The Painful Burden of Health Care Costs

BY DENNIS HEFFLEY, WILLIAM LOTT AND ALDO PONCE

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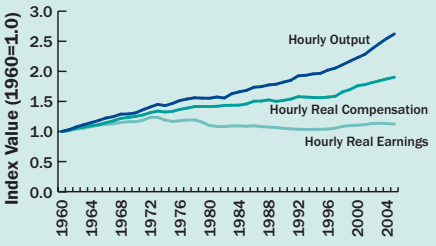
Working harder with little to show for it? If so, you have plenty of company. Earlier this year, the Federal Reserve's *Survey of Consumer Finances* reported that the average real income of American families fell 2.3 percent between 2001 and 2004. When incomes fail to keep up with inflation, households either must dig into savings or cut their consumption of goods and services: fewer bags of groceries, smaller apartments, macaroni and cheese instead of a meal out. So, are workers really becoming less productive? Are they being compensated less for their efforts? Or are they just being paid differently? And do rising health care costs have anything to do with these patterns?

COMPENSATION LAGS PRODUCTIVITY

Firms compensate their workers with money wages or salaries (earnings) and with employee benefits-health insurance, life insurance, retirement plans, etc. The earnings/benefit mix of total compensation is affected by a combination of public policies (*e.g.*, income tax exemptions for most fringe benefits), employee preferences for benefits *versus* money income, and employer decisions about how to structure compensation packages to best attract and retain qualified workers. But regardless of the mix, we might expect *total compensation*, adjusted for inflation, to closely track worker *output*. In the graph (below left), U.S. data for the last 45 years show that real compensation (earnings plus fringes) per hour worked has grown less rapidly than hourly output, as measured by real GDP per hour worked in the non-farm sector.

We've normalized each series in the diagram—hourly output, real hourly compensation, and real hourly earnings—to a value of 1.0 in 1960. This allows us to readily see the rate of growth in each variable. The top two lines show that hourly output in 2005 was more than 2.6 times its 1960 level-an average annual growth rate of 2.17%. Hourly real compensation grew more slowly (1.44% annually), but still managed to nearly double between 1960 and 2005. The extent to which real compensation has failed to keep pace with output may itself be an interesting story, but the focus here is on the other gap—between compensation and earnings—since this gap reflects the growing role of fringe benefits in the rewards to workers.

HOURLY OUTPUT OUTPACES REAL COMPENSATION AND REAL EARNINGS, 1960-2005



Source: *The Connecticut Economy* based on data from the *Economic Report of the President 2006*, and the Bureau of Labor Statistics.

REAL EARNINGS LANGUISH

Surprisingly, hourly real earnings in 2005 were only slightly higher than they were in 1960. After a period of reasonable growth (1960-1972), real earnings per hour fell throughout the remainder of the 1970s, stabilized during the mid-1980s, fell a bit more in the late 1980s and early 1990s, and only began to grow again in the late 1990s. This strikingly lackluster performance seems to support widespread

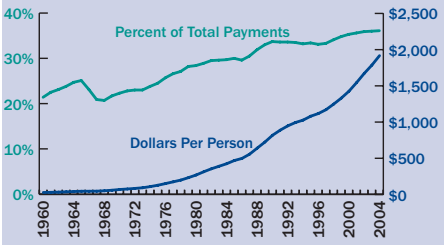
concerns about wage stagnation and the diminished prospects of the average American worker.

Or does it? While the hourly monetary rewards to workers have barely kept up with inflation, the benefits component has grown more rapidly. In fact, given the poor wage performance, it appears that fringe benefits account for nearly *all* of the growth in hourly real compensation over the last 45 years.

THE SHIFT TO FRINGES

So what has caused such a large shift from money earnings to fringe benefits? Part of the reason is that most fringes are not counted as taxable income to workers, while employers can deduct their *total* compensation costs for hired labor from taxable income. But another likely explanation is the rising costs to employers of providing health insurance to their employees—presumably driven by the benefit payments made by insurers to cover growing health care costs. The graph above shows that payments by private insurers have indeed grown, both per capita and as a percentage of U.S. personal health care spending.

PAYMENTS BY PRIVATE INSURERS: FRACTION OF TOTAL PAYMENTS AND DOLLARS PER PERSON, 1960-2004



Source: *The Connecticut Economy* based on data from the Centers for Medicare and Medicaid Services (CMS) and population data from the *Economic Report of the President 2006*.

Payments by private insurers amounted to just $28 per person in 1960, less than 22% of the $129 in personal health care expenditures per capita from all sources. By 2004, per capita health care expenditures had increased more than 41-fold, to $5,309 per person-an average annual growth of 8.8% over the 44-year period. Of this amount, $1,917, or just over 36%, was paid by private insurers. So private insurers' role as a payer of health care charges has grown, and the bulk of the insurance is provided through work, as part of the compensation package.

If anything, the above figures understate the magnitude of the problem facing firms and why their health-insurance costs might crowd out wages. Many employers offer family coverage, so each worker often brings along one or more dependents. On a *per worker* basis, payments by private insurers rose from $92 in 1960 to $4,287 in 2004, or 9.1% annually. Furthermore, even these figures only reflect *payments* by insurers, not what they charge employers for such coverage. A recent report from Mercer Health & Benefits, LLC, puts that figure at $7,523 per worker nationally, and $7,992 in Connecticut (see *Hartford Courant*, November 20, 2006, p. 2).

Any way you slice it, health care costs are pushing up premiums and forcing employers to adjust. Judging by the first graph, it looks like one of those adjustments has been limiting average wage gains to little more than cost-of-living provisions. While workers may not relish this outcome, many employees seem willing to forego higher wages to preserve insurance benefits. News accounts have pointed to the

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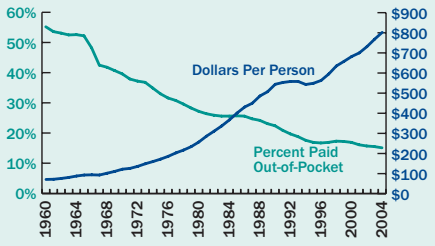
problem of "job lock"—reluctance to switch jobs for fear of losing health insurance.

OTHER SOURCES OF PAIN?

Workers have also complained of reductions in health insurance coverage and higher out-of-pocket payments, but the evidence here is mixed. The graph below shows that out-of-pocket payments for health care have indeed risen, from $71 per capita in 1960 to $802 in 2004. That's more than an 11-fold increase, yet the $71 in 1960 was equivalent to $453 in 2004, so the inflation-adjusted increase in out-of-pocket payments was much smaller. Moreover, the graph also shows that, despite complaints about "reduced coverage," the percentage of personal health care spending paid out-of-pocket (the average "coinsurance rate") has fallen sharply, from

OUT-OF-POCKET HEALTH CARE SPENDING: ON THE RISE OR NOT?



Source: *The Connecticut Economy* based on data from the Centers for Medicare and Medicaid Services (CMS) and population data from the *Economic Report of the President 2006*.

55.2% to 15.1%. So, currently, only about one of every seven dollars of all personal health care spending—on physician and dental services, hospital care, drugs, etc.—is paid directly by consumers. The other six bucks come from private and public insurance.

For any individual, more complete coverage is hardly a source of pain, yet *collectively* this may indeed be the major ailment. Standard models of insured health care markets predict that increased coverage—a lower coinsurance rate—increases demand and makes consumers less sensitive to the gross price of health care. This, in turn, boosts gross health care prices, increases the quantity of care delivered, and expands total health care spending.

Another way that we all bear the rising cost of health care is through taxes used to finance public insurance programs—Medicare for the elderly and Medicaid for the poor. Both programs were introduced in the mid-1960s. Payments by public insurance programs rose from $28 per capita in 1960 to $2,356 in 2004, more than doubling the public sector's share of personal health care spending, from 21.4% in 1960 to 44.4% in 2004. The expansion, by the way, does *not* reflect the more recent introduction of Medicare drug coverage.

NO EASY REMEDIES

There seems to be no shortage of blame for the growing gap between workers' output and their rewards: overpaid managers, higher corporate profits, tax-happy bureaucrats, competition from illegal immigrants, weaker unions—all have been cited as reasons for wage stagnation and the sagging real income of American workers. Such factors might explain the output-compensation gap, but they fail to explain why the mix of compensation has shifted away from wages toward fringe benefits. The growth in health insurance coverage provides an explanation, but it also poses a dilemma.

The degree of health insurance coverage, private and public, has expanded substantially since 1960, as evidenced by the declining percentage of charges paid out-of-pocket. This has boosted gross health care prices, increased consumption, and greatly expanded total spending. In turn, health insurance premiums have soared, causing a painful shift of compensation from wages to fringe benefits to preserve coverage. Faced with higher health care prices, however, some workers have pushed for even more complete coverage, which simply aggravates the market-level effects.

So what's the answer? There are no easy ones. Managed care has shown little capacity to solve the problem, and may have even contributed to it (*The Connecticut Economy*, Fall 2004). Price controls on health care are politically tempting, but force markets to adjust in undesirable ways, including longer waits, "informal payments" (bribes), and lower-quality care. Removing health insurance from the workplace also has been suggested, but won't happen as long as health insurance remains an untaxed form of compensation. The best hope may lie in structuring health insurance to reward more healthful lifestyles and prudent health care choices, but to have an impact the rewards need to accrue to the individual, not just the insurer or employer. Given the lack of growth in real wages, the typical worker might welcome such rewards.

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