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HEALTH CARE COVERAGE FOR THE UNINSURED AND THE UNDERINSURED

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Recorder: VINCENT W. DONNELLY

o The panel will discuss the growing public sense of urgency to deal with a worsening crisis in the ability of millions of Americans to obtain quality health care that is also affordable. Several states (Massachusetts, California, etc.) and the U.S. Congress are presently considering bills requiring employers to purchase health insurance for their employees and dependents. Other suggestions receiving attention involve the expansion of state Medicaid programs, state risk pools, and various tax incentives/ penalties. Representatives from insurers, employers and government will present their opinions.

MR. VINCENT W. DONNELLY: We are here to discuss a significant health care problem -- the plight of the increasing number of U.S. citizens who do not have any private or publicly provided health insurance. While there have always been people without health insurance, it is not just the increase in their number which has led our state and federal governments to recently begin searching for a viable legislative solution. I really believe that legislative solutions began to be seriously considered once it was reported that the uninsured were poor, but predominatly employed. Since the recent federal budget deficits deter any major consideration of broad, federally funded solutions, the fact that a majority of the uninsured are employed has led government to draft legislation demanding the expansion of employer-sponsored health insurance programs. It is in that setting that we consider the problem and various legislative solutions. Originally a representative from state government was scheduled to join our panel and add appropriate balance (e.g., insurers, employers, and government) but family matters have intervened. Therefore, you will hear a somewhat biased presentation.

Our first speaker, Mr. Charles Eby, is the Director of the Department of Research Statistics and Actuarial Services for the Health Insurance Association of America (HIAA). He brings to this discussion a broad background in health care policy analysis. He has developed national health planning guidelines and has evaluated the Professional Standards Review Organization (PSRO) program

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for the federal government. For the last few years, however, he has worked in the area of health care financing. Prior to joining the HIAA just four short months ago, Charles spent two years dealing with health care financing issues in the office of policy analysis at the Pharmaceutical Manufacturers Association, three years in the policy department of the BC/BS Association, and five years at the Rand Corporation here in southern California.

Mr. Eby will be followed to the podium by Mr. Frank V. Toti, Jr., a legislative representative for the National Federation of Independent Business (NFIB). Frank's main focus for the federation is labor-management issues. From 1981 to 1984 he served as a legislative assistant to Congresswoman Claudine Schneider of Rhode Island. He joined NFIB in 1984. Frank holds a BA in History from Providence College and an MA in History from Catholic University.

MR. CHARLES L. EBY: I work for the Health Insurance Association of America, representing about 350 commercial health insurance companies, which account for about 80% of the commercial health insurance market. Roughly 600 to 700 other companies account for the remaining 20% of the commercial market. The entire commercial health insurance market accounts for about 37% of all private health coverage. If you combine those factors, member firms of the HIAA account for about 30% of all private health business benefits in the United States, and they cover about 60 million people.

There is tremendous change underway in the health care system, particularly in provider formats and physician supply. Provider formats are changing with the dramatic increase in for-profit organizations, growth of chains, and blurring of the line between insurers and providers. The growth in physician supply is leading to a rapid increase in the number and percentage of physicians that are employed and those that are part of some kind of organized provider group such as PPOs and HMOs, with attendant implications for cost incentives.

Traveling around the country and talking to different groups, it seems to me that we can put people into two categories. They either think that the new era that is dawning in health care is a golden one which is going to rationalize the health care system, squeeze out all kinds of fat, and put real hard-nosed business managers in the hospitals; or else they think that the beginning of this era is a terrible disaster, the growth of for-profit organizations creates a strong conflict of interest with the ethical factors of health care and the United States is eventually going to experience a terrible backlash to the economic and business driven changes that are occurring. But there is one commonality between both of these groups: they both think that something is going on that makes the 35 to 37 million uninsured in the United States a terrific problem, and they both think that the situation cannot remain the way it is, that something has to be done to fix it.

So far 30 states have initiated studies, demonstrations, or legislation relating to the uninsured. Several things are causing them to focus attention on this problem. There has been a constriction of Medicaid coverage or eligibility over the last decade. One of the major impacts of the Reagan/Stockman revolution has been a decrease in the number of near poor who are eligible for Medicaid. At the same time there has been a dramatic decrease in federal grant programs providing direct services to the poor and near poor; neighborhood health centers are an example. There has also been a decrease of private giving to nonprofit provider groups (e.g., community hospitals), and there has been a decrease in the indirect subsidy for charity care that has traditionally been provided in the

country through cost shifting (i.e., charging payers what they can afford rather than what it cost to provide services). These changes have, in turn, resulted in growing limitations on the amount of free care given by voluntary hospitals, and that is also related to the growth of for-profit hospitals who may be less inclined or less able to provide free care. Many places in the United States lack a free care institution. A third of the major cities are without a place where you can go and know that you can receive care regardless of your coverage status. Furthermore, the provision of free care is highly concentrated (10% of the hospitals give 50% of the free care), leading to severe problems for those who remain in the fray and continue to provide free care.

The percentage of people in poverty covered by Medicaid has been declining for years. Now, it is true that after 1984 when our data series stopped, there have been some changes in federal law which have broadened the categories of people who are allowed to be eligible. This has broadened the "envelope" for eligibility created by federal law, but the practical impact of that change depends on the responses of states, and whether or not they take advantage of it.

But Medicaid is just one factor in the growth of the uninsured. A host of factors affect the number of people without insurance. Some employers have stopped providing health insurance. Others have rapidly increased the share of costs paid by employees. For those under 65 the results of all these factors taken together is that those without coverage have increased from about 15% of the population in 1980 to about 18% in 1987. Sources of coverage for those who do have coverage are mainly employment-based. Sixty-seven percent of those covered have it through an employer, 8% have it through Medicare or Medicaid, and 7% have it through some other means.

Now let me make a brief digression here and say a couple of words about the significance of being uninsured. Does it matter? What does it do to people? There is evidence that those without coverage receive significantly less care than those with coverage. The Rand health insurance experiment compared people with virtually full coverage to those with virtually no coverage and saw a huge difference in utilization. That difference in utilization did not make major differences in health status, except for children and those who were chronically sick. A study of MediCal disenrollment at UCLA followed people through a period when they were disenfranchised from MediCal, and tracked the effect on their health status, with similar results. Now, one other part of research that has a bearing on the significance of this is the variation from area to area in the amount of health care consumed per capita. There is enormous variation in per capita consumption of health care services from one small geographic area to the next, with really no apparent explanation in terms of health needs or demographics or any other factor that seems like it might be a logical explanation. A number of people have suggested that these variations are evidence that there is a lot of unnecessary care provided, and that if you can constrain the amount of care through financial incentives, the unnecessary care will fall off. People won't go to the doctor for a hangnail, but they will still go when they break a leg.

Unfortunately, in recent work at the Rand Corporation, a couple of different studies that are unrelated in methodology and data have concluded that there is no correlation between the percentage of inappropriate care in a population and the amount of care consumed by that population. In other words, the percentage of inappropriate care does not seem to be higher in groups receiving a lot of care; so whatever causes these variations in per capita consumption, when you

squeeze down on the amount that is consumed it doesn't seem like the inappropriate procedures are disproportionately excluded. That raises questions about the earlier argument that constraining the amount of care consumed might not be a problem because all you would do is get rid of the fat.

To review, one concrete manifestation of the change in the number of people with coverage and the characteristics of their benefits (e.g., higher cost sharing) is that more and more people are refraining from seeking health care because of the cost consideration. In view of those studies that I just mentioned, we may not be squeezing out just the care that is unnecessary.

Because it's a very important factor right now, one other side issue that I want to mention is AIDS. In our public policy discussions regarding the role of private insurance and AIDS, AIDS interest groups tend to place a lot of emphasis on the characterization of people who are HIV-positive as being uninsurable. They believe that it is a frequent occurrence and that it will greatly add to the broader problem of the uninsurable, which is one component of those without insurance. We'll address some data later as to the relative importance of the uninsurable as a component of those without insurance. But nobody has any very good information at this point on the specific role of AIDS, either presently or over the next ten to twenty years, as a component of those without insurance. Nevertheless, it is something we are going to have to address within the insurance industry.

When people are asked if insurers should be prohibited from requiring applicants to take HIV tests, the majority of people in the United States say no. On the other hand, that tends to conflict with a consensus that everybody is entitled to health insurance regardless of their health.

How should coverage be provided to those without insurance? Mandating employer benefits and some kind of federal program are the leading candidates. Americans are schizophrenic about their views on the role of government. If you ask people if the government should see that everyone who needs health care gets it, the vast majority of people say yes. Are you willing to pay more federal taxes to provide that? Forget it. So there is a basic inconsistency in public attitudes about this issue which may be characteristic of many important issues that become legislative issues in the Congress.

Now let me go on to demographics. What do we know about the uninsured? Before HIAA started putting together some figures and doing some analysis, we had made some assumptions. We thought generally that people without insurance were poor people who fell through the cracks of Medicaid. If they were employed, they probably were employed in a very marginal fashion, so the solution to the problem was not one involving private insurance; it was a government solution because these people didn't have any attachment to an existing mechanism for providing health insurance. But upon analysis we found otherwise.

Most of those without insurance are employed. This includes people who work more than 15 hours a week but the vast majority work more than 35 hours a week. The base for all of the following percentages is 35 million people without coverage, so that when I say that 64% of the uninsured are employees and dependents, that means 64% of 35 million. Of these, 51% include full-timers (over 35 hours a week) and their dependents. The reason why people who are employed do not have insurance is the result of a number of factors. Part of it is the market decision by employers not to provide benefits. This usually

happens in very low-wage industries: food service, agriculture, etc. Part of it is a market decision by employees who work for people who provide benefits and require an employee contribution. Part of it is due to underwriting practices in the individual insurance markets. It turns out that in trying to provide solutions to the problem of the uninsured, it is very important to know the demographics of those who are employed but without insurance. But we don't have very good information on that at the present time.

My department at the HIAA is about to field a survey asking employers about health benefits. This year we're going to add some questions about the demographics of employees with and without insurance. I'm not sure how it will work because I think it's going to be difficult for some employers to answer the questions. But we're going to try to improve the information that we have on the demographics of those who are employed but without insurance.

The self-employed and their dependents are 11% of the 35 million. For the self-employed and employees taken together, about three-fourths of those without insurance earn less than $10,000 a year. Nevertheless, almost three-fourths of those without insurance have a closer tie to the work place than they do to the welfare office. That was a surprise to us, and that's a very important revelation. The significance of this for public policy is that the solution to this problem probably involves private insurance. It isn't just a government problem, because these aren't all poor, unemployed people.

One-third of those without insurance are below the federal poverty level. One-third are between one and two times the federal poverty level and one-third are above two times the federal poverty level. The federal poverty level for an individual these days is approximately minimum wage, or about $7,000 a year, and about $11,000 a year for a family of four. Federal rules say you can't provide Medicaid to people above a certain income, but states are free to set any lower ceiling they want to; and many states have much, much lower ceilings.

Finally, we come to those who are uninsurable. This group is a very small part of the problem of those without insurance. Right now there are about a million people who are uninsurable. However, if we look ahead, there are other factors that may make this aspect of the problem worse. The Office of Technology Assessment (OTA) is nearing the end of a year-long effort to assess the role of diagnostic testing in insurance. One part of the report is going to look at the potential for new testing technology. The focus will be on the growing ability to test people to determine the likelihood that they will require health care at some time in the future. OTA believes that the growth of genetic testing technology is going to mean a decrease in access to health insurance and that more and more people will be deemed uninsurable as a result. I'm not so sure that they're right with that forecast that if you get a more precise test to identify or forecast health care costs and it replaces a less precise test that you've been using, then you're going to exclude more people from coverage.

What do we do about the problems of those without insurance? I think you can roughly put policy options in one of three categories. The first is the magic bullet approach: if you pool all bad risks, they somehow magically become good risks. Next there is the free lunch group that makes somebody else pay for it. I might categorize the Kennedy bill that way. Finally, there is the scapegoat approach: there is something wrong with what we are doing in underwriting, or there is something wrong with preexisting condition exclusions, and all we have

to do is prohibit these undesirable practices and the problem will go away. One characteristic shared by all three views is insurance reform.

One proposal that has been put forward that everyone is aware of now is the Kennedy bill that was introduced last May. Just briefly, it will allow employers only one prototype plan to choose from at the base price, although they could have other plans at higher prices. It would mandate compliance by employers and it only deals with employers. The unemployed uninsured are not addressed. It would force community rating, and it would exclude all vendors other than a small number of regional carriers selected by the government.

The HIAA has just gone through a strenuous internal deliberation on how to solve this problem, and we arrived at a number of principles that we think should guide reform. First, the public sector must be held responsible for the poor, and this is going to mean an expansion of Medicaid in a number of specific ways. Second, insurers must be able to offer more affordable coverage to employers in an effort to make it feasible for them to offer benefits to low-wage employees. This means that insurers have to be able to offer what we call prototype plans; i.e., standard, minimum coverage plans that could be available at a reasonable cost. In order to do that it's going to be necessary to eliminate state-mandated benefits. Third, coverage has to be available to everyone, including uninsurable individuals and uninsurable groups. There should be state risk pools for uninsurable individuals funded very broadly from general revenue or some other public source of funding. For uninsurable groups there should be a newly created nonprofit reinsurance entity to which uninsurable small groups can go, and it should be privately funded. Also, tax incentives are necessary to encourage coverage. We think that there should be 100% tax deductibility for the premiums of the self-employed. And finally, the insurance industry would be prepared to consider the possibility of a tax penalty of up to 5% of payroll on employers who do not provide benefits. We don't advocate trying that now because we think there is a good chance other less stringent measures will work to solve the problem.

MR. FRANK V. TOTI, JR.: It is a pleasure to be able to discuss an issue of ever-increasing importance at both the state and federal level: providing health coverage to the uninsured. You may be asking why NFIB sent a person who deals with labor-management issues as opposed to health issues. The reason is that for NFIB members, the question of mandated health insurance is more of an employment question than a health policy issue. The questions our small business members ask themselves every day are: How can I, as a small business owner, attract and keep employees? What do I have to provide in wages and fringe benefits? Can I afford it?

Efforts are underway in Congress to enact a mandated health insurance program. Introduced by Senator Kennedy, S. 1265 has been reported out of the Senate Labor and Human Resources Committee. I want to assure you that Senator Kennedy is serious about his bill. He sat for almost an hour the morning of the mark-up waiting for a quorum so they could proceed. Congressman Henry Waxman, sponsor of the House bill, H.R. 2508, began initial hearings yesterday in his Health Subcommittee of the House Energy and Commerce Committee.

Before I delve further into the subject at hand, I would briefly like to explain what the NFIB is, and who we represent. The NFIB is an umbrella business association representing some 540,000 small businesses across the country. NFIB member firms range across the entire spectrum of industry: manufacturing,

agriculture, construction, service, retail, wholesale, insurance and real estate. The small business members of NFIB employ about seven million workers. The average NFIB member has ten employees. Ninety-eight percent of our members have less than one hundred employees. Forty-nine percent have annual gross sales of less than $350,000.

NFIB's prime mission is to be the most effective advocate and guardian of small and independent business and a competitive free enterprise system. To that end, we lobby at both the federal and state levels. We have lobbyists in all 50 state capitals, and also in Washington, D.C., and Puerto Rico.

NFIB is also involved in research and education. The NFIB Foundation conducts research on a wide range of small business issues, either in-house or through outside institutions. The 1985 "Employee Benefit Survey" that I will reference later was conducted in-house by the Foundation. We are also involved in entrepreneurial education at the elementary, secondary, and postsecondary levels.

Policy positions at NFIB are established through vote by the general membership. Six times a year, in a publication entitled *Mandate*, our small business members are asked to vote Yes, or No, or Undecided on five policy issues. Arguments are posed both for and against the proposition and members are asked to choose. I believe that will provide you with sufficient background for the rest of my presentation.

Health insurance for the uninsured -- it is unlikely that you will have much disagreement across the political spectrum. Between 34-37 million people are uninsured, at a cost of treatment of $8 billion a year, and some solution or solutions need to be found. Reasonable people can and do differ over which method or methods should be selected to solve this problem.

Why the call for mandated benefits? Traditionally in the past, Congress, after identifying a pressing societal need, often created a program funded out of general revenues to solve the problem. In these days of high and persistent federal deficits, Congress, though still able to identify societal needs, finds itself without the wherewithal -- revenues -- to provide a remedy.

It is the conflict between two items -- a societal need versus a lack of federal funding -- that has lured members of Congress to turn to the employer community as the answer to their prayers. That is how we find ourselves at this juncture. Congress believes it has found the perfect solution to its problems: they can take credit for legislation without having taxpayers foot the bill, by mandating that employers provide these benefits.

Many influential members of the House and Senate believe that the mandating of a particular benefit -- health insurance -- or the establishment of a new minimum labor standard -- parental leave -- is the only proper way to handle this situation. On behalf of the 540,000 members of NFIB, I can tell you flat out, that we totally disagree with that proposed solution; and in fact we firmly disagree that that is the only way to address the problem.

In April 1987, NFIB polled its members on the issue of mandated health insurance. By an overwhelming margin, 89% opposed a federal mandate. Only 7% supported the concept. This strong vote in opposition to mandated health benefits was foreshadowed by a recommendation from the 1986 White House

Conference on Small Business. More than 1,800 delegates representing the entire United States voted opposition to all types of mandated benefits.

Very briefly, let's look at the population of the uninsured. There is general agreement that there are around 34-37 million individuals -- men, women, and children -- who lack health insurance coverage. Of that total 49% are workers, one-third are unemployed, and 16% are self-employed. Of those employed, three quarters earn less than $10,000 a year. Workers aged 21-24 have the highest rate of noncoverage. Fifty-two percent of uninsured workers are under the age of 30. Many are likely to be employed in retail, service, and construction industries -- those sectors of the economy generating the most jobs, while at the same time being unable to offer coverage.

So, in many instances, when we speak of the uninsured who are workers, we are talking about marginal employees working in marginal firms. At any one time, 20% of businesses are considered marginal, either as new start-ups or expiring businesses.

Three-quarters of those workers who are uninsured earn less than $10,000 a year. Their employers do not earn much more. According to a recent report in the *Monthly Labor Review* (May 1987), in 1983 the median annual earnings for full-time business owners -- men and women -- were $15,600 and $4,894 respectively. This is compared to male and female employees who earn $20,039 and $12,079 respectively. These figures are supported by the fact that 16% of the uninsured are self-employed individuals.

You may ask why, based upon those facts and figures, small firms oppose mandated health insurance. The answer is that small firms are labor-intensive -- they hire people, not machines. People are a small firm's most important, as well as expensive, resource. Generally, in the first five years of a small firm's life, no profit is generated. The single largest tax liability for small firms from the first day of business is payroll taxes -- Social Security taxes and Federal Unemployment Tax Act (FUTA) taxes. A study by the firm of Touche Ross for NFIB found that for many young firms, over 70% of their tax liability is payroll taxes. As a result, anything which would result in an increase in employee costs poses a significant problem for the small business owner.

Why should policymakers be concerned about the effects of mandated benefits like health insurance on small businesses? The answer is simple. Over the past decade more than 14 million net new jobs have been created in the American economy. More people are working now than ever before. According to David Birch from MIT, more than 70% of this net job creation has been in small firms with less than 100 employees, with over 70% of that figure in firms with less than 20 employees.

From our perspective, it comes down to a question of whether Congress wants to encourage further job creation by small business or choke it off. In addition, two-thirds of all workers have their start in a small firm. So for most workers, small business is their entryway into the workforce. Small firms hire proportionately more women, youth, minorities and senior citizens than do large firms. Additionally, secondary wage earners constitute a large portion of the small business workforce.

As you can see, the composition of the small business workforce contributes directly to the problems small firms face with regard to obtaining affordable

health coverage. Employee turnover, adverse selection, and higher administrative costs affect the ability of small firms to afford and obtain health insurance coverage. Generally, a small firm must be in business for at least 24 months before any carrier will offer coverage.

In spite of these problems and roadblocks, small firms want and do offer competitive wages and fringe benefits. How much they can offer and to whom is dependent on several factors.

Let's take a look at what small business is currently doing in the area of providing health coverage to its workforce. The following information comes from two studies conducted in-house by the NFIB Foundation. The first was done in 1978 and is entitled "National Health Insurance Report on Small Business." The second, conducted in late 1985, is entitled "Small Business Employee Benefits."

The studies suggest that there exits a hierarchy of benefits in small firms. Paid vacations and health insurance are the two most common employee benefits offered by small firms and are the first to be provided. Later benefits that are added to the mix in order of introduction are paid sick leave, paid life insurance, employee discounts, and pension plans.

Not surprisingly, there is a direct correlation between firm size and the provision of benefits. Roughly 40% of firms which do not sponsor health plans have less than 10 employees. As the size of the firm increases, so do the benefits that are available to the employee. According to the 1985 results, 65% of firms offer health insurance to at least some of their employees. This represents an increase of eight percentage points from the 1978 study. Forty-two percent of small firms offer health insurance to all full-time employees. Employee tenure is the most frequently used method to determine eligibility for health benefits. Field survey data from April 1987 indicates that as many as 75% of firms that provide fringe benefits offer health insurance. For the remaining one-third that did not provide coverage, the most frequently cited reasons were: generally covered under a spouse's or parent's plan; employee turnover too great; insufficient profitability; premiums too high; and couldn't qualify for group policy.

The 8% increase in firm coverage from 1978 to 1985 may sound small, but this was accomplished both as the total number of small firms increased, and as the cost of premiums doubled in the same time frame. In 1985, the median monthly health insurance premium paid by small employers was over $1,766, more than double the monthly premium paid in 1978. According to a *Washington Post* report, health insurance premiums for many small firms rose by as much as 70% in 1987.

This rise in the cost of health insurance was substantiated by a 1986 NFIB survey entitled "Problems and Priorities." When members were surveyed in 1983, their number one problem was high interest rates. In 1986, it was the cost of health insurance. Their number two problem was the cost and availability of liability insurance.

With regard to the types of coverage provided, the vast majority of firms offer plans that include hospitalization/surgical and major medical. Nearly two-thirds of employers offering plans pay the entire premium cost. Small firms are more likely to pay 100% of the premium than larger firms. From an administrative angle, it is easier for the employer to pay 100% rather than hassle with copayments. Small employers do not have full-time human resource personnel to deal

with this situation. They must do it themselves or in many cases, pay someone outside the firm to do it for them.

So that is the current state of health insurance coverage in small firms as best we know it. I would like to turn now to what types of proposals NFIB supports with regard to resolving the problem of the uninsured.

In testimony before the Small Business Committee, the Senate Labor Committee and the Health Subcommittee of the House Energy and Commerce Committee, NFIB has made clear its views on the issue of health insurance coverage, and the solutions that are supportable by the small business community. First, we favor the elimination of state mandates. Opposition is based not only on philosophy but on the real costs of the mandates to employers by increasing their health insurance premiums. At last count, there were over 600 state mandates. They arise not from constituent demand, but from organized groups with a specific goal, many times the providers of the service themselves. It is interesting to note that the Kennedy bill, as reported, contains a mandate for mental health treatment. You can be sure that when the full Senate takes up the measure, many more will be offered and adopted.

The mandating of certain types of coverage eliminates the flexibility of plan design so that a small employer can purchase only what he or she needs and at a cost they can afford. In Maryland for example, state-mandated insurance benefits were estimated to have increased the combined average cost of group and individual BC/BS coverage by more than 11% in 1984.

The result is that small firms are spending scarce resources on health insurance benefits that they and their employees may not want or use. Further, in order to pay for these mandates, other types of coverage are being reduced or eliminated in order to maintain and control costs.

Unlike large firms, small firms do not have the option of self-insuring to escape from state mandates. Of those surveyed in 1985, only 4% of those offering plans were self-insured. NFIB supports efforts to eliminate state mandates as a viable option to protect and encourage health plan coverage among small firms.

As I mentioned earlier, payroll taxes are paid by small firms from the first day they open their doors. Further, small firms are not generally profitable until their fourth, fifth, or sixth year in business. In 1987, the federal government forgave $35 billion in taxes in order to provide health coverage to 146 million people. The current system of providing a reduction in taxable income is not a viable alternative for many new small firms, where coverage is lacking. If you're not making money, there's nothing against which to take a tax deduction.

For this reason, the small business community supports the creation of a payroll tax credit as a viable incentive to encourage the expansion of health care coverage into new and expanding small businesses. As I stated earlier, the government already provides tax relief to the tune of $35 billion a year for health care coverage. Expansion of this assistance to marginal firms with marginal workers will, in our view, prove to be a productive use of federal resources.

The next proposal is also the one for which concrete results can be shown if it is enacted. Prior to the 1986 Tax Reform Act, no deduction for health insurance was available to the self-employed, or unincorporated business.

By legal form, 29% of sole proprietorships offer coverage, as compared to 49% of Subchapter S corporations, and 77% of corporations. In the smallest size category of 1-9 employees, corporations are more than twice as likely to provide coverage than a sole proprietorship or Subchapter S corporation. In addition, as I stated earlier, 16% of all uninsured workers were self-employed.

In 1986, some relief was provided by granting a 25% tax deduction for health insurance. However, this provision sunsets in three years. NFIB believes that health benefits can and should be expanded among these small businessmen and businesswomen by treating them equitably -- a permanent, 100% tax deduction for health insurance premiums. Congressman John LaFalce, Chairman of the House Small Business Committee has introduced a bill, H.R. 3605, to do just that.

The small business community is not alone in opposing passage of mandated health benefits. The vast majority of the big business community is equally opposed, as are health insurance carriers and health care providers. However, there are some in the business community who do support S. 1265, and I would like to take a moment to comment on their rationale.

First, it is my understanding that only one small business group in the entire country supports Senator Kennedy's bill, the Small Business Service Bureau in Worcester, Massachusetts. The Small Business Service Bureau is not only located in the Senator's home state, but they are in the business of selling and marketing health insurance to small firms.

Second, the large corporations that have endorsed the bill -- American Airlines, Chrysler Corporation and Baxter Travenol -- have all done so under the call of "competitiveness." These corporations believe that the lack of coverage in the small business community results in higher costs to their plans and they want an end to the cost shifting. These corporations charge that small firms refuse to cover their workers with a health plan. The information I have provided to you earlier strongly indicates that it is not a question of willful refusal on the part of small businessmen and businesswomen, but rather they lack, for various reasons, the ability to provide health benefits.

Joseph Califano, the former Secretary of Health, Education and Welfare and now in charge of containing health care costs for Chrysler Corporation, testified that a minimum health care bill would improve American competitiveness by taking the nation's charity burden off the balance sheets of our nation's competitive businesses. I seem to remember some nine years ago, when a major American corporation was facing financial trouble as a result of its uncompetitive behavior. How did they solve their problems? They went to Congress and received one of the largest government bailouts in history. The company was the new Chrysler Corporation.

The problem of the uninsured is a complex and difficult one that will require the assistance of all segments of our society in order to arrive at a series of solutions. In my view, there is no one, single, right answer. The approach must be a multi-faceted one -- it must be both flexible and resilient. The very composition of the uninsured population itself suggests that one single approach will not resolve the problem in any satisfactory manner. That is the reason why S. 1265 is not the answer.