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TRENDS AND ISSUES

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# TRENDS IN HEALTH CARE SPENDING AND HEALTH INSURANCE

**David P. Richardson, Ph.D.**
**Principal Research Fellow**
**TIAA-CREF Institute**

## EXECUTIVE SUMMARY

Recent trends in health care and health insurance suggest market pressures continue to transform the market for health care. Rapidly rising costs of coverage for health insurance puts tremendous pressure on both private and public insurance systems, resulting in a realignment of health care risk burdens between employers, households, and government. Some main findings from this paper are:

- Over the past four decades, the growth of health care spending has outpaced overall growth in the economy, with health care spending rising from about 5 percent of GDP in 1960 to about 16 percent of GDP in 2006.
- Total financing by households is falling. In 1987, about 40 cents of health care costs were financed by households, either through premiums or out-of-pocket payments. In 2006, it is estimated that households paid only 31 cents of every dollar of spending.
- A significant proportion of health care spending is attributable to a small proportion of the population, with five percent of the population accounted for nearly 50 percent of health spending. The elderly comprise 15 percent of the population but are responsible for 34 percent of health spending.
- Nearly two out of three dollars spent on retiree health care is financed by public programs. Continued solvency issues with the Medicare program imply that future retirees may face substantially larger health care financing risk. Ensuring the continued provision of retiree health insurance as a employment based benefit requires a consolidated approach incorporating better pre-funding of employment based insurance, more cost-conscience (consumer driven) vehicles for providing a benefit, and a renewed partnership between all stakeholders regarding the allocation of financing burdens.

## INTRODUCTION

National trends in health care spending affect everyone – the insured and the uninsured, employers, employees, retirees, dependent family members, health care providers, and the financial services industry. These trends affect insured households that purchase claims on health care benefits before they know their actual demand, and uninsured households that purchase health care as they consume it. Because total system costs are distributed across different types of risk pools, conditions in one part of the market can have spillover effects in other parts of the market. This paper examines national trends in health care and discusses the effect of these trends on the retiree health care market. We show that there are growing market pressures on the continued provision of both publicly and privately sponsored retiree health insurance, increasing the health expenditure risk to future generation of retirees. Guaranteeing the continued viability of the retiree market will require innovative solutions and a renewed partnership between all stakeholders.

Over the past four decades, the growth of health care spending has outpaced overall growth in the economy, with health care spending rising from about 5 percent of GDP in 1960 to about 16 percent of GDP in 2006. Over the same time period, the financing burdens for health care have shifted significantly away from households and to the government and private insurance. In 1966, out-of-pocket spending by households accounted for about 40 cents in every dollar in health care spending, with government programs accounting for about 30 cents and private insurance about 22 cents. By 2006, out-of-pocket spending accounted for only 12 cents, with government financing covering about 47 cents and private insurance accounting for about 34 cents of every health care dollar. Even after accounting for household financed premium payments to Medicare and private insurance, it is estimated that households only bear about 31 cents of every dollar in financing burdens, a decline of about 25 percent since 1987. This low (and falling) household financing burden has raised questions about the sensitivity of households to rapidly rising health care costs and has resulted in a transition towards "consumer driven" health insurance designed to realign incentives by placing greater financing burdens on households.

These long-term trends signal the tremendous pressures on the health insurance system, both publicly provided and privately purchased. Medicare spending growth is significantly out of line with projected revenues, with Part A projected to become insolvent by 2019[1]. In the private market, employers are taking a variety of measures to reduce their own exposure to rapidly rising health insurance costs – reducing benefits, realigning cost burdens, and even dropping coverage as a benefit. Perhaps no group is at greater risk than the post-65 population; they are the biggest consumers of health care and have the greatest reliance on public and private insurance for financing these services. Overall, about 99 percent of individuals aged 65 and over rely on some form of health insurance in financing health care. About 95 percent of retirees rely on Medicare to fund some of their health care expenditures, with 9 percent also relying on Medicaid. Approximately two-thirds of retirees also rely on some form of private health insurance, with about 36 percent receiving employment based coverage and 28 percent have direct purchased insurance. Overall, about two-thirds of retiree health care spending is financed by public insurance. While the current generation of retirees may be unlikely to face coverage or benefit reductions, future generations should be preparing to pay a greater proportion of their retiree health care costs because of market pressures that are creating incentives for a radical realignment of health care burden. Understanding these trends and market pressures both informs decisions and constrains the choices available to households and employers to ensuring that health insurance remains an integral part of employees' and retirees' benefit package.

1 Medicare Trustees (2008)

## TRENDS IN NATIONAL HEALTH CARE SPENDING AND FINANCE

Health care spending in the United States has been growing rapidly for over 45 years, both in real terms and as a share of Gross Domestic Product (GDP). Taken alone, this rapid growth should not be considered a problem as long as the market is functioning properly and households continue to value increased health care consumption relative to other goods. However, maintaining the current growth rate of health care spending is not sustainable. The Congressional Budget Office (CBO, 2007) demonstrates that, using simple projections of current growth rates, health care spending will be almost 100 percent of gross domestic product (GDP) by 2082. Using more conservative growth rates, the CBO estimates that health spending will be at about half of GDP by 2082. While these estimates may prove unrealistic, understanding national trends is important because they demonstrate that health care spending is creating market pressures–particularly in the market for employer sponsored health insurance–that in turn create incentives for substantial changes in health care spending and financing. These pressures will likely result in realignments of both the relative financing obligations and the risk burdens of health care between households, employers, and the government.

### TRENDS IN HEALTH CARE SPENDING

Figure 1 shows health care spending as a percentage of GDP. Between 1960 and 2006, health care spending as a percent of GDP increased from about 5 cents to about 16 cents of every dollar of GDP. Measured in constant 2006 dollars, in 1960 we spent about $152 billion, on health care. By comparison, we spent approximately $1.02 trillion and $2.11 trillion on health care in 1990 and 2006, respectively. Note that about 43 percent of the total increase occurred in the 14 year period between 1980 and 1993. The next 7 years saw no growth in spending relative to GDP. After a brief period of strong growth between 2001 and 2003, the share of GDP devoted to health care has stabilized at about 16 percent of GDP.

What changed in the early 1990s to slow the growth of health care? Part of the answer is a fundamental change in the way health insurance contracts are underwritten. Figure 2 shows that as recently as 1988, roughly 3 out of 4 workers were covered by a conventional fee-for-service plan, with the remainder covered by some type of managed care plan. By 2000, only 8 in 100 were covered by a conventional plan and by 2005 only 3 in 100 were by a conventional plan. The almost total transition into managed care contracts helps control spending in a number of ways, from offering incentives for health/wellness checks, to steering participants to less costly but equally effective methods of care, or by making participants more cost conscience in their health care decisions. This change has also been attempted in the Medicare program, with the addition of Medicare + Choice (Part C) in 1997, though with substantially less take-up.[2]

To gain a better understanding on the sources of spending growth, it is useful to consider the distribution of health care spending. Figure 3 shows that in 2005, the incidence of health care spending was unevenly distributed across the population, with 20 percent of individuals (households) responsible for about 80 percent (68 percent) of spending and with 50 percent of individuals (households) responsible for about 97 percent (92 percent) of health care spending. The distribution also shows the impact of catastrophic care, with 5 percent of individuals responsible for about 49 percent of spending.

Figure 4 shows spending by age cohort over the period 1987 to 2004. While spending by age cohort appears relatively stable over time, these percentages do not take into account differences in the size of the age cohort. For example, in 2004 the youngest cohort (aged 0 to 18) accounted for about 13 percent of health care spending but represented about 32 percent of the population. By comparison, the oldest cohort (aged 65 and older) accounted for about 34 percent of the spending but represented only 15 percent of the population. On per capita basis, the oldest cohort spends on average about 5.6 times as much as the youngest cohort and about 3.3 times as much as the middle cohort.

2 This part of the program is now known as Medicare Advantage.

Given the rapid growth and uneven distribution of health care spending, are there certain types of health care spending that drive overall spending growth? Figure 5 shows the share of each health care dollar devoted to certain types of spending over the period 1965 to 2006. Spending on health care services (physician and clinical services) and nursing home care has been very stable since 1965. In contrast, the proportion of spending on hospital care has fallen significantly since 1975, due in part to innovations in managed care that reduced the frequency and length of unnecessary in-patient hospital visits.[3] Other types of spending, such as program administration, home health care, dental care, and other professional services, have been stable since 1975. The one area of significant increase is prescription drug spending, which is predicted to double between 1975 and 2016. Overall, the percent of spending devoted to inpatient care, physician services, and prescription drugs has remained fairly constant over time at around 60 to 65 percent, with the percentage devoted to prescription drugs becoming relatively more important as a component of health care spending.

Prescription drug spending differs from most other health spending in important ways. First, prescription drugs are a product as opposed to a service. This means the underlying cost drivers are different from those found in the rest of the industry. Second, prescription drug spending has historically has been financed more by household out-of-pocket spending relative to other health care spending, tending to make households relatively more sensitive to drug prices. Third, until recently, public spending on prescription drugs has been minimal. The addition of a prescription drug benefit to the Medicare program brings a massive shift in spending from private to public sources, with the risk of reducing the price sensitivity which retirees and plan sponsors have demonstrated in the past.

Overall, the national trends have been an increasing share of total income devoted to health spending, with a small proportion of the population accounting for the majority of the cost. While the transition to managed care contracts has moderated the growth rate of spending, there continues to be increased budget pressure on households, business sponsors, and the government, with each sector facing different constraints in meeting this obligation.

## TRENDS IN HEALTH CARE FINANCE

Three groups bear responsibility for financing health care – households, businesses, and the government. How these burdens are allocated affects incentives for the demand for health care, the demand for and continued provision of employer sponsored insurance, and the long-run viability of both public and privately provided health insurance. Understanding financing trends is important because changes in these relative burdens affect all market participants.

Figure 6 provides information on sources of health care financing for the period of 1966 to 2006.[4] The broad categories are out-of-pocket, private insurance, other private, Medicare, Medicaid, and other public. Out-of-pocket is household health spending not covered by insurance. Private insurance are premiums paid by businesses, households, and governments for private household health insurance. Other private includes industrial in-plant, philanthropy, and other non-patient revenues. Medicare includes contributions by businesses, households, and governments, whereas Medicaid includes only government payments. Other public is a panoply of programs including vocational rehabilitation, substance abuse programs, Indian health services, Department of Defense, Department of Veteran Affairs, public health activities, state/local workers' compensation, temporary disability insurance, and other miscellaneous programs.

In 1966, household out-of-pocket spending accounted for about 40 cents of every dollar for health spending. Medicare, Medicaid, and private insurance paid about 30 cents of every dollar, with the remainder coming from other public and private sources. Over the next 40 years, the proportion of health spending financed out-of-pocket by households

3 Current projections provided in the Medicare Trustees (2008) report assume that managed care will continue to control growth of hospital spending both through utilization and through relative price inflation.

4 The year 1966 is notable as the first year of expenditures for the Medicare and Medicaid programs.

fell significantly and was replaced by a mixture of privately and publicly financed insurance–to the point where only about 12 cents on the dollar is financed out-of-pocket by households and about 70 cents is financed by private insurance, Medicare, and Medicaid. This large shift in financing burdens is very important if it causes a loss in households' sensitivity to health care costs.

Figure 7 provides information on financing burdens by broad category of payer – households, private businesses, and government.[5] Direct household financing, either to premium or out-of-pocket payments, has fallen about 25 percent over the past 20 years, from about 40 cents to about 31 cents of every dollar of spending on health services and supplies.[6] By comparison, private business spending has been steady at about 25 cents per dollar while other private (philanthropy), has fallen from about 5 cents to 3 cents per dollar. These reductions mean that government financing burdens of health care have risen dramatically, from about 29 cents to 41 cents of every dollar spent on health services and supplies. Over this time period, state and local spending has risen slightly, from about 15 cents to about 17 cents per dollar, with the remaining growth attributable to Medicare, Medicaid, and other federal health programs. This trend increases the substantial pressure on the viability of federal programs. For example, the Medicare Trust fund is projected to become insolvent in 2018, and many states are reducing Medicaid benefits due to budget priorities.

The long-term trends in health care spending and financing indicate that direct household financing burdens have fallen substantially during a time period when household demand for health services has risen dramatically. The shift in financing burdens away from the private sector and to the government places considerable stress on federal programs designed to insure the adequacy and availability of health care. The growing financial instability of the Medicare and Medicaid programs expose households to increasing expenditure risk, especially for the post-65 population that rely most heavily on government programs.

## TRENDS IN HEALTH INSURANCE

This section discusses national trends in coverage and the cost of coverage for health insurance. The previous section showed that the long-term trend has been for health insurance to bear a progressively larger burden in financing health care. As more of the cost is shifted onto the cost of coverage, the pressure from rapid premium growth has created tremendous stress on employment based health insurance, with a resulting decline in employment based coverage throughout the economy. This effect is most pronounced in the market for retiree health insurance, with private firms dramatically reducing benefits or terminating coverage.

### PREMIUMS

A major challenge with sustaining a competitive, solvent market for health insurance is loss of coverage due to rapidly increasing premiums. Figure 8 shows the growth of health insurance premiums relative to wage growth, overall inflation, and average health care expenditures. While wage growth and inflation have been consistently in the range to 2 to 5 percent per year, average premium growth was below 5 percent in only one year, 1993. Premium inflation tends to follow trends in spending, with rapid growth in the 1980s, followed by an easing of market pressures in the 1990s, and an increase in the early 2000s. Note that premium inflation has also far outpaced growth in per capita health expenditures in all periods except the late 1990s. One explanation given for this trend is that health expenditures are primarily financed through insurance payments (as opposed to out-of-pocket payments), then

5 Household obligations include premiums to employer sponsored and individually purchased health insurance, one-half of employee taxes and total self-employment taxes to Medicare Part A, premiums paid to Medicare Part B, and out-of-pocket health spending. Private business spending includes employer contributions to private health insurance premiums and to Medicare Part A, contributions to workers compensation and temporary disability insurance, and industrial in-plant health services. Government spending includes employer contributions to private health insurance and Medicare Part A, adjusted Medicare payments, Medicaid payments, and other health program expenditures

6 Health services and supplies comprise about 96 percent of total health spending.

7 A study by Families USA (2005) estimates that by 2010 the uninsured will add about $1,500 to the cost of coverage for a family health insurance policy.

premiums must cover most expenditures for both the insured and uninsured populations.[7] The result is that premium growth averaged 9.9 percent but per capita health expenditures only averaged 6.3 percent over the 1999 to 2006 period. The strong growth of premiums puts pressure on labor compensation, impacting the structure of wages and benefits for both workers and retirees. It also places tremendous pressure on retiree health insurance benefits because employers cannot trade-off cash for benefits as with active employees. Employers must make a decision between reducing the generosity of retiree health insurance benefits, reducing the generosity of other benefits, or reducing the generosity of employee compensation (cash and benefits).

### HEALTH INSURANCE COVERAGE

Figure 9 shows recent trends in coverage rates for the US population for the 1999 to 2006 period. Coverage has declined slightly over the past seven years, falling from 86 percent to 84.2 percent coverage. The trend in the underlying structure of coverage suggests a shifting in risk burdens, with private coverage falling by about 4.6 percentage points and government coverage increasing by about 2.5 percentage points.[8] This shift in coverage increases pressure on government programs and shifts financing risk to insured households.

Figure 10 shows coverage rates for non-elderly age cohorts (ages under 65) over the 1999 to 2006 period. Coverage for the non-elderly population has declined for all age cohorts with the exception of children under the age of 18. Of particular interest is the large decline in coverage for those aged 18 to 24 relative to when this group is under 18. In 2006, about 1 in 5 adults lost coverage between the age 18 and 24. It then takes a working lifetime for an age cohort to collectively make up the loss in coverage, with those aged 55 to 64 having coverage rates approximately the same as the youngest cohort. There has also been a shift in risk burdens away from privately provided insurance and towards government sponsored insurance, with the strongest shift has been for those under 18, with a decline in private coverage of about 5.5 percentage points but an increase in government coverage of about 6.8 percentage points. Overall, the trend in non-elderly coverage is a steady shift in risk burdens away from employers and towards households and government.

The need for health insurance coverage for the elderly (aged 65 and over) is different from the rest of the population because of the likelihood of more frequent and intense utilization, resulting in greater risk of large negative wealth shocks for a retired household. The Medicare system was created in the mid-1960s, partly due to concerns over the ability of the private market to adequately cover the elderly population. As a result, the elderly have the highest coverage rates in the economy. Figure 11 shows that health insurance coverage is almost universal for the elderly population. While overall coverage remains high at about 99 percent in 2006, coverage has fallen slightly for both for government and private sponsored insurance coverage. Overall, coverage rates indicate continued reliance on government programs as the primary source of coverage, with fewer than 2 out of 3 individuals covered by some form of private, supplemental insurance.

## THE RETIREE HEALTH CARE MARKET: A CLOSER LOOK

Despite the highest insurance coverage rates of any age demographic, perhaps no group is more at risk to adverse health care market pressures than retirees. This relatively higher risk is based on the potential of a perfect storm for retirees and near retirees–the financial stresses on the Medicare and Medicaid systems, the steady decline in both the coverage and generosity (for those who retain coverage) of employer sponsored health insurance coverage, and continuously high medical inflation. All of these factors work to shift more of the risk burdens of retiree health care onto aged households.[9] This section of the paper focuses on sources of coverage and financing for the post-65 population and discusses current market pressures that continue to affect the market.

8 The private and government totals do not sum to total coverage because some individuals are covered by both a private and a government plan.

9 These include funding, investment, longevity, and morbidity risks.

## NATIONAL TRENDS IN AVERAGE RETIREE HEALTH CARE SPENDING

Health care spending rises, on average, with age. This is particularly true of the post-65 population, with the frequency and intensity of health services rising with age. Two trends are evident in Figure 12, which presents data on average personal health care spending by the post-65 population. First, real average spending has grown sharply for various age cohorts. Between 1987 and 1996, real average spending increased by about 40 percent for those aged 65 – 74, and about 45 percent for the older cohorts. Between 1996 and 2004, real average spending increased about 29 percent for the 65 – 74 age cohort, with real average spending increases of 26 percent and 13 percent for the 75- 84 and 85+ groups. Second, average spending rises sharply with age. In 2004, for example, average spending by those aged 65 – 74 and 75 – 84 was about 42 percent and 64 percent of average spending for the post-85 population. These averages highlight the importance of adequate financial resources for meeting health care needs in retirement, particularly given the current financing pressures on the Medicare system, with Part A projected by become insolvent by 2018, and with short run estimates of total system spending exceeding total Medicare revenues by an amount that legally requires Congress to enact solvency preserving legislation–either increasing revenues or reducing benefits.[10]

## NATIONAL TRENDS IN RETIREE HEALTH CARE SOURCES OF FINANCE

Retirees have three main sources of finance for health care – public insurance (Medicare and Medicaid), private insurance (Employer sponsored and direct purchase), and other household resources. Figure 13 shows the relative importance of these sources over the past 20 years. Several interesting trends emerge. First, the oldest elderly (85+) have consistently had the greatest out-of-pocket burden of any retiree group. Second, each age group has become more reliant on public insurance to finance health care. The most pronounced changes have been for the oldest retirees with an almost 14 percent increase in reliance on public funds between 1987 and 2004. Third, the impact of Medicaid has changed substantially for the youngest and oldest retirees. The youngest retirees have significantly increased reliance on Medicaid funds while reducing reliance on private funds. Surprisingly, the reverse trend holds for the oldest retirees, with a noticeable decline in reliance on Medicaid finance.

Public funds currently finance about 70 percent of health care expenditures for the Medicare eligible population. This increased reliance on public insurance may be viewed as creating large unfunded liabilities for retirees (or society in general) given that neither Medicare nor Medicaid is a fully funded system.[11] This problem is compounded by the longer term trend in lower out-of-pocket finance by retirees, which reduces retirees' price sensitivity to health care services. Given the lack of sustainability of these retiree health care trends, one likely result is increased future funding risk for all retirees, suggesting a need for current workers to begin pre-funding (through private markets and employer sponsored trusts) of these future higher risk exposures.

## RECENT TRENDS IN RETIREE HEALTH INSURANCE COVERAGE

Almost all retirees are now covered by some type of health insurance. As shown in Figure 11, over 98 percent are covered by some type of health insurance, with about 95 percent having government sponsored insurance, and about 61 percent with some form of private coverage. While in the longer run, employer sponsored retiree health insurance coverage has fallen by about half, Figure 14 shows that employment based coverage has been stable the past decade. By contrast, the percentage covered by direct purchase has fallen significantly. However, part of this effect may be due to the introduction of Medicare Advantage plans.

10 The Medicare Trustees are required to issue a funding warning if the 45 percent standard in not met for two consecutive years. In response, the President is required to submit solvency legislation to Congress, which must consider the legislation on an expedited basis.

11 A system is fully funded if it has assets sufficient to cover the present discounted value of expected future liabilities.

## HEALTH COSTS IN THE RETIREE MARKET

A major concern for many retirees is being able to afford health insurance throughout retirement. For most retirees, Medicare is the primary insurance provider, with other forms of insurance providing supplemental coverage. Even with Medicare, the costs of health care represent a substantial burden for many retirees. A recent study by Fronstein, Salisbury, and VanDerHei (2008) estimates that a couple aged 65 in 2008 needs at least $194,000 to cover premiums and out-of pocket costs if using a combination of Medicare and a Medicare supplemental policy. For couples with employer sponsored retiree health insurance, at least $154,000 is needed.

For those with employer sponsored retiree health insurance, the cost of coverage varies significantly between the pre-65 and the Medicare-eligible populations. The reason is that employer sponsored retiree health insurance is the primary source of coverage for the pre-65 group, whereas employer sponsored insurance is the supplemental payer for the Medicare eligible population. According to a Kaiser-Hewitt study (2006), in 2006 the average premiums the largest private employer plans were $552 and $270 per month for the pre-65 and Medicare eligible retirees, respectively. These average coverage costs were about 15 percent and 9.6 percent higher than the previous year for rates were pre-65 and Medicare eligible retirees, respectively. For both groups, the financing was shared, on average, about 59 percent by the employer and 41 percent by the beneficiary.

The growth in the retiree health care spending has outpaced growth in retiree incomes. According to a recent study by Neuman et.al. (2007), median out-of-pocket spending by Medicare beneficiaries increased from about 12 percent to about 15.5 percent of income between 1997 and 2003. The quartile of beneficiaries with the largest burdens spent at least 30 percent of their incomes on health care in 2003. Overall, the trends in cost of coverage and spending, coupled with the solvency issues and costs stresses on public and private insurance sources, highlight the need for current workers to begin accumulating assets solely for expected increases in financing burdens for retiree health care expenses.

## RECENT TRENDS IN ACADEMIC AND PRIVATE SECTOR RETIREE HEALTH INSURANCE

The Academic and Large Private Employer sectors are two segments of the economy that continue to have high coverage rates for retiree health insurance benefits. However, these sectors are moving in different directions regarding the continued provision of this very important employee benefit. These differences may be attributable to varying sources – labor market pressures, government policies, and employer objectives. Overall, the academic sector, relative to large private sector firms, has adopted or planned fewer changes to the retiree health insurance benefit. While there may be important differences in underlying incentives, the academic sector is confronted with the same pressures to begin pre-funding of future retiree health insurance liabilities, the same issues of scale and scope, and the same set of market opportunities.

Figure 15 presents coverage rates for faculty retiree health insurance in 2006. About 80 percent of institutions offer some form of continued health insurance coverage (not including COBRA) for eligible retired faculty and their spouse, with a significantly smaller proportion provided health insurance coverage to other beneficiaries. Of those covered, over 80 percent of institutions provide medical coverage, with significantly smaller numbers offering vision (42 percent), dental (56 percent) and long-term care (37 percent).

Cost sharing burdens for coverage fall primarily on the covered retiree. As shown in Figure 16, about 83 percent of institutions require retirees to pay some or all of their medical coverage, with over 95 percent of institutions requiring retirees to pay at least part of the coverage for other covered lives. Cost sharing arrangements for other health care benefits are even less generous, with about 92 percent of institutions requiring retirees to contribute to the cost of vision and dental coverage and about 96 percent requiring retirees to pay 100 percent of the premium for long-term care insurance.

Even in the face of consistent market pressures, most institutions have maintained the relative value of their retiree health insurance benefits over the 2000 to 2006 period.

Figure 17 provides information on how retiree health insurance benefits have changed relative to employee benefits since 2000. About 45 percent of institutions report no change in either group's benefit whereas about 26 percent of institutions have decreased the generosity of both group's benefit. Fewer than 1 in 10 institutions had reduced the generosity of retiree health insurance benefits relative to active employee benefits. Perhaps more surprising are the number of institutions that are planning changes to the generosity of retiree health insurance benefits. As shown in Figure 18, only about one in ten responding institutions had plans to decrease the generosity of benefits, with 87 percent of institutions planning on maintaining retiree health insurance premiums at their current level.

These recent trends in the higher education sector stand in stark contrast to how large private sector firms are responding to national trends and market forces. According to a recent Kaiser-HRET study (2008), about 99 percent of large firms and 59 percent of small firms offer health insurance benefits to employees. Of those offering health insurance to active employees, about 33 percent of large employers and only 5 percent of small employers offer a retiree health benefit. Large private sector firms have also been more active in reducing the generosity of retiree health insurance benefits, with a recent Kaiser-Hewitt study (2006) indicating that about 90 percent of large private sector employers reduced the generosity of retiree benefits between 2005 and 2006. These employers have used a variety of methods to shift risk away from the firm and onto employees and retirees. The most common methods are to shift more of the burden of financing the cost of coverage onto retirees and by increasing the amount that retirees are expected to pay out-of-pocket for their health care. At the extreme end, about one in ten large employers terminated all subsidized health insurance benefits for future retirees. The implication is that private sector employers are rapidly reducing their own risk exposure by shifting retiree health care risks onto their current and future retirees.

## CONCLUSIONS

Trends in health care and health insurance suggest there are market pressures that will radically transform the market for health care. Rapidly rising costs of coverage for health insurance puts tremendous pressure on both private and public insurance systems, resulting in a transfer of health care risks away from employers and government and onto households. The continued solvency problems of the Medicare system increase the likelihood that millions of current and future retirees will bear more of the funding risk of future health care expenses. In addition, recent FASB and GASB changes regarding the reporting of retiree health liabilities highlights the funding crisis of employer sponsored plans.[12]

Recently, a number of public policy proposals have focused on realigning health care burdens. Some proposals call for realigning tax incentives to provide more government subsidies for direct purchase insurance. Other proposals call for various forms of universal insurance coverage, with the hope of slowing growth of the cost of coverage while improving health outcomes. Regardless of what proposals are passed and in what form, ensuring the continued provision of retiree health insurance as a employment based benefit requires a consolidated approach incorporating better pre-funding of employment based insurance, more cost-conscience (consumer driven) vehicles for providing a benefit, and a renewed partnership between all stakeholders regarding the allocation of funding burdens.

Employers can achieve these objectives in the absence of government mandates by establishing fully-funded health care trusts that provide flexibility in funding, investments, and distributions for participants. By establishing a separate trust solely for health care expenses, employers provide a mechanism for ensuring that retiree health care costs are covered while realigning and capitating some of the employers own market risk.

12 See Clark (2008a, 2008b) for a good discussion of the impact of GASB on public systems.

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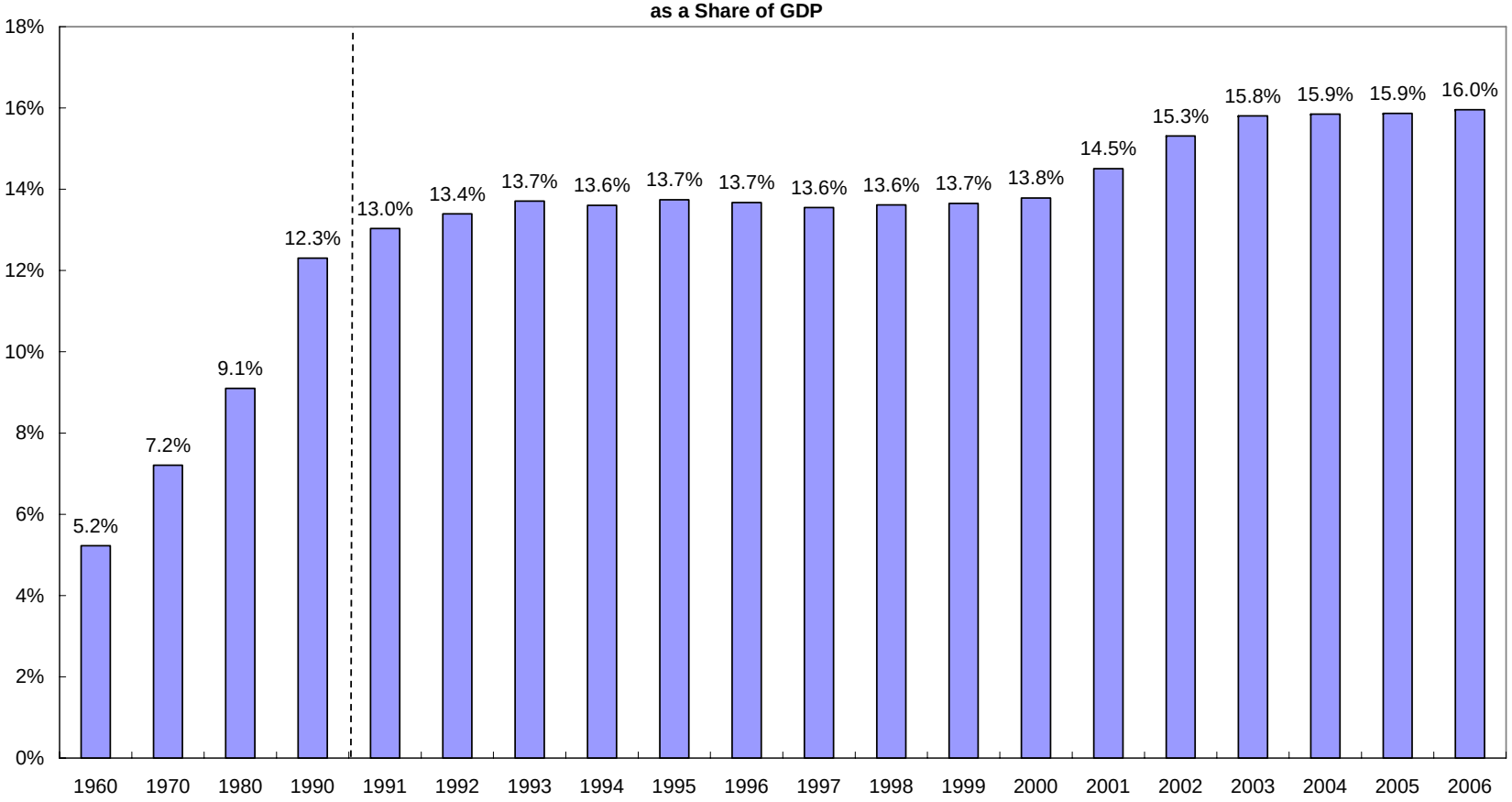
## ABOUT THE AUTHOR

David P. Richardson is a Principal Research Fellow at the TIAA-CREF Institute. Prior to joining the Institute, he served as Senior Economist for Public Finance at the White House Council of Economic Advisers and held the New York Life Chair in Risk Management and Insurance at Georgia State University. Previously, Dr. Richardson worked as a Financial Economist in the Office of Tax Policy at the U.S. Treasury, and was an assistant professor in the Department of Economics at Davidson College. His research interests focus on public pensions, employer plans, and household financial security, including retirement preparedness, retiree health care, and the allocation of retirement risk burdens.

**Figure 1**

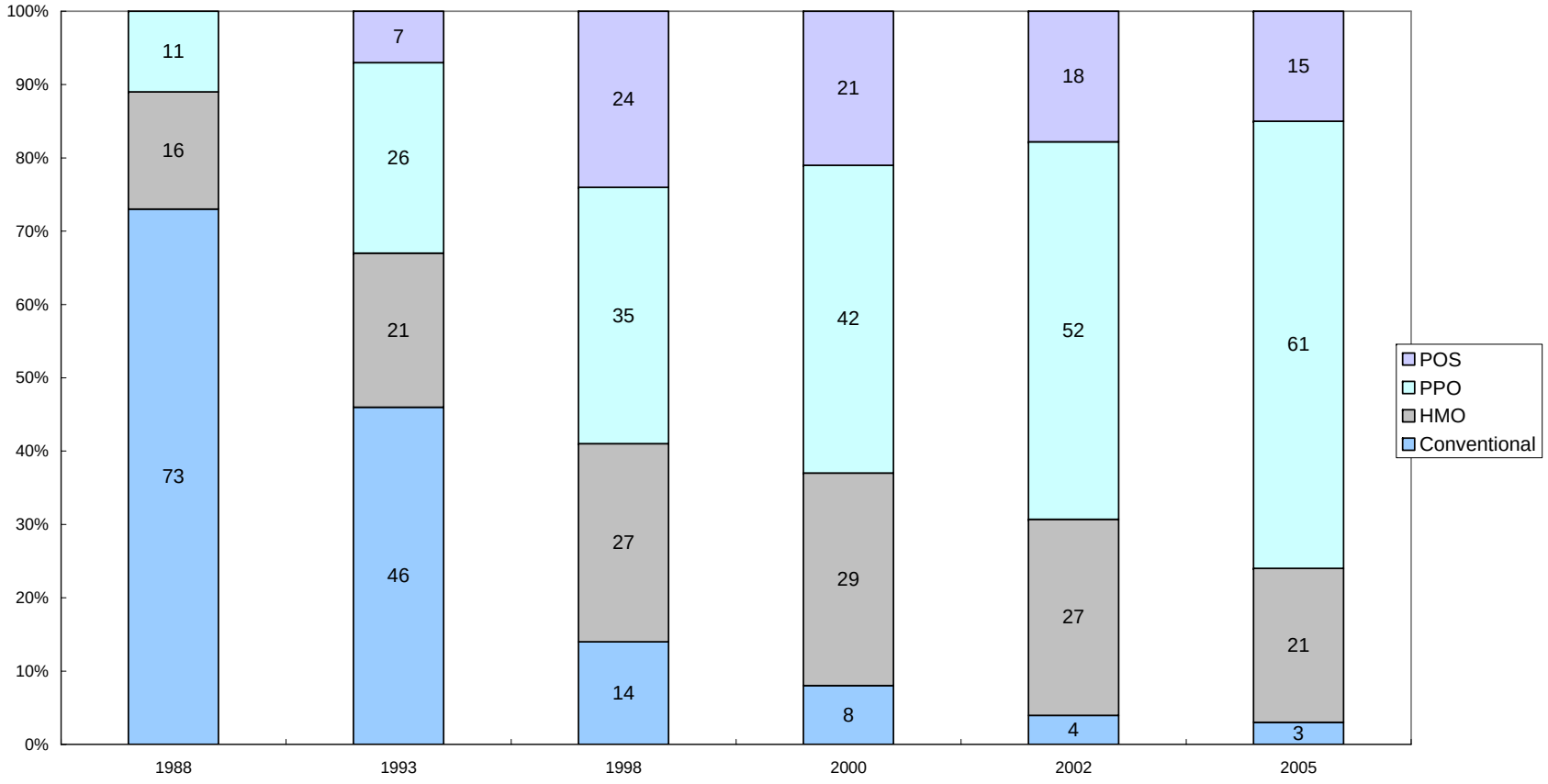
**National Health Expenditures**

**as a Share of GDP**



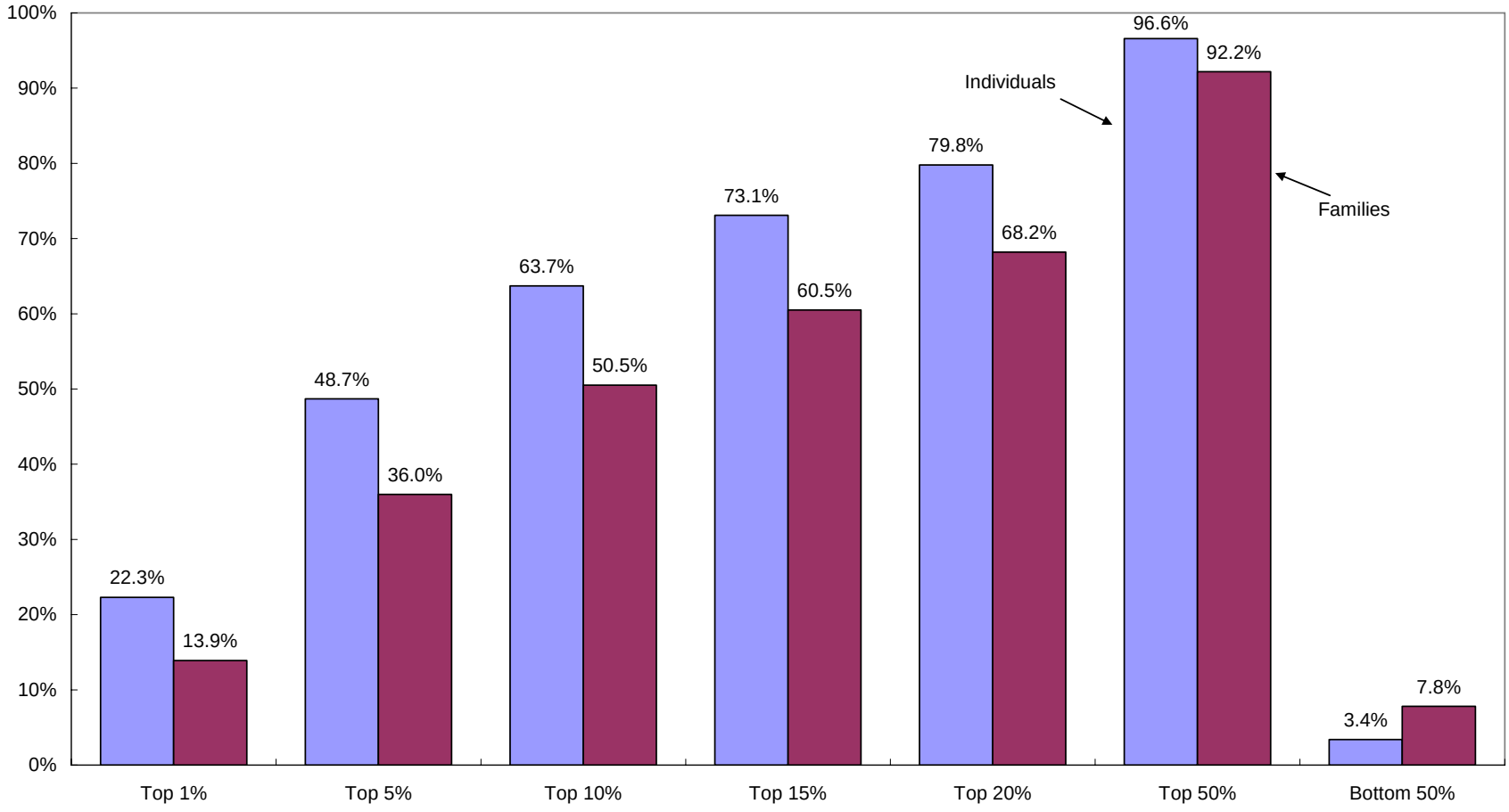

Source: Center for Medicare and Medicaid Services, National Health Expenditures Data

**Figure 2**
**Participation in Employment Based Coverage**
**by Type of Insurance Plan**



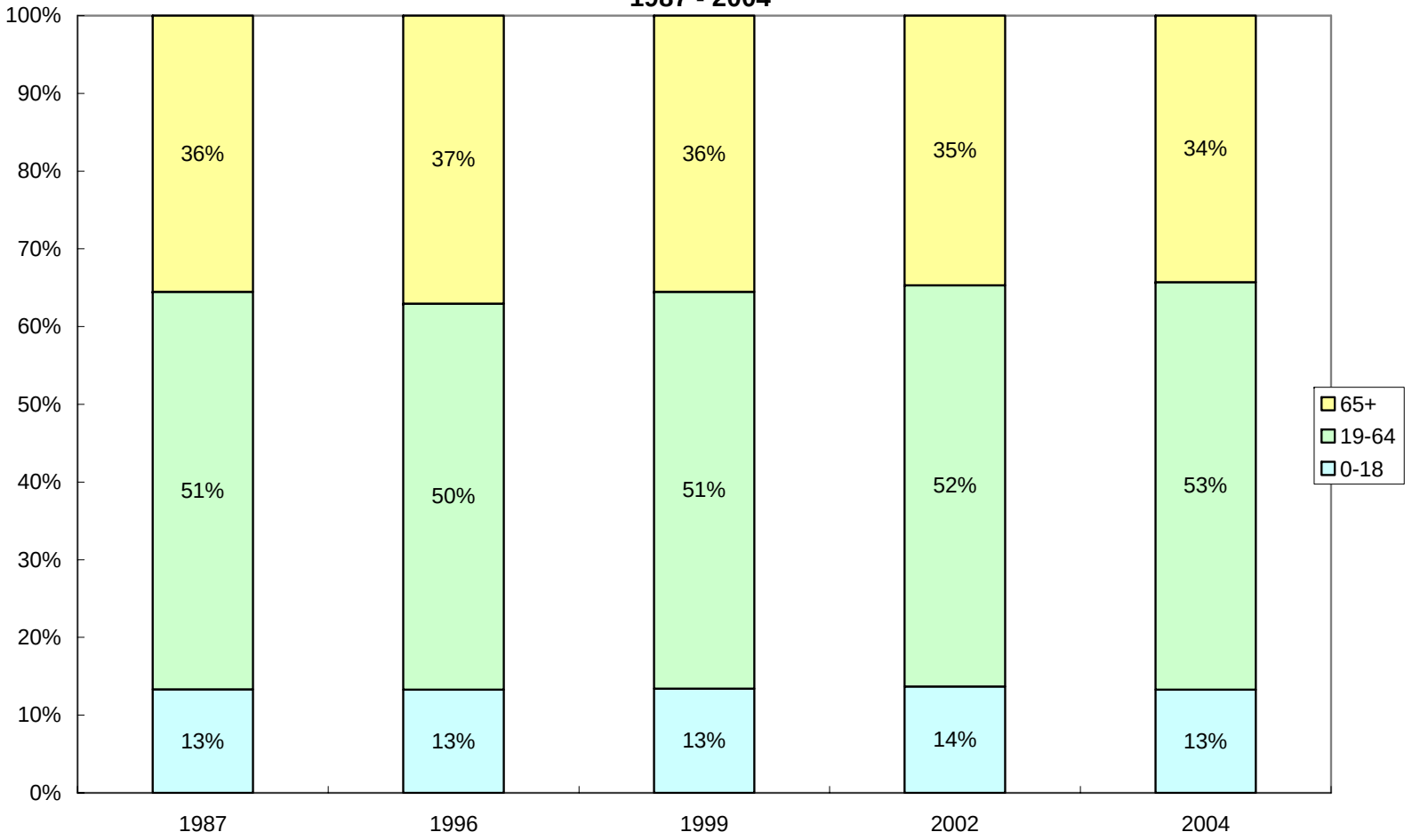

Source: Kaiser Family Foundation: Trends and Indicators in the Changing Health Care Marketplace

**Figure 3**
**Concentration of Health Spending in 2005**



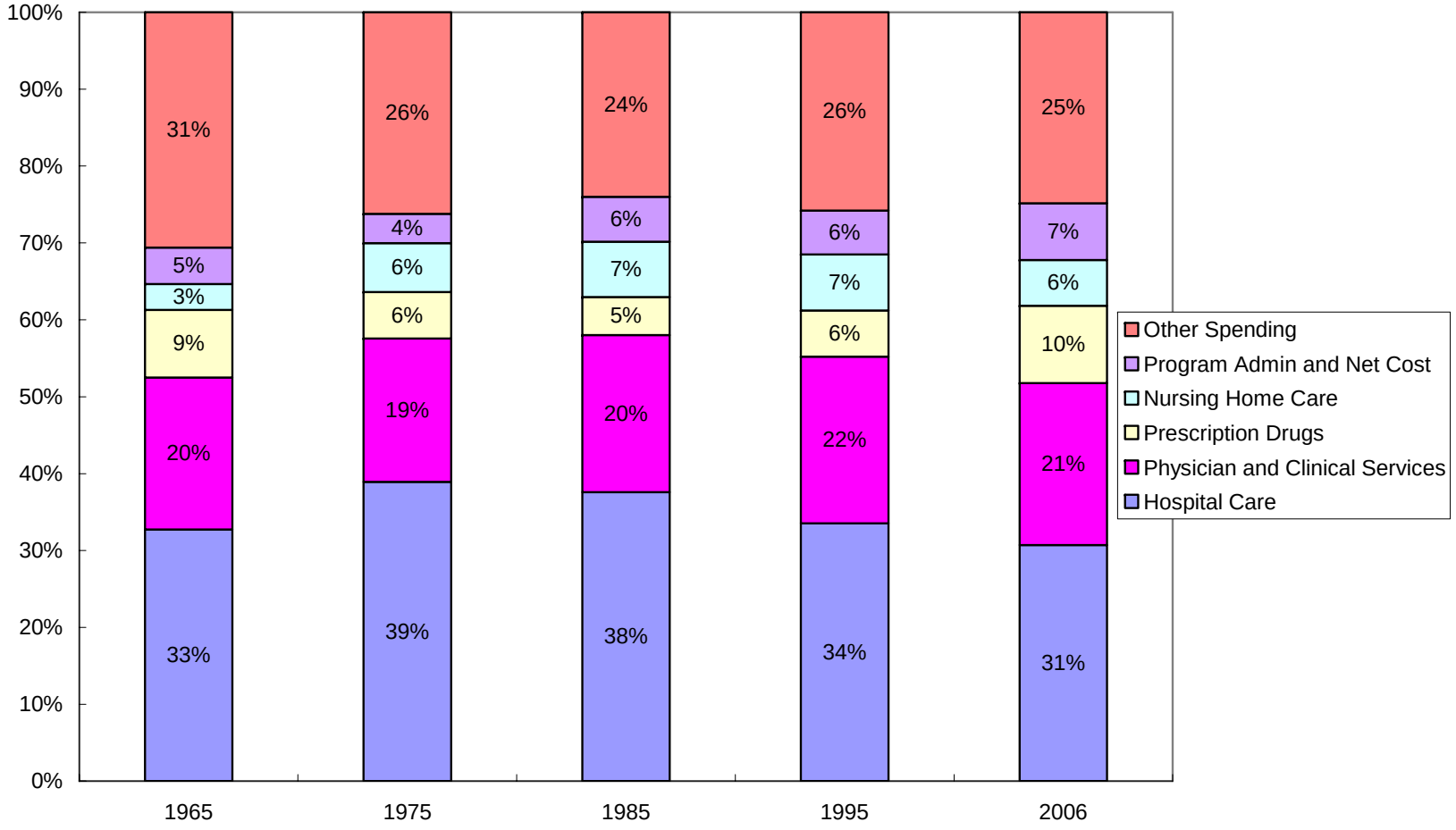

Source: Department of Health and Human Services: Medical Expenditure Panel Survey

**Figure 4**
**Percent of Total Health Care Spending by Age Group**
**1987 - 2004**



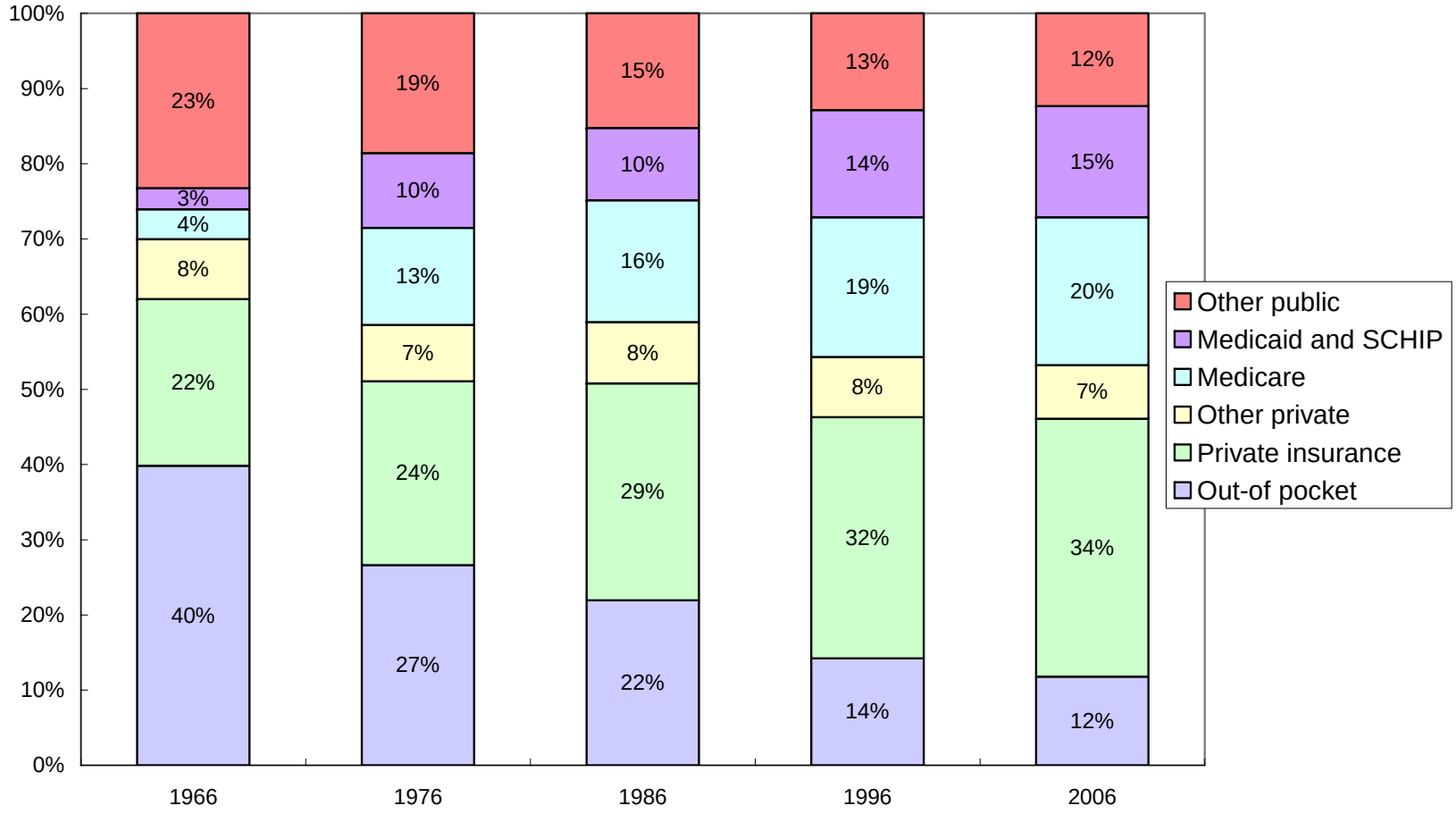

Source: Center for Medicare and Medicaid Services, National Health Expenditures Data

**Figure 5**
**Sources of Health Care Spending**
**1965 - 2006**



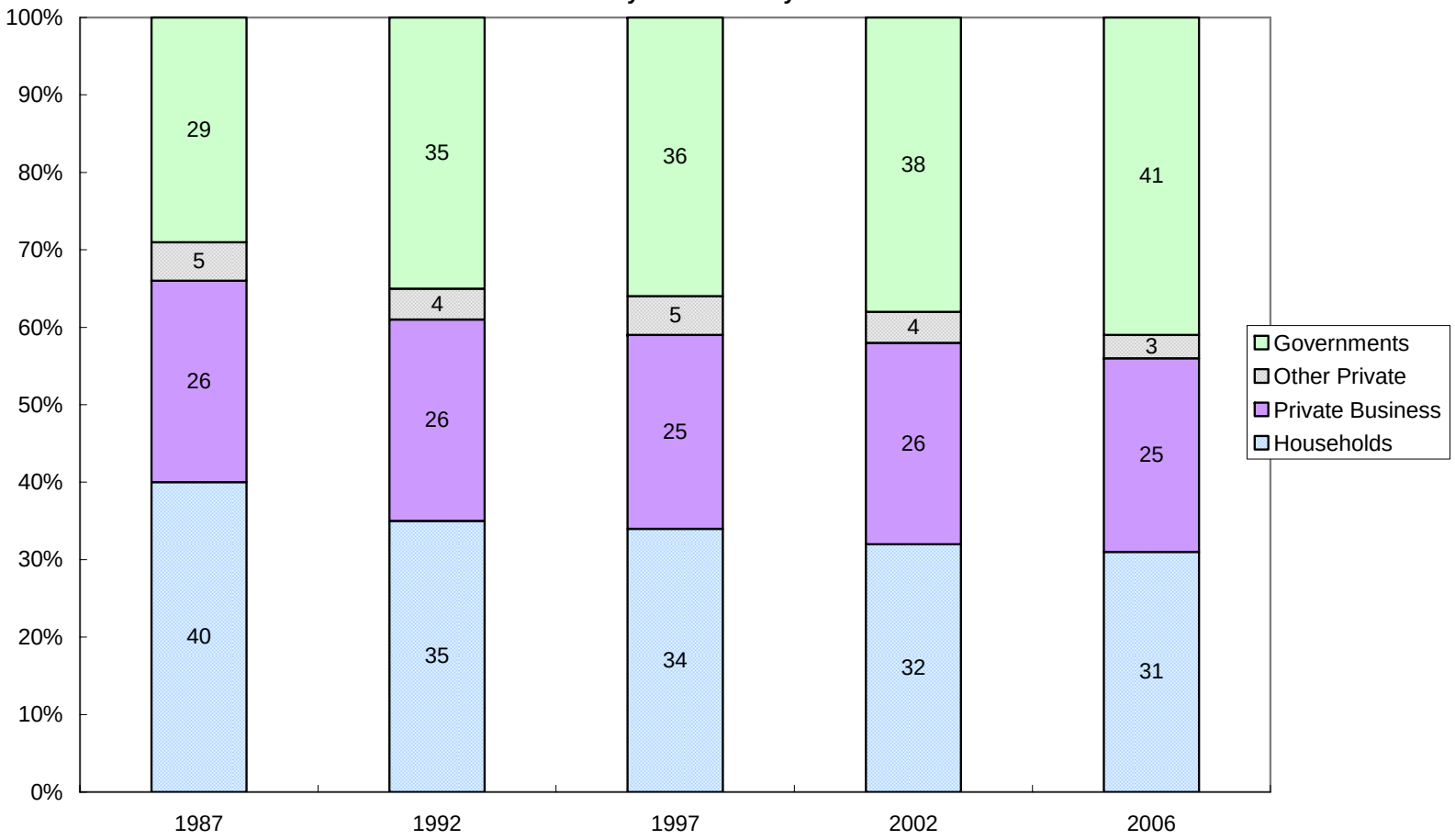

Source: Center for Medicare and Medicaid Services, National Health Expenditures Data

**Figure 6**
**Sources of Health Care Financing**
**1966 to 2016**



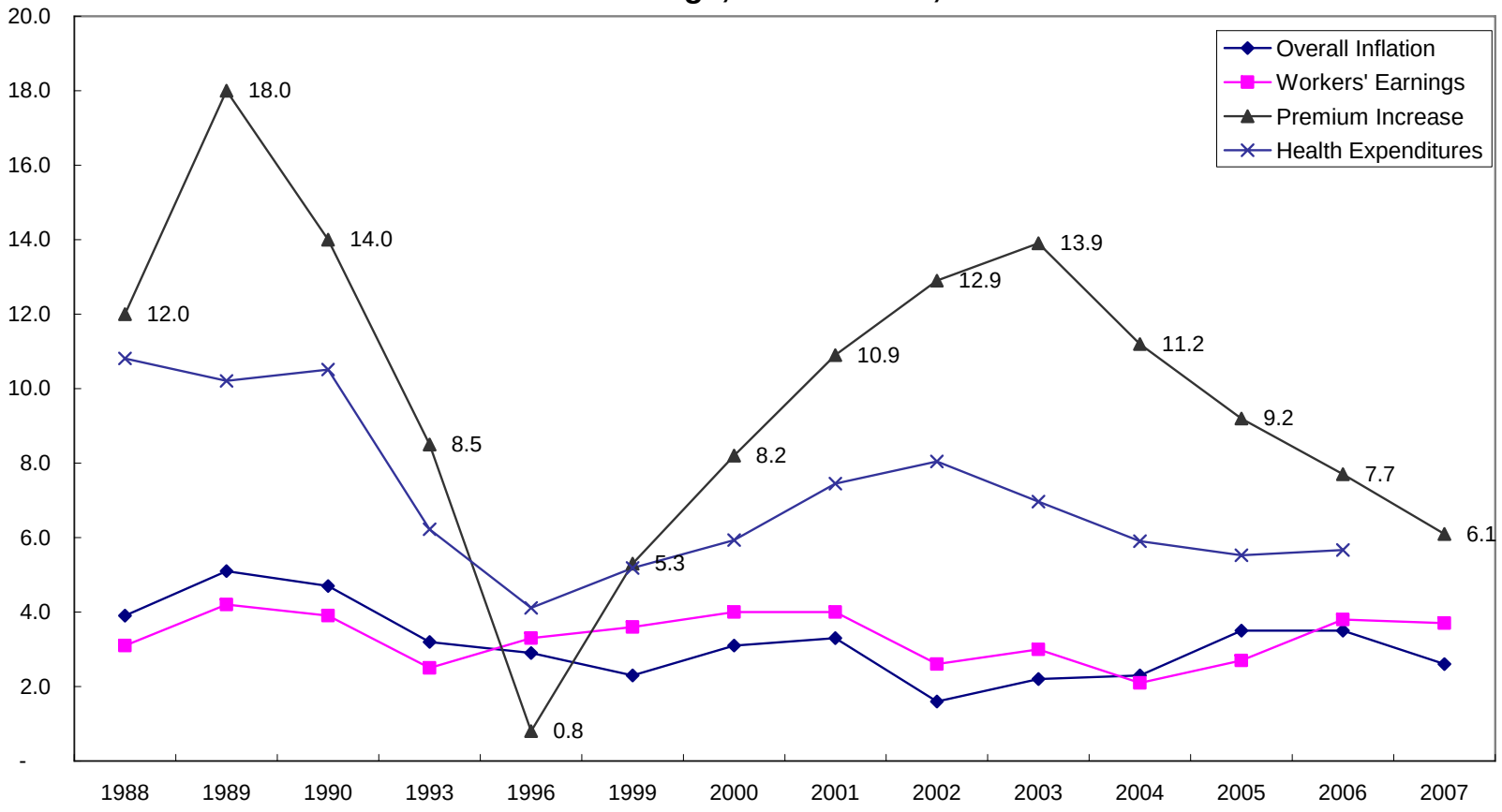

Source: Center for Medicare and Medicaid Services, National Health Expenditures Data

## Figure 7
## Financing of Spending on Health Services and Supplies
### by Source of Payment



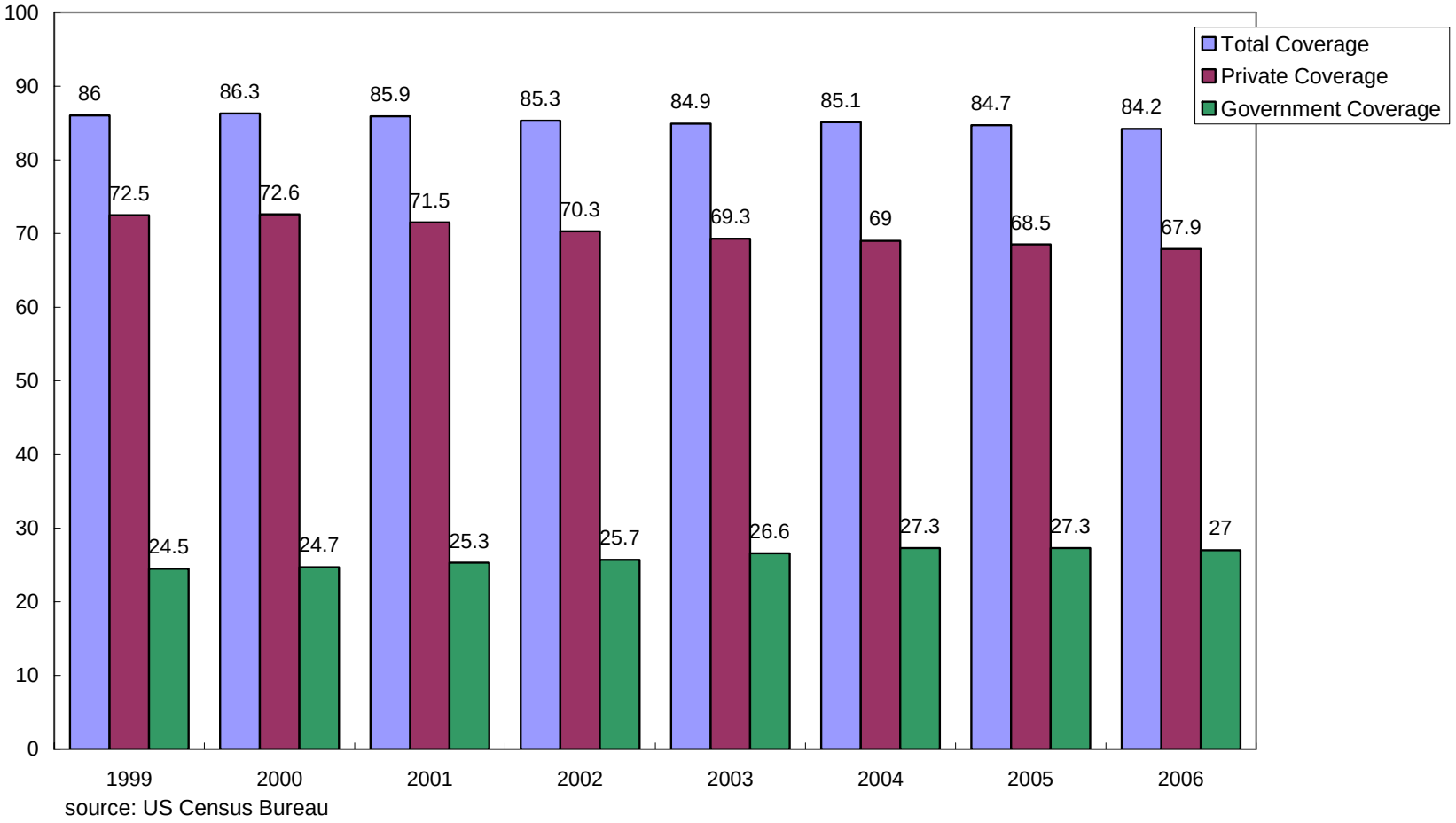

Source: Center for Medicare and Medicaid Services, National Health Expenditures Data

**Figure 8**
**Average Percentage Increase in Health Insurance Premiums and Expenditures, Workers Earnings, and Inflation, 1988 - 2007**



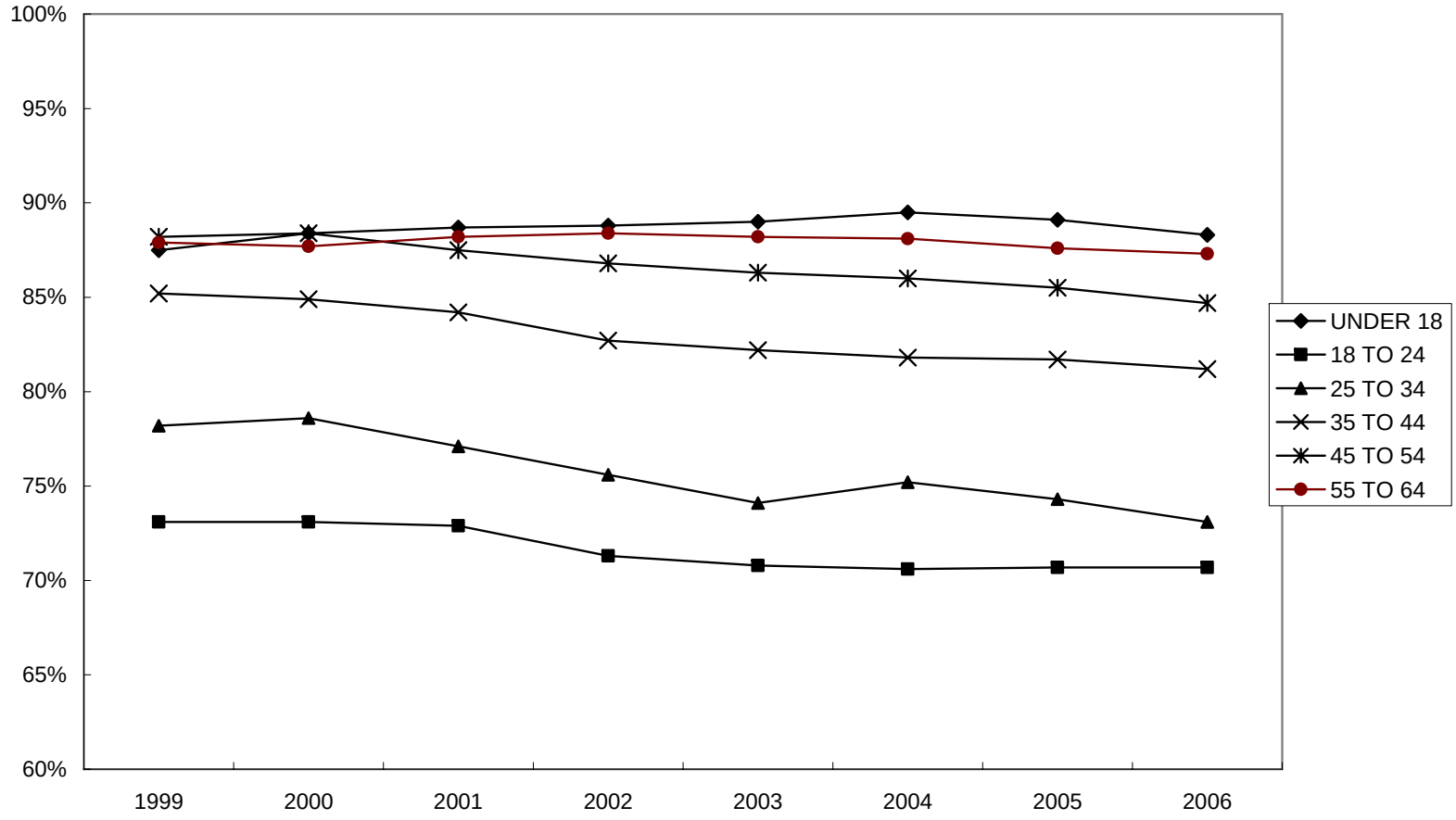

Sources: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, Bureau of Labor Statistics, Consumer Price Index, Bureau of Labor Statistics, Current Employment Statistics Survey,Center for Medicare and Medicaid Services, National Health Expenditures Data

**Figure 9**
**Percent of Population Covered by Health Insurance: 1999 - 2006**



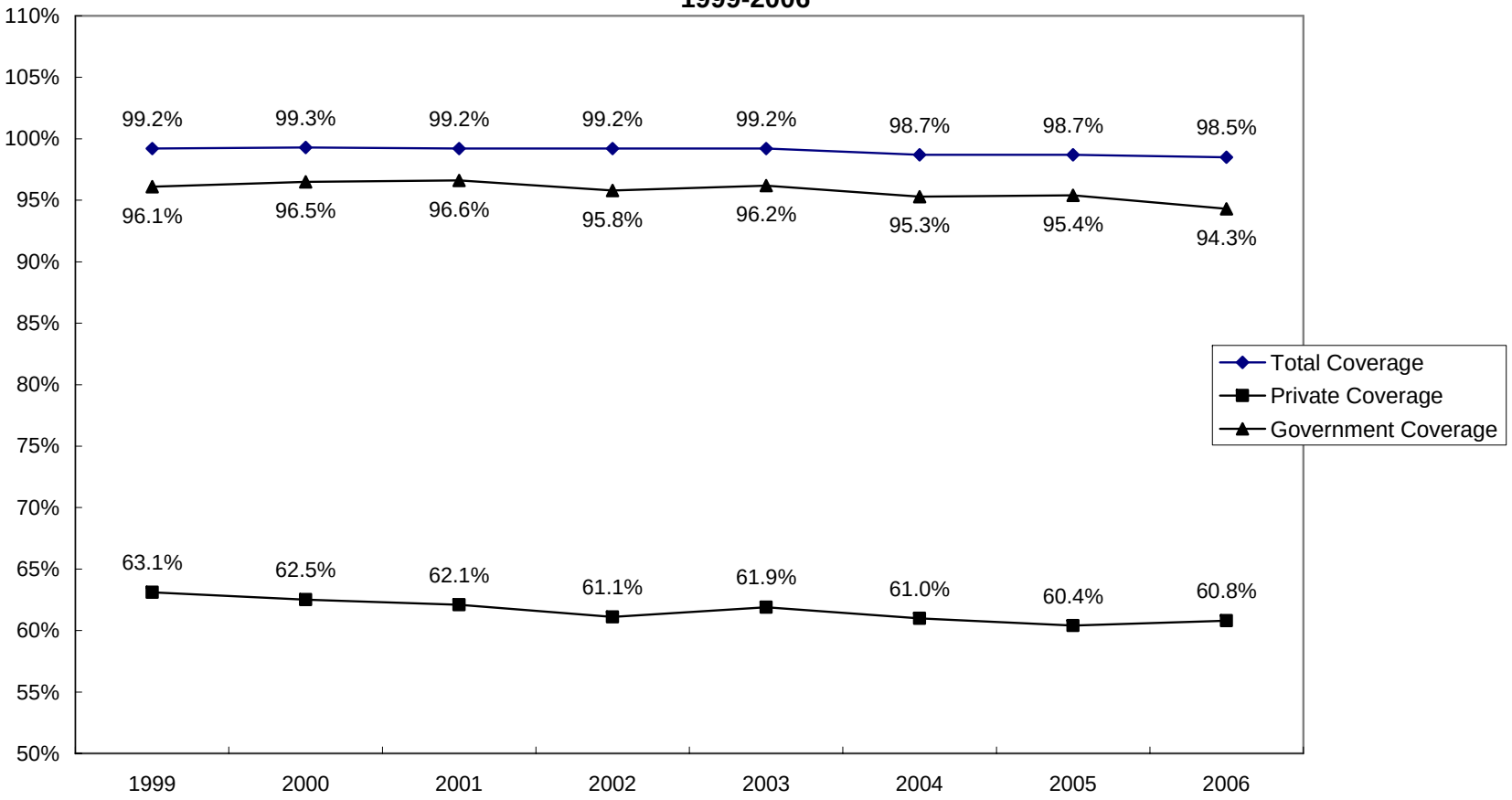

source: US Census Bureau

**Figure 10**
**Health Insurance Coverage by Age Group:**
**Non-elderly population: 1999-2006**



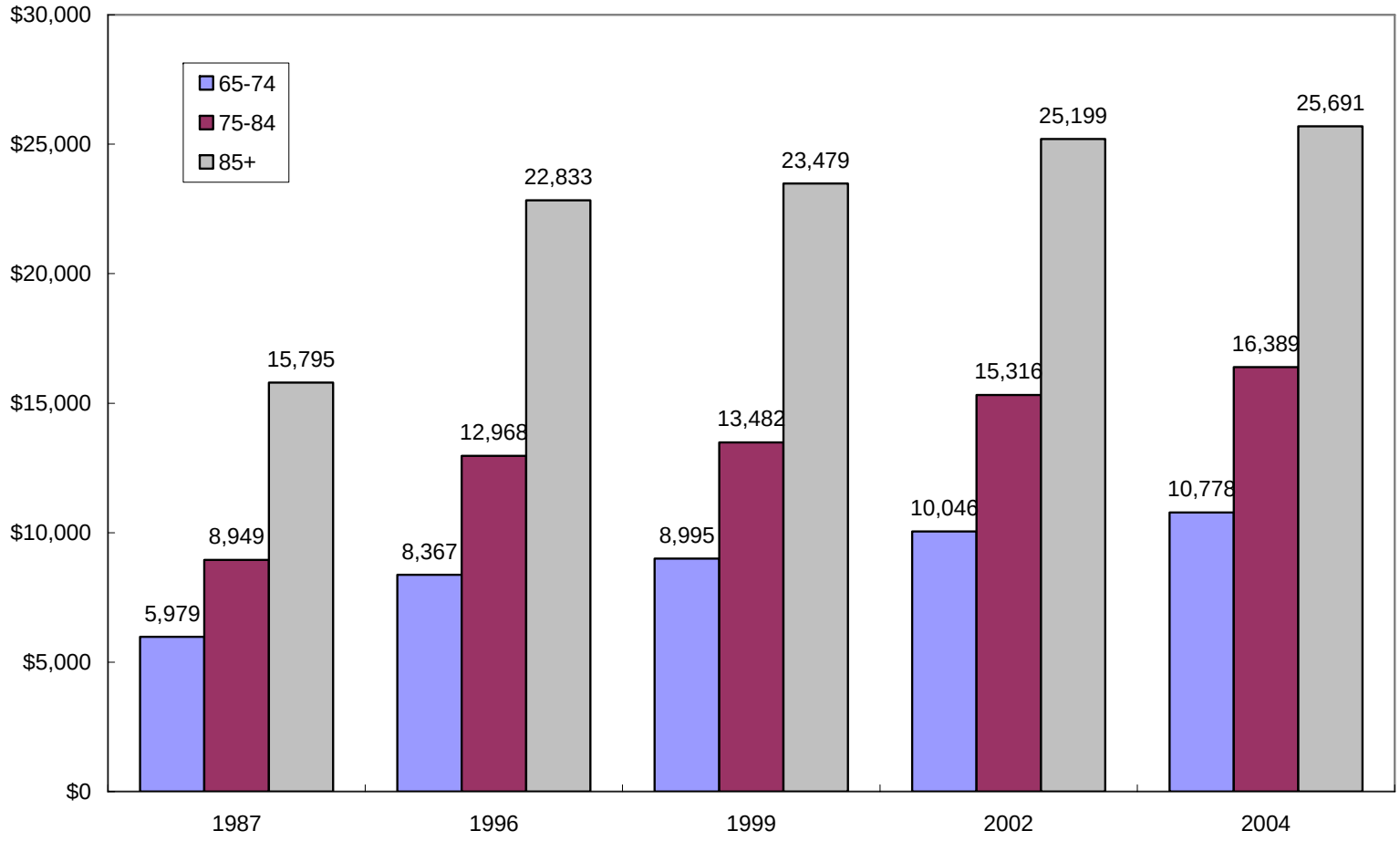

Source: US Census Bureau

**Figure 11**
**Health Insurance Coverage for the Elderly:**
**1999-2006**



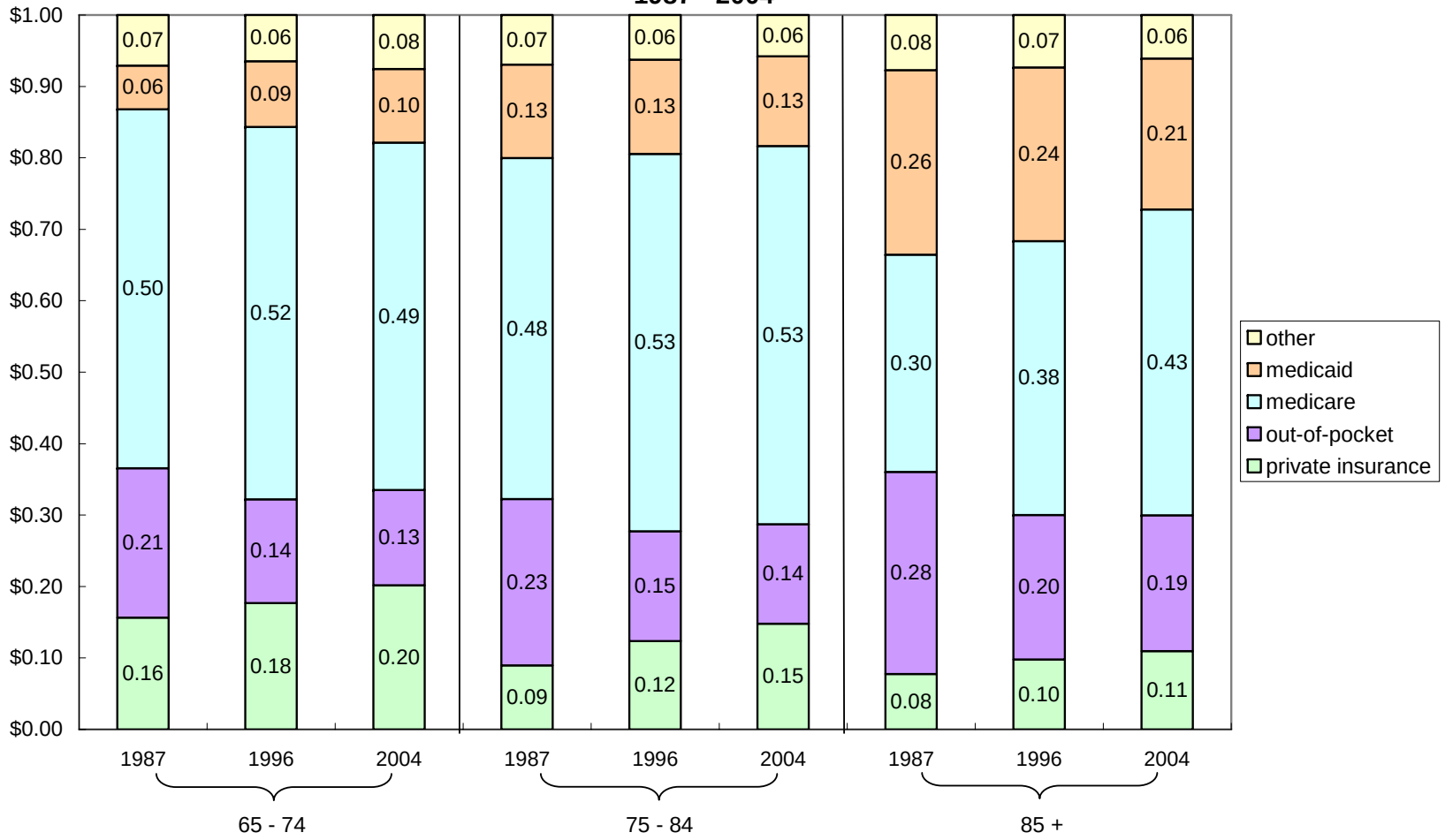

Source: US Census Bureau

**Figure 12**
**Per Capita Health Spending by Post-65 Population: 1987 to 2004**
**2004 dollars**



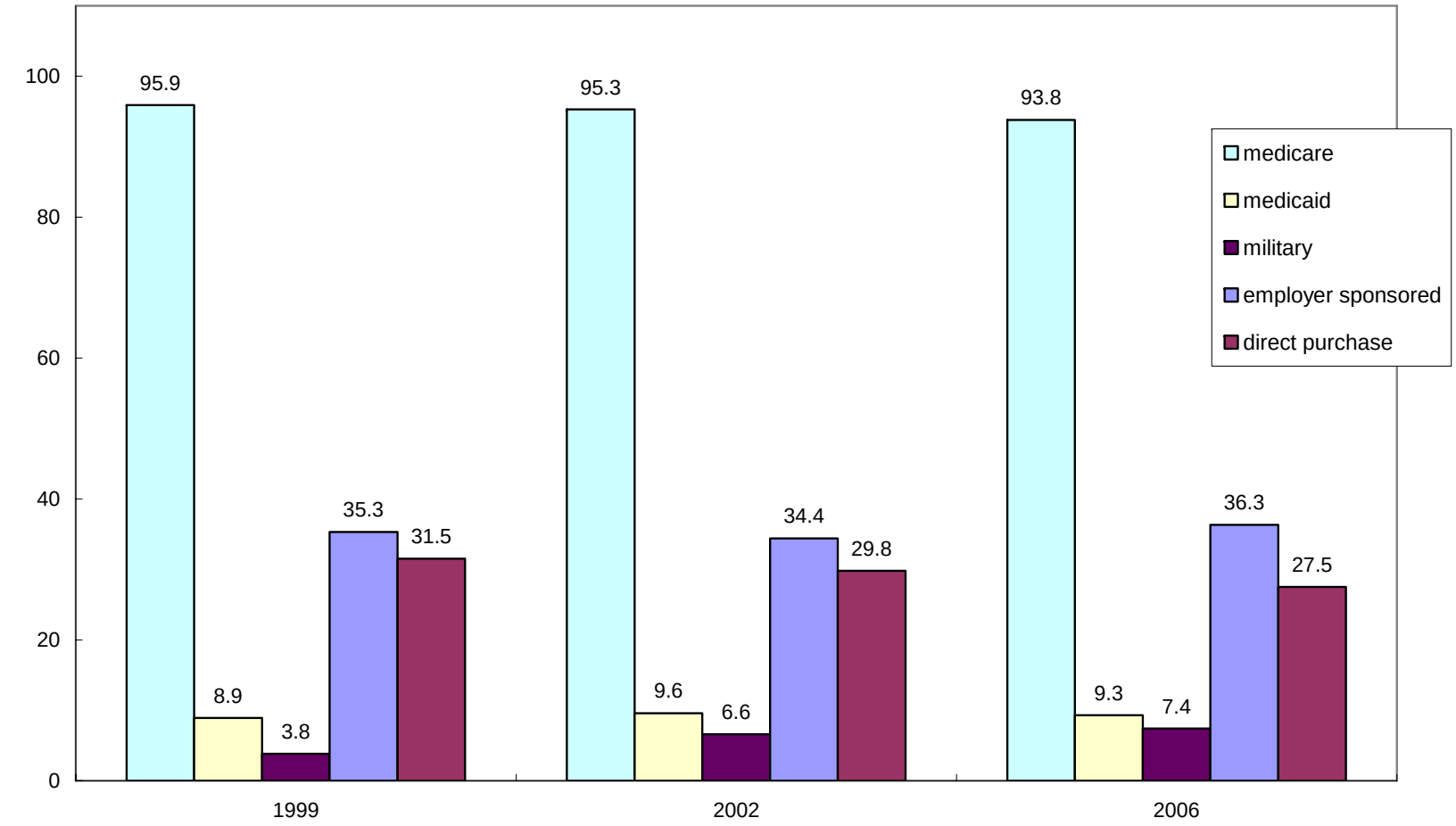

Source: Center for Medicare and Medicaid Services, National Health Expenditures Data

**Figure 13**
**Sources of Health Care Finance for the Elderly**
**1987 - 2004**



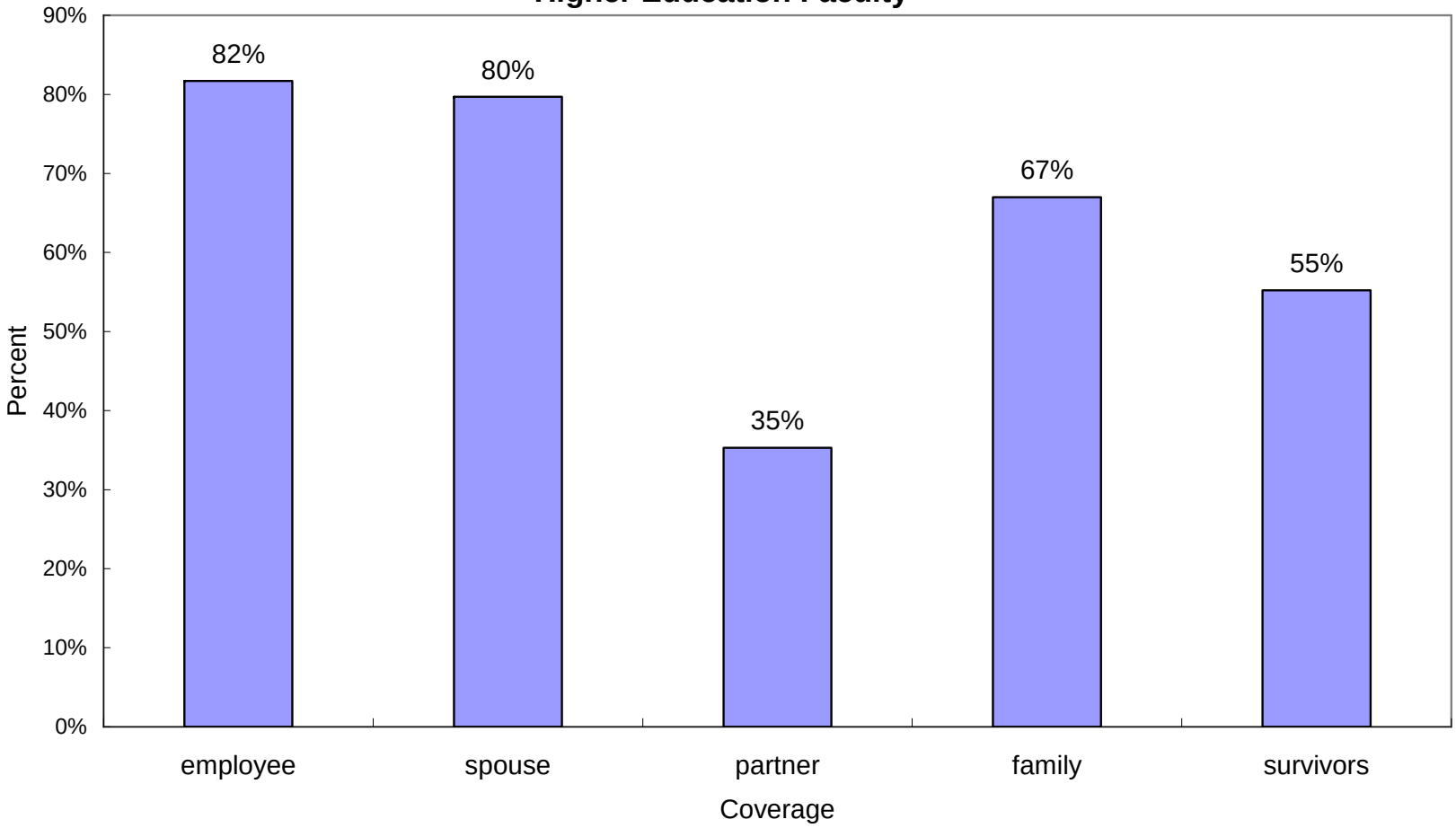

Source: Center for Medicare and Medicaid Services, National Health Expenditures Data

**Figure 14**
**Source of Coverage for the Elderly**
**1999 - 2006**



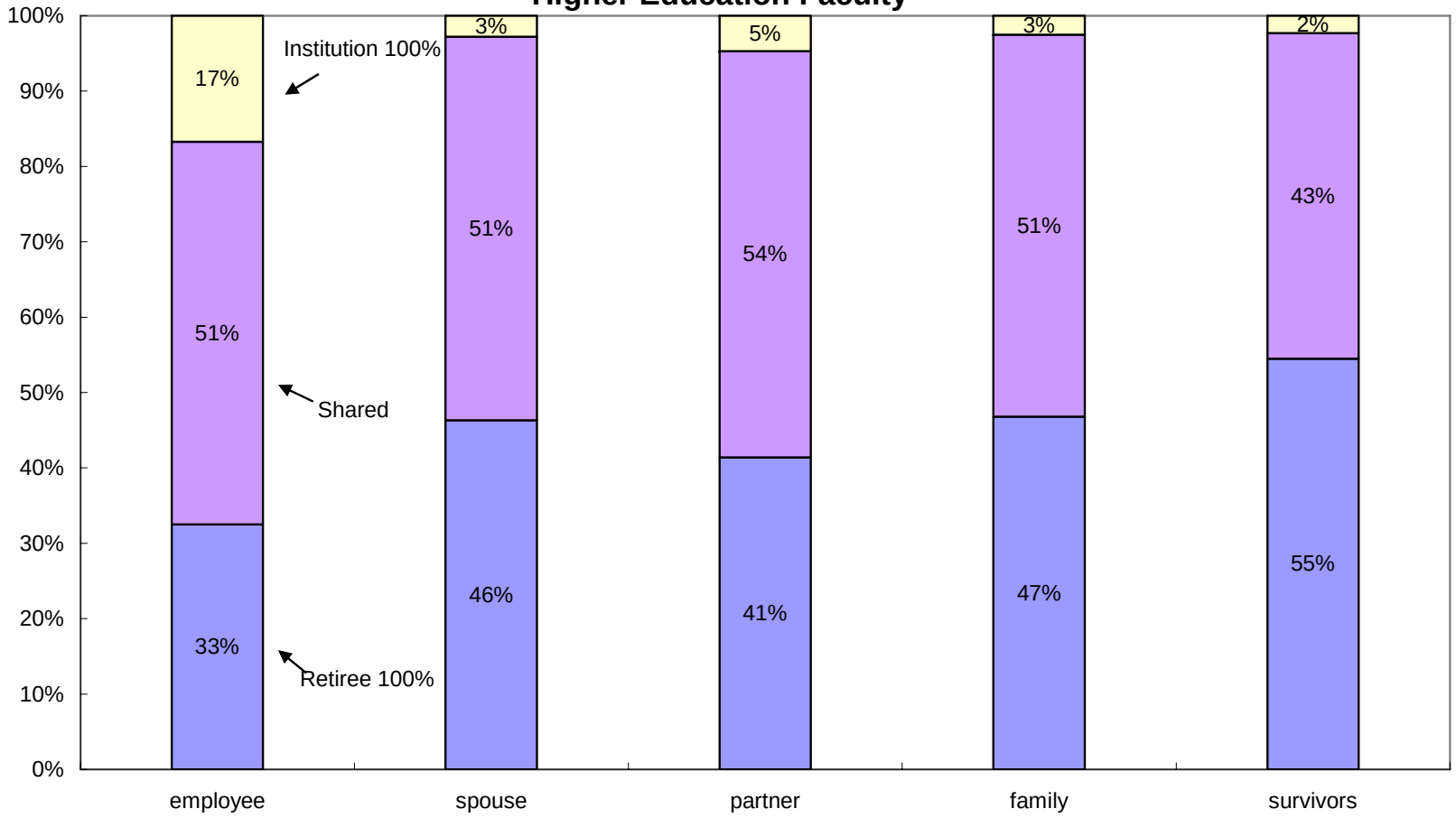

Source: U.S. Census Bureau

**Figure 15**
**Retiree Health Insurance Coverage - 2006**
**Higher Education Faculty**



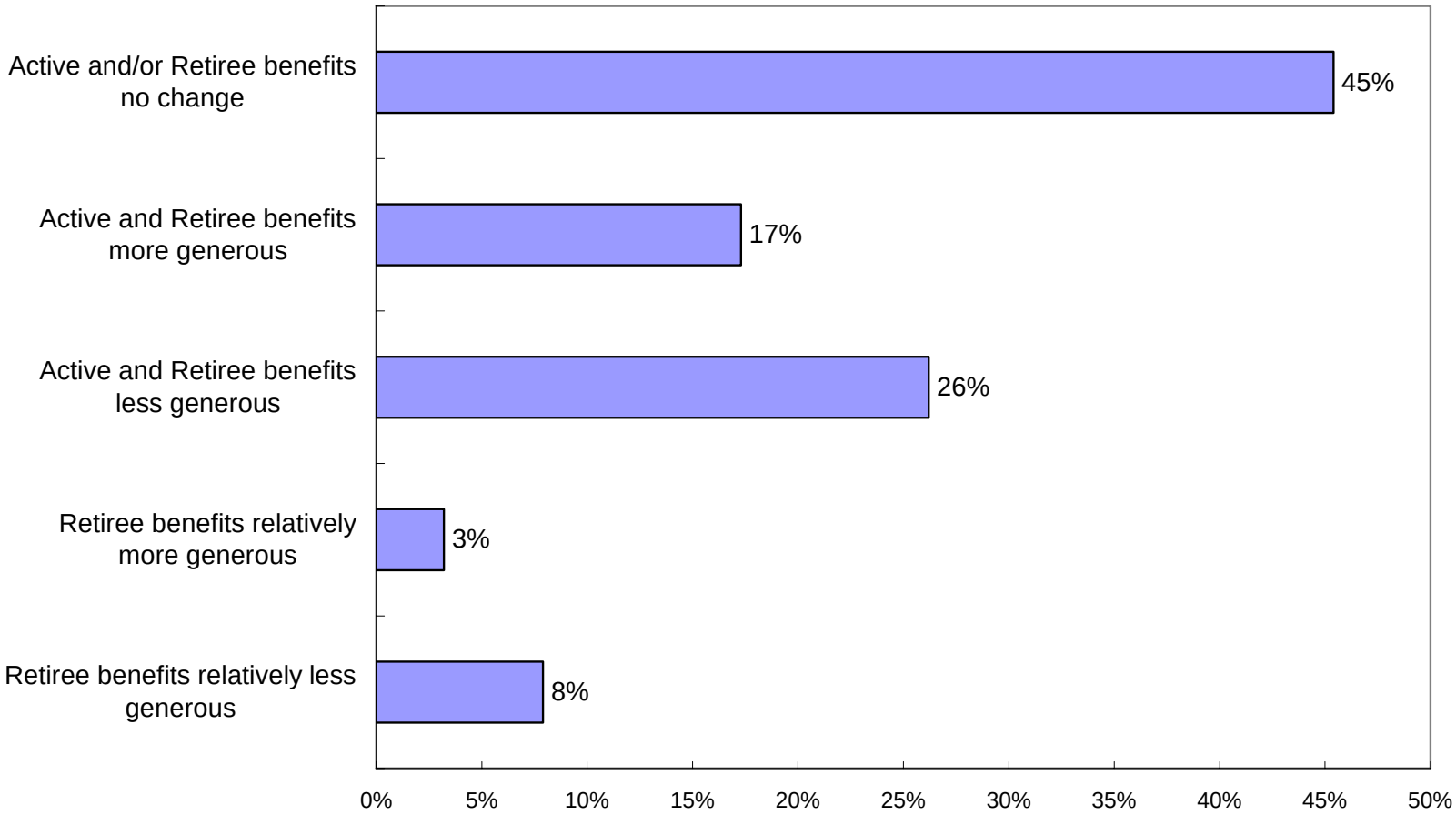

Source: American Association of University Professors, Faculty Retirement Policy Survey

**Figure 16**
**Retiree Health Insurance Premium Payment - 2006**
**Higher Education Faculty**



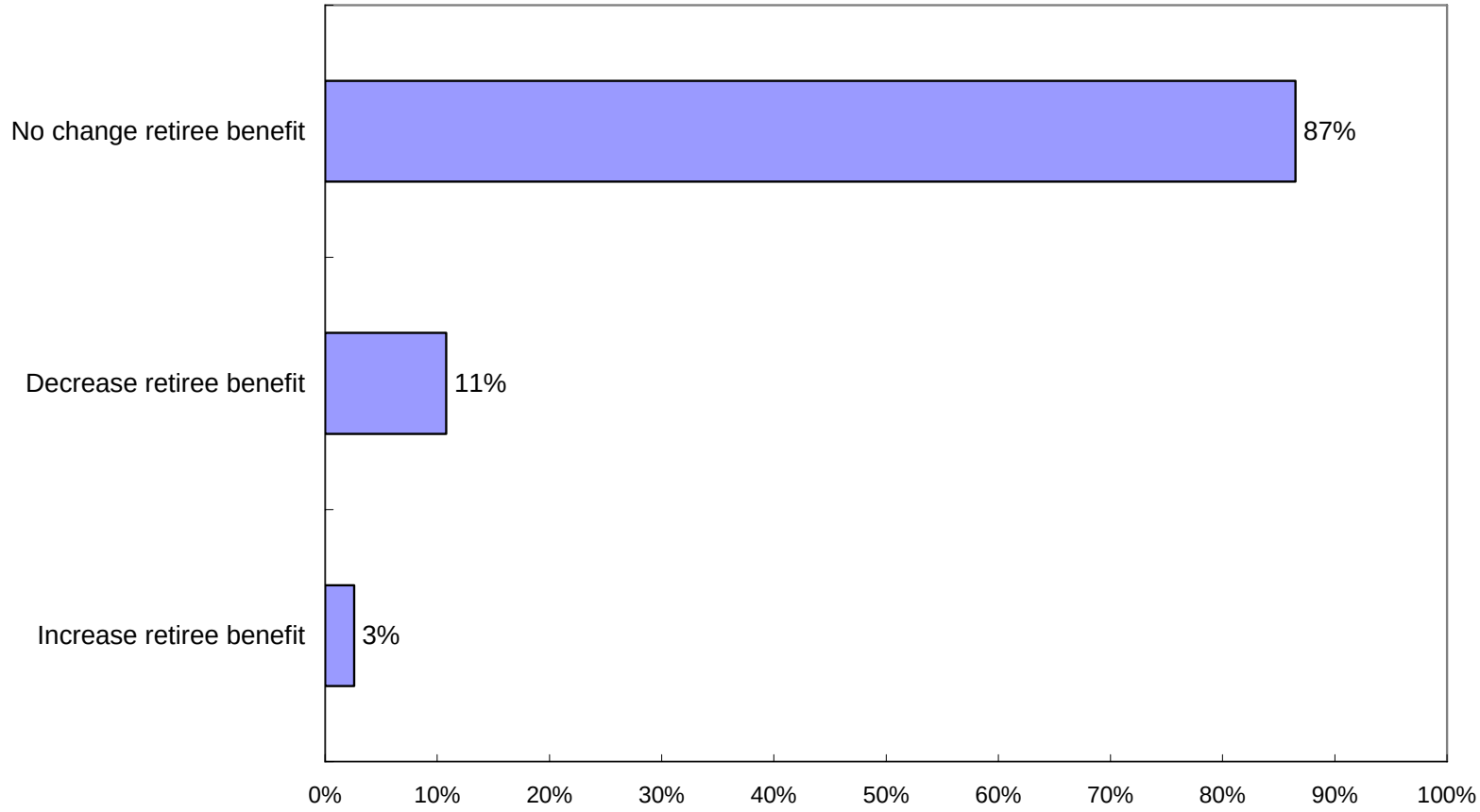

Source: American Association of University Professors, Faculty Retirement Policy Survey

**Figure 17**
**Health Insurance Changes since 2000**
**Higher Education Faculty**




Source: American Association of University Professors, Faculty Retirement Policy Survey

**Figure 18**
**Potential Future Changes to Retiree Health Benefits - 2006**
**Higher Education Faculty**




Source: American Association of University Professors, Faculty Retirement Policy Survey