The Business Sector's Response to Rising Health Care Costs:

Implications for a Demand-Driven Economy

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Introduction

In response to rapidly escalating health care costs, both large and small employers have adopted various coping strategies to control and offset health benefits inflation. Even though the provision of health care insurance is optional or discretionary for most employers in the U.S., save for collectively bargained labor agreements, most businesses continue to offer some form of health insurance benefit. In this, they are guided by sound business considerations such as competitive labor markets, labor relations and worker productivity, as well as by tax incentives (Madrian, 2005). A key in recruiting and retaining employees, most businesses have been reluctant to entirely give up their policy of providing health care benefits, implementing, instead, a range of measures designed to reduce and offset their health care expenses, as well as control health benefits inflation (Seshamani, 2007; Buchmueller, 2000; Galvin and Delbanco, 2006). Even small businesses have sought these measures, as they have been crippled from attracting more experienced and qualified personnel by their inability to offer competitive health benefits (NFIB 2001). As case studies by Deloitte Consulting (2006), Christianson and Trude (2003), Seshamani (2007), and many others, indicate, employers are prepared and have tried every strategy within the limits of the law and market competition that they believe will produce some kind of savings on health care costs. In this paper, we will examine a number of such coping strategies undertaken by U.S. employers, and will draw the implications of their tactics for productivity, growth and stability in a demand-driven economy.

How U.S. Employers Are Coping With the Rising Costs of Health Care Benefits

The strategies to control and offset the costs of health care benefits date back to the early 1990s when large corporations found themselves at the forefront of the transition from traditional indemnity plans to managed care (Bodenheimer and Sullivan, 1998; Maxwell et al., 2001). At that time, more and more employers were limiting health care choices for their employees, as Health Maintenance Organizations (HMOs) and Point-of-Service (POS) plans became established in an effort to control premium increases and reduce firms' expenditures on health care (Darling, 1991). With the evolution of insurance market from traditional indemnity plans to HMO managed care, to Preferred Provider Organizations (PPOs) in the late 1990s, and onto the growing focus on consumer-driven health plans, employee health care benefits and their financing methods saw a significant transformation aimed at reducing the health care bill of the U.S. employers (Bodenheimer and Sullivan, 1998; Darling, 1991). Changes in health care plan design to reduce or eliminate certain high-cost benefits, increases in employee premium contributions, cost-shifting methods such as deductibles, co-insurance and co-payments; limiting new employees' eligibility for health care benefits, eliminating coverage for dependents, freezing or reducing real wages to offset health insurance expenses, contracting with lower-cost health care plans, negotiating aggressively with insurance companies and health care providers, among other measures, were implemented in various combinations by different employers (see Kaiser Family Foundation and Health Research and Education Trust (KFF-HRET) Surveys).

With rich plan design cited among the major cost drivers in health benefits inflation, the majority of U.S. employers have found health care plan re-design to be an attractive coping mechanism (Deloitte Consulting, 2006). This mechanism makes health care plans less expensive

by eliminating specific high-cost benefit categories or pairing down certain groups of benefits thus offering a less generous coverage (Lee and Tollen, 2002). Federal regulations stipulating certain mandated benefits limit the extent to which plan re-designs can be carried out, while agreements with unions can also exert a restraining influence as is often observed in unionized manufacturing industries (Lee and Tollen, 2002; The Robert Wood Johnson Foundation, 2005).

Most often, plan re-designs are accompanied by increases in employee premium contributions. As the KFF-HRET (2008) reports, about 80 percent of American workers with single coverage and 93 percent of those with family coverage had to make a contribution toward the total premium for their coverage in 2008. Such a contribution averaged at 16 percent of the premium for single coverage and 27 percent of the premium for family coverage (2008). In absolute terms, this amounted to an annual average contribution of $721 for single and $3,354 for family coverage (2008). The absolute amounts of premium contributions paid by American workers have increased dramatically over the past decade, as Table 1 below demonstrates. Only two years ago (2006), an average worker contribution was that of $627 for single coverage and $2,973 for family coverage. At the beginning of the decade (2001), these numbers were only $355 and $1,787, respectively. Overall, from 2001 to 2008, American workers saw their average premium contributions for single coverage more than double (a 103 percent increase), while average premium contributions for family coverage increased almost twice (an 88 percent increase) (see Table 1 below).

Table 1:
Average Annual Worker Premium Contributions, All Firms (Plans) and PPO Plans, Selected Years

Average annual worker premium contribution	**2001**		**2002**		**2006**		**2007**		**2008**	
	All firms	PPOs	All firms	PPOs	All firms	PPOs	All firms	PPOs	All firms	PPOs
Single coverage	$355	$351	$454	$432	$627	$637	$694	$717	$721	$731
Family coverage	1,787	1,838	2,084	2,152	2,973	2,915	3,281	3,236	3,354	3,344

Source: Claxton et al., 2006; KFF-HRET Employer Health Benefits Survey, 2002, 2006, 2007, 2008.

Notably, there is much variation in the shares of premiums that employees have to pay. For example, in 2008, 14 percent of covered workers were enrolled in a plan for which they had to contribute more than half of the premium for family coverage, while 19 percent of covered workers were enrolled in a plan for which they had to pay somewhere between 25 and 50 percent of the premium for single coverage (KFF-HRET, 2008). In 2007, 15 and 21 percent of covered workers, respectively, had to make similar premium contributions (KFF-HRET, 2007). Besides, small firm (3-199 workers) employees bear a larger burden of health care premiums compared to their counterparts in large firms (200+ workers). In 2008, 30 percent of small firm employees with health care coverage were enrolled in a plan for which they had to contribute more than half of the premium for family coverage, while only 6 percent of large firm employees had to pay a similar share. While an annual average premium contribution for family coverage averaged at $4,101 for small firm employees (2008), large firm employees paid more than one thousand dollars less ($2,982) in the same year (KFF-HRET, 2008). Likewise, small firm employees face larger annual increases in premium contributions relative to their counterparts in large and medium-size businesses (The Robert Wood Johnson Foundation, 2005).

It is not uncommon that employee premium contributions may be assessed relative to their base pay in order to cushion low income earners. This means that premium contribution rates may vary with the distribution of wages within firms. On average, workers in firms with a higher proportion of low-wage earners [1] contribute a larger share of the total premium (18 percent for single and 35 percent for family coverage in 2006) than workers in firms with a lower proportion of low-wage earners (15 percent for single and 26 percent for family coverage in 2006) (Claxton et al., 2006).

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[1] Where at least 35 percent of workers earn $22,000 or less per year (KFF-HRET, 2008)

The firms' expenditures on employee health benefits can also be reduced via such cost-sharing methods as deductibles, co-payments and co-insurance. Because they shift a larger share of health care costs away from the insurer and onto the patient, health care plans with higher deductibles, co-payments and co-insurance have lower premiums (Hellander, 2006). In addition, such cost-sharing methods are believed to lower the costs of premiums via reductions in health benefits utilization levels (Bodenheimer, 2005; Keeler, 1992).

More specifically, a deductible is the amount of money a patient must pay to a physician or a hospital before the insurance company is liable to pay for the services s/he received[2]. Over the past decade, American workers have witnessed a rapid growth in the amounts of deductibles they have to pay. For example, while an average annual deductible for a PPO enrollee with single coverage was $275 in 2003, it increased more than twice by 2008, jumping to $560 (KFF-HRET, 2003; 2008). For PPO enrollees with family coverage, an average annual aggregate deductible increased to $1,344 by 2008. Overall, in just two year (from 2007 to 2008), the percentage of workers enrolled in a plan with a deductible of at least $1,000 for single coverage rose 8 percentage points (from 10 to 18 percent of covered workers). The increase was larger for small firms, where 16 percent of covered employees had an annual deductible of at least $1,000 in 2007 compared to 35 percent of covered employees in 2008 (KFF-HRET, 2008).

A co-payment (also known as a co-pay) is a small fee (a flat dollar amount) paid by a patient for each medical service s/he received (e.g. a physician office visit, a hospital admission, etc.). A co-insurance is a percentage (rather than a specific amount) of the cost of a medical service that a patient is responsible for [3] in addition to co-payments and deductibles. As the KFF-HRET (2008) reports, 79 percent of covered workers had a co-payment for a physician office

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[2] In other words, a deductible is a portion of any medical claim that is not covered by a health insurance provider, and has to be paid by a patient before the benefits of his or her policy can apply.
[3] For definitions see http://www.medical-billing-coding.org/Content246.htm

visit in 2008, where an average co-payment was $19 for primary care and $26 for specialty physicians. In the same year, 11 percent of covered workers had a co-insurance obligation for a physician office visit, where an average co-insurance rate was 17 percent. Most covered workers also face cost-sharing arrangements when they are admitted to a hospital or have outpatient surgery. In 2008, 24 percent of covered workers had a co-payment arrangement for hospital admissions, where an average co-payment was $216 (per hospital admission). For the 37 percent of covered workers with a co-insurance obligation, an average co-insurance rate was 17 percent. The spread of co-insurance plans has increased dramatically over the past years. For example, 37 percent of large employers (20,000+ employees) offered co-insurance health plans in 2005, compared to 26 percent in 2004 (Hellander, 2006).

With prescription drug costs cited among the main drivers in health benefits inflation (23 percent of large employers surveyed by Deloitte Consulting in 2006 cited this cost driver), most covered workers also face co-payment arrangements for the cost of prescription drugs. Such co-payments are believed to somewhat control health benefits inflation via both cost-sharing and decreases in prescription drug utilization levels. Most employers have implemented the so called ‘tiered’ co-payment arrangements, where co-pays are assessed based on the cost and type of drugs. The use of such tiered arrangements has increased dramatically over the past decade. While only 29 percent of covered workers faced three-tier cost-sharing arrangements in 2000, already in two years (2002), the majority (57 percent) of covered workers had such arrangements (KFF-HRET, 2003). By 2008, over three-quarters of covered workers faced three or more levels of tiers of cost sharing for prescription drugs. Among workers enrolled into three- or four-tier plans in 2008, an average co-payment was $10 for the first-tier drugs (often called ‘generics’), $26 for second-tier drugs (the so called ‘preferred’), and $46 for third-tier drugs (often called

'non-preferred'). In the same year, an average co-payment amount for the fourth-tier drug was $75, while an average co-insurance rate was 28 percent (KFF-HRET 2008). More employers are also using prior drug authorization programs in an effort to control benefits inflation by managing access to certain drugs. In addition, employers have introduced annual maximums in order to make employees use more generic than brand name drugs. Besides, it is not uncommon that Over the Counter (OVC) drugs are excluded from health plan coverage (Takeda Prescription Drug Benefit Cost and Plan Design Survey Report, 2003).

In addition to the cost-sharing methods described above, employers have implemented a range of other measures aimed at controlling their health care bill. In this, eligibility management has become a rather popular strategy whereby some groups of employees are excluded from qualifying for coverage or coverage for specific plan benefits. As a rule, these groups include new, part-time, contract and temporary workers. New employees are being increasingly subjected to waiting periods or tenure status systems before they can qualify for company health benefit programs or specific groups of benefits. For part-time, contract and temporary workers the likelihood of health insurance coverage is very low. For example, while only 31 percent of all employers offered health benefits to part-time employees in 2006, only 3 percent of employers offered health insurance to temporary workers (KFF-HRET, 2006). Because of their limited eligibility for health care coverage, part-time, temporary and contract workers became a special target for U.S. employers (Cowan and Hartman, 2005; Baicker and Chandra, 2005; Eibner and Marquis, 2008). For example, the number of workers employed in temporary jobs increased 9 percent from 2003 to 2005, while the U.S. labor force expanded by only 1 percent during the same period (Skala and Hellander, 2006).

Reducing health care plan choices for their employees has become another common strategy among the U.S. employers. Aiming to reduce the administrative expenses associated with multiple health plans management, the majority of firms are no longer offering several health care plans choices, limiting their offer to one plan. As the KFF- HRET (2006) reports, 57 percent of large firms that offered health care benefits in 2006 limited their offer to one health care plan, while 89 percent of small firms followed the same strategy. Less than 1 percent of small firms and 11 percent of large firms offered three or more health care plan choices in 2006 (KFF-HRET, 2006). Four years earlier (2002), most covered workers still had a choice of a health care plan, with almost half of covered workers having a choice of three or more plans (KFF-HRET, 2002). This strategy of compelling employees stick with whichever single health plan their employer offer, could be viewed as a tactic to make employees drop or refuse coverage if they have alternative sources of health insurance.

Recently, many employers have tried to push their workers into the so called 'consumer-driven' or 'consumer-directed' solutions to the health care crisis. A Health Savings Account (HSA) is one of them. Federally enacted in 2003, HSAs allow employees to save (solely) for their medical expenses on a tax-free basis (including a tax-free interest). A key advantage of a HSA is that the funds not withdrawn in any given year can be rolled over and used for future medical expenses. However, to establish a HSA an employee must enroll into a high deductible health care plan (HDHP) provided by his employer. While the premiums for HSA-qualified HDHPs are generally lower compared to all other plan types, this is partly due to the much higher deductibles and other out-of-pocket expenses that the HSA-qualified HDHPs entail (Hoffman and Tolbert, 2006). For example, while an average contribution to a HSA-qualified HDHP with family coverage was $1,522 in 2008, a PPO enrollee with family coverage paid $3,344. At the same time, however, a worker who established a HSA-qualified HDHP had a much higher average aggregate annual

deductible of $3,911 compared to the $1,344 paid by a PPO enrollee (2008)[4] (KFF-HRET, 2008). Besides, the personal nature of HSAs "means that sick people quickly exhaust their meager savings and face high out-of-pocket costs" (Skala and Hellander, 2006, p. 174). Notably, not all employers offering HSA-qualified HDHP make contributions to the HSAs established by their employees. Among all firms offering HSA-qualified HDHPs in 2008, only 28 percent made contributions to their employees' HSAs for single or family coverage (covering 26 percent of workers in HSA-qualified HDHPs) (KFF-HRET 2008).

While HSAs with HDHPs currently occupy a relatively small segment of the health insurance market, their share has been growing over the recent years. Up from 2 percent in 2005, 11 percent of firms providing employee health benefits offered a HSA-qualified HDHP in 2008, compared to 7 percent in 2007. HSA-qualified HDHPs covered about 4 percent of insured workers in 2008, compared to 3 percent in 2007. Here, the participation rate is higher for small firms (3-199 workers), where 8 percent of covered workers were enrolled into a HSA-qualified HDHP in 2008, compared to 3 percent of large firms' (200+ workers) employees (KFF-HRET, 2007; 2008).

By encouraging employees to set up HSAs with HDHPs "it is assumed that consumers will eventually become more cost-conscious, enabling them to make more cost-effective decisions about their health and health care" (Hoffman and Tolbert 2006, p. 4). However, according to a 2005 survey, more than three-quarters of Americans (77 percent) had an unfavorable opinion of HSAs and similar high-deductible health plans, reporting that with this type of health care coverage they would feel vulnerable to high medical bills (Skala and Hellander, 2006).

[4] There is also much variation in the amounts of deductibles that covered employees have to pay under the HSA-qualified HDHPs. For example, in 2008, 11 percent of workers covered by a HSA-qualified HDHP had a deductible of $3,000 or more for single coverage, compared to 54 percent of HSA/HDHP enrollees with a deductible of $2,000 or more in 2007 (KFF-HRET, 2008).

Increases in employee premium contributions, growing deductibles, co-payments and co-insurance, decreases in the generosity of benefits, eligibility management and other cost-control measures undertaken by American employers have led to dramatic reductions in employee coverage rates. As the KFF-HRET (2002) reports, among firms that offered health coverage in 2002, only 67 percent of workers had job-based health insurance, compared to 65 percent in 2008. If we account for both firms that offer and do not offer health benefits, only 60 percent of workers were covered by employer-provided health plans in 2008, down from 63 percent in 2000 (KFF-HRET, 2008; 2006). Coverage rates are generally higher for large firms compared to small employers. As the KFF-HRET (2006) survey showed, among firms that offered health insurance, only 53 percent of small firm employees had employment-based coverage in 2006, compared to 63 percent of large firm employees. Overall, the percentage of all firms offering employee health benefits declined from 66 percent in 1999 to 60 percent in 2007 (KFF-HRET, 2008).

Health care coverage for dependents has declined significantly as well. In this, a sharpest decline in coverage was experienced among employees' children (under 18) who saw their coverage rate decline from 65.6 percent in 2000 to 60.5 percent in 2005 (Gould, 2006). More and more businesses are now in favor of government programs such as State Children's Health Insurance Program (SCHIP) and Medicaid to help cover their employees' children (Perry et al., 1999).

Employee health benefits coverage rates are likely to fall in the future, as the recent KFF-HRET (2008) survey demonstrates. Among surveyed employers that offered health coverage in 2008, large percentages reported that they were very or somewhat likely to increase premium contributions (40 percent of surveyed employers), raise deductibles (41 percent), increase cost-

sharing for office visits (45 percent), as well as expand cost-sharing for prescription drugs (41 percent) in 2009. An additional 12 percent of firms reported that they were somewhat likely to restrict eligibility for coverage. Besides, more businesses reported their eagerness to enroll workers into HSA-qualified HDHPs, with 21 percent of surveyed employers somewhat likely and 4 percent very likely to do so in 2009 (KFF-HRET, 2008).

A wage-benefit trade-off is another mechanism through which employers' health benefits expenses can be offset, in this case, through falling or stagnant real wages or reductions in non-medical benefits. More specifically, the total compensation package of an employee which consists of wages (salaries), medical and non-medical benefits, can be re-arranged so that the share of wages and non-medical benefits is reduced in response to the rising share of health care benefits, keeping the *total* compensation package relatively unaffected. This means that American workers bear a large portion of increases in their health care benefits costs through real wage cuts (or lower real wage increases) and reductions in other benefits such as pensions (Reinhardt, 1989; Krueger, 1991; Gruber, 1994; Feldstein, 1999; Sheiner, 1999; Christianson and Trude, 2003; Cowan and Hartman, 2005; Baicker and Chandra, 2005). In other words, employers can offset their health care bill by taking a portion of real wages and non-medical benefits away from the American workers. As Blumenthal (2006) has put it, workers "pay for their own health insurance in the form of wages or benefits foregone" (Blumenthal, 2006, p. 85). This disturbing conclusion has now been acknowledged by most economists (Eibner and Marquis, 2008). Likewise, Allan Hubbard, an economic advisor to President Bush has stated in an interview with *Wall Street Journal* that "[e]mployers are spending more money on health care, and that's robbing people of wage increases" (January 12, 2006).

The evidence of a wage-benefits trade-off can be found in the U.S. private sector employment. For example, while wages and salaries of private sector employees grew at an annual average rate of 1.23 percent from 2001 to 2003, health benefits spending by their employers increased at an annual average rate of 7.2 percent. At the same time, despite these escalating health benefits expenses, the total compensation package of a business sector employee grew at an annual average rate of 2.23 percent (2001- 2003). This means that total compensation did not increase in full proportion to health benefits infation, as employers were able to keep wage growth low (below the rate of inflation) and reduce (or eliminate) certain non-medical benefits (Cowan and Hartman, 2005).

Furthermore, many large companies have tried to lessen their health care 'burden' by reducing or eliminating retiree health benefits obligations. Recently, these obligations have featured as a major issue among large corporations in the airline, automobile, construction, steel and mining industries. These 'legacy costs,' the companies claim, are now absorbing a much larger portion of health care expenditures than what they spend on active employees. Aiming to reduce or eliminate retiree health benefits, large corporations have been involved in ongoing negotiations with unions for the establishment of Voluntary Employees' Beneficiary Associations (VEBAs) or trust funds managed by unions or together with the companies. Besides, many large corporations have sought protection in bankruptcy laws. For example, while Goodyear managed to agree with the union on the establishment of a VEBA and a closure of some plants[5], companies like Delphi and Dana sought Chapter 11 bankruptcy protection to avoid their huge retiree health care obligations[6] [7]. Likewise, Horizon Natural Resources was protected

[5] "Goodyear Strike Ends as Workers Accept Contract," *Dallas Business Journal*, December 29, 2006. See the story online at http://dallas.bizjournals.com/dallas/stories/2006/12/25/daily29.html
[6] The Economist, October 14, 2005. Auto parts maker, Delphi went into bankruptcy with unfunded liability for Other Post-Employment Benefits (OPEBs) amounting to $31 billion, consisting mostly of retiree health benefits.

from honoring health benefits to 1000 active miners and 2300 retirees when it filed for bankruptcy protection in 2002[8]. Similarly, Bridgestone – Firestone ratified a 3-year contract with the union agreeing to close down some plants and contribute employees' $1 of a cost of living adjustment (COLA) to help defray retiree health care expenses. Companies like Chrysler are currently engaged in active negotiations with United Auto Workers (UAW) to establish similar VEBAs and dispose retiree health benefits (Krisher, 2007).

As a result of these and similar cases, only 31 percent of large employers offered retiree health benefits in 2008 compared to 66 percent in 1988 (KFF-HRET, 2008; Skala and Hellander, 2006). Large companies with 'legacy costs' have also supported proposals for the Medicare's Prescription Drug Benefit Program so that their drug costs could be subsidized for qualifying retirees. In 2003, the Medicare Prescription Drug, Improvement and Modernization Act became law. The Act introduced a prescription drug benefit program under Medicare Part D, as well as a federal subsidy to employers who sponsor retiree health care benefit plans (Takeda Prescription Drug Benefit Cost and Plan Design Survey Report, 2003).

To cover their active employees, large businesses have relied upon competitive bidding processes "whereby companies solicit bids from competing [health] carriers to choose the most cost-effective" (Maxwell et al., 2001, p. 183). Competitive bidding processes are commonly accompanied by aggressive in-person negotiations about prices, utilization levels, administrative fees, pooling charges, commissions and network fees, etc. (Maxwell et al., 2001). Other companies have formed purchasing coalitions in another effort to exert more purchasing clout on the insurance and health care industries (Sapolsky et al., 1994). Attempting to circumvent health plan giants, such coalitions often opt for direct contracting with groups of hospitals and

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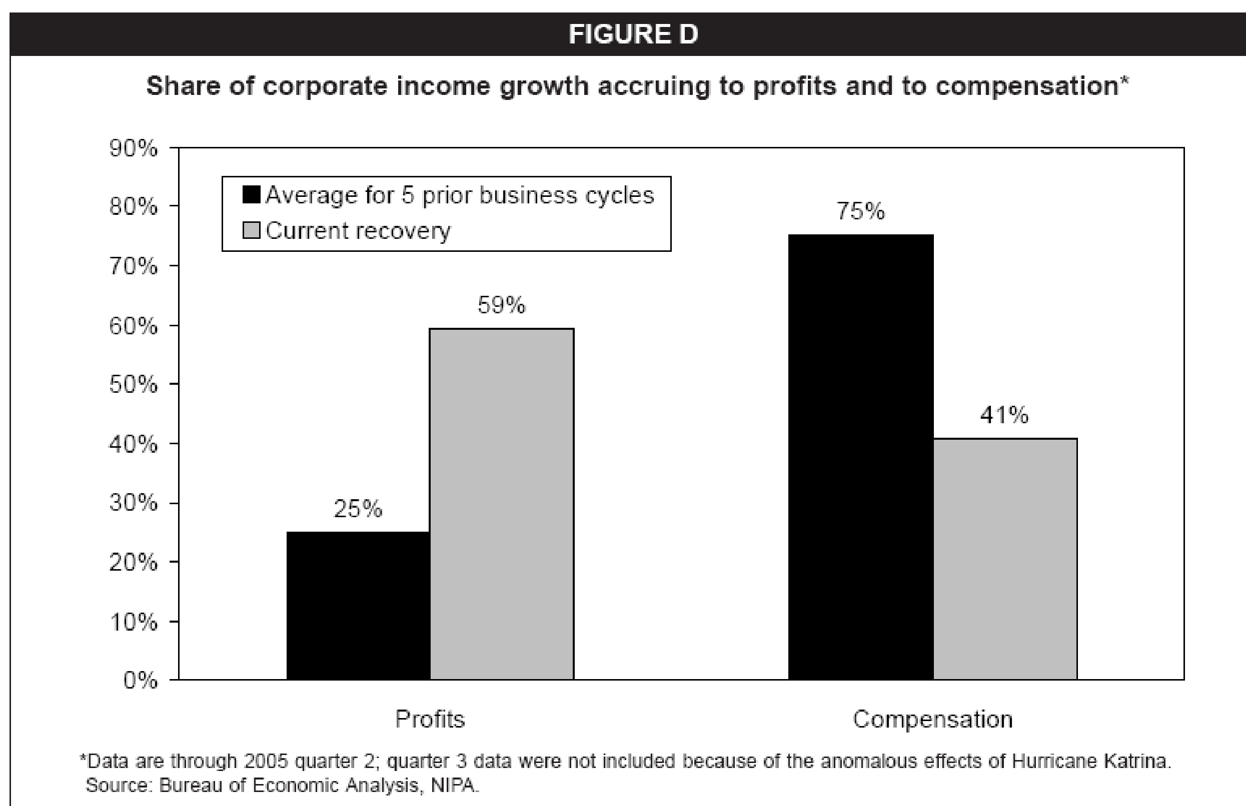
[7] Dana Corporation agreed with United Auto Workers Union to establish a VEBA trust fund managed by the union into which Dana would pay specified amounts over a period of time.
[8] "Coal Miners Lose Health Benefits," *CBS News*, August 9, 2004.

physicians, called ‘care systems’ (Bodenheimer and Sullivan, 1998). Value-based purchasing (VBP) emerged as another novel concept on the health care markets whereby some large companies require more accountability, quality and employee satisfaction information as part of the criteria to choose the most cost-effective insurer (Bodenheimer and Sullivan, 1998; Maxwell et al., 2001). Other businesses have been making use of the so-called insurance company ‘captives’ whereby an insurance company becomes a wholly-owned subsidiary of an employer providing insurance at rates that make health care plans effective and efficient. Alternatively, many firms find it more profitable to completely outsource their health benefits administration in an effort to save administrative costs. In this case, employee health benefits are managed by specialized firms through web-based systems whereby employees enroll and manage their plan status changes and benefit options online (Sourcing Analytics Inc., 2005).

The above outlined coping strategies and the dynamics in the relationships between employers, insurance companies and health care providers warrant that employers can manage their health care costs without adversely impacting the profitability of their businesses. This conclusion is particularly relevant for large corporations which dominate the economic landscape of the U.S. For example, Maxwell et al. (2001) who studied “Corporate Health Care Purchasing among Fortune 500 Firms” from 1995 to 2000, found that large employers “experienced relatively modest premium increases over the […] five years, with half reporting 2-5 percent average annual increases” (Maxwell et al., 2001, p. 186). While real wages of American workers have stagnated or decreased and their health coverage declined, corporate profits have grown strongly (Allegretto and Bernstein, 2006). As Figure D below demonstrates, in comparison to previous business cycles, “the share of corporate income accruing to compensation is lagging far

behind historical trends, while the share going to profits is way ahead of its historical average" (Allegretto and Bernstein, 2006, p. 4).



Source: Allegretto and Bernstein, 2006, p. 4

The situation is much more difficult for small firms, however, because "it costs small businesses more than their larger counterparts to provide health benefits to their employees" (Republican Policy Committee, 2006, p. 1). Citing prohibitive costs of health insurance, insufficient time and resources to handle health care matters (the way large businesses employ whole departments of personnel to handle such matters), and a lack of bargaining power while purchasing health care plans, more and more small businesses decide not to provide health benefits to their employees (Fronstin, 2000; 2003; see also NFIB surveys[9]). As the KFF-HRET (2008) reports, the percentage of small firms with 3 to 9 workers that offer health care benefits declined from 56 percent in 1999 to 45 percent in 2007. Among small firms with 3 to 199

[9] See NFIB surveys on http://www.nfib.com/page/sbet

workers, the percentage declined from 65 to 59 percent during the same period. However, this does not mean that *all* employees in those firms have health care coverage. For example, while 60 percent of small firms (3-199 workers) offered employee health benefits in 2006, only 53 percent of those firms' employees were covered.

When opting to maintain their health insurance policy, rather than terminate it, small businesses have been forced to implement short-term survival-type measures such as reducing other business expenditures, hiring less and firing more workers, holding off equipment purchases, and keeping fewer inventories on hand (see NFIB surveys[10]). A wage-benefit trade-off is another common strategy undertaken by small employers. As a recent survey has found, 65 percent of small businesses reduced pay raises or eliminated bonuses, while 36 percent reduced non-medical benefits in response to escalating health benefits inflation (Langner et al., 2007).

Long-term measures implemented or contemplated by small businesses include health insurance purchasing pools and federally-regulated Association Health Plans (AHPs). Purchasing pools are entities established by industry trade associations or state legislatures in an effort to pool together as many small businesses as possible to improve their bargaining power with health insurance companies over administrative fees, plan discounts and choices, etc. In addition, pooling workers from many small firms can lower premiums since an expanded pool of employees spreads the risks of insurance. Association Health Plans (AHPs) offer an example of such purchasing pools, which are federally regulated (Gencarelli, 2005). Besides, more and more small businesses have tried to join federal health care plans (where possible) and extend Medicaid for their employees' children (Fronstin, 2000).

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[10] See NFIB surveys on http://www.nfib.com/page/sbet

Implications for a Demand-Driven Economy

As the above analysis demonstrated, in response to rising health care premiums, U.S. employers have implemented a range of coping strategies designed to offset or reduce their health care bills, as well as control health benefits inflation. Among these strategies, increases in employee premium contributions, rising deductibles, co-payments and co-insurance have been notable. Moreover, while American workers have been spending a growing portion of their incomes on health-related expenditures, they saw their real wages stagnate or decline. As the National Coalition on Health Care (NCHC) (2007) reports, 43 percent of Americans under the age of 65 spent more than $2,000 a year as out-of-pocket expenditure on health care in 2003, compared to 37 percent in 1996. In 2004, more than 14 million Americans spent more than 25 percent of their income on health care, up from 11.6 million in 2000 (Skala and Hellander, 2006). Between 2000 to 2007, average out-of-pocket expenses for deductibles, co-payments and co-insurance incurred by American workers increased 115 percent, while their real wages fell by 3 percent (NCHC, 2007). Between 2001 and 2008, average employee premium contributions for family coverage increased 87 percent, while those for single coverage more than doubled. In 2008, American workers spent an average of $3,354 per year as a premium contribution for family coverage, a 13 percent increase relative to 2006 (KFF-HRET 2008).

As a result of these escalating health-care expenditures, the household finances of the American workers have suffered tremendously, limiting their ability to spend on non-medical items. As the Employee Benefit Research Institute (EBRI)(2006) survey showed, more and more American workers report difficulties paying for basic necessities, such as food, heat and housing (28 percent in 2006 up from 18 percent in 2004), and other bills (37 percent in 2006 compared to 30 percent in 2004) (EBRI 2006). Moreover, health care expenses have become a major cause

for bankruptcy filings among American families. As a recent study by Himmelstein et al. (2005) indicated, almost half of bankruptcy filings in 2001, affecting 1.458 million American families, were due to medical causes. This is despite the fact that three quarters (75.7 percent) of medical debtors had health insurance at the onset of the bankrupting illness (2001). With an average medical debt amounting to almost $12,000 in 2001, most medical debtors cited medical bills and drug costs as the main contributors to their bankruptcy, together with lost income due to employment curtailment because of illness (or to care for someone). Experiencing serious economic privations during the years leading into bankruptcy, almost half of medical debtors lost their phone service; almost one third had water or electricity service shut down; more than one-fifth went without food (Himmelstein et al., 2005). Health expenses incurred by American families were also associated with mortgage problems. As a 2005 survey has found[11], more than 25 percent of those with mortgage problems cited medical debt as a reason for their inability to make regular mortgage payments (NCHC, 2007).

Clearly, the household finances of the American families and their ability to spend on consumer goods and services have been seriously undermined by rising health care expenses. But consumer spending on goods and services, accounting for the largest share of the gross domestic product (GDP) (more than two-thirds) is the “primary force in the expansion of the U.S. economy” (Richards, 2008) and the main engine of job growth (Toossi, 2002). Consumer purchasing decisions (what, when, and how much to buy) determine how much of goods and services will ultimately be produced, as firms base their production and investment decisions upon expectations of consumer demand. Firms’ decisions to produce and invest, in turn, determine how many workers will be employed and how many new jobs will be created. Some

[11] The Access Project. “Home Sick: How Medical Debt Undermines Housing Security.” Boston, MA, November 2005.

of the jobs will be generated in the final goods and services industries, while the rest will be created in the intermediate goods industries (i.e. industries that provide inputs for the production of final goods and services) (Keynes, 1936; Toossi, 2002).

As American workers increasingly spend a growing portion of their incomes on health-related expenditures and curtail their spending on consumer goods and services, this slows down the economy and contributes to an employment slump. As Richards (2008) reports, real consumer spending grew by only 2.9 percent in 2007, the slowest growth rate since 2003 (Richards, 2008). In the wake of weaker consumer demand, American businesses responded by hiring fewer workers, as indicated by reductions in job openings and hires rates (Boon, 2008). As a result, employment growth slowed from 1.6 percent in 2006 to 0.8 percent in 2007, the lowest annual growth rate since 2003 (Richards, 2008). By the end of 2007, unemployment reached 7.4 million people, while the rate of unemployment was that of 4.8 percent. Nearly all of the increase in total unemployment in 2007 (600,000) was attributable to job losses (Borbely, 2008). Construction, manufacturing, retail trade, transportation and warehousing industries were among those suffering the largest employment losses. Cutting more than one-quarter million jobs in 2007, manufacturing industry experienced its sharpest decline since 2003. Reducing its workforce by almost 8 percent (79,000 employees), the motor vehicles and parts industry posted its largest annual employment loss since 2001. Computer and electronics industry posted severe employment cuts, curtailing almost twice as many jobs in 2007 as in the previous 3 years combined. Employment gains in transportation and warehousing industry, which benefits from positive trends in retail trade and manufacturing, were virtually null in 2007 (Richards, 2008).

It is no surprise that while consumer goods and services industries experienced challenging economic conditions, the health care industry expanded. Posting 453,000 new jobs

in 2007, health care and social assistance industries accounted for more than half of all net job creation in the private sector (Richards, 2008). During the same year, involuntary part-time employment[12] increased by 268,000 totaling at 4.5 million, while service sector jobs experienced another year of employment growth, increasing by 326,000 jobs (Borbery, 2008).

Of course, we do not aim to imply that rising health care expenses incurred by American households have been the sole factor behind the recent slide in consumer expenditures on goods and services (non-medical). The point is that escalating health care expenses together with other factors such as rising fuel and food prices, as well as the mortgage crisis, have undermined the ability of American households to spend on consumer goods and services, contributing to the recent decline in our demand-driven economy.

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[12] Involuntary part-time workers are those who would prefer to work full time, but could not find a full-time job (Borbery, 2008).

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