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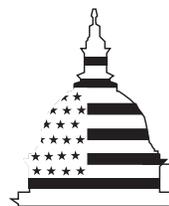
Before the Subcommittee on Employer-Employee
Relations, Committee on Education and the Workforce,
House of Representatives

For Release on Delivery
Expected at 9:30 a.m.
Friday, June 11, 1999

PRIVATE HEALTH
INSURANCE

Impact of Premium
Increases on Number of
Covered Individuals Is
Uncertain

Statement of William J. Scanlon, Director
Health Financing and Public Health Issues
Health, Education, and Human Services Division



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Private Health Insurance: Impact of Premium Increases on Number of Covered Individuals Is Uncertain

Mr. Chairman and Members of the Subcommittee:

Approximately 150 million individuals obtained health insurance through the work place in 1996, either through their own employer or the employer of a family member. During the last several years, an increasing number of these individuals have enrolled in some form of managed care rather than in fee-for-service plans. Recently, concerns have grown regarding the ways in which some managed care plans operate and the adequacy of the information that plans and their providers share with members.

In response to these concerns, several legislative proposals have been made to require health insurance plans to adopt specified operational practices. The proposals apply to all types of plans but would likely have their greatest impact on health maintenance organizations (HMO). Other types of plans—such as preferred provider organizations (PPO) and indemnity, or fee-for-service, plans—will likely be affected to a lesser degree. Included in the various proposals are requirements, for example, to disclose certain information,¹ guarantee patient access to emergency and specialty services, implement internal and external grievance policies, and guarantee freedom of communication between providers and patients. Some lawmakers are concerned, however, that these types of mandates could increase the cost of health insurance and have the unintended consequence of reducing the number of individuals covered by private health insurance.

To help inform congressional consideration of these proposals, you asked us to present the findings of a study we did for Senator Jeffords last July that analyzed the relationship between private insurance premium increases and changes in the number of covered lives.² My remarks today are based on that study. Specifically, I will focus on (1) the trends in employers' decisions to offer insurance and employees' decisions to purchase it, (2) an assessment of recent studies that have estimated the relationship between premium increases and insurance coverage, and (3) conditions or factors that could affect the impact of premium increases on insurance coverage.

¹Legislative proposals would require each plan to disclose, for example, information on appeals procedures, restrictions on reimbursement for care received outside of the plan's network of providers, and the location of plan providers and facilities.

²Private Health Insurance: Impact of Premium Increases on the Number of Covered Individuals Is Uncertain (GAO/HEHS-98-203R, July 7, 1998).

In summary, from the late 1980s to the mid-1990s—a period of rising health insurance premiums—the proportion of employees offered coverage rose from about 72 percent to 75 percent, while the share that accepted insurance fell from approximately 88 percent to 80 percent. The extent to which various factors contributed to the fall in the acceptance rate is unclear. It may have resulted from employees being asked to pay a larger share of the premiums or other factors, such as decreases in some workers' real income. Medicaid-eligibility expansions and changes in benefit levels also may have contributed to the fall in the acceptance rate.

Few studies have attempted to estimate the effects of premium increases on insurance coverage, and no study adequately estimates the coverage loss that might result from new legislative mandates. Studies by the Lewin Group, for example, suggest that 300,000 to 400,000 individuals might drop or lose insurance coverage if premiums increased 1 percent. However, these estimates assume across-the-board premium increases. The potential coverage loss might be much lower if mandates primarily affect HMO premiums and employers and employees can switch to different types of coverage. Furthermore, serious data limitations affect the precision of many of these studies' estimates.

Finally, many factors can affect the impact that health insurance mandates have on the number of individuals covered by private insurance. For example, if new mandates result in changes that individuals consider worthwhile, they may be willing to pay higher premiums. The extent to which employers pass on premium increases to employees, employees' opportunities to switch to less expensive plans, and changes in economic factors—such as income or changes in public insurance program eligibility requirements—can also affect the number of individuals with private health insurance.

Background

Between 1995 and 1997, real health insurance premiums (adjusted for inflation) remained nearly constant or fell slightly across all plan types. (See table 1.) This represents a sharp decline from the previous 5 years—in 1990, inflation-adjusted growth was as high as 11.6 percent for indemnity plans and 10.6 percent for HMOs. In 1998, premiums increased for all insurance types, but the increase was much lower than was experienced in the early 1990s.

Private Health Insurance: Impact of Premium Increases on Number of Covered Individuals Is Uncertain

Table 1: Percentage of Real Annual Growth in Premiums, by Type of Health Plan, 1991 to 1998

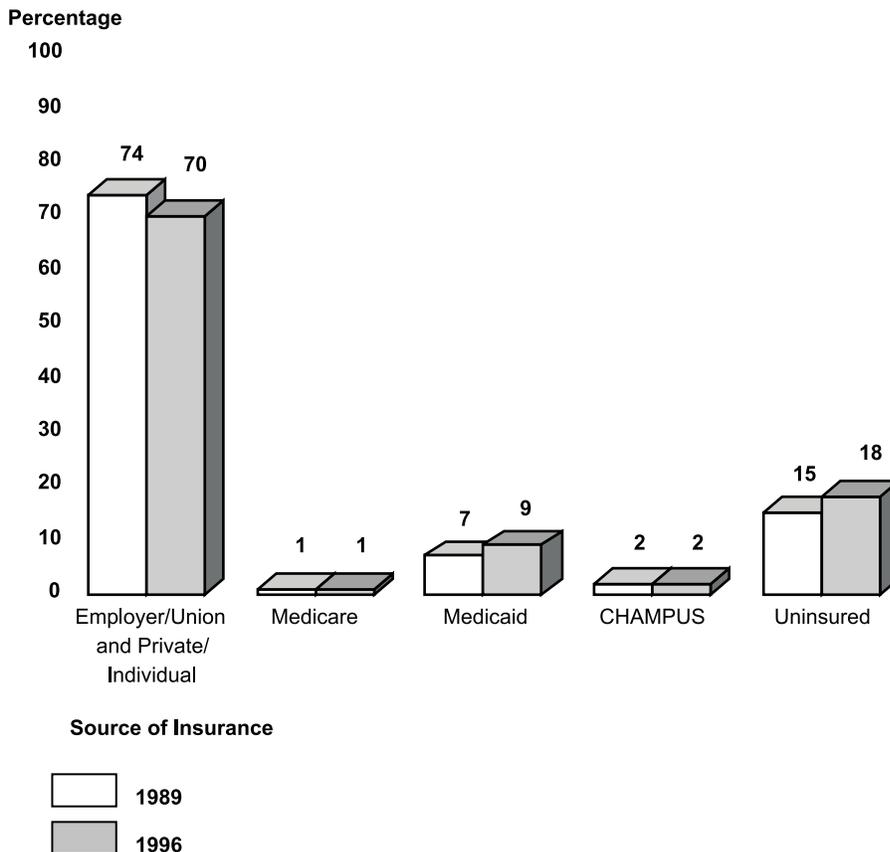
Plan type	1991	1992	1993	1994	1995	1996	1997	1998
Indemnity	7.8	8.0	5.5	2.5	-0.1	-1.8	0.3	1.9
PPO	5.9	7.6	5.2	0.6	0.7	-2.4	-0.2	2.3
HMO	7.9	6.8	5.3	2.7	-2.4	-3.4	-0.3	1.3

Sources: GAO calculations based on data from KPMG Peat Marwick (1991-98) and Bureau of Labor Statistics' Consumer Price Index. Includes employer and employee shares of premiums for workers in private firms with at least 200 employees.

In 1996, about 70 percent of the population under age 65 was covered by health insurance purchased through an employer or union or purchased privately as an individual, according to Current Population Survey (CPS) data. About 12 percent was covered by Medicare, Medicaid, or the Civilian Health and Medical Program of the Uniformed Services, and about 18 percent was uninsured. From 1989 to 1996, the percentage of the population covered by employer-sponsored, union-sponsored, or individual insurance³ decreased slightly, but these options still remained a prominent source of coverage for people under age 65. (See fig. 1.) During the same period, the proportion of the population covered by Medicaid and the proportion without insurance both increased.

³Individual insurance is coverage that an individual purchases directly from an insurer or through a broker.

Figure 1: Sources of Health Insurance for People Under Age 65, 1989 and 1996



Sources: U.S. Bureau of the Census, CPS (March 1989 to March 1997).

More Workers Were Offered Insurance, but Fewer Accepted Coverage as Premiums Increased

Recent studies suggest that employers typically do not stop offering health insurance when premiums increase. Between 1988 and 1996, health insurance premiums—unadjusted for inflation—increased by about 8 percent per year on average. During approximately the same time period, one study found that the fraction of workers offered insurance by their employers grew slightly, from 72.4 percent to 75.4 percent.⁴ The proportion of workers who had access to employer-sponsored insurance, either through their own employer or the employer of a family member, remained essentially constant at about 82 percent. Another study reported

⁴P. Cooper and B. Schone, "More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996," *Health Affairs* 16(6) (Nov./Dec. 1997).

that the fraction of small firms (those with fewer than 200 employees) offering insurance coverage grew from 46 percent in 1989 to 49 percent in 1996.⁵ The study also found that 99 percent of large firms offered insurance in 1996.

Fewer workers, however, are choosing to accept employer-sponsored coverage for themselves or their dependents. In 1987, 88.3 percent of workers accepted coverage when their employers offered it. In 1996, only 80.1 percent of workers accepted coverage. The fall in the acceptance rate was relatively large for workers under age 25 (from 86.5 percent to 70.1 percent) and those making \$7 per hour or less (from 79.7 percent to 63.2 percent). The fraction of workers who accepted employer-sponsored insurance either through their own job or that of a family member also declined, from 93.2 percent to 89.1 percent. Consequently, even though a greater percentage of employers offered insurance, a smaller proportion of workers was covered by employer-sponsored insurance in 1996 compared with 1987.

The fall in the acceptance rate may be attributable partly to required increases in employees' insurance premium contributions. One study found that employees in small firms paid an average of 12 percent of single coverage premiums in 1988 and employees in large firms paid 13 percent.⁶ In 1996, the employee share had risen to 33 percent in small firms and 22 percent in large firms. According to the Lewin Group, the combined effect of the increase in premiums and the increase in the employees' share of those premiums resulted in workers paying 189 percent more in real terms for single coverage and 85 percent more in real terms for family coverage in 1996 compared with 1988.

Other factors also may have contributed to the drop in the acceptance rate. A decline in real wages for some workers may have made coverage less affordable. Expansions in Medicaid eligibility provided a coverage alternative for some families and may have decreased workers' willingness to accept employer-sponsored insurance. Furthermore, possible changes in benefit packages may have made coverage less desirable.

⁵P. Ginsburg and others, "Tracking Small-Firm Coverage, 1989-1996," *Health Affairs* 17(1) (Jan./Feb. 1998).

⁶J. Gabel and others, "Small Employers and Their Health Benefits, 1988-1996: An Awkward Adolescence," *Health Affairs* 16(5) (Sept./Oct. 1997).

Study Designs Limit the Ability to Predict Potential Coverage Loss From New Health Insurance Requirements

Relatively few studies have analyzed the relationship between an increase in the cost of insurance and the change in the number of individuals covered. Several studies have examined the extent to which insurance premium subsidies might affect employers' decisions to offer insurance, but these results do not directly address the question of how much coverage loss might arise from an increase in premiums. The relevance of two studies that attempted to answer this question is limited because of implicit assumptions embedded in the studies' designs and shortcomings in the available data.

In November 1997, the Lewin Group estimated that 400,000 fewer people might be covered by health insurance if new legislation caused premiums to rise by 1 percent. Its estimate was largely based on studies of the effects of insurance premium subsidies on employers' decisions to offer insurance. These studies focused primarily on small employers and varied widely both in their research questions and their findings. The Lewin Group selected a midpoint estimate from a range of estimates it judged to be the best available. It then adjusted the estimate to account for the likelihood that individuals might obtain insurance through working family members' policies, the individual insurance market, or public insurance programs if premiums rose on their employer-sponsored policies. However, the Lewin Group's estimate of potential coverage loss did not consider the possibility that employers or employees might switch to different types of insurance products if one type became relatively more expensive. Because many of the proposed federal mandates are expected primarily to affect HMOs and have little or no impact on PPOs and indemnity plans, Lewin's estimate may overstate the potential coverage reduction.

To correct for some shortcomings of its earlier study, the Lewin Group performed its own data analysis and released the findings in January 1998. The results indicated a lower potential coverage loss of 300,000 individuals for every 1 percent increase in premiums.⁷ The findings of the 1998 Lewin Group's analysis, however, may have been affected by data limitations. Specifically, the analysis rests on an accurate measure of health insurance premiums paid by employees. Because this information was unavailable, the Lewin Group had to impute this amount. In addition, two aspects of the study's design limit its ability to predict insurance coverage reductions

⁷The new estimate was based on the Lewin Group's statistical analysis of the relationship between what employees paid for insurance and the probability that they, their spouses, and their dependent children would have employer-sponsored health insurance. Lewin used complex statistical models to estimate the proportion of the population covered by employer-sponsored insurance grouped by a number of demographic characteristics, including race, age, income, full-time/part-time status, occupation, industry, firm size, and the imputed employee share of the premium costs.

that might result from new legislative mandates. First, the coverage loss estimate—just as in the first study—applies to situations where all premiums increase by 1 percent. A 1-percent increase in HMO premiums would likely result in a smaller coverage reduction if employers and employees switched to other types of health coverage. Second, the Lewin Group explicitly assumed that all observed coverage changes resulted from employees' decisions to not accept coverage.⁸ This assumption is broadly supported by findings from other studies. However, to the extent that some employers decided to no longer offer insurance, the Lewin Group's estimate incorrectly predicts employees' reactions to changes in premiums.

Multiple Factors Affect Potential Impact of Premium Increases on Number of Covered Individuals

Insufficient information is currently available to accurately predict the reduction in the number of individuals covered by private insurance (referred to as coverage changes) that may result from health insurance premium increases associated with new federal mandates. One problem is that estimates of the effects of mandates on premiums have some uncertainty. However, even if the premium increase was known with certainty, previous research and economic theory suggest that the impact on coverage depends on a number of conditions. Coverage changes will depend on the extent to which premiums rise for employees and whether they can switch to insurance plans less affected by the mandates. The specific policy adopted also can affect how employees respond to resulting premium increases. Finally, changes in many economic and other factors can cause coverage changes that mask or exaggerate the impact of premium increases. The following list describes several conditions that could affect observed changes in health insurance coverage if new federal mandates increase insurance costs.

- The percentage of premiums paid by employees and the amount of any premium increase that employers pass on to employees. If, as recent evidence suggests, employees' decisions largely affect the extent of coverage, then the relevant price increase is the percentage increase in their contribution. For example, about two-thirds of employees in small firms had to contribute toward premium costs in 1996. Those employees paid about 50 percent of the total premium. If total premiums rise by 1 percent and employers pass on the full increase to employees, then the employees' contribution would rise by 2 percent.

⁸The data used in the Lewin study do not indicate whether observed coverage losses are the result of employers' decisions not to offer insurance or employees' decisions not to accept it.

- The extent to which additional benefits are valued by consumers. If higher insurance premiums are the result of additional benefits that consumers value, then any coverage loss will be less than the coverage loss that might occur if premiums increased but benefits stayed the same (or the additional benefits had little consumer value). In a November 1997 letter, the Lewin Group noted that its “estimates of the number of persons losing coverage will differ depending upon the health policy being analyzed” and pointed out that “some proposals that increase premium costs are often associated with other provisions that may either lessen or intensify incentives for individuals to drop coverage.”
- The extent to which employees can switch plans that have no or low premium increases. Proposed new federal mandates are expected primarily to increase costs for HMOs. Faced with a rise in HMO premiums, some employees may switch to PPOs or indemnity insurance rather than drop coverage entirely.
- Changes in other insurance benefits. Instead of raising premiums in response to new mandated benefits, insurance companies and employers may find ways to reduce other parts of the insurance package to keep premiums constant. It is unknown how employees might respond to such changes in their insurance plans.
- Changes in real wages and other factors. Changes in economic conditions or eligibility for public insurance programs can also affect private insurance coverage. For example, the Lewin Group estimated that a 1-percent rise in real income could increase private insurance coverage by nearly 0.37 percent (about 550,000 workers and dependents). Likewise, expansions in Medicaid eligibility could cause some workers to substitute public insurance for employer-sponsored family coverage.

Conclusions

The extent to which new legislative requirements for health insurance providers could affect the number of individuals with insurance coverage depends on the answers to several questions. To what extent will insurers raise premiums? Will fewer employers offer coverage to their employees, or will employers pass some or all of the increased premium costs onto their employees? How many employees will decline offered coverage if they must pay higher premiums?

The available studies offer only limited insights into these issues and illustrate the difficulty of estimating how the number of individuals covered by health insurance might be affected. Many of the studies we reviewed were hampered by incomplete data. Moreover, the design of the studies and the assumptions they incorporated limit their applicability to

the current issue. Studies by the Lewin Group, for example, estimate coverage loss that might result from an across-the-board premium increase. Legislation that affected some types of insurance providers' costs more than others might have a much smaller impact if beneficiaries can switch from plans with larger premium increases to plans with smaller premium increases. Finally, a host of other factors—including, for example, the extent to which individuals value the results of the specific mandates and general economic conditions—will likely play a role in determining the impact that legislative mandates have on the number of insured individuals.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions.

GAO Contact and Acknowledgments

For future contacts regarding this testimony, please call William J. Scanlon at (202) 512-7114. Key contributors to this testimony include James C. Cosgrove and Susanne M. Seagrave.

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