46.6 Million and Counting:
A Look Behind the Number of Uninsured Americans
Alliance for Health Reform and Kaiser Family Foundation
October 19, 2006

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ED HOWARD: My name is Ed Howard. I'm with the Alliance for Health Reform. On behalf of our chairman, Jay Rockefeller, our vice chairman, Bill Frist, and the rest of our Board, I want to welcome you to a program on that dirty little secret of American social policy - that is, the large and growing number of Americans who lack health insurance. Census Bureau tells us that the number went up again last year, so did the percentage world without coverage, and the picture for children is especially disheartening. You're going to hear a lot more about the specifics of that in the next hour and 45 minutes. What's more, the increase comes at a time of relatively strong economic growth. It appears, at least for health coverage purposes, that a rising tide can swamp some boats.

Our partner in today's program is the Kaiser Family Foundation's Commission on Medicaid and the uninsured. We're happy to have Diane Rowland, who is both the executive vice president of the Foundation and the executive director of the Commission. You'll hear from her presently. Let me just do a little housekeeping if I can, before we do that. Background information in your packets, including the slides from the speakers who have them, if you're watching on C-SPAN and have a computer with Internet access, you'll be able to follow

along during the presentations by going to our Web site, www.allhealth.org and clicking on the link to the $46 Million and Counting briefing that you'll see there on the home page. By tomorrow, you'll be able to watch a webcast of this session on www.kaisernetwork.org and get all the materials posted there as well, and on our Web site. And in a few days, you'll have a transcript of the briefing on both Web sites.

At the appropriate time, I ask you to fill out those green question cards or come to the microphones with your questions. At the end, don't forget to pull out those blue evaluation forms and fill them out so that we can make these briefings better for you the next time. Only one other thing, as a courtesy to our speakers and to each other, would you take the time now to shut off your cell phones, pagers - mute them or do whatever you can to make sure that you're the only one who knows that it's going off? Thank you.

As I noted, we have with us Diane Rowland, who is not only the director of the Commission and the Foundation executive, but one of the most respected and sought-out analysts in health care in the country. We're very pleased to have you with us this afternoon, Diane.

DIANE ROWLAND SC.D.: Thank you, Ed, and thank all of you for coming and once again listening to us talk about the uninsured. It seems that this issue is an annual one, because

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each year we watch the number of the uninsured grow, and each year we seem unable to address this overwhelming problem. What we are doing today though, I think, is to provide some insight into some of the challenges that we face in trying to address the growing uninsured problem. We're looking at what's leading to increases in the uninsured, what's happening to employer-based coverage, and I know we'll consider in our discussion some of the implications for public programs, for safety net providers and, in fact, for the entire health care system and our overall health care cost as a nation.

I'm really pleased that we're able to provide you with background today, some updated materials, the new primer on the uninsured that the Commission has put out, along with the two analyses prepared for the Commission by the researchers that you'll hear from today from the Urban Institute: One analyzing why the number of the uninsured continues to increase, despite the rebounding of our economy and better economic times; the second, an assessment of the change in employer-based coverage from 2001 to 2005. I think both of these studies are very critical to our understanding of what's going on with employer-based coverage, the mainstay of our health insurance system, but also has implications for the gaps we're asking public programs to fill. I'm delighted

that we have such a good program in terms of both two excellent papers for presentation, along with two great discussants. Thank you.

ED HOWARD: Thanks, Diane, and you're absolutely right. It's a terrific panel, let's get right to it. Let's hear first from John Holahan, who is the director of the Urban Institute's Health Policy Center, one of the town's most respected health policy analysts and, as Diane mentioned, the author of one of the papers that is being released today, the one that asks and pretty much answers the main question on the agenda, which is, why did the number of uninsured continue to increase? John, what's the story?

JOHN HOLAHAN: I'll try to answer that. Thanks, Ed and Diane. The paper looks at what happened to the change in coverage in the past year that is between 2004 and 2005. Then it attempts to put 2005 in the context of the previous five years, or the entire decade. Essentially, the story is that the poor response to insurance rates continues to decline but at a slower rate than they had before, even after the economy improved, roughly around 2003.

The key findings from the past year are that the number of uninsured increased by 1.3 million from 44.8 million to 46.1. This overall, over the entire five-year period is an increase of about seven million. That is, seven

million since 2000. Adults accounted for one million of the increase in the past year. 1.1 million were from low-income families. That is below 200-percent of the federal poverty line, which is about $40,000 a year per family of four. The uninsured grew in 2005, primarily because of the continued decline in employer-sponsored insurance, which, as I said has declined throughout this decade, but at a little slower rate in the last couple of years, but nonetheless continue to decline and drove the ultimate finding.

Unlike earlier years in this decade, there was no increase in Medicaid and SCHIP coverage to offset the employer-sponsored insurance decline that is both the un-insurance rate and the number of uninsured increase in the past year. The declines in employer-sponsored insurance were greatest among children from low- and middle-income families, and these changes created an increase of 300,000 uninsured children, reversing the small gain that had occurred in the previous four years.

The next part of the paper looks at the issue of, did things change, or how did things change in the last two years as opposed to 2000-2003? That is an important change in what happened in the economy during this period. If you look at the data, real GDP up through 2003 was essentially flat, but then grew by 3-percent in ’04 and 2-percent in ’05.

Unemployment continued to increase up through 2003 and then fell. What this chart shows is the same picture, but in a little bit different way, ’00 to ’03, there was an increase in the population, 7.6 million, but an increase of only 100,000 in the number of people living in a family with at least one full-time worker. There was an increase of 2.2 in people living in households with a part-time worker, and 5.4 million in a household or a family, that is, with no workers. You can see that that change fell dramatically in ’03, where you get a big increase in the number of people in a family with at least one full-time worker, no change in part-time worker, some small increase in the number of people with no workers. So the issue is how to change [misspelled?] this economic turnaround, affect the change in employer response and insurance. The next couple of slides show you that.

I need to stop and say, how do you go about reading this chart? It says its percentage point changes, and everything in those three sets of bar graphs is percentage point changes in coverage. They look small, but they are really big. A percentage point change for the non-elderly population is 2.6 million people. That’s point number one. The second is that the percentage point changes need to be offsetting, so if you get a one percentage point drop in employer-sponsored insurance, it needs to be offset by an

increase in some other form of coverage, or else the un-insurance rate will increase. The next point is that all of those numbers should balance out to zero. They do not on these charts, because we left out Medicare, Champus, private non-group coverage, smaller forms of coverage that don't change a lot.

What this is telling you, between '00 and '03, now is this is three years of data together, so it would be expected to be a bit larger, is you saw a drop of 3.9 percentage points in the rate of employer sponsored insurance. That is, it fell from 67.8-percent to 63.9-percent just in those three years. There is offset to a small degree by an increase in public coverage, but not enough to keep the un-insurance rate from going up. So the population grew overall in the bottom bars there by 7.6 million, and between the increase in population increase, the number of un-insurance rate, the number of uninsured increased by 5.1 million.

In the next year, when the economy starts to turn around, the drop in employer coverage is less. Medicaid offset some of that. The increase in the un-insurance rate was not statistically significant, and we ended up largely because of population growth, with an increase of 800,000 more uninsured. In the past year, we get a drop in employer-sponsored insurance, no change in public coverage, as a

result the un-insurance rate ticked up and resulting in a bit higher jump in ’05 than in ’04, in the number of uninsured. That is an increase of 1.3 million.

If we put a slide here, and it’s in the chart of what happens to people who are in 200-percent of the poverty line, you’ll see a somewhat similar picture, although a little bit more dramatic.

What I wanted to focus on is what happened to low-income children, because there it is a little different. What happened is between ’00 and ’03, a drop of over five percentage points in employer-sponsored insurance, but this was more than offset by the growth in public coverage and, as a result, the percentage of children without coverage fell by 1.6 percentage points. The number of children overall was growing enough that you don’t see an increase in the number of uninsured kids. Another way of saying that if the overall number of children hadn’t increased, the number of uninsured children would have fallen.

In the next year, ’04, there is not a significant change in employer coverage, but Medicaid seems to increase, uninsured rates seem to fall. They are not statistically significant, in the overall population, they are for the group between 100- and 200-percent of the federal poverty line, but in the increase in Medicaid and the decline in

employer sponsored insurance.

In ’05 though, a major thing happened. The rate of employer-sponsored insurance for children fell by more, there was no increase in public coverage for kids, and the uninsured rate increased. The number of uninsured children, there at the bottom, increased by 300,000, and this, as I said earlier, pretty much offset all of the gains in the previous four years.

In the packet we found late last night that there was a mistake, and that the 1.6-percent change there, was shown as a positive change. It was actually a decline, and we corrected it for the slides, but not in time to get it into your packets.

Where would we like to go with this? Will the declines in employer-sponsored insurance continue? I think it’s likely. The Kaiser HRET Survey that was released in the last few weeks showed, once again, that premiums were growing faster than wages by about twofold, also faster than the underlying inflation rate. Premiums went up by 7.7-percent, wages 3.8-percent. That’s a factor and that seems likely to continue, but there are also changes in where we as Americans work and where we live that are also driving the rate of employee sponsored insurance down. What this chart shows is that over the last five years what happened to employment.

There was an increase of 1.7 million people who are self-employed, an increase of 2.3 million who were working in small firms, only a small increase in medium-size firms, and actually a decline in large firms. This started to turn around a little bit in the past year, but over the five-year period, this is the picture. Why that is significant is that it means that we're moving towards places of work where we are less likely to have employer coverage and more likely to be uninsured and away from those larger firms where the rates of employer-sponsored insurance are greater.

Another way of looking at this is by industry, and here we classified industries by the rate of employer sponsored insurance in 2000, and the high ESI industries are manufacturing, finance and government. Low ESI industries are service, construction, agriculture, industries like that. So here, you can see that the growth in jobs is really in these low ESI industries, as we call them. There is actually a drop in those industries that are more likely to offer coverage, so you can see that we're moving towards work where ESI rates are much lower, 64-percent versus 83-percent, and un-insurance rates are higher.

One other thing that is not on these slides that I'll mention is that the population is also shifting towards the South and the West where the same things are true: Employer-

sponsored insurance rates are lower and un-insurance rates are higher. All of those demographic changes, together with the growth in premiums relative to wages, are not a good indication that the system is not doing anything other than what we've seen and that continues to deteriorate a bit, although presumably at a slow rate.

To sum up, despite the improving economy, improving economy after 2003, the share of Americans with employer based coverage continues to decline. In the last year, Medicaid and SCHIP did not offset that drop and, as a result, there was an increase in the number of uninsured. A large majority of the 1.3 million uninsured were adults, those of low income families. The new thing that has changed in the past year is that the number of new children increased and particularly in the places where the declines in employer-sponsored insurance were greatest; that is, between 100- to 200-percent of poverty, and in the middle income group, between 200- and 400-percent of poverty. With that, I'll stop and move along.

ED HOWARD: Yes, thank you, John. Next we're going to hear from Bowen Garrett, senior researcher at The Health Policy Center that John directs. He is also one of the authors of the other new study in your packets that Diane mentioned, the one that examines the relationship between the

uninsured and the trends in employer-sponsored coverage. He has a long string of research interests that are recorded in the biographical information in your packets, a lot of mental health background, and he's done more than a decade's work on the uninsured. We're pleased to have you to your first Alliance briefing. Bo.

BOWEN GARRETT: Thank you, Ed. Thank you, Diane. I'd also to thank the Alliance for Health Reform and the Kaiser Commission on Medicaid and the Uninsured for organizing this session. I should acknowledge my co-authors on this research, Lisa Clemens-Cope, a colleague at the Urban Institute and Catherine Hoffman at the Kaiser Commission.

In this research, we take a somewhat narrower view than the work that John just presented. We focus strictly on employees in the slides that I'm going to be presenting. We look at changes from 2001 to 2005. By focusing on employees, we restrict our analyses of the self-employed. We also focus on adults, age 19 to 64, and exclude full-time students. Our first finding is that employer sponsored insurance rates fell from 81-percent in 2001 to 77-percent in 2005. What this study tries to do is get behind that number and report the reasons for that decline in employer-sponsored coverage. When we're looking at the reasons, we're particularly focusing on changes in employers sponsoring health benefits to their

employees, whether those employees in sponsoring firms are eligible for benefits. Sometimes a firm may offer to some workers, but not offer to all workers such as new workers or part-time workers. We also, for employees who have an offer of coverage, we look at whether they participate or take up that coverage. Then we look at how these reasons differ by age in firm size and income.

I should just point out quickly that these data are from a combined file that is nationally representative for the February and March CPS, which allows us to look at this time period, which in the two most recent time periods were able to examine and dig into the reasons for the decline in ESI.

So underlying these changes in health insurance were significant changes in the country's work force, some of which John has already discussed, so I'll just briefly go over a few more. One point four million people became unemployed over this period while five million people left the labor force altogether from 2001 to 2005. While the number of workers grew with the population, most of that growth is attributable to poor workers, 1.8 million of the 2.2 million growth. People moved to jobs in smaller businesses, and more people became self-employed. All of these changes tended to reduce the number of insured.

This slide looks at the extent to which that fall in ESI coverage was picked up by changes in other types of coverage. What we see here is that for Medicaid and other public coverage there wasn't really much of a change, only a .5 percentage point increase, whereas the fall from employer sponsored coverage was four percentage points. Likewise, for private individual and non-group coverage, there was only an increase of half of a percentage point. As a result, the uninsured rate increased, so the fall in ESI is translating directly to an increase in the number of uninsured to the point where by 2005, there were 17-percent of employees uninsured.

This next slide presents our main finding, which is the breakdown in that change and the ESI coverage among employees. What we find is that 48-percent – so the main single reason for the decline – was due to fewer employers sponsoring coverage, or rather fewer employees working for employers who sponsor coverage. The second largest reason was that employees were less likely to take up the coverage that they were offered. That affected about a little more than a quarter of workers. The two smallest reasons were loss due to lower eligibility for coverage among employees, and lastly loss due to coverage as a dependent for employees who didn't have their own ESI coverage.

These changes did not happen uniformly for different types of workers, so we look at workers by their income levels, specifically employees by their income levels. What we see on this slide is that there are very large differences by income. In general, lower-income workers with incomes below the poverty level were much less likely than higher-income workers to have coverage. That was true in both years. The poverty level is about $20,000, or a little bit shy of that in 2005 for a family of four. So the first year of bars are very low-income people. The next pair of bars is what I refer to as near poor individuals with incomes of 100-percent and 200-percent of the federal poverty level, and in the middle-income workers and higher-income workers.

What we see here is that there were initial gaps by income in the levels of ESI coverage, but those gaps became worse over this time period. What we see is that for the poorest employees, there was a fall by six percentage points, and that was also true for near poor employees, while middle income employees had experienced a 4-percent decline and the highest income category that we look at, there was virtually no decline in ESI coverage.

This slide looks at the reasons for the decline in ESI among employees by these same income categories, specifically we look just in this figure at employer

sponsorship and employee take-up rates. What we see is that for the poorest employees, and also for the near-poor employees, there were very large drops due to employer sponsorship of about three percentage points. The near poor employees experienced a little bit less of a drop due to falling take up rates. For middle-income employees, the fall was somewhat lower, but it was equally attributable to lower sponsorship and lower take-up. To the extent that there was any decline for the higher-income employees, it was exclusively due to sponsorship changes, not take-up changes.

In the policy brief that is in your packet, we go through findings like we just did for income, also by age and by firm size. I'll just briefly just mention some of those findings now. By employer size, the largest declines were among employees and firms with fewer than 25 workers. Most of the decline for workers in small firms was due to sponsorship, very little change in take up for those workers. By employee age, the largest declines were among younger adults age 19 to 34. For those younger employees, the declines were both due to lower sponsorship and to lower take up. In the forthcoming full report, we provide further analyses that look at differences by other characteristics.

To wrap it up, ESI coverage fell from 81-percent in 2001 to 77-percent in 2005. The main reason was that fewer

employees worked for businesses sponsoring health benefits. These declines were deepest among poor and near poor employees, employees in small firms, and employees under age 35. The last point is based on projections at health care costs and therefore, premiums are likely to continue to grow faster than family incomes. If that comes to pass, we can expect further declines in job-based coverage and a continuation of the trends that we've provided here. Thanks.

ED HOWARD: Thanks very much, Bo. Now we'll get some perspective on these rather stark facts that you've seen laid out from a couple of different points of view. First, we'll hear from Charles N. Kahn III, aka Chip Kahn, who is the president of the Federation of American Hospitals. He's been a senior staffperson in both the House and the Senate. He entered the Trade Association of Health Insurance companies in the early '90s. More recently, he's been known by the company he keeps, as he joins with various strange bedfellow configurations in search of a consensus that might help reduce the number of uninsured Americans. Chip, thanks for being with us.

CHARLES N. KAHN III: Thanks, Ed. I'm going to quickly make seven points, and talk about the policy implications of what we've heard.

First, I think we can conclude now – Diane Rowland

and I were talking before we came up here, about it's sort of the same old song every year, and I think we're to a point now where even with some up ticks over time of employer-based coverage, we can conclude that we're not going to solve the problem of those who are uninsured by the economy moving employer coverage. It just isn't going to happen. I'll conclude with some thoughts about employer coverage, but it, itself, the employers are not going to solve the problem for us.

Second, I think the losses we've seen are in an obvious place. They're with the people or the businesses with the least disposable income, people who are low-income, people who are younger, and people who are small employers or work for small employers. So that is no surprise, but I think it's an important insight when we think about the policies that we might implement to solve the problems. There are related effects of the fact that we have less people insured. In terms of the rubber hitting the road, we recently surveyed our members, and for 600-plus hospitals that we asked the question about, their uncompensated care cost, these are not charges. These are their costs, rose from approximately $5.1 million on average in '04, to seven million dollars in '05. I don't have the '06 numbers yet obviously, but clearly this issue is becoming one in the emergency room, in other parts

of the hospital, and these are just one set of hospitals across the country. A considerable growth rate and it's having a considerable effect.

I think the public is feeling it. We do a survey every year. Linda Duvall from American Viewpoint does a survey of 1,000 Americans for us. We usually do it in September. We did it in the third week, and we have done this since 2003. We asked a particular question, "What was the chief financial concern of the Americans we surveyed?" Then in 2003, the chief concern was losing their health insurance, and around 20-percent of people said it was a chief concern. By 2006, just a few weeks ago, 34-percent – and there was growth each of the years between those two data points. So the public is feeling stressed on this issue, obviously from those who deliver care to Americans. They are feeling the pinch from this issue, and my feeling is something ought to be done. The question is, "Is it going to happen organically?" My next point is, "Does it require public policy?" and I conclude from looking at the data, looking at the trends that public policy is necessary. This is not going to solve itself, no matter what we hope or pray. Regardless of the fiscal health of the federal endeavor, the federal government, something is going to have to come there to actually make this curve change, first point.

Second, my view is that when we seek solutions, we ought to go where the ducks are. It's really clear low-income people, small employers, it all ties together. Those are the people who are both more uninsured than other Americans, and more likely to become uninsured in the future. Policies ought to be designed to address their issues, which means that they lack disposable income, so they need greater subsidization to purchase coverage and get care.

Finally, I don't think it's perfect. We can argue about what – and this really takes on an ideological veil, we can argue about what we want the health care system to look like. At least from my standpoint, 85-percent of Americans, give or take a percentage, have coverage, and we ought to design a policy that focuses on the 15-percent and a policy that will do the best we can to sustain those who have coverage now with it being paid for wherever the money is coming from to pay for it, rather than rebuilding the whole house. Anyway, that's my contribution to the discourse, and I look forward to the other remarks and the questions.

ED HOWARD: Terrific. Thank you, Chip. To round out our presentations, we have Jeanne Lambrew, who is affiliated both with the Center for American Progress at George Washington University, where she is an associate professor. She served at the Department of Health and Human Services

during the early years of the Clinton administration, then later, at the White House at the OMB. She played key roles in the Children's Health Insurance Program and Medicare Reform Initiatives, among others, and she is a veteran of previous Alliance programs. We're glad to have you back, Jeanne.

JEANNE LAMBREW: Thank you very much and I do want to thank John and Bo for the excellent studies, for Kaiser Family Foundation for sponsoring them, and for the Alliance for bringing you all together to talk about it.

I think I am going to try to make this a little more interesting and disagree right off the bat on the facts, because even though Chip and Diane rightly say that there is an element of the same old song going on, I think there are three notable, different and sobering trends that these scholars have noted in their studies.

The first is actually what's not there. When we looked at Bo's slides, we saw that it actually is not people declining health insurance as much people not being offered insurance that is driving most of the decline in employer based coverage. What we've actually seen health insurance premiums go up by 87-percent since the year 2000 is shocking, but there are not more people who are just turning it down. In other words, people still are paying for health insurance. They value health insurance, which is kind of a surprise

given the wage stagnation and the other struggles that families have had in the past six years. So I'm actually quite surprised we haven't seen more people not being able to afford the types of insurance that is offered.

Second, I think that we really have to look hard at this statistic that we have fewer firms offering health insurance. The private insurance system has been a voluntary system. It's been how we've all mostly gotten our health insurance for the past nearly 100 years. If you look back at the history of health reform in the U.S., and the fact that this is declining, the lynchpin of the system is declining, is quite important, quite significant and quite serious. I think we need to take that very seriously as a trend of what's going on out there.

Third, the fact that we saw the rate of uninsured children go up last year for the first time since the passage of the Children's Health Insurance Program a decade ago, is new and disturbing. So I think there are three new important facts here that we need to focus on. I also think that when we look at these facts, and look at the solutions being supported by the White House and the past Congress, I think there is a jarring disconnect that I think we ought to talk about.

The first is that consumer-driven health care is the

answer. We've heard about what this is, it's health savings accounts, it's trying to have high-deductible Medicare plans with accounts to pay for the deductible, it's putting people on Medicaid into similar types of high deductible plans, getting them accounts to have more control over their health care spending, but also more liability, more so-called skin in the game. Yet when we see costs going up so dramatically, the idea that people are not paying enough for health care just doesn't really fly with the public and with the statistics. I think we have a solution that doesn't seem to be matching the problem.

We also have lots to talk about in entitlement reform. There were discussions of a commission this year. The president announced he will be taking the issue of entitlement reform very seriously in his budget that will come out next year. Yet when you look at these data, what you see is without Medicaid, without Children's Health Insurance Program, we would have had significantly more uninsured people. Those programs protected low income people from losing coverage in this past five-, six-year period. I think it's important to recognize that had those entitlement reforms been in effect during this past period, the numbers we're looking at today would have been much higher.

We also hear a lot about fiscal responsibility and

trying to offset programs. Next year we will be discussing the reauthorization of the Children's Health Insurance Program, which because of the budget rules, will cost. If we just want to continue covering children at the levels we're covering them today, it will cost us $30 billion to $40 billion over 10 years. We will hear a lot about, how do we offset that? How do we finance that? Yet just two years ago, just three years ago, we finance a drug benefit that costs 10 times as much as that without offsets. So I think we have this jarring disconnect what we're willing to pay for drugs for seniors without offsets, but not pay for continuing coverage to cover low-income children through the Children's Health Insurance Program, which I think is something that we're going to have to deal with.

Lastly just a few weeks ago, Congress left town without fixing a problem that exists today. Today in the Children's Health Insurance Program, 17 states lack enough money to continue coverage of the kids they have in their programs today. This could mean several hundred thousand children lose coverage in the year 2007, because we haven't allocated the funding for that. Again, the issue has been cost. We can't afford it, yet the cost of filling in those gaps and just at least protecting the coverage we have today, even though we have this uninsured children's rate going up,

it’s about $900 million less than the reduced stock option package of the United Health Plans departing CEO. One person’s stock option is more than the cost of covering these 100,000 kids, and yet in this country we have these disconnects and jarring statistics sit side-by-side without being angry. I would say part of the theme here is these statistics do make me angry. I’m hoping that we can really have a change in this, so what I’ll talk about now is my views on the positive changes. What should maybe happen next year, what could maybe happen next year, and with a potentially change in Congress, what might happen next year.

With that in mind, I think there are three categories of policies. Hopefully we’ll be talking about in less than a year. The first is back to this category of do no harm. We have an increasing number of uninsured, and our priority has to be figuring out ways to stop that. How do we least stabilize the coverage situation so it’s not continuing to deteriorate? Clearly, trying to fill in the shortfalls in the Children's Health Insurance Program, and extending and preserving that program has to be part of that, but I also think we can talk about the Medicaid matching rate and protecting saves against unexpected increases in their costs, trying to make sure that program is stable and really trying to fill in its program gaps.

There are also a number of pretty solid incremental ideas on how we can begin to get at target populations. I consider them the young, the poor, the older people and people in small businesses. We can do better at covering low-income children through policies like bonuses for insuring kids through Medicaid and Children's Health Insurance Program, simplified eligibility and outreach. While we can cover low income parents, which we know would actually be one of the most effective policies of getting their children into these programs, because parents and kids come in units. They come in packages, and if you cover the parent, you'll get the kids.

If you look at older adults and think about how that population is approaching Medicare eligibility, either letting some people buy in early or looking at alternative solutions to help that near elderly population that is quite at risk in terms of their health status. Re-insurance is an idea that some of you may have heard about in previous health care debates. It's the idea of saying if we figure out where we spend our money, let's spend our money on the sickest people, the most expensive, which will help defray the cost for all of us in the system. That's an idea that's out there that could be adopted in the next Congress.

As Chip noted, we still have this small business

problem. Why can't we figure out a bi-partisan way that supports covering creating pools or some other responsible vehicle for insuring small business workers and other people in that category? There are lots of ideas out there. I would say, as Chip said, "We need to go where the ducks are." The low-income people are where most of the uninsured people are, and if we really try to look at what are the evidence-based policies to take care of those folks, it really is public programs. Public programs have worked for this crowd. We should really look at that, put aside our ideology to say we really need to fill in for our low-income populations.

I really do want to end with a little bit of a disagreement, which is we can't just target the uninsured, because if we just focus on the 15-percent of the uninsured, we'll keep seeing more people coming into that bracket. What these studies show is without trying to figure out how we solve the system reforms, we'll never be able to solve the uninsured problem. It is because we are seeing a fraying of our private sector system that we have our own share of problems today.

Stated simply, we're going to have to have major comprehensive health reform to really get at this issue of the uninsured, nothing short of that will really work. I will say, on an optimistic note, I think that the policy

disagreements here are not as big as people think. I think Chip is right. We have 85-percent of our people in some sort of system. If we could stitch together our systems to really make a seamless coverage web we could really get everybody in. I think there is a lot of shared agreement on how we would structure the subsidies for that to make it progressive so that low income people could afford it. I think most of us agree that we should have some shared responsibility in how we all pitch in to pay for such a system, and I think that we all agree that it is a priority to make sure that everybody has some sort of health insurance, that this is a goal that we can look across bi-partisan lines and agree on.

I would also say that the politics are coming close. If you look at these business statistics, what you can see is that businesses are struggling with it and I think that the business leaders in this country are going to begin to come around to try to embrace this. We have seen this with certain CEOs beginning to stand up and stand out on this issue, as profits are now being eclipsed by health insurance benefits. I think we'll see more support and leadership in the business community for this. We've seen state governors begin to reach out on both sides of the aisle. Governor Romney of Massachusetts clearly embraces this as an issue. We've seen in Maine, in Illinois, and in other states real efforts to

try to address this issue. It no longer is the political pariah that it once was.

I'll end by saying I think we may be seeing the top of that pendulum of going in the wrong direction having policies that are not connected, I am hopeful that with more statistics, more studies, and frankly, more leadership, we'll find ourselves addressing these big serious issues of the uninsured sooner than later. Thanks.

ED HOWARD: Thank you, Jeanne. There you have it, a pretty comprehensive view of what the problem has become, and some suggestions on how to deal with it from different perspectives. It's your turn. We now want to hear from you. There are microphones that we ask you to go to. When you go to them, identify yourself, if you would. Direct the question, if you can, to a particular panelist, if you want to, and be as brief as you possibly can so we can get through as many questions. Those of you who would like to write a question because you can't get out, do so and hold it up. One of the staff will take it from you and get it up here. Yes, sir.

BOB HALL: I'm Bob Hall with the American Academy of Pediatrics. The question is directed to Jeanne Lambrew. Yesterday's Children's Health Group meeting, Lisa Dubay presented a data analysis showing that 70-percent of the

uninsured children in the U.S. are actually eligible for Medicaid or SCHIP, but not enrolled. Additionally, more striking, it seemed, was that 52-percent of parents that were polled knew that children can be covered through SCHIP or Medicaid even if their families are not on welfare. With the *Washington Post* reporting a week ago that over 10,000 Virginians have lost coverage as a result of the new citizenship and identification requirements, as passed as a result of the Deficit Reduction Act. What simplified eligibility enrollment procedures can we encourage states to take, or encourage the federal government to encourage states to take in order to increase the amount of kids who are actually covered?

JEANNE LAMBREW: Sure. That is an excellent question, and quite a serious problem. The two simple areas are: Make it easy for families to get their children in, and make it easy for families to keep their children on. What we know is that excessive documentation rules, in person applications, verification of income stubs and, most recently, families have to bring original birth certificates to apply for Medicaid. Now, if we all think about where your birth certificate is today, could you find it and could you bring it at the moment that when it’s needed to get your child signed up for health insurance, has become a major barrier

for American citizens, as well as people who have low income or have challenges in getting that information. This is a major issue. We need to simplify our enrollment processes, make the re-determinations happen less frequently. We know that if you do this once a year, and not every quarter, you will keep more people in the programs who are eligible.

Lastly, we do know that as people transition out of Medicaid, they often are eligible either for transitional Medicaid, or Children's Health Insurance Program, or other means. We need to work it harder on making it easy to keep those people in an insurance situation.

Stated simply, we've been going in the wrong direction in the last year, in going back on what we've learned in terms of eligibility simplification. I'm hoping through public policy, we can be more aggressive about promoting policies and also insulating states from any potential cost of those.

JOEL SEGAL: Hi. Good afternoon. I'm Joel Segal with Representative John Connors' office, and I handle health care issues. First is a comment, second is a question. It is so important if we could get your organization to sponsor hearings in the Congress when we get back into session where we need people who are uninsured and underinsured to testify, because I've been here for seven years and I think we have a

lot of members of Congress who care about this issue, but they may not really understand the depth of the crisis. We really can't handle the calls coming into our office day after day with the worst horror stories that you can imagine with people who need care. If you could maybe consider doing that, it would be real helpful to the public and to the Congress.

The second question that I have is for Miss Lambrew. You seem to be an advocate of expanding public programs. Since Medicare is the most efficient public health insurance program in the nation, has a three-percent administrative overhead versus maybe 15- to 30-percent with private health insurance companies and HMOs, shouldn't we seriously consider the discussion of bills like Representative Connors, Jindal or Stark to extend Medicare to everybody, because it would increase quality, it would save money and also strengthen and improve it so the cost could even go down. I'd just like to hear your perspective on that.

JEANNE LAMBREW: I'll start by saying there is a means question and an ends question. I guess that my view, the view of my colleague at the American Center for Progress, where I'm a part-time fellow, is our number one goal. Our goal is to get everybody in to some coverage situation. We need to have everybody in this country have health insurance.

That is our number one goal. That coverage should be affordable, meaning that we're not charging people too much for coverage. It should be meaningful coverage, so that what you get is actually worth what you're paying for, and it should be giving you the access to the types of hospitals and providers that are out there that really can provide the type of care that we need.

We do need to contain costs as well. We can go into that in a second, but short of that the question is the means. Is the best means to do that through Medicare for all? Is it through a public private mix? Is it through a federal employees plan? I think that I personally am more agnostic on that, because the truth of the matter is I think we often let our means be the enemy of our end. I would say, personally, whatever we can do to stitch together a system where everybody is in, has affordable and meaningful coverage, I'll take it. I think that we need to potentially figure out how do we get from here to there? It could be that Medicare for all is that plan. Maybe the wins are coming. We've angered the insurance companies, and angered the inefficiencies in our health care system where that is the vehicle and I'll be supporting it if that is the vehicle. I'm not sure that's the case, given that we've fought for a decade to expand Medicare to cover near elderly people who have very little luck with

it, but that's a political calculation, not a policy question, not on policy grounds. If it can pass, I'm for it.

CHARLES N. KAHN III: I guess I'll step into it. I completely concur with Jeanne's point, and I think that some of the numbers about Medicare would be quite different if Medicare covered all Americans. I think the 3-percent is a cheap number, but it's an administrative process that appropriators in Congress ratchet down on, and if all Americans were in the coverage, I don't think you could get away with 3-percent of you'd have a system that wouldn't work. I think that having a single payor system in this country would be problematic and in a sense right now we have a lot of private coverage subsidizing the public coverage, whether it's Medicaid, which clearly doesn't pay for the full cost of delivery, or Medicare that pays for the full cost of delivery some years and not others. I think if we tried to put it all on one tab, we'd have big problems.

You need public-private partnership in terms of funding, and that's even before you get to all the issues of American want choice and other matters. Within the context of the current system, if there was the will to come up with the federal money and the new policy, to keep the structure that we have in place, and as both Jeanne and I said, go where the ducks are we could accomplish the same goal.

ED HOWARD: If I could ask you to forebear for a bit, we have a bunch of cards we want to try to get to.

DIANE ROWLAND SC.D.: We have a question here when we're talking about solutions, many have pointed out, obviously that Massachusetts is moving forward with an innovative new law to try and achieve universal coverage within that state. The question is, is there anything we can learn at the federal level from the Massachusetts experience, or is its passage and possible success limited to an environment like Massachusetts with fewer uninsured, more ESI and recently well-off state and good Medicaid-based coverage? John, since I know you've done a lot of work with the Massachusetts experiment, why don't you take this question?

JOHN HOLAHAN: I think it probably does offer a lot for people wanting a solution at the national level, as well as for states, but I think people want to have to move toward universal coverage and have to be willing to pay for it. Essentially, Massachusetts, to simplify it a bit, is a Medicaid expansion with income-related subsidies on top of that. The ability to purchase coverage within a purchasing arrangement and a mandate on individuals, or at least now adults, that they have coverage. There is a mandate, if it's affordable. Affordability depends on the subsidy schedule. They ended up making the subsidy schedule fairly generous.

Whether or not there is money in the budget to accommodate that kind of affordability schedule is an issue that they're going to have to wrestle with, but with some additional money, it will work.

I have a hard time seeing us in this country going down the road to a single-payer, or an employer mandate. Having an individual mandate with a purchasing arrangement with generous and adequate subsidies, and essentially putting the mandate on individuals and families is a pretty reasonable way to approach it. The key thing is making it affordable. Without that, it's not fair and it won't work.

CHARLES N. KAHN III: I think the Massachusetts experience, which we really don't know yet because they've just begun the planning for it, does illustrate that there is no free lunch. There has to be some money from someplace. They do have the advantage over a state like California or Texas of having, I believe it's 7-percent uninsured, or some number in that range. Whereas these other states may have 20- or 25-percent uninsured, so what we'll learn from there is whether you can put it all together, but we have to conclude that even if it's successful that in these other states it's going to take a lot more money. I go back to my point, that's where you get into the real public policy question of where the money is going to come from. I do believe that it is

partially just a money issue. You can organize it if you put the money on the table.

JEANNE LAMBREW: I'll just add two things. One is that not only is there no free lunch, there is no free lunch in Massachusetts, because Massachusetts had about $385 million worth of federal Medicaid dollars and a waiver deal that it could reinvest into this coverage system. So we all pay for the lunch in Massachusetts.

I also would say though, pulling away from the policies, I think the policy story is still unfinished. We don't know yet the outcome of this. The politics is pretty interesting. There was this guillotine. The money was going to go away by July 1 in this waiver deal if they didn't act. There is a valid initiative that would have been very aggressive with an employer mandate and other provisions in it to really make things happen. There is this kind of guillotine hanging out over the state and it really pours people to the table. They came to the table mostly behind the scenes to figure out this agreement and they even took some of the more controversial details and gave them to an expert commission by them trying to hash them out in legislation. We can learn from the process and the politics of what happened in Massachusetts, which is, we need an action-forcing event, and we need a way to hash out these difficult details like

what is affordable coverage and what benefits should be covered in a way that is not our usual process through committee markups, amendments and lobbyists coming from the left and right to try and do this in a public setting. There are some interesting lessons we can learn about the passage of that legislation as well.

DAVID HOGBERG: David Hogberg, National Center for Public Policy Research. This question is primarily directed at Professor Lambrew, but I'll throw it out to the entire panel here. You talk about policy disconnects, but aren't some of what you're advocating also policy disconnects, and by that I mean during the '90s, states expanded their Medicaid budgets, they opened up SCHIP programs and here we are 10, 15 years later, we still have an uninsured problem and based on the numbers it might actually be getting worse. It seems to me that to keep doing what we've been doing and expect a different result. We all know that's called the definition of insanity. Basically, the only thing that I'd say is that by opening up these programs you are probably giving employers who have low-income employees the easy option of dumping their employees off on the public system. I'd just like you to address that, and thank you.

JEANNE LAMBREW: Sure. I'm actually going to ask John in a second for help on this question because I think these

are actually partly data questions. The data questions being have our public program expansions made a difference to the uninsured and have we seen crowd out. Is the employer reduction that we're seeing exclusively among low income employers and among populations for whom there has been a public program expansion like children? I'll do the shorthand and I'll let John elaborate, but I think that we have seen according to most of our data sets, a decline in the rate of number of uninsured children. That is mostly attributable to the fact that we have through Medicaid and the Children's Health Insurance Program expanded coverage.

I also think the declines in the employer-based system are not uniquely in either states that have been generous in their expansions. In fact, I think that if you look at a state like Massachusetts, both has a very generous private employer-based coverage system as well as a generous public program, and there is not a lot of evidence of crowd out there. I will actually let John, from the data, talk about the crowd-out issue.

JOHN HOLAHAN: The crowd-out issue is a tough problem and there is no doubt that it exists to some extent. In the data that we've looked at, you see comparable declines in employer sponsored insurance despite the fact that low-income adults don't have the availability of public coverage to them

anywhere near the same way that children do. If the rates of dropping or losing employee coverage are comparable when the circumstances or the availability of public coverage is very different, it's pretty hard to make a case that it's a crowd-out issue in what we've seen.

The other point is we've had very different experience with children and adults in terms of changes in non-insurance rates until this past year. Even then the increase in the number of uninsured children is much less than for adults. It's clear that the public programs where they're adequate to the extent that they're larger have really offset the decline in employer-sponsored insurance, so I'm not sure that it's just fair to say it isn't working. It's working when we really try to make it work, otherwise it doesn't. There is a system there that is at least holding things where they are, but the larger point that a lot of us have been making is that the decline in employer sponsored insurance is likely to continue, whether or not as we go into the future the willingness to support expansions of these programs to offset it is a real issue that we're going to have to face.

CHARLES N. KAHN III: First, let me say incremental programs are incremental programs and should be judged in those terms, so the numbers show that these programs have

been very successful, albeit they were incremental in nature. The Massachusetts lesson, which we don't know how with the last Act will be, but the Massachusetts lesson is that if you're really going to close the gaps, you have to do something comprehensive. Even though they don't have an employer mandate, they do have overtime significant employer responsibility. Whether that works or not, whether they take the right approach, we'll find out.

Also the individual mandate is really an important building block here. Now you can look at the individual mandate and make do as a punitive kind of thing. In a sense, it should be looked at as simply identifying the people, identifying all of us and making sure that all of us have the bucks on our head when it comes to class premium payments. It's just a question of whether if you're low income, somebody is going to have to put those bucks on your head. If you're not, if you're well employed, if your employer provides the coverage, then you're not. Then the money will be there. The individual mandate to me says everybody has to be identified and we have to have a strategy for everybody. That's why I feel that we need to think about it seriously. If you want to focus on something punitive, it's going to lose and it's a political loser, but if you look at as we're going to make sure that everybody has coverage and that's

what it's about, then maybe it offers us a model. Maybe Massachusetts is telling us something.

DIANE ROWLAND SC.D.: It's clearly been noted that Medicaid and SCHIP did help fill the gap for low income children that were losing private coverage. When these questions sort of ask us to do a crystal ball, what impact do we think the changes enacted in the DRA could have on the public programs ability to continue to meet the needs of children?

Second, rather the increase this year in state tax revenues in the better economic situation states are facing may mean that they'll now bolster their Medicaid program, especially their SCHIP program. So are we expecting better trends, worse trends? What do we think is going to happen next year to coverage for children?

JOHN HOLAHAN: The point about the state revenues getting better clearly will be helpful. I think there are a lot of states, particularly in regard to children, interested in expansions or at least maintaining eligibility levels. You could see this time next year a decline in employer sponsored insurance for children, but offset by public program growth. On the other hand states have a lot of priorities other than health care. Whether their additional state revenues are going to continue to flow into the health care system is a

question that I think we'll have to watch. I honestly don't know, but I would think that what we saw this year may reverse, or may not.

ALWYN CASSIL: Hi, Alwyn Cassil with the Center for Studying Health System Change. I have a question for Bo. Looking at his Figure Five, where you talk about 48-percent of the decline in ESI being attributable to employer sponsorship, I think it is something that you talked about, but you glossed over, and I think it helps to explain why the safety net didn't catch people in 2005 the way that it did during the economic downturn. That is the changing nature of jobs in this country. The new jobs are coming without benefits. It's not necessarily so much that employers are dropping coverage as more new jobs are being created in industries and in regions of the country where they are much less likely to offer to begin with. It reinforces the point that we can't grow our way out of this because the jobs we're growing don't come with benefits. Do we have, of that 48-percent – I know you can't do it from the census numbers, because it's a household survey, so we know that the proportions of firms offering has dropped significantly, but most of that drop has been within small firms that affect relatively few people. You hear this, I think there is this common perception that employers are bailing right and left

on the employer system. Do you have any data that tells us how big is this problem, because this 48-percent is not just employers dropping coverage? Correct?

BOWEN GARRETT: You make many good points. This is looking at employees, so we are looking at what happens overall. It could be attributable to two reasons as you indicate, both current employers dropping their coverage and also the turn in the labor market. What the newly created jobs are doing versus what the dissolving jobs had done. I believe that some of the Kaiser Employer surveys show that there are drops in the rate of firm levels, at the firm level who offer coverage, at least over the entire time period of 2001 to 2005 that I looked at. Although small firms are small, there are a lot of them, so there are many workers, many employees overall the whole economy in them. What's happening for small firms does have an impact on the overall number.

JEANNE LAMBREW: Let me just add, this highlights the challenge we have when we think about how do you shore up the employer-based system. Very difficult to think about policy that would affect the offering of employer-based coverage short of requirements. That's why there are a lot of good ideas out on the table that think about how do we think through both maintaining what is out there, and what do

people like. The truth of the matter is, most people like their employer-based coverage, but also looking at alternatives so that people have the type of group health insurance that is affordable, offers the kind of benefits they want in ways that are not going to constrict them if they change jobs or their jobs change on them.

DIANE ROWLAND SC.D.: On a different note, we are also looking at the uninsured and we're talking about the rising health care costs. This question asks for comments on what contributes to the rising cost increases, and what can we do to try and bring down the premium costs so that insurance is more affordable. Maybe Chip can start with that.

CHARLES N. KAHN III: In Monday's *USA Today*, Paul Ginsburg from the Center that just asked the question said that, "People want more, and they're getting more, and that's why health care costs are going up." Part of the question overtime actually could be answered by the discussion we're having today. Within our system, there are incredible inefficiencies, partly having to do with so many people entering the system without the funds at a given time, without the health care coverage, and I think there are ways found to pay for it, but it makes it more expensive for everybody else. I know that one of the issues about health reform and expanding coverage has always been we have to

control the costs first before we can spend more public money, taxpayer money on providing more coverage. I would make an argument that I think to some extent we could turn that around and say that if there was a level playing field in terms of coverage across all Americans, it actually would lead, probably, to reduction in certain inefficiencies and a more even, direct payment rather than indirect payment for a lot of the care.

Would that solve our entire cost problem? No. We have driving technology. We have an incredibly expensive infrastructure to support in terms of the public enterprise and the private enterprise in health care. We have a system that is inefficient. We need to improve our quality. We're all working on that. We're not there yet, but I think this issue of having all Americans come to the game of health care on equal footing is one that has to be settled for us to be able to finally rationalize the cost side.

JEANNE LAMBREW: I'm going to fully agree with that and just go a couple of steps further, because I think that is exactly right. I also think that when we think through our cost drivers, we have our new century's epidemic is chronic illness. We really see that smoking, heart disease, obesity and diabetes are our new plagues in this new century, so a greater focus on prevention has to be part of this reform

system that Chip talked about. I think we need to have more research on what works and what doesn't work, so when we are looking at an expensive drug that there might be some alternative that is equally effective, yet less expensive. We need to know more about what we're purchasing, which leads to my last cost driver issue we need to focus on, which is price. Yes, people want more and they get more, but we also pay, according to most studies, the most in terms of prices in the world on our health care. Giving our demand side actors, either employers or purchasing pools, whomever, some more clout to really try to negotiate lower prices and it needs to part of the solution.

DIANE ROWLAND SC.D.: This question is how the study authors looked at the declining quality of coverage. Employers are not just reducing coverage, they are also increasing co-pays, deductibles and reducing the number of services covered. Is there a relationship between declining employee take up and the decline in the scope of coverage?

JOHN HOLAHAN: I think the quick answer is no. The current population survey doesn't ask that kind of question. There is no doubt that the benefit package is diminishing, but there are two things that are happening that's keeping premiums growing faster than they otherwise would, but it means you're getting less for what you pay. The first should

keep coverage from declining. The second, we go the other way. It's hard to tell.

DIANE ROWLAND SC.D.: Maybe Bo, you could follow up with the other question that we have is for the uninsured workers overall. Are there more uninsured employees because employers don't offer or is it because employees don't participate?

BO GARRETT: If you just focus on the uninsured workers and take the sum total of where people start out and the trends we've seen recently, there are about 19 million uninsured employees in our study. The majority of them do not have access to employer sponsored coverage through their own job or the job of a family member. Most of the uninsured are uninsured among employees because they don't have access, not because they had access and chose not to pick up. This is discussed also in the brief.

CHARLES N. KAHN III: If I might add something? If we look at the increase in the cost of those who come to hospitals who receive free care or only pay part of it, we find in the excess $2 million in the figures that I gave, that's about two-thirds from those who are uninsured, and about a third from co-insurance and deductibles that don't get paid. One of the things that is happening because of the increases in co-payments, and I think the increases in co-

payments do serve some positive function. The negative side of it and probably with those with chronic illnesses is that maybe some of them are waiting longer, they'll end up in the hospital and the care ultimately, or some care gets provided, but it falls back in the system for somebody else to pay for. There is a good and a bad from the cost sharing side and we have to be careful about where the threshold is on that, but whatever it does in terms of moderating use, you begin moderating use that shouldn't be moderated.

OLGA PIERCE: Hi, I'm Olga Pierce from United Press International. The question I'd like to ask is it seems like the trend has been that employer-based coverage is ratcheting down and some of that has been picked up by Medicaid and other programs that are ratcheting up slowly. I'm just wondering, is there some sort of limit? Is there a core level of employer-based coverage that we anticipate enduring, or will the linear trend just continue until eventually we see almost no employer-based coverage at all?

JOHN HOLAHAN: There probably is a minimum, but where it is we don't know. Right now with federal tax policy, there is an advantage to people with middle income, or higher income people are much better off getting compensation through health insurance than getting the same dollars to wages and salaries. That is the natural breaking point and

unless we change that it would buttress that system for people above certain income levels. At the same time, that benefit is much less for lower-income people, where we see the problem growing and developing.

CHARLES N. KAHN III: You make an important point. There really are three big federal programs in terms of funding health care. There is Medicaid, which is federal, state. There is Medicare, which is obviously federal, and then there is the tax exclusion, which is really getting to be an extremely large number. So there is a lot of money on the table for people that have good jobs to get subsidized by the government. Employers in our labor market have a lot of incentive to provide coverage. It's the low-income side and I'm really interested, and I hope we can answer soon this new business versus old business, existing business question. That might help us through this issue too.

DIANE ROWLAND SC.D.: There is a follow-up question that really goes very closely to that, which is for Jeanne and Chip. What are the most important features of a tax credit that might be designed to help employers either offer or maintain their health care for employees? Are there some ways to do it that would have less adverse effects, other ways that might promote and shore up the system?

JEANNE LAMBREW: I'm going to actually parse the

question, which is to say tax credits to employers have been tried in various ways. There was a big experiment in New York awhile back. It's not been found to be very successful to get the tax credits to the employers. When you hook the tax credit to the workers, on the other hand, it may make that employer based insurance more affordable. There have been efforts to try to do that. I will just say a couple of pros and how you design a tax credit and a couple of cons about the vehicle.

The pros is actually the way you would design it that would make it most effective is trying to make it as a percentage, probably, of the premium because we have such variation in costs across the nation. If you're in New York versus Idaho, they are very different cost structures, and you have to be careful about a flat tax credit and what it would mean in different areas of the country, or within an age group. A young person would cost different than an older person. A person with a risk would cost more than somebody else. It's hard to calibrate a tax credit in our current health care market. You also need to make it refundable if you're going to try to target it to the low income workers.

Going back to the original where the ducks are - I'm not sure why ducks are the analogy, but we'll go back to the ducks. They are mostly low-income people, and so you really

have to make sure that they have enough tax liability to make that tax credit workable. It should be advanced, meaning it gets to the person before they have to pay the premium, not next April because it won't help them if they're low-income and have a cash flow problem. I'll say that the con of the approach is that most low-income people change jobs in a year, have a tenuous relationship with the work force by definition. That's why they're low-income, and so tax credits may not be the best way, or the most efficient way to try to get subsidies to a low income population.

CHARLES N. KAHN III: I think that the tax credit approach as another increment of reform, only in incremental reform is always going to have a lot of problems, and Jeanne talked about some of those. I do believe the following; if we're going to approach building the private coverage that we ought to have truth in advertising. If we're talking about an advanced refundable tax credit, why don't we just get real about it and say we're going to give certain people vouchers and then design a voucher program rather than trying to go through all the hoops in the tax structure?

I think the way to solve many of the problems that have been confronted by the tax credit is to throw the tax credit concept out and replace it with a voucher concept. How you determine eligibility is up for grabs, but then you have

an eligibility issue, you have a funding issue for the vouchers, and then you have the decision to make as to how much on various income levels do you want to subsidize people.

It would be a lot more straightforward, however - I'll get back to Massachusetts for a second - I think all these kinds of mechanisms that we have experimented with or would like to use to buttress the current system are not going to work that well unless it's part of a comprehensive package and you can see all of the pieces falling together. Otherwise, it's only going to have marginal data. That will only have marginal success. The children's programs have had more than marginal success, but it still is limited.

DIANE ROWLAND SC.D.: In terms of the issues and the uninsured rates that we've been talking about today, one question here is how that relates to ethnic and racial groups. Do they bear more of the increase in the uninsured? What's the impact of some of this data on contributing to racial and ethnic disparities?

JOHN HOLAHAN: We looked at that and at the end, because of the length of the paper was getting, kept it out. As a recall there was a fairly significant growth in uninsured among Hispanics, not surprisingly, but if you really wanted to see where is the growth in the overall

problem really occurring, it's really among whites and among native citizens, just because they are so much larger as the base. So it's white native citizens that are really bearing the brunt of this growth in the uninsured. Not in proportion to their overall numbers, where it's a bigger issue among Hispanics, but it's not a problem of minorities by any means.

JEANNE LAMBREW: I'd just like to say that's the growth of the uninsured, but if we look at the distribution of the uninsured, it's still disproportionately minority.

JOHN HOLAHAN: Disproportion relative to the population.

JEANNE LAMBREW: To the population. Yes, correct.

JOHN HOLAHAN: In numbers, but not [inaudible] but white and native citizens at any point in time, are the bulk of the uninsured.

BO GARRETT: We weren't able to look at race and ethnicity in the policy brief, but in the larger report that will be coming out soon we were able to look at that, and we do find some striking differences in the rates. Of course, non-Hispanic whites are the majority of the population, and so will drive a lot of the growth [inaudible] for them. The rates of decline of ESI were higher for non-Hispanic blacks and for Hispanics, around 6-percent each in our work over this longer 2001-to-2005 time period.

JEANNE LAMBREW: I'll just say a quick note, that I was just recently looking at the research on evaluations on Children's Health Insurance Program, and what we have found in some states, like New York is that when you enroll children into these programs, the racial disparities become insignificant in terms of other access means. It will not solve, coverage will not solve our racial disparities, but it does make a difference, a potentially major difference in some of our disparities.

CHARLES N. KAHN III: Just to add to that, in the Medicare program there has been a lot of research and there are tremendous disparities in terms of actual delivery of care. We go into all the reasons for that, so I'm not sure coverage is critical to getting it to a point, but we have other system issues in terms of disparities.

DIANE ROWLAND SC.D.: Chip, the question here is, will the strange bedfellows get to agreement?

CHARLES N. KAHN III: The more important question is will the strange bedfellows get to a successful and active law. Hope springs eternal, I'll answer the question.

DIANE ROWLAND SC.D.: Jeanne, you mentioned some awareness by large employers of government action being necessary to help complement their work, especially as we look at the issues facing the auto industry. Do you see any

movement in terms of these large employers toward being more available to discuss and advocate for improved government policy on the uninsured?

JEANNE LAMBREW: I'll just go by what's public and by what Chip said is his optimism, which is it was about a year ago where there was a forum potentially in this room where we had the heads of Starbucks, Costco, Honeywell, a bunch of the major corporations saying along side Senators Boxer and Grassley, Governors Romney and another democratic governor, we need a change. We need a systemwide change. It can't be that we just keep going along, as Chip said in his organic way. There have been some leaders, and there have been some individual leaders stepping out. There is a group called the HR Policy Association, Human Resource Policy Association, which has last spring issued a report saying, we're the ones doing a good job and we know we can continue doing a good job. We need help from the policymakers. We need to engage, and they are beginning a process to do this.

You see selective experiences, but we can't forget that if we go and engage by, no offense to our Washington based advocacy groups, our National Association of Manufacturers, our Chamber of Commerce, or any other business groups. There are two challenges that they have. Number one is they are membership organizations and they have always

somebody in their organization who will be hurt. It's the lowest common denominator problem. They can't lead because somebody will be affected by changing this big status quo and, equally important, many of those groups have as organizational representative's people in the health care industry who have even a different type of stake involved. It's hard to expect leadership to come from the Washington based groups. You can correct me if I'm wrong, but I do think that it's out there. It has to be out there, because if the business leaders don't recognize this, their stockholders will, their corporate boards will. We will have to see a change in this, because it just can't sustain these kinds of cost increases. Sheer economics.

DIANE ROWLAND SC.D.: This question focuses on some of the creative programs at the state level, pooled insurance, California, Washington State. What have we learned from these experiences, and do they offer any guidance to where we might go toward solutions in the future?

CHARLES N. KAHN III: They're limited. They can be successful with certain populations, but they're obviously expensive on a person-by-person, unit-by-unit basis. If you could find another way to spread that risk, it would be great, but there it just gets back down to a matter of economics. They're successful if the state is willing to put

in the amount of money it takes on a person by person basis, because these are expensive people. These are people who are sick, or their families will have people that are ill and they are going to be hard to insure.

JEANNE LAMBREW: I'll just say, Diane and Kaiser are in this study as well, and we did a study at the Center for American Progress in this. We looked at Medicaid and its payment for high-cost cases. The Medicaid program for community based people, put aside people in nursing homes for whom Medicaid is the primary payor, insurers, a huge percentage of the most expensive people in this country, 24-percent of the most expensive people all across the board of all ages in the country are covered at some point by Medicaid. So Medicaid actually is the high-risk pool, if you want to call it that, for our nation because it really doe, for people who are low-income, disabled, or duly eligible for Medicare, pay for those costs. So I think we should neglect the fact that Medicaid actually is serving this function in many ways.

DIANE ROWLAND SC.D.: This question asks the panel what they think that high-deductible health plans and health savings accounts will have as an effect on the number of the uninsured. They know that Jeanne has already expressed her view on that, but wondered if other panel members would be

willing to comment. Are high-deductible health plans and health savings account going to help significantly reduce the number of uninsured? Are they part of the solution?

JOHN HOLAHAN: The answer is that they could help ensure younger and healthier people making reasonable incomes. At the same time, they have the potential to have such risk segmentation issues, that is creating pools of relatively healthy people and increasing the cost that other people bear, that you have to keep in mind that you could see some deterioration of coverage in those other risk pools that are losing the healthy people that were attracted to these kinds of plans. It's a complicated question, but the attraction to young and healthy people with reasonable incomes is obvious. The overall effect is less clear.

CHARLES N. KAHN III: In a pluralistic system, all kinds of benefit structures ought to be offered to people because they want different structures, whether it's farmers and ranchers or others who are use to high deductible coverage, it's really what [inaudible] to say coverage is, is some tax protected money in a savings account. It really is more importantly, a high-deductible coverage. I wouldn't necessarily say younger and wealthier. It depends on lifestyle and outlook as to whether or not that kind of coverage can work for somebody. For small business people,

for ranchers, for farmers, for people that are used to that kind of coverage, they can make it work for themselves, and it can be somewhat less costly.

The fact is right now, if you look at the individual market, regardless of the HSA side of it, the individual market premiums have not increased that much in recent years, but that's mostly because the deductibles are getting higher and higher. The small employers that have been purchasing that coverage have made a choice, a trade-off. At least right now, it works in the mix. Ultimately the question is, how many more people is that less expensive coverage going to bring in? And probably not that many.

JEANNE LAMBREW: I'm not sure if I'm allowed to say anything because I already had an opinion, but just let me just say one quick thing, which is separate out the high deductibles from the accounts. We're spending a fair amount of tax dollars on these accounts, especially with proposals to try to make them more tax deferred, greater contributions to that. If you were given a choice between do you want to spend this, I think it's about, and I'm making this up because I can't remember the number, $40 billion, $50 billion on these accounts and the subsidies for these accounts. Is that the best way to cover the uninsured? I think it's a valid public policy question. Some people would argue that if

you're goal is to cover the uninsured, creating these tax deferred accounts is not the right way to go.

DIANE ROWLAND SC.D.: Looking at another option that is on the table to help improve coverage is re-insurance. This question is directed at you, Jeanne, in terms of how would you pay for a re-insurance proposal akin to the one that Senator Kerry had as part of his health proposal. Do you think a re-insurance strategy is an effective next step in trying to get health insurance more affordable?

JEANNE LAMBREW: The latter question, I would ask Chip what he thinks. I think your insurance company background –

CHARLES N. KAHN III: There was this debate, and Ed will remember it, back in the early '90s or late '80s. There was a big fight in the Senate between Senator Mitchell and Senator Kennedy, I think, between whether we wanted in long-term care to fund the back end or the front end. It went on for a long time and they never enacted a policy. I personally believe that from an insurance standpoint, just looking at it from an insurance standpoint, the back end is the easiest part to insure, because you're insuring against something not happening frequently for most of the insureds, so why would you want to subsidize that?

With all due respect, it never made any sense to me,

because if you're going to have private insurance, that's what the private market can insure against. Whereas, it's the upfront stuff that recurs a lot and so it drives this movement towards high deductible co-payments that causes your price pump. I don't know what the policy is for the front end for the people who have less money, but I don't think it's going to help employers that much. It's actually going to take them off the hook in a place where there is a market that works.

JEANNE LAMBREW: I'll agree in two ways. Number one, I don't think the re-insurance is ever going to be so much of a percentage of high expenditures, there is nothing left to insure. I think it was always a fraction of that. Two is if you think about the uncertainty, what is called a risk premium. Part of what you're paying your insurance overhead is an amount due to the unpredictability of that kind of risk. So you could potentially reduce the insurance company overhead by having some sort of re-insurance. As a public policy, we probably all could agree that if we try to figure out where we spend our limited government dollars, our public dollars, spending it on the most vulnerable, meaning the lowest income, and the most sick makes some sense. That's sort of a good public policy to say, let's target our resources towards those who are the sickest, who are the most

in need. That is something that we probably should think about in creative ways.

CHARLES N. KAHN III: Something just occurred to me from what you said. I guess I think that it's good to have those private insurers for the employers that they are providing coverage to, having all the risk. If you throw the government in there and you want a public program up there, I may not like it for other reasons, but it's a lot more rational. If you're going to subsidize the insurers though, the problem is they are going to figure out how to do real well in a system in which they have to accept less risk, but you are paying them money. If we're going to have a private system, let the insurers do what they're good at, which is work out risk at the high end.

DIANE ROWLAND SC.D.: I think we already know that a lot of the highest-risk people have already gotten into the Medicaid program because of their disabilities and are already part of the public risk.

CHARLES N. KAHN III: That's true, but there are a lot of people who cost a lot of money in the other pool. I don't know the data, but my guess would be in Medicaid the people that we are talking about that are expensive are people that are expensive over time.

DIANE ROWLAND SC.D.: And are unlikely to get private

insurance.

CHARLES N. KAHN III: Right. Whereas in the employer side we're probably talking about people with heart transplants, cancers, not these long-term things that in a given year could be very expensive. Actually, it's interesting how there is a lot spent on few people in each year, but I believe the data shows that over time it's not the same people every year in the private market. That tells me that insurers can figure out how to insure against that.

JEANNE LAMBREW: I will just counter the example I think most people know, which is about HIV/AIDS. We do have a situation where inadequate coverage in private coverage has meant that people with HIV/AIDS have difficulty accessing the drugs that they need, working when they can't work. They become disabled, they quality for Medicaid and then they can't go back to work once they get those medications because of the limitations that we did pass legislation in 1999 to aide them with a Medicaid buy in to continue their drug coverage through Medicaid. It's silly to help them at the back end, go back to work and not help them at the front end and try to prevent them from becoming disabled in the first place.

We have gaps in our private insurance system. As much as I'd like to think they are picking up all those people and

all those costs, the reality is different, so we do have unintended consequences and Medicaid is picking up people for whom you otherwise would think private insurance could do it.

JOHN HOLAHAN: I just wanted to add something. It goes along with what Chip was saying. In the early work that we did in helping with designing the Massachusetts work, we had a proposal for re-insurance that would pay 90-percent of the cost any time anybody exceeded $35,000 in expenses. They never included that, and I've come to believe that they were right. It really didn't have that big of an effect on premiums maybe reducing by 5- to 10-percent. There have been a series of meetings that Lisa Clemens-Cope and Lynn Blomberg [misspelled?] had at the Urban Institute where insurers came and were pretty convincing that that kind of risk they can really deal with. It's the chronic $12,000 person, $15,000 person that they really have trouble with. That's the person that they don't want. The person who is episodically one year, very high cost is an insurable risk. The problem is identifying those people who are consistently well above average, but not near those re-insurance thresholds is the public policy problem that I think we need to deal with.

ED HOWARD: Before I go to the microphone, I'll give you a second bite at the apple. Let me just say that we're nearing the end of the question time, so if you would pull

out those blue evaluation forms and fill them out as you formulate that last question.

MALE SPEAKER: Thank you for allowing me to ask a second question. This question would go to Mr. Kahn. This is about the virtue or the wisdom of increasing coverage by putting people in to the existing private health insurance system, so this is just strictly academics. The second leading cause of bankruptcy in America according to Physicians for National Health Program is from unpaid medical bills. The majority of the people who file for bankruptcy were insured at the time that they filed.

Number two, I owe $100,000 in medical bills, most of those medical bills that I owe, I was insured at the time, but because of the pre-existing condition clauses in my Blue Cross-Blue Shield policy, I can't even get a cell phone. Once your credit is destroyed when you can't pay your bills and there are literally millions of people who are going through this, so the question that I have is, why would we want to continue to pursue a policy that basically has failed a lot of people without examining the wisdom of that?

CHARLES N. KAHN III: Let me start off with a glib response, which I apologize for, but I just feel compelled to make to the first part of your question and I'll answer the second part of your question, and recognize it as I should.

Despite the fact that that article was in a peer review journal, there is something called the Data Quality Act, which sets criteria, OMB sets criteria for research that could be used for federal law. I cannot imagine that that study would pass muster. I have no respect for the peers who read it and allowed it to be published. That all being said, there are a lot of people who are going bankrupt in health care, and I can't argue with that.

At the end of the day though, I believe for most of us that a private group system in the non-senior and non-indigent markets can be well served by group system. I'm with you. Individual coverage, and I guess about 14-percent or so of those that have private coverage have individual coverage, it's a very difficult market and these pre-existing conditions come in, but I think with HIPA and the group market, if you had the subsidies that most of this would be okay. I wonder if we really analyzed the bankruptcy situations, situation by situation, whether the insurance side of public policy could solve that under any circumstances.

DIANE ROWLAND SC.D.: As a final question to our panelists: What role, if any, do the panelists feel that patient advocacy community can and should play in health care reform? Marching orders.

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

JEANNE LAMBREW: I'll go first. Important role, clearly an important role, somebody said earlier that was getting at the mandate that they should figure out who are these uninsured and underinsured people and bring them up here to Congress. Actually, we find ourselves often looking at numbers and data only and not looking at the faces, the names and the stories. It's a critical role and not just consumer advocacy groups, but the different disease groups. Right now we really have mobilization around people with different types of cancer, or different types of diseases are quite powerful and they could use their leverage, not only for the small policies, but also thinking about the big picture, because the truth is these are systemic problems that would be best served for their patients through major change.

CHARLES N. KAHN III: I really think we need balance from patient advocacy, national good and policy rationality. It's a hard balance. If we look back to the early '70s with the renal dialysis patients being wheeled in to the Ways and Means Room, and that basically led to renal dialysis being included under Medicare, because you have this little bizarre little aspect of Medicare that treats all those people under 65 after a given amount of time that have renal failure. So I really think there has to be a balancing. There has to be a

recognition of the individual issues. Jeanne brought up a real important one with, does HIV/AIDS necessarily fit into the insurance model that we have? We have to be careful about where the individual stories as important as they are, leads us. On the other hand, we can't all be numbers and green eyeshades, because then we're going to be led in other ways. There has to be a balancing between the two.

DIANE ROWLAND SC.D.: I think we've given you a lot of numbers and statistics about who the uninsured are, why they're uninsured and what's happening to uninsured coverage. We certainly tried in our discussion and from your great questions to focus a little bit on where we ought to be going and what some of the solutions are. It's never been easy to talk about the uninsured and how to solve it. I guess if it was, we would have done it already, but we thank you today and I'll turn it over to Ed for your participation in helping us to maybe move one step closer. We hope that someday, we won't have to have a discussion about the uninsured. We'll be talking about the challenge of maintaining better coverage or improving coverage for our population. With that, to Ed.

ED HOWARD: I look forward to co-sponsoring that briefing. Let me add my personal thanks and that of the Alliance for your participation. To Diane and Rikay Sing [misspelled?], and the rest of the staff of the Kaiser

Commission for being an integral part of putting this thing together, the staff of the Alliance for making it run so smoothly. I did want to say in addition to the blue form, which you are all going to fill out for me please, there was on the hand out table one other item we've just published on the Web for reporters, a source book that goes through the basics of a bunch of issues, including the uninsured. We've reprinted a chapter of that source book for you. If you didn't get one on the way in, you can get one on the way out. You can see the whole thing on our Web site.

Remember you can see the webcast, probably at 2:00 a.m. see the rerun of the C-SPAN coverage, and ask you to join me in thanking our panel for what was a very enlightening discussion. Nice job.

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