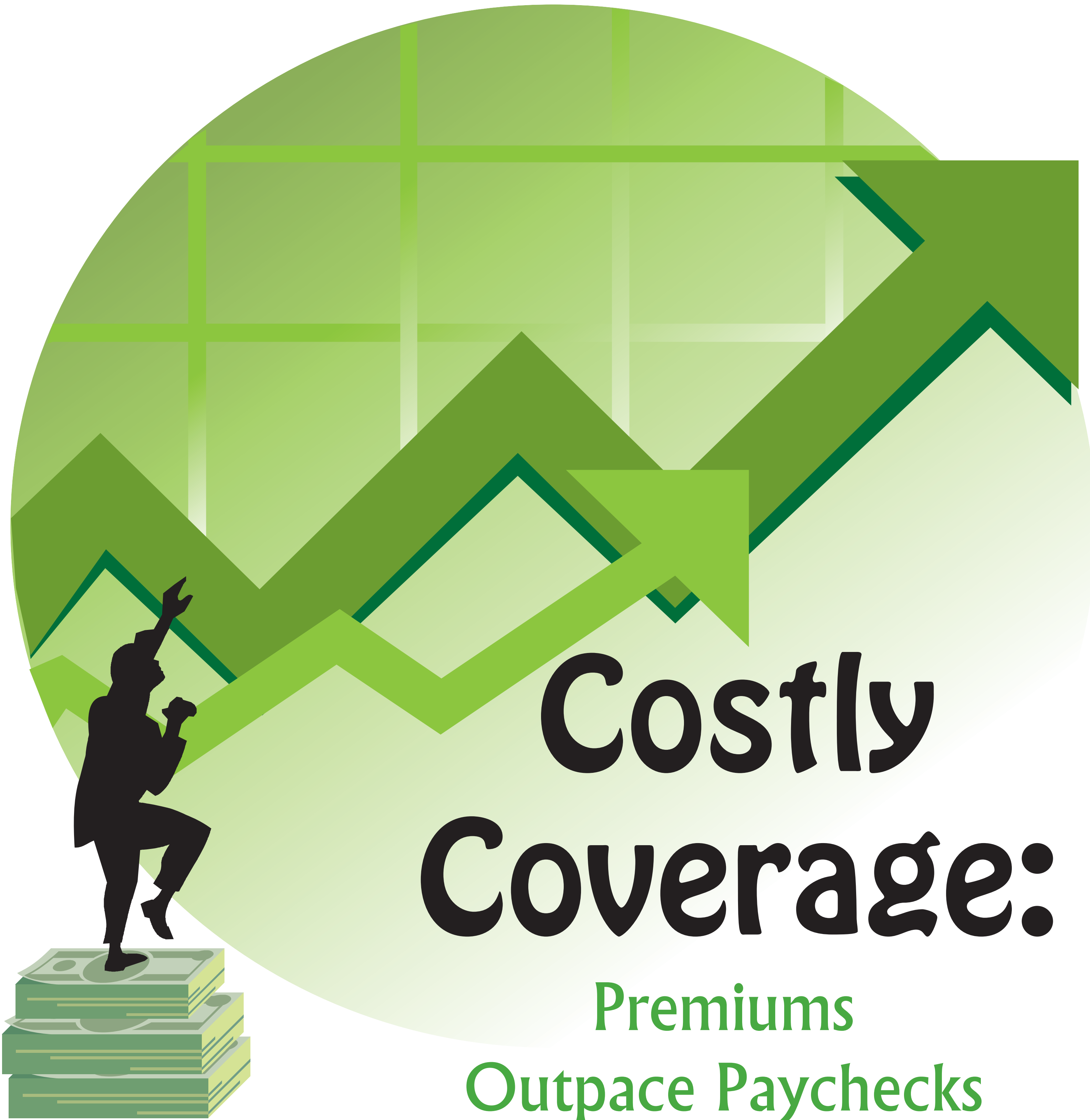

Costly Coverage:

Premiums Outpace Paychecks In Nevada

Families USA

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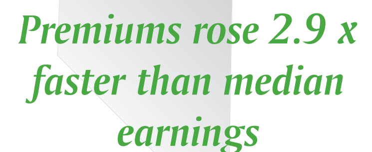
INTRODUCTION

Over the past decade, the cost of health insurance has skyrocketed, while working families' wages have merely inched upward. As the recession lingers on, this situation continues to worsen. Reduced hours and job losses have left millions of families struggling to afford their share of premiums and millions more with no coverage at all. The combination of stagnant wages and rising health care costs is placing a growing strain on family budgets, and many families have reached a breaking point. Quite simply, Nevada's families are being priced out of health coverage.

In addition to higher premiums, working families now face higher out-of-pocket health care costs, such as higher deductibles, copayments, and costs for services that are not covered by their insurance plans. As a result, health care costs are consuming an ever-larger portion of family budgets. It is clear why many Nevada families feel worse off economically than they did a decade ago.



This report, which is based on data from the U.S. Census Bureau and the U.S. Department of Health and Human Services, examines what these trends mean for Nevada's working families. Over the past decade (2000 through 2009), family health insurance premiums for Nevada's workers rose 2.9 times more quickly than median earnings. On average, health care premiums for families rose by 82.6 percent, while median earnings rose by only 28.4 percent. If nothing is done to reverse this trend, health insurance will become increasingly unaffordable for families in Nevada and across the nation.

KEY FINDINGS

Spiraling Health Insurance Premiums for Nevada's Workers and Employers (2000-2009)

- Health insurance premiums for Nevada's working families grew quickly over the last 10 years, increasing by 82.6 percent from 2000 to 2009 (Table 1).
- For *family* health coverage in Nevada, the average annual premium (employer and worker share of premiums combined) rose from $6,688 to $12,211, an increase of $5,522 (Table 1).
- For *family* health coverage in the state, the employer's portion of annual premiums rose from $5,719 to $8,413 (a difference of $2,694), while the worker's portion rose from $969 to $3,798 (a difference of $2,828) (Table 1).

Table 1

Increases in Premiums for Family Coverage in Nevada, Job-Based Health Insurance, 2000-2009

Premiums By Source of Payment	2000	2009	Dollar Change	Percent Change
Total Premium Spending per Worker (Employer and Worker Share)	$6,688	$12,211	$5,522	82.6%
Share of Premium Paid by Employer	$5,719	$8,413	$2,694	47.1%
Share of Premium Paid by Worker	$969	$3,798	$2,828	291.9%

Source: Estimates prepared by Families USA based on Medical Expenditure Panel Survey (MEPS) data.

- For *individual* health coverage in Nevada, the average annual premium (employer and worker share of premiums combined) rose from $2,578 to $4,174, an increase of $1,597 (Table 2).
- For *individual* health coverage in the state, the employer's portion of annual premiums rose from $2,349 to $3,256 (a difference of $907), while the worker's portion rose from $229 to $918 (a difference of $690) (Table 2).

Table 2

Increases in Premiums for Individual Coverage in Nevada, Job-Based Health Insurance, 2000-2009

Premiums By Source of Payment	2000	2009	Dollar Change	Percent Change
Total Premium Spending per Worker (Employer and Worker Share)	$2,578	$4,174	$1,597	61.9%
Share of Premium Paid by Employer	$2,349	$3,256	$907	38.6%
Share of Premium Paid by Worker	$229	$918	$690	301.7%

Source: Estimates prepared by Families USA based on Medical Expenditure Panel Survey (MEPS) data.

Slow Wage Growth for Nevada Workers

- Between 2000 and 2009, the median earnings of Nevada's workers rose from $25,411 to $32,635—a mere $7,224, or 28.4 percent (Table 3).
- From 2000 to 2009, health insurance premiums for Nevada's families rose 2.9 times faster than median earnings (Table 4).

Table 3

Growth in Earnings in Nevada, 2000-2009

Median Earnings		Dollar Change	Percent Change
2000	2009		
$25,411	$32,635	$7,224	28.4%

Source: Estimates by Families USA based on U.S. Census Bureau's American Community Survey (ACS) data for median worker earnings.

Table 4

Growth in Premiums in Nevada for Family Health Coverage Compared to Growth in Earnings, 2000-2009

2000-2009		Premium Increase As a Multiple of Earnings Growth
Percent Change in Total Family Premiums	Percent Change in Median Earnings	
82.6%	28.4%	2.9

Source: Estimates by Families USA.

DISCUSSION

Overview

This report analyzes trends in job-based health insurance premiums and workers' earnings over the 10-year period from the beginning of 2000 to the end of 2009. Our findings draw attention to a disheartening trend: Over the past 10 years, Nevada's working families have seen their health care costs go up significantly faster than their earnings. As a result, health insurance premiums now place a greater burden on family budgets than ever before.

Premiums for job-based health insurance have risen rapidly over the past 10 years: Health insurance premiums for Nevada's working families have risen by 82.6 percent—2.9 times faster than median earnings in Nevada (Table 4). As premiums rise, it becomes more challenging for employers to offer quality, affordable health coverage to their employees, and employers are forced to make difficult decisions about such coverage. For some employers, particularly those that operate small businesses, the cost of health insurance has simply become too high. Between 2000 and 2008, the share of U.S. firms that offered health coverage declined by 6 percentage points (from 69 percent of firms to 63 percent), with small businesses being the most likely to drop coverage.[1]

While some employers have decided that they can no longer offer coverage at all, others attempt to control health care costs by "thinning" health benefits—offering plans with higher deductibles, copayments, and co-insurance, as well as plans that cover fewer benefits.[2] Still more cut costs by placing limits on which employees are eligible for coverage or by eliminating coverage for spouses and children of employees (dependent coverage). Between 2001 and 2005, for example, a loss of dependent coverage accounted for 11 percent of the decline in job-based insurance.[3] In addition, many employers do not offer coverage to part-time, temporary, or seasonal workers.[4]

As a larger portion of health care costs is shifted onto workers, Nevada's families are finding that health care costs are consuming an ever-growing share of their budgets, and more are being priced out of coverage with every passing week. The health reform legislation currently under debate in both houses of Congress offers an opportunity to reverse this trend.

Rising Premiums, Stagnant Earnings

In Nevada, health insurance premiums for job-based health insurance rose rapidly for both individuals and families from 2000 to 2009. Average premiums rose from $2,578 to $4,174 for individuals, and from $6,688 to $12,211 for families (these numbers include both the employer and the worker share of premiums) (Tables 1 and 2). During this 10-year period, premium costs borne by workers alone for family coverage rose from $969 to $3,798 (an increase of 291.9 percent), and for individual coverage, these costs rose from $229 to $918 an increase of 301.7 percent) (Tables 1 and 2).

While health insurance premiums rose rapidly, median earnings for Nevada's workers grew slowly. As a result, average health premiums for *family* coverage rose 2.9 times faster than median earnings from 2000 to 2009 (Table 4).

Why Are Premiums Increasing So Much Faster than Earnings?

Our findings are clear: Health coverage is simply becoming too costly for Nevada's working families. Four primary factors are spurring this rapid increase in premiums. First, the amount our nation spends on health care grows each year, driven by the rising cost and increased use of health care services. Second, the health insurance marketplace currently lacks necessary oversight. In most markets, the regulation of insurance companies is weak at best, and this gives insurers an unfair advantage over consumers when it comes to the price of premiums. Third, consolidation among insurers has resulted in near monopoly power, with a small number of insurers controlling a large share of the market in much of the country. Fourth, the growing cost of care for Americans without health insurance is shifted onto those with coverage, driving up premiums even more. The health reform legislation that is currently pending in the House and the Senate would address each of these four factors, reducing the rate of increase in premiums and helping make coverage more affordable for all.

1. **Rising Health Care Spending**

Between 2000 and 2009, per capita national spending on health care will have grown from $4,789 to a projected $8,160, an increase of 70.4 percent.[5] Much of this increase can be attributed to the rising cost of treating common chronic conditions. Between 1987 and 2002, the cost of treating 20 common conditions—including diabetes, heart disease, and asthma—accounted for more than two-thirds (67 percent) of the increase in private health insurance spending.[6]

In 2005, 133 million people—nearly half of Americans—had at least one chronic condition.[7] Care for people with chronic conditions now accounts for three-quarters of U.S. health spending, with diabetes alone costing more than $174 billion annually.[8] What is more, managing these complex conditions requires coordination across a range of health care providers, including primary care physicians, specialists, and other health care professionals. Our fragmented health care system makes coordinating care among multiple providers difficult, if not impossible.

Advances in medical technologies, including the development of new drugs, devices, and procedures, have improved our ability to diagnose and treat chronic conditions. These new technologies can save money and lives when used appropriately. However, when profit motives lead to overuse of expensive technologies, patients can suffer, and health care costs increase unnecessarily.

If chronic conditions continue to become more prevalent and more costly to treat, overall health spending will continue to rise—and so will premiums.

The proposed health reform bills in the House and the Senate include measures that are intended to slow the increase in health spending, particularly spending for chronic diseases. Health reform will invest substantially in prevention, ensuring that every American has access to a range of preventive services, from cholesterol testing to cancer screenings, at low or no cost. At the same time, investments at the community level will improve public health through efforts to reduce smoking, obesity, and other risky behaviors.

In addition, the federal health reform bills include measures that will promote and offer incentives for the coordination of health care, ensuring that chronic conditions are managed appropriately. Over time, these efforts will help reduce the prevalence of chronic conditions and stop these conditions from becoming so severe that they require costly hospital or emergency care. Proper coordination of medical care can also ensure that Americans receive the newest state-of-the-art technologies and treatments based on evidence of what enhances their health. Investing in care coordination will help avert the catastrophic costs associated with treating chronic diseases that have progressed to an advanced stage.

2. An Insurance Market without Necessary Protections

Another major cause of rising premiums is the weak (or nonexistent) regulation of insurance companies. Currently, insurance companies are governed by a hodgepodge of state and federal rules. In many states, insurance companies have free rein over how much of each dollar they collect in premiums is retained as profit or spent on overhead, such as advertising and marketing.[9] In addition, in some markets, insurers are free to charge people more—or deny coverage altogether—based on age, health status, and a range of other factors.[10] Insurers in some markets may also increase premiums when people become sick, or even drop or deny coverage once an individual is ill.[11] These practices make health insurance unaffordable or unavailable for the very people who need coverage the most.

Health reform would bring significant improvements to the insurance marketplace, ensuring that consumers are treated fairly by insurance companies. For the first time, insurers will be required to sell coverage to all Americans, regardless of age, gender, or health status. They will no longer be able to deny coverage based on any of these factors. In addition, insurers will be held accountable for how they spend the premiums they collect: Every insurer will be required to spend at least a specified amount of each dollar collected in premiums on health care services. If they fail to do this, they will have to give rebates to plan enrollees. In addition, health reform will strengthen consumer protections, preventing insurers from raising premiums based on health need or revoking coverage when enrollees need it most. Together, these measures will work to ensure that every American is treated fairly and has quality health coverage at a reasonable price.

3. Too Little Competition

The problems caused by lack of insurance market regulation are compounded by the growing dominance of insurance companies in numerous markets across the country. Over the last decade or so, many insurance companies have merged. This consolidation means that there is less and less competition between insurers in many markets, leaving families with fewer plans to choose from.[12] For example, a 2008 study found that 94 percent of commercial insurance markets were "highly concentrated," resulting in near-monopoly power among insurance companies.[13] In 44 percent of major metropolitan areas, a single insurance company controls half or more of the market, and in 89 percent of major metropolitan areas, a single insurer controls at least 30 percent of the market.[14]

This lack of competition among insurers leaves families at risk, reducing the number of available plans and giving insurers even more leverage over consumers when it comes to the premiums charged. Health reform will help increase competition in the health insurance market and protect consumers in a number of ways. First, it will introduce a new marketplace, called an "exchange" or "gateway," in which families will be able to purchase health coverage. Insurers wishing to sell coverage through an exchange will be required

to provide information on benefits and out-of-pocket costs that will allow consumers to comparison shop between plans. Creating this new marketplace, coupled with increased transparency in costs and coverage, will allow consumers to better understand their plan options. And requirements that hold insurers accountable for how premium dollars are spent will help increase competition among private insurers.

In addition, the federal health reform bills may create a new public health insurance option that could compete with the plans offered by private insurers. This public insurance option would be available alongside private insurance plans within the new exchange and would meet the same requirements for transparency, plan coverage, and benefits as private plans. Creating a public insurance option would help increase competition in the insurance marketplace, thereby holding premiums down for all.

4. Costs Shifted from the Uninsured to the Insured

When millions of Americans go without health insurance, those with coverage pay the price in the form of higher health insurance premiums. How does this happen? The uninsured are placed in a difficult situation when they need care: For many, the high cost of health services causes them to delay seeking care for as long as possible. However, when a health problem becomes serious, uninsured people will go to a doctor or hospital even if they are unsure of how they will pay for these services. In 2008, the uninsured received $116 billion worth of care from hospitals, doctors, and other providers.[15]

The uninsured struggle to pay for as much of their health care as they can. In 2008, on average, they paid for more than one-third (37 percent) of the cost of the care they received out of their own pockets. Government programs and charities paid for another 26 percent of this care. The remaining amount, $42.7 billion in 2008, was left unpaid.[16] This care is referred to as "uncompensated care." To cover the costs of this uncompensated care, health care providers charge higher rates when insured people receive care, and these increases are passed on to those who have health insurance in the form of higher premiums, known as a "hidden health tax." In 2008, this hidden health tax increased premiums for family health coverage by an average of $1,017 and, for single individuals, by $368.[17]

If nothing is done to reduce the number of uninsured and the uncompensated care that is provided to them, this hidden health tax will continue to raise premiums, making coverage more and more costly for families.

Health reform would extend coverage to millions of Americans, and as people gain coverage and the number of uninsured shrinks, the amount of uncompensated care will decrease as well. This will reduce the need for doctors and hospitals to charge more to people with insurance. Insurers, in turn, will not have to pass along these costs in the form of higher premiums, and this will help make coverage less costly for all.

What Do Rising Premiums Mean for American Families?

As premiums increase and health plans cover fewer benefits, working families are shouldering a growing share of health care costs. This is exacerbated by the fact that earnings have failed to keep pace with these rising costs. As a result, more and more working families are facing catastrophic medical costs, and this burden is becoming too great to bear.

In 2009, approximately 53.2 million non-elderly Americans *with insurance* are in families that will spend more than 10 percent of their pre-tax income on health care costs.[18] In addition, 33 percent of *insured* adults report having problems with medical bills or say that they are in the process of paying off medical debt.[19]

The problem is even worse for people with high health care costs relative to their income—the "underinsured."[20] Three out of five underinsured adults (60 percent) went without needed care (such as skipping a test or treatment recommended by a doctor or not filling a prescription) because of cost in the last year.[21] In addition, 43 percent of underinsured adults reported that they were unable to pay their medical bills in the last year, and nearly half (47 percent) reported that they were paying off accrued medical debt.[22]

When the burden of high medical costs becomes too great, working families often have no choice but to make drastic changes in their lifestyle, and sometimes, they declare bankruptcy. Before resorting to bankruptcy, working families do all that they can to prevent financial ruin. One study found that, in the two years prior to filing for bankruptcy, more than 40 percent of those who file for bankruptcy lost telephone service, approximately one-fifth were unable to afford groceries, and three in five went without needed medical or dental care because of the costs associated with this care.[23] If going without these vital services is not enough to avert financial ruin, bankruptcy often becomes the only option. In 2007, nearly two-thirds (62.1 percent) of bankruptcies were due, at least in part, to medical costs.[24]

Illness, high medical costs, and the resulting financial insecurity form a vicious circle. Illness leads to higher medical costs that, in turn, lead to financial difficulties. To make matters worse, workers who face a serious illness are often forced to reduce the hours they work, causing earnings to drop. They may end up losing their jobs completely, along with the health coverage that those jobs provided. Faced with the loss of insurance, families with mounting medical debt are drawn even deeper into financial turmoil.

CONCLUSION

Over the last decade, in Nevada and across the nation, skyrocketing health insurance premiums have far outpaced the modest increases in median worker earnings. As a result, costly coverage is consuming an ever-larger portion of family budgets and causing substantial hardships. If this trend continues, more and more families will be priced out of coverage and will join the ranks of the uninsured and underinsured. This crisis will only worsen unless leaders in Washington, D.C. and in the states take decisive and meaningful action to implement health reform that will make coverage affordable and accessible to all.

ENDNOTES

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METHODOLOGY

Estimates in this report are based on data drawn from U.S. federal government sources, including the Department of Health and Human Services (HHS) and the Census Bureau. A more detailed methodology is available upon request.

Premiums

Estimates of job-based health insurance premiums are based on data from the Medical Expenditure Panel Survey (MEPS) that is conducted by the Agency for Health Care Research and Quality (which is within HHS). Premiums were trended forward from 2008 to 2009 using data on projected per capita increases in private health insurance premiums from the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary, published in *Health Affairs* on February 24, 2009.

Earnings

Estimates of median worker earnings are based on 2000 to 2007 data from the Census Bureau's American Community Survey. Earnings were trended forward to 2009 using state-specific factors derived from observed data from 2000 to 2007.

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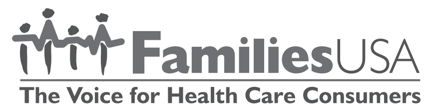

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