Statement before the Joint Economic Committee
United States Congress

On "Income, Poverty, and Health Insurance Coverage: Assessing Key Census Indicators of Family Well-Being in 2008"

How What We Think We Know about the Uninsured Really Adds Up

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The views expressed in this testimony are those of the author alone and do not necessarily represent those of the American Enterprise Institute.

Chair Maloney and Members of the Committee:

Thank you for inviting me to testify before you today. I am a resident fellow at the American Enterprise Institute. This testimony has been prepared and submitted in advance of today's release of the annual Consumer Population Survey (CPS) on Income, Poverty, and Insurance Coverage, as conducted by the U.S. Census Bureau. Hence, rather than try to hit an unknown and moving target in advance, I will attempt to help place within a broader context whatever those latest findings might suggest regarding the most recent level and nature of persons lacking insurance in the U.S. I primarily will be drawing upon some recent work of mine at AEI regarding what we do know more broadly about the uninsured, some of the limitations in trying to measure the scope and dimension of the problems of the uninsured, and several often-neglected considerations in assessing the broader issue of how to improve health outcomes at lower overall costs.

Pick a Different Survey and Get a Different Number of Uninsured Americans

One normally begins with trying to determine just how many Americans lack health insurance. The short answer is "too many," but the total numbers depend on whom you ask and how they measure the problem. The CPS provides the most commonly reported figure. It was about 45.7 million people for 2007, as of last year's survey released in August 2008. Although that estimate actually was lower than the 2006 figure of 47 million, we should know by the time of today's hearing how much the number of uninsured has increased since then, due in large part (if not solely) to the devastating effects of a recession that began early last year, deepened throughout 2008, and had yet to end as of the second quarter of this year.

Two other surveys by the federal government report different estimates of the uninsured, because they are handled by other federal agencies, use somewhat different ways to measure the problem, and assess it for different periods in time. The National Health Interview Survey (NHIS), conducted by the National Center for Health Statistics of the Centers for Disease Control and Prevention, reported in June that 43.8 million persons of all ages were uninsured at the time of their interview in 2008. The NHIS provides several additional measures of the uninsured beyond what is increasingly viewed as more of the single "point in time" estimate provided by the CPS. The latest NHIS report also finds that 55.9 million had been uninsured for at least part of the entire year of 2008 prior to the interview, and 31.7 million had been uninsured for more than a year at the time of the interview.

The Medical Expenditure Panel Survey (MEPS), managed by the Agency for Healthcare Research and Quality, reported just last month that 70.7 million non-elderly individuals were uninsured at some point during calendar year 2007, 53.5 million were uninsured during the first half of that year, and 39.9 million were uninsured all year. By way of comparison, MEPS data indicate that a somewhat higher number of non-elderly individuals (57.4 million) were uninsured during the first half of 2008 than was the case for the first half of 2007.

All of the major federal surveys tell us part, but not all, of a complex story. They may be "close enough for government work" but remain fundamentally designed differently, to measure other things besides insurance status. They vary in the length of time without insurance that is measured, the period that respondents must recall, how insurance is defined, and how questions are asked; as well as time lags in the compilation and reporting of data.

Longer-Term Insurance Trends

Because some of the respective survey questions and methods have changed over time, longer-term analysis over past decades becomes more complicated. Perhaps the most useful analysis of those long-term insurance coverage trends can be found in a July 1, 2009 National Health Statistics Reports publication on "Health Insurance Coverage Trends, 1959-2007," which relies on past NHIS Findings. It concludes that, since 1990, the percentage of nonelderly persons without coverage has remained stable, although the number increased by more than 6 million persons, to 43.3 million in 2007. As is the case with other health measures for the U.S. population, it's more instructive to account for changes in the denominator as well as the numerator by relying more on percentages than on raw numbers alone. To recap more broadly, what we generally know is that the percentage of non-elderly Americans without insurance coverage at any one time has increased slightly in the last 15 to 20 years, but it has remained within a relatively narrow range – usually between 14 and 16 percent of the overall population.

How Long Are People Uninsured?

The share of the uninsured without coverage for more than a year may have increased in recent years as well, but it still generally represents somewhat more than half of all those uninsured at any time during a year. U.S. Department of Health and Human Services researchers found in a 2004 study that about half of those uninsured for at least one month during a two-year period turned out to be uninsured for over a year. Using much older but richer data in the late 1990s within the Survey of Income and Program Participation (SIPP), the Congressional Budget Office estimated in 2003 that about 16 percent of those uninsured at any time during a year remained uninsured for more than 24 months. The lengths of spells without insurance are

important, because different solutions are needed to address the different problems they present. In any case, the broader issue of slowly declining rates of insurance coverage in the United States remains more like a chronic condition (needing better diagnosis and more than one kind of targeted treatment) than a crisis (needing emergency surgery).

Who Tends to Be More Likely to Be Uninsured?

The CPS and the NHIS are the most informative surveys on the demographics and characteristics of the uninsured. Today's CPS report should update past indicators to some degree. The uninsured tend to be younger, with those most likely to be uninsured between ages 19 and 24. Almost all adults age 65 and above are covered primarily by Medicare, and many of them have supplemental private insurance. Men are a little bit more likely than women to be uninsured. Married individuals and persons with more than a high school education are much more likely to be insured. Most of the uninsured are in good to excellent health. The likelihood of being insured rises with income and full-time work status, although nearly half of the uninsured are full-time workers. Hispanics are considerably more likely than those in any other ethnic category to be uninsured. More than a quarter of the uninsured are foreign-born. Based on past Census Bureau estimates, about 10 million uninsured are not citizens and roughly half of them are illegal immigrants. .

Is the "Real" Number of Uninsured Smaller than It Seems?

One can torture statistics in both directions regarding the number of "uninsured." until they plea to lesser or greater crimes. A smaller number for the "seriously" uninsured can be derived by taking into account such factors as the Medicaid undercount and the voluntarily

uninsured, as well as the above-referenced number of undocumented immigrants without insurance.

With regard to Medicaid, millions of potential beneficiaries do not enroll in its various types of coverage across different state programs. Reasons include ineffective and limited outreach efforts, as well as dissatisfaction with what coverage provides. Delaying enrollment is encouraged by the option to gain retroactive Medicaid coverage that may be available for three months prior to application if the individual would have been eligible during the retroactive period. But a somewhat lesser number of those "uninsured" individuals officially lacking Medicaid, or other coverage, may actually have Medicaid insurance after all. The so-called "Medicaid undercount" is derived from findings that Medicaid coverage levels based on survey data are consistently lower than the count of Medicaid enrollees obtained from the program's administrative records. On the high side, a recent study concluded that the CPS overestimates the uninsured population by as much as 9 million people for this reason alone! However, the latest research suggests that the undercount's effect is smaller, because it's more likely to involve Medicaid enrollees erroneously reporting that they have some other type of health insurance rather than none at all.

Some skeptics of estimates of the number of uninsured point to millions of individuals in relatively higher-income households who could afford to buy coverage, but do not, and therefore describe them as "voluntarily" uninsured. According to the last CPS report released in August 2008, more than 17.7 million uninsured live in households earning more than $50,000 a year, and household income is above $75,000 for more than 9.2 million uninsured. However, those numbers overstate the actual income available to those uninsured individuals, because household units are defined more broadly than are insurance purchasing units. As the composition of

"households" changes, their income isn't the same as family income available for spending on health insurance. The rising cost of coverage remains the primary barrier to insurance coverage for the uninsured, and in some cases, its value just may not be "worth it" for those in higher income families. But a more narrow and consistent measure of the higher income uninsured is closer to 2 million, involving people with regular incomes over $50,000 who lack insurance for spells of more than a year.

Affordability of Insurance Coverage Remains the Main, But Not the Only, Problem

The main reason cited by individuals for why they lack insurance is that it costs too much, but it's not the only factor. Adults with weak or uncertain preferences for health insurance are less likely than others to obtain job offers with insurance, to enroll in offered coverage, and to be insured. On the other hand, individuals with higher health risks are more likely to seek and obtain health insurance coverage, particularly in the large employer group market. Higher premiums for higher risks are not a significant contributor to the large uninsured population.

Two recent measures of the "affordability" of insurance coverage suggest some approximate benchmarks that move beyond assuming that taxpayers must subsidize whatever uninsured individuals are unwilling, as opposed to unable, to pay. Bundorf and Pauly proposed several definitions of affordability based on the insurance purchasing behavior of other consumers with similar characteristics, rather than an arbitrarily chosen income threshold, in a 2006 Journal of Health Economics study. When they used a behavioral definition of health insurance as "affordable" if the majority of people in similar circumstances purchased coverage, their study found that health insurance was affordable to over 50 percent of the uninsured in 2000. Even increasing the affordability threshold to one where no less than 80 percent of

individuals with similar characteristics purchased private health insurance, Bundorf and Pauly estimated that approximately one-quarter of the uninsured would still be classified as able to afford coverage. To be sure, no single definition of affordability can fully classify individuals or predict their actual behavior.

June and Dave O'Neill, in a more recent Employment Policies Institute study, used a more simplified and arguably arbitrary income-based measure of affordability to estimate whether uninsured status is voluntary or involuntary. They considered uninsured units with incomes above 2.5 times the federal poverty threshold as voluntarily uninsured, relating that threshold to the percentage of individuals above it that obtain private coverage. (They found that 79 percent of those with incomes between 2.5 and 3.75 times their poverty threshold did so.) The O'Neill measure of affordability concluded that about 16 million of the population between ages 18 and 64, reported as uninsured in 2006, were "voluntarily" uninsured in the sense that their incomes were high enough to enable them to afford a health insurance policy. They represented more than 40 percent of the total uninsured within their CPS-based population for that period and age bracket.

How Much Care Do the Uninsured Receive?

The uninsured certainly receive a fair amount of health care through various payment mechanisms, with a good bit of it seemingly "for free." However, the care the uninsured consume remains less than that of the insured. It also is not received as quickly, and it is not delivered as effectively. People lacking health insurance pay out of pocket, receive uncompensated care, rely on other forms of private and public insurance (such as worker's compensation), and wait until they have access to health insurance. Overall, the full-year

uninsured receive, as one lower-end estimate, about 43 percent of the dollar amount of medical care per person of those who have private insurance coverage for the entire year. (Some earlier estimates placed this figure closer to 50-55 percent). People uninsured for only part of the year spend more than 75 percent (and perhaps as much as 80 percent) of what the full-year privately insured do for health care services.

How Much of that Care for the Uninsured Is Uncompensated, and Shifted to Private Insurance Premiums?

Best estimates indicate that the total dollar amount of uncompensated care in 2008 amounted to roughly $56 billion. The same group of Urban Institute researchers (Hadley et al) providing that figure also calculated that federal, state, and local government funds accounted for $43 billion that was available to pay for that uncompensated care, even after adjusting for possible misallocation of funds spent in the name of the uninsured. Their study concluded that attributing increased private health insurance premiums to any expanded costs of treating the uninsured is a misperception; particularly when a net balance of only about $14.5 billion (using the higher of the two uncompensated care measures they suggested) was arguably financed by the privately insured in the form of higher (cost-shifted) private payments for care and, ultimately, higher insurance premiums. Indeed, they estimated that the amount of uncompensated care potentially available for private cost-shifting is most likely even lower, at about $8 billion in 2008, which was less than 1 percent of private health insurance costs ($829.9 billion).

Other recent competing estimates of cost shifting from uncompensated care to private insurance premiums have undercounted other sources of payment for care received by the uninsured and crudely assumed that the costs of care for the part-year uninsured would be

proportionate to the portion of the year that they were uninsured (unlike Hadley et al., who adjust for the clustering of more health spending into periods of insurance coverage), while tossing in some other estimation errors and omissions. One of the clinching arguments for the Hadley et al. view of cost-shifting is their statistical demonstration that the share of hospitals' overall costs due to uncompensated care remained remarkably stable over time amidst rising levels of uninsurance -- even as hospitals' cost-to-charge markup ratio for private payers has fluctuated for other reasons in a completely uncorrelated manner.

Because most of the costs of uncompensated care are covered by various taxpayer-funded payments (particularly disproportionate share payments to hospitals likely to treat more uninsured and low-income patients), there just isn't much left in what remains to be "shifted" to private insurance premium payers. To the extent such cost shifting can occur not just in theory but in practice, it's due much more to public programs like Medicaid and Medicare that have the legal power to pay much lower "below-market" rates of reimbursement to hospitals and doctors. Expanding low-paying Medicaid coverage might actually make any possible cost shifting to private premium payers worse, not better.

Don't the Uninsured Just Get Necessary, Though More Costly, Care at Overcrowded Hospital Emergency Rooms?

Federal law requires hospital emergency departments to screen and stabilize anyone arriving there with a serious medical condition, regardless of the person's ability to pay. It's sometimes said that"no one goes to the emergency room anymore; it's too crowded." But the rise in emergency department visits over the last decade came from disproportionate increases in use by non-poor persons and not the uninsured. The visit rates by Medicaid patients (82 per 100 persons with Medicaid) are more than 70 percent higher than those of the uninsured (48 per 100

persons with no insurance). Uninsured patients represented 17.4 percent of ED visits in 2006. Between 1996 and 2003, major contributors to ED utilization appeared to be disproportionate increases in use by nonpoor persons and by persons whose usual sources of care was a physician's office.

Does Insurance "Discrimination" Based on Pre-Existing Conditions Make Private Health Insurance Unavailable to Millions of Americans?

A recent report prepared by the HHS Office of Health Reform cites a July 2009 Commonwealth Fund study that estimated that 12.6 million non-elderly adults – 36 percent of those who tried to purchase health insurance directly from an insurance company in the individual insurance market – were "discriminated against" because of a pre-existing condition in the previous three years. The study design was described by the Commonwealth Fund as based on 130 adults insured all year with individual insurance, and nearly 1390 adults similarly insured all of 2007 with employer-sponsored insurance, all of whom were interviewed from June through October, 2007. One particular question evidently asked them (it's unclear if those answering also included some or all of the more numerous survey respondents with employer-sponsored coverage) whether they had tried to purchase coverage in the individual market between 2004 and 2007. However, the actual findings beneath the sweeping headline described above were rather thin. They failed to distinguish between those seeking individual coverage that were turned down completely, had a specific health problem excluded from their coverage, or were charged *a higher price*. Most other analysts studying individual insurance markets would suggest that the latter category (somewhat higher rate-ups of preferred and standard charges) account for the vast majority of the above categories of alleged "discrimination." Note, too, that the 1996 HIPAA provisions prohibiting discrimination on the basis of health status in

employer group plans, as well as setting limits on pre-existing condition waiting periods, for those employees maintaining continuous insurance coverage largely have eliminated any such similar practices in that much larger private insurance market.

For a more standardized and deeper estimate of the relative size of the "medically uninsurable" population not receiving coverage (rather than just those paying more for it), one must go back to the 2001 MEPS, which was the last federal survey to ask respondents under the age of 65 about being denied coverage for medical reasons. In the 2001 MEPS Household Full Year Consolidated File, roughly 2 million persons under the age of 65 said that they were denied health insurance coverage at some time in the past (but not necessarily during 2001). That number also did not necessarily represent individuals who were uninsured in 2001. The numbers reported immediately below relate to denial of insurance by health status and the medical reason for denial (a person could state more than one reason).

Total Individuals

Claiming denial of health insurance	1,980,000
(0.8 Percent of total pop under 65)	
Denied due to diagnoses of cancer	200,000
Denied due to hypertension	190,000
Denied due to diabetes	410,000
Denied due to coronary artery disease	140,000
Denied other reason	1,210,000

Uninsured Individuals

Claiming denial of health insurance	650,000
(1.3 Percent of uninsured under 65)	
Denied due to diagnoses of cancer	60,000
Denied due to hypertension	50,000
Denied due to diabetes	150,000
Denied due to coronary artery disease	40,000
Denied other reason	230,000

The Household Component of the 2002 Medical Expenditure Panel Survey (MEPSHC) also indicates that for persons with high medical expenditures under the age of 65, the most likely ones in that category are those who have private insurance. Among those non-elderly, non-institutionalized persons in the top 5 percent of the health expenditure distribution during calendar year 2002, more than 70 percent had private insurance during the year, and only 4 percent were uninsured.

Are Millions More Insured Americans Becoming Increasingly "Underinsured" as They Face Rapidly Rising Levels of Cost Sharing?

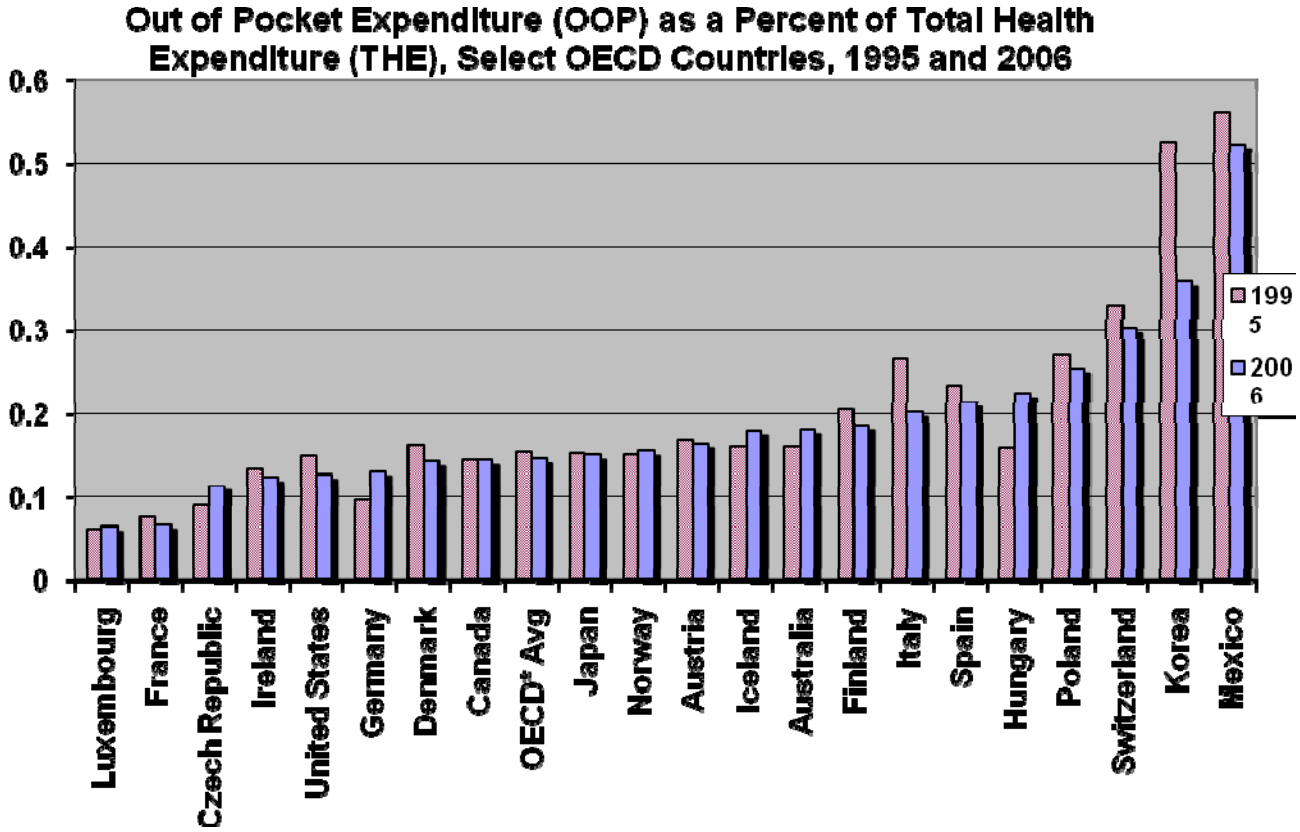
Some exaggerated calculations of recent trends in cost-sharing levels confuse changes in absolute dollar amounts for deductibles, coinsurance, and copayments with their relative percentage as a share of overall health spending, which is rising even more rapidly. Some would disagree over the appropriate spending denominator, as well as federal survey instrument, to use for this calculation. The National Health Expenditure Accounts data compiled annually by the

Centers for Medicare and Medicaid are the most comprehensive ones, and they offer the longest time series for analysis. However, the NHEA methods treat out-of-pocket (OOP) spending as more of a residual category that therefore tends to be lower than the OOP share of private health spending estimated by MEPS.

If one nevertheless uses total national health spending as the most appropriate denominator (rather than just private health spending, due to the NHEA's statistical bundling of OOP spending by Medicare beneficiaries with other OOP spending by the non-elderly population), the overall OOP, or "first-party payment" portion, of national health spending continued to decline to a record low of 12 percent in 2007.

On the other hand, the 2008 NHIS suggests that the share of private health insurance plans with greater dollar amounts of cost sharing has been growing in recent years. It reports that 19.2 percent of persons under age 65 with private health insurance were enrolled in a high-deductible health plan (HDHP), although only 5.2 percent of persons under age 65 actually were enrolled in consumer-directed health plan (CDHP). An HDHP is defined as a private health plan with an annual deductible of not less than $1,100 for self-only coverage or $2,200 for family coverage. A CDHP is defined as a HDHP with a special account to pay for medical expenses.

A different way to size up the relative level of cost sharing in the U.S. health system is to compare it to that of most other developed nations, using the common methodology of the OECD. By those standards, cost sharing in the U.S. as a percentage of total national health spending declined from 1995 to 2006, and, at 12.8 percent, it is lower than the dollar-weighted OECD average (14.7 percent), of its reporting members, as well as the percentage of cost sharing in all but four other such nations (Luxemburg, France, Czech Republic, and Ireland).



Finally, some estimates of the out-of-pocket burden of health spending in the U.S., described as a percentage of a worker's income, mix traditional measures of cost sharing with the employee-paid share of employer-group premiums. In any case, the more accurate and telling measure of the overall share of a worker's total compensation that is devoted to health care costs first would attribute the full cost of an employer-sponsored insurance premium (including both the employer's premium contribution and the employee's contribution) to the worker's total "income," and then determine what share of that amount is represented by the total employer-group premium paid from total compensation PLUS any additional cost-sharing expenses incurred.

By that type of measure, mandating (or assuming) that an average worker enroll in the average comprehensive group plans offered by employers today would cost his or her family close to $13,000 a year in all-in premium alone (without even any lesser amounts of OOP cost sharing). This would place that burden already well beyond the 10 percent, or even 15 percent, threshold share of earnings sometimes selectively cited as too unreasonable and unaffordable for more visible, but more narrowly defined, "cost sharing" measures of workers' health expenses relative to their wage income. As a rough illustration, a worker earning $ 52,000 a year in wages (already well above median levels) and another $13,000 in an employer-provided family insurance policy coverage is already essentially devoting, or having preempted, 20 percent of total compensation to insurance premium costs alone, before any cost sharing kicks in!

To conclude, many of the estimates of the levels and dimensions of uninsurance remain inexact and dependent on what one intends to measure. We do know, or at least should begin to know, the following:

The cost of insurance, and, even more so, the cost of health care itself, remain the most decisive factors behind coverage levels – particularly at the margins of spending decisions and particularly for lower-income health consumers. Insurance premiums over time must reflect the underlying costs of healthcare as it is delivered and demanded

The relative share of insurance obtained from employer-sponsored coverage has been declining, and it will continue to do so. Reduced employment growth, lower take-up rates by workers offered coverage, and more restricted eligibility for coverage within firms all are factors in the latter; with the effects greatest among smaller businesses.

Public program insurance coverage has been growing, particularly for the lowest-cost groups (children).

Subsidies to encourage greater coverage by the currently uninsured, particularly in a voluntary purchasing market, need to be substantial to have significant impact.

Even in the midst of resumed economic growth sometime ahead, we may have already reached the point of diminishing returns in trying to stretch tax and regulatory subsidies even further. It's increasingly hard for them to catch up with healthcare costs that continue to grow faster than the overall economy.

Third-party payment mechanisms drive up health care costs, and lower income consumers are the most likely to be the first ones squeezed out of the less-affordable markets they help create.

Targeting of subsidies and other forms of public assistance to access health care is crucial. Not every person uninsured for shorter periods of time represents as great a problem as the chronically uninsured.

The real solutions will come from keeping people healthier to begin with and treating their medical conditions more effectively and efficiently. Changing public policies that keep the entry price of insurance coverage too high for too many Americans would provide a starting point for more progress. Reversing decades of overregulation, mistargeted tax subsidies, and lack of transparency in the healthcare sector would not solve all problems, but it surely would help reduce them.