C. Gordon, *On the Fringe: The Substandard Benefits of Workers in Part-Time, Temporary and Contract Jobs* (New York: The Commonwealth Fund, Dec. 2005).

[15] S. R. Collins, C. Schoen, J. L. Kriss, M. M. Doty, and B. Mahato, *Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help* (New York: The Commonwealth Fund, updated Aug. 2007).

By far, the young adults most at risk of lacking coverage are those from low-income households. About 24 percent of adults ages 19 to 29 live in households with incomes below 100 percent of the poverty level, but more than two-fifths (41%) of the 13.3 million young adults who are uninsured live in households with incomes below poverty (Figure 12).[16]

Nearly half of uninsured young adults are white. But Hispanics are disproportionately represented among the young and uninsured. While Hispanics represent 19 percent of adults ages 19 to 29, they represent 32 percent of uninsured young adults. Hispanics and African Americans are both at greater risk of being uninsured than white young adults: 34 percent of African Americans and 52 percent of Hispanics ages 19 to 29 are uninsured, compared with 23 percent of whites in that age range.

Nineteenth birthdays are crucial milestones in U.S. health insurance coverage. Both public and private insurance plans treat this age as a turning point for coverage decisions. Employer health plans often do not cover young adults as dependents after age 18 or 19 if they do not go on to college. Public programs, such as Medicaid and the State Children's Health Insurance Program (SCHIP), also typically have one set of income and eligibility standards for children and another for adults—with the 19th birthday as the critical divide.

Medicaid and SCHIP reclassify all teenagers as adults the day they turn 19. As a result, young adults who had been insured under Medicaid or SCHIP as children typically do not have an option to stay on public coverage, unless they are able to qualify for Medicaid as adults. Regardless of school, work, or dependent status, they lose their eligibility as dependents or children. Most low-income young adults become ineligible for public programs, since eligibility for adults generally is restricted to very-low-income parents or disabled adults.

Even teenagers with disabilities who qualified for Medicaid before their 19th birthdays have to go through a new set of screening tests to determine whether they will still be eligible for benefits as disabled adults.[17] This means that young adults with disabilities or chronic health conditions who are able to work are at much higher risk of being uninsured than children with disabilities. In an analysis of data from the 1999 Survey of Income and Program Participation, Fishman found that 22 percent of young adults with disabilities were uninsured compared to about 10 percent for disabled children 11–18 years of age.

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[16] In 2005, the under-65 poverty thresholds were $10,160 for one person, $13,078 for two adults, $15,720 for two adults and one child under 18, and $19,806 for two adults and two children under 18. See C. DeNavas-Walt, B. D. Proctor, and C.H. Lee, *Income, Poverty, and Health Insurance Coverage in the United States: 2005*, Current Population Reports, Consumer Income (Washington, D.C.: U.S. Census Bureau, Aug. 2006).

[17] E. Fishman, "Aging Out of Coverage: Young Adults with Special Health Needs," *Health Affairs,* Nov./Dec. 2001 20(6):254–66.

The needs of foster children aging off Medicaid have been addressed through federal law, but few states have taken advantage of it. The Foster Care Independence Act of 1999, allows states to continue Medicaid coverage for former foster children up to age 21.[18] In October 2007, North Carolina implemented the Expanded Foster Care Program, which extends Medicaid coverage to children who were in foster care at their 18th birthday through the month they turn 21. These young adults are automatically enrolled in this program without regard to income or assets.[19] So far, only a handful of states have implemented programs to cover former foster children up to age 21 through Medicaid, including Texas[20] and recently Ohio.[21]

As a result of the combined impact of public and private insurance rules, uninsured rates jump sharply at age 19. Turning 19 increases the uninsured rate nearly threefold; it rises from 11 percent among children age 18 and under to 30 percent among those ages 19 to 29 (Figure 13). Low-income young adults are particularly vulnerable to being uninsured. Among those in families living below the poverty level, more than half (51%) are uninsured, compared with about one of five (20%) low-income children age 18 and under. Those young adults with slightly higher incomes (100%–199% of poverty) fare only marginally better—roughly two of five (42%) are uninsured.

Minorities. Minorities, particularly those with low incomes, are at higher risk of lacking health insurance. Doty and Holmgren found that 62 percent of working age Hispanics and 33 percent of African-Americans were uninsured for some time during 2005 compared to 20 percent of whites in the same age group (Figure 14).[22] The authors found that Hispanic adults are particularly disconnected from the health system: they are substantially less likely than whites to have a regular doctor, to have visited a doctor in the past year, or to feel confident about their ability to manage their health problems. In earlier research, the authors found that 80 percent of Hispanics in households with incomes under 200 percent of poverty had experienced a time uninsured over a four year period compared to 66 percent of African-Americans and 63 percent of whites in that income group.[23] This is in spite of the fact that Hispanics in lower income households

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[18] U.S. Social Security Administration, Legislative Archives of the 106th Congress, The Foster Care Independence Act of 1999, http://www.ssa.gov/legislation/legis_bulletin_112499.html, accessed Nov. 9, 2007.

[19] North Carolina Department of Health and Human Services, Family and Children's Medicaid MA-3230 Eligibility of Individuals Under Age 21, http://info.dhhs.state.nc.us/olm/manuals/dma/fcm/man/MA3230-08.htm, accessed Nov. 9, 2007.

[20] Texas Department of Family and Protective Services, Medicaid for Young People Transitioning from Foster Care, http://www.dfps.state.tx.us/Documents/Child_Protection/pdf/transitionalmedicaid.pdf, accessed Nov. 9, 2007.

[21] Voices for Ohio's Children, Summary of Child Health Expansions in Amended Substitute House Bill 119, http://www.vfc-oh.org/cms/resource_library/legislation/0331e68e882ad01e/, accessed Nov. 9, 2007.

[22] M. M. Doty and A. L. Holmgren, *Health Care Disconnect: Gaps in Coverage and Care for Minority Adults* (New York: The Commonwealth Fund, Aug. 2006).

[23] M. M. Doty and A. L. Holmgren, *Unequal Access: Insurance Instability Among Low-Income Workers and Minorities* (New York: The Commonwealth Fund, Apr. 2004).

were more likely to have been employed full-time continuously over that time period than either African-Americans or Whites in the same income group.

Unemployed. A provision in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers of 20 or more employees to continue offering health insurance coverage to employees who leave their jobs either voluntarily or involuntarily, except for reasons of gross misconduct, or whose hours are reduced below insurance qualifying levels. Eligible employees and their dependents can purchase COBRA coverage for 102 percent of the premium for 18–36 months depending on the reason for eligibility.[24] The Trade Act of 2002 created advanceable and refundable Health Coverage Tax Credits (HCTCs) to subsidize 65 percent of the cost of COBRA or individual market coverage for workers displaced by international trade who receive Trade Adjustment Assistance and certain early retirees. The target population is under 250,000 and take-up has been relatively limited.[25]

Despite COBRA, more than half of unemployed adults under age 65 are uninsured, greater than three times the rate of employed adults (Figure 15).

Like employer-based coverage in general, lower wage workers are far less likely to be COBRA-eligible than higher wage workers (Figure 16). Kapur and Marquis found that of workers with household incomes of less than 200 percent of poverty who left a job voluntarily, 53 percent were uninsured one-month after leaving their job compared to 28 percent of higher income workers.[26] But 50 percent of lower income job leavers were uninsured prior to leaving their job compared to 22 percent of workers with incomes of 200 percent or more of poverty. Higher income workers who voluntarily left their jobs were somewhat more likely to have COBRA (8% vs. 3%) than their lower income counterparts, much more likely to gain coverage through a new job (16% vs. 4%) and much more likely to gain coverage through a family member's employer (31% vs. 10%)

Even when lower wage workers are eligible for COBRA benefits, the full cost of the premium, now averaging more than $12,000 a year for a family plan, plus the 2 percent fee may be unaffordable, particularly as a share of an unemployment benefit.[27] Kapur and Marquis found for example, that of lower income workers who were eligible for COBRA through their jobs and left their jobs, 48 percent were uninsured one-month

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[24] Employees and their beneficiaries are eligible to buy coverage for 18 months after the employee leaves a job. If an employee dies, divorces, separates, becomes eligible for Medicare, or a dependent ages off a policy, dependents can qualify for COBRA for 36 months. People who the Social Security Administration certifies as too disabled to work can also purchase COBRA for up to 29 months from the date of the defining event.

[25] S. Dorn, J. Varon, and F Pervez, *Limited Take-Up of Health Coverage Tax Credits: A Challenge to Future Tax Credit Design* (New York: The Commonwealth Fund, Oct. 2005).

[26] K. Kapur and M. S. Marquis, "Health Insurance for Workers Who Lose Jobs: Implications for Various Subsidy Schemes," *Health Affairs,* May/June 2003 22(3):203–13.

[27] J. M. Lambrew, *How the Slowing U.S. Economy Threatens Employer-Based Health Insurance* (New York: The Commonwealth Fund, Nov. 2001).

later compared to 27 percent of higher income COBRA-eligible workers who left their jobs. Lower income workers and higher income workers took up COBRA at about the same rate (18%) but higher income workers were much more likely to have gained coverage through a new job (29% vs. 9%).

People with Disabilities in Two-Year Waiting Period for Medicare. There are an estimated 1.7 million people who are disabled and in the waiting period for Medicare (Figure 17). Of those, about one-third have coverage through a former employer or though a spouse's employer, just over a third are covered by Medicaid, 9 percent purchase coverage through the individual insurance market, and 15 percent, or nearly 265,000 people, are without health insurance. Those with COBRA coverage through a former employer or who purchase it through the individual market are financially burdened with the full premium.

In a 2005 Commonwealth Fund study of older adults, 41 percent of disabled Medicare beneficiaries ages 50–64 said that they had been uninsured just prior to entering Medicare (Figure 18).[28] More than four of five (84%) said that becoming eligible for Medicare was very important.

Consequences of Gaps in Health Insurance Coverage for the Health and Economic Security of Families

This widening gap in our health insurance system in which growing numbers of people find themselves each year is unacceptable on both moral and economic grounds, and contributes to poor overall health system performance. In an extensive review of the evidence in 2003, The Institute of Medicine (IOM) concluded that the most important determinant of access to health care is adequate health insurance coverage.[29] People who lack health insurance have fundamentally different life experiences than do those who are insured.[30]

Poor Access to Care. In three nationally representative telephone surveys of U.S. adults conducted in 2001, 2003, and 2005, the Commonwealth Fund found that people who spend anytime without coverage over a 12-month period report significantly higher rates of cost-related access problems.[31] Specifically, respondents were asked if, because of cost, they did not go to a doctor or clinic when sick; had not filled a prescription; skipped a medical test, treatment, or follow-up visit recommended by a doctor; or did not

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[28] S. R. Collins, K. Davis, C. Schoen, M. M. Doty, S. K. H. How, and A. L, Holmgren, *Will You Still Need Me? The Health and Financial Security of Older Americans* (New York: The Commonwealth Fund, June 2005).

[29] Institute of Medicine, *Hidden Costs, Value Lost: Uninsurance in America* (Washington, D.C.: National Academies Press, June 2003).

[30] Institute of Medicine, Committee on the Consequences of Uninsurance, *Care Without Coverage: Too Little, Too Late*, (Washington D.C.: National Academies Press, 2002).

[31] Duchon, Schoen, Doty et al., *Security Matters,* 2001; Collins, Doty, Davis et al., *Affordability Crisis,* 2004; Collins, Davis, Doty et al., *Gaps in Health Insurance,* 2006.

see a specialist when a doctor or the respondent thought it was needed. In 2005, about three of five adults reported any one of the cost-related access problems, more than two times the rate of adults who were insured all year (Figure 19). Using data from the Commonwealth Fund 2006 Quality of Care Survey, Beal and colleagues found that adults who spent any time uninsured in the prior year were significantly less likely to have a regular doctor or medical home and significantly less likely to say that they always or often receive the health care they need when they need it.[32]

Poor quality health care is particularly devastating and can have long-term implications for uninsured adults with chronic health problems. In five chronic disease categories that the IOM studied, uninsured adults were less likely to receive appropriate care for management of their conditions and had worse clinical outcomes than insured adults with chronic illness.[33] In a recent article in the *Journal of the American Medical Association*, Hadley found that uninsured patients who experienced an injury or were newly diagnosed with a chronic health condition received less medical care, were more likely to report not being fully recovered but no longer receiving care, and were more likely to report lower health status seven months after the event than were insured patients who experienced a similar medical event.[34] The Commonwealth Fund Commission on a High Performance Health System found that only one-quarter (24%) of uninsured adults with diabetes had received all three recommended services for diabetes in the last year (i.e., HbA1c test, retinal exam, and foot exam), less than half the rate of privately insured adults with diabetes (54%).[35] Collins and colleagues found that nearly 60 percent of non-elderly adults with a chronic health condition who had been uninsured for some time in 2005 did not fill a prescription or skipped a dose of their medication for their condition because of cost, compared with 18 percent of those who had coverage all year (Figure 20).[36] The authors also found that more than one-third (35%) of uninsured

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[32] A. C. Beal, M. M. Doty, S. E. Hernandez, K. K. Shea, and K. Davis, *Closing the Divide: How Medical Homes Promote Equity in Health Care: Results from The Commonwealth Fund 2006 Health Care Quality Survey* (New York: The Commonwealth Fund, June 2007).

[33] Specifically, the IOM found in its review of the literature that uninsured cancer patients died more quickly from their illnesses; uninsured diabetes patients were less likely to receive recommended care and far more likely to go without checkups for two years or more; uninsured patients with cardiovascular disease were much less likely to take recommended prescription medications and were in worse health than insured patients; uninsured patients with end stage renal disease were more likely to be in more severe renal failure when they begin dialysis than insured patients; and uninsured adults with mental illness were less likely to receive care consistent with clinical guidelines.

[34] J. Hadley, "Insurance Coverage, Medical Care Use, and Short-Term Health Changes Following an Unintentional Injury of the Onset of a Chronic Condition," *Journal of the American Medical Association,* Mar. 14, 2007 297(10):1073–84.

[35] C. Schoen, K. Davis, S. K. H. How, and S. C. Schoenbaum, "U.S. Health System Performance: A National Scorecard," *Health Affairs* Web Exclusive (Sept. 20, 2006):w457–w475; Commonwealth Fund Commission, *Why Not the Best?* 2006.

[36] Collins, Davis, Doty et al., *Gaps in Health Insurance,* 2006.

adults with a chronic condition went to an emergency room or stayed overnight in a hospital for their condition, compared with 16 percent of those who were insured all year.

Health and Economic Implications for Families and the Nation. What are the consequences of such poor quality care? People without coverage have both poorer health status and shorter life expectancies. The IOM estimates that 18,000 avoidable deaths occur each year in the U.S. as a direct result of individuals being uninsured. Moreover, the IOM estimated that the lost "health capital" of going without coverage ranges between $1,645 and $3,280 for each additional year without health insurance. Based on this estimate the IOM projected that the aggregate, annualized cost of uninsured people's lost capital and earnings from poor health and shorter lifespans falls between $65 billion and $130 billion for each year without coverage. Considered another way, the nation stands to gain $65 billion to $130 billion in potential economic value if it provided insurance coverage to the approximately 40 million uninsured people at the time of the IOM study.

Recent research suggests that gaps in coverage for uninsured people with chronic health conditions may have long run cost implications for the health system, and the Medicare program in particular. McWilliams and colleagues found that among adults with chronic conditions, previously uninsured adults who acquired Medicare coverage at age 65 reported significantly greater increases in the number of doctor visits and hospitalizations and in total medical expenditures than did previously insured adults, with the difference persisting through age 72. The findings suggest that the costs of providing health insurance for uninsured near-elderly adults may be partially offset by subsequent reductions in health care use and spending once they enter Medicare.[37]

Being uninsured or underinsured can also have immediate minor to catastrophic financial consequences for families. In recent years, hospitals have become increasingly aggressive in obtaining payment from uninsured patients, charging self-pay patients much higher rates than those negotiated by private insurers. In 2004, Anderson found that hospitals charged self-pay patients rates that were often 2.5 times those paid by most insurers and greater than three times hospitals' Medicare-allowable costs.[38]

Using the Commonwealth Fund Biennial Health Insurance Survey, Collins and colleagues found that more than half of working-age adults who had been uninsured during 2005 reported problems paying medical bills during that time or were paying off accrued medical debt, compared to 26 percent of those who had been insured all year (Figure 21).[39] Confronted with medical bills and debt, many people are forced to make

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[37] J. M. McWilliams, E. Meara, A. M. Zaslavsky et al., "Use of Health Services by Previously Uninsured Medicare Beneficiaries," *New England Journal of Medicine,* July 12, 2007 357(2):143–53.

[38] G. F. Anderson, "From 'Soak the Rich' to 'Soak the Poor': Recent Trends in Hospital Pricing," *Health Affairs*, May/June 2007 26(3):780–89.

[39] Collins, Davis, Doty et al., *Gaps in Health Insurance,* 2006.

trade-offs among spending and saving priorities. In the Commonwealth Fund survey, 40 percent of uninsured adults with medical bill problems were unable to pay for basic necessities like food, heat, or rent, and nearly 50 percent had used all their savings to pay their bills (Figure 22).[40]

Costs of Uncompensated Care. The financing of care for people who are uninsured is inefficient and characterized by cost-shifting. Hadley and Holahan estimate that the total costs of uncompensated care in the U.S. were $40.7 billion in 2004.[41] Hospitals incurred about 63 percent of the uncompensated care costs, physicians about 18 percent, and clinics and direct care programs, like Veterans Affairs and the Indian Health Service, 19 percent. Federal, state, and local funding available in 2004 to reimburse uncompensated care costs amounted to $34.6 billion, or 85 percent of the total. More than two-thirds of that funding is provided through the federal government, primarily in the form of payments to hospitals through disproportionate share hospital payments. Physicians are unlikely to receive government funds for providing uncompensated care unless they practice in community health centers or direct service programs. Some researchers have argued that private payers finance uncompensated care costs that are not covered by public funds through surcharges to private payers, with these higher costs ultimately leading to higher private insurance premiums. Estimates of this "hidden tax" range from 8.5 percent of premiums nationally 10.6 percent in California.[42]

Uncompensated care costs might be far higher if uninsured people used as much health care as insured people do. Hadley and Holahan estimate that adults and children without health insurance for a full year receive just 55 percent of the medical care that those who are insured for the full year receive.[43]

Physicians also report inefficiencies in securing pharmaceuticals, as well as follow-up medical care, for uninsured patients. In a study of 12 cities across the country, Hurley and colleagues found that community health centers carefully guarded limited drug supplies and dollars because only a few patients with chronic conditions could quickly exhaust supplies.[44] Gusmano and colleagues found that physicians practicing in community health centers often encounter difficulties obtaining specialized services for

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[40] Ibid.

[41] J. Hadley and J. Holahan, *The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending?* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, May 2004). Available at http://www.kff.org/uninsured/upload/The-Cost-of-Care-for-the-Uninsured-What-Do-We-Spend-Who-Pays-and-What-Would-Full-Coverage-Add-to-Medical-Spending.pdf.

[42] L. M. Nichols and P. Harbage, *Estimating the "Hidden Tax" on Insured Californians Due to the Care Needed and Received by the Uninsured* (Washington, D.C.: New America Foundation, May 2007).

[43] Hadley and Holahan, *Cost of Care for Uninsured,* 2004.

[44] R. E. Hurley, H. H. Pham, and G. Claxton, "A Widening Rift in Access and Quality: Growing Evidence of Economic Disparities," *Health Affairs* Web Exclusive (Dec. 6, 2005):w5-566–w5-576.

their uninsured patients.[45] According to the Hurley study, physicians in community health centers often cope with this limitation by sending patients to emergency departments, which are required by law to provide emergency care regardless of ability to pay, and which maintain call lists of specialists. Yet the researchers found that specialty call lists have become weakened by the opportunities increasingly available to specialists for lucrative practices in free-standing facilities. Moreover, even when specialty care can be secured in emergency departments it is very difficult for uninsured patients to gain access to follow-up care.

Health Care Reform Is Necessary to Fill the Gaps

It is essential on both moral and economic grounds that the United States move forward to guarantee affordable, comprehensive and continuous health insurance for everyone. The Commonwealth Fund Commission on a High Performance Health System released a report in October that argues that universal coverage is essential to a high performance health system.[46] Without universal coverage, we cannot have a health system with more effective, higher quality, and efficiently delivered care and one which ensures longer, healthier and more productive lives. It is unacceptable that people without health insurance collectively lose between $65 billion and $130 billion a year in lost productivity and earnings, and are more at risk of premature death. Several proposals for universal coverage have been put forth, or implemented in the case of Massachusetts, by governors, members of Congress, and 2008 presidential candidates. This is a welcome development and is highly promising for reversing the inexorable climb in the uninsured over the past several years.

The Commission on a High Performance Health System recommended in its report several key principles for health care reform proposals. They include:

- Provides equitable and comprehensive insurance for all.
- Insures the population in a way that leads to full and equitable participation.
- Provides a minimum, standard benefit floor for essential coverage with financial protection.
- Premiums, deductibles, and out-of-pocket costs are affordable relative to family income.
- Coverage is automatic and stable with seamless transitions to maintain enrollment.

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[45] M. K. Gusmano, G. Fairbrother, and H. Park, "Exploring the Limits of the Safety Net: Community Health Centers and Care for the Uninsured," *Health Affairs,* Nov./Dec. 2002 21(6):188–94.

[46] S. R. Collins, C. Schoen, K. Davis, A. Gauthier, and S. C. Schoenbaum, *A Roadmap to Health Insurance for All: Principles for Reform* (New York: The Commonwealth Fund, Oct. 2007).

- Provides a choice of health plans or care systems.
- Health risks are pooled across broad groups and over lifespans; insurance practices designed to avoid poor health risks are eliminated.

In the absence of universal coverage, there are several policies that would help fill the gaps in the existing system by building on existing public and private group insurance and also create an essential foundation for universal coverage that would meet the principles outlined above:

- **Build on Public and Private Group Insurance to Extend Coverage to Vulnerable Age Groups and the Disabled**
    - Allow states to extend eligibility for Medicaid and SCHIP coverage beyond age 18. The Foster Care Independence Act of 1999 which allows states to extend Medicaid coverage to children in foster care beyond age 18 could be expanded to cover all children in Medicaid. Depending on the income eligibility levels, extending coverage up to age 25 would cover 3.3 million uninsured young adults ages 19–25 in families with incomes under 100 percent of poverty and 5.7 million with incomes under 200 percent of poverty.
    - Seventeen states have already redefined the age at which a young adult is no longer a dependent for purposes of insurance, ranging from age 24 to age 30. Other states should follow their lead, insuring that young adults can remain on their parents' plans while they make the transition to college, graduate school and work.
    - Allow older adults ages 55–64 to buy-in to Medicare.
    - End the two-year waiting period for coverage of the disabled under Medicare. The Lewin Group estimates that the cost to the federal government of immediately ending the waiting period would be about $9.1 billion in 2007, but that figure is expected to decline over time since there would be fewer people enrolling all at once and less pent up demand for health services from uninsured or underinsured people in the waiting period.[47]

[47] S. R. Collins, K. Davis, and J. L. Kriss, *Analysis of Leading Congressional Health Care Bills 2005–2007: Part I, Insurance Coverage* (New York: The Commonwealth Fund, Mar. 2007).

- **Build on Public and Private Group Insurance to Extend Coverage to Low Income Workers and Families**
    - Expand Medicaid to cover everyone under 150 percent of poverty; consider providing federal matching funds for sliding scale premiums at higher income levels
    - Require employers to continue and finance COBRA coverage for up to two months for employees who lose their jobs. Federal government could provide premium assistance for 70 percent of COBRA premiums for unemployed workers.
- **Connect Public and Private Group Insurance to Realize Efficiencies from Pooling Large Groups of People**
    - Create a national health insurance "connector" based on the Federal Employees Health Benefits Program or Medicare, with sliding scale premium subsidies, restrictions against risk selection on the part of carriers, and federal reinsurance.

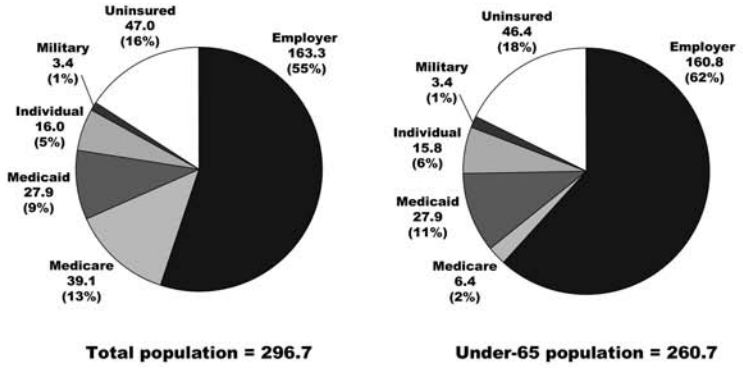
We are at a crossroads where a majority of the public is asking its leaders to address our health insurance problem with comprehensive reform, even if it requires a substantial investment of public and private funds.[48] States like Massachusetts are leading the nation in this effort and national policy leaders are responding with well thought out proposals. If we do not rise to the occasion and move forward with policy strategies designed to effectively cover everyone and address our shortcomings in quality and cost, health care costs will continue to climb apace and our uninsured problem will continue to ascend the economic scale. We are a wealthy and innovative country, we have the resources and the technology to move affirmatively to universal coverage in a way that improves quality and controls costs. The time is upon us to resolve ideological differences over favored strategies and find consensus based on pragmatism and fact.

Thank you.

[48] Kaiser Family Foundation Health Tracking Poll: Election 2008, Aug. 2007.

Figure 1. Employers Provide Health Benefits to More than 160 Million Working Americans and Family Members

Numbers in millions, 2006



Source: S. R. Collins, C. White, and J. L. Kriss, *Whither Employer-Based Health Insurance? The Current and Future Role of U.S. Companies in the Provision and Financing of Health Insurance* (New York: The Commonwealth Fund, Sept. 2007). Data: Current Population Survey, Mar. 2007.

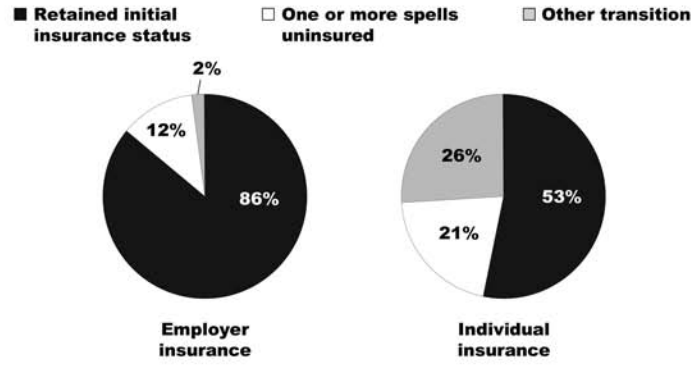
Figure 2. Individual Market Insurance Is Not an Affordable Option for Many People

Adults ages 19–64 with individual coverage or who thought about or tried to buy it in past three years who:	Total	Health problem	No health problem	<200% poverty	200%+ poverty
Found it very difficult or impossible to find coverage they needed	34%	48%	24%	43%	29%
Found it very difficult or impossible to find affordable coverage	58	71	48	72	50
Were turned down or charged a higher price because of a pre-existing condition	21	33	12	26	18
Never bought a plan	89	92	86	93	86

Source: S. R. Collins, J. L. Kriss, K. Davis, M. M. Doty, and A. L. Holmgren, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families* (New York: The Commonwealth Fund, Sept. 2006).

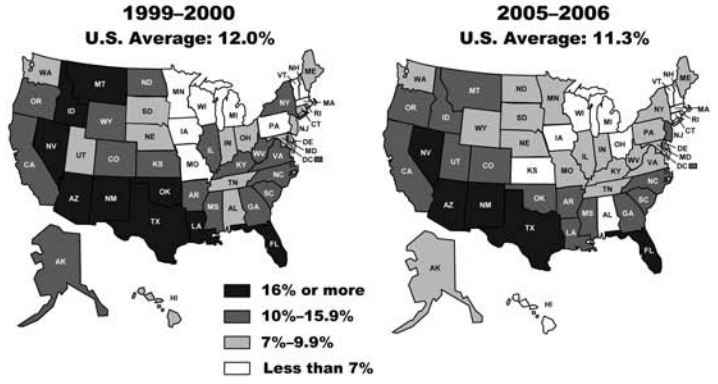
Figure 3. People with Employer Insurance Have More Stable Coverage than Those with Individual Market Insurance

Retention of initial insurance over a two-year period, 1998–2000



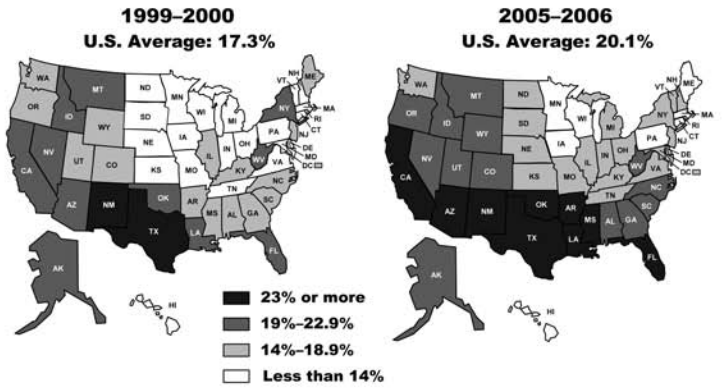
Source: K. Klein, S. A. Glied, and D. Ferry, *Entrances and Exits: Health Insurance Churning, 1998–2000* (New York: The Commonwealth Fund, Sept. 2005). Data: Authors' analysis of the 1998–2000 Medical Expenditure Panel Survey.

Figure 4. Percent of Uninsured Children Declined Since Implementation of SCHIP, But Gaps Remain



Source: J. C. Cantor, C. Schoen, D. Belloff, S. K. H. How, and D. McCarthy, *Aiming Higher: Results from a State Scorecard on Health System Performance* (New York: The Commonwealth Fund, June 2007). Updated data: Two-year averages 1999–2000, updated with 2007 CPS correction, and 2005–2006 from the Census Bureau's March 2000, 2001 and 2006, 2007 Current Population Surveys.

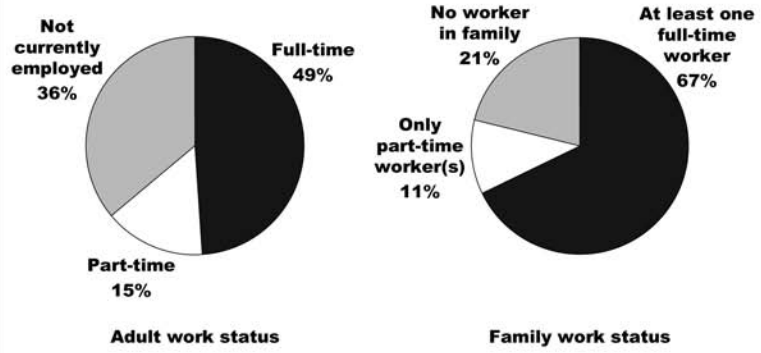
Figure 5. Number of States with 23 Percent or More Uninsured Nonelderly Adults Rose from 2 to 9 in Last Six Years



Source: J. C. Cantor, C. Schoen, D. Belloff, S. K. H. How, and D. McCarthy, *Aiming Higher: Results from a State Scorecard on Health System Performance* (New York: The Commonwealth Fund, June 2007). Updated data: Two-year averages 1999–2000, updated with 2007 CPS correction, and 2005–2006 from the Census Bureau's March 2000, 2001 and 2006, 2007 Current Population Surveys.

Figure 6. The Majority of Uninsured Adults Are in Working Families

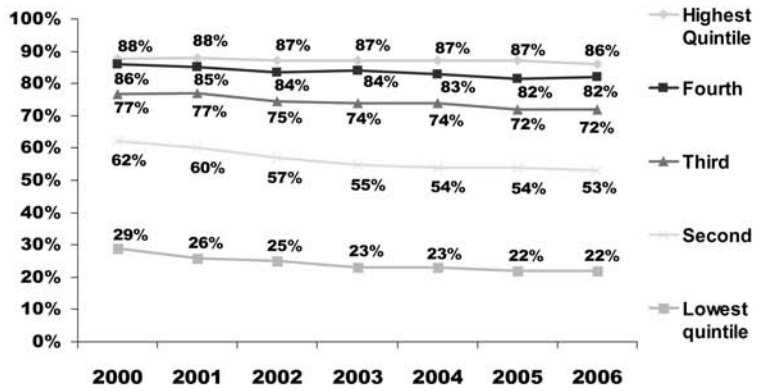
Adults ages 19–64 with any time uninsured



Note: Percentages may not sum to 100% because of rounding.
Source: S. R. Collins, K. Davis, M. M. Doty, J. L. Kriss, and A. L. Holmgren, *Gaps in Health Insurance: An All-American Problem* (New York: The Commonwealth Fund, Apr. 2006).

Figure 7. Employer-Provided Health Insurance, by Income Quintile, 2000–2006

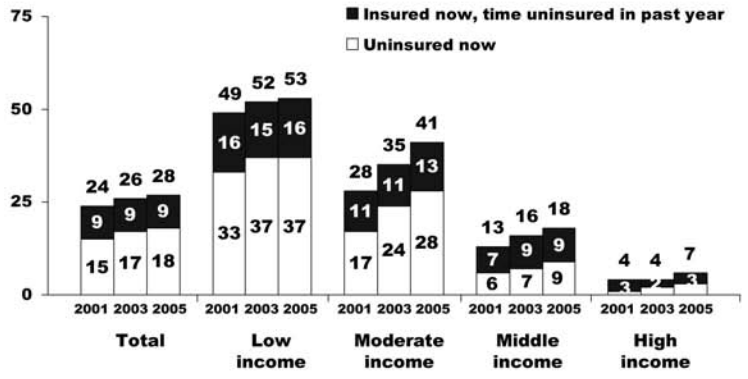
Percent of population under age 65 with health benefits from employer



Source: E. Gould, *The Erosion of Employment-Based Insurance: More Working Families Left Uninsured,* EPI Briefing Paper No. 203 (Washington, D.C.: Economic Policy Institute, Nov. 2007).

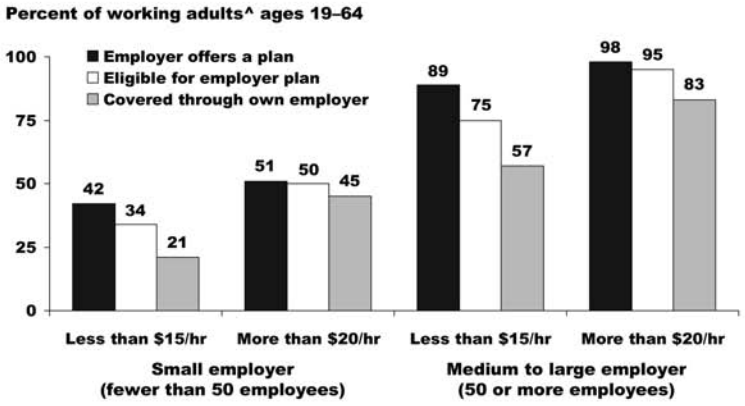
Figure 8. Uninsured Rates High Among Adults with Low and Moderate Incomes, 2001–2005

Percent of adults ages 19–64



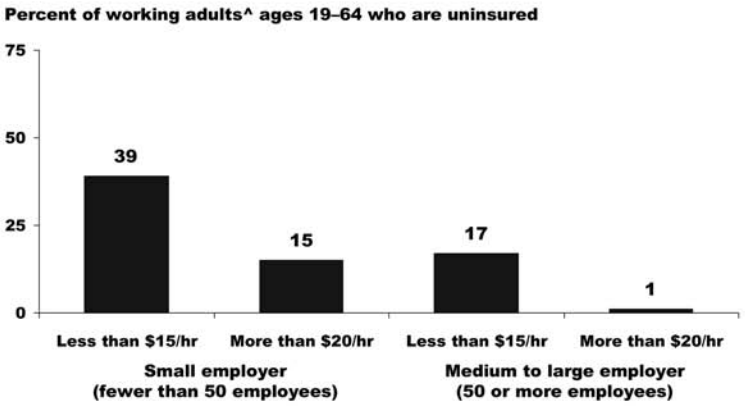
Note: Income refers to annual income. In 2001 and 2003, low income is <$20,000, moderate income is $20,000–$34,999, middle income is $35,000–$59,999, and high income is $60,000 or more. In 2005, low income is <$20,000, moderate income is $20,000–$39,999, middle income is $40,000–$59,999, and high income is $60,000 or more.
Source: The Commonwealth Fund Health Insurance Surveys (2001, 2003, and 2005).

Figure 9. Workers Who Are Offered, Eligible for, and Participate in Their Employer's Health Plan, by Firm Size and Hourly Wage



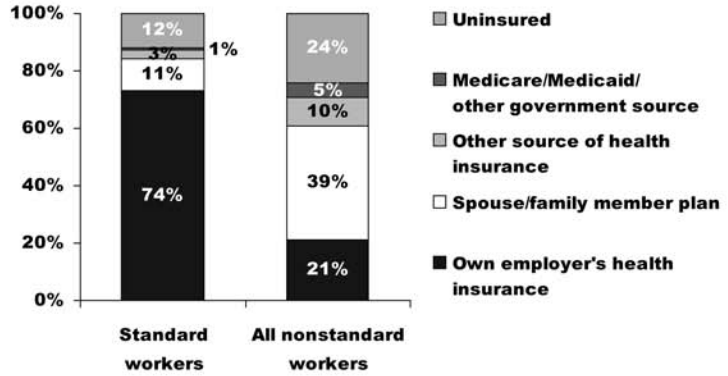
^ Includes both part-time and full-time workers.
Source: S. R. Collins, C. Schoen, D. Colasanto, and D. A. Downey, *On the Edge: Low-Wage Workers and Their Health Insurance Coverage* (New York: The Commonwealth Fund, Apr. 2003).
Updated data from The Commonwealth Fund Biennial Health Insurance Survey (2005).

Figure 10. Percent Uninsured Workers by Firm Size and Hourly Wage



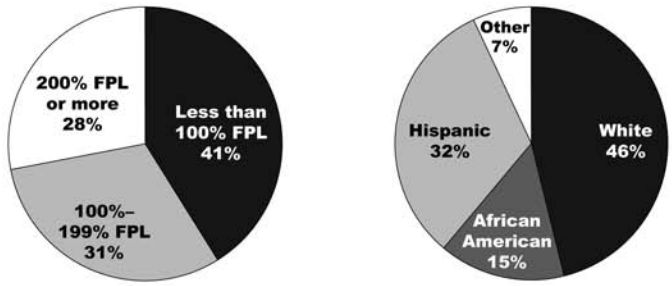
^ Includes both part-time and full-time workers.
Source: S. R. Collins, C. Schoen, D. Colasanto, and D. A. Downey, *On the Edge: Low-Wage Workers and Their Health Insurance Coverage* (New York: The Commonwealth Fund, Apr. 2003).
Updated data from The Commonwealth Fund Biennial Health Insurance Survey (2005).

Figure 11. Nonstandard Workers Are Less Likely to Have Health Insurance Coverage Through Their Own Job, 2001



Notes: Self-employed independent contractors are excluded from analysis. "Other source of health insurance" includes insurance from the individual market, from another job, from a previous job, or from an association, school, or other unidentified source.
Source: E. Ditsler, P. Fisher, and C. Gordon, *On the Fringe: The Substandard Benefits of Workers in Part-Time, Temporary, and Contract Jobs* (New York: The Commonwealth Fund, Dec. 2005).
Data: Authors' analysis of the 2001 Contingent Work Supplement to the Current Population Survey.

Figure 12. Distribution of Uninsured Young Adults Ages 19–29, by Poverty Status and Race/Ethnicity, 2005



Uninsured young adults = 13.3 million

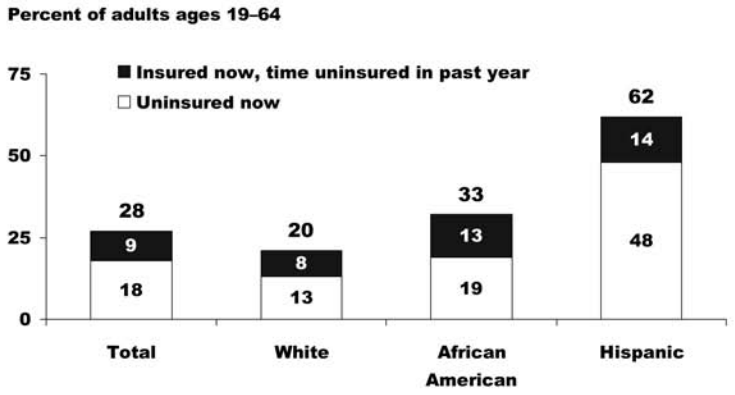
Source: S. R. Collins, C. Schoen, J. L. Kriss, M. M. Doty, and B. Mahato, *Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help* (New York: The Commonwealth Fund, updated Aug. 8, 2007).
Data: Analysis of the March 2006 Current Population Survey by S. Glied and B. Mahato for The Commonwealth Fund.

Figure 13. Percent Uninsured, Children and Young Adults, by Poverty Level, 2005

Percent Uninsured	Children Age 18 and Under	Young Adults Ages 19–29
Total	11%	30%
<100% FPL	20	51
100%–199% FPL	16	42
≥200% FPL	7	16

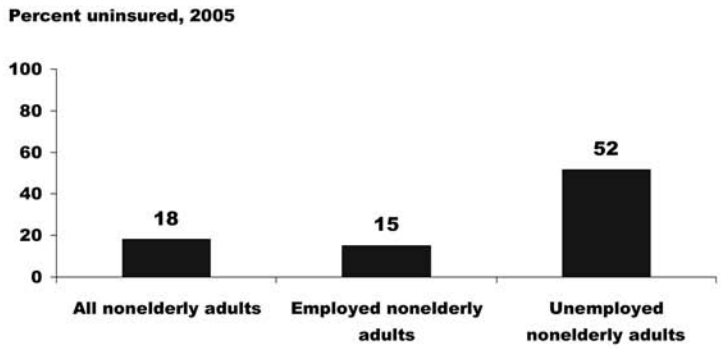
Source: S. R. Collins, C. Schoen, J. L. Kriss, M. M. Doty, and B. Mahato, *Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help* (New York: The Commonwealth Fund, updated Aug. 8, 2007).
Data: Analysis of the March 2006 Current Population Survey by S. Glied and B. Mahato for The Commonwealth Fund.

Figure 14. Uninsured Rates Are High Among Hispanics and African Americans, 2005



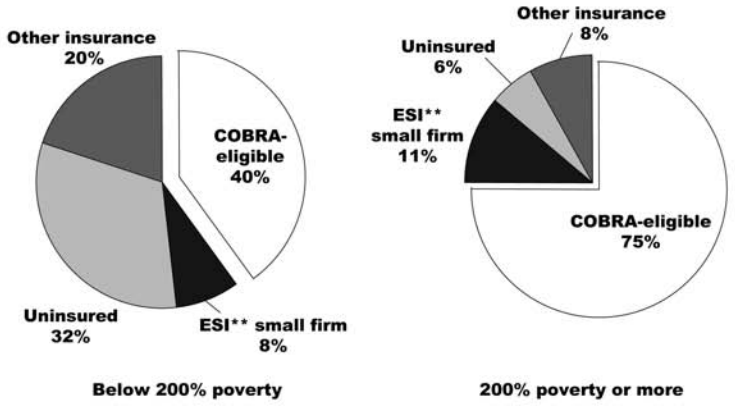
Note: Because of rounding, totals above stacked bars may not reflect the sum of each insurance category.
Source: M. M. Doty and A. L. Holmgren, *Health Care Disconnect: Gaps in Coverage and Care for Minority Adults* (New York: The Commonwealth Fund, Aug. 2006).

Figure 15. More Than Half of Unemployed Adults Are Uninsured



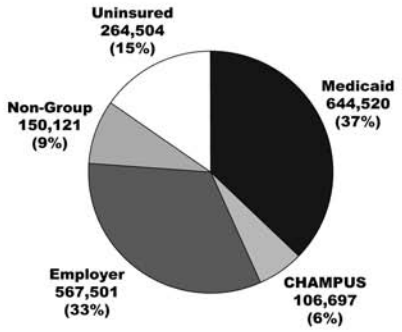
Source: J.L. Lambrew, *How the Slowing U.S. Economy Threatens Employer-Based Health Insurance* (New York: The Commonwealth Fund, Nov. 2001).
Updated with data from the Commonwealth Fund Biennial Health Insurance Survey (2005).

Figure 16. Lower Income Workers Are Least Likely to Be Eligible for COBRA*



* The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers with 20 or more employees to offer continuation of health insurance coverage to former employees. ** Employer-sponsored insurance coverage.
Source: L. Duchon, C. Schoen, M. M. Doty, K. Davis, E. Strumpf, and S. Bruegman, *Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk* (New York: The Commonwealth Fund, Dec. 2001).

Figure 17. People with Disabilities in the Waiting Period for Medicare in 2007, by Source of Coverage

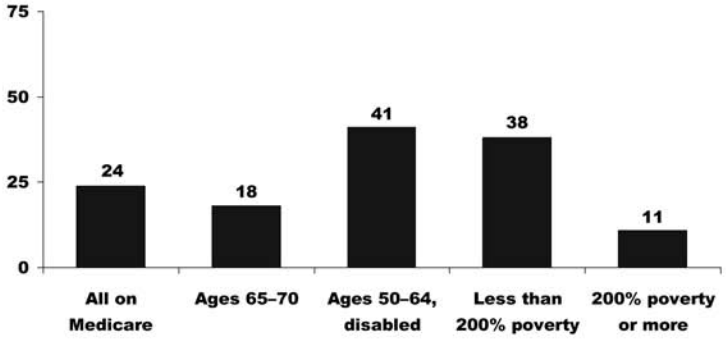


Total people currently in waiting period = 1,733,343

Note: Number of people in the waiting period was estimated using the number of SSDI awards to disabled workers, widowers, and adult children in 2004 and 2005 from the Social Security Administration Annual Statistical Supplement (2005 and 2006).
Source: S. R. Collins, K. Davis, and J. L. Kriss, *An Analysis of Leading Congressional Health Care Bills, 2005-2007: Part I, Insurance Coverage* (New York: The Commonwealth Fund, Mar. 2007).

Figure 18. Nearly One-Quarter of Medicare Beneficiaries Were Uninsured Just Before Enrolling

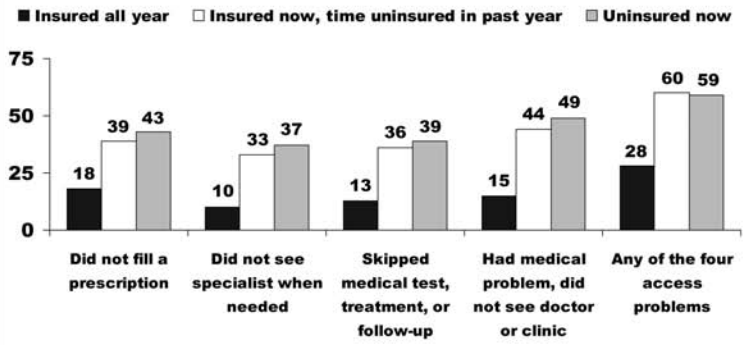
Percent of Medicare beneficiaries ages 50–70



Source: S. R. Collins, K. Davis, C. Schoen, M. M. Doty, S. K. H. How, and A. L. Holmgren, *Will You Still Need Me? The Health and Financial Security of Older Americans* (New York: The Commonwealth Fund, June 2005).
Data from the Commonwealth Fund Survey of Older Adults, 2004.

Figure 19. Lacking Health Insurance for Any Period Threatens Access to Care

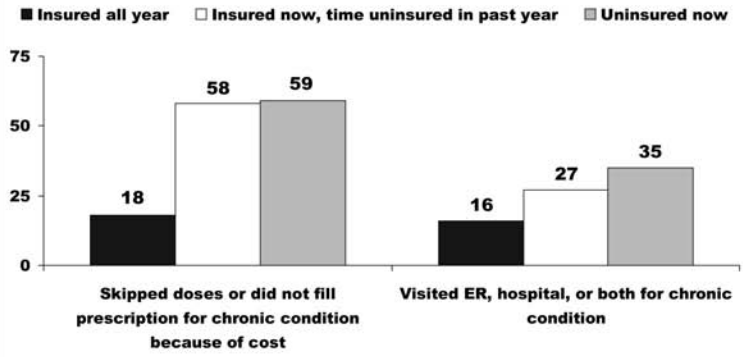
Percent of adults ages 19–64 reporting the following problems in past year because of cost:



Source: S. R. Collins, K. Davis, M. M. Doty, J. L. Kriss, and A. L. Holmgren, *Gaps in Health Insurance: An All-American Problem* (New York: The Commonwealth Fund, Apr. 2006).

Figure 20. Adults Without Insurance Are Less Likely to Be Able to Manage Chronic Conditions

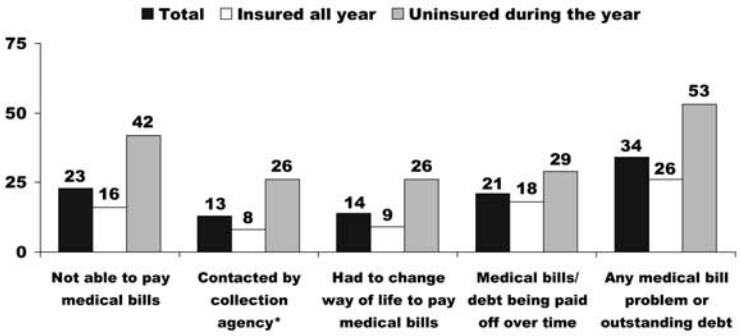
Percent of adults ages 19–64 with at least one chronic condition*



* Hypertension, high blood pressure, or stroke; heart attack or heart disease; diabetes; asthma, emphysema, or lung disease.
Source: S. R. Collins, K. Davis, M. M. Doty, J. L. Kriss, and A. L. Holmgren, *Gaps in Health Insurance: An All-American Problem* (New York: The Commonwealth Fund, Apr. 2006).

Figure 21. Many Americans Have Problems Paying Medical Bills or Are Paying Off Medical Debt

Percent of adults ages 19–64 who had the following problems in past year:



* Includes only those who had a bill sent to a collection agency when they were unable to pay it.
Source: S. R. Collins, K. Davis, M. M. Doty, J. L. Kriss, and A. L. Holmgren, *Gaps in Health Insurance: An All-American Problem* (New York: The Commonwealth Fund, Apr. 2006).

Figure 22. One-Quarter of Adults with Medical Bill Burdens and Debt Were Unable to Pay for Basic Necessities

Percent of adults ages 19–64 with medical bill problems or accrued medical debt:

Percent of adults reporting:	Total	Insured all year	Insured now, time uninsured during year	Uninsured now
Unable to pay for basic necessities (food, heat or rent) because of medical bills	26%	19%	28%	40%
Used up all of savings	39	33	42	49
Took out a mortgage against your home or took out a loan	11	10	12	11
Took on credit card debt	26	27	31	23

Source: S. R. Collins, K. Davis, M. M. Doty, J. L. Kriss, and A. L. Holmgren, *Gaps in Health Insurance: An All-American Problem* (New York: The Commonwealth Fund, Apr. 2006).

Chairman MCDERMOTT. Thank you very much for your testimony.

Mr. Pollack, since 1993 at least. It is good to have you here again. He is the founding executive director of Families USA.

STATEMENT OF RON POLLACK,
FOUNDING EXECUTIVE DIRECTOR, FAMILIES USA

Mr. POLLACK Thank you Mr. Chairman, and thank you members of the panel for inviting me here today, I appreciate it. I want to just start with a contextual comment. You started, Mr. Chairman, by talking about a number of people who are uninsured in the latest Census Bureau numbers from the Current Population Survey, and it tells us that 47 million were uninsured in 2006. Now, there is a dispute among policy analysts as to what this means. The literal question asked was, "were you uninsured throughout the course of the year."

Some policy analysts, many policy analysts actually, interpret the data as telling you how many people were uninsured at the time the survey was undertaken. But under either interpretation, it doesn't tell you how many people were affected by being uninsured at some point over the course of a year.

By the way, 47 million sounds like an unascertainable number, and people can't put their hands around it. The way I like to talk about it is 47 million is more than the aggregate, underscore the word "aggregate," population of 24 States plus the District of Columbia; that is extraordinary. The number of people who are uninsured almost exceeds the population of half the States in the United States. But, as bad as that is, it doesn't reflect how many people go in and out of being uninsured.

For that reason, we have submitted to the Committee a recent report that Families USA released, that is based on other Census Bureau data, to look at how many people were uninsured at some point over the last 2 years. The number is astounding. The number of people who were uninsured at some point over the last 2 years was 89.6 million people. This is not double counting people who were uninsured 1 year and then a second year these are separate, people who were uninsured at some point over the course of the last 2 years.

Mind you, most of these people were uninsured for periods that you can't consider trivial. Over half were uninsured for more than 9 months in the 2-year period. Almost two-thirds were uninsured for at least 6 months in that 2-year period. So, this is rather substantial, and obviously it is likely to get worse because the cost of insurance premiums is rising faster than wages.

There are a variety of impacts that this created, and I guess this is the heart of what you wanted me to talk about. There are health care impacts for the persons who are uninsured, which reflects their limited incomes. Then there are other impacts, even for people who are insured. So, let me just talk about some of the health impacts for people who are uninsured.

The uninsured are far less likely to have a usual source of care outside the emergency room. Uninsured adults are almost seven times more likely than insured adults to consider the emergency room as their usual source of care. The uninsured are more likely

to go without screenings and preventive care. Uninsured adults are 30 percent less likely than insured adults to have had a check-up in the past year. They are more likely to be diagnosed with a disease in an advanced stage.

The uninsured are likely to delay, or forgo, needed care. Fifty percent of insured adults, in fair or poor health, reported that they needed care in the last year, but were unable to see a physician because of cost. One in three uninsured adults did not fill a drug prescription in the past year because they couldn't afford the cost.

Uninsured Americans are more likely to be sicker and to die earlier. Of course you know the Institute of Medicine statistic that 18,000 people are estimated to die annually because of their uninsured status. Uninsured children admitted to a hospital due to injuries were twice as likely to die while in the hospital as their insured counterparts.

Now, all of this has some very significant economic impacts, even for those people who are insured. We issued a report, not too long ago, that looked at what the impact is on those of us who purchase insurance to pay for the uncompensated care of those who are uninsured. In 2005, the premium add-on to pay for the uncompensated cost of the uninsured for family health coverage was $922. Today, I suspect, when we do an update on this, we are likely to find that people are paying $1,000 or more as an add-on to their insurance premiums to pay for the uncompensated care of the uninsured.

More than one out of three who were uninsured were contacted by a collection agency in the past year, and 3 out of 5 uninsured have reported problems with their medical bills. Let me end by saying that clearly, dealing with this growing problem, of people who are uninsured, deserves top priority attention. Rather than going through a list of things that we believe should be done, let me just close by saying that I think for us to finally address this problem, we are going to have to do business differently than we have ever done before.

It means we are going to have to address this in a bipartisan fashion. We are going to have to transcend ideology. There are groups of what, I guess, some people generally call "strange bedfellow organizations" that have been working together. They transcend ideology, they transcend partisanship, and my hope is that, come 2009, if this Congress truly wishes to address this problem in a serious way, that we will be able to come here with a proposal that can earn the support of people on both sides of the aisle. So, I thank you, Mr. Chairman.

[The prepared statement of Mr. Pollack follows:]

Prepared Statement of Ron Pollack,
Founding Executive Director, Families USA, Washington, DC

Families USA thanks the Subcommittee on Income Security and Family Support of the House Committee on Ways and Means for the opportunity to present testimony on the impact of gaps in health coverage on income security. This testimony focuses on the issue of the uninsured more broadly, as well as the effects of the crisis of the uninsured on the uninsured themselves, people with insurance, and the U.S. economy.

I. Magnitude of the Problem

Every year, the U.S. Census Bureau—in its Current Population Survey (CPS)—reports the number of people who are uninsured. This widely quoted number is intended to offer an estimate of how many people did not have any type of health insurance for the entire previous calendar year. In August 2007, the CPS reported that there were 47.0 million uninsured people in the United States in 2006. This represents an increase of nearly 2.2 million people over 2005. The number of uninsured is also now larger than the combined population of 24 States plus the District of Columbia.

There are many people, however, who are uninsured for a portion of a year but not for the entire year. These individuals are not reflected in the widely quoted Census Bureau number, but they may be profoundly affected by their uninsured status—in terms of both their physical and their economic well-being. To understand the scope of the problem—to know how many Americans are directly affected by a lack of health insurance—we need to broaden our sights and include those who are uninsured for a portion of the year.

A recent analysis by Families USA reveals that 89.6 million people under the age of 65—more than one out of every three non-elderly Americans—went without health insurance for all or part of 2006–2007. In addition, we found that the number of uninsured people increased dramatically over our study period: Between 1999–2000 and 2006–2007, more than 17.0 million Americans under the age of 65 joined the ranks of the uninsured.

Our findings demonstrate that the crisis of the uninsured affects a diverse array of people. Americans from every income group, every racial and ethnic group, and nearly every age group are uninsured. In addition, as previous research has demonstrated, the vast majority of the uninsured are from working families. Four out of five individuals who were uninsured during 2006–2007 were from working families, and 70.6 percent of the uninsured were from families with one or more people employed full-time. Moreover, the majority of people who are uninsured remain uninsured for substantial periods of time: Over one-half (50.2 percent) were uninsured for more than nine months, and almost two-thirds (63.9 percent) were uninsured for more than six months. The effects of being uninsured—even for a period of a few months—can be devastating, both financially and physically. Furthermore, as the duration of time without health insurance increases, so do the chances of facing catastrophic financial and health problems.

II. What the Crisis of the Uninsured Means for the Uninsured

Being uninsured—even for a period of a few months—can have profound effects on an individual's physical and economic well-being. Without insurance to cover the costs of routine health care, the uninsured often go without screenings or preventive services. Uninsured adults are more than 30 percent less likely than insured adults to have had a checkup in the past year. Even when uninsured adults do receive preventive care and know they have a chronic condition, they are less likely to receive proper follow-up care. For example, uninsured patients with high blood pressure are less likely to have their blood pressure monitored and controlled, and they are less likely to receive disease management services.

In addition, people without insurance are more likely to delay or forgo necessary medical care. When sick, uninsured adults are more than three times as likely as insured adults to delay seeking medical care. And uninsured children are nearly five times more likely than insured children to have at least one delayed or unmet health care need.

The consequences of going without necessary care can be dire. Uninsured Americans are sicker and die earlier than those who have insurance, and consistently report that they are in poorer health than people with private insurance. Lower levels of self-reported health status, in turn, are a powerful predictor of future illness and premature death. In fact, uninsured adults are 25 percent more likely to die prematurely than adults with private health insurance coverage, and the deaths of 18,000 people between the ages of 25 and 64 each year can be attributed to a lack of health insurance.

Without the protection of insurance, uninsured Americans are also at financial risk when faced with the need for health services. Three out of five uninsured adults under the age of 65 reported problems with medical bills. And, over the course of a year, more than one out of three uninsured people are contacted by a collection agency about outstanding medical bills. When the burden of health care costs becomes too great, the consequences can be catastrophic. Faced with medical debt, families often have no choice but to consider drastic changes in lifestyle and, eventually, bankruptcy. Since 2000 alone, 5 million American families have filed for bank-

ruptcy following a serious medical problem. In all, approximately half of bankruptcies are due, at least in part, to medical expenses.

III. What the Crisis of the Uninsured Means for the Insured

What happens when the uninsured are sick and need health care? Certainly, the uninsured are much less likely to receive health care, and many never do. Those who seek care, however, struggle to pay as much as they can. Even after making tremendous personal sacrifices, the contributions made by the uninsured toward their medical bills cover an estimated 35 percent of the cost of care they receive from doctors and hospitals. The remaining amount is primarily paid by two sources: Roughly one-third is reimbursed by a number of government programs, including Medicaid and Medicare Disproportionate Share Hospital (DSH) payments from the federal government and state and local programs, and two-thirds is paid through higher premiums for people with health insurance.

Families USA estimates that almost $29 billion worth of unpaid care received by the uninsured in 2005 was financed by higher premiums for privately insured patients. As a result, the cost of private insurance was, on average, 8.4 percent higher in 2005 than it would have been if everyone in the United States had health insurance. This translates into $341 more a year for the average individual premium and $922 more a year for the average family premium.

How does the cost of care for the uninsured end up being passed on in the form of higher private health insurance premiums? The cost of care not directly paid for by the uninsured or by government programs or philanthropy is built into the cost base of physician and hospital revenue. Providers attempt to recover these "uncompensated care" dollars through various strategies. One key strategy is to negotiate higher rates for health care services paid for by private insurance. The extent to which providers can do this varies from State to State; nonetheless, the rates always reflect a significant amount of uncompensated care. Given that most health care providers are not driven to bankruptcy and our health care system survives from year to year, we can say with certainty that those with health insurance finance the residual two-thirds cost of care for the uninsured provided by hospitals and doctors. Ironically, this increases the cost of health insurance and results in fewer people who can afford insurance—a vicious circle.

IV. What the Crisis of the Uninsured Means for the U.S. Economy

The crisis of the uninsured also has consequences for the nation's economy as a whole. While the microeconomic effect of going without health insurance on the individual has been studied extensively and is cited frequently, the macroeconomic effect of so many Americans going without health insurance is less frequently discussed. Economists estimate that between $65 and $130 billion of productivity is lost each year due to people going without health insurance in America.

Access to health insurance at every age is vital to the productivity of a nation's workforce. Ensuring that children have a healthy start sets the foundation for future productivity and helps kids reach their full potential. Insured children are less likely to have developmental delays that may affect their ability to learn. In addition, improving health increases educational attainment and raises earnings potential by 10 to 30 percent.

Once a worker is in the labor force, consistent access to quality health coverage is critical. Studies have shown that insured employees are healthier, and better health, in turn, is related to increased productivity. In fact, one study showed that providing health insurance alleviates one in 10 days missed for illness. Three in four employers believe that health benefits are extremely, very, or somewhat important for improving employee productivity. In addition, providing health insurance ensures that employees have access to primary and preventive care that keeps them healthy and productive in the long-run.

Moreover, health insurance reduces turnover. The cost of hiring and training new employees drains business productivity. Many studies show that workers with health insurance change jobs less frequently. Nearly three-quarters of workers said that health insurance was a very important factor in their decision to take or keep a job. While the importance of health insurance to the individual is clear, these data demonstrate the significance of health insurance in ensuring a healthy, productive labor force. The current epidemic of the uninsured places not only American families, but also businesses, and our nation's economic vitality at risk.

V. Why is the Number of Uninsured on the Rise?

Millions of people are currently uninsured, and this problem has grown substantially over the last few years. One of the primary factors driving the increase in the uninsured is health insurance premium increases. Between 1999 and today, premiums have risen rapidly, increasing by double-digit amounts every year between

2001 and 2004. Moreover, these rising premiums have far outstripped increases in worker earnings. Between 2000 and 2006, premiums for job-based health insurance increased by 73.8 percent, while median worker earnings rose by only 11.6 percent. As premium costs outpace wages, more people end up without health insurance: For each percentage point increase in health care costs relative to income, the number of uninsured people increases by 246,000.

Faced with the rising cost of health insurance premiums, employers must make difficult decisions. Some employers, particularly small businesses, have concluded that they can no longer afford to offer health insurance to their workers and have dropped coverage, further increasing the number of uninsured Americans. Other employers continue to offer health insurance, but they now ask their employees to pay a greater share of the premiums. In addition, a growing number of employers seek to hold down costs by offering "thinner coverage"—coverage that offers fewer benefits and/or charges higher deductibles, copayments, and co-insurance.

Working families must contend with a set of difficult decisions. Even if someone in the family has an offer of coverage, he or she is likely to be required to pay more for fewer benefits than in the past. Between 2000 and 2006, the employee share of family insurance premiums increased by 78.2 percent. As a result, more and more working families are being priced out of job-based insurance.

Workers without an offer of job-based coverage—and those who cannot afford to purchase their employer's plan—may seek coverage on their own. Finding an individual insurance plan that meets their needs and their budget is likely to be extremely challenging. One recent survey found that nine out of 10 people who sought individual coverage never purchased a plan—either because they couldn't find an affordable plan, they were rejected for coverage, or they were offered a plan that excluded coverage for the very care they were most likely to need. Without the availability of affordable, quality coverage, more American families are at risk of becoming uninsured and suffering the economic and physical consequences that are likely to follow.

VI. Conclusion

As this testimony demonstrates, the current crisis of the uninsured detrimentally affects not only the uninsured themselves, but also people with health insurance and the economy as a whole. Ensuring that all Americans have access to quality, affordable health insurance coverage is imperative to protecting the economic and physical well-being of all Americans. Moreover, popular support for reforming health care is evidenced by the fact that health care has become the top domestic issue in recent polls and public option surveys. Families USA is glad to see that presidential and other candidates are making health care a central issue of their campaigns. The challenge for the upcoming months and years will be for our nation's leaders to move from debate to action—making health care a top budget and issue priority, and ensuring that every American has reliable and continuous access to high-quality, affordable health coverage.

[The Families USA report follows:]

Wrong Direction:

One Out of Three Americans Are Uninsured

A REPORT BY
Families USA

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Wrong Direction:
One Out of Three Americans Are Uninsured

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INTRODUCTION

According to public opinion surveys, health care is currently the top domestic concern for Americans. There are many reasons for this concern, but one of the most important is the relentless growth in the number of people without health coverage.

To find out how many people are affected by this lack of health coverage, Families USA commissioned The Lewin Group to analyze data from the Census Bureau's Current Population Survey (CPS) and the Survey of Income and Program Participation (SIPP). This analysis enabled us to determine how many people were uninsured for some portion of the 2006-2007 two-year period.

The analysis found that 89.6 million people under the age of 65 were uninsured for some or all of that two-year period. This constitutes more than one out of every three non-elderly Americans. That also represents an increase of 17 million uninsured Americans from 1999-2000 to 2006-2007.

This report provides a detailed analysis of who these uninsured Americans are, where they live, how long they have been without health coverage, and their demographic characteristics. It also shows that four out of five Americans who were uninsured during the 2006-2007 period were in working families.

With more and more people directly experiencing a lack of health coverage, this problem is already receiving top priority attention from the political candidates running for office in 2008. It remains to be seen, however, whether this attention will ultimately translate into policy changes that will result in every American having reliable and continuous access to high-quality, affordable health coverage.

KEY FINDINGS

More Americans Are Uninsured: 1999-2000 to 2006-2007

- 89.6 million people under the age of 65 went without health insurance for some or all of the two-year period from 2006-2007 (Table 1).
- 72.5 million people under the age of 65 went without health insurance for some or all of 1999-2000 (Table 1).
- The number of people who were uninsured at some point in a two-year period increased by more than 17 million between 1999-2000 and 2006-2007 (Table 1).
- More than one out of three people (34.7 percent) under the age of 65 were uninsured for some or all of 2006-2007 (Table 1).
- 29.6 percent of people under the age of 65 were uninsured for some or all of 1999-2000 (Table 1).

Table 1

Uninsured People under Age 65

	1999-2000	2006-2007	Increase
Total Number Uninsured	72,534,000	89,558,000	17,024,000
Total Percent Uninsured	29.6%	34.7%	

Source: Estimates prepared by The Lewin Group for Families USA (see Technical Appendix for details).

More States Are Affected: 1999-2000 to 2006-2007

- The number of states where more than one-third of the people under the age of 65 were uninsured for all or part of a two-year period more than doubled—rising from nine states in 1999-2000 to 20 states plus the District of Columbia in 2006-2007 (Table 2).
- The states where more than one-third of the people under the age of 65 were uninsured for one month or more in 2006-2007 are: Texas (45.7 percent of the total non-elderly population was uninsured), New Mexico (44.3 percent), Arizona (41.8 percent), California (40.5 percent), Florida (40.1 percent), Mississippi (38.7 percent), Nevada (38.4 percent), Louisiana (38.1 percent), Oklahoma (37.7 percent), Georgia (37.6 percent), South Carolina (37.4 percent), Arkansas (37.2 percent), Utah (35.2 percent), Alabama (35.1 percent), the District of Columbia (35.1 percent), West Virginia (35.1 percent), Alaska (34.8 percent), North Carolina (34.6 percent), Oregon (34.6 percent), Colorado (34.2 percent), and Montana (33.9 percent) (Table 2).

Table 2

Uninsured People under Age 65, by State

State	1999-2000		2006-2007		Rank by Percent Uninsured, 2006-2007
	Total Number	Percent of Non-Elderly Population	Total Number	Percent of Non-Elderly Population	
Alabama	1,183,000	30.1%	1,383,000	35.1%	16
Alaska	186,000	30.7%	215,000	34.8%	17
Arizona	1,607,000	36.8%	2,216,000	41.8%	3
Arkansas	697,000	31.0%	899,000	37.2%	12
California	10,909,000	35.2%	12,987,000	40.5%	4
Colorado	1,161,000	29.6%	1,443,000	34.2%	20
Connecticut	632,000	21.8%	837,000	27.5%	44
Delaware	171,000	24.7%	226,000	30.8%	31
District of Columbia	142,000	31.4%	168,000	35.1%	14
Florida	4,363,000	34.4%	6,039,000	40.1%	5
Georgia	2,231,000	31.3%	3,096,000	37.6%	10
Hawaii	308,000	28.3%	321,000	29.3%	38
Idaho	385,000	34.4%	426,000	32.9%	24
Illinois	3,049,000	27.7%	3,601,000	32.4%	25
Indiana	1,315,000	25.0%	1,757,000	31.7%	27
Iowa	553,000	22.3%	664,000	26.2%	48
Kansas	613,000	26.4%	682,000	29.1%	39
Kentucky	972,000	27.7%	1,109,000	31.0%	29
Louisiana	1,471,000	37.6%	1,344,000	38.1%	8
Maine	277,000	24.2%	311,000	27.1%	45
Maryland	1,048,000	23.7%	1,522,000	30.9%	30
Massachusetts	1,291,000	22.3%	1,439,000	25.8%	49
Michigan	2,237,000	24.5%	2,524,000	28.5%	40
Minnesota	873,000	20.2%	1,084,000	24.2%	50
Mississippi	785,000	32.2%	967,000	38.7%	6
Missouri	1,075,000	21.8%	1,465,000	29.3%	37
Montana	271,000	33.6%	271,000	33.9%	21
Nebraska	352,000	23.9%	437,000	28.2%	41
Nevada	627,000	35.6%	826,000	38.4%	7
New Hampshire	252,000	22.1%	271,000	23.9%	51
New Jersey	1,871,000	26.1%	2,447,000	32.0%	26
New Mexico	659,000	41.7%	745,000	44.3%	2
New York	4,984,000	30.3%	5,491,000	33.2%	22
North Carolina	1,982,000	29.5%	2,609,000	34.6%	19
North Dakota	141,000	26.7%	152,000	28.0%	42
Ohio	2,534,000	25.3%	2,936,000	29.6%	35
Oklahoma	914,000	32.2%	1,144,000	37.7%	9
Oregon	861,000	28.1%	1,094,000	34.6%	18
Pennsylvania	2,326,000	22.9%	2,918,000	27.8%	43
Rhode Island	173,000	20.2%	278,000	29.8%	34
South Carolina	1,037,000	30.9%	1,372,000	37.4%	11
South Dakota	152,000	24.6%	195,000	29.4%	36
Tennessee	1,278,000	25.3%	1,687,000	33.1%	23
Texas	7,063,000	38.7%	9,320,000	45.7%	1
Utah	570,000	28.1%	822,000	35.2%	13
Vermont	134,000	24.2%	145,000	26.6%	47
Virginia	1,599,000	26.2%	2,018,000	30.3%	33
Washington	1,436,000	27.5%	1,698,000	30.6%	32
West Virginia	473,000	31.9%	540,000	35.1%	15
Wisconsin	1,183,000	24.2%	1,281,000	26.8%	46
Wyoming	129,000	29.6%	141,000	31.4%	28
U.S. Total *	**72,534,000**	**29.6%**	**89,558,000**	**34.7%**	

* Numbers do not add due to rounding.

Source: Estimates prepared by The Lewin Group for Families USA (see Technical Appendix for details).

- The 10 states with the largest number of uninsured people for some or all of 2006-2007 were California (12,987,000), Texas (9,320,000), Florida (6,039,000), New York (5,491,000), Illinois (3,601,000), Georgia (3,096,000), Ohio (2,936,000), Pennsylvania (2,918,000), North Carolina (2,609,000), and Michigan (2,524,000) (Table 2).

Number of Months Uninsured

- Of the 89.6 million uninsured individuals, more than half (50.2 percent) were uninsured for nine months or more. Nearly two-thirds (63.9 percent) were uninsured for six months or more (Tables 3 and 4).
- Among all people under the age of 65 who were uninsured in 2006-2007, nearly one in five (18.7 percent) were uninsured for the full 24 months during 2006-2007; 19.4 percent were uninsured for 13 to 23 months; 12.1 percent were uninsured for 9 to 12 months; 13.7 percent were uninsured for 6 to 8 months; and 29.5 percent were uninsured for 3 to 5 months. Only 6.7 percent were uninsured for 2 months or less (Tables 3 and 4).

Table 3

Duration without Health Insurance for Uninsured People Under Age 65, 2006-2007

Months Uninsured	Number Uninsured	As Percent of All Uninsured
1-2 Months	5,966,000	6.7%
3-5 Months	26,415,000	29.5%
6-8 Months	12,252,000	13.7%
9-12 Months	10,794,000	12.1%
13-23 Months	17,360,000	19.4%
24 Months	16,772,000	18.7%
Total*	**89,558,000**	**100.0%**

* Numbers do not add due to rounding.

Source: Estimates prepared by The Lewin Group for Families USA (see Technical Appendix for details).

Work Status of the Uninsured

- Four out of five individuals (79.3 percent) who went without health insurance during 2006-2007 were from working families: 70.6 percent were employed full-time, and 8.7 percent were employed part-time (Table 5).
- In addition, 4.2 percent were looking for work (Table 5).
- Of the people who were uninsured during 2006-2007, only 16.5 percent were not in the labor force—because they were disabled, chronically ill, family caregivers, or were not looking for employment for other reasons (Table 5).

Table 4

People under Age 65 Who Were Uninsured for Six Months or More During 2006-2007, by State

State	Uninsured During 2006-2007	Uninsured 6+ Months	
	Number	Number	Percent
Alabama	1,383,000	876,000	63.3%
Alaska	215,000	132,000	61.4%
Arizona	2,216,000	1,492,000	67.3%
Arkansas	899,000	576,000	64.1%
California	12,987,000	8,557,000	65.9%
Colorado	1,443,000	954,000	66.1%
Connecticut	837,000	503,000	60.1%
Delaware	226,000	135,000	59.7%
District of Columbia	168,000	98,000	58.3%
Florida	6,039,000	4,106,000	68.0%
Georgia	3,096,000	2,012,000	65.0%
Hawaii	321,000	180,000	56.1%
Idaho	426,000	270,000	63.4%
Illinois	3,601,000	2,226,000	61.8%
Indiana	1,757,000	1,084,000	61.7%
Iowa	664,000	380,000	57.2%
Kansas	682,000	410,000	60.1%
Kentucky	1,109,000	678,000	61.1%
Louisiana	1,344,000	859,000	63.9%
Maine	311,000	182,000	58.5%
Maryland	1,522,000	936,000	61.5%
Massachusetts	1,439,000	838,000	58.2%
Michigan	2,524,000	1,479,000	58.6%
Minnesota	1,084,000	604,000	55.7%
Mississippi	967,000	618,000	63.9%
Missouri	1,465,000	874,000	59.7%
Montana	271,000	178,000	65.7%
Nebraska	437,000	262,000	60.0%
Nevada	826,000	559,000	67.7%
New Hampshire	271,000	157,000	57.9%
New Jersey	2,447,000	1,572,000	64.2%
New Mexico	745,000	497,000	66.7%
New York	5,491,000	3,363,000	61.2%
North Carolina	2,609,000	1,691,000	64.8%
North Dakota	152,000	95,000	62.5%
Ohio	2,936,000	1,739,000	59.2%
Oklahoma	1,144,000	740,000	64.7%
Oregon	1,094,000	715,000	65.4%
Pennsylvania	2,918,000	1,726,000	59.2%
Rhode Island	278,000	168,000	60.4%
South Carolina	1,372,000	880,000	64.1%
South Dakota	195,000	117,000	60.0%
Tennessee	1,687,000	1,036,000	61.4%
Texas	9,320,000	6,507,000	69.8%
Utah	822,000	535,000	65.1%
Vermont	145,000	84,000	57.9%
Virginia	2,018,000	1,260,000	62.4%
Washington	1,698,000	1,034,000	60.9%
West Virginia	540,000	353,000	65.4%
Wisconsin	1,281,000	760,000	59.3%
Wyoming	141,000	88,000	62.4%
U.S. Total*	**89,558,000**	**57,178,000**	**63.9%**

* Numbers do not add due to rounding.

Source: Estimates prepared by The Lewin Group for Families USA (see Technical Appendix for details).

Table 5

People under Age 65 without Health Insurance during 2006-2007, by Family Employment Status

Family Employment Status At End of Period	Number Uninsured	As Percent of All Uninsured
Employed Full- or Part-Time	71,051,000	79.3%
Employed Full-Time	63,229,000	70.6%
Employed Part-Time	7,822,000	8.7%
Unemployed (seeking work)	3,730,000	4.2%
Not in Labor Force	14,777,000	16.5%
Total*	**89,558,000**	**100.0%**

* Numbers do not add due to rounding.

Source: Estimates prepared by The Lewin Group for Families USA (see Technical Appendix for details).

Every Racial and Ethnic Group Is Affected

- Although racial and ethnic minorities are more likely to be uninsured, white, non-Hispanic people accounted for nearly half (48.5 percent) of the uninsured in 2006-2007 (Table 6).
- Every racial and ethnic group experienced significant growth in the proportion of the non-elderly population that was uninsured between 1999-2000 and 2006-2007 (Table 7).
  - From 1999-2000 to 2006-2007, the proportion of the white, non-Hispanic population under the age of 65 that experienced a period without health insurance grew from 22.9 percent to 26.0 percent.
  - For the black, non-Hispanic population, the proportion increased from 39.8 percent to 44.5 percent.
  - For Hispanics, the proportion increased from 51.5 percent to 60.7 percent.
  - For other minorities, the proportion increased from 37.5 percent to 38.2 percent.

Nearly Every Age Group Is Affected

- Of the total 89.6 million uninsured people in 2006-2007, 64.2 million were uninsured adults (18 to 64 years old) (Table 8).
- More than one-third of the uninsured (34.9 percent) were ages 25 to 44—the age group that makes up the largest percentage of the uninsured (Table 8).

Table 6

People under Age 65 without Health Insurance during 2006-2007, By Race and Hispanic Origin

Race and Hispanic Origin	Number Uninsured	As Percent of All Uninsured
White, Non-Hispanic	43,463,000	48.5%
Black, Non-Hispanic	14,579,000	16.3%
Hispanic	24,806,000	27.7%
Other*	6,711,000	7.5%
Total**	**89,558,000**	**100.0%**

* "Other" includes those who identify themselves as American Indian, Aleut or Eskimo, Asian or Pacific Islander, or as a member of more than one group (e.g., white-black, white-Asian, black-Asian).

** Numbers do not add due to rounding.

Source: Estimates prepared by The Lewin Group for Families USA (see Technical Appendix for details).

Table 7

Uninsured People under Age 65, by Race and Hispanic Origin

Race and Hispanic Origin	1999-2000	2006-2007
White, Non-Hispanic		
Number Uninsured	38,789,000	43,463,000
Percent of Subgroup Uninsured	22.9%	26.0%
Black, Non-Hispanic		
Number Uninsured	12,838,000	14,579,000
Percent of Subgroup Uninsured	39.8%	44.5%
Hispanic		
Number Uninsured	16,242,000	24,806,000
Percent of Subgroup Uninsured	51.5%	60.7%
Other*		
Number Uninsured	4,664,000	6,711,000
Percent of Subgroup Uninsured	37.5%	38.2%

* "Other" includes those who identify themselves as American Indian, Aleut or Eskimo, Asian or Pacific Islander, or as a member of more than one group (e.g., white-black, white-Asian, black-Asian).

Source: Estimates prepared by The Lewin Group for Families USA (see Technical Appendix for details).

Table 8

People under Age 65 without Health Insurance during 2006-2007, by Age

Age	Number Uninsured	As Percent of All Uninsured
0-17 Years	25,382,000	28.3%
18-24 Years	15,017,000	16.8%
25-44 Years	31,212,000	34.9%
45-54 Years	11,003,000	12.3%
55-64 Years	6,944,000	7.8%
Total*	**89,558,000**	**100.0%**

* Numbers do not add due to rounding.

Source: Estimates prepared by The Lewin Group for Families USA (see Technical Appendix for details).

The Census Bureau and the Families USA Study: Two Different and Valid Measures of the Uninsured

The estimates of the number of Americans facing the physical and financial consequences of being uninsured that are presented in this study are based on a methodology that Families USA developed with The Lewin Group, a health and human services research consulting firm with more than 35 years of experience in empirical research and data analysis.

The estimates presented here are a different measure than the widely quoted estimates of uninsured Americans that are released by the Census Bureau each year. The most recent Census Bureau release reports an estimated 47.0 million (15.8 percent of the population) uninsured Americans in 2006. This number, derived from the Census Bureau's annual Current Population Survey, is intended to offer an estimate of how many people did not have any type of health insurance for an entire calendar year. There are many people, however, who are uninsured for a portion of a year but not for the entire year. These individuals are not reflected in the Census Bureau's estimate.

Thus, this study was designed to take a closer look and improve our understanding of how many people experience a significant gap in coverage. The Census Bureau's Current Population Survey (CPS) asks respondents a series of questions in March, which a respondent must answer by looking back at the time period from January 1 through December 31 of the previous year. If, and only if, the respondent answers that he or she did not have any kind of health insurance at any point during that previous calendar year will that person be counted as uninsured. (In spite of this, some health policy experts maintain that the CPS more closely reflects a point-in-time estimate of the uninsured.) However, there are many people who are uninsured for periods of time that do not neatly fall within a 12-month calendar year. The Families USA-Lewin methodology used in this study examines how many people under the age of 65 were without health insurance for at least one month—and up to the entire 24 months—during the two-year periods of 1999-2000 and 2006-2007.

By taking this closer look, we found that many more people experienced a significant gap in health coverage than is usually recognized, and that number is increasing rapidly. Our methodology includes, for example, a person who was uninsured from August 1, 2006, to April 1, 2007. This person would not be counted as uninsured in either 2006 or 2007 by the Census Bureau's Current Population Survey. Similarly, a person who was uninsured from January 1, 2006, until November 1, 2007—22 months without health insurance—would be counted by the Census Bureau as uninsured in 2006 but not counted as uninsured in 2007 (even though the person was uninsured for 10 months of 2007). No picture of the causes and consequences of being uninsured is complete unless it includes all who experience a significant gap in health coverage.

As described more fully in the Technical Appendix (see page 21), this study's estimates of the number of uninsured Americans are based exclusively on the most recent data projections from the Census Bureau's Current Population Survey, as well as its Survey of Income and Program Participation.

DISCUSSION

According to the U.S. Census Bureau, an estimated 47.0 million Americans were uninsured in 2006. This widely quoted number, which was derived from the Census Bureau's annual Current Population Survey (CPS), is designed to be an estimate of how many people did not have any type of health insurance for the entire previous calendar year. Although the CPS numbers provide a useful annual estimate of coverage and a tool that can be used to track trends in coverage from year to year, they are limited in their ability to paint a complete picture of the health insurance crisis.

This study was designed to take a closer look at the uninsured in America and to improve our understanding of how many people experience significant gaps in coverage and how this has changed over time. For this analysis, Families USA examined trends in health insurance coverage from the beginning of 1999 to the end of 2007 (our methodology allowed us to project through the end of 2007—see the Technical Appendix for details). We looked at trends in health insurance over two two-year periods: 1999-2000 and 2006-2007. This study not only measures the number of uninsured people over a longer period of time than the CPS alone (two years versus one), it also measures the number of people who are uninsured for different lengths of time (see box on page 8).

Our analysis yielded disturbing results: We found that 89.6 million people under the age of 65—more than one out of every three (34.7 percent) non-elderly Americans—went without health insurance for all or part of 2006-2007. In addition, we found that the number of uninsured people increased dramatically over our study period: Between 1999-2000 and 2006-2007 alone, more than 17.0 million Americans under the age of 65 joined the ranks of the uninsured (Table 1).

A Shared Problem

Our findings demonstrate that uninsurance affects a diverse array of people. Americans from every income group, every racial and ethnic group, and nearly every age group are uninsured. Moreover, this is a problem that has grown significantly over the years. Between 1999-2000 and 2006-2007, the number of states where more than one out of three people under the age of 65 were uninsured for all or part of the two-year period more than doubled—rising from nine states in 1999-2000 to 20 states plus the District of Columbia in 2006-2007 (Table 2).

Our analysis also found several key characteristics that the uninsured have in common. First and foremost, as previous research has demonstrated, the vast majority of the uninsured are from working families.[1] Four out of five individuals (79.3 percent) who were uninsured during 2006-2007 were from working families; 70.6 percent of the uninsured were from families with one or more people employed full-time (Table 5).

Why Do the Numbers of Uninsured Vary across States?

Four primary factors influence the uninsured rate in each state:

1. **Labor market variations**: The composition of a state's labor market affects the state's percentage of uninsured. Individuals who work in low-wage jobs, and those who work on a part-time, temporary, or seasonal basis ("nontraditional workers"), are less likely to have health insurance than those who work in higher-wage, full-time jobs. In states with a larger proportion of nontraditional or low-wage workers, the rates of uninsured tend to be higher.
2. **Demographics**: Demographic factors such as the age of state residents influence the uninsured rate. Among adults, the likelihood of being uninsured declines as individuals age. A state with a higher proportion of non-elderly individuals over the age of 45 is therefore likely to have lower levels of uninsured than a state with a higher proportion of individuals under the age of 45.
3. **Public programs**: Medicaid and CHIP eligibility levels, as well as the availability of other state health insurance programs, affect insurance coverage in each state. States that have expanded Medicaid or Children's Health Insurance Program (CHIP) coverage beyond federally set minimums, and those states that offer coverage through other state-run health insurance programs, tend to have lower rates of uninsured than states that have not expanded coverage.
4. **State policies and insurance laws**: Today, the regulation of the health insurance industry is a hodgepodge of federal and state rules. Some states provide stronger protection against discrimination than others, and there are few limits on insurance company profits. State rules, such as those that govern whether insurance companies can deny coverage and the price that can be charged, affect the rate of uninsured.

Second, the majority of people who are uninsured remain uninsured for substantial periods of time. Our findings demonstrate that nearly two-thirds (63.9 percent) of those who went without health insurance for some or all of 2006-2007 were uninsured for six months or more. More than half (50.2 percent) were uninsured for nine months or more. The effects of being uninsured—even for a period of a few months—can be devastating, both financially and physically (see "Why Insurance Matters" on page 16). Furthermore, as the duration of uninsurance increases, so do the chances of facing catastrophic financial and health problems.[2]

Why Is the Number of Uninsured on the Rise?

The results of our analysis are clear: Millions of people are currently uninsured, and this problem has grown substantially between 1999 and today. How have we gone so far in the wrong direction? Increases in health insurance premiums, a changing labor market, and underfunded health care safety net programs have all contributed to the growth in the number of uninsured Americans during this period.

- **Health Insurance Premiums on the Rise**

  Premiums for both job-based and individual health insurance have risen rapidly between 1999 and today, increasing by double-digit amounts annually between 2001 and 2004. Moreover, these rising premiums have far outstripped increases in worker earnings.[3] Between 2000 and 2006, premiums for job-based health insurance increased by 73.8 percent, while median worker earnings rose by only 11.6 percent.[4] As premium costs outpace wages, more people end up without health insurance: For each percentage point increase in health care costs relative to income, the number of uninsured people increases by 246,000.[5]

  Faced with the rising cost of health insurance premiums, employers must make difficult decisions. Some employers, particularly small businesses, have concluded that they can no longer afford to offer health insurance to their workers and have dropped coverage, further increasing the number of uninsured Americans.[6] Other employers continue to offer health insurance, but they now ask their employees to pay a greater share of the premiums. In addition, a growing number of employers seek to hold down costs by offering "thinner coverage"—coverage that offers fewer benefits and/or that comes with higher deductibles, copayments, and co-insurance.[7]

  Working families also must contend with a set of difficult decisions. Even if someone in the family has an offer of coverage through his or her employer, he or she is likely to be required to pay more for fewer benefits than in the past. Between 2000 and 2006, the employee share of family insurance premiums increased by 78.2 percent.[8] As a result, more and more working families are being priced out of job-based insurance.[9]

Workers without an offer of job-based coverage—and those who cannot afford to purchase their employer's plan—may seek coverage on their own. Finding an individual insurance plan that meets their needs and their budget is likely to be extremely challenging. One recent survey found that nine out of 10 people who sought individual coverage never purchased a plan—either because they couldn't find an affordable plan, they were rejected for coverage, or they were offered a plan that excluded coverage for the very care they are most likely to need.[10]

In order to bring America's uninsurance crisis under control, the rapid rise in premiums must be slowed. To do this, we must address the root causes of premium increases. One of the main causes is the rise of underlying health care costs: Throughout the study period of this report, both hospital and prescription drug costs increased at rates far greater than inflation.[11]

While these cost increases were some of the primary drivers of rising overall health care costs, the development and increased use of new medical technologies also played a significant role.[12] Advances in medicine, such as the development of new biological drugs, surgical procedures, and diagnostic tools, have improved the quality of care for a number of medical conditions. New technology, however, comes at a high price. Some health care experts estimate that the costs associated with these new medical technologies account for as much as half of the increase in overall health care spending.[13]

New medical technologies and rising underlying costs have led to rapid increases in the amount we spend on health care. Between 1999 and 2007, the amount we spent annually on health care for each American grew from $3,818 to a projected $6,249—an increase of 63.7 percent.[14] As underlying health care costs continue to go up, health insurance becomes even less affordable, and the number of uninsured people rises.

Premium increases caused by the rise in underlying health care costs are compounded by policies that favor insurance companies over working families. Many states lack consumer protections that would help ensure that insurance companies treat people fairly. In some markets, for example, insurers can discriminate against people because of age, health status, and a range of other factors. In these markets, insurers are free to charge high premiums, eliminate coverage of certain services, or deny coverage. Moreover, health insurance companies are generally free to decide how much of each dollar they collect in premiums will be spent on health care, how much will be spent on overhead (such as marketing and advertising), and how much will be retained as profits. Health insurance companies are now spending more than ever on overhead and pulling in record profits, even as the price of insurance continues to rise and more and more working Americans find themselves uninsured.[15]

Lack of consumer protections is exacerbated by a trend in mergers among insurance companies. A 2007 study found that there were more than 400 insurance company mergers in the last 12 years, which resulted in near-monopoly power among insurance companies. In nearly two-thirds of major metropolitan areas, a single insurer controls half or more of the market; in 96 percent of metropolitan areas, a single insurer controls at least 30 percent of the market.[16] Without rules to govern the influence and growth of large insurers, premiums are likely to continue their rapid ascent. Appropriate oversight can help bring down the cost of premiums, making health care more affordable for all Americans.

- **A Changing Labor Market**

  Labor market dynamics also have a profound effect on insurance coverage. The likelihood that workers are offered health insurance is closely related to a range of factors, including the industry that they work in, the hours that they work, whether they are permanent or temporary employees, and the size of the company. Traditionally, full-time, permanent employees in professional or government jobs—so-called "white-collar" workers—have been the most likely to have job-based health insurance. The vast majority of white-collar workers have health coverage. In contrast, so-called "blue-collar" workers who are employed in the service or agricultural sectors, as well as workers who are employed on a part-time, temporary, seasonal, or contract basis, are far less likely to have insurance. One recent study found that just one out of five (21 percent) such "nonstandard" workers had job-based health insurance. In contrast, three-quarters (74 percent) of full-time, permanent, salaried employees had job-based coverage.[17]

  Although these differences in coverage between white- and blue-collar workers have existed for years, data indicate that job-based health insurance is becoming increasingly scarce in all sectors. The proportion of Americans with employer-based insurance dropped by 4.5 percentage points between 2000 and 2006 (from 64.2 percent in 2000 to 59.7 percent in 2006).[18] This decline has been driven in part by a shift from jobs that typically offer health insurance, such as those in the manufacturing sector, to those that typically do not offer health insurance, such as those in the retail and service sectors.[19]

  In addition, much of the decline in employer-based insurance is associated with the rising costs of that coverage. As insurance premiums rise, employers have an incentive to shift workers to positions that do not offer health coverage. Moving workers into part-time, seasonal, temporary, or other nonstandard positions enables employers to avoid the cost of providing health insurance. Currently, 34.3 million people—about a quarter of the U.S. workforce—are nonstandard workers, and the proportion of nonstandard workers is likely to grow if premiums continue to rise.[20]

These labor market dynamics also help explain some of the demographic trends we discussed earlier in this analysis. Although rising health care costs lead to declines in health insurance across the board, individuals in low-wage, nonstandard jobs are less likely to have insurance in the first place, and they are more likely to lose coverage when premiums rise. As a result, racial and ethnic minorities—who are disproportionately employed in sectors that do not typically offer health benefits or in nonstandard jobs—are more likely to be uninsured.[21]

- **An Underfunded Safety Net**

  Medicaid and the Children's Health Insurance Program (CHIP) provide health coverage to more than 60 million low-income people, primarily children and families.[22] Without these programs, millions more would be uninsured.

  Although these programs are vitally important, many people wrongly assume that Medicaid and CHIP offer coverage to all low-income and vulnerable Americans. Contrary to this assumption, Medicaid and CHIP are targeted programs that serve specific groups of low-income people—mainly children and their parents. These programs do not cover millions of other low-income Americans who are uninsured and no less needy—typically low-wage workers and their dependents.[23] Moreover, the current structures of Medicaid and CHIP give each state and the District of Columbia wide latitude to set their own rules about who is eligible, in addition to income guidelines and enrollment procedures.

  In almost all states, income eligibility levels differ radically based on family status. In nearly four out of five states, for example, a child is eligible for public health coverage (through either Medicaid or CHIP) if that child's family income is below 200 percent of the federal poverty level ($34,340 for a family of three in 2007). However, the eligibility standards are much lower for parents than they are for children. The average income eligibility level for working parents is 65 percent of the federal poverty level—only $11,161 in annual income for a family of three in 2007.[24] Even worse, in an overwhelming majority of states, childless adults who do not qualify for disability-related coverage can be penniless and still not qualify for meaningful public health coverage.[25] In addition, most states that offer any form of coverage to childless adults either charge hefty out-of-pocket costs or provide limited benefits that do not include all of the services typically provided by health insurance, such as catastrophic care and specialty services.[26] Bare-bones plans such as these leave working adults exposed to the same financial and physical risks that the uninsured face.

  In light of state variations in Medicaid and CHIP, it is clear that there are many holes in the current safety net. To reduce the number of uninsured, states must have the resources necessary to extend vitally important coverage to Americans in need.

CONCLUSION

This study sheds more light on one of the worst predicaments facing our country today: More Americans than ever before are uninsured, and the situation is rapidly worsening. With more than one out of three non-elderly Americans now uninsured—17 million more than just a few years ago—the problem is reaching crisis proportions. Rising health insurance premiums are putting health coverage out of reach for many workers and employers, while changing labor markets and employment patterns are leaving more workers without even an offer of coverage. At the same time, mergers in the insurance industry are increasing the power that insurance companies have over vulnerable consumers. Furthermore, federal rules leave public health programs, such as Medicaid, unable to provide assistance to the millions of low-income working people who are uninsured but do not meet eligibility requirements. Together, these factors are crippling our nation's health care system.

Our country is at a crossroads: We can make addressing the health coverage crisis the top domestic priority, or we can continue moving in the wrong direction. The trends documented in this report show the terrible consequences of inaction. This crisis will only worsen until there is national leadership in Washington, D.C. that takes decisive and meaningful action to ensure that health coverage is available and affordable for all.

Why Insurance Matters

1 The uninsured are less likely to have a usual source of care outside the emergency room.

- Uninsured adults are up to four times less likely to have a regular source of care than the insured.[27]
- Uninsured children are nearly 13 times less likely to have a regular source of care than insured children.[28]
- Uninsured adults are almost seven times more likely than insured adults to consider the emergency room their usual source of care (19 percent compared to 3 percent).[29]
- Two-thirds of all care provided to uninsured Americans is provided by hospitals.[30]

2 The uninsured often go without screenings and preventive care.

- Uninsured adults are more than 30 percent less likely than insured adults to have had a checkup in the past year.[31]
- Uninsured women are two times less likely than insured women to have had a pap test in the last year.[32]
- Uninsured adults are more likely to be diagnosed with a disease in an advanced stage. For example, uninsured women are substantially more likely to be diagnosed with advanced stage breast cancer than women with private insurance.[33]
- Even when uninsured adults do receive preventive care and know they have a chronic condition, they are less likely to receive proper follow-up care. For example, uninsured patients with high blood pressure are less likely to have their blood pressure monitored and controlled, and they are less likely to receive disease management services.[34]

3 The uninsured often delay or forgo needed medical care.

- Uninsured Americans are up to three times more likely to report having problems getting needed medical care.[35] Uninsured adults are more than three times as likely as insured adults to delay seeking medical care (47 percent versus 15 percent).[36] And uninsured children are nearly five times more likely than insured children to have at least one delayed or unmet health care need.[37]
- Nearly 70 percent of uninsured adults who are in poor health, and nearly 50 percent of uninsured adults in fair health, report that when they needed care in the past year, they were unable to see a physician because of cost.[38]
- One in three uninsured adults did not fill a drug prescription in the past year, and the same proportion went without recommended tests or treatment due to cost.[39]
- Uninsured people with chronic health conditions or injuries receive less care than their insured counterparts and are less than half as likely to receive any of the recommended follow-up care.[40] For example, uninsured people with heart disease have 28 percent fewer ambulatory care visits (in physicians' offices, clinics, or hospital outpatient settings) than insured people with heart disease.[41]

- Previously uninsured adults report greater use of health services and require more costly care once they obtain Medicare coverage at age 65 compared to those who were previously insured.[42]

4 Uninsured Americans are sicker and die earlier than those who have insurance.

- The uninsured consistently report that they are in poorer health than people with private insurance. Lower levels of self-reported health status, in turn, are a powerful predictor of future illness and premature death.[43]
- Uninsured adults are 25 percent more likely to die prematurely than adults with private health insurance coverage.[44]
- Every year, the deaths of 18,000 people between the ages of 25 and 64 can be attributed to a lack of health insurance. This makes uninsurance the sixth leading cause of death, ahead of HIV/AIDS and diabetes.[45]
- Uninsured Americans between 55 and 64 years of age are at much greater risk of premature death than their insured counterparts. This makes uninsurance the third leading cause of death for the near elderly, following heart disease and cancer.[46]
- Uninsured children admitted to the hospital due to injuries were twice as likely to die while in the hospital as their insured counterparts.[47]
- Uninsured patients are three times more likely to die in the hospital than insured patients.[48] Moreover, uninsured patients are more likely to experience lower-quality care. For example, uninsured patients with colorectal carcinoma (a type of colon cancer) were found to have worse postoperative outcomes, such as complications of surgery, and a greater risk of dying after surgery.[49]

5 The uninsured pay more for care—and so do the rest of us.

- Uninsured patients are unable to negotiate the discounts on hospital and doctor charges that insurance companies do. As a result, uninsured patients are often charged more than 2.5 times what insured patients are for hospital services.[50]
- Three out of five uninsured adults (60 percent) under the age of 65 reported problems with medical bills. [51]
- Nearly one-third of uninsured adults under age 65 had to make significant changes to their lifestyle to pay medical bills.[52]
- Over the course of a year, more than one out of three uninsured people are contacted by a collection agency about outstanding medical bills.[53]
- Uninsured Americans received approximately $43 billion in "uncompensated care"—care for which the provider was not paid—in 2005.[54] Although the uninsured struggle to pay as much as they can, the average premium for family health insurance provided by an employer was $922 higher in 2005 due to the cost of health care for the uninsured that they could not afford to pay themelves.[55]

ENDNOTES

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TECHNICAL APPENDIX

Estimating Lack of Health Insurance at the National and State Level at Any Time in 1999-2000 and 2006-2007

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EXECUTIVE SUMMARY

The Lewin Group estimated the number of individuals under age 65 without health insurance for at least one month over the 1999-2000 and the 2006-2007 periods. Estimates were calculated by combining several data sources. National and state estimates were calculated using the Survey of Income and Program Participation (SIPP) and the Current Population Survey (CPS). The SIPP was chosen because of its large sample size, state identifiers, and monthly reporting of health insurance status. The CPS provides the most recent data on health insurance coverage, employment, income, and population estimates, and it supports state-level estimates.

For the 1999-2000 period, national estimates were based on waves seven through 12 of the 1996 Panel of the SIPP and adjusted to reflect the population characteristics of the March 2000 CPS. For the 2006-2007 period, national estimates were based on waves four through nine of the SIPP and adjusted to reflect the population characteristics of the March 2006 CPS.

State-level estimates were derived by applying a set of SIPP-derived regression equations to data from the March 2000 CPS and March CPS respectively. In the case of the 1999-2000 period, the logistic regression models predicted whether an individual would not have health insurance for at least one month over a 24-month period from the beginning of April 1998 to the end of March 2000. The 2006-2007 models predicted whether an individual would not have health insurance over a 24-month period from the beginning of February 2006 through January 2008.

Separate equations were estimated for children and non-elderly adults. In addition to demographic and socioeconomic variables directly in the CPS, we added state-level variables to reflect changes in Medicaid coverage for children through the end of 2000 for the 1999-2000 estimates and through 2006 for the 2006-2007 estimates.

INTRODUCTION

For this report, we developed state-level estimates of the number of individuals who did not have health insurance at any point over a two-year period and of those without insurance for six months or more over a two-year period. We produced separate estimates for children (those younger than 18) and non-elderly adults (adults ages 18-64). We also produced tables showing the number and proportion of uninsured by selected characteristics.

There are several methods for estimating the number of uninsured people. A point-in-time estimate reports the number of people who are without health insurance at one point in time (e.g., on a given day or in a given month). Alternatively, an estimate over a period of time reports the number of people who are without health insurance at any time during the period (e.g., during the last year).

We used an estimate of the uninsured over a period of time for both analyses for several reasons. First, because many of the uninsured are without insurance for a short period of time, a point-in-time estimate understates the population at risk of being without health insurance. Second, estimates based on individuals who are uninsured over a period of time provide a more accurate representation of all of the people who lose their insurance. This is because a point-in-time estimate will contain a disproportionate share of people who were uninsured for a long period of time, and these individuals often have a different mix of characteristics than those who are uninsured for a short period of time.[1]

For the 1999-2000 analyses, we used the 1996 SIPP and the March Annual Supplement of the 2000 CPS. We used the 1996 SIPP because it contains the data to provide monthly insurance information longitudinally over the two-year period. We used the CPS because it provides the state-level estimates. Both surveys are nationally representative and contain basic demographic and economic characteristics of the non-institutionalized population. The 1996 SIPP contains 48 months of data, from which we used records for individuals with 24 months of data spanning 1998 and 2000. This file contained approximately 47,642 individuals, of which about 40,570 were non-elderly people, including 11,592 children. The 2000 CPS contained data on approximately 133,710 individuals, of which about 117,802 were non-elderly people, including 36,493 children.

In the case of the 2006-2007 analyses, we used the 2001 Panel of the Survey of Income and Program Participation (SIPP) and the March Annual Supplement of the 2006 Current Population Survey (CPS). This SIPP file contained approximately 51,788 individuals, of which about 44,308 were non-elderly people, including 12,808 children. The 2006 CPS contained data on approximately 208,562 individuals, of which about 188,149 were non-elderly people, including 62,810 children.

STATE-LEVEL ESTIMATES

There are no reliable state-level estimates of health insurance coverage over a period of time. Although the SIPP allows estimates over a period of time and specifically captures coverage of dependents, its sample does not support state-level estimates (although it includes state identifiers for analytic purposes). The CPS allows state-level estimates, and the March 2000 and 2006 CPS reflects augmented samples, which allow greater statistical accuracy for state-level estimates. The CPS asks whether an individual was covered at any time over the prior year by each of the following: Medicare, Medicaid, private health insurance, or military health.[2] Combining the questions allows one to count individuals who, in theory, were not covered by any type of insurance during the year. The resulting estimate, which should be a period-of-time estimate, actually appears to be more comparable to a point-in-time estimate generated from the SIPP than to an all-year estimate (Table 1).

Technical Appendix Table 1

1999 Estimates of the Prevalence of Uninsurance among People under Age 65

Data Source	Percent Uninsured All Year	Percent Uninsured At Any Time during The Year	Percent Uninsured At a Point In Time
Current Population Survey	15.9%	n/a	n/a
Survey of Income and Program Participation	8.5%[a]	25.4%[a]	16.6%[b]
Medical Expenditure Panel Survey	12.2%	25.0%	17.3%

[a] Calculated using longitudinal weight for year 1999.

[b] Calculated using monthly weight for month 24, roughly representing the end of 1999.

Note: The Medical Expenditure Panel Survey (MEPS) asks about health insurance status in each quarter over a one-year period.

Some researchers have hypothesized that the CPS may be closer to a point-in-time estimate because the individuals who are interviewed may be reporting their current health insurance status rather than their coverage over the past year.[3] However, Robert Bennefield of the Bureau of the Census argued that the CPS primarily appears to underreport insurance coverage in general, resulting in higher than expected reporting of the percent uninsured.[4] However, a verification question added to the CPS beginning in 2001 only modestly reduced the CPS uninsured estimate (e.g., from 17.4 percent to 16.1 percent in the March 2002 CPS). Given that the point-in-time prevalence of uninsurance from the SIPP was much closer to the CPS prevalence rate than the uninsured-all-year estimate from the SIPP, we chose to treat the CPS data as point-in-time estimates in order to generate our over-a-period-of-time estimates.

SIPP Equations

In order to use the state-level information available from the CPS to generate estimates of the lack of health insurance for one or more months among those with health insurance at a point in time, we estimated logistic regression equations that describe the relationship between an individual's characteristics at a point in time and their health insurance status over the course of two years. We generated these equations using data from the SIPP. Tables 2a and 2b present selected characteristics of the population that is insured at a point in time from the SIPP and CPS files used in the analysis.

The SIPP files for both analysis periods necessarily include individuals with data over the two-year periods 1999-2000 and 2003-2004 respectively. Survey dropouts and additions over the period tend to distort the sample because lack of insurance may be more common among survey dropouts, whose lives may be more transient and subject to dislocation (as demonstrated by their lack of continued participation in the survey). To adjust for this, we used the weights made available by the Census for both periods and adjusted them by age, sex, race, and income group to match the population in both periods.[5] Adjusting the weights this way mitigates the bias in health insurance coverage caused by survey dropouts because health insurance coverage is also correlated with the factors used to adjust the weights. Moreover, the regression equations include these same factors and therefore control for them. We note that results from the logistic regression equations were very similar with and without the weights, suggesting that the bias produced by survey dropouts is minimal.[6]

Because we are using the CPS as a point-in-time insurance estimate, we assume that people indicating no coverage in the March CPS lack coverage in March of each of the CPS survey years. Using March as a proxy for the end of the prior calendar year, we already know that all individuals reporting a lack of coverage in the March CPS are uninsured for at least one month over the two-year reference period. Thus, we exclude these individuals from the 1+ month equations and leave the equation to predict which of those who have coverage at the end of the survey year lack it at some other point during the previous two years. In contrast, all records are used for the 6+ month equations, and lack of insurance at the end of the year is used to predict lack of insurance for 6+ months.

We estimated four separate equations for each of the analysis periods from the SIPP data to predict the following outcomes:

- Children uninsured 1+ months over two years
- Children uninsured 6+ months over two years
- Adults uninsured 1+ months over two years
- Adults uninsured 6+ months over two years

Technical Appendix Table 2a

Comparison of SIPP and CPS Data Used in Model Characteristics of People Under 65 without Health Insurance at a Point in Time, 1999-2000 Estimates

	SIPP 1999-2000[a]	CPS March 2000[b]
Age		
Less than 6	4.3%	7.8%
6 to 17	22.9%	16.0%
18 to 34	39.7%	39.0%
35 to 64	33.1%	37.2%
Family Income as Percent of Federal Poverty Level		
<100%	23.6%	27.4%
100-199%	30.0%	28.2%
200-299%	19.5%	17.5%
300-399%	11.8%	9.6%
400%+	15.2%	17.2%
Race		
White, non-Hispanic	57.8%	50.2%
Black, non-Hispanic	18.7%	17.1%
Hispanic	18.9%	25.8%
Other Race	4.6%	7.0%

[a] Based on 1999-2000 SIPP sample, weighted using monthly weight for month 24.

[b] Model assumes that estimate of lack of insurance from March 2000 CPS represents a point-in-time measure for March 2000.

Technical Appendix Table 2b

Comparison of SIPP and CPS Data Used in Model Characteristics of People Under 65 without Health Insurance at a Point in Time, 2006-2007 Estimates

	SIPP 2003-2004[a]	CPS March 2006[b]
Age		
Less than 6	13.3%	5.7%
6 to 17	17.7%	12.4%
18 to 34	37.0%	41.4%
35 to 64	32.0%	40.5%
Family Income as Percent of Federal Poverty Level		
<100%	26.1%	28.0%
100-199%	26.1%	29.0%
200-299%	18.5%	18.3%
300-399%	10.3%	9.6%
400%+	19.0%	15.1%
Race		
White, non-Hispanic	48.5%	46.7%
Black, non-Hispanic	16.3%	14.9%
Hispanic	28.1%	31.2%
Other Race	7.1%	7.3%

[a] Based on 2003-2004 SIPP sample, weighted using monthly weight for month 24.

[b] Model assumes that estimate of lack of insurance from March 2006 CPS represents a point-in-time measure for March 2006.

We estimated separate equations for children and adults because children's insurance coverage has been driven in recent years by changes in the State Children's Health Insurance Program (SCHIP). These equations perform two functions: First, applying them to the CPS allows us to generate state-level, over-time estimates of uninsurance from the (assumed) point-in-time information available from the CPS. Second, by incorporating key state-level variables that influence insurance coverage (i.e., unemployment and SCHIP enrollment), the equations allow us to reflect insurance trends through the end of the analysis years.

Table 3 summarizes the samples and variables used for each equation. The equations use a combination of variables representing characteristics of the individual, their parents (for children), and their state. The following variables represent the characteristics of the individual in all equations:

- **Age** (0-5, 6-16, 17, 18-20, 21-34, 35-60, 61-64): Age groups were chosen to correspond to likely differences in availability of insurance by age. For example, Medicaid eligibility in some states is more restrictive for children ages 6-16 than for children ages 0-5, and more restrictive still for children above age 16.
- **Family income as a percent of the federal poverty level (FPL)** (<=100%, 101-199%, 200%+): Family income is the same for all members of a family. The poverty level used is the Federal Poverty Threshold, which is the measure typically used for statistical reporting of poverty rates.
- **Race/ethnicity** (white, non-Hispanic; black, non-Hispanic; Hispanic; other)
- **Sex** (male/female)

The following variable represents the characteristic of the individual for adults, but represents the characteristics of the parents of children:

- **Education** (less than high school diploma, high school diploma [including some college], college degree or higher): For children, if both parents have the same employment status, education represents the education of the most educated parent. If one parent is employed and the other is not, education represents the education of the working parent.

The following state-level variables were added to the SIPP to capture characteristics of an individual's state that could affect his/her likelihood of having insurance:

- **Children's Medicaid coverage** (continuous variable): This variable is important because changes in Medicaid coverage for children between the two analysis years may vary considerably by state as SCHIP coverage expands in some states and contracts in others (see Tables 4a and 4b). We calculated annual children's Medicaid enrollment as a percentage of children in the state with family income below 200 percent of the Federal Poverty Threshold. This measure is meant to capture states' progress in covering low-income children through the end of the analysis year. Enrollment includes standard Medicaid plus the State Children's Health Insurance Programs. To

Technical Appendix Table 3

Samples and Variables Used for Logistic Regression Equations from SIPP Predicting Lack of Insurance over 24 Months

	Children		Adults	
	Uninsured 1+ Months	Uninsured 6+ Months	Uninsured 1+ Months	Uninsured 6+ Months
Sample	Sample: Children (age <18) with health insurance in month 24	Sample: Children (age <18) with health insurance	Sample: Adults (ages 18-64) in month 24	Sample: Adults (ages18-64)
Dependent	Uninsured any time over 2 years	Uninsured for 6+ months over 2 years	Uninsured any time over 2 years	Uninsured for 6+ months over 2 years
Independent Variables:				
Age	0-5 6-16* 17	0-5* 6-16 17*	18-20 21-24 25-34 35-60* 61-64	18-20 21-24 25-34 35-60* 61-64
Family Income (as % of federal poverty level)	<100% FPL 100-199% FPL 200%+ FPL*	<100% FPL 100-199% FPL 200%+ FPL*	<100% FPL 100-199% FPL 200%+ FPL*	<100% FPL 100-199% FPL 200%+ FPL*
Race/Ethnicity	White, non-Hispanic* Black, non-Hispanic Hispanic Other	White, non-Hispanic* Black, non-Hispanic Hispanic Other	White, non-Hispanic* Black, non-Hispanic Hispanic Other	White, non-Hispanic* Black, non-Hispanic Hispanic Other
Sex	(Not used)	(Not used)	Male	Male
Education	Parent has less than high school diploma Parent is a high school graduate Parent is a college graduate * (Note: Child assigned education of the more highly educated parent, or education of employed parent if only one parent employed)	Parent has less than high school diploma Parent is a high school graduate Parent is a college graduate * (Note: Child assigned education of the more highly educated parent, or education of employed parent if only one parent employed)	Individual has less than high school diploma Individual has high school diploma Individual has college degree or higher*	Individual has less than high school diploma Individual has high school diploma Individual has college degree or higher*
Employment Status	Employed @ month 24* Unemployed @ month 24 Not in lobor force*	(Not used)	Employed @ month 24* Unemployed @ month 24 Not in labor force*	(Not used)
Health Coverage Status for Month 24	(Not used)	Uninsured for month 24	(Not used)	Uninsured for month 24
Medicaid	Percent of children in state < 200% of Federal Poverty Threshhold enrolled in Medicaid/SCHIP annually	Percent of children in state < 200% of Federal Poverty Threshhold enrolled in Medicaid/SCHIP annually	(Not used)	(Not used)

* Indicates reference group omitted from equation.

calculate, we summed Medicaid enrollment estimates and counts of the number of children covered by SCHIP plans that are not already part of the state Medicaid plan. We then divided by the estimated number of children with family incomes below 200 percent of the Federal Poverty Threshold from the CPS to calculate enrollment rates in the general target population. This measure may not, and is not meant to, resemble states' own estimates of children's Medicaid enrollment rates. For example, combining annual enrollment counts with point-in-time estimates from CPS tends to systematically inflate enrollment rates. This bias should have no meaningful effect on the projected estimates or a state's ranking because it is consistent across all states and between years.

- **Employment status** (employed, unemployed, not in labor force): We used employment at the end of the period.

Explanatory variables were generally kept in the modeling equations only if they were significant at the 0.05 level. For example, in the children equation, employment was significant in the 1+ month equation but not significant in the 6+ month equation. The resulting coefficients for the four equations are described in Tables 5a and 5b and 6a and 6b.

In each case, the probability that an individual lacks health insurance (for 1+ or 6+ months) for each analysis period is $e^Y/(1+e^Y)$.

Applying Equations to the CPS Data

Before applying the equations to the March CPS, we added the most recent state-level data on Medicaid enrollment. The added variables reflect changes through the end of 2000 and 2006 respectively (see Tables 4a and 4b). Thus, in applying these equations to the March CPS, we produced state-level estimates that reflect coverage conditions through the end of each of the analysis years. We note, however, that the population reflected in these estimates represents the total U.S. population as of March of the analysis year. We further adjusted the weights to reflect population growth between March and December of the analysis year.

Applying the equation to the augmented March CPS produces the probability that each individual would not have health insurance at some point during a two-year period. We then sum the product of individuals' probabilities and their weights to calculate the number of people without coverage. For the 1+ month estimates, we then add the individuals who report no coverage in March (because individuals already known to lack insurance at a point in time were excluded from the equation). The sum of the individuals estimated to currently have health insurance but who are predicted to not have health insurance for at least one of the other 23 months and those who reported no health insurance in the CPS equals the total number of people who were reported to be uninsured at some point over a two-year period.

For the 6+ month estimate, we simply apply the equation to produce the probability of lacking insurance for six months or more and multiply these probabilities by the weights.

Technical Appendix Table 4a

Annual Percent of Children under 200% Federal Poverty Level Enrolled in Medicaid/SCHIP, 1999-2000

State	1999	2000	State	1999	2000
Alabama	69.4%	65.7%	Montana	49.3%	44.5%
Alaska	100.8%	104.1%	Nebraska	91.5%	92.7%
Arizona	67.4%	56.8%	Nevada	50.5%	35.7%
Arkansas	64.6%	85.0%	New Hampshire	72.8%	70.4%
California	85.6%	77.2%	New Jersey	81.4%	88.1%
Colorado	62.4%	59.6%	New Mexico	85.6%	76.7%
Connecticut	93.7%	89.8%	New York	100.5%	68.2%
Delaware	116.8%	74.2%	North Carolina	79.1%	84.7%
District of Columbia	116.6%	141.2%	North Dakota	45.7%	45.3%
Florida	77.1%	73.6%	Ohio	75.3%	64.6%
Georgia	87.3%	71.2%	Oklahoma	73.4%	108.7%
Hawaii	70.1%	72.9%	Oregon	73.3%	68.8%
Idaho	35.6%	59.3%	Pennsylvania	87.3%	76.7%
Illinois	84.8%	85.9%	Rhode Island	105.3%	106.6%
Indiana	66.0%	85.2%	South Carolina	88.8%	103.7%
Iowa	69.4%	70.3%	South Dakota	90.7%	97.6%
Kansas	62.1%	59.8%	Tennessee	103.5%	116.7%
Kentucky	76.8%	104.5%	Texas	58.1%	61.5%
Louisiana	72.9%	76.4%	Utah	50.4%	47.1%
Maine	86.3%	87.8%	Vermont	128.1%	104.0%
Maryland	118.2%	136.9%	Virginia	77.9%	76.6%
Massachusetts	97.0%	77.9%	Washington	94.8%	132.4%
Michigan	84.2%	74.7%	West Virginia	100.2%	92.9%
Minnesota	93.0%	87.9%	Wisconsin	68.9%	62.8%
Mississippi	70.1%	90.4%	Wyoming	62.4%	54.5%
Missouri	102.9%	107.6%			

Note: Some states exceed 100 percent because 1) eligibility has been extended to children with family incomes greater than 200 percent of the Federal Poverty Level, and 2) the numerator represents enrollment over a one-year period, while the denominator represents population at a point in time.

Source: Lewin analysis of annual enrollment data for Medicaid and SCHIP, and CPS data on children by family income.

Techincal Appendix Table 4b

Annual Percent of Children under 200% Federal Poverty Level Enrolled in Medicaid/SCHIP, 2005-2006

State	2005	2006	State	2005	2006
Alabama	92.0%	90.9%	Montana	57.8%	61.6%
Alaska	119.3%	119.5%	Nebraska	101.0%	99.3%
Arizona	93.3%	94.2%	Nevada	57.7%	54.9%
Arkansas	111.1%	119.9%	New Hampshire	129.3%	134.3%
California	104.9%	102.9%	New Jersey	90.3%	81.9%
Colorado	77.7%	80.9%	New Mexico	109.4%	102.1%
Connecticut	127.9%	117.0%	New York	112.0%	117.8%
Delaware	111.2%	105.8%	North Carolina	85.0%	88.7%
District of Columbia	129.8%	124.2%	North Dakota	68.2%	74.2%
Florida	93.5%	100.1%	Ohio	106.7%	111.1%
Georgia	107.3%	105.1%	Oklahoma	111.5%	111.2%
Hawaii	116.3%	108.4%	Oregon	70.7%	64.2%
Idaho	88.8%	94.9%	Pennsylvania	91.7%	92.1%
Illinois	105.4%	114.1%	Rhode Island	105.2%	111.4%
Indiana	93.3%	87.7%	South Carolina	104.6%	101.5%
Iowa	93.1%	97.6%	South Dakota	106.6%	108.7%
Kansas	78.1%	76.2%	Tennessee	119.0%	116.5%
Kentucky	92.8%	98.4%	Texas	79.6%	82.2%
Louisiana	124.9%	145.0%	Utah	60.0%	64.0%
Maine	115.7%	112.9%	Vermont	166.9%	178.1%
Maryland	114.2%	108.4%	Virginia	86.8%	83.8%
Massachusetts	112.6%	115.1%	Washington	113.2%	119.1%
Michigan	99.5%	103.8%	West Virginia	98.4%	100.5%
Minnesota	125.0%	120.5%	Wisconsin	87.9%	94.6%
Mississippi	102.1%	100.5%	Wyoming	124.1%	90.9%
Missouri	123.8%	119.1%			

Note: Some states exceed 100 percent because 1) eligibility has been extended to children with family incomes greater than 200 percent of the Federal Poverty Level, and 2) the numerator represents enrollment over a one-year period, while the denominator represents population at a point in time.

Source: Lewin analysis of annual enrollment data for Medicaid and SCHIP, and CPS data on children by family income.

Technical Appendix Table 5a

SIPP Logistic Regression Equation Results for Children 1999-2000

	Children 1+ Months Uninsured	Children 6 Months Uninsured
Intercept	-1.7201*	-2.3640*
Age 0-5	0.00274	(Not used)
Age 6-16	(Not used)	0.0921
Age 17	-0.5192*	(Not used)
Poverty Level 0-100%	0.9566*	0.7872*
Poverty Level 100-200%	0.8059*	0.7091*
Black, non-Hispanic	0.4399*	0.4606*
Hispanic	0.3991*	0.5732*
Other Race	0.5350*	0.5037*
< High School	0.8930*	1.1943*
High School	0.7140*	0.8342*
State Medicaid Enrollment	-0.0890*	-0.0167*
Unemployed	-0.0944*	0.0210*
Employed	-0.0711*	(Not used)
Uninsured (month 24)	(Not used)	3.7274

* Significant at the 0.05 level.

Technical Appendix Table 5b

SIPP Logistic Regression Equation Results for Children 2006-2007

	Children 1+ Months Uninsured	Children 6 Months Uninsured
Intercept	-1.6873*	-2.4781*
Age 0-5	0.0447	(Not used)
Age 6-16	(Not used)	0.2244
Age 17	-0.7688*	(Not used)
Poverty Level 0-100%	0.8254*	0.5636*
Poverty Level 100-200%	0.5848*	0.4997*
Black, non-Hispanic	0.3173*	0.2935*
Hispanic	0.5165*	0.5105*
Other Race	0.4639*	0.5159*
< High School	0.8498*	0.9742*
High School	0.6092*	0.7128*
State Medicaid Enrollment	-0.3103*	-0.9488*
Unemployed	-0.0943*	0.3202*
Employed	-0.0606*	(Not used)
Uninsured (month 24)	(Not used)	3.3822

* Significant at the 0.05 level.

Technical Appendix Table 6a

SIPP Logistic Regression Equation Results for Adults 1999-2000

	Adults 1+ Months Uninsured	Adults 6 Months Uninsured
Intercept	-3.1386*	-3.8742*
Age 18-20	0.5282*	(Not used)
Age 21-24	1.4206*	1.0174*
Age 25-34	1.0102.*	0.7326*
Age 61-64	-0.3748*	-0.4890*
Povetry Level 0-100%	1.0493*	0.8328*
Poverty Level 100-200%	0.8652*	0.8066*
Black, non-Hispanic	0.3240*	0.3682*
Hispanic	0.4797*	0.6169*
Other Race	0.3365*	0.3169*
Unemployed	0.4184*	(Not used)
< High School	0.9331*	1.0477*
High School	0.5812*	0.6412*
Uninsured (month 24)	(Not used)	4.3552*

* Significant at the 0.05 level.

Technical Appendix Table 6b

SIPP Logistic Regression Equation Results for Adults 2006-2007

	Adults 1+ Months Uninsured	Adults 6 Months Uninsured
Intercept	-2.9753*	-3.8090*
Age18-20	0.2884*	(Not used)
Age 21-24	1.349*	0.8979*
Age 25-34	0.8178*	0.6387*
Age 61-64	-0.5013*	-0.3710*
Poverty Level 0-100%	1.0261*	0.8677*
Poverty Level 100-200%	0.8089*	0.7544*
Black, non-Hispanic	0.5354*	0.4814*
Hispanic	0.9187*	0.9304*
Other Race	0.4212*	0.3988*
Unemployed	0.3419*	(Not used)
< High School	0.9312*	1.0943*
High School	0.5537*	0.7081*
Uninsured (month 24)	(Not used)	4.3139*

* Significant at the 0.05 level.

DEFINITION OF OUTPUT TABLE VARIABLES

Below we define the variables used to report the results by individuals' characteristics.

Health insurance: We defined individuals as being uninsured if they did not report having private health insurance, Medicaid, Medicare, CHAMPUS, CHAMPVA, or military health insurance in a given month of the two-year period. We counted the duration without insurance as the total number of months during the two years observed from the data that an individual lacked insurance. Months without insurance need not be consecutive. This distribution by number of months is truncated for those whose spell began before the observed period and those whose spell continued beyond the end of the 24-month period. Therefore, the distribution should not be interpreted as total spell duration. The distribution likely over-represents shorter stays.

Income: The income measure we use is family income as a percentage of the Federal Poverty Threshold. U.S. tables show a detailed distribution (<100%, 100-199%, 200-299%, 300-399%, 400%+), while selected state-level tables show a more aggregated distribution (<200%, 200%+) due to sample size restrictions.

Race/Ethnicity: We present the distribution of uninsured individuals across racial and ethnic groups. We divided people into four mutually exclusive racial-ethnic categories: White, non-Hispanic; Black, non-Hispanic; Hispanic; and Other. We classified people as Hispanic if they reported their ethnic origin as Mexican, Chicano, Puerto Rican, Cuban, Central or South American, or other Spanish.

Education: For adults, we report the educational attainment of the individual. For children, we report the educational attainment of the most highly educated parent if both or neither parents are working, or the employed parent if only one parent is working. The levels we created were: less than high school graduate, high school graduate (including some college), and college graduate or higher.

Family employment: Family employment was constructed by using the highest employment status between the reference person and his/her spouse. For example, if the reference person worked part-time but his/her spouse worked full-time, the family would be categorized as working full-time.

Family employment status at the end of 24-month period: We report the family employment status for the last month of the 24-month period (in the output tables, roughly January 2003). The variable was composed of the following categories: employed full-time, employed part-time, unemployed, and not in the labor force.

Family employment status over 24 months: At the national level only, we also report duration of family employment over the 24-month period. Because employment duration is available from the SIPP but not the CPS (which provides state-level estimates), we could not report it at the state level. The variable was composed of the following categories: employed full-time all 24 months, employed at least part-time all 24 months, unemployed at least one month, unemployed for 24 months, and not in the labor force.

Age: We report age at the end of the 24-month period.

CAVEATS AND LIMITATIONS

As we indicated earlier, there are no direct estimates of the number of individuals without health insurance over a period of time by state. Therefore, similar to small area analyses developed by the Census, we used the econometric models to calculate these estimates. All of the variables included in the model had significant coefficients, with the exception of the 0-5 age group dummy variable in the children's equations and the male dummy variable in the adult 1+ month equation. The state-level employment and Medicaid enrollment variables produced large coefficients and therefore had relatively large impacts on the resulting estimates of lack of insurance.

Even though the CPS sample was enhanced beginning in 2001, bias in the state estimates introduced by the sampling frame within a state still exists. For example, if all the households interviewed in a small state come from the same metropolitan statistical area in the state, they may not accurately represent the characteristics of residents of the entire state.

The model we specified assumed that the reported percent of uninsured children from the CPS was similar to the point-in-time estimate of the SIPP. As indicated earlier, researchers have differing opinions on this matter.

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[1] Katherine Swartz and Timothy McBride "Spells without Health Insurance: Distributions of Durations and Their Link to Point-in-Time Estimates of the Uninsured," *Inquiry* 27 (1990): 281-288.

[2] In 2001, a verification question that asks specifically whether someone was uninsured all of last year was added.

[3] Charles Nelson and Kathleen Short, *Health Insurance Coverage 1986-88* (Washington: Bureau of the Census, 1990); Katherine Swartz, "Dynamics of People without Health Insurance: Don't Let the Numbers Fool You," *Journal of the American Medical Association* 271, no. 1 (1994): 64-6.

[4] Robert L. Bennefield, *A Comparative Analysis of Health Insurance Coverage Estimates: Data from CPS and SIPP*, presented at the 1996 Joint Statistical Meetings of the American Statistical Association, 1996.

[5] The exclusion of individuals with fewer than two years of data necessarily excludes children younger than age 2. Analysis of monthly samples indicated that insurance coverage rates for children under age 2 were similar to the rates for children ages 2 to 5. We therefore assigned coverage to the under 2 group at the same rate as the 2 to 5 group.

[6] It was beyond the scope of this report to quantify the extent to which those who dropped out of the survey might have different health insurance coverage patterns even after controlling for age, sex, race, and income.

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Chairman MCDERMOTT. Thank you very much for your testimony.

Mr. Gottlob, who is a senior fellow at the Milton and Rose Friedman Institute Foundation.

STATEMENT OF BRIAN J. GOTTLOB, SENIOR FELLOW, MILTON AND ROSE D. FRIEDMAN FOUNDATION

Mr. GOTTLOB. Thank you, Mr. Chairman. I have not been here before so it is indeed an honor and a privilege for me to be able to testify today.

The Friedman Foundation encourages greater economic opportunity and security by supporting research activities and increased educational opportunities for children from all socio-economic backgrounds.

Among my research activities for the Friedman Foundation is I have attempted to monetize or place some dollar values on some of the public or social costs that are associated with dropping out of high school. For too long the costs of dropping out of high school have been assumed to be primarily fall on an individual and primarily in terms of the earnings impact on an individual over their lifetime.

But there are significant costs to society, and among those and among the most significant are the problem that you're here today to address, and that is the lack of health insurance coverage and also increases in Medicaid enrollment and Medicaid caseloads.

There's been a lot of reforms that have proposed to fundamentally change the way we provide health care, the way we ration it or the way we pay for it. What I would like to do today is argue for policies that focus on increasing educational attainment and reducing high school dropout rates across the country as an effective means for dealing with these issues.

There is no doubt that increasing high school graduation rates will increase health insurance coverage, and at the same time provide powerful other benefits to society while at the same time presenting no fundamental risks to our health care system.

I do want to talk a little bit about the number that you've been presented with today: 47 million uninsured individuals. While that is troubling and it demands your best efforts to address, before concluding that we need to make basic, fundamental changes to our health care system, I think we ought to understand a little bit more about that population of 47 million.

Included in that group is 10.2 million individuals who are not U.S. citizens. It includes about 11 million who chose not to participate in employer-sponsored health plans that were available to them. A lot of those are young workers who, thinking as I did once that I was immortal, don't opt to participate in those plans. Almost half, 49 percent or 23 million, are of African-American or Hispanic origin. I didn't include this in my testimony, but there's also a large number, probably several million who would qualify for Medicaid and have insurance, but they haven't applied for it.

Looking at the most recent year, because that number is also troubling, or the most recent 6 years: an 8 million increase and about a third, 2.57 million, are not U.S. citizens. More recently, in the last year of the 2.1 million increase in uninsured population, 38 percent are not U.S. citizens. 4.5 million are of Hispanic origin, both citizens and non-citizens, 1 million African-Americans, about 45 percent or 3.7 million have family incomes above 75,000. That truly is a problem with the fundamental nature of our health care

system. There's been virtually no increase in the uninsured among individuals and households making less than $25,000.

I don't cite those figures to stereotype the population and I certainly don't want to engage in the already overheated debate on immigration, but what I think the data suggests is that there's a tremendous heterogeneity among the population of the uninsured. That does not lend itself to blanket prescriptions to address the problem.

I see in the data an overrepresentation of individuals from demographic groups that are characterized by lower levels of educational attainment and higher levels of high school dropout rates. Others can see different things in the trends, but we can't escape the notion that the data suggests that there are a variety of factors, including many outside of the health care system, that are characterizing the lack of health insurance among our population.

Lower levels of educational attainment and higher dropout rates reduce health insurance. About 40 percent of the working age high school dropout population are not in the labor force, so they can't get health insurance from their employer. Dropouts comprise 12 percent of the working age, 20 to 64 population, but make up 30 percent of the working age uninsured. Dropouts are twice as likely to be receiving or having someone in their family receive Medicaid benefits.

Employer provided health insurance is still the dominant source of coverage, but when someone drops out, they cannot avail themselves of that. If all working age dropouts in this country, and there's about 20 million of them, if all of them had been high school graduates and we applied those same percentages, about 4 million would be covered by private insurance. If you add independents, it would be at least 10 million who would be covered, an additional 10 million. The cost of dropouts to the Medicaid program is about an additional 3.5 million Medicaid beneficiaries every year and a cost of about $7 billion.

If everyone graduated, no one dropped out, we wouldn't eliminate that, but we would reduce it. We would reduce it by that 3.5 million and $7 billion in costs. Attacking the problem of high school graduation rates with the same figure that we want to attack, the health care issue, I think will yield not only benefits in the health care side, but also substantial other public benefits and societal benefits. Just because you are on the Committee on Ways and Means, I have to point out that the lost earnings impact of high school dropouts in this country is almost $200 billion and a tax cost of about $31 billion.

What can be done to address the problem? Well, there is no one, single solution. I believe there's a lot of innovative practices that are being attempted and more will follow. I personally believe that the educational system in the country contains far too much segregation of students and families according to income and educational attainment of parents. This segregation has profound impacts on the differential, educational opportunities of children. No matter how much we increase funding for education, there maintains a separate tacit but equal structure to educational opportunities in this country. The result is a lot more separation and a lot less equality.

In conclusion, some of the most effective means of reducing the number of uninsured individuals in this country do not involve fundamental changes to our health care system. In addition, they confer benefits outside of the health care and health insurance arena. I suggest that some of the factors that are contributing to the lack of health insurance are not simply fundamental flaws of the health care system to maximize public benefits while addressing declines in health insurance. We ought to look to opportunities to create those synergies; and, increasing high school graduation is one way to dramatically reduce the future incidence of individuals without health insurance.

Thank you.

[The prepared statement of Mr. Gottlob follows:]

Prepared Statement of Brian J. Gottlob, Senior Fellow, Milton and Rose D. Friedman Foundation, Indianapolis, IN

Mr. Chairman and Members of the Committee:

Thank you for inviting me to testify on the important issue of health insurance coverage and income security in the United States. The Friedman Foundation encourages greater economic opportunity and security by supporting research and activities that increase the educational opportunities and achievement of children from all socioeconomic backgrounds.

In addition to my work with the Friedman Foundation, I am a principal in an economic research and consulting firm. My testimony today is based on my work for the Friedman Foundation, but some of my comments may also reflect personal views rather than the views of the Foundation.

Among my research activities for the Friedman Foundation I have attempted to place dollar values or "monetize" several of the public or social costs associated with the low high school graduation rates that are characteristic of many school districts across the country. The impact of dropouts is especially apparent in the low rates of private health insurance and in the higher Medicaid enrollments among dropouts. In addition, the higher percentage of uninsured among dropouts can raise the cost of private health insurance when the cost of health services for the uninsured is not paid and must be recovered by raising prices on all other payers.

For too long the costs of failing to obtain a high school diploma have been expressed primarily in terms of the cost to individual dropouts. These private costs, typically expressed in terms of lost annual earnings and over a lifetime, are large. My research indicates, however, that the cost to the public in terms of higher government expenditures and lower revenues are no less dramatic.

Many reforms have been proposed to the way we provide, ration, or pay for health care in this country. To increase the percentage of the population that is covered by health insurance I want to instead argue for policies that focus on increasing educational attainment and reducing high school dropout rates across the country. The benefit of this approach is that we know that the failure to obtain a high school diploma is strongly related to the lack of health insurance as well as with higher utilization of government provided health insurance and associated health care expenditures. There should be no debating that higher graduation rates will increase health insurance coverage with no risk of unintended consequences to the health care system.

The benefit to individuals and to society of focusing on policies that reduce high school dropouts extend well beyond health insurance coverage. Even modest increases in graduation rates will have a clear and dramatic impact on future rates of health insurance coverage at the same time it increases government revenues and reduces government expenditures.

Overview

The uninsured population in this country has risen by more than 8 million since the year 2000, to a total of just under 47 million in 2006. That number is troubling and demanding of our best efforts to reduce it, but before concluding that the basic structure of our nation's health care system must be revamped it is prudent to look more closely at trends in the incidence of health insurance coverage and more broadly at the factors that have contributed to them.

Using the same U.S. Census Bureau data on trends in the population without health insurance that, in part, have prompted this hearing, I will highlight some

of the more significant trends in insurance coverage that can be overlooked with a focus on the aggregate numbers.

The 47 million estimated by the Census Bureau to be uninsured include:[1]

- 10.2 million who are not U.S. Citizens.
- About 11 million who chose not to participate in an employer sponsored health plan that was available to them. Young adult workers are especially prone to decline participation in employer-sponsored health plans.
- Almost one-half (49% or 23 million) who are African-American or of Hispanic origin.

The troubling increase of over 8 million uninsured in the United States between 2000 and 2006 includes the following trends:

- Almost one-third (2.57 million) are not U.S. Citizens. More recently, among the 2.1 million increase in the uninsured population between 2005 and 2006, 38 percent are not U.S. Citizens.
- Almost 4.5 million are of Hispanic origin (both citizens and non-citizens.)
- Just over 1 million are African-American.
- About 2.3 million (or 27%) are Non-Hispanic white individuals.
- About 45% or 3.7 million have family incomes of $75,000 or more.
- Virtually no increase in the number of uninsured (44,000) among individuals in households making less than $25,000.

Highlighting the above data and trends from the Census Bureau in no way minimizes the very real concerns over the decline in health insurance coverage or to stereotype the population or characteristics of the uninsured, or discount or minimize their plight. Finally, neither I nor the Friedman Foundation has any interest in fanning the flames of an overheated heated debate on immigration policy.

If anything, these data highlight heterogeneity among the population of the uninsured that does not lend itself to blanket policy prescriptions to increase the number of those with health insurance coverage. Rather, I believe the data suggest that a broader set of policies should be considered to increase health insurance coverage in our country.

At the risk of being accused of "seeing what I know" rather than seeing what the data are revealing, I see in the data an overrepresentation of individuals in demographic groups that are characterized by lower overall levels of educational attainment and elevated levels of high school dropout rates. Others may see the trends differently but we cannot escape the fact that the data suggest that a variety of factors, including many outside of the characteristics of our health care system, appear to greatly influence the size of the population without health insurance. Thus efforts to increase health insurance should examine policies outside the sphere of our health care system that may exert a large or a larger influence on the size of the uninsured population.

Aside from the impact of educational attainment, the rise in the number of uninsured individuals among households with annual income of $75,000 is perhaps the most revealing trend in health insurance coverage. The trend likely reflects a decline in the number of employers providing health insurance, changes in cost sharing arrangements between employers and employees that results in fewer employees opting to participate in employer provided plans, or some combination of the two. An increase in the self-employed who have traditionally had lower rates of health insurance coverage is also a contributor.

The decline in employer provided health insurance is a complex phenomenon that is affected by many variables such as cost shifting to private payers, the impacts of coverage mandates and regulations, medical service cost inflation, demographics and many other factors. As a result, reversing the declining trend of employer provided insurance will be among the most challenging avenues for increasing insurance coverage.

The Impact of Dropouts on Health Insurance Coverage

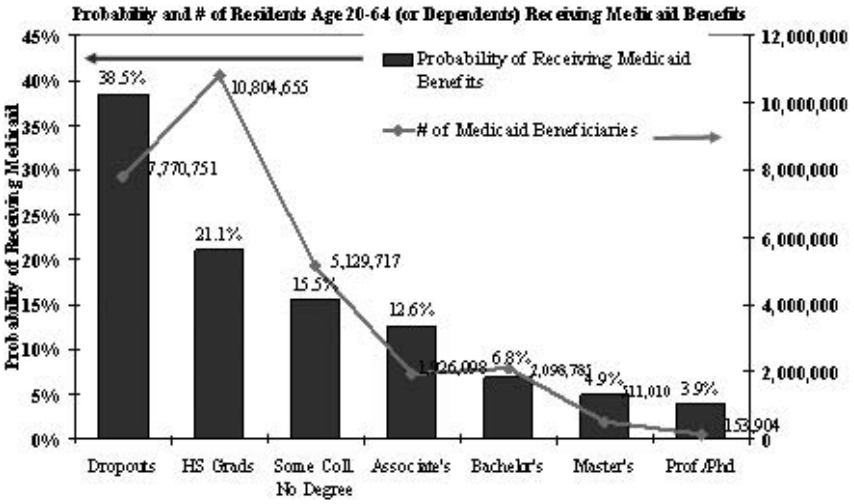
Lower levels of educational attainment and higher dropout rates reduce health insurance coverage and increase government expenditures.

- Almost 40% of working-age high school dropout ages 20–64 are not in the labor force. Less than one-quarter of dropouts receive employer-provided health insurance coverage.

[1] Data on health insurance coverage and trends are from the U.S. Census Bureau analyses available at http://pubdb3.census.gov/macro/032007/health/h09_000.htm and http://www.census.gov/hhes/www/hlthins/hlthin00/hi00ta.html

- Dropouts comprise about 12% of the working age (20–64) population but make up almost 30% of the working-age uninsured.
- Dropouts are nearly twice as likely as high school graduates (38.5% to 21.1%)[2] to be receiving Medicaid benefits or to have someone in their household (dependent children) receiving benefits.

Figure 1—Dropouts Represent About 12% of the Working-Age (20–64) Population but 27% of Medicaid Recipients



Source: Friedman Foundation analysis of US Census Bureau's "Current Population Survey" March 2006 & 2007 data

Data from the 2006 and 2007 March Supplement of the Census Bureau's Current Population Survey indicate that there are approximately 20 million high school dropouts ages 20–64 in this country. The low rate of private insurance coverage among the population of dropouts increases the demand for government provided insurance such as Medicaid (Figure 1).

Employer provision of health insurance is still the dominate source of coverage for Americans and the higher rates of employment of high school graduates compared to dropouts mean that reductions in dropout rates would dramatically reduce the number of uninsured. If all working age high school dropouts somehow were transformed into high school graduates, with the same patterns of insurance coverage as exist among current high school graduates, then the number of uninsured working age adults would drop by almost 4 million. In addition, an increase of 4 million insured would result in additional coverage of many dependents and would likely mean that at least 8 million, and quite possible more, individuals would have health private insurance coverage.

Similarly, increasing high school graduation rates will lower government expenditures for health care by reducing Medicaid beneficiaries by an estimated 3.5 million. At an average annual beneficiary cost of $2,000 (not including the elderly and disabled who have much higher annual costs) Medicaid expenditures would be reduced by $7 billion annually (Table 1).

Even if the dropout rate were reduced to zero, however, a large number of individuals would still be without health insurance coverage and the number receiving Medicaid benefits would not decline by the entire number of Medicaid beneficiaries among the dropout population. Nevertheless the problem would be more manageable and it would be more directly attributable to problems in the health care system rather than artifacts of other economic, demographic, and social factors.

[2] These data are from my analysis of the 2006 and 2007 March Supplement of the U.S. Census Bureau's "Current Population Survey".

Table 1: Annual Medicaid Expenditures Attributable to Dropouts[3]
(Note: Does Not Include Elderly and Disabled)

	# 20–64	% On or W/ Child on Medicaid	# On or W/ Child on Medicaid	Total Cost = # × Avg. Cost	# On Medicaid if All Graduated	Total Cost = # × Avg. Cost
Dropouts	20,201,421	38.5%	7,777,547	$15,555,094,170	0	$0
HS Grads	51,136,662	21.1%	10,789,836	$21,579,671,364	15,052,336	$30,104,671,026
Some Coll. No Degree	33,116,954	15.5%	5,133,128	$10,266,255,740	5,133,128	$10,266,255,740
AA. Degree	15,289,612	12.6%	1,926,491	$3,852,982,224	1,926,491	$3,852,982,224
Bachelor's	30,805,745	6.8%	2,094,791	$4,189,581,320	2,094,791	$4,189,581,320
Master's	10,413,640	4.9%	510,268	$1,020,536,720	510,268	$1,020,536,720
Prof/Ph.D	3,957,896	3.9%	154,358	$308,715,888	154,358	$308,715,888
Total	164,921,930	17.2%	28,386,419	$56,772,837,426	24,871,371	$49,742,742,918
	Difference (Annual Medicaid Cost of Dropouts):				**3,515,047**	**$7,030,094,508**

[3] Ibid.

Pursuing policies that increase high school graduation rates as a strategy for increasing health insurance coverage will allow state and local governments to partner with the federal government and to play a prominent role in addressing this important issue.

Attacking the problem of low high school graduation rates with the same vigor and attention we give to low health insurance coverage rates will yield large benefits outside of the health care system. One reason why health care and health insurance command so much of our efforts and attention is that we understand the significance these issues have to each of us. In contrast, the dropout problem that so significantly impacts health insurance coverage, commands far less public and policy maker attention because it is incorrectly assumed to have only a limited impact on a majority of the population.

By documenting some of the public as well as private costs of dropouts, my research seeks to bring the same public concern for the problem of high school graduation rates that is evident in concerns over health insurance. Public costs such as higher rates of crime and incarceration, poorer health, higher unemployment rates, lower productivity, economic growth, and government revenues, as well as higher government expenditures for health care and public assistance are all consequences of low high school completion rates.

Impact of Dropouts on Government Revenues

It is well documented that high school graduates have much higher earnings than do high school dropouts. The impact of the lower earnings of dropouts on government revenues is less well documented. Table 2 shows that the lower average annual earnings of 20 million working-age dropouts implies wage and salary earnings in the U.S. that are $194 billion lower than if all dropouts had obtained a high school diploma.[4]

Table 2: Earnings Impact of Dropouts Age 20–64[5]

	#	Avg. Wages & Salary	Total Earnings	If Dropouts Were HS Grads
Dropouts	20,201,421	$13,078	$264,186,103,270	$0
HS Grads	51,136,662	$22,682	$1,159,866,426,485	$1,618,068,997,181
Some Coll. No Degree	33,116,954	$24,954	$826,393,846,725	$826,393,846,725
AA Degree	15,289,612	$31,449	$480,841,478,827	$480,841,478,827
Bachelor's	30,805,745	$46,331	$1,427,245,568,723	$1,427,245,568,723
Master's/Prof./Ph.D	14,371,536	$69,578	$999,944,168,962	$999,944,168,962
Total	**164,921,930**	$31,278	**$5,158,477,592,991**	**$5,352,494,060,417**
			Difference	**$194,016,467,426**

[5] Analysis of 2006 and 2007 "Current Population Survey" March Supplement data

In addition to the increase in the annual earnings of residents and a reduction in Medicaid and other government expenditures, increasing graduation rates would yield large increases in tax revenue. We used the tax simulation model (TAXSIM) of the National Bureau of Economic Research to model the income tax impacts attributable to the population of working age dropouts in the U.S.[6]

[4] This estimate is appropriate to illustrate the earnings impact of educational attainment, but it does not consider the "equilibrium effects" that would occur in the labor market if all dropouts actually did graduate—that is, the ways in which the larger economy, employment, and wage rates might be affected in response to such a increase in high school graduation rates.

[6] We had to make some simplifying assumptions in calculating tax liabilities. Most important, because we had no data on spousal income for the population of high school dropout taxpayers, we treated all taxpayers as if they were filing as single taxpayers, We calculated tax liabilities for taxpayers with zero to three dependent child exemptions and weighted the number of returns according to the percentage of dropouts with and without dependent children, as gleaned from the CPS. Because there are a number of additional tax deductions, exemptions or credits that can apply to taxpayers age 65 and older, we limited our tax analysis to residents under the age of 65. The complexities of individual tax filings could not be captured when trying to model more than 20 million tax returns of working-age dropouts, but our results provide a rea-

In combination, the lower earnings and decreased tax payments of high school dropouts, along with the higher cost of tax credits attributable to dropouts, results in an income tax cost of $31 billion attributable to dropouts (Table 3). The secondary revenue impacts that would result from increased earnings and expenditures from a reduction or elimination of dropouts are not documented here but would yield additional federal and state revenues equal to or greater than those highlighted here.

Table 3: Estimated Income Tax Cost of Dropouts [7]

	Wage & Salary Income	Estimated 2007 Tax Liability			
		0 Child	1 Child	2 Children	3 or More Children
HS Grads	$22,682	$1,730	–$358	–$2,990	–$4,027
Dropouts	$13,078	$446	–$2,686	–$4,845	–$4,845
	Difference	**$1,284**	**$2,328**	**$1,855**	**$818**
	×	12,141,799	3,455,105	2,940,309	2,447,059
	20,201,421	$15,590,069,916	$8,043,484,440	$5,454,273,195	$2,001,694,262
	Dropouts				
	(Age 20–64)		**Grand Total:**	**$31,089,521,813**	

[7] Earnings data from the Current Population Survey. Tax liabilities were estimated using the National Bureau of Economic Research "TAXSIM" model.

What Can be Done to Increase Graduation Rates

There are a number of initiatives that show promise for increasing high school graduation rates and innovations are being tested on a small scale all the time. There is no single best solution and I believe that innovation and new initiatives should be encouraged. Based on the numbers I have discussed here, even modest increases in graduation rates should yield fiscal benefits capable of supporting additional efforts to reduce dropouts by State and local governments while significantly reducing the number of uninsured in the process. As importantly, these benefits will be realized without risk of unintended consequences to our health care system.

I believe that the educational system in this country contains far too much segregation of students and families according to income and educational attainment of parents. This segregation has profound impacts on the differential educational opportunities available to children. No matter how much we have increased funding, education that maintains a tacit "separate but equal" structure to educational opportunities seems to have succeeded only in separation while failing at equality. The result is that the long-term economic opportunities for many are greatly limited. Restricting educational opportunities to assigned schools maintains the inherent segregation in education along income and parental education lines and will assure the continuation of segregation in our education system and likely maintain existing differences in educational opportunity.

That said, regardless of what policies to increase graduation rates are instituted, it is most important to acknowledge the critical role that increasing educational attainment can play in reducing the percentage of our population that lacks health insurance coverage, at the same time increasing graduation rates will yield additional public benefits and reduce public costs.

Increasing graduation rates is a forward looking policy prescription. We cannot retroactively increase graduation rates for the 20 million working-age dropouts in our population but by increasing high school completion rates we can increase future revenues and lower future public expenditures in a way that allows for more attention and resources to be directed at those for whom the future is now and the past cannot be changed.

Conclusion

Some of the most effective means of reducing the number of uninsured individuals in this country do not involve fundamental changes to our health care system. Other than as a citizen I have no stake in maintaining any aspect of our current system of health care or health insurance but even a cursory review of the data on health insurance coverage suggests that some of the major factors contributing to the lack

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sonable estimate that is likely to be within a few percentage points of the true income-tax cost associated with the earnings differential between high school graduates and dropouts

of health insurance are not simply the result of fundamental flaws in our health care system. To maximize public benefits while addressing declines in health insurance we ought to look for opportunities to provide more than insurance to the individuals who lack coverage.

Increasing high school graduation rates is one way to dramatically reduce the future incidence of individuals without health insurance, at the same time it will increase economic opportunities for individuals, increase public benefits and reduce public costs.

Chairman MCDERMOTT. Thank you very much, Mr. Gottlob.

Perhaps you're a good segue into what my real question to this panel is. You say let's increase the number of people who finish high school. That will knock off "x" millions of people off the 47 million, or whatever the number is, that are uninsured. We really, I'm sure, don't know what the number is, but let's say, some 4.7 million. Then I look at Ms. Collins' report here, Dr. Collins. They say, well let's allow States to extend eligibility to Medicaid; and let 17 States redefine the age at which a young adult is no longer dependent, and they want older people to buy into Medicare and the 2-year waiting period and other SSI. To me, what I'm hearing is bandaids here.

Now, how many, if you took all those people, and I'll let you, Dr. Collins, be the one to start. If you took all the people that you suggested we do, all the things you suggested we do, these bandaids of these various parts of the system, how many people would we take out of the 47 million who are uninsured?

Ms. COLLINS. How many people? I mean, I think the State Children's Health Insurance Program and the Medicaid program are good examples of what happens when you just cover certain parts of the population. You have a lot of people that drop off, because they don't re-enroll, that don't know that they're eligible. So, you really do need more of a universal system where people are automatically enrolled through the tax system, for example. So, I think the bandaids that we suggest are in absence of a more universal system, but I think the most efficient approach would be to put everybody into the system. But I think the bandaid approach is an alternative to build in that direction.

Chairman MCDERMOTT. I mean, if you're taking these people and trying to cover the ones, you would keep the Medicaid system separate from Medicare and just keep adding into each of the systems. How do you look at that? Is that the best way to do it?

Ms. COLLINS. I think the best way to do it is to cover everybody. I think if we're thinking in terms for budgetary reasons, for political reasons of building toward universal coverage, you could start on these public insurance programs that work so well: the Medicaid program, the Medicare program, the State Children's Health Insurance Program. Bring in the employer system as a piece of this and build toward universal coverage over time.

Alternatively, we could do what others have proposed and expand the Medicare Program to everybody. I think the analysis that the Commonwealth Fund has done has really shown that this is the most efficient way in terms of saving overall health care costs, insuring everyone so they don't lose coverage, that they have stable coverage over their lifetime. But if you're looking toward building

toward universal coverage at an incremental way that moves toward universal coverage, these are suggestions for that.

Chairman MCDERMOTT. In a public policy way, which one of these would you do first?

Ms. COLLINS. You know, it's so hard to say, because people are so much in need in each of these groups. Young adults, an example that Ms. Johnson gave about her life, is just extraordinary to listen to. So, how can you decide which vulnerable group you ensure first.

Chairman MCDERMOTT. You don't think a 59-year-old auto worker who retires and is in the retiree program is more important than Ms. Johnson?

Ms. COLLINS. I think it's hard to decide that. I think that's why it would be more equitable to ensure everyone at the same time.

Mr. POLLACK Mr. Chairman, I think there's a general misunderstanding about the scope of public coverage, and I'm not suggesting that everything be achieved through public coverage changes. There is going to have to be some accommodation of both public and private sector coverage.

I want to go over, however, what I think is a mythology about public coverage. There's an assumption that anyone who's poor is going to have health care coverage, because we have a safety net, such as Medicaid. It's just a fallacious assumption. We treat people very differently based on their family relationship status. Take three different groups as an illustration: children, the parents of those children, and non-parental adults.

For children, we cover children in virtually every state, if their family incomes are below 200 percent of the Federal poverty level. At least they're eligible. They may not be enrolled, but they are eligible for coverage in virtually every State, if they are in families with incomes below 200 percent of poverty—roughly $34,000 in income for a family of three, $41,000 for a family of four. Some States go higher, and, obviously, there is a debate about how high it should go.

With respect to parents, the median income eligibility standard for the safety net Medicaid program is today 69 percent of the Federal poverty level. It is one-third of what it is for children.

For non-parental adults, such as the person you were talking about if that person is single or doesn't have any dependent children right now, the situation is most problematical. In 43 States, you literally can be penniless and you are ineligible for public coverage. So for a lot of people and families that are poor and need help and need a safety net, they currently do not have alternatives, because they're ineligible for public coverage.

Then you get to the question of enrolling people who are eligible, but you have today a system of eligibility, which actually has its roots, believe it or not, in the 16th Century Elizabethan "poor laws" of England where they said in order to get welfare you had to be poor and to also meet some deserving category.

We have that today with respect to Medicaid. As a result, people who are poor, if they don't fit one of these deserving categories, are ineligible for safety net coverage. That should be changed. That should be a high priority.

Ms. JOHNSON. I just want to say this on behalf of youth and foster care, and this is me just pouring out my heart. Your health

to become a success is very important to become a successful adult; and, there are already so many negative statistics that are placed on youth and foster care.

When I was traveling over the summer as a foster club all star, I learned that when they did research last year that 27 percent of youth in foster care end up incarcerated. 52 percent end up homeless; 35 percent end up pregnant. Me being a former foster youth, knowing why, I committed. A lot of people wouldn't believe it, but I got in a lot of trouble. I wouldn't call it criminal, because I never was arrested. But part of the reason was because I didn't get to seek the counseling that I needed for the traumatic experiences that I experienced.

So, as not giving myself an excuse, but as an outlet, I did things that were horrific, or things that weren't great. But I had no outlet and I was told I couldn't go see a counselor and I couldn't talk to anyone, because you had to pay for it. I didn't have Medicaid, so I couldn't pay for it. Even some of my peers now are getting pregnant, because when they get pregnant, it's almost like putting themselves back into the system, because they know that even after they have their baby for a certain amount of time, they can still have medical coverage or medical insurance. That's one of the things that they talk about that I've witnessed them talk about while being pregnant: "Well, at least I have medical coverage." So, my question to them was, okay. You're pregnant now as a way for you to still continue to keep medical coverage after you had this child.

I feel like all the statistics that are already placed on my population are feeding into each other. Like, if I don't get the counseling that I need for the stress disorder and everything else that I have, I am liable to commit a crime. Because I am liable to drop out of high school and if I am homeless and I am not in school, of course I am not working. I am unemployed. So, there go all those negative statistics back on my population again. I feel like for me, I was very vulnerable.

Of course, I was taken away from my grandmother and put into foster care. I was young at the time and I didn't have any choice. I feel like now that I've aged out of care, I am paying that price. I feel like it's not fair that I can't qualify for health care and I can't say anything. Youth that do have their biological parents, they are allowed to stay on their parents' health care insurance until age 24, as long as they're still in college. I feel like the State became my parent, so shouldn't I be provided with the same equal benefits as youth that have their biological parents?

I'm not 24. I'm 22, and I still can't get health care. I'm still sick to this day from the condition that I stated earlier, because it lingers on for so long as a result of me not having medical insurance. You know if you're sick and it lasts so long, it starts to damage other things. That's why I'm still sick to this day, because it's a long process of healing the condition that I have, because I waited so long to get it treated, because I did not have medical insurance.

I was told, "why don't you just be like regular people and go get on insurance?" Okay. I'm a college student. Nobody is helping me. I don't have any parents. I can't call home like most people and say, I'm sick, or I need this. I have to do it for myself, so do you

honestly think I can afford to pay that high deductible? I've tried, because I don't want to be the one to bring myself back into the system after I have already exited it.

So, I have tried other means. I work. So, I have tried to go to the doctor's office and pay the amount there is to pay, but I found myself having to pay like $250 that I did not have just to go to the doctor. So, I found myself doing what most people do, just don't get it treated. Because the bills at the emergency room are just so expensive, and I know that I cannot afford them. So, I just allow this illness to linger on, because I had no way to pay for it. I feel like we are very deserving of this help, because we have been through so much already and there is nobody there to help us once we age out of care. There is nobody there.

Chairman MCDERMOTT. Thank you.

I am going to move to Mr. Herger. I've gone way over my time. So, Mr. Herger, you are open.

Mr. HERGER. Thank you, Mr. Chairman.

Chairman MCDERMOTT. We won't turn the clock on just yet. Turn the clock off.

Mr. HERGER. I want to thank each of our witnesses this morning. Ms. Johnson, I particularly want to thank you.

All of us on this panel that are in this room are very much aware of the percentages and what they are against someone in your position that grew up in your circumstances. To see you out there, even though you are struggling, obviously you are by every standard definition, you are on your way to being a successful person. You really are right now, and I want to commend you for what you're doing. I also want to commend you for being a role model. I commend you for going out and being this all-star and talking to others and doing what you're doing. I want to encourage you to continue on the path you are and bringing this to our notice.

It's a big challenge we have, as each of you know. It is a big challenge. I think each and every one of you have brought up some very important points—47 million Americans without health care. What do we do about it? There is a big move to perhaps, we said, socialize it completely. Everybody has health care. I mean, this is ideal, but in reality, we can't pay for what we currently have, as we are aware.

Medicare is going broke now, faster than social security; and, so how do we get to where all of us agree we need to be? But from a practical standpoint in a nation that is in debt, how do we get there and get there efficiently, and how do we have a system that works? We've seen socialized medicine around the world. We see the Canadians. We see the long lines they wait in and how they come down here. That, I don't think, is the answer. I don't have the answer here, and Mr. Pollack I appreciate what you said, I think that we have to have a combination of both the safety nets that would help the individuals like Ms. Johnson and others who don't have it, or the 59-year-old person that the Chairman was talking about.

Yet the private sector can help pay for it where we can. One of the ways to do that, I think, is a problem that you pointed out, Mr. Gottlob, is if someone doesn't have the education. You are in the process of getting that education Ms. Johnson, and the road you

are going down, eventually you will get it. Probably most of us on this Committee, if not every one of us, has been somewhat where you are going through school, being broke, struggling, working hard, investing today for getting something tomorrow, the American dream type of thing that you are in the process of living right now.

You will be getting the dividends down the line and giving an example how to do that. I think the real problem, one of the major problems, is getting our young people through high school. Because if you don't get through high school, then you are thrown into the system that you were describing where there is virtually no hope. People won't hire you. It's tough enough to be hired if you have a high school education, let alone not a high school education at all. If we are looking at first steps or some of the most important first steps, I believe this idea of at least getting our young people, and those who do not have the blessing that have the parents—it sounds like you have a grandmother—how do we help you get through high school and how do we make sure that you have the health care you need in the process?

Mr. Gottlob, in your studies, have you seen any programs or suggestions on how we can ensure that others like Ms. Johnson that are in that position can make it through the first step of high school, and then maybe college, but for sure at least high school?

Mr. GOTTLOB. I think that there are a number of programs that are proving their worth in reducing the dropout problem. I categorize, basically, two broad categories. There's the very big kind of reforms, the broad categorical reforms, which include things like early intervention in young people's lives, even at the preschool age. Those programs take a long time to evaluate and study. We really haven't gotten to the point yet that, you know, there's definitive studies, but I think those are very encouraging.

There's other activities providing different kinds of alternative education charter schools that open up alternative ways for people to obtain an education who might not fit into the very narrow structure of many of our public schools. When you look at the population of dropouts, however, one of the things that you see is that there are many reasons why people drop out. There's a tremendous variety of reasons, so I think that there's a lot of tactical programs that are proving very successful.

There are things like, one of the things that is very much associated with dropouts is lack of success in the ninth grade, the very first year of high school. A lot of school districts are instituting what are called academies that are basically smaller schools within a larger school environment, makes it feel like a smaller school. Students within that ninth grade are allowed to choose which of the academies. It functions in a way that makes kids successful in that initial first year. That's proven very successful.

You know, vocational education has gotten a bad name in a lot of ways. Everybody is striving for a higher education and beyond, and that's a noble goal. So vocational education has seen a decline, and one of the things that that's done is I think it has pushed a lot of what I like to call kids at the margin out of our schools who in my State, where a lot of our population of dropouts are young males who are marginally attached to their school, who because of

low unemployment rates in my State, see an $8 an hour job as a great opportunity to leave school. Well, $8 at age 16 doesn't look so good when you're 30 and you've got children.

Those students at the margin, if they had the opportunity to maintain some attachment to the labor force within a program of vocational education that allowed them to learn some trades, some occupations, along with a core academic curriculum I think has proven successful in the limited instances where it's been instituted.

Those are just a couple of examples. There are many. The key message is that I think that the ways in which we will accomplish this goal will be as varied as the characteristics of the population that is dropping out, but there are real opportunities.

Chairman MCDERMOTT. Thank you. Mr. Lewis will inquire.

Mr. LEWIS. Thank you very much, Mr. Chairman.

Again, I want to thank each of you for being here. Ms. Johnson, thank you for your testimony. Thank you for pouring out your heart and telling your story. I don't understand when someone discovers a health condition and you don't have the money; how do you pay for seeing a doctor? What was it like? What do you get the resources from? Or you just didn't go and see a doctor?

Ms. JOHNSON. Actually, I just go give you a brief note of how it happened. Like I said, when I first realized that I was sick was my sophomore year of college. You know, it was something that was so simple when I finally figured out what it was. If I had been going to get the yearly physical exams, then they would have been able to detect it a lot earlier.

What made it stressful was actually figuring out who to reach out to and tell them what was going on with me, because like I said, I didn't have an adult or somebody in my life at that time I could call it, "Hey look, this is what's wrong with me. What do I do?" Once I reached out to the Georgia Department of Human Resources, there was some ladies that worked with me. Once I reached out to them and told them what was going on, "Okay," they said, "the next step is to figure out how we can get you taken care of."

So, Grady is a well-known hospital in Atlanta. We contacted Grady and they told me that they could put me on a waiting list to be seen. I was like, okay, so I did sign up for the waiting list to receive the appointment. But I never got it, I guess because of them just having so many people on the waiting list.

I contacted some local OB–GYN clinics right there in the county which I lived in, and the payment just to come in for that one day was so much. That's where I got the estimate of around $250, because that's how much they wanted just for that 1 day. At the time I was in between transition in school, so I wasn't working as much. So, I didn't have the money.

So, the next step was to try to find a local health department. The one in Clayton County, which is where I live now, where I'm going to school at Clayton State University, was the one where I would literally have to get up early in the morning at like six. Someone from the Georgia Department of Human Resources would come and pick me up, because I didn't have a car at the time, and take me to that facility. There were already, believe it or not, they

didn't believe it when I told them that there were already people there waiting at seven, that early in the morning, so they took me themselves so that they could see that that was the issue.

We got there and there were literally already a lot of people waiting to get into this particular health department. I went three times, and all three times I was not able to be seen. They would tell me that they didn't have enough nurses there that day for what I needed. They couldn't do it. So I was turned away then.

So, then I realized that when I was getting my associate's degree, there was a health department there. It was an hour and a half away from which I lived. So, I finally called them. They were like, Ms. Johnson, we know you don't live in our county, but just go ahead and come in. If you're that sick, just go ahead and come in. When I came in, it was the most embarrassing experience of my life, because the doctor looked at it. She was like, "How could a person get this sick? How could you let your condition wait this long until where you are this sick?"

That was the most embarrassing day of my life. They gave me almost every antibiotic you could think of, and I still had the problem. I didn't know how to explain to this lady that I didn't have health insurance and that I didn't know who to go to. Then I tried to contact all the places around me, and nobody was helping me. I didn't have the money, and finally the State of Georgia did pay for me to go. But even they were still having problems with getting me the medical attention. This was the Georgia defects that I reached out to that even they could testify to was that it was still difficult getting me treated without their health care insurance.

I tried to even reapply to see if I was still qualified for Medicaid, and I couldn't. I even tried to reapply at 19, and they said I was still ineligible. Right now, the Jim Casey Youth Opportunity Initiative Program called the Metro Atlanta Youth Opportunity Initiative, they have a door opener called Kaiser Permanente where you can pay $20 a month for full coverage. When I first came to the Atlanta Metro area, they had a freeze on the program because they had already accepted so many people into the program, so at that time I could not get in. But they have now reopened Kaiser Permanente. They offer backup, and I'm now in the process of applying for that.

The only thing is since I've had the reoccurring condition for so long, that's one of their requirements, that you not have a condition that you've already had long-term before enrolling. So, then, there I go again, back into where I started from.

Mr. LEWIS. Well, thank you, Ms. Johnson. My time is running out. Before you leave, we should get your number to one of my staff persons and we'll try to do what we can in Atlanta, and Clayton County ought to be of help to assist you.

Mr. Chairman, could I just ask another question?

Chairman MCDERMOTT. Yes.

Mr. LEWIS. Not of Ms. Johnson, but thank you so much.

Mr. Pollack, thank you so much for this unbelievable data that you provided in your testimony and also in your report. It is my hope that maybe in 2009, or someplace down the road, that you would come back and testify again, and we could maybe get the

ball rolling toward some comprehensive health for all of our citizens.

I happen to believe that health care is a right and not a privilege. It doesn't matter that you live in this country; you should have it. I would like for you to respond to some of the generalization that Mr. Gottlob made concerning Hispanic and African-American that happen to be, maybe, uninsured. I didn't quite understand where he was going. Maybe he can explain it. But if you could, deal with it?

Mr. POLLACK Let me refer to some numbers that are in the report that you just referred to. I said to you earlier in my testimony that, over the course of the last 2 years, 89.6 million people were uninsured at some point in that 2-year period. Now, all of these people are under 65 years of age, because if you are 65 years of age or older, you are eligible for Medicare. This constitutes a little more than one out of three non-elderly people, it's 34.7 percent of people under 65 years of age.

But getting to your question about the effect in terms of racial disparities, we broke this down from the Census Bureau data in terms of non-Hispanic whites, non-Hispanic blacks, and Hispanics. The percentages I'm going to give you are all percentages for people under 65 years of age. For non-Hispanic whites, 26 percent of the population under 65 years of age, a little more than one out of every four people, were uninsured at some point over the prior 2 years. Among non-Hispanic blacks, the percentage of people under 65 years of age who experienced a lack or loss of health insurance was 44.5 percent. Among Hispanics, the percentage was 60.7 percent. In other words, more than three out of five Hispanics were uninsured at some point over the last 2 years.

So, even though as my colleague on this panel indicated, about half the uninsured are white, non-Hispanics, the likelihood of being uninsured is very different, based on race and ethnicity.

Mr. LEWIS. Do you subscribe to the idea of the concept that everybody, every person, every human being that lives in America should have health care?

Mr. GOTTLOB. I certainly think everybody should be able to avail themselves of the same health care opportunities that are available to everyone else. Representative Lewis, I just want to make it clear that when I cited those statistics, what I was trying to do, and I mentioned this in follow-up, is to note that one of the things that characterizes those numbers is a high percentage of demographic groups that have very, very low, or lower rates of high school graduations—Hispanic population, African-American population. So, I was trying to draw the connection between insurance coverage and graduation.

So, that was the purpose. Certainly not, and when I talk immigration I certainly didn't want to, and I mention this, fan the flames of the immigration debate. That's not the purpose. There's tremendous heterogeneity in the data, but there is one kind of common theme, and one of those big themes is a lack of educational attainment. That is a very big predictor.

Mr. LEWIS. Isn't it in the best interest of the health of all of our citizens, of all the people that live in this country, that everybody should have health care?

Mr. GOTTLOB. Absolutely. Absolutely, and one of the reasons why I stress graduation rates so much is that you can provide everyone with health coverage. If you do that, it still won't put food on the table. It still won't pay the rent.

Mr. LEWIS. But a lot of the people without health care, they're working people. They work every single day. Every single day they get up, they go to work, but they cannot afford health care.

Mr. GOTTLOB. Absolutely.

Mr. LEWIS. The working poor.

Mr. GOTTLOB. By increasing the educational attainment, they will be better positioned to meet those other needs in addition to health care. That's really the point, that there are tremendous synergies between educational attainment, coverage of health care, and the resources, assets that individuals and families have, and the resources that ultimately are available to this government to address some of the issues in health care that aren't solved by increasing educational attainment.

Mr. LEWIS. Thank you, Mr. Chairman.

Chairman MCDERMOTT. Yes, Mr. Camp.

Mr. CAMP. Well, thank you. I appreciate all the witnesses for being here.

As many others have said, much of what we are talking about is not in the jurisdiction of this Subcommittee, or, frankly, in the jurisdiction of the Committee on Ways and Means. If we were the Commerce Committee, we might be able to do something about some of these issues.

But I do think that in the CRS report that I had introduced into the record there are demographic characteristics in terms of health coverage by type. 35.6 percent of the uninsured are Hispanic, according to CRS, the Congressional Research Service; 21.7 percent are African-American; 12.5 percent, white. So, this does disproportionately affect certain populations in the United States. I think having that information before the Subcommittee can only be helpful in terms of trying to find solutions.

But, as we talk about this issue, it seems to me that if we were to adopt many of the ideas being suggested by several witnesses to expand Medicaid, expand SCHIP, we would still not impact the high school dropout rate. That number would still stay the same, would it not Mr. Gottlob?

Mr. GOTTLOB. That's correct. There would not likely be a change. There isn't any research to my knowledge that indicates a relationship between health care coverage providing provision of health care coverage and a reverse in terms of increasing.

Mr. CAMP. So, we'd still have elevated rates of poverty and unemployment and far less lifetime annual earnings than individuals who have more education. Is that correct?

Mr. GOTTLOB. There clearly are benefits to families who are not insured to receiving when they receive insurance. There can be reduced expenditures on their part, but it doesn't fundamentally for the most part change their earning capacity.

So, their situation, whether they're skilled or unskilled, their educational attainment isn't fundamentally changed. Now, are there instances where it could be? Yes. But in the aggregate, it doesn't fundamentally change the resources, intellectual and other-

wise that are available to individuals and families to make their lives better.

Mr. CAMP. You mentioned on page 7 of your testimony, there are a number of initiatives that show promise for increasing high school graduation rates.

Could you just list several of those initiatives for us?

Mr. GOTTLOB. Yeah, I think. You know, alternative education at the high school level, kids who are at risk of dropping out, there are alternative schools that can help graduation rates. I mentioned the problem, I think. One of our big problems in the educational system is the segregation of our public education according to income and educational attainment of the parents. Mixing and breaking up some of that segregation I think will have profound impacts on educational quality and ultimately graduation rates. There are some tactical measures that I have talked about in terms of specific district-level kinds of initiatives that I think show promise.

There is a laboratory of school districts out there, and States that are doing innovative things and improving, in my State I know, improving graduation rates. When they do that they provide additional benefits to all of us, and that is the point of my testimony.

Mr. POLLACK Mr. Camp, I share my colleague's enthusiasm about equal educational opportunities.

Mr. CAMP. By the way, that is not in the jurisdiction of this Committee either. If we were on Education and Labor, we could talk about that issue.

Mr. POLLACK I understand that. But I must take issue with the notion that the provision of health care is largely irrelevant to educational attainment. That's just false.

If a child doesn't get a check-up and that child has a vision problem, or that child doesn't get a check-up and that child has a hearing problem, those things are not going to get corrected. How is that child going to get a decent education?

If a child can't get check-ups and get basic health care provided to them and they're absent from school, how does that not affect their educational attainment? There is a real correlation between the provision of health care and educational attainment and general development.

Mr. CAMP. Thank you for that comment.

My time is about to expire, but in your testimony you mentioned that coverage of children was almost universal in this country.

Mr. POLLACK No. No, wait a minute.

Mr. CAMP. It is.

Mr. POLLACK No.

Mr. CAMP. It's my time, sir, and thank you for your comment. I do have another question I want to ask Dr. Collins.

You had mentioned expanding Medicare so adults 55 to 64 could buy into it. That is in the authority of this Committee. How much would something like that cost and would premiums cover the full cost to taxpayers for all people covered? Would those premiums be means tested in some way? If you could describe in greater detail that idea, that thought.

Ms. COLLINS. Okay. Just one additional comment on this. The IOM has estimated that people lose between $65 Billion and $130 Billion each year collectively, because they don't have health insur-

ance coverage. That includes lost productivity, earnings, and lost educational achievement.

Mr. CAMP. Missing work and missing pay.

Ms. COLLINS. Well, human capital development, educational attainment was one of the things that the IOM identified. So, there really are some costs.

But anyway, on the issue of the Medicare buy-in, the Commonwealth Fund did an analysis of a bill that was introduced by Congressman Stark about the Medicare buy-in, and we looked at the details of that plan with the Lewin Group. I would have to go back and look at the data and get back to you. But I believe we were thinking it looked like it was on the order of $26.9 billion a year in Federal costs, but I'd have to look into that.

Mr. CAMP. I realize I maybe caught you off-guard on that, but if you could supply that later, I certainly would appreciate it.

Ms. COLLINS. Sure, happy to do that. I think that also we would want to think about what that benefit package would look like. Would we want to make it look more like the Federal employees health benefits plan, for example, and also to make it affordable, to make the premiums affordable for lower income, older adults who really do comprise the majority of uninsured older adults as they do the majority of people who are uninsured in the United States?

Mr. CAMP. All right. Thank you.

Thank you, Mr. Chairman.

Chairman MCDERMOTT. Thank you. Mr. Davis?

Mr. DAVIS. Thank you, Mr. Chairman.

All of us are under tight time constraints, because there are votes.

Mr. Pollack, Mr. Camp did not seem to be terribly understood on the answer to his questions. I want to give you a chance to answer it now.

You were talking about the number of uninsured children that continue in the United States. Would you just elaborate what those numbers are?

Mr. POLLACK Well, sure. There are approximately nine million children in the country who are uninsured, and of that number approximately two-thirds, about six million, are actually eligible under the current eligibility standards established by the States for SCHIP.

Mr. DAVIS. That would be typically 200 percent of poverty.

Mr. POLLACK That's right. That's right.

Mr. DAVIS. Which would be, for example, in my State that would be roughly $41,000 for a family of four.

Mr. POLLACK Correct. $34,000 for a family of three. That's right. The overwhelming majority of States are at approximately that income eligibility level.

Mr. DAVIS. So, just to make sure everyone in the room who's interested gets that point, two-thirds of the uninsured are eligible for the SCHIP program. They just simply haven't had the opportunity or the informational resources to take advantage of it.

Mr. POLLACK Or the States have not received sufficient funds to enroll them. We're just seeing what's happening, for example, in California. California is telling us that if we essentially keep the

same funding level for the SCHIP program as we had in the previous year, they're going to cut-back children who are currently in the program.

Mr. DAVIS. I would submit that that's the case in Alabama. It's the case, I think, in the States of virtually every single member of this Committee.

I move to my second observation. One of the problems I think that we have, Mr. Pollack, and I think you would agree with me on this, as we try to fashion the political will, because frankly it is not that we are not smart enough to figure out how to address the health care problems, there are a range of things that we can do.

Dr. Collins pointed out some of them. You pointed out a number of them. Mr. Gottlob pointed out a number of them. Ms. Johnson pointed out a number of them. There are a range of things that we can do. This is not beyond our intellectual capacity. It's not too big a problem for us to get our hands around. This is not rocket science. The problem has, frankly, been one of political will.

One of the reasons I think we struggle to garner the political will is because of some of the misinformation that lurks on the other side of this argument. I am troubled when I hear the President of the United States suggest that there's a significant portion of people who are affluent, who have resources, who just elect to be free riders, who elect to essentially be uninsured and let the emergency room take care of them. There's some whiff of that in his rhetoric, even when he talks about the SCHIP program.

When I listen carefully to what he says, I hear something in his rhetoric that suggests that, well, the people who really need it get it. There's a group of folks who don't really need it that the liberal democrats are now trying to push into the program.

Do you hear something of that in his rhetoric, Mr. Pollack?

Mr. POLLACK Well, of course. The President has said everyone gets health care. You know, of course, they can go to an emergency room. Well, come to the emergency room and take a look at the care that people receive, people having to wait in line. This is the most expensive form of care.

So, there's a huge disparity in terms of the care people get when they're insured versus when they're uninsured. I wish frankly that the President would adhere to his own message that he gave in Madison Square Garden in 2004 when he accepted the Republican nomination for President. Then, he said, "we've got millions of children who are eligible who are not currently enrolled. My administration is going to reach out to those folks and get them enrolled in public coverage." Now unfortunately the President, who has had the opportunity to do this, has turned his shoulder.

Mr. DAVIS. Just to add to that point, the former Mayor of New York, Mr. Giuliani, who I think has some interest in getting the job himself, has made some misstatements I've heard in debates.

He during one debate suggested there was a significant number of people who just don't want to get health insurance and that they're basically just careless individuals. I thought he overstated that point.

The last observation I'll make, Mr. Pollack, is thank you for making the observation that the scope of public coverage is weaker

than most Americans believe. In my State of Alabama, the only way you are eligible for Medicaid is if you have dependency with 133 percent of poverty. You can be, as you put it, stone, cold broke. You can be penniless and be a 21-year-old woman who is working at a convenience store who doesn't have a dependent, and you are ineligible for Medicaid in the State of Alabama and a number of other States.

For some reason, there's a myth that some on the right take advantage of that. Well, there's some program out there that will reach out and act as a safety net for many of the poor and the uninsured. The actual scope of Medicaid coverage is far weaker than many people believe it to be. We need to, I think, begin to look at underwriting a much stronger floor for the Medicaid program.

Thank you, Mr. Chairman.

Chairman MCDERMOTT. We've got about 5 minutes left, and Ms. Berkley, if you could maybe lean just a little bit for the gentleman to your right.

Ms. BERKLEY. Okay. Nudge me, if I go on too long.

I'm sorry I wasn't here at the beginning. I had to testify in front of another Committee, but what I did here I thought was profoundly moving. Ms. Johnson, one thing that you said is so right.

If you are a ward of the State, when you age-out of foster care, the least the State could do is provide health insurance for you. When my kids were 18 they were no sooner ready to age-out of my home than the man on the moon. If they didn't have a home to go to and parents to take care of them, I'd hate to think where they'd be right now. so I want to applaud you for everything you have done. But that's what we should be doing, making sure that we take care of that gap in between aging out and being 24 years old.

The other thing, and I want to make sure that I do get this in, Mr. Chairman, for high growth areas like my State. Everything we've discussed including SSI, ineligibility, and waiting times, are exacerbated because we have a lack of staff, a lack of ability to get this done, and far too many people needing the services.

So, for the two and a half years average, I guarantee in my community and my district, people are waiting three and a half years, because of the backlog. Let me mention what is going on very quickly, and then I'll hand it over to Mr. Van Hollen.

I visit my schools in the underprivileged, if that's the right word, areas in Las Vegas, which is a pretty affluent place, and we've got high employment rates. But I've got a huge dropout rate. I'll tell you this. When these kids go to school in these disadvantaged areas, they come with no breakfast. They've got a mouthful of cavities. They are sick as dogs. They should be home, but there's nobody home to take care of them because their parents are working at jobs that don't provide health coverage. Half of them come from non-English speaking families, and quite frankly, as a parent I don't want my kid sitting next to that child. That child needs to have care, and that's why that SCHIP program is so terribly important.

It's no surprise to me that we have a high dropout rate, because once you go through that in your initial years and you never catch on, by the time you are in the ninth grade, you want out. As soon

as you turn 16, you are going to find an alternative way of spending your time, because school isn't it.

You are absolutely right, Mr. Gottlob, that's a huge problem for this country, because we can't afford in the 21st century to leave anybody behind. But I think it starts early, much earlier than high school. It starts not only with nutritious meals and a stable family environment, if we could make that happen, but good quality health care to take care of these kids.

Chairman MCDERMOTT. Mr. Van Hollen?

Mr. VAN HOLLEN. Thank you, Mr. Chairman.

Chairman MCDERMOTT. You can take this as far as you want.

Mr. VAN HOLLEN. Thank you, Mr. Chairman.

I will be brief, given the bells that just went off. I just want to thank all the witnesses for being here. As our colleague Artur Davis said, providing health coverage in the United States, universal comprehensive health coverage, is a matter of mustering the political will to do it. I hope that after the next presidential elections we'll be able to come up with a plan as a country that will address all of our people.

In the meantime until we get to that point, we have to spend our time trying to fill the gaps, and that's obviously what we are focused on today. I want to float one proposal that we have put out there in the form of legislation. Mr. Pollack, I want to thank you and Families USA for supporting it. I bring it to the attention, briefly, of others on the Committee and the panel, if you are not.

Under the Medicaid program, states can ask for a waiver to include non-Medicaid individuals within a prescription drug program. In the State of Maryland under a former Republican Governor, former member of this body, Mr. Erlich, and a Democratic legislature, sought a waiver from the Administration to say the State of Maryland would like to include individuals up to 300 percent of the Federal poverty level in their bargaining pool when they bargain for prescription drugs under the Medicaid program. That would have the benefit, number one, of covering a lot more people, up to 300 percent of poverty, which is where we are talking about the SCHIPS program being right now. It would cover the kind of people Mr. Davis was talking about, the woman who worked at the convenience store who is not eligible for Medicaid and is struggling to pay the high costs of lots of health care, including prescription drugs.

It wouldn't cost the Federal Government a dime, and you'd cover a lot more people. I wondered if you could just comment on it, Mr. Pollack, and if others are familiar with this particular gap filler.

Chairman MCDERMOTT. One minute to vote.

Go ahead.

Mr. POLLACK As you correctly indicated, we support the legislation. Maine has also tried to do something very similar. I think it would help both those currently on Medicaid and those not on Medicaid. It would create a larger bargaining pool, and, as a result, the State would be in a stronger position to bargain for cheaper prices.

So, I think it would be good, not just for current Medicaid beneficiaries, but the particular target of the legislation: those who are not eligible, and who really need help. They could get help. So, we think it's a very constructive proposal.

Chairman MCDERMOTT. Thank you very much. Thank all the members of the panel, particularly Ms. Johnson for coming and doing this. But all of you, we stand adjourned.

[Whereupon, at 11:32 a.m., the hearing was adjourned.]

[Questions for the Record follow:]

The Honorable Jim McDermott
Chairman
Subcommittee on Income Security and Family Support
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Dear Chairman McDermott:

I am writing in response to your request for additional information related to the testimony I provided before your Subcommittee on November 14 during the hearing, "The Impact of Gaps in Health Coverage on Income Security." Once again, I wanted to thank you for the opportunity to provide the Committee with information and recommendations regarding promising policy solutions to address the financial problems children and families face as they navigate our health care system.

As President of First Focus, a bipartisan advocacy organization committed to making children and their families a priority in federal policy and budget decisions, I am heartened by your leadership on this issue, and would like to thank you and mMembers of the Subcommittee for bringing the important voice of children to the health care discussion.

Along with your questions, I am providing below the additional information you requested in your letter of November 28th.

1. States currently have the option of extending Medicaid coverage to former foster children up to age 21. Based on Ms. Johnson's testimony, this would be of great help to former foster youth who transition from care into adulthood. How many States are currently extending Medicaid coverage to former foster youth? What more can Congress do to help these vulnerable adolescents receive coverage?

In 2005, over 24,000 teens left foster care at the age of 18. The range of services and supports available to children who age out of the foster care system varies considerably from State to State. Sadly, most teens aging out of care receive minimal services, and feel abandoned at a time when they need a great deal of guidance and support.

The outlook for these kids is fairly grim. One in four will be incarcerated within the first 2 years after leaving the system, and over one-fifth will become homeless at some point. Only 58 percent will obtain a high school degree at age 19—compared to 87 percent of non-foster kids. These teens are also more likely to experience serious mental health problems and to be involved in the juvenile justice system. In fact, in a recent study of youth aging out of the Illinois foster care system, caseworkers identified one-third of these youth as having one or more significant mental health, medical, prenatal, substance abuse or developmental needs. Other studies have similarly found that large numbers of youth aging out of care have diagnosable mental health disorders. For instance, a recent study by Casey Family Programs found that 54 percent of youth have a mental health diagnosis after leaving care.

Two key pieces of legislation, the Foster Care Independence Act 1999 (P.L. 106–169) and the Deficit Reduction Act of 2005 (P.L. 109–171) have created a critical opportunities for States to extend Medicaid coverage for youth who have aged out of the foster care system.

The Chafee option, enacted through P.L. 106–169, allows States to extend Medicaid coverage to former foster children ages 18 to 21, but not enough States are doing so. A 2007 report by the America Public Human Services Association (APHSA) found that since the enactment of the Foster Care Independence Act, 17 States (CA, NV, UT, AZ, WY, SD, KS, OK, TX, IA, IN, MS, FL, SC, NJ, RI, MA) have moved to extend their Medicaid programs using this provision to provide care for youth aging out. In addition, five States (NM, MO, WI, NC, MD) are planning to extend their Medicaid coverage using the Chafee option. The report also found that extending Medicaid coverage is in fact affordable using this option.

While 22 States are (or will soon) extend Medicaid eligibility to foster youth aging out of care via the Chafee option, the remaining 28 States and the District of Columbia use several other programs to provide health coverage for youth aging out of the foster care system. Several States have utilized section 1115 waivers under

the Medicaid program to extend care, while others offer former foster youth the opportunity to qualify for additional benefits if they remain in care or in an education setting.

For instance, in Alabama, a State plan category exists for foster youth who remain in State custody (up to age 21) in order to retain Medicaid eligibility. In Alaska—Denali KidCare—a program designed to ensure that kids and teens in working and non-working families have access to health insurance, is available to youth who are 19 years old for a 12 month period (youth need to reapply for the program every 6 months). The State uses an 1115 waiver to extend the program. Alaska also provides Medicaid to Alaskan Native youth who age out of the foster care system through the Native Health Care Program. In fact, the majority of Alaska's youth in foster care are Alaskan Natives, and they have access to critical health care via this program. In Idaho, foster youth are eligible to receive Medicaid until age 19 under title XIX whether they exit or stay in continued care. After age 19, they may still qualify for Medicaid if they fall under the TANF, SSI or disability criteria. Lastly, in Kentucky, youth who age out of foster care at 18 have a reduced benefit medical card that is valid until their 19th birthday. These are just a few examples of State efforts to piece together a health care system for youth aging out of care. Unfortunately, there is considerable variability in access across programs, and restrictions on eligibility. In addition, a number of States only extend coverage for youth to age 19.

We believe that Medicaid coverage should continue for all youth in foster care until at least the age of 21. Congress can help by enacting legislation to do just that. A number of proposals, including the Medicaid Foster Care Coverage Act (H.R.1376) and the Foster Care Continuing Opportunities Act (S. 1521) expand eligibility for Medicaid to foster care adolescents through age 21. We support such efforts to expand coverage to youth aging out of foster care and believe that federal policy is essential to ensuring continuity in care for vulnerable adolescents.

2. I was interested in your testimony regarding the high rates of low income children who are eligible for Medicaid and SCHIP but are not currently enrolled in these programs. You noted in your prepared statement that 62% of all uninsured children are eligible for, but not enrolled in, either Medicaid or SCHIP. You reference a study showing that 36% of those children were in families with incomes below the poverty line and another 41% were in families with incomes of 100%–200% of the federal poverty line. Obviously, we have some work to do. While we are not here today to discuss SCHIP reauthorization, I would be interested in your thoughts on why the SCHIP bill offers a greater opportunity to enroll the poorest children first?

Over the last decade, SCHIP has amassed an impressive record of success in providing cost-effective health insurance coverage for children—increasing the number of children enrolled in the program from 660,000 in 1998 to 6.6 million in 2006. At a time when the numbers of uninsured adults has been on the rise, SCHIP has reduced the number of uninsured children in our Nation by one-third.

Unfortunately, as I noted in my testimony, a large portion of those children who are eligible for Medicaid or SCHIP remain uninsured. Both of the Children's Health Insurance Program Reauthorization Acts (CHIPRA I and CHIPRA II) (H.R. 976, H.R. 3963) passed by Congress this fall included provisions that would provide critical assistance to States to facilitate the enrollment of the very poorest of these children who are eligible but not enrolled in Medicaid or SCHIP. Specifically, the CHIPRA bills included two key provisions—to provide States with an Express Lane Eligibility option and to provide grants to support State, local, and community-based outreach and enrollment campaigns—which are among the only new tools provided that would strengthen outreach and enrollment efforts for this hard-to-reach population.

Express Lane Eligibility

Both CHIPRA I and CHIPRA II included Express Lane provisions that would allow States to adopt simplified enrollment processes to determine a child's eligibility under Medicaid or SCHIP. Under Express Lane Eligibility, States would be able to expedite the enrollment of currently eligible children by targeting outreach to those children who are already participating in needs-based programs. It is estimated that more than 70 percent of low-income, uninsured children are in families that are already enrolled in the Food Stamp Program, the Women with Infants and Children (WIC) program, or the National School Lunch Program (NSLP). The idea of Express Lane is to give States the flexibility to find a child income-eligible for Medicaid or SCHIP based on the fact that they have already been found eligible for

nutrition assistance or other comparable programs that operate under similar financial guidelines.

Express Lane proposals enjoy long standing bipartisan support in both the House and the Senate. It was included in then-Majority Leader Frist's child health bill during the 109th Congress, which the administration supported, and bipartisan legislation (S. 1213) that was introduced earlier this year in the Senate by Senators Bingaman (D–NM) and Lugar (R–IN). The Express Lane Eligibility option is designed to target the very poorest uninsured and eligible children who have been the hardest to reach through other methods.

Outreach and Enrollment Grants

In addition, the reauthorization legislation allocates $100 million for fiscal years 2008 through 2012 for outreach and enrollment grants, with 10 percent of the funding dedicated to a national enrollment campaign, and 10 percent for outreach grants targeting Native American children.

According to the provision, remaining funds would be distributed by the U.S. Department of Health and Human Services to State and local governments and other community-based organizations, including safety net providers, schools, or other entities best positioned to reach low-income children through outreach campaigns. Most important, outreach campaigns would be geared to rural areas and racial and ethnic populations which are known to be underenrolled in Medicaid or SCHIP. The legislation also provides an enhanced matching rate in SCHIP and Medicaid for translation and interpretation services for families for whom English is not the primary language.

The research is conclusive that that community-based organizations are often best positioned to help identify families with children who are eligible for coverage. This is particularly the case for minority populations who are disproportionately represented among the ranks of the uninsured.

We believe the enactment of these provisions would provide States important new tools to reach eligible, low-income children who are not enrolled in health coverage.

I hope this information is helpful and, once again, thank you for the opportunity to testify before your Subcommittee. We are grateful for your leadership in addressing the health care needs of our most vulnerable children and families and we look forward to working with you in the future to ensure better care for all of our nation's children.

Sincerely,

Bruce Lesley
President

[Responses to Questions for the Record posed by Chairman McDermott to The Commonwealth Fund follow:]

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December 19, 2007

Congressman Jim McDermott
Chairman
Subcommittee on Income Security and Family Support
Committee on Ways and Means
U.S. House of Representatives

Dear Congressman McDermott,

I am writing in response to your questions related to the hearing before the Subcommittee on Income Security and Family Support on the impact of gaps in health coverage on income security on November 14. Your letter only recently came to my attention and I greatly apologize for missing the December 12 deadline to respond. I sincerely hope that my attached responses are still helpful to you.

Thank you very much for the invitation to testify on this important and timely issue. Please let me know if I can be of further assistance.

Sincerely,

Sara R. Collins, Ph.D.
Assistant Vice President

Attachment

Committee on Ways and Means
Subcommittee on Income Security and Family Support
U.S. House of Representatives
Hearing on "The Impact of Gaps In Health Coverage on Income Security"
November 14, 2007

Responses to Questions from Chairman McDermott

Sara R. Collins, Ph.D.
Assistant Vice President
The Commonwealth Fund
December 19, 2007

1. How does the U.S. spending on health care per capita compare to other industrialized nations? How do basic health statistics compare to other industrialized nations?

How does the U.S. spending on health care per capita compare to other industrialized nations?

U.S. spending on health care comprised 15.3 percent of gross domestic product in 2005, compared with 9.1 percent in the median Organization for Economic Cooperation and Development (OECD) country (Figure 1). Per-capita spending on health care in the U.S. totaled $6,401 in 2005, twice that of the median for all 30 OECD countries at $2,922.[1] Americans also spend two times as much on out-of-pocket expenses than do residents of other industrialized countries (Figure 2).

The U.S. leads all other industrialized countries in the share of national health expenditures devoted to health care administration. In 2003, spending on health and insurance administration commanded 7.3 percent of national health spending. Similar spending in other industrialized countries ranged from 5.6 percent of national health expenditures in Germany to around 2 percent in France, Finland, and Japan (Figure 3).[2] Davis and colleagues estimate that if the U.S. had a similar level of administrative spending to that of France, Finland, and Japan it would have saved $97 billion on health

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[1] J. Cylus and G. F. Anderson, *Multinational Comparisons of Health Systems Data, 2006* (New York: The Commonwealth Fund, May 2007).

[2] C. Schoen, K. Davis, S. K.H. How, S.C. Schoenbaum, "U.S. Health System Performance: A National Scorecard," *Health Affairs* Web Exclusive Sept. 20, 2006, W457-475; The Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from a National Scorecard on U.S. Health System Performance* (New York: The Commonwealth Fund) Sept. 2006.

public and private insurance systems, like Germany and Switzerland, would have saved an estimated $32 to $46 billion in that year.

How do basic health statistics compare to other industrialized nations?

The Commonwealth Fund Commission on a High Performance Health System's *National Scorecard on U.S. Health System Performance*, finds that the U.S. health system falls far short of achievable benchmarks and that reached by other countries for health outcomes, quality, access, efficiency, and equity.[4] The Commission found that out of a possible 100 points based mostly on benchmarks that have been achieved within the U.S. or other countries, the U.S. received a score of 66, or one-third below benchmark levels of performance. The U.S. scored particularly poorly on indicators of efficiency, with wide variation in cost and quality across the country and with much higher spending levels than other countries. The U.S. ranks 15th out of 19 countries on mortality from conditions "amenable to health care"—that is, deaths that could have been prevented with timely and effective care (Figure 4). In fact, 115 people per 100,000 Americans die from illnesses amenable to medical care before age 75, compared to 75 to 84 per 100,000 in the top three countries—France, Japan, and Spain. The U.S. ranks at the bottom among industrialized countries on healthy life expectancy at birth or at age 60. And out of 23 countries, the U.S. ranked last on infant mortality, with a rate of 7 infant deaths per 1,000 births, more than double the rates of the top three countries—Iceland, Japan and Finland—and well above the median rate for high-income industrialized countries (4.4 per 1,000 births) (Figure 5).

In a survey of five countries, Schoen and colleagues found that the U.S. had the highest share of adults reporting cost-related problems accessing needed health care (Figure 6). In 2004, 40 percent of U.S. adults and 57 percent of adults with below-average incomes reported they went without care during the year because of cost—four times higher than in the United Kingdom, a country with universal health insurance coverage and other protective policies.[5] In 2005, more than one-quarter (26%) of U.S. adults and more than one-third (36%) of uninsured U.S. adults went to an emergency room for a condition that

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[4] C. Schoen, K. Davis, S. K.H. How, S.C. Schoenbaum, "U.S. Health System Performance: A National Scorecard," *Health Affairs* Web Exclusive Sept. 20, 2006, W457-475; The Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from a National Scorecard on U.S. Health System Performance* (New York: The Commonwealth Fund) Sept. 2006.

[5] C. Schoen, R. Osborn, P. T. Huynh, M. M. Doty, K. Davis, K. Zapert, and J. Peugh, "Primary Care and Health System Performance: Adults' Experiences in Five Countries," *Health Affairs* Web Exclusive (Oct. 28, 2004):w4-487–w4-503.

could have been treated by a regular doctor. This is two and three times the rate reported by British respondents (12%) and four and six times the rate reported by Germans (6%).

2. Why must individuals who receive federal disability benefits wait two years before they become eligible for health coverage under the Medicare program?

Federal law requires people with a severe and permanent disability to wait two years after they begin receiving Social Security Disability Insurance (SSDI) before they can be covered under Medicare. The primary reason why Congress applied the two year waiting period was to keep the costs of the program down. [6]

There are an estimated 1.7 million people who are disabled and in the waiting period for Medicare . Of those, about one-third have coverage through a former employer or though a spouse's employer, just over a third are covered by Medicaid, 9 percent purchase coverage through the individual insurance market, and 15 percent, or nearly 265,000 people, are without health insurance. Those with COBRA coverage through a former employer or who purchase it through the individual market are financially burdened with the full premium.

In a 2005 study of older adults, 41 percent of disabled Medicare beneficiaries ages 50-64 said that they had been uninsured just prior to entering Medicare. [7] More than four of five (84%) said that becoming eligible for Medicare was very important.

Prior research has found that people in the two year waiting period who are uninsured experience significant hardship and report skipping or delaying needed health care because of costs. [8] It is critical that we end the two-year waiting period for coverage of the disabled under Medicare. The Lewin Group estimates that the cost to the federal government of immediately ending the waiting period would be about $9.1 billion in 2007, but that figure is expected to decline over time since there would be fewer people

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[6] B.Williams, A. Dulio, H. Claypool, et al. *Waiting for Medicare: Experiences of Uninsured People with Disabilities in the Two-Year Waiting Period for Medicare* (New York: The Commonwealth Fund) October 2004.

[7] S.R. Collins, K.Davis, C. Schoen, et al., *Will You Still Need Me? The Health and Financial Security of Older Americans* (New York: The Commonwealth Fund) June 2005.

[8] B.Williams, A. Dulio, H. Claypool, et al. *Waiting for Medicare: Experiences of Uninsured People with Disabilities in the Two-Year Waiting Period for Medicare* (New York: The Commonwealth Fund) October 2004.

enrolling all at once and less pent up demand for health services from uninsured or underinsured people in the waiting period.[9]

3. Unemployed workers that received health insurance through their employer may be able to continue to purchase their health coverage through COBRA for up to 18 months. Do many unemployed workers continue to purchase insurance through the program? Why are unemployed workers not taking advantage of COBRA?

A significant problem is that a significant share of lower income workers who would benefit from COBRA coverage is not eligible for the benefits. And even when they are, because they must pay 102% of their former employer's premium, many find it unaffordable. Like employer-based coverage in general, lower wage workers are far less likely to be COBRA-eligible than higher wage workers (Figure 7). In a Commonwealth Fund Survey only 40 percent of workers with incomes under 200 percent of poverty had COBRA-eligible benefits compared to 75 percent of workers in households with incomes of 200 percent or more. Kapur and Marquis found that of workers with household incomes of less than 200 percent of poverty who left a job voluntarily, 53 percent were uninsured one-month after leaving their job compared to 28 percent of higher income workers.[10] But 50 percent of lower income job leavers were uninsured prior to leaving their job compared to 22 percent of workers with incomes of 200 percent or more of poverty. Higher income workers who voluntarily left their jobs were somewhat more likely to have COBRA (8% vs. 3%) than their lower income counterparts, much more likely to gain coverage through a new job (16% vs. 4%) and much more likely to gain coverage through a family member's employer (31% vs. 10%)

Even when lower wage workers are eligible for COBRA benefits, the full cost of the premium, now more than $12,000 a year for a family plan, plus the 2 percent fee may be unaffordable, particularly as a share of an unemployment benefit. [11] Kapur and Marquis found for example, that of lower income workers who were eligible for COBRA through their jobs and left their jobs, 48 percent were uninsured one-month later compared to 27 percent of higher income COBRA-eligible workers who left their jobs. Lower income workers and higher income workers took up COBRA at about the same rate (18%) but

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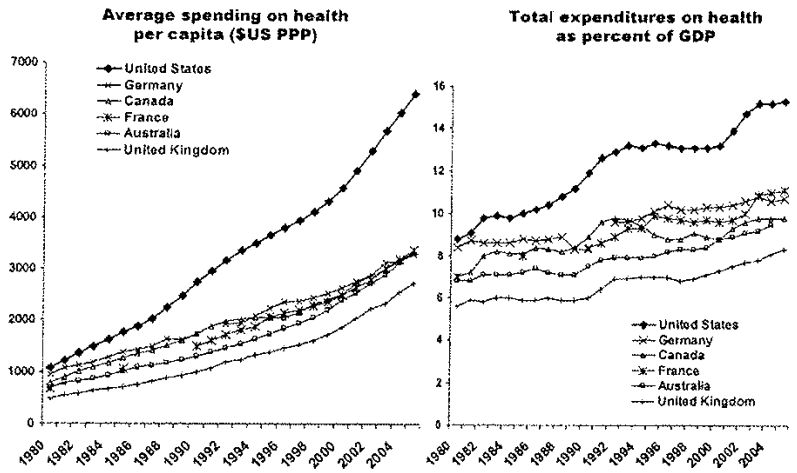
[9] S.R. Collins, K. Davis, J.L.Kriss, *Analysis of Leading Congressional Health Care Bills 2005-2007: Part I, Insurance Coverage* (New York: The Commonwealth Fund) March 2007.
[10] K. Kapur and M.S. Marquis, "Health Insurance for Workers Who Lose Jobs: Implications for Various Subsidy Schemes," *Health Affairs* 22(3) (May/June 2003) :203-213
[11] J.M.Lambrew, *How the Slowing U.S. Economy Threatens Employer-Based Health Insurance* (New York: The Commonwealth Fund) November 2001.

higher income workers were much more likely to have gained coverage through a new job (29% vs. 9%).

Figure 1. International Comparison of Spending on Health, 1980–2005



Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.
Updated data from OECD Health Data 2007.

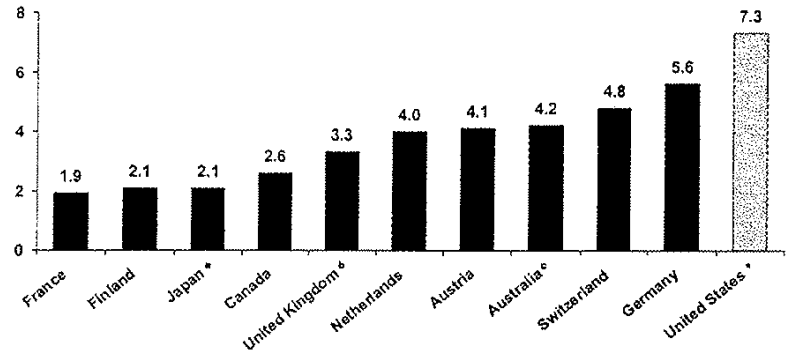
Figure 2. Americans Spend More Out-of-Pocket on Health Care Expenses

*2003
†2003 Total Health Care Spending, 2002 OOP Spending

Source: The Commonwealth Fund, calculated from OECD Health Data 2006.

Figure 3. Percentage of National Health Expenditures Spent on Health Administration and Insurance, 2003

Net costs of health administration and health insurance as percent of national health expenditures

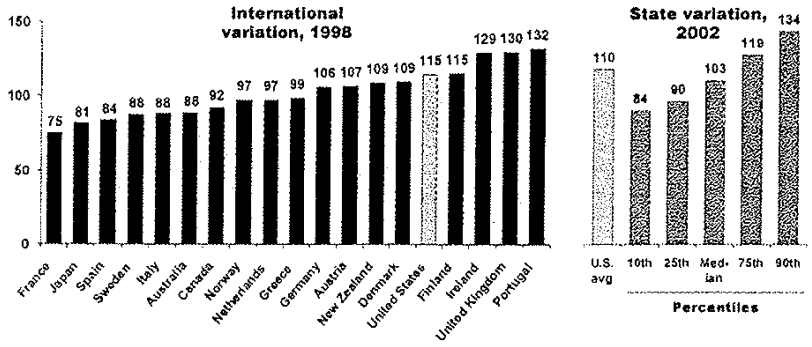


a2002 b1999 c2001
*Includes claims administration, underwriting, marketing, profits, and other administrative costs; based on premiums minus claims expenses for private insurance.
Data: OECD Health Data 2005.
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

Figure 4. Mortality Amenable to Health Care

Mortality from causes considered amenable to health care is deaths before age 75 that are potentially preventable with timely and appropriate medical care

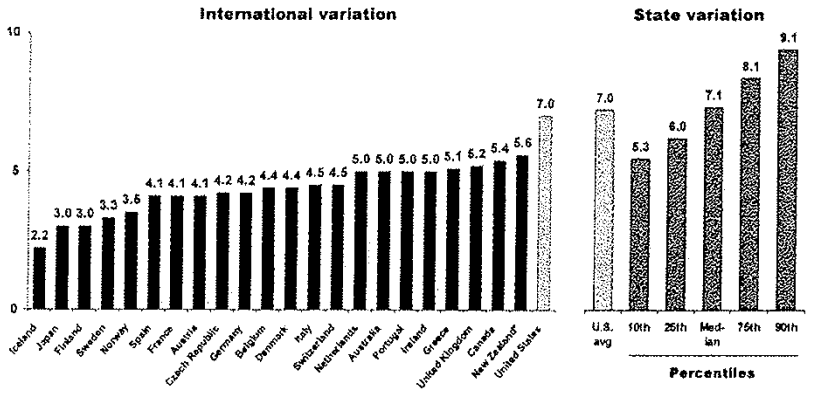
Deaths per 100,000 population*



*Countries' age-standardized death rates, ages 0–74; includes ischemic heart disease.
See Technical Appendix for list of conditions considered amenable to health care in the analysis.
Data: International estimates—World Health Organization, WHO mortality database (Nolte and McKee 2003); State estimates—K. Hempstead, Rutgers University using Nolte and McKee methodology.
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

Figure 5. Infant Mortality Rate, 2002

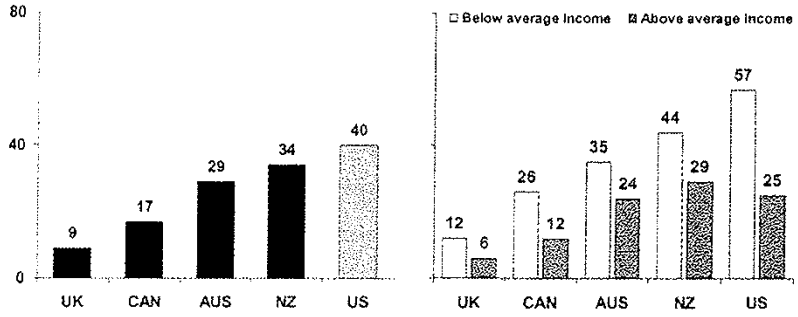
Infant deaths per 1,000 live births



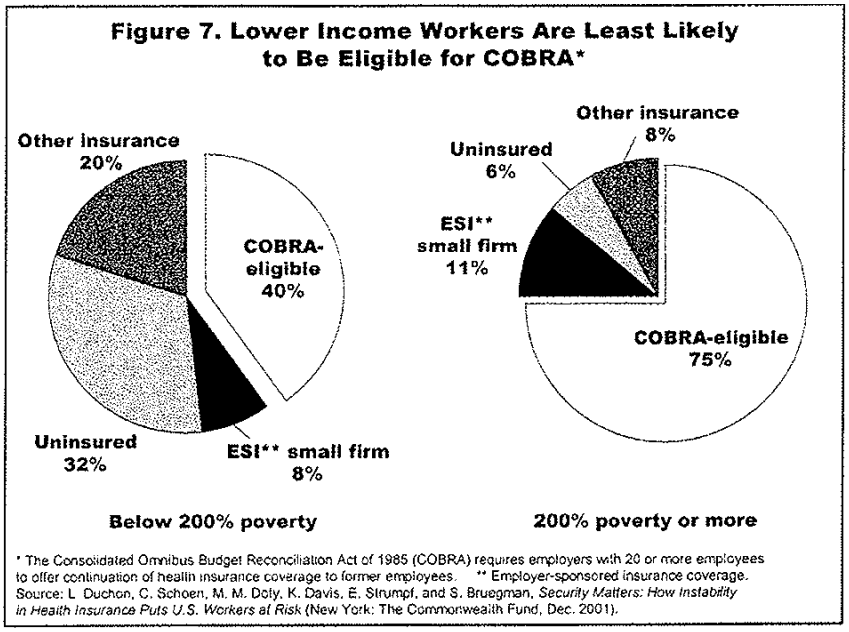
*2001.
Data: International estimates—OECD Health Data 2005;
State estimates—National Vital Statistics System, Linked Birth and Infant Death Data (AHRQ 2005a).
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

Figure 6. Access Problems Because of Costs in Five Countries, Total and by Income, 2004

Percent of adults who had any of three access problems* in past year because of costs



* Did not get medical care because of cost of doctor's visit, skipped medical test, treatment, or follow-up because of cost, or did not fill Rx or skipped doses because of cost.
UK=United Kingdom; CAN=Canada; AUS=Australia; NZ=New Zealand; US=United States.
Data: 2004 Commonwealth Fund International Health Policy Survey of Adults' Experiences with Primary Care (Schoen et al. 2004; Huynh et al. 2006).
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.



[Submissions for the Record follow:]

Statement of Business Coalition for Benefits Tax Equity

Mr. Chairman, in conjunction with the Subcommittee's hearing on the impact of gaps in health coverage on income security, the 44 members of the Business Coalition for Benefits Tax Equity salute your leadership in addressing an important health coverage challenge through introduction of H.R. 1820, the Tax Equity for Health Plan Beneficiaries Act of 2007. Enactment of H.R. 1820 would advance Congress's efforts to eliminate gaps in health coverage.

Employers across the United States in increasing numbers have made the business decision to provide health benefits to the domestic partners of their employees. As of June 2007, 53% of Fortune 500 companies (266) are offering domestic partner health coverage, a more than twelve-fold increase since 1995. These employers have recognized that the provision of domestic partner health coverage is an essential component of a comprehensive benefits package. This coverage helps corporations such as those in our coalition attract and retain qualified employees and provides employees with health security on an equitable basis.

Unfortunately, federal tax law has not kept pace with corporate change in this area and employers that offer such benefits and the employees who receive them are taxed inequitably. This reduces the number of individuals who utilize employer-provided health coverage.

Issues Under Current Law

Currently, the Internal Revenue Code ("Code") excludes from income the value of employer-provided insurance premiums and benefits received by employees for coverage of an employee's spouse and dependents, but does not extend this treatment to coverage of domestic partners or other persons who do not qualify as a "dependent" (such as certain grown children living at home who are covered under a parent's plan or certain children who receive coverage through a grandparent or parent's domestic partner). In addition, when calculating payroll tax liability, the value of non-spouse, non-dependent coverage is included in the employee's wages, thereby increasing both the employee's and employer's payroll tax obligations. An employee of median income level who receives employer-provided major medical coverage of average cost for himself and a domestic partner faces an annual tax bill of $4,710

in income and payroll taxes, $1,555 (or nearly 50%) more than that paid by a similarly situated co-worker with spousal coverage. However, this employee has no additional income to meet this higher tax burden. These higher tax levels can lead employees to decline the domestic partner coverage altogether, contributing to America's problem of the uninsured and to the gaps in health coverage the Subcommittee is considering today.

The current inequitable tax regime also places significant administrative burdens on employers. It requires employers to calculate the portion of their health care contribution attributable to a non-spouse, non-dependent beneficiary and to create and maintain a separate system for the income tax withholding and payroll tax obligations for employees using such coverage.

Employers such as ours that offer domestic partner benefits want to end these tax inequities so that the benefits we provide help to cover more Americans and so that all our employees are treated equitably under the tax laws. Ending the tax inequities will also eliminate the need for what are often complex communications to employees about how the tax penalties operate. Finally, ending the inequities will allow us to jettison the separate and burdensome administrative systems that we must currently establish to track the income tax withholding and payroll tax obligations for employees using domestic partner coverage.

H.R. 1820 Provides a Solution

H.R. 1820 would end these and other current tax inequities with respect to employer-provided coverage for non-spouse, non-dependent beneficiaries, such as domestic partners. Specifically, the bill would make the following important changes:

1. The value of employer-provided health insurance for a domestic partner or other non-dependent, non-spouse beneficiary would be excludible from the income of the employee if such person is an eligible beneficiary under the plan. Employers would retain the current flexibility to establish their own criteria for demonstrating domestic partner status. In a corresponding change, the cost of health coverage for domestic partners or other non-spouse, non-dependent beneficiaries of self-employed individuals (e.g., small business owners) would be deductible to the self-employed person.

2. The legislation would make clear that employees paying for health coverage on a pre-tax basis through a cafeteria plan would be able to do so with respect to coverage for a domestic partner or other non-spouse, non-dependent beneficiary.

3. Many employers, particularly in the collectively bargained context, use tax-exempt Voluntary Employees' Beneficiary Associations ("VEBAs") to provide health coverage. Today, VEBAs are prohibited from providing more than de minimis benefits to a domestic partner or other non-spouse, non-dependent beneficiary.

The legislation would permit a VEBA to provide full benefits to non-spouse, non-dependent beneficiaries without endangering its tax-exempt status.

4. In contrast to current law, employees would be permitted to reimburse medical expenses of a domestic partner or other non-spouse, non-dependent beneficiary from a health reimbursement arrangement ("HRA") or health flexible spending arrangement ("Health FSA").

5. The value of employer-provided health coverage for a domestic partner or other non-dependent, non-spouse beneficiary would be excluded from the employee's wages for purposes of determining the employee's and employer's FICA and FUTA payroll tax obligations.

We look forward to working with you to advance this legislation and applaud your inquiry as to how to address gaps in health coverage.

The Business Coalition for Benefits Tax Equity is a coalition of employers that supports eliminating the federal tax inequities that result when corporations voluntarily provide health care coverage to the domestic partners (and other non-spouse, non-dependent beneficiaries) of their employees. Coalition members are listed below.

Aetna
Hartford, CT

A.H. Wilder Foundation
St. Paul, MN

American Benefits Council
Washington, DC

Ameriprise Financial, Inc.
Minneapolis, MN

Bausch & Lomb Inc.
Rochester, NY

Best Buy, Co., Inc.
Richfield, MN

BlueCross BlueShield of MN
Eagan, MN

Capital One Financial Corp.
Falls Church, VA

Carlson Companies
Minneapolis, MN

Charles Schwab & Co, Inc.
San Francisco, CA

The Chubb Corporation
Warren, NJ

Citigroup
New York, NY

CNA Insurance
Chicago, IL

Corning, Inc.
Corning, NY

Coors Brewing Co.
Golden, CO

Cullen Weston Pines & Bach LLP
Madison, WI

The Dow Chemical Co.
Midland, MI

Eastman Kodak
Rochester, NY

EDS
Plano, TX

Ernst & Young
New York, NY

General Mills Inc.
Minneapolis, MN

Hewlett-Packard Co.
Palo Alto, CA

HSBC North America
Prospect Heights, IL

IBM Corp.
Armonk, NY

ICMA Retirement Corporation
Washington, DC

Intel Corporation
Santa Clara, CA

JP Morgan Chase & Co.
New York, NY

Levi Strauss & Co.
San Francisco, CA

Marriott International, Inc.
Washington, DC

Medtronic, Inc.
Minneapolis, MN

MetLife, Inc.
New York, NY

Microsoft Corporation
Redmond, WA

Motorola
Schaumburg, IL

Nike Inc.
Beaverton, OR

PG&E Corporation
San Francisco, CA

PricewaterhouseCoopers
New York, NY

Project for Pride in Living
Minneapolis, MN

Prudential Financial
Newark, NJ

Replacements, Ltd.
Greensboro, NC

Russell Investment Group
Tacoma, WA

San Fran. Health Svs. Sys.
San Francisco, CA

Texas Instruments
Dallas, TX

Time Warner Inc.
New York, NY

Xerox Corporation
Rochester, NY

Statement of Child Welfare League of America, Arlington, Virginia

The Child Welfare League of America (CWLA), representing public and private nonprofit, child-serving member agencies across the country, is pleased to submit testimony to the Subcommittee on Income Security and Family Support. CWLA appreciates the opportunity to submit comments to the Subcommittee on the vital issue of current gaps in health coverage. We commend Chairman McDermott and members of the Subcommittee for your attention to the increasing difficulty in obtaining and accessing quality, affordable health care and the corresponding impact on vulnerable populations, including children and youth involved with the child welfare and foster care systems.

Health Care Needs of Children in the Child Welfare System

In federal fiscal year 2005, there were 506,483 children in out-of-home care and during that same year, approximately 800,000 children spent at least some time in a foster care setting.[1] Many children that enter the foster care system are at an extremely high risk for both physical and mental health issues as a result of biological factors and/or the maltreatment they were exposed to at home. Some children are in out-of-home care for other reasons, such as their parent(s) voluntarily placing them or feeling compelled to do so. For example, the Government Accounting Office estimates that in 2001, due to limits on public and private health insurance, inadequate supply of services, and difficulty meeting eligibility requirements, parents placed over 12,700 children into the child welfare or juvenile justice systems solely so that these children would be more likely to receive necessary mental health services.[2] Regardless of why the child has come into the child welfare or foster care systems, removing the child from his/her home, breaking familial ties and the continued instability that often ensues greatly exacerbate any original vulnerability.

Numerous studies have documented that children in foster care have medical, developmental and mental health needs that far surpass those of other children, even those living in poverty. One study found that 60% of children in care have a chronic

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[1] Child Welfare League of America. (2007). Special tabulation of the Adoption and Foster Care Analysis Reporting System. Washington, DC: Author.

[2] U.S. General Accounting Office (GAO) (2003). *Child welfare and juvenile justice: Federal agencies could play stronger role in helping states reduce the number of children placed solely to obtain mental health services* (GAO–03–397). Available online at http://www.gao.gov.

medical condition and one-quarter have three or more chronic health problems.[3] Many also experience developmental delays in regards to language and cognition.[4] When compared to the general population, children younger than six in out-of-home care have higher rates of respiratory illness (27%), skin problems (21%), anemia (10%), and poor vision (9%).[5] In regards to mental health, it is estimated that between 54% and 80% of children in out-of-home care meet clinical criteria for behavioral problems or psychiatric diagnosis.[6] In one study, researchers found that between 40% and 60% of children in out-of-home care had at least one psychiatric disorder and that this population of children used both inpatient and outpatient mental health services at a rate 15 to 20 times higher than the general pediatric population.[7]

Medicaid's Vital Role in Assisting Children in Care

When children are removed from their home base and placed in State custody due to no fault of their own, Medicaid steps in to provide many of these children with physical and mental health care that helps them get on the road to recovery. In addition to Medicaid's Early, Periodic Screening, Diagnostic, and Treatment (EPSDT) and the Targeted Case Management Option, Medicaid Rehabilitative Services are especially vital, as they offer a realistic opportunity to—in the least restrictive setting possible—reduce the physical and/or mental disabilities that many children in foster care have, thereby restoring the child's functioning level, decreasing lingering and long-term negative impacts, and ultimately reducing costs. Rehabilitative services are also community-based and consumer—and family-driven services, in line with both the President's New Freedom Commission on Mental Health and the U.S. Surgeon General's recommendations.

Many children and youth involved with the child welfare and foster care systems—many of whom have experienced life-altering trauma and have little or no familial support—are already slipping through the cracks and it is essential to bridge rather than widen the gaps. Unfortunately, however, CMS recently proposed a regulation (CMS–2261–P/72 Fed. Reg. 45201) that would significantly limit access to Medicaid Rehabilitative Services for many vulnerable populations—who are both Medicaid-eligible and greatly in need of services, including children involved with the child welfare and foster care systems. The regulation would entirely take away federal Medicaid dollars for rehabilitative services that are deemed "intrinsic to" other programs, including child welfare and foster care. The authority of CMS to implement such a provision is questionable, as Congress specifically debated and rejected adopting an "intrinsic to" test in regards to rehabilitative services when enacting the Deficit Reduction Act of 2005.

Federal Medicaid dollars, for example, would not be available for rehabilitative services provided in a therapeutic foster care setting unless they are medically necessary, clearly distinct from packaged therapeutic foster care services, and given by a qualified provider. As the Surgeon General indicated in his 1999 report on mental health, with care provided in private homes with specially trained foster parents, therapeutic foster care is considered "the least restrictive form of out-of-home therapeutic placement for children with severe emotional disorders."[8] The proposed regulation's language, while not explicitly prohibiting therapeutic foster care, whittles away at its core so much that access will surely be restricted, if not completely shut off. As a result, because there is a continuum of care in foster care, children who cannot be maintained in regular foster care due to serious emotional or other health issues will be forced into more restrictive settings—a result that cannot be justified by any amount of federal savings.

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[3] Simms, M.D., Dubowitz, H., & Szailagyi, M.A. (2000). Needs of children in the foster care system. *Pediatrics*, 106 (Supplement), 909–918.

[4] Halfon, N., Mendonca, A., & Berkowitz, G. (1995). Health status of children in foster care: The experience of the Center for the Vulnerable Child. *Archives of Pediatric and Adolescent Medicine*, 149, 386–392.

[5] Takayama, J.I., Wolfe, E., & Coulter, S. (1998). Relationship between reason for placement and medical findings among children in foster care. *Pediatrics*, 101, 201–207.

[6] Clausen, J., Landsverk, J., Ganger, W., Chadwick, D., & Litrownik, A.J. (1998). Mental health problems of children in foster care. *Journal of Child and Family Studies*, 7, 283–296; Halfon et al. (1995); Urquiza, A.J., Wirtz, S.J., Peterson, M.S., & Singer, V.A. (1994). Screening and evaluating abused and neglected children entering protective custody. *Child Welfare*, 123, 155–171.

[7] dosReis, S., Zito, J.M., Safer, D.J., & Soeken, K.L. (2001). Mental health services for foster care and disabled youth. *American Journal of Public Health*, 91, 1094–1099.

[8] U.S. Department of Health and Human Services (HHS). (1999). *Mental health: A report of the Surgeon General*. Rockville, MD: Author. Available online at http://www.surgeongeneral.gov/library/mentalhealth/home.html.

As Twila Costigan, Manager of the Adoption & Family Support Program at CWLA member agency Intermountain (Helena, MT) testified before the U.S. House of Representatives Oversight and Government Reform Committee on November 1, 2007, "rehabilitative services are used to allow program staff to go into therapeutic foster homes to model and teach effective interventions to parents and children. Staff also work with the child to help them develop personal skills to allow them to identify and communicate their feelings to the adults in their lives—rather than acting out these feelings of rage, sadness, fear, humiliation, jealousy and anxiousness in destructive ways." Ms. Costigan's testimony declares sadly that "the loss of the Medicaid Rehabilitative services has the likely consequence of eliminating Therapeutic Foster and Group Home care for the Severely Emotionally Disturbed children in Montana."

CWLA also strongly advocates that rather than requiring a "clearly distinct" billing method, States be afforded the discretion to define therapeutic foster care as a single service and pay through a case, daily, or appropriate mechanism. Packaged services allow the necessary amount of time and attention to be spent on children suffering from intense mental issues. The alternative imposes the significant administrative burden of relegating activities into somewhat arbitrary time blocks, which ultimately takes time away from the child and reduces services' effectiveness and the child's progress.

CWLA also has concerns about soon-to-be released regulations regarding the use of Medicaid Targeted Case Management. TCM allows States to target a select population to receive in-depth case management services—even across child-serving systems—thereby assisting the child in accessing much needed medical and social services. At least thirty-eight States employ the TCM option to provide greater coordination of care for children in foster care and the children who receive TCM services fare better in a wide array of areas. Specifically, TCM recipients are more likely to receive physician services (68% compared to 44%); prescription drugs (70% compared to 47%); dental services (44% versus 24%); rehabilitative services (23% versus 11%); inpatient services (8% versus 4%) and clinic services (34% compared to 20%).[9]

Medicaid and its components, including EPSDT and the Rehabilitative Services and Targeted Case Management options, must remain strong, viable streams of care. Aggressive efforts must be made to thwart any contrary actions so that Medicaid may fulfill its purpose of bettering the health of some of our nation's most vulnerable children.

Access Concerns

Many of the challenges associated with the provision of health care for children in out-of-home care relate to funding, specifically the constraints posed by the Medicaid program. In many States, providers report very low reimbursement rates and long waits for payment. In some communities, providers have declined to continue to see patients who have Medicaid as their health care coverage. As the number of providers for children in out-of-home care decreases, access and choice diminish, waiting lists become commonplace, and services are delayed. At the same time, a number of States have mandated that children in out-of-home care shift from fee-for-service Medicaid to Medicaid managed care. These changes in the delivery and funding of health care services have led to concerns that services for children in out-of-home care will be rationed and that services that were already difficult to obtain under the fee-for-service model, particularly mental health services, will become even more difficult to access.[10]

In addition, health care providers often lack experience in treating the physical and mental health problems that children in out-of-home care experience. They may face serious obstacles in obtaining accurate medical histories for children, including information about current and prior medications. On the child welfare workforce end, child welfare caseworkers are often young, have limited professional experience, and are managing caseloads that far exceed recommended standards—all of which likely contribute negatively to the timely and appropriate provision of health care for children in foster care. Final concerns include: distance to providers and lack of transportation, placement changes while in out-of-home care, barriers to in-

[9] Geen, R., Sommers, A., & Cohen, M. (August 2005). *Medicaid Spending on Foster Children.* Available online at http://www.urban.org/UploadedPDF/311221_medicaid_spending.pdf. Washington, DC: The Urban Institute.

[10] American Academy of Pediatrics. (2002). Health care of young children in foster care: Committee on Early Childhood, Adoption and Dependent Care. *Pediatrics*, 109, 536–541.

formation sharing between the health care and child welfare systems, and failures to coordinate the child's health care and child welfare plans.[11]

Youths Leaving Foster Care Due To Age

Certainly there is no group of America's youth more deserving of Congress' attention than those in foster care or those who leave foster care after turning age 18. Every year 20,000–25,000 young people exit the foster care system.[12] These young people leave care simply because there is an age limit on federal funding. While some States may extend this support beyond age eighteen and the Chaffee Independent Living Program offers limited funding for transitional services to these young people, all too often the end result is that foster children find themselves on their own at age eighteen.

Barriers to a Secure Adulthood

Adolescents constitute a major segment of the youngsters the child welfare system serves. In 2005, 29 percent of children in care were 15 years of age or older.[13] Most youth enter out-of-home care as a result of abuse, neglect, and exploitation. Others have run away from home or have no homes. Young people transitioning out of the foster care system are significantly affected by the instability that accompanies long periods of out-of-home placement during childhood and adolescence. These young people often find themselves truly "on their own," with few, if any, financial resources, no place to live, and little or no support from family, friends, and community. The experiences of these youth place them at higher risk for unemployment, poor educational outcomes, health issues, early parenthood, long-term dependency on public assistance, increased rates of incarceration, and homelessness. The resulting harm to the youth themselves, their communities, and the society at large is unacceptably high.

Health Needs and Lack of Health Coverage

For the 20,000–25,000 youth who age out of care each year, many times their health needs linger into adulthood. Foster care alumni experience a disproportionate amount of both physical and mental health issues, including post-traumatic stress disorder and major depression. Compounding this problem is the fact that 33% of foster care alumni lack health insurance—a rate almost twice as high as the general population.[14] The Chafee program allows States to extend Medicaid coverage to former foster children between ages 18 and 21. Despite Medicaid's tremendous advantage for youth in foster care, however, only 17 States had implemented the extension as of December 2006.[15]

Legislative Steps

The Child Welfare League of America desires for all children in foster care to receive coordinated, continuous, comprehensive, and culturally competent health care services and supports legislation working toward that goal.[16] Services must be coordinated in terms of providing cross-system training and continuity in service both while the child is in State custody and after he or she leaves as a result of reunification, placement with a relative, adoption, or aging out of care. Because children in foster care experience a wide array of and disproportionate amount of health needs, services must be comprehensive and address children's medical, mental, dental, emotional, and developmental needs. This is not just a goal or desire of CWLA, but it is a necessary component to reducing the number of children in foster care. Something we all seek.

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[11] Child Welfare League of America (CWLA). (2007). Standards of Excellence for Health Care Services for Children in Out-of-Home Care. Washington, DC: Author.

[12] Children who aged out of foster care are captured by the AFCARS emancipation data element. Children who exit care to emancipation are those who reached the age of majority; CWLA, Special tabulation from AFCARS.

[13] Adoption and Foster Care Analysis and Reporting System (AFCARS) data submitted for the FY 2005, 10/1/04 through 9/30/05.

[14] Pecora, P.J., Kessler, R.C., Williams, J., O'Brien, K., Downs, A. C., English, D., White, J., Hiripi, E., White, C. R., Wiggins, T., & Holmes, K. (2005). Improving family foster care: Findings from the Northwest Foster Care Alumni Study. Available online at http://www.casey.org/Resources/Publications/NorthwestAlumniStudy.htm. Seattle, WA: Casey Family Programs.

[15] Patel, S. & Roherty, M. (2007). *Medicaid Access for Youth Aging Out of Foster Care*. Washington, DC: American Public Human Services Association. Available online at http://www.aphsa.org/Home/Doc/Medicaid-Access-for-Youth-Aging-Out-of-Foster-Care-Rpt.pdf.

[16] Child Welfare League of America (CWLA). (2007). Standards of Excellence for Health Care Services for Children in Out-of-Home Care. Washington, DC: Author.

Proposed Medicaid Regulations that Would Restrict Access to Needed Care

Rather than making such sweeping changes to vital community-based services such as Medicaid Rehabilitative Services and Targeted Case Management through rulemaking, CWLA believes that these important decisions should be debated thoroughly and done through the legislative process. CWLA strongly supports long-term efforts to ensure that Medicaid and its components remain financially supported, accessible streams of care. In the immediate, CWLA urges Congress to pass a moratorium on the proposed Rehabilitative Services regulation. Such a moratorium—that would halt any Administrative action that restricts coverage or payment under Rehabilitative Services until January 1, 2010—was included as Section 616 of the Children's Health Insurance Program Reauthorization Act of 2007 (H.R. 3963). However, because the fate of that reauthorizing legislation is currently uncertain, CWLA would strongly support a similar moratorium in another legislative vehicle.

Health Care for Youth Transitioning Out of Foster Care

The Medicaid Foster Care Coverage Act of 2007, H.R. 1376, has been introduced by Representative Dennis Cardoza (D–CA-18). We support this bill and commend Congressman Cardoza for introducing this bill. This legislation which has bipartisan support including the support of five members of this Subcommittee, addresses a critical issue for young people leaving foster care, the fact that by some surveys 33% of foster care alumni lack health insurance. Congressman Cardoza's legislation would make sure that young people leaving the system due to their age be assured that they will at least have the safety net of continued Medicaid coverage until their twenty-first birthday. For this population we need to do so much more including increasing our efforts to prevent these young men and women from reaching the point of "aging-out" of the child welfare system. For now we can take this one basic, minimum step of allowing them continued access to a doctor.

Conclusion

CWLA appreciates the opportunity to offer our comments to the Subcommittee in regard to gaps in health coverage and the accompanying growing challenges for vulnerable populations, including children and youth in the child welfare and foster care systems. As this Subcommittee moves forward, we look forward to a continued dialogue with its members and all Members of Congress. We hope this hearing serves as a building block for future efforts that work to ensure coordinated, continuous, and comprehensive health care coverage for all children—especially those at-risk of placement, those already in foster care, and those transitioning out of the child welfare system into adulthood.

Statement of Human Rights Campaign

On behalf of the Human Rights Campaign and our over 700,000 members and supporters nationwide, I thank Representative McDermott for calling this hearing on the impact of gaps in health coverage. As the nation's largest civil rights organization advocating for the Gay, Lesbian, Bisexual, and Transgender ("GLBT") community, the Human Rights Campaign strongly supports measures that will ensure health coverage for all Americans.

GLBT families are faced with a particular challenge in the area of health insurance. Families rely heavily on employer-provided health insurance, a benefit that is increasingly offered to same-sex couples. Recognizing that their lesbian and gay employees deserve equal pay for equal work, and that they need a diverse workforce to compete in today's economy, over one half of the Fortune 500 companies now offer equal health benefits to their employees' same-sex domestic partners—up from only one in 1992. Unfortunately, our tax system does not reflect this advance toward true meritocracy in the workplace. Under current federal law, employer-provided health benefits for domestic partners are subject to income tax and payroll tax. As a result, a lesbian or gay employee who takes advantage of this benefit takes home less pay than the colleague at the next cubicle. Some families have to forego the benefits altogether because of this unfair tax—adding them needlessly to the millions of uninsured Americans in this country.

Here is an example of the inequity: In 2006 Steve earned $32,000 per year and owed $3,155 in federal income and payroll taxes. Steve's employer also paid the monthly premium of $907 for Steve's family health coverage, of which $572 the amount in excess of the premium for self-only coverage. None of this coverage was taxable under current law. Steve's co-worker, Jim, earned the same salary and had the same coverage for himself and his partner, Alan. However, the value of the cov-

erage provided to Alan is subject to federal income and payroll taxes. As a result, $6,864 of income is imputed to Jim and his federal income and payroll tax liability increased from $3,155 to $4,710. This represents nearly a 50% increase over Steve and Emily's tax liability.

For many families, especially those with modest incomes, the tax hit is more than they can bear. In Steve and Alan's case, the additional $1,555 in tax liability is beyond their means. Put simply, taxing these benefits can exclude families from employer-provided benefits. With over 40 million Americans uninsured, and Medicaid now costing taxpayers $4,072 per individual, we should be working to decrease the number of uninsured, not creating hurdles while corporate America is attempting to provide equal benefits.

It is time for the federal government catch up with America's leading corporations and to stop taxing domestic partner benefits. The Tax Equity for Health Plan Beneficiaries Act, H.R. 1820, introduced by Subcommittee Chairman McDermott, would eliminate the tax inequity and render health insurance more affordable for gay and lesbian families.[1] This is a common-sense bill that brings our tax system up to date with corporate best practices. We encourage Congress to support this healthy proposal and work toward its passage.

Statement of National Association of Disability Examiners

Mr. Chairman and members of the Subcommittee, thank you for providing this opportunity for the National Association of Disability Examiners (NADE) to present a statement on the Impact of Gaps in the Health Coverage on Income Security.

NADE is a professional association whose purpose is to promote the art and science of disability evaluation. The majority of our members work in the State Disability Determination Service (DDS) agencies and thus are on the "front-line" of the disability evaluation process.

Our members feel that there is an area of critical importance to the disabled population of our country that should be considered by those involved with this hearing—the 24 month Medicare waiting period for Title II disability claimants. While this Subcommittee oversees the Title XVI program, the Medicare Waiting Period has an impact on a large cross-section of the population and could serve to fill some of the gaps in health coverage discussed at this hearing.

Most Social Security disability beneficiaries have serious health problems, low incomes and limited access to health insurance. Many cannot afford private health insurance due to the high cost secondary to their pre-existing health conditions. Members of the National Association of Disability Examiners (NADE) are deeply concerned about the hardship the 24 month Medicare waiting period creates for these disabled individuals, and their families, at one of the most vulnerable periods of their lives.

In 1972, Congress passed Social Security legislation extending Medicare coverage to persons who had been receiving disability cash benefits for 24 consecutive months. Congress is to be commended for providing these health care benefits for the disabled American population. The original purpose of the Medicare waiting period was to "help keep program costs within reasonable bounds, avoid overlapping private insurance protection and provide assurance that the protection will be available to those whose disabilities have proven to be severe and long lasting."

In the original 1972 legislation there was one exception to the 24 month Medicare waiting period. Individuals with chronic renal disease would only have to wait three months before receiving Medicare benefits. In 2000, Congress passed legislation, implemented in 2001, that eliminated the Medicare waiting period for those individuals with amyotrophic lateral sclerosis (ALS), commonly known as Lou Gehrig's disease. In both of these situations, it was felt that the health of the affected individuals warranted more timely access to Medicare coverage.

Currently nearly six million disabled individuals receive Medicare benefits, and Medicare plays a vital role in ensuring that these individuals have access to appropriate and affordable health care. NADE believes that requiring some disabled individuals to serve a waiting period before receiving health care benefits and not requiring others to do so is fundamentally unfair and causes a tremendous hardship for individuals with disabilities at one of the most vulnerable periods of their lives.

All Title II Social Security disability beneficiaries, except for the two groups mentioned above, are required to serve a 24 month waiting period before becoming eligi-

[1] A similar bill has been introduced in the Senate—the Tax Equity for Domestic Partner and Health Plan Beneficiaries Act (S. 1556).

ble for Medicare benefits. The Medicare waiting period begins with the first month of receiving Social Security disability cash benefits which is five full months after the onset of a disability. This means that the majority of Social Security disability beneficiaries actually wait twenty-nine months after the onset of their disability before becoming eligible for Medicare health insurance benefits.

The majority of Social Security disability beneficiaries have impairments that are severe and long lasting. Currently less than one percent of Social Security disability beneficiaries have their benefits terminated each year. Another four percent die during the Medicare waiting period. Many beneficiaries suffer irrevocable physical and mental deterioration while waiting for Medicare coverage and needed health care services. Early intervention and provision of needed health care services as soon as possible after the onset of disability, and at a time when the individual needs it most, could improve both these statistics and the quality of life for individuals with disabilities. NADE supports the elimination or, at the very least a reduction, of the 24 month waiting period for Medicare benefits for all Title II disability beneficiaries. This change is needed to ensure fundamental fairness in the program and equity to all Social Security disability beneficiaries.

Eliminating, or reducing, the 24 month Medicare waiting period for Social Security disability beneficiaries would address the insurance needs of a high-risk, high-need population and provide financial relief and access to health care services at a time when health care needs are especially pressing and few alternatives exist.

Social Security beneficiaries in the Medicare waiting period face enormous problems. Research conducted by the Commonwealth Fund, in conjunction with the Henry J. Kaiser Family Foundation and the Christopher Reeve Paralysis Foundation, found that Social Security disability beneficiaries reported "skipping medications, putting off needed care, feeling depressed and anxious about the future, and believing they were not in control of their own lives" during the 24 month Medicare waiting period.

Although some Social Security disability beneficiaries may initially be found eligible for SSI (thereby receiving Medicaid benefits), many lose that health care coverage when they complete their five-month waiting period and begin receiving Social Security disability cash benefits. Thus many disability beneficiaries are without *any* health insurance for at least some portion of their 24 month Medicare waiting period. Without health care coverage, individuals' health conditions cannot improve, nor can they return to work, participate in their communities or stop depending on family members and friends for their basic needs. Beneficiaries need better access to health services before they can consider working again. Many individuals with disabilities might return to work if afforded access to necessary health care and related services.

NADE members, who work on the "front-line" of the disability program, have first-hand experience with the hardships that the 24 month Medicare waiting period places on disabled beneficiaries. During continuing disability reviews NADE members all too often see individuals whose conditions, without proper health care coverage, have markedly deteriorated and who are significantly worse than when they were initially awarded disability benefits. The financial and emotional toll this has taken on the disabled beneficiary and their families is disheartening. Many individuals who could have been cured and/or found to be no longer disabled continue to be disabled due to the lack of access to needed health care services during the early stages of their disability. Such medical care could, in many cases, have improved both their disabling condition(s) and their overall situation in life.

The Medicare waiting period is an often insurmountable barrier for individuals with disabilities. It offers frustration and emotional distress to people and families who are already hurting. Individuals with disabilities perceive the waiting period as being "punitive" and inherently unfair. Some individuals feel that the government is "just waiting for" people to die. Moreover, for many individuals, it will cost more in the long run for health care and services as individuals' conditions deteriorate because they are not receiving appropriate treatment. NADE strongly believes that Social Security disability beneficiaries and their families who are forced to deal with the trauma of disability, should not then be forced to deal with deteriorating health, financial pressures and emotional frustration caused by the Medicare waiting period. Medicare coverage at the onset of an individual's disability would relieve not only a significant financial, but also a significant emotional burden for disability beneficiaries and their families.

Most Americans with disabilities wish to lead active, healthy and productive lives and believe that employment is an important key to achieving this goal. Improvements in health care and early intervention of needed medical services could increase rehabilitation successes, provide greater employment opportunities and enhance the ability of people with disabilities to be more active and productive. Early

interventions and access to needed health care services would provide not only greater emotional and economic stability for disabled individuals, it would decrease costs to the Social Security disability program as well.

The Social Security Administration has proposed some new demonstration projects under their Work Opportunity Initiative to help overcome the barrier that the 24 month Medicare waiting period poses for those disability beneficiaries and applicants who wish to work. The demonstration projects provide supports, incentives and work opportunities to people with disabilities at the early stages of the disability determination process. Three of these proposed demonstration projects provide immediate medical benefits to applicants for disability benefits by offering comprehensive, affordable health care coverage. This allows beneficiaries to receive needed medical services early on in the onset of disability to enhance their vocational profile to return to work. Such interventions are not only good business practice from a financial standpoint, but from a humane and public relations aspect as well. NADE fully supports all initiatives and demonstration projects designed to assist disabled individuals in their efforts to obtain needed health care, promote self-sufficiency and return to work.

NADE members strongly believe that claimants and their families, who are forced to deal with the onset of disability, should not then be forced to deal with the lack of health care coverage. For both Social Security and SSI disability, the definition of disability is the same, the medical listings are the same, and the adjudicative procedures used to process the claims are the same. However, the health care benefits provided to those who are found disabled are not.

Disabled individuals who receive SSI disability benefits are eligible to receive health care coverage under the Medicaid program immediately upon being found eligible for SSI benefits. Because the SSI disability beneficiaries can receive health care benefits immediately, the perception clearly exists that the individual who has worked and contributed to the nation's workforce and economy is penalized for having done so! Most Social Security disability beneficiaries face a daunting combination of low income, poor health status, heavy prescription drug use and high medical bills. They spend their days trying to survive and get their most basic human and health care needs met. Access to the health care services provided by Medicare is crucial if individuals with disabilities are to maximize their potential, avoid far more costly hospitalizations and long-term institutionalization and lead fuller and more productive lives.

Congress passed the Americans with Disabilities Act in 1990 with the specific goals of ensuring equal opportunity, full participation in society, independent living and economic self-sufficiency for individuals with disabilities. Eliminating, or at least reducing, the 24 month Medicare waiting period would not only be an extremely humane gesture for these disabled workers and their families, it is perfectly aligned with the American with Disabilities Act and it is the "*right thing to do*!"

NADE recognizes that there are costs involved with eliminating the 24 month Medicare waiting period. Thus, our members would also support an incremental approach to reducing this. Some of the costs could be offset by a reduction in federal Medicaid expenditures. The Government Accountability Office (GAO) stated in their report on transforming government to meet the 21st century challenges that "policymakers must confront a host of emerging forces and trends shaping the United States . . . and . . . accompanying these changes are new expectations about the quality of life for Americans and . . . testing the continued relevance and relative priority for our changing society" of existing federal programs is critical to ensure "fiscal responsibility and facilitating national renewal." NADE agrees with GAO and feels it is time to change the Medicare waiting period to bring it into the 21st century.

Statement of Matthew Melmed, Zero to Three

Chairman McDermott and Members of the Subcommittee:

My name is Matthew Melmed. For the past 12 years I have been the Executive Director of ZERO TO THREE, a national non-profit organization that has worked to advance the healthy development of America's babies and toddlers for 30 years. I would like to start by thanking the Subcommittee for its interest in examining the impact of gaps in health coverage on income security. I would also like to thank the Subcommittee for providing me the opportunity to discuss the interaction between poverty, access to health care, and the healthy physical, social-emotional, and cognitive development of our nation's infants and toddlers.

For these youngest children, regular health care can spell the difference between a strong beginning and a fragile start that leaves them behind. In the battle of words and policies over who should receive help in obtaining health insurance, and therefore better access to health care, we often forget that there are some groups of people who simply can't wait—and babies are one of them. We hope that thinking about their needs can help spur action on behalf of all children and families.

When we as parents think back to our children's earliest years, we inevitably think of the many visits to the pediatrician. For many of us, it is daunting to imagine having to pay out of pocket for all that care or even worse, to imagine foregoing that care because of the trade-offs it would require in other basic necessities of life. And to contemplate the staggering medical bills for infants with the complications of preterm birth or low birth-weight would be overwhelming. Yet, many parents do face these circumstances as more than one in ten infants and toddlers are without health insurance.[1]

The pool of very young children at-risk is even greater because we know that a child's health and development are intricately related to the conditions in which lower-income families live. Two out of every five children under the age of three in America live in families considered low-income (at or below 200% of the federal poverty level).[2] Very young children are more likely to be poor than children as a whole, spending their critical early years developmentally in an environment that impacts them more severely than other age groups. Moreover, it takes only one event such as an accident, a baby requiring expensive neonatal care, or the loss of a job and the health insurance that may come with it to send a family spiraling down into the at-risk population.

For infants and toddlers, we cannot think of the developmental domains in isolation. Infancy and toddlerhood are times of intense cognitive, social-emotional, and physical development, and the development in these areas is inextricably related. So poor health in a very young child can lead to developmental problems in other areas and vice versa.

Too often we ignore the early years of a child's life in making public policy, failing to give children and families supports that could make a difference in how their lives unfold. Yet, we spend a great deal of time and money on needs identified later in life—for example, gaps in cognitive development upon entering preschool or more intensive special education services for problems that may have begun as much milder developmental delays left undiagnosed and untreated in a young baby.

Mr. Chairman, my message to you is that policymakers need to be aware of the important foundations laid in the early years of life and structure policies in such a way that they: 1) *promote* healthy development of infants and toddlers, 2) *prevent* many of the devastating physical, social-emotional, and cognitive impairments that these young children face in the future, and 3) *treat* acute and chronic illnesses, developmental delays, social-emotional problems, and learning disabilities in a timely manner. Simply put, babies and their families can't wait—we know that early intervention and prevention work best and we know that living in poverty can increase parental stress and compromise the healthy development of young children. We need policies that support parents and other caregivers in providing young children with the strong foundation they need for healthy development.

The Effects of Health Care Gaps on Infants and Toddlers

Like other children, infants and toddlers are not immune to the growing health insurance gap in our country. Even though 52% of infants and toddlers in low-income families have at least one parent who works full-time,[3] the economic reality of the labor force is that employer-sponsored health insurance is becoming more and more of a rarity. In fact, nearly 12% of children under the age of three—1.9 million infants and toddlers—lack health insurance.[4]

The health insurance gap affects babies even before birth when one considers the prenatal care to which their mothers may or may not have access. The March of Dimes estimates that an American newborn has a "1-in-5 chance of being born to a mother who lacks health insurance."[5] Their mothers are therefore less likely to

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[1] Annie E. Casey Foundation analysis of data from the 2007 Current Population Survey.

[2] Douglas-Hall, Ayona and Chau, Michelle. 2007. *Basic facts about low-income children: Birth to age 3*. September 2007. http://www.nccp.org/publications/pub_765.html (accessed September 20, 2007).

[3] Ibid.

[4] Annie E. Casey Foundation analysis of data from the 2007 Current Population Survey.

[5] March of Dimes. 2006. *Newest American baby faces health challenges*. http://www.marchofdimes.com/printableArticles/15796_21848.asp, (accessed November 9, 2007).

receive prenatal care, including screenings and diagnostic tests, which can improve their health as well as their babies' health.

What does it mean for a baby or toddler to lack access to health care? One likely consequence is missed doctor visits at which preventive care or early screening would take place. The Academy of Pediatrics recommends eight well-baby care visits with a pediatrician in the first year of life, with five more by the time the child reaches the age of three. These visits focus on preventive pediatric health care, including vision, hearing, lead, and developmental screenings; psychosocial/behavioral assessments; and promotion of proper oral health care.[6] *These screenings and assessments are critical during the birth to three period to detect impairments, developmental delays and disabilities, and life-threatening disorders. If diagnosed early, these delays and disorders can be successfully managed or treated to prevent more severe and costly consequences later in life. In addition to well-baby visits, those of us who are parents know families are likely to find themselves in the pediatrician's office many more times for childhood illnesses. For the family without health insurance, paying for this number of visits can seem daunting indeed.*

The result is not just a matter of conjecture. Research shows that without adequate health insurance, infants and toddlers fall victim to a host of poor health outcomes. In fact, uninsured children are almost five times more likely than insured children to have at least one delayed or unmet health care need.[7] Uninsured infants and toddlers are also less likely to have a regular pediatrician or medical home.[8] As a result, they are less likely to obtain preventive care or be diagnosed and treated early for illnesses, instead waiting until conditions are no longer manageable before seeking care in the Emergency Room (ER) of their local public hospital. In fact, in the last 50 years, the number of visits to ERs has increased more than 600% in the United States,[9] with children 0–18 accounting for over 31 million visits to the ER every year.[10] Children under the age of three represent the largest proportion of medically and injury-related ER visits in the country.[11]

Emergency Rooms are the safety net of the United States health care system, but they are not a substitute for routine care, nor should they be. ERs are overcrowded and overburdened, leaving less staff and resources for those who truly need emergency care. For example, asthma, the leading cause of pediatric hospitalizations and missed school days,[12] is a chronic condition, but one that is manageable with proper attention and medication. By waiting until an attack is imminent rather than controlling environmental triggers on an ongoing basis, care becomes much more expensive and difficult to obtain. Yet, uninsured families and those living in poverty often do not have a choice as access to regular health care is unreachable.

Infants and toddlers also require 20 doses of vaccines before they are two years old to protect them against 12 preventable diseases.[13] Vaccines are cost-effective public health measures that have decreased the incidence of several childhood diseases in the United States, including diphtheria, measles, mumps, rubella, and meningitis by 99% and completely eradicated polio.[14] Not so long ago, these diseases caused death and paralysis among the most vulnerable youth. While the majority of our nation's infants and toddlers do receive the full range of recommended immunizations, nearly 18% of infants and toddlers do not.[15] Because uninsured children and those living in poverty are less likely to have a regular pediatrician,

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[6] American Academy of Pediatrics and Bright Futures. 2007. *Recommendations for preventive pediatric health care.* http://aappolicy.aappublications.org/cgi/reprint/pediatrics;105/3/645.pdf (accessed November 9, 2007).

[7] American Academy of Pediatrics. 2007. *Children's health care coverage*. http://www.aap.org/advocacy/washing/ ChildrensHealthCareCoverage.pdf (accessed November 9, 2007).

[8] American Academy of Pediatrics. 2004. Overcrowding crisis in our nation's Emergency Departments: Is our safety net unraveling? *Pediatrics* 114 (3): 878–888. http://aappolicy.aappublications.org/cgi/reprint/ pediatrics;114/3/878.pdf (accessed November 9, 2007).

[9] Ibid.

[10] American Academy of Pediatrics. 2001. Care of children in the Emergency Department: Guidelines to preparedness. *Pediatrics* 107 (4): 777–781. http://aappolicy.aappublications.org/cgi/reprint/pediatrics;107/4/777.pdf (accessed November 9, 2007).

[11] Ibid.

[12] Ku, Leighton, Lin, Mark, and Broaddus, Matthew. 2007. *Improving children's health: A chartbook about the roles of Medicaid and SCHIP.* Center for Budget and Policy Priorities. http://www.cbpp.org/schip-chartbook.pdf (accessed November 9, 2007).

[13] American Academy of Pediatrics. 2007. *Immunizations*. http://www.aap.org/advocacy/washing/Immunizations.pdf (accessed November 9, 2007).

[14] Ibid.

[15] American Academy of Pediatrics. 2007. *Statistics*. http://www.aap.org/advocacy/washing/Statistics.pdf (accessed November 9, 2007).

they are also less likely to receive the full range of recommended immunizations, thereby threatening not only their health, but the public's health as well.

The Cost of Extraordinary Care

Even if uninsured families are able to pay for routine visits, a serious health condition can push them over the edge financially. The high costs of hospital care for premature or low-birthweight infants, in particular, can be overwhelming for parents without health insurance. One factor leading to these conditions is a lack of prenatal care, which as noted above, is more likely to be a factor for women who lack health insurance, creating a devastating chain of events for mother and baby. The March of Dimes estimates that, in 2005, preterm births "cost the United States at least $26.2 billion, or $51,600 for every infant born preterm."[16] A 1999 study of neonatal intensive care found that the median treatment cost for all infants in the study was $49,457 (in 1994 constant dollars) while costs at the 90th percentile was $130,377. The lowest birthweight infants had a higher median cost at $89,546.[17]

For parents who have jobs that do not provide health insurance, such medical bills must seem insurmountable. In a study of families that had filed for bankruptcy, caring for premature infants and chronically ill children was a common theme.[18] Sometimes it is the loss of a job when the parent must care for the child that is the final straw.

The Impact of Poverty on the Healthy Development of Infants and Toddlers

I would like to focus in on lower-income children, who are at greater risk for a variety of poorer outcomes and vulnerabilities than middle-income infants and toddlers, including health impairments, social-emotional problems and diminished school success.[19] The health-related experiences of infants and toddlers on the lowest rungs of the income ladder and their developmental consequences illustrate that lacking support for good health care does not just mean missing a few doctor visits. These experiences also give us a sense of the trade-offs families must sometimes make in choosing among essentials for their families.

Of the 12 million infants and toddlers living in the United States, 21%—a staggering 2.6 million infants and toddlers—live in poor families (defined as families with incomes at or below the federal poverty level or $20,650 for a family of four).[20] When one takes into account those families who are classified as low-income (at or below twice the federal poverty level or $41,300 for a family of four), the percentage and number of infants and toddlers living in dire economic conditions jumps to 44% or 5.4 million.[21] While the number of children of all ages living in poor families has increased over the past several years, the number of infants and toddlers living in poor families has increased at an even faster rate (16% vs. 11%).[22] What is particularly troubling, in addition to the rise of childhood poverty, is the fact that very young children are disproportionately impacted by economic stress—that is, the negative effects of poverty are likely to be more severe when children are very young and their bodies and minds are still developing.

Gaps in health coverage and access to adequate health care are costly, not just for the affected infants, toddlers, and families themselves, but to all of society. Poverty, itself, raises direct expenditures on health care by $22 billion per year.[23] It is important to keep in mind, however, that it is not just those families living in poverty or near poverty who are at-risk, but there are many more families who are susceptible to poor health outcomes. In fact, in 2006, almost 23% of the uninsured

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[16] March of Dimes. 2006. *Premature birth: The economic costs*. http://marchofdimes.com/printableArticles/ 21198_10734.asp. (accessed November 9, 2007).

[17] Rogowski, Jeannette. 1999. Measuring the cost of neonatal and perinatal care. *Pediatrics* 103 (1): 329–335. http://pediatrics.aappublications.org/cgi/content/full/103/1/SE1/329 (accessed November 9, 2007).

[18] Himmelstein, David U., Warren, Elizabeth, Thorne, Deborah, and Woolhandler, Steffie, 2005. Illness and injury as contributors to bankruptcy. *HEALTH AFFAIRS*—Web Exclusive http://content.healthaffairs.org/cgi/reprint/ hlthaff.w5.63v1?maxtoshow=&HITS=10&hits=10 &RESULTFORMAT=&author1=Himmelstein&andorexactfulltext=and&searchid=1 &FIRSTINDEX=0&resourcetype=HWCIT (accessed November 9, 2007).

[19] Shonkoff, Jack and Phillips, Deborah. *From neurons to neighborhoods: The science of early childhood development.* Washington, DC: National Academy Press.

[20] Douglas-Hall, Ayona and Chau, Michelle. 2007. *Basic facts about low-income children: Birth to age 3.*

[21] Ibid.

[22] Ibid.

[23] Holzer, Harry J., Schanzenbach, Diane W., Duncan, Greg J., and Ludwig, Jens. 2007. *The economic costs of poverty in the United States: Subsequent effects of children growing up poor.* Institute for Research on Poverty Discussion Paper no. 1327–07. http://www.irp.wisc.edu/publications/dps/pdfs/dp132707.pdf (accessed November 9, 2007).

in the United States reported having household incomes above $50,000 a year, a 2% increase from the previous year.[24] All it takes is a terrible accident, the loss of stable employment (and any health coverage which might go along with it), or a mental health disturbance to send a family reeling.

Health Impairments

One health issue facing low-income children is food insecurity—lacking adequate resources to meet basic food needs.[25] In the United States, there are 12.6 million households that are considered food insecure, with 12.4 million children affected.[26] Nearly 17 percent of U.S. households with children younger than six are food insecure.[27] Choosing between adequate food and adequate health care may be one of the dilemmas facing families without health insurance.

Not only do food insecure households purchase less food in general, but they are also more likely to purchase low quality food or skip meals altogether. Access to fresh fruits and vegetables is often limited or priced out of reach, causing low-income parents to purchase higher-calorie, less nutritious, and energy-dense foods in order to maximize their caloric intake while they have the resources to buy food at that particular moment.[28] Reliance on less nutritious foods and limited physical activity has resulted in an explosion of childhood obesity. In 2000, 10.4% of children between the ages of two and five were considered obese.[29] Not surprisingly, children from lower socioeconomic families are more at-risk for obesity than more affluent children.[30] Of course, this is important because children who are obese and/or live in food insecure households face a number of health impairments that can have devastating lifetime effects. Because food insecure and obese children often have compromised immune systems, they are less able to resist illnesses and, therefore, are more likely to be hospitalized.[31] In fact, children from food insecure households are 90% more likely to suffer from poor or fair health and experience 30% higher rates of hospitalization.[32] Long-term consequences may include development of juvenile diabetes, hypertension, asthma, anemia, sleep apnea, and several social-emotional problems and cognitive deficiencies discussed below.[33]

Social-Emotional Problems

Families who struggle to make ends meet are often stressed to the limit, looking for any way possible to help mitigate the effects of poverty for their children. Yet, the very fact that parents may be spending more time working to earn the money to feed their children means they are less available for their children. Early relationships are the active ingredient for healthy social-emotional development in very young children. These early relationships form the foundation upon which all subsequent relationships will be formed. Important behavioral, physiological, and emotional regulation systems are being formed during these critical years.[34] Parents or caregivers who are absent, physically or mentally, cannot bond as strongly with their babies, creating a higher likelihood that parents and very young children will face a host of poor social-emotional outcomes.

The existence of maternal depression and other adult mental health disorders, for example, can negatively affect children if parents are not capable of providing consistent sensitive care, emotional nurturance, protection and the stimulation that young children need.[35] Maternal depression, anxiety disorders, and other forms of chronic depression affect approximately 10 percent of mothers with young children[36]—this number is even higher for families in poverty. In fact, findings at en-

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[24] U.S. Census Bureau. 2007. Income, poverty, and health insurance coverage in the United States: 2006. http://www.census.gov/prod/2007pubs/p60-233.pdf (accessed November 9, 2007).

[25] Parker, Lynn. 2007. Food insecurity and obesity. *ZERO TO THREE JOURNAL* 28 (1): 24–30.

[26] Ibid.

[27] Ibid.

[28] Ibid.

[29] Milano, Kim. O. 2007. Prevention: The first line of defense against childhood obesity. *ZERO TO THREE JOURNAL* 28 (1): 6–11.

[30] Ibid.

[31] Parker, Lynn. 2007. Food insecurity and obesity.

[32] Ibid.

[33] Ibid.

[34] Shonkoff, Jack and Phillips, Deborah. *From neurons to neighborhoods: The science of early childhood development.*

[35] Cohen, Julie, Onunaku, Ngozi, Clothier, Steffanie, and Poppe, Julie. 2005. *Helping young children succeed: Strategies to promote early childhood social and emotional development.* Washington, DC: National Conference of State Legislatures and ZERO TO THREE.

[36] O'Hara, Michael W. 1994. *Postpartum depression: Causes and consequences.* New York, NY: Springer-Verlag Inc.

rollment from the Early Head Start Research and Evaluation Project indicate that 52 percent of mothers reported enough depressive symptoms to be considered clinically depressed.[37] Not surprisingly, lack of health insurance can add to parental stress. An analysis of data from the 2000 National Survey of Early Childhood Health found that "mothers with uninsured children and those with children with missed or delayed care were both significantly more likely to be in poor mental health."[38]

Early and sustained exposure to parental stress and depression can influence the physical architecture of the developing brain, preventing babies and toddlers from fully developing the neural pathways and connections that facilitate later learning. Young children can sense the stresses their parents or caregivers are experiencing, which in turn, can affect the behavior and mental health of children themselves. Children, particularly those who are from food insecure families, are at higher risk of developing aggression, anxiety, depression, and hyperactivity than food secure children.[39] According to the Fragile Families and Child Wellbeing Study, food insecure families were much more likely to experience mental health problems in mothers and behavioral problems in their three-year-olds than food secure families.[40] As children grow older, these behavioral problems continue to be prevalent. Children from food insecure families were not only more likely to receive mental health counseling, but were also more likely to fight with their peers and steal than their more affluent peers.[41]

Diminished School Success

Health impairments and social-emotional problems also directly affect later school success. Children who are sick or hospitalized miss more days of school and have trouble learning, resulting in lower grades and test scores and poorer cognitive development, school readiness, and success.[42] Children who start behind, stay behind. When developmental delays and health impairments are detected and treated early, however, children have a much better chance of school success. In fact, a study of California's Children's Health Insurance Program found that after one year of enrollment in the program, children were more attentive in class (57% after vs. 34% before) and more likely to keep up with their school activities (61% after vs. 36% before).[43] Without early and effective treatment, costs increase to all of society as special education costs are estimated at about $4 billion per year.[44]

Shifting the Focus from Treatment to Promotion and Prevention

As outlined above, the economic costs to society for poor physical, social-emotional, and cognitive development of our nation's infants and toddlers is absolutely staggering. The good news is that we can do a lot to lower those costs by shifting the focus from treatment to promotion and prevention. ZERO TO THREE's recommendations include:

Ensuring Access to a Medical Home for Every Child in the U.S.

Every child in the United States should have access to a medical home—a regular pediatrician they see for ongoing care and follow-up. The American Academy of Pediatrics calls for "accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective care."[45] A regular pediatrician would facilitate all aspects of pediatric care, including supervision of care; patient and parent counseling about health, nutrition, safety, and mental health; and the importance of well-child visits, immunizations, and screenings and assessments. He or she should also refer a child to early intervention services when appropriate and coordi-

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[37] U.S. Department of Health and Human Services, Administration for Children and Families. 2003. Early Head Start Evaluation and Research Project, *Research to practice: Depression in the lives of Early Head Start families.* Washington, DC. http://www.acf.hhs.gov/programs/opre/ehs/ehs_resrch/reports/dissemination/research_briefs/ research_brief_depression.pdf (accessed May 10, 2007).

[38] Mistry, Ritesh, Stevens, Gregory D., Sareen, Harvinder, De Vogli, Roberto, Halfon, Neal, 2007. Parenting-related stressors and self-reported mental health of mothers with young children. *American Journal of Public Health* 97(7): 1261–1268.

[39] Parker, Lynn. 2007. Food insecurity and obesity.

[40] Ibid.

[41] Ibid.

[42] Ibid.

[43] Ku, Leighton, Lin, Mark, and Broaddus, Matthew. 2007. *Improving children's health: A chartbook about the roles of Medicaid and SCHIP.*

[44] Holzer, Harry J., Schanzenbach, Diane W., Duncan, Greg J., and Ludwig, Jens. 2007. *The economic costs of poverty in the United States: Subsequent effects of children growing up poor.*

[45] American Academy of Pediatrics. 2002. The medical home. *Pediatrics* 110 (1): 184–186. http://aappolicy.aappublications.org/cgi/reprint/pediatrics;110/1/184.pdf (accessed November 9, 2007).

nate care with other early childhood programs.[46] By relying on a single consistent health care provider, lower-income families can avoid unnecessary and more expensive treatment in ERs, walk-in clinics, and urgent care facilities, thereby reducing costs to all of society.

Providing Adequate SCHIP Coverage for All Eligible Infants and Toddlers

The State Children's Health Insurance Program (SCHIP) has also dramatically improved the health and well-being of our most vulnerable children. Since SCHIP began in 1997, the percentage and number of low-income uninsured children has fallen by more than one-third.[47] This is particularly important as publicly-insured children (those enrolled in SCHIP and Medicaid) are more likely to have chronic conditions requiring ongoing care, such as asthma, learning disabilities, and health conditions.[48] By insuring these children, we can safely and effectively manage conditions rather than relying on the nation's safety net for more expensive urgent care. Furthermore, children in SCHIP are more likely to receive well-child visits, immunizations, screenings, dental care, and other forms of preventive care, further reducing the need for more costly interventions later.[49]

Expanding Access to Comprehensive Early Childhood Programs

Comprehensive high quality early learning programs for infants and toddlers, such as Early Head Start, can help to protect against the multiple adverse influences that may hinder their development across all domains. Research from the Early Head Start Research and Evaluation Project, and its companion follow-up results, concluded that the program is making a positive difference in areas associated with children's access to health care, children's success in school, family self-sufficiency, and parental support of child development. For example, 28 months after enrollment in the Early Head Start program, 95% of infants and toddlers had received one or more well-child exams, 99% had received immunizations, and 69% had received screenings tests (41% for hearing and 28% for lead).[50] Early Head Start also produced statistically significant, positive impacts on standardized measures of children's cognitive and language development. Early Head Start children demonstrated more positive approaches to learning than control group children.[51] Early Head Start also had significant impacts for parents, promoting family self-sufficiency and parental support of child development. Early Head Start children had more positive interactions with their parents than control group children—they engaged their parents more and parents rated their children as lower in aggressive behavior than control parents did. Early Head Start parents were also more emotionally supportive and less detached than control group parents and provided significantly more support for language and learning than control group parents.[52] By expanding access to quality early learning programs, we can reach children early in life when we can have the greatest chance to improve future success.

Increasing Investments in Family Income Supports and Nutritional Programs

Finally, income supports and nutritional programs help low-income families improve the healthy physical, social-emotional, and cognitive development of their children. Child tax credits, the Earned Income Tax Credit, and a meaningful minimum wage are key to helping families obtain self-sufficiency. In addition, federal nutrition programs such as the School Breakfast, School Lunch, After School Snacks, and Summer Food Service Programs provide nutritionally-balanced foods for low-income children. The Food Stamp program helps low-income families purchase more food and improve their diets. The Child and Adult Care Food Program provides funds

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for meals and snacks for children in child care and Head Start/Early Head Start programs. And, the Supplemental Nutrition Program for Women, Infants, and Children (WIC) Program provides low-income nutritionally at-risk pregnant, breastfeeding and postpartum mothers, infants, and children under the age of five with food, nutrition education, and health care referrals. All of these programs provide economic supports to struggling low-income families in an effort to improve outcomes for their children.

Conclusion

During the first three years of life, children rapidly develop foundational capabilities—physical, social-emotional, and cognitive—on which subsequent development builds. These areas of development are inextricably related. When young children do not have access to health care because they are uninsured (or for other reasons), every aspect of their development can suffer. These years are even more important for infants and toddlers living in poverty. All young children should be given the opportunity to succeed in school and in life. We must ensure that infants, toddlers, and their families living in poverty have access to quality, accessible, consistent, and culturally appropriate health care and insurance. We must also ensure that low-income children have access to developmentally appropriate early learning programs such as Early Head Start to help ensure that they are ready for school. And, finally, we must ensure that families struggling to make ends meet receive income supports and nutrition assistance to ensure that their infants and toddlers grow up healthy, happy, and ready to learn. Providing supports to low-income at-risk families will have a trickle down effect on our youngest children and thereby have even more positive long-term benefits in our efforts to break the intergenerational cycle of poverty.

I urge the Subcommittee to consider the very unique needs of babies living in poverty as you address the impact of gaps in health coverage on income security. Too often, the effect of our overall policy emphasis is to wait until at-risk children are already behind physically, emotionally, or cognitively before significant investments are made to address their needs. We must change this pattern and invest in at-risk infants and toddlers early on, when that investment can have the biggest payoff—preventing problems or delays that become more costly to address as the children grow older.

Thank you for your time and for your commitment to our nation's at-risk infants, toddlers and families.

Why Health Insurance Is Important

Randall R. Bovbjerg and Jack Hadley

Having health insurance is important because coverage helps people get timely medical care and improves their lives and health. Some may believe that people always have access to medical care because they can always go to an emergency room. But even areas with well supported safety-net care do not remove barriers to access to the same extent as does having health insurance. "Coverage matters," concluded the Institute of Medicine (IOM) during a recent multiyear appraisal.[1] Indeed, the prestigious IOM estimated that lack of coverage was associated with about 18,000 extra deaths per year among uninsured adults.[2] Several points deserve emphasis.

Having health coverage is associated with better health-related outcomes.

1. Uninsured people receive less medical care and less timely care.

Overall, uninsured people get about half as much care as the privately insured, as measured in dollars spent on their care—even taking into account free care received from providers. This discrepancy holds true even when spending is adjusted for age, income, health status, and other factors.[3] (This finding and most information presented here do not come directly from District sources, for which data are often lacking. But most patterns are believed to be generally true of all locations.)

Uninsured adults get fewer preventive and screening services and on a less timely basis. Shortfalls are documented for many types of illness or condition, including screening for cervical and breast cancer as well as testing for high blood pressure or cholesterol. Cancers, for example, are more likely to be diagnosed at a later stage of illness, when treatment is less successful. Uninsured pregnant women use fewer prenatal services, and uninsured children and adults are less likely than their uninsured counterparts to report having a regular source of care, to see medical providers, or to receive all recommended treatment.

Shortfalls are particularly notable for chronic conditions. For instance, uninsured adults with heart conditions are less likely to stay on drug therapy for high blood pressure.[4]

Some uninsured people may decide not to obtain insurance precisely because they expect not to need medical care, so simple comparisons of the insured and uninsured can be misleading.5 However, many studies adjust for factors like age and health status that affect need for care. One recent study examined people who experienced an unintentional injury or a new chronic condition—times when care is more clearly needed. Uninsured individuals were less likely to obtain any medical care, and if they did receive some initial care, they were more likely to get none of the recommended follow-up care.[6]

2. Uninsured people have worse health outcomes.

The "bottom line" for uninsured people is that they are sicker and more apt to die prematurely than their insured counterparts. Conversely, having health coverage is associated with better health-related outcomes. Evidence comes from many studies using a variety of data sources and different methods of analysis.[7] Death risk appears to be 25 percent or higher for people with certain chronic conditions, which led to the IOM estimate of some 18,000 extra deaths per year.

Some complain that low health status may be a cause of uninsured status, rather than the other way around. (Note that this objection is the opposite of the complaint noted above that good health may promote uninsurance.) Again, however, as the IOM noted, several studies use statistical methods to adjust for this "reverse causation," and still find that lack of health insurance results in poorer health outcomes. The study of unexpected accidents and new chronic conditions also addressed this issue; its short-term follow-up showed that uninsured accident victims were more likely to have ended treatment without being fully recovered, and that those with chronic conditions still reported worse health status.[8]

3. Lack of insurance is a fiscal burden for uninsured people and their families.

Uninsured people do not benefit from the discounted medical prices that are routinely negotiated by

private health plans or imposed by public programs. Until recently, those without coverage were billed full hospital charges, for example. The low incomes of some patients qualify them for charity care, but others have often been dunned for unpaid bills. Uninsured families report medical bill problems at double or triple the rate of insured families, and medical bills have been found a contributing factor in a sixth or more of bankruptcies, according to various surveys.[9]

A recent movement to reduce charges for the uninsured has gained strength among public officials and from hospitals, and it may have alleviated this problem. On the other hand, affordability problems have increased along with rapid growth in the costs of care.

The IOM noted that low levels of insurance in an area can also burden medical providers because of higher demand for free or reduced-cost care.

4. The benefits of expanding coverage outweigh the costs for added services.

Expanding coverage would improve health, lengthen lives, reduce disability, help control communicable diseases, and raise productivity. Newly insured people would get more services, above what they currently pay out of pocket or receive from medical providers in the form of uncompensated care. This can be expected to raise medical spending, but by less than the value of longevity and other benefits achieved.[10] Such estimates are complex to make and do not address political issues concerning the sources for financing increases in spending, especially the likelihood that expansions would shift some spending from the private to the public sector.

5. Safety-net care from hospitals and clinics improves access to care but does not fully substitute for health insurance.

Proximity to safety-net hospitals or clinics increases access to care, according to studies using various methodologies.[11] Better access presumably improves health outcomes, although this effect appears less well documented, and safety-net access may provide less continuity of care than insurance. Comparison across states shows that access to care is better where governments and private payors better support the safety net, but that the improvement is less than that insurance achieves.[12] Similarly, communities that have high capacity of community health clinics have better access to care than communities with low capacity, but the effect on access of higher insurance coverage rates is even greater.[13] Insurance likely costs more as well, however, and it can be argued that public budgeting can control public safety-net subsidies, whereas an insurance entitlement like Medicaid is a more open-ended commitment of public resources.

Support for safety-net care can be seen as complementary to insurance expansion. Some people will always remain uninsured, and community clinics add capacity to otherwise underserved geographic areas. Clinics may also be better for addressing access problems attributable to cultural and language barriers.

6. Cautions are appropriate in using these findings.

Most benefits of insurance coverage are estimated for coverage in general, not for every type of insurance. Medicaid has sometimes been separately analyzed and achieves less on some measures than does private coverage.[14] One possible reason is that enrollees more often go on and off coverage; another is that Medicaid programs often pay lower rates to participating providers.

Private insurance coverage that differs from traditional patterns—for instance, limited-benefit coverages or plans with very high deductibles—might also achieve lesser health improvements. Conversely, adding additional benefits to existing conventional coverage will not necessarily achieve improvements of proportionate magnitude. Insurance and access to safety-net services are far from the only influences on health and longevity. Environmental and public health measures can have major impacts as well, including promotion of vaccinations, smoking cessation, and maintenance of healthy weight.[15]

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The Costs and Benefits of an Excellent Education for All of America's Children

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Overview

Broad policy decisions in education can be framed around a simple question: Do the benefits to society of investing in an educational strategy outweigh the costs?

We provide an answer for those individuals who currently fail to graduate from high school. The present cohort of 20-year olds in the US today includes over 700,000 high school dropouts, many from disadvantaged backgrounds. We investigate the economic consequences of improving their education.

First, we identify five leading interventions that have been shown to raise high school graduation rates; and we calculate their costs and their effectiveness. Second, we add up the lifetime public benefits of high school graduation. These include higher tax revenues as well as lower government spending on health, crime, and welfare. (We do not include private benefits such as higher earnings). Next, we compare the costs of the interventions to the public benefits.

We find that each new high school graduate would yield a public benefit of $209,000 in higher government revenues and lower government spending for an overall investment of $82,000, divided between the costs of powerful educational interventions and additional years of school attendance leading to graduation. The net economic benefit to the public purse is therefore $127,000 per student and the benefits are 2.5 times greater than the costs.

If the number of high school dropouts in this age cohort was cut in half, the government would reap $45 billion via extra tax revenues and reduced costs of public health, of crime and justice, and in welfare payments. This lifetime saving of $45 billion for the current cohort would also accrue for subsequent cohorts of 20-year olds.

If there is any bias to our calculations, it has been to keep estimates of the benefits conservative. Sensitivity tests indicate that our main conclusions are robust: the costs to the nation of failing to ensure high school graduation for all America's children are substantial.

Educational investments to raise the high school graduation rate appear to be doubly beneficial: the quest for greater equity for all young adults would also produce greater efficiency in the use of public resources.

The Size of the Challenge

The Importance of Education

Is excellent education for all America's children a good investment? We know that education is expensive, but poor and inadequate education for substantial numbers of our young may have public and social consequences that are even more costly. This study examines not only the costs of investing in services to provide an excellent education but also the costs of not doing so.

An individual's educational attainment is one of the most important determinants of their life chances in terms of employment, income, health status, housing, and many other amenities. In the United States we share a common expectation that all citizens will have access to high quality education that will reduce considerably the likelihood of later lifetime inequalities. Yet, large differences in educational quality and attainments persist across income, race, and region. Even with similar schooling resources, educational inequalities endure because children from educationally and economically disadvantaged populations are less prepared to start school. They are unlikely to catch up without major educational interventions on their behalf.

In the U.S. we typically view educational inequality as a challenging public policy issue because of its implications for social justice. If life chances depend so heavily on education, it is important that educational inequalities be redressed so as to equalize opportunities in a democratic society. But, beyond the broader issue of fairness, such inequalities may create costly consequences for the larger society in excess of what it would take to alleviate the inequalities. An excellent education for all of America's children has benefits not only for the children themselves but also for the taxpayer and society. Poor education leads to large public and social costs in the form of lower income and economic growth, reduced tax revenues, and higher costs of such public services as health care, criminal justice, and public assistance. Therefore, we can view efforts to improve educational outcomes for at-risk populations as a public investment that yields benefits in excess of investment costs.

What is an Excellent Education?

Precisely what constitutes an excellent education differs among observers. Some would argue for high student performance on standardized achievement tests. Others would say that all students should meet meaningful levels of proficiency in key subjects. Others would emphasize the ability to solve problems and to analyze complex situations.

We adopt high school graduation as a minimal criterion for an excellent education. High school graduation captures both the cognitive and non-cognitive attributes that are important for success in adulthood. It is usually a minimum requirement for engaging in further training and higher education. It opens up a range of future possibilities that would otherwise be closed to individuals. Most importantly, we focus on high school graduation because for the population as a whole we are far from fulfilling even this educational goal. Recent data also shows the U.S. currently lags behind a number of other industrialized nations in terms of high school graduation (OECD, 2006).

High School Graduation

Much attention has recently been devoted to determining rates of high school graduation. Some students may complete high school but not graduate; others may obtain a General Educational Development (GED) diploma. And graduation standards vary considerably across states.

Even without full consensus on a high school graduation standard, there is general agreement on two facts. First, graduation rates are low in absolute terms. On-time public high school graduation rates are approximately 66%–70%, meaning that at least three out of ten students do not graduate through the regular school system within the conventional time allotted. Second, graduation rates vary by gender and race. On-time public high school graduation rates for black males are as low as 43%. This compares to 48% for Hispanic males and 71% for white males. Female rates vary similarly across races, but with higher graduation rates overall. Thus, although a large proportion of each cohort meets conventional educational expectations, a significant number have not received an 'excellent' or even 'adequate' education.

TABLE 1 NUMBER OF 20-YEAR OLDS WHO ARE HIGH SCHOOL DROPOUTS

	Less than 9th grade	*9–11th grade (incl. GED)*	*Cohort size*	*Dropouts (%)*
Male	*63,000*	*450,000*	*2,252,000*	*23%*
White	18,000	194,000	1,362,000	16%
Black	6,000	69,000	301,000	25%
Hispanic	38,000	168,000	358,000	58%
Other	1,000	19,000	230,000	9%
Female	*33,000*	*259,000*	*1,983,000*	*15%*
White	6,000	100,000	1,225,000	9%
Black	>1,000	71,000	296,000	24%
Hispanic	25,000	63,000	283,000	31%
Other	2,000	26,000	179,000	16%

SOURCES: Current Population Survey (March 2005).
NOTES: Gender and race-specific adjustments are made for institutionalization and GED receipt.

To fully examine the current economic consequences, we focus on those persons who are not high school graduates at age 20 in 2005 (thereby allowing for those who graduate late). Table 1 shows the numbers of dropouts by gender and race at age 20. Our focus is on those with 9th–11th grade education and GEDs. These persons are at the margin of high school graduation and would likely be most positively impacted by educational interventions that would help them complete high school. In total, this group is over 700,000 persons. Below we calculate the economic consequences of failing to ensure that these persons become high school graduates.

Educational Interventions to Raise High School Graduation Rates

Possible Interventions

To raise the rate of high school graduation we need to identify effective educational interventions. From an extensive search, we found very few interventions that demonstrably increased high school graduation rates on the basis of rigorous and systematic evaluation. (We discuss other promising interventions below).

TABLE 2 INTERVENTIONS THAT DEMONSTRABLY RAISE THE HIGH SCHOOL GRADUATION RATE

Intervention		*Details of the intervention*	*Extra high school graduates if intervention is given to 100 students*
PPP	Perry preschool program	1.8 years of a center-based program for 2.5 hours per weekday, child:teacher ratio of 5:1; home visits; and group meetings of parents.	19
FTF	First Things First	Comprehensive school reform of: small learning communities with dedicated teachers; family advocates; and instructional improvement efforts.	16
CSR	Class size reduction	4 years of schooling (grades K–3) with class size reduced from 25 to 15.	11
CPC	Chicago child-parent center program	Center-based pre-school program: parental involvement, outreach and health/nutrition services. Based in public schools.	11
TSI	Teacher salary increase	10% increase in teacher salaries for all years K–12.	5

SOURCES: Belfield et al. (2006); Quint et al. (2005); Finn et al. (2005); Reynolds et al. (2001); Loeb and Page (2000).

We identified five interventions that demonstrated improvements in high school graduation rates based on a credible evaluation. These are summarized in Table 2. Two of the interventions take place in pre-school, one is implemented in elementary school, one in high school, and one through the K–12 years. The pre-school programs involved intensive educational programs with small group sizes and parental involvement. The class size reduction intervention is based on Project STAR, a four-year randomized field trial in Tennessee. The high school intervention was First Things First, a comprehensive school reform; we base our estimates on the site where this reform was fully implemented. Finally, the teacher salary increase proposal is for a 10% increase in wages across all K–12 years. Table 2 shows the impacts of these interventions on increasing the number of high school graduates per 100 students. Although most students would graduate anyway, the effectiveness of each intervention is in the additional number of graduates it yields out of 100 students receiving the intervention. The Perry preschool program is the most effective with 19 new high school graduates; at the opposite end of the spectrum, increasing teacher salaries by 10% would yield 5 new graduates.

Cost Per Intervention

Each of the interventions costs money. Table 3 reports the costs per person receiving the intervention, based on the inputs needed in each case. These costs also account for three important factors.

First, we must compare these costs with the later educational benefits in a consistent manner. We take the perspective of the current cohort aged 20. We express all costs and benefits in present value terms for a person aged 20. As intervention costs are incurred before age 20 (in the case of pre-school, 16 years earlier), they are weighted up following standard procedure; and since benefits are obtained after age 20, they are weighted down. This process uses a discount rate of 3.5% and converts all figures into 2004 dollars to obtain present values of costs and benefits at age 20.

Second, our analysis is designed to compare the public benefits of additional high school graduates with the public costs. However, because we cannot target interventions perfectly, some students who receive the intervention would have graduated anyway. Therefore, the unit cost of delivering the intervention to each student is not the same as the amount needed to yield an additional high school graduate. Rather, the cost per new graduate will reflect the fact that delivering the interventions to 100 students will only generate between 5 and 19 new high school graduates. Therefore the cost per new graduate is much higher than the per student cost.

Third, increasing the number of high school graduates will mean extra costs from extending attendance in secondary school as well as in college for those who are newly motivated to continue their educational career. We include extra high school costs assuming two extra years are needed to graduate. Conservatively, we include extra college costs assuming that the new graduates continue on and complete college at the same rate as those of students in the lowest quartile for reading achievement.

TABLE 3 PRESENT VALUE COSTS PER EDUCATIONAL INTERVENTION AT AGE 20

Interventions to raise high school graduation		*Cost per student* [a]	*Cost per expected high school graduate* [b]
FTF	First Things First	$5,500	$59,100
CPC	Chicago child-parent center program	$4,700	$67,700
TSI	Teacher salary increase	$2,900	$82,000
PPP	Perry preschool program	$12,500	$90,700
CSR	Class size reduction	$13,100	$143,600

SOURCES: See Table 2 and NCES (2002).
NOTES: [a] The unit cost of delivering the intervention. [b] The cost of delivering the intervention to 100 students and the induced extra attainment in high school and college for the new high school graduates. Discount rate is 3.5%.

Therefore, we express our results in terms of an 'expected high school graduate', i.e. someone who graduates from high school but may also attend college. This hypothetical individual is synthesized from the probabilities: of terminating education after high school or briefly attending a two-year college (approximately three-quarters of students do this); of completing a two-year degree or attending a four-

year college (one-in-six high school graduates); and of completing a four-year degree (approximately one-in-twelve graduates). Each new 'expected high school graduate' has some probability of more education beyond high school. This imposes more costs, but it also generates more benefits because the advantages of being educated do not stop at high school graduation.

Table 3 shows the total costs per student and per new expected high school graduate. The actual cost per student ranges from $5,500 to $13,100. But only some of these students will be 'new' graduates. The cost per expected new graduate accounts for: delivering the intervention to students who would graduate regardless; extra high school costs for the new graduates; and extra college costs for those who go on to further study. These costs are considerably higher than the unit costs of delivering the intervention. The cost per new expected high school graduate ranges from $59,100 for First Things First to $143,600 for an intervention to reduce class size. These total cost figures show that a significant investment is required to generate and support each new high school graduate. At issue is whether this is an investment worth making.

The Effects on Labor Market Income and Tax Revenue

Education and the Labor Market

One of the best documented relationships in economics is the link between education and income: more highly educated people have higher incomes. Failure to graduate from high school has both private and public consequences: income is lower, which means lower tax contributions to finance public services.

Many studies using various methods have tested whether the education to earnings correlations indicate causation. This body of evidence is generally consistent: the economic return generated by schooling is not an omitted correlation between schooling and other personal characteristics (such as ability). And there is not clear evidence that the effect of schooling on earnings is associated solely with receipt of the credential; higher earnings genuinely reflect the skills learnt in school. There is no strong evidence that this general conclusion varies according to race, gender, or ability level. Thus, wage comparisons across education and age levels are likely to yield reliable estimates of the benefits of schooling.

We use national survey data from the Current Population Survey (CPS) to estimate the differences in earnings by education level. These data report on hourly wages, salaries, and time spent working. We can therefore account for both higher pay and the increased likelihood of being employed for those with a high school diploma. With data on incomes, we then apply a tax simulation model (TAXSIM) to calculate federal and state income taxes.

Table 4 shows the differences in labor market outcomes by education level by gender and race for all adults over 20. Dropouts are less likely to be employed, and they earn much less. (They are also more likely to be unemployed or out of the labor force). Lower earnings reflect both lower wages and a lower probability of being in

TABLE 4 LABOR MARKET OUTCOMES BY EDUCATIONAL ATTAINMENT (AGED 21–64)

	High school dropout	*High school graduate*	*Some college*	*BA degree or more*
Employment (%):				
Male: white	71	79	81	89
Male: black	49	66	70	83
Male: Hispanic	70	78	69	85
Male: other	71	79	77	88
Female: white	46	65	72	78
Female: black	46	63	70	84
Female: Hispanic	51	57	64	65
Female: other	48	62	69	73
Average annual earnings:				
Male: white	$22,800	$33,900	$40,300	$79,100
Male: black	$13,500	$21,800	$29,600	$53,800
Male: Hispanic	$21,400	$24,000	$26,000	$54,200
Male: other	$22,300	$30,100	$34,900	$69,700
Female: white	$7,800	$16,500	$20,400	$35,600
Female: black	$10,000	$14,200	$19,500	$40,600
Female: Hispanic	$9,900	$14,500	$17,300	$39,000
Female: other	$8,600	$15,700	$19,200	$36,900

SOURCE: Current Population Survey (March 2003 and 2004).
NOTES: Employment rates are based on populations, not labor force size. Annual earnings include those with zero earnings. No adjustment is made for incarceration rates.

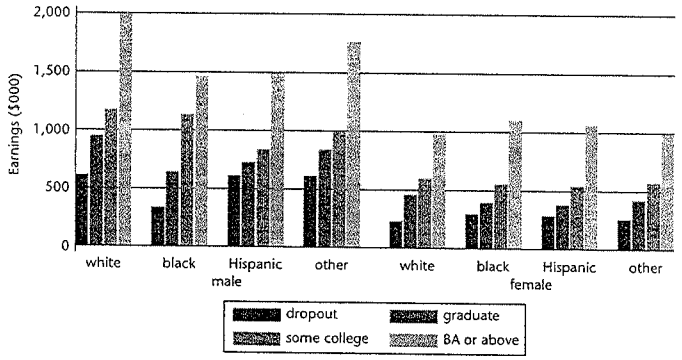
work. For example, at $10,000 per year, black female dropouts' incomes are 40% less than those of black female graduates, roughly half as much as those with some college, and one-quarter of those with a college degree. Similarly strong effects hold for all subgroups. These income differences translate into differences in tax revenues.

Lifetime Income and Tax Benefits from Graduation

We calculate earnings and tax payments across an individual's working life expressed in present values. To account for additional payments in property taxes and sales taxes, we add 5% to total income tax payments. The two charts below show extra lifetime earnings and additional lifetime tax payments after age 20 from finishing high school and going on to college.

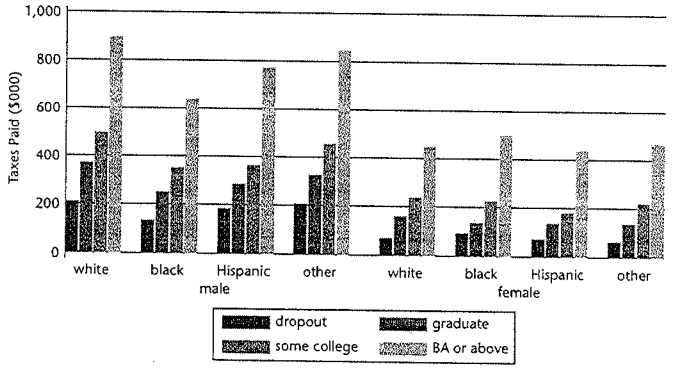
The extra lifetime earnings from graduation are substantial. As shown in Chart 1, male high school graduates earn $117,000–$322,000 more than dropouts; those with some college earn significantly more; and the difference in lifetime earnings between a high school dropout and a college graduate is $950,000–$1,387,000. Similarly, female high school graduates earn $120,000–$244,000 more than dropouts. Female college graduates also do well, earning roughly $800,000 more than high school dropouts.

CHART 1 LIFETIME EARNINGS BY EDUCATION LEVEL



SOURCES: Current Population Survey (March 2003 and 2004).
NOTES: Earnings figures include all persons, i.e., persons with positive or zero income. Figures are adjusted for differences in incarceration rates by education level (but not GED status). Productivity growth is assumed at 1.5% per year. Discount rate is 3.5%.

CHART 2 LIFETIME TAX PAYMENTS BY EDUCATION LEVEL



SOURCES: Current Population Survey (March 2003 and 2004); TAXSIM (NBER, Version 6).
NOTES: Figures are adjusted for differences in incarceration rates by education level (but not GED status). Income tax payments are calculated as the average of assuming all males are single and all males are household heads. Sales and property taxes are 5% of income tax payments. Discount rate is 3.5%.

Table 5 Lifetime total tax payments per expected high school graduate

	Tax payment *Extra lifetime contribution per expected high school graduate*	
	Male	*Female*
White	$202,700	$109,100
Black	$157,600	$94,300
Hispanic	$119,000	$85,000
Other	$168,600	$96,700
Average	*$139,100*	

Notes: An expected high school graduate is one who probabilistically either: terminates education after graduation; completes some college; or completes a BA Degree. Discount rate is 3.5%.

As shown in Chart 2, persons educated to high school and beyond pay considerably more in taxes. Male dropouts pay approximately $200,000 in taxes over the lifetime. Male high school graduates pay an additional $76,000–$153,000 and those who graduate from college pay an extra $503,000–$674,000. Female dropouts pay under $100,000 in taxes. Female high school graduates pay $66,000–$84,000 extra and female college graduates contribute $348,000–$407,000 extra.

The additional tax revenue per expected high school graduate is given in Table 5. Most graduates will terminate their education after high school, but some will progress onto college and a smaller fraction will complete college. Therefore, we calculate the average benefit based on the full amount of education each new graduate attains. The average lifetime benefit in terms of additional taxes per expected high school graduate is $139,100. The amounts vary by race and gender, but for each subgroup they are significant.

The Effects on Health Status and Expenditures

Education and Health

High school graduates have improved health status and lower rates of mortality than high school dropouts (Cutler and Lleras-Muney, 2006). Those with college education fare even better. One might therefore anticipate significant savings to the public health care system as education levels increase.

Those with higher educational attainment are less likely to use public programs such as Medicaid and they typically have higher quality jobs that provide health insurance. Because Medicaid eligibility is based on wages rather than health status, those with more education are less likely to qualify. But lower morbidity and mortality rates do not necessarily translate into lower medical costs: those with more education use more preventive care and tend to visit doctors more when they have less severe ailments. This offsets the cost savings from improved overall health. Moreover,

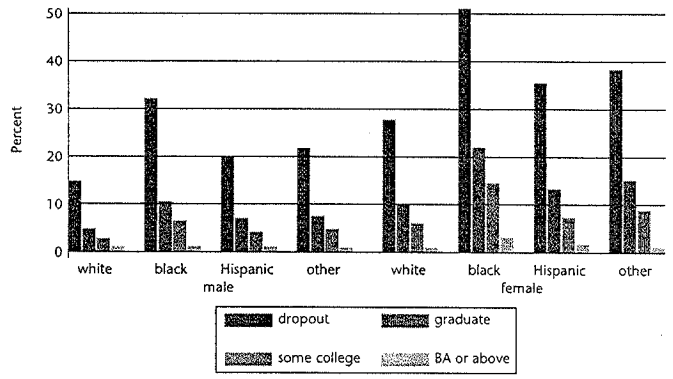
sicker people are more likely to die young, thus reducing Medicaid rolls. Therefore, improving educational attainment may produce little net change in per enrollee expenditures for those already enrolled in public programs.

All citizens are eligible for Medicare at age 65. However, because these effects are 45 years in the future for our cohort of 20-year olds, they are not economically significant. But, persons under 65 who are on social security disability income also qualify for Medicare, and their per enrollee costs are three times those of non-disabled enrollees. So, to the extent that education reduces the probability of disability, it should also proportionately reduce Medicare enrollment, and therefore reduce public costs.

In sum, increasing educational attainment will likely produce the following effects. First, given the causal link between educational attainment and income, the public sector will save money by reducing enrollment in Medicaid and other means-tested programs. Second, if there is a causal link between educational attainment and disability, the public sector will save money by reducing enrollment in Medicare among persons under the age of 65. It may also reduce expenditures among Medicaid beneficiaries by reducing the number of severely ill enrollees.

We use data from a nationally representative sample of over 40,000 non-institutionalized civilian subjects, the Medical Expenditure Panel Survey (2004). Information is available on health-related quality of life scores and public insurance enrollments. Public sector costs data are from the National Health Accounts.

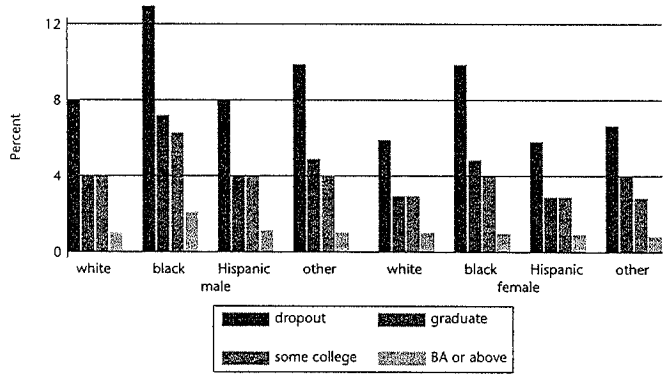
CHART 3 MEDICAID COVERAGE



SOURCES: Medical Expenditure Panel Survey (2004); National Health Accounts.

Charts 3 and 4 show Medicaid and Medicare coverage by education level. There are significant differences in coverage across education levels: graduates enroll at half the rate of dropouts; and those with college degrees enroll at very low rates. These enrollment differences reflect differences in health status as measured by quality-adjusted life years (QALYs): for example, for those aged 18–24, a high school dropout's health status is 0.89 QALYs, a high school graduate's is 0.91, and a college graduate's is 0.96. These health status differences and coverage disparities persist over the lifetime.

CHART 4 MEDICARE COVERAGE



SOURCES: Medical Expenditure Panel Survey (2004); National Health Accounts.

Lifetime Health Benefits from Graduation

These differences in coverage rates—reflecting genuine differences in health—translate into differences in annual per capita costs and so into lifetime costs. Table 6 shows the predicted total present value lifetime costs per capita (not per enrollee). High school dropouts will use public health system resources at much greater rates than graduates. The costs vary by gender and race, but the educational impacts are significant. For white females, for example, a dropout will receive $60,800 in Medicaid and Medicare payments or services over the lifetime up to 65. A high school graduate will receive $23,200 and a college graduate $3,600.

Table 6 Total present value lifetime public health costs per capita

	High school dropout	*High school graduate*	*Some college*	*BA degree or above*
Male:				
White	$43,500	$17,000	$12,900	$3,100
Black	$82,400	$34,200	$25,100	$6,000
Hispanic	$59,000	$23,300	$16,700	$4,000
Other	$61,600	$24,800	$18,200	$4,400
Female:				
White	$60,800	$23,200	$15,900	$3,600
Black	$107,200	$48,500	$33,500	$7,800
Hispanic	$73,700	$29,200	$19,600	$4,400
Other	$80,500	$33,600	$23,000	$5,300

Notes: Costs include Medicaid and Medicare. Discount rate is 3.5%.

Educational interventions that help students to graduate from high school (and in some cases progress on to college) should therefore yield savings to the public health system. Table 7 shows the lifetime economic benefit from raising the high school graduation rate.

Table 7 Lifetime total public health savings per expected high school graduate

	Public health expenditures Extra lifetime saving per expected high school graduate	
	Male	*Female*
White	$27,900	$39,600
Black	$52,100	$62,700
Hispanic	$37,800	$46,500
Other	$39,000	$49,200
Average	*$40,500*	

Notes: An expected high school graduate is one who probabilistically either: terminates education after graduation; completes some college; or completes a BA Degree. Discount rate is 3.5%.

Over the lifetime, the average saving to the public health system per expected high school graduate is $40,500. The savings are greater for females but they are also substantial for males.

The Effects on Crime Behavior and Expenditures

Education and Crime

Broadly, crime research finds that higher educational attainment reduces crime both by juveniles and adults. The causal mechanism may be either behavioral or financial. Higher educational attainment may directly influence criminal predispositions. Alternatively, by raising earnings and earnings potential, higher educational attainment reduces the pressure to commit crime and raises the opportunity cost. The relationship is clearest when looking at dropout status and incarceration: although they constitute less than 20% of the overall population, dropouts make up over 50% of the state prison inmate population (Bonczar, 2003). Moreover, disadvantaged groups—particularly black males—are disproportionately represented in the prison system.

The economic cost of crime is high. Victims bear most of the costs of crime, but these are not (directly) counted in the public's balance sheet. From the public perspective, there are four main costs: criminal justice system costs for policing and for trials and sentencing; incarceration costs (including parole and probation); state-funded victim costs (medical care and from lost tax revenues); and expenditures of government crime prevention agencies.

TABLE 8 ANNUAL CRIMINAL ACTIVITY BY DROPOUTS AGED 20

	Per 1,000 high school dropouts		*Impact from expected high school graduation*
	Arrests	*Crimes*	
Murder	0.48	0.82	–19.6%
Rape	0.69	2.43	–19.6%
Violent crime	14.02	32.24	–19.6%
Property crime	42.95	279.17	–10.4%
Drugs offenses	60.04	600.43	–11.5%

SOURCES: UCR (2004) adjusted for undersurvey; Wolf and Harlow (2003); Lochner and Moretti (2004).
NOTES: Violent crime includes robbery and aggravated assault. Property crime includes burglary, larceny-theft, arson, and motor vehicle theft. The share of total arrests by high school dropouts is based on incarceration rates.

We focus specifically on high cost crimes: murder, rape/sexual assault, violent crime, property crime, and drugs offenses. Table 8 shows the annual criminal activity for the cohort of 20 year olds who are dropouts. It shows high numbers of arrests and crimes for these five crime types. The final column shows the impact of high school graduation (adjusted for college progression) on the commission of these crimes. Overall crime rates are reduced by 10-20%. This reduction in crime is assumed to have a corresponding effect on incarceration rates.

Lifetime Criminal Activity and Graduation

Using Bureau of Justice Statistics data and survey information we calculate the public cost per crime and per arrest for each of these five crime types. Each crime imposes costs in terms of policing, government programs to combat crime, and state-funded victim costs. Each arrest also imposes costs in terms of trials, sentencing, and incarceration. The costs per crime and arrest vary according to the type of crime (mainly because of differences in prison sentences).

TABLE 9 TOTAL PRESENT VALUE LIFETIME COST-SAVINGS FROM REDUCED CRIMINAL ACTIVITY

	Criminal justice system expenditures Extra lifetime saving per expected high school graduate	
	Male	*Female*
White	$30,200	$8,300
Black	$55,500	$8,600
Hispanic	$38,300	$8,300
Other	$30,200	$8,300
Average	*$26,600*	

NOTES: An expected high school graduate is one who probabilistically either: terminates education after graduation; completes some college; or completes a BA degree. Annual criminal activity is assumed to decay to zero by age 65. The decay rate is based on the actual incidence of crime for each age group (UCR, 2004, Table 1). Discount rate is 3.5%.

To estimate the lifetime cost-saving from increased rates of high school graduation, we multiply the unit cost by the reduction in crime. The resulting lifetime cost-savings to the criminal justice system are reported in Table 9. The average saving per new high school graduate is $26,600. However, this amount is significantly higher for males than females, reflecting the big difference in criminal activity. Most of these savings are from lower incarceration costs, although there are also substantial savings from lower criminal justice system costs.

The Effects on Welfare and Expenditures

Education and Welfare

Greater educational attainment is associated with lower receipt of public assistance payments or subsidies. The relationship may be caused directly by lower rates of single motherhood or teenage pregnancy associated with high school graduation. Additionally, more education produces higher incomes which reduce eligibility for means-tested programs. However, more educated persons are better able to navigate the welfare system and claim benefits to which they are entitled. This offsets somewhat the gains from reducing welfare entitlements through increased educational attainment.

The impact of education on welfare payments may be significant. Annually, the federal government spends $168 billion and state governments spend $25 billion on the following need-tested benefit programs: cash aid, food benefits, housing aid, training, and energy aid (CRS, 2004). As incomes rise with education, eligibility for these payments will be reduced.

To estimate welfare costs we adopt a model derived by Waldfogel et al. (2005) for analysis of single mothers. First, we identify the impact of education in reducing non-elderly welfare receipt from three sources: Temporary Assistance for Needy Families (TANF); food stamps; and housing assistance. We also include state-level payments on a proportionate basis. Second, we calculate the monetary savings from reductions in welfare receipt over the lifetime for those who are new high school graduates.

Table 10 Welfare receipt by education level

	Less than high school	*High school graduate*	*Some college or above*
Temporary Assistance for Needy Families (ages 21–64)	553,000	623,700	40,100
Housing assistance (ages 21–64)	745,000	841,800	54,100
Food Stamps (age 20)	95,700	226,000	

Sources: DHHS (2005); Census (2003); Barrett and Poikolainen (2006); Rank and Hirschl (2005).
Notes: Distribution by education for housing assistance based on TANF distribution. Food stamp receipt for high school graduates includes those with higher education.

Table 10 shows significant differences in TANF receipt by education level. Almost half of all recipients have less than a high school education, a proportion much higher than their representation in the population. Those with any college education are highly unlikely to receive welfare. TANF caseloads are predominantly female (approximately by a factor of ten), with black and other race groups disproportionately represented. Similarly, of the 1.6 million persons annually receiving housing assistance, a disproportionate number are high school dropouts. Finally, the most extensive program is food stamps, in which 9.6 million non-elderly adults participated in 2004. Again, education is important, with receipt rates for dropouts almost double those for high school graduates. These differences add up: over a lifetime 64% of adult dropouts will have ever used food stamps, compared to 38% of high school graduates (Rank and Hirschl, 2005, 142).

We apply CPS data to calculate the relationship between education and welfare receipt. Being a high school graduate is associated with a lower probability of TANF receipt by 40%, of housing assistance by 1%, and food stamps by 19%. For those with some college or above, welfare receipt is even more sharply reduced: by 62% for TANF, by 35% for housing assistance, and by 54% for food stamps. Overall, there are likely to be significant cost-savings from reducing welfare caseloads by raising high school graduation across all three programs.

Welfare Receipt and High School Graduation

We now apply these impacts to the unit costs of welfare. For TANF, the average monthly benefit is approximately $355 and for food stamps it is $85 (DHHS, 2005; Barrett and Poikolainen, 2006). We add administrative costs to these figures to assess the full fiscal burden. For housing assistance, we calculate spending of $3,100 per person annually based on reported total expenditures in 2002 (CRS, 2004). Total costs per year are calculated as the impact times the unit cost.

TABLE 11 WELFARE COST-SAVING PER EXPECTED HIGH SCHOOL GRADUATE

	Welfare expenditures Extra lifetime saving per expected high school graduate	
	Male	*Female*
White	$1,200	$5,000
Black	$3,300	$9,000
Hispanic	$1,200	$3,100
Other	$1,200	$3,100
Average	*$3,000*	

NOTES: Expected high school graduate status adjusts for progression on to college. Lifetime welfare cost-savings adjust for the decline in these forms of welfare receipt with age. Welfare programs are TANF, housing assistance, food stamps, and state-level programs on a proportionate basis. Discount rate is 3.5%.

Annual figures can be extrapolated to calculate lifetime effects of increasing educational attainment. Lifetime figures are present values from the perspective of an individual currently aged 20. These are reported in Table 11. The average cost-saving per expected new graduate is $3,000 over the lifetime. The largest proportion of the savings comes from reductions in TANF payments although there are non-trivial savings in housing assistance and food stamps as well. The total figure is relatively low (compared to the other domains) for the following reasons: welfare is time-limited; children and the elderly receive high proportions of welfare funds; and males do not receive much welfare (but they constitute a large proportion of all dropouts). Also, we have omitted benefits for other welfare programs (mostly at the federal level) where we have insufficient evidence. Nevertheless, the cost savings are still significant, particularly for female dropouts.

The Aggregate Consequences of High School Graduation

The Cost and Benefits of High School Graduation

High school graduation is associated with higher incomes, better health, lower criminal activity and lower welfare receipt. This has private benefits, but it also produces significant public benefits. When we calculate these benefits in a consistent form, their magnitudes are substantial (see also Heckman, 2000).

Table 12 Present value lifetime public economic benefits

	Total lifetime economic benefit per expected high school graduate	
	Male	*Female*
White	$262,100	$162,000
Black	$268,500	$174,600
Hispanic	$196,300	$143,000
Other	$239,000	$157,300
Average	*$209,100*	

Notes: Benefits are gross, i.e. they do not account for the costs of additional educational attainment. An expected high school graduate is one who probabilistically either: terminates education after graduation; completes some college; or completes a BA degree. Discount rate is 3.5%.

Table 12 shows the lifetime economic benefits per expected high school graduate. Each new graduate will, on average, generate economic benefits to the public sector of $209,100. These are gross benefits and do not account for what it costs for the necessary educational interventions to raise the graduation rate or fund college progression contingent on graduation. The amounts vary by gender and race, with high school graduation providing a gross public saving of $196,300–$268,500 for males and $143,000–$174,600 for females.

It is important to state that we are not proposing that policy should be based crudely on net present values across subgroups (not least because an alternative criterion—the rate of return—yields a different ranking). We present disaggregated figures to show that the conclusions are not in fact driven by one group and that population-wide interventions are easily justified. A broader perspective must be adopted to decide where the most urgent investments should be made, taking into account the causes of any fiscal differences. These causes might include the potency of education's effects based on the quality of available schools, the progression rates to college, the extent of involvement in the labor market, and the receipt of public services. Other important considerations are the extent of labor market discrimination within and across education groups and the value society places on work outside the labor market. Investigation of all these factors is beyond our scope and so we emphasise that the gross public benefits from graduation are very large for all cases.

Table 13 Net public investment returns

Per additional expected high school graduate	Interventions to raise high school graduation rates				
	First Things First	*Chicago Parent-Child Center*	*Teacher salary increase*	*Perry Preschool*	*Class size reduction*
Costs (C)	$59,100	$67,700	$82,000	$90,700	$143,600
Benefits (B)	$209,100	$209,100	$209,100	$209,100	$209,100
Benefit/cost ratio (B/C)	3.54	3.09	2.55	2.31	1.46
Net present value (B-C)	$150,100	$141,400	$127,100	$118,400	$65,500

Notes: Numbers are rounded to nearest $100. Costs include delivering the intervention and any subsequent public subsidies for high school and college. Discount rate is 3.5%.

The net public benefits of high school graduation are also substantial. Table 13 shows that the benefits easily exceed the costs for each intervention. The first row shows the educational cost per new graduate, i.e. the sum of intervention and attainment costs for each of the five interventions which have been proven to raise graduation rates. These costs range between $59,100 and $143,600. The second row shows the average economic benefits per high school graduate of $209,100. These are lifetime benefits, discounted back to age 20. The last two rows show the benefit–cost ratio, i.e. the factor by which the benefits exceed the costs, and the net present value, i.e. the difference between the benefits and the costs. Taking the median intervention—teacher salary increase—the benefits are 2.55 times greater than the costs and the net present value from this investment is $127,100. For the upper bound intervention—First Things First—the benefits exceed the costs by a factor of 3.54. For the lower bound intervention—class size reduction—the benefits exceed costs by a factor of 1.46.

The aggregate consequences of raising the high school graduation rate for each age cohort are economically significant. Each cohort of 20-year olds includes over 700,000 high school dropouts. The fiscal consequence is $148 billion in lost tax revenues and additional public expenditures over the lifetime. If this number was reduced by half through successful implementation of the median educational intervention, the net present value economic benefit would be $45 billion. This figure is an annual one because each cohort includes the same number of dropouts. And it does not count the private benefits of improved economic well-being that accrue directly to the new graduates themselves. If the interventions only reduced the number of dropouts by one-fifth, the net economic benefit would be $18 billion.

Sensitivity Tests

The net economic benefits of investments to raise high school graduation rates appear to be very large. This conclusion is unlikely to change if alternative assumptions are applied. Our economic analysis, based on the best available evidence, has used conservative assumptions. Clearly, if we can identify more effective interventions or if these interventions are less effective when scaled up, net benefits will be affected. But, these influences are not easily measured. Also important are demographic changes, which are likely to raise the need for educational investments (Tienda, 2005). The main assumptions—and how they affect the results—are given in Box 1.

BOX 1 KEY ASSUMPTIONS AND THEIR CONSEQUENCES

Assumptions	*Effect on net economic benefits*
Educational interventions can be accurately targeted to at-risk groups	+++
Inclusion of juvenile benefits (crime, teenage pregnancy)	++
Higher taxes impose economic distortion (deadweight loss) on taxpayers	++
Inclusion of intergenerational, family, and civic benefits from graduation	++
Undercounting of persons in poverty	+
Fall in wages with more graduates in the labor market	–
Increase in the costs of delivering each intervention	– –
No college progression by high school graduates	– –
Higher discount rate	– –

NOTES: Number of plus or minus signs indicates the approximate strength of the effect.

The net benefits would increase significantly if the educational interventions could be targetted more accurately to at-risk individuals. (The results given above assume that interventions have to be given to all students, regardless of whether they would drop out). The net benefits would also go up if we counted other effects of education, such as lower juvenile crime or teenage pregnancy, improved civic engagement (NCOC, 2006), and the deadweight loss in collecting taxes. As well, because sample surveys undercount those in poverty, benefits would likely increase if more accurate data was available. In contrast, factors which would reduce the return include: a fall in market wages as more graduates enter the labor market; an increase in the cost of delivering each intervention; no progression on to college by new high school completers; and a higher discount rate. We test the two most conservative assumptions (no college progression and a discount rate of 5%) and find that the net economic benefits are still strongly positive.

In summary, it seems unlikely that sensitivity tests using alternative assumptions would overturn the fundamental conclusion of this analysis, namely that the net present value of public investments to ensure high school graduation is significantly positive across all subgroups of the population.

Moving Forward

Educational Interventions for Future Generations

In this study we have found that the monetary value of the public benefits of reducing high school dropouts exceeds considerably the public costs of getting results through demonstratively successful educational interventions.

Notably, we selected only those interventions for which rigorous and credible evaluations were available and which showed positive impacts on reducing high school dropouts. Although this process is supported by mainstream authorities in evaluation (Mervis, 2004), only five interventions met these criteria. However, there are new and promising interventions which should be considered. These interventions were not included in our calculations because of a lack of reliable information on their effectiveness. It is our hope that over time we will obtain excellent evaluations of their impact and that they will show even more powerful results.

New Ways to Raise the High School Graduation Rate

A number of potential candidates for increasing high school graduation may have even more powerful effects than the interventions that were the focus of this study. These new interventions reflect a convergence of agreement on a common set of features that lead to increased high school graduation rates and educational success. These features are: (1) small school size; (2) high levels of personalization; (3) high academic expectations; (4) strong counseling; (5) parental engagement; (6) extended-time school sessions; and (7) competent and appropriate personnel.

Small size describes a small school or a small program within a school in which students and staff are known to each other and accountable. *Personalization* refers to a caring environment in which every student is perceived as an important member of the community by both staff and other students and in which individual personal and academic needs are addressed. *High academic expectations* call for a demanding level of academic work that each student is expected to meet if given appropriate assistance. *Strong counseling* refers to the ready availability of personnel who can provide guidance and advice to students facing considerable personal challenges. *Parental engagement* enlists the efforts of the parent in support of the educational aspirations and accomplishments of their child and the school. *Extended time* refers to longer school days, weeks (Saturday classes) and school years to allow sufficient time for instruction and other activities designed to enable students to succeed. *Competent and appropriate personnel* refer not only to teaching qualifications of personnel, but also to their commitment to the mission of the school.

There is wide agreement that these types of changes should not be done on an individual basis, but should be done in combination to comprise a different school and schooling experience (Quint, 2006). For example, although there is a vigorous "small school" movement in the U.S., the evidence suggests that shrinking school size is unlikely to be adequate to improve educational outcomes in the absence of other changes. More generally, learning is a cumulative process such that youth interventions will not be effective for those students without basic literacy and numeracy skills (see Cunha and Heckman, 2006). It is also necessary to have institutional support so that interventions are implemented properly.

Among the five interventions reviewed in our cost-benefit analysis, First Things First (FTF) has components that draw upon the features set out above. Perhaps it is not a coincidence that FTF also has the largest economic benefits relative to costs. (Because FTF represents an investment in high school, there is a shorter period of time before the investment pays off relative to pre-school and elementary school investments.) Even so, FTF includes class size reduction, and it is conceivable that it could be even more effective if its students had a strong pre-school experience and a more selective draw of teachers through higher salaries. In this respect we believe that the overall model represented by the FTF results is one that should be evaluated further in its different forms.

One of the most complete versions of the model is that of the Institute for Student Achievement (ISA) which includes all the features set out above (www.studentachievement.org). The model includes a college-preparatory curriculum with counseling, professional staff, and parental involvement. ISA has developed its approach in schools for more than a decade and served about 8,000 students in 32 partner schools in 2005. Early evaluation information is promising (AED, 2006), including advantages in student attendance and behavior as well as teacher reports of student support. But there is a pressing need for evaluations using experimental and quasi-experimental methods to validate ISA's educational effects.

Other models that show promise along some educational dimensions are Talent Development High Schools and career academies (such as those following the model of the National Academy Foundation, which partners with over 600 academies nationally). Both have been subjected to rigorous evaluations and have shown positive results but they have not yet been validated in terms of high school completion (Quint, 2006). One promising model of reform that operates in existing size high schools is Achievement Via Individual Determination (AVID) which was started in 1980 and is now found in more than 1,000 schools in 40 states (www.avidonline.org). AVID seeks out students in the middle of the academic distribution who are not doing the quality work that they are capable of and provides dedicated teachers and rigorous educational experiences for students willing to take on the AVID commitment. Intensive support is also received from college tutors. It, too, requires tighter evaluation studies before conclusions can be drawn on its effects, although less formal studies have found strong results.

A good case can also be made for accelerating the middle school and secondary curriculum to insure that all students experience a similar set of challenging courses with workshops and other instructional supports to support those students with particular learning needs. A rigorous, longitudinal evaluation of this reform in mathematics showed that even the most advanced students benefit, and those who entered middle schools with the poorest records are brought into a productive mainstream in which they take more advanced mathematics courses and improve substantially their mathematics achievement (Burris et al., 2006). Finally, the Knowledge is Power Program (KIPP) may be another middle school reform with longer term benefits. It too emphasizes high expectations as well as committed principals and parents. Again, evaluation shows achievement gains in the early grades (EPI, 2005).

Of course not all educational interventions need to be initiated in the schools. A substantial amount of the variance in educational performance is associated with influences in the home, school, and community (Rothstein, 2004). Studies of high school dropouts also confirm the importance of differences in conditions outside of the school. These findings suggest that the strongest programs for increasing high school graduation rates and subsequent college participation will combine interventions in the school with those in the family, neighborhood, and community. Ferguson (2005) describes in detail the possible options and their consequences.

Clearly, there are a large number of potential approaches that have promising evaluation support, even if such support falls short of what is needed for a rigorous cost-benefit analysis. Thus, our conclusions do not need to be narrowly tied to the smaller set of interventions that were included in our calculations. Indeed, it is highly unlikely that there is 'one best intervention'. Instead, given the total number of dropouts and the varations in their circumstances and educational needs, a variety of interventions—possibly in combination—should be implemented. Nevertheless, there should be strong evaluations for all those reforms that show promise in order to include them in future cost-benefit studies.

Raising Benefits and Reducing Costs

As mentioned above, we view our estimates as conservative assessments of the public returns to public investments in raising high school graduation rates. Even so, the returns are substantial and could be higher if benefits were increased and costs were reduced. Clearly the most direct way of raising benefits is to establish more powerful methods of improving high school graduation rates. More recent approaches may have even more potent impacts on improving educational results. If so, we can raise benefits by shifting to those that are shown to be most productive according to evaluation methods based upon high standards of validity.

But, one effective strategy that could cut the cost considerably would be if the intervention could be targeted to those students most likely to drop out or most likely to benefit from it. When the intervention is targeted to the entire school (including those students who would have graduated anyway), it requires more resources than if it were targeted to a particular group of vulnerable students. Thus, targeting the intervention or portions of the intervention, if possible, represents a way of reducing the cost for each additional student that graduates.

More Than Money

This study has shown that by focusing resources on students who are receiving inadequate education, it is possible to obtain benefits far in excess of the costs of those investments. Increases in tax revenues and reductions in taxes paid into public health, criminal justice, and public assistance would amount to many billions of dollars a year in excess of the costs of educational programs that could achieve these results. But, it is important to note that this is more than just good public investment policy with monetary returns. A society that provides fairer access to opportunities, that is more productive and with higher employment, and that has better health and less crime is a better society in itself. It is simply an added incentive that the attainment of such a society is also profoundly good economics.

Further Information

Full information on the calculations in this document is available in a Technical Appendix from levin@tc.edu.

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