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RESHAPING THE FUTURE OF AMERICA'S HEALTH

ROUNDTABLE DISCUSSION

BEFORE THE

JOINT ECONOMIC COMMITTEE
CONGRESS OF THE UNITED STATES

ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

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RESHAPING THE FUTURE OF AMERICA'S HEALTH

WEDNESDAY, OCTOBER 1, 2003

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

The Committee met at 10:45 a.m., in room 216, Hart Senate Office Building, the Honorable Robert F. Bennett, Chairman of the Joint Economic Committee, presiding.

Members Present: Senators Bennett, Sessions; Representatives Maloney, Ryan.

Staff Present: Donald Marron, Leah Uhlmann, Colleen J. Healy, Melissa Barnson, Lucia Olivera, Rebecca Wilder, Wendell Primus, John McInerney, Diane Rogers, Rachel Klastorin, Nan Gibson.

OPENING STATEMENT OF SENATOR ROBERT F. BENNETT, CHAIRMAN

Senator Bennett. I want to welcome our panelists. I'll have a little more to say about that in a moment and thank them for their willingness to come back because this roundtable was scheduled from a previous time. The Senate is very inconsiderate of our schedules. They require us to vote at very odd times, and we had a number of votes that morning that required the cancellation, rather postponement to this hour of the roundtable. So I'm grateful to the panelists for rearranging their schedules and apologize to them for any inconvenience that we may have caused.

We are going to try something different this morning. Rather than using the traditional Congressional hearing format, we are going to be in a roundtable approach. I want to try this approach because too often the traditional adversarial atmosphere of a hearing limits the discussion between Members and panelists.

The current debate on health care is dominated by the discussion of benefits, deductibles, insurance coverage, payment levels, and the like. The attention of policymakers has been drawn away from the most important health care issue—the actual health of the American people. In the time I've been in the Senate, we've spent little or no time discussing health. We've spent all our time discussing these other aspects of the health care system.

America has the pre-eminent health care system in the world. It is also the most expensive health care system in the world. But despite our pre-eminence and our spending, there are some disturbing trends emerging with serious implications for the health of the American people in the future.

The numbers are overwhelming. Obesity is epidemic in the United States. In recent years, diabetes rates among people ages 30 to 39 rose by 70 percent. We know that this year, more than 300,000 Americans will die from illnesses related to overweight and obesity.

We also know that about 46.5 million adults in the United States smoke cigarettes, even though this single behavior will result in disability and premature death for half of them.

Compounding the problem, more than 60 percent of American adults do not get enough physical activity, and more than 25 percent are not active at all.

Some groups of Americans are particularly hard hit by these disturbing trends, especially the epidemic growth in diabetes. Native Americans are two to three times more likely to have diabetes than whites. And NIH reports the diabetes among African Americans has doubled in just 12 years.

Many of the problems I just mentioned are completely preventable. Having the pre-eminent health care system is not a replacement for a healthy lifestyle. Americans need to be responsible for their own health and prudent consumers of their own health care.

Much of current medicine is reactive and not proactive. The more proactive approach that emphasizes targeted screenings, patient education, and proper follow-up by medical providers can go a long way to help improve the health and productivity of the American people, and incidentally, reduce the cost of providing traditional health care.

However, poor preventive screening, redundant or inappropriate treatment, simple medical mistakes, and lack of oversight, do little for the health and do increase the cost of care.

So this morning, our goal is to focus on health, and not just health insurance. As we examine the challenges that face Americans over the next five to ten years, there are at least two questions that must be asked. First, what are the major health challenges that face Americans over the next five to ten years? Second, what are the most innovative tools available to meet these challenges?

Our roundtable discussion this morning will include the unique insight of the Surgeon General, Richard Carmona, who is spearheading President Bush's *HealthierUS* initiative. The *HealthierUS* initiative helps Americans to take action to become physically active, eat a nutritious diet, get preventive screenings, and make healthy choices. We are very happy that the Surgeon General was able to find time to join this morning's discussion, and we look forward to hearing his thoughts on these vital issues.

We're also pleased to have Mr. Joe Oatman, who is currently Senior Vice President of Fortis Health. He is here to elaborate on the initiatives the insurance industry is taking to promote healthy lifestyles and keep down costs. Many insurance plans and employers, including Fortis Health, have taken a "carrot and stick" approach to encouraging beneficiaries to exercise, quit smoking, or follow doctor's orders while monitoring chronic illness. Some companies reduce premiums and increase interest rates on health care saving accounts, or give away gym equipment as rewards for healthier lifestyles. Health and Human Services Secretary Tommy

Thompson met with Fortis Health and other insurers in July to persuade them to find ways to reduce the public cost of treating America's obesity epidemic.

Finally, we are pleased to have Dr. Diane Rowland of the Kaiser Family Foundation. Dr. Rowland is a nationally recognized expert on Medicaid and the uninsured. Like physical inactivity or cigarette smoking, the lack of health care coverage is a risk factor for long-term health problems. We look forward to Dr. Rowland's insights on the particular problems facing lower income Americans and those without access to health insurance.

The ground rules are that we will hear briefly from each of our panelists, but we do not want the traditional opening statement and presentation of policy, we want a statement that will trigger interaction and conversation, and I will recognize Members of the Committee for the same kind of statement. Congressman Stark, who is the Ranking Member, is maybe coincidentally ill today and therefore not able to be with us. We will put his statement in the record, and we regret he will not be here for his traditional brand of questioning and prodding, which always keeps the Committee on its toes.

Mrs. Maloney, you have the obligation to pick up that particular lance and carry it forward. So, with that statement on my part and Congressman Stark's statement as the official opening statement of the Minority, we will go immediately in the roundtable kind of conversation and General Carmona, we will start with you.

[The prepared statement of Senator Robert Bennett appears in the Submissions for the Record on page 27.]

Representative Maloney. Mr. Chairman, on behalf of Mr. Stark, I would like to put a statement in the record. He sends his regrets, he is very ill today. It's good that you're having this health care hearing today.

Senator Bennett. Yes. His statement is included in the record.

[The prepared statement of Representative Pete Stark appears in the Submissions for the Record on page 28.]

Representative Maloney. He wanted very much to have this report from FamiliesUSA on the census numbers of the uninsured numbers is the largest increase in the past decade. The total number of uninsured now exceeds the cumulative population of 24 states and the District of Columbia. I'd like permission to place this in the record with the accompanying map that shows the uninsured. Likewise, a report from the Center on Budget and Policy Priorities, "Number of Americans Without Health Insurance Rose in 2002," and a report that shows that the increase would have been much larger if Medicaid and the SCHIP enrollment gains had not offset the loss of private health insurance. So I request permission to place both reports, along with his statement in the record. Thank you.

[Families USA report entitled, "Census Bureau's Uninsured Number is Largest Increase in Past Decade," submitted by Representative Stark appears in the Submissions for the Record on page 51.]

Senator Bennett. Without objection it will appear with his statement.

General Carmona, let's kick this conversation off and be prepared to be interrupted and questioned as we go along, in ways that are probably not traditional in a congressional hearing, but that I hope will be productive in giving us a record and understanding of where we are.

Surgeon General Carmona. Thank you Mr. Chairman.

Senator Bennett. Don't worry Members. If you have a question just ask for recognition and we will do our best to accommodate you regardless of when you come or whose turn it is. We want it to be a true roundtable.

Surgeon General Carmona. Thank you, Mr. Chairman. It's a pleasure to be with you here today and thank you and your colleagues for your leadership in calling this discussion.

Nearly two out of three of all Americans are overweight or obese. That's a 50 percent increase from just a decade ago.

More than 300,000 Americans will die this year alone from heart disease, diabetes, and other illnesses related to overweight and obesity.

Obesity-related illness is the fastest growing killer of Americans. The good news is that it's *completely preventable* through healthy eating—nutritious foods and appropriate amounts and physical activity. The bad news is, Americans are not taking steps to prevent obesity and its co-morbidities.

The same is true for other diseases related to poor lifestyle choices such as smoking and substance abuse.

Put simply, we need a paradigm shift in American health care.

There is no greater imperative in American health care than switching from a treatment-oriented society to a prevention-oriented society. As American waistlines have expanded, so has the economic cost of obesity, now totaling about $93 billion in extra medical expenses a year.

Overweight and obese Americans spend $700 more a year on medical bills than those who are not overweight. We simply must invest more in prevention, and the time to start is during childhood, in fact, even before birth.

Fifteen percent of our children and teenagers are already overweight. Unless we do something now, they will grow up to be overweight adults. None of us wants this to happen.

We can't allow our kids to be condemned to a lifetime of serious, costly, and potentially fatal medical complications associated with excess weight. The science is clear.

The fundamental reason that our children are overweight is this: *Too many children are eating too much and moving too little.*

The average American child spends more than four hours every day watching television, playing video games or surfing the web.

Instead of playing games on their computers, I want kids to play games on the playground. As adults, we must lead by example, by adopting healthy behaviors in our own lives. We've got to show kids it doesn't matter whether you're picked first or last, but that they're in the game. Not all kids are going to be athletes, but they can be physically active.

We've got to *show* them how to reach for the veggies or healthy snacks rather than fatty sugary snacks that they've become accustomed to.

Our commitment to disease prevention through healthy eating, physical activity and avoiding risk is one that our entire society must be prepared to make in order for this to be effective.

As you mentioned, President Bush is leading the way through the *HealthierUS* prevention initiative.

HealthierUS simply says, "Let's teach Americans the fundamentals of good health; physical activity, healthy eating, getting check-ups and avoiding risky behavior."

Secretary Thompson is leading the Department of Health and Human Service's efforts to advance the President's prevention agenda through *Steps to a HealthierUS*, which emphasizes health promotion programs, community initiatives and cooperation among policymakers, local health agencies, and the public to invest in disease prevention.

As important as these efforts are, we cannot switch America's health care paradigm from treatment to prevention through government action alone. The fight has to be fought one person at a time, one day at a time. All of us must work together, in partnership, to make this happen.

Secretary Thompson has asked employers to make health promotion part of their business strategy. In September, he released a report, *Prevention Makes Common Sense*, highlighting the significant, economic toll of preventable diseases on business workers and the nation. The key finding of the report, obesity-related health problems cost U.S. businesses billions of dollars each year in health insurance, sick leave, and disability insurance.

The report highlights the need for and cost effectiveness of employment-based prevention strategies. Recently, I joined my colleague and former Surgeon General David Satcher and the National Football League in kicking off their partnership to promote school-based solutions to the obesity epidemic. I also joined basketball star, LeBron James in launching Nike's PE2GO program, which provides equipment and expertise to schools so they can offer fun physical activity, school-based programs.

As Members of Congress, you can influence the behavior of your constituents in many ways, obviously first by leading by example. Secretary Thompson put himself on a diet and challenged all HHS employees to get in shape by being physically active for at least 30 minutes a day. You could issue the same challenge to your staff members and your constituents. Secretary Thompson has lost 15 pounds and continues to work out every day and as you know, follow the example of our President, who has a pretty ambitious routine on a daily basis of working out and setting that example.

You can also help educate your constituents about the importance of prevention, through town hall meetings and by establishing partnerships in your own communities. The total direct and indirect cost attributed to obesity is about $117 billion per year or $400 for every man, woman, and child in the country.

I'm a doctor, not an economist, so I've seen the cost in more than just dollars and cents. It's about a mother who can no longer provide for her children. It's about a child who can no longer ask a father for advise. It's about real human cost, 300,000 American lives lost each year. Just a 10 percent weight loss through healthier eating and moderate physical activity can reduce an over-

weight person's lifetime medical cost by up to $5,000, maybe even save that person's life, not to mention what it will do for their self esteem and self sense of well-being and for the well-being of their loved ones. Where else can you get that type of return on an investment?

Thank you and I look forward to our discussion.

[The prepared statement of Surgeon General Carmona appears in the Submissions for the Record on page 29.]

Senator Bennett. Thank you very much.

We might as well start the discussion off right at the beginning. The one thing you can do to absolutely guarantee your financial future is to write a book about diet.

[Laughter.]

That is the absolute home run, everybody has a diet book. Dr. Atkins was very famous, Mr. Pritikin became famous, and so on. And like every household, we have on our shelves a whole bunch of diet books.

There is a growing theme among these diet books, which I have raised in my other assignment as Chairman of the Agriculture Appropriation Subcommittee, that one of the reasons for obesity is that Americans are eating too many carbohydrates and that carbohydrates, according to some of these medical sources, actually produce more fat than fat does. And that by starving themselves from eating fat and pigging out if you will on carbohydrates, Americans are getting fatter even while they are on diets. And according to some of these folks, the villain is the USDA food pyramid, which is very heavy on carbohydrates.

We have colleagues here in the Senate, Senator Sessions and I, who have lost 50 pounds and done it entirely by cutting out the carbohydrates. Not cutting them out, but cutting them down and saying, we will not eat anything but leafy vegetables as carbohydrates, but we will cut out the heavy emphasis on grains that the USDA pyramid calls for. We increased our intake of protein, and yes, sometimes the fat. And they are walking examples that they've been able to lose very substantial poundage.

I've never had a weight problem, I guess because of my genes, but joining my wife as she struggles with hers, I've lost 8 to 10 pounds by cutting down on the amount of carbohydrates that I have consumed and they are supposedly healthy carbohydrates. Fruit juice, for example. By switching from fruit juice to water, that alone—well I won't go on and on about this. Let's not——

[Laughter.]

But the reason I raise it is because you emphasize the school activity. You emphasized the importance of dealing with our children. The USDA pyramid is scripture in schools, and our kids are being told over and over again to eat more carbohydrates and there is a whole industry that has grown up: walk down the aisle of the supermarket and it says "fat free" and you read the label and they're filled with carbohydrates. Now there is no fat, and I love them, and I ate them and I thought "Boy, I'm doing great, look, I've cut down on all my fat." But, I didn't seem to be able to do anything about my weight. It seems to me it is the responsibility of the Federal Government, if they are leading this charge, to do more than just urge us to eat less and exercise more. If indeed there is some sci-

entific basis for this, and I recognize this is a major debate within the scientific community, but if, in fact, there is some scientific basis for the idea that Americans are not eating enough protein and eating too much carbohydrate, then it ought to be the government that does the science and the government that comes out with the study instead of all of these independent gurus who keep getting rich selling books. Now, do you have a reaction to that? Or perhaps Mr. Oatman, you have experience with that? Let's start the roundtable with a very simple one, which is, is the USDA food pyramid good or bad?

Mr. Oatman. I can respond to that. This is not a corporate position or a company position, but a personal comment. I have worked with the low carbohydrate diet since April of this year and lost 40 pounds. My wife has worked with it and lost 50 pounds and——

Senator Bennett. Exhibit B.

Mr. Oatman. I would have to echo your comments considerably Mr. Chairman that I think we need lots of good scientific research on this very topic and that by working on helping people understand the education component, what is the appropriate diet and having strong scientific evidence behind that is very critical to making the changes that are needed to improve this area of obesity, which is an epidemic.

[The prepared statement of James Oatman appears in the Submissions for the Record on page 31.]

Senator Bennett. Any other comments?

Surgeon General Carmona. Yes, I think you've covered very broadly the whole issue that's so complex before us. An issue that often is not discussed as it relates to this is the issue of health literacy. Because you know, overall we are largely a health illiterate society. You pointed to that in many of your statements. People are confused, they read different books, they watch infomercials in the middle of the night, they don't know what is science and what is hype. And so, there is a considerable body of information out there, good scientific information about physical activity, about the value of a balanced diet. Clearly, carbohydrates are part of that, as are proteins, as are fat. Fats are essential in our diet. But it's the balance, that's what we're talking about, creating energy balance which really is how much you take in, what your needs are, which we find are very individualized, depending on how old your are, how active you are and so on, and how much you put out every day. Marathon runner versus a sedentary officer worker.

So there is no simple answer for each person, but one of the things that we feel is important is that we must build the health literacy into society so that society has the capacity to understand these messages and be able to ask the right questions of their health care providers and purchase the right foods so that that will constitute a healthy diet.

Dr. Rowland. Mr. Chairman, I also think one has to take into account affordability. For many of the lowest income families, the food that's most available at the cheapest price is often the food that's the worst for them. We need to really think about ways to make carrots more available than some of the other kinds of Big Macs that people can get so quickly. When people are waiting in line at a hospital for their child to be seen, the place you go is

Burger King or McDonald's for the 99 cent meal. I think that is another part of what we have to deal with.

[The prepared statement of Diane Rowland appears in the Submissions for the Record on page 32.]

Senator Bennett. Senator Craig has a diet that forbids him carrots.

[Laughter.]

Representative Maloney. Mr. Chairman I would like to follow up on the Chairman's comment on the food pyramid and the Surgeon General mentioned that the public should be more informed and better educated, but if the education coming from the federal FDA or the Surgeon General or the federal government is faulty, we should be told that. When we go to the store, they have all these advertisements that say "fat free." Well, maybe we should require them to say that "fat free" means you may be gaining more weight if you eat it. It's the exact opposite of what it is and with all of the diets that are out there, and we have two examples here where they lost 50 pounds—I'm going to go on your diet, I'd like to lose some weight.

Senator Bennett. I lost five.

Representative Maloney. You lost five. Okay. But in any event, there are many, many diets out there that say that the Federal Government's food pyramid is faulty, that it is incorrect, that it is unhealthy actually. And my question really follows up on the Chairman's, what are we doing to review the health pyramid? Is this something we have to pass legislation on or is this something that is under review right now? The public should know. You said they should be more informed, but the government needs to tell them what's healthy for them and I was taught the food pyramid in school and it's still being taught. Should that be changed? Is it under review? The scientific evidence seems to indicate, if these books are correct, it's a faulty pyramid for health.

Surgeon General Carmona. I'd be happy to comment. It is under review. Heath and Human Services and the Department of Agriculture have a group that has been convened for some time now, reviewing the elements of the food pyramid, the constituents that make that up. But I'd like to, maybe, just make a comment about the issue. Is it bad information? You know, science evolves very, very quickly and at the time when the food pyramid evolved, and the best science was allied to it at that time, this was the best that was to offer. But science evolves so rapidly now—almost on a daily basis—that it's hard to have something fixed for years and say this is the best way to do something. Look at the genomic project, for example, and how quickly that's come before us.

So I think what we have is an evolution. We're learning much more about the value of different constituents of diet, how they should be appropriated across the board and I think what we're seeing is really the new science that's come before us. And we have to figure out a way that we can keep this as a dynamic process. It will never be static, in our lifetime or our children's lifetime, because the science is going to move too quickly. We always have to be prepared to incorporate that. Those meetings are taking place now and there is a recognition within the federal government that that needs to occur because of the reasons I've mentioned.

Representative Maloney. When will the report be available? And you mentioned, science changes swiftly, yet the food chart hasn't changed in my lifetime.

Surgeon General Carmona. You're absolutely right. Representative Maloney. So if it changing swiftly, it's not being reflected

Senator Bennett. It has changed, it has changed, but it's gotten heavier on the carbohydrates.

Representative Maloney. Really? Wow.

Surgeon General Carmona. This is not a trivial issue.

Representative Maloney. When will the report be due? When was the report due in HHS?

Surgeon General Carmona. I don't have a date for you. I can get that for you. I'm not personally involved in that, but there is a group of both USDA and HHS folks that are working on this now and have been for some time.

Senator Bennett. I raised this issue during the appropriations hearings with the USDA and put the cat among the pigeons, as they say. Rather significantly, there was a lot of reaction among the witnesses. Not to beat this, but Dr. Rowland, if General Carmona's comment is correct and obesity is costing us $117 billion a year, half of that would go a long way towards solving some of the problems you are concerned about, wouldn't it?

Dr. Rowland. It certainly would.

Senator Bennett. Okay.

Representative Ryan. Do you mind if I go in another tangent?

Senator Bennett. Absolutely.

Representative Ryan. Mr. Oatman, in your testimony, you highlight three elements of lower cost via lifestyle changes and the third one you talk about is incentives and I want to ask the three of you, to kind of throw it out there.

Senator Bennett. We haven't asked you for your testimony yet, so I'm glad you read it, go ahead.

Representative Ryan. They are a constituent.

Senator Bennett. Okay.

Representative Ryan. But a good one. Incentive structures. How do you assemble a good incentive structure to encourage people to engage in healthy lifestyles? I'm thinking of an employer in Wisconsin who is really cutting edge on this who has a program for his employees, has a couple hundred employees, who gives them a better deal on their health insurance, on their out-of-pocket costs on co-pays and their deductibles, if they agree to sign up to this healthier lifestyle program in the company. Go to the gym, get a free membership, have a better diet, and if they engage in this, then they get lower cost out-of-pocket. If they don't, and all screening and assessment is a part of that, if they chose not to do that, they're going to have to pay for it. And that is a real clear incentive structure and the take-up rate for this program in this company I think is about 92 percent and their health care cost, where you see most employers are talking about double digit health care increases in their premiums, they have been keeping them at single digit increases.

So, there is one example of a company, you know, actually putting a very solid incentive structure in place. Can you tell us more

about what the market is doing? What you as a market participant are doing to put good incentive structures out there so the consumer actually, it pays to have a healthier lifestyle. And I'm also interested in the rest of the panelists, what you are seeing. I know Kaiser, I mean you are the cutting edge: researchers in a lot of these areas, what do you see that's taking place, the new phenomenon in the marketplace, are there things that we can do in tax laws or public policy to improve the availability of these new incentive structures? Let me just throw it out for the incentive structure discussion.

Mr. Oatman. Sure. Let me respond to that. I think what that employer is doing is very remarkable and what more people need to do. We've tried to accomplish similar things in some of the products that we sell. There are four basic components to the kinds of things that we have done that we think have proven to be very, very successful.

The first is medical saving accounts (MSAs). We are the largest writer of medical savings accounts and we have seen that the health care of people that decide to pay a significant portion of the first dollars of health care spending themselves and where they have got more responsibility for that is significantly lower. And it's not only significantly lower at the time they buy the policy, but it continues for many years into the future, that they continue to have lower costs because they're very much engaged in the game.

Senator Bennett. Can I just ask you on that point. Is there any indication that because they are paying the costs, they don't seek care that they really need, or is it, in fact, the change in lifestyle that makes them healthier?

Mr. Oatman. You would think that if they were not getting the care they needed, then you might see an increased incidence of the more catastrophic and serious things and we do not see that. We see a lower incidence of the serious things as well.

Senator Bennett. Thank you.

Mr. Oatman. I think there is evidence that is not happening.

Dr. Rowland. However, some of what we see with the use of those accounts is that younger, healthier people who are less likely to have a lot of health expenses are the ones who opt for that account. Very few people with serious chronic illness, which is where most of the cost in our health system occurs, or with ongoing diabetes, are in these kinds of programs.

Representative Ryan. What adverse selections data is out there for MSA? I know MSA is going to cap and they're fairly limited, but could you address that as well since I think that's where we are headed?

Mr. Oatman. Actually, we were surprised. We thought that indeed that might happen, that the younger people would buy this product and healthier people would buy this product. In fact, we've seen a different pattern. In fact, the average age of the buyer is older, generally it's a very much a cross section of customers that buy it, that look very much like the rest of our business and quite frankly we were surprised by that. We felt we would see something different.

Representative Ryan. Is it because they'll buy an MSA and then a catastrophic plan. So it's people who may be less healthy,

who know that they're really going to need catastrophic coverage at some point and they'd rather manager their cost and get a better deal in their health insurance. So is it, in fact, that you are getting some sicker people into these MSAs, for those reasons? That it's actually the reverse argument of an adverse selection argument?

Mr. Oatman. I don't think that it's a reverse selection or a positive selection. It seems to me that it is pretty much like the same kind of customer. The one interesting thing too is that for someone who gets sick, a typical family MSA account with a $3,400 deductible, their costs are capped at that $3,400. And often, in many other products that are not MSA products, a very sick person could end up going to a much higher number of out-of-pocket cost. So actually, for the sick person, the MSA account tends to work pretty well in limiting to a fixed dollar amount, their out-of-pocket expenditures. And we see that as people do get sick, they are very pleased with their product, and they hang on to it and it serves them very well.

Senator Bennett. Is it portable from employer to employer?

Mr. Oatman. Currently, the medical savings accounts that are offered are only offered to the self-employed and to small employers. And quite frankly, our experience has been limited to mostly the self-employed. Because of the lack of portability many small employers are not adopting it as much. They are tending to go for a health reimbursement account, it's tended to be the way they have gone. Many of the limitations I think on medical savings accounts have limited their applicability to a very small subset of self-employed people and with the expansion of MSA rules, we think they would have much broader applicability.

Representative Ryan. Your business—I think because you are a Wisconsin company I'm familiar with your business—your business in HRAs really grew drastically after the IRS ruling on Health Reimbursement Accounts (HRA). Could you explain why that occurred and what benefits HRAs have over MSAs and why it's easier to get that product out to the marketplace?

Mr. Oatman. We market HRA exclusively to small employers and in fact, the average size of employer group that buys our product is six lives. We introduced a health reimbursement account product and found that our sales very, very quickly went to 25 percent of our sales, that employers are hungering for this kind of solution to health care costs.

Representative Ryan. Just for everybody else who isn't familiar with the IRS ruling, could you just quickly describe that? Some people might want to know that.

Mr. Oatman. I'm not sure I'm familiar with all of the details, but basically, the employer can set up an account for an employee and the employee can use that account for health care expenses under the deductible, and unlike medical spending accounts that many large employers have, this account can be carried forward year after year. So, it's a very positive thing for the employee as well.

Representative Ryan. No use-it-or-lose-it rule?

Mr. Oatman. It's no "use-it-or-lose-it" rule with that product and we found that employers are looking for a way to responsibly partner with their employees in the health care cost equation and so

have been looking for solutions. As a result of this, it took off well beyond our expectations.

Senator Bennett. Let me ask a question that I think Dr. Rowland is interested in. Are these employers those that would otherwise cancel their insurance because of the cost and therefore increase the number of uninsured? Do you think you are reducing the number of uninsured with this product?

Mr. Oatman. Yes. The data is very early and we haven't done all the analytics on health reimbursement accounts. I can give you the numbers on medical savings accounts. We are finding that half of the people that are buying that product, previously had no insurance coverage at all. So it's addressing a need for people who previously were not in the market and have decided to get into the segment.

Representative Ryan. Is that just in all MSA, or your pool of business?

Mr. Oatman. Our pool of business. I'm unfamiliar with the rest of the business.

Senator Bennett. Is there anybody else offering this same mix that would expand the amount of data that we can look at for this phenomenon?

Mr. Oatman. Yes. There are a number of carriers that are offering these products. I think that you will see an expansion of health reimbursement accounts, now that the IRS has favorably ruled on them. Medical savings accounts are offered by rather more limited number of carriers because they didn't want to make the investment, given that there was a termination date associated with the legislation.

Senator Bennett. We fought that fight in the Senate—and basically we lost it—to try to get more opportunity for medical savings account experimentation. I don't think the opportunity to experiment is big enough to give us enough data to make it complete.

Dr. Rowland. Mr. Chairman, we do an annual survey of employers of the health benefits that they offer, and in this year's 2003 survey we saw among some of the jumbo firms, those over 2,000 employees, the beginning of offering of a broader mix of services, including some of the medical reimbursement accounts with the catastrophic plan attached to it. That was one area in which many of the employers said they were going to look at instituting in the future. Mostly, however, in our survey, it was those very, very large firms where they felt they could have a whole mix of insurance options as opposed to the firms under 200. So, we're talking about very different markets here.

Representative Ryan. Dr. Rowland, have you looked at the connection between incentive structures and these health reimbursement type of accounts? The question I'm asking is, because right now we're in the middle of a Medicare conference report, we're debating health savings accounts. It's another iteration, but it has all of the benefits basically of all of these different products kind of wrapped into one product. No use-it-or-lose-it, it's portable for the employee, the employee and the employer can put tax deductible dollars into it, you have to buy catastrophic coverage.

The question I'm trying to get at is, do we have evidence and data that suggests that you can get the right kind of incentive

structure set up inside these plans where an employee has his or her own money at stake and the first dollar of coverage, the employer sets up some kind of incentive system so they lead a healthier lifestyle. Their own money is at stake because it's money that has been given to them by their employer that is part of their property or they put their own tax deductible into it. Is there evidence that suggest that you can get these incentives set up and if we fix some of the strings and the problems that are associated with Medical Savings Accounts (MSA), Flexible Spending Accounts (FSA), Health Reimbursement Arrangements (HRA), which is essentially what Health Savings Accounts (HSA) have attempted to do. I know I'm throwing a lot of acronyms out.

Senator Bennett. You sound like you work for the Pentagon.

[Laughter.]

Representative Ryan. Can we get a good—can we really push this incentive issue?

Dr. Rowland. There's really not much data that I'm aware of on the use of incentives at all. We're just beginning to pick up some of the employer's strategies to contain cost in our last survey, but none of them include anything along the lines of the wellness incentive. We can certainly ask that in this year's survey which is about to go into the field.

Representative Ryan. It would be interesting to see that.

Dr. Rowland. What we do know however is, in some of the public opinion work we've done trying to assess health insurance options that the public views, that many members of the public are very concerned about ending up with health care costs they can't afford and so they seem very risk-adverse in some of our questioning to go into a system with a high deductible. So I think there is really a pretty limited understanding of what these plans are or how they operate.

Representative Ryan. Sure. I understand a lot of those questions don't necessarily say that you'll have the money in your account to cover the deductible and then when you reach that level, your insurance kicks in.

Dr. Rowland. Well, and as you pointed out, one of the problems is that the structure of these plans vary so tremendously from one to another that you're really comparing apples to oranges in most of the cases.

Representative Maloney. Dr. Rowland, in your comments earlier, you mentioned that in some cases, families may not be making good health choices because they cannot afford more protein. Have you done any studies on what the impact has been on granting Medicaid, which has really capped the amount of money that can go to the poor and the competition with health care, and have you thought about incentives of maybe more food stamps would go farther if you bought vegetables as opposed to potato chips or that type of thing that could encourage healthier eating patterns?

And the Surgeon General, you mentioned quite a bit about exercise and the importance of it. I represent the Rusk Institute, which really was a trailblazer in rehab and exercises as a tool to heal. And what they do there is absolutely remarkable. I feel that future research will really change the way we approach our lives because with exercise, you can literally heal people that are very, very ill

and any studies that the government may be doing on the impact of exercise.

Everyone says exercise and build it into your life, but when we look at our public school system, oftentimes gym classes, after-school programs, the very programs that begin a healthy life pattern, where you learn that that has to be part of your life, regrettably are being cut out of many public education programs. What are we doing to counter that? Obviously, if we raise healthy people, the cost on our medical system both for individuals, for business, for the government is far, far less. Also, any comments on screening?

Obviously, if we screen people early and find out what health ailments they may have, whether it's prostate cancer or breast cancer, the degree of probability of healing it and healing it in a cost effective way goes up dramatically. So those are items if anyone wants to comment from both the panel and the Chairman and so forth.

Senator Bennett. Feel free to dip into your opening statement now. This is your opportunity to read those things that we didn't give you a chance to read.

Dr. Rowland. Well let me just comment from the perspective from low-income families and their access to affordable foods. Most of the work that we've looked at involves the Native American population and some of the real disparities in terms of the kinds of foods that were made generally available through some of our assistance programs. I think there has been a lot of work now to try to remedy that, but historically that has been an area where we've know that the choice of food has been particularly poor for the health of that population.

In terms of my own statement, I do recognize that advances in improving health and combating obesity offer a great promise in the health care system. But I also am concerned that for many Americans, those gaps will not be closed by just improving healthy behavior alone. Health insurance really is a key to the door for getting people into the health system for both preventive care as well as for the follow-up medical care that may be needed. And yesterday's statistics from the Census Bureau reporting that we had 43.6 million Americans in 2002 who were uninsured, I think provided a wake up call for all of us that this is a problem that's growing and not a problem that's going away.

But what I'd like to put before the Committee's consideration is that we also have to think about the consequences of lack of health insurance. And in my longer statement, I reviewed much of the evidence on the fact that an uninsured population is also not a healthy population. They have less access to care, they tend to postpone or forego needed care, go without needed prescriptions, and receive less preventive care. I think the Surgeon General would agree, that this also brings them in later at a point where their diseases have advanced more so they are less likely to gain some of the therapeutic advantages that early detection may bring. And as a result, they have a higher mortality rate.

I think we can't be complacent when the Institute of Medicine (IOM) is estimating that some 18,000 Americans die prematurely each year because of their lack of health insurance. But it also is a substantial burden on our society as a whole. Lack of coverage

in the middle ages means that when people come on to the Medicare program, they are in poorer health. We now estimate that about $10 billion a year could be saved in Medicare alone if we had people engaged in healthier behaviors as well as in having health insurance coverage to treat illnesses before they age onto the Medicare program.

I think these statistics compel us to try to provide both a coverage initiative as well as a healthy behavior initiative to make our nation a healthier place. And unfortunately, in today's economy, I think the employer-based coverage we've enjoyed, as well as the public coverage, are in serious jeopardy.

Last year, employer premiums rose by 14 percent. We now pay $9,000 on average a year for a family health insurance policy, unaffordable for many of the lowest income. The employee's share for those policies is roughly $2,400 a year, which is a very big burden on employees and I think we're going to see in the future, more and more low wage employees not able to even pick up the health insurance offered by their employer and we're seeing employers really struggle with how they can limit their cost and now we can expect some employers to decide not to offer coverage because of the price tag.

On employer behavior, we've had very promising statistics in that there has been no drop off in the percent of employers offering coverage, but there has been a drop off in the percentage of employees who are able to gain insurance through the workplace.

On top of that, the good news in this year's Census data was that while the employer coverage was slipping and creating more uninsured Americans, Medicaid actually grew and provided some coverage to pick up at least some of the children who may have lost coverage when their families were uninsured. But Medicaid itself is now in dire fiscal straits because of the revenue depletion at the state level and the fact that states are making more and more difficult choices about how to restrict their Medicaid budgets. Virtually every state is looking at reducing eligibility, reducing benefits, really unraveling some of the progress that's been made since 1997 when the State Children's Health Initiative was passed to complement Medicaid and really try to address our uninsured children.

So I think as a society, one of our pressing problems remains how do we maintain coverage in the employer-based sector and in Medicaid and how do we expand coverage so that everyone is on an equal playing field to get the preventive care they need and to be able to participate fully in the many benefits of our health system—whether that is early education, wellness programs or other things. Lack of health insurance really is undermining the health of our nation, just as some of our unhealthy behaviors are.

Senator Bennett. Thank you very much. May I offer a slight correction? You say the cost is $9,000 a year and $2,400 of that is paid by the employee?

Dr. Rowland. Right.

Senator Bennett. All of that is paid by the employee?

Dr. Rowland. Right.

Senator Bennett. We have created the fiction in this country that it's free. But having been an employer, I know that if the em-

ployee does not return enough economic value to me by his labor to cover the full $9,000, I can't afford him. And even though it doesn't show up on his W-2, he earned that entire $9,000. And if we can get that concept firmly rooted in people's minds, that this isn't free, this is your money, it might go a long way towards solving the educational problem that you talk about, because a lot of folks say "Well, I don't have to worry about that. That's the employer's money, it's free to me. So whatever he decides to do, is just so much gravy to me."

No, it's your money and you ought to take control of it and be educated about it and have some degree of say as to how it is spent. And that gets us back to cafeteria plans and all the rest of that.

I don't know that you have any numbers on this, I discovered when I was running a business, and we did set up a cafeteria plan, where we said you have X number of, we called them "flex bucks," we will spend—pick a number, it was about $350 a month—that you, the employee, can dictate how it's going to be spent. And, you tell us "here is the cafeteria of options." Well, the first employee comes in and he says, "Are you out of your mind? I've got four children, I want every dime of that $350 to go to health coverage, and of course, I'll have to add another $150 myself to get the coverage I need for my family. I have no options. What do you mean cafeteria plan? I need every bit of it."

Then the next employee comes in and she says, "Well you know, my husband works at Hill Air Force Base and he is covered under the Federal Employee Health Benefits Program, and I don't need any health coverage. And I'd like the $350. We've got little kids; I'd like it to go to daycare. Could you spend it that way?" We'd say "Sure. Give us the name of the daycare, we'll send the $350 a month check to your daycare."

The next employee comes in and says, "Hey, my husband works for a law firm and he has got all kinds of health care coverage at his law firm, I don't need health benefits and I don't have any small children. Can you put that in my 401K?" And we'd say "Yeah, we can put it in your 401K," etcetera.

Well, it made for a much happier workforce because they began to get control of these benefit dollars. But the great thing that hit me, that I would like some statistics on, if anybody has them, how much double coverage do we have? Where we have two-income families, are both husband and wife in plans where the employer is paying for both of them, when in fact, they would be covered by just one. Is there some duplication there? We are spending more GDP than any other country in the world. We're not necessarily healthier than any other country in the world. Although we do have better health care than anybody else, except for the people who fall between the cracks. How much of that is eaten up in duplication and administration and checking and all other rest of that. Does anybody have any reaction?

Dr. Rowland. There is some duplicate coverage. Although what we do find is that one of the major reasons that an individual cites as not taking up their employer's offer is that they're getting coverage through their spouse. We see also one of the new incentives that many employers are starting to offer is they are giving bo-

nuses to employees who will sign up for their coverage through a spouse's plan as one of their strategies for reducing their overall health care costs.

So I know in one situation, one employee of ours said her spouse was offered $1,000 in additional salary for the year if he did not elect the health insurance coverage and instead signed with hers through Kaiser.

Senator Bennett. Yeah, and that $1,000 means that the employer probably saved $4,000 or $5,000 on it. You are in the insurance business. Do you have any reaction to this?

Mr. Oatman. We're in, of course, as I mentioned in the individual and small group segment and quite frankly, we don't see very much duplicate coverage in that end of the market. Obviously, if an individual is going to buy coverage, there is no duplicate coverage there and similarly with small employers, I think that they know their employees, know the situations, and often you don't find as much duplicate coverage in our end of the market. So our experience with it is pretty limited.

Senator Sessions. A couple of things, Mr. Oatman, one regarding medical savings accounts and those type plans. I have heard recently that the uninsured who are often poor, not always, but often, much poorer, when they go to the doctor, that they pay much more for the same care two, three, four times, what someone who is insured would. And I wonder if that impacts adversely medical saving account holders also.

Mr. Oatman. Let me explain.

Senator Sessions. Medical, less physicians, excuse me, hospital care probably more often.

Mr. Oatman. The medical savings account customer has the benefits of the negotiated rates that we have with doctors and hospitals, even on the portion which they fund themselves.

Senator Sessions. Is that true with all the plans that you know of?

Mr. Oatman. Certainly all of the plans that we offer the insured has the benefit of those deductions. I do think it's a tragedy that the uninsured people who can least afford it have to pay full retail.

Senator Sessions. Unfortunately, that's a serious problem Mr. Chairman. One more thing. There was this very moving article in one of the newspapers about a lady who was a nurse in charge of—I'll ask the Surgeon General and others who want to comment—in helping people who were diabetic. And she was highly motivated, visited people in their homes, gave rewards to people who stayed on their diet and exercised and did the things that had the ability to improve their health condition. But the science on even that kind of care was not really encouraging in the number of people who lost substantial amount of weights, who stayed consistently on their diet, it still was rather discouraging actually, the numbers there. So I guess my question is, I'm not sure we used to have this many people in this condition, is this a lifestyle thing that really does need to be addressed early, that once you have a lifetime of poor eating habits, it's much less like to be able to change than otherwise?

Surgeon General Carmona. Senator, I think you've hit the nail on the head. It is a lifestyle issue and I agree with my col-

league, Dr. Rowland, about the impact of health insurance and the need for it. But many of the things that we can do as a society really involve lifestyle and really very little cost.

Getting some physical activity every day, the issue of exercise, the word exercise turns off some people. "I don't want to exercise." Well, take a walk. Go play with your kids, you know, park in the back of the parking lot in the mall and walk through the mall rather than looking for the closest spot to the door. Take the stairs when you have a few flights, rather than the elevator, and put some groupings of physical activity together throughout the day. Eating a healthy diet, which we've heard some of the barriers to, is hard. Some of the barriers that have not been mentioned are also cultural. Because even when we have the funds and even when the populations who are those that we classify as underserved, often people of color—Black, Hispanic, Native Americans—the cultural barriers, even with the money, prevent them from readily changing their diet. Because the——

Senator Sessions. Well, frankly, it's cheaper, sometimes a good diet is often cheaper.

Surgeon General Carmona. Yes sir. But you know, when, on the Native American reservation—I'll use my own example in my family. My grandmother was an immigrant here, spoke no English and she made some good food for the family, very poor Latino family. But if you evaluated your cooking, based on healthy standards, it was filled with grease and lard and tasted awfully good. But that's part of the culture and breaking those cultural norms, on the Native American reservation, where I visit frequently—I was just in Montana on the Crow reservation—and as Dr. Rowland pointed out, the diets leave something to be desired.

But, when you look at their cultural norms, how they prepare their food, how they buy, even if they have the money, it's still an issue or, I termed it literacy earlier, building capacity, education into society to make those changes. We have the science. The problem is we have this wonderful diversity that makes us the best nation in the world, but that diversity also makes it very difficult to deliver culturally competent messages that would result in transformational behavior. That is, eating more healthy, cooking your food the right way and such.

Senator Sessions. I guess—let me be explicit on it. Isn't it one of these things where if it's not done early, it's much harder to change later? And is there a plan out there to deal—I know there has been a lot of talk about helping young people who are overweight how to confront that and deal with it. Do we have any plans that might be effective at this point, you think on how to deal with that?

Surgeon General Carmona. Well, yes sir. Your point again is well taken. The earlier we start, the better it is. When you move through life it's much more difficult to break those bad habits. You know, James Baldwin I think said it best, if I quote him correctly, that, "We spend a lifetime telling our kids what to do, but they never fail to imitate us." And so, our children often end up looking like we do. And if we are couch potatoes and not physically active, and eating the wrong foods, then our children probably are going to head in that direction.

We have programs within HHS now, and I know of many community programs that start in the schools very early in getting the kids engaged in physical activity. That's where it has to start. Also we must engage the parents and the school systems and the administrators for the understanding of what constitutes a balanced diet while those children are in school, and the physical education part.

It really does take a whole community to change this. The capacity has to be built in throughout society and as early as possible. We have the Healthier Steps Program within HHS that President Bush and Secretary Thompson have been pushing very successfully. I've been out as a Surgeon General throughout the United States speaking to school administrators and school districts about the value of these very simple measures of reducing risks, exercising, or some physical activity and a balanced diet. We have spoken out strongly to the National Groups of School Administrators and Teachers to not remove physical activity from the curriculum as we see being done in many school districts because they can't afford the teacher or they don't have the time. There are lots of reasons. But the bottom line is, there is a huge impact to those children when they are not physically active and they are spending four hours in front of the TV.

So, to answer your question, we are starting to target these audiences earlier. We're spending a lot of time with children. One program I'm specifically involved in, the 50/50, 50 states, 50 schools, where I have targeted a school in every state, working with the leadership in the state to bring a symbolic message, if you will, to grammar schools and encourage children to stay active. But I'm not just speaking to the children, I'm speaking to their parents, speaking to the community leaders and hopefully spread that word through the country, that this is very important. And it's not just about insurance or money, it's about taking some personal responsibility, understanding the issues, staying active, eating healthy, reducing risk in your life.

Dr. Rowland. Senator, while much of the work I do with the foundation focuses on health insurance coverage, another aspect of the work we undertake is to look at the use of the Internet and TVs and their availability in the homes and their utilization in homes, especially among children. And I know that many of our studies are very alarming in terms of the number of hours and the increasing number of hours that children spend either watching TV or in front of the computer, neither of which have a lot of activity to them. We are beginning to look more at the messages they get from watching TV shows, from watching bad behavior on TV shows and we've engaged in trying to do a number of public education and health education activities by getting some of the Hollywood writers to cover things a little more effectively. I think we need to try to change the way entertainment media portrays a child's afternoon to one in which they're outside doing physical activity instead of inside at the computer and eating carbohydrates while they are sitting at the computer. This is an area where we could really try to change the way the public views this issue with more than just discussion—with actually observing how the entertainment media covers this situation.

Senator Sessions. I believe I saw in *The Wall Street Journal*, something about that and it indicated that one soft drink a day was 50,000 calories a year, and I forgot how many pounds that translated in and all things else being equal. What about PSA? Public Service Ads (PSA) that give some concrete suggestions if you'd like to reduce your weight, even for kids aimed even at kids, you know, make this change and have some kid say that you know, I lost this by doing such and such. Do we have any PSAs that might be helpful?

Surgeon General Carmona. Senator, we've done some PSAs in partnering with private organizations who are stakeholders in this, but we also are trying to do this much smarter. Some of our staff, some of whom are sitting behind me are looking at better ways to understand the marketplace just like the private sector does to sell products. And we have to do a better job of delivering those messages in a culturally competent way. I often joke with my staff that the last thing the kids watching MTV want to see is some middle aged guy in a white uniform telling them to be healthy. But you know, if Carson Daily and the latest pop icon says it, you know, with maybe the Surgeon General or somebody with a position of authority, it's probably going to go over.

Senator Sessions. That could describe how they keep their weight under control. What they do every day.

Surgeon General Carmona. We're trying to get those best practices from the market and looking at—because really what we're looking at across society is multiple markets that we have to motivate to change their behavior and one size doesn't fit all.

Dr. Rowland. Dr. David Satcher has just joined the Kaiser Foundation Board of Trustees and I know that he will be pushing us in the work we do with BET and with MTV to try and develop more programming and more ads that actually will give some better messages about this issue as well. We have found that PSA placements are very difficult to get at a good time, but have entered in a number of partnership with groups like MTV so that we do these ads as part of their programming and we develop the ads and they actually give the programming time to us to try to further public health education messages. I think we should broaden our messaging and work with the Surgeon General on that.

Senator Bennett. I don't want to disparage the ad effort because I think it's essential and I'm in favor of everything you're talking about, and we do have the example with cigarettes. We have seen a cultural change in smoking in this country so that now people don't assume it's the norm and you really discover that when you go outside the United States. I used to own a business in Japan, and over there everybody smokes, and that's the norm. And you come to America and it's no smoking in this building, no smoking, etcetera, etcetera, and we've seen the number of smokers come down particularly among young people fairly significantly.

However, an economic incentive I think has to be linked to it. I remember, and Mrs. Maloney has left, but at the height of the energy crisis in California, when the demand for energy was causing enormous spikes—and ultimately it looks like Gray Davis might pay the price for that next week—there were all kinds of PSAs saying "turn off your washing machine in the afternoons, only use

your appliances at night, help us, help us, help us." And the behavior did not change appreciably until the increased cost of electricity hit the average household in California and the crisis almost disappeared overnight. "Oh, it's going to cost me X amount more if I don't do what the ad is saying." So we've got to link some economic incentives here. I'm not quite sure how we can do it.

Mr. Oatman. Mr. Chairman could I speak momentarily to that issue?

Senator Bennett. Sure.

Mr. Oatman. We do, in our individual products charge people more if they are tobacco users, and we find that gets a strong message across to people when they can see tangibly what is the economic cost in terms of their health coverage for this. We often have people come back and say, "I'd like to now reapply, I've stopped smoking for a year, can I get a lower rate?" And so that is a very effective way not only to communicating the message, but getting the behavior change you're looking for.

Senator Bennett. So that leads to the theoretical question, can you say X dollars per pound for a certain level if we have indeed an epidemic of obesity?

Mr. Oatman. Yes, we do, in fact, do that as well. We charge extra for people that are BMIs that are overweight and BMIs that are obese and we have different levels and we track the statistics and know the cost of that and put that into the cost of our products so at the end we'll send a message.

Senator Bennett. Has it produced significant behavior change?

Mr. Oatman. I can't honestly say whether that one has produced behavior change. I know the smoking one has, but the weight one I don't have any particular data on it to suggest that it resulted in changes.

Senator Bennett. The hour is going and you have been very patient. Let me raise one more issue and get your reaction to it. Health care is really nothing more than data management. "Where does it hurt?" You are a doctor, you can't cure me until you get a body of data about me. "Where does it hurt? How long? When did it start? What happened?" Okay, you get above that level to, "Let's do an MRI, let's do some other kinds of tests." All right, now, with this amount of data in front of me, I can now make a diagnosis and a decision and recommend a course of treatment.

We do not have anything approaching a significant database about our nation's health. There are tiny individual bits of data scattered around, but we do not have what our current technological capacity could give us. So let me get Buck Rogers here for just a minute—and of course; the 21st Century is now here, so Buck Rogers is obsolete. Let's say 22nd Century but, maybe 21st. We have the capacity for an individual to carry his entire medical record around with him on a credit card, in his wallet. And we have the capacity to update that continually. So you talk about screening and there is evidence from some of the other panelists who were scheduled to be with us at the previous roundtable and couldn't come back on this occasion, that they've been able to increase the health and reduce the price in their risk pool quite significantly through screening.

Now your average HMO is going to say to you, "We're not going to cover the cost of screening every single person, we'll wait until somebody shows some symptoms and then we'll cover the cost of treating those symptoms, but it's too expensive." Well, the evidence of this particular group is, it saves money. And they screened every single employee of the company with whom they were working, for a variety of congenital conditions, and discovered, while the percentages were small, those people that didn't know they had (fill in the blank), were enormously expensive claims on the system walking around with the claims to come three to five years down the road. And by screening and discovering what they were and then monitoring their activity, whether it was exercise or diet or medication, they prevented heart attacks, they prevented hospitalizations, they staved off, in some cases, diabetes and so on, and saved huge amounts of money, even though the initial screening seems to cost something now.

The key to this working is the willingness on the part of the employee in this situation, the individual, if we do it on a national basis, to have his data in a central databank where it can be accessed, and they can be nudged. Where you can say to the—you sit down at the console of the giant register as it were, and you say, "Okay, give me the names of everybody here who had this kind of result a year ago and let me go out and find out what they're doing."

The privacy advocates will come at us and say this is an enormous violation of privacy. But from a health care standpoint, this is the tool that could vastly increase the health of Americans and ultimately reduce costs, because as I say, the groups that have done this have found that their population gets healthier and the cost of providing health care goes down.

Let's take a look at that and get your reactions to it. If there was to be some kind of an attempt at creating a truly significant large database and Dr. Rowland, maybe some kind of public money available to screen every child regardless of whether they have coverage or not in public schools, to begin to produce that database so that public providers of health care would have that tool available for them for people who are on Medicaid or Medicare and some way to have portability—I mean, the portability is there once the data is there—and so the individual says "Okay, I'm now covered." Well, whoever is providing their health care coverage now has access to the database.

Mr. Oatman you are in an interesting niche market. How would you access the database? Let's just put aside our biases about Big Brother and the implications of somebody being able to have access to that database for some evil purpose and stipulate for the sake of this conversation that the access will always be benign. How helpful would it be to producing a healthier population and helping do something about this skyrocketing cost?

Dr. Rowland. Well obviously, what you've talked about is the ideal of what a Health Maintenance Organization was supposed to be all about. It was supposed to be about enrolling, having screening and then being followed up. What's happened in our current fragmented health care system is that nobody really wants to take on the responsibility for screening because it's an up-front cost and

the long run savings may accrue to someone else because health care coverage switches back and forth. So, having the screening in our fragmented system financed separately is probably an important concept. The only program that has a built-in requirement for screening is the Medicaid program for children, called the Early Periodic Screening Diagnosis and Treatment Program. However, the governors have been complaining for many years about that particular program because it requires full treatment for anything screened in the children. So that's the one example we currently have of national screening, and in that program screening picks up a lot of disability early among children and if they are treated for it, they go to school, they learn better and do better.

So I think that clearly, screening is important if it's followed up with treatment, but our current fragmented system doesn't provide much of a mechanism for giving insurers an incentive to do that.

Mr. Oatman. Let me speak to that because—I'm a great believer of screening and assessment. I think to the extent that we could do annual screening on things like weight, cholesterol levels, blood pressure, many things which are reasonably controllable by the individual, it could have a payback for us, if we could then tie that with the incentive. But right now, we can not tie it to an incentive. The state laws basically wouldn't allow me to adjust my premium every year based on that regular assessment to get the message to people to get the behavioral change. And if we had the freedom with state premium laws to make adjustments, based upon regular assessment of health cost, it would have an economic advantage and we would be spending the money on it. But right now, we don't have the ability to leverage it into incentives for an existing customer.

Senator Bennett. In other words, there is no payback to you.

Mr. Oatman. Right, because I can't——

Senator Bennett. If you do the screening, it's just a cost with no particular benefit.

Mr. Oatman. Yes. Take for instance someone that has been a customer for a few years and perhaps has gained weight, isn't managing their health. If I could do a regular assessment of that and charge them more for that behavior, I think I can impact their behavior and I think that would have a payback in doing that. But I don't have the freedom under current state laws to make those adjustments to premiums after I've sold the policy to the individual. So I do think if we got creative about this and thought about it, we could find some ways to make it economically feasible to do assessment on an ongoing basis, and it would prove valuable.

Surgeon General Carmona. I think Senator, that's a key, what Mr. Oatman said, making it economically feasible. Because in fact, as Dr. Rowland pointed out also with the screening, not only from a public health standpoint, it's obviously the way to go. We're talking about the cost, but when an insurer deals with it and takes on that responsibility, often they are saddled with more cost after they've made the diagnosis, and they are committed then to have to care for that person. So from the public health standpoint, I think there is no disagreement that screening as the way to go is one of the best methods of prevention. We do it now. We've gone through it with kids with PKU, with thyroid testing, diabetes, hy-

pertension, cholesterol, and it's proven. In fact, within HHS, we have the Guide to Clinical Preventive Services put out by ARC, and it's one of the best books around that talks about the evidence base for screening and the cost benefit analysis for all types of screening. More screenings than most people have ever heard of that are out there and have been studied. But really, it comes down to that cost benefit ratio and who pays for that screening.

Let me make another point on the database though. I think one of the things, and I think Dr. Rowland might mention it because I always mention it as it relates to Kaiser. We have some wonderful national databases in Kaiser. As you know, one of those—we don't have a national database, but we do have large groups, Fortis for one, Kaiser and many others that we have through our statistical centers at HHS, where we study large populations for just that reason—to see trends that are emerging, to look at epidemiological trends, to try to make predictions as to where we are going. We're doing it now knowing that we have 9 million children that are overweight and obese and we're looking 20 years forward when they become middle aged. What will our population look like then? How much will it cost? How much diabetes will be in society? How much accelerated cardiovascular disease?

How much cancer as a result of that obesity epidemic? So we are doing that. But I agree with you that we probably could do it better with larger databases, especially one that relates to underserved populations who often don't get picked up in some of these databases because they may be the uninsured and are not captured. So there are some inequities in the system, but I think it has it has improved a great deal.

Senator Bennett. Well, that's really the reason for these hearings, or this discussion and I'm very grateful to you for your willingness to participate in it, and I'll just close it off with this summary of where we are.

This is the Joint Economic Committee and we exist to look at the economy as a whole, both Houses, that's why it's joint, House and Senate. The American economy is really the wonder of the world. Our economy is enormously resilient. We've taken hits that in past history would have thrown an economy into terrible tailspin. One after the other, the bursting of the bubble of the late 1990s, which was inevitable, dropped the stock market, we lost $7 trillion worth of wealth, numerous jobs, particularly in the high tech industry wiped out as some of the illusions of that industry were exposed. Followed by the shaking of confidence in the governance of American industry. People wanted to flee investment in American because of Enron and WorldCom and the other shocks, 9/11, the terrorist attack, the enormous difficulties that followed that, the geopolitical uncertainties, the decision to respond to 9/11 militarily, which I happen to agree with and support, I think it was the right thing to do, but that puts another tremendous strain on the economy.

One after the other and in historic terms, compared to past recessions and past problems, the economy weathered that series of shocks with enormous resilience and is the envy of every other economy in the world. Every other industrialized country, even with our unemployment rates where they are, even with our GDP

growth, as anemic as it has been, every other industrialized country in the world would kill to have our numbers.

So, the Joint Economic Committee, we look out into the future and say, the future really looks pretty good, and it does, until we start looking at health care and the numbers. You were talking about it, General Carmona, the numbers in the next 50 years become truly frightening. We are living longer, which is a good thing. Our population is growing, which is a good thing. But the cost, if we do not do something about medical cost, the cost that will hit us in the Medicare out years as this population starts—the baby boomers start to retire in the next decade or less—and they are going to stay in that position longer and their demands on Medicare are going to be higher. It's happening in the rest of the population, ironically we discussed this at a previous hearing. The more technology we apply to the health care challenge, the more we bring down the cost per procedure and the more procedures we stimulate, so the cheaper the procedure becomes, the greater the cost to society overall.

If all we were interested in was money, we'd say, let them die and save the money. But we do a tremendous job in keeping people living longer and then we have this enormous challenge.

So, as I say, as we look out over the economy, the one thing that truly is frightening, if we cannot get it under control, is the health care costs that are waiting for us several decades down the road. And we've got to think creatively, we've got to start experimenting, Mr. Oatman, with the kind of thing that you are doing. We've got to open up the question of the database. We've got to face what could happen to us if we did more screening and paid for it and say to the states, "Okay, whatever it takes." We've got to keep this going, because the individual employer may not see the long-term benefit or the individual insurer may not see the long-term benefit, America as a whole, 50 years from now, has got to see the long-term benefit in healthier people and thereby ultimately lower health care cost, or the whole economy will be over. So that's a little bit too apocalyptic, but the whole economy will be in trouble, would be a better way of saying it. So, that's why we have focused on these kinds of discussions rather than the traditional political shouting matches over current situations in health care and why your observations here this morning have been so particularly helpful to us.

We're building a record, which we hope the appropriate legislative committees can take advantage of as they look at these challenges that we face. Thank you very much again for your willingness to come.

The hearing is adjourned.

[Whereupon, at 12:15 p.m. on Wednesday, October 1, 2003, the roundtable discussion was adjourned.]

Submissions for the Record

PREPARED STATEMENT OF SENATOR ROBERT F. BENNETT, CHAIRMAN

Good morning and welcome to today's roundtable discussion: "Reshaping The Future Of America's Health."

We would like to try something a little different this morning. Rather than using the traditional congressional hearing format, we will be using a roundtable approach. I want to try this approach because too often the traditional approach limits the discussion between the Members and the witnesses.

The current debate on health care is dominated by a discussion of benefits, deductibles, insurance coverage, and payment levels. The attention of policymakers has been drawn away from the most important health care issue—the actual health of the American people.

America has the pre-eminent health care system in the world. America also has the most expensive health care system in the world. Despite our pre-eminence and our spending, there are some disturbing trends emerging with serious implications for the health of the American people in the future.

The numbers are overwhelming. Obesity is epidemic in the United States. In recent years, diabetes rates among people ages 30 to 39 rose by 70 percent. We know that this year, more than 300,000 Americans will die from illnesses related to overweight and obesity.

We also know that about 46.5 million adults in the United States smoke cigarettes, even though this single behavior will result in disability and premature death for half of them.

Compounding the problem, more than 60 percent of American adults do not get enough physical activity, and more than 25 percent are not active at all.

Some groups of Americans are particularly hard hit by these disturbing trends, especially the epidemic growth in diabetes. Native Americans are two to three times more likely to have diabetes than whites. And, NIH reports that diabetes among African Americans has doubled in just 12 years.

Many of the problems I just mentioned are completely preventable. Having the pre-eminent health care system is not a replacement for a healthy lifestyle. Americans need to be responsible for their own health and prudent consumers of their own health care.

Much of current medicine is reactive, not proactive. A more proactive approach that emphasizes targeted screenings, patient education and proper follow up by medical providers can go a long way to help improve the health and productivity of the American people. However, poor preventive screening, redundant or inappropriate treatment, simple medical mistakes and lack of oversight do little but increase the cost of care.

This morning our goal is to focus on health, not just health insurance. As we examine the challenges that face Americans over the next five or ten years, there are at least two questions that must be asked: What are the major health challenges that face Americans over the next five to ten years? What are the most innovative tools available to meet these challenges?

Our roundtable discussion this morning will include the unique insight of Surgeon General Richard Carmona, who is spearheading President Bush's *HealthierUS* initiative. The *HealthierUS* initiative helps Americans to take action to become physically active, eat a nutritious diet, get preventive screenings, and make healthy choices. We are very happy the Surgeon General was able to find time to join this morning's discussion and look forward to hearing his thoughts on these vital issues.

We are also pleased to have Mr. Jim Oatman, currently Senior Vice President of Fortis Health. He is here to elaborate on initiatives the insurance industry is taking to promote healthy lifestyles and keep down costs. Many insurance plans and employers, including Fortis Health, have taken a "carrot and stick" approach to encour-

aging beneficiaries to exercise, quit smoking or follow doctor's orders while monitoring chronic illness. Some companies reduce premiums, increase interest rates on health care savings accounts, or give away free gym equipment as rewards for healthier lifestyles. Health and Human Services (HHS) Secretary Tommy Thompson met with Fortis Health and other insurers in July to persuade them to find ways to reduce the public cost of treating America's obesity epidemic.

We are also very pleased to have Dr. Diane Rowland of the Kaiser Family Foundation. Dr. Rowland is a nationally recognized expert on Medicaid and the uninsured. Like physical inactivity or cigarette smoking, the lack of health care coverage is also a risk factor for long-term health problems. We look forward to Dr. Rowland's insights on the particular problems facing lower income Americans and those without access to health insurance.

We welcome each witness's thoughts on the challenges facing health care today. I want to thank Ranking Member Stark for his interest and help in organizing this hearing and in bringing these distinguished experts before the Committee. I ask all of you to join me in a bipartisan spirit as we engage in this important task.

PREPARED STATEMENT OF REPRESENTATIVE PETE STARK,
RANKING MINORITY MEMBER

Thank you Chairman Bennett for holding this roundtable discussion on "Reshaping the Future of America's Health." I expect this will be a far-reaching discussion about ways of improving care and responding to the health care challenges facing the nation. Certainly, there are public health issues, such as diabetes and heart disease, which are going to require new innovations and research. But the most crucial issue we face is increasing access to care and improving public health insurance programs.

Our nation—wealthy as it is—continues to leave more than 41 million people without health insurance. The downturn in our economy will only make these numbers grow. Every American should have affordable, quality health care coverage and expanding health care coverage to the uninsured, especially children, must be a top priority.

In July, the President unveiled his *HealthierUS Initiative*, which encourages Americans to be physically active, eat a nutritious diet, get preventative screenings, and make healthy choices. But the President's "eat your broccoli" health initiative won't help millions of Americans get important preventative screenings, such as mammograms, cholesterol tests, or prostate exams. Such potentially life-saving preventative tests are skipped by millions of the uninsured and even millions more of insured Americans who simply can't afford high out-of-pocket costs needed to pay for them.

Medical experts, doctors, hospital executives, and academic leaders have increasingly concluded it is time for some form of universal health coverage to be considered. Just last month over 7,700 doctors nationwide, including the former Surgeon General Dr. David Satcher, endorsed a "Medicare for all" national health insurance plan.

The Institute of Medicine of the National Academies recently found that the benefits of insuring uninsured Americans would be substantially greater than the cost of the increased utilization of health services. Specifically, the report found that since uninsured Americans have shorter life spans, poorer health, and higher morbidity rates than Americans with health insurance, they cumulatively forego $65 to $130 billion a year in economic value that could be realized if they had health insurance. In contrast, the cost of the additional health care the uninsured do not currently access because they are uninsured totals $35 to $70 billion a year.

In short, it's costing us more to leave Americans uninsured than to insure them. For what the President wants to spend in Iraq in 2003 and 2004, we could provide health coverage for the uninsured for a year.

My favored approach to universal health care is to build on the success of the Medicare program, which provides universal coverage for our nation's seniors and people with disabilities. Unfortunately, Republicans in Congress would like to privatize Medicare. Rather than dismantle Medicare as we know it, we should expand and improve the program, including broadening preventative benefits and adding a prescription drug benefit.

Protecting Medicaid for low-income Americans is also a vital issue in improving the health of the U.S. population and preventing further increases in the number of uninsured. However, the program has come under increasing economic pressures in both the short- and long-term.

During the Bush recession and current economic slump states are being forced to make tough choices between Medicaid and educational programs. Paltry federal relief did not come soon enough this year to prevent 44 states from having Medicaid cost overruns, thus forcing many states to trim the Medicaid roles and cut back on optional health services.

Millions of low-income Americans would be placed at risk by a Bush Administration plan to cap federal government spending by block granting the program. But this would only exacerbate the long-term structural funding problems of Medicaid as states face mounting costs of long-term care for an aging society.

As we look to the future of health care, the federal government needs to assume more responsibility for insuring that all Americans receive quality care, not less.

Thank you Mr. Chairman and I look forward to the discussion with our panelists.

PREPARED STATEMENT OF RICHARD H. CARMONA, M.D., M.P.H., F.A.C.S., SURGEON GENERAL, U.S. PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Thank you, Mr. Chairman. It is a pleasure to be here with all of you. And I commend you for your leadership in calling for this discussion.

What if I told you 2 in 3 Americans already had symptoms of a condition that could kill them, and that the disease rate was growing every year?

You would say, "You're the Surgeon General. Do something! Now!"

In fact, it's true.

Nearly 2 out of 3 of all Americans are overweight and obese; that's a 50 percent increase from just a decade ago.

More than 300,000 Americans will die this year alone from heart disease, diabetes, and other illnesses related to overweight and obesity.

Obesity-related illness is the fastest-growing killer of Americans. The good news is that it's *completely preventable* through healthy eating—nutritious foods in appropriate amounts—and physical activity. The bad news is, Americans are not taking the steps they need to in order to prevent obesity and its co-morbidities.

The same is true for other diseases related to poor lifestyle choices, such as smoking and substance abuse.

Put simply, we need a paradigm shift in American health care.

There is no greater imperative in American health care than switching from a treatment-oriented society, to a prevention-oriented society. Right now we've got it backwards. We wait years and years, doing nothing about unhealthy eating habits and lack of physical activity until people get sick. Then we spend billions of dollars on costly treatments, often when it is already too late to make meaningful improvements to their quality of life or lifespan.

Overweight and obese Americans spend $700 more a year on medical bills than those who are not overweight. That comes to a total of about $93 billion in extra medical expenses a year.

We simply must invest more in prevention, and the time to start is childhood—even before birth.

Fifteen percent of our children and teenagers are already overweight. Unless we do something now, they will grow up to be overweight adults.

None of us want to see that happen.

We can't allow our kids to be condemned to a lifetime of serious, costly, and potentially fatal medical complications associated with excess weight. Being overweight or obese increases the risk and severity of illnesses such as diabetes, heart disease, and cancer.

Those are the physical costs. There are also social and emotional costs of being overweight.

We first see this emotional pain on the school playground, when children's self-esteem drops because they are teased, or on the dance floor, because they are never asked to dance.

None of us want to see our kids go through that.

The science is clear. The reason that our children are overweight is very simple: *Children are eating too much and moving too little.*

The average American child spends more than four hours every day watching television, playing video games, or surfing the web. They know more about the running style of "Sponge Bob Square Pants" than Gail Devers or Maurice Green.

Instead of playing games on their computers, I want kids to play games on their playgrounds.

As adults, we must lead by example by being responsible, and adopting healthy behaviors in our own lives.

We've got to *show* them it doesn't matter whether you're picked first or last, only that you're in the game. Not all kids are going to be athletes, but they can all get some exercise.

We've got to *show* them how to reach for the veggie tray rather than the unhealthy snack.

We've got to *show* them how to encourage their peers to adopt healthy behaviors rather than ridiculing them.

As James Baldwin put it, "Children have never been very good at *listening* to their elders, but they have never failed to *imitate* them."

Our commitment to disease prevention through healthy eating, physical activity, and avoiding risk—is one our entire society must be prepared to make in order for it to be effective.

President Bush is leading the way through the *HealthierUS* prevention initiative.

HealthierUS says, "Let's teach Americans the fundamentals of good health: exercise, healthy eating, getting check-ups, and avoiding risky behavior."

Secretary Thompson and the Department of Health and Human Services are advancing the President's prevention agenda through *Steps to a HealthierUS*, which emphasizes health promotion programs, community initiatives, and cooperation among policy makers, local health agencies, and the public to invest in disease prevention.

Steps also encourages Americans to make lifestyle choices that will prevent disease and promote good health, from youth, such as avoiding tobacco use, which is still the leading preventable cause of death and disease in America, and avoiding alcohol, drug use and other behaviors that result in violence and unintentional injuries.

Congress has approved funds for *Steps* in FY 2004 for community initiatives to reduce diabetes, obesity, and asthma-related hospitalizations.

We cannot switch America's health care paradigm from treatment to prevention through government action alone. This fight has to be fought one person at a time, a day at a time.

All of us must work together, in partnership, to make this happen.

Last week, I joined former Surgeon General David Satcher and the National Football League in kicking off their partnership in promoting school-based solutions to the obesity epidemic.

This week I joined NBA player LeBron James to launch Nike's PE2GO program, which provides equipment and expertise to schools so that they can offer fun physical activity. School-based programs that focus on physical activity offer one of our best opportunities to improve children's health—today and in the future. We welcome partnerships like these to improve the health of children from the earliest ages.

As Members of Congress, you can influence the behavior of your constituents in many ways, starting through your own example. Secretary Thompson put himself and the entire Department of HHS on a diet, and lost 15 pounds. I challenge you to do the same with your staff members.

You can also help educate your constituents about the importance of prevention through Town Hall Meetings and by establishing partnerships in your own communities.

As I said, it will take *all* of us to switch from a treatment-oriented society to a prevention-oriented society, but the effort will be worth it, both to individuals and to the larger community.

I'm a doctor, not an economist, but I know we can save both the human costs in pain and suffering, and economic costs in dollars and cents by investing in prevention.

Think about it: the total direct and indirect costs attributed to overweight and obesity is about $117 billion per year, or $400 for every man, woman and child in this country.

Just a 10 percent weight loss—through healthier eating and moderate physical activity—can reduce an overweight person's lifetime medical cost by up to $5,000. Not to mention what it will do for their self-esteem and sense of well-being.

Where else can you get that type of return on investment?

Thank you and I look forward to our discussion.

PREPARED STATEMENT OF JAMES E. OATMAN, SENIOR VICE PRESIDENT, FORTIS HEALTH

I. INTRODUCTION

As 75 million baby-boomers reach the prime years of their lives they are facing an epidemic of chronic disease. In spite of the fact that medical advances of the 20th century improved life expectancy from 47 years at the beginning of the century to 77 years at the end of the century, some very troubling trends developed in the last quarter of the 20th century.

- The incidence of cancer is up over 25 percent.
- The incidence of heart disease is up over 50 percent.
- The incidence of diabetes has doubled.
- The prevalence of obesity has more than doubled.

The data is in and we now know that lifestyle changes can make significant reductions in all these disease categories. We individually need to take personal responsibility for significant lifestyle changes to improve our health. When looking at the cause of health care cost increases perhaps it is time to stop pointing fingers and literally look in the mirror.

II. KEY ELEMENTS OF LOWER COSTS VIA LIFESTYLE CHANGES

Three key elements will be required if we are to witness significant improvements are:

A. Education

People need a consistent, reliable source of information on the efficacy of health improving behaviors. Health and Human Services has done an excellent job of collecting and distributing information on health improvements. Our health care providers should be encouraged to deliver the message to their patients. Employers can play an active role in educating in the workplace.

B. Screening & Assessment

People need a method to measure their current health status in order to calibrate their current health status against a reliable standard. Benchmarking key indicators such as diet, exercise, weight, cholesterol levels, blood pressure levels, alcohol consumption, and driving habits against acceptable standards is the second step towards making changes. This is a personal responsibility, we each have to maintain our health and well-being.

C. Incentives

Incentives are the final and essential component to motivate people to make behavioral changes. Proper rewards and incentives applied by health care payors serve as an important impetus to reinforce the message and secure important lifestyle changes.

III. HEALTH INSURANCE PRODUCTS THAT ENCOURAGE HEALTHY LIFESTYLES

D. Medical Savings Accounts

At Fortis we have observed that the cost of health care is lower and annual increases in costs are also lower for individuals who chose to self-fund a significant portion of the first dollars spent on health care. Direct personal responsibility for health care costs has an impact on controlling costs.

E. Health Reimbursement Accounts

In increasing numbers employers are embracing health reimbursement accounts as a method to engage employees in a partnership to control health care spending. Health Reimbursement Accounts are relatively new, but reports on early data is encouraging.

F. Lifestyle Discounts at Point of Sale

For many years Fortis has offered discounts for improved lifestyles. We reward people who control their weight, cholesterol and blood pressure. We also include smoking habits and driving habits in our assessment. We have found people with better lifestyles consume less health care and continue to spend at lower levels for long periods of time.

G. Renewal Incentives to Encourage Healthy People to Continue to Fund the Pool

Unfortunately, most state laws significantly restrict the ability of an insurance carrier to introduce incentives at renewal. Fortis believes that if insurers were granted more latitude in providing incentives at renewal to reward healthy lifestyles

this would have positive outcomes. With appropriate incentives more healthy people would retain their coverage at renewal. They would then stay in the insured pool helping to finance the less healthy and not enter the ranks of the uninsured.

PREPARED STATEMENT OF DIANE ROWLAND, SC.D., EXECUTIVE VICE PRESIDENT, KAISER FAMILY FOUNDATION AND EXECUTIVE DIRECTOR

HEALTH CHALLENGES FACING THE NATION

Health insurance coverage remains one of the nation's most pressing and persistent health care challenges. When asked to identify the top health care priorities for the nation, the public consistently ranks lack of health insurance coverage as a top priority. Nearly 1 in 3 Americans (31 percent) rated increasing the number of Americans covered by health insurance as the "most important" health issue for Congress and the President to deal with, in a public opinion survey this summer.

The most recent data—released this week from the Census Bureau—show that 43.6 million adults and children were without health insurance in 2002—more than one in every seven Americans. The new statistics reveal that this is not only a large problem, but a growing problem for millions of Americans. From 2001 to 2002, the number of Americans lacking health insurance increased by 2.4 million due to the decline in employer-sponsored coverage (Figure 1). Public coverage expansions through Medicaid helped to moderate the growth in the uninsured, most notably by providing coverage to children in low-income families, but were not enough to offset the decline in private coverage.

The uninsured come predominantly from working families with low and moderate incomes—families for whom coverage is either not available or not affordable in the workplace (Figure 2). Public program expansions through Medicaid and the State Children's Health Insurance Program (SCHIP) help to fill some gaps, especially for low-income children, but the fiscal crisis in the states is now putting public coverage at risk. Unfortunately, the economic downturn, coupled with rising health care costs and fiscal constraints on public coverage, all point to continued growth in our uninsured population.

THE CONSEQUENCES OF LACK OF INSURANCE

The growing number of uninsured Americans should be of concern to all of us because health insurance makes a difference in how people access the health care system and, ultimately, their health. Leaving a substantial share of our population without health insurance affects not only those who are uninsured, but also the health and economic well-being of our nation.

There is now a substantial body of research documenting disparities in access to care between those with and without insurance. Survey after survey finds the uninsured are more likely than those with insurance to postpone seeking care; forego needed care; and not get needed prescription medications. Many fear that obtaining care will be too costly. Over a third of the uninsured report needing care and not getting it, and nearly half (47 percent) say they have postponed seeking care due to cost (Figure 3). Over a third (36 percent) of the uninsured compared to 16 percent of the insured report having problems paying medical bills, and nearly a quarter (23 percent) report being contacted by a collection agency about medical bills compared to 8 percent of the insured. The uninsured are also less likely to have a regular source of care than the insured—and when they seek care, are more likely to use a health clinic or emergency room (Figure 4). Lack of insurance thus takes a toll on both access to care and the financial well-being of the uninsured.

There are often serious consequences for those who forgo care. Among the uninsured, half report a significant loss of time at important life activities, and over half (57 percent) report a painful temporary disability, while 19 percent report long-term disability as a result (Figure 5). Moreover, there is a growing body of evidence showing that access and financial well-being are not all that is at stake for the uninsured (Figure 6). Lack of insurance compromises the health of the uninsured because they receive less preventive care, are diagnosed at more advanced disease stages, and once diagnosed, tend to receive less therapeutic care and have higher mortality rates than the insured. Uninsured adults are less likely to receive preventive health services such as regular mammograms, clinical breast exams, pap tests, and colorectal screening. They have higher cancer mortality rates, in part, because when cancer is diagnosed late in its progression, the survival chances are greatly reduced. Similarly, uninsured persons with heart disease are less likely to undergo diagnostic and revascularization procedures, less likely to be admitted to hospitals with cardiac

services, more likely to delay care for chest pain, and have a 25 percent higher in-hospital mortality.

Urban Institute researchers Jack Hadley and John Holahan, drawing from a wide range of studies, conservatively estimate that a reduction in mortality of 5 to 15 percent could be achieved if the uninsured were to gain continuous health coverage. The Institute of Medicine (IOM) in its analysis of the consequences of lack of insurance estimates that 18,000 Americans die prematurely each year due to the effects of lack of health insurance coverage.

Beyond the direct effects on health, lack of insurance also can compromise earnings of workers and educational attainment of their children. Poor health among adults leads to lower labor force participation, lower work effort in the labor force, and lower earnings. For children, poor health leads to poorer school attendance with both lower school achievement and cognitive development.

These insurance gaps do not solely affect the uninsured themselves, but also affect our communities and society. In 2001, it is estimated that $35 billion in uncompensated care was provided in the health system with government funding accounting for 75-80 percent of all uncompensated care funding (Figure 7). The poorer health of the uninsured adds to the health burden of communities because those without insurance often forego preventive services, putting them at greater risk of communicable diseases. Communities with high rates of the uninsured face increased pressure on their public health and medical resources.

A recent IOM report estimates that in the aggregate the diminished health and shorter life spans of Americans who lack insurance is worth between $65 and $130 billion for each year spent without health insurance: (Figure 8). Although they could not quantify the dollar impact, the IOM committee concluded that public programs such as Social Security Disability Insurance and the criminal justice system are likely to have higher budgetary costs than they would if the U.S. population under age 65 were fully insured. Research currently underway at the Urban Institute by Hadley and Holahan suggests that lack of insurance during late middle age leads to significantly poorer health at age 65 and that continuous coverage in middle age could lead to a $10 billion per year savings to Medicare and Medicaid.

THE CURRENT ENVIRONMENT

Given the growing consensus that lack of insurance is negatively affecting not only the health of the uninsured, but also the health of the nation, one would expect extending coverage to the uninsured to be a national priority. However, all indicators point to this year as one in which we can expect little action on coverage, despite the significant growth in our uninsured population.

With the poor economy and rising health care costs, employer-based coverage—the mainstay of our health insurance system—is under increased strain. Health insurance premiums rose nearly 14 percent this year—the third consecutive year of double-digit increases—and a marked contrast to only marginal increases in workers' wages (Figure 9). As a result, workers can expect to pay more for their share of premiums and more out-of-pocket when they obtain care, putting additional stress on limited family budgets. With average family premiums now exceeding $9,000 per year and the workers' contribution to premiums averaging $2,400, the cost of coverage is likely to be increasingly unaffordable for many families (Figure 10). For many low-wage workers, the employee share of premiums may now equal 10 to 20 percent of total income, causing those who are offered coverage to be unable to take it up. However, for most low wage workers, especially those in small firms, it is not a question of affordability—because the firms they work in do not offer coverage.

From 2000 to 2001, employer-based health insurance coverage declined for low-income adults and children. However, Medicaid and SCHIP enrollment increased in response to the sharp decline in employer-based coverage for children, offsetting a sharper increase in the number of uninsured (Figure 11). The latest Census Bureau statistics on the uninsured for 2002 underscore the important relationship between public coverage and loss of employer-sponsored coverage. Between 2001 and 2002, health insurance provided by the government increased, but not enough to offset the decline in private coverage. Most notably, while the number of uninsured adults increased, the number of uninsured children remained stable because public coverage helped fill in the gaps resulting from loss of employer coverage.

For many low-income families, Medicaid is the safety net that provides health insurance coverage for most low-income children and some of their parents. However, Medicaid coverage provides neither comprehensive nor stable coverage of the low-income population. In 2001, Medicaid provided health insurance coverage to over half of all poor children, and a third of their parents, but only 22 percent of poor childless adults (Figure 12). Most low-income children are eligible for assistance

through Medicaid or SCHIP, but in most states parents' eligibility lags far behind that of their children. While eligibility levels for children are at 200 percent of the federal poverty level ($28,256 for a family of 3 in 2001) in 39 states, parents' eligibility levels are much lower. A parent working full-time at minimum wage earns too much to be eligible for Medicaid in 22 states (Figure 13). For childless adults, Medicaid funds are not available unless the individual is disabled or lives in one of the few states with a waiver to permit coverage of childless adults. As a result, over 40 percent of poor adults and a third of near-poor adults are uninsured.

In recent years, with SCHIP enactment and Medicaid expansions, states have made notable progress in broadening outreach, simplifying enrollment processes, and extending coverage to more low-income families. Participation in public programs has helped to reduce the number of uninsured children and demonstrated that outreach and streamlined enrollment can improve the reach of public programs. However, the combination of the current fiscal situation of states and the downward turn in our economy are beginning to undo the progress we have seen.

States are now experiencing the worst fiscal situation they have faced since the end of World War II. Over the last two years, state revenues have fallen faster and further than anyone predicted, creating substantial shortfalls in state budgets. In 2002, state revenue collections declined for the first time in at least a decade, falling 5.6 percent from the previous year (Figure 14). These worsening fiscal pressures mean that state budget shortfalls will reach at least $70 billion in FY2004. At the same time, Medicaid spending has been increasing as health care costs for both the public and private markets have grown and states face growing enrollment in the program, largely as a result of the weak economy. However, even as Medicaid spending grows, it is not the primary cause of state budget shortfalls. While state Medicaid spending rose in FY2002 by $7 billion more than projected based on recent trends, this contribution to state budget deficits is modest compared to the $62 billion gap in state revenue collections relative to projections.

The state revenue falloff is placing enormous pressure on state budgets and endangering states' ability to provide the funds necessary to sustain Medicaid coverage. Turning first to "rainy day" and tobacco settlement funds, states have tried to preserve Medicaid and keep the associated federal dollars in their programs and state economies. But, as the sources of state funds become depleted, states face a daunting challenge in trying to forestall new or deeper cuts in Medicaid spending growth. Earlier this year in the Jobs and Growth Tax Relief Reconciliation Act, Congress provided $20 billion in state fiscal relief, including an estimated $10 billion through a temporary increase in the federal Medicaid matching rate. This has helped states avoid making deeper reductions in their Medicaid spending growth. However, this fiscal relief will expire next year, and it seems unlikely that states' fiscal conditions will improve by then.

Because Medicaid is the second largest item in most state budgets after education, cuts in the program appear inevitable—in the absence of new revenue sources—as states seek to balance their budgets. Indeed, survey data the Kaiser Commission on Medicaid and the Uninsured released at the end of September indicates that every state and the District of Columbia put new Medicaid cost containment strategies in place in fiscal year 2003, and all of these states planned to take additional cost containment action in fiscal year 2004 (Figure 15).

States have continued to aggressively pursue a variety of cost containment strategies, including reducing provider payments, placing new limits on prescription drug use and payments, and adopting disease management strategies and trying to better manage high-cost cases. However, the pressure to reduce Medicaid spending growth further has led many states to turn to eligibility and benefit reductions as well as increased cost-sharing for beneficiaries. Although in many cases these reductions have been targeted fairly narrowly, some states have found it necessary to make deeper reductions, affecting tens of thousands of people.

The fiscal situation in the states jeopardizes not only Medicaid's role as the health insurer of low-income families, but also its broader role as the health and long-term assistance program for the elderly and people with disabilities. Although children account for half of Medicaid's 51 million enrollees, they account for only 18 percent of Medicaid spending (Figure 16). It is the low-income elderly and disabled population that account for most of Medicaid spending—they represent a quarter of the beneficiaries, but account for 70 percent of all spending because of their greater health needs and dependence on Medicaid for assistance with long-term care (Figure 17).

It is these broader roles for the elderly and disabled population that drive Medicaid's costs. Most notably, for 7 million low-income elderly and disabled Medicare beneficiaries, Medicaid provides prescription drug coverage, long-term care assistance, vision care, dental care, and other services excluded from Medicare. While

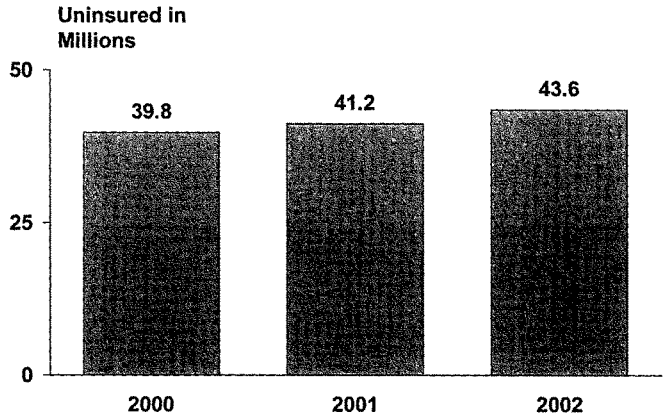
these dual eligibles represent 10 percent of the Medicaid population, they account for over 40 percent of Medicaid spending. Most of the growth (77 percent) in Medicaid spending last year was attributable to elderly and disabled beneficiaries, reflecting their high use of prescription drugs—the fastest growing component of Medicaid spending—and long-term care, where the bulk of spending on these groups goes. These are all areas in which states will find it difficult to achieve painless reductions and understandably areas where states are seeking more direct federal assistance, especially with the costs associated with dual eligibles.

CONCLUSION

Looking ahead, it is hard to see how we will be able to continue to make progress in expanding coverage to the uninsured or even maintaining the coverage Medicaid now provides. This week's latest statistics on the uninsured from the Census Bureau show that lack of health coverage is a growing problem for millions of American families. The poor economy combined with rising health care costs make further declines in employer-sponsored coverage likely. The state fiscal situation combined with rising federal deficits complicate any efforts at reform. In the absence of additional federal assistance, the fiscal crisis at the state level is likely to compromise even the ability to maintain coverage through public programs. Although Medicaid has demonstrated success as a source of health coverage for low-income Americans and a critical resource for those with serious health and long-term care needs, that role is now in jeopardy. Assuring the stability and adequacy of financing to meet the needs of America's most vulnerable and addressing our growing uninsured population ought to be among the nation's highest priorities.

Figure 1

Number of Nonelderly Uninsured Americans, 2000-2002



SOURCE: U.S. Census Bureau, 2002 Current Population Survey, 2003.

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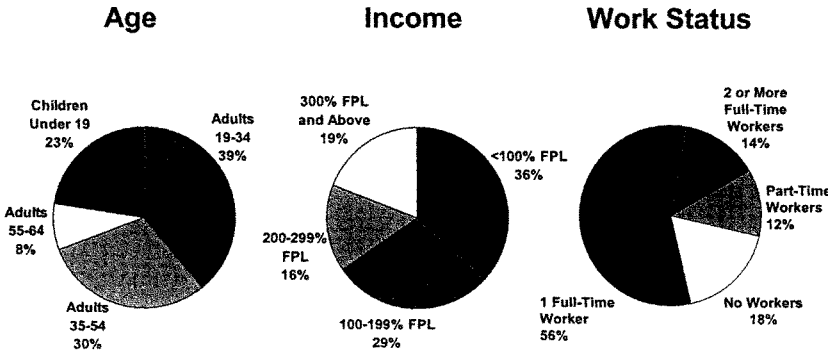
Figure 2

Characteristics of the Uninsured, 2001



Total = 41 million uninsured

Note: The federal poverty level was $14,128 for a family of three in 2001.
SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured, analysis of March 2002 Current Population Survey, 2003.

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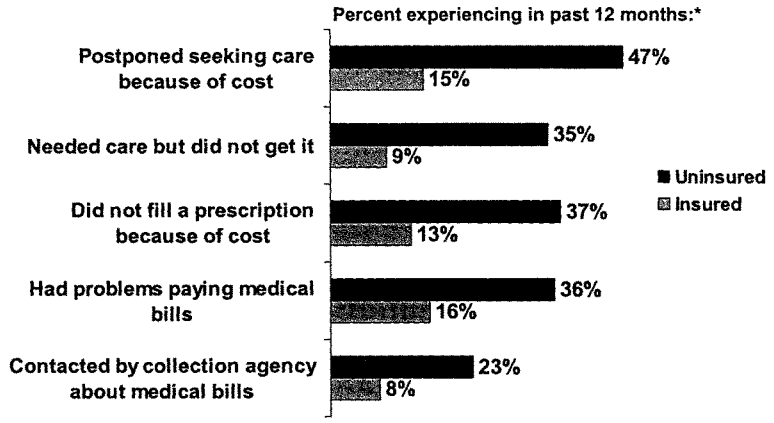
Figure 3

Barriers to Health Care by Insurance Status, 2003



Notes: *Experienced by the respondent or a member of their family.
Insured includes those covered by public or private health insurance.
Source: *Kaiser 2003 Health Insurance Survey.*

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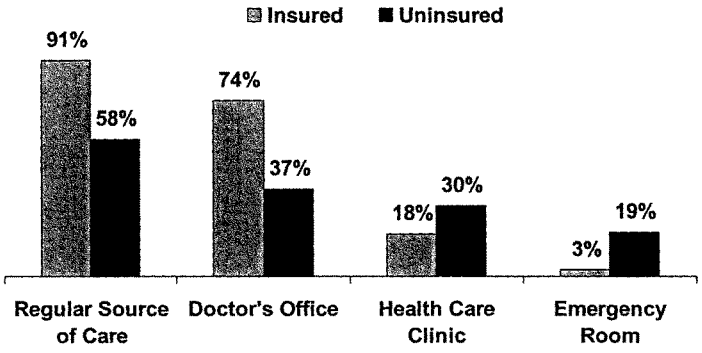
Figure 4

Sources of Care by Insurance Status, 2003



Note: Insured includes those covered by public or private health insurance.
Source: *Kaiser 2003 Health Insurance Survey.*

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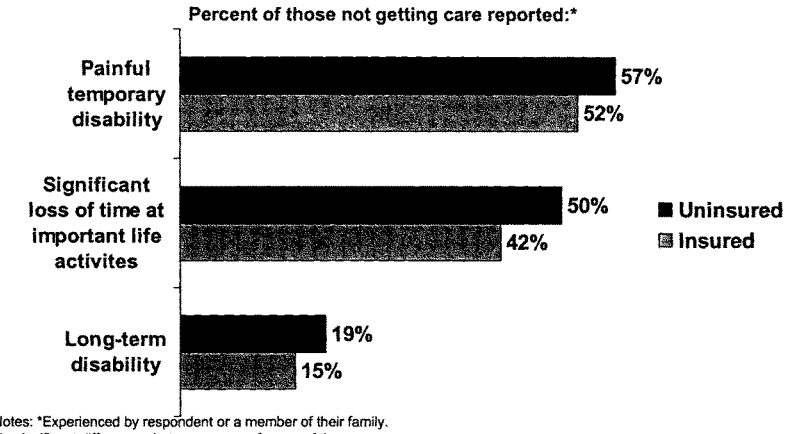
Figure 5

Consequences of Not Getting Care by Insurance Status, 2003



Notes: *Experienced by respondent or a member of their family.
No significant differences between groups for any of these measures.
Insured includes those covered by public or private health insurance.
Source: *Kaiser 2003 Health Insurance Survey.*

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Figure 6

The Consequences of Being Uninsured

Research demonstrates that the uninsured:

- **use fewer preventive and screening services;**
- **are sicker when diagnosed;**
- **receive fewer therapeutic services;**
- **have poorer health outcomes (higher mortality and disability rates); and**
- **have lower annual earnings because of poorer health.**

SOURCE: Hadley, Jack. "Sicker and Poorer – The Consequences of Being Uninsured: A Review of the Research on the Relationship between Health Insurance, Medical Care Use, Health, Work, and Income," *Medical Care Research and Review* (60:2), June 2003.

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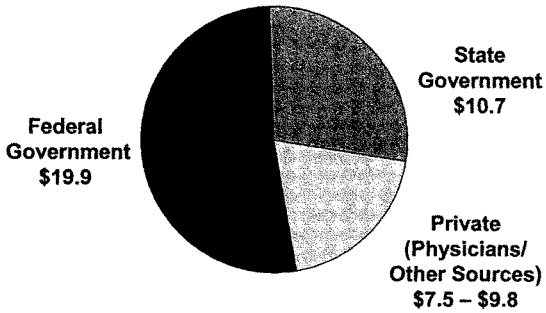
Figure 7

Sources of Funding Available for Uncompensated Care, 2001
(in billions)



Total = $38.1 – 40.4 Billion

SOURCE: Hadley and Holahan, February 2003

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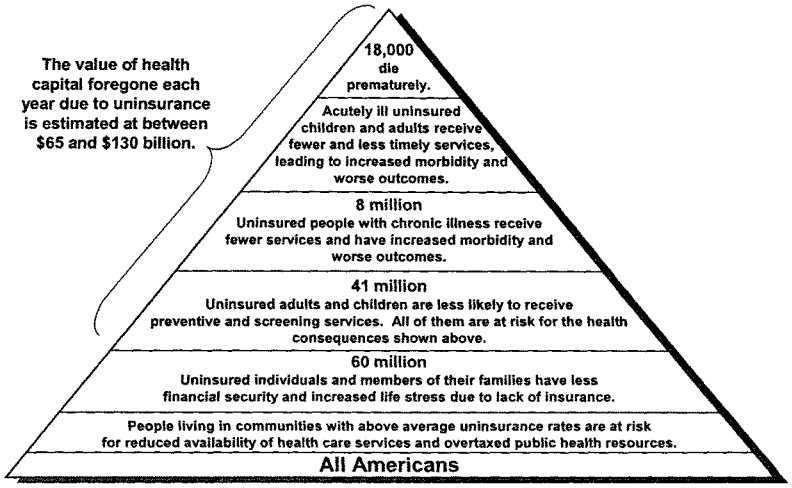
Figure 8

The Consequences of Uninsurance



SOURCE: Institute of Medicine, *Hidden Costs, Value Lost*, June 2003.

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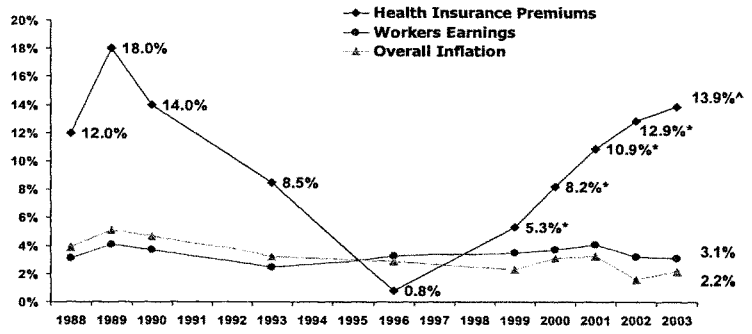
Figure 9

Increases in Health Insurance Premiums Compared to Other Indicators, 1988-2003



Notes: Data on premium increases reflect the cost of health insurance premiums for a family of four.
*Estimate is statistically different from the previous year shown at p<0.05: 1996-1999, 1999-2000, 2000-2001, 2001-2002.
^ Estimate is statistically different from the previous year shown at p<0.1: 2002-2003.
SOURCE: KFF/HRET Survey of Employer-Sponsored Health Benefits; KPMG Survey of Employer-Sponsored Health Benefits: 1988, 1989, 1990, 1993, 1996.

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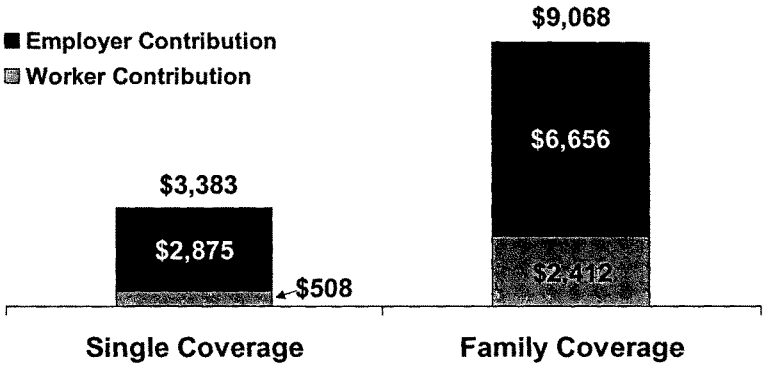
Figure 10

Average Annual Premium Costs for Covered Workers, 2003



SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2003.

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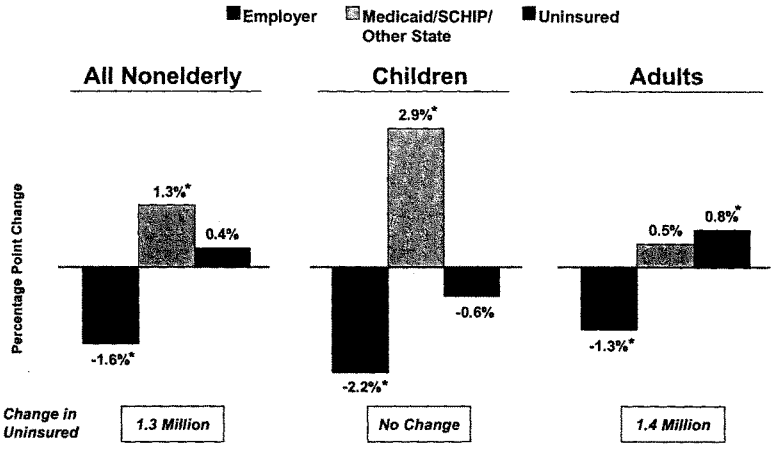
Figure 11

Changes in Health Insurance Coverage Among Low Income Nonelderly Americans, 2000-2001



*Indicates change is significant at the 95% confidence level
Low Income is less than 200% FPL
SOURCE: Urban Institute, 2002, based on data from the March Current Population Surveys, 2001 and 2002.

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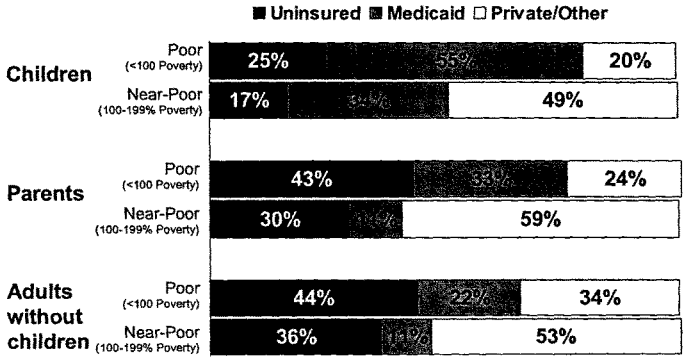
Figure 12

Health Insurance Coverage of Low-Income Adults and Children, 2001



Note: Adults age 19-64. Federal Poverty Level was $14,128 for a family of three in 2001.
SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured, analysis of March 2002 Current Population Survey, 2002.

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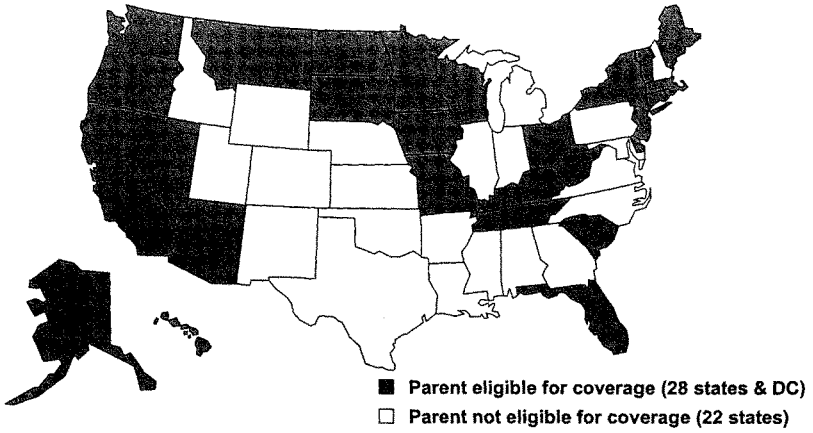
Figure 13

Medicaid Coverage of Parents Working Full-Time at Minimum Wage, 2001



Note: Assumes parent works 35 hours per week at $5.15 per hour.
SOURCE: KCMU analysis of Maloy et al. and Broaddus et al. in conjunction with Elizabeth Schott and Matthew Broaddus.

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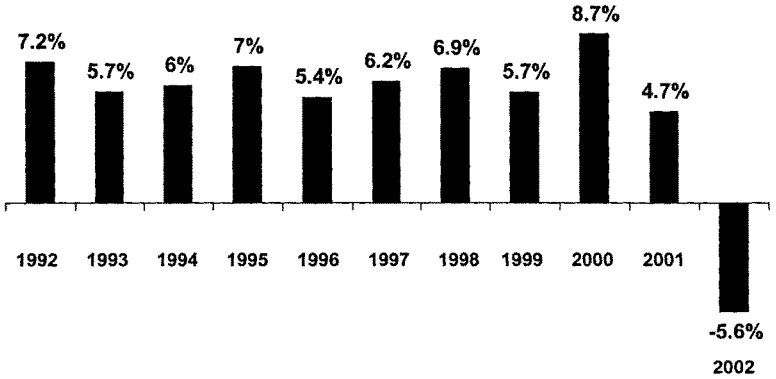
Figure 14

Change in State Tax Revenue Collections, 1992-2002



SOURCE: Rockefeller Institute of Government, Fiscal Year 2002 Tax Revenue Summary, May 2003. Changes are shown in nominal terms and are not adjusted for tax-related legislative changes.

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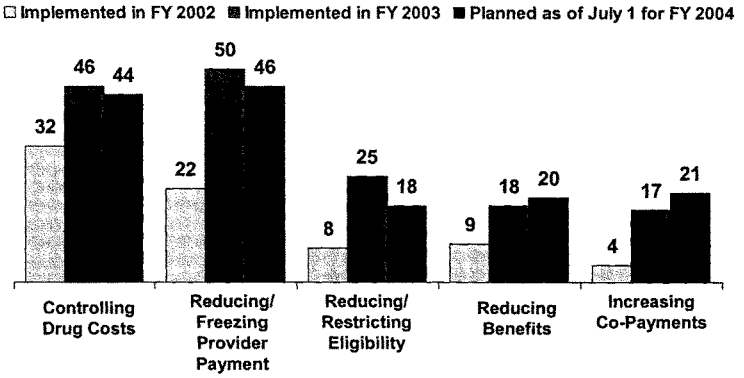
Figure 15

States Undertaking Medicaid Cost Containment Strategies FY 2002 - FY 2004



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, June and December 2002 and September 2003.

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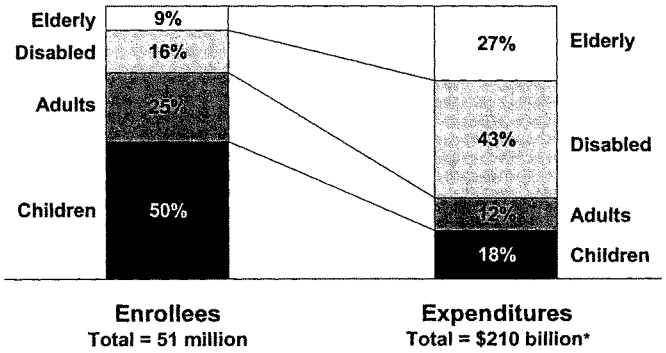
Figure 16

Medicaid Enrollees and Expenditures by Enrollment Group, 2002



*Expenditures on services based on historical state share data.
SOURCE: Kaiser Commission estimates based on CMS and March 2003 CBO data.

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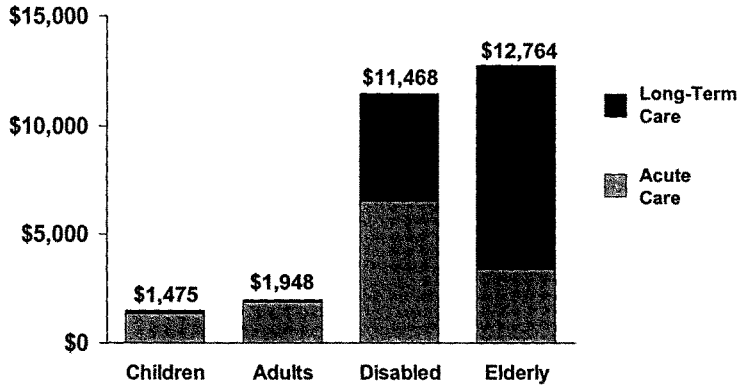
Figure 17

Medicaid Expenditures Per Enrollee, 2002



*Expenditures on services based on historical state share data.
SOURCE: KCMU estimates based on CBO March 2003 Baseline and Urban Institute data.

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Tuesday, September 30, 2003

CONTACT: Leighton Ku
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202-408-1080

NUMBER OF AMERICANS WITHOUT HEALTH INSURANCE ROSE IN 2002

Increase Would Have Been Much Larger If Medicaid and SCHIP Enrollment Gains Had Not Offset the Loss of Private Health Insurance

The ranks of those without health insurance grew from 41.2 million in 2001 to 43.6 million in 2002, according to new data the Census Bureau has just released.[1] The percentage who lack insurance rose from 14.6 percent in 2001 to 15.2 percent in 2002.

The primary factor behind the increase in the number of uninsured was an erosion in both adults' and children's private health insurance coverage, driven by the weak economy, rising unemployment and the increasing costs of health care. These developments made it harder last year for workers and their dependents to retain employer-sponsored health insurance coverage.

In response to the loss of private insurance coverage and the increase in the number of low-income families and other individuals, enrollment in the Medicaid program and the State Children's Health Insurance Program responded by expanding to pick up millions more people in 2002.

"If enrollment in Medicaid and the State Children's Health Insurance Program (SCHIP) had not grown in 2002, the number of Americans without health insurance would have been much higher," said Leighton Ku, Senior Fellow in Health Policy at the Center on Budget and Policy Priorities. Ku noted that enrollment in Medicaid grew by 3.2 million in 2002, while enrollment in SCHIP increased about 600,000 (not including children counted as Medicaid beneficiaries), according to state administrative data.

"Medicaid's ability to respond during economic downturns to cover substantial numbers of newly eligible people who would otherwise be uninsured depends directly on its status as an entitlement program, under which funding levels increase when need grows," Ku said. "Had federal Medicaid funding been capped under a block grant, as the Bush Administration proposed earlier this year, rather than rising automatically in response to the increased need, states would not have been able to afford to cover substantial numbers of additional people who lost their jobs and their health insurance, and the ranks of the uninsured would have swelled to a much greater degree."

[1] Robert Mills, *Health Insurance Coverage in the United States: 2002*, Current Population Reports P60-223, U.S. Census Bureau, September 2003. For the March 2003 Current Population Survey (CPS), being uninsured means that a person did not have any insurance coverage during 2002. Having Medicaid or private coverage means a person had that form of health insurance for at least some part of the year.

Although there that are signs the economy is now gradually recovering, evidence suggests that private health insurance coverage will continue to deteriorate in 2003. Unemployment rates have been modestly higher so far in 2003 than they were in 2002, and health care costs are still surging. Medicaid enrollment is continuing to grow, as well, although at a somewhat slower pace than in 2002. These developments indicate that the number of people without health insurance is likely to increase again in 2003, for the third consecutive year.

Key Findings from the New Census Data

- The percentage of non-elderly adults (those aged 18 to 64) with private health insurance slipped from 70.9 percent in 2001 to 69.6 percent in 2001 (see Table 1). A small part of this loss was offset by growth in Medicaid coverage, which increased from 6.7 percent of non-elderly adults in 2001 to 6.9 percent in 2002. The overall percentage of non-elderly adults who lacked health insurance climbed from 18.5 percent in 2001 to 19.5 percent in 2002.

- Private health insurance coverage for children also dropped, falling from 68.4 percent of children in 2001 to 67.5 percent in 2002. In contrast to what happened to coverage for adults, however, the loss of children's private insurance coverage was *entirely* offset by increases in enrollment in Medicaid and SCHIP. The percentage of children insured through one of these programs increased from 22.7 percent in 2001 to 23.9 percent in 2002. As a result, there was a very small reduction in the percentage of children who are uninsured — from 11.7 percent in 2001 and 11.6 percent in 2002 — although this change was not statistically significant.

Table 1

Changes in Selected Categories of Insurance Coverage, 2001 to 2002, Based on the Current Population Survey

	Private Health Insurance		Medicaid or SCHIP		Uninsured	
	2001	2002	2001	2002	2001	2002
Total U.S. Population	70.9%	69.6%	11.2%	11.6%	14.6%	15.2%*
Selected Subpopulations						
Children, under 18 years	68.4%	67.5%	22.7%	23.9%	11.7%	11.6%
Adults, 18 to 64 years	73.7%	72.2%	6.7%	6.9%	18.5%	19.5%*

* The change in the percentage of those uninsured is significant with 90 percent or better confidence. The Census Bureau reported significance levels for changes in the uninsured, but did not report them for changes in private insurance or Medicaid/SCHIP coverage.

Note: Coverage by other forms of health insurance (e.g., Medicare or military health coverage) is not shown in this table. People may report having more than one type of insurance during the year.

Source: March 2002 and 2003 Current Population Surveys, analyzed by the Center on Budget and Policy Priorities.

These new Census Bureau findings parallel other recently released data about health insurance coverage from the Centers for Disease Control and Prevention[2] and the Urban Institute.[3] The other surveys also found that growth in publicly-funded health insurance has helped to offset the loss of private insurance. The CDC data indicate that about 2.5 million more children and 1.4 million non-elderly adults were covered by public health insurance programs — principally Medicaid and SCHIP — in 2002.

Other findings of interest from the new Census data include:

- In 18 states, there was a statistically significant increase in the percentage of people who were uninsured between the 2000-2001 period and the 2001-2002 period. These states are Colorado, Idaho, Indiana, Maryland, Michigan, Mississippi, Missouri, Nevada, New Hampshire, New Jersey, North Carolina, Oregon, Pennsylvania, Rhode Island, Texas, Vermont, Virginia, and Wisconsin. One state — New Mexico — experienced a statistically significant reduction in the percentage of people who are uninsured.

- People who are poor were more than twice as likely to be uninsured as those who were *not* poor. The percentage of poor people who are uninsured stood at 30.4 percent in 2002, compared to 13.2 percent for those with incomes above the poverty line.

- The *number* of poor people who are uninsured rose from 10.1 million in 2001 to 10.5 million in 2002. The *percentage* of poor people who are uninsured, however, did not change significantly in 2002. The increase in the number of poor Americans without insurance was spurred by growth in the overall number of poor Americans, not by a change in the proportion of poor people with health coverage.

- Substantial racial and ethnic disparities exist in health insurance coverage. In 2002, some 10.7 percent of white, non-Hispanic Americans were uninsured, compared to 20.2 percent of African-Americans, 18.4 percent of Asians and 32.4 percent of Latinos.[4] The risk of being uninsured is particularly high for immigrants who are not citizens: 43.3 percent of non-citizens were uninsured.

---

[2] Leighton Ku, "CDC Data Show Medicaid and SCHIP Played A Critical Counter-Cyclical Role In Strengthening Health Insurance Coverage During The Economic Downturn," Center on Budget and Policy Priorities, Sept. 23, 2003.

[3] Stephen Zuckerman, "Gains in Public Health Insurance Offset Reductions in Employer Coverage among Adults," *Snapshots of America's Families III, No. 9,* Sept. 2003. Genevieve Kenney, Jennifer Haley and Alexandra Tebay, "Children's Insurance Coverage and Service Use Improve," *Snapshots of America's Families III, No. 1,* July 2003.

[4] This year, the Census Bureau began presenting data about racial categories in a new way, letting people report being more than one race. Thus, the Bureau now reports data for those who report being only one race (e.g., Asian) or being that race alone or in combination with other races (e.g., Asian alone or in combination). For the sake of simplicity, we report percentages for those who are white alone, non-Hispanic, African-American alone and Asian alone.

- The percentages of white, non-Hispanic people and of African-Americans who are uninsured rose in 2002. The percentage who are uninsured did not change significantly among Latinos or Asians, but among both of these racial/ethnic groups, the percentage of people without insurance is very high.

Why Private Health Insurance Declined and Public Coverage Rose

Three key factors pushed the number of people with private health coverage lower in 2002. First, unemployment rates climbed from 4.7 percent in 2001 to 5.8 percent in 2002, and a large number of newly jobless workers and their dependents lost employer-sponsored health insurance. Second, some smaller businesses responded to soaring health care costs — employer-sponsored insurance premiums surged an average of 12.7 percent in 2002 — by dropping health coverage for their workers.[5] Third, many other businesses asked employees to pay more for health insurance, with the result that some employees could no longer afford to purchase coverage for themselves or their dependents.

The main reasons that Medicaid and SCHIP coverage increased were that more people fell into poverty and became eligible for benefits and also that more low-income people needed public coverage as a result of losing private health insurance. In addition, some states improved enrollment procedures in Medicaid or SCHIP, particularly for children, making it simpler for families of newly unemployed workers to enroll.

Medicaid enrollment grew despite the fact that some states were beginning to implement eligibility cutbacks by late 2002, in response to budget shortfalls. A larger number of states have instituted such cuts — or have changed enrollment procedures in ways that make it more difficult for eligible families to enroll or remain enrolled — in 2003.

Despite signs that the economy is beginning to recover, preliminary evidence suggests that health insurance trends for 2003 are likely to be similar to those for 2002 and that the number of uninsured people is likely to increase further this year. Unemployment rates so far in 2003 have modestly exceeded those of 2002, and private, employer-sponsored health insurance premiums are still growing at double-digit rates. (A recent survey reports an average increase of 13.9 percent in 2003.[6]) These trends suggest that private health insurance coverage is continuing to drop in 2003. States report that Medicaid caseloads are continuing to rise, but at a somewhat slower pace than in 2002.[7]

---

[5] Kaiser Family Foundation and Health Research and Education Trust, "Employer Health Benefits: 2002 Summary of Findings," August 2002.

[6] Kaiser Family Foundation and Health Research and Education Trust, "Employer Health Benefits: 2003 Summary of Findings," August 2003.

[7] Vernon Smith, et al., *States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004: Results from a 50 State Survey,* Kaiser Commission on Medicaid and the Uninsured, September 2003. This study reports that states estimate that Medicaid enrollment will rise 7.8 percent in 2003.

Medicaid's Responsiveness Depends on Its Entitlement Status

During economic downturns like that experienced in 2002, the "counter-cyclical" role of Medicaid as an entitlement program is evident. To cover more uninsured people through Medicaid — and to do so while also meeting rising costs for prescription drugs and long-term care, especially for the low-income elderly and disabled — costs more money. Medicaid expenditures rose more than 13 percent in 2002. Under Medicaid's entitlement funding structure, federal funding levels increased automatically in 2002 to match states' Medicaid expenditures, without being limited by predetermined federal funding caps or grant levels.

If Medicaid funding were capped under a block grant, as the Bush Administration proposed earlier this year, federal funding would not have been as responsive to mounting health care needs as the economy soured. A funding cap would have placed states in the awkward position of either having to pay for millions of new low-income enrollees entirely with state funds — something that would have been extremely difficult, if not impossible, for many states, given the budget shortfalls they faced — or to take harsh actions to cut Medicaid expenditures, such as eliminating health care coverage for various categories of low-income elderly and disabled people, parents, or children, placing eligible people who apply for Medicaid on waiting lists and leaving them uninsured until "coverage slots" open, or eliminating coverage for some important medical services. If states had been forced to hold down Medicaid enrollment in the face of rising poverty and eroding private health care coverage, many more Americans would have been uninsured last year.

The experience of other social programs provides evidence about how entitlement programs respond in a counter-cyclical fashion to meet increased demands for assistance when the business cycle turns down. In Medicaid and the Food Stamp Program — both entitlements — enrollment has grown during the economic slump in response to increased need.[8] In contrast, caseloads in the TANF block grant have been falling despite the poor economy and high unemployment levels,[9] and limited funding for child care from TANF and the Child Care Block Grant is leading to reductions in the number of children in working families who receive child care assistance.[10]

The economic slump also has led to a sharp drop-off in state revenues, causing serious state budget shortfalls. In response to these concerns, Congress passed bipartisan state fiscal relief legislation earlier this year that provided $10 billion in federal Medicaid aid by temporarily increasing the federal Medicaid matching rate, as well as an additional $10 billion in broad state fiscal relief grants. This fiscal relief is helping states cope with their budget crises in 2003 and the first half of 2004. Many states have been able, with these funds, to avert or lessen the

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[8] Joseph Llobrera, "Food Stamp Caseloads Are Rising," Center on Budget and Policy Priorities, forthcoming revision, September 2003.

[9] Shawn Fremstad, "Falling TANF Caseloads Amidst Rising Poverty Should Be a Cause for Concern," Center on Budget and Policy Priorities, revised Sept. 5, 2003.

[10] Sharon Parrott and Jennifer Mezey, "New Child Care Resources Are Needed to Prevent the Loss of Child Care Assistance for Hundreds of Thousands of Children in Working Families," Center on Law and Social Policy and Center on Budget and Policy Priorities, July 15, 2003.

severity of Medicaid cutbacks that they otherwise would have instituted and that would have further increased the ranks of the uninsured.[11] Moreover, the fiscal relief legislation gives states an incentive to avoid restricting Medicaid eligibility from September 2003 through June 2004; states that restrict eligibility during that period would lose most of the additional federal Medicaid funds.

This federal fiscal relief expires in mid-2004. State budget outlooks remain dire in many states, and unemployment remains high. If state budget conditions and general employment growth do not improve significantly before the fiscal relief ends and the fiscal relief is not extended until a stronger economic recovery takes hold, larger cuts in the provision of health insurance coverage through Medicaid could begin being implemented about a year from now.

# # # #

The **Center on Budget and Policy Priorities** is a nonprofit, nonpartisan research organization and policy institute that conducts research and analysis on a range of government policies and programs. It is supported primarily by foundation grants.

[11] Vernon Smith, et al., *op cit.*

FamiliesUSA
The Voice for Health Care Consumers

EMBARGOED FOR RELEASE
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CENSUS BUREAU'S UNINSURED NUMBER IS LARGEST INCREASE IN PAST DECADE

Total Number of Uninsured Now Exceeds the Cumulative Population of 24 States and the District of Columbia

Ron Pollack, Executive Director of Families USA, Available for Analysis

The following is the statement of Ron Pollack, Executive Director of Families USA, about the Census Bureau's newly released findings that the number of uninsured Americans rose to 43.6 million during 2002:

"Last year's growth in the number of people without health coverage is the largest increase in a decade. The huge number of uninsured Americans now exceeds the cumulative population of 24 states plus the District of Columbia.[1] **[See attached map.]**

"The increase in the number of people without health coverage is the *direct* result of our weak and jobs-losing economy. This increase was caused by unemployment growth, double-digit health cost increases, and employers – who find spiraling health costs to be unaffordable – passing on more and more of those costs to their workers.

"The only silver lining in the Census Bureau report is that, once again, public programs – especially Medicaid – covered more people and cushioned the loss of employer-provided health insurance. It underscores the importance of protecting the Medicaid program.

"The Census Bureau's report should be a clarion call to the President and the Congress to take effective action quickly so that recently laid-off people and workers in jobs that provide no health coverage can gain such coverage for themselves and their families. The failure to do so may have significant repercussions in the 2004 elections."

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Families USA is the national organization for health care consumers. It is nonprofit and nonpartisan and advocates for high-quality, affordable health care for all Americans.

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1 Alaska, Arkansas, Connecticut, Delaware, District of Columbia, Hawaii, Idaho, Iowa, Kansas, Maine, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Dakota, Oklahoma, Oregon, Rhode Island, South Dakota, Utah, Vermont, West Virginia, and Wyoming.

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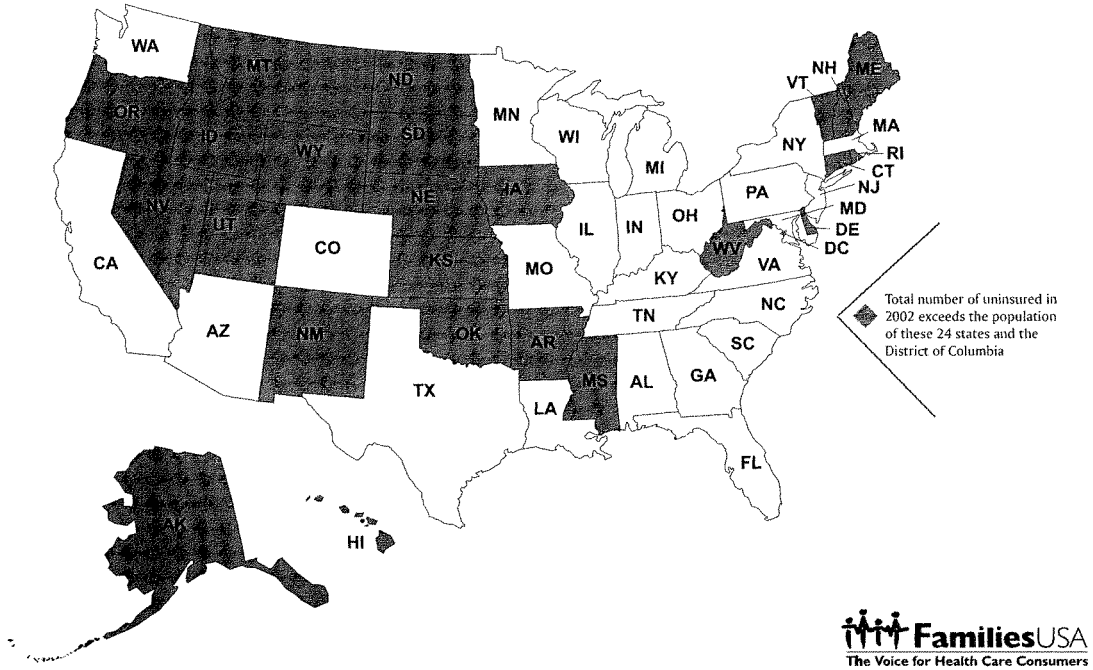
Number of Uninsured Now Exceeds Cumulative Population of 24 States Plus the District of Columbia



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