



The Great Cost Shift

Why Middle-Class Workers Do Not Feel
the Health Care Spending Slowdown

By Topher Spiro, Maura Calsyn, and Meghan O'Toole March 2015

Center for American Progress



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Introduction and summary

In recent years, the growth in overall health care costs has slowed dramatically. But for millions of Americans with employer-sponsored insurance, or ESI, this slowdown is illusory. From 2008 through 2013, the average annual growth rate of employees' monthly premium contributions and out-of-pocket expenses, adjusted for inflation, was more than double that of average annual growth in real per-capita national health care spending, which was less than 2 percent per year.^{1*} This growth has also outpaced employers' costs of offering these benefits by more than 40 percent.²

Employees experiencing higher health care costs tend to blame the Affordable Care Act, or ACA, even though the law largely leaves the employer-based system alone.³ In fact, many employers report that the ACA has had only a negligible influence on their health care costs.⁴

The actual reason why employee and employer costs are increasing at different rates is because employers have, over time, shifted greater responsibility for health care expenses to their employees through higher deductibles, higher copayments, and higher coinsurance—a practice that began long before the passage of the ACA. Other employers pay smaller shares of their employees' health care premiums.

To some degree, this long-term cost shifting has contributed to the overall health care slowdown.⁵ Increased cost sharing discourages the use of health care—individuals tend to spend less on their health care when they are subjected to higher fees or deductibles—which has lowered overall health care spending. Employees with higher cost sharing are more likely to avoid or delay even beneficial and cost-effective care.⁶ Employers, insurers, and public health care programs benefit from these savings, while individual employees with significant health care needs face greater out-of-pocket costs. Employees have increasingly reported that their health care costs are unaffordable.⁷ In other words, almost everyone in the health care system is realizing savings, but employees' costs are rising.

*The data cover the period from 2007 through 2013, but annual growth rates are calculated for 2008 through 2013 because the data for years prior to 2007 are not available.

Unlike changes to wages, which are straightforward and transparent, these types of changes to employees' health benefits can be hard to understand, making cost-shifting efforts difficult for employees to detect. For this reason, the Center for American Progress recommends the following three reforms:

- Increased transparency about employers' and employees' health care costs and savings
- Shared savings rebates to limit cost shifting to employees
- Reducing employees' cost-sharing burdens by expanding the ACA's free preventive-services benefit

These reforms will allow millions of Americans with ESI to benefit from the slowdown in health care spending. If employers ask their employees to shoulder a greater share of their health care costs, employees also should share in the resulting savings.

Measuring the value of health benefits

Employer-sponsored health insurance is the most common form of health insurance in the United States. In 2014, 55 percent of firms offered health insurance to their employees, and 149 million nonelderly Americans—about half of all Americans—obtained health insurance through their employers.⁸ Among firms that offer health insurance, 62 percent of employees are covered by their employer's health insurance. These offer and coverage rates have remained constant in recent years.

Typically, employers that offer health insurance pay the majority of their employees' health insurance premiums as part of their total compensation package. Employees are usually responsible for a portion of the premiums, but that amount varies significantly. The Kaiser Family Foundation found that the average employee premium contribution in 2014 was \$1,081 for single coverage, with 20 percent of employees paying less than \$649—60 percent of the average—and 31 percent of employees paying more than \$1,513—140 percent or more of the average.⁹

Employees are also responsible for out-of-pocket costs that they pay directly for health care services, such as to their doctors and for items such as prescription drugs. Out-of-pocket costs include deductibles, copayments, and coinsurance. A deductible is the amount patients owe for covered health care services before the health insurance plan begins to pay any costs. Copayments are a fixed amount—\$20, for example—that an individual pays for a covered health care service, such as a visit to the doctor, usually at the time of service. Coinsurance is a percentage share of the costs of a covered service that individuals must pay.¹⁰ For example, after a person meets his or her deductible amount and the plan begins to pay for health care services, a coinsurance rate of 20 percent means that the person will still pay 20 percent of the cost of a particular item or service.

The Affordable Care Act capped the out-of-pocket costs for individuals and families enrolled in nongrandfathered health care plans—both for employer-sponsored insurance and insurance purchased in the new Marketplaces. This requirement covers the majority of those with ESI; 74 percent of covered employees were enrolled in nongrandfathered plans in 2014, which was up from 44 percent in 2011.¹¹ The

annual limits in 2015 are \$6,600 for an individual plan and \$13,200 for a family plan.¹² Premiums, out-of-network expenses, and spending on noncovered benefits do not count toward meeting the cap.

How much an individual will actually pay out of pocket for health care varies significantly based on the structure of the health insurance plan, the use of services, and the types of services used. Plans with lower monthly premiums usually have higher deductibles and out-of-pocket costs, and plans with higher monthly premiums usually have lower deductibles and out-of-pocket costs. Therefore, plan designs are more or less suitable for different individuals based on how many health care services they are likely to need. For example, an individual with a chronic condition that requires frequent medical appointments and multiple prescription drugs would likely be better served by a plan that has higher monthly premiums but lower cost sharing.

There are countless variations on health insurance cost-sharing requirements, which is one of the reasons why comparing health care options is extraordinarily confusing for consumers. Actuarial value, or AV, is a calculation that determines the value of a specific plan, and it can be used to compare different health care benefit designs and their relative generosity.¹³

The AV compares the value of the health care items and services covered by a plan for a typical enrollee and how much of these costs the individual enrollee will bear, excluding premium contributions from the employer and employee and including any employer contributions to health savings accounts.¹⁴ In other words, the AV is the percentage of average total costs for covered benefits that the plan will cover in a year. For example, if a plan has an AV of 80 percent, then the employee—if he or she uses an average amount of health care—can expect to pay out of pocket about 20 percent of the total costs of covered services each year, as well as monthly premiums. The actual percentage of costs that individuals pay depends on the services that they use.

Under the ACA, all plans sold on the federal and state Marketplaces are categorized by a metal level—bronze, silver, gold, or platinum—that corresponds to their AVs of 60, 70, 80, or 90 percent. These metal levels help consumers compare plans with very different benefit designs. For example, two plans with different deductible and coinsurance amounts for covered services may both have an AV of 80 percent. The first has a \$0 deductible but 30 percent coinsurance for hospitalizations. The second has a \$1,000 deductible but 10 percent coinsurance after the deductible is met for hospitalizations.

Trends in employers' and employees' health care costs

Health care costs have moderated in recent years; health spending has grown at a low rate for the past four years, and 2011 was the first time in a decade that spending on health care grew more slowly than the U.S. economy.¹⁵ However, spending is still rising and proving to be unsustainable for both employers and employees.

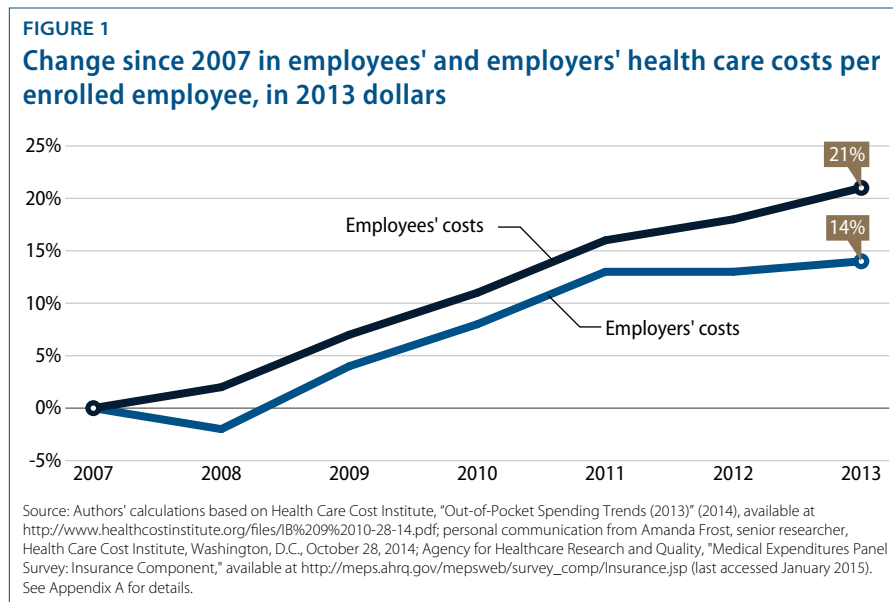
Understandably, employers have been experimenting with ways to control their costs. For example, some employers try to incentivize consumers to choose more high-value and necessary medical care through the use of high-deductible health plans, the consequences of which are detailed later in this report.¹⁶ A growing number of employers have instituted wellness programs to improve employees' health in return for incentives such as premium discounts or cash rewards. Yet the evidence so far shows that these programs do not save money and usually do not improve health.¹⁷

To look at how employers' health care decisions are affecting employees, we analyzed total health care costs, employers' health care costs, and employees' health care costs from 2007 through 2013, per enrollee, using data from the Health Care Cost Institute, or HCCI, and the Insurance Component of the Medical Expenditure Panel Survey, or MEPS.¹⁸ All costs cited below are real and adjusted for inflation in 2013 dollars. The methodology and data are further described in Appendix A.

Disproportionate burden of health care costs on employees

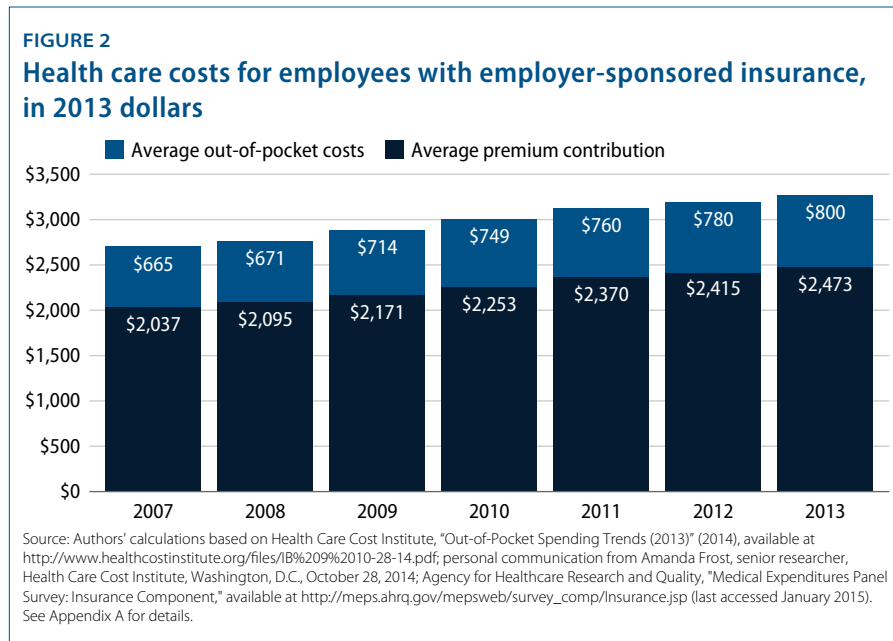
The total cost per enrollee of employer-sponsored insurance—premium contributions from both employers and employees and out-of-pocket costs—increased from the previous year every year from 2009 through 2013, and there was a slight decrease of less than 1 percent in 2008. Between 2007 and 2013, the total per-capita cost increased 16.5 percent—from \$9,026 to \$10,512.¹⁹

These cost increases have not been shared equally between employers and employees. As Figure 1 shows, employees' costs increased by 21.1 percent between 2007 and 2013, while costs for employers only rose by 14.5 percent. In this period, employees' costs grew faster than overall costs, while employers' costs grew more slowly than overall costs. This trend in cost shifting from employers to employees is even more obvious from 2011 to 2012, when employees' costs increased by 2.1 percent as employers' costs actually decreased by 0.5 percent.²⁰



Employees' costs

Figure 2 shows a summary of employees' increasing costs by year. In 2013, the average employee paid \$3,273 in health care costs. Increases in employees' premium contributions have accounted for the majority of the growth in employees' costs each year.²¹



Employers have not compensated employees for their rising health care costs with wage increases. In fact, wages fell during this period, further compounding the problem of rising health care costs. Among all families, the median real income actually fell by \$5,116 between 2007 and 2013—from \$68,931 to \$63,815.^{22*} As a result, the average American worker has felt pinched by both stagnating wages and increasing health care costs.

*These data differ slightly from CAP's "Middle Class Squeeze" report, which uses different methodology for calculating median income.

Premium contributions

Premium contributions are growing faster for employees than for employers. From 2007 through 2013, employees' premium contributions increased by 3.3 percent per year, on average. Employers' premium contributions increased at a lower rate of 2.3 percent per year, on average, and even had negative growth rates in two of these years.²³ Employees' premiums will continue to grow: Almost two-thirds of companies surveyed in 2012 and 2013 said that they planned to increase employee premium contributions.²⁴ With private exchanges and defined-contribution plans—under which employers give each employee a fixed dollar amount to purchase insurance—projected to become much more common in future years, this trend will only get worse.²⁵

Out-of-pocket costs

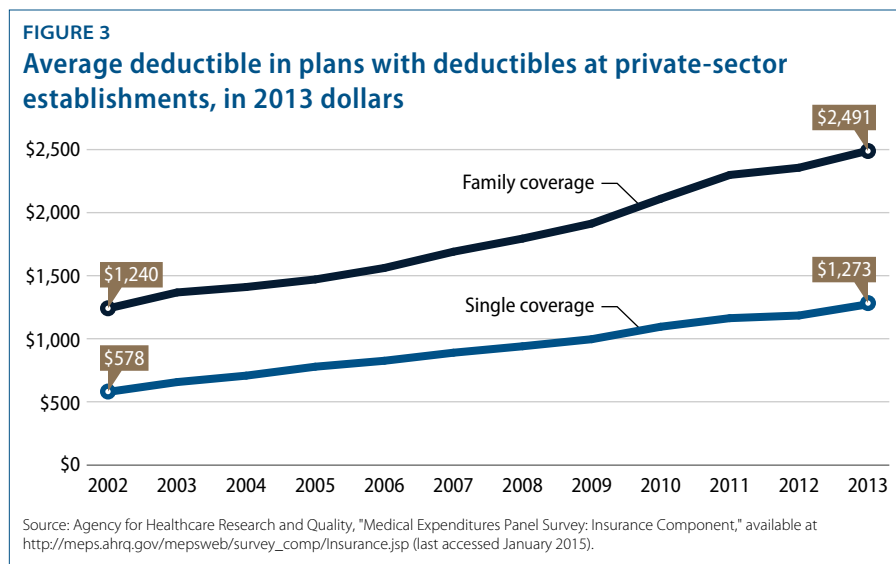
Employees' out-of-pocket costs also increased every year from 2007 through 2013, averaging 3.1 percent growth per year. In 2013, the average employee with ESI paid \$800 out of pocket.²⁶ However, this average out-of-pocket estimate understates the financial burden for some workers and overstates it for others. Some workers will face few or no out-of-pocket costs, while those with greater health care needs will have much higher costs that can result in significant financial strain. Additionally, as people tend to reduce their use of health care services when they have higher cost sharing, out-of-pocket costs may be rising for the same or a less amount of treatment.²⁷

High-deductible plans with lower premiums and high deductibles—\$1,000 for single coverage and \$2,000 for family coverage—target first-dollar expenditures and can result in significant out-of-pocket expenses in the early part of the benefit year or in the initial stages of an illness. Primary care, prescription drugs, and outpatient services are most commonly affected, so individuals who need those services will likely pay a significant portion of their deductible. Because young children tend to use more primary care services than other patients, these types of benefit designs can be particularly problematic for their families and can sometimes discourage use that turns out to be cost effective.²⁸ Similarly, other cost-sharing requirements shift costs to less healthy employees. For example, requiring coinsurance instead of copayments for expensive specialty drugs can increase certain employees' costs by thousands of dollars per month.

Out-of-pocket expenses have risen not just because overall health care costs have grown but also because employers are increasingly selecting plans for their employees that include these types of cost-sharing structures. These trends will continue: 77 percent of companies reported in 2012 and 2013 that they plan to increase cost sharing using deductibles and copayments.²⁹

For example, the prevalence and amount of deductibles have risen steadily. The percent of private-sector employees who were enrolled in a plan with a deductible grew from 48 percent in 2002 to 81 percent in 2013.³⁰

As Figure 3 shows, the real amount of the average deductible for employees with ESI more than doubled between 2002 and 2013, from \$578 to \$1,273 for single coverage and from \$1,240 to \$2,491 for family coverage. This increase in cost sharing through higher deductibles has contributed to the slowdown in health care cost growth over the past few years.



High-deductible plans have become much more common. In 2014, 18 percent of covered workers were enrolled in plans that had a deductible of \$2,000 or more, compared with only 3 percent in 2006.³¹ According to the National Business Group on Health, one-third of large employers—those with more than 50 full-time-equivalent employees—plan to offer only high-deductible health plans in 2015.³²

Consequences of rising employee costs

Employers choose benefit designs with greater cost sharing not only to lower their own costs but also to encourage employees to be more cost conscious. When consumers face higher out-of-pocket costs, they may reduce unnecessary health care and shop around for the highest value and best deal for necessary care. Therefore, enrollment in a high-deductible health plan may be a good idea for some employees.³³ The RAND Corporation found that families who switched from a traditional health plan to a high-deductible health plan spent about 20 percent less on health care in the next year than families who remained in traditional plans.³⁴

However, high deductibles and other cost sharing increase the risk of adverse health outcomes and can make health care unaffordable, especially for those with low to moderate incomes or with chronic health care needs.

Research has found that higher cost sharing and high-deductible plans induce consumers to reduce or delay their use of preventive care, such as immunizations and cancer screenings, even when these services are covered with no cost sharing.³⁵ Two out of five adults with high deductibles compared with their income reported that they had delayed or declined needed care because of their deductible.³⁶ High out-of-pocket costs are also associated with nonadherence to medication.³⁷ Furthermore, even though high-deductible plans are designed to incentivize patients to choose high-value services, consumers often do not receive the information that they need to allow them to make these types of informed choices about their health care.³⁸

This cost shifting also has placed great financial pressure on many employees. In a Commonwealth Fund survey, 13 percent of adults with private insurance reported that they had deductibles of 5 percent or more of income, and low- and moderate-income adults were even more likely to have high deductibles relative to income.³⁹ Of these adults, 43 percent said that their deductible was somewhat, very difficult, or impossible to afford. Almost one-third, 29 percent, of privately insured adults with a deductible of 5 percent or more of their income reported that they had skipped a medical test, treatment, or follow-up visit recommended by a doctor

because of their deductible.⁴⁰ Patients who are responsible for significant cost sharing have also been shown to reduce their spending on other essential goods, including food and clothing.⁴¹

These findings call into question whether these cost-shifting strategies will actually result in sustainable long-term savings and whether consumer welfare could decrease as a result. The health of individuals who do not follow their prescription regimens or who delay preventive care could deteriorate, necessitating future costly hospitalizations or treatment.

Policy recommendations to reduce cost shifting and improve affordability

An employee's total compensation can be defined as the sum of take-home salary, the employer's health insurance premium contribution, and other benefits—such as retirement benefits or paid time off—minus the employee's health insurance premium contribution and out-of-pocket expenditures. Therefore, when employees' health care costs—premiums and out-of-pocket costs—rise faster than employers' premium contributions—holding all other parts of compensation equal—the value of the employees' total compensation falls. Currently, a lack of transparency prevents many, if not most, employees from recognizing when their employers' health care costs are growing at a lower rate than their own. As long as health care costs continue to grow and changes in health benefits are difficult for employees to detect, employers who wish to shift costs to their employees can do so quietly, shielded by this lack of transparency.

To protect consumers, the Affordable Care Act placed a limit on out-of-pocket costs for individuals enrolled in new health insurance plans, which was an important step toward protecting individuals from excessive out-of-pocket costs. However, the current limits are quite high and do not prevent additional cost shifting up to those amounts. For example, even with the ACA's out-of-pocket limits in place, an employee earning \$30,000 could still spend almost one-third of his or her income on health care expenses.* The law also requires that preventive care be covered for free with no cost sharing, which offers important, yet still limited, financial help to patients.

* CAP analysis used the out-of-pocket maximum limit for an individual in 2015 of \$6,600 and a maximum annual premium contribution of \$2,850, which is 9.5 percent of the income of \$30,000. The ACA defines affordable ESI as premium contributions for single coverage not exceeding 9.5 percent of income. See Patient Protection and Affordable Care Act, H. Rept. 3590, 111 Cong. 2 sess. (Government Printing Office, 2010).

The following three proposals would build on the ACA's protections:

- Changes in employees' health care costs should be more transparent. Employers should provide employees with an annual notice that describes any changes in the distribution of premium contributions and/or actuarial value.
- In certain limited situations, employers should share savings realized from significant cost shifting and changes to AV that decrease employees' total compensation and increase the risk of high out-of-pocket costs.
- The ACA's free preventive-services benefit should also include three primary care visits each year.

Increased transparency: Annual notice to employees

Employees can easily notice changes to their wages or to their premium contributions, which are deducted from paychecks. However, it is very difficult for most employees to know how their employers' premium contributions are changing relative to their own and to fully understand how changes in the design of their plans may affect their out-of-pocket costs or save their employers money. Because employer-offered health insurance plans are not currently categorized at the same metal levels of AV as plans offered on the federal and state Marketplaces, it is also challenging for employees to compare different health insurance plans and realize how much of their costs they are being asked to cover. Greater transparency can empower employees to better understand their health care expenses and help them make health care decisions, prevent employers from concealing any changes in total compensation, and encourage employers to share savings with their employees.

The ACA requires employers to provide employees with a Summary of Benefits and Coverage during each open enrollment period, for new hires, and upon the request of an employee. This document is intended to provide consumers with "clear, consistent and comparable information about their health plan benefits and coverage."⁴² Supplementing the Summary of Benefits and Coverage with a consumer-friendly notice on the relative changes to employers' and employees' premium contributions over the upcoming year and the AV of the plan will provide much-needed transparency. As part of the notice, plans' AVs should be classified according to the ACA metal levels.

The new notice would include the following:

- **Premium amounts**—including growth in premium contributions and the percent contributed by employers and employees
- **Actuarial value of the plan**—including any change in the AV and metal level of the plan

An example of this annual notice is shown below:

Dear Employee,

This year, the total monthly premium for your health insurance plan was \$X. Currently, you contribute \$Y per month (yy percent of the total), and we contribute \$Z (zz percent of the total).

Starting January 1, 2015, the total monthly premium for your health insurance plan will be \$XX. Your monthly contribution will be \$YY (yyy percent of the total, an increase/decrease of yyyy percent from last year), and we will contribute \$ZZ (zzz percent of the total, an increase/decrease of zzzz percent from last year).

Your current plan is a bronze/silver/gold/platinum/in between levels [level specified] plan and has an actuarial value of A percent. This means that, on average, A percent of your covered benefits will be paid for by the plan—and you will be responsible for x percent through your deductible, copayments, and coinsurance. You are also responsible for paying for noncovered services and for services that you receive from a doctor, hospital, or other health care provider who is not participating in the plan. The actual percentage of costs that you will pay this year depends on the services that you need during the year.

In 2015, the actuarial value for your plan will be B percent, which categorizes the plan as a bronze/silver/gold/platinum/in between levels [level specified] plan, and is an increase/decrease of y percent from 2014.

Please contact the benefits manager for any questions about your health insurance plan.

Employers may also change the insurance plan for all employees or offer a new plan option. A second example of the notice for these scenarios is shown in Appendix B.

This annual notice would be required of all businesses and would add little administrative burden, as all businesses are required to provide the Summary of Benefits and Coverage and to calculate the information necessary for the notice each year already.

Shared health care savings with employees

Depending on how businesses choose to tackle the challenge of rising health care costs, their employees may also benefit. For instance, many businesses have adopted reforms aimed at lowering costs for both employers and employees while improving their employees' health. Transparency from annual notices should encourage these types of reforms; employees will be able to better assess changes in their total compensation and to compare their costs to their employers' costs, and employers will have a greater incentive to make sure that their employees benefit from changes in their health care benefits.

Transparency will also allow employees to recognize when their employers are benefiting from changes that are leaving them less well off financially. For example, some employers may decrease their premium contributions or change their benefit designs, such as transitioning all employees to high-deductible plans, and not compensate employees in any way for the additional risk and higher out-of-pocket costs.

In more extreme cases, if an employer's health care costs grow at a significantly lower rate than other businesses' costs because it shifted costs to its employees, the employer should compensate employees with a shared savings rebate. The shared savings rebate would be a portion—50 percent—of any savings that result from changes to the structure of their health insurance plans or from requiring greater employee premium contributions. This requirement would still allow employers to experiment with ways to control health care costs and retain a portion of savings but would ensure that employees also share in the savings.

Employers would pay the shared savings rebate when their 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 large group plans. Employers would have to share half of their savings on health care costs beyond the state's trend with their employees. A buffer zone would limit shared

savings rebates to situations in which average costs for employers are at least 1 percentage point lower and average costs for employees are at least 1 percentage point higher than the state's trend.*

This policy would apply only to large firms—defined as those with more than 50 employees—as is consistent with the ACA's definition of large employers. Employers' and employees' average per-enrollee costs would be measured retrospectively using annual premium amounts and average out-of-pocket costs per enrollee based on claims data.** The Department of Health and Human Services would publish the states' trends in costs for the large group market, as it has stated that it is monitoring the trends and rates in this market as part of the rate review process.⁴³ Alternatively, the Department of Health and Human Services or the Department of Labor could come up with a different method to calculate each state's trend.

These calculations would not add much administrative burden, as employers or third-party administrators already have data on the costs of health care benefits—claims data, the AV of their plans, and the share of premiums paid by employers and employees. The shared savings rebate would be administered in a similar way as the medical loss ratio rebate—employers would provide employees with direct compensation or apply the savings to reduce employees' future premium payments.

The following two examples illustrate situations where the shared savings rebate would take effect. First, in 2014, an employer offered one health insurance plan with an AV of 85 percent. The employer contributed \$2,964 in premiums annually per enrollee with individual coverage. Each enrolled employee with individual coverage paid \$1,000 annually for premiums and was responsible for an average of \$700 in out-of-pocket costs.***

Let's assume that the total costs per enrollee at the company increase 3.5 percent in 2015. The employer continues to pay \$2,964 per enrolled employee, while keeping the AV of the offered plan the same. The overall cost growth means that employees, on average, will pay \$724 in out-of-pocket costs in 2015 and their premium contributions must increase 13.9 percent to \$1,139. The out-of-pocket and premium increases mean that total employees' costs increase by 9.6 percent, compared with

*The Department of Labor could also decide that an alternative to the 1-percentage-point buffer zone is more appropriate after a full analysis of the data.

**The states' trends and employer and employee costs for individual and family coverage also should be calculated separately to make sure employers do not shift costs between the different coverage options.

*** Claims data would provide the average out-of-pocket costs in practice, but for this example, \$700 is a calculation of 15 percent—based on 85 percent AV—multiplied by the total cost per employee, \$4664.

the 0 percent increase for the employer. At the end of the year, it is calculated that the state's trend in health care costs also increased by 3.5 percent, which means that the employer is saving money on health care costs relative to trend and by more than the buffer zone, and the employees' cost increase is outside the buffer zone as well.

Therefore, the employer would pay a shared savings rebate. As a comparison, the shared savings rebate would not have taken effect if the employer's costs had grown by even 2.5 percent—the difference between the state's trend, 3.5 percent, and the buffer zone, 1 percentage point—to \$3,038. Because the employer's costs have not grown by 2.5 percent, the shared savings rebate amount per enrolled employee is \$37—half of the difference between \$3,038 and \$2,964, the actual employer's cost per enrolled employee in 2015.

TABLE 1
Illustrative example: Employees' premium contribution increases

	2014	2015	Growth rate
Total costs per enrollee	\$4,664	\$4,827	3.5%
Employees' premium contribution	\$1,000	\$1,139	13.9%
Employees' average out-of-pocket costs	\$700	\$724	3.4%
Total cost to employees	\$1,700	\$1,863	9.6%
Employer's premium contribution per enrollee	\$2,964	\$2,964	0.0%
State's trend			3.5%
Rebate amount			\$37

A second example is one where, when faced with costs per enrolled employee increasing by 3.5 percent from 2014 to 2015, the employer chooses to reduce the AV of its health plan instead of increasing premium amounts. In such a scenario, even if premium contributions decrease for both employers and employees, the shared savings rebate may still apply because employees are at risk of much higher out-of-pocket costs. For instance, if the AV of the plan decreases from 85 percent to 80 percent; employees' premium contributions decrease by 10.2 percent, from \$1,000 to \$898; and the employer's premium contributions stay the same, at \$2,964, the shared savings rebate will take effect. Relative to the state's trend of 3.5 percent, the employees' total growth rate is 9.7 percent, and the employer's growth rate is 0 percent. The rebate amount comes to \$37 per enrolled employee.*

* As in the first example, \$37 is half of the difference between the employer's actual 2015 costs, \$2,964, and the employer's 2014 costs increased by 2.5 percent—the 3.5 percent state trend minus the 1-percentage-point buffer zone—or \$3,038.

TABLE 2
Illustrative example: Actuarial value decreases

	2014	2015	Growth rate
Total costs per enrollee	\$4,664	\$4,827	3.5%
Employees' premium contribution	\$1,000	\$898	-10.2%
Employees' average out-of-pocket costs	\$700	\$964	37.9%
Total cost to employees	\$1,700	\$1,863	9.7%
Employer's premium contribution per enrollee	\$2,964	\$2,964	0.0%
State's trend			3.5%
Rebate amount			\$37

Reduced cost sharing for primary care visits

A third policy solution to reduce the pressure of higher out-of-pocket costs on consumers is to address the affordability of specific health care services. The ACA requires health plans to provide a wide range of preventive services with no cost sharing from coinsurance, copayments, or deductibles.⁴⁴ Lawmakers should expand the free preventive-services benefit to include three primary care visits per year for all individual and group health plans. This could be particularly helpful for parents with young children who may need to see their pediatricians relatively frequently.⁴⁵ For example, these no-cost visits could be very helpful during flu season if parents needed to take their sick child to the doctor.

This policy would allow people access to important primary care services without cost and would ensure that consumers received valuable health care benefits before spending up to thousands of dollars on their deductibles and other cost sharing. It also complements the existing preventive health benefit; it will improve patients' health and decrease costs by creating a healthier population and treating illnesses sooner rather than later. High-quality primary care has been shown to improve care coordination, quality of services, and health outcomes, as well as contain costs.⁴⁶ Removing barriers to accessing primary care will especially benefit families with young children and people with chronic illnesses, who tend to use more primary care services.⁴⁷

Conclusion

Rising health care costs remain a challenge for employers, but without the policy changes outlined in this report, employers are likely to continue to keep a disproportionate amount of the savings they realize from increasing cost sharing and other cost-containment efforts. Increasing transparency so that employees know when cost shifting occurs is an important first step, but more aggressive reforms offer additional protections to employees by guaranteeing that they receive at least some benefit from employers' cost-saving measures and have easier access to important health services.

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Appendix A

Methodology

In order to compare employers' health care costs to employees' health care costs, we used data from the Health Care Cost Institute and the Agency for Healthcare Research and Quality, or AHRQ.⁴⁸ HCCI's annual reports on the health care costs of individuals under age 65 who are covered by employer-sponsored insurance provide a measure of per-capita out-of-pocket expenditures for the years 2007 through 2013.* These data do not include out-of-pocket expenses for which consumers did not submit a claim; consequently, per-capita out-of-pocket costs are likely underestimated. AHRQ administers the annual Medical Expenditure Panel Survey, which provides data on average premiums per employee by type of coverage, employee premium contributions, and deductible amounts for employees of private-sector establishments in the survey's Insurance Component. We calculated an average premium contribution for employees and employers using weighted averages of premium amounts and the percent of employees enrolled in single, employee-plus-one, and family plans. MEPS did not collect these data in 2007, so we averaged the premium and deductible amounts for 2006 and 2008 to produce an estimate for costs in 2007. Another common source for annual premium and deductible amounts is the Kaiser Employer Health Benefits Survey. We used MEPS instead of the Kaiser survey because MEPS provided the percentage of employees enrolled in individual, employee-plus-one, and family coverage, which was necessary for calculating an average premium amount per employee.

* HCCI's data is based on fee-for-service health care claims from four of the largest health insurance providers. HCCI defines out-of-pocket expenditures per capita as "payments made directly to a health care provider by the insured, including any copayments, coinsurance payments, and deductible payments. Any health care payments made out-of-pocket for which a claim was not filed (such as over-the-counter medicines), are not included in this metric. Out-of-pocket expenditures per capita are calculated by dividing total out-of-pocket expenditures by the insured population." See Health Care Cost Institute, "2012 Health Care Cost and Utilization Report" (2013), available at <http://www.healthcostinstitute.org/2012report>.

By combining the HCCI and MEPS data, we created a measure of employees' costs per capita—employees' premium contributions plus out-of-pocket expenses—and compared it with employers' costs per enrolled employee—employers' premium contributions. Overall costs per capita for the ESI market are the sum of the employees' and employers' costs.

We adjusted all amounts for inflation—in 2013 dollars—using the Consumer Price Index Research Series Using Current Methods, or CPI-U-RS, to accurately compare costs across years.⁴⁹ A summary of the data appears in the table below.

TABLE A 1

Employer and employee health care costs, 2007–2013, in 2013 dollars

	2007	2008	2009	2010	2011	2012	2013
Out-of-pocket costs							
Out-of-pocket expenditures per enrolled employee	\$665	\$671	\$714	\$749	\$760	\$780	\$800
Growth rate							
Out-of-pocket expenditures per enrolled employee		0.9%	6.4%	5.0%	1.5%	2.6%	2.5%
Premium costs per enrolled employee at private-sector establishments							
Average premium amount per enrolled employee	\$8,361	\$8,275	\$8,768	\$9,087	\$9,545	\$9,556	\$9,712
Average employee premium contribution	\$2,037	\$2,095	\$2,171	\$2,253	\$2,370	\$2,415	\$2,473
Average employer premium contribution per enrolled employee	\$6,323	\$6,180	\$6,597	\$6,835	\$7,174	\$7,141	\$7,238
Growth rate							
Average premium amount per enrolled employee		-1.0%	5.9%	3.6%	5.0%	0.1%	1.6%
Average employee premium contribution		2.8%	3.6%	3.8%	5.2%	1.9%	2.4%
Average employer premium contribution per enrolled employee		-2.3%	6.7%	3.6%	5.0%	-0.5%	1.4%
Combined premium and out-of-pocket costs							
Total out-of-pocket expenditures and premium costs per enrolled employee	\$9,026	\$8,946	\$9,481	\$9,836	\$10,305	\$10,336	\$10,512
Total out-of-pocket expenditures and employee premium contribution per enrolled employee	\$2,702	\$2,766	\$2,884	\$3,002	\$3,131	\$3,196	\$3,273
Employer premium contribution per enrolled employee	\$6,323	\$6,180	\$6,597	\$6,835	\$7,174	\$7,141	\$7,238
Growth rate							
Total out-of-pocket expenditures and premium costs per enrolled employee		-0.9%	6.0%	3.7%	4.8%	0.3%	1.7%
Total out-of-pocket expenditures and employee premium contribution per enrolled employee		2.4%	4.3%	4.1%	4.3%	2.1%	2.4%
Employer premium contribution per enrolled employee		-2.3%	6.7%	3.6%	5.0%	-0.5%	1.4%
Growth from 2007							
Total out-of-pocket expenditures and premium costs per enrolled employee		-0.9%	5.0%	9.0%	14.2%	14.5%	16.5%
Total out-of-pocket expenditures and employee premium contribution per enrolled employee		2.4%	6.7%	11.1%	15.8%	18.3%	21.1%
Employer premium contribution per enrolled employee		-2.3%	4.3%	8.1%	13.5%	12.9%	14.5%
Deductibles							
Percent of private-sector employees enrolled in a plan with a deductible	68.6%	70.7%	73.8%	77.5%	77.8%	79.6%	81.3%
Average deductible for employees with single coverage	\$889	\$940	\$996	\$1,095	\$1,163	\$1,184	\$1,273
Average deductible for employees with family coverage	\$1,690	\$1,794	\$1,913	\$2,110	\$2,299	\$2,356	\$2,491

Note: All amounts are adjusted for inflation and are in 2013 dollars.

Source: Authors' calculations based on Health Care Cost Institute, "Out-of-Pocket Spending Trends (2013)" (2014), available at <http://www.healthcostinstitute.org/files/IB%209%2010-28-14.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 Component," available at http://meps.ahrq.gov/mepsweb/survey_comp/insurance.jsp (last accessed January 2015).

Appendix B

Below is an example of the annual notice for scenarios where employers change their insurance plans or offer a new plan option.

Dear Employee:

In 2014, you were enrolled in current plan name. The total monthly premium for that plan was \$X. Currently, you contribute \$Y per month (yy percent of the total), and we contribute \$Z (zz percent of the total).

Starting January 1, 2015, we are changing your health care plan/offering a new option [depending on if there is an option].

- *Current plan name*
- *New plan name*

[If there is the option to stay in current plan] If you stay in current plan name, the total monthly premium for your health insurance plan will be \$XX. Your monthly contribution will be \$YY (yyy percent of the total, an increase/decrease of yyyy percent from last year), and we will contribute \$ZZ (zzz percent of the total, an increase/decrease of zzzz percent from last year).

New plan name will have total monthly premiums of \$L. Your monthly contribution will be \$M (m percent of the total, an increase/decrease of mm percent from last year), and we will contribute \$N (n percent of the total, an increase/decrease of nn percent from last year).

Current plan name is a bronze/silver/gold/platinum/in between levels [level specified] plan and has an actuarial value of A percent. This means that, on average, A percent of your covered benefits will be paid for by the plan—and you

will be responsible for x percent through your deductible, copayments, and coinsurance. You also are responsible for paying for noncovered services and for services that you receive from a doctor, hospital, or other health care provider who is not participating in the plan.

[If there is the option to stay in current plan] In 2015, the actuarial value for current plan name will be B percent, which categorizes the plan as a bronze/silver/gold/platinum/in between levels [level specified] plan and is an increase/decrease of y percent from 2014.

New plan name is a bronze/silver/gold/platinum/in between levels [level specified] plan and has an actuarial value of R percent, an increase/decrease of S percent from 2014. This means that, on average, R percent of your covered benefits will be paid for by the plan.

[If there is an option for a new plan] If you elect to change your health insurance plan, you will have the opportunity to do so during the open enrollment period. Please contact the benefits manager for any questions about your health insurance plan.

Endnotes

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