What Could Family Income Be If Health Insurance Were More Affordable?

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BACKGROUND AND OBJECTIVES: Adjusted for inflation, household income has been relatively flat since the mid-1990s, but the inflation rate of employer-sponsored health insurance has been greater than both household income growth and general inflation for 50 years. We estimated the effect on average family income if health insurance inflation matched the general inflation rate since 1996, and those savings were given to employees as income.

METHODS: We used data from the Medical Expenditure Panel Survey, the Milliman Medical Index, and other federal sources to model the relationship between private health insurance costs and household income over the last 15 years.

RESULTS: If the cost of family health care costs had kept pace with the Consumer Price Index (CPI) rate since 1996, the average family income could have been $8,410 higher in 2010 ($68,805 versus $60,395), 13.9% more than actual earnings.

CONCLUSIONS: If health care costs had not exceeded the CPI rate since 1996 and if all the excess costs were converted into employee wages, median family income could be substantially higher today.
kept pace with premium increases, totaling between 19.8% and 21.1% of premium costs. We applied this ratio of OOP costs/premium costs from the Milliman Medical Index to the MEPS insurance premium data to generate OOP estimates for each year.

Statistical Analyses
We created a scatter plot to compare the annual percentage cost increase for family health insurance premiums over the years 1996–2009 versus the percentage cost increase for median family income over the years 1997-2010. We matched the insurance inflation rate from 1 year with the income inflation of the next year (e.g., health care cost inflation rate from 1996 was matched with the income inflation of 1997); we repeated the exercise for all years through 2010. SPSS was the statistical software used (SPSS 17.0, Chicago).

This project was classified as exempt research by the JPS Health Network Institutional Review Board.

Results
Premium Versus Income Inflation
During the pre-recession era of 1997–2007, years with high growth in health insurance premiums were followed by low growth in family income the following year (standardized β=-0.861, P=.001) (Figure 1). This correlation did not change substantially when the premium and income growth rates were plotted for the same year (standardized β=-0.696, P=.025). In the recessionary years of 2008–2010, family income declined, family premium inflation slowed somewhat; thus, the relationship between family income and premium costs showed less correlation from 1997–2010 (Standardized β=0.092, P=.765).

If the rate of health care cost increases had been similar to the CPI rate and all the savings were converted to employee income, the impact on wages is shown in Figure 2. The difference in 2010 could have been $8,410 ($68,805 versus $60,395), a 13.9% increase. If the OOP cost growth was not considered and only traditional insurance premium costs were included, the difference in 2010 could have been $6,985 ($67,380 versus $60,395), a 11.6% increase.

The actual growth in family income from 1996 to 2010 was 2.6% per year (not adjusted for inflation). If the excess amount spent on health care costs were allocated toward wages instead, family income would have grown at 3.6% per year.

Discussion
Our results show that if health insurance premiums and OOP costs had risen more slowly between 1996 and 2010, at a similar rate to the CPI rate, and if all the excess costs were converted into employee wages, median family income could be substantially higher. Productivity gains realized by American workers and businesses could have translated into higher family incomes instead of a more expensive health care system.

Further, many families have experienced the elimination of previously covered services and a steeper increase in deductibles and copayments since 2009.

For example, the 2010 Kaiser Family Foundation and Health Research and Educational Trust employer survey reported that 30% of employers have reduced the scope of health benefits or increased cost sharing, and 23% have increased the share of the premium a worker has to pay. Among large firms (200 or more workers), 38% have reduced the scope of benefits or increasing cost sharing, up from 22% in 2009, while 36% have increased their workers’ premium share, up from 22% in 2009. Even if family incomes rise as a result of the slowing of insurance premiums, the increased cost burden now placed on employees would likely subsume any additional salary dollars, especially for persons with chronic illness. The cost of health care continues to comprise a growing portion of the total US economy. It has risen from 13.7% of GDP in 2000 to 17.3% of GDP in 2010. Over the period 1960–1999, the growth of national health care expenditures exceeded the GDP by 2.4% per year. This same 2.4% differential occurred from 2000–2009. Efforts to bend the US health care cost curve have had no noticeable effect over the previous

Figure 1: Annual Inflation of Family Health Insurance Versus the Next Year’s Family Income
decade or at any other decade in the last 50 years. Additionally, our analysis did not fully account for the total impact of health care inflation on employed Americans, because we did not include the increasing costs to finance Medicare and Medicaid—nearly $900 billion in 2009.18

Limitations
Our results represent a theoretical shift of health care costs to wages that may not accurately portray how monies would have been allocated if not spent on health care costs. For example, business revenue currently earmarked for employee health insurance premiums might not go directly to employee paychecks and could, instead, be used to grow the business or pay dividends to shareholders. Some employees might prefer this shift as sustainability, growth, and job security could be more important priorities than wage increases. In one study, researchers estimated that a 10% increase in health insurance premiums reduced the probability of being employed by 1.2 percentage points, reduced hours worked by 2.4%, and increased the likelihood that a worker is employed only part time by 1.9 percentage points.19 These findings demonstrate that even if more employer revenue is taken out of the health care system and applied to employees’ incomes, there is a complex balance between income, hours worked, and having a job in the first place.

Previous research has found that even taking work hours and employment levels out of the discussion, historically lower health care costs have not directly translated into higher income by an equivalent amount. One study using observational data estimated that for workers covered by employer-sponsored health insurance, a 10% increase in premiums results in an offsetting decrease in wages of only 2.3%.18 Others have also concluded that the insurance-wage trade-off is not dollar for dollar, but the correlation is higher, more in the range of 0.4 to 1.0.11 Perhaps if the wage-benefit trade-off was more explicitly presented as a choice from employer to employee, these correlations would more closely be realized as a dollar-for-dollar trade-off.

Our analysis was also limited to families with employer-sponsored private insurance and does not include families on Medicare, Medicaid, other publicly funded health care plans, or the uninsured.

Implications
The recession of 2008–2010 led to stagnant family incomes and a rise in unemployment rates. Even as the economy begins to recover, unemployment rates in the United States continue to hover around 9%. Health care costs have not followed this trend and continue to outpace general inflation. The impact that these out-of-control health care costs have on the rest of the nation’s economy is not well understood by government officials, the media, or the general public.9,20-22 Dollars spent on costly health care services are dollars that cannot be used for other purposes. If the most expensive technology in health care is a physician’s pen, then the most expensive phrase is “medically necessary.” The health care industry has a tremendous amount of power to direct how billions of dollars are spent every day, which are paid from revenue in the business community and taxes in government programs such as Medicare and Medicaid. Historically, this transfer of funds has happened with little interference or questioning from the rest of American society. Oversimplified axioms suggesting that health care costs can be reduced by eliminating waste and inefficiency, or that we can achieve higher quality at a lower cost as the rule rather than the exception, have only served to delay the United States from having
deeper discussions about the best allocation of societal resources.

The American Academy of Family Physicians has made public statements on health care systems and costs, including a call for universal health insurance coverage and claims that the patient-centered medical home can reduce health care costs. Family medicine has always thought of its physicians as being patient centered. Perhaps our patients would rather have more income and fewer marginally effective medical tests and treatments. Perhaps their health would improve less from having more screenings and scans but improve more from having more disposable income, less worry about losing their job, and less stress from living paycheck to paycheck. We should ask them. If they want to take advantage of this trade-off, we should advocate for our patients to achieve this goal.

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References