Testimony of
Mark McClellan, Member,
Council of Economic Advisers

Before the Senate Health, Education,
Labor, and Pensions Committee
on the Uninsured
March 12, 2002

Mr. Chairman, the Administration looks forward to working with this Congress, on a bipartisan basis, to address the pressing need to improve access to health insurance for uninsured Americans. Almost 40 million Americans are reported to go without health insurance coverage for an entire year, and as many as 20 million others are without health insurance coverage during some part of the year. In addition, millions more Americans are struggling to afford rising health insurance premiums, with little help from the government. The problem of health care affordability is one that requires action this year. We appreciate your effort to find common ground to provide relief for Americans who are uninsured, as well as those who are having more and more difficulty getting affordable health insurance.

The President has introduced a comprehensive set of proposals to ensure that all Americans have affordable health insurance coverage options, with a particular emphasis on creating affordable options for the uninsured. All of these proposals are part of a broad vision for promoting health care quality and access by developing flexible, market-based approaches to providing patient-centered health care coverage for all Americans. Reflecting the urgency of the need for action, this vision involves strengthening every component of our health care system.

Many of these proposals, such as new proposals to assist employees with high out-of-pocket costs and to help small businesses offer affordable health insurance options, are directed toward strengthening employer-provided health insurance. In addition, the President has proposed health insurance credits that will enable millions of Americans who do not have employer-provided coverage to purchase obtain health insurance. The health insurance credits will improve the functioning of private health insurance markets, and improve the quality of health care by empowering patients to choose the coverage that best meets their needs. Additional funding included in the President's budget for Medicaid and the State Children's Health Insurance Program (SCHIP), coupled with the results-oriented "health insurance flexibility and accountability" model demonstration program, will permit all states to expand coverage through these programs. Finally, the President has proposed substantial improvements in the health care safety net, reflecting his commitment to a major expansion of the successful community health center program. Other proposals in the President's budget will strengthen the ability of our entire private health care delivery system to provide high-quality, high-value care – so that the American health care system can continue to be the engine for dramatic improvements in the health of Americans.

I will devote a substantial portion of this testimony to discussing health insurance credits, as they comprise one of the most innovative policy approaches proposed in the President's budget this year. Health insurance credits use the infrastructure of the tax system to expand access to health insurance. Health insurance credits have been included in proposals developed by both Republicans and Democrats. Many of the distinguished Members of this Committee and of the Senate have supported legislation to provide health insurance credits. We must seek to bridge partisan divides to come to agreement on this key issue which enjoys such bipartisan support. To help do so, the President has proposed health insurance credits that build on the best features of previous proposals, and that include new innovations to address past criticisms of tax credit proposals.

The President's budget backs up his agenda for making health insurance more affordable with over $125 billion in new funding. We hope that these specific proposals will provide a foundation for decisive action in Congress this year to address the serious problem of health care affordability and the uninsured.

The Problem of the Uninsured

In 2000, 14 percent of Americans reported that they were uninsured for the entire year. Although many opportunities exist for the uninsured to get needed care, persons without health insurance are much more likely to go without effective health care, or they may rely on inefficient episodic care at hospital emergency rooms. As a result, our health system spends more than it should on complications of diseases that could have been prevented and on inefficient approaches to delivering health care. Even worse, not having insurance makes it harder for Americans to take control of their health and work with health care professionals to stay healthy.

The uninsured population does not consist only of the very poor or the unemployed. In 2000, 85 percent of the uninsured population were in families with at least one worker. Furthermore, while 24 percent of the uninsured had incomes below the poverty line, a large fraction, 29 percent, had incomes between 100 and 200 percent of poverty. Nearly three-quarters of the uninsured below 200 percent of poverty are adults, many of whom do not live in households with children.

Insurance coverage differs significantly by race and ethnicity. In 1998-2000, 32 percent of Hispanics were uninsured, compared to almost 20 percent of blacks and Asians. In contrast, just 10 percent of non-Hispanic whites were uninsured.

Uninsured Americans are a diverse population, and the approaches available in the United States to provide good health insurance are also diverse. Thus, increasing health insurance coverage is best accomplished through a range of approaches. In all parts of our health care system, however, an important goal is to give all Americans the opportunity to choose health insurance coverage that best meets their needs. The rapid pace of change in medical care means that coverage needs to be able to adapt to keep up. The policies we implement to help the uninsured should not only guarantee them access to good coverage today; they should ensure that Americans will be able to get coverage for the even more valuable treatments coming in the

years ahead. The key to increasing health insurance coverage is addressing the problems that are making insurance less available, less efficient, and less affordable for many Americans, while doing so in a way that encourages the flexibility and innovation in health insurance coverage that is essential for keeping up with changes in medical care.

Addressing the Key Problems Facing Health Insurance

One major goal of health insurance is to allow individuals to join together to reduce their risk of high medical expenses, by spreading that risk. Individuals trade the uncertainty of very unpredictable health care costs for the greater certainty of a known premium and protection from very high medical expenses. An important element of insurance is thus the "pooling" of risk – people sign up for insurance before they know how much they will spend on health care, and then the premiums of those who have low expenses help subsidize spending on those with high expenses.

A second major goal of health insurance is to make sure that Americans have access to the most innovative, high-value health care available. The American health care system leads the world in Nobel prizes and in the development of new drugs, devices, and other treatments to prevent and cure illnesses. To make sure these impressive medical breakthroughs translate into good care, health care coverage must be innovative as well. One need look no further than the lack of prescription drug coverage in Medicare to understand the consequences of out-of-date health care coverage. In the years ahead, far more breakthroughs are possible – such as customized treatments based on a clear understanding of an individual's genetic makeup, and specialized "disease management" programs that rely on the Internet and other modern telecommunications technologies that allow patients with chronic illnesses not only to stay out of the hospital, but also out of the doctors office. Innovative health care coverage is essential for creating an environment for medical practice that encourages innovation, value, and continuous improvement in health care.

Several problems can interfere with the ability of insurance markets to achieve these goals. A key problem is lack of choice and competition. As the President has said, our health care system works best when it supports patient-centered care: it should support the ability of patients to work with health care professionals to decide on the best possible treatments. To have control over their health care, Americans need the opportunity to choose the health care coverage that is best for them. Without good choices, patients do not have the power to make sure that they are getting the best value from the health care system for their own needs. Instead, government or health plan bureaucrats effectively make decisions for them about what is covered, how their care is reimbursed, and how treatments are provided. In other countries, this has led to queues for treatments, poor quality, and lagging availability of innovative care. Our country has chosen another path: private sector health care based on trust in patients and their physicians. This path rewards innovation in delivering the best possible health care. But the tremendous potential of our health care system is threatened when patients do not have choices about their health care coverage. For this reason, the President strongly believes that we must take action to improve the health care coverage options available to Americans.

A second problem is adverse selection. If only individuals whose health insurance expenditures are likely to be high sign up for insurance, then the pooling of risk that is the key to insurance is undermined. Just as individuals with higher expenses want more insurance, insurance companies want customers with lower expenses, and may design their plans to appeal to those with low risk.

Health insurance credits can help solve these problems in health insurance markets by making more coverage options affordable, increasing participation, and reducing adverse selection. Greater affordability and participation will encourage competition to provide coverage that delivers high-value, innovative care. Thus, well-designed health insurance credits reinforce the best features of our private, highly innovative health care system.

To work effectively, especially for families with modest means, credits must be refundable and advanceable.

- Refundability means that the value of the credit does not depend on taxes owed; even people who owe no taxes can still receive its full value.
- Advanceability means that those eligible for the credit have the option of using it when they are actually purchasing insurance, to reduce their monthly premium payments, rather than having to wait until they file their tax return at the end of the year. An effective advanceable credit should also be "non-reconcilable": people who are eligible should not have to worry about their actual income at the end of the year, which may have been a deterrent to the advance use of some other refundable tax credits.

The President's health insurance credit addresses these practical concerns. From the standpoint of a person who does not have employer coverage and is struggling to afford health insurance, it's very simple: he or she is automatically eligible based on their tax return, and then can have the credit paid directly to the insurance plan of their choice when they are paying their health insurance premiums. This means that Americans who are struggling to afford coverage today will be able to choose among health insurance options that are much less expensive than the options available to them now. This is a fast and effective way to reduce the number of uninsured Americans significantly while allowing them to remain in mainstream health insurance plans that encourage innovation in health care.

Health insurance credits are not the only promising direction for building a more effective health care policy that encourages high-quality, innovative care. There is no single approach that can work with the best features of all of our health care institutions to help ensure that our health care system remains the best in the world. After describing the health insurance credits, I will summarize the President's proposals for strengthening employer-provided health insurance and publicly-provided health insurance.

Health Insurance Credit for Americans Who Do Not Have Employer-Provided Coverage

Current law provides a number of tax incentives for individuals to obtain health insurance coverage. Employer-provided health insurance and reimbursements for medical care are generally excluded from gross income for income tax purposes and from wages for employment

tax purposes. Active employees participating in a cafeteria plan may pay their employee share of premiums and other medical care expenses on the same pre-tax basis. In addition, for self-employed individuals who are not eligible for subsidized employer coverage, 70 percent of health insurance premiums are deductible for 2002, and 100 percent are deductible for 2003 and thereafter.

However, as noted above, millions of Americans still are without health insurance coverage. The refundable health insurance credit proposed in the President's Budget is designed to provide these incentives to assist uninsured individuals in purchasing health insurance.

The President's proposed health insurance credit is refundable, so even those without income tax liability can receive the benefit of the credit. In fact, the largest subsidies will be targeted to low-income families, and only individuals who are not covered by public or employer-based health insurance will be eligible for the credit. Therefore, the credit will be of most help to individuals who are most likely to be uninsured—childless adults who are generally not eligible for public insurance and persons in families with incomes too high to participate in public insurance programs and too low to find affordable coverage options in the private market. The credit will help families who prefer the innovation and flexibility of private insurance options to public insurance, and will enable families to obtain coverage for the entire family from the same providers. The credit is also designed to be available at the time the individual purchases health insurance. That is, people eligible for the credit can receive it in advance, before filing their tax returns, to reduce their monthly checks for insurance premium payments. In addition, because the advance credit is based on income from the previous year, the credit is "non-reconcilable." Earning more income in the current year does not reduce the value of the credit, and no end-of-year reconciliation is necessary. Taxpayers who did not claim the advance credit would be eligible to claim the credit at the end of the year when filing their tax return. Eligible health insurance plans would be required to meet minimum coverage standards, including coverage for high medical expenses.

The credit would provide a subsidy of up to 90 percent of a capped amount of health insurance premiums. The maximum credit would be $1,000 per adult and $500 per child for up to two children. The maximum subsidy percentage of 90 percent would apply for low-income taxpayers and would be phased down at higher incomes. While the subsidy percentage would be phased down with income, the maximum premium that could be taken into consideration in calculating the credit amount would be fixed at $1,111 for an adult and $556 for a child. These dollar amounts would be indexed by the Consumer Price Index for all-urban consumers. The health insurance tax credit would be effective beginning next year.

Individuals with no dependents who file a single return and have modified Adjusted Gross Income (AGI) up to $15,000 would be eligible for the maximum subsidy rate of 90 percent and a maximum credit of $1,000. The subsidy percentage for these individuals would be phased down ratably from 90 percent to 50 percent between $15,000 and $20,000 of modified AGI, and then phased out completely at $30,000 of modified AGI. For example, the maximum credit for these individuals would be $556 at $20,000 of modified AGI.

All other filers (including single filers with dependents, heads of households, and joint filers) with modified AGI up to $25,000 would be eligible for the maximum subsidy rate of 90 percent, and the maximum credit of $1,000 per adult and $500 per child for up to two children. The subsidy percentage would be phased out ratably between $25,000 and $40,000 of modified AGI in the case of a policy covering only one individual, and between $25,000 and $60,000 of modified AGI in the case of a policy or policies covering more than one person.

The maximum credit for these other filers would vary by income and the number of adults and children covered by a policy. For example, the maximum tax credit would be $3,000 for a low-income family with modified AGI up to $25,000 who obtained a policy covering two adults and two or more children. The maximum credit would be phased down to $1,714 as the family's modified AGI rose to $40,000. For a policy covering only two adults, the maximum credit would be $2,000 for families with modified AGI up to $25,000 and $1,143 for families with $40,000 of modified AGI.

The credit would be used for qualifying health insurance purchased in the non-group market. In addition, qualifying health insurance could also be purchased through private purchasing groups, state-sponsored insurance purchasing pools and state high-risk pools. At state option, effective after December 31, 2003, the tax credit would be allowed for certain individuals not otherwise eligible for public health insurance programs to purchase insurance from private plans that already participate in State sponsored purchasing groups, such as Medicaid, SCHIP, or state government employee programs.

States could, under limited circumstances, provide an additional contribution to individuals who claim the credit in connection with purchases of private insurance through Medicaid or SCHIP purchasing groups. The maximum additional state contribution would be $2,000 per adult for up to two adults for individuals with incomes up to 133 percent of poverty. The maximum state contribution would phase down ratably reaching $500 per adult at 200 percent of poverty. Individuals with income above 200 percent of poverty would not be eligible for a state contribution. States would not be allowed to provide any other explicit or implicit cross subsidies.

This proposal contains a number of new, important, and innovative features. First, the credit amount varies with family size and composition, reflecting the impact of these factors in the non-group market. For example, two adults face higher premiums, and will receive a larger credit, than a single adult. Likewise, families with children face higher premiums, and will receive a larger credit, than families without children. Second, the credit is "advanceable," and eligibility for the advance credit is based on the individual's prior year's tax return. This design guarantees certainty of the amount of the credit and makes it available at the time individuals purchase health insurance. They do not have to wait until they file their tax returns after the year is over. Third, the proposal allows the credit to be used toward private insurance purchased through private purchasing groups, state-sponsored insurance purchasing pools and state high-risk pools. This provision will increase coverage options, achieve economies of scale, and encourage risk pooling in the non-employer market.

In designing a policy to expand health insurance coverage to the uninsured, one concern is that the policy not inadvertently decrease the health insurance options available to those presently insured. Some have suggested that if the purchase of health insurance outside of the employer market became sufficiently attractive, employers might stop providing health insurance coverage to their workers, potentially resulting in a net decrease in health insurance coverage among the population. Based on these concerns, the Administration's proposal has been carefully designed to minimize "crowdout" of subsidized employer coverage, and thus will expand coverage substantially. Several elements of the credit design contribute to this desirable result. Most importantly, low-income individuals and families, who are least likely to have employer-based health insurance, will receive the largest incentives under this proposal. In addition, the health credit subsidy rate decreases with income, requiring larger individual contributions for any given policy and making it a less attractive alternative to the employer-provided insurance at higher income levels. The health credit is further limited by a cap on the amount of premium eligible for subsidy. Although the subsidy rate and the cap on the eligible premium are generally adequate for making good health insurance affordable, they are less generous than the subsidies provided in most employer plans.

The credit is also designed to target individuals who are most likely to be uninsured during at least some part of the year. Approximately six million such individuals are expected to gain additional coverage as a result of the credit. Most of these individuals are not offered employer-based insurance over the course of their uninsured spells. The credit will provide a strong new incentive for these persons to find coverage in the individual market. It will also allow many families that are already purchasing coverage in the individual insurance market, and receiving very little government assistance in doing so, to obtain better coverage at a lower out-of-pocket cost.

The credit will significantly increase participation and quality of coverage in non-group health insurance markets. These improvements will not come at the expense of employer group markets. Those low-income Americans who are eligible for the largest credit are less likely to have employer-sponsored health insurance. Around 80 percent of uninsured workers are not offered health insurance by their employers. Only 36 percent of people under age 65 with income below 200 percent of the federal poverty line have employer-sponsored health insurance, while 81 percent of those above do. Furthermore, the generosity of employer-sponsored insurance is determined by the tax benefits for the group of employees, not the attractiveness for low-income employees only. Tax benefits for employer coverage will remain large for the middle- and higher-income workers that make up most of the employees of most firms that offer generous employer-sponsored plans. Those workers' incomes are too high for them to get more attractive benefits from the proposed health credit. Thus, employer-provided coverage will remain more attractive for firms that offer generous coverage today. That is, the phase-out and cap on the credit ensure that employers will continue to offer insurance and that employees will continue to enroll. The proposed credit will simply eliminate an inequity in the current system that disadvantages workers without employer coverage, helping them to purchase the coverage that meets their needs.

Recent research also suggests that the credit would provide good, affordable health insurance options for the vast majority of individuals who are eligible for the credit. This is the subject of a

detailed state-by-state analysis by the Council of Economic Advisers, which finds that for lower-income Americans, the proposed health insurance credit generally covers more than half of the premium the purchaser would face, and would almost always covers more than a third. This study is available on the CEA website. A recent study by the health insurance distributor eHealthInsurance found that three-quarters of premiums for individual health insurance plans that it sold were less than $2,000 and three-quarters of family premiums were less than $5,000.

The credit would make health insurance affordable not just for the healthy or the young. I would like to use this opportunity to clear up some misperceptions caused by a recent Kaiser Family Foundation report on the topic. That report claimed that those with chronic health conditions were unable to obtain reasonably-priced comprehensive health insurance in the non-group market, based on a survey of the plans that would be available to some hypothetical insurance purchasers. But a close examination of the survey results reported in the study reveals that virtually all applicants were able to obtain at least one good policy in every area of the country that was surveyed. The one applicant who generally could not get an insurance offer (a person who was HIV positive) could still obtain subsidized insurance through high-risk pools available in most states. Earlier this year, the House of Representatives passed legislation that would provide additional Federal subsidies for high-risk pools, to help ensure that affordable coverage would be available in all states for persons with preexisting conditions. Adequately-funded high risk pools are a proven approach to help make sure that all persons in a state can get good coverage. The total health care expenses that such individuals with preexisting conditions would face are generally much higher in the states that rely on community rating and guaranteed issue compared to states with working high-risk pools.

Further, as I noted above, another effective approach to further ensure that affordable coverage options are available to all eligible lower-income persons involves state-sponsored purchasing groups. Many states have set up purchasing groups that allow SCHIP-eligible families to choose among private insurance plans, and all states offer a range of private insurance choices to their employees through purchasing groups. The President's proposal permits at state option certain low-income individuals to purchase private insurance through such state-sponsored health insurance purchasing groups.

We believe that the availability and certainty of the advance credit will make it extremely attractive to Americans who do not have employer-subsidized insurance, making it more effective in expanding health insurance coverage. The credit induces persons currently experiencing spells without insurance to buy cost-effective protection, limiting the cost per covered person. According to estimates by the Treasury Department's nonpartisan professional staff, the credit would be taken up by approximately 17 million Americans. This includes a net total of 6 million Americans who would otherwise have been uninsured for some or all of the year. It also includes well over 8 million Americans who previously were purchasing non-employer coverage and who now would be able to afford better insurance. And the comprehensive Treasury analysis shows that only 15 percent of those taking up the credit are persons who otherwise would have purchased employer coverage. This amounts to a total reduction in employer-provided coverage of around 1 percent – and even this minimal reduction could be addressed by taking steps like those the President has proposals to make employer-provided health insurance more affordable and attractive.

This crowdout rate compares favorably to alternative proposals for providing health insurance coverage for Americans who do not have access to employer-subsidized insurance. Any proposal that expands alternatives to employer coverage, including expansions of Medicaid or SCHIP eligibility. For example, research published in a prominent economic journal by Professors David Cutler and Jonathan Gruber showed that 50 to 75 percent of the "new" coverage resulting from Medicaid expansions in the early 1990s was actually crowdout of employer coverage. And further research by Professors Janet Currie and Gruber suggested that quality of care (in particular, prenatal care) may have deteriorated for the persons moving from employer coverage into Medicaid as a result. While some reports suggest less substantial crowdout, a recent comprehensive review of the many studies of Medicaid expansions concluded that 20 percent or more of the coverage expansions were actually the replacement of employer coverage with Medicaid. Moreover, these studies were primarily focused on low-income Medicaid expansions involving children (up to 133 percent of poverty). The studies have generally concluded that Medicaid expansions involving families at higher income levels would cause even more crowdout.

A final strength of the President's proposal is that it provides assistance to a broad range of individuals who currently receive no assistance with health care costs. The credit is available to persons who do not get employer subsidies for health insurance for a variety of reasons, whether due to job loss, employment in a firm that does not offer health insurance, or any other cause. As part of economic stimulus legislation, in the absence of such comprehensive assistance in current law, the Administration also supported provisions in the Bipartisan Senate Centrist proposal (passed by the House of Representatives) which would have provided a temporary health insurance credit to assist displaced workers. This credit would have helped displaced workers keep their health care coverage – through COBRA plans, "mini-COBRA" plans, and other types of qualified non-group health insurance. Eligible unemployed workers would have included those receiving unemployment insurance benefits and those who would be eligible for benefits except that their rights to benefits were exhausted or the period during which their benefits were payable ended.

In contrast, alternative proposals would provide less effective assistance for displaced workers. Consider a COBRA-only subsidy. This subsidy would provide no benefit to approximately half of displaced workers with health insurance, because they work for small firms not covered by COBRA or they purchase non-employer policies. It is also poorly targeted to displaced workers, since most people eligible for COBRA did not lose their jobs. Another proposed alternative for health insurance for some unemployed workers – the expansion of Medicaid to cover an entirely new category of eligible persons, a category not based on income or medical needs – is likely to provide neither timely assistance nor the coverage that workers prefer. Extending Medicaid to cover these displaced workers would require State legislation, would involve delays because many State legislatures are not even in session, and would force many workers to choose new health care providers. Many States have made clear that, because of tight budgets, they cannot afford such unprecedented expansions beyond their core target populations anyway. Moreover, such expansions would take away resources from their ability to fund better coverage for their priority populations: low-income children, families, and seniors.

For a similar budgetary cost (and at no budgetary cost to States), the health insurance credit for displaced workers would be available for a longer period of time, would offer workers a greater choice among health insurance plans, and would not weaken employer incentives to continue to provide health insurance to their workers. The credit would also reduce adverse selection in both the employer market and in the individual market (because many people who otherwise would have gone without health insurance will purchase coverage).

The President's health insurance credit proposal is one component of the Administration's approach to achieve the President's overall goal of supporting patient-centered health care, by encouraging innovation in the financing and delivery of health care services. Market-based approaches such as this will encourage high-quality, high-value coverage by giving patients the ability to choose the coverage that best meets their needs. In turn, innovative coverage will permit Americans to benefit from the tremendous potential of our health care system in the 21st century. Coupled with these additional proposals for strengthening employer coverage and for providing more assistance to individuals with the greatest health care needs, the health insurance credit is a critical part of the Administration's comprehensive approach for ensuring that all Americans have good, affordable private health care coverage options.

Policies to Strengthen Employer-Provided Health Insurance and Make It More Affordable

The President 's Budget also contains many other initiatives designed to expand health insurance coverage. Some of these are focused on making better, more affordable coverage options available through private health insurance.

The President's budget loosens the restrictions on Medical Savings Accounts (MSAs) and Flexible Spending Arrangements (FSAs) to make "health account" plans more attractive to employers, who otherwise might choose not to offer employee health insurance. MSAs give individuals greater control over their health care spending, and make out-of-pocket spending on health care more affordable. A major trend in the last few years in private employer-provided insurance has been enrollment in "preferred provider" and "point of service" plans that give employees more choices of providers and less HMO red tape to get the treatments they prefer. But these plans generally come with significant deductibles and out-of-pocket payments. Unfortunately, current tax law doesn't support this trend: in general, premium payments (the main cost of HMOs that feature low copays but significant restrictions on providers in order to control utilization) are tax-deductible, but out-of-pocket payments must be made out of after-tax earnings.

The President has proposed to correct this inequity in employer coverage and provide better support for health insurance plans that allow greater employee choice, by allowing individuals to make pretax contributions to a health account that could be used with a much broader array of insurance plans available today. Under the proposal, all employees and individuals who purchase a high-deductible health plan (up to $1,000 for individuals and $2,000 for all other cases) would be eligible to contribute to an MSA up to the amount of the deductible. The plan would be allowed to cover basic care (i.e., preventive services) without counting against the deductible. With the health account, employees could make the out-of-pocket payments for

health care with pretax dollars, making it easier for them to afford the payments that often go along with broad choice of providers and treatments.

The proposal would also make improved MSAs available to all employees, and would not discriminate, as current law does, on the basis of how many employees their employer has. The substantial reduction in the deductible, and the enhanced opportunity to use pre-tax dollars to pay out-of-pocket health care costs, is likely to encourage less healthy individuals to participate. Indeed, such a plan is likely to compare favorably for many people with significant health care needs to low-copay plans typically offered by employers today, which often include significant provider network restrictions and other restrictions on the utilization of certain costly medical treatments. Thus, the improved health account plans would be unlikely to lead to the enrollment of much healthier individuals than in the other health plan options that an employer offers. The improved health account arrangement would be made a permanent program in law, providing more incentives for insurers, financial organizations, and others to spend the start-up money and effort to create MSA products and integrate them effectively with the other health plan options they offer.

The President's budget also proposes improvements in Flexible Savings Arrangements (FSAs) to make them work more effectively as health accounts. FSAs are tax-free accounts that many employers have set up to help give employees more control over their medical expenses as well as better protection against out-of-pocket spending. However, FSAs are subject to an end-of-the-year "use it or lose it" requirement that limits their value for protecting against unexpected out-of-pocket medical expenses. The President proposes to expand FSAs to encourage employers and employees to increase their use of these accounts. Under the proposal, employees could roll over as much as $500 in unspent health care contributions to an FSA for use in the following year or to their 401(k) plan for retirement income or health expenses at older ages.

Some of the most rapid increases in health insurance premiums in the last few years have occurred in small businesses. The President supports legislation that provides for the creation of association health plans, to enable small employers to provide better and more affordable health care coverage options for their employees – like those that many large employers can offer. This provision would allow large industry associations and other groups formed on the basis of factors other than expected health care costs to pool together to offer health insurance options. Through the establishment of uniform federal standards for association health plans, small employers will be able to achieve greater purchasing power, administrative efficiencies, and flexibility in benefit design. Strong Federal certification and solvency standards will assure that all healthcare benefits promised by the new association health plans would be there when needed, and design and offering requirements will assure that the associations provide consistent services to all eligible small businesses regardless of their expected medical costs.

Together, these proposals provide an additional $15 billion in support for employer-provided health insurance, in addition to the current tax deduction for employer-provided health insurance worth over $120 billion per year.

Improved Health Care Options in Medicaid and the State Children's Health Insurance Program, and Improved Health Care Safety Net

The President is also committed to improving the opportunities for Americans with modest means to get mainstream health insurance coverage through the Medicaid and SCHIP programs. This requires reducing the burdens associated with Medicaid laws and administrative guidelines that historically have hampered the ability of states to expand coverage and to adopt cost-effective private sector innovations in providing coverage.

As a first step, the Administration introduced the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative in August 2001. The HIFA demonstration initiative encourages States to develop comprehensive insurance coverage for individuals with incomes up to twice the Federal poverty level using Medicaid and SCHIP funds. It gives States the flexibility to increase health insurance coverage through support of private group health coverage and simplifies the waiver application process. Arizona and California received the first HIFA demonstrations in December 2001 and January 2002, respectively. These SCHIP expansions provide coverage for parents up to 200% of the poverty line. The Administration will continue to build on the HIFA demonstration initiative in FY 2003. States will be encouraged to use program resources to extend coverage to more of their neediest residents and reduce the number of people without health insurance coverage.

The President's 2003 budget will also strengthen SCHIP by making available to states an estimated $3.2 billion in unused SCHIP funds that otherwise would return to the federal treasury. The SCHIP law requires states that did not use their full SCHIP allotment during the previous three years to return the unused funds, making additional enhanced-match funds available to every state. Coupled with the flexibility provided under HIFA to expand coverage for both children and adults with incomes under 200 percent of poverty, the availability of more enhanced-match funds would give every state a greater opportunity to increase coverage for the uninsured. However, essentially all states are facing budget shortfalls this year and are struggling to maintain their existing Medicaid and SCHIP coverage in the face of rapidly-rising costs. Thus, a strategy for reducing the number of uninsured which depends solely on providing flexibility and enhanced-match funds for states is unlikely to succeed.

The President's budget will also provide $350 million in FY 2003 to continue funding Medicaid for families in transition from welfare to work. This coverage helps to ensure that work pays for families by preventing them from losing their health coverage when they start jobs.

Strengthening the Health Care Safety Net

Community Health Centers (CHCs) are a critical part of the health care safety net, delivering primary and preventive health services to 11 million patients who are either uninsured or have inadequate coverage. The President's budget includes $1.5 billion for CHCs, a $114 million increase that would continue toward the Administration's long-term objective of adding 1,200 new and expanded health center sites over five years and serve an additional 6.1 million patients. The increase for fiscal year 2003 would support 170 new and expanded health centers, and provide services to a million additional patients.

Since 1970, over 20,000 doctors, nurses, dentists, midwives, and mental health clinicians have been placed in medically underserved communities through the National Health Service Corps (NHSC). The President's budget includes $191.5 million -- a $44 million increase -- to strengthen the NHSC. With the increased funding, the NHSC will provide scholarships or loan assistance to about 1,800 professionals practicing in underserved areas - an increase of over 460 participants.

Conclusion

The absence of health insurance coverage for some 40 million or more Americans is a problem calling for immediate solutions. The President's Budget sets forth a comprehensive package of solutions, including fully developed proposals for the use of health insurance credits to offset the cost of obtaining health insurance. Health insurance credits have received broad bipartisan support, and are widely viewed as a critical part of any strategy that addresses the problem of uninsurance while strengthening America's uniquely innovative private health care system. If enacted, the President's health insurance credit can lead to a significant reduction in the uninsured population and at the same time lead to improvements in the market for individually purchased health insurance, greater choice and flexibility for individuals in determining the coverage that best fits their needs, and improvements in the quality and price of health care provided to all Americans.

The President's health insurance credit proposals are one part of his broader strategy to address the problem of the uninsured, along with proposals to increase the availability and affordability of employer-provided health insurance and to strengthen the Medicaid and S-CHIP programs. Collectively, these proposals support a broad range of approaches to give all Americans access to high-quality, affordable options for health care coverage. The President's budget also provides a stronger safety net for Americans without adequate coverage. Together, these proposals will provide health security and additional health insurance coverage for many millions of Americans, while preserving the best features of our highly innovative health care system. The Administration hopes to work closely with Congress, on a bipartisan basis, to make this vision a reality. I will now be happy to answer any questions you may have.