

Testimony by
Ronald F. Pollack, Executive Director
Families USA

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Examining Innovative Health Insurance Options
for
Workers and Employers

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Committee on Education and the Workforce

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Thank you for inviting me to testify today. Families USA is the national organization for health care consumers. Our mission is to ensure that all Americans have access to high-quality, affordable health care. Families USA strongly supports comprehensive, affordable health insurance for all residents of this nation.

One Out of Three Americans Without Health Insurance

Last week, Families USA released a new report that examined the number of Americans who experienced the physical and financial risk of being uninsured. We believe it is a shame and disgrace that in the two-year period 2002-2003, approximately 82 million people – *one out of three* Americans who are not eligible for Medicare – were uninsured for some period of time.¹ Contrary to popular perception, the overwhelming majority of people—more than four in five—who are without health insurance were connected to the workforce. Of these working uninsured, many—but certainly not all—are in low-wage jobs:

- Nearly two-thirds (60.9 percent) of individuals in families with incomes at or below 100 percent of the federal poverty threshold (\$18,660 a year for a family of four in 2003) were uninsured at some point over the past two years.
- More than half (53.5 percent) of individuals in families with incomes between 100 and 200 percent of the federal poverty threshold (up to \$37,320 a year for a family of four in 2003) were uninsured in that period.
- The likelihood of being uninsured decreases considerably as income increases. However, a quarter (25.2 percent) of working individuals and their families with incomes between 300 and 400 percent of the federal poverty threshold (from \$55,980 to \$74,640 a year for a family of four in 2003) were uninsured at some point over the past two years.

The growing number of Americans without health insurance is now a phenomenon that significantly affects middle class and working families. As a result, this problem is no longer simply an altruistic issue affecting the poor, but a matter of self-interest for almost everyone. Our new report describes the reasons why hard-working Americans are without health insurance coverage, and points out that any attempt to provide coverage to a significant number of uninsured individuals must address the problem of lower-wage workers who are not offered or cannot afford employer-based health insurance. Any solution must address the problem of insurance policies with deductibles and co-payments that are so high that the policy is unusable by lower-income individuals and families. For example, “consumer directed health care,” with its high deductibles, is a cruel joke for those who today have trouble filling their gas tanks as they struggle to stay within very tight family budgets.

Further, solutions to the uninsured that build on the employer-based health insurance system also must address the gaps in health insurance coverage that occur with gaps in employment.

We all understand that going without health insurance can have terrible physical and financial consequences. Perhaps the most compelling statistic that drives this point home is from the Institute of Medicine: Every year about 18,000 Americans die prematurely and unnecessarily because they do not have health coverage.² That is about two deaths per hour. While we meet this morning, several of our fellow citizens are dying needlessly because they do not have health insurance. Millions more suffer from poorer health, lost income, bankruptcy, and stunted lifetime opportunities because they do not have coverage.

While not the topic of today's hearing, I also would like to point out that earlier this week the Supreme Court delivered some bad news for an estimated 131 million workers and their families that have employer-based coverage. In a unanimous decision, the Court ruled in *Aetna v. Davila* that patients cannot sue their managed care companies for damages in state court.³ There is now no meaningful way for patients to hold their HMOs accountable for improper denials of care. As a result, there will be no economic deterrence to prevent HMOs from making wrongful decisions that cause significant harm to workers and their families. While these workers won't join the ranks of the uninsured, they may be considered "underinsured" or "incidentally uninsured" when they do not receive the vital health care that they need.

In response to this week's decision, we hope that Congress will reconsider passage of a strong patients' rights law. This Supreme Court decision provides new urgency to the passage of a strong federal Patients' Bill of Rights law, and I thank Representatives Andrews and Dingell, as well as other Members of Congress, for reintroducing a new version of the bill.

Medicare Modernization Act: A Missed Opportunity to Stabilize Retiree Health Benefits

The Medicare Modernization Act provides about \$89 billion in subsidies to encourage public and private employers to continue to offer retiree prescription drug coverage. The subsidy is 28 percent of the cost between \$250 and \$5,000, provided the retiree plan has at least the actuarial value of the basic Medicare benefit. Despite this subsidy, the CBO predicts that about one in four (2.7 million beneficiaries) will see their current better-than-Medicare coverage reduced or eliminated in the coming years. This continuing deterioration of retiree coverage is one of the most controversial and disturbing features of the new law.

The wording of the law is not perfectly clear, but it appears that the subsidy will be paid even if an employer reduces the actuarial value of the plan to just above the actuarial value of the Medicare benefit. As employers start to do this, it will create great anger and fear among beneficiaries. The thought that companies will get billions in subsidies yet have reduced their retiree benefits will be another negative feature of the new legislation.

Congress and this Committee should provide early oversight of this issue to see what companies are planning to do and what can be done to prevent the loss of benefits by 2.7 million seniors and people with disabilities. In the meantime, we urge Congress, as soon as possible, to condition the subsidy on the maintenance of retiree prescription drug benefits at the level they were on, say, January 1, 2004. Only companies that continue to offer superior benefits should get the subsidy. It should also be made crystal clear that the subsidy applies to the employer's share of the program—not the beneficiaries. For employers to get a subsidy on the gross value of the benefit, while they are reducing their net expense by shifting costs onto individuals, would be considered an outrage by most Americans.

Employer-based Approaches to Expanding Health Insurance Coverage

While we all agree about the seriousness of the problem of the uninsured, we are struggling to find solutions that will allow us to move forward in the next few years with positive federal initiatives to expand health insurance coverage to uninsured Americans—and do so without undermining the existing employer-based coverage that the majority of us rely on. Unfortunately, three of the proposals that are seriously being considered by Congress do little to expand health insurance coverage to uninsured Americans and **threaten the stability of employer-based coverage**. I would like to comment on these proposals and urge Members of Congress to reconsider their merits:

- Health Savings Accounts
- Tax credits to buy insurance in the individual market
- Association Health Plans

By comparison, I also would like to share with you four alternative proposals for your consideration. Families USA has been promoting these proposals for several years as a positive agenda that will significantly reduce the number of uninsured in our nation without threatening the stability of existing employer-based coverage:

- Reinsurance assistance to small businesses
- Tax subsidies for unemployed workers to purchase COBRA or other group insurance coverage with consumer protections
- Tax credits for small businesses offering health insurance coverage to low-wage workers
- Public program safety net modernization

With respect to positive proposals, I also would like to acknowledge Representative Andrews' and Representative Payne's bill, "The Group Health Plan Coverage Expansion Act of 2003" (H.R. 2321), which would strengthen the employer-based system so that it better serves workers with serious illnesses by prohibiting group insurance plans from imposing lifetime limits on the value of benefits and prohibiting group health plans from charging workers more based on a pre-existing condition.

Before I present Families USA's perspectives on the HSAs, individual tax credits, and AHPs, I would like to briefly comment on the HR Policy Association's announcement last month that large employers plan to come together to offer health insurance to workers who do not currently have access to employer-based coverage.⁴ The proposal targets part-time workers, contract workers, independent agents and consultants, pre-Medicare retirees, people who have exhausted COBRA, and students who are no longer eligible for their parents' coverage; pooling them together; and providing a range of coverage options for them at different prices.

We appreciate that large employers are taking steps to solve the problem of the uninsured and are willing to use their bargaining power to help individuals access health coverage. However, we are concerned that, even with negotiated prices, many working Americans will not be able to afford this coverage. Since more than 20 million of the people who were uninsured over the past two years are in low-income households – earning less than \$18,660 a year for a family of four in 2003 -- premium costs of up to \$2000 per year remain too high a price for them to pay.⁵ We are also concerned that stripped-down benefits packages that might be offered to make premiums more affordable might not provide meaningful coverage for people who have or who may develop significant health care needs. What these packages will save workers in the front-end through lower premiums will cost them more later on through higher deductibles, copayments, and uncovered services. As well meaning as this proposal is, there is ample reason to doubt that this will be an effective response to workers without health coverage through their jobs, particularly lower-wage workers.

Approaches that Threaten the Stability of Employer-Based Coverage

Health Savings Accounts

HSAs were established by the new Medicare prescription drug law. Only individuals who enroll in high-deductible health insurance plans may establish these accounts. Not only are contributions to these accounts tax-deductible, but earnings on the money in the accounts accrue tax-free, and withdrawals are not taxed if they are used for out-of-pocket medical expenses. The Administration's fiscal year 2005 budget more than doubled the previous ten-year cost estimates for the HSA provisions in the new Medicare law from \$6.7 to \$16 billion.

We believe that the HSAs will be harmful to the nation's employer-provided insurance system. Attached to this testimony is a health policy paper from Families USA on how these programs work, and why they are bad for American society as a whole.⁶ Our analysis of HSAs finds that this approach: 1) does not effectively target resources to the uninsured Americans who most need help with the cost of health insurance; 2) does not impact the underlying cost of health care; 3) makes it easier for employers to shift costs to workers; and 4) has an enormous potential to dangerously undermine the core principle of risk sharing among individuals in employer-based health insurance.

HSAs Do Not Effectively Target Limited Federal Resources to the Uninsured

HSAs—an income tax deduction strategy—do little or nothing to help most uninsured people and fail to target resources to those Americans who most need help with health insurance costs. The large number of people living on incomes below 100 percent of poverty who have no health insurance also do not pay taxes and do not benefit from an income tax deduction. Likewise, for people living on incomes between 100 and 200 percent of poverty who have no health insurance (up to \$37,320 for a family of four annually), the tax deduction offers very little help. They would receive *at most* a small tax deduction of ten percent, which does practically nothing to make health insurance affordable for their families.⁷ A ten percent subsidy won't go far to help low-income workers and their families to find the “extra” cash needed to put into an HSA when they already struggle to make ends meet on very tight family budgets.⁸

HSAs Do Not Impact the Underlying Cost of Health Care

The majority of health care costs delivered in this country is not for elective care or care where choices of treatment or providers even come into play. In fact, 70 percent of all health care outlays are consumed by only ten percent of the population—the very sickest Americans.⁹ To have any real impact on the vast majority of health care services, we need to control the cost of the largest and most expensive treatments for serious illness and disabilities. This kind of health care treatment is most often immediately needed, is physician-guided, and involves decisions that literally make the difference between life or death, sustained health or long-term disability or negative health consequences. When patients confront these “big ticket” health care decisions, they rely on their physicians’ recommendations, go to the closest facility, and appropriately want the best care in accordance with scientific-based evidence. It is fallacious to talk about buying health care the same way we buy a toaster, a television, or even a car.

The health care expenditures that patient/consumers may be in a position to “shop” for—the spending represented by the dollars in a HSA—only have the potential to impact a very small percent of the total health care spending in the nation. At the same time, HSAs may present a “choice” to patient/consumers that could actually increase health care costs. Some of the health services that some people may “choose” to avoid in order to save the money in their HSAs are check-ups, diagnostic testing, and preventive care. In the long run, this behavior will increase the utilization of health care as conditions go untreated and escalate into more difficult and expensive serious illness.

HSAs Make It Easier to Shift Costs from Employers to Workers

While the impact of HSAs may not be felt immediately, over time HSAs create a structure that will make it easier for employers to shift more costs to their workers. Some proponents of HSAs argue that this is not the case because currently many employers are setting up alternative HSA plans that, on the surface, may look like a reasonable deal to all workers compared to the traditional plan offered by the employer. For example, while the deductible may rise from \$300 to \$800, the employer agrees to put \$500 in the worker’s HSA. The worker will then face the same window of \$300 out-of-pocket costs

before the traditional coverage kicks in as in the lower deductible plan. But what happens over time with this kind of HSA/high deductible plan structure?

There is no doubt that employers are moving toward these plans to save money. (And we do not argue that many employers are in desperate need of help with the cost of health insurance for their workers. We maintain that HSAs are the wrong way to help employers.) Premiums do go down as the size of the deductible grows, but it takes a significant jump in the deductible to bring down premiums. Thus, employers will want to move toward higher and higher deductible plans but they won't want to "make up the difference" in the growing deductible gap with HSA dollars. For example, in a year or two an employer will move to a plan with a deductible of \$1,000, yet continue to only make a \$500 contribution to the worker's HSA. The worker will then face an increase in out-of-pocket costs from \$300 to \$500.

HSAs Will Lead to Adverse Risk Selection

As you know, insurance is about spreading risk as broadly as possible. Again, 70 percent of all health care outlays are consumed by only ten percent of the population. Looking at health insurance claims, historically only five percent of the public has always used about 50 percent of the health care dollar.¹⁰ None of us can predict with certainty who will end up in that five percent high cost group. The only way to make insurance affordable for everyone, especially for those who are part of the five percent group with significant medical needs, is to spread the risk as broadly as possible. HSAs move insurance coverage away from risk sharing and toward risk segmentation.

Here is what happens if an employer offers workers a choice between a high-deductible health insurance plan with a tax-break versus a more traditional health insurance plan with reasonable deductibles and copayments. The HSA plans, with high deductibles, will likely siphon off healthier people who anticipate few medical treatment costs and hope to shelter more income from taxes in the account. The people who can't afford to put cash into HSAs will stay in insurance plans with a smaller deductible and lower copayments. So will people who have health problems and who expect to have health care expenses. As the traditional plans lose their healthier enrollees, they will be left with a higher proportion of unhealthy people. More unhealthy people will mean higher per capita costs, so premiums will have to be raised. The faster the premiums rise, the more healthy people with financial wherewithal will decide to opt into HSA plans. This continuing cycle of "cherry picking" healthy people will make the insurance we are used to — plans with smaller deductibles—extremely expensive for those who need them.¹¹

The Administration's HSA Expansion Proposal – How to Spend \$25 Billion to Increase the Number of Uninsured

The President's budget proposed an expansion of HSAs by allowing individuals to take another tax deduction for the cost of insurance *premiums* for the high-deductible

plans linked to an HSA—*only* if these plans are bought in the private, individual market. This new deduction would cost the government an *additional* \$25 billion over 10 years.

Again, this even larger drain of federal resources will not help the vast majority of uninsured Americans obtain health coverage. About 36 percent of uninsured Americans do not earn enough to pay taxes, so they would receive no benefit from this proposed tax deduction. Another 29 percent would be able to deduct, at most, ten percent of the cost of their premiums. Further, like the President’s individual tax credit proposal, HSAs will hurt the nation’s employer-based health insurance system. They will encourage healthier and wealthier workers to leave the traditional group market in favor of high-deductible plans. Those workers who stay in traditional plans will then face higher premiums. This proposal would only benefit high-income, healthy people, nearly all of whom already have access to health insurance.

Worse than not helping uninsured Americans, this proposal may **add to the number of uninsured**. An analysis by Jonathan Gruber, a highly regarded economist at MIT, estimates that nearly eight million people would use the proposed tax deduction—but only about 1.1 million of these people (13 percent) would have been previously uninsured. Further, Dr. Gruber finds that the HSA deduction would lead to some employers dropping existing employer-based coverage, or electing not to offer coverage, because their workers could use the tax deduction in the individual market. In total, Dr. Gruber estimates that employers would drop coverage for 2.1 million workers—**and 1.2 million of these workers would become uninsured**.¹²

Tax Credits to Buy Insurance in the Individual Market

This year, the President proposed tax credits to help people purchase health insurance in the individual market but did not provide funding for the proposal. If funded, the President’s individual tax credits would cost an estimated \$70 billion over ten years. Individuals with incomes under \$15,000 could receive a maximum of a \$1,000 tax credit annually towards the purchase of health insurance. Families with incomes below \$25,000 would receive a \$2,000 to \$3,000 tax credit. The tax credit would gradually decline, ending for individuals with incomes of \$30,000 and for families with incomes of \$60,000. For people who do not owe taxes, the tax credit would be refundable. However, the individual market is not the answer for most uninsured people, and the size of the proposed credits is too small to help most of the uninsured, who are generally among the lowest income in our society. Further, the individual insurance market is deeply flawed: it will not help those who most need help with the high costs of health care.

The Administration claims that this tax credit will help 4.5 million low-income, uninsured people purchase insurance, but the tax credit is far too small to make this claim credible. Meaningful coverage would cost at least three times as much as the maximum value of the tax credit. The average annual cost of family health insurance provided by employers in 2003 was over \$9,000 (and more than \$3,300 for an individual).

The cost of comparable coverage in the individual, non-group health insurance market would be even higher, especially for older and sicker consumers—if that coverage were available to them at all. A recent Families USA investigation found that, in 48 states, there were no standard \$1,000 policies available for a healthy, non-smoking 55-year-old woman. Even healthy, non-smoking 25-year-old women could not buy a \$1,000 policy in 19 states.¹³ Those plans that were available for less than \$1,000 had high deductibles and very limited benefits. Services like prescription drugs, emergency services, inpatient hospital visits, and mental health were either severely restricted or not provided at all.

In addition, the individual health insurance market discriminates against individual consumers on the basis of health status. Sicker people can be rejected for coverage entirely. For example, a 2001 study by the Kaiser Family Foundation inquired about the availability of insurance for hypothetical consumers with varying health status in diverse insurance markets.¹⁴ Applicants were rejected for coverage 37 percent of the time. The study also found that people with health problems who do find health insurance often face higher premiums, high deductibles, or substantial exclusions on their policies. Moreover, someone who is healthy now and purchases an affordable individual policy could face unaffordable increases in premiums if he or she develops medical problems in the future.

Further, this proposal would undermine employer-provided health coverage, since the tax credits could not be used by employees seeking to pay for health coverage in the workplace. Employers will be tempted to drop health insurance for their employees, wrongly believing that workers could use tax credits to purchase coverage in the individual market. In addition, some young and healthy workers may voluntarily opt out of their employer-based coverage to use their tax credit in the individual market. The resulting pool of workers remaining in employer plans will be, on average, older and sicker, driving up the cost of the coverage. This "adverse selection" could cause even more young and healthy workers to depart, raising premiums even further. These rising costs could ultimately force employers to stop offering health insurance or to substantially increase the premiums employees must pay. Older and less healthy workers could lose their coverage and become uninsured.

Finally, individual tax credits are not a cost-effective approach to reducing the number of uninsured Americans. Two-thirds of the tax credits may go to people who already have health insurance.¹⁵ Thus the number of uninsured Americans will not be significantly reduced.

Association Health Plans

We believe that the current Association Health Plan (AHP) proposal poses a serious threat to our existing employer-based health insurance system and violates the important principle: First, Do No Harm. AHPs, which allow small employers to band together to purchase health insurance outside of most state insurance laws, will weaken consumer protections and undermine the existing group market.

Proponents argue that AHPs are simply intended to allow small businesses to band together to purchase health coverage as a group and, therefore, to secure more favorable insurance premiums. Conceptually, such banding together makes good sense and, in fact, nothing in federal or state law prevents small businesses from coming together to purchase health insurance. However, recent proposals to foster AHPs, including legislation now pending in Congress (H.R. 660), would exempt AHPs from state regulation—overriding rules that protect the financial solvency of the plans, that ensure that critical services are covered, and that prevent discrimination based on health status.

Instead, AHPs will be able to design their benefit packages to be attractive only to firms with healthy workers. They will also be able to target industries, sectors, and geographic regions with the healthiest employees and leave out small businesses with older or sicker workers—those who most need coverage. This ability to “cherry-pick” will drive up the cost of coverage for small businesses with less healthy workers, who will then be left in the insurance pool by themselves. This will drive up costs for the many employers who do not or cannot form or join a healthy AHP on their own. In fact, the Congressional Budget Office (CBO) has estimated that, under AHPs, 20 million employees of small employers, including dependents, would experience a premium rate increase.¹⁶

Approaches that Do Not Threaten Employer-Based Coverage

I would like to now briefly describe four proposals that Families USA believes will significantly reduce the number of uninsured in our nation **without threatening the stability of employer-based coverage.**

Reinsurance Assistance to Small Businesses

Four out of five people without health coverage today are in working families.¹⁷ Typically the breadwinners in these families work in small businesses whose owners feel that health benefits are too expensive and volatile – and, therefore, they don’t offer health benefits at all. Unless these small businesses receive effective and well-targeted support, it is unrealistic to expect that they will introduce health coverage for their employees

For small businesses, health costs are likely to be considerably more volatile than the costs experienced by large corporations. A serious illness for even one employee can result in very substantial premium increases for a small business, while larger businesses can absorb those unusual individual claims by spreading the cost risks over a much larger workforce. Therefore, this cost volatility is a significant obstacle for any small business.

To extend employer-provided health coverage, it would be reasonable to consider a federal back-up system that reinsures the relatively few, but costly, large claims incurred by insurers of small businesses, such as individual health expenses in excess of \$50,000. Seventy percent of all health care outlays are consumed by only ten percent of

the population.¹⁸ High cost claims account for less than half of one percent of all health insurance claims but generate 20 percent of the nation’s health care costs. Such a reinsurance system would not only reduce the volatility of future premium increases, but they would also decrease current premiums that small business owners incur—by at least ten percent.

Some have said that this reinsurance program will do nothing to control run-away medical inflation and simply shifts costs from the private sector to the federal government. Families USA maintains that this approach not only will decrease premiums for small businesses, but also can and should be designed to promote health care cost containment. A reinsurance program could help control costs by tying participation in it to a requirement that the insurer participate in various “best practices.” For example, an employer’s ability to benefit from lower rates could be made contingent on participation in a plan that employed the latest medical information technology practices, electronic prescribing, electronic medical records, etc. Participation in wellness programs, chronic care, and disease management programs also could be a requirement for getting the subsidy. In this way, the program could lead the way in encouraging the adoption of true long-range cost containment strategies.

Tax Subsidies for Unemployed Workers to Purchase COBRA or Other Group Insurance Coverage with Consumer Protections

Certainly today’s hearing underscores the many areas where there is little or no bipartisan agreement about how to reduce the number of uninsured Americans. However, one possible approach that should be part of the mix of solutions to reducing the number of uninsured seems to have generated across-the-aisle cooperation: the potential to help unemployed workers with a tax credit approach.¹⁹ Since the 65 percent tax credit included in the Trade Adjustment Assistance Reform Act of 2002 (P.L. 107-210) was passed, a diverse group of organizations have worked together in an unprecedented effort to develop a workable infrastructure for administering the tax credit. Substantial progress has been made, with nearly 75 percent of those eligible for the tax credit now having a state-approved option for using this tax credit.²⁰

By expanding the health coverage tax credit to the remainder of the unemployed, an estimated 4 million people, including dependents, could be kept off the uninsured rolls. Unfortunately, the size of the tax credit—65 percent of the cost of premiums—may not make it a viable solution for lower-income individuals and families. Families USA would recommend that for low-income unemployed people, the size of the subsidy be increased. In addition, the consumer protections in the original TAARA tax credit need to be strengthened so that older individuals and individuals in less-than-perfect health can use the credit. There must be guaranteed issue, no pre-existing condition exclusions, and plans must offer a community-rated premium without underwriting for health status, medical history, age, gender, and other factors.²¹

Tax Credit for Small Businesses Offering Health Insurance Coverage to Low-wage Workers

The percentage of small firms (3-199) workers) that offer health insurance has not changed in the last couple years—hovering at about 65 percent. For small businesses with low-wage workers (firms with 35 percent or more of the workers earning \$20,000 a year or less), the offer rate drops to 54 percent. At the same time, the cost of coverage for small businesses has been rising at rates between 15 and 25 percent per year.

To expand the number of low-wage workers with access to employer-based health insurance coverage, Families USA has proposed a tax credit that would be effectively designed to target help to low-wage workers at small businesses. This approach efficiently uses federal resources to decrease the number of uninsured workers who most need help while supporting the stability of employer-based health insurance coverage for those workers who now have it.

Public Program Safety Net Modernization

Medicaid and the State Children’s Health Insurance Program (SCHIP) are the most important safety-net health programs in America today. Medicaid, by far the program with the largest enrollment, serves approximately 51 million lower-income people,²² most of whom would be uninsured but for Medicaid. The program, however, does not reach many millions of others who are uninsured and no less needy – typically low-wage workers and the dependents of those workers. This is because Medicaid’s current structure creates eligibility standards that resemble a crazy-quilt.

Eligibility for Medicaid varies substantially from one state to another. Medicaid eligibility also *differs quite radically based on family status*. In nearly four out of five states, for example, *a child* is eligible for public health coverage (through either Medicaid or SCHIP) if that child’s family income is below 200 percent of the federal poverty level.²³ *For parents*, however, the eligibility standards are very different and considerably lower than they are for children: In 36 states, parents with incomes below poverty (below \$15,260 for a family of three) cannot qualify for public health insurance. A parent in a family of three working full time all year at the minimum wage (\$5.15 an hour) would earn too much to qualify for Medicaid in half the states, even though the family’s annual income would only be about \$10,700—well below the poverty level. Thus, parents of children eligible for Medicaid or SCHIP are often ineligible for public health coverage. In fact, seven out of ten low-income, uninsured parents do not qualify for Medicaid.²⁴

For adults who are not parents – individuals living alone or childless couples – the federal safety net is almost all holes and no webbing. In 42 states, childless adults can literally be penniless and still fail to qualify for Medicaid or any other public health coverage. Thus, contrary to public belief, there are many millions of low-income people – usually low-paid workers in jobs that provide no health care coverage – who are ineligible for safety-net health coverage.

This arbitrary eligibility system needs to be modernized. Eligibility for Medicaid should be made more uniform and should no longer be predicated on family status.

Everyone with family income below a specified level – such as 200 percent of the federal poverty level – should be eligible for public health coverage, irrespective of his or her state of residence or family status, especially if he or she cannot obtain health coverage in the workplace. An incremental step towards this goal would be to provide health coverage to low-income parents of children eligible for SCHIP or Medicaid coverage.²⁵ It would enable approximately 7 million currently uninsured parents to gain public health coverage, *and* – in so doing – would improve children’s enrollment in such coverage by allowing them to sign up for health coverage as a family unit.

End Notes

¹ Kathleen Stoll and Kim Jones, *One in Three: Non-Elderly Americans Without Health Insurance, 2002-2003* (Washington: Families USA, June 2004). Of these 81.8 million uninsured individuals, **two-thirds (65.3 percent) were uninsured for six months or more.**

² Institute of Medicine, *Hidden Costs, Value Lost: Uninsurance in America* (Washington: National Academies Press, 2003), p. 107.

³ *Aetna v. Davila, Cigna v. Calad*, 542 U.S. ____ (2004). Available online at (<http://www.supremecourtus.gov/opinions/03slipopinion.html>).

⁴ Prepared Remarks, Health Care Policy Roundtable Press Conference (Washington: Leadership Action Plan on the Uninsured, May 10, 2004).

⁵ Kathleen Stoll and Kim Jones, *One in Three: Non-Elderly Americans Without Health Insurance* (Washington: Families USA, June 2004).

⁶ Families USA, *Tax-Free Savings Accounts for Medical Expenses: A Tax Cut Masquerading as Help to the Uninsured* (Washington: Families USA, July 22, 2003); Kathleen Stoll and Kim Jones, *One in Three: Non-Elderly Americans Without Health Insurance, 2002-2003* (Washington: Families USA, June 2004).

⁷ *Ibid.*, p. 2.

⁸ A 2003 Congressional Budget Office analysis found that only six percent of workers with incomes below \$20,000 made any contribution to a 401(k) retirement plan, and only 27 percent of those in the \$20,000-\$40,000 range did.

⁹ Karen Davis and Cathy Schoen, “Creating Consensus on Coverage Choices,” *Health Affairs*, Web Exclusive (April 23, 2003) p. W3 – W206. Available at content.healthaffairs.org/cgi/content/full/hlthstaff.w3.199v1/DCI

¹⁰ Marc L. Berk and Alan C. Monheit, “The Concentration of Health Care Expenditures, Revisited,” *Health Affairs*, 20, No. 2 (March/April, 2001): p.12.

¹¹ For additional discussion of HSAs and increased cost-shifting and how it leads to adverse risk selection, see Kathleen Stoll, *What’s Wrong with Tax-Free Savings Accounts for Health Care* (Washington: Families USA, November 20, 2003).

¹² Edwin Park and Robert Greenstein, *Proposal for New HSA Tax Deduction Found Likely to Increase the Ranks of the Uninsured* (Washington: The Center on Budget and Policy Priorities, May 10, 2004).

¹³ Kathleen Stoll and Erica Molliver, *A 10-Foot Rope for a 40-Foot Hole: Tax Credits for the Uninsured, 2002 Update* (Washington: Families USA, May 2002).

¹⁴ Karen Pollitz, Richard Sorian, and Kathy Thomas, *How Accessible Is Individual Health Insurance for Consumers in Less-Than-Perfect Health?* (Washington: The Henry J. Kaiser Family Foundation, June 2001).

¹⁵ Jonathan Gruber and Larry Levitt, “Tax Subsidies for Health Insurance: Costs and Benefits,” *Health Affairs*, 19, No. 1 (January/February, 2000): 72-85.

¹⁶ Congressional Budget Office, *Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and HealthMarts* (Washington: CBO, January 2000).

¹⁷ Kathleen Stoll and Kim Jones, *One in Three: Non-Elderly Americans Without Health Insurance, 2002-2003* (Washington: Families USA, June 2004), p. 5.

¹⁸ Karen Davis and Cathy Schoen, “Creating Consensus on Coverage Choices,” *Health Affairs*, Web Exclusive (April 23, 2003), p. W3-206, available at content.healthaffairs.org/cgi/content/full/hlthaff.w3.199v1/DC1.

¹⁹ Sonya Schwartz, *A Shelter in the Storm: How A Subsidy Could Help Unemployed Workers Get Health Insurance* (Washington: Families USA, October 2003).

²⁰ Stan Dorn, *Health Coverage Tax Credits Under the Trade Act of 2004* (New York: Commonwealth Fund, April 2004).

²¹ For more detailed discussions of a possible TAARA tax credit expansion, see Sonya Schwartz and Adele Bruce, *The Trade Act Health Insurance Subsidy: An Update from the States* (Washington: Families USA, December 2003); Sonya Schwartz and Marc Steinberg, *A Shelter in the Storm: How a Subsidy Could Help Unemployed Workers Get Health Insurance* (Washington: Families USA, October 2003).

²² John Holahan and Brian Bruen, *Medicaid Spending: What Factors Contributed to the Growth Between 2000 and 2002?* (Washington: Kaiser Commission on Medicaid and the Uninsured, September 2003), p. 4.

²³ Donna Cohen Ross and Laura Cox, *Preserving Recent Progress on Health Coverage for Children and Families: New Tensions Emerge* (Washington: Kaiser Commission on Medicaid and the Uninsured, July 2003), p. 2.

²⁴ Marc Steinberg, *Working without a Net: The Health Care Safety Net Still Leaves Millions of Low-Income Workers Uninsured* (Washington: Families USA, April 2004).

²⁵ The FamilyCare Act of 2001, 107th Congress, S. 1244, H.R. 2630.