CBO TESTIMONY

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

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NOTICE

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Mr. Chairman, I appreciate the opportunity to appear before this Subcommittee to discuss trends in the number of people without insurance and the costs of health care.

OVERVIEW OF THE HEALTH CARE SYSTEM

The U.S. health care system has many strengths. Because of the resources devoted to research and because our current financing system encourages the rapid dissemination of new technologies, we are able to provide the highest quality care in the world. The substantial majority of the population--generally, those with health insurance--have access to care without waiting, and there are few limits on our choices of providers, alternatives for treatment, or types of health coverage.

Yet, over the past two decades, criticisms of the health care system have grown: substantial numbers of people remain without health insurance, either private or public, and health care spending per person is much higher than in other countries and is rising faster than the gross domestic product (GDP). Moreover, unless the system is modified substantially, we may anticipate further deterioration of insurance coverage and continued rapid increases in spending for health care.

TRENDS IN INSURANCE COVERAGE

In March 1992, about two-thirds of the population under age 65 had health insurance through an employment-based group, either because their own employer offered it or because they were insured as a dependent of a worker whose employer offered group coverage (see Appendix Table 1). Another 10.5 percent of the nonaged population was insured through a public program--Medicaid (8.7 percent), Medicare (1.4 percent), or the Department of Veterans Affairs (0.3 percent). Another 6.5 percent was insured through individual insurance policies unrelated to employment. The remaining 15.9 percent of the nonaged population--about 35.2 million people--were without insurance coverage. (Because almost all of the elderly participate in Medicare, they make up a negligible proportion of the uninsured.) Since 1980, the proportion of the population under 65 without health insurance has increased by more than one-fourth.

Three-fifths of the uninsured had incomes less than 200 percent of the poverty level (see Appendix Table 2). Children were less likely than others to be uninsured--12.7 percent of children were uninsured versus 17.3 percent of the population aged 18 to 64. Moreover, although white people account for more than three-quarters of the uninsured, nonwhite people are much more likely to lack coverage.

Employment-Based Insurance

Excluding employer-paid fringe benefits from the taxable income of the employee encourages reliance on employment-based group insurance to provide financial protection against health care costs. For example, an employee with a marginal federal income tax rate of 28 percent, a federal payroll tax rate of more than 15 percent, and a state income tax rate of 5 percent can obtain $1 worth of health insurance coverage paid by an employer at a marginal cost to the employee that is equivalent to about 52 cents of after-tax income.

Excluding the employer-paid share of health insurance from taxable income will provide an implicit federal subsidy for group insurance of about $70 billion in 1993. Similar provisions in state income tax codes will provide about $10 billion in implicit subsidies annually. Despite these subsidies, not all employees receive health insurance coverage through their employment. About three-quarters of the uninsured are in the workforce or are in a family where at least one person is employed (see Appendix Table 3). The remaining uninsured have no family connection to the employed labor force.

A major factor affecting the availability of employment-based group insurance is the size of the employing firm. Only 39 percent of firms with fewer than 25 workers offer insurance, whereas virtually all firms with 100 or more workers do so (see Appendix Table 4). One reason that small firms are less likely to offer insurance may be that the administrative costs associated with small groups are quite high. Firms with fewer than 50 employees face administrative costs of at least 25 percent of the cost of benefits, compared with 12 percent or less for groups with 500 or more employees.

Regardless of their size, firms that do not offer health insurance have substantially higher proportions of low-income workers than firms that do offer it. In addition, the decline in the proportion of full-time workers with employment-based health insurance--from 77.2 percent in 1982 to 73.8 percent in 1987--appears to have primarily affected low- and moderate-wage workers. With health care costs rising much more rapidly than wages, this gradual erosion of health insurance coverage is likely to continue. It may be offset in part, however, by Medicaid eligibility continuing to expand, which will occur through the beginning of the next century.

Consequences of Being Uninsured

People without insurance use fewer services than do the insured, and although some of the forgone services may be of limited value, important ones are apparently also not obtained. A recent study of five medical procedures that are expensive and have a substantial discretionary element found that, among the hospitalized, those without insurance were 29 percent to 75 percent less likely to undergo the procedures, even though the uninsured were sicker when they were admitted. Uninsured patients were also significantly more apt to die in the hospital, even after one adjusts for factors such as their poorer health. Clearly, the consequences of being uninsured can be severe, both for the individual and for society.

TRENDS IN SPENDING FOR HEALTH CARE

In 1991, the United States spent $751.8 billion on health care--or about $2,870 per person. The annual rate of increase in per capita spending, adjusted for general inflation, between 1980 and 1991 was 4.5 percent. CBO's projections suggest that, by the year 2000, per capita spending on health care will exceed $4,600 (in 1991 dollars). This country already spends much more on health than do other developed countries, both in absolute dollars and as a share of

national income--12.4 percent of gross domestic product in 1990, compared with 9.0 percent in Canada, 8.1 percent in the former West Germany, 6.5 percent in Japan, and 6.1 percent in the United Kingdom (see Appendix Figure 1).

As health spending has risen, its distribution by payer has also changed. The share of personal health spending that people pay out of pocket declined from 53.4 percent to 21.9 percent between 1965 and 1991. In contrast, private insurance payers and governments have taken on an increasing share. Private insurance accounted for 24.3 percent of health spending in 1965 and 31.7 percent in 1991; federal, state, and local governments paid for 20.3 percent in 1965, before Medicare and Medicaid were in place, but 42.9 percent in 1991 (see Appendix Figure 2).

Impact on Consumers

Even though household spending has declined as a share of total health expenditures, it was relatively stable as a percentage of income--around 3.5 percent over the 1984-1991 period for nonaged households. In contrast, households headed by a person aged 65 or older spent around 11 percent of income on health care (see Appendix Figure 3), and other evidence suggests

their out-of-pocket spending, relative to after-tax income, has risen substantially since 1972.

In fact, a small fraction of the population each year accounts for an exceptionally high proportion of total spending for health care. In 1987, the 50 percent of the population with the lowest health care bills accounted for only 2 percent of total spending on health, while the 10 percent with the highest expenditures accounted for 75 percent. This pattern holds for both the population under age 65 and for the aged population.

Impact on Providers

During the past decade, much of the effort to control health care costs has focused on hospital spending--both through managed care that attempts to control hospital admissions and lengths of stay and through Medicare's prospective payment system. Nevertheless, during that period hospital spending continued to rise. For example, in 1980 the United States spent $169.5 billion (in 1991 dollars) on hospital care, compared with $288.6 billion in 1991. This growth was the result of a striking 72 percent increase, after accounting for general inflation, in expenses per admission (adjusted for the

growth in outpatient visits), which more than offset a 14.1 percent drop in admissions over this period.

Hospital margins based on total revenues, over the same period, also remained at higher levels than in preceding decades. Although hospital margins declined from 5.9 percent to 4.8 percent between 1985 and 1990, they rose to 5.2 percent in 1991, compared with an average of 2.4 percent between 1965 and 1975 (see Appendix Figure 4). Despite the evidence that hospitals are on average more than covering their costs, some hospitals, including many that serve a high proportion of uninsured and Medicaid patients, are losing money.

Spending for physician services increased even more rapidly than spending for hospital services over the past decade. In 1980, the United States spent $295 per person (in 1991 dollars) on physician services; by 1991, the country was spending $542 per person--an 84 percent increase in real spending per person over an 11-year period.

Physicians' incomes, after expenses, also rose during the 1980s--more than 31 percent, after accounting for general inflation, between 1981 and 1989. In 1986, U.S. physicians earned considerably more than their colleagues in other countries, both in absolute and in relative terms--around 50 percent more

than physicians in Canada and West Germany, and three times as much as physicians in the United Kingdom. That year, U.S. physicians earned 4.5 times the average compensation of all U.S. workers, higher than the value in the other countries compared (see Appendix Figure 5).

Impact on the Federal Budget

The rapid growth of national spending for health care, overall and per capita, also has significant implications for the federal budget. In 1970, spending on health constituted 7.1 percent of the federal budget. By 1992, that share had grown to 16.1 percent. Even more disturbing, in its January 1993 federal budget baseline projections, which are being released today, CBO projects that health care will account for 23.6 percent of federal spending by 1998 (see Appendix Table 5).

After taking general inflation into account, CBO projects that federal Medicaid expenditures will rise at an average annual rate of 10.6 percent between 1992 and 1998. The corresponding growth rate projected for Medicare is 9.4 percent. In contrast, all other federal health expenditures are projected to grow at only 2.5 percent.

The annual rate of real growth in Medicare spending per enrollee was also substantially higher than growth rates in health spending per person in the nation throughout the 1970s and in the first half of the 1980s. But Medicare's real growth in spending per enrollee between 1985 and 1991 fell to 3.1 percent--a figure considerably less than the 4.8 percent growth in per capita expenditures the nation experienced (see Appendix Figure 6).

Most of this decline in growth stemmed from a substantial drop in the rate of increase in Medicare's spending for hospital services. Although the real rate of growth in physician spending also declined somewhat, it continued at a 5.6 percent annual rate per enrollee during the 1985-1991 period, compared with 1.0 percent for hospital spending (see Appendix Figure 7).

The average annual real rate of growth of per capita spending for hospital care in the nation, however, has been essentially stable over the 1980-1991 period, even though the rate of growth in Medicare's spending dropped substantially. This pattern illustrates a major factor in this country's inability to gain better control over health spending. In the U.S. multiple-payer system, successful efforts by one payer to reduce the growth in costs appear to be offset by more rapid increases in costs for other payers.

CONCLUSION

Despite the many strengths of this nation's health care system, serious problems exist. The number of people without insurance is growing, and this trend is expected to continue as employers respond to rapid increases in premiums for health insurance by limiting coverage and as insurers attempt to limit risk by excluding firms and individuals with exceptionally high needs for health care. Those most likely to be uninsured are least able to afford the health care they need--the poor not eligible for Medicaid. Exacerbating the problems faced by the uninsured are high and rapidly rising costs of care.

Health care costs are increasing far more rapidly than inflation and show no signs of abating despite the many attempts made to control costs by both public and private payers. In fact, CBO projects that health care will absorb at least 18 percent of GDP by 2000. Without a reduction in the rate of growth in health care spending, more people are likely to be uninsured, workers will receive lower increases in wages and salaries as more of their compensation is received in the form of health insurance, and federal spending for health entitlement programs will continue to rise more rapidly than any other component of the federal budget.

Addressing these dual problems of the nation's health care system is a formidable task. Solutions that would reduce the number of uninsured would, by themselves, raise health care costs. Controlling costs without ensuring health insurance for everyone would probably reduce access to care for the uninsured. Yet, without substantial changes in our health care system, it is almost certain that more people will be without insurance and the cost of health care will continue to rise rapidly.

TABLE A-1. HEALTH INSURANCE COVERAGE OF THE NONAGED POPULATION, BY SOURCE OF COVERAGE, MARCH 1992

Insurance Status and Source of Coverage	Number of People (Millions)	Percentage of Nonaged Population
Total	220.8	100.0
Insurance Status		
Insured	185.7	84.1
Uninsured	35.2	15.9
Source of Insurance Coverage[a]		
Employment-based	148.2	67.1
Other private	14.3	6.5
Public	23.2	10.5
Medicaid	19.3	8.7
Medicare	3.2	1.4
Veterans Affairs	0.7	0.3

SOURCE: Congressional Budget Office calculations based on data from the Current Population Survey, March 1992.

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

"Nonaged" refers to people under age 65.

a. "Source of Insurance Coverage" refers to the individual's primary insurance coverage when there are multiple sources of coverage.

TABLE A-2. CHARACTERISTICS OF THE NONAGED UNINSURED POPULATION, MARCH 1992

Characteristics	Number of Uninsured People (Millions)	Percentage of Uninsured People	Percentage of the Nonaged Population With These Characteristics Who Are Uninsured
Total Uninsured	35.2	100.0	15.9
Age			
Children under age 18	8.4	23.8	12.7
Young adults, 18 to 24	6.6	18.7	26.9
Adults, 25 to 54	17.6	50.0	16.1
Adults, 55 to 64	2.6	7.5	12.4
Income Level			
Below the poverty level	10.2	29.0	31.7
100 percent to 199 percent of poverty	11.3	32.2	28.3
200 percent of poverty and above	13.6	38.8	9.2
Race			
White	26.9	76.6	14.7
Black	6.5	18.4	22.4
Other	1.8	5.0	19.5

SOURCE: Congressional Budget Office calculations based on data from the Current Population Survey, March 1992.

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

"Nonaged" refers to people under age 65.

TABLE A-3. WORK FORCE CONNECTIONS OF THE NONAGED UNINSURED POPULATION, MARCH 1992

Characteristics	Number of Uninsured People (Millions)	Percentage of Uninsured People	Percentage of the Nonaged Population With These Characteristics Who Are Uninsured
Total			
Total Uninsured	35.2	100.0	15.9
Work Force Connection			
Employed	16.0	45.6	15.0
Dependent of Employed Person	9.5	27.2	12.9
No Work Force Connection	9.6	27.3	23.9
Employment Level			
Full-Time Worker	11.1	31.5	13.0
Dependent of Full-Time Worker	7.5	21.4	11.5
Part-Time Worker	4.9	14.1	23.3
Dependent of Part-Time Worker	2.0	5.8	22.8
None	9.6	27.3	23.9

SOURCE: Preliminary Congressional Budget Office calculations based on data from the Current Population Survey, March 1992.

NOTES: Dependents of employed people are: (a) their children under age 19 (or under age 24 if they are full-time students); and (b) their nonworking spouses. Dependents of full-time workers are in family health insurance units where either the head or the spouse works full time. Full-time work is defined as 35 hours or more per week.

Details may not add to totals because of rounding.

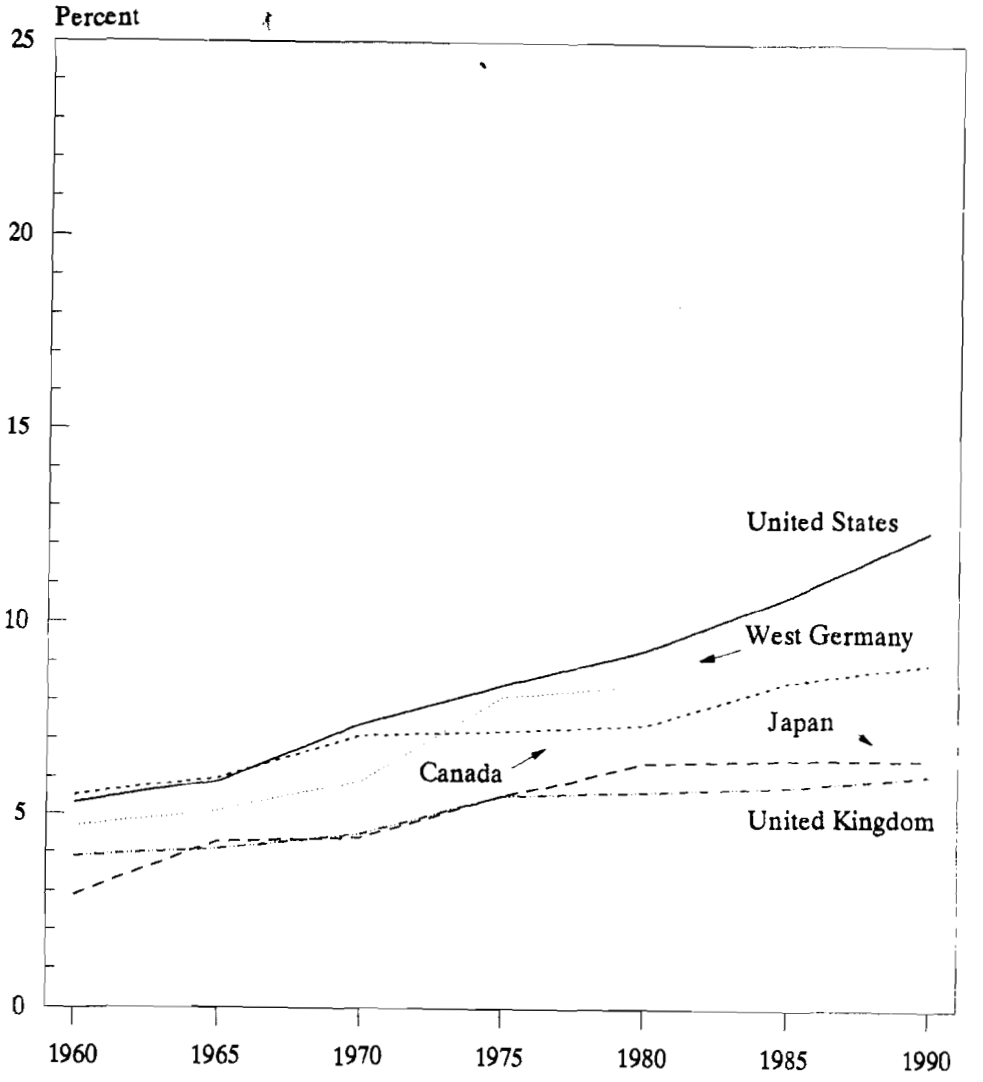
"Nonaged" refers to people under age 65.

TABLE A-4. AVAILABILITY OF EMPLOYMENT-BASED INSURANCE PLANS, BY SIZE OF FIRM, 1989

Size of Firm (Number of Employees)	Percentage of Firms Offering Insurance	Percentage of Employees in Firms Offering Insurance
Under 25	39	55
Under 10	33	42
10 to 24	72	70
25 to 99	94	94
100 to 499	99	97
500 to 999	100	100
1,000 and Over	100	100
Total	43	77

SOURCE: The 1989 Employer Survey by the Health Insurance Association of America.

Figure A-1.
Health Expenditures as a Percentage of Gross Domestic Product, United States and Selected Countries, 1960-1990

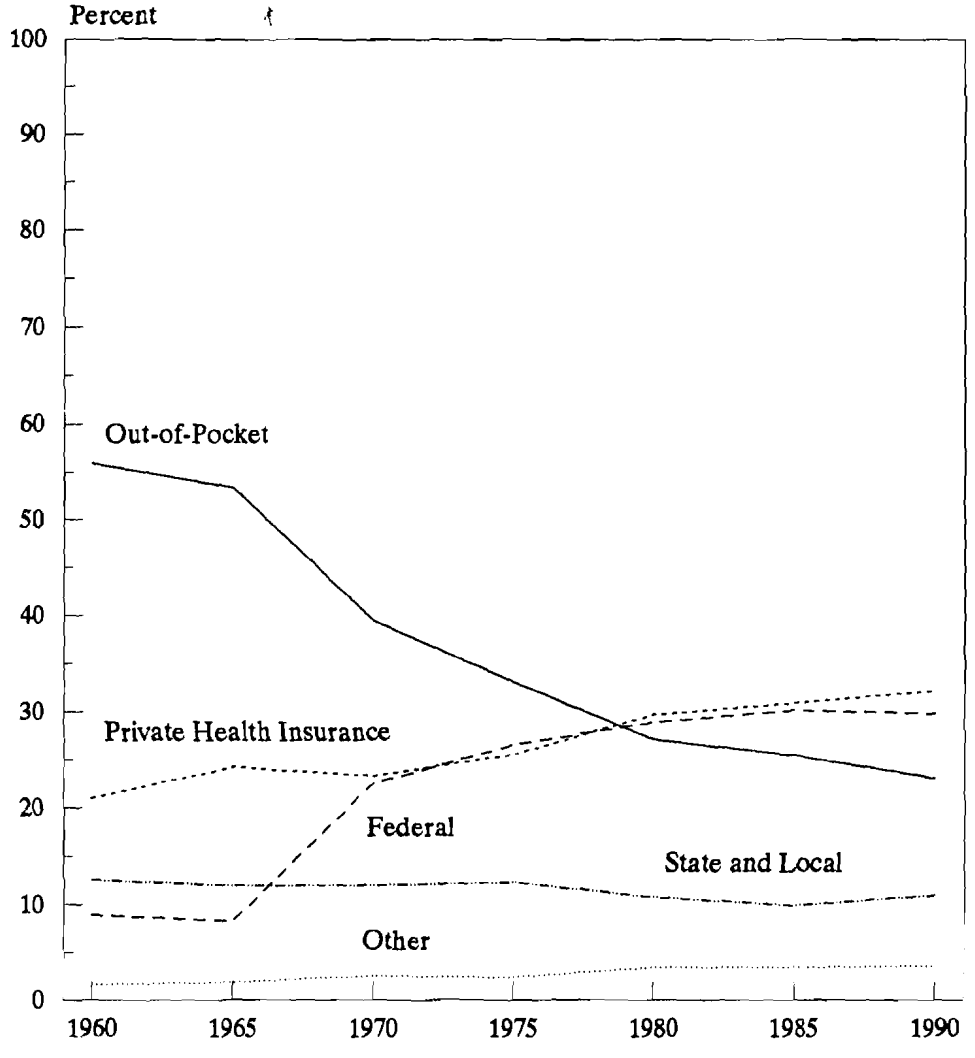


SOURCE: Congressional Budget Office using data from the Organization for Economic Cooperation and Development, Health Data File, 1991.

NOTES: Gross domestic product is equal to gross national product less net property income from abroad. Use of gross domestic product for international comparisons of health spending eliminates variations arising from differences in the rate of foreign transactions in different economies.

Data are plotted at five-year intervals.

Figure A-2.
Distribution of Spending for Personal Health Care, by Source of Payment, 1960-1990



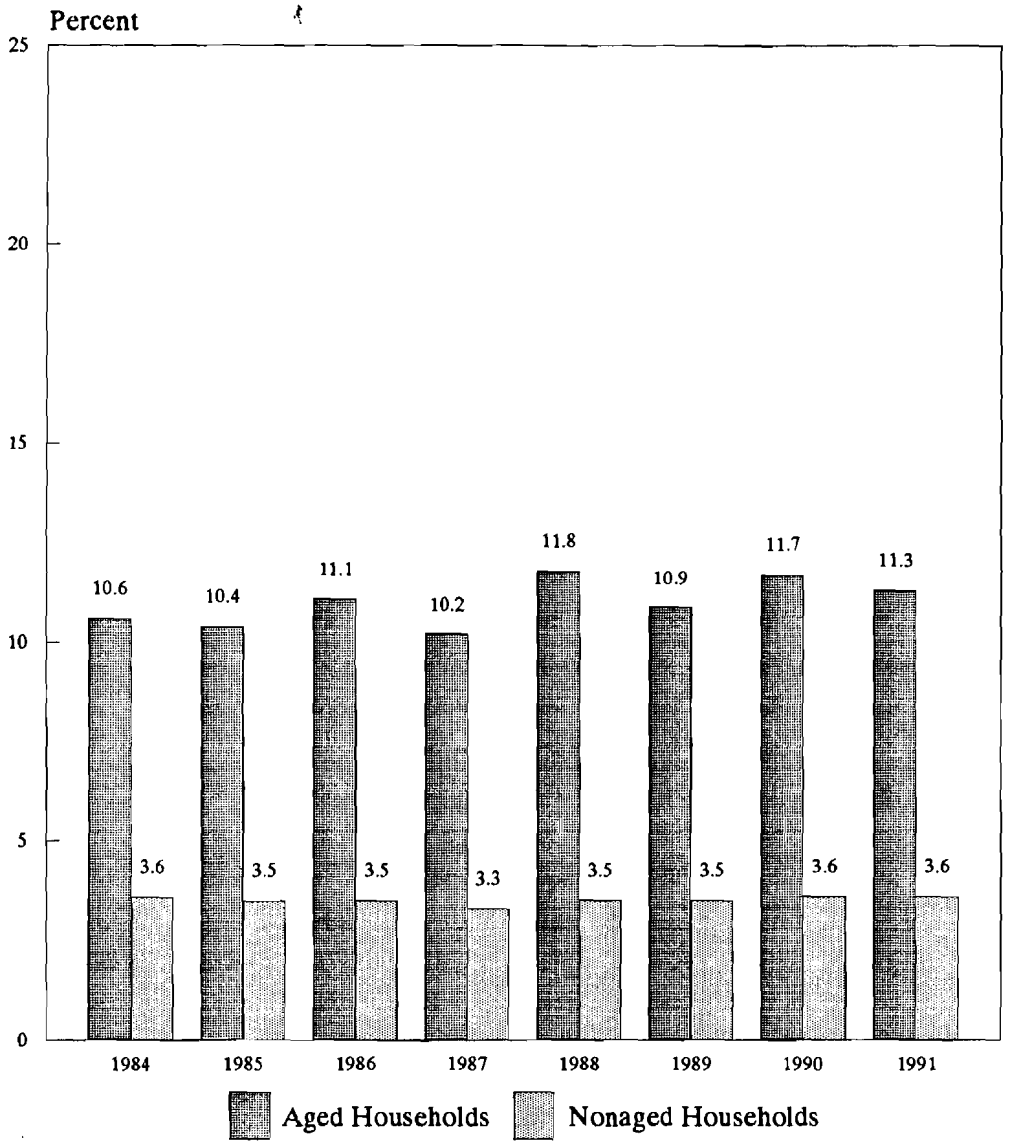
SOURCE: Congressional Budget Office calculations based on data from the Health Care Financing Administration, Office of the Actuary, 1992.

NOTES: Personal health care expenditures are equal to national health expenditures less spending for public health, research, construction, and administrative costs.

The "Other" category includes philanthropy and industrial in-plant spending for health.

Data are plotted at five-year intervals.

Figure A–3.
Direct Spending for Health as a Percentage of Income, by Aged Households and Nonaged Households, 1984–1991

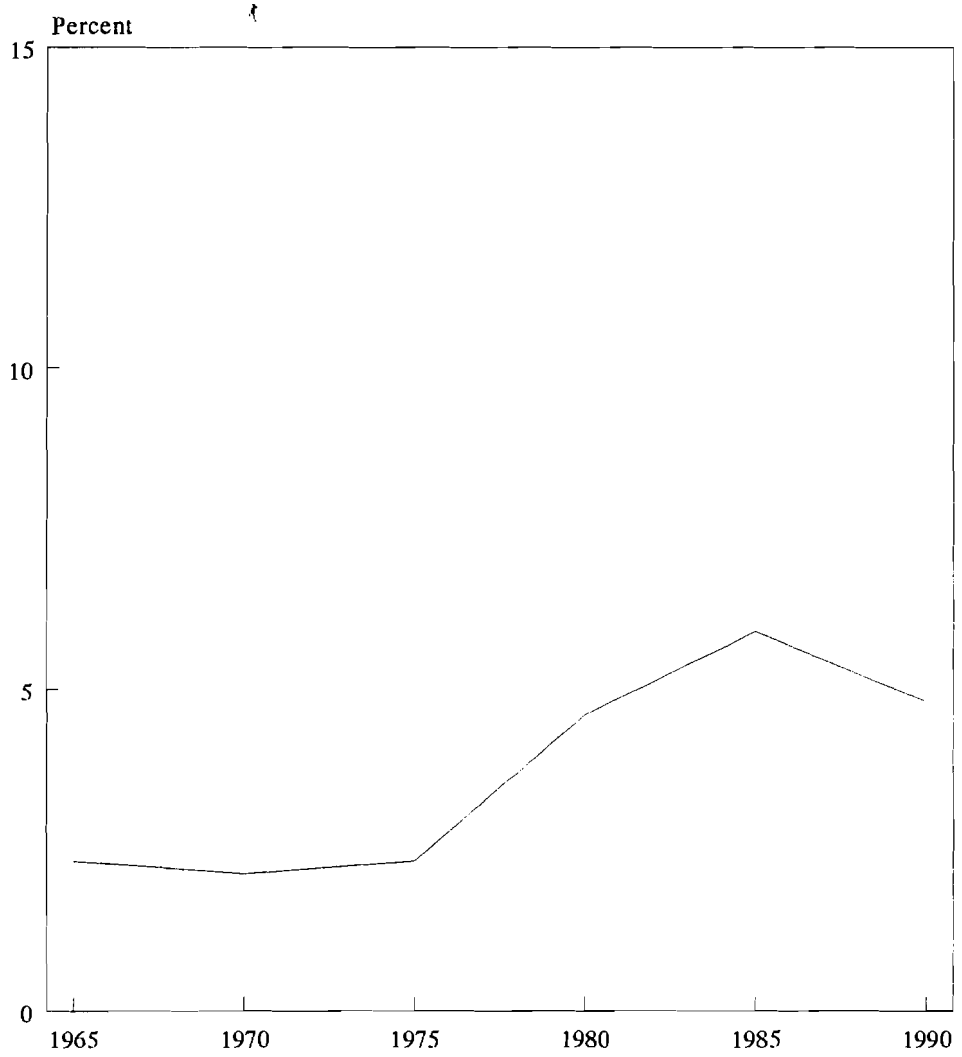


SOURCE: Congressional Budget Office calculations based on data from the Consumer Expenditure Surveys of the Bureau of Labor Statistics, 1984–1991.

NOTES: Data are tabulated by age of reference person. Aged households are those in which the primary owner or renter of the household is age 65 or over. Such households may include some individuals under age 65. Nonaged households are those in which the primary owner or renter of the household is under age 65.

"Direct spending on health" includes the amount directly paid for health insurance premiums by a household, as well as other out–of–pocket expenses for health services.

Figure A–4.
Hospital Margins Based on Total Revenues, 1965–1990

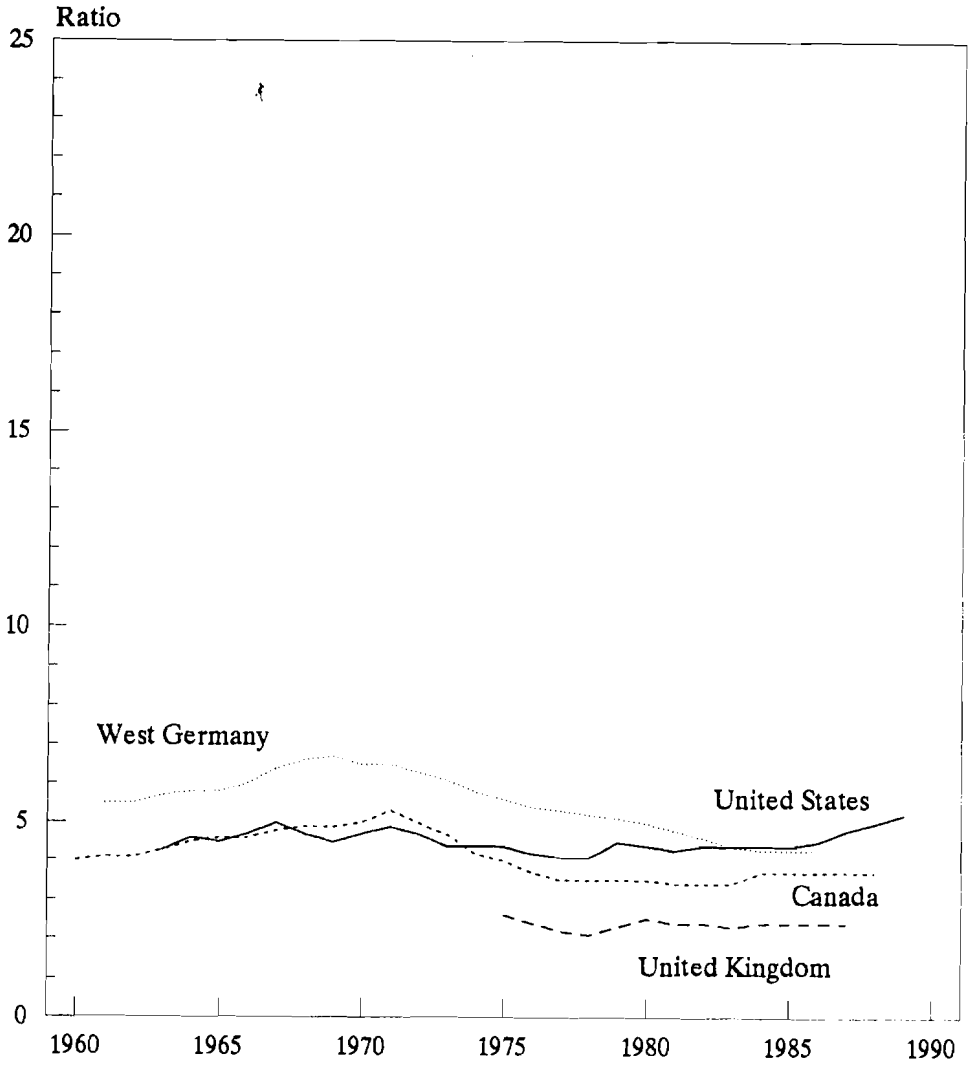


SOURCE: Congressional Budget Office calculations based on data from the American Hospital Association, National Hospital Panel Surveys, 1965–1990.

NOTES: Margins are defined as the ratio of hospitals' aggregate total revenues minus aggregate total costs to aggregate total revenues.

Data are plotted at five–year intervals.

Figure A-5.
Ratio of Average Income of Physicians to Average Earnings of All Workers, United States and Selected Countries, 1960-1989



SOURCE: Congressional Budget Office calculations based on data from the Organization for Economic Cooperation and Development, Health Data File, 1991.

NOTES: Reliable data on physicians' incomes in Japan are not available.

The concepts and estimating methodologies used to compile average earnings per worker are not the same across countries, nor necessarily within each country over time. Among the issues that cannot be taken fully into account are the regional or national basis of the estimates, whether or not both salaried and self-employed professionals are included in the figures, the exact nature of the professional groups covered, the treatment of part-time and female workers, and whether or not the income definitions used reflect income tax, census or national-accounts concepts.

Data for the following years were missing and values were imputed by Congressional Budget Office: 1966, 1968, 1976, and 1980 for the United States; 1962, 1963, 1964, 1966, 1967, 1969, 1970, 1972, 1973, 1975, 1976, 1978, 1979, 1981, 1982, 1984, and 1985 for West Germany. Data missing at the beginning and end of the time period were not imputed.

TABLE A-5. FEDERAL SPENDING ON HEALTH, FISCAL YEARS 1965-1998

	1965	1970	1975	1980	1985	1990	1991	1992	1993	1994	1995	1996	1997	1998
In Billions of Dollars														
Total Federal Spending	118.2	195.6	332.3	590.9	946.3	1,251.7	1,323.0	1,381.9	1,452.9	1,506.8	1,574.5	1,642.8	1,733.0	1,839.1
Federal Health Spending	3.1	13.9	29.5	61.8	108.9	168.0	188.6	222.7	254.2	286.1	320.2	355.5	393.2	434.2
Medicare	n.a.	6.2	12.9	32.1	65.8	98.1	104.5	119.0	134.1	152.3	171.7	192.7	215.3	239.3
Medicaid	0.3	2.7	6.8	14.0	22.7	41.1	52.5	67.8	80.3	91.9	105.0	117.7	131.0	145.9
Veterans Affairs	1.3	1.8	3.7	6.5	9.5	12.1	12.9	14.1	14.9	15.7	16.2	16.7	17.2	18.0
Other	1.5	3.2	6.1	9.2	10.9	16.6	18.7	21.8	24.9	26.2	27.3	28.4	29.7	31.0
As a Percentage of Total Federal Spending														
Federal Health Spending	2.6	7.1	8.9	10.5	11.5	13.4	14.3	16.1	17.5	19.0	20.3	21.6	22.7	23.6
As a Percentage of Federal Spending on Individual Health Programs														
Federal Health Spending	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Medicare	n.a.	44.6	43.7	51.9	60.4	58.4	55.4	53.4	52.7	53.2	53.6	54.2	54.8	55.1
Medicaid	9.7	19.4	23.1	22.7	20.8	24.5	27.8	30.4	31.6	32.1	32.8	33.1	33.3	33.6
Veterans Affairs	41.9	12.9	12.5	10.5	8.7	7.2	6.8	6.3	5.9	5.5	5.1	4.7	4.4	4.1
Other	48.4	23.0	20.7	14.9	10.0	9.9	9.9	9.8	9.8	9.2	8.5	8.0	7.5	7.1

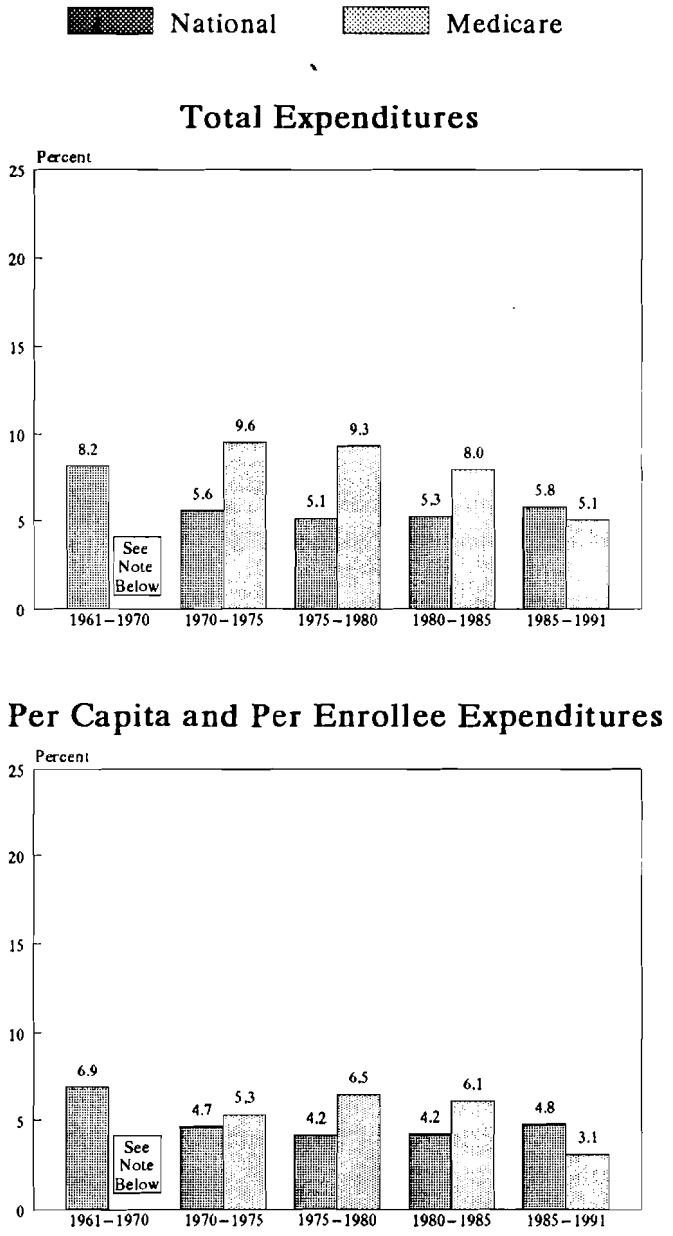
SOURCE: Congressional Budget Office calculations and projections, January 1993.

NOTES: Medicare expenditures are shown net of premium income from beneficiaries.
"Other" includes federal employee and annuitant health benefits, as well as other health services and research.
"Federal health spending" excludes spending for the military's CHAMPUS program.

Spending for discretionary programs in the 1993-1998 period is increased each year to reflect projected inflation, starting from the 1993 appropriated levels. Although CBO's projections of total federal spending assume compliance with the discretionary spending limits for the 1993-1995 period, the Budget Enforcement Act does not specify programmatic changes to achieve those limits. Thus, it is not possible to adjust projections for individual programs to reflect the overall limits.

Details may not add to totals because of rounding.

Figure A–6.
Average Annual Growth Rates of Real National and Medicare Expenditures for Health, Total and Per Capita, 1961–1991

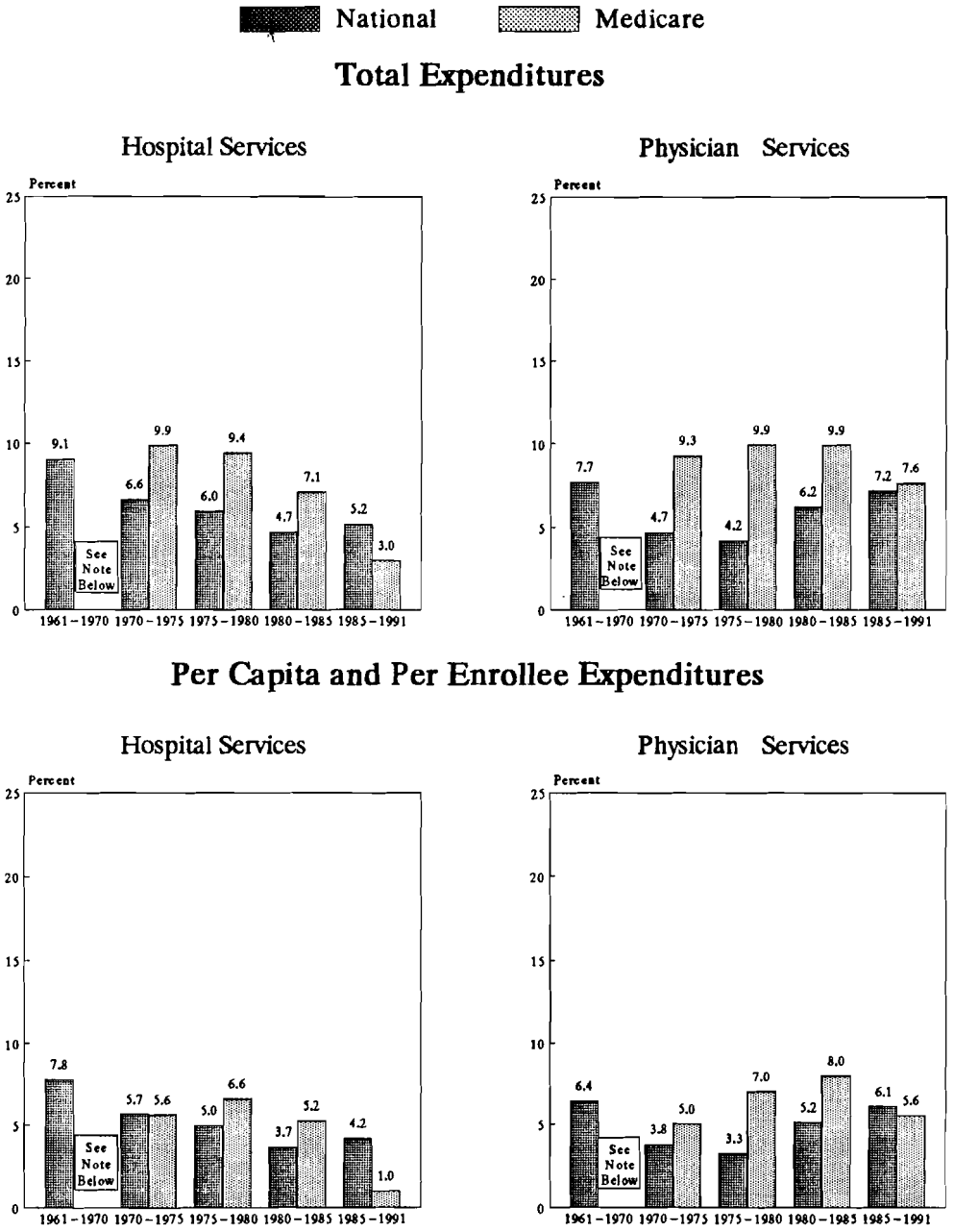


SOURCE: Congressional Budget Office calculations based on data from the Health Care Financing Administration, Office of the Actuary, 1992.

NOTES: The word "real" is used here to mean adjusted for general inflation rather than for inflation in the prices of health services, which is almost certainly different. Health expenditures are adjusted to 1991 dollars using the consumer price index.

Growth rates are not available for total and per enrollee Medicare expenditures during the 1961–1970 period as the Medicare program was not enacted until the mid–1960s.

Figure A–7.
Average Annual Growth Rates of Real National and Medicare Expenditures for Hospital and Physician Services, Total and Per Capita, 1961–1991



SOURCE: Congressional Budget Office calculations based on data from the Health Care Financing Administration, Office of the Actuary, 1992

NOTES: The word "real" is used here to mean adjusted for general inflation rather than for inflation in the prices of health services, which is almost certainly different. Health expenditures are adjusted to 1991 dollars using the consumer price index.

Growth rates are not available for total and per enrollee Medicare expenditures during the 1961–1970 period as the Medicare program was not enacted until the mid–1960s.