Statement
Before the Committee on Ways and Means
U.S. House of Representatives

Hearing on

Long-Term Strategies for Health Care

By
Dallas L. Salisbury
President
Employee Benefit Research Institute

17 April 1991

EBRI

2121 K Street, NW, Suite 600
Washington, DC 20037-1896
(202) 659-0670

Statement Summary

Dallas L. Salisbury
Employee Benefit Research Institute

- **Health insurance is a top priority for Americans.** A recent EBRI/Gallup poll found that 61 percent of working Americans regard health insurance as their most important employee benefit. Ninety-two percent of Americans who said they have family physicians rate the quality of care they receive as excellent or good; among respondents who had been hospitalized during the past year, 82 percent rate the care they received as excellent or good. Yet, largely due to uncertainty of coverage and cost, 56 percent rate the overall health care system as fair or poor. When asked what they liked most about their care, however, the public cited factors that are synonymous with higher costs.

- Given public policy options of "free" mandated employer coverage and "free" national health insurance, both proposals received majority support (56 percent and 54 percent, respectively). Interestingly, 84 percent said employers should be required to provide coverage if employees paid part of the cost, but support for government-provided health insurance declined to 27 percent if it meant higher taxes.

- Eighty-four percent of nonelderly Americans had health insurance in 1989, leaving more than 16 percent, or 34.4 million people without health insurance coverage. Most of the uninsured (54.4 percent) were working adults, while the remainder were nonworking adults (16.7 percent) or children (28.7 percent). More than 85 percent of the uninsured were either workers or dependents of workers.

- **The majority of the uninsured (54.4 percent) were either full-time, full-year workers or dependents of such workers. The remaining uninsured were in families headed by full-year, part-time workers (8.2 percent), workers with some unemployment (9 percent), or nonworkers (14.5 percent).**

- **Health insurance provision is a function of employer size.** Twenty-six percent of self-employed workers and 31 percent of workers in firms with fewer than 25 employees were covered by their own employers' plan compared with nearly 72 percent of employees in firms with 1,000 or more employees. Self-employed workers and workers in firms with fewer than 25 employees made up 49.9 percent of all uninsured workers in 1989. An additional 15 percent of all uninsured workers were in firms with 25–99 employees. **Health insurance provision is a function of income.**

- Thirty-six percent of wage and salary workers earning less than $10,000 annually were covered through their employer's plan compared with 90 percent of those earning more than $50,000 annually. Sixty percent of the uninsured were in families with income under 200 percent of the poverty level.

- Individuals between the ages of 18 and 29 are more likely to be uninsured than those in all other age groups. Almost 10 million children—or nearly 16 percent of all children—were not covered by private health insuance and were either ineligible or did not receive publicly financed medical assistance in 1989. More than one-half (56.1 percent) of uninsured children were living in a family headed by a full-year, full-time worker.

- **The uninsured do generally have access to health care—they do not readily have access to financing.** The result is significant cost shifting to pay for uncompensated care by those who do pay for health care services. The greatest burden hits small employers that provide health insurance. Community rating and composite group rating could help lower costs for small employers, but cost shifting due to uncompensated care would only be solved by universal access to financing. **For small businesses, the "problem" might be that they would pay more for the "reform" than they now pay for health insurance.**

- U.S. health care expenditures exceeded $675 billion and 12 percent of GNP in 1990. Providing individuals with benefit promises in the future that are as comprehensive as those today will result in continued rapid growth of expenditures. The aging of the population affects costs. For example, Medicare expenditures accounted for 1.97 percent of GNP in 1990 and are projected to reach 3.01 percent in 2000 and 6.8 percent in 2060. Washington DC small employers are charged over $1,000 per month for family coverage for a 55 year-old compared to $370 per month for a 29 year-old. Cost growth and underwriting practices have caused many small employers to drop insurance, and population aging combined with age rating will cause more erosion in coverage among employees of small firms in the future. **Age rating also has the effect of making the tax exemption for employer-provided health insurance relative to income most valuable for older, low-income workers with health insurance.**

- Concern over the current level and growth of health spending may be driven in part by the fact that health care expenditures represent an increasingly large component of employee compensation and public budgets. **Health care costs, however, are only one component of total compensation. Total compensation as a proportion of corporate after-tax profits has actually declined since 1985.** Employers could explictly trade off health expenditure growth for a slight reduction in wages if employees were willing. Such a solution is not available for governments in controlling the costs of social programs.

- Some employers have made aggressive efforts to control the growth of health expenditures by making employees more careful buyers of health care services through plan features such as mandatory contributions to monthly premiums, co-payments, and deductibles. **However, research indicates that these initiatives have produced a temporary reduction in health expenditure growth but have not reduced actual health care costs.**

I am pleased to appear before you today to discuss long term strategies for health care. My name is Dallas Salisbury. I am the president of the Employee Benefit Research Institute (EBRI), a nonprofit, nonpartisan, public policy research organization based in Washington, DC. EBRI has long been committed to the accurate statistical analysis of public policy benefits issues. Through our research, we strive to contribute to the formulation of effective and responsible health, welfare, and retirement policies. In keeping with EBRI's mission of providing objective and impartial analysis, our work does not contain recommendations.

◆ Introduction

The American public values the financial protection provided by health insurance. The health care delivery system in the United States has performed a number of miracles that were not possible 30, or even 10, years ago. People are surviving heart attacks and cancers that once were fatal; vital organs are being transplanted into individuals who then lead normal lives; premature babies are growing up healthy; diseases have been eradicated. At the same time, national health expenditures have been increasing at twice the rate of general price inflation for over a decade. Thirty-four million Americans lack health insurance, which limits their ability to pay for health care services.

The rapid increase in health care costs has challenged the health care delivery system and increased the costs of private and public health insurance coverage to the consumer. The results have been a reduction in health insurance coverage and introduction of cost management techniques that have reduced the providers' ability to subsidize uncompensated care.

u Public Attitudes on Health Care

The public will be the arbiter of whether or not health reform initiatives are focused properly. To assess the shifting tides of public opinion, EBRI and The Gallup Organization, Inc. have conducted a monthly series of national public opinion polls on public attitudes toward economic security issues such as health insurance, health care satisfaction, and the value of benefits since June 1989. As elected officials well know, the tide of opinion can shift rapidly and a move from "what do you want?" to "what are you willing to pay?" can produce very different results.

Our surveys indicate that obtaining health insurance is a top priority for most Americans. A 1990 EBRI/Gallup poll found that 61 percent of working Americans regard health insurance as their most important employee benefit; 59 percent said they would not accept a job that did not provide health benefits. Respondents said that their employer would have to pay them an average of $4,219 in additional income to forgo their current employer-provided health benefits. Individuals prefer the hidden costs of lower wages over direct payments like premium co-payments.

Not only do Americans value the provision of insurance, the majority are satisfied with the health care they receive. However, they are not satisfied with the U.S. health care system as a whole. A 1991 EBRI/Gallup poll found that while more than half of Americans (56 percent) rate the U.S. health system as fair or poor, most of those who stated they have family physicians rate the quality of care they receive as excellent or good (92 percent). In addition, among respondents who had been hospitalized during the last year (26 percent of all respondents), a large majority (82 percent) rate the care they received as excellent or good.

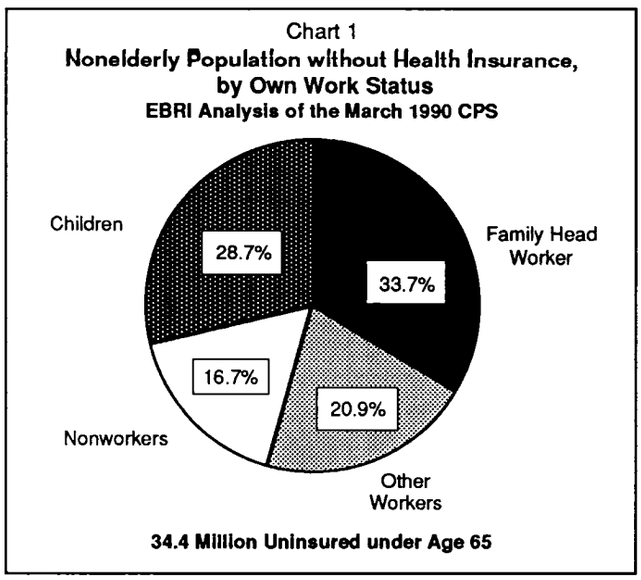
When asked what they liked most about the overall quality of the care they received from their physicians, respondents cited factors that are synonymous with higher cost such as attention and care (12 percent), friendliness (11 percent), and availability (10 percent). When asked what they liked least about their care, no single factor received special emphasis, but they were factors that generally reduce cost including waiting time (8 percent), insufficient time spent by physician with patient (6 percent), and limited availability (4 percent). In addition to giving high ratings to their personal health care, respondents also expressed satisfaction with their health insurance benefits.

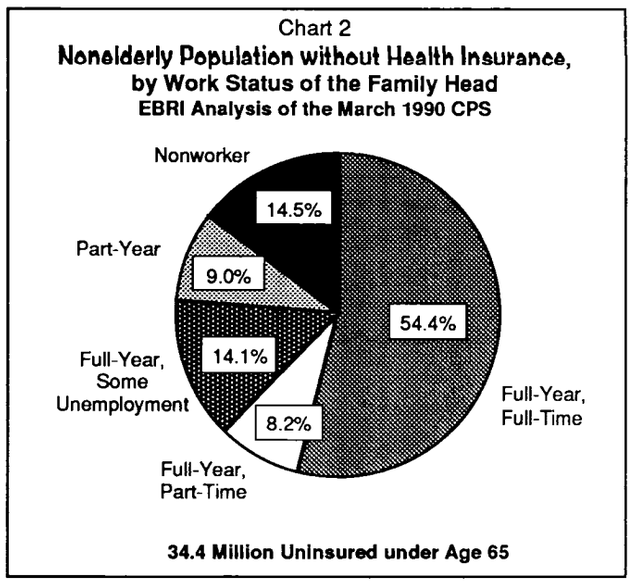
These findings suggest that the satisfaction that insured Americans feel for their health care may reduce their willingness to accept reform proposals that may alter or ration the care they receive.

A 1990 EBRI/Gallup survey explored public attitudes toward policy options for health care reform. These surveys indicate a preference for employment based insurance versus government provision. Fifty-four percent of respondents said the federal government should provide health coverage for all Americans. Twenty-seven percent continued to support government-provided health insurance even if it meant higher taxes, but would be willing to pay only an additional $337.10 in taxes per year, on average. More than one-half of respondents (56 percent) said that employers should be required to provide health benefits at no cost to employees. More than four respondents in five (84 percent) said employers should be required to provide coverage if employees paid part of the cost; these respondents said they would be willing to pay an average of $59.50 per month (or $714 per year).

◆ Access to Health Insurance[1]

Almost 180 million persons under age 65—representing 84 percent of that population—were covered by either private or publicly financed health insurance in 1989. However, about 16 percent of the nonelderly population—or 34.4 million people—received neither private health insurance nor publicly financed health coverage. Leaders representing business,





increased taxes.[2] In a recent public opinion survey, 94 percent of respondents agreed that health care should be available to everyone, even if they cannot afford it.[3] Although the uninsured represent an important public policy concern, no agreement has been reached on a national strategy to guarantee access to health care or assure reasonable payment for that care.

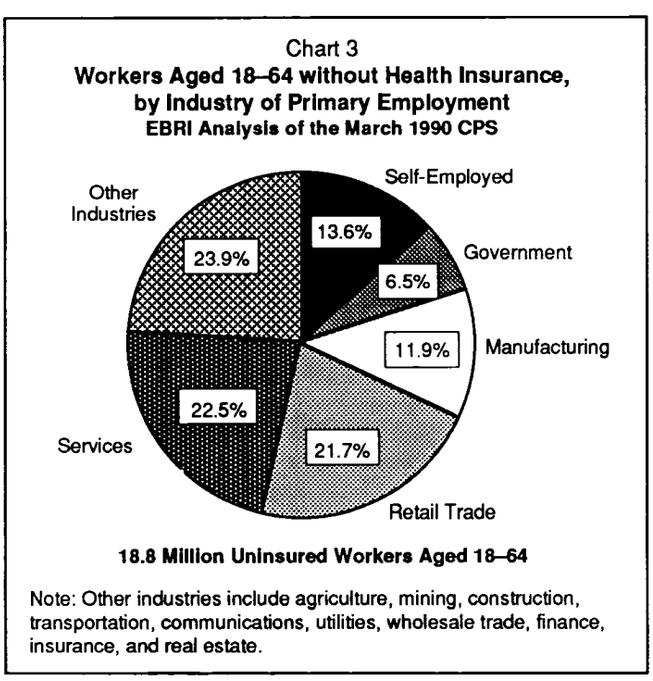
The March Current Population Survey (CPS) provides an important source of information about the economic and health insurance status of the U.S. population.[4] This information can be useful in the analysis of legislative proposals designed to expand access to health care services.

Most of the uninsured were working adults (54.6 percent), while the remainder were nonworking adults (16.7 percent) or children (28.7 percent) (chart 1). Between 1988 and 1989, the proportion of the population that was uninsured increased slightly from 15.7 percent to 16.1 percent. Some of this increase can be attributed to sampling error and slight changes in Employee Benefit Research Institute (EBRI) methodology. Therefore, this report does not conclude that there has been a significant increase in the number of uninsured persons in the United States. However, even without an increase, the size of this population continues to be significant.

Some uninsured individuals have limited access to basic health care services partly because they lack private health insurance and are ineligible for (or do not otherwise receive) publicly financed health care. Uninsured individuals may be forced to seek medical care for preventable ailments that could have been treated less expensively if they had received access to preventive health services. The cost of inefficient, uncompensated care is borne by all payers in the health care delivery system. It is estimated that uninsured patients accounted for 11 percent of personal health care expenditures in 1988, $32 billion, even though they had 37 percent fewer physician contacts and 69 percent fewer inpatient days.[5] The money spent annually on inappropriate care for uninsured patients may be more effectively spent by expanding access to basic health care services.

Employment Status

In 1989, more than 85 percent of the uninsured were working or living in a family headed by a worker (chart 2). The May CPS shows that workers not covered directly by their employers' plans were often covered by their spouses' plans or



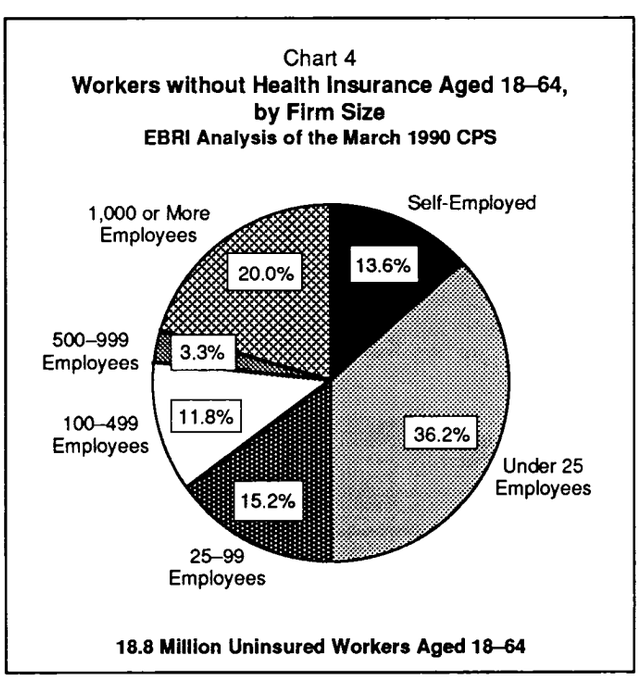
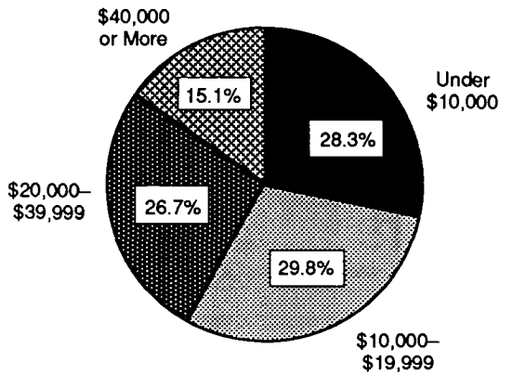
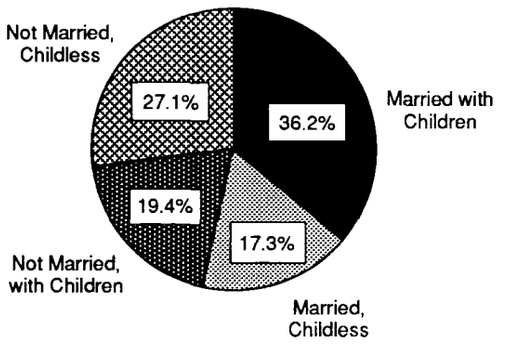


Chart 5
Nonelderly Population without Health Insurance, by Family Income
EBRI Analysis of the March 1990 CPS



34.4 Million Uninsured under Age 65

Chart 6
Nonelderly Population without Health Insurance, by Family Type
EBRI Analysis of the March 1990 CPS



34.4 Million Uninsured under Age 65

other insurance. However, 47 percent of workers not covered were either ineligible for or could not afford their employers' plans.[6] Although some of the uninsured were in families whose head of household experienced unemployment during the year, more than 60 percent were in families in which the family head was employed either full or part time throughout the year. The majority (54 percent) of the uninsured were either employed full time year round or dependents of such workers. However, of all steadily employed full-time workers and their dependents only 12 percent were uninsured during 1989. Fifty-eight percent of all uninsured workers usually worked at least 35 hours per week. Generally, part-time workers and their dependents were more likely to be uninsured than their full-time counterparts. Among part-time workers, families of those employed fewer than 17 hours per week were more likely to be insured (77 percent) than families of those working 17 to 34 hours per week (69 percent). The reason for this difference may be that publicly financed health coverage is less available to the latter group. Nonworkers were more likely to be uninsured than all other working groups—nearly 21 percent did not have any health insurance in 1989.

Unemployment—Workers who experienced some unemployment were much more likely to be uninsured than those who were consistently employed. Among individuals working more than 35 weeks during the year, with no unemployment, 13.8 percent were uninsured. In contrast, 19.2 percent of those persons working 35 weeks or more and reporting some unemployment were uninsured. Among all persons aged 18-64 with some unemployment, those who reported being unemployed because they could not find work were the most likely to be uninsured (44 percent). Least likely to be uninsured were those who reported they were unemployed because they were in school, taking care of their homes or families, or retired.

Industry—The majority of uninsured workers reported their industry of primary employment was retail trade, services, or manufacturing (chart 3)—industries that employ a majority of the work force. Workers most likely to be uninsured were either self-employed or working in agriculture, construction, retail sales, or services. Agricultural workers may be migratory and/or be paid low hourly wages. Construction industry workers may be employed on a contractual basis for a particular project. Because workers in these industries may not work consistently for the same employer, they are less likely to have employer-sponsored health insurance. Workers in the retail sales and service industries, which employ many part-time workers and experience rapid turnover, are often subject to waiting periods before becoming eligible for benefits.

Firm Size—Almost one-half of all uninsured workers were either self-employed or working in firms with fewer than 25 employees in 1989 (chart 4). More than 21 percent of self-employed persons were uninsured, compared with 15 percent of all workers. Almost 28 percent of workers in firms with fewer than 25 employees were uninsured, compared with only about 8 percent of those in firms with 1,000 or more employees. Small employers often are unable to obtain reasonably priced health insurance for their employees because insurers generally charge them higher premiums due to the greater risk posed by a small group. In 1989, although only 22 percent of the nonelderly population lived in families whose head of household worked for a firm with fewer than 25 employees, this group accounted for nearly 40 percent of the uninsured.

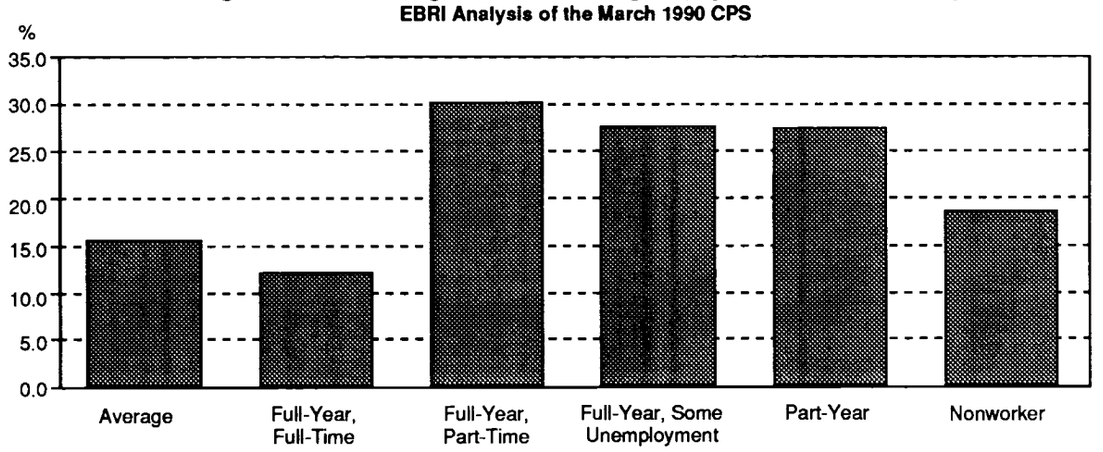
Income

The uninsured are concentrated disproportionately in low-income families. In 1989, nearly 60 percent of the uninsured were in families with annual incomes under $20,000 (chart 5). While more than 37 percent of families with incomes of less than $5,000 were uninsured, only 9.5 percent of families with incomes above $20,000 were uninsured. Families with incomes below the federal poverty level were more likely to be covered by publicly financed health programs or be uninsured than to be covered by private insurance. As income increases, the percentage of the population without health insurance and the percentage covered by publicly financed programs decrease, while the percentage covered by private health insurance increases. Because eligibility levels for Medicaid, the primary publicly financed health program for the nonelderly, are discontinued at certain income levels (rather than being phased out),[7] the percentage uninsured among families with incomes below the poverty level was slightly less than that among families with incomes just above this level. This situation occurs because families with incomes just above the poverty level are less likely to be eligible for

Chart 7

Percentage Uninsured among Children under Age 18, by Work Status of Family Head

EBRI Analysis of the March 1990 CPS



publicly financed insurance. At the same time, these people are also less likely than those with higher incomes to receive employer-sponsored health insurance.

Workers with low earnings are more likely to be uninsured than those with high earnings. Among all workers, 28.3 percent of those with annual earnings below $10,000 were uninsured, compared with about 4 percent of those with annual earnings of $50,000 or more. This is primarily because low-income workers tend to be employed in industries that are less likely to offer health insurance and/or have a weaker or temporary attachment to the work force. These workers may also be employed only part time or unemployed at times.

Family Type

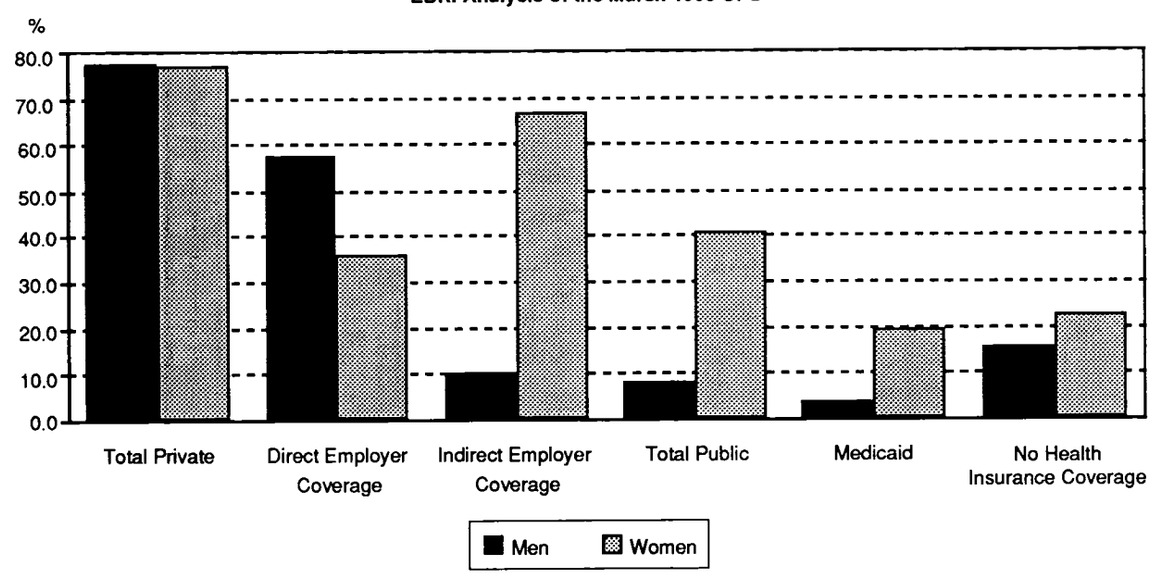
Marital Status—The majority of the uninsured are in families of married couples either with or without children (chart 6). These families represent the majority of the nonelderly population. Compared to their unmarried counterparts, these people are more likely to have private insurance partly because many have income from two sources. Among poor and near-poor families (with incomes of up to 124 percent of the poverty level), both married (44 percent) and not married individuals (47 percent) without children were uninsured more often than other family types. Families with children were less likely to be uninsured, partly because they are more likely to be eligible for publicly financed health programs. Low-income single-parent families are more likely than two parent families to receive public assistance. Nearly 60 percent of those in single-parent families were covered by Medicaid in 1989, compared with only 27 percent of those in two-parent families. Therefore, even though members of two-parent families were more likely to be covered by private health insurance (38 percent) than members of single-parent families (18 percent), they were also more likely to be uninsured than single-parent families (38 percent compared to 26 percent).

Children—Almost 10 million children—or nearly 16 percent of all children—were not covered by private health insurance and were either ineligible or did not receive publicly financed medical assistance in 1989. More than 70 percent of these children were in families with incomes below 200 percent of the federal poverty level. Children were more likely to be uninsured if their family head was either self-employed (22 percent) or working in a firm with fewer than 25 employees (30 percent). Nineteen percent of children in families whose head of household was unemployed were uninsured.

Chart 8

Percentage of Men and Women Aged 18–64 with Selected Sources of Health Insurance Coverage

EBRI Analysis of the March 1990 CPS



However, most uninsured children were in families whose family head was a full-time, full-year worker (56 percent). These children were much less likely to be uninsured than those whose family head worked only part time or experienced some unemployment (chart 7). Almost 77 percent of uninsured children were living in a family whose head of household was also uninsured.

Other Demographic Characteristics

Sex and Age—Men were more likely to be uninsured than women in all age groups except between ages 55-64. Women were generally less likely than men to be covered directly by an employer health insurance plan but were more likely to receive employer coverage as dependents of other workers and publicly financed health coverage. Women aged 55-64, although more likely to receive indirect employer-sponsored health insurance, were less likely than men in this age group to be covered by private or publicly financed health insurance. This may occur partly because men receive coverage more often than women through their previous employer or through the Medicare disability program.

Persons aged 55-64 were least likely to be uninsured (chart 8), while those aged 21-24 were most likely to lack coverage. These young persons may no longer be covered by a family policy and may not have become permanent members of the work force. Many young workers may not currently participate in their employer-sponsored insurance plan because of a waiting period prior to eligibility.

◆ Health Care Costs[8]

U.S. expenditures on health care exceeded 12 percent of Gross National Product (GNP) in 1990—more than twice the proportion of GNP than in 1960 and more than that in any other industrialized country. In the last 25 years, the U.S. health care sector has outgrown other sectors in the economy by an average of 3 percent annually. The aging population and advances in medical technology mean that this trend is likely to continue. Current discussions of health care expenditures focus on perceived problems in the system, such as quality and access to health care, but they also encompass the notion that the United States is spending "too much" on health care—that health care consumption and expenditures are inherently too high. These perceptions have led employers and government policymakers (who together account for 63 percent of total U.S. expenditures on health services and supplies) to make assorted proposals for reforming the financing and delivery of health care.

Why are Health Care Expenditures Growing?

Between 1947 and 1987, the U.S. health care sector outgrew the combined other sectors of the economy by an average of 2.5 percent annually. Health care prices rose 1.6 percent faster annually than non-health care prices, and the quantity of health care delivered grew 0.9 percent faster than other quantities. More recently, from 1977 to 1987, the health care sector outgrew other sectors of the economy by an annual average of 3.0 percent, with medical services prices outgrowing prices in non-health industries by an average of 3.0 percent, and the quantity of medical services delivered averaging the same growth as quantities of other goods and services delivered. The relatively rapid growth of prices may be explained by factors such as the growth in the price of medical labor and capital and the slower growth in medical productivity than in non-health sectors of the economy. Reasons for the relatively rapid growth in the quantity of health care services delivered between 1957 and 1977 (1.2 percent between 1957 and 1967 and 2.4 percent between 1967 and 1977) include the development and utilization of new technologies and the spread of health insurance. Ongoing increases in health services wages and the aging baby boom generation may cause the price and quantity of health care services, respectively, to continue to outgrow those of other goods and services.

As the baby boom generation ages, the elderly population will grow from 31.7 million people in 1990 (13 percent of the population) to 70.1 million people (23 percent of the population in 2060), and the demand for health care services will

Table 1
Age Related Health Premiums for a Washington, DC Employer with 28 Employees, 1987–1991

Age and Type of Coverage	Total Premium Cost (Employer and Employee)				
	March 1987	March1988	March 1989	March 1990	March 1991
Single Coverage					
Less than 29	$ 71.36	$ 89.90	$140.16	$148.44	$159.74
Aged 30–34	89.20	112.40	175.20	185.54	199.68
Aged 35–39	107.04	132.40	210.26	222.64	239.60
Aged 40–44	130.82	164.82	256.96	272.12	292.86
Aged 45–49	154.60	194.80	303.70	321.60	346.10
Aged 50–54	166.50	209.78	327.04	346.34	372.70
Aged 55–59	166.50	209.78	327.04	346.34	372.70
Over Age 60	166.50	209.78	327.04	346.34	372.70
Family Coverage					
Less than 29	$177.16	na	$324.66	$343.60	$ 369.82
Aged 30–34	212.58	$251.72	389.58	412.30	443.78
Aged 35–39	248.00	293.68	454.52	481.04	517.72
Aged 40–44	336.58	na	616.84	652.82	702.62
Aged 45–49	425.16	na	779.16	824.62	887.52
Aged 50–54	478.32	na	876.56	927.70	998.48
Aged 55–59	499.56	na	945.52	968.94	1,042.84
Over Age 60	499.56	na	915.52	968.94	1,042.84

Table 2

Employer Spending on Health Insurance,[a] Wages and Salaries, and Total Compensation[b] in Billions of Dollars and as A Percentage of Corporate After Tax Profits, Selected Years 1948-1989

	Employer Spending on Health Insurance[a]		Employer Spending on Wages and Salaries		Employer Spending on Total Compensation[b]	
		Percentage of corporate		Percentage of corporate		Percentage of corporate
Year	$ billions	after-tax profits	$ billions	after-tax profits	$ billions	after-tax profits
1950	$ 0.7	3%	$ 147.2	589%	$ 155.4	622%
1960	3.4	13	272.8	1003	296.7	1091
1970	14.6	35	551.5	1323	618.3	1483
1980	71.6	48	1372.0	916	1638.2	1094
1985	124.3	97	1975.2	1546	2367.5	1853
1989	178.1	103	2573.2	1491	3079.0	1784

Source: EBRI tabulations of data from the U.S. Department of Commerce, National Income and Product Accounts.
[a]Includes employer contributions for group health insurance, Medicare Hospital Insurance, and military medical insurance.
[b]Includes wages and salaries, health benefits, and all other non-cash benefits.

increase. The elderly population accounts for a disproportionately high share of health care expenditures because the incidence of sickness increases with age. In 1989, for example, elderly individuals (age 65 and over) averaged 9.1 annual physician contacts, almost twice as many as individuals between the ages of 25 and 44. Likewise, patients age 75 and older averaged 4,098 days of hospital care per 1,000 persons per year, more than seven times as many days as patients between the ages of 35 and 44. Table one demonstrates the age rated individual and family premiums for group health coverage for an employer whose firm size is 28 in Washington, D.C. between 1987 and 1991. It clearly shows the implications of population aging.

In addition to increasing the quantity of health care services provided, the increasing ratio of elderly to working individuals will contribute to an increase in the proportion of GNP that is accounted for by health expenditures. Medicare expenditures alone, which are estimated to have represented 1.9 percent of GNP in 1990, are projected to increase to 3.0 percent of GNP in the year 2000 and 6.8 percent of GNP in 2060. These figures suggest that health care financing for the elderly will continue to be a difficult issue for both public policymakers and private employers. Given the magnitude of such projections, it is not surprising that many employers with relatively large retiree populations have been at the forefront of proposals to reform the U.S. health care delivery system.

Why are We Concerned About the Growing Health Care Sector?

In many cases, when observers discuss a sector of the economy that is flourishing, it is considered to be a favorable situation. After all, growing businesses often create desirable by-products such as jobs, revenues (both of which generate tax revenues), capital investment, investment in research and development, and foreign exports. Health care delivery industries supplied 16 percent of net new jobs between 1980 and 1990. Further, industries such as pharmaceuticals and medical equipment have higher than average levels of investment on research and development in addition to a positive balance of trade. Given these facts, why are so many parties upset over the current boom of the health care sector?

Concerns over the current level and growth of health spending may be driven in part by employers' perception that health care expenditures represent an increasingly large component of employee compensation (5.8 percent in 1989 compared with 1.5 percent in 1965), federal and state governments' perception that Medicare and Medicaid represent a growing proportion of public budgets (29.5 percent in 1989 compared with 11 percent in 1965), and individuals' perception that a greater proportion of their disposable income is going toward the purchase of health insurance and health care services (5.1 percent in 1989 compared with 4.2 percent in 1965). Indeed, health expenditures do represent a growing proportion of compensation, disposable income, and public budgets.

Employers—The employer share of total health expenditures has remained between 28 and 30 percent since 1980. Nonetheless, health care expenditures are the fastest-rising component of employee compensation. Because employers' health care expenditures represent a growing cost of production, many argue that such spending puts them at a competitive disadvantage and is hampering their individual competitiveness and U.S. competitiveness overall. These observers are apt to measure employer health care expenditures as a percentage of corporate profits or to divide such expenditures by unit output thereby yielding the amount of health care in the price of a unit product (a car, for example). Health care costs, however, are only one component of total compensation, the measurement that is generally used to determine productivity and competitiveness. Table 2 illustrates that employer spending for total compensation as a proportion of corporate after-tax profits has actually *declined* since 1985 and that employer spending on wages and salaries is a much more significant determinant of total labor expenditures than is employer spending on health care.

The notion that benefits are only one element of a total compensation package that an employee and employer negotiate is not new. Outside of collectively bargained contracts, however, some employers claim that they do not (and could not) make *explicit* trade-offs between benefits and cash compensation.

Many economists, however, argue that such trade-offs *are* made in the long run—whether implicitly or explicitly—and that it is therefore employees—not employers—who bear the burden of increasing health care costs in the form of lower non-health compensation. If that argument is true, it is unlikely that increasing business spending on health care costs per se is eroding global competitiveness. Rather, it is employees who are experiencing a decline in the income they

otherwise might have had available for non-health consumption. Regardless of who bears the burden of increasing health care expenditures, in the aggregate, employer spending on health care represents less than 6 percent of total labor costs. Therefore, changes in employer health expenditures have less impact on the growth rate of total compensation than do changes in employer expenditures on wages and salaries (which represent 84 percent of wages and salaries) (table 3).[9] Moreover, since labor productivity generally measures output in terms of *total* labor costs, total compensation seems to be a more relevant measure for issues of competitiveness and profitability.

Governments—Health care spending has grown as a proportion of revenues at both the federal level and the state and local government level. Federal government health care spending represented 15.1 percent of federal revenues in 1989, more than 4 times as much as in 1965, before the implementation of Medicare and Medicaid. As a proportion of total U.S. health expenditures, the change is not nearly as significant. Federal government expenditures on health care accounted for 9 percent of total expenditures on health services and supplies in 1965, 15 percent in 1967 (after the implementation of Medicare and Medicaid), and 16 percent in 1989. State and local health spending represented 14.4 percent of state and local revenues in 1989, nearly twice as much as a proportion of revenues as in 1965. In terms of total U.S. spending on health services and supplies, however, state and local spending has changed little, representing 12 percent of total U.S. expenditures in 1965 and 14 percent in 1989.

While the proportion of the total health care bill paid by governments has remained essentially constant since the implementation of Medicare and Medicaid, the share of public budgets consumed by health care continues to grow because public budgets have remained relatively fixed as a proportion of GNP while health care expenditures have increased. The increase in the proportion of public budgets consumed by health care expenses suggests that increases in public health spending are now coming at the expense of other public expenditures such as infrastructure and education (human capital). This may represent a more likely threat to American competitiveness than employer contributions to health expenditures.

Individuals—Despite the fact that more employers today require premium contributions for group plans than they did 10 years ago, and deductibles are higher and copayments more common, individual health spending as a share of adjusted personal income has increased by only 0.9 percentage points since 1965. Moreover, individual households pay a considerably smaller proportion of total U.S. health spending than they did in 1965, and virtually the same proportion as they have since 1980. However, if one accepts the premise that employer increases are passed on to employees in the form of lower wages and salaries, individuals may be bearing more of the burden of growing health care expenditures.

What initiatives have employers and insurers undertaken to reduce health care expenditures?

Employers and insurers continue to implement various measures in an effort to manage health care costs. Cost containment initiatives include cost sharing through copayments, deductibles, and premium sharing; alternative delivery systems such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs); utilization review techniques; expanded coverages for services or settings believed to be more cost effective; and health promotion programs. Cost management programs may be voluntary or there may be a financial incentive for participation. While some

Table 3
Annual Growth Rates:
Employer Spending on Total Compensation, Wages and Salaries, and Health Insurance, 1960–1989

Year	Health Insurance	Wages and Salaries	Total Compensation
1961	9.7%	2.8%	3.0%
1962	13.5	6.7	7.1
1963	9.5	5.2	5.5
1964	13.0	7.3	7.4
1965	13.5	7.7	7.8
1966	25.4	10.1	10.8
1967	14.9	7.1	7.3
1968	24.7	10.0	10.3
1969	16.0	9.8	10.2
1970	18.7	6.4	6.9
1971	11.7	6.0	6.7
1972	17.2	9.3	10.1
1973	25.1	10.9	11.9
1974	12.1	9.0	9.7
1975	17.2	5.5	6.4
1976	22.6	10.4	11.5
1977	19.5	10.5	11.2
1978	15.2	12.6	13.0
1979	17.2	11.8	12.2
1980	15.2	9.6	9.8
1981	18.9	10.1	10.3
1982	14.7	5.0	5.5
1983	11.0	5.7	6.0
1984	9.0	9.7	9.6
1985	5.2	7.4	6.9
1986	9.3	6.1	6.1
1987	9.6	7.4	7.1
1988	10.0	8.0	8.1
1989	8.8	5.9	5.9

Source: EBRI tabulations of U.S. Department of Commerce, 1990.

employers have reported success with specific initiatives, others remain dissatisfied, and most continue to search for ways to control their increasing costs.

Employer efforts to control their health care expenditures through mandatory contributions to monthly premiums, copayments, increased deductibles, and the implementation of choicemaking benefit plans may have begun to sensitize patients to the magnitude of health care costs. In 1989, 48 percent of employees in medium- and large-sized establishments with group health coverage were in plans that required a contribution to premium for individual coverage ($25 per month, on average), up from 26 percent in 1980 ($9 per month, on average). However, even if patients are aware of the costs of health care, they can lack much of the information necessary to evaluate and make rational purchase decisions about health care treatment. Most purchase decisions, in fact, are made by the providers of health care, who themselves are largely unable to make fully informed decisions because medicine is an imprecise science. Therefore it is not certain whether cost sharing can effectively control the quantity of health care services delivered.

HMOs give providers financial incentives to provide cost effective care and are therefore generally identified with cost containment. A survey by A. Foster Higgins found that annual HMO premiums were lower, on average, than fee-for-service premiums in 1989 ($2,319 versus $2,600, respectively). These figures represent a 16.5 percent increase from 1988 for HMOs, compared with 20.4 percent growth for fee-for-service plans. However, many employers feel that HMOs have been unsuccessful in reducing costs. Their reasons include a 17 percent annual increase in premiums, coupled with the increased costs associated with offering HMO options, including the added administrative costs of multiple plans and possible increases in indemnity rates associated with adverse selection.[10] Employers are cutting back on the number of HMO options they offer and negotiating harder for rate cuts by pressing for increased experience rating (group rates based on actual historical claims experience from the group itself). According to the U.S. Department of Labor, HMO enrollment among employees with employer-sponsored health plans grew steadily from 2 percent in 1980 to 17 percent in 1989.

PPOs are a relatively new type of health care delivery network in which an organization, generally an insurer, contracts with a network of doctors, hospitals, and other health care providers to provide services at a discounted price schedule. Providers enter these agreements hoping to generate a higher volume of business. PPOs may be offered on a stand-alone basis or as an option within a traditional indemnity plan. In the latter case, insurers usually encourage participants to use the preferred providers by waiving deductibles or offering more attractive coinsurance provisions. PPOs appear to be gaining popularity: the U.S. Department of Labor found that in 1989, 10 percent of participants in medium-sized and large employer health plans were enrolled in PPOs, compared with only 1 percent in 1986. Employers are divided in their responses to PPO effectiveness at controlling costs. A. Foster Higgins & Co., Inc. found that 55 percent of employers surveyed said they were unable to measure the effect of PPOs on medical costs, while 24 percent said they reduced costs, 17 percent said there was no effect, and 4 percent said PPOs increased medical costs.

From the participant's perspective, the relative attractiveness of the various types of plans often depends on the value the individual assigns to freedom of choice in the selection of providers. Since Americans have long been accustomed to fee-for-service medicine, many place a high value on freedom of choice. For this reason, some insurers have found that plans that preserve the ultimate right to choose while giving powerful incentives to use an identifiable group of providers are more successful in the market. These plans allow the employee to choose a fee-for-service delivery mode or an HMO or PPO option within a single plan at the point of service. In these plans, participants incur fewer out-of-pocket expenses when using designated HMO or PPO providers than when they choose fee-for-service delivery. Allied-Signal and Southwestern Bell are notable among companies that have implemented such plans. AT&T plans to implement a point-of-service managed care network that will have the nation's largest enrollment and will be unique in that the company's unions have agreed to help write the standards and select the bidders. While they are a relatively new phenomenon, point-of-service plans are gaining in popularity. Interstudy found that enrollment in open-ended HMOs, which allow enrollees to opt for care from nonnetwork providers, rose 118 percent (from 476, 788 enrollees to 1,041,214 enrollees) from July 1988 to July 1990, compared with 7 percent growth in "pure" HMO enrollment over the same period.

In addition to offering plans with cost management features, some employers have begun to sponsor corporate programs that may help to manage health care costs (and possibly boost productivity) by promoting wellness. Such programs include smoking cessation, weight control, fitness, stress management, hypertension, health risk appraisal, and back care. While programs to promote wellness are generally voluntary, several companies—U-Haul International and Baker Hughes, Inc., among them—have established programs that require employees who smoke or who are significantly overweight or underweight to pay more than other employees toward the cost of health insurance.

◆ Conclusions

The majority of Americans consider health care to be a right. Although most prefer care with no cost, they are willing to share some costs explicitly and more costs on a hidden basis. Americans want "reform", but only reform that means more caring-providers, more accessibility, no risk of forfeiture, and lower costs.

Business, labor, and government also view health care as a right. Each is searching for a reform that will provide greater access at a lower cost. Yet, because they must find the money, they are in a tough position. Demographics and technology both play against those who want to spend less. The data in this testimony as well as other available data show that per capita health care costs rise dramatically with age. The average age of the population is increasing and there are growing numbers of people over age 65 and over age 85. Even if increased efficiency were able to reduce health care expenditures

numbers of people over age 65 and over age 85. Even if increased efficiency were able to reduce health care expenditures for each age group by 25 percent, health care spending would continue to increase as a result of changing demographics. Therefore, achieving health care reform that aims to reduce spending will be extremely difficult.

The government , labor leaders, and employers have been trying to make the health care system more cost effective as well as increase access and quality. Although their efforts may produce results, they cannot provide universal access to health services at a lower overall cost. The pursuit of greater access and better quality for better value can be successful, but not without paying for it.

◆ Endnotes

[1]These data are taken primarily from an EBRI Special Report entitled "Uninsured in the United States: The Nonelderly Population without Health Insurance" published in April 1990. To order, please call Debbie Moss at (202) 775-6315.

[2]Louis Harris and Associates, Inc. *Trade Offs and Choices: Health Policy Options for the 1990s*. (New York, NY: Louis Harris and Associates 1990).

[3]Northwestern National Life Insurance Company. *Americans Speak Out on Health Care Rationing*. (Minneapolis, MN: Northwestern Life Insurance Company, 1990).

[4]The March CPS questions individuals about their health insurance coverage throughout the preceding calendar year. Respondents to the 1990 survey were instructed to provide information about their health insurance coverage during 1989. Assuming accurate responses were given, the uninsured should include only those individuals who were without health insurance for the entire 12 months. However, a comparison of the results of the March 1990 survey with the Survey of Income and Program Participation has led some researchers to believe that many respondents actually answer the health insurance questions with reference to either a particular point in time or to some period of time less than the full year.

[5]Lewin/ICF. *The Health Care Financing System and the Uninsured* (Washington, DC: U.S. Department of Health and Human Services, 1990).

[6]These findings are from the May 1988 Current Population Survey.

[7]Medicaid eligibility levels are linked to AFDC eligibility levels, which are set by individual states. These levels vary from 14 percent of the federal poverty rate in Alabama to 79 percent in California. About two-thirds of the states have higher income eligibility thresholds for "medically needy" persons. All states are required to provide Medicaid coverage to pregnant women and children up to age 6 if their income is less than 133 percent of the federal poverty level.

[8]The following section draws from *EBRI Issue Brief #114*, "Health Care: What Role in the U.S. Economy?" forthcoming. To order, please call (301) 338-6946.

[9]While this is true in the aggregate, individual employer experience may vary. Retiree health care costs and age of active workforce as well as size of firm all affect this outcome.

[10]Various studies indicate that when there is a choice between an HMO and a traditional indemnity plan, younger, healthier employees may be more likely to opt for the HMO, leaving a higher-risk group in the indemnity plan and thereby causing indemnity premiums to increase.