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Statement

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Hearing on

Health Care Costs and Lack of Access

by

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Statement Summary
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- **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.

- 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 tradeoff 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.**

- 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. **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.

- **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 financng. **For small businesses, the "problem" might be that they would pay more for the "reform" than they now pay for health insurance.**

I am pleased to appear before you today to discuss health care costs and lack of access. 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.

◆ 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).

◆ Health Care Costs[1]

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 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.

Table 1
Age Related Health Premiums for a Washington, D.C. 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

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.

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

	Employer Spending on Health Insurance[a]		Employer Spending on Wages and Salaries		Employer Spending on Total Compensation[b]	
Year	$billions	Percentage of Corporate After-Tax Profits	$billions	Percentage of Corporate After-Tax Profits	$billions	Percentage of Corporate 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.

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).[2] 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.

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 data, 1990.

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 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.[3] 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.

◆ Access to Health Insurance[4]

Private health insurance and publicly financed health programs cover most Americans under age 65 and virtually all of those above age 65, providing access to preventive medical services. Most private health insurance coverage is employment based. Health insurance coverage has increased consumer demand for health care services and stimulated the development of new procedures and techniques. The increased cost of health care services has further increased consumer demand for health insurance.

Access to health insurance and access to health care services are different. Individuals without health insurance are able to access health services, but may face financial or other barriers that make access to health services more difficult than it is for those with insurance. Uninsured individuals face limited access to basic health care services in part because they lack private health insurance and are ineligible for (or otherwise not receiving) publicly financed health care. Uninsured individuals may be forced to seek care for preventable ailments that could have been treated less expensively with access to preventive health services. The cost of inefficient, uncompensated care is borne by all payers in the health care delivery system.

Eighty-four percent of Americans Have Health Insurance

In 1978, approximately 88 percent of the nonelderly population was covered by either private health insurance or a publicly financed health program. However, both the number and the percentage of the nonelderly population covered by health insurance have declined over the past 10 years. In 1989, 84 percent of the nonelderly population was covered, leaving more than 16 percent, or 34.4 million people, without health insurance coverage.

The majority of the nonelderly population receives health insurance coverage from private, employer-sponsored group health plans. Nearly 66 percent of the nonelderly were covered either through their own current or former employer or as a dependent of someone with employer coverage (table 4). Others were covered by individually purchased private health insurance (9 percent) and publicly financed health programs (12 percent).[5]

Most of the Uninsured Are Working Adults

In 1989, most of the uninsured were working adults (54.6 percent) 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. Even though only 12 percent of full-year full-time workers and their dependents were uninsured in 1989, they represented 54 percent of the uninsured because the majority of the workers are employed consistently on a full-time basis. Nonworkers were more likely to be uninsured than all other working groups—nearly 21 percent did not have any health insurance in 1989.

Table 4
Nonelderly Population with Selected Sources of Health Insurance by Work Status and Income Characteristics
EBRI Analysis of the March 1990 CPS

	Total	Total Private	Employer Coverage			Total Public	Medicaid	No Health Insurance Coverage
			Total	Direct	Indirect			
	(millions)							
Total	213.7	160.4	140.8	71.2	69.6	26.2	18.5	34.4
Own Work Status								
Family head worker[a]	74.9	60.9	54.6	51.2	3.4	4.3	2.1	11.6
Other workers	48.1	39.8	35.0	17.7	17.3	2.3	0.9	7.2
Nonworkers	27.5	15.2	11.7	2.2	9.5	8.4	5.4	5.7
Children	63.2	44.4	39.4	0.1	39.4	11.2	10.1	9.9
Family Head[a] Work Status								
Full-year, never unemployed	165.4	139.6	125.9	62.8	63.1	9.1	4.5	21.5
full-time	155.7	133.7	121.9	60.6	61.3	7.7	3.6	18.7
part-time	9.7	6.0	4.0	2.2	1.8	1.4	0.9	2.8
Full-year, some unemployment	15.6	8.8	7.5	3.8	3.6	2.6	2.1	4.8
Part-year	10.3	5.1	3.4	1.8	1.5	2.7	2.2	3.1
Nonworker	22.4	6.9	4.1	2.7	1.4	11.8	9.7	5.0
Income Level								
0-99% of poverty	28.3	6.3	3.5	1.5	2.1	13.1	12.4	9.8
100-124% of poverty	8.6	3.8	2.8	1.2	1.6	1.9	1.6	3.3
125-149% of poverty	8.7	4.9	3.7	1.5	2.3	1.5	1.1	2.8
150-199% of poverty	18.7	12.5	10.4	4.4	6.1	2.1	1.3	4.8
200-399% of poverty	74.0	62.8	56.2	25.8	30.3	4.4	1.7	9.2
400% or more of poverty	75.4	70.1	64.1	36.9	27.2	3.1	0.6	4.4
	(percentage within work status and income categories)							
Total[b]	100.0%	75.0%	65.9%	33.3%	32.6%	12.2%	8.7%	16.1%
Own Work Status								
Family head worker[a]	100.0	81.3	72.9	68.3	4.6	5.8	2.9	15.1
Other workers	100.0	82.8	72.8	36.8	36.0	4.7	1.9	15.0
Nonworkers	100.0	55.3	42.7	8.2	34.5	30.4	19.8	20.8
Children	100.0	70.3	62.4	0.1	62.3	17.7	15.9	15.6
Family Head[a] Work Status								
Full-year, never unemployed	100.0	84.4	76.1	38.0	38.1	5.5	2.7	13.0
Full-time	100.0	85.8	78.3	38.9	39.4	5.0	2.3	12.0
Part-time	100.0	61.3	40.7	22.4	18.3	13.9	9.4	28.6
Full-year, some unemployment	100.0	56.3	48.1	24.7	23.4	16.6	13.5	31.1
Part-year	100.0	49.3	32.4	17.7	14.7	26.4	21.4	29.7
Nonworker	100.0	30.8	18.2	12.2	6.1	52.6	43.5	22.2
Income Level								
0-99% of poverty	100.0	22.4	12.5	5.2	7.3	46.5	43.8	34.8
100-124% of poverty	100.0	43.7	32.2	13.3	18.8	22.4	18.5	38.3
125-149% of poverty	100.0	55.5	42.4	16.6	25.8	16.7	12.4	32.2
150-199% of poverty	100.0	67.2	55.8	23.4	32.4	11.2	6.9	25.7
200-399% of poverty	100.0	84.8	75.9	34.9	41.0	6.0	2.2	12.5
400% or more of poverty	100.0	93.0	85.1	49.0	36.1	4.1	0.7	5.8

[a] Family head refers to the family member with the highest reported earnings in 1989. In families of nonworkers, the family head is the family member with the highest reported personal income.
[b] Totals do no add to 100 percent because individuals may have coverage from more than one source.

The majority of uninsured workers reported their industry of primary employment as retail trade, services, or manufacturing. Workers were most likely to be uninsured if they were self-employed or working in agriculture, construction, retail sales, or services.

Health Insurance Coverage is a Function of Employer Size

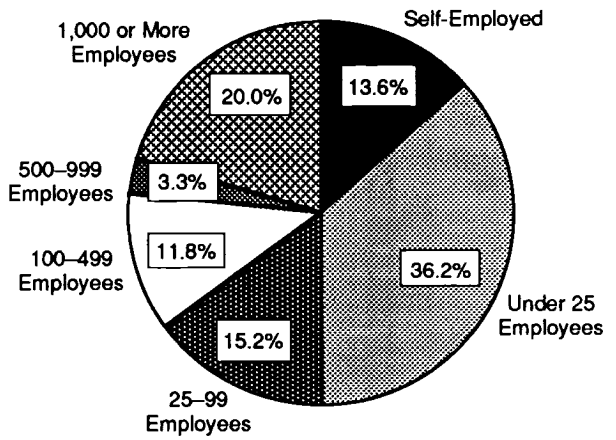
The rising cost of health insurance premiums and the practice of medical underwriting have made it expensive for small employers to offer health insurance to their employees. There are several reasons that small firms face higher costs. First, insurance companies usually charge higher premiums for group health coverage in a small firm because the risk is spread over fewer participants and frequently base premiums on age. In addition, because small firms often have higher turnover rates and seasonal unemployment, they face higher administrative costs when trying to provide coverage for these workers. Finally, because the fixed costs of offering health benefits are similar for firms of all sizes and small employers are unable to spread these costs over a large number of employees, their per capita cost of providing health insurance is higher than that of larger firms.

In 1989, 26 percent of self-employed workers and 31 percent of workers in firms with fewer than 25 employees were covered through their own employers' health plan compared with nearly 72 percent of those working for firms with 1,000 or more employees. Self-employed workers and workers in firms with fewer than 25 employees made up 49.8 percent of all uninsured workers in 1989 (chart 1). An additional 15 percent of all uninsured workers were in firms with between 25 and 99 employees. After taking indirect employer sponsored coverage and public coverage into account, almost 28 percent of workers in firms with fewer than 25 employees were uninsured compared with only 8 percent of workers in firms with 1,000 or more employees. In 1989, although only 22 percent of the nonelderly population lived in families whose family head worked for a firm with less than 25 employees, this group accounted for nearly 40 percent of the uninsured.

Health insurance coverage is related to income and earnings

Lower paid workers are less likely to be covered by employer sponsored health insurance than other workers and are, therefore, less likely to be covered by private health insurance. This may be related to the nature of the employment (part-time vs. full-time or part-year vs. full-year) or the industry (worker may be in a low paying industry or an industry less likely to offer health insurance). 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 wage and salary workers earning more than $50,000 annually. Among all wage and salary workers, 28 percent of workers with earnings below $10,000 were uninsured compared with only 2.0 percent of workers with earnings above $40,000.

Chart 1
Workers without Health Insurance Aged 18–64, by Firm Size
EBRI Analysis of the March 1990 CPS



18.8 Million Uninsured Workers Aged 18–64

Families with very low income were much more likely than those with higher income to be covered by publicly financed health programs. More than 46 percent of people in families with income below the poverty line were covered by public health insurance coverage in 1989 compared with only 4 percent of those in families with income above 400 percent of the poverty line.

The uninsured are concentrated disproportionately in low-income families. In 1989, 60 percent of the uninsured were in families with income under 200 percent of the poverty level ($24,200 for a family of four in 1989). Generally, as income increases, the percentage of the population without health insurance decreases.

Nearly 35 percent of individuals in families with income under the poverty line were uninsured compared with about 6 percent of those in families with income above 400 percent of the poverty level.

◆ 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 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.

◆ Footnotes

[1]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.
[2] 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 the outcome.
[3] 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.
[4] 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.
[5] Because individuals may be covered by more than one source, totals do not add to 100 percent.