

**Testimony**

**For**

**Congresswoman Hilda Solis  
And the  
Congressional Universal Health Care Task Force**

**“Hearing on the Uninsured”**

**Elena Rios, M.D., M.S.P.H.  
President  
National Hispanic Medical Association**

**Los Angeles, California**

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Congresswoman Solis and the other Members present: I represent the National Hispanic Medical Association, a non-profit organization established in Washington, DC in 1994, representing Hispanic licensed physicians in the United States. The mission of the organization is to improve health of Hispanics and other underserved. It is an honor to be here today to discuss such a critically important topic as Federal strategies to decrease the uninsured. I applaud your commitment to health.

## **Background**

### **A. America's Uninsured**

Currently, there are 43.9 million Americans or 18.4 per cent of the non-elderly population (under 65 years of age) who are not covered by health insurance. Arizona, Texas, New Mexico and California have the highest percentage of uninsured individuals.

Although there have been many positive trends in the health system over the past decade, the number of uninsured have continued to climb. The uninsured have grown over the decade, despite a robust economy. Projections call for a continued increase to 47 million uninsured by 2005. Growth in the uninsured is occurring in a time "surplus politics", and, at the same time, when many of the direct and indirect subsidies that have been critical to the financing of care for the poor and uninsured patients are being restricted and called to be phased out at the Federal level.

For example, the disproportionate care funds and the cost reimbursements for FQHCs are being phased out by Congress, there has been a decrease in Medicaid participation as a consequence of Welfare reform, there has been decreased benefits to immigrants as a result of Immigration reform, and there has been a serious cost reduction challenge to health care services by the Bush Administration for HRSA, SAMHSA, HCFA, and CDC. Moreover, there has been an economic downturn, so the time to act is now.

As we discuss recommendations for policy about the uninsured, it is critical to take into account the context of the health system. According to a new report from the Institute of Medicine, "Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century", health policy should focus on six areas for improvement of quality: It should be safe, effective, patient-centered, timely, effective, and equitable. Let me emphasize patient-centered- the argument now called cultural competence, that is, providing care that displays an understanding and respect for the values, in this case, of Hispanic patients.

In addition, there should be evidence- based medicine that warrants a greater reliance on information sharing of all in the health system – providers and patients. This would increase the ability to improve quality based on what works. Moreover, the report recommends that payments should encourage quality improvement.

Who are the uninsured? They tend to be working adults, lower-income. About 34% of The non-elderly have incomes below the Federal poverty level. 2001 Federal poverty level for a family of four is \$17, 650 About 80% of the non elderly have incomes 3 times

that or at a level of 300% FPL. The median family income of all uninsured families \$18,000. One in 3 of low income parents or 6.9 million parents lack health coverage(<200% FPL or \$29, 260 for a family of three). Low income working parents are at high risk of being uninsured because they cannot obtain affordable employer-based coverage. Unless they have incomes far under the Federal poverty line they are also not eligible for publicly-funded coverage. In a median state, a working parent of 2 becomes ineligible for public coverage when their earnings reach 69 percent of poverty.

The uninsured are predominantly members of families in which someone is employed. Only 23% do not have a worker in the family. Many who do work (80%) are not offered insurance.

In 1999, 33% were employed in small firms (<25employees); 10% were self-employed; 57% in firm with 25 or more employees; 31% in firms that employed 500 or more employees.

About 75% are adults (19-64) and 25% are children. Many are women with their own special needs, including pregnancy and women's health issues.

Employer coverage is key to expanding the coverage to workers without insurance. Employer trends show that there has been decreasing coverage due to increased premiums. However, about 80% of working insured are covered by employers. About 15% decline insurance from their employers.

## **B. The Special Case of Hispanic Uninsured**

Hispanics, estimated at 40 million, are the largest ethnic minority group in the U.S. They are projected to number 100 million in the U.S. by 2050, or 25% of the population. In addition, Hispanics are the largest minority group to be uninsured, with 2 out of 5 not having insurance. Hispanics have had a 40% increase in the uninsured population between 1977 to 1992, 36% of the increase from 1989 to 1997. They are less likely to be covered by employment-related insurance. Rates of health insurance coverage are lower for Hispanics whether they have low-incomes or are employed full time. High cost of insurance is the most common culprit.

Foreign born Hispanics were twice as likely to lack insurance as their U.S. born counterparts (49% vs 24%), the difference greatest for Hispanics of Mexican origin and smallest for Puerto Ricans. There is a strong relationship between length of U.S. residence and health coverage, linear progression as length of residency increases. Hispanics are also more likely than other racial and ethnic groups to be chronically uninsured and less likely to have continuous employer-provided coverage. Hispanic employees in small firms (less than 25 employees) participate less than non-Hispanic Whites or Blacks when insurance is offered. Recent immigrants were the least likely to be covered for a 36month period (1996-98) and most likely to be continuously uninsured.

Even full-time employed Hispanics were substantially less likely than non-Hispanic Whites or Blacks to be covered by their employers.

**WHY?** Employment characteristics, family structure, immigrant status, language and culture all play a role but this varies by different Hispanic sub-populations. In general, recent immigrants fare the worst on all levels of: affordability, employer-based health insurance, income, public insurance access.

Immigration policy is a special challenge.

### **Federal Health Policy in the 107<sup>th</sup> Congress**

“Uninsured people are an indication of market failure; (because)they impose spill-over costs on society in the form of public health risks and uncompensated charity care,” this according to a recent report by the Congressional Research Service.<sup>1</sup> Nowhere is this more glaring than in the numbers of Hispanic Americans without health insurance therefore access to health care. Current proposals basically seek to remedy this failure either through current public programs and/or a market based approach using tax credits. Fundamentally, all current proposals reduce to subsidizing health insurance for the uninsured by expanding eligibility in the Medicaid, Medicare, and SCHIP programs or would amend the tax code to provide tax incentives to individuals or employers towards the purchase of health insurance. Medical savings accounts and small group health plan arrangements are other incentives before Congress. Despite our interest in coverage for all Americans, incremental rather than major structural reforms are the flavor of the day and will continue to prove challenging to the Administration, Congress and state and local governments. Whatever policy results must be based on those who need it the most, low and moderate income families and individuals.

#### *White House*

President Bush has submitted his budget to Congress that calls for \$132 million towards expanding coverage for the uninsured. That is a very positive first step. Refundable tax credits, Medical Savings Account (MSA) expansion, and FSA carryovers basically all market based to increase health insurance access. Tax credit proposed is 90% of the premium, limited to \$1,000 per person under age 65 or to \$2,000 per family. Those covered by public insurance are not eligible.

President Bush anticipates that this would help about 6million previously uninsured when fully phased in by 2004. Additionally, President Bush wants an increase of 1200 Community Health Centers.

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<sup>1</sup>CRS Report IB98037: Tax Benefits for Health Insurance: Current Legislation, by Bob Lyke, Domestic Social Policy Division, April 19, 2001. pg. 6.

Using Medicaid 1115 waivers for expansion efforts like Tommy Thompson did in Wisconsin with “Badger Care,” 1115 of the Social Security Act allows the executive branch to waive statutory and regulatory provisions of major health and welfare programs, including both Medicaid and SCHIP. President Bush and governors show high interest to use 1115 authority to secure basic changes in public-sponsored health insurance programs (Kaiser Policy Brief-July 2001)

### *Congress*

#### Expanding Existing Public Programs

- < **Family Care Act of 2001**(S.1244, Kennedy, Snow, Rockefeller and H.R. 2360 Dingell, Brown, Waxman) provides for coverage for parents of children, pregnant women and immigrants up to age 19.
  
- < **Immigrant Children's Health Improvement Act of 2001** (S. 582, Graham, Chaffee, McCain) allows states the option to cover certain legal immigrants under the Medicaid and State Children's Health Insurance programs.
  
- < **Start Healthy, Stay Healthy** (S 1016 IS, Bingaman, Lugar, McCain) amends the Social Security Act to improve the health benefits coverage of infants and children under the Medicaid and State Children's Health Insurance program.
  
- < **MediKids Health Insurance Act of 2002** (S. 827, Rockefeller, Reed and H.R. 1733, Stark, Rangel) guarantees comprehensive health care coverage to all children born after 2001.
  
- < **Medi-Access Act of 2001** (H.R. 1142, Conyers, Christiansen, Bonior) permits uninsured families and individuals to obtain coverage under the Medicaid program, to assure coverage of doctor's visits, prescription drugs, mental health services, long-term care services, alcohol and drug abuse treatment services, and all other medically necessary services.
  
- < **Medicare Wellness Act of 2001** (S. 982, Graham, Jeffords, Kennedy and H.R.2058, Levin, Foley, Stark) seeks to promote primary and secondary health promotion and disease prevention services and activities among the elderly by financing preventive health benefits.
  
- < **Health Care Assurance Act of 2001** (S. 24, Lott, Specter) provides improved access to health care by expanding Medicaid to low income individuals, expansion of SCHIP, and deductions by self employed individuals.
  
- < **Medicare Early Access and Tax Credit Act of 2001** (S. 623, Rockefeller, Daschle and H.R. 1255 Stark, Brow, Gephardt) creates a new Part D allowing

early buy in to Medicare for individuals 62-65 and access to displaced workers and spouses age 55-62.

- < **COBRA Extension** (H.R. 1663, Moakley) extends the basic period for COBRA continuation from 18 months to five years.
- < **COBRA Coverage Extension and Affordability Act of 2001** (H.R. 2005, Stark, Moakley) extends COBRA to five years and for individuals age 55 and over when COBRA terminates to buy into Medicare with refundable tax credits for COBRA premium coverage.

### Tax Based Initiatives

- < **Patient Access, Choice, and Equity Act of 2001** (H.R. 2250, Cooksey, Arney, Ehrlich) provides tax credits to individuals towards financing of health insurance and medical care costs.
- < **Fair Care for the Uninsured Act of 2001** (S. 683, Santorum, Toricelli, Smith and H.R. 1331, Arney, Lipinski, Cannon) amends the tax code allowing individuals a refundable credit (payable up front to insurers) to purchase private health insurance and to establish state health insurance safety-net programs.
- < **Access to Affordable Health Care Act** (S. 674, Collins, Landrieu) provides new tax incentives to make health insurance more affordable for small businesses.
- < **Relief, Equity, Access, and Coverage for Health (REACH) Act** (S. 590, Jeffords, Breaux, Frist) amends the tax code to allow a refundable tax credit for health insurance costs to individuals.
- < **Child Tax Credit Expansion and Equity Act** (S. 833 Snowe, Dodd, Jeffords) expands the use of child tax credits.
- < **Leave No Child Behind** (Miller) ensures every child and their parents have health insurance through tax credits
- < **Child Health Bill** (S. 1266 Clinton) to expand child health assistance to children with family income up to 300 percent of poverty.
- < **Keep America Healthy Act of 2001** (H.R. 2789 Millender-McDonald, Rangel) to permit states to expand Medicaid eligibility to uninsured, poor adults; increases Medicaid to territories and Puerto Rico

- < **Health Insurance Affordability and Equity Act of 2001**(H.R. 1181, Johnson, Lobiondo, Rogers) provides non-refundable tax credits and incentives for private health coverage for previously uninsured.
- < **Small Business Health Fairness Act of 2001** (H.R. 1774 Fletcher, Dooley, Hastert, and S. 858 Hutchinson) creates self-insured association health plans targeting small employers so they could purchase health insurance.
- < **Medical Savings Account Availability Act** (H.R. 1524, Thomas, Lipinski, Johnson) expands and makes permanent the availability of MSA's to employers and individuals.
- < **Cafeteria Plans and Flexible Spending Accounts** (H.R. 1590 Ramstad., H.R. 167, Royce., H.R. 63, Dreier) amends the tax code to allow the transfers of benefits from one year to the next.

The research is showing that tax credits for individuals provides little or no relief to the affordability of health insurance. There are 5 major arguments to tax credits: 1) In a recent Congressional briefing by the Alliance for Health Reform, findings indicate that current tax credit proposals call for an inadequate amount of funding to cover an average premiums for a family in an individual market exceed \$7,300/year. For a family making \$30,000, they would have to pay \$5,300 or 18% of their income; 2) Older patients tend to have chronic diseases and high costs; 3) many low-income persons don't pay taxes; 4) to buy insurance, persons with limited income need cash in advance; and 5) tax savings are greater for high-income persons.

However, tax credits, as you can see have bipartisan support in Congress. Another method of tax credit that may become more popular also are employer tax credits, to add to the employer exemptions that currently exist. The latest tax credits for employers were those introduced by President Clinton (20% credit for small businesses) and in the 1999 Senate Omnibus tax bill (HR 2488) (60% of the cost of individual coverage up to \$1,000 and 70% of the cost of family coverage up to \$1,715. Comprehensive reform of employer based health insurance, capping exclusion of employer-paid insurance and replacing exclusion and deductions with tax credits could lead to increased coverage.

However, for all tax credits, there would have to be increased administration costs.

The literature also shows that comprehensive care and lower cost-sharing are thought to lead to better preventive care and possibly long run savings for certain medical conditions.

### Congressional Budget Resolution

In the recent Patient's Bill of Rights debate in Congress, a Congressional Budget Resolution was adopted in May that set aside \$28 billion of the \$1.35 trillion tax cut (roughly 1/50<sup>th</sup> of the total) over the next ten years to reduce the number of uninsured. Secretary Tommy Thompson noted in a recent interview that a promising strategy that

this funding should address is to expand coverage to the parents of eligible children for Medicaid and SCHIP. Other proposed strategies from Congress include to expand Medicaid and SCHIP for pregnant women, to give states option to cover some of the legal immigrants excluded from coverage by the 1996 Federal Welfare reform law, and to help states enroll more eligible children in coverage.

### **Other Federal Strategies to Decrease Uninsured**

The following is a listing of other strategies discussed in Congress to target access to uninsured, either directly or indirectly.

#### Delivery System

A. Health Delivery Services – Access Bill (Senator Frist, Kennedy/Congressman Bilirakus)

- Outreach and Education
- Application and Follow-up
- Retention
- Cultural Competence
- Language Services

1. Community Health Clinics
2. National Health Service Corps
3. Migrant Stream Programs
4. Telemedicine and Rural Health Programs
5. Healthy Community Access Program – consortiums in local communities

B. Physicians and other Providers

1. Health Professions Education
  - a. Recruitment & retention of minorities to health professions schools
  - b. Cultural Competence Curriculum
  - c. Spanish requirements
2. Graduate Medical Education
  - a. Cultural Competence Curriculum
  - b. International Medical Graduates
  - c. Council on Graduate Medical Education – interested in Hispanics in Medicine Report, 2002
3. Hispanic-Serving Health Professions Schools, Inc.
  - a. Research training programs to develop Hispanic research
  - b. U.S.-Mexico Border Health Research Initiative – Dec. 2001 – June 2003 (CDC/AHRQ) to develop a research agenda on access/utilization

- C. Disease Management
  - 1. Race/Ethnicity and Disparities in Health Initiative (Heart, Cancer, HIV/AIDS, Diabetes, Immunizations)
  - 2. Executive Department Programs
  
- D. Health Legislation – Other Targeted Populations
  - 1. Women – Congressional Women’s Caucus Legislation
  - 2. U.S.- Mexico Border Health (Bingamon)
  - 3. Hispanic Health Act of 2000 (Rodriguez) (106<sup>th</sup> Congress)
  
- E. Data Collection
  - 1. National Surveys should include Hispanic and uninsured
  - 2. Monitoring of data collection
  
- F. Research
  - 1. NIH Center for Minority Health and Health Disparities Research
    - a. Prevention, Translation, Cultural Competence, Biomedical
  - 2. AHRQ Health Services Research
  - 3. CDC Prevention Research
  - 4. HCFA Health Services Research
  - 5. National Research Council – has started the planning process for a 2002 Report on Hispanics in the United States policy and research issues

## **Recommendations**

1. Increase access to health insurance to Americans by expanding Federal programs, and include the following strategies:

a. Individual Issues:

- Knowledge about insurance
- Affordability – subsidies only with adequate tax credits
- Expand eligibility for Federal programs, especially parents
- Increase outreach from public programs
- Simplify applications
- Follow-up
- Family Plans

b. Employer Issues

- Affordability – subsidies, tax credits and education to small employers

2. Federal action is needed to increase Hispanic targeted educational public campaigns about health insurance coverage and the need for healthy lifestyle changes.

3. Develop research about Hispanics who are uninsured and their needs; Research to understand information about how Hispanic families and how individuals make decisions about health insurance; what affects their decisions to utilize health insurance. Support research about the uninsured, especially Hispanics and their challenges and strategies to meet those challenges at a community level, taking into account sub-group research.
  
4. Develop cultural competence strategies that work 1) for outreach to Hispanics about insurance coverage; 2) for retention of Hispanics in health insurance programs; 3) for physician role in education about the importance of health and health insurance; and 4) for the non-Hispanic physician and staff and for health facilities.
  
5. Target the development of legislation that provides incentives for employers with small firms, such as subsidies. It would be key to develop the ability of more small firms to afford health insurance.
  
6. Develop Immigration policy : 1) to remove states options to terminate nonemergency Medicaid coverage to and to prohibit states excluding foreign born children from SCHIP; 2) increase benefits to immigrants for health care services, including restoring food stamps, and 3) exploring policy discussions with Mexico.
  
7. Support Language services for the English Limited Proficient (LEP) person. Develop legislation for reimbursement for language services, including translation, from Medicare, Medicaid, and SCHIP.
  
8. Develop Health Professions legislation to increase recruitment of Hispanic student programs targeted at mentoring for the health professions.
  
9. Develop Leadership Development Programs, targeted at Hispanics in the health sector, especially in programs supported by the Federal government that serve the poor and in the U.S. Department of Health and Human Services.
  
10. Target Hispanic uninsured – increase support for demonstration programs, HCAP with targeted communities, increase funding for Medicaid to Puerto Rico and territories.

Hispanic California Facts>EBRI, Sept. 2000

California accounted for 17% of all uninsured in the country in '98. Underlying factors mainly due to education, job characteristics, citizenship status, all possibly reflecting “cultural differences.” Rise of uninsured in Ca. coincided with a decline in employment-based health coverage. 1 in 5 Californians are noncitizens. Among Hispanics, 44% did not graduate from HS and among Californians earning < than \$7/hr.,

60% of Hispanics were uninsured. Hispanic workers in Ca., were less educated and had lower wages than Hispanics in the U.S., more likely to work in small firms and work in the agricultural sector. Citizenship is the most important variable affecting health insurance coverage in Ca. Hispanics.

#### Principles/Values of Health Insurance

*Papers by Weil, Bilheimer, Zuckerman (Health Affairs, Jan. 2001)*

Need to examine and explore values that underlie current proposals and how they structure future options for additional/future incremental options. Short term effects > cost and how many people are covered but need to consider how these proposals shape the future health care system. Current proposals will affect longer-term prospects for further expansions and increased health insurance coverage not only now but into the future.

#### *Values(per Weil)*

- < Incremental steps can build institutions, ie SCHIP
- < Incremental steps can build expectations, ie ERISA led employers to play a major role in providing health insurance.

#### Critical questions to answer:

- < How does/will and where do the uninsured enter the insurance market?
- < What risk pool do people enter?
- < What is the government contribution? Defined benefit or defined contribution(specific \$ amount).
- < Does efficiency come at a cost to equity, and to who?
- < How are responsibilities divided between the feds and the states?
- <

**Weil's** idea is to build on: Employment based health coverage (Non-refundable tax credits for businesses), Medicaid expansion to all with annual incomes < 133 fed pov.level, SCHIP. Focus on those with incomes <200% of FPL, on low wage workers, families, and individuals, coverage to all based on income.

#### References

Meyer, J. Economic and Social Research Institute. Covering America: Real Remedies for the Uninsured. June 2001.

The Health Care Safety Net: Millions of Low-Income People Left Uninsured. Families USA, July 2001

Guyer, J. Congress Has a \$28 Billion Opportunity to Expand Coverage for Low-Income Working Families with Children. Center on Budget and Policy Priorities, July 2001

Expanding Health Coverage. Health Affairs, Vol. 20, No.1. January/February 2001.

Institute of Medicine. Crossing the Quality Chasm: the Health System of the 21<sup>st</sup> Century, June 2001.

Institute of Medicine. The Health Care Safety Net. May 2000.

Commonwealth Fund Reports:

Quinn, K. Working Without Benefits: The Health Insurance Crisis Confronting Hispanic Americans, March 2000.

Swartz, K. Markets for Individual Health Insurance: Can We Make Them Work with Incentives to Purchase Insurance?, Dec. 2000

Schur, C. Running in Place: How Job Characteristics, Immigrant Status, and Family Structure Keep Hispanics Uninsured, May 2001.

Medoff, J. How the New Labor Market is Squeezing Workforce Health Benefits, June 2001.

The Uninsured and Their Access to Health Care. Kaiser Commission. Medicaid and the Uninsured. January 2001.

Vladeck, Bruce. Making Medicare Work Better, Mount Sinai New York University, March 2001