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INCOME, POVERTY, AND HEALTH CARE COVERAGE: ASSESSING KEY CENSUS INDICATORS OF FAMILY WELL-BEING IN 2008

HEARING

BEFORE THE

JOINT ECONOMIC COMMITTEE
CONGRESS OF THE UNITED STATES

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

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INCOME, POVERTY, AND HEALTH CARE COVERAGE: ASSESSING KEY CENSUS INDICATORS OF FAMILY WELL-BEING IN 2008

THURSDAY, SEPTEMBER 10, 2009

CONGRESS OF THE UNITED STATES,
JOINT ECONOMIC COMMITTEE,
Washington, DC.

The committee met, pursuant to call, at 1:02 p.m., in Room 210, Cannon House Office Building, The Honorable Carolyn B. Maloney (Chair) presiding.

Representatives present: Maloney, Hinchey, Cummings, Brady, and Burgess.

Senators present: Casey and Brownback.

Staff present: Nan Gibson, Colleen Healy, Elisabeth Jacobs, Andrew Wilson, Dean Clancy, Lydia Mashburn, Jeff Schlagenhauf, and Chris Frenze.

OPENING STATEMENT OF THE HONORABLE CAROLYN B. MALONEY, CHAIR, A U.S. REPRESENTATIVE FROM NEW YORK

Chair Maloney. I would like to call this meeting to order and recognize other members for 5 minutes after my opening statement, and then I would like to introduce the first panel.

First, I would like to thank our witnesses for joining us today to discuss the 2008 official government statistics on income, poverty, and health insurance coverage that were released this morning by the Commerce Department's Census Bureau. These are among the most important indicators of family well-being, and the picture from 2000 to 2008 is rather grim.

Between 2000 and 2008 median income fell by nearly $2,200; the number of Americans living in poverty grew by 8.2 million, and nearly 8 million people joined the ranks of the uninsured. American families have lost a decade due to the failed economic policies of the Bush Administration.

Nearly one year ago this committee held a hearing at the request of the late Senator Edward Kennedy on poverty in America. Senator Kennedy was home. He was sick and he called and said, Please have this hearing. I want to watch it. I wish I could be there. But he was very devoted to helping the poor and was a strong and vocal and effective advocate, and although we have lost the lion of the Senate, his dream lives on in the Democratic Congress and in all of us. We will certainly continue his work on behalf of the less fortunate.

The economic fortunes of most Americans tend to rise and fall with the strength of the economy. During the economic expansion of the Clinton era when unemployed hovered at around 4 percent, poverty fell to 11.3 percent, its lowest level in decades. However, the weak economic recovery of the 2000s under the previous Administration did not lead to a further reduction in poverty, which now stands almost two full percentage points above its 2000 level.

Today in the United States one out of every eight people, almost 40 million, live in poverty. The majority of people living in poverty are among the working poor. Worse still, 19 percent of our children, or almost one in five, now lives in poverty.

Median household income fell to $50,000, the lowest level since 1997, which means that the typical American family actually lost economic ground during the last recovery. Our economy may have grown, but those gains did not trickle down to the vast majority of families and the gap between the haves and the have-nots grew larger.

Too many jobs do not pay enough or lack the benefits to ensure families can make ends meet. Over one-quarter of U.S. jobs pay low wages and do not provide health insurance or a retirement plan, according to the Center for Economic and Policy Research.

Today's data on health insurance coverage are a sobering reminder of the impact of our broken system. 46.3 million Americans are uninsured, a figure that rose 20.6 percent between 2000 and 2008. Nearly one in 10 children are growing up without health insurance and over 30 percent of Hispanics lack any coverage at all. The share of Americans with private health insurance eroded over the eight years of the Bush administration as the cost of providing employer-based coverage crept upwards. Insurance premiums charged to employers increased by more than 100 percent between 2000 and 2008.

The 2008 data reflect the first year of the Bush recession, but the legacy of his Administration's failed economic policies has continued to bring havoc on many families. Recent estimates suggest that continued increase in the unemployment rate between January of 2009 and August of 2009 mean that over 2 million more Americans have joined the ranks of uninsured so far this year.

The time for comprehensive health insurance reform is now. As the data show, our Nation's families simply cannot afford to wait any longer. America's Affordable Health Choices Act includes provisions that will stop the rise in uninsured Americans by making affordable comprehensive coverage available to all of our citizens.

The bill includes subsidies for low and moderate income families to purchase health insurance coverage as well as a well-designed health insurance exchange. Within that health insurance exchange, Americans will have the option of choosing between the private insurers or choosing a public option. The inclusion of a public option is key to promoting competition and bringing down costs, and competition and cost control is key to reversing the distressing trend in uninsurance that we have seen year after year in the census data before this committee.

I look forward to the witnesses' testimony. I thank them for their research, for their commitment and for being here today, and I recognize Senator Brownback.

[The prepared statement of Representative Maloney appears in the Submissions for the Record on page 40.]

Senator Brownback. Thank you very much. Thank you Madam Chairman. I appreciate that. Good to see you again. Welcome back from the break.

Chair Maloney. Good to see you again. We have one of our joint bills on the floor next week. I will tell you about it. On to passage.

OPENING STATEMENT OF THE HONORABLE SAM BROWNBACK, RANKING MINORITY, A U.S. SENATOR FROM KANSAS

Senator Brownback. Hopefully on to passage. Thanks. Also I thank the witnesses. I appreciate your being here as well.

There was an interesting dialogue happening last night, and that was on the question that this hearing is about, and that is how many people are not covered in the United States. So I am hopeful that our witnesses are going to be able to illuminate that number somewhat. The President used a figure, I think he said 30 million, and he said that the program will not cover illegal aliens. His adviser David Axelrod in the media afterwards said that the President made clear that this is a program for American citizens who are not covered.

Now, does that then exclude people that are here legally but are not American citizens? And it is important because it gets at what is the universe and what is the number that we are looking at. And I am hopeful we can get a paper out of the Joint Economic Committee about what is the number, how many people are not covered in the United States, and is it citizens, noncitizens, the people here legally, illegally, so that the American public can really look at this and understand what is the actual number of the universe that we are looking at. The percentage of citizens without insurance, according to this most recent survey, stood at 13 percent; for noncitizens 44.7 percent are without coverage. I think it is important if we can get at what is the actual universe and the number, and I think this committee can help out in the debate with getting the actual number.

Chair Maloney. I would be delighted to do a joint report on that with the minority.

Senator Brownback. If we can get that in agreement, that would be—I think that would be useful for us to be able to do.

The chairwoman was talking about ways to get at this and who the groups are. I would also note that family composition is a key part on insurance coverage. There is a report out that we put forward that among married individuals with a spouse present the rate of coverage is 10.6 percent while the range is from 21.2 to 33.4 among other status of individuals whether they are married or not. Education level matters; 7.7 percent of those with a Bachelor's Degree or higher lack coverage while more than 20 percent of those with only a high school education lack coverage. So I think too here we see ways to get at the issue and addressing issues, whether it is family structure, education, as important ones to address as well.

And finally I would hope that we would look at this whole health care debate as one we would want to go at incrementally to deal with and not do a massive dollop of Federal intrusion. We did—in Southeast Kansas a little community-based clinic got some Federal

support to get it started that is serving a region in my state where we have some high poverty level numbers. Got it started. It now is sustaining itself mostly off of community support but also off of people coming in and using the services. They provide health care services, dental services, psychological services within this clinic, and I thought that is a much more practical and cost-effective way and the size of the debt and the deficit that we are looking at and the out of control entitlement spending, instead of starting a new entitlement, wouldn't we be better off to be very narrow and focused on incremental movement and getting our entitlement spending under control as a much better way to go forward?

Anyway, I look forward to the witnesses helping us with what the actual number of that is and breaking that out.

Thank you, Chairwoman.

Chair Maloney. Thank you. And the Chair recognizes Mr. Hinchey from the great state of New York.

OPENING STATEMENT OF THE HONORABLE MAURICE D. HINCHEY, A U.S. REPRESENTATIVE FROM NEW YORK

Representative Hinchey. First of all, Madam Chairman, I want to thank you very much for conducting this hearing, and the timing of it I think is very, very appropriate. I am very anxious to hear the statements that are going to be made by Dr. Blank and Dr. Rouse, and I thank you both very much for being here with us. The information that you are going to be providing us in the context of other information which is outflowing as a result of recent surveys is going to be very important to this committee and to this Congress in order to deal with the economic circumstances that we are confronting. The circumstances are serious. This is the most serious economic condition that this country has faced since the 1930s, and we are beginning now to see some indications of improvement, but that has taken a long time.

The economic circumstances for households across America were worse at the end of last year than they were 8 years earlier. So that indicates quite clearly how long this deep recession has been going on, how it has fluctuated from time to time over the course of those 8 years, and what the emerging situation is now. And there is somewhat of a mild improvement apparently based in part at least on the introduction of the American Recovery and Investment Act, only 25 percent of which is actually out there now.

So it is quite clear that this Congress has a lot more to do, and in order to do it we are going to need the appropriate accurate information, and that appropriate accurate information is coming from a number of sources but particularly today obviously from you, and I thank you very much for being here and for doing that and I am very anxious to hear what you are about to say.

Thanks.

Chair Maloney. Mr. Brady for 5 minutes.

OPENING STATEMENT OF THE HONORABLE KEVIN BRADY, A U.S. REPRESENTATIVE FROM TEXAS

Representative Brady. Thank you, Madam Chairman. Not much news—I want to welcome the witnesses before the committee today. Not much news today.

The recession has taken a toll on families. Surprisingly, the number of uninsured is staying relatively stable as it has for quite a while. It has been around 15 percent and the number of those in poverty has increased and thankfully is still below the average of 13.9 percent since the 1960s. And we have a lot of work to do.

I do question the accuracy of our poverty numbers. A compilation based almost solely on the price of food versus net income and ignoring key issues such as energy and medical costs and other costs doesn't seem accurate and also by excluding what occurs to help people in the lower part of our economic ladder such as government assistance programs, food stamps, Medicaid, housing vouchers, and tax credits. I think in taking it in total we are not getting a good picture of those in poverty in America today. We deserve a good picture.

The National Academy of Sciences has proposed that we really incorporate a bundle of family expenditures. I think that is a better way to go, would give us that along with some adjustments for geography. Living in Manhattan and being poor is different than living in rural east Texas and being poor, and our statistics ought to reflect that.

I also question the data limitations emphasized by the Census Bureau itself in reviewing changes in median household income over several years. For example, according to the Census Bureau data, the current population survey aren't useful for looking at changes for the same household over time. So there is no attempt to follow households if they move nor are any households in the current population survey for more than 2 consecutive years. So we are not really tracking families as they move up and down, mainly up, the economic ladder.

Other census data consistently has shown high rates of movement from one income group to another over time, including the middle fifth. For example, according to one census study, about 50 percent of households in the middle fifth move to another income group over as little as 3 years.

The Census Bureau has said research shows health insurance coverage is underreported for a number of reasons. It reports the percentage of people without health insurance in 2008 is not statistically different from 2007 at 15.4 percent. But there is no doubt that this information today, rather than being used as an attempt to flog this government-run plan back to life, ought to be the starting point of how do we really get more accurate discussion, more accurate data on these two very important groups, families who are living in poverty and those who do not have health insurance.

The final point. I have been looking forward for many years to working on health care and was really pleased when the Republican Congress created the Children's Health Insurance Program and funded it for 10 years. I was pleased that we finally, as Republicans, were the ones who created some subscription drug plans for our seniors, which is working much better than expected or anticipated. And I was pleased that we doubled the research for the National Institutes of Health in such lifesaving medical breakthroughs in cancer and chronic illnesses. I still—and I am disappointed that although the House passed relief for small busi-

nesses and reforms, tort reforms in lawsuit abuse, it was defeated in the Senate over the years.

I still think the President is exactly right to push for health care reform in America today. Unfortunately, the American public is not buying this plan. They are absolutely right in knowing the government will interfere between the doctor and their patient, some of the most intimate decisions they are making. They know this will add terribly to the huge deficits we already have, and they know instinctively that this will lead to rationing in future years as it does in Medicare and as it does in the VA.

So I was disappointed last night. I thought the President was needlessly partisan, I think probably destroyed any opportunity for both parties to work together to really come up with a thoughtful solution for health care, which is really what families want to have happen.

With that, I yield back.

Chair Maloney. Thank you. Congressman Cummings.

OPENING STATEMENT OF THE HONORABLE ELIJAH E. CUMMINGS, A U.S. REPRESENTATIVE FROM MARYLAND

Representative Cummings. Thank you very much, Madam Chair. Today's Census Bureau report is a stark reminder of the economic inequalities that continue to permeate our society. While the current recession has been equal opportunity, impacting almost every sector of the economy and crossing racial and geographic boundaries, there is also a widening and growing gap between society's haves and have-nots. The inequalities that persist are disappointing, disheartening, and given the policies pursued by the previous Administration, clearly foreseeable. Eight years of blind adherence to deregulation and supply-side policies resulted in reduced income for African Americans and Hispanics, continuing gender pay inequity, and an increasing number of children born into poverty.

As my colleagues know, I have never been one to mince words and today is no exception. I remain outraged at the outlook facing so many African American children and so many children in our country. According to the Annie Casey Foundation, between 1994 and 2000, the child poverty rate fell by 30 percent. This was the largest decrease in child poverty since the 1960s. Key children's health indicators improved across every major racial group and in nearly all of the states. Since 2000, however, child poverty has increased roughly so that roughly 2.5 million more children lived in poverty in 2008 than in 2000. That is 2.5 million children who have been left behind in the wealthiest Nation in the world.

In my home state of Maryland approximately 133,000 children live below the poverty line, another 209,000 live at 125 percent of poverty. Through no fault of their own, these children find themselves questioning when or if the next meal is coming. A young man from Maryland named Deamonte Driver is a tragic example of how vulnerable our children are. In 2007 Deamonte needed $80, an $80 tooth extraction to fix a painful abscess. Without access to dental treatment, the abscess went untreated and predictably became infected. The infection spread to his brain and ultimately it took a 12-year-old from us. Deamonte died because he could not get

$80 worth of treatment. That happened in America. That happened 40 miles from where—less than 40 miles from where we are sitting right now.

One hundred forty-three million Americans find themselves without dental coverage. And while every one of them is at risk for serious health problems, again the most defenseless and vulnerable are our Nation's children and young adults. To that end I appeal to my colleagues in the Congress to guarantee that dental coverage was part—included in the recent State Children's Health Insurance Program. I am pleased that this legislation was included in the SCHIP bill that President Obama signed into law.

I know that today's report does not measure the impact of SCHIP, the stimulus, and the other actions taken to assist families who are most in need in our country. However, the report does underscore and reinforce the need for and the timeliness of these actions. Not only is poverty increasing but state and local governments cannot bear the brunt of the crisis and the public resources upon which the working class depend are becoming scarce.

As we saw earlier this summer, 18 states have been forced to borrow over $12 billion from the Federal Government to maintain their unemployment funds. Further, the essential temporary assistance to needy families has become increasingly unavailable under the weight of continuing economic turmoil.

Despite this dismal outlook, we are seeing signs of hope. Unemployment has held relatively steady over the last few months and the Labor Department announced this morning that initial jobless claims were fewer than expected.

So we still have a lot of work to do; however, today's report reminds us why continued decisive action by the Congress is required as well as a commitment to understanding the real impact of past policies on those who are at risk.

So I look forward to the testimony of all of our witnesses today and a productive discussion. The stakes for our families have never been higher.

And with that, Madam Chairman, I yield back.

[The prepared statement of Representative Elijah E. Cummings appears in the Submissions for the Record on page 41.]

Chair Maloney. Thank you very much.

Congressman Burgess.

OPENING STATEMENT OF THE HONORABLE MICHAEL C. BURGESS, M.D., A U.S. REPRESENTATIVE FROM TEXAS

Representative Burgess. Thank you, Madam Chairman. The hearing that we are having today, Income, Poverty, and Health Insurance Coverage: Accessing Key Census Indicators of Family Well-Being, is certainly curious in its timing coming after the presidential speech last night.

Undoubtedly the issues of economic disparity are especially acute in a recession. Incomes stagnate, jobs are lost, people are suffering. But, I cannot recall a single time this committee has held a hearing on the U.S. Census report on income poverty and health insurance coverage in the United States a mere 3 hours after the report was released to the public. This is after all an annual report, a report which is surveyed every year and delivered several months later.

So why the critical time, the curious timing, about holding this hearing? Indeed, in light of the President's speech last night, and Senator Brownback referenced this, we heard some curious numbers from the President last night. Instead of 47 million uninsured, he talked about 30 million uninsured, so I would be very interested to see the witnesses comment on that.

Issues of income and poverty have been with us for decades. When Medicaid was enacted, the percentage of poor in this country was around 13.9 percent, and today with the population 100 million larger, the poverty rate is 12.5 percent. So it arguably could show some progress, but it is essentially the same number. And again I would ask the question why is it critical to have—the timing of this hearing becomes, again, of interest.

Now Dr. Karen Davis, for which I have very high regard, is going to testify today before this committee and the title of her statement is Hearing on the Uninsured before the Joint Economic Committee. So if our witness is speaking about the uninsured, then that is what is really what this hearing is about. This hearing isn't about trying to find more answers in how we can solve the income disparities. If it were, we would have experts in education who would talk to us about the number one cause of economic disparity is the lack of education.

This hearing isn't about trying to find more answers about how we can solve issues of the poor. If it were, where are the advocates for the chronically poor who can tell us what makes people poor and what makes them remain that way?

This hearing is about health care, and merely providing health insurance is not always the answer. Providing health insurance to the poor will not give them better quality of care. Sometimes it doesn't even give them care at all. It can only help mitigate the cost of care.

Right now we have Medicaid and for kids we have the State Children's Health Insurance Program. Again it begs the question. When you look at the numbers in Medicaid there are 6.4 million people who the Census Bureau is not counting even though they are enrolled in the Medicaid program; so the Medicaid undercount is 6.4 million. Eligible but not enrolled in government coverage, an additional 4.3 million were eligible for public programs like Medicaid and the State Children's Health Insurance Program but were not enrolled. And again when we had the discussions about extending the State Children's Health Insurance Program, many of us on my side felt that it was critical to find those kids, albeit they are hard to find, albeit they live sometimes in desperate circumstances, but those are the very children that we should be helping with the State Children's Health Insurance Program and to expand coverage to higher income levels without going after the children that should be covered first seems to me to be an odd way to approach trying to improve a Federal program.

And income does not necessarily determine access to health care. We all know about the EMTALA laws. We have a provider mandate in this country. As a physician who practiced for 25 years, I was well aware that when I got a call in the middle of the night to attend a woman in labor, I had 30 minutes to show up or I could be fined as much as $50,000. Indeed, that was burned into my psy-

che, and there never once was a time where I failed to respond to that call in the middle of the night and deliver care, whether compensated or not, because I knew the Federal Government was holding a fairly big stick over me to ensure that that occurred.

The numbers are disconcerting, but at the same time I am not sure that we are following the numbers accurately and validly. Now Senator Brownback talked about community clinics, federally qualified health centers. I don't see the number of people covered. Fifty million people who get their care in a federally qualified health program are apparently not accounted for in the census report. There are huge problems with the geographic disparities of federally qualified health centers. I have worked for 5 years to get one in a relatively or a very—an area in my district that has a very high infant mortality rate, and we have only this July managed to get one opened up and it took an enormous amount of work both locally and up here to get that done. That shouldn't have been so hard to do because it was a program that was already in existence and didn't require a great deal of additional funding and yet will deliver a lot for the citizens of Fort Worth.

Now, as we analyze the critical issue of providing cost-effective health care to every American, I think it is important to note that access to health care should not depend on income, it should not depend on race nor should the solution immediately be to give everyone health insurance. Access to health care is critical but access to health insurance is merely a facilitator.

One of the takeaways I hope we have from this hearing is how we reduce the costs of health care so that everyone can afford it whether they are insured or not.

I yield back the balance of my time.

[A letter from Representative Michael C. Burgess, M.D. to Rebecca Blank appears in the Submissions for the Record on page 42.]

[A letter from Representative Michael C. Burgess, M.D. to Cecilia Rouse appears in the Submissions for the Record on page 43.]

[A letter from Cecilia Rouse to Representative Michael C. Burgess, M.D. appears in the Submissions for the Record on page 44.]

Chair Maloney. I thank the gentleman for his statement and all of the panelists for being here. I thank my colleagues.

I would now like to introduce the first panel. We have two panels today. Dr. Rebecca Blank is Under Secretary of Commerce for Economic Affairs as the economic adviser to the Secretary of Commerce and head of the Economic and Statistics Administration. Dr. Blank has management responsibility for the two top statistical agencies in the United States, the Census Bureau and the Bureau of Economic Analysis. Prior to coming to the Commerce Department, Dr. Blank was the Robert S. Kerr senior fellow at the Brookings Institution. Dr. Blank graduated summa cum laude in economics from the University of Minnesota and holds a Ph.D. in economics from MIT. She was dean of the Gerald R. Ford School of Public Policy at the University of Michigan and co-director of the National Poverty Center. Dr. Blank served as a member of President Clinton's Council of Economic Advisers.

Dr. Cecilia Rouse is a member of the President's Council of Economic Advisers. Dr. Rouse is currently on leave from Princeton University where she is the Theodore A. Wells Professor of Eco-

nomic and Public Affairs. She has been a senior editor of "The Future of Children" and the *Journal of Labor Economics*. She is the founding director of the Princeton University Education Research Section and has been the director of the Industrial Relations Section. She was a member of the MacArthur Foundation's Research Network on the Transition to Adulthood. Rouse served on the National Economic Council under President William Clinton from 1998 to 1999. She holds a Ph.D. in economics from Harvard University.

Thank you very much and, given the importance of this issue, I grant Dr. Blank and Dr. Rouse as much time as they may consume. Thank you.

STATEMENT OF DR. REBECCA BLANK, UNDER SECRETARY FOR ECONOMIC AFFAIRS, DEPARTMENT OF COMMERCE

Dr. Blank. Thank you very much. It is always dangerous to give too much time to speakers, you know.

Madam chairwoman, Ranking Member Brady and Senator Brownback, and distinguished members of the committee, I want to thank you for inviting me here to discuss the income, poverty, and health insurance data released today by the U.S. Census Bureau at the Department of Commerce. Today's data release provides detailed information on the economic circumstances of American families in the year 2008.

I don't need to remind you that 2008 was not a good year economically. The recession officially started in January of that year. GDP fell by 1.9 percent over the year, and employment fell by 2.2 percent, while the unemployment rate rose from 4.9 percent of the labor force to 7.2 percent. The last half of the year was particularly difficult with gas prices that reached over $4 per gallon in midsummer, a virtual collapse in the financial sector that fall, and the start of a global recession. Under these circumstances it is not surprising that the news in today's data release is not good.

The data released today indicate that between 2007 and 2008 real median household income fell by 3.6 percent, from just over 52,000 to just over 50,000. This is the lowest level recorded since 1998, indicating there was little growth for the average American family, the family that is in the middle of the income distribution, over the past 10 years. Median income fell in all families and among all race and ethnicity categories. These income changes were in part driven by declines in real median earnings of full-time workers among both men and women.

The poverty rate rose from 12.5 percent in 2007 to 13.2 percent in 2008, with 39.8 million individuals living in families whose income was below the official Federal poverty line. This is the highest poverty rate since 1997. Poverty also increased particularly among Hispanics and among noncitizens. Poverty increases were also concentrated in the Midwest and in the West. A bit of good news is that the elderly experienced no increase in poverty during 2008. And Mr. Brady, I would be delighted to come back and talk about what our poverty statistics do include and don't in question and answer if that would be useful.

I am not going to discuss the health insurance numbers in this report. That will be the subject of Dr. Rouse's testimony. These

2008 numbers are better understood when they are put in the context of the historical trends. Since 1979, income among middle American families has risen but most of that increase occurred during the expansion of the 1980s and the expansion of the 1990s.

If you have a copy of my testimony, Table 1 shows this, but I will also say it verbally. Table 1 indicates that median income rose just under 11 percent in the expansion following the recession of the early 1980s. It rose 13 percent following the recession of 1991. But the expansion of the 2000s was different. Median income rose only 1.6 percent during the expansion between 2001 and 2007. With the economic turndown in 2008, we are back to a level of median income similar to where we were 10 years ago. Middle income Americans made no gains in income over this time period.

We see a similar pattern when we look at poverty rates. The poverty rate always rises steeply during recessions but falls during expansions. As Table 1 indicates, poverty fell by 1.5 percentage points during the expansion of the 1980s and fell by almost 3 percentage points during the expansion of the 1990s. Following the expansion that came after 2001, however, poverty continued to rise. Poverty rose by 8/10 of a percentage point over the expansion of the 2000s. So a higher share of the population was poorer in 2007 than in 2001. The 2008 data show a further steep increase as expected in a recession year, but the fact that the expansions in the 2000s did nothing to reduce poverty means increases in 2008 are off a higher base.

Clearly, the bad news about income and poverty in today's data mirrors the bad news throughout the economy in 2008. The reduced income and higher poverty numbers directly reflect the increases in unemployment over 2008 that lowered earnings among American families.

But we are seeing now some signs of recovery in the economy, and private sector forecasts predict positive GDP growth during the second half of this year. I expect that the economy overall will not show the same declines from 2008 into 2009 as it did from 2007 into 2008. Unfortunately, even with an improving economy, the higher unemployment rates that we are experiencing, and will continue to experience during 2009, will almost surely lead to further declines in income and further increases in poverty in the current year. Unemployment lags the business cycle, and until job growth is reestablished, income and poverty will not change those trends.

The long-term challenge is to assure that the economic recovery that we are entering brings better economic times to all Americans with increases in income throughout the income distribution. This Administration, since taking office at the beginning of 2009, is working on a host of policies designed to improve the lives of American families. We are focused on improving educational opportunities from preschool through college, reforming health care so that all Americans have access to insurance and families are not bankrupted by health emergencies, and helping to create a growing sector of green business and green jobs to improve both energy efficiency and to employ more Americans in jobs that make the environment better for us all. Furthermore, the stimulus package approved by Congress this past winter raises incomes and helps cre-

ate jobs, improving family well-being in 2009 relative to what it would have been without this additional assistance.

Today's data tells us what we already knew: 2008 was not a good year economically for Americans. Fortunately, this is old news. There are signs of economic recovery throughout the economy aided by the measures that Congress and this Administration have taken to restore credit markets and stimulate economic growth. We have good reason to believe the news in future years is likely to be better.

Thank you.

[The prepared statement of Rebecca Blank appears in the Submissions for the Record on page 48.]

Chair Maloney. Thank you so much.

Dr. Rouse.

STATEMENT OF DR. CECILIA ROUSE, MEMBER, COUNCIL OF ECONOMIC ADVISERS

Dr. Rouse. Chair Maloney, Vice Chairman Schumer, Ranking Members Brady and Brownback, and other distinguished members of the committee, thank you very much for inviting me to join you today to discuss the Census Bureau's release of data on income, poverty, and health insurance coverage in the United States in 2008.

The data released today provide an important piece of our overall understanding of the economic conditions that existed during the first year of the current recession. Based on survey data of households last March regarding their income and health insurance coverage during the 2008 calendar year, the data confirmed what we had already surmised. Along with rising unemployment last year, families were trying to get by with less income and many more had slipped into poverty and the number of people without health insurance continued to increase. These data confirmed that the recession was well underway in 2008.

These trends reinforced the need to expand health insurance coverage to more Americans, as would be achieved through the President's plan for health insurance reform. They also provide a new lens for which to view the critical importance of the American Recovery and Reinvestment Act of 2009 and many other programs proposed by President Obama designed to help increase incomes, reduce poverty, and pull the economy out of recession.

In the remaining minutes of my oral testimony, I would like to give an overview of the trends in health insurance coverage in the census report as well as amplifications for health insurance reform as articulated by the President last night. I would then like to review some of the Administration's policies designed to increase incomes and reduce poverty. More complete remarks are included in my written statement.

According to the new census estimate, the number of individuals without health insurance increased significantly from 45.7 million in 2007 to 46.3 million in 2008. The data also indicates that the fraction of U.S. residents without health insurance stood at 15.4 percent in 2008, a rate that was only slightly higher than that in 2007 and substantially higher than that in 2000. The estimated

number of U.S. residents without health insurance increased by almost 8 million from 2000 to 2008.

These overall changes mask important differences by the type of health insurance that individuals have. The fraction of U.S. residents with employment-based health insurance declined significantly from 59.3 percent in 2007 to 58.5 percent 2008, continuing a trend from the past several years, as there has been a 5.7 percentage point decline in the fraction of U.S. residents with private employment-based health insurance since 2000. In contrast, from 2007 to 2008, the fraction of individuals with public health insurance increased substantially.

Most of this increase was attributable to a rise in the fraction with Medicaid or CHIP, which was likely driven by the declining incomes caused by the first year in the recession. The change in health insurance coverage from 2007 to 2008 differed significantly by age. For example, the fraction of adults between the ages of 18 and 64 without health insurance increased significantly and as a result more than one out of every five nonelderly adults was without health insurance in 2008, an increase of more than 3 percentage points since 2000. In contrast, the fraction of children without health insurance declined significantly during the same period to nearly—to just under 10 percent in 2008. As a result of this decline, both the number and fraction of children without health insurance is at its lowest level since the census began collecting such comparable data in 1987.

A close examination of the Census Bureau's data reveals that the decline in the number of children without health insurance was almost entirely driven by an increase in their Medicaid coverage, which more than offset a substantial decline in private health insurance coverage among children. While this strongly suggests that Medicaid has cushioned the effects of the economic downturn on children, we must remember that prior to 2007 increases in Medicaid coverage were serving to offset substantial declines in private health insurance coverage among children, which fell from 70.2 percent in 2000 to 64.2 percent in 2007.

Before discussing the Administration's policies, it is worth highlighting that the estimates from the Census Bureau are meant to count the number of individuals who are continuously uninsured throughout the year and yet a big motivation for health insurance reform is to address the instability that results when people risk losing their health insurance when they move, lose their job, or change jobs.

Estimates from other surveys regarding the number who are uninsured at some point—at any one point during the year suggest that the number of those who experience such instability is much higher. It is also important to remember that the census data are from 2008. Recent survey data from Gallup indicate that the fraction of adults without health insurance has continued to increase this year. Gallup data suggest a 1.5 percentage point increase in the percent of adults who are uninsured in the average month in the first 6 months of 2008 compared to the average month since—in the first 6 months of 2009.

The Administration has aggressively worked to ensure that all Americans are covered by health insurance. In February, President

Obama signed into law an historic expansion of the Children's Health Insurance Program, and the Recovery Act included the unprecedented government subsidy of COBRA payments, enabling millions of unemployed workers to maintain their health insurance while continuing to look for new employment. Of course reform as articulated by the President last night would result in an even larger expansion of health insurance coverage by providing new tax credits to help people buy insurance and to help small businesses cover their employees.

In the President's plan, individuals would be able to shop for health insurance in an exchange where they could compare the price and quality of alternative insurance products and select the one that best fits their needs. The President's plan would also provide more stability and security for those who currently have insurance by prohibiting excluding individuals with preexisting conditions and preventing insurance companies from dropping coverage when people are sick and need it most. It would also cap out-of-pocket expenses to protect people financially when they get sick and eliminate extra charges for preventative care.

The trends summarized above during the last several years are likely to continue without decisive action. Health insurance premiums are rising three times more rapidly than wages and thus an increasing share of workers and their families will simply be unable to afford insurance if current trends continue.

The committee also asked me to address what steps the Administration is taking to reverse the trends in income and poverty and improve the well-being of families across the country. The largest and most visible strategy pursued by the Administration and Congress was to pass the nearly $800 billion Recovery Act. Through a balanced package of State fiscal relief, individual tax credits, and an increase in the Federal safety net, much of the Recovery Act provides short-term help to the ailing economy. For example, it has helped states maintain important state programs such as Medicaid and to retain public sector employees during a time of fiscal distress. The Recovery Act also includes billions of dollars in tax relief for more than 95 percent of working families to help them retain more of their take-home pay. It also includes a significant increase in the Federal safety net which is benefiting millions of struggling Americans while simultaneously helping to buoy the economy by supporting aggregate demands.

Yesterday the Center on Budget and Policy Priorities released estimates that find that several provisions of the Recovery Act, including improvements in health unemployment insurance, tax credits for working families, and an increase in food stamps, prevented 6 million Americans from falling into poverty and reduced the severity of poverty for an additional 33 million in 2009. Clearly getting people back to work is critical for increasing incomes and reducing poverty. To this end the Recovery Act increased funding for job training, which can be vital to helping displaced workers retrain for promising jobs in areas of high demand.

Recognizing that we not only want to recover from this recession but also build an even stronger economy, the Recovery Act also contained provisions to help boost incomes in the longer term. Two of the best documented long-term public investments to raise in-

comes are those in early childhood education and public education. The President's 2010 fiscal year budget goes even further with investments in high-quality early childhood education, a simplified Federal financial student aid form, and an ambitious plan to invest in our Nation's community colleges.

Finally, the President's budget also calls for funding promising strategies to help those who were struggling even before the start of the current recession. As one component, his budget proposes investing in innovative, comprehensive strategies for helping neighborhoods. The budget also proposes grants to states to provide home visits for low income parents and pregnant women. Such home visitation programs have been shown through rigorous research to be highly effective in improving child health and development, readiness for school, and improving parenting ability.

Thank you for giving me an opportunity to review the data in this new census report and to share the Administration's strategies for returning prosperity to all Americans. I am happy to answer any questions you may have.

[The prepared statement of Cecilia Rouse appears in the Submissions for the Record on page 52.]

Chair Maloney. Thank you. And I will begin the questioning. Many of us are very focused on expanding health insurance coverage in the President's speech last night, so I would like to address the health care issue.

Our Nation's businesses are under tremendous cost pressures right now, and due to rising health insurance premiums and falling revenues, they are under even more pressure. Could you elaborate, Dr. Rouse or Dr. Blank, on how these trends have impacted individual health insurance coverage both over the course of the last year and the longer term?

Dr. Rouse. I am happy to respond, although, Dr. Blank, if you want to as well.

So there is no question that with increasing health insurance premiums, an increasing number of employers are dropping coverage for their workers. Those who are not—part of the reason that they are dropping the coverage is because the premiums are just too expensive. Those companies that are not dropping coverage are shifting some of the increase in premiums onto the compensation of employees. So what workers are finding is that a greater share of their total compensation is in the form of health insurance coverage rather than in the form of take-home pay.

Chair Maloney. And how will the health insurance reform proposals currently under consideration in Congress help ease the erosion in health insurance coverage rates?

Dr. Rouse. The President's plan would help to—first of all, a major component of the President's plan is to get the—try to get the cost increases under control. And so if we are able to slow the rate of growth of health insurance costs, that will definitely spill over into controlling the cost of health care premiums, which will lower the cost for employers and workers. In addition, when there are millions of Americans who are uninsured, many of them do seek access in other places, and part of those uninsured costs are also being borne by those individuals who do have insurance and also by expanding coverage is another form—that is one small com-

ponent of actually controlling some of the increasing costs in health insurance.

Chair Maloney. Dr. Rouse, the CEA released a report earlier this year explaining why health insurance reform was critical to our Nation's economic health, and that report suggested that health insurance reform could have a dramatic impact on families' incomes. The health reform legislation proposed by the President would result in almost 10,000 in additional income for the typical family of four.

Could you elaborate on the connection between health reform and family income?

Dr. Rouse. As I was just mentioning, one of the problems with our current system of health insurance is that the costs have continued to skyrocket. And if we are able to bend the curve on health care costs, if we are able to slow the increase in costs of health insurance, what that will mean is that instead of workers taking so much of their compensation in the form of health care insurance, instead they will be able to take home a greater share of total compensation in terms of income.

Dr. Blank. Can I also respond to that?

Chair Maloney. Certainly.

Dr. Blank. One of the real concerns in terms of trying to look at the well-being of families is to look at what they actually have to spend on food, clothing, shelter, and necessities. Out-of-pocket medical expenditures have been growing in this country. And if indeed health insurance reform is effective at both covering more people with access as well as controlling costs, that really will affect the well-being in terms of the take-home pay that people have to spend on the things that they want to spend it on, as opposed to the things they have to spend it on, such as health care.

Chair Maloney. My time is almost up, but the health insurance reform proposal includes subsidies aimed at making health insurance affordable for low and moderate income families, and could you elaborate on why such subsidies are important for achieving universal coverage?

Dr. Rouse. The President's plan—a major component of the President's plan is that there should be shared responsibility. In order for there to be—the way insurance works is by pooling risks across many individuals we can lower the cost for any one individual, and he strongly believes that there should be shared responsibility across individuals, businesses, and the government. However, with that shared responsibility could be quite difficult for many families, for especially low income families, and so in order to ensure that everybody is covered by health insurance the President's plan recognizes that there will need to be subsidies for some families.

Chair Maloney. Thank you. My time has expired.

Senator Brownback.

Senator Brownback. Thank you very much. Ladies, thank you very much for joining us too and for your presentation.

I believe the President's price tag on the proposal was—I thought he said last night around $900 billion over 10; is that correct?

Dr. Rouse. That is correct.

Senator Brownback. I didn't quite catch last night how he was breaking down the payment for that. He did say he is not going to add to the deficit. So where is the money coming from?

Dr. Rouse. The President is committed to paying for the entire plan. He does not believe that the plan should add to the deficit, $1 to the deficit. The plan will be paid for through a combination of making Medicare and Medicaid more efficient. Currently there is——

Senator Brownback. How much out of that?

Dr. Rouse [continuing]. I think—I should probably get back to you with the exact. I don't think—we are still working on—we have to see the details, but I think he is working at roughly half of it would come out of squeezing the inefficiency in the current system, and then he is also looking to raise revenue elsewhere.

Senator Brownback. So about $450 billion out of savings from Medicare and Medicaid and $450 billion in tax increases?

Dr. Rouse. This will depend very heavily on what the ultimate plan looks like, but what the President is committed to doing is finding savings from the inefficiency in the current program and raising revenue in other places.

Senator Brownback. Have you had a chance to look at that anywhere on how you save that quantity of money on Medicaid or Medicare? I mean that is a pretty big number to try to squeeze efficiencies in a system that—I presume people have been trying to do that for some period of time but——

Dr. Rouse. I believe that is certainly true. There is a lot of evidence that if you look at the expenditures in the United States compared to other countries that we spend a lot more compared to other countries for the kind of outcomes, health outcomes that we get. If you look at data across counties in the United States, you find that in two counties where there are similar demographics, similar health care provisions, similar outcomes, in one county they are spending much more than the other.

So we know there is inefficiency. Medical experts, researchers and doctors, have been looking at this and specifically identified ways in which the current system is inefficient, and the President is looking at a range of options and will consider a range of options in order to do so.

Senator Brownback [continuing]. What number of Americans presently are not getting health care?

Dr. Rouse. I don't actually know the answer to that question.

Dr. Blank. I don't know. Some of the most recent data we have available is this data. Unfortunately, there is quite a lag on this; so we know who doesn't have insurance. That is a different question than who doesn't get health care.

Senator Brownback. That is correct.

Dr. Blank. Obviously a good number of people get some form of uncompensated care through emergency services. So I think the evidence is it is much more expensive to provide those goods and services.

Senator Brownback. But do you know of any data where we could collect that, what percent or what number of Americans are not getting health care?

Dr. Blank. The Medical Expenditure Survey does collect all sorts of information on exactly what type of health care over a period of time people do receive. So——

Senator Brownback. I want to know who is not getting health care.

Dr. Blank [continuing]. You mean the definition of both what is needed as opposed to what is received, and I don't believe we have a data set that does that clearly.

Senator Brownback. Are you working at that data set?

Dr. Blank. I know there is work inside the Department of Health and Human Services to improve some of their measures on this. They have a variety of more detailed health insurance and medical coverage and care surveys that they collect. I can't speak to the specifics of that.

Senator Brownback. It is pertinent and germane to the earlier question because you have got a system that—you cited the Gallup poll. I have seen a Gallup poll that says 80-plus percent of Americans are satisfied with their own health care. Maybe you haven't seen that one or I would be happy to provide that to you. And you have a huge amount of cross-subsidization taking place in this current system. And you are going to take $450 billion out of it in Medicare and Medicaid, and if you do that you are going to have a big impact on the system. I presume you are going to try to make it up on the other end of it as a proposal, but I wonder if you are going to really end up with a better system than if you would go incrementally at these pieces where we are now, trying to get at cost and get at coverage rather than let's go at a different system. And if you are going to pull that much money out of the current system on it, which I really—I will be very impressed to see getting $450 billion out of Medicare and Medicaid without impacting current coverage and support for it. And part of the proposal is to up Medicaid rates and coverages in the states, which is going to drive up costs to the states. I think this is a pertinent number to find both of those out because it is going to have a big impact on current recipients of health care in the system.

So I am hopeful we can get that number of Americans that are not currently getting any health care, or have some lack of coverage, and the impact that is going to have when you take $450 billion out of Medicare and Medicaid.

My time is up. I hope you could help us with some of those numbers.

Chair Maloney. Thank you, Senator.

Mr. Hinchey.

Representative Hinchey. I think it is very clear. We have a circumstance in health care where the price of health care is going up and the number of people who are able to obtain health insurance is going down. More and more people are losing their health insurance. We have a very dramatic set of circumstances there.

More than 46 million Americans without health insurance, and if they are getting health care, they are not getting it in a preventive way. They are getting it only when they are desperate and they can find their way into the emergency room of a hospital or some other situation. This is what is driving up the price of health

care in this country so dramatically and how it has risen so much over the course of the last decade.

I would like to ask you a question about income and equality. As I mentioned and as you mentioned, Dr. Blank, the households were economically worse off at the end of 2008 than they were in 2000. The situation got substantially worse over the course of those 8 years. You had real median household income in 2007 go down $324, or 0.6 percent below where it was in 2000. In 2008, real median household income in the U.S. fell 3.6 percent—from $52,163 in 2007, to just over $50,000 in 2008.

So the real median income for the wealthiest households in this country increased, and increased dramatically, between 2000 and 2007, while incomes for households at the middle and lower incomes declined. That is the situation that we have seen over the course of the previous 8 years. Income at the lowest 20th percentile fell 6 percent, $1,285; and at the 10th percentile it fell by 4.5 percent, $579. As a result of that, we have seen minorities experiencing the largest drop in household income between 2000 and 2007.

The income inequality remained unchanged in 2008.

I would just ask you if you can give us an answer to this question: What policies can be attributed to cause the situation for lower-income earners and minorities to have become worse off during that period of time between 2000 and 2008?

Dr. Blank. So there is enormous research literature in the economics profession, as you can imagine, trying to answer exactly that question. And I think that the consensus is that a good amount of this is simply shifts in the demand for different types of skills in the labor market, so that we have gone through an extended period where the demand for more skilled workers is rising quite rapidly and the demand for less skilled workers is falling. The result of that, in part, has been rises in the wages among more skilled workers, who are up near the top of the income distribution, and declines in the wages of less skilled workers, who are near the bottom of the distribution.

Now, there are other things happening as well in terms of shifts between the U.S. versus other countries. There are shifts in terms of unionization which—as unionization continues to decline, that reduces wages disproportionately among low-skilled workers.

So you see a number of trends happening out there, all of which have resulted in exactly these shifts. Some research suggests that at the very top of the distribution a disproportionate share of the very large income growth was occurring in the financial sector. That, of course, mirrors the whole bubble of the financial sector that we are all too well aware of, given what happened in 2008 when some of that broke.

Representative Hinchey. Ms. Rouse, any comments on that?

Dr. Rouse. I was also going to talk about the role that—it is very clear that what employers demand now are workers with strong analytical skills, strong interpersonal skills, skills that one acquires by not only completing high school, but actually going on to postsecondary education. So there is a very strong relationship between this rising inequality and the types of education that indi-

viduals have, which underscores the importance of a strong educational and training program.

Representative Hinchey. I assume that the change in Federal taxes in 2003 had an impact on that as well. It put more money in the hands of the wealthiest people, as we have seen, and it also caused a decline in the income and economic sustainability of middle-income and lower middle.

Dr. Blank. All the indications of people who have looked at the effects of those tax changes agree that is absolutely true. The data, you are looking at here, is pretax income, so this does not net out taxes. So the numbers you were citing would look even bigger if you took that into account.

Representative Hinchey. Thank you very much.

Chair Maloney. Mr. Brady.

Representative Brady. Thank you, Madam Chairman. Unfortunately, the numbers show that actually the top 1 percent wage earners actually gained more under President Clinton's years and ended up paying more taxes under President Bush's years. This sort of points, though, to the problem here which is, I think this new government is relying too much on funny numbers for important policy decisions.

The stimulus was a great example. We were promised that the unemployment rate would not go above 8 percent if we passed that bill. It is at 9.7 percent today and still growing. Said it would create an immediate jolt to the economy. We have lost another 2 million jobs.

And in the sector—I always follow the manufacturing and construction sectors because we were told by the Administration economists that the stimulus would disproportionately create new jobs in the manufacturing and construction sectors. In fact, they have lost 900,000 jobs since March. They have actually—the areas where the White House promised the big job gains have seen the biggest losses.

The stimulus, unfortunately, is slow. Too much of it is wasted and not focused on jobs, which is why the majority of Americans not only believe the stimulus isn't working, but it will make the situation worse for the country in future years.

The poverty numbers, I think, are equally flawed.

Dr. Blank, in testimony just last September before this committee you said, "There's widespread agreement that our poverty measure is badly flawed. It needs to be updated." You observed, "In the year since the current definition was developed, the biggest expansions in antipoverty assistance come through the tax system, such as expansion of the earned income tax credit, through in-kind benefits such as food stamps and Section 8. Because the historical poverty measure is based only on family cash income, it is unaffected by many of these changes."

You went on to say, "Why does this matter? Our measure of poverty rate is insensitive to many of the most significant policy changes designed to help low-income families that we've made in this country. In a fundamental way our poverty measure has undercounted policy gains."

Dr. Blank, do you still hold this position, that our poverty measure is badly flawed and needs to be updated?

Dr. Blank. Our official poverty measure measures only certain things and not others. It is a measure of pretax income, cash income. And pretax cash income is primarily what people get from their jobs. So in a recessionary period, when you lose a lot of employment, precash income tells you how much has been lost because of that loss of employment. In that sense it tells you something, but it does not measure the effect of a lot of the policies that we have in place.

Representative Brady. You would stand by that statement that this poverty measure is badly flawed and needs to be updated?

Dr. Blank. I strongly encourage people to look at the official measure as well as a variety of the alternative measures that the U.S. Census Bureau produces.

Representative Brady. Your position is this same?

Dr. Blank. I certainly will agree that you need to look at more than just the official poverty number.

Representative Brady. I don't have time to pin you down. I am just wondering, has it changed, or do you still have the same view?

Dr. Blank. I have the same view that we need to go beyond the official measure.

Representative Brady. Let me ask about the income measure, too, because I think this, too, has been, again, funny numbers.

One of the complaints both Democrats and Republicans have had about the No Child Left Behind program is that it measures class by class each year. It doesn't follow children from grade to grade to follow all the progress.

Our income numbers have the same flaw; as the Census Bureau has said, it is not a picture of what has happened to the same households over a time period. Medians like those from the current population survey conceal an enormous amount of movement in the income of individual households, and the numbers seem to prove the Census Bureau out, as their numbers show that about 60 percent of households in the middle fifth can exit in as little as 3 years.

So my question is, within the income data, why don't we update it or add another indicator that actually follows households so we can see what that growth in income truly is? It seems like we are taking snapshots of different parts of the horse race rather than the snapshot of the entire race that families are running.

Dr. Blank. Two answers to that. One is that the median household income, I think, answers a particular question that is different than what you are asking. It tells you what is the income level below which half of the people in 2008 lived. You can compare that to what is the income level below which half of the people in 2007 or 2006 lived.

That is actually an incredibly interesting statistic. It doesn't say that it is the same person in the middle of the distribution, but it does tell you what the well-being of America looks like in terms of where are people placed.

Your question about longitudinal data is right on. It is very important to follow households over time if you want to understand the dynamics of income distribution, who is moving up and who is moving down at any point in time. The Census Bureau has a major survey called the Survey of Income and Program Participation—

that they are in the midst of revising, actually, through long discussions and some additional appropriations from Congress—that does exactly that; it follows the same households for 3 to 4 years at a time.

Representative Brady. I think getting a more accurate picture that way will be helpful again as we delve into all the policy issues.

Madam Chairman, thank you.

Chair Maloney. I want to thank the gentleman for his questioning and certainly would join him in a letter to the Appropriations Committee for funding for a longitudinal study such as Dr. Blank put forward.

Also, I would like to ask both Dr. Blank and Dr. Rouse to put in writing to the committee—I think it is an important question—if you wanted to improve the poverty measure, how would you improve it? What else would you include in it?

I think that is something this committee and members on both sides of the aisle should take a look at. Maybe it could be the subject of another hearing.

Mr. Cummings.

Representative Cummings. Thank you very much, Madam Chair. Thank you all for your testimony.

The Chair had a report done recently on women and how women are affected with regard to health care and health insurance. One of the very interesting pieces of that report was they talked about women who may have been married and they—the husband was older. He then goes on to Medicare and there is a gap; and she may not have been working for a while or whatever, and it leads to—so she has to find insurance.

And I was just wondering, it is not just women, but how are the near-elderly fairing—I am just curious—with regard to poverty? Because we have got safety nets. Certainly, we have got Medicare and then, of course, you have got Social Security, but what about folks who come short of that age-wise?

Dr. Blank. This report does not do that type of age breakdown. Once we actually can go into the raw data and look at that, you can answer that question.

Here is what I do know, that the burden of job loss often follows disproportionately on people who are not quite at 65. They are people who lose their jobs. When they lose their jobs, they have a great deal of difficulty finding another job. They often retire early because of the difficulty of finding other jobs. The challenges they face include both income challenges as well as health insurance challenges, since they aren't yet eligible for Medicaid.

So if you look at displaced worker surveys, surveys of workers who have part of major plant closings, a disproportionate number of those who either never come up to the same income level again or never work again are exactly the group you are talking about, the workers over the age of 55 who have not yet hit eligibility for Medicare and Social Security.

Representative Cummings. Another issue, as far as the biggest changes in income and poverty, I am trying to figure out, geographically where have they been found? Does it always track the states with the highest unemployment, and do you track the pov-

erty rate with other data such as foreclosure rates and things of that nature?

Dr. Blank. The foreclosure rates don't figure into this report except as they affect income and poverty numbers. What you see is that the biggest increases in poverty and also the largest reductions in income are occurring in the Midwest and they are occurring over in the western states. That is absolutely consistent with both what we are seeing in our foreclosure data—some of the worst-hit states in foreclosure are in the West—and what we are seeing in unemployment data with some of the highest unemployment data are there in the Midwest, in the so-called Rust Belt, which is really feeling the effects of this recession on manufacturing.

Representative Cummings. So you are saying that it is consistent with unemployment then?

Dr. Blank. Yes. Unemployment and poverty tend to track each other reasonably closely.

Representative Cummings. Does the current census data show that expanding economic opportunity generally is a viable method of closing health care disparities and should, therefore, be seen as an important public health intervention?

Dr. Rouse. The report certainly shows that the rate of uninsurance among those that have been working is much lower than the rate of uninsurance among those who haven't worked in the prior year. Unfortunately, there is not more nuanced data, at least in this report, that would allow us to go beyond that.

Representative Cummings. The President said something last night that was very interesting, and—he said something to the effect that during a 2-year period one out of every three Americans had an insurance gap.

Why did you smile?

And that said a lot to me, because what that says is that we—I heard a lot of my Republican colleagues talk about this 47 million, but then you heard on any given day you may have up to 68 million people with no insurance. And that seems to be kind of consistent with that gap problem.

The gap problem also is significant in that as we get older, just in case people didn't know it, you are more likely to get a preexisting condition, and so therefore, if you have got a gap and you don't have COBRA or whatever, you have got a problem getting insurance.

Is that a fair statement?

Dr. Rouse. Absolutely.

The reason I smiled is because when we look at the census data that was released, it is one measure of how to think about uninsurance. But really a lot of the motivation for the President's plan is the fact that health insurance is unstable; and so if you look at data that tries to measure were you ever uninsured during the course of this year, the rate of those who have had a period of uninsurance is more like 71 million.

And so really it is much, much worse when we look at and consider the instability of the current health insurance market.

Representative Cummings. I see my time is up. Thank you.

Chair Maloney. Thank you.

Senator Casey.

Senator Casey. Thank you very much, Madam Chair. Thank you for allowing Senators to come over here to be a part of this hearing.

Chair Maloney. Thank you for being here.

Senator Casey. I do want to pick up on something that he said as well as what others said. I am glad he raised that question of health care because I have got a lot to say, but I have only got 4 minutes and I do want to get a question in.

Just with regard to the data, first, that you outline—and I appreciate both of you being here and your testimony and your public service. One of the things that I try to keep an eye on is, what are the differentials with regard to poverty or income, median income or poverty by race, for example. I think some of them are stunning and instructive about the challenge we have ahead of us.

I guess median household income fell 3.6 percent 2007 to 2008. That is all median income; is that correct?

Dr. Blank. That is right.

Senator Casey. African American households fell 2.8 percent and Hispanic households, 5.6 percent, correct? Big losses across the board.

The poverty rate numbers are maybe even more stunning. Sometimes that income number doesn't say much. But am I correct to say that between 2007 and 2008, poverty among the demographic category called Hispanic is up to now 23.2 percent?

Dr. Blank. That is correct.

Senator Casey. Almost a quarter. And among African Americans, unchanged in that year, but still even higher—24.7.

So in both groups you have got almost a quarter of them living in poverty, both African Americans and Hispanics. So it tells you something about the challenge we have coming out of a recession because, of course, this measure in 2007, when things were relatively, and in some cases, a lot better economically across the board, going into 2008.

But I would ask you if you can comment on that in the context of that time period and those numbers in relationship to where we are now in a recession, but contrary to what we have heard here today, the Fed saying today in an AP story that we are coming out of a recession. Unfortunately, a lot of people won't feel that for a long, long time—feel it in a positive way, because job loss will still be high.

Do you have anything you want to say about the time periods within which those numbers were measured?

Dr. Blank. The biggest impact of recession on poverty and income is through unemployment. And unemployment disproportionately hits lower-skilled and lower-wage workers; the people who lose their jobs are those who are lower wage, who are working part-time, who may be even trying to hold second jobs. So if you look at the distribution of unemployment, it is very skewed towards the bottom end of the income distribution.

What happens to income and to poverty is that disproportionately income declines and poverty goes up among exactly the groups of workers who tend to be low-income workers; and that is disproportionately single-female-headed households, persons of

color, people of Hispanic background, exactly the groups you are pointing to.

Senator Casey. And this is a hard question to answer. I know you can't answer with any precision, probably either of you, smart as you are.

But if we are looking at that 24.7 percent poverty rate for African Americans and 23.2 for Hispanics in that 2007–2008 period, if you could snapshot it today, meaning this part of 2009, you don't have to be an expert extrapolator to say that number is probably up in both instances; is that correct?

Dr. Blank. I would expect that to be true since unemployment has risen since the middle of 2008, which is the way to think about these numbers.

Senator Casey. I will use my remaining 30 seconds to just do a little bit of rebuttal on what we had heard on health care.

First of all, the Finance Committee in the Senate has not weighed in yet on a lot of the costs. That is their job to do. It wasn't the job of the President to outline specific cuts, specific ways to pay for this. The Congress still has a lot of work to do; we have got to get to work and get it done and give him a bill. That is point number one.

Point number two, for those who forgot, we spend $2 trillion every year—$2 trillion every year—on the health care system, and we are trying to fix it with a fraction of that. Another point we should make: that we are spending $2 trillion on a system that doesn't work for people. It denies them coverage and treatment on preexisting conditions; it discriminates against women; and it hammers them, as Dr. Blank said, with regard to out-of-pocket costs.

So at some point in time we are going to have to choose the team we are on here. We are either on the team that is moving forward with President Obama to fix a lot of what is wrong or you are on another team. And I will let others describe what team they are on.

In terms of how we can pay for it, it is going to be a long list of things. Tax policy is part of it. I have my own ideas about that. Antifraud measures are part of it. Prevention is part of it. Best practices are part of it.

The Geisingers, not to just brag about Pennsylvania, have figured this out in the private sector. The savings from prevention, the savings from how we manage disease better, all those savings and better health outcomes are not government theories; they have been proven in the private sector. What we are trying to do is take those really good ideas and make them the norm, not the exception.

So we can figure this out. We know how to do a lot of this. When I say we, I mean the American people; not government, the American people. We can figure this out. And for those who complain about government and government health care, which is about half of what the American people get—some kind of American health, thank goodness. Thank God we are smart enough to do that.

And I will end with this. One-third of rural kids in American get Children's Health Insurance or Medicaid, one-third of rural kids. So for those who are talking about cutting government and attacking government health care, they better think about a lot of people,

including rural kids in America; not just kids in big cities, but rural kids as well.

And I know what it is going to do to our state if we don't take action on health care. In the next 7 years the average family income is going to have to dedicate 52 percent of their income to health care. I don't know a family in Pennsylvania, or America—haven't met them yet, hope I never meet them—who will walk up to us and say, "Don't do anything about health care. Just let it go the way it is. I can pay 52 percent of my income to health care. Don't worry about me. I will be just fine and so will my family."

That is where we are headed, folks, if we don't do anything about health care.

Unfortunately, the numbers nationally are about the same: 52 percent of the income in Pennsylvania, 45 for the country. That is the direction we are headed right now, inexorably, undeniably, if we just sit back and say, "It got a little complicated. We couldn't do it."

Chair Maloney. Thank you so much, Senator Casey. Thank you very much for those words.

And I want to thank our distinguished panelists.

I now would like to introduce the second panel, but I first would like to note that the record will remain open for 2 weeks so that witnesses on this panel can revise their written testimony to include the new census data that was just released a few hours ago.

I would also like to ask unanimous consent to place in the record a statement by Nobel Laureate Joseph Stiglitz, a professor at Columbia University.

[The prepared statement of Joseph Stiglitz appears in the Submissions for the Record on page 58.]

Chair Maloney. First, we have Dr. Karen Davis with the Commonwealth Fund. Dr. Davis is a nationally recognized economist with a distinguished career in public policy and research. Before joining the Fund she served as chairwoman of the Department of Health Policy and Management at Johns Hopkins School of Public Health, where she also held an appointment as Professor of Economics. She served in the Department of Health and Human Services between 1977 and 1980 and was the first woman to head a U.S. public health service agency.

Dr. Harry Holzer is Professor of Public Policy at Georgetown University. Dr. Holzer was a founding director of the new Georgetown Center on Poverty, Inequality, and Public Policy. He is currently a Senior Fellow at the Urban Institute, a Senior Affiliate at the National Poverty Center at the University of Michigan, a National Fellow of the Program on Inequality and Social Policy at Harvard University, a Nonresident Senior Fellow at The Brookings Institution, and a Research Affiliate of the Institute for Research on Poverty at the University of Wisconsin at Madison.

Prior to coming to Georgetown, Professor Holzer served as Chief Economist for the U.S. Department of Labor and Professor of Economics at Michigan State University. He holds a Ph.D. in Economics from Harvard University.

Thomas Miller is a former Health Economist for the Joint Economic Committee between 2003 and 2006, where he worked on health care policy and regulation. Prior to joining the committee,

he worked as the Director of Health Policy Studies at the Cato Institute and as Program Director at Economic Policy Studies. Mr. Miller has also worked as a private attorney and as a journalist. He received his J.D. from Duke University School of Law and a B.A. from New York University.

I thank you all for coming and for your dedication to public service.

Chair Maloney. I would like first to call on Dr. Davis. Thank you.

STATEMENT OF DR. KAREN DAVIS, PRESIDENT, THE COMMONWEALTH FUND

Dr. Davis. Thank you, Madam Chairman, Senator Casey. It is a pleasure to be invited to testify at this hearing on income, poverty, and health insurance coverage.

This morning, the U.S. Bureau of the Census released the alarming news that the number of uninsured Americans hit 46.3 million, up from 45.7 million in 2007. This increase would have been much worse without the growth in government-provided insurance, a 4.4 million increase, including a 3.0 million increase in coverage under Medicaid. In contrast, employment-based coverage declined by about 1.1 million, down from 177.4 million in 2007 to 176.3 million in 2008.

Today's data release shows the importance of the Nation's safety net insurance system—Medicaid and the Children's Health Insurance Program, CHIP. The major bright spot in this new data was the fact that the rate of uninsured children is at its lowest since 1987, at 9.9 percent. This improvement was a reflection of increased coverage for children under government health insurance programs, which rose from 31.1 percent in 2007 to 33.2 percent in 2008.

However, more than 7.3 million children remain uninsured, which highlights the importance of the reauthorization and expansion of the CHIP program to 4 million more uninsured low-income children earlier this year.

States have also played an important role in stepping up to the plate to address the issue of the uninsured. Massachusetts, which enacted health reform in April of 2006, has moved into first place, with the lowest uninsured rate in the Nation. Today, we learned that in Massachusetts only 5.5 percent of the population was uninsured in 2008, compared with 25.1 percent in Texas, the state with the highest uninsured rate. Massachusetts leads the Nation as a result of its 2006 comprehensive health reform.

The most alarming news in today's census release is that the number of adults under age 65 without health insurance is high and rising, with 20.3 percent of adults ages 18 to 64 uninsured in 2008, up from 19.6 percent in 2007, an additional 1½ million uninsured adults.

There were about 1 million fewer people covered by employment-based coverage, down from 177 million to 176 million, and this included a marked decline in coverage among part-time workers. But even these numbers may be an understatement of the individuals affected by the severe and ongoing recession.

If census numbers are based on counts of people without coverage at any point in the year, these numbers—in other words, if people were insured early in 2008, and lost their coverage later in the year, they are counted as insured for 2008. So the continued rise in the unemployment rate in 2009 likely means many more uninsured in 2009.

Since the start of this decade, when 38 million were uninsured, health insurance coverage has steadily eroded—a jump in uninsured of 20 percent over the decade. Even before the severe recession, the number of uninsured was projected to grow to 61 million people by 2020. We simply cannot afford to continue on our current course.

This tragedy of gaps in health insurance coverage has real consequences for Americans—not just those who are uninsured, but those who are underinsured as well. Earlier, one of the members asked about people not getting the care that they need. The 2007 Commonwealth Fund Biennial Health Insurance Survey shows that 68 percent of the uninsured went without needed care because of cost. Uninsured and underinsured people with chronic conditions are less likely than people with health coverage to report managing their conditions, more likely to report not filling prescriptions or skipping doses of drugs and, as Mr. Hinchey noted, more likely to use emergency rooms and be hospitalized.

The health insurance system in this country is fundamentally broken. It does not accomplish what insurance was created to accomplish, ensure access to needed care and protect against the financial hardship that medical bills can cause. The deterioration in health insurance coverage has reached the point where financial hardship is not the exception, but the rule.

Our study shows that 72 million people report problems with medical bills or accumulated medical debts. More than three-fifths of them incurred those bills when they were insured, not when they were uninsured. In fact, a total of 116 million adults, two-thirds of those under age 65, are either uninsured at some point during the year, underinsured, or report difficulties obtaining needed care and paying their medical bills.

We pay a price for being the only major country without health insurance coverage. The Council of Economic Advisors estimates that covering the uninsured would result in a net increase in economic well-being totaling $100 billion a year. Coverage for all would increase the labor supply and level the playing field for large and small businesses.

Recognizing the seriousness of our flawed health insurance system, Congress began to take action early this year to cover more people who are at high risk. Reauthorization and expansion of CHIP will cover an estimated 4.1 million uninsured low-income children, in addition to the 7 million children already covered. The CHIP program has been a major success, as we see in the declining rate of uninsured children.

Provisions in the American Recovery and Reinvestment Act of 2009 are also helping prevent the loss of health insurance coverage as a result of the severe and sustained economic recession. The act provided $86.6 billion over 27 months to help states maintain and expand Medicaid enrollment as more unemployed working families

qualified for coverage. In addition, it provided a 65 percent premium subsidy to help recently unemployed workers retain their employer coverage under COBRA, a program Senator Kennedy helped establish in 1985.

Measures to help achieve health reform now under consideration in the Congress would also help with the long-term trend in the number of uninsured by creating health insurance exchanges by providing income-related premium assistance for individuals up to three to four times the Federal poverty level, by expanding the Medicaid program for those up to 133 to 150 percent of the poverty level, by having an essential benefit package with a cap on cost-sharing, and by sharing employer financing of coverage with special assistance for small businesses.

The Congressional Budget Office estimates that the House bill would reduce the number of uninsured people by 37 million people by 2019. The comprehensive reforms proposed by the President will help spark economic recovery, put the Nation back on the path to fiscal responsibility, ensure that all families are able to get the care they need while protecting their financial security.

The cost of inaction is high. The time has come to take bold steps to ensure the health and economic security of this and future generations. Health reform is an urgently needed investment in a better health system and a healthier and economically more productive America.

Thank you.

[The prepared statement of Karen Davis appears in the Submissions for the Record on page 59.]

Chair Maloney. Great.

Dr. Holzer.

STATEMENT OF DR. HARRY HOLZER, PROFESSOR OF PUBLIC POLICY, GEORGETOWN UNIVERSITY AND INSTITUTE FELLOW, URBAN INSTITUTE

Dr. Holzer. Thank you, Madam Chairwoman, Mr. Brady, and Mr. Cummings, for giving me the opportunity to speak to you today about the income and poverty numbers that the Census Bureau released this morning. I will focus on the income and poverty numbers exclusively and not on health care.

We now know that the years 2000 through 2007 represented a complete business cycle. And so comparing those two end years, 2000 and 2007, enables us to infer a secular trend in income and poverty that the Nation experienced for most of the current decade; and then the additional differences between 2007 and 2008 represent only the beginning of the most serious economic downturn since the 1930s.

There is a lot to discuss in this report. I am going to limit myself to four points.

Point number one: The numbers for the period 2000 to 2007 are really quite disturbing. Real median income failed to rise over the entire period and poverty did rise over that secular period. Indeed, the poverty rate rose quite substantially, by about 2 percentage points for certain groups like children and African Americans.

Quite disturbingly, these trends occurred while the Nation's overall productivity rose by nearly 20 percent. So both low-income and

middle-income American families failed to share in the economic prosperity generated by our economy in that 7-year period.

Now, of course, there are important questions about how these numbers are measured, as Mr. Brady pointed out earlier, and especially how we adjust for inflation and how we measure poverty. However, it is quite clear to me the faulty measurement does not likely account for these trends.

My second point: Between 2007 and 2008 the beginning of the current recession did cause real income to fall and poverty to rise. We have heard about a lot of those numbers already. The data do show that some groups, like Hispanics and Asians in some regions of the country, like the Midwest, were harder hit than others. I am most struck by the fact that the deterioration we have seen is very widespread and affects virtually all regions and all demographic groups.

Point number three: The worst is yet to come. Even if the recession officially ends this year, meaning that the production of goods and services and the economy begins to recover, the unemployment rate will continue to worsen for the rest of this year and into next year. That is because employment is a lagging indicator, with employers creating new jobs and hiring more workers only after they are confident of a strong recovery and product demand that cannot be met by their current workers and by the current inventories.

So real incomes will continue to fall and poverty will continue to rise certainly for 1 more year and maybe for a few more and almost certainly by more than we have witnessed so far between 2007–2008. In fact, I would predict that the biggest increases in poverty declines and income will occur during the next year, and it will likely take several years beyond 2010 before real income and poverty fully recover from the effects of this downturn.

Therefore, my fourth point is on policy: I think, in light of all these facts, economic policy over the next few years must focus both on the severe near-term impacts of the current recession and on the longer-term stagnation in the incomes of low- and middle-income Americans, with the greatest attention paid to those most vulnerable.

So how might we accomplish these twin policy goals? Over the next 2 years, I think we need to continue to focus on the downturn and ensure that workers who cannot find employment due to no fault of their own face an adequate safety net. That means that unemployment insurance will need to be extended beyond the provisions of this year's recovery legislation.

For low-income and part-time workers who are still ineligible for unemployment insurance—and there are a lot of them—other forms of cash assistance and food stamps and perhaps even community service jobs will need to be provided; and the states facing severe fiscal crises may need some additional assistance, as well, beyond what appeared in ARRA.

But we must also begin to implement policies that address the longer-term stagnation in the incomes of American workers and their families. When the economy and the labor market do begin to recover, jobs will be created that require more skills than most Americans currently have, and that is true even in positions that don't necessarily require a 4-year college degree, more in the mid-

dle of the skill distribution. Therefore, we need to invest more effectively in the education and the training of all of our workers through everything from high-quality prekindergarten programs, K through 12, into higher education and job training for disadvantaged youth and adults.

There are other approaches besides education and training that also might help, such as higher minimum wages and more collective bargaining, and these policy tools might be employed as well.

There will continue to be hard-to-employ, poor people whose skills and wages might not improve over time. For them, we need to create stronger incentives to work and supports when they do work, even at low wages. And, of course, I will say, echoing the previous speaker, that health insurance reform must remain a top priority, not only to ensure coverage for millions of families who now lack such protection or who might lose it, but to ensure that growing medical costs do not continue to absorb the earnings growth of increasingly productive American workers.

I will be happy to elaborate more on these points during the discussion period that follows.

Thank you very much.

[The prepared statement of Harry Holzer appears in the Submissions for the Record on page 78.]

Chair Maloney. Mr. Miller.

STATEMENT OF THOMAS P. MILLER, RESIDENT FELLOW, AMERICAN ENTERPRISE INSTITUTE

Mr. Miller. Thank you, Chairwoman Maloney, Congressman Brady, and all the members of the Joint Economic Committee. It is a pleasure and honor to be appearing before this body on the other side of the table as a witness on this important issue after previously serving on the committee staff for 3 years earlier this decade.

I didn't go into witness protection, though. I am currently a Resident Fellow at the American Enterprise Institute and quite visible on that front, I think.

To very briefly update my prepared testimony in light of this morning's release of the CPS supplement relating to health insurance coverage, we have already heard most of the statistical highlights. My takeaway points are: there is no noticeable, substantially significant trend that is a change from the past, and the deepest effects of the 2009 impact of the recession have not been fully captured in what, after all, are last year's data.

We may continue to avoid the worst that some imagine, but repairing the economy and restoring vigorous economic growth is job number one. However, we certainly also need to reform our overall health care system and particularly its many misaligned incentives to encourage improved value in health care services, enhanced information that is relevant and actionable, and better decision-making by all parties, including health care consumers.

We should and can redirect existing subsidies in a more targeted manner to assist better the most vulnerable members of the population, but the supply of resources for transfer payments is exhaustible. If everyone believes that someone else is paying most of their health care bills, those health costs will grow even higher in

the future while we run out of imaginary dollars to shuffle back and forth.

More actors in the system need to be able to find out what services and products and political promises actually are worth what they are said to be and determine what they, rather than someone else, would be willing to pay for them.

Now, turning to a few summary highlights of my prepared testimony, our various efforts to measure dimensions of the problems of the uninsured help to some degree, but they do remain inexact and less precise than sometimes assumed. Various sources of information, including the CPS, tell parts of a rather complex story with a number of subnarratives.

For example, I think I have heard some confusion here in describing what the CPS actually measures. It is right on the box on the opening page, which says, This is measuring, most of the time, a moment in time at which people are uninsured, rather than what was once assumed, measuring people being uninsured for the entire year.

They have been saying this for the last couple of years. Sometimes it doesn't get through. There are other surveys which give a more nuanced, elongated cross-sectional measure as to exactly how long someone has been uninsured.

The portion of the total number of uninsured on which we most need to focus are indeed the long-term, more chronically uninsured. That is a big enough problem as it is. The costs of health care are intertwined with the affordability of health insurance, and reforming the delivery system, as well as lessening the demands we place upon it, would deliver the most return on our investments in true reform.

I am not here to buy or sell, or cheerlead for or against any particular proposals on Capitol Hill today, unless you ask me to. However, some diversionary factoids of the uninsured debate need to be placed in perspective. The magnitude of alleged cost-shifting, for example, from the uninsured's receipt of uncompensated care to the premium costs of the privately insured has been overstated. So, too, is the relative burden of the uninsured imposed on our emergency care services.

We do need to fix a more limited problem of lack of coverage for the medically uninsurable, preferably with more transparent, targeted subsidies that cap maximum out-of-pocket exposure to high-cost medical conditions and with additional protections for those maintaining continued insurance coverage. Again, the magnitude of that significant problem has been overstated as well.

Although some would see underinsurance spreading throughout the majority of our current private health insurance policies, that perception does not square with the actual percentage of the U.S. health care spending dollar that continues to be paid through third parties rather than patients themselves.

We certainly can and must do better, but the most important changes will begin with improving how health care is delivered and how our personal health is maintained and improved.

Thank you.

[The prepared statement of Thomas P. Miller appears in the Submissions for the Record on page 80.]

Chair Maloney. Thank you very, very much.

I thank all of the panelists. I will begin the questioning first with Dr. Davis.

As you pointed out in your testimony, we have achieved almost universal coverage in medical care for elderly Americans through Medicare, and we are making tremendous progress toward ensuring all of our Nation's children. Why do you think there is such resistance to providing universal coverage for everyone else?

Don't working Americans that are struggling every day to make ends meet, don't they deserve health coverage too? Why is there such resistance, do you think?

Dr. Davis. It is shortsighted. There are health and economic costs of having people who are uninsured. If workers are uninsured, they are more likely to go without prescription drugs, for example, to control the chronic conditions, more likely to have complications of those conditions, whether it is a stroke from hypertension, amputation from diabetes; and as a result, they are going to become disabled and unable to work or, unfortunately, die prematurely as a result of being unable to get the care that they need. It is obviously an economic problem for the families themselves.

We find that there are 72 million adults, ages 18 to 64, who have difficulty paying medical bills or have accumulated medical debt. We ask about what are some of the consequences of that. They use up all of their savings, they take out credit card debt. They even take out home loans. They forgo other basic necessities to pay medical bills.

So these are serious economic problems for households and they are serious economic consequences for businesses and for the Nation as a whole.

As I said in my testimony, the Council of Economic Advisers estimates that we lose half of 1 percent of the gross domestic product because of this problem in our Nation.

Chair Maloney. Thank you very much.

Dr. Holzer, of all the troubling information in this new report, the one that troubles me the most is the continuing growing gap between the haves and the have-nots. How can we reverse this trend of increasing inequality in our Nation?

Dr. Holzer. I think since there are a variety of factors that contributed to that growing inequality, it will require a variety of policy responses.

I think it is very important, as some of the previous speakers suggested, to start with education and training and to invest more and more effectively, the entire range of education, starting with pre-K, going all the way up to higher education, and to give more middle-income Americans low-income Americans access to higher education.

But I think there are other things going on besides that. The economic outcomes we see in the job market are a function both of labor market trends and labor market institutions. Labor market institutions, like the minimum wage and collective bargaining, which historically have protected the lowest income Americans from the most severe effects of the markets, I think we have allowed those institutions to weaken too much over time. So I think we could do more on that front to bolster their protective effects.

Again, for those people who will face low wages no matter what they do, I think more income supports like expansions of the earned income tax credit, child care, transportation assistance and, of course, health care coverage, all those things would help to narrow the gap.

Finally, a lot of the growth and inequality has really occurred at the very, very, very top end of the income distribution, the top 1 percent, the top one-tenth of 1 percent. Of course, as Dr. Blank said before, some of that reflected the financial market bubble that has burst. I still sense those people are going to do very, very well for themselves even after that bubble is burst. There, I think there are financial market regulations to make compensation more effective in that sector, and returning to a more progressive tax structure. I think all of those things would start to address the problem you have just laid out for us.

Chair Maloney. Great answer, the best answer I have ever heard. I ask this to every official that comes before this committee and the Financial Services Committee. Great answer.

Families never recovered from the last recession before they got hit by the current downfall, did they? Is that true, they never had an opportunity to recover, and they were hit and really lost a decade of growth and opportunity?

Dr. Holzer. That is correct. Again, one can quibble with exactly the right way to measure this. Some people believe—I believe—that our measures of inflation that we used to adjust over time might be a little overstated, so if you adjusted for that, maybe they got back to the level they were at in 2000.

But as I emphasized before, we have had nearly 20 percent productivity growth over the 7-year period preceding the downturn. That is fairly stunning, almost unprecedented in productivity growth, and for none of that to show up in the median incomes of American families is truly a stunning development.

Again, I think there is no one reason for why that occurred. But what we can say is, policy did nothing to help. In some ways, tax policy made things worse. And I think starting to make sure that when we have a prosperous economy that is more widely shared really does need to be a top priority for economic policy.

Chair Maloney. I think the point in your testimony that even during the affluent years we didn't share the prosperity, we grew the disparity, is a really stunning report.

My time has expired, and I recognize my colleague, my good friend on the other side of the aisle, Mr. Brady.

Representative Brady. Thank you, Madam Chairman.

First, congratulations, Dr. Holzer, for being the best answer ever from the Chair. Put that in your resume starting right now.

Mr. Miller, what happened? The rate of children without health care coverage actually declined in 2008. When was the last time it was this slow?

Mr. Miller. I don't know that historically. What we have essentially proven is that we can insure the cheapest people to insure and have public coverage crowd out private coverage. That has some benefits to it in terms of covering more children, but those resources did not go to necessarily the place where people were most in need of health insurance and additional health care.

Representative Brady. I think one of the reasons the American public is now adamantly opposed to the new government-run plan is the deficit. Huge numbers, according to CBO, on top of Medicare's bankruptcy and the military, appropriately, plus all the huge deficits we are running today.

Do you agree with the CBO's appraisal that the Democrat health proposal would add hundreds of billions of dollars of Federal spending over the next decade?

Mr. Miller. Well, it is clear from the earlier CBO analysis that the proposals have not bent the cost curve down; they have turned it back up. And what is more disturbing—and there was just a report yesterday by way of the Petersen Foundation, done by the Lewin folks, which says you should not look at just the teaser rate.

Remember, this urgent crisis, we don't really do anything for 4 years, it is so important. Of course, there are a lot of bureaucrats to hire and regulations to write. So the cost of that first 10 years is really for 6 years of a phase-in period. And then, when you look beyond that period of time, as CBO pointed out as well, when you have those future costs growing again at a rate much more above the rate of the resources to support them, you are making the problem worse rather than better.

The early years will be tough enough, but the outyears will really kill us, all at a time where we are double counting what we say we are saving in Medicare to help Medicare beneficiaries, but actually we are spending it twice to also pay for this expansion. It is creative accounting. It makes a good speech, but double-entry bookkeeping still is done by some people.

Representative Brady. It does look like an adjustable rate mortgage or one of those zero interest credit card rates. The question is never, Can you afford the first payments? Can you afford them once it gets cranked up? And I think that is the public's concern as well.

A lot of people look at the maze of bureaucracy, 31 new Federal agencies, commissions and mandates in this bill. They worry that the bureaucracy imposed by this health plan will interfere between them and their doctors as they make decisions. Your view?

Mr. Miller. Well, that is probably why we need the first 4 years to fill all those boxes. It is going to take a while to staff it up.

Actually, beyond just the structure, what you always have to realize in legislation on Capitol Hill is—and I have worked on it—there are broad pieces of language which empower much more beyond that. All the regulations that fill in those details, the broad grants of discretionary authority to the health choices commissioner—interesting Orwellian title, but we can mean different things by that. Because you can do something and aren't prohibited from doing it, you have got a lot of time on your hands to make sure that you can get things just right when they didn't work the first couple of years.

So it is the empowerment of the multiple stages of later, follow-on regulation; just one more detail because we couldn't quite get it in legislative language, but we know eventually you folks—the round pegs—will fit into that square hole.

Representative Brady. Rationing is a concern by a lot of people, one they have seen occur in other government-run plans

around the world. They see it in the veterans' care today, where we have very long wait lines, very slow processing, especially disability cases, and even cut some veterans off. You see it in Medicare today, although it is a little more hidden then. You see it in rationing of physician reimbursements, for example.

Your thoughts about, will this new health care plan ultimately lead to rationing as the government in future years just doesn't have enough money to cover all these demands? Because we already know from Medicare and others this has occurred already. Your thoughts.

Mr. Miller. We can always do one thing and sacrifice other things and then you make those type of choices, but they tend to be someone else's choices rather than yours.

The real reaction to rationing is not the reality that resources are limited and you can't have everything, but it is who is going to make those choices. The rationing word really applies to more arbitrary, distant decisions that don't pay attention to what your needs and your preferences are, your conversation with those who are treating you, how do you use your family resources, as opposed to what seems to be a standardized pattern of, "Well, this works for most of the folks in the average population; fall into line."

So it is that resistance, not to the economic realities that the sky is not unlimited, but to distant, arbitrary, third-party decisions on what is the most vital set of decisions in everyone's personal life that is what is terrifying some Americans and certainly raising legitimate concerns among many more.

Representative Brady. Do we have real competition in the health care insurance today?

Mr. Miller. We could do better. We have a large number of insurance companies. And we can play games. I used to work in antitrust law. It is all how you define the market. You can make something look like a monopoly or look like it is perfectly competitive, depending on who is drawing the boxes.

There are ways to have more competition in health insurance. Part of it is thinking about reducing barriers to entry for more competitors, rather than creating one large competitor that gets to set its own prices and determinations. That is different from empowering other insurance companies or other ways to deliver care, such as through interstate purchasing.

But there are other ways as well to have more buyers and sellers than have the alternative of thinking a muscular public plan will be benign in its later years after it promises low prices at the start.

Representative Brady. Madam Chairman, I went over time, and, like you, want to see health care reformed, just have some differences in how to get there. Thanks.

Chair Maloney. I want to thank my colleague.

But I would like to ask Dr. Davis and Dr. Holzer to respond to Mr. Miller's comments on rationing and who makes the decision. Under the Democratic plan, the doctors and the patients are making these decisions, but I would like to hear your response if you would so wish.

Dr. Davis. Absolutely.

There is no provision that would ration care under health reform. In fact, if we look at the Medicare program, the surveys that we

have done of Medicare beneficiaries, a rate that it is much easier for them to get access to care.

And for people under age 65, they are much more satisfied with their care. They have a greater choice of physician. It is easier to get an appointment. I think we have got a long experience about access to care.

On the point about competition in the insurance market, in all but three states in this country, two insurance companies cover 50 percent of the enrollment or more. Mr. Miller said he has worked in antitrust. When I studied antitrust economics, our rule of thumb was if four firms control more than 50 percent of the market, you don't have a competitive market. We have two insurance companies controlling the market in all but three states.

And then the final point that I would like to make in response to Mr. Miller's comments is just a technical point about the definition of the uninsured in the report. What the census says is that people were considered uninsured if at any—if they were uninsured for the entire year. If they were covered by any type of health insurance at any point during the year, they were considered to be insured.

So these are not point-in-time estimates, and it is a problem with the recession, that if you had coverage in early 2008, lost your job and were uninsured at the end of 2008, you were not counted in these uninsured numbers because you had to have been without health insurance for the entire year to be counted as uninsured.

Chair Maloney. Thank you.

Dr. Holzer.

Dr. Holzer. Well, I want to be very careful in answering this because I think both of my colleagues here have much more expertise in health care. So I will tread very softly. I will just make a couple of quick comments.

Mr. Miller suggested that this proposal will not bend the cost curve down; it will bend it up. I think that is inaccurate. I think the right way to think about this is that again we do spend over $2 trillion a year right now. If we believe that an extra $90 billion would be spent every year covering the uninsured, that is an increase, that is a one-time permanent increase of about 4 percent. That would raise the whole curve up by 4 percent. But then if you do manage to restrain the growth in health care spending over time, let us say somehow we were very successful and brought that down by 1 percent a year, then after 4 years you have already offset the growth in costs associated with higher coverage, and then beyond that you are reducing that cost, not raising it. So I think we have to be careful to throw those allegations around.

Another thing is when one talks about the CBO estimates, quite frankly our entire profession sometimes needs to be a little more humble in some of the estimates it puts out there. And I would say this regardless of who is in charge of CBO. There is a lot of uncertainty about those estimates.

Now, Jon Gabel of NORC, the National Opinion Research Center, had a piece in *The New York Times* a week or two ago saying that there is a long history of CBO understating cost savings in Medicare associated with policy changes. And, you know, the errors—if the errors bounce around, sometimes they are bigger, sometimes

they are smaller, then they net out. But what we are saying is CBO has consistently underestimated. And it is very hard. Look, it is not a big criticism of CBO. It is very hard to know what a lot of these savings, the exact magnitude they will generate. And I don't think the CBO model is really in a position to cost out a lot of potential reductions. So some of the CBO projections are a little bit disturbing, but I think we need to be careful and not put too much weight on those as we discuss the possible savings.

Mr. Miller. If I may, I will be very brief.

Chair Maloney. Sure.

Mr. Miller. The issue of the antitrust analysis is the local market, not the state. Some antitrust people have actually written about this in Health Affairs, Bill Kovacic, David Hyman. It is a game. The big box of the state is not relevant to what is going on in the local markets.

The language in the current CPS survey, I want to quote it directly, no interpretation whatsoever: This "estimate in the number of people without health insurance more closely approximates the number of people who were uninsured at a specific point in time during the year than the number of year of people insured for the entire year."

That is not my language. That is written in the report by the authors.

Finally, Jon Gabel had a very truncated analysis of CBO's performance. It bounced all over the lot, and they have gone in the other direction in other evaluations as well. I can find plenty of other folks who will tell you these costs are going up and we haven't yet made a serious effort to actually change what is the trajectory of what is projected. We are actually aggravating the problem rather than making it better.

Chair Maloney. I want to thank all of you. I wish every Member of Congress had not been in another meeting and was able to hear your testimony today. But I would like, Dr. Davis, for you to put in writing for the committee, because I would like to circulate it to my colleagues, your statement that every state in the Union, save three, have only two insurance companies controlling more than 50% of the market, therefore there is not adequate competition. I think that is astonishing.

In any event, I know that many of you worked very hard to get here and came long distances. I want to thank you for being here. I want to thank you for your service to this committee and to your universities, to government, to the private sector, all the things you have done with your distinguished careers, and for really talking about this very important indicator of family well-being. This committee will continue to focus on improving the standard of living of Americans. Your testimony has been incredibly valuable. Thank you so much for being here.

The hearing is adjourned.

[Whereupon, at 3:06 p.m., the committee was adjourned.]

SUBMISSIONS FOR THE RECORD

PREPARED STATEMENT OF CAROLYN MALONEY, CHAIR, JOINT ECONOMIC COMMITTEE

I want to thank our witnesses for joining us today to discuss the 2008 official government statistics on income, poverty, and health insurance coverage that were released this morning by the Commerce Department's Census Bureau. These are among the most important indicators of family well-being, and the picture from 2000 to 2008 is rather grim.

Between 2000 and 2008, median household income fell by nearly $2,200, the number of Americans living in poverty grew by 8.2 million, and nearly 8 million people joined the ranks of the uninsured.

American families have lost a decade due the failed economic policies of the Bush administration.

Nearly one year ago, this committee held a hearing at the request of the late Sen. Edward Kennedy on poverty in America. Sen. Kennedy devoted his career to being a strong and vocal champion for the poor. Although we have lost the beloved liberal lion of the Senate, his dream lives on in us and we will continue his work on behalf of the less fortunate.

The economic fortunes of most Americans tend to rise and fall with the strength of the economy. During the economic expansion of the Clinton era, when unemployment hovered at around 4 percent, poverty fell to 11.3 percent, its lowest level in decades.

However, the weak economic recovery of the 2000s under the previous Administration did not lead to a further reduction in poverty, which now stands almost two full percentage points above its 2000 level.

Today in the United States, one out of every 8 people—almost 40 million—lives in poverty. The majority of people living in poverty are among the working poor. Worse still, 19 percent of our children, or almost one in five, now lives in poverty.

Median household income fell to $50,303, the lowest level since 1997, which means that the typical American family actually lost economic ground during the last recovery. Our economy may have grown, but those gains did not trickle down to the vast majority of families and the chasm between the "haves" and the "have nots" grew larger.

Too many jobs do not pay enough or lack the benefits to ensure families can make ends meet.

Over one quarter of U.S. jobs pay low wages and do not provide health insurance or a retirement plan, according to the Center for Economic and Policy Research.

Today's data on health insurance coverage are a sobering reminder of the impact of our broken system on American families. 46.3 million Americans are uninsured, a figure that rose 20.6 percent between 2000 and 2008. Nearly one in ten children are growing up without health insurance, and over 30 percent of Hispanics lack coverage.

The share of Americans with private health insurance eroded precipitously over the eight years of the Bush Administration, as the cost of providing employer-based coverage crept steadily upwards.

Insurance premiums charged to employers increased by more than 100 percent between 2000 and 2008. The 2008 data reflect the first year of the Bush recession, but the legacy of his Administration's failed economic policies has continued to wreak havoc on families.

Recent estimates suggest that continued increases in the unemployment rate between January 2009 and August 2009 mean that over 2 million more Americans have joined the ranks of the uninsured so far this year.

The time for comprehensive health insurance reform is now. As the data show, our nation's families simply cannot afford to wait any longer.

America's Affordable Health Choices Act (H.R. 3200) includes provisions that will stop the rise in uninsured Americans by making affordable, comprehensive coverage available to all citizens.

The bill includes subsidies for low- and moderate-income families to purchase health insurance coverage, as well as a well-designed health insurance exchange.

Within that health insurance exchange, Americans will have the option of choosing between private insurers or choosing a public option.

The inclusion of a public option is key to promoting competition and bringing down costs—and competition and cost-control is key to reversing the distressing trends in un-insurance that we have seen year after year in the Census data.

I look forward to the testimony of our witnesses.

PREPARED STATEMENT OF REPRESENTATIVE ELIJAH E. CUMMINGS

Thank you, Madam Chair:

Today's Census Bureau report is a stark reminder of the economic inequalities that continue to permeate our society.

While the current recession has been "equal opportunity"—impacting almost every sector of the economy and crossing racial and geographic boundaries—it has also widened the growing gap between society's "haves" and "have-nots."

The inequalities that persist are disappointing, disheartening, and given the policies pursued by the previous administration, foreseeable.

Eight years of blind adherence to deregulation and supply-side policies resulted in reduced income for African-Americans and Hispanics, continuing gender pay inequality, and an increasing number of children born into poverty.

As my colleagues know, I have never been one to mince words, and today is no exception. I remain *outraged* at the outlook facing so many American children.

According to the Anne E. Casey Foundation, between 1994 and 2000, the child poverty rate fell by 30 percent. This was the largest decrease in child poverty since the 1960s.

Key children's health indicators improved across every major racial group, and in nearly all of the states. Since 2000, however, child poverty has increased so that roughly 2.5 million more children lived in poverty in 2008 than in 2000. That is 2.5 million children who have been left behind in the wealthiest nation in the world.

In my home state of Maryland, approximately 133,000 children live below the poverty line. Another 209,000 live at 125% of poverty.

Through no fault of their own, these children find themselves questioning when, *or if*, the next meal is coming.

A young man from Maryland named Deamonte Driver is a tragic example of how vulnerable our children are.

In 2007, Deamonte needed an $80 tooth extraction to fix a painful abscess. Without access to dental treatment, the abscess went untreated, and predictably, became infected.

The infection spread to his brain and ultimately took a 12 year old from us. Deamonte *died* because he could not get $80 worth of treatment.

143 million Americans find themselves without dental coverage. And while every one of them is at risk of serious health problems, again the most defenseless and vulnerable are our nation's children and young adults.

To that end, I appealed to my colleagues in Congress to guarantee that dental coverage was included in the recent state Children's Health Insurance Program. I am pleased that this legislation was included in the S-CHIP bill that President Obama signed into law.

I know that today's report does not measure the impact of S-CHIP, the Stimulus, and other actions taken to assist the families who are most in need in our country.

However, the report does underscore and reinforce the need for and timeliness of these actions.

Not only is poverty increasing, but state and local governments cannot bear the brunt of the crisis, and the public resources upon which the working class depend are becoming scarce.

As we saw earlier this summer, 18 states have been forced to borrow over $12 billion from the federal government to maintain their unemployment funds.

Further, the essential Temporary Assistance to Needy Families has become increasingly unavailable under the weight of continuing economic turmoil.

Despite this dismal outlook, we are seeing signs of hope—unemployment has held relatively steady over the last few months, and the Labor Department announced this morning that initial jobless claims were fewer than expected.

However, today's report reminds us why continued decisive action by the Congress is required, as well as a commitment to understanding the real impact of past policies on those who are most at risk.

So, I look forward to the testimony of all our witnesses today and a productive discussion—the stakes for our families have never been higher.

With that, I yield back.

MICHAEL C. BURGESS, M.D.
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JOINT ECONOMIC COMMITTEE

CONGRESSIONAL HEALTH CARE CAUCUS,
CHAIRMAN

September 23, 2009

The Honorable Rebecca Blank
Under Secretary for Economic Affairs
U.S. Department of Commerce
1401 Constitution Ave., NW
Washington, DC 20230

Dear Ms. Blank:

Thank you for your appearance before our Joint Economic Committee on September 9, 2009. Your remarks regarding the subject of "Income, Poverty, and Health Insurance Coverage: Assessing Key Census Indicators of Family Well-Being in 2008" were insightful; however, I do have a follow-up question. **How many of those who get treated at federally qualified health centers are insured? Uninsured?**

I look forward to receiving your response.

Sincerely,

Michael C Burgess, M.D

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JOINT ECONOMIC COMMITTEE

CONGRESSIONAL HEALTH CARE CAUCUS,
CHAIRMAN

September 23, 2009

The Honorable Cecilia Rouse
Member, Council of Economic Advisers
Executive Office of the President
725 17th Street NW
Washington, DC 20502

Dear Ms. Rouse:

Thank you for your appearance before our Joint Economic Committee on September 9, 2009. Your remarks regarding the subject of "Income, Poverty, and Health Insurance Coverage: Assessing Key Census Indicators of Family Well-Being in 2008" were insightful; however, I do have a follow-up question.

In your testimony, you could not recall how President Obama would find the approximately 900 billion dollars in offsets to fully pay for his health care plan without increasing the deficit. Please give us a breakdown of exactly where the $900 billion in funds will be offset in current programs. For example, you stated that $450 billion in cuts will come from Medicare and Medicaid. Please state with specificity what program, in what agency, in what dollar amount, per year, these cuts will come from.

I look forward to receiving your response.

Sincerely,

Michael C Burgess, M.D

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EXECUTIVE OFFICE OF THE PRESIDENT
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MEMBER

November 3, 2009

The Honorable Michael C. Burgess, MD
229 Cannon House Office Building
Washington, DC 20515

Dear Dr. Burgess:

I am pleased to provide a response to your follow-up question regarding my testimony during the hearing of the Joint Economic Committee on September 9, 2009, entitled "Income, Poverty, and Health Insurance Coverage: Assessing Key Census Indicators of Family Well-Being in 2008."

You asked for clarification regarding offsets in current programs to finance Health Insurance Reform proposals supported by the Administration. The Administration is working closely with members of Congress to advance legislation for health insurance reform that provides stability and security for the American people, and upholds the President's commitment that reform will not add to the federal deficit. To that end, the President has identified specific sources of savings and revenue totaling $948 billion for a Health Care Reserve Fund to fully finance health reform.

Specifically, the budget for the Department of Health and Human Services (HHS) for Fiscal Year 2010, published in May, contains an historic commitment to making the Medicare and Medicaid programs more stable and efficient by identifying $309 billion in savings dedicated to a reserve fund to finance health insurance reform. The sources and timeframe of these savings and efficiency reforms are outlined line-by-line in Table 1 at the end of this letter, and described in further detail in the HHS FY 2010 budget-in-brief document available online. In addition, the FY 2010 Budget also includes revenue proposals totaling $326 billion that would be put into a Health Care Reserve Fund. In addition to savings outlined in the FY 2010 budget, the President has identified an additional $313 billion in savings. These additional savings are outlined in detail in Table 2 at the end of this letter.

In summary, through a combination of savings on current programs and fiscally responsible revenue increases, the Administration has identified a total of $948 billion in financing over the next ten years to meet the President's commitment that health insurance reform will not add to the deficit. Importantly, the draft legislation that has passed the five committees in Congress each contains different sets of savers and new revenues to finance health insurance reform. The President looks forward to working with the Congress to arrive at a reform package that optimally balances the goals of cost containment, expanded coverage, and improvements in quality while not adding a dime to the deficit.

Sincerely,

Cecilia Rouse

cc: The Honorable Carolyn B. Maloney
Chair, Joint Economic Committee

Table 1. Savings on Medicare and Medicaid to Finance Healthcare Reform in the FY 2010 Budget

Medicaid Proposals to Finance Health Care Reform ($ millions)	2010	2010-2014	2010-2019
Increase Medicaid Brand-name Drug Rebate from 15.1% to 22.1%.....	-250	-2,120	-5,090
Extend Drug Rebates to Medicaid Managed Care Organizations.....	-770	-3,810	-8,770
Apply Additional Rebate to New Formulations of Existing Drugs.....	-150	-1,270	-3,050
Interaction of Medicaid Drug Rebate Proposals.....	-270	-1,320	-3,040
Mandate National Correct Coding Initiative.....	-10	-175	-620
Expand Medicaid Family Planning Services.....	--	-5	-65
Pathway for FDA Approval of Generic Biologics: Medicaid Impact...	--	-10	-350
Reallocate Medicaid Improvement Fund.....	--	-100	-700
Total, Medicaid Proposals to Finance Health Reform	**-1,450**	**-8,810**	**-21,685**

Medicare Proposals to Finance Health Care Reform ($ millions)	2010	2010-2014	2010-2019
Align Incentives Toward Quality:			
Encourage Hospitals to Reduce Readmission Rates.....	0	-2,450	-8,430
Create Hospital Quality Incentive Payments.....	0	-2,980	-12,110
Encourage Primary Care Physicians to Administer the Flu Vaccine.....	0	0	0
Enable Physicians to Form Voluntary Groups that Coordinate Care.....	*	*	*
Subtotal, Align Incentives Toward Quality	0	-5,430	-20,540
Promote Efficiency and Accountability:			
Establish Competitive Bidding for Medicare Advantage.....	0	-47,590	-177,200
Bundle Payments Covering Hospital and Post-Acute Settings.....	0	-820	-16,100
Address Financial Conflicts of Interest in Physician-Owned Hospitals.....	*	*	*
Ensure Appropriate Payments for Imaging Services using Radiology Benefit Managers	0	-70	-250
Improve Home Health Payments to Align with Costs.....	-460	-12,150	-34,070
Improve Medicare Payment Accuracy.....	-60	-750	-2,100
Establish Pathway for FDA Approval of Generic Biologics /1.....	0	20	-6,000
Reallocate Medicare Improvement Fund.....	0	-23,130	-23,130
Subtotal, Promote Efficiency and Accountability	-520	-84,490	-258,850
Encourage Shared Responsibility:			
Establish Income Related Part D Premium Consistent with Part B Policy.....	0	-2,410	-8,070
Subtotal, Encourage Shared Responsibility	0	-2,410	-8,070
Total, Medicare Proposals to Finance Health Care Reform	**-520**	**-92,330**	**-287,460**
Total, Medicare and Medicaid Proposals to Finance Health Care Reform	**-1,970**	**-101,140**	**-309,145**

Source: Department of Health and Human Services Fiscal Year 2010 Budget in Brief, May 7, 2009. http://www.hhs.gov/asrt/ob/docbudget/2010budgetinbrief.pdf.

Paying for Health Care Reform: New Savings

The President has insisted that reform be deficit-neutral based on real savings and revenue estimates as determined by impartial scorers. Thus, in addition to the proposals included in the FY 2010 Budget, the Administration has put forward policy options to further rein in federal health spending, make the system more efficient, and deliver better quality of care.

Table 2. Additional Savings to Create a Deficit-Neutral Plan	2010-2019 ($ millions)
Incorporate productivity adjustments into Medicare payment updates ($ millions)	-110,000
Reduce hospital subsidies for treating the uninsured as coverage increases	-106,000
Pay better prices for Medicare Part D drugs	-75,000
Other	-22,000
Total, Additional Medicare and Medicaid Savings	**-313,000**

Source: Whitehouse.gov. "Paying for Health Care Reform: $313 Billion in Additional Savings to Create a Deficit Neutral Plan." http://www.whitehouse.gov/MedicareFactSheetFinal/.

- **Incorporate productivity adjustments into Medicare payment updates.** Productivity in the U.S. economy has been improving over time. However, most Medicare payments have not been systematically adjusted to reflect these system-wide improvements. We should permanently adjust most annual Medicare payment updates by half of the economy-wide productivity factor estimated by the Bureau of Labor Statistics. This adjustment will encourage greater efficiency in health care provision, while more accurately aligning Medicare payments with provider costs.

- **Reduce subsidies to hospitals for treating the uninsured as coverage increases.** Instead of paying hospitals to treat patients without health insurance, we should give people coverage so that they have insurance to begin with. As health reform phases in, the number of uninsured will go down, and we would be able to reduce payments to hospitals for treating those previously uncovered. This would be done by establishing a new mandatory mechanism to better target payments to hospitals for unreimbursed care remaining after coverage increases. Beginning in FY 2013, payments would be gradually phased down so that by 2019, funding would equal 25 percent of Medicare/Medicaid Disproportionate Share Hospitals (DSH) funding in 2013, and updated by inflation.

- **Pay better prices for Medicare Part D drugs.** In its meeting with the President and subsequent communication, the pharmaceutical industry has committed itself to helping to control the rate of growth in health care spending. There are a variety of ways to achieve this goal. For example, drug reimbursement could be reduced for beneficiaries dually eligible for Medicare and Medicaid. The Administration is working with the Congress to develop the most appropriate policy to achieve these savings.

Other Savings

- **Adjust payment rates for physician imaging services to better reflect actual usage.** To provide more accurate payment for physician imaging services, the Department of Health and Human Services would increase the equipment utilization factor for advanced imaging (such as magnetic resonance imaging (MRI) and computed tomography (CT) machines) from 50 percent to 95 percent. This proposal – which is closely aligned with a Medicare Payment Advisory Commission (MedPAC) recommendation – would better reflect how these technologies are actually used.

- **Adopt MedPAC's recommendations for 2010 payments to skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals.** To bring down costs and maintain quality, we should update payments based on MedPAC's consideration of multiple variables, such as quality, access to care, and adequacy of payment. Doing so would implement MedPAC's 2010 payment recommendations for skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals.

- **Cut waste, fraud, and abuse.** It is important that patients get the best care, not just more care. Unnecessary treatments are not only expensive, but also can harm the health of the patient. To discourage physicians from ordering unnecessary or excessive treatment, we should increase the scrutiny of physicians in high-risk areas or those that order a high volume of high-risk services (such as home health, durable medical equipment, and certain infusion drugs) through additional pre-payment review.

Understanding the Recently Released Data from the Census Bureau, Showing Income, Poverty and Health Insurance Coverage for 2008

Testimony by
Rebecca M. Blank
Under Secretary for Economic Affairs
U.S. Department of Commerce
before the
Joint Economic Committee
September 10, 2009

Madam Chairwoman, Ranking Member Brady, and distinguished members of the Joint Economic Committee, thank you for inviting me here to discuss the income, poverty and health insurance data released today by the U.S. Census Bureau at the Department of Commerce. Today's data release provides detailed information on income, poverty, and health insurance coverage among American families during 2008.

I am certain that I do not need to remind you that 2008 was not a good year economically. The recession officially started in January of that year. GDP fell by 1.9% over the year and employment fell by 2.2%, while the unemployment rate rose from 4.9% of the labor force to 7.2%. The last half of the year was particularly difficult, with gas prices that reached over $4/gallon in mid-summer, a virtual collapse in the financial sector in the fall, and the start of a global recession. Under these circumstances, it is not surprising that the news in today's data release is not good.

Income

The data released today indicate that between 2007 and 2008, real median household income fell 3.6%, from $52,163 to $50,303. This is the lowest level recorded since 1998, indicating there was little growth in median income over the past 10 years. Median income fell among all families, and among all race and ethnicity categories. Income inequality remained largely unchanged during 2008. Both men and women's earnings declined. These income changes were in part driven by declines in real median earnings of full-time workers.

Poverty

The poverty rate rose from 12.5% in 2007 to 13.2% in 2008, with 39.8 million individuals living in families whose incomes were below the Federal poverty line. This is the highest poverty rate since 1997. Poverty increases were particularly large among Hispanics and among non-citizens. Also, poverty increases were concentrated in the Midwest and in the West. A bit of good news is that the elderly experienced no increase in poverty during 2008.

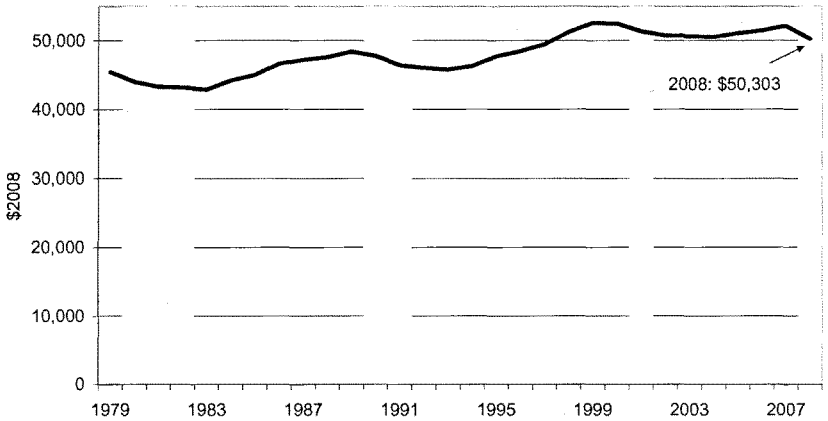
Health Insurance

The number of Americans who were not covered by health insurance rose from 45.7 to 46.3 million, although the share of the population that was uninsured stayed relatively constant at 15.4%. (I will say little about the health insurance coverage numbers in this report, since they will be discussed by my colleague Dr. Rouse.)

Long-term Trends

These 2008 numbers are better understood when they are put in the context of the historical trends. Let me talk first about the trends in income and then turn to poverty.

Figure 1
Real Median Household Income: 1979-2008
(2008 Dollars)



Note: The shaded areas represent recessions.

Figure 1 shows how real median household income has changed from 1979 through 2008. The darker areas in the graph show recession years and highlight how income has changed following the recession of the early 1980s, the recession of the early 1990s and the recession of 2001. This is particularly interesting since we are quite concerned with income growth as we emerge from the recession of 2008-09. It is clear that income rose over the entire 1979-2008 period, but most of this increase occurred during the expansions of 1982-1990 and 1991-2000. Table 1 indicates that median income rose 10.7% in the expansion following the recession years of the early 1980s, and rose 13.0% following the 1991 recession. But the expansion of the 2000s was very different. It was not until 2007 that median household income was as high as it had been in 2000. Median household income rose only 1.6% during the expansion between 2001 and 2007. With the economic turndown in 2008, we are back to a level of median income similar to where we were 10 years ago. In short, while the 2008 declines in median income are discouraging, they are even more discouraging when placed in the context of the past

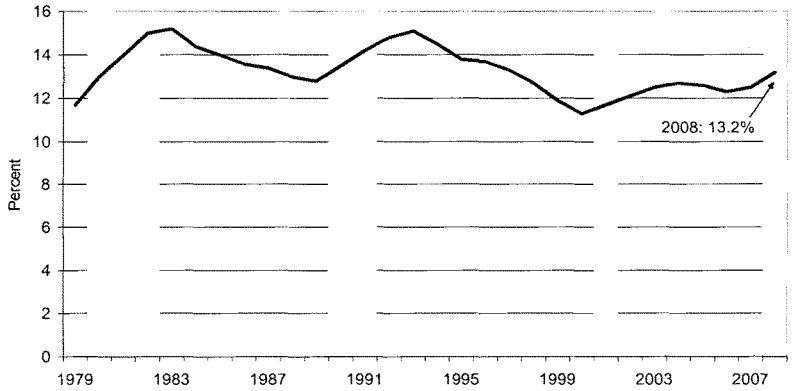
eight years. Middle-income American households made no gains in income over this time period.

Table 1
Trough-to-Peak Changes in Income and Poverty in Three Recent Recessions

	Real Median Household Income	Poverty Rate
	Percent Change	Percentage Point Change
1982-1990	10.7	-1.5
1991-2000	13.0	-2.9
2001-2007	1.6	0.8

We see a similar pattern when we look at poverty rates. Figure 2 shows the poverty rate from 1979 through 2008. As the figure shows, the poverty rate always rises steeply during recessions, but falls during expansions. As Table 1 indicates, poverty fell by 1.5 percentage points during the expansion of the 1980s and by almost 3 percentage points during the expansion of the 1990s. In the recession of 2001, poverty went up as anticipated, but never really came down. Rather than falling, poverty rose by eight-tenths (0.8) of a percentage point during the expansion of the 2000s, so that a higher share of the population was poor in 2007 than in 2001. The 2008 data show a further steep upward increase, as expected in a recession year. But the fact that the expansion of the 2000s did nothing to reduce poverty means that the increases in 2008 are off a higher base.

Figure 2
Poverty Rate: 1979-2008



Note: The shaded areas represent recessions.

Clearly, the bad news about income and poverty in today's data release mirrors the bad news throughout the economy in 2008. The reduced income and higher poverty numbers

directly reflect the increases in unemployment over 2008 that lowered earnings among American families.

But we are already seeing some signs of recovery in the economy and private-sector forecasts all predict positive GDP growth during the second half of this year. I expect that the economy will not show the same declines from 2008 into 2009 as it did between 2007 and 2008. Unfortunately, even with an improving economy, the higher unemployment rates during 2009 will almost surely lead to further declines in income and further increases in poverty. Unemployment lags the business cycle and until job growth is strong, income will not recovery.

The long-term challenge is to assure that the economic recovery that we are entering brings better economic times to all Americans, with increases in income throughout the income distribution. Greater earning opportunities among lower-income workers provides the best way to assure future declines in poverty.

This Administration, since taking office at the beginning of 2009, is working on a host of policies designed to improve the lives of American families. We are focused on improving educational opportunities from preschool through college; reforming health care so that all Americans have access to insurance and families are not bankrupted by health emergencies; and helping to create a growing sector of Green Businesses and Green Jobs, to both improve energy efficiency and employ more Americans in jobs that make the environment healthier for us all. Furthermore, the stimulus package approved by Congress this past winter, raises incomes and helps create jobs, improving family well-being in 2009 relative to what it would have been without this additional assistance.

Today's data tell us what we already knew: 2008 was not a good year economically for Americans. Fortunately, this is old news. There are signs of economic recovery throughout the economy, aided by the measures that Congress and this Administration have taken to restore credit markets and stimulate economic growth. We have good reason to believe that the news in future years will be better.

THE FIRST YEAR OF THE RECESSION: KEY CENSUS INDICATORS OF FAMILY WELL-BEING IN 2008 AND THE ADMINISTRATION'S POLICY RESPONSES IN 2009

Cecilia Elena Rouse
Member, Council of Economic Advisers

Testimony before the Joint Economic Committee
September 10, 2009

Chair Maloney, Vice Chairman Schumer, Ranking Members Brady and Brownback, and members of the Committee, thank you for inviting me to join you today to discuss the Census Bureau's release of data on income, poverty, and health insurance coverage in the United States in 2008.

The data released today provide an important piece of our overall understanding of the economic conditions that existed during the first year of the current recession. Based on survey data of households last March regarding their income and health insurance coverage during the 2008 calendar year, the data confirm what we had already surmised: along with rising unemployment, last year families were trying to get by with less income, many more had slipped into poverty, and the number of people without health insurance continued to increase. These data confirm that the economic recession was well underway in 2008.

These trends reinforce the need to expand health insurance coverage to more Americans as would be achieved through the President's plan for health insurance reform. They also provide a new lens through which to view the critical importance of the American Recovery and Reinvestment Act of 2009 (ARRA) and many other programs proposed by President Obama designed to help increase incomes, reduce poverty, and pull the economy out of recession.

In my remaining testimony, I would like to first discuss the trends in health insurance coverage in the Census report as well as the implications for health insurance reform as articulated by the President last night. I would then like to review some of the Administration's policies designed to increase incomes and reduce poverty.

Trends in Health Insurance Coverage and the Importance of Health Care Reform

The data released by the U.S. Census Bureau today shed light on the health insurance coverage of U.S. residents during 2008. Survey respondents were considered to be insured if they reported that they were covered by any type of health insurance for all or part of the 2008 calendar year. According to the new Census Bureau estimates, the number of individuals without health insurance increased significantly, from 45.7 million in 2007 to 46.3 million in 2008. The Census data also indicate that the fraction of U.S. residents without health insurance stood at 15.4 percent in 2008, a rate that was slightly higher than that in 2007 and substantially greater than the

rate in 2000 (13.7 percent). The estimated number of U.S. residents without health insurance increased by 7.9 million from 2000 to 2008.

Employment-based Health Insurance Continued to Decline in 2008

These overall changes mask important differences by the type of health insurance that individuals have. The fraction of U.S. residents with employment-based health insurance declined significantly, from 59.3 percent in 2007 to 58.5 percent in 2008, continuing a trend from the past several years. As shown in the following table, there has been a 5.7 percentage point decline in the fraction of U.S. residents with private employment-based health insurance since 2000.

Table 1: Distribution of Types of Health Insurance Coverage among U.S. Residents in 2000, 2007, and 2008 (percentage)

Type of Health Insurance	2000	2007	2008	Δ 2000-08	Δ 2007-08
Any Private Plan	72.6	67.5	66.7	-5.9	-0.8
Employment-Based	64.2	59.3	58.5	-5.7	-0.8
Direct-Purchase	9.6	8.9	8.9	-0.7	0.0
Any Government Plan	24.7	27.8	29.0	+4.3	+1.2
Medicare	13.5	13.8	14.3	+0.8	+0.5
Medicaid/CHIP	10.6	13.2	14.1	+3.5	+0.9
Military Health Care	3.3	3.7	3.8	+0.5	+0.1
Uninsured	13.7	15.3	15.4	+1.7	+0.1

Note: Numbers represent percentages of U.S. residents in each year. Some individuals report coverage from multiple sources.

In contrast, from 2007 to 2008, the fraction of individuals with public health insurance through Medicaid, Medicare, or the military increased substantially, from 27.8 percent in 2007 to 29.0 percent in 2008. Most of this increase was attributable to a rise in the fraction with Medicaid/CHIP (hereafter Medicaid) which was likely driven by the declining incomes caused by the first year of the recession.

Insurance Coverage Declined among Working-age Adults and Increased among Children

The change in health insurance coverage from 2007 to 2008 differed significantly by age. For example, the fraction of adults between the ages of 18 and 64 without health insurance increased significantly, from 19.6 percent in 2007 to 20.3 percent in 2008. As a result, more than one out of every five non-elderly adults was without health insurance in 2008, an increase of more than 3 percentage points since 2000. The report also reveals that the majority of uninsured non-elderly adults worked full-time and that the vast majority worked either full-time or part-time.

In contrast to the change for non-elderly adults, the fraction of children without health insurance *declined* significantly during this same period, from 11.0 percent in 2007 to 9.9 percent in 2008. As a result of this decline, both the number and the fraction of children without health insurance is at its *lowest* level since the Census started collecting comparable health insurance data in 1987. The fraction of elderly U.S. residents without health insurance was almost unchanged, declining slightly from 1.9 percent in 2007 to 1.7 percent in 2008.

A close examination of the Census Bureau's data reveals that the decline in the number of children without health insurance was almost entirely driven by an increase in their Medicaid coverage. From 2007 to 2008, the fraction of children with Medicaid increased from 28.1 percent to 30.3 percent. This more than offset a substantial decline in private health insurance coverage among children, which fell from 64.2 percent to 63.5 percent during the same period. While this strongly suggests that Medicaid has cushioned the effects of the economic downturn on children, even prior to 2007 increases in Medicaid coverage were serving to offset the substantial declines in private health insurance coverage among children, which fell from 70.2 percent in 2000 to 64.2 percent in 2007.

Inequality in Insurance Coverage across Racial/Ethnic Groups and by Income Remains High

The Census Bureau report also shows there was a significant increase in the fraction of non-Hispanic Whites without health insurance, which rose from 10.4 percent in 2007 to 10.8 percent in 2008; there was also a significant increase (from 16.8 to 17.6 percent) among Asians. The corresponding rates in 2008 for Blacks and Hispanics were substantially higher, at 19.1 percent and 30.7 percent, respectively. Interestingly, the fraction of Hispanics without health insurance declined significantly from 2007 to 2008, while there was no statistically significant change in this fraction for Blacks.

The data also reveal that individuals in low-income households remained significantly less likely to have health insurance than other individuals. For example, while 8.2 percent of individuals in households with incomes of $75,000 or more were without health insurance in 2008, the corresponding fraction for individuals in households with incomes of less than $25,000 was nearly three times higher at 24.5 percent.

Census Data Do not Reflect the Instability in Health Insurance Coverage during the Year

Before discussing the Administration's policies, it is worth highlighting that the estimates from the Census Bureau are meant to count the number individuals who are continuously uninsured throughout the year. And yet, a big motivation for health insurance reform is to address the instability that results when people are at risk of losing their health insurance when they move, lose their job, or change jobs. Estimates from other surveys regarding the number who are uninsured at some point during the year suggest that the number of those who experience such instability is much higher. For example, data from the *Medical Expenditure Panel Survey* suggest that 70.7 million non-elderly U.S. residents were without health insurance in at least one month during the 2007 calendar year.[1]

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[1] MEPS data: http://www.meps.ahrq.gov/mepsweb/data_files/publications/st259/stat259.pdf.

Census Data Do Not Reflect Likely Increases in the Rates of Uninsurance during 2009

It is also important to remember that the Census data are from 2008. Recent survey data from Gallup indicate that the fraction of adults without health insurance has continued to increase this year. This is not surprising given the economic downturn, which intensified beginning in September of 2008. Gallup data suggest that 14.7 percent of adults were uninsured in the average month in the first six months of 2008 versus 16.2 percent in the average month in the first six months of 2009.[2]

The Administration's Strategies to Expand Health Insurance Coverage

The Administration has aggressively worked to ensure that all Americans are covered by health insurance. In February President Obama signed into law an historic expansion of the Children's Health Insurance Program (CHIP) which extended health coverage to 4 million uninsured children. This expansion will reduce the number of uninsured children in the U.S. by approximately 50 percent by 2013. Further, the ARRA included the unprecedented government subsidy of COBRA payments enabling millions of unemployed workers to maintain their health insurance while continuing to look for new employment.

Of course, reform would result in an even larger expansion of health insurance coverage. Reform as specified in current drafts of Congressional legislation and as articulated by the President in his speech to Congress last night would achieve this by providing new tax credits to help people buy insurance and to help small businesses cover their employees.

In the President's plan individuals would be able to shop for health insurance in an exchange, where they could compare the price and quality of alternative insurance products and select the one that best fits their needs. As specified in a July 2009 CEA report, this exchange would differentially benefit small businesses and their employees, who are currently at a serious disadvantage relative to their larger competitors because of the much higher prices they must pay for health insurance.[3]

The President's plan would provide more stability and security for those who currently have insurance by prohibiting pre-existing conditions exclusions and preventing insurance companies from dropping coverage when people are sick and need it most. It would also cap out-of pocket expenses to protect people financially when they get sick. And it would also eliminate extra charges for preventive care to improve health and save money.

The trends summarized above during the last several years are likely to continue without decisive action. Health insurance premiums are rising three times more rapidly than wages, and thus an increasing share of workers and their families will simply be unable to afford insurance if current trends continue. Additionally, reform-induced reductions in the cost of health insurance will allow workers to take home more of their compensation in the form of earnings.

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[2] Gallup Survey: http://www.gallup.com/poll/121820/one-six-adults-without-health-insurance.aspx.

[3] Executive Office of the President. Council of Economic Advisers. "The Economic Effects of Health Care Reform on Small Businesses and their Employers." July 25, 2009.

Administration Policies to Reverse the Trends in Income and Poverty

The Committee also asked me to address what steps the Administration is taking to reverse the trends in income and poverty and improve the well-being of families across the country. The largest and most visible strategy pursued by the Administration and Congress was to pass the $787 billion ARRA. Through a balanced package of state fiscal relief, individual tax cuts, and an increase in the federal safety net, much of the ARRA provides short-run help to the ailing economy. For example, ARRA has helped states maintain important state programs and to retain public sector employees during a time of fiscal distress.

The Recovery Act also includes billions of dollars in tax relief for more than 95 percent of working families to help them retain more of their take-home pay. Today's Census report indicates that 13.2 percent of individuals in the U.S. lived in poverty in 2008 up from 12.5 percent in 2007; 18.5 percent of families with (related) children lived in poverty in 2008. While before the ARRA a family of four with one parent working full time at the minimum wage would fall below the poverty line, reforms to the Making Work Pay and Child Tax Credits would lift them above the poverty line. In total, these provisions of the Recovery Act will help lift more than two million Americans out of poverty in 2009.

The ARRA also included a significant increase in the Supplemental Nutrition Assistance Program (SNAP), funding for food banks and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), as well as an increase and extension of unemployment benefits which are helping millions of struggling Americans while simultaneously helping to buoy the economy by supporting aggregate demand.

The Center on Budget and Policy Priorities estimates that several provisions of the ARRA including improvements in unemployment insurance, the tax credits for working families, and the increase in food stamps prevented 6 million Americans from falling into poverty and reduced the severity of poverty for an additional 33 million more in 2009.[4]

Clearly getting people back to work is also critical for increasing incomes and reducing poverty as changes in income and the poverty rate are highly correlated with employment. As evidence, the poverty rate among those that had worked at some point in 2008 was 6.4 percent compared to 22 percent among those that worked less than one week during the year. To this end, the ARRA increased funding for job training, such as that through the Workforce Investment Act (WIA). Evidence suggests that these types of training programs can improve labor market outcomes for participants by increasing employment rates and wages.[5] These programs are therefore vital to helping displaced workers retrain for promising jobs in areas of high demand.

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[4] Sherman, Arloc. "Stimulus Keeping 6 Million Americans out of Poverty in 2009, Estimates Show." Center on Budget and Policy Priorities. September 9, 2009.

[5] See, for example, Dyke, Andrew, C. Heinrich, P. Mueser, K. Troske, and K. Jeon. "The Effects of Welfare-to-Work Program Activities on Labor Market Outcomes." *Journal of Labor Economics*, 2006, 24(3): 567-608; Hotz, V. Joseph, G. W. Imbens, and J. A. Klerman. "Evaluating the Differential Effects of Alternative Welfare-to-Work Training Components: A Reanalysis of the California GAIN Program." *Journal of Labor Economics*, 2006, 24(3):521–566; and Dyke, Andrew, C. Heinrich, P. Mueser, K. Troske, and K. Jeon. "The Effects of Welfare-to-Work Program Activities on Labor Market Outcomes." *Journal of Labor Economics*, 2006, 24(3): 567-608.

Recognizing that we not only want to recover from this recession but also to build an even stronger economy, the ARRA also contained provisions to help boost incomes in the longer term. Two of the best documented long-term public investments to raise incomes are those in early childhood development and public education. The ARRA includes over $4 billion in increases to the Child Care Development Block Grant, Head Start, and Early Head Start. Further, the ARRA includes one of the largest one-time federal reforms of public education through the Race to the Top Fund.

The President's FY2010 budget goes even further. With the savings achieved by eliminating the Federal Family Education Loan (FFEL) program, the Administration proposes to invest substantially in improving early childhood education and simplify access to federal financial student aid. These savings would also fund the American Graduation Initiative which is an ambitious plan to invest in our nation's community colleges by improving completion rates, renovating and modernizing their infrastructure, making better use of technology, and encouraging innovative curricular and programmatic reform.

Finally, the President's budget also calls for funding promising strategies to help those who were struggling even before the start of the current recession. As one component, his budget proposes investing in innovative, comprehensive strategies for helping neighborhoods. These strategies include improving K-12 education with a full network of supportive services, transformative housing interventions, and programs to individuals with significant barriers to employment to obtain the skills they need to succeed in the workforce. The budget also proposes grants to states to provide home visits to low-income parents and pregnant women. Such home visitation programs have been shown through rigorous research to be highly effective in improving child health and development, readiness for school, and improving parenting ability.

Thank you for giving me an opportunity to review the data in this new Census report and to share the Administration's strategies for returning prosperity to all Americans. I am happy to answer any questions you may have.

PREPARED STATEMENT OF JOSEPH STIGLITZ

The report on Income, Poverty, and Health Insurance Coverage in the United States: 2008 results are not surprising—these dismal results reflect the reality facing a majority of American families. The country began the downturn in a situation where families had not fully recovered from the last recession—median household income in 2007 adjusted for inflation was still lower than it was in 1999 and 2000. The precipitous 3.6% drop this year has dramatically compounded these problems, resulting in a total decline of real income for the typical family of $2,200 over the past eight years. All the gains to the economy have gone to the people at the top. At the bottom, matters are even worse, as 8.2 million joined the ranks of those in poverty, a more than 26% increase. But even these numbers do not reflect fully the strains on the average American family: there are almost 8 million people without health insurance.

These results—like the crisis itself—are not just simply something that happened to the United States, an accident beyond our control. They are the result of misguided policies. They reemphasize the point that growth in GDP is an inadequate measure of economic performance. These results highlight the importance of the work of the International Commission on the Measurement of Economic Performance and Social Progress, which I chair and which will issue its report next Monday, September 14.

PRELIMINARY 9/7/09

CHANGING COURSE:
TRENDS IN HEALTH INSURANCE COVERAGE 2000-2008

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Invited Testimony

HEARING ON THE UNINSURED

Joint Economic Committee
September 10, 2009

This testimony draws on Commonwealth Fund work authored by Sara R. Collins, Michelle Doty, Cathy Schoen, and colleagues. The editorial assistance of Chris Hollander of The Commonwealth Fund is gratefully acknowledged. The views presented here are those of the author and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

CHANGING COURSE:

TRENDS IN HEALTH INSURANCE COVERAGE 2000-2008

Executive Summary

This morning the U.S. Bureau of the Census released the alarming news – the numbers of uninsured hit TK in 2008, up from 45.6 million in 2007. Over the last decade, insurance coverage has steadily eroded, rising from 38 million uninsured in 2000. Even before this severe recession, the number of uninsured was projected to grow to 61 million in 2020. We simply can not afford to continue on our current course.

The need for health reform is urgent and compelling:

- The number of uninsured Americans has jumped over 20 percent between 1999 and 2008.
- In 2006, 75 million people were uninsured for all or part of the year, representing 25 percent of the total population and 27 percent of those under age 65.
- Uninsured rates are particularly high among low-income individuals. Half of those with family income under $20,000 were uninsured at some point during 2007. But over the last decade, more and more middle-class families have joined the ranks of the uninsured. Two of five (41%) of those with moderate incomes ($20,000 to $39,999) were uninsured at some point during 2007, up from 28 percent in 2001.
- The rapid rise in unemployment endangers the health coverage of many more working Americans. A recent study found that for every percentage-point increase in the unemployment rate, the number of uninsured increases by approximately 1 million. If unemployment were to rise to 10 percent, 6 million more people would be uninsured than in 2007.
- According to a Commonwealth Fund study released yesterday, only 25 percent of those working for firms with fewer than 50 employees had coverage from their own employer in 2007, down from 35 percent in 2003. By contrast coverage through one's own employer increased from 70 percent to 74 percent for employees of firms with 50 or more employees over that period.

- The number of *underinsured*—people with inadequate coverage that ensures neither access to care nor financial protection—has jumped 60 percent between 2003 and 2007, from 16 million to 25 million.
- Analysis of the 2007 Commonwealth Fund Biennial Health Insurance Survey shows that 68 percent of the uninsured went without needed care due to cost. Uninsured and underinsured people with chronic conditions, for example, are less likely than the insured to report managing their conditions, more likely to report not filling prescriptions or skipping doses of drugs, and more likely to use emergency rooms and be hospitalized.

The health insurance system in this country is fundamentally broken. It does not accomplish what insurance is created to accomplish – ensure access to needed care and protect against the financial hardship of medical bills. The deterioration in health insurance coverage has reached the point that financial hardship is not the exception but the rule.

- Seventy-two million people report having problems paying medical bills or accumulated medical debt. To pay their bills, far too many people are unable to afford basic necessities, use up their savings, take on credit card debt, or even home loans.
- Three-fifths (61%) of those with problems paying medical bills or accrued medical debt were insured at the time the debt was incurred.
- A total of 116 million adults ages 19-64 – 65 percent of all non-elderly adults –are uninsured at some point during the year, or are underinsured, or struggle to obtain needed care and pay their medical bills.

As a nation, we pay a price for being the only major country without health insurance for all. Workers miss work from preventable illness, die from conditions amendable to medical care, or retire early from preventable disability. Children miss school or drop out of high school without graduating because of preventable health problems. The Council of Economic Advisers estimates that covering the uninsured would result in a net increase in economic well-being of $100 billion a year, or 2/3 of one percent of the Gross

Domestic Product. Coverage for all would increase the labor supply, and level the playing field between large and small businesses.

Recognizing the seriousness of our flawed health system, Congress took action early this year to cover more people at high risk. Reauthorization of the Children's Health Insurance Program (CHIP) will cover an estimated 4.1 million uninsured low-income children in addition to the 7 million covered in 2008. The CHIP program has been a major success – the trends in numbers of uninsured children – unlike those of uninsured adults have improved over the last decade.

Provisions in the American Recovery and Reinvestment Act of 2009 (ARRA) have also helped prevent the loss of health insurance coverage as a result of the severe and sustained economic recession. It provided $86.6 billion over 27 months to help states maintain and expand Medicaid enrollment as more unemployed working families qualified for coverage. In addition, ARRA provided a 65 percent premium subsidy to help recently unemployed workers retain their employer-based coverage under COBRA. for up to nine months.

Measures in health reform bills currently under consideration in the Congress include:

- Creation of health insurance exchanges that expand insurance choices and competition and set market rules ensuring that coverage is available to all on comparable terms.
- Income-related premium assistance up to three or four times the federal poverty level.
- Expansion of Medicaid up to 133 to 150 percent of poverty.
- Requirement that plans include an essential benefit package and income-related assistance with cost sharing up to four times the federal poverty level.
- Shared employer responsibility in financing coverage for workers with assistance to small businesses.

The Congressional Budget Office estimates that if the House bill is enacted, the number of people uninsured would decline to 17 million people in 2019. Employer-sponsored insurance would remain the primary source of insurance for most families, covering 60 percent of the population or 166 million people. About 10 million people would become newly enrolled through Medicaid, with most previously uninsured.

Recognizing the plight of families facing an unraveling safety net of health insurance coverage, the President last night reiterated his call for bold change to address the crushing burdens of rising health care costs for both businesses and families.
Failing to act will lead to greater and greater numbers of Americans without adequate, affordable insurance -- unable to obtain the care they need, with families struggling under the weight of rising health insurance premiums and out-of-pocket costs of health care. Health insurance premiums have risen from 11 percent of family incomes in 1999 to 18 percent today. If we continue on our current course, they will reach 24 percent by 2020.

Health reform could provide substantial relief to families by slowing the growth in health insurance premiums, and share responsibility for premiums among households, employers, states, and the federal government. Estimates prepared for the Commonwealth Fund suggest that the average family would save $2300 in 2020 from comprehensive health reform embracing competition and choice.

The comprehensive reforms proposed by the President will help spark economic recovery, put the nation back on a path to fiscal responsibility, and ensure all families are able to get the care they need with financial security. The cost of inaction is high. The time has come to take bold steps to ensure the health and economic security of this and future generations. Health reform is an urgently needed investment in a better health system and a healthier and economically more productive America.

CHANGING COURSE:
TRENDS IN HEALTH INSURANCE COVERAGE 2000-2008
Karen Davis

Thank you, Mr. Chairman, for this invitation to testify on trends in health insurance coverage over the last decade. This morning the U.S. Bureau of the Census released the alarming news – the numbers of uninsured hit TK in 2008, up from 46 million in 2007.[1] Over the last decade, insurance coverage has steadily eroded, rising from 38 million uninsured in 2000.[2] Even before this severe recession, the number of uninsured was projected to grow to 61 million in 2020.[3] We simply can not afford to continue on our current course.

The Administration and Congress enacted important legislation earlier this year to stem the rising tide of uninsured with coverage of an additional 4.1 million low-income children under the Children's Health Insurance Program and important provisions to enhance federal matching for Medicaid and provide premium assistance to unemployed workers to continue their employer coverage under COBRA. Yet these measures are not sufficient to reverse the long-term trend. Enactment of health reform is urgently needed to ensure affordable health insurance for all Americans.

Gaps in Insurance Coverage a Serious and Growing Problem

The U.S. is the only major industrialized country that does not ensure health coverage for all. As we learned today, TK million Americans – TK percent of those under age 65 – went without the coverage essential to gaining access to health care. Millions more have unstable coverage and lose coverage for a period of time as a result of becoming ill, changing jobs, or other circumstances. In 2006, 75 million people were uninsured for all or part of the year, representing 25 percent of the total population and 27 percent of those under age 65.[4]

Uninsured rates are particularly high among low-income individuals. Half of those with family income under $20,000 were uninsured at some point during 2007.[5] But over the

last decade, more and more middle-class families have joined the ranks of the uninsured. Two of five (41%) of those with moderate incomes ($20,000 to $39,999) were uninsured at some point during 2007, up from 28 percent in 2001.

The rapid rise in unemployment endangers the health coverage of many more working Americans. Since employment-sponsored insurance is the major source of coverage for working families, loss of a job often means loss of insurance. A recent study found that for every percentage-point increase in the unemployment rate, the number of uninsured increases by approximately 1 million. If unemployment were to rise to 10 percent, 6 million more people would be uninsured than in 2007.[6]

Even those with jobs are at risk of losing coverage as rising premiums increasingly price small businesses and working families out of the health insurance market. The erosion of health insurance coverage over the last decade has been particularly stark among small businesses. According to a Commonwealth Fund study released yesterday, only 25 percent of those working for firms with fewer than 50 employees had coverage from their own employer in 2007, down from 35 percent in 2003.[7] By contrast coverage through one's own employer increased from 70 percent to 74 percent for employees of firms with 50 or more employees over that period. Low-wage workers earning less than $15 an hour are particularly at risk. Only 16 percent of low-wage workers in small firms with fewer than 50 employees had coverage from their own employer in 2007, compared with 32 percent of small firm workers earning $20 an hour or more. For high-wage workers in large firms, 83 percent had coverage from their own employer.

The White House Office of Health Reform notes that small business workers who are not offered coverage often end up uninsured.[8] Without employer assistance paying premiums, workers often go without coverage or buy very expensive policies with limited benefits on the individual insurance market. Over one-third (36%) of working adults in small firms were uninsured at some time during 2007.[9] Most of those who are adequately insured are those fortunate enough to be covered by a family member's employer – putting the entire family at risk of losing coverage if the covered worker loses his or her job. By contrast for

workers in firms with 50 or more employees, 15 percent are uninsured at some time during the year.

Rates of insurance coverage vary widely across the U.S. A few states, such as Massachusetts, have enacted comprehensive reform. Massachusetts now has the lowest rate of uninsured in the nation.[10] But the dominant trend has been a marked increase in rates of uninsured adults. While the rate of uninsured adults was 23 percent or higher in two states in 1999-2000, by 2006-2007 it exceeded that rate in nine states. The one bright spot is the reduction in rates of uninsured children in most states as a result of the Children's Health Insurance Program

Under the current health system, even those with coverage are often underinsured – with inadequate financial protection and access to care. Insured individuals are increasingly spending a high percent of their income on medical care despite having continuous coverage. Insured adults are defined as underinsured if they spent 10 percent or more of their income on out-of-pocket health care costs (or 5 percent if low income), or have deductibles of 5 percent or more of income.[11] As of 2007, there were an estimated 25 million underinsured adults in the United States, up 60 percent from 2003. While low-income individuals and families are hit the hardest, the problem has moved up the income ladder and now affects the middle class. Between 2003 and 2007, the underinsured rate nearly tripled among adults with incomes above 200 percent of the federal poverty level.

Employees of small firms are particularly at risk of being underinsured. They receive fewer benefits, pay higher premiums, and often face larger deductibles compared with those working for larger businesses. On average, small firms pay up to 18 percent more in premiums than large firms do for the same health insurance policy.[12] Smaller businesses also pick up a smaller share of premiums, further increasing costs to their workers. Deductibles have risen sharply in smaller firms (with three to 199 employees), with the mean deductible for single coverage rising from $210 in 2000 to $917 in 2008.[13] For larger firms, deductibles increased from $157 to $413 over this period. Employees of small firms are more likely to report having limits on covered benefits and are more likely to rate their coverage as fair or poor.

Consequences of Gaps in Coverage

The economic and health consequences of being uninsured or underinsured are stark. Analysis of the 2007 Commonwealth Fund Biennial Health Insurance Survey shows that 68 percent of the uninsured went without needed care due to cost.[14] Uninsured and underinsured people with chronic conditions, for example, are less likely than the insured to report managing their conditions, more likely to report not filling prescriptions or skipping doses of drugs, and more likely to use emergency rooms and be hospitalized.[15] The uninsured are also less likely than the insured to receive preventive care such as immunizations, Pap tests, mammograms, and colon cancer screening. People without insurance who have life-threatening conditions such as cancer are at very high risk for preventable deaths due to delays in detection plus lack of adequate treatment.[16]

With the rise in health care costs in the last decade, the inability to get needed care has risen across all income groups. While almost two-thirds (62%) of those with incomes below $20,000 reported not getting needed care because of costs, even for those with incomes above $60,000, almost one-third (29%) reported such problems in 2007 – double the rate in 2001.[17]

When they do obtain health care, the uninsured and underinsured often incur burdensome medical bills and accumulate unpaid medical debt. Half of the uninsured reported a medical bill problem or accumulated medical debt in 2007.[18]

Rising health insurance premiums have fueled erosion in insurance benefits and shifted financial risk onto individuals and families.[19] In part as a result of an infatuation with high deductible health plans based on the untested theory that having patients pay more for their own care would lead patients to economize on care and help control rising costs, employers have shifted more costs to employees in the form of higher deductibles and greater cost-sharing. This has not been an effective solution to rising costs, but instead has resulted in many of the insured experiencing problems accessing care and paying medical bills. Fifty-three percent of those who are underinsured reported one of four instances of going without needed care due to costs: not filling a prescription; skipping a

recommended medical test, treatment, or follow-up; having a medical problem but not visiting a doctor; or not getting needed specialist care because of costs. Forty-five percent of the underinsured reported one of three medical debt or bill problems: having problems paying medical bills; changing their way of life to pay medical bills; or being contacted by a collection agency for inability to pay medical bills.

The deterioration in health insurance coverage has reached the point that it is not the exception but the rule. Seventy-two million people report having problems paying medical bills or accumulated medical debt.[20] To pay their bills, far too many people are unable to afford basic necessities, use up their savings, take on credit card debt, or even home loans. This is not just a reflection of being uninsured. Three-fifths (61%) of those with problems paying medical bills or accrued medical debt were insured at the time the debt was incurred.

The health insurance system in this country is fundamentally broken. It does not accomplish what insurance is created to accomplish – ensure access to needed care and protect against the financial hardship of medical bills. A total of 116 million adults ages 19-64 – 65 percent of all non-elderly adults – are uninsured at some point during the year, or are underinsured, or struggle to obtain needed care and pay their medical bills.[21]

As a nation, we pay a price for being the only major country without health insurance for all.[22] Workers miss work from preventable illness, die from conditions amenable to medical care, or retire early from preventable disability. Children miss school or drop out of high school without graduating because of preventable health problems. The Council of Economic Advisers estimates that covering the uninsured would result in a net increase in economic well-being of $100 billion a year, or 2/3 of one percent of the Gross Domestic Product. Coverage for all would increase the labor supply, and level the playing field between large and small businesses. We can not lose sight of the cost of inaction in either economic or human terms.

Steps Congress Has Taken

Recognizing the seriousness of our flawed health system, Congress took action early this year to cover more people at high risk. Reauthorization of the Children's Health Insurance Program (CHIP) will cover an estimated 4.1 million uninsured low-income children in addition to the 7 million covered in 2008.[23] This expansion of coverage is not yet reflected in the uninsured numbers released today.

The CHIP program has been a major success – enrolling millions of children under state-run programs subject to federal guidelines. As a result of CHIP, the trends in numbers of uninsured children – unlike those of uninsured adults have improved over the last decade. In 1999-2000 nine states had 16 percent or more children uninsured. By 2005-2006, that number had dropped to five. As a result of CHIP, millions of children have received preventive and primary care essential to health and healthy development.[24]

Provisions in the American Recovery and Reinvestment Act of 2009 (ARRA) have also helped prevent the loss of health insurance coverage as a result of the severe and sustained economic recession. It provided $86.6 billion over 27 months to help states maintain and expand Medicaid enrollment as more unemployed working families qualified for coverage. The federal matching rate was increased by 6.2 percent for all states, and more for states with marked increases in unemployment. The condition of funding was the maintenance of Medicaid eligibility.

In addition, ARRA provided subsidies to help recently unemployed workers retain their employer-based coverage under COBRA.[25] Under the leadership of the late Senator Edward M. Kennedy, the 1985 Consolidated Omnibus Budget Reconciliation Act (COBRA) permits workers in firms of 20 or more employees to retain their health insurance coverage for 18 months by paying the full premium plus a 2 percent additional administrative fee. ARRA built on this legislation by providing a 65 percent subsidy for COBRA continuation premiums for laid-off workers and their families for up to nine months. Eligible workers pay 35 percent of the premium to their former employers. To qualify, a worker must have been involuntarily separated between Sept. 1, 2008, and Dec. 31, 2009. This subsidy phases out for individuals whose modified adjusted gross income exceeds $125,000, or $250,000 for those filing joint returns.

This provision is extremely valuable to unemployed workers who have little options for affordable coverage without this assistance. The individual insurance market has more costly premiums than employer coverage, more limited benefits, and often is unavailable at any premium for those with health conditions.[26]

It should be recognized, however, that the COBRA premium assistance will not reach all of the unemployed. Most importantly, only 38 percent of workers with incomes below twice the poverty income level are eligible for COBRA. They either work for small firms not subject to COBRA requirements or for a firm that does not provide them with health insurance even when employed.[27]

Further, many unemployed individuals and families will still find coverage unaffordable even with this assistance.[28] The average COBRA family premium is $12,680. The worker's 35 percent share of this premium is $4, 438 – a hefty sum for unemployed families adjusting to loss of a job and a paycheck.

Implications of Health Reform for Affordability and Adequacy of Health Insurance Coverage

The health reform provisions currently under consideration in the Congress would go a long way toward fixing our broken health insurance system. The most important provisions improving insurance coverage include:

- **Insurance Exchange with market rules**
    - **Both the House bill and the Senate HELP bill** call for the creation of a health insurance exchange with expanded choices and competition. Market rules would prohibit discrimination against those with health conditions requiring insurance to be available to all with premiums that are the same for everyone at the same age and family structure, regardless of health status.
- **Sliding scale premium subsidies**
    - **The House bill** would cap family or individual premium payments purchased through an insurance exchange at no more than 1.5 percent of

income for those earning 133 percent of poverty or $28,200 for a family of four and rising to no more than 12 percent of income for those with incomes at 400 percent of poverty, or about $84,182 for a family of four.

- **The Senate HELP bill** would provide premium assistance on a sliding scale up to 400% of poverty for insurance purchased through an insurance exchange such that premiums are no more than 1 percent of income for people with incomes of 150 percent of poverty or less and no more than 12.5 percent of income for those with incomes at 400 percent of poverty.

- **New Medicaid income eligibility level**
  - **The House bill** expands eligibility for Medicaid up to 133 percent of poverty or $28, 200 for a family of four.
  - **The Senate HELP bill** expands eligibility for Medicaid to 150 percent of poverty or $31,804 for a family of four.
- **Benefits**
  - **The House bill** would instruct the insurance exchange to define an essential benefit package. The exchange would offer four benefit tiers, though only the level of cost-sharing would be allowed to vary across the three lowest tiers. All health plans including employers must provide at least the "basic" essential benefit package inside and outside the exchange.
  - **The Senate HELP bill** would instruct the Secretary of HHS to define an essential health benefits package that would be equal in scope to typical employer plans. The Secretary would be required to establish at least three cost-sharing tiers for the essential benefits package.
- **Cost-sharing assistance for low-income families**
  - **The House bill** would reduce cost sharing in the basic plan such that the share of costs covered by the basic plan would rise from 70 percent to 97 percent for those earning 133-150 percent of poverty, 93 percent for those earning 150 – 200 percent of poverty and down to 72 percent of costs covered for those earning 350 percent of poverty.
- **Shared employer responsibility**

- **The House bill** as reported out of the Energy and Commerce Committee would require employers to offer coverage to their employees and contribute at least 72.5% of the premium cost for single coverage and 65% of the premium cost for family coverage of the lowest cost plan that meets the bill's "essential" benefits package requirements or pay 8% of payroll into the Health Insurance Exchange Trust Fund. The House bill exempts small businesses with payrolls of less than $500,000 from the bill's 8% payroll tax for employers that do not offer health insurance and phases in employer shared financial responsibility beginning with a 2 percent payroll tax for firms with annual payrolls between $500,000 and $585,000, and rising to 8% for firms with payrolls above $750,000. The House bill as reported out of the Energy and Commerce Committee provides a tax credit equal to 50% of the amount paid by a small employer. The tax credit is phased out for employers with 10 to 25 employees, and is also phased out for employers with average wages of $20,000 to $40,000 per year.
- **The Senate HELP bill** requires employers to offer health coverage to their employees that meets the federal standard of "minimum qualifying coverage" and to contribute at least 60 percent of the premium cost. Employers who do not "play" would pay $750 annually for each full-time employee who is not offered coverage, and $375 for each uncovered part time worker. The bill also requires employers to include dependents up to age 26. The Senate HELP bill exempts small businesses with fewer than 25 employees from the mandate. In addition, the first 25 employees of any firm are not subject to the $750 per worker payment if the firm decides not to offer coverage. The Senate HELP bill provides tax credits for up to three years for firms of 50 workers or less with an average wage of $50,000 or less who offer coverage and pay 60% or more of their employees' premiums. The credit is equal to $1,000 for each employee with single coverage and $2,000 for family coverage. Bonus payments are available for each additional 10 percentage point increase in premium contributions.

The Congressional Budget Office estimates that if the House bill is enacted, the number of people uninsured would decline to 17 million people in 2019. Employer-sponsored insurance would remain the primary source of insurance for most families, covering 60 percent of the population or 166 million people. About 10 million people would become newly enrolled through Medicaid, with most previously uninsured.

The Ways and Means Committee has prepared charts illustrating premium and out-of-pocket cost maximums for families and children. The first chart below shows how much in premiums families of four pay today and the maximum each family would pay under the House bill.

AMERICA'S AFFORDABLE HEALTH CHOICES ACT WILL REDUCE PREMIUMS

Under HR 3200*, premiums will decrease and coverage will increase relative to today's coverage in the non-group market. HR 3200 will make health insurance affordable, particularly for those with modest incomes. Monthly premiums would be limited to no more than a certain percentage of a family's income.

INCOME LEVEL		WHAT YOU PAY TODAY Premiums for a Typical High Deductible Plan		MAXIMUM PREMIUMS YOU WOULD PAY UNDER HR 3200 IN THE EXCHANGE		MAXIMUM PREMIUMS YOU WOULD PAY IN THE EXCHANGE UNDER ENERGY AND COMMERCE AS REPORTED	
Federal Poverty Level	2009 Annual Income	% of Income	Monthly Premium	% of Income	Monthly Premium	% of Income	Monthly Premium
133 % FPL	$29,327	34%	$827	1.5%	$37	1.5%	$37
150% FPL	$33,075	30%	$827	3%	$83	3%	$83
200% FPL	$44,100	23%	$827	5%	$184	5.5%	$202
250% FPL	$55,125	18%	$827	7%	$322	8%	$368
300% FPL	$66,150	15%	$827	9%	$496	10%	$551
350% FPL	$77,175	13%	$827	10%	$643	11%	$707
400% FPL	$88,200	11%	$827	11%	$809	12%	$882

*As introduced and reported by the House Ways and Means, Education and Labor, and Energy and Commerce Committees

Prepared by the Committee on Ways and Means *July 31, 2009*

The second chart shows examples of how much in deductibles and co-insurance people could end up paying, and how those would compare with a typical high deductible plan and with the typical health insurance plan for federal employees.

SEEING YOUR DOCTOR WILL BE MORE AFFORDABLE WITH COST SHARING ASSISTANCE IN THE EXCHANGE

Under HR 3200, affordability credits will limit out-of-pocket costs for families with low or modest incomes by limiting cost sharing for doctor visits, hospital stays and other services and creating an overall cap on out-of-pocket expenses. In addition, HR 3200 eliminates annual and lifetime caps that insurance companies sometimes use to limit covered care. This means people will pay less and get the care they need without fear of bankruptcy due to medical costs. Below are examples of cost sharing under America's Affordable Health Choices Act compared to cost sharing under the Federal Employees Health Benefit Plan (FEHBP) or a high deductible health plan in the non-group or individual market.

Illustrative Plan Options*

Coverage in the Exchange Federal Poverty Level	2009 Annual Income	Deductible	Co-Insurance**	Out-Of Pocket Cap
133% - 150% FPL	$29,327 - $33,075	$100	10%	$900
150% - 200% FPL	$33,075 - $44,100	$200	15%	$1,450
200% - 250% FPL	$44,100 - $55,125	$500	15%	$4,400
250% - 300% FPL	$55,125 - $66,150	$1,000	20%	$7,450
300% - 350% FPL	$66,150 - $77,175	$2,400	20%	$8,520
Above 350% FPL	$77,175+	$3,000	15%	$10,000
Typical High Deductible Plan				
ALL INCOMES		$2,200	20-25%	$10,000
FEHBP (Insurance Coverage for federal employees and Members of Congress)				
ALL INCOMES		$600	15-30%	$9,934

* These examples show possible cost sharing for insurance coverage for a family of four; the Administration would establish the actual levels based on the value cost bands in the legislation (e.g., for those with incomes between 133-150 FPL the actuarial value equals 97 percent, which means the family pays 3 percent of the cost sharing for the plan; between 150-200% FPL the value is 93; between 200-250% FPL the value is 85; between 250-300% FPL the value is 78; between 300-350% FPL, the value is 72; for those above 350% FPL, the value is 70) ** Percent consumer pays of the cost of the service received.

Prepared by the Committee on Ways and Means *July 31, 2009*

Urgent Need for Comprehensive Reform to Ensure Affordable Coverage for All

Recognizing the plight of families facing an unraveling safety net of health insurance coverage, the President last night reiterated his call for bold change to address the crushing burdens of rising health care costs for both businesses and families. Building on the action of Congress earlier this year, he has called for moving forward to secure insurance coverage for all and change the health system through competition and choice.

Failing to act will lead to greater and greater numbers of Americans without adequate, affordable insurance -- unable to obtain the care they need, with families struggling under the weight of rising health insurance premiums and out-of-pocket costs of health care. Health insurance premiums have risen from 11 percent of family incomes in 1999 to 18 percent today. If we continue on our current course, they will reach 24 percent by 2020.[29]

The average American family simply can not afford to spend one-fourth of their income on health insurance.

Health reform could provide substantial relief to families by slowing the growth in health insurance premiums. Estimates prepared for the Commonwealth Fund suggest that the average family would save $2300 in 2020 from comprehensive health reform embracing competition and choice.[30] This includes an insurance exchange with a public health insurance plan that fosters competition and choice in the market for health insurance, and reforms in provider payment methods that reward value rather than volume of services. System reforms to reach attainable benchmark performance on patient outcomes and prudent use of resources, use of modern information technology, investment in population health, and rewards for providers willing to be accountable for ensuring that patients achieve the best possible outcomes would both save lives and slow spending from 6.5 percent a year to 5.2 percent a year over the next decade.

Although politically difficult, there is an urgent need to move in a new direction. The comprehensive reforms proposed by the President will help spark economic recovery, put the nation back on a path to fiscal responsibility, and ensure all families are able to get the care they need with financial security. The cost of inaction is high. With both a historic political opportunity and a clear path toward a high performance health system, the time has come to take bold steps to ensure the health and economic security of this and future generations. Health reform is an urgently needed investment in a better health system and a healthier and economically more productive America.

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PREPARED STATEMENT OF HARRY J. HOLZER, PROFESSOR OF PUBLIC POLICY, GEORGETOWN UNIVERSITY AND INSTITUTE FELLOW, URBAN INSTITUTE [1]

Thank you for giving me the opportunity to speak before you this afternoon about the income and poverty numbers for 2008 that were released this morning by the Census Bureau.

We now know that the years 2000–2007 represented a complete business cycle, and comparing 2000 and 2007 enables us to infer the secular trend that the nation experienced for most of the current decade. And the differences between 2007 and 2008 represent only the beginning of the most serious economic downturn since the 1930s.

While there is a great deal to discuss in a short period of time, I would like to emphasize the following four points:

(1) *The numbers for the period 2000–07 are quite disturbing—real median income failed to rise over this entire period, while poverty did rise*. Indeed, the poverty rate rose substantially (by about 2 percentage points) for certain groups, like children and African Americans. Moreover, these trends occurred while the nation's productivity rose by nearly 20 percent. Thus, both low- and middle-income American families largely failed to share in the economic prosperity generated during this period.

Of course, there are important questions about how these numbers are measured, and especially how we adjust for inflation and health care costs over time. But faulty measurement likely does not account for most of these findings.

(2) *Between 2007 and 2008, the beginning of the current recession caused real income to fall and poverty to rise*. The data show that some groups (like Hispanics and Asians) and some regions of the United States (like the Midwest) were harder hit than others. But it is also noteworthy that the deterioration we see so far has been very widespread, affecting most demographic groups and regions.

(3) *The worst is yet to come*. Even if the recession officially ends this year—meaning that the production of goods and services in the economy begins to recover—the unemployment rate will likely continue to worsen for the rest of this year and into next year. This is because employment is a "lagging indicator," with employers creating new jobs and hiring more workers only after they are confident of a strong recovery in product demand that cannot be met from their current inventories and current workers. Real income, therefore, will continue to fall and poverty will continue to rise for a few more years—and almost certainly by much more than what we have witnessed between 2007 and 2008. It will likely take several years beyond 2010 before real income and poverty fully recover from the effects of the downturn (that is, return to 2007 levels).

(4) *Economic policy over the next few years must focus both on the severe near-term impacts of the current recession and on the longer-term stagnation experienced by low- to middle-income Americans*, with the greatest attention paid to those who are most vulnerable.

How might we accomplish these policy goals? Over the next few years, we must ensure that those who cannot find work due to no fault of their own, and their families, are protected by an adequate safety net. Unemployment insurance (UI) will need to be extended beyond the provisions in this year's recovery legislation. For low-income and part-time workers ineligible for UI, other forms of cash assistance or food stamps and perhaps community-service jobs will need to be provided. States facing severe fiscal crises may need some additional assistance as well.

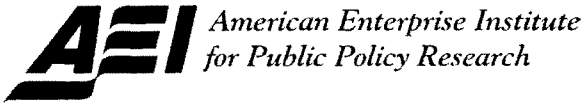
But we must also begin to implement policies that address the longer-term stagnation in the incomes of American workers and their families. When the economy and the labor market do begin to recover, jobs will be created that require more skills than many Americans currently have—even in positions that do not require four-year college degrees. Therefore, we need to invest more effectively in the education and training of our workers through everything from pre-kindergarten programs to higher education and job training for disadvantaged youth and adults. Other approaches to earnings enhancement, such as higher minimum wages and more collective bargaining, might be encouraged as well.

For the hard-to-employ poor whose skills and wages might not improve over time, we need to create stronger incentives and supports for them to work in greater num-

[1] The views expressed are those of the author and should not be attributed to any institution.

bers, even at low wages. And health insurance reform must remain a top priority—to ensure coverage for the millions of families who now lack such protection or might lose it, and to ensure that growing medical costs do not continue to absorb the earnings growth of productive American workers.

I will be happy to elaborate more on these points during the discussion period to follow.



Statement before the Joint Economic Committee
United States Congress

On "Income, Poverty, and Health Insurance Coverage: Assessing Key Census Indicators of Family Well-Being in 2008"

How What We Think We Know about the Uninsured Really Adds Up

Tom Miller

Resident Fellow

American Enterprise Institute

September 10, 2009

The views expressed in this testimony are those of the author alone and do not necessarily represent those of the American Enterprise Institute.

Chair Maloney and Members of the Committee:

Thank you for inviting me to testify before you today. I am a resident fellow at the American Enterprise Institute. This testimony has been prepared and submitted in advance of today's release of the annual Consumer Population Survey (CPS) on Income, Poverty, and Insurance Coverage, as conducted by the U.S. Census Bureau. Hence, rather than try to hit an unknown and moving target in advance, I will attempt to help place within a broader context whatever those latest findings might suggest regarding the most recent level and nature of persons lacking insurance in the U.S. I primarily will be drawing upon some recent work of mine at AEI regarding what we do know more broadly about the uninsured, some of the limitations in trying to measure the scope and dimension of the problems of the uninsured, and several often-neglected considerations in assessing the broader issue of how to improve health outcomes at lower overall costs.

Pick a Different Survey and Get a Different Number of Uninsured Americans

One normally begins with trying to determine just how many Americans lack health insurance. The short answer is "too many," but the total numbers depend on whom you ask and how they measure the problem. The CPS provides the most commonly reported figure. It was about 45.7 million people for 2007, as of last year's survey released in August 2008. Although that estimate actually was lower than the 2006 figure of 47 million, we should know by the time of today's hearing how much the number of uninsured has increased since then, due in large part (if not solely) to the devastating effects of a recession that began early last year, deepened throughout 2008, and had yet to end as of the second quarter of this year.

Two other surveys by the federal government report different estimates of the uninsured, because they are handled by other federal agencies, use somewhat different ways to measure the problem, and assess it for different periods in time. The National Health Interview Survey (NHIS), conducted by the National Center for Health Statistics of the Centers for Disease Control and Prevention, reported in June that 43.8 million persons of all ages were uninsured at the time of their interview in 2008. The NHIS provides several additional measures of the uninsured beyond what is increasingly viewed as more of the single "point in time" estimate provided by the CPS. The latest NHIS report also finds that 55.9 million had been uninsured for at least part of the entire year of 2008 prior to the interview, and 31.7 million had been uninsured for more than a year at the time of the interview.

The Medical Expenditure Panel Survey (MEPS), managed by the Agency for Healthcare Research and Quality, reported just last month that 70.7 million non-elderly individuals were uninsured at some point during calendar year 2007, 53.5 million were uninsured during the first half of that year, and 39.9 million were uninsured all year. By way of comparison, MEPS data indicate that a somewhat higher number of non-elderly individuals (57.4 million) were uninsured during the first half of 2008 than was the case for the first half of 2007.

All of the major federal surveys tell us part, but not all, of a complex story. They may be "close enough for government work" but remain fundamentally designed differently, to measure other things besides insurance status. They vary in the length of time without insurance that is measured, the period that respondents must recall, how insurance is defined, and how questions are asked; as well as time lags in the compilation and reporting of data.

Longer-Term Insurance Trends

Because some of the respective survey questions and methods have changed over time, longer-term analysis over past decades becomes more complicated. Perhaps the most useful analysis of those long-term insurance coverage trends can be found in a July 1, 2009 National Health Statistics Reports publication on "Health Insurance Coverage Trends, 1959-2007," which relies on past NHIS Findings. It concludes that, since 1990, the percentage of nonelderly persons without coverage has remained stable, although the number increased by more than 6 million persons, to 43.3 million in 2007. As is the case with other health measures for the U.S. population, it's more instructive to account for changes in the denominator as well as the numerator by relying more on percentages than on raw numbers alone. To recap more broadly, what we generally know is that the percentage of non-elderly Americans without insurance coverage at any one time has increased slightly in the last 15 to 20 years, but it has remained within a relatively narrow range – usually between 14 and 16 percent of the overall population.

How Long Are People Uninsured?

The share of the uninsured without coverage for more than a year may have increased in recent years as well, but it still generally represents somewhat more than half of all those uninsured at any time during a year. U.S. Department of Health and Human Services researchers found in a 2004 study that about half of those uninsured for at least one month during a two-year period turned out to be uninsured for over a year. Using much older but richer data in the late 1990s within the Survey of Income and Program Participation (SIPP), the Congressional Budget Office estimated in 2003 that about 16 percent of those uninsured at any time during a year remained uninsured for more than 24 months. The lengths of spells without insurance are

important, because different solutions are needed to address the different problems they present. In any case, the broader issue of slowly declining rates of insurance coverage in the United States remains more like a chronic condition (needing better diagnosis and more than one kind of targeted treatment) than a crisis (needing emergency surgery).

Who Tends to Be More Likely to Be Uninsured?

The CPS and the NHIS are the most informative surveys on the demographics and characteristics of the uninsured. Today's CPS report should update past indicators to some degree. The uninsured tend to be younger, with those most likely to be uninsured between ages 19 and 24. Almost all adults age 65 and above are covered primarily by Medicare, and many of them have supplemental private insurance. Men are a little bit more likely than women to be uninsured. Married individuals and persons with more than a high school education are much more likely to be insured. Most of the uninsured are in good to excellent health. The likelihood of being insured rises with income and full-time work status, although nearly half of the uninsured are full-time workers. Hispanics are considerably more likely than those in any other ethnic category to be uninsured. More than a quarter of the uninsured are foreign-born. Based on past Census Bureau estimates, about 10 million uninsured are not citizens and roughly half of them are illegal immigrants. .

Is the "Real" Number of Uninsured Smaller than It Seems?

One can torture statistics in both directions regarding the number of "uninsured." until they plea to lesser or greater crimes. A smaller number for the "seriously" uninsured can be derived by taking into account such factors as the Medicaid undercount and the voluntarily

uninsured, as well as the above-referenced number of undocumented immigrants without insurance.

With regard to Medicaid, millions of potential beneficiaries do not enroll in its various types of coverage across different state programs. Reasons include ineffective and limited outreach efforts, as well as dissatisfaction with what coverage provides. Delaying enrollment is encouraged by the option to gain retroactive Medicaid coverage that may be available for three months prior to application if the individual would have been eligible during the retroactive period. But a somewhat lesser number of those "uninsured" individuals officially lacking Medicaid, or other coverage, may actually have Medicaid insurance after all. The so-called "Medicaid undercount" is derived from findings that Medicaid coverage levels based on survey data are consistently lower than the count of Medicaid enrollees obtained from the program's administrative records. On the high side, a recent study concluded that the CPS overestimates the uninsured population by as much as 9 million people for this reason alone! However, the latest research suggests that the undercount's effect is smaller, because it's more likely to involve Medicaid enrollees erroneously reporting that they have some other type of health insurance rather than none at all.

Some skeptics of estimates of the number of uninsured point to millions of individuals in relatively higher-income households who could afford to buy coverage, but do not, and therefore describe them as "voluntarily" uninsured. According to the last CPS report released in August 2008, more than 17.7 million uninsured live in households earning more than $50,000 a year, and household income is above $75,000 for more than 9.2 million uninsured. However, those numbers overstate the actual income available to those uninsured individuals, because household units are defined more broadly than are insurance purchasing units. As the composition of

"households" changes, their income isn't the same as family income available for spending on health insurance. The rising cost of coverage remains the primary barrier to insurance coverage for the uninsured, and in some cases, its value just may not be "worth it" for those in higher income families. But a more narrow and consistent measure of the higher income uninsured is closer to 2 million, involving people with regular incomes over $50,000 who lack insurance for spells of more than a year.

Affordability of Insurance Coverage Remains the Main, But Not the Only, Problem

The main reason cited by individuals for why they lack insurance is that it costs too much, but it's not the only factor. Adults with weak or uncertain preferences for health insurance are less likely than others to obtain job offers with insurance, to enroll in offered coverage, and to be insured. On the other hand, individuals with higher health risks are more likely to seek and obtain health insurance coverage, particularly in the large employer group market. Higher premiums for higher risks are not a significant contributor to the large uninsured population.

Two recent measures of the "affordability" of insurance coverage suggest some approximate benchmarks that move beyond assuming that taxpayers must subsidize whatever uninsured individuals are unwilling, as opposed to unable, to pay. Bundorf and Pauly proposed several definitions of affordability based on the insurance purchasing behavior of other consumers with similar characteristics, rather than an arbitrarily chosen income threshold, in a 2006 Journal of Health Economics study. When they used a behavioral definition of health insurance as "affordable" if the majority of people in similar circumstances purchased coverage, their study found that health insurance was affordable to over 50 percent of the uninsured in 2000. Even increasing the affordability threshold to one where no less than 80 percent of

individuals with similar characteristics purchased private health insurance, Bundorf and Pauly estimated that approximately one-quarter of the uninsured would still be classified as able to afford coverage. To be sure, no single definition of affordability can fully classify individuals or predict their actual behavior.

June and Dave O'Neill, in a more recent Employment Policies Institute study, used a more simplified and arguably arbitrary income-based measure of affordability to estimate whether uninsured status is voluntary or involuntary. They considered uninsured units with incomes above 2.5 times the federal poverty threshold as voluntarily uninsured, relating that threshold to the percentage of individuals above it that obtain private coverage. (They found that 79 percent of those with incomes between 2.5 and 3.75 times their poverty threshold did so.) The O'Neill measure of affordability concluded that about 16 million of the population between ages 18 and 64, reported as uninsured in 2006, were "voluntarily" uninsured in the sense that their incomes were high enough to enable them to afford a health insurance policy. They represented more than 40 percent of the total uninsured within their CPS-based population for that period and age bracket.

How Much Care Do the Uninsured Receive?

The uninsured certainly receive a fair amount of health care through various payment mechanisms, with a good bit of it seemingly "for free." However, the care the uninsured consume remains less than that of the insured. It also is not received as quickly, and it is not delivered as effectively. People lacking health insurance pay out of pocket, receive uncompensated care, rely on other forms of private and public insurance (such as worker's compensation), and wait until they have access to health insurance. Overall, the full-year

uninsured receive, as one lower-end estimate, about 43 percent of the dollar amount of medical care per person of those who have private insurance coverage for the entire year. (Some earlier estimates placed this figure closer to 50-55 percent). People uninsured for only part of the year spend more than 75 percent (and perhaps as much as 80 percent) of what the full-year privately insured do for health care services.

How Much of that Care for the Uninsured Is Uncompensated, and Shifted to Private Insurance Premiums?

Best estimates indicate that the total dollar amount of uncompensated care in 2008 amounted to roughly $56 billion. The same group of Urban Institute researchers (Hadley et al) providing that figure also calculated that federal, state, and local government funds accounted for $43 billion that was available to pay for that uncompensated care, even after adjusting for possible misallocation of funds spent in the name of the uninsured. Their study concluded that attributing increased private health insurance premiums to any expanded costs of treating the uninsured is a misperception; particularly when a net balance of only about $14.5 billion (using the higher of the two uncompensated care measures they suggested) was arguably financed by the privately insured in the form of higher (cost-shifted) private payments for care and, ultimately, higher insurance premiums. Indeed, they estimated that the amount of uncompensated care potentially available for private cost-shifting is most likely even lower, at about $8 billion in 2008, which was less than 1 percent of private health insurance costs ($829.9 billion).

Other recent competing estimates of cost shifting from uncompensated care to private insurance premiums have undercounted other sources of payment for care received by the uninsured and crudely assumed that the costs of care for the part-year uninsured would be

proportionate to the portion of the year that they were uninsured (unlike Hadley et al., who adjust for the clustering of more health spending into periods of insurance coverage), while tossing in some other estimation errors and omissions. One of the clinching arguments for the Hadley et al. view of cost-shifting is their statistical demonstration that the share of hospitals' overall costs due to uncompensated care remained remarkably stable over time amidst rising levels of uninsurance -- even as hospitals' cost-to-charge markup ratio for private payers has fluctuated for other reasons in a completely uncorrelated manner.

Because most of the costs of uncompensated care are covered by various taxpayer-funded payments (particularly disproportionate share payments to hospitals likely to treat more uninsured and low-income patients), there just isn't much left in what remains to be "shifted" to private insurance premium payers. To the extent such cost shifting can occur not just in theory but in practice, it's due much more to public programs like Medicaid and Medicare that have the legal power to pay much lower "below-market" rates of reimbursement to hospitals and doctors. Expanding low-paying Medicaid coverage might actually make any possible cost shifting to private premium payers worse, not better.

Don't the Uninsured Just Get Necessary, Though More Costly, Care at Overcrowded Hospital Emergency Rooms?

Federal law requires hospital emergency departments to screen and stabilize anyone arriving there with a serious medical condition, regardless of the person's ability to pay. It's sometimes said that"no one goes to the emergency room anymore; it's too crowded." But the rise in emergency department visits over the last decade came from disproportionate increases in use by non-poor persons and not the uninsured. The visit rates by Medicaid patients (82 per 100 persons with Medicaid) are more than 70 percent higher than those of the uninsured (48 per 100

persons with no insurance). Uninsured patients represented 17.4 percent of ED visits in 2006. Between 1996 and 2003, major contributors to ED utilization appeared to be disproportionate increases in use by nonpoor persons and by persons whose usual sources of care was a physician's office.

Does Insurance "Discrimination" Based on Pre-Existing Conditions Make Private Health Insurance Unavailable to Millions of Americans?

A recent report prepared by the HHS Office of Health Reform cites a July 2009 Commonwealth Fund study that estimated that 12.6 million non-elderly adults – 36 percent of those who tried to purchase health insurance directly from an insurance company in the individual insurance market – were "discriminated against" because of a pre-existing condition in the previous three years. The study design was described by the Commonwealth Fund as based on 130 adults insured all year with individual insurance, and nearly 1390 adults similarly insured all of 2007 with employer-sponsored insurance, all of whom were interviewed from June through October, 2007. One particular question evidently asked them (it's unclear if those answering also included some or all of the more numerous survey respondents with employer-sponsored coverage) whether they had tried to purchase coverage in the individual market between 2004 and 2007. However, the actual findings beneath the sweeping headline described above were rather thin. They failed to distinguish between those seeking individual coverage that were turned down completely, had a specific health problem excluded from their coverage, or were charged *a higher price*. Most other analysts studying individual insurance markets would suggest that the latter category (somewhat higher rate-ups of preferred and standard charges) account for the vast majority of the above categories of alleged "discrimination." Note, too, that the 1996 HIPAA provisions prohibiting discrimination on the basis of health status in

employer group plans, as well as setting limits on pre-existing condition waiting periods, for those employees maintaining continuous insurance coverage largely have eliminated any such similar practices in that much larger private insurance market.

For a more standardized and deeper estimate of the relative size of the "medically uninsurable" population not receiving coverage (rather than just those paying more for it), one must go back to the 2001 MEPS, which was the last federal survey to ask respondents under the age of 65 about being denied coverage for medical reasons. In the 2001 MEPS Household Full Year Consolidated File, roughly 2 million persons under the age of 65 said that they were denied health insurance coverage at some time in the past (but not necessarily during 2001). That number also did not necessarily represent individuals who were uninsured in 2001. The numbers reported immediately below relate to denial of insurance by health status and the medical reason for denial (a person could state more than one reason).

Total Individuals

Claiming denial of health insurance	1,980,000
(0.8 Percent of total pop under 65)	
Denied due to diagnoses of cancer	200,000
Denied due to hypertension	190,000
Denied due to diabetes	410,000
Denied due to coronary artery disease	140,000
Denied other reason	1,210,000

Uninsured Individuals

Claiming denial of health insurance	650,000
(1.3 Percent of uninsured under 65)	
Denied due to diagnoses of cancer	60,000
Denied due to hypertension	50,000
Denied due to diabetes	150,000
Denied due to coronary artery disease	40,000
Denied other reason	230,000

The Household Component of the 2002 Medical Expenditure Panel Survey (MEPSHC) also indicates that for persons with high medical expenditures under the age of 65, the most likely ones in that category are those who have private insurance. Among those non-elderly, non-institutionalized persons in the top 5 percent of the health expenditure distribution during calendar year 2002, more than 70 percent had private insurance during the year, and only 4 percent were uninsured.

Are Millions More Insured Americans Becoming Increasingly "Underinsured" as They Face Rapidly Rising Levels of Cost Sharing?

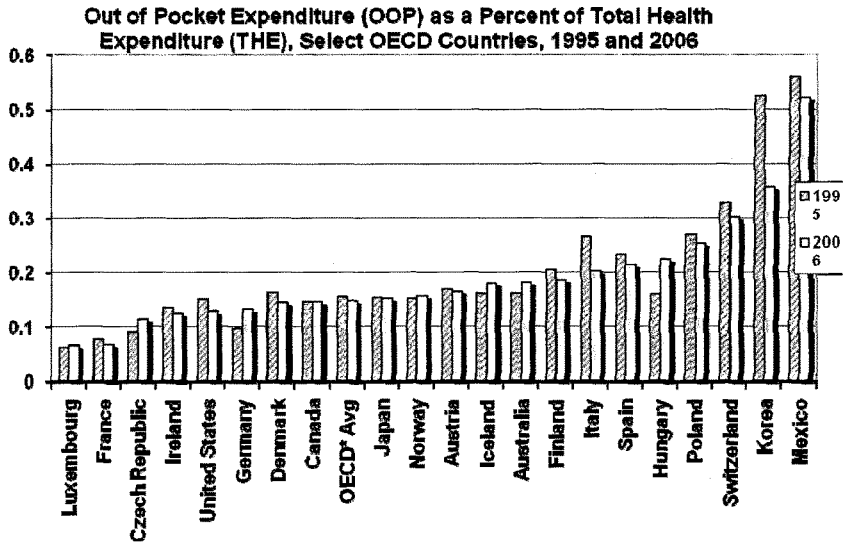
Some exaggerated calculations of recent trends in cost-sharing levels confuse changes in absolute dollar amounts for deductibles, coinsurance, and copayments with their relative percentage as a share of overall health spending, which is rising even more rapidly. Some would disagree over the appropriate spending denominator, as well as federal survey instrument, to use for this calculation. The National Health Expenditure Accounts data compiled annually by the

Centers for Medicare and Medicaid are the most comprehensive ones, and they offer the longest time series for analysis. However, the NHEA methods treat out-of-pocket (OOP) spending as more of a residual category that therefore tends to be lower than the OOP share of private health spending estimated by MEPS.

If one nevertheless uses total national health spending as the most appropriate denominator (rather than just private health spending, due to the NHEA's statistical bundling of OOP spending by Medicare beneficiaries with other OOP spending by the non-elderly population), the overall OOP, or "first-party payment" portion, of national health spending continued to decline to a record low of 12 percent in 2007.

On the other hand, the 2008 NHIS suggests that the share of private health insurance plans with greater dollar amounts of cost sharing has been growing in recent years. It reports that 19.2 percent of persons under age 65 with private health insurance were enrolled in a high-deductible health plan (HDHP), although only 5.2 percent of persons under age 65 actually were enrolled in consumer-directed health plan (CDHP). An HDHP is defined as a private health plan with an annual deductible of not less than $1,100 for self-only coverage or $2,200 for family coverage. A CDHP is defined as a HDHP with a special account to pay for medical expenses.

A different way to size up the relative level of cost sharing in the U.S. health system is to compare it to that of most other developed nations, using the common methodology of the OECD. By those standards, cost sharing in the U.S. as a percentage of total national health spending declined from 1995 to 2006, and, at 12.8 percent, it is lower than the dollar-weighted OECD average (14.7 percent), of its reporting members, as well as the percentage of cost sharing in all but four other such nations (Luxemburg, France, Czech Republic, and Ireland).



Finally, some estimates of the out-of-pocket burden of health spending in the U.S., described as a percentage of a worker's income, mix traditional measures of cost sharing with the employee-paid share of employer-group premiums. In any case, the more accurate and telling measure of the overall share of a worker's total compensation that is devoted to health care costs first would attribute the full cost of an employer-sponsored insurance premium (including both the employer's premium contribution and the employee's contribution) to the worker's total "income," and then determine what share of that amount is represented by the total employer-group premium paid from total compensation PLUS any additional cost-sharing expenses incurred.

By that type of measure, mandating (or assuming) that an average worker enroll in the average comprehensive group plans offered by employers today would cost his or her family close to $13,000 a year in all-in premium alone (without even any lesser amounts of OOP cost sharing). This would place that burden already well beyond the 10 percent, or even 15 percent, threshold share of earnings sometimes selectively cited as too unreasonable and unaffordable for more visible, but more narrowly defined, "cost sharing" measures of workers' health expenses relative to their wage income. As a rough illustration, a worker earning $ 52,000 a year in wages (already well above median levels) and another $13,000 in an employer-provided family insurance policy coverage is already essentially devoting, or having preempted, 20 percent of total compensation to insurance premium costs alone, before any cost sharing kicks in!

To conclude, many of the estimates of the levels and dimensions of uninsurance remain inexact and dependent on what one intends to measure. We do know, or at least should begin to know, the following:

The cost of insurance, and, even more so, the cost of health care itself, remain the most decisive factors behind coverage levels – particularly at the margins of spending decisions and particularly for lower-income health consumers. Insurance premiums over time must reflect the underlying costs of healthcare as it is delivered and demanded

The relative share of insurance obtained from employer-sponsored coverage has been declining, and it will continue to do so. Reduced employment growth, lower take-up rates by workers offered coverage, and more restricted eligibility for coverage within firms all are factors in the latter; with the effects greatest among smaller businesses.

Public program insurance coverage has been growing, particularly for the lowest-cost groups (children).

Subsidies to encourage greater coverage by the currently uninsured, particularly in a voluntary purchasing market, need to be substantial to have significant impact.

Even in the midst of resumed economic growth sometime ahead, we may have already reached the point of diminishing returns in trying to stretch tax and regulatory subsidies even further. It's increasingly hard for them to catch up with healthcare costs that continue to grow faster than the overall economy.

Third-party payment mechanisms drive up health care costs, and lower income consumers are the most likely to be the first ones squeezed out of the less-affordable markets they help create.

Targeting of subsidies and other forms of public assistance to access health care is crucial. Not every person uninsured for shorter periods of time represents as great a problem as the chronically uninsured.

The real solutions will come from keeping people healthier to begin with and treating their medical conditions more effectively and efficiently. Changing public policies that keep the entry price of insurance coverage too high for too many Americans would provide a starting point for more progress. Reversing decades of overregulation, mistargeted tax subsidies, and lack of transparency in the healthcare sector would not solve all problems, but it surely would help reduce them.

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