Statement of
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before the
Committee on Labor and Human Resources
United States Senate

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NOTICE

This statement is not available for public release until it is delivered at 10 a.m. (EST), Wednesday, November 4, 1987.

One of every six Americans under age 65 — or 37 million people — has no health insurance and, consequently, receives only about two-thirds as much health care as the rest of the population. This circumstance, which may lead to deteriorating health over the long run, is especially notable for the 12 million uninsured children who do not choose their insurance status for themselves. Moreover, part of the cost of care that the uninsured receive is shifted to others. The insured and their employers, for instance, pay higher hospital charges that cover bad debts and charity care. Ultimately, taxpayers pay other costs — through subsidies to public hospitals, for example.

Numerous proposals have been set forth to address the problem of the uninsured, reflecting the diversity of reasons why different groups lack coverage. One option — S. 1265, known as the Minimum Health Benefits for All Workers Act of 1987 — would require that employers provide health insurance for their employees and pay most of its cost. This statement addresses three topics:

- The magnitude of the problem and S. 1265's response;
- The bill's direct impacts on individuals and firms; and
- Its indirect effects on labor markets and governments' budgets.

THE PROBLEM AND S. 1265'S RESPONSE

The number of uninsured is large, and it has been growing rapidly over this decade. The top panel of Figure 1 shows the nonelderly population's sources of health insurance, if any, in 1987. 1/ Currently, about 67 percent of this population is covered through employment-based sources, 8 percent by Medicaid or Medicare, and 7 percent by some other source such as individual policies. Nearly 18 percent, or 37 million people, have no health insurance — up from 15 percent, or 30 million people, in 1980.

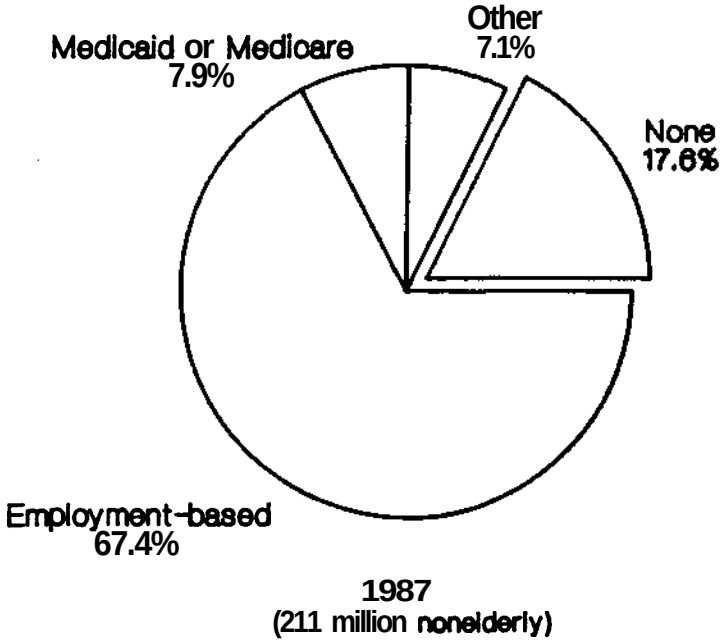
The bottom panel of Figure 1 shows the percentage change in the number covered by each insurance source since 1980. Because the total nonelderly population grew by 6 percent, but employment-based insurance grew at only half that rate, the proportion of the population covered by this source dropped. Moreover, the number covered by other, largely private, insurance actually declined by 10 percent. On the other hand, Medicaid and Medicare covered 17 percent more people in 1987 than in 1980. The net effect of all these changes was a 25 percent growth in the number of uninsured.

This increase contradicts the common expectation that, as the economy recovered from the 1981-1982 recession and employment expanded, the number of uninsured would drop. One contributing factor is that, although the proportion of workers with employment-based health

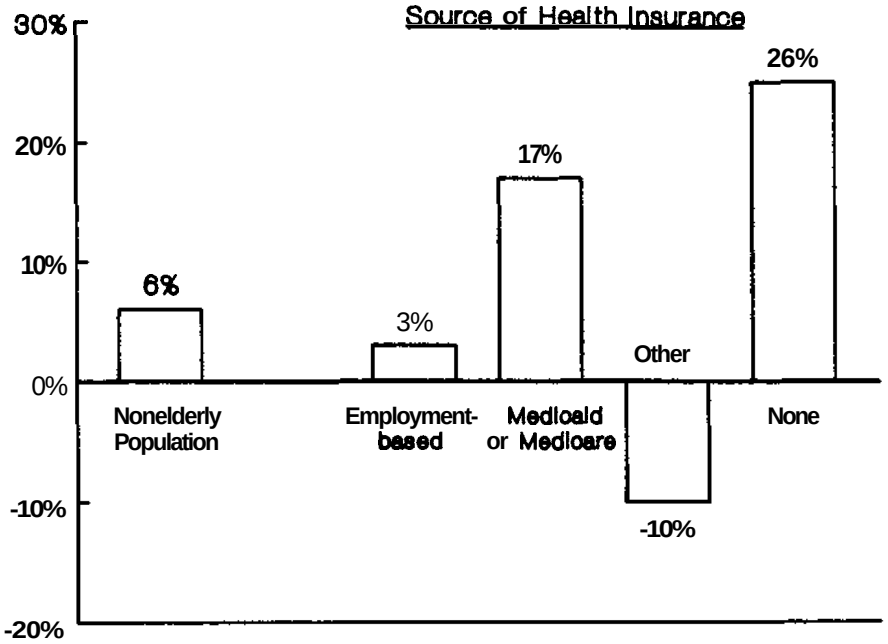
1. The elderly are omitted from this discussion of the problem since they are almost universally insured by Medicare.

Figure 1.

Sources of Health Insurance for the Nonelderly Population, 1987



Percentage Change in the Nonelderly Population and Their Sources of Health Insurance, 1980-1987



SOURCE: Congressional Budget Office tabulations of the March 1980 and March 1987 Current Population Surveys.

NOTE: The surveys ask respondents about insurance coverage during the last year. Because of recall error, however, the responses are more likely to reflect current or recent coverage. Therefore, for example, these figures assume that the March 1987 survey reflects insurance coverage in the early months of 1987.

insurance changed little from 1980 to 1987, a smaller proportion of their dependents had employment-based coverage in the latter year. This lack of coverage for dependents may, in turn, reflect less generous contributions by employers as they attempted to control rapidly rising expenditures for fringe benefits.

The Minimum Health Benefits for All Workers Act of 1987 (MHB) is designed to expand the number of Americans with employment-based health insurance. It would work as follows.

- Each employer would be required to provide health insurance for all full-time employees — defined as those working 17.5 hours or more a week — regardless of any other health coverage they might have. The spouses and dependents of these employees would also have to be covered, unless they were insured by other employment-based plans.

- The act would specify a minimum plan covering inpatient and outpatient hospital care, inpatient and outpatient physician care, and diagnostic tests. Its cost sharing would be limited to maximum annual deductible amounts of $250 per person and $500 per family; a maximum coinsurance rate of 20 percent; and a maximum total out-of-pocket cost of $3,000 per family per year.

- Each employer's plan would have to meet these minimum standards or provide at least the equivalent in actuarial value, with three exceptions. Each plan would have to provide prenatal and well-baby care and none could impose a waiting period for eligibility or exclude coverage for preexisting conditions.

- Employers would be required to pay at least 80 percent of the cost of the plan for most workers, and to pay the full cost for workers earning $4.19 per hour or less. Employees would be required to accept the plan.

- The MHB requirements would apply to all firms covered by the Fair Labor Standards Act.

- Small employers would be required to select from a few plans for their geographic area that would be approved and regulated by the federal government.

- The act would become effective between 12 and 24 months after enactment.

DIRECT EFFECTS ON INDIVIDUALS AND EMPLOYERS 2/

As Table 1 shows, MHB would require insurance for 51 million people, including 23 million — or nearly two-thirds — of those who were previously uncovered. 3/ In essence, only individuals and families where no one was employed at least 17.5 hours a week would continue to be without health insurance.

About 29 million of the 51 million people who would acquire new health insurance are already insured to some extent. About 9 million of them are covered by individual policies. Because these policies tend to be relatively expensive and their benefits would generally overlap with those from the new employment-based group insurance, many of the individual policies would probably be dropped by their owners. Since these people would pay at most 20 percent of the new plans' premiums, the direct effect would be to improve their coverage and lower their cost. 4/

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2. This section discusses the direct effects of MHB under the assumption that the only behavioral changes that would occur would be higher contributions for health insurance paid by individuals and employers as required by the act. The next section considers other possible responses.

3. Of the 51 million, 33 million, or 65 percent, would be employees and the remainder would be their spouses and dependents. The calculations ara based on average premiums of $708 for coverage of individuals and $1,798 for family coverage. These premiums were estimated by the Actuarial Research Corporation.

4. The following section describes indirect effects that would adversely affect some members of this group.

In contrast, the three million people affected by MHB who currently participate in Medicaid would almost certainly continue to do so, because Medicaid's provisions are more generous than those of most employment-based plans and participation is essentially free. (By law, Medicaid would become the secondary payer for those who acquired private health insurance; that is, Medicaid would be responsible only for care not covered by the private plan.) Thus, members of this group would seldom find their health coverage improved. Moreover, the roughly 40 percent of them who

TABLE 1. PEOPLE AFFECTED BY S. 1265, IF FULLY IMPLEMENTED, CALENDAR YEAR 1988 (In millions) a/

	Workers	Dependents	Total
Total Number Affected by Required Insurance b/	33	18	51
Previously uninsured	12	10	23
Previously insured by non-employment-based source	8	8	16
Previously insured by employment-based source of family member	13	0	13

SOURCE: Congressional Budget Office estimates based on the March 1987 Current Population Survey.

NOTE: Details may not add to totals because of rounding.

a. These estimates assume that people working 18 hours a week or more would be covered by the act, unless they were domestic laborers or they were self-employed but did not employ others in their businesses.

b. An additional 4 million workers would not be subject to the requirements of S. 1265 for their own coverage, because of existing employment-based insurance, but they would have to insure one or more dependents who were not covered under employment-based plans. These workers are not shown in this table as being affected by S. 1265, but their newly insured dependents are counted.

earn $4.20 an hour or more might have to pay the employee's share of the new plans' premiums, thereby reducing the resources they would have available for other purposes. 5/

Finally, for 13 million workers, the new coverage from their own employer would overlap with benefits provided through another family member's employment-based plan. Employees would have to participate in their own employer's plans; whether they would continue to participate as dependents in other plans would depend on whether the additional coverage would be worth the additional premiums they would have to pay, if any.

As Table 2 shows, the act would also require that $27.1 billion in incremental health insurance costs be paid through employment-based plans. These premiums would initially be paid primarily by employers. The bulk of employers would, however, either be unaffected by MHB — because they already offer health insurance plans that would satisfy the actuarial equivalency test — or would just have to add the prenatal and well-baby benefits, for an aggregate cost of about $2 billion. In sharp contrast, employers that would be required to purchase new policies for their workers or dependents would incur direct costs of about $22 billion or about $900 per employee. Because this amount would represent a 12 percent increase in

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5. The impact on the four million participants in other government programs, such as Medicare, which would also become secondary payers, would depend on the government programs' provisions and cost, as well as those of the employment-based plans.

these employees' wages, the affected employers might have some difficulty adjusting in the short run.

Table 3 shows the characteristics of the workers who would be affected by MHB. They tend to be employed by small firms, be concentrated in certain industries, and have lower incomes. Overall, only 29 percent of all workers would be affected by the act, compared with nearly 60 percent of those who work for firms employing fewer than 25 people. Nonetheless, 19 percent of employees who work in firms employing 1,000

TABLE 2. INCREMENTAL HEALTH INSURANCE COSTS PAID THROUGH EMPLOYMENT-BASED PLANS UNDER S. 1265, IF FULLY IMPLEMENTED, CALENDAR YEAR 1988 (In billions of dollars)

Total a/	27.1
New policies	25.1
Employer contributions	21.8
Employee contributions	3.3
New benefits under existing policies	2.0

SOURCE: Congressional Budget Office estimates based on the March 1987 Current Population Survey and premiums estimated by the Actuarial Research Corporation.

NOTE: Details may not add to totals because of rounding.

a. These estimates exclude the cost of policies that would cover workers who were previously insured under plans based on the employment of other family members, because the added cost of these new policies would be approximately offset by reduced costs of benefits under the family members' current plans. The costs of policies for workers previously covered by individual policies or government programs are included, however, because much of the cost of their health care would be transferred to the employment-based plans.

TABLE 3. PERCENTAGE DISTRIBUTION OF CHARACTERISTICS OF WORKERS AFFECTED BY S. 1265, IF FULLY IMPLEMENTED

Characteristic a/	All Workers b/	Not Affected c/	Affected c/
All Workers	100	71	29
Size of Firm			
Under 25 employees	100	42	58
25 - 99	100	63	37
100 - 499	100	74	26
500 - 999	100	79	21
1,000 or more	100	81	19
Industry			
Agriculture	100	38	62
Construction	100	62	38
Finance	100	76	24
Manufacturing	100	84	16
Mining	100	85	15
Public Administration	100	87	13
Retail Trade	100	49	51
Services			
Professional	100	71	29
Other	100	53	47
Transportation	100	83	17
Wholesale Trade	100	80	20
Family Income (in 1986 dollars)			
Under $10,000	100	33	67
$10,000 - $19,999	100	64	36
$20,000 and over	100	75	25

SOURCE: Congressional Budget Office tabulations of Current Population Surveys — May 1983 for firm size and March 1987 for industry and family income.

NOTE: Details may not add to totals because of rounding.

a. This table does not show several other characteristics of workers, since they do not differ much for those who would and would not be affected by S. 1265. These characteristics include age, sex, and geographic location.

b. Includes all workers who would potentially be affected by S. 1265.

c. Workers who would not be affected are those currently covered by employment-based health insurance provided by their own employer or union. All other workers would be affected, regardless of any employment-based coverage through a family member's policy or any coverage not based on employment.

people or more would also acquire new coverage. 6/ Similarly, over 60 percent of all agricultural workers would be affected, as would about half of those in retail trade and nonprofessional services, compared with less than 20 percent of employees in manufacturing, mining, public administration, and transportation. About 67 percent of workers with family incomes below $10,000 would be affected, compared with only 25 percent of those with family incomes of $20,000 or more.

INDIRECT EFFECTS ON LABOR MARKETS AND GOVERNMENTS' BUDGETS

Employers could respond to a requirement that they provide health insurance in several ways that, in aggregate, might affect the economy, especially the labor markets for low-wage workers. In addition, both spending and revenues for the federal government and the states would change. Analyzing such effects is extremely difficult, however, and the results are sensitive to a number of assumptions.

Economic Effects

The immediate effect of MHB would be to raise employers' costs for health insurance, if they did not already offer plans that met the act's requirements or if their employees were not enrolling themselves or their spouses and dependents. If the affected employers did nothing in response, their profits would fall by the amount of their additional contributions.

6. Congressional Budget Office estimates based on the May 1983 Current Population Survey, the most recently available one that gathered information on the sizes of firms.

Alternatively, over time, they might raise the prices of their products or reduce their employees' compensation, compared with the levels they otherwise would have attained.

Although the exact division among these alternatives is not known, employers would almost certainly strive to minimize the impact on profits. Because raising prices would reduce sales of their products, affected employers would probably adopt this strategy only to the extent that they could not shift costs to their employees. This shift could be accomplished by limiting wage increases, by reducing fringe benefits of other types than health insurance, or by cutting the quantity of labor employed. Because most of the workers who would be affected receive little or no compensation in the form of fringe benefits, the long-run effect would be to lower wages by about the amount of employers' required contributions.

Wages could not decline this much, though, for workers earning at or just above the minimum wage. The top panel of Figure 2 shows three versions of employer's hourly costs for workers with hourly wage rates ranging from $3.35, the current minimum wage, to $4.50. 7/ The bottom

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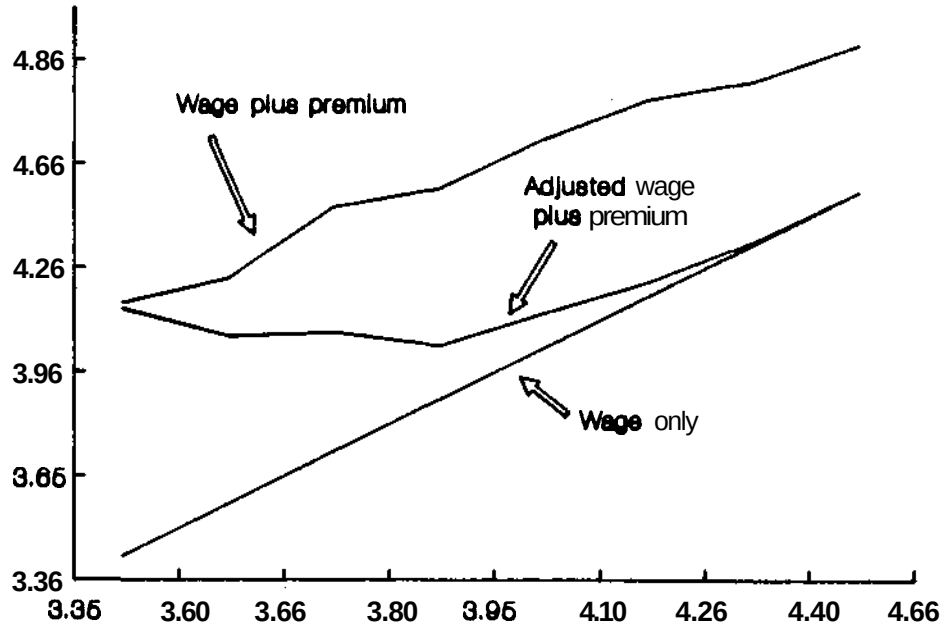
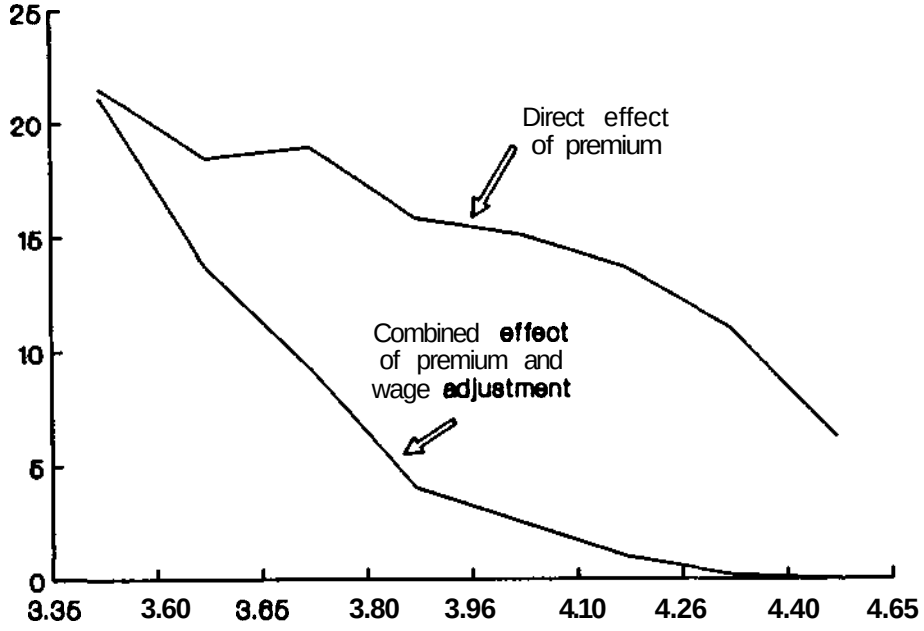
7. Figure 2 is based on simulations using information about wage rates, hours worked, and family structure from the March 1987 Current Population Survey and premiums estimated by the Actuarial Research Corporation. The increase in an employer's average hourly cost that would result under MHB would vary with the wage rate, because people earning higher wage rates work more hours per week, on average, than those earning less. Consequently, a fixed premium for health insurance would increase higher hourly wage rates by fewer cents per hour than it would raise lower hourly wage rates.

Figure 2.

Employers' Cost Per Hour of Wages and Health Benefits Required Under S. 1265, for Low-Wage Workers



Percentage Increase in **Employers'** Cost Per Hour Under S. 1265, for Low-Wage Workers



SOURCE: Congressional Budget Office calculations using information about wage rates, hours worked, and family structure from the March 1987 Current Population Survey and premiums estimated by the Actuarial Research Corporation.

line shows these costs, if compensation consists of wages only. The top line includes the additional cost of the premiums the employer would be required to pay under MHB. The middle line shows how much lower the sum of wages and premiums could be, if wages fell to offset fully the new premiums but were not allowed to fall below the minimum wage. In this case, workers who previously cost the employer $3.35 per hour would now cost about $4.00 per hour, as would most workers who were previously paid between $3.35 and $4.00. Since workers earning lower wages are generally less productive than those earning more, the interaction of MHB's provisions with the minimum wage would put currently uninsured low-wage workers at a strong disadvantage in the labor market.

The bottom panel of Figure 2 makes this point in somewhat different terms. The top line shows that the direct effect of MHB would be to add about 20 percent to the hourly cost of workers paid the minimum wage, compared with roughly 10 percent at $4.30 per hour. The bottom line shows the more dramatic difference in labor costs that would occur if employers shifted as much of the increased premiums as possible to employees through lower wages. The lowest-wage workers would still become 20 percent more expensive, whereas there would be almost no effect on the cost of those previously earning over $4.00 an hour.

These changes in employers' relative costs could, in turn, cause some disemployment — either through layoffs or reductions in hours — of the approximately 6 million workers who now earn under $4.00 per hour and

would be affected by MHB. Also, employers could recast 20-hour-per-week jobs as 17 hours per week, or change full-time jobs into part-time jobs of 17 hours a week or less, to avoid providing health insurance. From a different perspective, employers with high proportions of low-wage workers might find it difficult to adjust sufficiently before the act became effective to avoid lower profits. On the other hand, these adverse effects on employees and employers might diminish over time, if the minimum wage were not raised in concert with inflation and productivity growth in these jobs.

These adverse effects on some low-wage employees and some firms might be mitigated, if S. 1265 were modified somewhat. For example, the time between enactment and the act's effective date could be lengthened, to give employers longer to adjust. Alternatively, low-wage workers might be liable for some of the required premiums — up to 10 percent, for instance --rather than requiring firms to pay all of the premiums for workers with wages under $4.19 an hour. Or, newly established businesses might be exempted for a certain number of months. On the other hand, these alternatives would delay the expansion in coverage, shift more of the health insurance costs to low-wage workers, or provide fewer people with coverage.

Budgetary Effects

As Table 4 indicates, MHB would have little effect on the federal budget. If it were fully implemented for 1988, outlays for health care would decline by about $5.1 billion that year, but revenues would fall by around $5.0 billion,

for a net impact of reducing the deficit by roughly $100 million. In keeping with the Congressional Budget Office's general practices, these estimates are static — that is, they consider the direct changes in behavior that would result from requiring health coverage for workers and their immediate families, ignoring successive rounds of behavioral responses that might ensue. The estimates assume, however, that total wages would fall by the full amount of the premiums required of employers.

TABLE 4. EFFECTS ON THE FEDERAL BUDGET OF S. 1265, IF FULLY IMPLEMENTED, CALENDAR YEAR 1988 (In billions of dollars)

Effect	Magnitude
Change in Federal Deficit	-0.1
Outlays a/	-5.1
Medicare	-3.2
Medicaid	-1.1
Department of Defense	-0.8
Revenue Loss a/	5.0
Individual income tax	2.2
Social Security and Medicare payroll taxes	2.8

SOURCE: Congressional Budget Office estimates based on the March 1987 Current Population Survey, a sample of 1985 Medicare claims data, the 1984 Health Interview Survey, and premiums estimated by the Actuarial Research Corporation.

NOTE: Details may not add to totals because of rounding.

a. Note that negative outlays reduce the federal deficit, while positive revenue losses increase it.

Spending. Federal outlays for health care would fall, since the new employment-based health insurance benefits would substitute for some now provided through federal programs, such as Medicare and Medicaid. The magnitude of the savings, however, would be quite dependent on actively enforcing secondary-payer provisions. The estimates also assume that all workers would participate in employment-based plans, even though their share of the employment-based premium — up to 20 percent of the total or about $360 per year for family coverage — might purchase few or no additional benefits for many of them. If these assumptions were not fully met, or if enforcing the secondary-payer provisions raised administrative costs, the savings could be much lower.

Medicare would save about $3.2 billion in 1988, because employment-based plans would be the primary payers for essentially all beneficiaries employed at least 17.5 hours a week. 8/ About 1.7 million Medicare beneficiaries and their spouses would acquire new employment-based insurance under MHB, unless employers responded by hiring fewer workers age 65 and older or by hiring them for at most 17 hours each week.

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8. Medicare is now a secondary payer for employed beneficiaries who choose to participate in their employers' health plans (often called the "working-aged" provision). S. 1265 would require many of them to participate, however, whereas now it is up to each beneficiary.

Private plans would also become the primary insurers for about three million individuals eligible for Medicaid, yielding federal savings of about $1.1 billion. In addition, because the states pay about 45 percent of total Medicaid costs, they would save an additional $900 million. Some state and local governments might also pay less for charity care, although the extent of these savings would depend on how much needed care is not now being provided to those who would continue to be uninsured.

Revenues. Federal revenues would fall by about $5.0 billion, as shown in Table 4 — about $2.2 billion less would be collected by the federal personal income tax and about $2.8 billion less by the Social Security and Medicare payroll tax. Most states would also have lower personal income tax receipts.

These revenue losses would be direct consequences of the differential treatment of wages and salaries — which are taxable — and of employers' contributions for employees' health benefits -- which are not subject to either income or payroll taxes. 9/ The portion of the additional premiums

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9. These estimates assume that the act would not change the nominal level of the gross national product and that employers would lower wages by an amount equal to their share of the health insurance costs that would result from MHB. Thus, the taxable wage base would fall by the amount employers paid in additional health insurance premiums. The estimates are not particularly sensitive to the assumption about shifting, however. If only part of employers' contributions were shifted to employees through lower wages, with the remainder paid from profits, for example, revenues from the personal income tax system would not fall as much; instead, corporate income tax revenues would fall.

that would be paid directly by employees would probably not affect revenues, because it would be paid from after-tax income.

CONCLUSION

S. 1265 would resolve a substantial portion of the problem of the uninsured, by assuring that nearly two-thirds of them — 23 million people — would acquire employment-based health insurance. Unfortunately, though, some members of this group — those earning about the minimum wage — might find themselves either without work or with fewer hours in any one job, so that they would not qualify for insurance in the end. Moreover, employers with high proportions of low-wage workers would find their costs of doing business increased substantially. These adverse effects could be mitigated by modifying the bill's provisions, but then coverage would be delayed or low-wage workers would have to pay more for it.