American Medical Association
Physicians dedicated to the health of America

Trends Report

Health Care Financial Trends Report • Health Policy Group **August 2003**

Health Insurance Costs and Coverage

Economics of Health Insurance

Although it is difficult to quantify the exact impact of health insurance cost increases on the uninsured, it is easy to see that they make the problem more severe. As health care costs continue to rise, health insurance costs rise with them, though not in lock-step. Consumer demand and improvements in medical technology continue to push the costs of medical care upward. The competitive structures of the labor market and the health insurance market can ease or worsen the underlying cost growth trend, but they ultimately cannot prevent all of those cost increases from being reflected in our premiums. Some of those cost increases may be reflected in a short-term decline in insurers' profitability. And when competitive conditions and the regulatory structure of the market permit, insurers will attempt to raise premiums to profit-maximizing levels. So when premiums do go up, they sometimes rise at higher rates than the rate of general or medical inflation, in order to catch up with the past cost increases that went unmatched by premium increases, or to take advantage of the opportunity to maximize profits, or both.

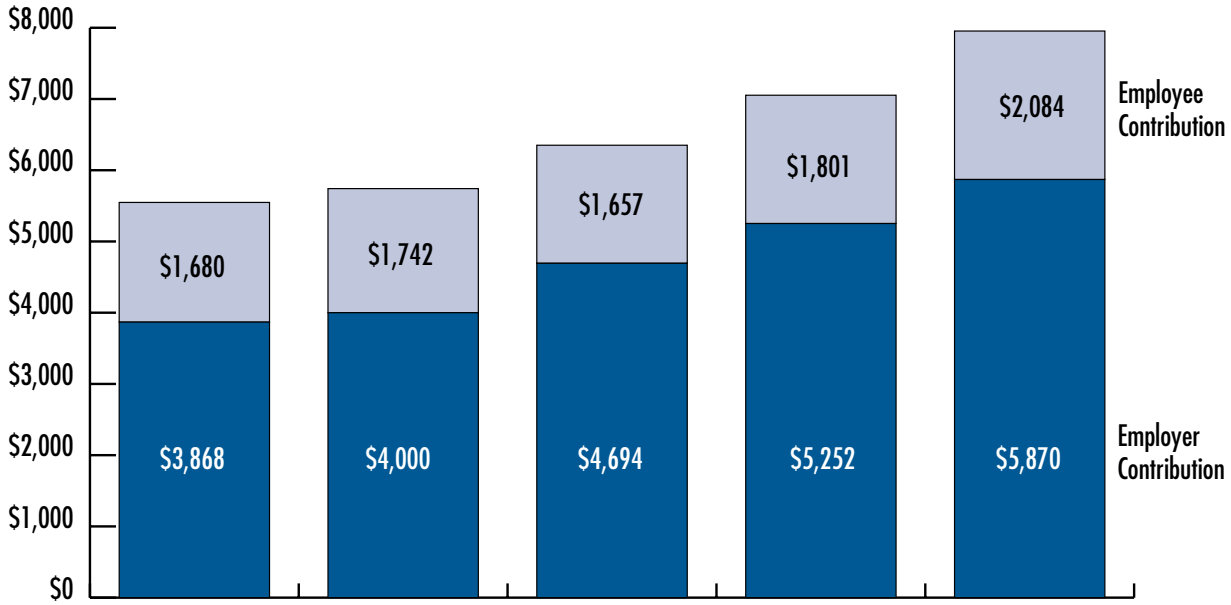
Other factors also influence the revenues or costs of insurance carriers, such as increasing market concentration (e.g., see Other Sources of Related Information: the AMA's "Competition in Health Insurance Markets"), changes in investment income and increases in reinsurance costs. Their effects will also be reflected in premiums, profitability, or both, at some point in time. Taken together, these are the principal factors that account for why health insurance premiums have increased in each of the last five years, with double-digit rate increases in the past three years and projected again for 2003. They also help us to understand why the net cost of private health insurance (i.e., premium revenue minus claims payments) is projected by the Centers for Medicare and Medicaid Services (CMS) to become the fastest growing component of National Health Expenditures (see October, 2002 HCFT Report, p.4).

Health Insurance Costs: Who Pays?

The meaning of the term "health insurance cost" depends on who you are. To insured persons, it means the premiums they pay for health insurance. To insurance companies, it means their costs of doing business, which include their claims payments (i.e., medical loss cost) plus all their business expenses, such as marketing, administration, and overhead. Exhibit 1 shows the dramatic recent growth in health insurance premiums over the past five years from the

Health Care Financial Trends is a quarterly report intended to provide timely analysis of a variety of national data widely used to shape policy and political debates on socioeconomic issues of interest to the AMA and the Federation. The feature topic of this edition of Trends is Health Insurance. For more information visit our web site at **www.ama-assn.org/go/healthpolicy**

Exhibit 1
Average Annual Health Insurance Premiums for Employer-Sponsored Family Coverage, 1998-2002



	1998*	1999	2000	2001	2002
Total =	$5,548	$5,742	$6,351	$7,053	$7,954
Annual Increase =		3.5%	10.6%	11.1%	12.8%

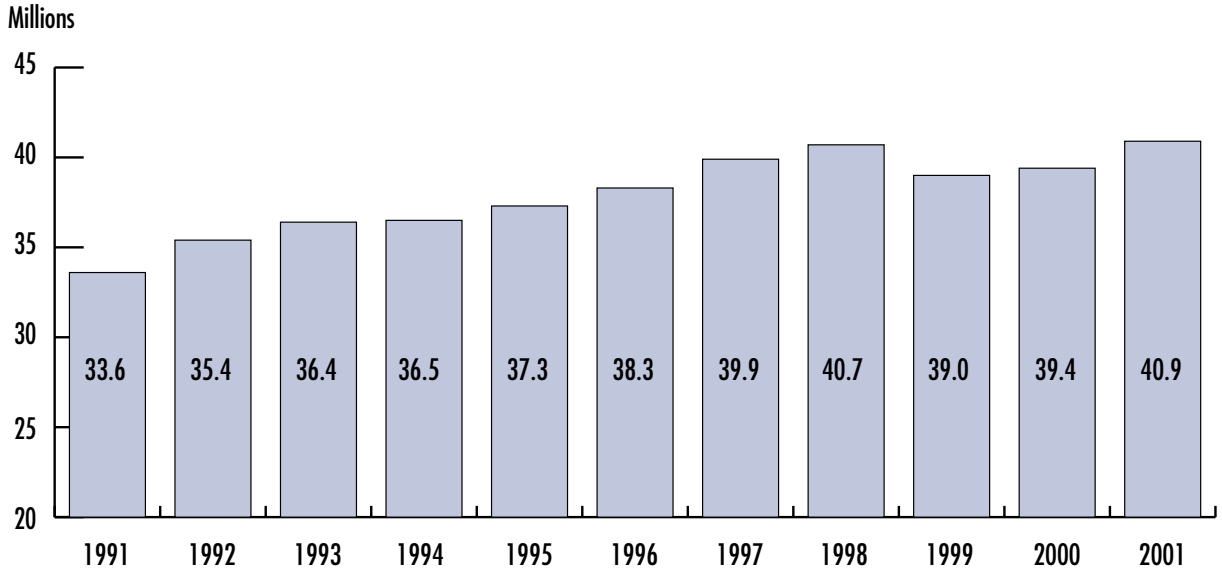
Average Annual Growth Rate = **9.4%** Cumulative Premium Increase 1998-2002 = **43.4%**
Cumulative Consumer Price Inflation = **10.4%**

Source: KFF/HRET Survey of Employer-Sponsored Health Benefits: 2002.
*1998 employer share estimate based on data from firms with 200+ employees.

perspective of the average worker with employer-sponsored, family coverage. Although premiums increased at an average annual rate of 9.4% from 1998 to 2002, they grew much more slowly in the years before 2000 and more quickly afterward. Overall, percent growth in premiums was four times greater than the percent growth in consumer prices (43.4% v. 10.4%) from 1998 to 2002.

Employer-sponsored health insurance costs also can be confusing when they are presented, as in Exhibit 1, in terms of the share of premium paid by the employer versus the share of premium paid by the employee. In fact, employer health insurance expenses are paid out of their compensation budgets and are tax deductible business expenses just like cash wage and salary compensation. In reality, the total compensation for employees is the cost of their employer-paid health insurance premium plus their wages and any other compensation they receive. This means that the employer share of premium is effectively 0%, while the employee share of premium is 100%. Therefore, in 2002, the average cost to employees of family coverage was not $2,084, but rather, $7,954. If employees' health insurance were not wholly or partly paid by employers, then their

Exhibit 2
Total Nonelderly Americans Without Health Insurance, 1991-2001



Source: Employee Benefit Research Institute (EBRI) estimates of the U.S. Census Bureau Current Population Survey, March Supplements 1992-2002, from EBRI Issue Brief #252, December, 2002, Figure 1, p.4.

wages, on average, would be higher by approximately the same amount of money their employers would have spent on their health insurance premiums (83%-100%, according to some estimates), all other market conditions being equal. This fact is extremely important in evaluating arguments against health insurance reform that suggest reforming the employer-based system will harm consumers by eliminating employer subsidization of consumer health insurance. In fact, there is actually little or no such employer subsidy in the first place.

The Uninsured

Perhaps the single greatest problem with our current health care system is that so many people are left out. Exhibit 2 shows that the number of the uninsured has been steadily increasing for most of the past 11 years and is currently at an all time high of 40.9 million. That statistic is intended to reflect the number of people who lack insurance for the entire calendar year indicated. Though there is some debate as to the accuracy of that specific number, it is nevertheless clear that the true number is still enormous (in the tens of millions), that the trend of increases in the size of the uninsured population is real, and that the number of persons experiencing a lack of coverage at some point in a given year is much higher (close to 60 million according to the Congressional Budget Office). Studies indicate that the uninsured receive less preventive, routine, and necessary care, have poorer health outcomes, and have lower earnings than insured persons. They also face the enormous financial risk associated with chronic or catastrophic illness. Even so, the uninsured consume a great deal of expensive care, and much of the care provided to them is directly or indirectly financed through tax revenues. Together, these facts demonstrate that the problem of the uninsured has vast implications for the welfare of broad segments of society, and therefore merits the utmost concern of our policymakers.

A Closer Look at the Uninsured

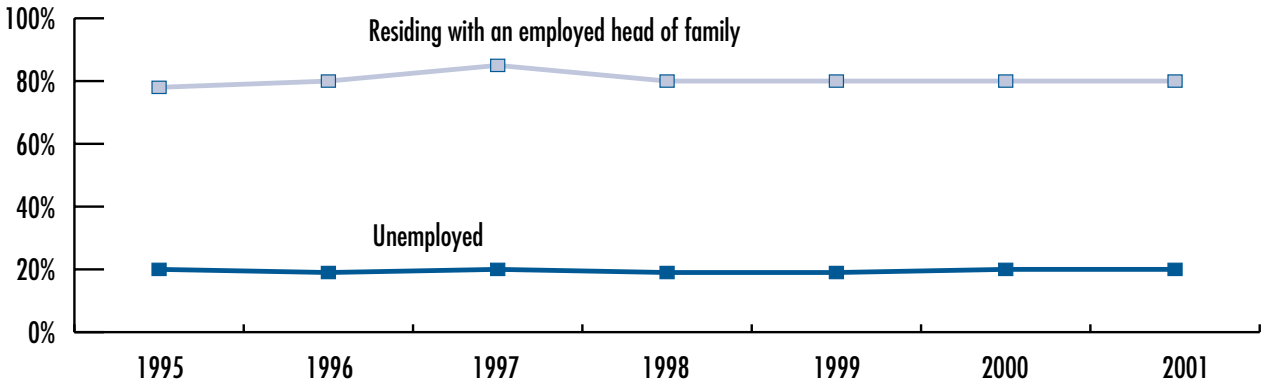
The uninsured population is not necessarily the group you might expect. Two of the common misconceptions about our employer-based system and the uninsured are that those who have jobs have insurance, and those who don't have insurance, don't have jobs. As Exhibit 3 shows, neither of those statements is correct.

Exhibit 3 shows the status of the nonelderly uninsured population with respect to employment status of the head of the family, and employment status of the individual. The reason for looking at the nonelderly population is that the vast majority of the elderly (over 65 years old) have Medicare coverage. Among the uninsured, however, only 18-20% were unemployed, and about 84% resided in households headed by an employed person. Exhibit 3 illustrates one of the greatest ironies of our employer-based system as it is currently structured: being employed or being the dependent of an employed person, has historically been no guarantee of health insurance coverage.

Determinants of Employer-Based Coverage

The percent of wage and salary workers who have employer-sponsored coverage (about 63%) is determined by the percent who are eligible (the offer rate) and the percent who accept (the take-up rate). Not all firms offer coverage, and those that do may offer it to some employees but not to others. Over the past 10 years, however, workers have been offered and have accepted coverage at very consistent rates. And while these rates are averages across all firms, more detailed analysis shows that offer rates are systematically lower among smaller firms than among larger firms. The coverage rates are simply the product of the offer rates times the take-up rates. Exhibit 4 shows that less than two-thirds of workers obtain health insurance coverage through their own employers. But the coverage rates for workers slightly understate the extent of the nonelderly, adult population covered by employer-based health insurance (just over two thirds), as indicated by the graph. The disparity between the two statistics is due to the inclusion of workers' employed and unemployed covered spouses and adult dependents among the latter. Even so, coverage through other sources, both private and primarily public, does not fill the gap left by the employer-based system, as it is currently structured.

Exhibit 3
Percent of US, Nonelderly, Uninsured Population



Source: Employee Benefit Research Institute (EBRI) Issue Briefs, 1996-2002.

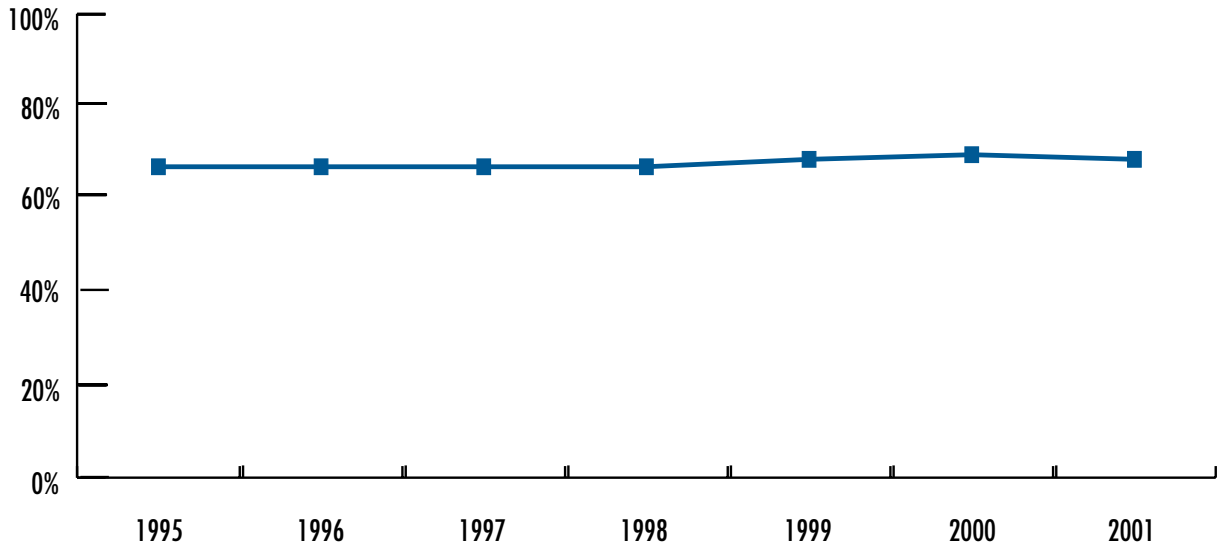
Exhibit 4
Offer Rates, Take-Up Rates, and Coverage Rates Among Workers, 1993-2001

	Offer		Take-Up		Coverage
1993	74%	X	85%	=	63%
1995	75%	X	83%	=	62%
1997	75%	X	83%	=	62%
1999	76%	X	83%	=	63%
2001	77%	X	82%	=	63%

Source: Employee Benefit Research Institute (EBRI) estimates based on Feb. US Census Bureau Current Population Survey, various years, from May 2003 EBRI Issue Brief #257, pp. 15-16.

Note: The coverage rates above for workers above are specific to own-name coverage, ie, they exclude workers who have employment-based coverage as a spouse or dependent. The coverage rates below include nonworkers and workers covered under the name of an other worker, such as a working spouse.

Rate of Employer-Based Coverage for Nonelderly Adults, 1995-2001



Source: Employee Benefit Research Institute (EBRI) estimates of the U.S. Census Bureau Current Population Survey, March Supplements, from EBRI Issue Briefs 1996-2002.

How The AMA Proposal Works

The AMA proposes a system of individual selection and ownership of health insurance that includes the following key elements: tax credits, the development of new health insurance markets, and appropriate market regulation.

Provide Tax Credits to Individuals and Families

The existing tax exclusion for employer expenditures on health insurance is highly regressive, because those with the highest incomes receive the greatest amount of subsidy. For example, an employer premium contribution of $7,000 generates a $2,100 subsidy for a person in the 30% tax bracket, but only a $1,050 subsidy for a person in the 15% tax bracket. The AMA believes the tax exclusion should be replaced with tax credits to those individuals and families who need them to afford health insurance. The tax credits should be inversely related to income, refundable, and advanceable, so that families who owe little or no income tax still receive the tax credit, and those who cannot afford monthly out-of-pocket premium payments will be able to purchase coverage without waiting for a year-end tax credit.

Foster the Development of New Health Insurance Markets

The AMA supports the development of health insurance markets that offer a wide range of affordable coverage options. We believe that empowering people with tax credits and freedom of choice will dramatically transform today's health insurance markets. The new system will make health plans more responsive to patients, rein in premiums and health care costs, and stimulate the development of new forms of health insurance that better meet the wide range of needs of individuals and families. The influx of average-risk people into the individual health insurance market will prompt insurers to replace costly medical underwriting practices with simplified, automated ones. This will make coverage more affordable, particularly for those with pre-existing or chronic conditions.

The AMA also promotes alternative means of pooling risk along the lines of existing prototypes, such as small group purchasing alliances and Internet-based health insurance vendors. Alternative insurance pools should be encouraged by exempting them from selected state regulations

The Choice of Coverage

The problems with our current system stem not only from the lack of access to employer-based coverage for many, but also from the lack of choice available to those who are offered employer-based coverage. 92% of firms offering coverage to employees restricted their choice to a single, take-it-or-leave-it option. In 2002, only half of all employees had three or more plans to choose from, half had two options or less, and more than a third had no choice between plans. Even worse, those firms that offer a choice of plans frequently offer choices of different plans by the same insurer, which reduces the insurer's incentive to improve the value of any one of the plans it offers in order to successfully compete for individual subscribers. In order for choice to spur competition to attract individuals, individuals must have a choice of insurers, not just plans. This limitation of consumer choice often reduces insurers' responsiveness to the price and quality concerns of consumers.

Filling the Gap

Federal and state government health programs fill some of the gap between those who have employer-based coverage and those who do not. But with 16.5% of the nonelderly population — 40.9 million people — lacking health insurance in 2001, it is difficult to ignore the failures of the American health care system. A wide range of research documents the enormous human and social costs of sustaining a large and growing uninsured population (e.g., see Other Sources of Related Information: *The Kaiser Commission on Medicaid and the Uninsured,* and *Institutes of Medicine*), which is beyond the scope of this report.

Over the years, a number of plans for expanding health insurance coverage to the uninsured have been suggested, including proposals advocating single-payor systems, employer "mandates," the expansion of government programs, the use of tax credits, and combinations of these approaches. Among the key advantages of the health insurance reform proposal developed by the AMA are:

- near-universal coverage
- social equity (through redistribution of the federal subsidy to those in greatest need of assistance)
- empowerment of consumers and markets through expanded choice.

The AMA Proposal, *continued*

regarding mandated benefits, premium taxes, and small-group rating laws, while safeguarding state and federal patient protection laws. Individuals should be allowed to "buy in" to state employee purchasing pools or the Federal Employees Health Benefits Program (FEHBP).

Implement Appropriate Market Regulation

The AMA recognizes that for markets to function properly, it is important to establish fair ground rules. Neither free-market mechanisms nor market regulations alone will fully meet the needs of high-risk individuals with chronic illness or conditions that are expensive to treat. The huge number of state and federal health insurance market regulations has created as many problems as it has solved. Regulations intended to protect high-risk individuals have typically backfired by driving up premiums and leading a disproportionate number of young, healthy individuals to do without coverage. The combination of guaranteed issue, strict community rating, and extensive benefit mandates has had disastrous unintended effects on costs, coverage, and choice.

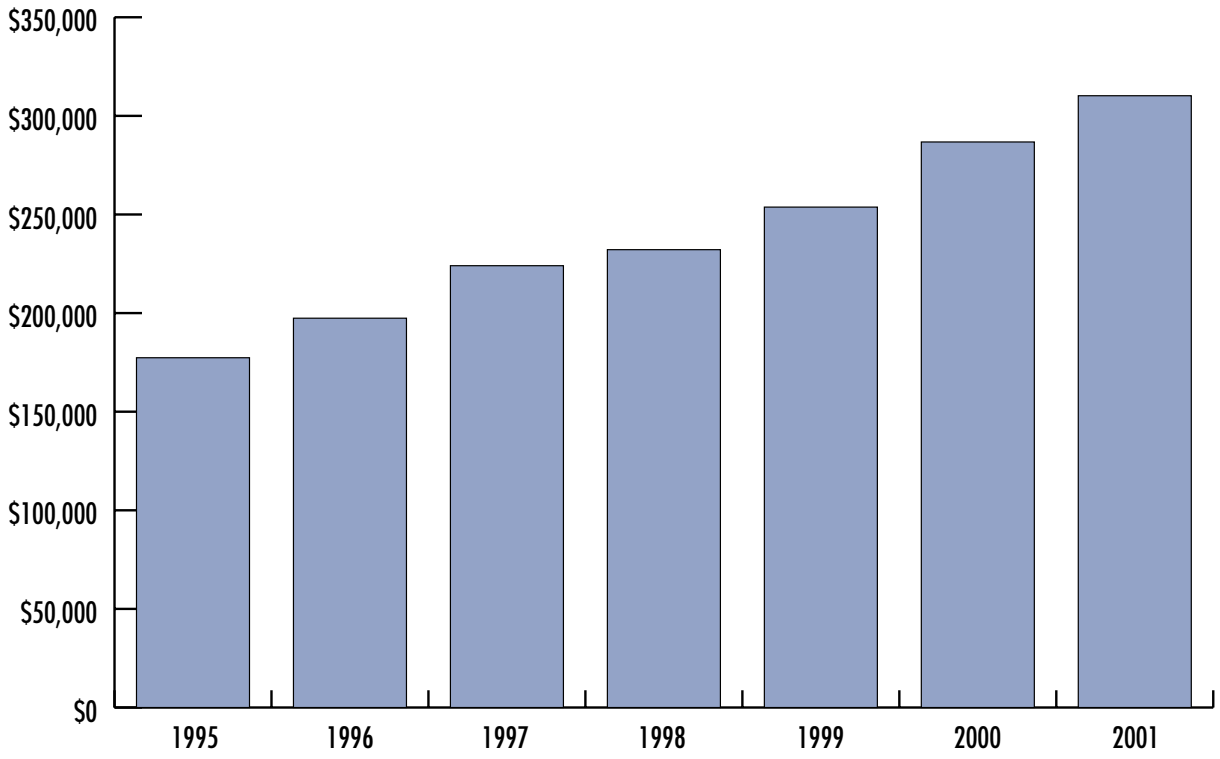
The AMA believes that a more rational approach includes greater uniformity across markets, modified community rating, guaranteed renewability, and subsidization of high-risk individuals through general tax revenues rather than through community rating or premium taxes. Such a regulatory environment would: assist high-risk individuals without unduly driving up health insurance premiums for the rest of the population; give individuals incentives to be continuously insured; and enable rather than impede private-market innovations such as medical savings accounts (MSAs), consumer-driven health care plans, defined contribution health benefits, and new forms of coverage.

Additional details are contained in the AMA publication "Expanding Health Insurance: The AMA Proposal for Reform," available on the AMA's Health Policy website at: **http://www.ama-assn.org/ama1/pub/upload/mm/363/expandinghealthinsur.pdf.**

PLI Update

The legal liability crisis confronting physicians continues largely unabated in many areas, as evidenced by Physician Insurers Association of America (PIAA) and Jury Verdict Research (JVR) data released since the last time HCFT reported on this topic (see April, 2002 issue of HCFT Report). As Exhibit 5 shows, indemnity costs increased by almost 10% per year over the past six years, driving PLI rates ever higher, with the average indemnity payment for a paid claim topping $310,000 in 2001.

Exhibit 5
Indemnity Payment Per Paid Claim 1995-2001 (on behalf of individual defendants)

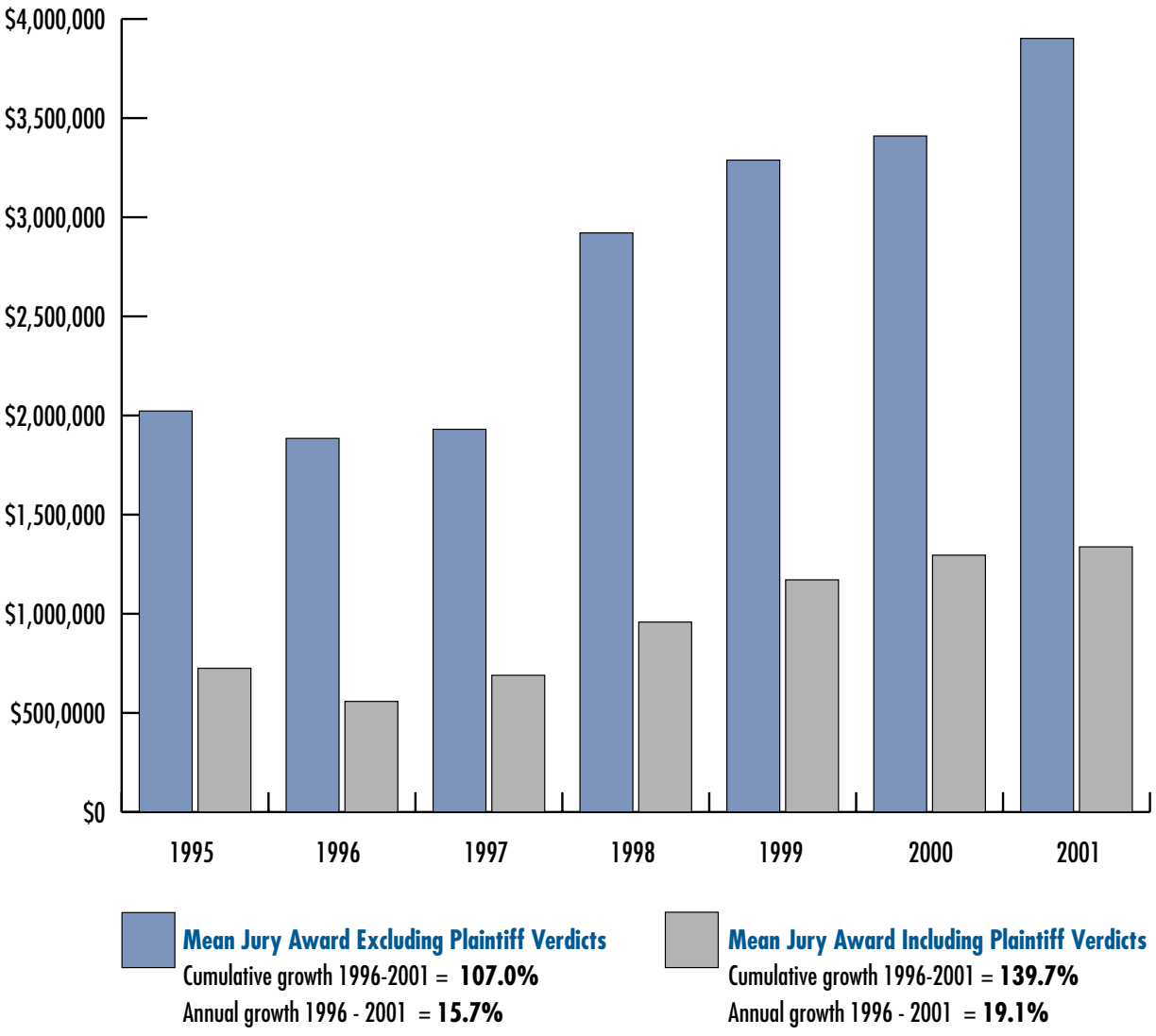


Source: Physician Insurers Association of America (PIAA) Trend Analysis of Claims by Close Year. All rights reserved. Data reproduced with permission. Indemnity payments per paid claim (graph) are expressed in "current" or "nominal" dollars. "Inflation" refers to urban consumer inflation for the "All Items" series as measured by the Consumer Price Index published by the Bureau of Labor Statistics.

PLI Update *(continued)*

In response to the trial bar's concerns about the exclusion of plaintiff verdicts from their calculation of jury verdict compensatory award means, the current year's round of JVR data include reports of average jury awards both with and without those $0 judgments included in the calculation. The results, presented in Exhibit 6, show that no matter how you choose to consider the trend in award means, the escalation has been dramatic, with awards more than doubling, and annual rates of growth in excess of 15%, over the last six years.

Exhibit 6
Mean Medical Liability Compensatory Jury Verdict Awards, 1995-2001



Data Sources and Descriptions

Primary Source of Size and Characteristics of Uninsured Population

Counts of the uninsured in the U.S. are estimates based on survey samples. There are four federally sponsored, nationally representative surveys of the US civilian noninstitutionalized population used for this purpose: Current Population Survey (CPS); Survey of Income and Program Participation (SIPP); National Health Interview Survey (NHIS); and the Medical Expenditure Panel Survey (MEPS). These data sources yield different estimates of the number of uninsured because of differences in survey design and in the definition of uninsured. The CPS data provide an estimate of the uninsured throughout the year prior to the survey. The data from SIPP and MEPS can be used to construct estimates of the duration of spells without coverage, as well as point-in-time, monthly, and annual estimates. Estimates of the uninsured based on the NHIS refer to coverage in an "average" month during the year. In general, while changes in health insurance coverage trends are best measured by a sequence of point-in-time estimates from annual surveys (e.g. CPS), the analysis of length of spells of noncoverage require a panel survey design (e.g. SIPP or MEPS). No single reference period provides a definitive profile of the state and dynamics of health insurance coverage.

Current Population Survey

The annual March Supplement of the US Census Bureau's CPS, the source of official US statistics on health insurance coverage, is a survey of 60,000 households. Respondents are asked if they had any of various types of private or public health insurance in the previous calendar year. Since 2000, if they answer "no" for every type of coverage, they are then also asked to verify that they had no coverage at any time during the previous calendar year. The effect of adding this verification question to the survey was to decrease the 1999 count of the uninsured from 42.1 million to 39.0 million.

The CPS is relatively timely, statistically reliable, and can be highly stratified due to the extremely large sample size. The Congressional Budget Office (CBO) speculates that CPS overestimates the number of people who are uninsured all year, due to three response bias tendencies: People understate their coverage, generally; people forget what their coverage status was toward the beginning of the long reference period (up to 16 months for the CPS); and people incorrectly tend to report their current insurance status when asked to report, instead, their status over the entire previous year. The CPS estimate more closely tracks the other surveys' estimates of the number of uninsured at a given point in time, rather than their estimates of the number of people who lacked coverage for the entire year.

Survey of Income and Program Participation

The SIPP is a longitudinal survey of about 8,000 housing units per month conducted by the Census Bureau. SIPP interviews determine persons' health insurance experiences week-by-week over the previous 4 months. SIPP allows estimates of the duration of spells without health insurance, and estimates for various time periods, such as point-in-time, monthly, annual, or over the full term of the panel (study period for each household), creating a more complete picture of the uninsured than one can obtain from static estimates (e.g., CPS) alone. The 4-month reference period mitigates bias due to memory limitations. Because of the longitudinal nature of the survey, attrition may contribute to bias to the degree that those who drop out differ systematically from those who remain in the sample from the beginning to the end. For example, the dropouts may be those who are most likely to be uninsured for a whole year, which would partially reconcile the disparity between SIPP and CPS. The data are released on a much less timely basis owing to the length of the panel. The number of uninsured is calculated as a residual of those not reporting any source of coverage.

Medical Expenditure Panel Survey

MEPS is sponsored by the Agency for Health Care Policy and Research (AHCPR) and the National Center for Health Statistics (NCHS). MEPS defines private insurance as coverage for hospital and physician services, but excludes single-service and dread disease policies. MEPS collects data continuously at both the individual and household levels. Two calendar years of information are collected from each household in a series of five data collection rounds over a $2^1/_2$-year period. Data collection is repeated each year on a new sample of households. MEPS, like SIPP, provides information on changes in the health insurance coverage experiences of individuals over time, enabling point-in-time, monthly, and annual estimates of health insurance coverage. It shares the benefits and drawbacks of longitudinal survey methodologies. The number of uninsured is calculated as a residual of those not reporting any source of coverage.

National Health Interview Survey

NHIS is conducted by the National Center for Health Statistics (NCHS). The NHIS samples the population on a continuous basis. Weekly samples are later consolidated to produce monthly and annual files. The yearly sample is composed of 36,000 to 47,000 households, depending upon the year. The NHIS identifies the uninsured as those who lacked coverage in the month prior to the survey, and therefore can be used to estimate the size of the uninsured population at a given point in time. These several monthly estimates can be consolidated into an average monthly estimate of the uninsured population. The number of uninsured is calculated as a residual of those not reporting any source of coverage.

Secondary Sources Used in this Report

Employee Benefit Research Institute Issue Briefs

EBRI time series data, including characteristics of the uninsured and coverage rates by coverage type and by a wide variety of demographic variables, are presented (near year end) in its annual Issue Briefs devoted to the topic of health insurance coverage, based on analysis of CPS data.

Kaiser Family Foundation/Health Research and Educational Trust (Kaiser/HRET) Employer Health Benefits Annual Survey

Time series data regarding employer-sponsored health insurance access, take-up and coverage rates, premiums, and plan choice. Statistics are typically stratified by such variables as employer share, firm size and geography.

Other Sources of Related Information

American Medical Association

The 2002 edition of "Competition in Health Insurance Markets" contains the second annual comprehensive study of concentration of US health insurance markets, which are found to be heavily concentrated.

The Kaiser Commission on Medicaid and the Uninsured

The February 2003 report "Who Pays and How Much?: The Cost of Caring for the Uninsured" estimates the amount of uncompensated care provided to the uninsured population (approximately $35 billion in 2001, with 71% allocated to full-year uninsured, and 29% allocated to part-year uninsured) and tracks the funding sources of that care.

The May, 2002 report "Sicker and Poorer: The Consequences of Being Uninsured" synthesizes the major findings of the past 25 years of health services research assessing the most important effects of health insurance. The report evaluates thousands of citations and 230 research articles to assess the consequences of being uninsured for health status and economic opportunity and concludes that health insurance does lead to improved health and better access to care. The major findings from the paper include: the uninsured receive less preventive care, are diagnosed at more advanced disease stages, and once diagnosed, tend to receive less therapeutic care (drugs and surgical interventions); having health insurance would reduce mortality rates for the uninsured by 10%–15%; and better health would improve annual earnings by about 10%–30% and would increase educational attainment.

The February, 2003 chartbook "Health Insurance Coverage in America: 2001 Data Update" provides year 2001 data on health insurance coverage, with special attention to the uninsured. It includes trends and major shifts in coverage and a profile of the uninsured population.

Institutes of Medicine

The June 17, 2003 Report titled "Hidden Costs, Value Lost: Uninsurance in America" uses sophisticated econometric models for estimating total costs of the uninsured, including the $35-65 billion in costs resulting from shorter lifespan and poorer health attributable to the lack of health insurance.

The Center for Studying Health System Change

Access, take-up, and coverage rates are estimated from HSC's Community Tracking Study Household Survey data, which are collected from a nationally representative sample of about 60,000 people.

Congressional Budget Office

The May, 2003 CBO paper titled "How Many People Lack Health Insurance and For How Long?" compares the methodologies and measures of the uninsured population of the four federally sponsored surveys described above.

Why are Health Insurance Premiums Rising so Rapidly?

To learn more about how PLI premium growth, health insurance reform, and other socioeconomic factors impact medical practice, visit the AMA's Health Policy Web site at: http://www.ama-assn.org/go/healthpolicy

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