

BRIEFING ONE
IDENTIFYING THE UNINSURED AND THEIR IMPACT ON U.S. HEALTHCARE
BOBBY JINDAL, HHS ASSISTANT SECRETARY FOR PLANNING & EVALUATION

Assistant Secretary Jindal discussed the demographics of the uninsured, the source of his information, and the President's FY2003 budget request. We learned from Assistant Secretary Jindal that according to the March 2001 Current Population figures:

- 38.7 million Americans were without health insurance for all of 2000. (14% or more than 1 in 7 Americans). This is the second consecutive annual decrease in the uninsured rate. The previous year the uninsured rate was 39.3 million Americans.
- The uninsured include some of the most vulnerable in our society: approximately 12 million children, 17 million low-income Americans, 7 million African-Americans (18.5%) and 11 million Hispanics (32%).
- Most of those who became insured between 1999 and 2000 had previously received insurance from the employment-based market. In 2000, 3.7 million more Americans were covered in this market. 70% of Americans in 2000 were covered by employment based plans as compared to 9.2% in the individual market. What is notable about 70% is that for the second year in a row, the increase in employment based coverage was significant—from 69% in 1999 to 70% in 2000.
- Yet, more than half, or 56%, of the uninsured and their dependents worked full-time, full-year jobs. 31.8% of those in the agriculture industry were uninsured as compared with 8% in the financial industry.

Medicaid and SCHIP—the figures demonstrate that SCHIP is working.

- The percentage of children uninsured dropped from 12.6% in 1999 to 11.6% in 2000. The increase in employment based coverage accounted for most of the change.
- 24.2% of Americans had government insurance. Of that 10.4% of Americans are enrolled in Medicaid—up 0.1% from the previous year. Although Medicaid insured 12.4 million poor people, 9.2 million others still were uninsured.
- Among the near poor (those with a family income greater than, but less than 125% of the poverty level), 26.9% (3.3 million people) lacked health insurance in 2000. This percentage increased significantly from 24.7% in 1999.
- Private health insurance among the near poor (40.3%) and government health insurance (44.6%) did not change significantly from 1999.
- Among low income Americans (below 200% of poverty), Medicaid covers 40% of children and 17% of nonelderly adults.

- One in five Children were covered by Medicaid in 2000. In addition over 2 million children are enrolled in SCHIP. Nearly all low-income children are eligible for Medicaid or SCHIP, 24% remain uninsured.
- Children 12 to 17 years old were more likely to be uninsured than those under 12—12.3% compared with 11.3%.
- 20.4% of all children were covered by Medicaid/SCHIP. Of those 35.8% were black, 32.8% were Hispanic, 18.6% were Asian and Pacific Islander, 17% were white, and 13.2% were white non-Hispanic.

Employment Based Coverage –

- Small businesses employ roughly 60% of the uninsured.
- Of the 140.4 million workers in the United States who were 18 to 64 years old 57.1% had employment based health insurance coverage *in their own name* in 2000.
- 65.6% of all Americans (ages 0 and including those 65 and over) had employment based health coverage.
- Employment based coverage grew from 69% in 1999 to 70% in 2000.
- Only 35% of small low-wage firms (where 1/3 of the workers make less than \$20,000 a year) offer their employees benefits compared to 85% of small higher-wage firms (where less than 1/3 of the workers make less than \$20,000 a year).
- 31.6% of workers age 18 to 64 that worked in businesses with less than 25 employees had employment based health insurance coverage in 2000.
- 56% of workers age 18 to 64 that worked in businesses with 25 to 99 employees had employment based health insurance coverage in 2000.
- 66.9% of workers age 18 to 64 that worked in businesses with 100 to 499 employees had employment based health insurance coverage in 2000.
- 68.9% of workers age 18 to 64 that worked in businesses with 500 to 999 employees had employment based health insurance coverage in 2000.
- 70% of workers age 18 to 64 that worked in businesses with 1,000 or more employees had employment based health insurance coverage in 2000.
- 70.5% of children in 2000 were covered by employment based coverage or privately purchased insurance.

BRIEFING TWO
LEGISLATIVE APPROACHES TO REDUCING THE UNINSURED
CONGRESSIONAL RESEARCH SERVICE EXPERTS: HINDA CHAIKIND (PRIVATE HEALTH
INSURANCE AND MEDICARE+CHOICE), JEAN HEARNE (PRIVATE HEALTH INSURANCE,
SCHIP, AND MEDICAID), AND ROBERT LYKE (HEALTHCARE TAX ISSUES)

At our second briefing three analysts from the Congressional Research Service provided an overview of legislative proposals to address the uninsured as well as issues to consider when drafting legislation to address the problem. Among the questions considered were: What has Congress done in the past to lower the amount of uninsured? What has Congress done to rectify this current crisis? And, what can Congress do in 2002 to provide health insurance for America's most vulnerable?

We discussed state high-risk pools; the purpose they serve, experiences with them and the importance of them.

- State high risk health insurance pools and similar state programs serve the so called “uninsurable” population—those with pre-existing conditions that make it difficult to obtain affordable private health insurance coverage.
- Nationally, enrollment in risk pools continues to grow
- Sharp increases in health care costs have led to rising claims and increased funding pressures for risk pools, particularly for those that rely on annual state appropriations (Louisiana and Illinois).
- There is more interest than ever in new broader based ways to fund pool subsidies. More states are spreading the funding of the pools over a more inclusive base, and are interested in creating low income premium subsidy programs. Recently, Montana and Utah took these steps; however, Montana needs funding for their program.
- Affordability and competitiveness are a major concern for all health insurance markets, but particularly for the individual insurance markets.
- Risk pools are a way to guarantee access and help provide more stability in the individual market.
- Overall enrollment in the 28 operating state high risk pools (excluding Tennessee and New Hampshire) was reported at 127,406, that is up almost 13% from a year ago. Twenty three state programs had increases in enrollment. Texas grew more than 50 percent, primarily because it is a new program with a large population. Wisconsin, Oregon and Indiana—three long established larger state programs—also grew by over 20 percent, as did smaller programs in Colorado and Montana. Five states declined in enrollment, four of them by insignificant amounts. Due to inadequate funding, California dropped the most, by more than 15 percent, because the state pool has been forced to adopt a declining pool enrollment cap due to inadequate funding. The waiting list to get in the program is now over two years.
- Different factors affect growth in enrollment in different states. Some of the factors include continued growth in federally eligible portability enrollees under HIPAA and high costs of small employer coverage which moves people into the individual market.

- States want to set up risk pools or expand them, but in many cases lack the funding. Arizona, North Carolina, and Florida are among those states. Congressman Fletcher worked to get language in the budget resolution that states “It is the view of the Committee that grants to the States for the establishment of health insurance risk pools merit serious consideration.” There was a proposal in the third Economic Security proposal Bill by the House would do just this. Congressman Fletcher is planning on introducing similar legislation.
- State high risk health insurance pools are programs that states initiate as a safety net to guarantee that everyone has a right to purchase health insurance protection, regardless of health conditions. Risk pools keep the individual insurance market viable for more companies to compete in and will continue to evolve as they have for the past 24 years as a means to provide cost effective guaranteed access to insurance.
- For more state and national facts and figures, contact Rep. Fletcher’s office.

The CRS officials compared the amount of money the United States spends on health care as compared with other countries, and noted the differences in our healthcare structures that result in a large number of uninsured in the United States compared to Europe.

CRS officials led a discussion about different approaches to getting all Americans insured: Is mandating coverage and or moving to the individual market the way to go? Is a hybrid system of employment-based care and the individual market a better solution?

Finally, the group discussed health care tax credits, challenges with reaching all of the uninsured through the use of credits and the differences in current and past legislative initiatives.

BRIEFING THREE
THE PRESIDENT'S FY2003 BUDGET AND PROVISIONS AFFECTING THE UNINSURED
JANET HALE, ASSISTANT SECRETARY OF HEALTH AND HUMAN SERVICES
FOR BUDGET, TECHNOLOGY, AND FINANCE

Assistant Secretary Hale outlined the President's FY2003 \$489 billion budget (outlays) for HHS. She discussed the provisions in the budget to:

- increase funding for bioterrorism response readiness, including hospital capacity, and food safety inspections
- increase NIH funding
- provide \$190 billion for Medicare reform and for expanding Medicare Plus Choice
- create a prescription drug benefit for low-income seniors, which the Administration views as a first step toward creating a comprehensive prescription drug program
- increase funding to improve patient safety, in particular by developing new technologies to standardize information on medical records

Assistant Secretary Hale discussed the proposal in the budget to address the uninsured. This includes:

- \$89 billion in tax credits that provide up to \$3,000 in benefits to individuals for purchasing health insurance
- the extension of SCHIP funding so that states do not lose unspent funds

Chairman Fletcher asked if the funding to increase patient safety through technology would be used in concert with bioterrorism readiness efforts. He emphasized the need to improve and standardize medical information systems. Assistant Secretary Hale concurred that this was important, and HHS would work to standardize medical information systems.

Assistant Secretary Hale answered an inquiry from staff about the mechanics of the tax credit. She explained that the credit is phased at higher income levels and would be based on the individual's previous annual income. Therefore, an individual can give the credit to an insurance agency in order to purchase healthcare coverage instead of waiting to be reimbursed after filing taxes.

Subcommittee Chairman Fletcher emphasized the need to create high-risk pools and to move the healthcare system toward increased patient responsibility for decision-making. Assistant Secretary Hale agreed.

ADDITIONAL INFORMATION FROM CHAIRMAN FLETCHER

- The New England Journal of Medicine article, “Lack of Health Insurance and Decline In Overall Health in Late Middle Age,” October 11, 2001

Elderly Morbidity –

1. In the general population, persons without health insurance have a higher mortality rate than persons with private insurance.
2. There is an increased risk in adverse health outcomes among the uninsured participants regardless of sex, race, and income—and this is consistent with the results of a previous study.
3. The increase in the risk of a major decline in health for the uninsured was greater among participants who were in better health.
4. Recent studies show that intermittently uninsured persons were less likely than others to have a primary care provider, more likely to delay seeking care, and more likely to go without needed care.
5. Conclusion of article: the lack of health insurance is associated with an increased risk of a decline in overall health among adults 51 to 61 years old.

Kaiser Family Foundation’s two new reports demonstrate how specific changes in the unemployment rate affect both the number of uninsured Americans and the demand for Medicaid coverage.

- “Rising Unemployment and the Uninsured”
<http://www.kff.org/content/2001/6011/6011.pdf>
examines the relationship between the unemployment rate and increases in the uninsured and finds that **for every percentage point increase in the unemployment rate, 860,000 people will become uninsured.** This suggests that 1.2 million more non-elderly Americans became uninsured due to the rise in unemployment (1.4 percentage points) between December 2000 and October 2001.

- “The Impact of Rising Unemployment on Medicaid”
<http://www.kff.org/content/2001/4026/4026.pdf>
illustrates the relationship between rising unemployment and increased Medicaid enrollment and spending. According to this new analysis, **an increase in the unemployment rate from 4.5 percent to 5.5 percent would be likely to increase Medicaid enrollment by 1.6 million Americans and state Medicaid spending by \$1.2 billion.** These projections reflect increases in Medicaid coverage as more people lose both jobs and income and move into lower income groups that qualify for coverage. *However, if states restrict or reduce eligibility due to increased fiscal pressure, Medicaid enrollment could be curbed, which would in turn increase the number of uninsured.*

- NASCHIP, National Association of State Comprehensive Health Insurance Plans, Comprehensive Health Insurance for High Risk Individuals, Fifteenth Edition, 2001/2002, A State by State Analysis.
- Communicating for Agriculture, www.selfemployedcountry.org, 14th edition, 2000.