CBO TESTIMONY

Statement of
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Director

The Uninsured and Rising Health Insurance Premiums

before the
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

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Chairman Johnson and Members of the Subcommittee, I appreciate the opportunity to be here today to discuss the characteristics of people without health insurance and the relationship between health insurance premiums and insurance coverage. Although more than 240 million people in the United States have health insurance today through a variety of private and public sources, millions of others do not; and the percentage of Americans who are uninsured has risen in each of the last two years for which information is available.

In my testimony today, I will discuss some important characteristics of the uninsured population that have received relatively little attention but that have important implications for federal policies to expand insurance coverage. I will also discuss the implications of rising health insurance premiums for insurance coverage rates and the potential costs of federal programs to expand coverage.

Characteristics of the Uninsured Population

In recent years, it has been frequently stated that about 40 million Americans lack health insurance coverage. That estimate, by itself, presents an incomplete and potentially misleading picture of the uninsured population. The uninsured population is constantly changing as people gain coverage and lose coverage. Furthermore, people vary greatly in the length of time that they remain uninsured. Some people are uninsured for long periods of time, but more are uninsured for shorter periods.

There are several alternative measures of the number of people who lack insurance coverage. One describes those people who do not have coverage for a sustained period (say, one year)—the long-term uninsured. Alternatively, another identifies how many individuals have experienced any spell without insurance during a particular period. Finally, the most commonly used measure (a mixture of those two others) counts the number of individuals without insurance on any particular day or in a certain week. Those different approaches yield different numbers because of the continual movement of people into and out of the uninsured population. The Congressional Budget Office's (CBO's) recent analysis[1] found that in 1998:

- Between 21 million and 31 million people were uninsured all year;
- At any point in time during the year, about 40 million people were uninsured; and
- Nearly 60 million people were uninsured at some point during the year (see Figure 1).

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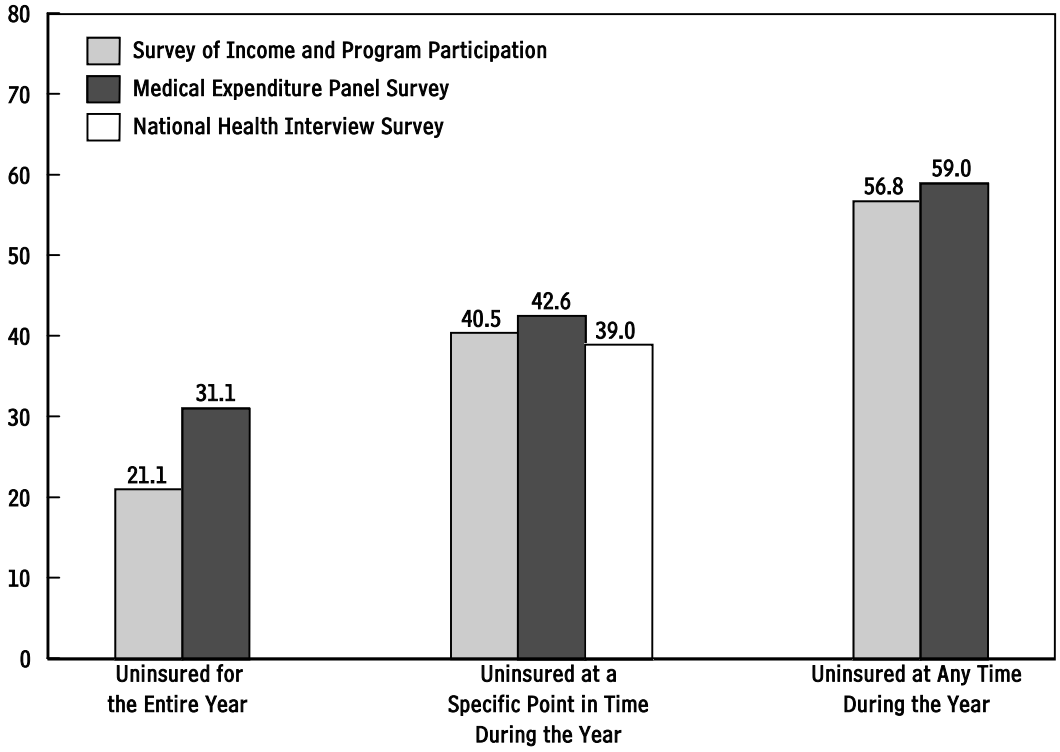
1. Congressional Budget Office, *How Many People Lack Health Insurance and for How Long?* (May 2003).

Figure 1.

Estimated Number of Nonelderly People Without Health Insurance in 1998

(Millions)



Source: Congressional Budget Office.

Note: The Survey of Income and Program Participation is conducted by the Census Bureau. The Medical Expenditure Panel Survey is conducted by the Agency for Healthcare Research and Quality. The National Health Interview Survey, which reports only the point-in-time estimate, is sponsored by the Centers for Disease Control and Prevention.

CBO conducted the analysis for 1998 because that was the most recent year for which suitable data were available to construct all three measures. More recent analyses by researchers at the Agency for Healthcare Research and Quality indicate that those three measures of the uninsured remained fairly stable in the subsequent period from 1998 to 2001.[2]

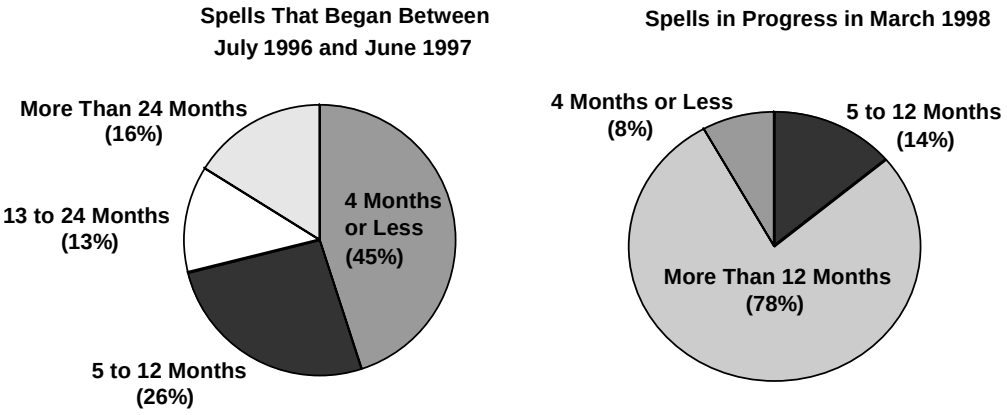
Nearly 30 percent of Americans under age 65 who become uninsured in a given year remain so for more than 12 months, while 45 percent obtain coverage within

2. Agency for Health Care Research and Quality, *The Uninsured in America—1996-2002*, Statistical Brief No. 24, available at www.ahrq.gov.

Figure 2.

Distribution of Uninsured Spells Among Nonelderly People in a Given Year and at a Given Point in Time, by Duration

(Percent)



Source: Congressional Budget Office based on data from the first 11 waves of the 1996 panel of the Census Bureau's Survey of Income and Program Participation, which followed respondents over a period of 41 months (from March 1996 through July 1999).

four months (see Figure 2).[3] Those estimates were obtained by CBO using data from the Census Bureau's Survey of Income and Program Participation for 1996 through 1999. They are very similar to the findings of previous studies that have examined earlier time periods.

Those estimates of the duration of uninsured spells describe the experiences of people who become uninsured in a given year. However, almost 80 percent of the people who lack health insurance at a particular time end up being uninsured for more than 12 months (see Figure 2). Although long uninsured spells occur less frequently than short spells, they are more likely to be under way at any given time.

People with less education, those with low income, and Hispanics are more likely than others to be uninsured (see Table 1). They are also somewhat more likely to remain uninsured for long periods. For example, people in families in which no one attended college account for 64 percent of uninsured spells of more than

3. Congressional Budget Office, *How Many People Lack Health Insurance Coverage and for How Long?*

Table 1.

Nonelderly People Without Health Insurance in 1998, by Selected Characteristics

(Percent)

Characteristic	Nonelderly People: Uninsured at Any Time During the Year	Nonelderly People: Uninsured All Year	Distribution of the Population Uninsured All Year
Age			
Less than 19	26.8	7.3	24.9
19-24	41.9	14.4	13.7
25-34	31.1	12.3	21.9
35-44	20.2	9.3	19.7
45-54	15.1	7.6	12.6
55-64	14.0	6.7	7.2
Race/Ethnicity			
White, Non-Hispanic	18.4	6.3	48.4
Black, Non-Hispanic	33.4	10.7	15.3
Hispanic	47.4	22.5	30.8
Other	31.1	10.9	5.5
Family Income Relative to the Poverty Level[a]			
Less than 200 percent	47.9	19.5	74.9
200 percent to 399 percent	17.4	5.3	19.8
400 percent or more	6.0	1.6	5.3
Education[a, b]			
No high school diploma	50.4	24.6	28.4
High school graduate	33.1	12.7	36.4
Some college course work	22.1	7.3	26.6
Bachelor's degree or higher	9.9	2.6	8.7
Family Employment Status[a]			
At least one full-time worker all year	15.0	5.9	42.9
Part-time or part-year work only	46.1	16.1	46.6
No work	32.8	13.1	10.6

(Continued)

Table 1.

Continued

(Percent)

Characteristic	Nonelderly Americans: Uninsured at Any Time During the Year	Nonelderly Americans: Uninsured All Year	Distribution of the Population Uninsured All Year
Health Status[c]			
Excellent	23.7	8.9	28.8
Very good	25.1	9.3	32.8
Good	24.6	9.1	24.5
Fair	25.1	8.7	8.9
Poor	25.3	10.3	5.1
Memorandum:			
Total Nonelderly Population	24.5	9.1	100.0

Source: Congressional Budget Office based on an analysis of data from the 1996 panel of the Survey of Income and Program Participation.

a. For family-level variables, families are defined as health insurance eligibility units, which are composed of individuals who could be covered as a family under most private health insurance plans.

b. Education measures the highest education level among the adults in the family.

c. Information on health status was collected only for survey respondents who were at least 15 years of age.

12 months but only 49 percent of uninsured spells that end within four months (see Table 2). That difference probably reflects, at least in part, the fact that people who did not attend college are less likely than others to have access to employment-based insurance.

Adults are somewhat more likely than children to remain uninsured for long periods. The availability of Medicaid coverage may explain some of that discrepancy: coverage is available to many children in low-income families, but the majority of low-income adults are not eligible for the program. In addition, evidence suggests that single adults without children may be less inclined to seek insurance, on average, than adults with children, which may cause them to experience long spells without insurance.

The vast majority of the uninsured are in working families. Some 43 percent of the people who were uninsured all year in 1998 were in families in which at least one person worked full time all year, and 47 percent were in families in which at

Table 2.

Comparison of the Characteristics of Nonelderly People with Short Uninsured Spells and Long Uninsured Spells

(Percent)

Characteristic	Duration of Uninsured Spell	
	Four Months or Less	More Than 12 Months
Total	100.0	100.0
Age[a]		
Children	47.3	37.5
Adults	52.7	62.5
Race/Ethnicity		
White, Non-Hispanic	56.7	48.8
Black, Non-Hispanic	19.7	18.2
Hispanic	18.4	27.6
Other	5.2	5.4
Family Income Relative to the Poverty Level[b, c]		
Less than 200 percent	61.6	77.0
200 percent to 399 percent	26.7	21.0
400 percent or more	11.7	7.0
Education[a, c]		
No high school diploma	17.8	26.6
High school graduate only	31.0	37.6
Some college	35.5	26.8
Bachelor's degree or higher	15.6	9.0

Source: Congressional Budget Office based on an analysis of data from the 1996 panel of the Survey of Income and Program Participation.

Note: Estimates in this table are based on uninsured spells that began between July 1996 and June 1997. People with uninsured spells lasting more than 24 months had very similar characteristics to those of people with uninsured spells lasting more than 12 months.

a. Age and education were measured as of the first month of the uninsured spell. Education measures the highest education level among the adults in the family.

b. Family income relative to the poverty level was computed as the mean over the four-month period before the beginning of the uninsured spell.

c. For family-level variables, families are defined as health insurance eligibility units, which are composed of individuals who could be covered as a family under most private health insurance plans.

least one person worked part time or for a portion of the year (see Table 1, column 3). Studies have found that over three-quarters of uninsured workers are not offered insurance by their employer.[4] Low-wage workers are less likely to be offered insurance by their employer and are less likely to accept it if it is offered.

Medicaid is an important source of coverage for children and parents in low-income families, the disabled, and the low-income elderly. However, the number of people who report in population surveys that they have Medicaid coverage is smaller than the number indicated by the program's administrative data. Survey estimates could therefore overstate the number of people who are uninsured. But some evidence, albeit limited, indicates that many of the Medicaid enrollees who do not report being covered by Medicaid mistakenly report another type of coverage, so the bias in estimates of the uninsured may be small.

About half of all uninsured children in 2002 were eligible for Medicaid or the State Children's Health Insurance Program (SCHIP), according to one study.[5] For uninsured people who are eligible but not enrolled, Medicaid provides a form of conditional coverage. Such people can apply for Medicaid at the time that they obtain care and then receive retroactive coverage for their expenses.[6] Because of that provision, some policymakers view those people as insured. Others view them as uninsured because they may not realize that they are eligible for Medicaid and therefore may delay or avoid seeking medical care.

Trends in Insurance Coverage

The vast majority of nonelderly Americans who have health insurance are covered through their own or a family member's employer. According to the Census Bureau's Current Population Survey (CPS), 161 million nonelderly Americans (or

4. See, for example, Bowen Garrett, Len M. Nichols, and Emily K. Greenman, *Workers Without Health Insurance: Who Are They and How Can Policy Reach Them?* (Washington, D.C.: Urban Institute, 2001).

5. Genevieve Kenney, Jennifer Haley, and Alexandra Tebay, "Children's Insurance Coverage and Service Use Improve," *Snapshots of America's Families,* vol. 3, no. 1 (Washington, D.C.: Urban Institute, July 2003).

6. In principle, that provision also applies to SCHIP. However, seven states have placed caps on their enrollments in SCHIP because of budget shortfalls. See Vernon K. Smith and David M. Rousseau, "SCHIP Program Enrollment: June 2003 Update," Kaiser Commission on Medicaid and the Uninsured (Washington, D.C.: Henry J. Kaiser Family Foundation, December 2003).

64 percent of the nonelderly population) had employment-based insurance in 2002.[7]

A smaller proportion of Americans have employment-based insurance today than in 1987 (see Figure 3).[8] The decline in coverage occurred primarily from 1987 to 1993, when the share of the nonelderly population with employment-based coverage fell by nearly 6 percentage points. From 1993 to 2000, the percentage with employment-based coverage stabilized and then increased, before falling in 2001 and 2002. The percentage with employment-based coverage in 2002 stood at about the same level as in 1993.

The percentage of nonelderly Americans without health insurance coverage rose gradually during most of the period from 1987 to 2002, although it fell in 1999 and 2000 (see Figure 3). The uninsurance rate did not increase by as much as employment-based coverage fell because of offsetting changes in the percentage of people who were covered by Medicaid and SCHIP. The share of the nonelderly population that was covered by private nongroup insurance remained relatively stable at about 7 percent. In 2002, about 17 percent of the nonelderly population was uninsured—about 3.5 percentage points higher than in 1987.

Health Insurance Premiums and Insurance Coverage

Rapidly rising health insurance premiums are a source of concern first because they are likely to reduce the percentage of people who have health insurance. They also increase the amount of federal subsidy that must be extended to individuals or firms to achieve a specified reduction in the number of people who are uninsured, and the associated growth in health care spending raises the cost of expanding public programs such as Medicaid and SCHIP.

Just how much of the change in insurance coverage rates that has occurred over the past 15 years results from changes in premiums, changes in unemployment rates, and other factors is unknown. But in the two periods in which employment-based coverage dropped (from 1987 to 1993 and from 2000 to the present), health insurance premiums rose rapidly. Private health insurance premiums grew much

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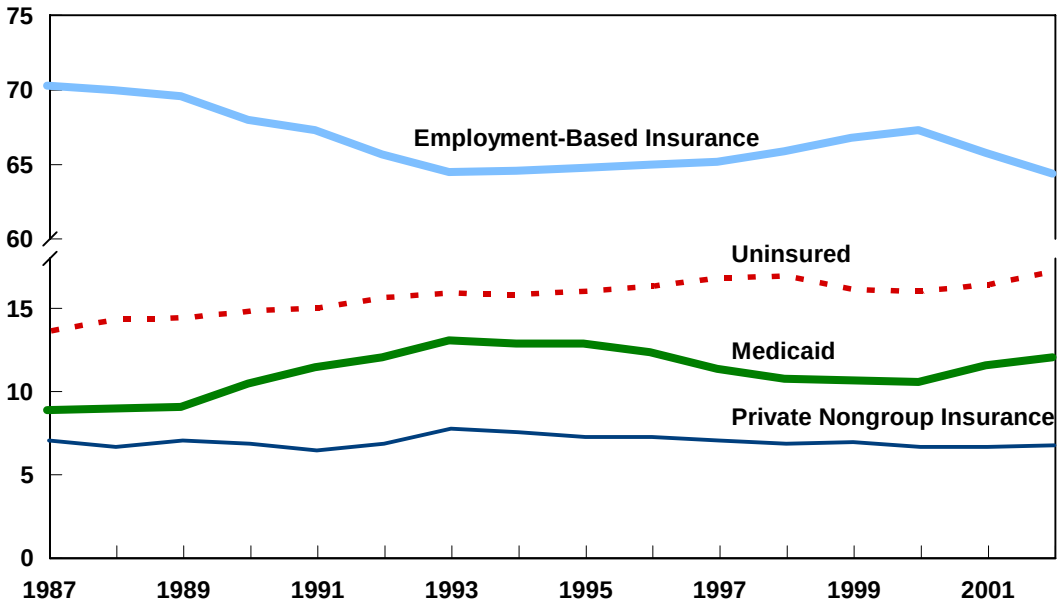
7. Researchers disagree about how the CPS estimates of the insured and uninsured should be interpreted. Like many health care analysts, CBO believes that those estimates provide a close approximation of the numbers at a specific point in time. See Congressional Budget Office, *How Many People Lack Health Insurance and for How Long?*

8. The CPS estimates for 1987 to 2002 have been adjusted to account for changes that were made in the survey design during that period. The estimates are from Paul Fronstin, *Sources of Health Insurance Coverage and Characteristics of the Uninsured: Analysis of the March 2003 Current Population Survey*, Issue Brief No. 264 (Washington, D.C.: Employee Benefit Research Institute, December 2003).

Figure 3.

Percentage of Nonelderly Americans With Employment-Based Health Insurance, Medicaid, and Private Nongroup Insurance and Those Without Insurance, 1987 to 2002



Source: Paul Fronstin, *Sources of Health Insurance Coverage and Characteristics of the Uninsured: Analysis of the March 2003 Current Population Survey*, Issue Brief No. 264 (Washington, D.C.: Employee Benefit Research Institute, December 2003).

Notes: The author adjusted the estimates to account for changes that the Census Bureau made to the design of the Current Population Survey.

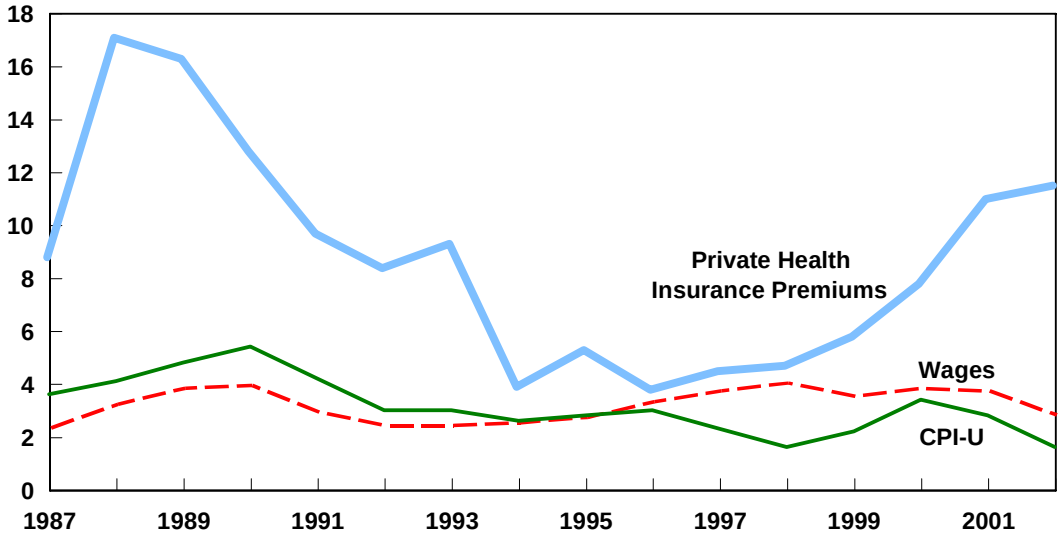
The estimates for Medicaid include enrollment in the State Children's Health Insurance Program.

The percentages of people with Medicare and military coverage are not shown.

more rapidly than wages and the prices of other goods and services from 1987 to 1993 and then grew at a more moderate pace until accelerating again in 1999 (see Figure 4). Thus, employment-based coverage rates fell during periods of rapidly rising premiums and stabilized (and even increased) when the growth of premiums slowed. Those simple correlations suggest that rising premiums contributed to the decline in coverage. Other factors, such as cyclical changes in employment, changes in the characteristics of the health plans offered, expansions in public coverage, and demographic changes probably also contributed.

Figure 4.

Annual Percentage Change in Private Health Insurance Premiums, Wages, and the Consumer Price Index, 1987 to 2002



Sources: Data on health insurance premiums are from the Center for Medicare and Medicaid Services' national health accounts, as reported in Katharine Levit and others, "Health Spending Rebound Continues in 2002," *Health Affairs*, vol. 23, no.1 (January/February 2004), pp. 152-153; data on wages and the CPI-U are from the Department of Labor, Bureau of Labor Statistics.

Note: CPI-U = consumer price index for all urban consumers.

In discussing the effect of increases in premiums on coverage, distinguishing among different causes of such increases is important. Clearly, an increase in premiums having nothing to do with the quality of the insurance benefit (a tax on premiums, for example) would lead to a reduction in the number of people with health insurance since the price increase would lead some people to drop their coverage. However, the growth in health care spending that has driven the increase in premiums in recent decades has been largely caused by the advancing capabilities of modern medicine. Increases in premiums therefore have reflected, at least in part, changes in the product itself, leaving the effect of premiums on decisions to purchase coverage less clear-cut.

Determining how increases in premiums affect insurance coverage rates is also complicated by the fact that a general upward trend in the cost of medical services can make insurance more appealing, because covering potentially costly medical needs without insurance is more difficult. Although that argument applies to many individuals, others—particularly those with limited financial resources—

are more likely to drop coverage when faced with rising premiums and to then rely on care furnished by safety net providers such as community health centers, local health departments, and public hospitals.[9]

The rapid growth in premiums from 1987 to 1993 may have contributed to the reported decline in the rates at which employees take up the offer of employment-based coverage. According to one study, the reduction in the insurance coverage rate among workers from 1979 to 1997 resulted from two factors: a decline in the rate at which full-time workers accepted an offer of insurance from their employer and a decrease in the proportion of part-time and new full-time workers who were eligible for the insurance that their employer offered.[10] There was no decline in the proportion of workers whose employer offered insurance.

As noted, increasing unemployment rates, too, reduce insurance coverage, because losing a job sometimes puts a worker's employment-based health insurance at risk. In a recent analysis, CBO found that health insurance coverage rates declined significantly among people who received unemployment insurance (UI) benefits for at least four consecutive months in 2001 or early 2002.[11] Some 82 percent of such workers had health insurance coverage (from any source) before they began receiving UI benefits, but only 58 percent had coverage by the final month of those benefits.

Federal legislation (the Consolidated Omnibus Budget Reconciliation Act of 1985, known as COBRA) requires firms with 20 or more employees to continue offering health coverage to workers who separate from their firm. However, firms may charge former employees up to 102 percent of the full (group) premiums for that coverage. Therefore, unemployed workers may face a large increase in their out-of-pocket premiums under COBRA. The reduction in coverage estimated for recipients of unemployment insurance probably stems, in part, from many of those people opting not to purchase coverage under that law.

Policy Implications

Policies aimed at increasing insurance coverage will be more effective if designed in light of the characteristics of the uninsured population. In particular, policy-

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9. David M. Cutler, *Employee Costs and the Decline in Health Insurance Coverage*, Working Paper No. 9036 (Cambridge, Mass.: National Bureau of Economic Research, July 2002).

10. Henry S. Farber and Helen Levy, "Recent Trends in Employer-Sponsored Health Insurance Coverage: Are Bad Jobs Getting Worse?" *Journal of Health Economics*, vol. 19, no. 1 (January 2000), pp. 93-119.

11. Congressional Budget Office, *Family Income of Unemployment Insurance Recipients* (March 2004).

makers should be mindful of the dynamic nature of the uninsured population as well as the distinction between the short-term and long-term uninsured. For people with short spells of being uninsured, policies might have the goal of filling the temporary gap in coverage or of preventing such a gap from occurring. For people with longer periods without insurance, policies might seek to provide or facilitate an ongoing source of coverage.

An issue that complicates any policy initiative to expand health insurance is the crowding out of existing sources of coverage. "Crowd-out," which results when coverage through a new government policy initiative replaces private coverage that people would have otherwise had, can occur in various ways. Some employees may drop their employment-based coverage if a government program provides health insurance at a lower premium. Or employers may reduce or drop coverage if the demand from their employees lessens because a government program provides an alternative source of coverage. A related issue concerns health insurance tax credits or similar subsidy programs. Some proposals would extend credits or subsidies to people who would have been insured even without them. Through both phenomena, federal aid is extended to people who otherwise would have been insured. As a result, the federal cost per *newly* insured person could be substantially greater than the cost for each person who uses the federal program or who receives the tax credit.

Information on the amount of crowd-out associated with policies to expand insurance coverage comes primarily from analyses of occasions during the late 1980s and early 1990s when states extended Medicaid coverage to pregnant women and children with income above the federal poverty line.[12] According to those analyses, an estimated 10 percent to 25 percent of the people who were enrolled in Medicaid when eligibility expanded would have otherwise been covered by private insurance.[13] The variation in the estimates arises to some extent from the use of different methods in measuring the effect. Such estimates may also vary because of differences in the types of people eligible for the public programs being measured. In particular, crowd-out rates increase as programs extend the level of income that enrollees may have, as the eligible population includes an increasing share of people who have private insurance instead of no insurance.

Finally, incremental reforms probably cannot provide insurance for everyone, and attempting to achieve 100 percent coverage would be very expensive. As an alter-

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12. No estimates of the crowd-out associated with tax inducements for insurance coverage are available.

13. For a review of the literature on crowd-out, see *Understanding the Dynamics of "Crowd-out": Defining Public/Private Coverage Substitution for Policy and Research* (report prepared by the Academy for Health Services Research and Health Policy under The Robert Wood Johnson Foundation's Changes in Health Care Financing and Organization Program, June 2001).

native, policymakers could consider policies aimed at expanding insurance coverage in conjunction with policies to strengthen the system through which the uninsured receive medical care—for example, through increased funding of community health centers and public hospitals.