Health Insurance:
A Vital Consideration

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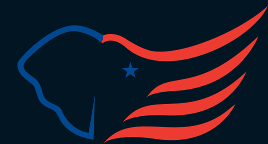

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The Honorable Nancy Johnson

21st Century Health Care System

The two health care issues on the public mind are rising costs and the growing number of uninsured. Unfortunately, the cost problem makes an honest and effective solution to the uninsured problem impossible. Yet inaction is not an option. And cutting reimbursements will only further reduce access to care and erode care quality.

Fortunately, the foundation has been laid to both reduce costs and improve quality, but Congress needs to act on three significant issues to assure that outcome. Passage of a Health Information Technology bill will accelerate the development of a progressive health care delivery system that can deliver the most recent information to doctors at the time of diagnosis, eliminate inappropriate and redundant care, reduce administrative costs and create a more proactive, patient centered and affordable health care system. Passage of legislation assuring fair methods of measuring the quality of provider performance will build the trust necessary for Pay for Performance to truly advance care quality. And lastly, passage of legislation to provide consumers with better information on quality, cost and their responsibilities for their own health and wellness is crucial to the success of a 21st century, integrated care system.

If we fail to meet these challenges and continue to rely on cutting provider payments even as practice costs rise, we will continue to reduce access to care and compromise care quality. Medicaid is already a false promise, paying providers so little that beneficiaries have a hard time finding a doctor to care for them. And Medicare is on the same course, as the law dictates cutting physician payments 5% a year for five years!

While payment laws are outdated, so is the narrow focus on illness treatment.

In the Medicare Modernization Act (MMA) we focused on the 20% of Medicare patients with multiple chronic diseases because they use 80% of Medicare dollars. Since similar statistics characterize private plan costs, developing a patient centered system, capable of care management amongst multiple physicians and both medical and community care programs, is key to improving quality and controlling costs.

Electronic health records, electronic prescribing of medication, electronic decision support are all essential to bringing the latest information to the service of patients and physicians during the diagnostic process. These tools are equally essential to educating and involving patients in their own care as preventative health and chronic diseases management require; to eliminating duplicative tests from labs to MRI's and the handwriting problems that cause costly and painful prescribing errors; and to eliminating the repetitive administrative costs of over and over recording name, addresses, telephone number, allergies and your Medicaid history. Studies have demonstrated that 30% of all healthcare spending, or about $3 billion annually was for duplicative paperwork, redundant tests of all kinds, inappropriate care or avoidable hospitals and emergency room visits. Only HIT systems can address these issues and both slow spending growth and enhance care quality.

Courtesy of Rep. Johnson's office

While much has been done, through Medicare pilots and ARHQ research grants, Congress needs to act now to pass a health information technology (HIT) bill. We must clearly establish the public-private collaboration essential to setting standards to ensure interoperability without compromising the pace of technological development, and to providing financal support to the local processes that build the knowledge and trust essential to such a systemic change and help providers with the cost of the new technology.

Complimenting a health technology bill, we need a legal structure that assures that clinical standards for practice performance will originate with physicians and that measurement methodologies will be based on science and assure fairness. Only then can a system that pays for quality performance replace our totally outdated physician payment law.

Lastly, ways to accurately communicate with health care consumers regarding care choices, patience responsibilities, cost and quality must be developed. For patient involvement in an era of chronic illness and rich technological and pharmaceutical options is essential and must be well grounded in information.

Clearly, annual payment adjustments must be attended to and a raft of ideas are on the table to modestly increase access to care for the uninsured. In the long run however, modernizing Medicare's underlying laws, to pay for quality and better inform health care consumers, coupled with adoption of modern HIT systems, are the real answer to assuring the survival of high quality public and private healthcare in America. Then and only then will all Americans have access to both the preventive care and illness treatment that is so important to each fulfilling their own potential.

— The Honorable Nancy Johnson served 12 terms in the U.S. House of Representatives before joining the firm of Baker, Donelson, Bearman, Caldwell & Berkowitz, PC earlier this year. She is one of the nation's leading experts on health care.

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Living Without Health Insurance: Why Every American Needs Coverage

Grace-Marie Turner

With the increasing ability of the medical profession to save and improve our lives, Americans value the security of health insurance to cover their health costs. For public policy solutions to be effective in reducing the number of those who do not have the security of health insurance, we must look beyond the numbers to find real solutions. When we look at the trend lines for health insurance coverage in the U.S., it is clear that we must chart a new course.

The number of people without health insurance is steadily rising, now 44.8 million, according to recent revised Census Bureau estimates,[1] and the number of people with coverage through the workplace is falling, from 69% in 2000 to 61% in 2006.[2] If public policy solutions are to be effective in reducing the number of uninsured, it is important to look beneath these numbers to see who is uninsured, why, and what solutions are likely to work to expand coverage.

About 80% of the uninsured are workers or their dependents.

Analyses show those who are most likely to be uninsured are young adults, those working for small businesses and their dependents, lower-income workers, and minorities. To increase coverage for those who are most likely to be without insurance, new strategies must be explored.

A profile of the uninsured

About 80% of the uninsured are workers or their dependents. These are people who make too much to qualify for public programs, such as Medicaid and the State Children's Health Insurance Program, but don't have the good, higher-paying jobs that come with health insurance.

There are two choices: dramatically expanding public programs to cover this population or finding new ways to help them access private coverage. Research by Jonathan Gruber of MIT suggests that the former may not be the best strategy. With a little creativity, there are existing public funds that could be used to efficiently expand access to private coverage for this target population.

Before creating solutions to increase access to health insurance for those who do not have it, it is essential to define who is most likely to be uninsured. There are four major groups:

- Young adults: Among young adults aged 19-24, 38.2% do not have health insurance.[3] For this population of people

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who are overwhelmingly healthy and believe in their invulnerability, the cost of insurance is the biggest issue.

- Employees of small businesses: Only 60% of small firms offered coverage in 2006. And the smallest firms are least likely to provide coverage: Only 48% of firms with 3 to 9 workers offer health insurance to their workers. The drop in employment-based health insurance has been primarily among small companies employing 3 to 199 workers. In contrast, 98% of large firms with 200 or more workers offered health insurance in 2006.[4]

  The reason firms cite for not offering health insurance is the high cost of coverage, with 74% saying that the high price of premiums is a "very important" reason they don't offer health insurance.[5] Some firms are just too small to manage their businesses as well as the complexities of health insurance. The National Restaurant Association says, for example, that some employees may only work for a restaurant for a few days, making it almost impossible to enroll these workers in health plans and for their job to be a stable source of coverage.

- Lower-income Americans: In 2005, 37% of non-elderly people with incomes under 100% of federal poverty were uninsured compared to just 7% of those with incomes of 300% of poverty or above.[6] Lower-income workers need targeted subsidies to help them afford insurance.

- Minorities: An estimated 32.3% of Hispanics are uninsured, compared to 10.7% of whites and 19% of blacks.[7] This suggests that outreach to the Hispanic community with new options and information about those options would be an important component of an effort to increase enrollment in health insurance.

Even though a profile of the uninsured captures these primary categories, the actual faces in this group without coverage are ever-changing. According to the Congressional Budget Office, the uninsured population is constantly shifting as people gain and lose coverage. Furthermore, the length of time that people remain uninsured varies greatly. Some people are uninsured for long periods of time, but more are uninsured for shorter periods. About 45% are uninsured for four months or less.[8] This is primarily a phenomenon of our system of job-based health insurance where people lose their health insurance when they lose their job and have periods of no insurance while they wait to get covered again.

As Congress focuses on the problem of the uninsured, it would be helpful to look at the success of past strategies in expanding access to public coverage.

Many of the uninsured are eligible for public programs; 25% are eligible but not enrolled in public programs. Another 20% have incomes high enough to afford coverage, defined as 300% of poverty or above, according to a report published in *Health Affairs*.[9]

The CBO says that 16% are continually uninsured for more than two years, and they tend to be people with less education, those with low incomes, and Hispanics. These longer-term uninsured are an important group for Congress' attention as they clearly have fewer opportunities for private coverage.

Crowd out

As Congress focuses on the problem of the uninsured, it would be helpful to look at the success of past strategies in expanding access to public coverage, especially through Medicaid expansions and the creation of the State Children's Health Insurance Program.

Over the past two decades, the number of people without health insurance and the number of people with publicly-supported health insurance both have risen.[10] According to Jonathan Gruber of MIT, from 1984 through 2004, the share of the non-elderly population in the U.S. that was uninsured rose from 13.7% to 17.8%. At the same time, the share of the non-elderly U.S. population that is publicly insured rose from 13.3% to 17.5%. In other words, Gruber shows that despite an enormous expansion in public health programs, the number of uninsured continues to grow.

Gruber's research suggests that most of the rise in public insurance comes from a fall in private insurance. His data analyses show that between 1984 and 2004, the share of the U.S. non-elderly population with private health insurance fell from 70.1% to 62.4%. His estimates suggest that expansions of public insurance

are crowding out private insurance at the rate of 60%. That means, in general, that private insurance coverage is reduced by 60% as much as public insurance rises.

Because there is a great deal of attention to expanding the State Children's Health Insurance Program, it is important to look at these findings to make sure that a program expansion wouldn't simply be replacing private insurance with taxpayer-supported coverage. Gruber finds that crowd-out is most likely to take place with those in higher income categories – the target category for SCHIP expansion – because they are more likely to have options for private coverage.

It is only logical that people would opt for public coverage if it were offered because taxpayer-supported insurance is almost always less expensive for recipients than private insurance. But it may be worth rethinking this strategy if the goal of the added spending on SCHIP is to reduce the number of uninsured. Gruber's research suggests that expanding SCHIP could add more children to public rolls but not have a significant effect on reducing the number of uninsured children.

According to the Kaiser Commission on Medicaid and the Uninsured, a surprising percentage of poor and near-poor adults – those earning 200% of poverty or below – have employment-based or other private health insurance.[11] The Kaiser study shows that 45% of non-elderly people who earn between 100% and 199% of poverty (up to $20,420 in 2007) have private health insurance, either coverage they get through work (39%) or individual policies (6%). About a third of lower-income adults are uninsured and one-quarter have public coverage, primarily through Medicaid or SCHIP.

With so many competing priorities for taxpayer dollars, it would be a clear mistake to replace private coverage for those who have it with expanded public health programs.

Making private insurance more expensive

It is also essential to examine the consequences of a major expansion of SCHIP or other public programs on the market for private insurance. Expansion of government health programs drives up the cost of private health insurance, according to health actuary Mark Litow of Milliman Consultants and Actuaries. Here's why: He estimates that private health plans pay about 64% of the full charges of doctors, hospitals, labs, etc. Medicare pays about 37% of these "undiscounted" charges. And Medicaid pays only about 30%.[12]

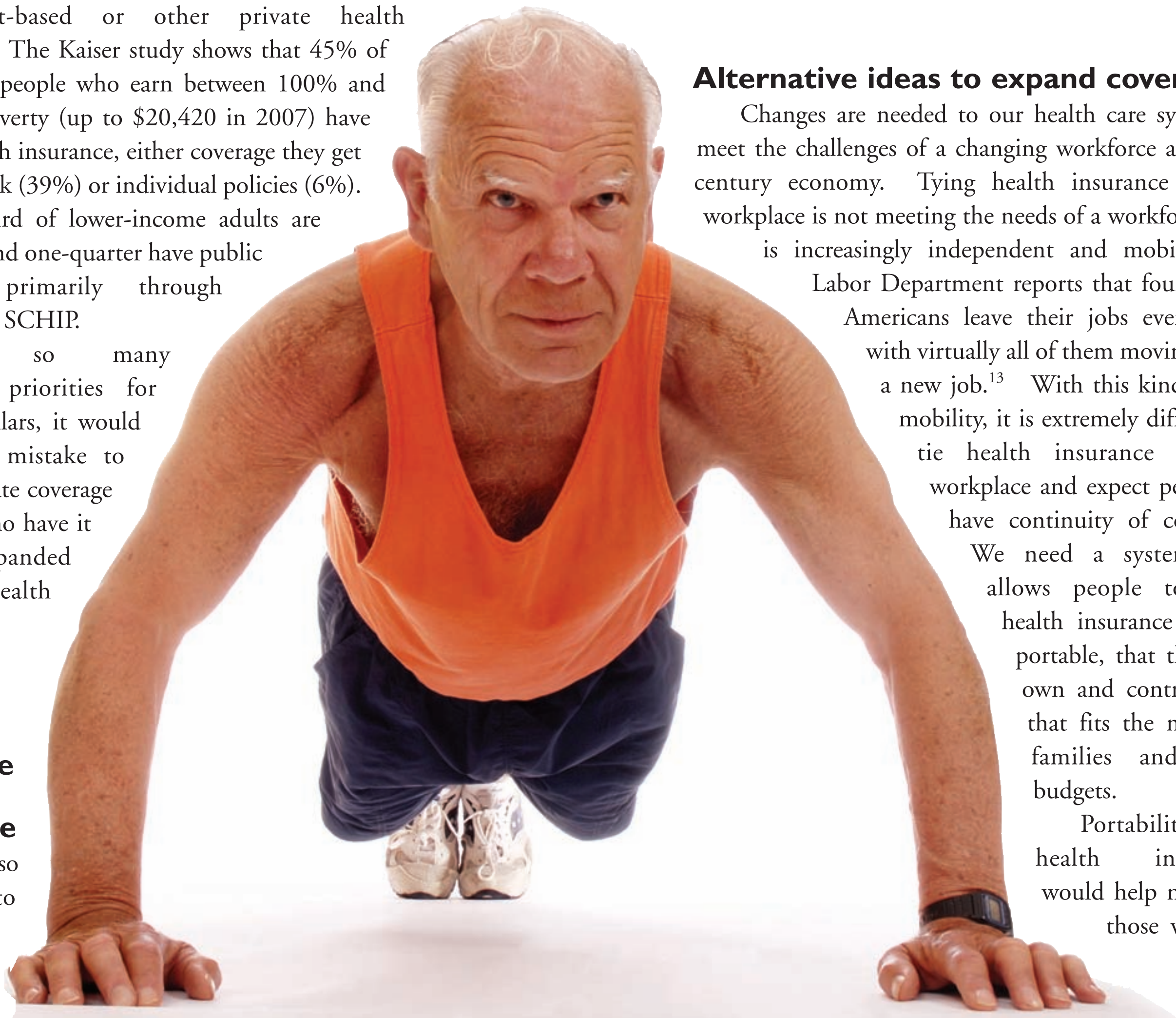
It is only logical that if more of the market is taken up by programs paying only 30% of a provider's charges, more pressure will be put on others to make up at least some of the difference. Litow argues that expanding government programs puts added pressure on the cost of private health insurance. As public programs expand, private plans must pay more. Their costs rise, driving up premiums and causing more people, especially individuals and small businesses, to drop out of the market, thereby swelling the ranks of the uninsured.

With 160 million Americans receiving health coverage through the workplace, it is essential that legislative changes do not make it more difficult for employers to provide coverage by inadvertently driving up their premiums through expansion of public programs.

Alternative ideas to expand coverage

Changes are needed to our health care system to meet the challenges of a changing workforce and 21st century economy. Tying health insurance to the workplace is not meeting the needs of a workforce that is increasingly independent and mobile. The Labor Department reports that four in ten Americans leave their jobs every year, with virtually all of them moving on to a new job.[13] With this kind of job mobility, it is extremely difficult to tie health insurance to the workplace and expect people to have continuity of coverage. We need a system that allows people to have health insurance that is portable, that they can own and control, and that fits the needs of families and their budgets.

Portability of health insurance would help not only those who are



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uninsured, but also those who are worried they could lose their coverage. It would give new security to millions of workers who are worried that if they lose their jobs, they will lose their health insurance. With the cost of health insurance and health care rising every year, they fear they would not be able to afford coverage on their own. The middle class is increasingly afraid that they are one premium payment away from joining the ranks of the uninsured.

America can lead the way in creating a health care system that fits with our 21st century economy by putting in place new policies that respond to consumer demands for more affordable, portable health insurance. The first step is giving favorable tax treatment of health insurance to people whether they buy coverage on their own or get it at work, as President Bush has proposed. Then Congress could offer refundable tax credits for those in lower-income categories who need additional help in purchasing policies.

Additionally, Congress could allow those eligible for public programs to apply the value of the subsidies for which they are eligible toward the purchase of private health insurance. This would mean that citizens could take the value of their Medicaid benefit and apply it toward employer-offered coverage. Or they could take the value of their SCHIP subsidy to add their children to their policies at work. Finally, legislators could create new opportunities for people to purchase group health insurance through organizations that may be more stable forces in their lives than their jobs, such as churches, labor unions, and professional and trade associations.

This combination of a general tax deduction or credit, with additional financial assistance for lower-income people, and flexibility to turn SCHIP and Medicaid benefits into defined contributions would retarget existing funds to increase access to private health insurance.

Building on this base of private coverage would be more economical for taxpayers and would give workers eligible for public subsidies the dignity of private insurance coverage, including broader access to private physicians and medical facilities.

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Consumers, not just in the United States, but in all developed countries, are demanding a much greater role in decisions involving their health care. Women especially believe that they, rather than a corporate human resources director, could make better decisions involving health coverage for their families if only they were given the chance.[14]

Giving people more power and control over their health care and health insurance creates new incentives for them to engage in managing their health. Many companies realize this and are instituting new programs to give employees incentives to better manage their health spending. A number of studies have shown that if people are given the tools, the information, and the incentive to manage their care, outcomes can be dramatically improved. And we could transform our health care system into one that responds to the changes of a 21st century workforce and meets the needs of a diverse population of health care consumers.

— Grace-Marie Turner is President of the Galen Institute, a not-for-profit health and tax policy research organization. Her article was adapted from testimony before the House Committee on Energy and Commerce Subcommittee on Health, April, 2007.

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