Hitting the Wall: When Health Care Costs are No Longer Manageable

By Tevi D. Troy and D. Mark Wilson
American Health Policy Institute (AHPI) is a non-partisan 501(c)(3) think tank, established to examine the impact of health policy on large employers, and to explore and propose policies that will help bolster the ability of large employers to provide quality, affordable health care to employees and their dependents. The Affordable Care Act has catalyzed a national debate about the future of health care in the United States, and the Institute serves to provide thought leadership grounded in the practical experience of America’s largest employers. To learn more, visit americanhealthpolicy.org.
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Introduction

Relying on any system to continue requires that such a system is sustainable. If it is not, then, as the late economist Herb Stein has said, “it will stop.” In stopping, however, such a system will impact those who rely on it and assume that it will continue. History is replete with examples of permanent seeming systems that eventually went away: The Roman and Ottoman empires, and the Soviet Union. This trend has moved into today’s age with once seemingly permanent institutions folding—including the massive wave of major hospitals closures across the U.S.; the recent closing of colleges such as Sweet Briar College, a women’s college established in 1901; and even U.S. military bases, forts, posts and sanctions around the world, including the fifteen bases that the Pentagon recently announced that will close between 2018 to 2021. Even the biggest and strongest institutions are subject to extinction.

When it comes to health care, 87% of Americans are dependent on one of two seemingly permanent systems: 33% of Americans rely on a variety of government programs, including Medicare, Medicaid, and the new Affordable Care Act exchanges. And 54% get the health care from employer sponsored health insurance, which today covers over 169 million Americans. Despite all of the tumult in U.S. health care over the past few years, employer sponsored health insurance (ESI) has remained a reliable constant. ESI provides health coverage to a majority of Americans, and a majority of them tell pollsters they are satisfied their current means of health care coverage.

That said, it is clear that changes are coming to both government programs and to ESI, and they are coming as a result of a variety of pressures facing American health care. These pressures have been long in building, but many of them are reaching a state where they will eventually force fundamental changes. The American health care system could potential handle or absorb any one challenging trend, but in combination they may be too much to bear. The concurrent strains in both ESI and government-run programs, which combined cover or subsidize the vast majority of Americans, could leave millions of Americans without any affordable health care options.

This paper will examine some of these pressures, and look at independent estimates of when each of them will be reaching a crisis point. According to these analyses, each system will be facing its own crisis in a narrow window of time, specifically the years between 2025 and 2030. The fear is that the convergence of these negative trends in a short window of time could lead employers and the federal government to make drastic changes to their health care delivery models, which in turn will lead to other changes in the health care system, as previously covered individuals scramble to find alternative ways to secure comparable benefit levels. Should all of these problematic trends converge in a short period of time, it is possible that the American health system will at that point be hitting the wall.
A large component of the upcoming challenge we are facing is a demographic one. The various federal health care spending programs face enormous long-term unfunded liabilities. These liabilities will be coming due as the baby boomers continue to retire for the next decade and a half. There were about 76 million baby boomers born between 1946 and 1964, the peak baby boom years. These baby boomers are turning 65 at a rate of about 10,000 a day. By 2030, 18 percent of the population will be over 65, which is up from about 13 percent today.\(^1\) All of these aging and retiring baby boomers will place additional pressure on our already overburdened health system, in a number of ways. First, the sheer number of people on Medicare will be a problem as the ratio of taxpayers per beneficiary shrinks. Second, the elderly tend to have higher health costs than the non-elderly, meaning that overall health spending will be going up as well.

The Congressional Budget Office (CBO) projects that spending per enrollee in federal health care programs will continue to increase at a faster pace than per capita GDP over the next 25 years. While the growth rate of spending per Medicare beneficiary is projected to remain very low over the next few years as many relatively healthy boomers retire and have lower medical care utilization, these costs are projected to increase gradually through 2039, as a large number of boomers hit their end of life costs in the next 10 to 20 years.\(^2\) Come 2039, at the peak of the growth rate of Medicare spending, America’s oldest baby boomers will be 94 years old. At that point, many of them will be relying on costly long term and end of life health care costs.
Another problem with the large number of pending retirees is the way in which we finance our entitlement programs. The federal government uses a “trust fund” fiction in which current tax dollars are used for federal spending programs, but are also assigned to cover future entitlement obligations. This system can work as long as contributors significantly outnumber recipients. But as baby boomer retirements shrink that taxpayer per beneficiary ratio, the trust funds start to run out, and soon.

The trust fund bankruptcies begin not with the retirement programs but with a disability program. The federal disability insurance program, which covers benefits for 11 million Americans, has been running an annual deficit of more than $23 billion per year since 2010, and its trust fund will be exhausted in 2016. At that point disability benefits will have to be cut by 19 percent. The program currently has a $1.2 trillion unfunded obligation that will eventually have to be made up by cutting benefits, raising taxes, or both.

The retirement programs follow in the 2030s. In 2023, the Medicare program begins to regularly spend more than it takes in, and by 2030 the Medicare HI trust fund is depleted. At that point, the federal government faces a stark choice: reduce benefits by 15 percent, or raise taxes to cover the shortfall. Medicare currently has a $28.5 trillion unfunded obligation.

In 2022, the Social Security program begins to spend more than it takes in, and by 2034 the Old Age Survivor Insurance trust fund is depleted. At that point, the federal government faces an even starker choice: reduce Social Security benefits by 25 percent, or raise taxes to cover the shortfall. Social Security currently has a $9.4 trillion unfunded obligation.

The retirement programs are not the only programs in trouble. Medicaid and ACA subsidies are growing faster than the economy as well. Over the next ten years (2016 to 2025), ACA subsidies will cost $895 billion. Medicaid, which is covering the bulk of the newly insured under the ACA, will see its expenditures double over the next decade, rising from $541 billion today to more than $1 trillion annually by 2025. Overall, federal health spending will come close to doubling as a share of GDP by 2039. In this period, all other federal spending, with the notable exception of interest on the debt, is expected to shrink.

Unsustainable long term spending will have real implications for the country. Medicaid is a shared responsibility program. The federal government pays for a majority of the spending, but the states pick up a big share as well. As a result, over a quarter of all state spending goes to Medicaid, making it the largest single expenditure in state budgets on the aggregate. This means that Medicaid spending will be crowding out other state spending, on roads, public safety, and on education. One of the reasons that tuition at state schools is twice what it was in the 1980s is because of Medicaid spending. As Catherine Rampell wrote in The New York Times, tuition hikes result from the fact that “Struggling states have to prioritize other mandatory spending, like Medicaid.”

Beyond the Medicaid problem, some states that have established ACA exchanges are experiencing higher than expected costs as well. The costs of the IT systems that run the exchanges, especially, are heavy cost burdens on states. In order to be self-sustaining, some states have turned to the federal government to take on these functions, while others are getting creative with dealing with these costs. For example, in her budget, Rhode Island Gov. Gina Raimondo recently proposed a new fee—3.8 percent for qualified health plans (QHPs) and 1 percent for Small Business Health Options Program (SHOP) plans—to help cover the exchange’s administrative costs. The state legislature is expected to vote on the proposal by July 1, 2015. New York State has found that it has insufficient funds for pay for the expected $150
million annual costs of its state run exchange. As a result, Governor Andrew Cuomo proposed a $69 million tax to pay for the costs of the exchange. Unsurprisingly, the New York State legislature was unhappy with the proposal, but the fact remains that the exchanges impose even higher costs on already strained state budgets.\textsuperscript{16}

**Employee Affordability**

Government’s financial challenges are only one aspect of the looming health care financing crisis. Individual Americans are finding that their costs are becoming less and less affordable, even for those in employer sponsored health care. The Affordable Care Act established an affordability metric for health insurance, and determined that premiums surpassing 9.5 percent of income should be considered “unaffordable.” The problem with this determination is that it does not consider deductibles along with premiums. When deductibles are folded in, 37 percent of private sector employees who are heads of families will face the prospect of unaffordable health coverage by 2020. By the year 2025, a majority of private sector employees will fall into the unaffordable category, as 53 percent will surpass the 9.5 percent threshold in both premiums and deductibles.\textsuperscript{17} These figures notwithstanding, it should be remembered here that few Americans would consider spending 9.5 percent of their income on health care as something that they can afford.

Public opinion polls back up these estimates, demonstrating the level of uncertainty families face regarding the costs of health care. According to a New York Times/CBS poll, 46 percent of Americans find basic health care affordability to be a hardship for them and their family. Two years ago, this was at 36 percent.\textsuperscript{18} A Gallup poll corroborates the finding, as 41 percent of Americans report dissatisfaction with their current cost of health care.\textsuperscript{19} Although employees are generally more satisfied with the cost of their coverage, over 23 percent are dissatisfied with the premiums they pay, and 27 percent are dissatisfied with the deductibles they pay when receiving care.\textsuperscript{20}

Both the costs of and the worries about health are on the rise for Americans in employer sponsored plans. These plans, which have long been the backbone of our health system, are becoming less and less affordable to average Americans and their families. As the prospect of a majority of recipients finding employer sponsored health looming larger, the pressure will build to find some kind of alternative for these employees.

Unfortunately, public policy is pushing employer plans in the opposite direction, toward less generous plans. The ACA’s Cadillac Tax was sold as a plan to hit only the highest value health plans, but it is increasingly hitting plans held by middle income earners. Already, 62 percent of employers are finding that the Cadillac Tax, or excise tax, is having an impact on their health care strategy, according to a recent TowersWatson survey.\textsuperscript{21} In addition, the Cadillac Tax will have a creeping impact, as it will be impacting more and more plans as time goes on. In 2031, even an average cost family health plan will likely cross the Cadillac Tax threshold. At that point, there will likely be few if any high value plans, as employers will reduce the value of their health care offerings to avoid being hit with the 40 percent penalty imposed by the Cadillac Tax. Furthermore, it is very much an open question whether at that point employer sponsored plans will be considered affordable at all.\textsuperscript{22}
From the employer perspective, they are facing larger and larger costs for providing health care. While employers have to absorb some of these increased costs, the costs also get passed on to employees. According to a 2014 Kaiser Family Foundation and Health Research & Educational Trust study, the overall rate of inflation since 1999 was 43 percent. During the same period, workers earnings increased 54 percent, health care premiums rose 191 percent, workers contributions to premiums increased 212 percent. This premium increase does not even include co-pays and deductibles.23

In addition to the rising cost of health overall, there is also the issue of costs imposed on employers by the ACA. According to an analysis of over 100 internal large employer estimates, the ACA is imposing additional costs of between $4,800 and $5,900 per employee over a 10 year period. Over that 10 year period, these marginal costs due to the ACA add up to somewhere between $163 million and $200 million per large employer, and between $151 billion and $186 billion for large employers as a whole.24 There is a question of whether ESI is built to last in today’s tumultuous health policy environment. A recent S&P Capital IQ analysis estimates that 90 percent of American employees who currently receive health insurance through their employers could be shifted to individual health insurance and government exchanges by 2020.25 Even an architect of the law, Ezekiel Emanuel, has predicted a similar shift and has gone so far to say that by 2025, fewer than 20 percent of workers will receive health care through ESI.26

Despite predictions that employer sponsored health insurance will no longer be the norm by the end of this decade, America’s health care system as currently configured relies heavily on employers to pay for health care, and there would be significant disruptions were employers to bow out over such a short time period. Thus, many employers remain committed to continuing to provide health care to their employees, retirees, and dependents, albeit through different strategies and benefits models.

Employers are trying to cope with both higher overall health costs and newly imposed marginal costs, but despite their best efforts, employer health care costs per covered life are still rising at twice the rate of inflation. While Consumer Directed Health Plans, or CDHPs, have shown some effectiveness in reducing health costs, 82 percent of large U.S. employers have already made the shift to CDHPs, meaning that the limits of this cost control option are being reached.27 Similarly, wellness programs, with which many employers have also experimented, do not appear to have the capacity to address long term health costs on their own. While many employers and employees alike have found them helpful, wellness programs in and of themselves cannot solve the problem. Some recent research has even questioned how much these programs can provide. As Health Affairs summarized its view of latest research on wellness plans, “those changes are not large enough, and the relationship between health risks and spending too weak, to result in reduction of health care cost, let alone in return of investment.”28

As a result of this combination of cost pressures and the lack of effective tools to deal with them, U.S. employers are looking to change their relationship with their employees with respect to health care, and there is now evidence that employees themselves would be amenable to accepting such changes. According to a study by the Employee Benefit Research Institute (EBRI), only 40 percent of employees want to continue along the same health care path they are on today.29 However, 40 percent want to be able to choose their health plan and are willing to provide additional resources, above what their employer pays, if necessary.30 Another 20 percent
want a lump sum payment from employers to allow them to pick their health coverage on their own. What this means is that 60 percent of employees are looking for some new kind of way to get affordable health coverage. And U.S. employers are actively seeking ways to find those new options.

**When Will American Health Care Hit the Wall?**

These troubling trends, in our fiscal situation, in health care affordability, in employer sponsored care, appear to be reaching crisis point in roughly the same period, between 2025 and 2030 (see chart). It is no coincidence that the completion of the retirement of the baby boomers takes place in that same period: the worker to retiree ratio 3.99 now, dropping to 2.67 by 2030, will be exacerbating our fiscal woes.

Demographics, however, are not the sole source of the emerging problems. Public policies lie at the heart of many of our challenges: when it goes into effect in 2018, the excise tax will incentivize employers to reduce the value of health plans to stay under the tax’s threshold; the ACA includes a host of marginal costs on employers that raise costs on employers and employees alike; relying on Medicaid to expand health coverage burdens overly strapped state budgets; and unrealistic entitlement program payouts threaten the fiscal viability of not only our entitlement programs, but of the U.S. as a whole.
**Conclusion**

Fortunately, while demographic realities are largely immutable, but public policies can be changed. The excise tax that will be impacting more and more health plans over time has not yet gone into effect. Perhaps it can be changed or eliminated before 2018, when it is scheduled to begin. Solving the excise tax will reduce, but not eliminate, some of the marginal costs that employers face, which could in turn limit the extent to which employers exit the system. As for our entitlement programs, the crisis may be staring us in the face, but it is still not too late to make real changes to future payment policies that could stave off a potential fiscal collapse.

Whatever happens in the years ahead, it is safe to assume that big changes are afoot. Government policies will likely change--but government is not the only place that such change can or will occur. Employers, fully understanding the marketplace power of the covered lives included in their respective plans, are already beginning to explore market-based remedies to the cost explosion. Both with respect to government policy and these market-based remedies the real question faced in this period is whether the changes will be planned out and thought through, or whether the changes will be reactive after disaster strikes.

To face these challenges, policymakers need to do two things. With respect to the public sector, there is still enough time to make changes now to shore up the public sector programs upon which an increasing number of Americans rely. To do this, policymakers need to stop making unrealistic promises and need to work to get outlays in line with available revenue. From the private sector perspective, policymakers should recognize that ESI is going to be changed and that public policy needs to support the ability of the private sector make the required changes. Wise policies would foster and encourage creative market-based remedies that will benefit employees, employers, the federal treasury and our entire economic system. Such a reformed ESI system can ensure that employers are still actively involved in providing health care to their employees and not turning that burden over to the public sector.
Although 82 percent of employers offer a CDHP, just 32.6% of employees are enrolled in one, and just 30% of employers offer only a CDHP plan to their employees.


30 Id.

31 Id.

32 Id.