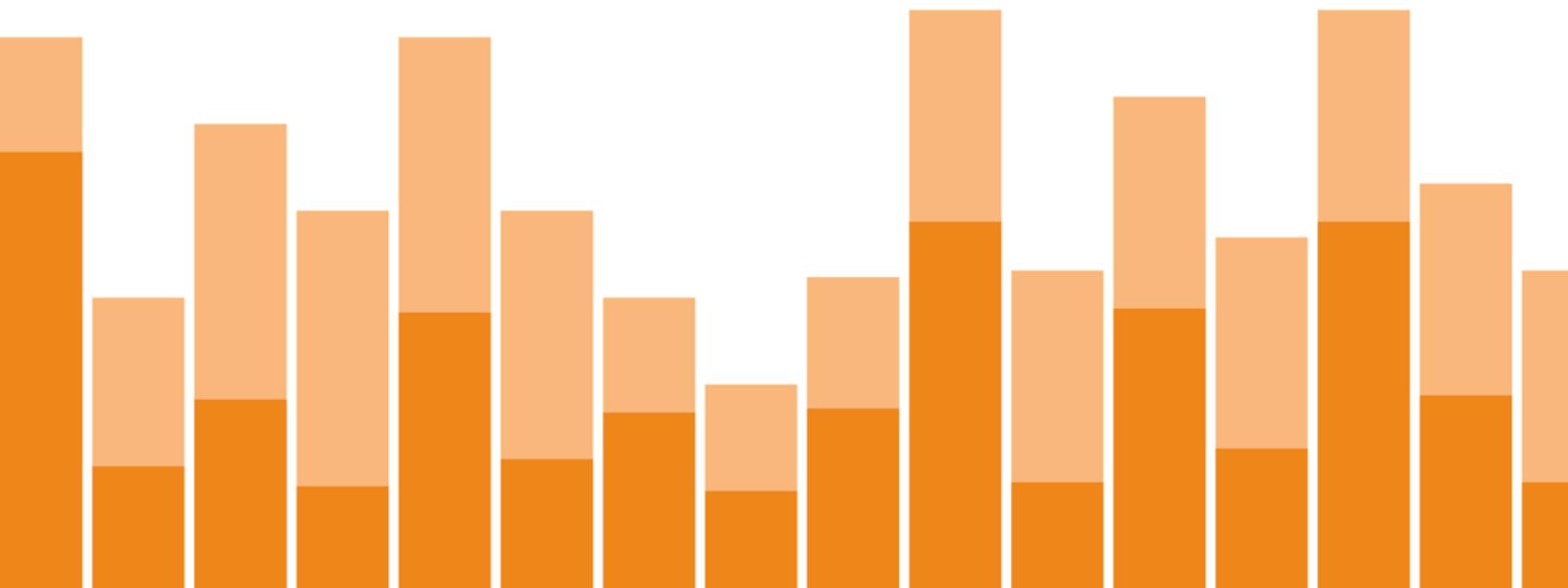


Health Coverage Cost Per Covered Life: Government vs. Employment- Sponsored Programs

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 AHPI serves to provide thought leadership grounded in the practical experience of America's largest employers. To learn more, visit americanhealthpolicy.org.

Contents

Executive Summary	1
Employer Health Care Costs Per Covered Life	3
Government Health Care Costs Per Covered Life	5
Household Health Care Costs Per Covered Life	9
Conclusion	11
Endnotes	13

Executive Summary

The Affordable Care Act (ACA) continues to drive the ongoing national debate over the cost of health care in the United States. A key element of this debate is the fact that the U.S. spends more on health care than any other developed country, specifically 50 percent more per capita than the next highest OECD country.¹ While the U.S. pays a lot of attention to overall spending, less attention has been paid to the differences in what employers, government, and individuals pay for health care, and the different trends in those costs. These differences are important for policy makers to be aware of in determining what future changes need to be made to the ACA, and to health care in general.

In 2012, employers spent \$578.6 billion providing health coverage for 168.6 million employees, retirees, and dependents. In that same year, the government (federal and state) spent \$1.1 trillion on health care for 118.8 million beneficiaries.² This translates into an average of \$3,430 per covered life for employer provided coverage and \$9,130 per covered life for government health care programs.³ In other words, government health care spending on a cost per covered life basis is 166 percent higher than private sector employer spending on that same basis. And while this difference is not surprising given the different age and health status of the populations covered, the different methods the private sector and government use for cost containment can have significant implications for providers and recipients alike.

If the ACA significantly increases the cost of providing health care for employers, as analysts and employers alike believe, this will incentivize employers to modify their health care plans and strategies to reduce their future health care costs. If these modifications and reductions drive more people into more costly government plans, it could have huge implications for the amount both government and households spend on health care in the future.

Utilizing data from the American Health Policy Institute's survey of over 350 companies that are members of the HR Policy Association, this study provides a snapshot comparison of the actual health care costs per covered life for more than 100 large employers (those with 1,000 or more employees), and similar per covered life costs for Medicare, Medicaid, and military/veteran related programs. In doing so, this study also provides insight into the overall inflation adjusted trends in the cost per covered life for the three major payers of health care in the United States: employers, government, and households.

In summary, the study found:

- On average, all U.S. employers spent \$3,430 per covered life on health care in 2012, up 13.6 percent from 2003 after adjusting for inflation.⁴
- On average, large U.S. employers (1,000 or more employees) spent \$4,990 per covered life on health care in 2013.⁵
- In 2012, government (federal and state) spent \$1.1 trillion on health care, or an average \$9,130 per covered life, up from \$8,010 in 2003, or 14.0 percent, after adjusting for inflation;
- Government spent over \$6,900 per covered life on health care for military and veterans health programs in 2012, up 10.6 percent from 2003 after adjusting for inflation;⁶
- Medicaid spent almost \$7,540 per covered life in 2012, *down* 2.8 percent from 2003 after adjusting for inflation;⁷
- Medicare spent \$10,830 per covered life in 2012, up 28.2 percent from 2003 after adjusting for inflation;⁸
- The average cost of government health care spending per covered life has risen almost 30 percent since 1995 after adjusting for inflation, from \$7,040 to \$9,130; and
- Households spent an additional \$2,570 per person on health care, up 11.6 percent from 2003 after adjusting for inflation.⁹

These data demonstrate that for a variety of reasons employers pay significantly lower health care costs per covered life than government programs, and the trends in health care costs are significantly different between employers, Medicare, and Medicaid.

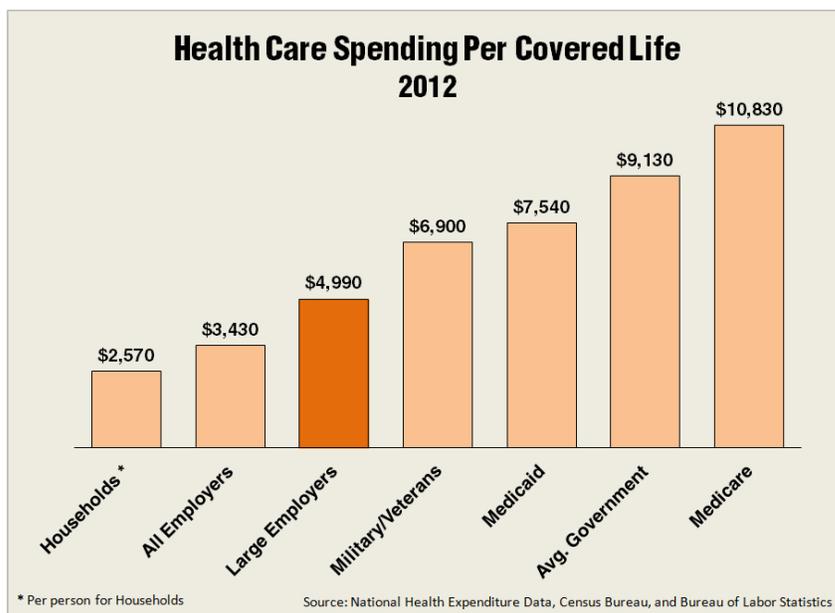


Chart A

Employer Health Care Costs Per Covered Life

Employer-provided health care has been the backbone of the American health care system for the past six decades. While employers as a whole spend \$3,430 per covered life, health coverage tends to be more generous and expansive at large employers (1,000 or more employees). According to data from the American Health Policy Institute's survey of over 100 large companies, large employers spent an average of \$4,990 per covered life on health care in 2013. The Bureau of Labor Statistics also found differences in health care spending between large and smaller employers. According to BLS, on average large employers (500 or more employees) spend \$7,820 per full-time employee compared to \$5,117 for medium size employers (100 to 499 employees), and even less for small employers.¹⁰

The difference in the average cost per covered life for employer-sponsored care and the various estimates for government programs is not surprising given the different age and health status of the populations covered. For example, the Medicare population is on average much older, with more chronic conditions than the population covered by employers. The Medicaid population, while younger, generally has a poorer health status than the employed and a higher percentage of individuals with disabilities. Further, the military has to address the substantial costs associated with the combat wounded (see *Chart A* on page 2). Despite these differences, a breakdown of health costs by source and a review of their cost trends can provide insight into a key element of health costs: the ability of different programs to control costs.

With respect to employers, the cost of employer-sponsored health care per covered life has risen 13.6 percent since 2003 after adjusting for inflation, from \$3,020 to \$3,430. From 1995 to 2003, employer health care costs jumped by an average 4.5 percent per year after accounting for inflation. Large employers responded to this unsustainable trend by implementing a variety of cost saving measures including: High Deductible Health Plans (HDHPs) coupled with Health Saving Accounts (HSAs) and Health Reimbursement Arrangements (HRAs); wellness programs; value-based insurance plans; and improved cost and pricing transparency tools.¹¹ Although these actions by employers were able to bend their health care cost curve and reduce the average annual rate of growth to 1.5 percent since 2003 after accounting for inflation (see chart below), they have not yet been able to collectively hold the growth in health care costs below the rate of overall inflation for an extended period of time. In 2012, employer health care costs per covered life rose at twice the rate of overall inflation (4.2% vs. 2.0%).

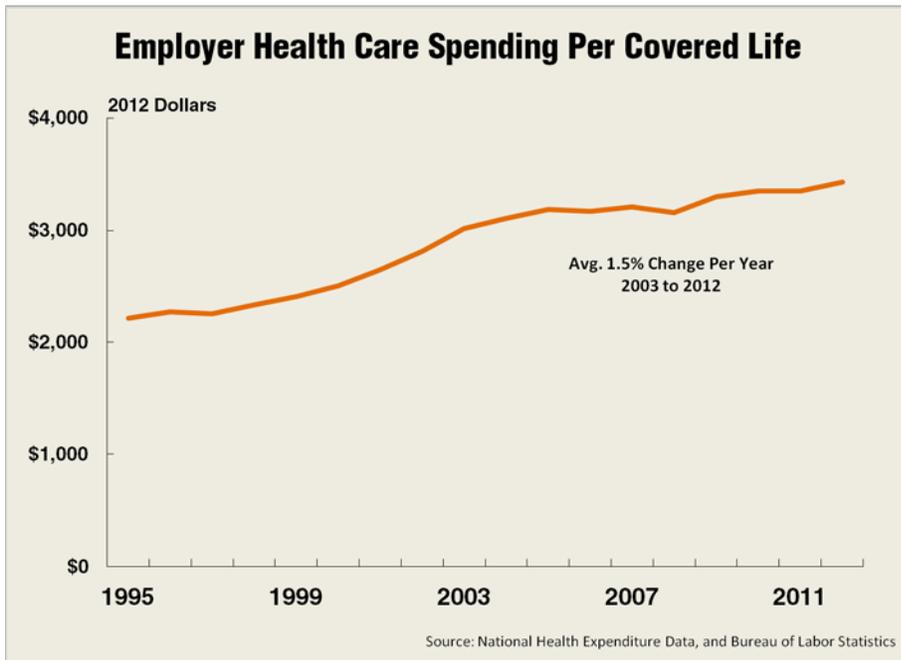


Chart B

A new report from Milliman shows the annual increase in the cost of employer-sponsored family coverage for a preferred provider plan increased 5.4 percent from 2013 to 2014.¹² According to the Milliman study, the emerging ACA reforms have had “little direct impact on the cost of care” in 2014 because most families are insured through large group employer plans and some of the most far-reaching ACA reforms are focused on insurance in the individual and small employer markets.¹³ Rather, the moderation in employer cost increases is the result of a “confluence of forces rather than any single event.”¹⁴ Although it is difficult to isolate the exact cost drivers, greater demand for Medicaid services generated by the ACA’s Medicaid expansion and more people covered by the public exchanges who were previously uninsured and not care will put upward pressure on supply, and possibly lead to higher provider reimbursement rates for employers. According to other Milliman reports, employers may also see cost-shifting because Medicare and Medicaid reimbursement rates tend to be lower than the cost of providing health care. To offset this negative margin, many providers have added a margin to private sector payers equal to about \$1,800 per American family.¹⁵

Government Health Care Costs Per Covered Life

In 2012, government (federal and state) spent \$1.1 trillion on health care, or an average \$9,130 per covered life, up from \$8,010 in 2003, or 14.0 percent, after adjusting for inflation. From 1995 to 2003, government health care costs rose by an average 1.7 percent per year after accounting for inflation; significantly less than the employer rate of increase (4.5%). Moreover, from 2003 to 2012, government health care costs rose by an average 1.6 percent per year after accounting for inflation, slightly more than the increase for employers (1.5%). Further, in 2012, government health care costs per covered life increased less than overall inflation (1.3% vs. 2.0%). In fact, since 2007, the trend in government health care costs per covered life has been relatively flat (see chart below). However, with implementation of the ACA in 2014, it is unclear if this recent trend can be sustained.

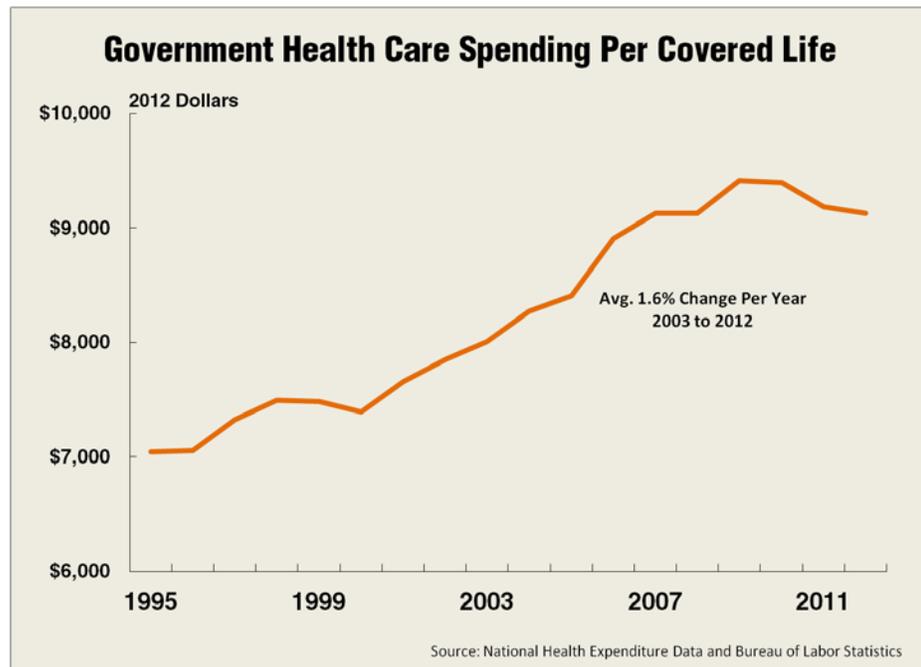


Chart C

Over 88 percent of government spending on health care comes from Medicare, Medicaid, Department of Defense and Veterans Administration (“the military”). At the same time, the cost per covered life, as well as spending trends, for these three programs are significantly different. As noted before, these differences, and their difference compared to the cost per covered life for employer-sponsored care, are mostly a result of the age and health status of the populations covered.

The average cost of government health care spending per covered life has risen almost 30 percent since 1995 after adjusting for inflation, from \$7,040 to \$9,130. Of course, there are significant trend differences between the three major programs. From 1995 to 2012, military health care costs per covered life jumped almost 56 percent and Medicare costs increased by 49 percent after accounting for inflation, while Medicaid costs rose just 2.8 percent. After rising 9.6 percent from 1995 to 1999, Medicaid costs per covered life adjusted for inflation have remained relatively flat (see chart below) for a number of unique reasons, including:

- State efforts to control costs by reducing and freezing provider reimbursements, eliminating benefits, limiting prescription drugs, and expanded managed care in the past two years;
- A shift of most prescription drug coverage for dual-eligible beneficiaries (those eligible for both Medicaid and Medicare) from Medicaid to the new Medicare Part D program in January 2006; and
- A decrease in the growth of federal Disproportionate Share Hospital payments for indigent patient care.

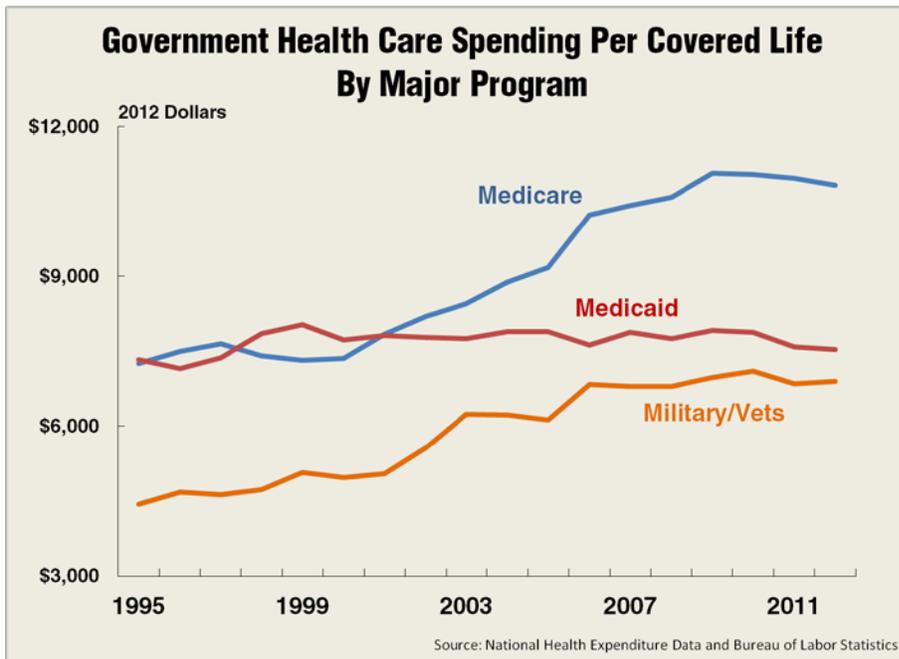


Chart D

Unfortunately, some of the steps taken to keep Medicaid costs from rising over the past ten years have simply shifted the actual costs of the program to private payers. According to a recent study by the Kaiser Family Foundation, data suggest that both Medicare and Medicaid payments are significantly less than actual hospital costs, while private insurance payments exceed hospital costs by over 30 percent.¹⁶ In 2013, the value of this difference, as well as uncompensated care from uninsured people, amounted to a shift of \$21.1 billion to private payers. This cost-shifting effectively added \$111 per covered life to employer-sponsored and household health care costs and makes it more difficult for employers to control their costs in the black box that is the U.S. health care system.¹⁷ However, cost-shifting may no longer be a viable strategy in the future.¹⁸ At a minimum, there is a limit to the cost shifting that employers and households can bear.

Further, improper Medicare and Medicaid payments, including fraud, were estimated to be \$64.8 billion in fiscal year 2011,¹⁹ or 6.8 percent of all Medicare and Medicaid spending. Improper Medicare payments were estimated at \$42.9 billion, or an average \$863 per covered life, while improper payments by Medicaid amounted to \$21.9 billion, or \$392 per covered life. The Medicare improper payments were primarily due to medically unnecessary services and insufficient documentation, while the improper payments in Medicaid were primarily due to ineligible or indeterminable beneficiary eligibility status. With the large expansion of the Medicaid program under the Affordable Care Act, it is highly likely that the amount of improper payments from Medicaid will increase this year.

The Department of Veterans Affairs (VA) also has serious problems with improper payments, long wait times and subpar care at some facilities that, according to some reports, may have led to the death of more than 1,000 veterans over the past ten years and has resulted in the VA paying nearly \$845 million to veterans and their families for medical malpractice.²⁰ In 2013, the VA made \$2.2 billion in improper payments,²¹ or about 4.4 percent of all VA health care expenditures. Given the recent reports surrounding VA health care services, it appears the Department may have been effectively rationing care as a way to control costs.

Household Health Care Costs Per Covered Life

In 2012, households spent \$792.4 billion on health care, or an average \$2,570 per covered life, up from \$2,300 in 2003, or 11.7 percent, after adjusting for inflation.²² From 1995 to 2003, household health care costs rose by an average 3.4 percent per year after accounting for inflation; slightly less than the employer rate of increase (4.5%).²³ Further, from 2003 to 2012, household health care costs rose by an average of 1.3 percent per year after accounting for inflation, slightly less than rate of increase for employers (1.5%). As with employers, household health care costs per covered life continued to increase significantly more than overall inflation (3.7% vs. 2.0%) in 2012.²⁴ Household costs accrue to all Americans and are not differentiated by whether they receive coverage from employers or government programs. The household spending figures reflect the additional costs individuals must pay for their health care coverage.²⁵ If cost cutting efforts, be they in government or private plans, were shifting costs to individuals, we would likely have seen a spike in these numbers. As the chart below shows, this does not appear to be the case.

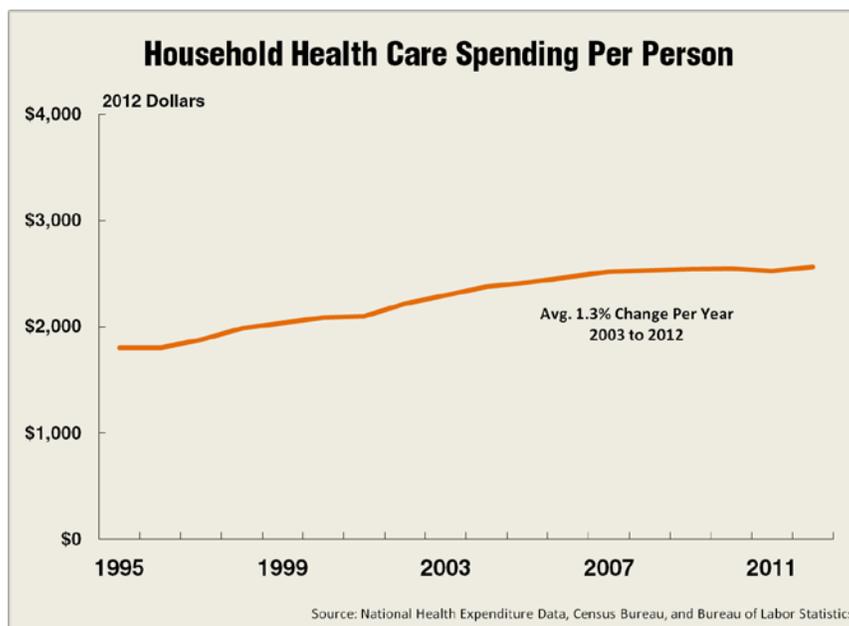


Chart E

Conclusion

Utilizing data from the American Health Policy Institute's survey of over 100 large employers and National Health Expenditure data, this study highlights the differences employers, government, and households pay for health care; both the amount they pay per covered life and the trends in those costs from 1995 to 2012. Policy makers should be aware of these differences as they determine what future changes need to be made to the ACA in order to avoid or minimize unintended consequences and potential cost-shifting.

The data demonstrate that for a variety of reasons employers pay significantly lower health care costs per covered life than government programs. This stems not only from the differences in the age and health status of the populations covered by employers and the government, but it also comes in part from the significant amount of improper payments that are still made by Medicare and Medicaid. For example, the \$21.9 billion in improper payments in Medicaid accounts for 15.5 percent of the difference in the program's cost per covered life compared to large employers. At the same time, large employers spend considerable time and resources studying trends within their health care plans and taking a variety of actions to address the underlying causes of what is driving their cost increases. One question is whether those same types of incentives to control costs are present in such government systems as Medicare and Medicaid, or whether costs are controlled by the government simply capping what it will pay for particular procedures, forcing private payers to pay those unreimbursed costs.

Although both employers and the government have taken steps to "bend" their health care cost curves, they have taken significantly different approaches. Large employers have adopted a consumer oriented approach that more actively engages their employees to seek out high quality, low cost health care. Medicaid, in contrast, has mandated reductions in provider reimbursements and shifted costs to both employers and Medicare, which has effectively enabled the program to reduce its cost per covered life by 2.8 percent from 2003 to 2012 (see chart below). However, these kinds of reductions in provider payments can have negative consequences on the availability of providers and the quality of care.

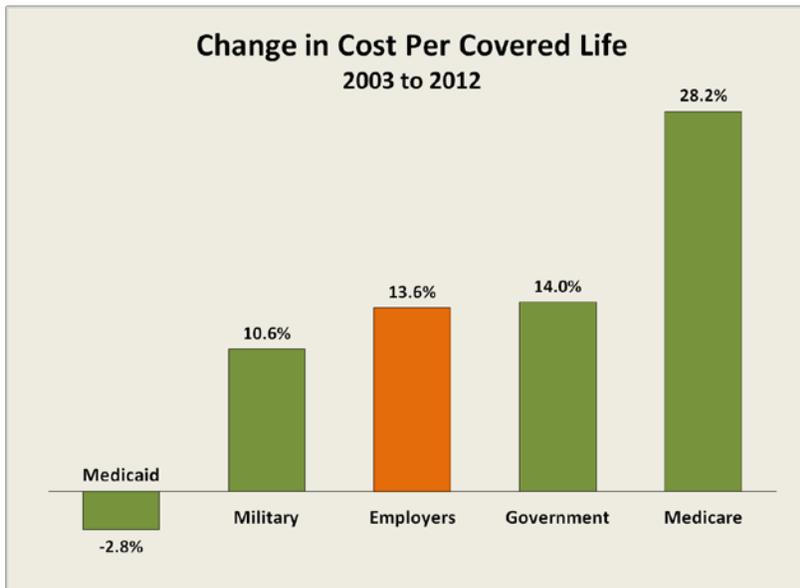


Chart F

Health care will be seeing large changes in the decade ahead. As a result of rising health care costs and the new employer mandate, it is likely we will see fewer people in employer sponsored health care in the future. A number of analysts, including former OMB official Dr. Ezekiel Emanuel and S&P Capital Research, have predicted that the number of employees in employer based health care will be approaching zero in ten years.²⁶ Employer sponsored health care may not go away, but it seems likely that the number of people in employer sponsored care will shrink, and a good number of displaced individuals will have to move to other forms of health care. Some of these people will move to the ACA exchanges, and we do not yet have data on the cost of covered lives in exchange-purchased plans. But not all of the transition will entail movement into the exchanges. The Congressional Budget Office predicts 13 million additional people will join Medicaid in the years ahead, and an aging society means that more people will be entering Medicare as well.²⁷

In all, it seems that the ACA, by intent or just in effect, will be driving more people from employer-based health care into government-based programs. This movement will have implications on the costs to individuals – both in out of pocket spending and taxes – as well as to government. If government policies move people from programs that cost less per individual to ones that cost more per individual, that could mean that we will be spending even more on health care than currently anticipated over the next decade. Furthermore, the difference in the methods that the private sector and government use for cost containment have implications for providers and recipients alike. Finally, to the extent that some government programs have tended to be worse at controlling costs than employers, this could lead to even higher costs, something policymakers need to take into account when making future changes to our complex and costly health care system.

Endnotes

¹ OECD Health Data 2013, "How Does the United States Compare, Organisation for Economic Co-operation and Development" 2013, available at: <http://www.oecd.org/unitedstates/Briefing-Note-USA-2013.pdf>.

² National Health Expenditure Data, Centers for Medicare & Medicaid Services, Sponsor Highlights, Tables 5, 19, and 22, available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/tables.pdf>; and Census Bureau, Average Population Per Household and Family: 1940 to Present, available at <http://www.census.gov/hhes/families/files/hh6.xls>. Although the Census Bureau reports 170.9 million people were covered by employer-sponsored health care in 2012, this study uses the National Health Expenditure estimate of 168.8 million for consistency with the other estimates in the report. The \$1.1 trillion estimate for government health care expenditures is the sum of spending on Medicare, Medicaid, Department of Defense, and Department of Veterans Affairs.

³ Calculated by AHPI. In 2012, households spent \$792.4 billion on health care and there were 2.55 people per household and 121.084 million households for a total of 308.764 million people. Therefore, in 2012, households spent an average \$2,570 per person on health care. See endnote 2 for data sources.

⁴ See endnote 2 for data sources.

⁵ Calculated by the American Health Policy Institute (AHPI). See Tevi D. Troy and D. Mark Wilson, "The Cost of the Affordable Care Act to Large Employers," American Health Policy Institute, May 2014, for a description of the data source for this estimate.

⁶ National Health Expenditure Data, Centers for Medicare & Medicaid Services, Sponsor Highlights, Table 22, available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/tables.pdf>; and National Health Expenditures by type of service and source of funds, CY 1960-2012, available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/NHE2012.zip>. The estimate for the number of military enrollees is "Other Public" which is predominately Department of Defense and Department of Veterans Affairs, but may be a slight overestimate because it includes a few smaller public programs.

⁷ National Health Expenditure Data, Centers for Medicare & Medicaid Services, Sponsor Highlights, Tables 5 and 22, available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/tables.pdf>.

⁸ National Health Expenditure Data, Centers for Medicare & Medicaid Services, Sponsor Highlights, Table 21, available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/tables.pdf>.

⁹ See endnotes 2 and 3.

¹⁰ William J. Wiatrowski, "Employment-based Health Benefits in Small and Large Private Establishments," Bureau of Labor Statistics, Beyond the Numbers, Table 3, April 2013, available at <http://www.bls.gov/opub/btn/volume-2/employment-based-health-benefits-in-small-and-large-private-establishments.htm>.

¹¹ Other steps employers have taken to reduce costs include: better negotiating of provider prices, better pharmacy management, implementing medical homes, on-site clinics, and centers of excellence, and the consolidation of health plan offerings.

¹² Milliman, 2014 Milliman Medical Index, May 2014, available at <http://us.milliman.com/uploadedFiles/insight/Periodicals/mmi/pdfs/2014-mmi.pdf>.

¹³ *Id.*

¹⁴ *Id.*

¹⁵ Will Fox and John Pickering, Hospital & Physician Cost Shift, Payment Level Comparison of Medicare, Medicaid, and Commercial Payers, Milliman, December 2008; and B. Pyenson, K.

Iwasaki, S. Goldberg, and K. Fitch, “High Value for Hospital Care: High Value for All?”, Milliman, April 2010.

¹⁶ Teresa A. Coughlin and John Holahan and Kyle Caswell and Megan McGrath, “Uncompensated Care for the Uninsured in 2013: A Detailed Examination,” The Henry J. Kaiser Family Foundation, May 30, 2014.

¹⁷ Calculated by AHPI as follows, \$21.1 billion divided by 189.5 million people covered by private health insurance.

¹⁸ Doug Proebsting, “Why Hospital Cost Shifting Is No Longer A Viable Strategy,” Milliman, June 2010.

¹⁹ Government Accountability Office, “Improper Payments: Remaining Challenges and Strategies for Government-wide Reduction Efforts,” GAO-12-573T, March 28, 2012. Improper payments means the care was not necessary or the bill was wrong.

²⁰ Senator Tom Coburn, “Death, Delay and Dismay at the VA: Friendly Fire,” June 2014, available at http://www.coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=577d9e90-ee2a-4eee-a52d-2cf394420761.

²¹ VA Office of Inspector General Office of Audits and Evaluations, “Review of VA’s Compliance with the Improper Payments Elimination and Recovery Act for FY 2012,” 12094241-138, pages 3 and 9, March, 15, 2013, available at <http://www.va.gov/oig/pubs/VAOIG-12-04241-138.pdf>.

²² National Health Expenditure Data, Centers for Medicare & Medicaid Services, Sponsor Highlights, Table 1, available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>; Census Bureau, Income, Poverty, and Health Insurance Coverage in the United States: 2012, September 2013, available at <http://www.census.gov/prod/2013pubs/p60-245.pdf>.

²³ National Health Expenditure Data, Centers for Medicare & Medicaid Services, Sponsor Highlights, Table 1, available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>.

²⁴ Calculated by AHPI using data from National Health Expenditure Data, Centers for Medicare & Medicaid Services, Table 5, available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/tables.pdf>, and Census Bureau, Income, Poverty, and Health Insurance Coverage in the United States: 2012, Table C-1, available at: <http://www.census.gov/prod/2013pubs/p60-245.pdf>; and Bureau of Labor Statistics, Consumer Price Index Databases, All Urban Consumers, All Items Less Medical Care, available at: <http://www.bls.gov/cpi/data.htm>.

²⁵ This includes any health insurance premiums, out-of-pocket expenses, and Medicare payroll taxes paid by individuals.

²⁶ Michael G Thompson, Robert A. Keiser, and Gary F. Albanese, “The Affordable Care Act Could Shift Health Care Benefit Responsibility Away From Employers, Potentially Saving S&P 500 Companies \$700 Billion,” S&P Capital IQ Global Markets Intelligence group, May 1, 2014, available at http://images.politico.com/global/2014/04/30/health_care_4-29_3.html; and Ezekiel J. Emanuel, “Reinventing American Health Care: How the Affordable Care Act will Improve our Terribly Complex, Blatantly Unjust, Outrageously Expensive, Grossly Inefficient, Error Prone System,” Public Affairs, New York, NY, 2014.

²⁷ Congressional Budget Office, “Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, April 2014,” Table 2, April 2014, available at http://www.cbo.gov/sites/default/files/cbofiles/attachments/45231-ACA_Estimates.pdf