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Statement

Before the

Committee on Finance
U.S. Senate

Hearing on

Health Insurance Reform

by

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Principal Points

- Eighty-three percent of nonelderly Americans and 99 percent of elderly Americans (aged 65 and over) were covered by either public or private health insurance in 1992.

- The number of nonelderly Americans without health insurance increased to 38.5 million in 1992 (17.4 percent of the nonelderly population), from 36.3 million in 1991 (16.6 percent), 35.7 million in 1990 (16.5 percent), and 34.4 million in 1989 (16.1 percent).

- These estimates provide a snapshot of insurance coverage at a given point in time during 1992. Adjusting estimates from surveys that follow individuals over time for population growth and increases in the number of uninsured to make them comparable with the 1992 estimates from the Current Population Survey yields estimates of 24 million Americans uninsured for the entire year, 38 million uninsured at any given moment during the year, and 58 million uninsured for some part of 1992.

- The uninsured tend to be young, live in families that are generally low income and headed by either nonworkers or workers employed by small employers.

- Some proposals move the insurance market toward community rating so that insurance would be offered to all small groups at common rates. Community rating results in increased premiums for groups that represent good health risks, while premiums for groups representing poorer risks would fall. Some of the healthier individuals would choose not to purchase health insurance as a result of the premium increase, while more of those individuals who are poorer health risks would purchase health insurance. The result would be an increase in the pool's average risk, increasing premiums and potentially creating a vicious cycle that could end in an unviable health insurance market.

- An Employee Benefit Research Institute simulation found that pooling working single adults with nonworkers and Medicaid eligible individuals increases worker premiums by almost 13 percent.

Americans With and Without Health Insurance: Implications for Reform

Mr. Chairman, I am pleased to submit this statement for the record on health insurance reform. The Employee Benefit Research Institute (EBRI), a nonprofit, nonpartisan public policy research organization, is dedicated to providing objective analysis of health care and other work force issues.

While the employment-based system for financing health insurance coverage continues to provide coverage for 63 percent of Americans under age 65, that source of coverage is eroding for many, especially those who are employed by smaller employers. Eighty-three percent of nonelderly Americans and 99 percent of elderly Americans (aged 65 and over) were covered by either public or private health insurance in 1992 (table 1). Although some of the nonelderly had public health insurance (15 percent), the most common source of coverage was private insurance—usually obtained through an employment-based plan.

The number of nonelderly Americans without health insurance increased to 38.5 million in 1992 (17.4 percent of the nonelderly population), from 36.3 million in 1991 (16.6 percent), 35.7 million in 1990 (16.5 percent), and 34.4 million in 1989 (16.1 percent). A primary reason for the increase in the number of uninsured was a decline in em-

Table 1
Nonelderly and Elderly Americans with Selected Sources of Health Insurance Coverage, 1989–1992
Employee Benefit Research Institute Analysis of the March 1990, 1991, 1992, and 1993 CPS

	Total Population				Nonelderly				Elderly			
Source of Coverage	1989	1990	1991	1992	1989	1990	1991	1992	1989	1990	1991	1992
						(millions)						
Total Population	243.3	246.0	248.7	251.7	213.7	215.9	218.1	220.8	29.6	30.1	30.6	30.9
Total with Private Health Insurance	180.4	178.9	178.4	177.5	160.4	158.3	157.7	156.6	20.0	20.6	20.7	20.9
Employer coverage	150.2	148.7	150.0	148.0	140.8	138.7	139.8	138.0	9.4	10.0	10.1	10.1
Other private coverage	30.3	30.3	28.6	29.6	19.7	19.7	18.0	18.8	10.6	10.6	10.6	10.8
Total with Public Health Insurance	54.5	58.1	61.2	63.2	26.2	29.2	31.7	33.4	28.3	28.9	29.5	29.8
Medicare	31.5	32.3	32.9	33.7	3.2	3.5	3.5	4.0	28.2	28.8	29.4	29.7
Medicaid	21.1	24.2	26.8	28.5	18.5	21.6	23.9	25.6	2.6	2.6	2.9	2.9
CHAMPUS/CHAMPVA[a]	7.0	7.0	7.1	6.9	5.9	5.9	5.9	5.7	1.1	1.1	1.2	1.2
No Health Insurance	34.7	36.0	36.6	38.9	34.4	35.7	36.3	38.5	0.3	0.3	0.3	0.4
						(percentage)						
Total Population	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Total with Private Health Insurance	74.2	72.7	71.7	70.5	75.1	73.3	72.3	70.9	67.7	68.4	67.7	67.7
Employer coverage	61.3	60.4	60.3	58.8	65.4	64.2	64.1	62.5	32.0	33.2	33.1	32.6
Other private coverage	12.4	12.3	11.5	11.8	9.2	9.1	8.2	8.5	35.7	35.2	34.7	35.0
Total with Public Health Insurance	22.4	23.6	24.6	25.1	12.3	13.5	14.5	15.1	95.8	96.0	96.3	96.6
Medicare	12.9	13.1	13.2	13.4	1.5	1.6	1.6	1.8	95.6	95.7	96.0	96.2
Medicaid	8.7	9.8	10.8	11.3	8.7	10.0	11.0	11.6	8.7	8.6	9.5	9.4
CHAMPUS/CHAMPVA[a]	2.9	2.8	2.9	2.7	2.8	2.7	2.7	2.6	3.7	3.7	3.8	3.9
No Health Insurance	14.3	14.6	14.7	15.4	16.1	16.5	16.6	17.4	1.0	1.0	0.9	1.2

Note: Details may not add to totals because individuals may receive coverage from more than one source.
[a]Includes only the retired military and members of their families provided coverage through the Civilian Health and Medical Program for the Uniformed Services and the Civilian Health and Medical Program of the Veterans Administration. Excludes active duty military personnel and members of their families.

ployment-based coverage, particularly among individuals (and their families) working in small firms. The number of nonelderly Americans with employment-based coverage in 1992 was 138.0 million (62.5 percent of the nonelderly population), a decrease from 139.8 million (64.1 percent of the total nonelderly population) in 1991 (table 1).

These estimates and most of those presented below are derived from the March 1993 supplement to the Census Bureau's Current Population Survey (CPS). Most researchers familiar with this survey agree that the numbers presented provide a snapshot of insurance coverage at a given point in time during 1992. Another Census survey, the Survey of Income and Program Participation (SIPP), follows a smaller group of individuals over a two-and-one-half-year period. The latest available information from SIPP indicates that, in 1987, 32 million (13 percent) Americans were uninsured at any given moment, 50 million (21 percent) were uninsured for some portion of 1987, and 16 million (7 percent) were uninsured for all of 1987. Adjusting those numbers for population growth and increases in the number of uninsured to make them comparable to the 1992 estimates from the Current Population Survey yields estimates of 24 million Americans uninsured for the entire year, 38 million uninsured at any given moment during the year, and 58 million uninsured for some part of 1992.

Employment-Based Coverage

The most important source of health insurance coverage is employment-based coverage. In 1992, 62.5 percent of the nonelderly were covered by employment-based insurance (table 1). This is a reduction from 1988, when 66.8 percent of the nonelderly were covered through an employment-based insurance plan.

Declines in employment-based health insurance coverage were somewhat offset by an increase in the number of Americans with coverage from a public source. The number of nonelderly Americans receiving public coverage steadily increased between 1989 and 1992—33.4 million nonelderly Americans received public coverage in 1992 (15.1 percent of the total nonelderly population), compared with 31.7 million, or 14.5 percent, of the nonelderly population in 1991; 29.2 million, or 13.5 percent, in 1990; and 26.2 million, or 12.3 percent, in 1989 (table 1). The increase in public coverage is, at least in part, due to the impact of the recent recession and to changes in Medicaid coverage for children and pregnant women.

Workers

Not surprisingly, workers were much more likely to be covered by employment-based health plans than nonworkers. Seventy percent of workers were covered by an employment-based plan, compared with only 37 percent of nonworkers. In addition, 77 percent of individuals in families headed by a full-year, full-time worker were covered by group health plans, compared with only 37 percent of those in families headed by other workers and 16 percent of individuals in families headed by a nonworker.

Workers were also more likely to be covered by an employment-based health plan if they worked for an employer with a larger number of employees. Insurers may charge less per capita for large employer plans because they are able to spread both risk and administrative costs over a greater number of people. Only 23 percent of self-

employed workers and 22 percent of workers in firms with fewer than 10 employees were covered through a group health plan sponsored by their own employer in 1992, compared with 70 percent of workers in firms with 1,000 or more employees.

Workers' family members were also more likely to be covered by an employment-based plan if the family head worked for a large firm. Among workers (and their families) in firms with fewer than 10 employees, 38.8 percent were covered by an employment-based plan, compared with 81.4 percent of workers (and their family members) in firms with 1,000 or more employees (table 2).

Income and Health Insurance Coverage

Income is also related to health insurance coverage. In general, individuals with higher levels of income are more likely to be covered by private health insurance, while those with lower levels of income are more likely to be covered by a publicly sponsored plan. In 1992, only 16 percent of individuals in families with income below $5,000 were covered by private health insurance, compared with 92 percent of those in families with income of $50,000 or

Table 2
Nonelderly Population with Selected Sources of Health Insurance, by Firm Size of Family Head's Employer, 1992
Employee Benefit Research Institute Analysis of the March 1993 CPS

Firm Size of Family Head's Employer	Total	Total Private	Employer Coverage			Other Private	Total Public	Medicaid	No Health Insurance Coverage
			Total	Direct	Indirect				
					(millions)				
Total	220.8	156.6	138.0	68.9	69.1	18.8	33.4	25.6	38.5
Nonworker	25.7	6.6	4.1	2.7	1.5	2.5	14.3	12.2	6.0
Fewer than 10	32.3	19.5	12.5	5.8	6.7	7.0	3.6	2.8	9.8
10–24	16.4	10.4	8.8	4.3	4.5	1.6	1.9	1.6	4.4
25–99	26.8	19.2	17.3	8.8	8.5	1.9	2.8	2.1	5.5
100–499	29.7	23.6	22.2	11.1	11.1	1.4	2.8	2.1	4.2
500–999	11.7	9.8	9.3	4.5	4.7	0.6	1.0	0.7	1.3
1,000 or More	78.3	67.4	63.7	31.6	32.1	3.8	6.9	4.0	7.2
					(percentage within coverage categories)				
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Nonworker	11.6	4.2	3.0	3.9	2.1	13.5	42.9	47.7	15.6
Fewer than 10	14.6	12.5	9.1	8.5	9.7	37.5	10.9	11.0	25.5
10–24	7.4	6.6	6.4	6.2	6.5	8.5	5.8	6.1	11.5
25–99	12.1	12.2	12.6	12.8	12.3	9.9	8.4	8.4	14.4
100–499	13.4	15.1	16.1	16.2	16.1	7.6	8.4	8.2	10.9
500–999	5.3	6.3	6.7	6.6	6.9	3.0	3.0	2.9	3.3
1,000 or More	35.5	43.1	46.2	45.9	46.4	20.1	20.6	15.8	18.8
					(percentage within firm size categories)				
Total	100.0%	70.9%	62.5%	31.2%	31.3%	8.5%	15.1%	11.6%	17.4%
Nonworker	100.0	25.8	16.0	10.3	5.7	9.9	55.7	47.6	23.4
Fewer than 10	100.0	60.4	38.8	18.0	20.7	21.8	11.3	8.7	30.4
10–24	100.0	63.1	53.4	26.1	27.3	9.8	11.9	9.5	27.0
25–99	100.0	71.7	64.8	32.9	31.9	7.0	10.4	8.0	20.7
100–499	100.0	79.6	74.9	37.5	37.4	4.8	9.5	7.0	14.2
500–999	100.0	84.3	79.6	38.9	40.7	4.8	8.6	6.3	11.0
1,000 or More	100.0	86.1	81.4	40.4	41.0	4.8	8.8	5.2	9.2

Note: Details may not add to totals because individuals may receive coverage from more than one source.

Table 3

Nonelderly Population with Selected Sources of Health Insurance Coverage, by Family Income as a Percentage of Poverty, 1992, Employee Benefit Research Institute Analysis of the March 1993 CPS

Family Income as a Percentage of Poverty	Total	Total Private	Employer Coverage			Other Private	Total Public	Medicaid	No Health Insurance Coverage
			Total	Direct	Indirect				
					(millions)				
Total	220.8	156.6	138.0	68.9	69.1	18.8	33.4	25.6	38.5
0–99%	33.0	6.1	3.6	1.5	2.1	2.5	17.2	16.4	10.8
100%–124%	9.8	4.0	3.1	1.2	1.9	0.9	2.9	2.5	3.5
125%–149%	9.6	4.7	3.7	1.5	2.2	0.9	2.0	1.6	3.4
150%–199%	20.2	12.6	10.7	4.5	6.2	1.8	3.0	2.0	5.6
200%–399%	74.7	61.8	55.6	25.5	30.1	6.3	5.2	2.5	10.4
400% or More	73.5	67.5	61.3	34.7	26.6	6.3	3.1	0.7	4.9
					(percentage within coverage categories)				
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
0–99%	15.0	3.9	2.6	2.1	3.0	13.4	51.5	63.9	28.1
100%–124%	4.4	2.5	2.2	1.7	2.7	4.8	8.6	9.6	9.0
125%–149%	4.4	3.0	2.7	2.2	3.2	5.0	6.0	6.4	8.8
150%–199%	9.1	8.0	7.8	6.5	9.0	9.7	9.0	8.0	14.5
200%–399%	33.8	39.5	40.3	37.0	43.5	33.6	15.4	9.7	26.9
400% or More	33.3	43.1	44.4	50.4	38.5	33.4	9.4	2.5	12.7
					(percentage within poverty status categories)				
Total	100.0%	70.9%	62.5%	31.2%	31.3%	8.5%	15.1%	11.6%	17.4%
0–99%	100.0	18.4	10.8	4.5	6.4	7.6	52.0	49.5	32.7
100%–124%	100.0	40.4	31.3	12.3	19.0	9.3	29.3	25.1	35.6
125%–149%	100.0	48.5	38.8	15.5	23.3	9.9	20.9	16.9	35.3
150%–199%	100.0	62.2	53.2	22.3	30.9	9.1	14.8	10.1	27.7
200%–399%	100.0	82.7	74.4	34.1	40.2	8.5	6.9	3.3	13.9
400% or More	100.0	91.9	83.4	47.2	36.2	8.5	4.3	0.9	6.7

Note: Details may not add to totals because individuals may receive coverage from more than one source.

more. Although many individuals in poor families are covered by public health plans, that coverage is far from universal. In 1992, less than 50 percent of the nonelderly with income below the poverty line were covered by Medicaid.

Characteristics of the Uninsured

In 1992, 17.4 percent of the nonelderly population—or 38.5 million people—were not covered by private health insurance and did not receive publicly financed health assistance, up from 36.3 million (16.6 percent) in 1991. Among the 38.5 million nonelderly Americans who did not have health insurance coverage in 1992, most were working adults (56.7 percent), while the remainder were children (25.4 percent) and nonworking adults (17.8 percent). The total number of uninsured under age 65 has increased from 33.6 million in 1988 to 38.5 million in 1992. Although some of this increase can be attributed to population growth, the percentage reporting no health insurance coverage has also increased from 15.9 percent to 17.4 percent.

The uninsured live in families that are generally low income and employed by small employers. Just over 60 percent of the uninsured live in families with total family income of less than 200 percent of the federal poverty level. Fifty-one percent of the uninsured live in families whose family head works for an employer with fewer than 100 employees.

Furthermore, increases in the number of individuals without health insurance were greatest among those whose family head worked for a small firm rather than for a large firm. Among the additional 4.2 million nonelderly Americans without health insurance coverage between 1989 and 1992, 19 percent were in families in which the family head worked for a firm with fewer than 25 employees; 21 percent were in families in which the family head worked for a firm with 25–99 employees; 25 percent were from families headed by a nonworker; 14 percent were from families in which the family head worked for a firm with 100–499 employees; and 21 percent were from families in which the family head worked for a firm with 500 or more employees. The increase in noncoverage among those in small firms was even more pronounced between 1991 and 1992. Forty-two percent of the additional 2.2 million individuals without coverage between 1991 and 1992 were in families in which the family head worked for an employer with fewer than 25 employees. An additional 15 percent were in families in which the family head worked for an employer with between 25 and 99 employees.

The uninsured also tend to be young. About 25 percent of the uninsured are children under the age of 18. Even among adults, the uninsured tend to be younger than those with coverage. Twenty-seven percent of those aged 18 to 29 are without health insurance, and that group comprised 40 percent of all uninsured adults.

Insurance Reform

The characteristics of the uninsured will be an important determinant of the impact of reforms on the health insurance market. Most of the health insurance reform proposals include a focus on the difficulty individuals and small groups have in obtaining health insurance at the same cost as larger groups. Small groups often face higher costs per participant because of their higher per capita administrative costs and insurance companies' limited ability to pool risks. Insurers currently price their policies on the basis of the expected risk of the individual group. If an insurer pools all the groups it insures together and charges a premium based on that total pool, some of the groups in the pool will pay higher premiums than they would if the premiums were set on their risk alone, while others will pay lower premiums.

In the current health insurance market, insurers who attempt to pool risk across groups will find the lower risk groups will choose another insurer whose premiums reflect only their own risks and are therefore lower. By changing the incentives that keep insurers from pooling small groups, employment-based coverage may expand to include many of the employed uninsured in small firms and their dependents.

Most proposals include some means for guaranteeing that all small groups have access to insurance and are not denied coverage based on individual characteristics. However, proponents of insurance market reform recognize that guaranteed availability alone accomplishes little unless premium rates for small groups are stabilized. Some proposals move the insurance market toward community rating so that insurance would be offered to all small groups at common rates. Others would allow insurers to adjust community rates for factors such as age, sex, geographic location, and industry type (class rating).

Some analysts argue that mandating community rating or eliminating demographic adjustments would raise rates for many groups and create incentives for adverse selection. Adverse selection occurs when individuals with greater health risks are disproportionately enrolled in a particular plan or group. Community rating limits insurers' ability to charge different premiums to groups on the basis of risk. As a result, premiums for groups that represent good health risks would rise with the implementation of community rating, while premiums for groups representing poorer risks would fall. Some of the healthier individuals would choose not to purchase health insurance as a result of the premium increase, while more of those individuals who are poorer health risks would purchase health insurance. The result would be an increase in the pool's average risk, increasing premiums and potentially creating a vicious cycle that could end in an unviable health insurance market. The likelihood of this scenario actually occurring depends on the sensitivity of the demand for health insurance to changes in premiums among individuals who represent good and bad risks and on the ability of individuals to determine their own risk status.

Generally, in the managed competition models that create regional health insurance purchasing cooperatives (HIPCs), low income families, individuals not connected with a group, and employees of small employers would purchase coverage through the cooperative. These cooperatives or alliances would community rate over a risk pool formed on the basis of employer size and individual work status. The composition of these cooperatives or alliances would determine the costs of health insurance and the distribution of these costs. Even if employees of small firms are, on average, healthier than most Americans, the other two groups are likely to be less healthy. For example, table 4 provides results of simulations on the premiums likely to be charged to single adult individuals in purchasing cooperatives under different assumptions about their composition.

Table 4
Simulation of Single Adult Premiums under Various Assumptions of Composition of Risk Pool. Assumes All Employees of Employers with Fewer Than 500 Employees Purchase Coverage through Health Insurance Purchasing Cooperative (HIPC), All Other Employees Purchase Coverage Outside HIPC

Composition of Risk Pool	Premiums Outside HIPC	Premiums Inside HIPC
Workers Only	$2,188	$1,979
and Nonworkers	$2,018	$2,097
and Medicaid	$1,683	$2,236

Source: Employee Benefit Research Institute simulations using the March 1993 supplement to the Current Population Survey and the National Medical Expenditure Survey.

Table 4 estimates single adult premiums that would arise under different risk pools. In the workers only pool, all employees of firms with fewer than 500 employees are included in the pool. The estimated premium is $1,979. When nonworking individuals are added to the pool, the annual premium rises by $118, and when individuals now receiving Medicaid are added, the premium rises by another $139 to a total of $2,236. Pooling working single adults with nonworkers and Medicaid eligible individuals increases worker premiums by almost 13 percent, or an estimated $21 per month.

Table 5
Simulated Single Adult Premiums Under Various Assumptions on Size of Employer in Risk Pool and Whether Medicaid Recipients are Included in the Pool

Composition of Risk Pool	Employer Size Cap		
	100	500	1,000
Medicaid Out	$2,181	$2,097	$2,068
All Under Cap In	$2,336	$2,236	$2,202

Source: Employee Benefit Research Institute simulations using the March 1993 supplement to the Current Population Survey and the National Medical Expenditure Survey.

Managed competition models often require that employers under a certain size must purchase coverage through a risk pool formed by a regional HIPC or alliance. As table 5 indicates, increasing the size of the employer required to purchase coverage through the HIPC or alliance decreases the premium charged for coverage within that pool. Including those presently covered by Medicaid in the pool increases the average premium by an average of about 7 percent. However, simulating the per capita costs of providing coverage to nonelderly Medicaid recipients after reform indicates these costs to be $3,309. Thus, including them in the risk pools lowers the per capita costs to federal and state governments by over 29 percent.

Tables 4 and 5 assume that all individuals purchase health insurance coverage. If some individuals choose not to purchase health insurance, and if these individuals are healthier, on average, than those who elect to purchase coverage, the premiums will be higher.

Changing the way risks are pooled will have important consequences in the health insurance market. Many small groups and individuals will see the costs of health insurance fall as a result, while others will see an increase. Even those groups whose premiums will increase under some form of community rating may be better off if the reforms stabilize premiums. Small employers who currently have good risk profiles may still not offer health benefits because one catastrophic illness could make these health benefits unaffordable. Some form of community rating reduces the variability in health insurance premiums.

Reforming the health insurance market by itself is unlikely to significantly increase health insurance coverage. Although some groups may see lower premiums as a result of insurance reforms, others will face premium increases, and the stabilization of health premiums may not be enough to offset these increases. Health insurance reform will redistribute the costs of health care services from the poorer risks who may currently be excluded from the market to the better risks. The burdens imposed by this redistribution will depend on the number of good risks who remain in the pool.