Chapter 5

Health care

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The middle-class squeeze on health care is real

- The health care costs paid by a family of four with an average employer-sponsored PPO plan rose by 85 percent from 2002 to 2012. When we include employers' premiums—which they generally pay for in lieu of increasing workers' wages—that family's health care costs increased by $9,000.[1]
- An increasing number of middle-class families are spending a significant proportion of their income on health care costs each year. In 2009, 19 percent of people under age 65 were in families who spent more than 10 percent of their family's income on health care, compared with only 14 percent of families in 2001.[2]
- One in five people report having trouble paying medical bills, and 1 in 10 people report being unable to pay medical bills.[3]
- In 1999, health care costs comprised 9 percent of total compensation for the median family of four. If its proportion of total compensation had remained at 9 percent in 2012—instead of almost doubling to 17 percent—the same family would have earned an additional $6,000 that year to spend on other essentials.[4]

Understanding how we got here

The United States spends approximately $3 trillion per year on health care—nearly $9,000 per person.[5] Although the rate of growth of health care costs has slowed considerably in recent years, this level of spending consumes about 17.5 percent of our national gross domestic product and is higher than health spending in any other country.[6] High and rising health care costs threaten the sustainability of the health care system and compromise investments in other critical areas of our economy, including education and transportation.

These costs also affect the economic security of middle-class families. Although families with members above age 65 face the highest costs—largely

For an example middle-class family of four, health care costs rose by 85 percent from 2002 to 2012. See figure 1.3

due to the significant costs associated with long-term care—families of all ages have become increasingly burdened by health care costs.[7] What's more, the lack of information on health care prices and quality also makes it difficult for families to estimate and budget for health care expenses.

Since 2000, increased spending on health insurance premiums and out-of-pocket health costs have also largely offset any income increases for median-income families.[8] As costs have risen, employers have also had to contribute more toward employees' health insurance premiums, depressing wage growth.[9] Therefore, while there has been a significant, recent slowdown in the growth of health care costs—due in part to the Affordable Care Act's payment and delivery system reforms—we must do more to sustain these efforts.

Policy recommendations

Reforms under the Affordable Care Act are helping millions of Americans access more affordable and high-quality health care. However, additional changes are still needed in order to lower the growth rate of health care costs and to bend the cost curve. While a number of policy changes are necessary to protect the health and economic security of middle-class families, some of the most important changes would be to:

- Accelerate the use of alternatives to fee-for-service payments to reduce costs and improve care coordination
- Leverage the new insurance marketplaces to further lower costs and improve the quality of plans
- Increase transparency to allow consumers to choose high-quality, lower-cost providers and services
- Reform restrictive state scope-of-practice laws to maximize the use of nonphysician providers
- Address cost shifting to employees by encouraging employers to share health care savings with employees

Health care

Prior to recent coverage gains under the Affordable Care Act, or ACA, approximately 11 million middle-class individuals were uninsured.[10] Although 90 percent of uninsured individuals were employed, one in four middle-class individuals did not have access to health insurance through their jobs, largely because many of them were employed by small businesses that did not offer insurance.[11] In addition, a lack of insurance more drastically affects communities of color, who have lower insurance rates than whites. Although most people of color have a full-time worker in the family, they are more likely to be in low-wage jobs that provide limited access to employer-sponsored health insurance.[12]

While access to affordable coverage is important for all families, it is particularly important for middle-class families who may not be able to afford premiums without financial assistance but whose annual incomes are higher than the incomes of those who qualify for Medicaid. In 2009, for instance, a parent with a full-time minimum-wage job made too much to qualify for Medicaid coverage in more than half of all states.[13] Three out of four families of four with annual incomes of about $44,000 to $88,000 that were covered by employer-based insurance were asked to contribute a greater share of their income toward premiums and to shoulder greater out-of-pocket costs.[14]

The most obvious example of this trend is the growing number of high-deductible health plans, or HDHPs. These plans generally require patients to pay out of pocket for all nonpreventive care until a sizable deductible is met and are linked to savings accounts that consumers can use to pay for their care. These plans are designed to encourage patients to make cost-conscious decisions about their health care, but this cost-sharing structure can create financial burdens for lower-income individuals and individuals with chronic conditions. In 2013, 20 percent of all workers in an employer-sponsored plan were in an HDHP, compared with zero individuals in 2000 and only 4 percent of individuals in 2006.[15]

The costs of coverage for middle-class families

Rising health care costs have increased expenses for more middle-class families. The health care costs paid by a family of four with an average employer-sponsored PPO plan rose by 85 percent from 2002 to 2012. When we include employers' premiums—which they generally pay for in lieu of increasing workers' wages—that family's health care costs increased by $9,000.[16]

Increased spending on health care by the middle class is a result of more expensive insurance premiums and higher out-of-pocket costs. Average premiums for employer-sponsored plans have increased above inflation. From 2012 to 2013, average family premiums increased by 4 percent, compared with the 1.1 percent increase in inflation.[17]

Families face other increases in their health care expenses as well. Many must pay for care prior to meeting their deductibles and then may be responsible for other co-pays and co-insurance. Since 2002, the percentage of people in employer-sponsored plans who had to meet a deductible before their insurance coverage began increased by 30 percent.[18] The average size of deductibles has also rapidly increased: Average annual deductibles for family coverage increased by 132 percent, to $2,220, between 2002 and 2011. Individual coverage increased by 152 percent, to $1,100, during that period.[19] In 2013, 38 percent of all people with employer-sponsored coverage were in plans with deductibles of at least $1,000.[20] With the exception of preventive services—which the ACA requires plans to cover with no cost sharing—an individual in such a plan would most likely have to pay the full cost of all health care services, such as a visit to a doctor and any associated X-rays or lab tests, until they met their $1,000 deductible.

Families' out-of-pocket costs also include cost-sharing requirements for services such as physician office visits, prescription drugs, hospital stays, and outpatient surgeries. Although the amounts of these costs vary by plan requirement and patient choice of provider—with cost sharing for in-network providers lower than for out-of-network providers—75 percent of covered people reported paying a co-payment to see primary care physicians and specialists in addition to any deductible.[21] Similarly, most workers are also responsible for additional cost sharing for hospital stays.[22]

High and rising health care costs squeeze middle-class families

Over the past decade, increases in premiums and other out-of-pocket health care costs have significantly outpaced the rate of inflation, as well as increases in wages

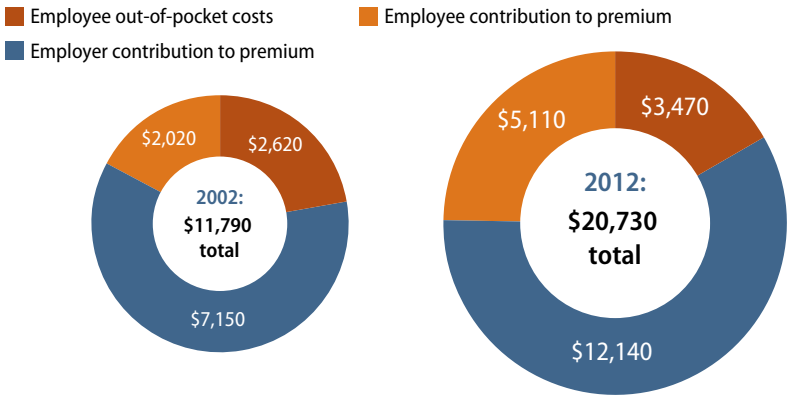
and median incomes.[23] This problem is even more severe for communities whose median incomes have decreased, such as African Americans, whose inflation-adjusted median household income decreased by 4.68 percent from 2010 to 2012.[24] Importantly, because employers must often choose between increasing workers' wages or continuing to offer health care benefit packages, increasing health costs have also depressed wage growth, further squeezing middle-class families.[25] One analysis shows that while health insurance premiums grew by more than 5 percent between 2000 and 2009, average hourly wages and salaries increased by less than 1 percent.[26]

Thus, while total compensation—wages plus an employer's contributions to health care premiums—for our example family of four increased by $5,700 from 2000 to 2012, rising health care premiums consumed most of this increase and reduced workers' take-home pay. In 2012, the full cost of health care premiums—including contributions made by employers and employees—consumed 18 percent of a family's total compensation. This is compared with just 10 percent in 2000. Our analysis indicates that if health care costs had maintained their proportion of total compensation—instead of eating into workers' wages—the average family of four would have received an extra $5,200 after taxes in 2012.[27]

FIGURE 5.1

2002–2012: Health care costs for middle-class families rose by $9,000

Annual health care costs for the average family of four in an employer-sponsored PPO plan, 2002 vs. 2012



Note: All dollars are 2012 dollars.

Source: CAP calculations based on National Institute for Health Care Management, "Spending for Private Health Insurance in the United States" (2012), available at http://www.nihcm.org/images/stories/DB4-Figure5.png.

As a result of high health care costs and stagnant incomes, 19 percent of people under age 65 in 2009 were in families who spent more than 10 percent of their income on health care. This is up from 14 percent of families in 2001.[28] Although families with people above age 65 face the highest costs, largely because of the significant costs that are associated with long-term care, health care costs have increasingly burdened families of all ages.[29] In 2012, one in five people reported having trouble paying their medical bills. One in 10 people reported that they were not able to pay their medical bills.[30]

Prior to the insurance reforms of the ACA, households with major medical expenses reported having more than $11,600 in unpaid credit card bills—about $4,000 more than average households with debt.[31] Additionally, although 95 percent of families with a member receiving cancer care were insured, 46 percent stated that medical costs were burdensome.[32] A lack of information on health care prices and quality also makes it difficult for families to estimate and budget for health care expenses.

How the ACA is helping middle-class families

Reforms under the ACA are already helping millions of Americans afford quality health care. The law includes premium tax credits for middle-income individuals who enroll in a health plan through an exchange. Beginning in 2014, millions of individuals and families will receive annual tax credits that average more than $4,000 to assist in purchasing insurance.[33] Importantly, the ACA also prohibits insurers from charging higher premiums or denying access to care based on pre-existing conditions or gender. The law also requires all nongrandfathered health plans to establish out-of-pocket limits, capping the amount enrollees must pay each year for in-network essential health benefits.

The ACA also requires plans to cover a number of preventive services with cost sharing, including important screenings, annual exams, and contraception. These services have the potential to greatly enhance health while lowering costs for individuals and families. Estimates show that in 2013, women saved $483 million on birth control pills alone, an average savings of $269 per woman.[34] Removing this considerable financial hurdle was especially important for many women of color who, prior to expanded preventive services through the ACA, did not obtain this type of care. Today, millions of African American women, Latinas, and Asian American women with private health insurance are currently receiving expanded preventive service coverage under the ACA.[35]

Policy recommendations

The Affordable Care Act has expanded access to health insurance, and its reforms have likely helped lower health care costs. But the ACA should only be a starting point for lowering costs; other policy changes are needed to continue to lower the growth rate of health care costs and to bend the cost curve.[36] Five policy changes that will help accomplish this and lower costs for middle-class families include:

- Accelerating the use of alternatives to fee-for-service payments to reduce costs and improve care coordination
- Leveraging the new insurance marketplaces to further lower costs and improve the quality of plans
- Increasing transparency to allow consumers to choose high-quality, lower-cost providers and services
- Reforming restrictive state scope-of-practice laws to maximize the use of nonphysician providers
- Addressing cost shifting to employees by encouraging employers to share health care savings with employees

Accelerate the use of alternatives to fee-for-service payments to reduce costs and improve care coordination[37]

Our current fee-for-service payment system leads to wasteful and potentially harmful uses of high-cost tests and procedures. Instead of paying a fee for each service, public and private payers should pay a fixed amount to doctors and hospitals for a defined bundle of services or for all of a patient's care. All payers and providers should accelerate the use of alternative payment methods, especially bundled payments.

Under a bundled payment arrangement, an insurer or employer pays a fixed amount to health care providers for a bundle of services or for all the care a patient is expected to need during a period of time. For example, a bundle for total knee replacement surgery could begin after the patient's diagnosis and include payment for the orthopedic surgeon; operating-room fees, including anesthesiology; and postacute care for 30 days. The bundle could also be expanded to include physical therapy and care for 90 days after the surgery. Health care providers have an incentive to coordinate care that the patient actually needs, using the fixed bundled payment amount. Providers' payments are also contingent on quality and patient-experience measures, which focuses greater attention on improving quality.

Bundled payments not only lower costs for health care payers, but they can also lower out-of-pocket costs for consumers. Insurers can pass along these savings in various ways, and the ACA's protections—including the "medical loss ratio" requirement that insurers spend a minimum percentage of premium dollars on care or otherwise pay rebates to their customers—make certain that insurers cannot use these savings simply to increase their profits.

As the largest payer, Medicare can lead the way in these efforts and encourage private payers to participate:

- Medicare should expand the current bundle of inpatient hospital services. Currently, this bundle includes services provided to patients up to three days prior to admission. That three-day window should be expanded to seven days.

- Medicare should expand the Acute Care Episode Demonstration program—which bundles payments for 37 cardiac and orthopedic procedures performed in hospitals.

- By 2017, Medicare should create bundled payments for at least two chronic conditions, such as adjuvant therapies for five leading cancers and care for coronary artery disease. Adjuvant therapies are additional treatments that lower the risk that cancer will return. For example, patients may receive chemotherapy or radiation following surgery to remove a tumor.

Action by Medicare would likely catalyze private payers to rethink their payment for high-volume or high-margin procedures or episodes of care. When insurers start to align payment with value, rather than volume, more closely, it will help lower costs not just for insurers but also for patients.

Leverage the new insurance marketplaces to further lower costs and improve the quality of plans

The new marketplaces—both state and federally run—should engage in active purchasing; this leverages their bargaining power to secure the best premium rates and to promote payment and delivery system reform. State marketplace officials have broad authority to establish requirements for plans that participate in the exchanges; the secretary of health and human services has similar authority for the federally facilitated marketplaces. Exchange officials should use this authority to exclude low-value plans and reward plans that offer more value to consumers.[38]

Another way to leverage insurance exchanges to lower costs is to require insurers who have not already done so to offer tiered insurance plans. Tiered insurance plans designate a tier of providers as high quality and low cost, and patients who choose these high-value providers will have lower cost sharing. Exchanges should offer at least one tiered product at the bronze and silver levels of coverage by 2016. To encourage consumers to select the tiered product, the insurer should offer a minimum premium discount.[39]

Transparency and consumer education are essential to increase awareness and trust in tiered products.[40] Quality and cost measures should be standardized and publicly disclosed, and standards should be set for how they are used to create tiers. Whenever possible, quality measures should use data from all payers. In contracts between insurers and providers, clauses that inhibit tiered products should be prohibited.[41]

Increase transparency to allow consumers to choose high-quality, lower-cost providers and services

Health care prices must be transparent and easy to understand. The Center for American Progress recently published a report that recommends a suite of policies necessary for greater price transparency.[42] The following steps should be taken immediately:

- The Department of Health and Human Services must ensure that the ACA's requirement that insurers provide cost-sharing information is implemented in a consumer-friendly way.

- The ACA's cost-sharing disclosure requirements should be modified so that the plan's quoted costs for episodes of care are guaranteed.

- Hospitals and other institutional health care providers should provide uninsured and out-of-network patients with episode-based costs, which would also be guaranteed.

- Insurers' provider directories should include rankings of higher-value providers to encourage patients to seek out their services.

Consumers also need to have information about which treatments are effective in order to make important health care decisions.

The ACA created a new independent nonprofit organization, the Patient Centered Outcomes Research Institute, or PCORI, to fund and disseminate research that evaluates the effectiveness of two or more prevention, diagnosis, or treatment options. This is known as comparative effectiveness research, or CER. CER will help patients and their doctors make informed decisions when choosing between different treatment options.

CAP has urged PCORI to rapidly scale up its investment in CER to at least 80 percent of its research funding by fiscal year 2016. Today, PCORI has dedicated far less of its funding to these purposes. While PCORI recently made a new funding announcement that has the potential to increase the share of its investment in CER, this single initiative should be part of a sustained commitment to funding high-priority CER. Future investments should focus on studies that:

- Address important gaps in evidence on treatments for common and high-cost conditions

- Produce actionable results in one to three years

- Synthesize existing CER studies

Reform restrictive state scope-of-practice laws to maximize the use of nonphysician providers

Restrictive state scope-of-practice laws prevent nonphysician providers from practicing to the full extent of their training. An extensive body of research has demonstrated that nurse practitioners and other nonphysician providers offer safe

and effective care at comparable quality to physicians for many services at a significantly lower cost.[43] Despite this, 31 states do not allow advanced-practice nurses to practice without physician supervision.[44] Making greater use of these providers would expand the workforce supply, which would increase competition and thereby lower prices.

Studies have shown that restrictive scope-of-practice laws limit the cost savings associated with care provided by nurse practitioners and other advanced-practice nurses.[45] As health coverage expands under the ACA, scope-of-practice reform can help meet increased demand for health services and counteract a potential provider shortage. We recommend that the federal government provide bonus payments to states that meet scope-of-practice standards delineated by the Institute of Medicine.[46]

Address cost shifting to employees by encouraging employers to share health care savings with employees

Lowering health care costs is the first step toward easing health care expenses for middle-class families. The second step is making sure that payers pass along those savings to consumers in the form of lower premiums or reduced cost sharing. As described above, because of changes made by the ACA, insurers' cost savings will eventually be reflected in premiums and other enrollee cost sharing. But those reforms do not apply to employers who are self-insured, functioning as their own insurer instead of purchasing health insurance from a health insurance company.

Today, employees know when their premiums or cost-sharing requirements increase, but they most likely do not know why their costs increase by a certain amount. Employers should provide this information each year when they announce benefit changes. These notices should explain how much the employer expects to pay, on average, for health care benefits per employee, as well as how much the employer expects the employee will spend, on average, for health care during the upcoming year. The employer should also explain how these amounts vary from the previous year and how much of the increase in employees' costs is due to medical inflation and how much is due to the employer shifting costs to employees. This greater transparency should discourage employers from cost shifting to their employees.

Conclusion

Together, these changes will help lower health care costs for middle-class families. Affordable, high-quality health care is essential to economic security. Lower health care costs also benefit middle-class families in other indirect yet important ways. When federal and state governments lower their health care costs, it frees up funding for other critical areas, such as education and transportation, which further benefits America's middle class.

Endnotes

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