





CHAPTER 5

Health Care

By Maura Calsyn and Thomas Huelskoetter

Health Care

Access to affordable health care coverage is a critical element of middle-class security. Affordable, comprehensive coverage improves both health outcomes and personal financial wellness, and health care is directly linked to workplace productivity. Quality coverage enables middle-class households to earn income and expand wealth.¹

Moreover, health insurance protects individuals and families from uncertain and high medical costs, which can lead to medical debt and threaten the economic security of many middle-class families.² In fact, studies have shown that more than half of all bankruptcies are related to medical bills.³ In 2016, about one-quarter—or 26 percent—of U.S. adults ages 18 to 64 said that “they or someone in their household had problems paying or an inability to pay medical bills” in the past year.⁴ Even among those with employer-sponsored insurance, about 1 in 5 reported having trouble affording their medical bills over the same period.⁵

For example, health care costs paid by a family of four with an average employer-sponsored preferred provider organization, or PPO, plan were \$24,671 in 2015—double what they were in 2005.⁶

How high health care costs squeeze middle-class family budgets

In recent years, health care cost growth has moderated, and the Affordable Care Act, or ACA, has expanded coverage to an estimated 20 million people.⁷ But spending is still rising, and for millions of middle-class Americans, health care costs continue to squeeze their household budgets.

The ACA is not the reason why employees are seeing their health care costs continue to go up. In fact, the law largely left the employer-based health care system alone, and many employers report that the ACA has had a negligible effect on their health care costs.⁸

Health care benefits are part of a worker's total compensation. Employers that offer health insurance as an employee benefit typically pay the majority of their employees' health insurance premiums. Employees pay a portion of the premium, but that amount can vary significantly across employers.

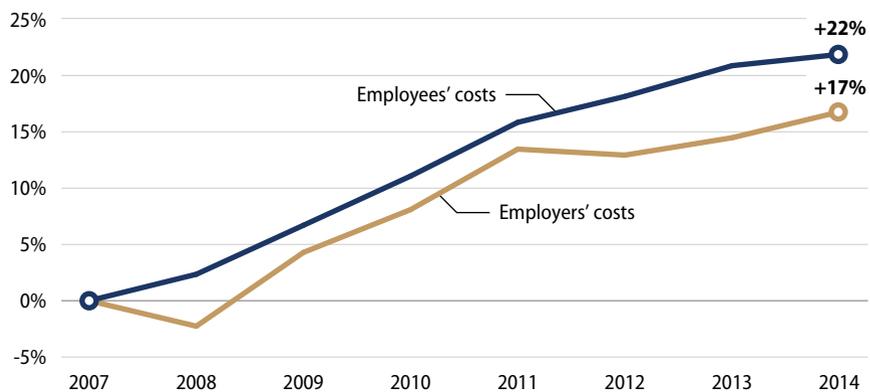
Due to high health care costs, employers have shifted greater responsibility for health care costs to their employees over time. Some employers are paying smaller portions of their employees' health care premiums; others are shifting expenses to their employees in the form of higher deductibles, higher copayments, and higher coinsurance—a practice that began long before the passage of the ACA.⁹ Yet, employers have been passing on a greater share of health care costs to their workers and have not been compensating them with higher wages.

Not only are total premiums continuing to grow, but the share that employees typically pay is also increasing. From 2007 to 2014, the average employee premium contribution increased 3 percent per year compared to an increase in the average employer premium contribution of 2.3 percent per year over the same period.¹⁰

Increased employee cost-sharing through higher deductibles, coinsurance, and copayments has also been a clear trend over the past decade and is projected to continue in future years. For example, the percent of private-sector employees who were enrolled in a plan with a deductible increased from 48 percent in 2002 to 84 percent in 2014.¹¹ Furthermore, in 2012 and 2013, 77 percent of companies reported that they planned to increase cost-sharing using deductibles and copayments.¹² Between 2007 and 2014, U.S. employees' average out-of-pocket costs increased by an average of 3.1 percent per year. This has also resulted in an increase in the number of high-deductible plans. In 2015, 19 percent of covered workers were in plans with high deductibles of \$2,000 or more compared with only 3 percent in 2006—and employers plan to increase the use of these plans even further.¹³

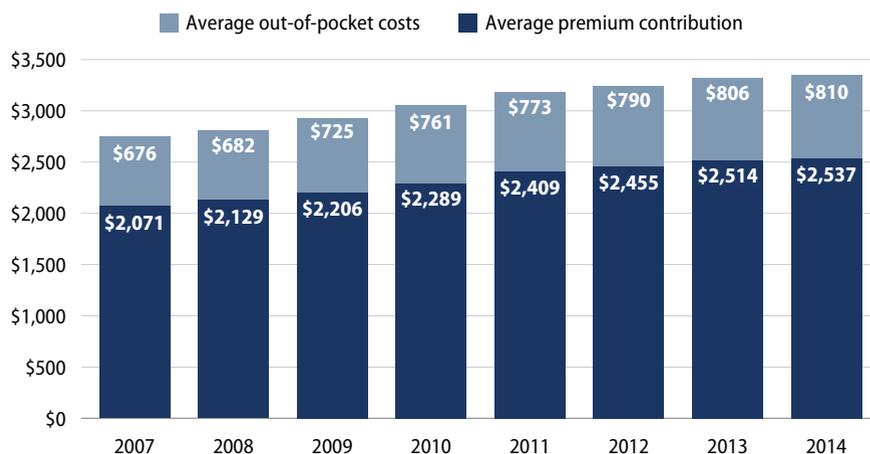
High deductibles target first-dollar expenditures, meaning that patients who have chronic conditions, require prescription drugs, or have other reasons for needing more care are responsible for significant out-of-pocket expenses in the early part of the benefit year or at the onset of treatment for an illness. Young children tend to use more primary care than other patients, so families with young children are also particularly affected by high deductibles and other cost-sharing.¹⁴

FIGURE 5.1
Change since 2007 in employees' and employers' health care costs per enrolled employee, in 2014 dollars



Sources: Authors' calculations based on Health Care Cost Institute, "Out-of-Pocket Spending Trends (2013)" (2014), available at <http://www.healthcostinstitute.org/files/IB%2009%2010-28-14.pdf>; Health Care Cost Institute, "2014 Health Care Cost and Utilization Report" (2015), available at <http://www.healthcostinstitute.org/files/2014%20HCCUR%2010.29.15.pdf>; personal communication from Amanda Frost, senior researcher, Health Care Cost Institute, Washington, D.C., October 28, 2014; Agency for Healthcare Research and Quality, "Medical Expenditures Panel Survey: Insurance/Employer Component," available at http://meps.ahrq.gov/mepsweb/survey_comp/Insurance.jsp (last accessed March 2016).

FIGURE 5.2
Health care costs for employees with employer-sponsored insurance, in 2014 dollars

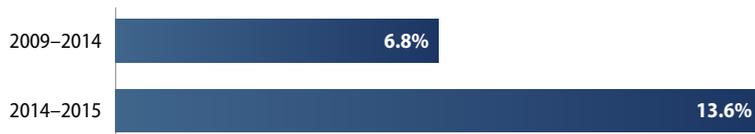


Sources: Authors' calculations based on Health Care Cost Institute, "Out-of-Pocket Spending Trends (2013)" (2014), available at <http://www.healthcostinstitute.org/files/IB%2009%2010-28-14.pdf>; Health Care Cost Institute, "2014 Health Care Cost and Utilization Report" (2015), available at <http://www.healthcostinstitute.org/files/2014%20HCCUR%2010.29.15.pdf>; personal communication from Amanda Frost, senior researcher, Health Care Cost Institute, Washington, D.C., October 28, 2014; Agency for Healthcare Research and Quality, "Medical Expenditures Panel Survey: Insurance/Employer Component," available at http://meps.ahrq.gov/mepsweb/survey_comp/Insurance.jsp (last accessed March 2016).

When combined, these trends meant that employees' per capita costs—premiums plus average out-of-pocket costs—grew 22 percent between 2007 and 2014 compared to 17 percent growth in employer's costs per enrolled employee. In 2014, an average employee with employer-sponsored health insurance was responsible for more than \$3,300 in health care costs.¹⁵

Spending on prescription drugs has also increased in the past few years.¹⁶ Not surprisingly, prescription drug costs are contributing to higher health care costs for middle-class families. For a typical family of four, drug spending accounted for 15.9 percent of total health care spending in 2015.¹⁷ The cost of prescription drugs is also growing significantly: Between 2014 and 2015, it grew by 13.6 percent, compared with average growth of 6.8 percent over the previous five years.¹⁸ For instance, the price of one commonly prescribed arthritis drug increased more than 126 percent over the past five years.¹⁹

FIGURE 5.3
Annual increase in prescription drug costs



Source: Milliman, "2015 Milliman Medical Index" (2015), available at <http://www.milliman.com/uploadedFiles/insight/Periodicals/mmi/2015-MMI.pdf>.

Americans have taken note of these rising costs. According to a recent poll from the Kaiser Family Foundation, 72 percent of Americans said prescription drug prices are unreasonable, while 74 percent said pharmaceutical companies “put profits before people.”²⁰ Meanwhile, drug companies had average net profits of almost 20 percent in 2012—twice the 9 percent average profit margin of the S&P 500 companies.²¹ And 9 of the 10 largest pharmaceutical companies spend more on marketing than on research and development.²²

Patients often have to choose between spending large amounts of money on their medications, changing medications, or forgoing them entirely. Cost-sharing requirements can discourage patients from purchasing costly medications, which can negatively affect their health and increase long-term costs.²³ In

one particularly egregious example, a social worker in Arkansas reported that she was unable to afford the coinsurance for medication to treat her lupus, even though she is employed and has health insurance. Her medication is so expensive that she would have to pay \$450 at least once a month for the drug—on top of her \$770 monthly insurance premium.²⁴ But it is not just the patients who need these products who pay these costs. Rising drug costs also increase premiums, deductibles, and cost-sharing for all consumers.²⁵

Policy recommendations

The ACA made monumental steps toward protecting all Americans from the risk of high health care costs through features that include coverage expansion, health insurance subsidies, requiring that insurers cover all pre-existing conditions, and free preventive care. Policymakers should now build on these fundamental protections to make care more affordable.

For example, out-of-pocket costs are still too high for many Americans. Even though the ACA put limits on out-of-pocket spending—\$6,850 for an individual and \$13,700 for a family in 2016—these totals still strain most middle-class budgets.²⁶ This means, as discussed above, that people who require prescription drugs for chronic conditions may end up paying thousands of dollars per year because of sky-high and rising drug prices.

Yet more needs to be done. The Center for American Progress has previously outlined several policies to lower health care costs for middle-class families.²⁷ These reforms, designed to lower the growth rate of health care costs and bend the cost curve, include:

- Accelerating the use of alternative payment models, especially bundled payments, to transition from paying for the quantity of care toward paying for the quality of care;
- Leveraging the new insurance marketplaces—through active purchasing, requiring insurers to offer tiered insurance plans, and standardizing and publicizing cost and quality measures—to further lower costs and improve the quality of available plans;
- Increasing price transparency to enable consumers to choose high-quality, lower-cost providers and services;
- Reforming restrictive state scope-of-practice laws to maximize the use of non-physician providers and allow them to practice to the full extent of their training.

Policymakers have made progress on the first recommendation. In early 2015, the U.S. Department of Health and Human Services made its first public commitment to making a certain percentage of Medicare payments through alternative payment models—50 percent by the end of 2018.²⁸ The Center for Medicare and Medicaid Innovation is also testing several different types of alternative payment and service delivery models—including a mandatory bundled payment model for hip and knee replacements—in an effort to lower health care costs and improve quality. Policymakers should continue these efforts and adopt CAP’s other past proposals as well.

Because lowering overall health care costs is only the first step toward easing health care expenses for middle-class families, further reform efforts should focus on decreasing cost shifting to employees and ensuring that employers pass along savings in the form of lower premiums or reduced cost-sharing.²⁹ Policymakers should also focus on drug prices because they are rising at a fast enough rate that they are affecting the overall rate of growth of health care costs.³⁰

Address cost shifting with increased transparency and shared savings

Increase transparency on annual costs for employees and employers

The average employee’s health care costs continue to grow at a faster rate than employers’ costs. There is also an information gap between employees and employers. Employees know when their own costs are going up because they can feel it in their paychecks, but it is much harder for them to know if and why their employers’ costs are also increasing. Greater transparency about the health care costs of employees and employers can illuminate and discourage cost shifting; it would also allow employees to better understand their costs.

For these reasons, policymakers should require employers to provide their employees with this information each year during the open enrollment period through a notice that describes any changes in the distribution of premium contributions. The notice would also provide information about changes to the actuarial value of each employee’s insurance plan—a calculation that determines the value of a specific plan and can be used to compare different health care benefit designs and their relative generosity.³¹

The notice should outline how much the employer expects to pay, on average, for health care benefits per employee over the next year, as well as how much the employer expects the employee will spend on health care benefits. The same information for the previous year should be provided so that employees can easily compare how the distribution of costs may have changed. This greater transparency would discourage employers from cost shifting to their employees and provide employees with helpful information on their health care costs.

In more dramatic cases of cost shifting, more aggressive reforms are needed to protect consumers. Policymakers should require large employers, as defined by the ACA, to share savings with employees in the most egregious cases of cost shifting. These cases would be limited to situations in which an employer's average health care costs per enrollee were lower and the average enrolled employee's costs were higher than the state's trend in average health care costs per enrollee in other large employer plans. In these situations, the employer would have to share half of its savings on health care costs beyond the state's trend. Some employers may significantly change their benefit designs—by transitioning employees to high-deductible plans, for example—but not compensate employees in any way for the risk of higher out-of-pocket costs.

A buffer zone should also be built in so that the rebates would apply only in the most egregious situations: those in which the average costs for employers are at least 1 percentage point lower and the average costs for employees are at least 1 percentage point higher than the state's trend. This rebate structure would still allow employers to experiment with methods to control health care costs and retain savings but would ensure that employees share in any savings.

Reduce cost-sharing for primary care visits

New legislation should require that all health care plans include three free primary care visits for each enrollee each year. This added benefit will make health care more affordable for all consumers, but it will likely be particularly helpful for middle-class families with young children, who are more likely to need additional primary care services. This proposal builds on the ACA's requirement that health plans provide a range of preventive services to enrollees with no cost-sharing.

Combat excessive drug prices

In addition to reduced cost-sharing, consumers need greater protection from excessively high drug prices. High prices may be appropriate for certain truly innovative, lifesaving drugs, but policymakers must adopt reforms that pay for these drugs without shifting too much of the burden onto individuals. Successful reforms must lower overall drug costs instead of simply changing who pays them. For example, limiting cost-sharing amounts without also adopting reforms to lower the overall cost of prescription drugs just masks the larger issue by shifting costs from patients with high-cost prescriptions to employers and insurers, who will in turn restructure benefits or raise premiums to account for added costs.

Categorize new drugs by their comparative effectiveness and develop payment recommendations

All new drugs should be categorized by their comparative effectiveness. Comparative effectiveness research, or CER, compares new treatments with existing options and provides evidence on the effectiveness, benefits, and harms of different options in order to inform health care decisions.³² The secretary of health and human services should designate research-based independent organizations to serve as clearinghouses for all CER data and to conduct additional CER for new drugs. These CER data should then be used to categorize each new drug in terms of whether it provides no added benefit, minor added benefit, or significant added benefit compared with existing drugs. Added benefits should include measures such as improved health status, shortened disease duration, extended life expectancy, reduced side effects, and improved quality of life.

Each independent organization should then develop voluntary payment ranges for new drugs based on these findings. Drugs with zero added benefit, for example, would have a recommended price of no greater than the price of existing drugs used to treat the same disease or condition. These payment ranges can inform price negotiations between insurance or government payers and drug companies and make sure that payers—and, ultimately, patients—are getting a value-based price for the drug.

Require drug companies to justify prices outside of the recommended payment range

Policymakers should incentivize drug companies to charge reasonable prices. If a negotiation between a drug company and a payer were to result in a price that fell outside of the recommended range, the drug company would need to submit the final price along with a detailed justification for its decision to independent organizations, which would then publicly post the information. If the drug company insisted on a price that was 20 percent higher than the highest price recommended by one of the organizations, then the payer could require arbitration. The U.S. Government Accountability Office would present a list of approved arbitrators to the parties.

Require drug companies to invest more in research and development

The ACA's medical loss ratio policy requires insurers to spend most of their revenue from premiums on medical expenses for consumers. To ensure that public support for pharmaceutical research and development is a sound investment of taxpayer dollars that leverages additional research spending by drug companies, drug companies should invest a minimum percentage of their annual revenue in research and development. If a company does not meet the minimum investment over a five-year period, the company should be required to refund a portion of the revenue derived from public programs, up to the shortfall amount. The refund would be dedicated to a new Research Incentive Fund to support the National Institutes of Health.

Lower out-of-pocket prescription drug costs for individuals

Lowering overall spending for prescription drugs will do little to improve the health or financial well-being of patients if payers continue to pass costs on to consumers through higher cost-sharing amounts. For this reason, a number of states have passed legislation to limit out-of-pocket spending on prescription drugs. The ACA out-of-pocket limits still apply, but these state laws further cap spending on prescription drugs within those total amounts.

California law, for example, limits cost-sharing for prescription drugs in two ways. First, it mandates that all health insurance plans include a separate \$250 deductible for pharmacy benefits.³³ Second, consumer cost-sharing for drugs is then generally limited to \$250 per month after the consumer reaches the deductible limit.³⁴ Together, these limits cap cost-sharing for drugs at \$3,250 per year, giving patients with chronic conditions greater predictability about their health care expenses and protection from extraordinarily high cost-sharing at the beginning of the year or when they first need treatment.³⁵

Policymakers should adopt similar requirements at the federal level to protect all consumers. First, the secretary of health and human services should adopt similar requirements for silver-level plans in all exchanges. Second, Congress should extend these limits to individuals with employer-sponsored insurance. This yearly limit is higher than the current average out-of-pocket maximum for prescription drugs for individuals covered by employer-sponsored plans. However, it will provide important financial protections for employees with high prescription drug costs whose expenses far exceed those of average employees.³⁶

Endnotes

- 1 Mark W. Stanton, "Employer-Sponsored Health Insurance: Trends in Cost and Access" (Rockville, MD: Agency for Healthcare Research and Quality, 2004), available at <http://archive.ahrq.gov/research/findings/factsheets/costs/empspria/index.html>.
- 2 Ibid.
- 3 Dan Mangan, "Medical Bills Are the Biggest Cause of US Bankruptcies: Study," CNBC, June 25, 2013, available at <http://www.cnbc.com/id/100840148>; Theresa Tamkins, "Medical Bills Prompt More Than 60 Percent of U.S. Bankruptcies," CNN, June 5, 2009, available at <http://www.cnn.com/2009/HEALTH/06/05/bankruptcy.medical.bills>.
- 4 Liz Hamel and others, "The Burden of Medical Debt: Results From the Kaiser Family Foundation/New York Times Medical Bills Survey" (Menlo Park, CA: The Henry J. Kaiser Family Foundation, 2016), available at <https://kaiserfamilyfoundation.files.wordpress.com/2016/01/8806-the-burden-of-medical-debt-results-from-the-kaiser-family-foundation-new-york-times-medical-bills-survey.pdf>.
- 5 Ibid.
- 6 Christopher S. Girod, Scott A. Wertz, and Susan K. Hart, "2015 Milliman Medical Index" (Seattle: Milliman, 2015), available at <http://us.milliman.com/uploadedFiles/insight/Periodicals/mmi/2015-MMI.pdf>.
- 7 U.S. Department of Health and Human Services, "20 Million People Have Gained Health Insurance Coverage Because of the Affordable Care Act, New Estimates Show," Press release, March 3, 2016, available at <http://www.hhs.gov/about/news/2016/03/03/20-million-people-have-gained-health-insurance-coverage-because-affordable-care-act-new-estimates>.
- 8 Linda J. Blumberg and others, "Implications of the Affordable Care for American Business" (Washington: The Urban Institute, 2012), available at <http://www.urban.org/uploadedpdf/412675-implications-of-the-affordable-care-act-for-american-business.pdf>; National Business Group on Health, "U.S. Employers Changing Health Benefit Plans to Control Rising Costs, Comply with ACA, National Business Group on Health Survey Finds," Press release, August 13, 2014, available at <http://www.businessgrouphealth.org/pressroom/pressRelease.cfm?ID=234>; Jeffrey Young, "Companies Predict Small 2015 Health Cost Rise – with a Catch," The Huffington Post, August 13, 2014, available at http://www.huffingtonpost.com/2014/08/13/employer-health-insurance_n_5673039.html?1407938784.
- 9 Topher Spiro, Maura Calsyn, and Meghan O'Toole, "The Great Cost Shift: Why Middle-Class Workers Do Not Feel the Health Care Spending Slowdown" (Washington: Center for American Progress, 2015), available at <https://www.americanprogress.org/issues/healthcare/report/2015/03/03/105777/the-great-cost-shift>.
- 10 Center for American Progress calculations based on Health Care Cost Institute, "2014 Health Care Cost and Utilization Report" (2015), available at <http://www.healthcostinstitute.org/2014-health-care-cost-and-utilization-report>; Agency for Healthcare Research and Quality, "Medical Expenditure Panel Survey: Insurance Component," available at https://meps.ahrq.gov/mepsweb/survey_comp/Insurance.jsp (last accessed March 2016).
- 11 Agency for Healthcare Research and Quality, "Medical Expenditure Panel Survey."
- 12 Al Dobson and others, "Health Care Spending Slowdown: The Consumer Paradox" (Vienna, VA: Dobson DaVanzo & Associates, LLC, 2014), available at <http://fah.org/upload/documents/Dobson-DaVanzo-Federation-Cost-Sharing-Report1.pdf>.
- 13 The Henry J. Kaiser Family Foundation, "2015 Employer Health Benefits Survey" (2015), available at <http://kff.org/health-costs/report/2015-employer-health-benefits-survey>.
- 14 American Academy of Pediatrics, "Policy Statement: High-Deductible Health Plans," *Pediatrics* 133 (5) (2014): 1461–1470.
- 15 Health Care Cost Institute, "2014 Health Care Cost and Utilization Report"
- 16 Altarum Institute, "Hospitals and Prescription Drugs Leading Health Spending Acceleration," Press release, April 10, 2015, available at <http://altarum.org/about/news-and-events/hospitals-and-prescription-drugs-leading-health-spending-acceleration#sthash.ncALR-WzD.dpuf>.
- 17 Girod, Wertz, and Hart, "2015 Milliman Medical Index."
- 18 Ibid.
- 19 Caroline Humer, "Exclusive: Makers Took Big Price Increases on Widely Used U.S. Drugs," Reuters, April 5, 2016, available at <http://www.reuters.com/article/us-usa-healthcare-drugpricing-idUSKCN0X10TH>.
- 20 Bianca DiJulio, Jamie Firth, and Mollyann Brodie, "Kaiser Health Tracking Poll: August 2015," (Menlo Park, CA: The Henry J. Kaiser Family Foundation, 2015), available at <http://kff.org/health-costs/poll-finding/kaiser-health-tracking-poll-august-2015>.
- 21 Sam Ro, "Here Are The Profit Margins For Every Sector In The S&P 500," Business Insider, August 16, 2012, available at <http://www.businessinsider.com/sector-profit-margins-sp-500-2012-8>.
- 22 Richard Anderson, "Pharmaceutical Industry Gets High on Fat Profits," BBC News, November 6, 2014, available at <http://www.bbc.com/news/business-28212223>.
- 23 Richard A. Hirth and others, "Out-Of-Pocket Spending and Medication Adherence Among Dialysis Patients in Twelve Countries," *Health Affairs* 27 (1) (2008): 89–102, available at <http://www.ncbi.nlm.nih.gov/pubmed/18180483>; Stacie B. Dusetzina and others, "Cost Sharing and Adherence to Tyrosine Kinase Inhibitors for Patients With Chronic Myeloid Leukemia," *Journal of Clinical Oncology* 32 (4) (2014): 306–311, available at <http://www.ncbi.nlm.nih.gov/pubmed/24366936>.
- 24 Ana Swanson, "How New Drugs Helping Millions of Americans Live Longer Are Also Making Them Go Broke," *The Washington Post*, June 30, 2015, available at <https://www.washingtonpost.com/news/wonk/wp/2015/06/30/how-new-drugs-helping-millions-of-americans-live-longer-are-also-making-them-go-broke>.
- 25 Girod, Wertz, and Hart, "2015 Milliman Medical Index."

- 26 HealthCare.gov, "Out-Of-Pocket Maximum/Limit," available at <https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit> (last accessed March 2016).
- 27 Jennifer Erickson, ed., "The Middle Class-Squeeze: A Picture of Stagnant Incomes, Rising Costs, and What We Can Do to Strengthen America's Middle Class" (Washington: Center for American Progress, 2014), available at <https://www.americanprogress.org/issues/economy/report/2014/09/24/96903/the-middle-class-squeeze>.
- 28 U.S. Department of Health and Human Services, "Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value," Press release, January 26, 2015, available at <http://www.hhs.gov/about/news/2015/01/26/better-smarter-healthier-in-historic-announcement-hhs-sets-clear-goals-and-timeline-for-shifting-medicare-reimbursements-from-volume-to-value.html>.
- 29 Ibid.
- 30 Altarum Institute, "Hospitals and Prescription Drugs Leading Health Spending Acceleration."
- 31 American Academy of Actuaries, "Actuarial Value Under the Affordable Care Act" (2011), available at http://actuary.org/files/publications/Actuarial_Value_Issue_Brief_072211.pdf.
- 32 Agency for Healthcare Research and Quality, "What Is Comparative Effectiveness Research," available at <http://effectivehealthcare.ahrq.gov/index.cfm/what-is-comparative-effectiveness-research1> (last accessed March 2016).
- 33 Covered California, "2016 Standard Benefit Plan Designs" (2015), available at http://hbex.coveredca.com/regulations/PDFs/2016%20Standard%20Benefit%20Plan%20Design_Second%20Readopt%2005%2021%2015_OAL%20approved_CLEAN.pdf.
- 34 Ibid.
- 35 Ibid.
- 36 For mean out-of-pocket maximums for PPO plans, see Christine Buttorff and others, "Comparing Employer-Sponsored and Federal Exchange Plans: Wide Variations in Cost Sharing for Prescription Drugs," *Health Affairs* 34 (3) (2015): 467–476, available at <http://content.healthaffairs.org/content/34/3/467>.