# CBO TESTIMONY

Statement of
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on
Health Care Costs and Insurance Coverage

before the
Subcommittee on Employer-Employee Relations
Committee on Education and the Workforce
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Mr. Chairman and Members of the Committee, I am pleased to be here today to discuss the relationship between health care costs and insurance coverage. Despite several factors that might boost health insurance coverage—such as the booming economy, expansions in Medicaid eligibility, state insurance reforms, federal legislation to improve the portability of health insurance, and several years of slow growth in health insurance premiums—the percentage of Americans who lack health insurance has grown. The number of people without insurance is likely to continue to increase, although that growth will be moderated by federal and state initiatives to expand coverage (such as the State Children's Health Insurance Program). Health insurance premiums will grow more rapidly than in the recent past, and more low-income families will move off the welfare rolls and Medicaid into entry-level jobs that do not offer coverage. Policies that further increase health care costs and premiums could result in larger reductions in insurance coverage than might otherwise occur.

My testimony today will outline what we know about the characteristics of the uninsured population and describe recent trends in health care costs and insurance coverage. Most of my remarks will focus on how policies that mandate benefits or impose other standards on health plans may contribute to higher premiums and lower coverage rates.

## CHARACTERISTICS OF THE UNINSURED POPULATION

According to the Current Population Survey (CPS), about 43 million people under age 65 lacked insurance coverage in 1997.[1] That estimate represented 18.3 percent of the nonelderly population and compares with 14.8 percent who lacked coverage a decade earlier. Most uninsured people were in working families, and one-quarter of them were children. More than half of them were in families with income below 200 percent of the poverty level.

Low-wage workers and those in small firms are much more likely to lack coverage than other workers. Most low-wage workers with access to employer-sponsored coverage—either through their own employer or that of a family member—enroll in employer-sponsored plans. But they are much less likely than other workers to have access to employer-sponsored coverage from any source. In 1996, for example, 55 percent of workers earning up to $7.00 an hour had access to employer-sponsored coverage from any source compared with 96 percent of workers earning more than $15.00 an hour. Similarly, 63 percent of workers in firms with fewer than 10 employees had access to such coverage compared with 93 percent of workers in firms with more than 100 employees.[2]

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1. Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1998 Current Population Survey," *EBRI Issue Brief*, no. 204 (Washington, D.C.: Employee Benefits Research Institute, December 1998).

2. Philip F. Cooper and Barbara Steinberg Schone, "More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996," *Health Affairs*, vol. 16, no. 6 (November/ December 1997), pp. 142-148.

The percentage of the population that is uninsured varies widely among the states, ranging from less than 15 percent in most midwestern and New England states to more than 20 percent in California and some of the southwestern states. That variation reflects differences in population characteristics, such as per capita income and the proportion of recent immigrants, and in labor force characteristics, such as the distribution of workers among different industries and the extent of unionization. States also differ in their policies regarding Medicaid eligibility, rules relating to the accessibility and affordability of coverage in the small-group market, and the extent to which they impose benefit mandates and other requirements on health insurance.

## TRENDS IN HEALTH CARE COSTS AND INSURANCE COVERAGE

Competition among health plans, and the associated shift from indemnity to managed care plans, contributed to a dramatic slowdown in the growth of health insurance premiums in the 1990s. On average, the annual rate of increase in premiums fell from double-digit levels in the late 1980s and early 1990s to 2 percent or less in 1995 through 1997. Over the past year, however, premiums have begun to grow more rapidly again as health plans that had held down premiums to capture a larger market share seek to improve their profit margins. Some analysts and health plans are predicting increases in the range of 6 percent to 10 percent in both 1999 and 2000. Others are predicting even larger hikes.

Rates of insurance coverage for both adults and children declined over the 1987-1997 period, and that decline appears to be continuing. Data from the CPS indicate that coverage of nonelderly adults fell fairly steadily until 1992 and then remained relatively stable before declining again in 1997. The percentage of nonelderly adults who were uninsured rose from 15.6 percent to 19.7 percent during the period. Coverage of children increased slightly from 1987 to 1992 and then started to fall. In 1997, 15 percent of children were uninsured.

Analysis based on the CPS suggests that the reductions in coverage rates that occurred between 1987 and 1992—a period in which premiums were growing rapidly—were attributable primarily to lower rates of employer-sponsored insurance.[3] One cannot, however, infer causality solely on the basis of that apparent association. Subsequent declines appeared to be attributable mainly to falling rates of Medicaid coverage, with the proportion of the population with employer-sponsored insurance remaining relatively steady through 1997.

Another recent study, which was based on data from other surveys taken in 1987 and 1996, found that the proportion of workers with employment-based coverage from any source fell from 76.2 percent to 73.2 percent over that period.[4] The study suggested that the decline generally resulted from lower rates of

3. Fronstin, "Sources of Health Insurance."

4. Cooper and Schone, "More Offers, Fewer Takers." This study uses data from the National Medical Expenditure Survey, 1987, and the Medical Expenditure Panel Survey, 1996.

participation in employer-sponsored plans rather than reductions in the rate at which employers offer coverage. For low-wage and young (under age 25) workers, however, the proportion with access to employer-sponsored coverage (through their own job or that of another worker in the family) fell, as did their participation rates.

## IMPACT OF INCREASING PREMIUMS ON COVERAGE

Health care costs are rising for many reasons including changes in medical practice, the development of costly new technologies, and greater use of prescription drugs and other services. A 1998 article in the *Wall Street Journal*, for example, described some of the new high-cost technologies that had recently come onto the market.[5] They included new brain surgery techniques for treating Parkinson's disease, three different $10,000-a-year drugs for treating multiple sclerosis, and improved inhalers for asthma patients that cost three times as much as other inhalers. Technological breakthroughs are also resulting in a wide range of powerful new drugs including antidepressants, medications for acquired immunodeficiency syndrome (AIDS), and drugs for reducing cholesterol levels. Demand for such drugs is being driven in part by direct-to-consumer advertising, and many health plans are reporting that their drug

5. Ron Winslow, " Health Care Inflation Revives in Minneapolis Despite Cost-Cutting," *Wall Street Journal,* May 19, 1998.

costs are soaring. Those rising costs are redistributed in the health care system in various ways including changes in covered health insurance benefits, higher premiums for health insurance, and reductions in coverage.

Government regulation at both the state and federal levels can also increase the costs of health insurance and lead to higher premiums. Examples of such regulations include:

- Mandates to cover specific benefits such as chiropractic services or minimum hospital stays for births;

- Regulations to change the way in which health plans operate—for example, requiring appeals procedures when benefits are denied or reducing insurers' ability to reject applicants with preexisting conditions; and

- Taxes on health insurance premiums.

States also regulate the premiums that insurers charge for health policies, often by requiring premiums charged to small firms to fall within specified limits. Such regulation is frequently thought to keep premiums affordable for employees in

those firms. Higher-risk groups have lower insurance costs because of the upper premium limit. But the lower premium limit is generally higher than insurers would charge to the good risks—people who are healthier and less likely to use health services. Consequently, the good risks tend to drop their coverage, which raises the average cost of insurance for those who remain in the small-group market.

The Congressional Budget Office (CBO) assesses the likely private-sector costs of proposed federal mandates on health insurers and health plans as part of its duties under the Unfunded Mandates Reform Act of 1995 (UMRA). The act requires CBO to estimate the aggregate amount that private-sector entities would have to spend to comply with the mandates, assuming that such entities take all reasonable steps to mitigate those costs. CBO's analysis is limited to the costs of the proposed legislation and does not consider its benefits. In recent years, CBO has analyzed proposals to require parity in the provision of mental health services, to ensure access and portability of insurance coverage, and, more recently, to expand patients' rights.

CBO's analysis of a proposed health insurance mandate takes into account how employers who offer health coverage would react to the additional costs imposed by the mandate. Employers might respond to such costs by reducing the generosity of insurance coverage, perhaps by raising cost-sharing requirements imposed on beneficiaries or by eliminating some benefits. Some employers might

drop health coverage altogether. They might also reduce the generosity of other employee benefits or the size of wage increases. Such actions limit the rise in labor costs that would otherwise occur because of an insurance mandate.

Employees and others buying insurance in the individual market would also respond to rising health insurance costs. Some would drop their coverage as premiums increased, while others would select less generous coverage if that option was available. Even beneficiaries who retained their health coverage without change after enactment of an insurance mandate would be affected, since their costs would increase.

In general, higher premiums are likely to result in some loss of coverage, although the magnitude of the reduction is difficult to predict. One should be cautious, however, about applying a single rule of thumb to assess the effects on coverage of changes in premiums that arise from different sources. Any mandate on health insurance that raises premiums, for example, could cause some decline in coverage—just as an increase in the price of any product could cause demand for that product to fall. But the specific nature of any insurance mandate will affect its impact on coverage. Consequently, potential declines in coverage can be estimated only by analyzing specific legislative proposals individually.

In particular, the loss of coverage that is likely to result from imposing an insurance mandate depends on a number of factors including the following (to simplify the discussion, consider a mandate to add a new benefit):

- A mandated benefit that is highly valued by consumers would cause fewer people to lose insurance coverage than a benefit of lower value having the same cost.

- A mandated benefit that is already offered by many health plans on a voluntary basis would cause fewer people to lose coverage than a benefit that is not commonly offered.

- Some states may already require the mandated benefit, which would lower the impact of the mandate for the nation as a whole. (Employer plans that are fully insured must comply with states' benefit mandates, but those that are self-insured are exempt from those mandates under the Employee Retirement and Income Security Act of 1974, or ERISA .

- A mandate that primarily affects insurance offered by large firms would be expected to lead to a smaller decline in coverage than one

that primarily affects small firms. Small firms and their workers are more sensitive to premium increases and are more likely to drop coverage because of a mandate.

## CONCLUSION

The number of people without health insurance continues to grow despite the booming economy, expansions in Medicaid eligibility, and other efforts to increase insurance coverage. Rising health care costs have made insurance less affordable for many Americans. Proposals that would impose new mandates on health plans and insurers are meant to improve the value of insurance to consumers, but they could also raise insurance costs and exacerbate the problem of growing numbers of the uninsured. Other proposals are intended to increase health insurance coverage by creating a less regulated environment in the small-group market through such vehicles as association health plans and health marts. Although those proposals could encourage the entry of some lower-cost health plans into the health insurance market, they might also decrease coverage among high-risk groups. Balancing the advantages and disadvantages of competing policies is a significant challenge facing the Congress in the months ahead.