

THE BOTTOM LINE

Growth in health care expenditure continues to outpace growth in the economy, leading many businesses to either increase employee cost-sharing requirements or remove health insurance benefits entirely. While some employees and their families have become eligible for public coverage – often at the expense of other state budget priorities – many become uninsured.

HEALTH CARE

A two-part series examining the rise in health care costs and the decline in health care coverage.

Part 1

NATIONAL HEALTH CARE AND INSURANCE TRENDS

According to the Centers for Medicare and Medicaid Services' (CMS) latest ten-year projections, spending on health care will increase an additional 7.6 percent in 2006. While high, the growth rate remains below the 9.1 percent spending increase experienced in 2002. Still, health care spending continues to grow faster than the economy and by 2015 spending is projected to constitute 20 percent of GDP (CMS 2006b). See Figure 1.

The rapid growth in spending presents a major competitiveness challenge for businesses, makes insurance increasingly unaffordable for families, and places additional strain on federal and state budgets.

In this brief, we begin by examining rising health care costs. Next, we provide an overview of public and private sector health care coverage and discuss why so many Americans are uninsured. The brief concludes with a review of the various state policy options under consideration.

A similar health care and insurance trend is apparent in Washington State. While mentioned briefly in this report, a more detailed discussion is available in the companion brief (WashACE Forthcoming).

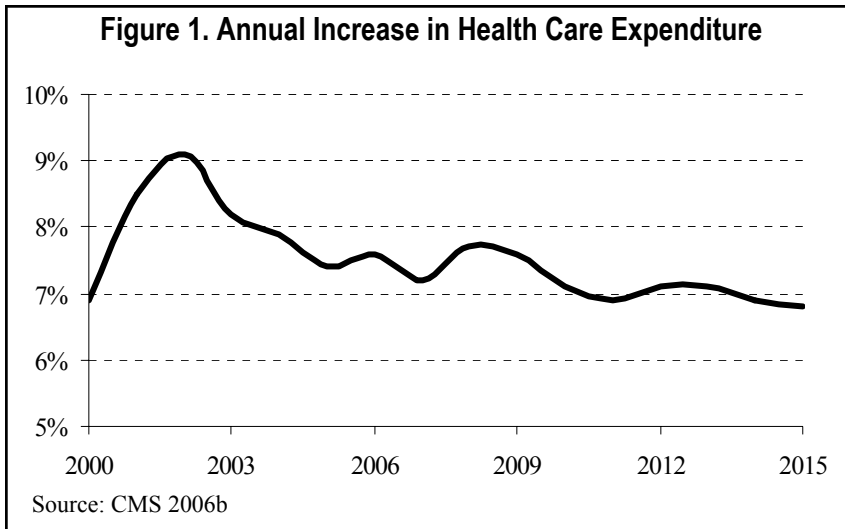
HEALTH CARE SPENDING TRENDS

In 1995, national health expenditure totaled \$1,020 billion. In 2005, health care spending rose to an estimated \$2,016 billion. And, by 2015, CMS projects that spending will reach \$4,044 billion. See Figure 2.

Growth in health care spending is in part due to rapid advances in technology, increased utilization, inflation, demographic changes, and the expansion of government health care programs. And, "as longevity improves and medical science continues to develop, the growth of premium medicine will present even greater challenges" (Kling 2006, p. 17).

Expenditure Breakdown. In 2006, an estimated 31 percent of national health expenditure will go towards hospital care. Twenty-one percent will be spent on physician and clinical services and another 10 percent on prescription drugs. Dental and other services will account for 10 percent of expenditure and nursing home and home health care for another 8 percent.

Funding Breakdown. In 2005, an estimated 54.6 percent of health care was funded by private sector spending, a slight increase from the 54.3 percent reported in 1995. In 2015, private sector spending is projected to



decrease to 52.5 percent. While the percent of funding from the private sector remains relatively stable, the source of private sector funds has shifted from out-of-pocket payments to private health insurance. In 1970 out-of-pocket payments made up 33.2 percent of health care spending, decreasing to 12.3 percent of spending by 2005.

Federal funding increased from 23.6 percent of health care expenditures in 1970 to 31.9 percent in 1995, but has been relatively stable over the past decade. In 2015, the federal government will fund 34.9 percent of health care expenditures. State and local governments will contrib-

ute an additional 12.9 percent (CMS 2006a).

HEALTH CARE COVERAGE

According to the Current Population Survey, in 2004 59.8 percent of people

had employment-based health insurance and 27.2 percent had government health insurance (Census 2005). See Figure 3.

Public Coverage. Government-administered programs such as Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP) provide health care benefits to a growing number of Americans. Medicare (which provides health care to people age 65 and older as well as people with certain disabilities) is strictly a federal program, but Medicaid and SCHIP are funded by the federal government and the states in partnership.

Medicaid covers approximately 13

percent of the non-elderly population (37.5 million in 2004) and provides health care coverage primarily to low-income children, their parents, and persons with disabilities (Census 2005, p. 16).

Under federal law, all states that participate in Medicaid are required to cover certain categories of people. The program also mandates provision of certain services, such as hospital care and physician services. Within these broad national guidelines, each state has established its own eligibility criteria, scope of services, and rates of payment.

While federal and state Medicaid spending growth slowed for the fourth consecutive year in 2005 to 7.7 percent, Medicaid spending takes up about 25 percent of states' budgets (CMS 2006b; Enos 2006a, p. A12).

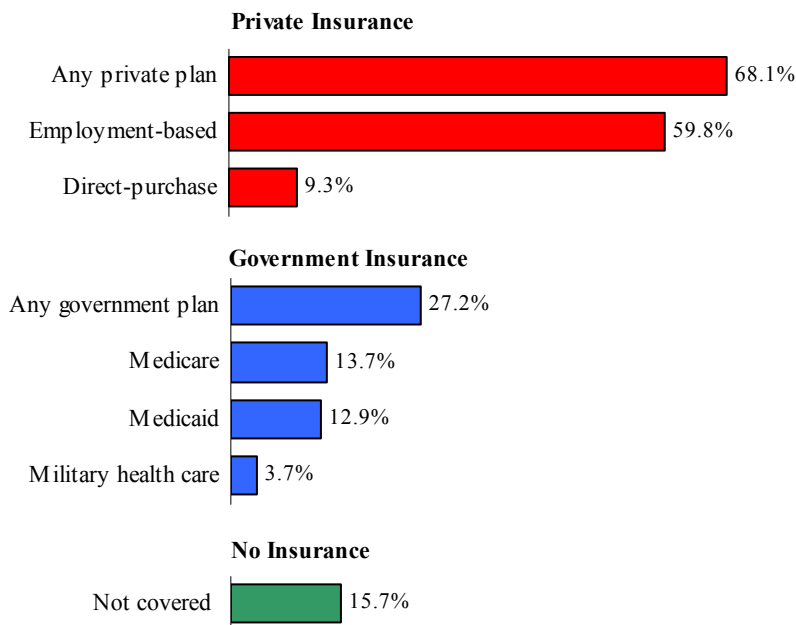
SCHIP covers low-income children not eligible for Medicaid. Within broad federal guidelines, each state determines the program's eligibility groups,

Figure 2. National Health Expenditure by Service, 2006 & 2015

	2006	2015
National Health Expenditure (Billions)	\$ 2,169.5	\$ 4,043.6
Hospital Care	\$ 662.5	\$ 1,230.9
Professional Services - Physician and Clinical Services	\$ 463.3	\$ 849.8
Professional Services - Dental and Other	\$ 216.7	\$ 411.6
Nursing Home and Home Health	\$ 181.5	\$ 320.5
Prescription Drugs	\$ 219.2	\$ 446.2
Other Medical Products	\$ 58.7	\$ 83.1
Government Administration and Net Cost of Private Health Insurance	\$ 157.1	\$ 301.8
Government Public Health Activities	\$ 67.0	\$ 130.9
Investment	\$ 143.6	\$ 268.9

Source: CMS 2006b

Figure 3. National Health Insurance Enrollment by Type of Coverage, 2004



Source: U.S. Census Bureau 2005

Note: The estimates by type of coverage are not mutually exclusive

benefit packages, member payment levels, and administrative procedures. Most states cover children up to 200 percent of the Federal Poverty Level (FPL) and 13 states, including Washington, cover children above this level (Kaiser 2006b, p. 14).

The federal government will spend an estimated \$24 billion on SCHIP between Fiscal Years 1998 and 2007 (CMS 2005).

PRIVATE SECTOR INSURANCE TRENDS

Between 2000 and 2004, the share of people receiving insurance through employers decreased 4.9 percentage points, the share receiving insurance through Medicaid increased 2.7 percentage points, and the share paying for individual insurance increased 0.3 percentage points (KFF 2005). Despite the decrease, job-related coverage remains the primary source of health insurance.

Eligibility. In 2003, 86.8 percent of employees worked for firms offering health insurance and 78.5 percent of these employees were eligible for employer-sponsored coverage

(some employees are ineligible because they are part-time employees or recent hires). About 80 percent of eligible employees chose to enroll in a health care plan (Branscome & Crimmel 2006).

Large firms are the most likely to offer coverage. Branscome and Crimmel estimate that, in 2003, 96.8 percent of employees of large firms worked where coverage was offered, compared to 61.6 percent of employees in small firms. (Kaiser reports lower eligibility levels, but the trend remains the same: large firms are more likely to offer insurance.)

Mandates. The type of coverage provided by employer-sponsored insurance varies greatly by company and plan. However, some states require insurance companies to cover certain types of providers or certain types of benefits. States can also regulate rating rules and limit the ability of insurance plans to exclude people from coverage. These regulations can profoundly affect the price and availability of health insurance.

According to Michael New, the presence of health plan liability laws increase monthly premiums by \$21.84, laws that give subscribers direct access to specialists increase monthly premiums by \$31.15, and provider due process laws increase monthly premiums by \$16.62 (2006, p. 5).

Premiums. Although the growth in health insurance premiums has once again moderated, the cost of providing coverage continues to grow faster than incomes. See Figure 4.

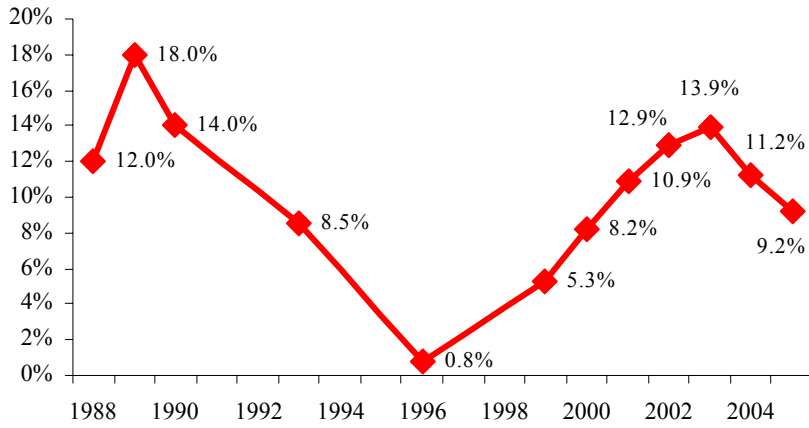
In 2003, the average annual premium for single coverage employer-sponsored health insurance was \$3,481, for which the average employee contribution was \$606. The average annual premium for family coverage was \$9,249, for which the average employee contribution was \$2,282 (Branscome & Crimmel 2006).

Retiree Health Care Benefits

In addition to Medicare, many retired workers receive health care benefits through their former employers. However, providing retiree coverage is becoming increasingly unaffordable. Not only is the cost of health care rising, the “baby boomer” generation is beginning to retire, beneficiaries are living longer, and stricter accounting standards are requiring employers to account for and disclose their obligations.

In response, many employers have sought concessions from future, current, and retired employees. A common strategy has been to reduce benefits by increasing retiree contributions to premiums, increasing cost-sharing requirements, terminating subsidies for future retirees, shifting to defined contribution plans, and/or imposing new caps. Many private sector employers have removed benefits entirely.

Figure 4. Increase in National Health Insurance Premiums, 1988-2005 (for a family of four)

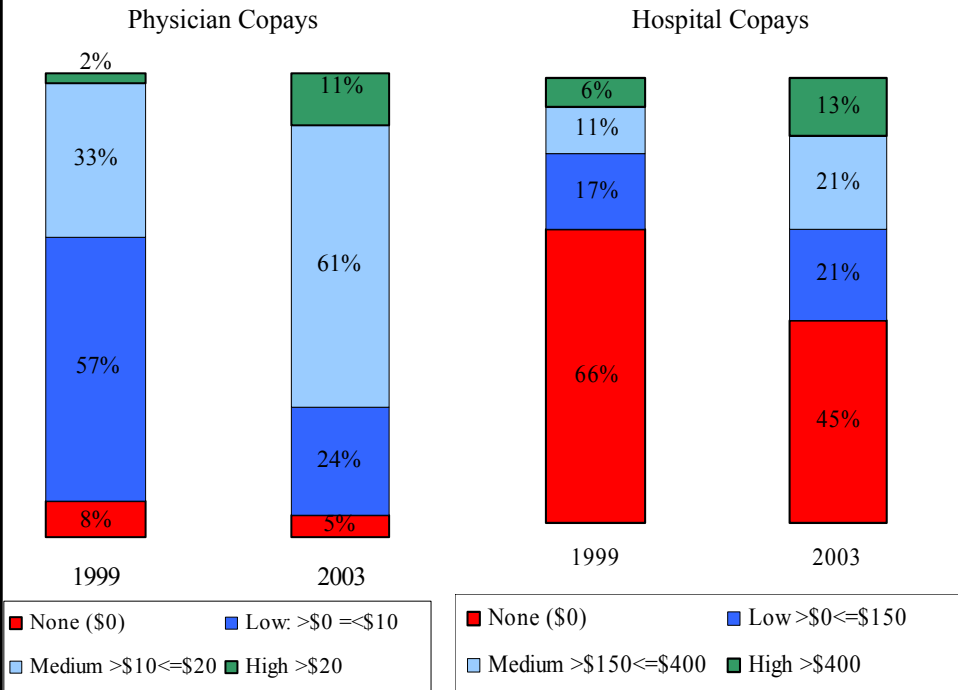


Source: Kaiser Commission on Medicaid and the Uninsured 2006b

In total, private sector health insurance companies paid out \$563 billion for member health care services in 2004. An additional \$95 billion went to administration costs (CMS 2006b).

Increased Employee Contributions. In response to the increased cost of providing health care benefits, many firms have expanded their cost-sharing requirements. One way to do this is to impose or increase copays for physician and hospital services. In 1999, 57.0 percent of private sector employees were enrolled in plans with low physician copays, decreasing to 23.5 percent of employees in 2003. Similarly, while 66.3 percent of private sector employees had no hospital copays in 1999, only 45.3 percent had no copays in 2003 (Crimmel et al. 2006). See Figure 5.

Figure 5. Physician and Hospital Copays for Insurance Enrolled Private Sector Employees



Source: Crimmel, Taylor & Zawacki 2006

Private policies. Those not covered through an employer and ineligible for government health care programs have the option of buying private policies. However, since non-group insurance premiums are based on individual risk, they are substantially more expensive than group plans.

THE UNINSURED

According to the U.S. Census Bureau, 45.8 million people (15.7 percent of the population) were without health insurance coverage in 2004. While the percent of the population without insurance fluctuates each year (with a low of 12.9 percent in 1987 and a high of 16.3 percent in 1998), and while the reported level varies by source, a persistently high number of Americans go without health insurance (2005, p. 16).

Most of the uninsured can obtain emergency care at a hospital receiving federal funds but there are no other national standards requiring service providers to offer care to those unable to pay (NCSL 2005 p. 9).

Who are the Uninsured? In 2004, 24.3 percent of people with household incomes less than \$25,000 were without health insurance, compared to 8.4 percent of people with household income of \$75,000 a year or more (Census 2005, p. 18). Low-income workers have a higher rate of uninsurance in part because they are less likely to have insurance offered to them through an

Figure 6. National Health Insurance Coverage of the Nonelderly by Federal Poverty Level, 2004

	Non-elderly (millions)	<u>Private</u>		<u>Public</u>		<u>Uninsured</u>
		Employer	Individual	Medicaid	Other	
Total	255.1	61.0%	5.4%	13.4%	2.3%	17.8%
<100%	45.8	15.0%	6.1%	39.1%	3.3%	36.5%
100-199%	43.9	38.8%	5.9%	23.0%	3.7%	28.5%
200-399%	74.8	71.8%	5.4%	6.1%	2.0%	14.7%
400%+	90.6	86.3%	4.7%	1.9%	1.3%	5.8%

Source: Kaiser Commission on Medicaid and the Uninsured 2006b

employer. And, even when offered, cost-sharing requirements often make coverage unaffordable. See Figure 6.

While the majority of the uninsured have at least one family member in the workforce, unemployed families are much more likely to be uninsured. In 2004, 17.8 percent of 18 to 64 year-olds working full-time were without health insurance, compared to 25.8 percent of those not working (Census 2005, p. 18).

Reasons To Insure. High uninsurance rates are a concern both

for individuals and for the community. For the community, large numbers of uninsured individuals leads to excessive use of emergency services, higher premium rates, and a less productive workforce. For the individual, lack of coverage increases the likelihood of poor health since the uninsured are less likely to:

- have a regular source of care,
- have had a recent physician visit,
- Use preventative services, and
- receive follow-up care.

Likewise, the uninsured are more likely to:

- delay seeking care,
- receive too little medical care,
- show up in emergency rooms for care that could be given more cheaply in a physician’s office,
- be diagnosed in the late stages of a disease, and
- be hospitalized for avoidable health problems.

On average, nonelderly uninsured individuals receive just over half the amount of health care that those with insurance receive (\$1,629 vs. \$2,975 in 2004). Thirty-five percent of the cost of care received by the full-year uninsured is paid out-of-pocket. Most of the remaining costs are referred to as uncompensated care (Kaiser 2006b, p. 8).

In 2004, the cost of uncompensated care totaled nearly \$41 billion. Federal and state governments paid \$34.6 billion of these costs (Kaiser 2006b, p. 9).

Hadley and Holahan estimate that achieving universal coverage would cost an additional \$802 per currently uninsured person per year, increasing the total annual cost of health care for these individuals from \$125 billion to \$173 billion. (Note, this estimate reflects “the potential increase in overall health spending directly attributable to the uninsured, but does not take into account the additional costs associated with major health coverage proposals.”) While a significant cost increase, Hadley and Holahan maintain that the \$48 billion is much less than the annual economic value of the foregone health of the uninsured (2004, p. 5–6).

Battling Theories

Before implementing health care policies, policymakers must determine what type of competition is needed.

In her book *Market-Driven Health Care*, Herzlinger asserts that, if the current third-party payment system is removed, consumer demand and market forces will create a health care delivery system offering high quality at low costs.

But in *Redefining Health Care*, Porter and Teisberg argue that the health care industry should restructure itself to provide value-based results. A shift to value-based competition, they maintain, will lead to better health and greater efficiency.

Inefficient Spending Practices

As personal income rises and as new treatments become available, it is natural for health care spending to increase. But while we are living longer, healthier lives, the current pattern of health care spending is considered wasteful and sometimes ineffective, with under-use, misuse, and overuse of treatments resulting in often fatal medical errors. To improve quality, many analysts suggest restructuring financial incentives for health care providers in order to make them better aware of the risks and benefits of each procedure. One way to do this would be to reward doctors who regularly follow best practices (Kling 2006, p. 88).

REFORM EFFORTS

Throughout the 1990s, health care reform efforts in both the private and public sectors focused on holding down costs. More recently, the focus has shifted to improving the quality of care, in the belief that better care will both improve health outcomes and lower overall spending. Reform efforts are also increasingly focusing on getting consumers directly involved in the decision-making process.

To increase access to insurance, some states have focused on lowering the effective price of coverage, either by making reduced-price coverage available or by subsidizing the purchase of private insurance. Others have focused on lowering or eliminating the barriers to coverage. And some have expanded their health care safety nets in order to provide coverage for low-income uninsured individuals.

The following sections provide an overview of some of the policy options currently being considered and implemented.

Consumer-Driven Health Care. Requiring employees and public assistance recipients to pay a larger share of their health care costs could slow the growth in medical spending by placing greater importance on market forces and personal responsibility.

One way to do this is to give employees a choice between a number of plans with varying networks of providers and benefit packages. Regardless of the plan chosen, the employers' contribution is fixed and the balance of the cost is borne by the employee.

States and employers can also pair high-deductible health insurance policies with tax-exempt personal accounts, such as Medical Savings Accounts, Health Reimbursement Arrangements, Flexible Spending Accounts or Health Savings Accounts (HSAs).

Because of the high deductibles, HSAs impose greater individual responsibility and consumer involvement than the more traditional, employer-paid plans. With higher cost-sharing requirements, HSAs are expected to lower demand for medical services. Lower demand, in turn, lowers health care costs. According to Schlienz, while the cost of standard insurance plans continue to increase, HSA costs are decreasing by 4 percent a year (2006).

But while these savings accounts are a viable solution for many, "they will not solve the coverage issues for low income people, nor effectively deal with the fact that 5 percent of us account for 50 percent of health care dollars spent each year" (Hill 2006).

Improving the decision making process. States and firms are also focusing on improving health care decision-making by providing consumers and providers with more information on the relative benefits of each care option.

In Washington, public and private sector employers, health providers, health provider associations, and health plans joined together to form the Puget Sound Health Alliance.

Wellness Programs. According to data from the SIPP 2001 panel survey, "compared with other health-status groups, those in progressively better health-status categories visited doctors less frequently, stayed fewer nights in hospitals, and took prescription medicine less frequently" (Bhandari 2006, p. 3). Therefore, focusing on preventative care is an important part of any cost-reduction strategy.

Increasing Consumer Responsibility

In 2006, economist Arnold Kling released a book titled “Crisis of Abundance: Rethinking How We Pay for Health Care.” According to Kling, the goal of insurance should be to protect consumers from large, unpredictable expenses, not insulate them from the cost of health care.

Today, approximately 86 percent of health care costs are paid by someone other than the patient (Kling 2006, p. 45). The problem with this is that, when a third party is paying, the consumer is less concerned with cost. According to Amy Finkelstein, the spread of third-party health insurance may be responsible for as much as half of the growth in health care spending between 1950 and 1990 (2006, p. 23).

By introducing market forces, consumers will have less incentive to overconsume health care services that are not absolutely necessary and which may not be cost-effective.

While many worry that increasing the consumer’s financial burden will result in underconsumption of health care, an experiment by RAND found that “cost sharing reduced care but had no effect on health” (Keeler 1992). Still, Kling concedes that there is evidence to suggest that some patients will forgo necessary care when faced with large out-of-pocket costs. To prevent this, he suggests subsidizing health care for people with low-incomes or unusually large medical expenses. For everyone else, Kling maintains that paying for care out of pocket is reasonable and that “Shifting responsibility to others only introduces administrative costs and economic distortions” (2006, 63).

With costs continuing to escalate, we can no longer have it all: “Either supply has to be restrained by a national health care budget, demand has to be restrained by giving consumers less insulation from costs, or the nation’s health care spending will grow unchecked” (Kling 2006, p. 53).

While a number of different strategies have been implemented (including company-sponsored sports teams, on-site fitness centers, mandatory medical checkups, and health-related workshops), the underlying principle of wellness programs is the same: The more businesses encourage employees to make healthy decisions with their lives, the more money the businesses save on health insurance.

Incentives to stay healthy. Rewarding healthier lifestyles and personal awareness could also reduce the overall cost of providing care.

In King County, government employees that complete a wellness assessment evaluation become eligible for lower out-of-pocket health care costs (Enos 2006a, p. A13).

In West Virginia, Medicaid recipients who fail to follow their doctor’s orders or who use emergency rooms for non-emergency care get their health benefits reduced.

Prescription Drugs. Within their Medicaid programs, some states have set limits on the use of brand-name drugs or on the number of prescriptions a patient can fill in a month. In addition several states – including Washington – have begun using evidence-based medicine in determining which medications to cover (Enos 2006a, p. A12-13). Evidence-based medicine is also increasingly being practiced in other areas. By using procedures proven to work, ineffective spending can be reduced.

Disease management: Statistics show that chronic illnesses such as diabetes, asthma and heart disease account for a significant share of premium increases. In response, some states are choosing to treat chronically ill patients as patients with complex health needs, instead of simply providing services specific to the illness, through what is known as a “case-management strategy.”

Medicaid flexibility at the state level. Another way to lower costs is to allow greater state flexibility in federally matched programs. While states are required to comply with federal mandates, they can apply for a waiver.

Vermont signed a Medicaid waiver in which the state agreed to a \$4.7 billion expenditure ceiling over the next five years. In return for agreeing to pay any outlays above the cap, the state will be allowed to establish its own managed care organization. Any profits will be invested in health care-related programs and services that would otherwise not be eligible under Medicaid (Daigneau 2006).

Expand Government Health Insurance Programs. While some states are turning to the private sector, others are expanding government programs. This can be done by increasing Medicaid and SCHIP eligibility and by strengthening enrollment efforts. For example, Washington includes unborn children in its definition of “child” in order to extend SCHIP coverage to low-income pregnant women (Yondorf et al. 2004, p. 45).

States can also establish high-risk pools for otherwise uninsurable residents or sponsor a state-funded insurance program.

But while expanding public programs can lower uninsurance rates, research suggests that it also crowds out private insurance. According to David Cutler and Jonathan Gruber, approximately half of the people added to Medicaid during the early 1990s expansion would otherwise have been covered by private insurance (1996).

Subsidizing purchase of private insurance. To expand access to private sector insurance, states can offer direct subsidies to lower-income workers. And to help lower premiums, states can allow insurers to offer policies with little or no mandates. States can also use public funds to cover a portion of health insurers' high-cost health claims. For example, New York reimburses health maintenance organizations for 90 percent of the costs incurred on a per person basis for Healthy NY claims between \$5,000 and \$75,000.

Insurance Exchange. In order to take advantage of the lower premiums offered to larger groups, states can replace their small-group and non-group insurance markets with a single insurance exchange, where individuals can buy personal coverage with pre-tax dollars. Companies can also join together to purchase health insurance.

Require Coverage. In addition to making coverage more accessible and affordable, states can make health insurance mandatory. For example, last April Massachusetts lawmakers passed legislation imposing fines on residents that fail to maintain credible coverage.

And, when awarding contracts, states can require or give preference to firms that offer their employees health insurance.

Pay or Play. Requiring large companies to either provide employees with health insurance or pay the government to provide these services has become an increasingly popular response to high uninsurance rates. But many believe it is unfair to single out large employers. Pay or play could also be in violation of the Employee Retirement Income Security Act of 1974, a federal law essentially preventing states from mandating employer-sponsored insurance. Last July, a federal judge overturned Maryland's Fair Share Health Care Fund Act.

DISCUSSION

With rising health care expenditures, declining employer-paid benefits, and growing demand for public services, states are faced with the challenge of expanding access to affordable care.

But with so many options available, and with no clear solution, each state will have to rely upon available information and the experience of others to tailor a reform effort specific to its population and circumstances. In doing so, lawmakers should strive towards making coverage affordable, flexible, health-enhancing, and available to as many residents as possible.

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