Chapter 2 literature review pdf

Search Languages Menu Log in/up HALLEX A rapid increase in health insurance premiums also affects households. Companies struggling with rising healthcare costs can limit wage growth, lower health insurance benefits, or require employees to pay more for costs or increase the number of hours worked (Goldman, Sood & Leibowitz, 2005; Cutler and Madrian 1996). Goldman, Sood & Leibowitz (2005) estimate that as health insurance premiums rise, companies fund about two-thirds of premium increases by lowering wages and the remaining third by reducing benefits. In 2002, the average household spent $2,350, or 4.8% of income, on health care, an increase from 1999, when average household health care spending was $1,959, or 4.5% of income. Because higher costs are passed on to consumers, they can opt out of health insurance or reduce demand for other goods and services.5 If companies are unable to offset the increase in health care premiums by adjusting wages, benefits or working hours, they may reduce employment or at least limit the employment of full-time workers who qualify for benefits, replacing them with part-time or temporary workers who are not eligible. Many companies are also struggling with the rapidly rising cost of health insurance for pensioners. Below we summarize the key findings on the impact of rising healthcare costs on households, including the latest trends. Latest trends: Data from the Kaiser/HRET survey show that employer health care premiums increased by 73% between 2000 and 2005 (KFF, 2006). Employee contributions to individual and family plans increased at similar rates, while the proportion of contributions paid by employees remained relatively stable since 2000 (16% for individual insurance and 27% for family insurance). Almost all large companies offer health insurance, and the percentage of large health care companies remained virtually unchanged between 2000 (99%) and 2005 (98%). However, small business bid rates fell from 68 % in 2000 to 59 % in 2005. The percentage of employees with health insurance from their own employer fell by 4 percentage points. Between 2000 and 2004, the rate of people without insurance increased by 1.5 percentage points throughout the year (Gould, 2005). Rising healthcare costs can increase the proportion of the population that is not insured. Chernew et al., (2005) analyzes data on two cohorts (1989-1991 and 1998-2000) of non-older Americans living in 64 large metropolitan statistical areas to estimate the link between rising insurance costs and the likelihood of insurance. Insurance decreased by 3.1 percentage points during the period covered by the survey and premiums by 53%. They show that more than half of the decrease in coverage rates experienced in the 1990s is due to an increase in the cost of health insurance. They forecast that the number of uninsured could increase by 1.9 million to 6.3 million over the next decade if real cost per capita increases outweigh gdp per capita growth 1 to 3 percentage points. Data from the Kaiser/HRET survey show that the proportion of large employers offering pensioner health insurance fell from 66% in 1988 to 33% in 2005 (KFF, 2006). Fronstin (2005) estimates that the proportion of early retirees with health benefits fell from 39.2% in 1997 to 28.7% in 2002. The proportion of Medicare-eligible retirees on health benefits fell from 28.1% to 25.5%. Gilmer and Kronick (2005) estimate that if current trends continue, the number of uninsured Americans will increase from 45 million in 2003 to 56 million in 2013. Cutler (2003) analyzes data from cps (1988, 1993, 2001) and Kaiser/HRET studies to estimate the relationship between employee participation in health care costs and take-up rates. It states that, despite the tax-exempt status of employer contributions to health insurance premiums, employers increase workers' contributions to health insurance premiums. In fact, the increasing share of workers in costs may explain the 75% decrease in growth rates during this period. He argues that the most likely cause of higher staff costs is the underlying trend of rising medical costs. It also analyses data on overall insurance rates and estimates that a decrease in the number of people who use the offer, rather than changes in offer rates and eligibility, may explain about a 60% drop in insurance provided by the employer. Cooper and Schone (1997) come to similar conclusions. They show that most of the decrease in the employer covered by insurance between 1987 and 1996 can be explained by a decrease in admission rates. A recent short edition by the Kaiser Family Foundation uses two recent years of data from the Kaiser/HRET survey of employee benefits and finds that the negative link between employee premiums and rates for the use of health insurance (KFF, 2007).6 Rising health care costs can lead to less generous health plans for households. Faced with rising health insurance costs, employers can switch to low premium, high deductible plans for their employees. For example, Wal-Mart Stores Inc. intends to make its primary health care a low-premium, high-deductible plan. Under the new health plan, new employees will have small premiums deducted from their payouts, about $10 a week, and will face higher deductiments when paying for medical care. They will be offered special health savings accounts where they can set aside money in interest-bearing accounts to save for medical purposes. (McClatchy Newspapers, 2006). Such changes to the health plans offered by employers could potentially force households to give up the medical care and treatment they need. Rising healthcare costs could increase consumer debt and reduce access to care. Data from The Commonwealth Health Insurance Fund in 2003 show that around 77 million (37%) Americans aged 19 and older have difficulty paying medical bills, have accrued medical debt, or both. Nearly two-thirds of people with a medical bill or debt problem health care due to costs – almost three times more than people without these financial problems (Doty and Others, 2005). Medical debt is also linked to further housing problems. For example, in a recent survey of low- and middle-income households, 50% reported having medical debt and a quarter reported further housing problems as a result of debt (Seifert, 2005). Himmelstein et al. (2005) surveyed personal bankruptcy filers in five federal courts and found that about half mentioned medical reasons as the reason for their bankruptcy. Among those whose illnesses led to bankruptcy, out-of-pocket costs averaged $11,854 from the onset of the disease. A recent report published by the Access Project documents how low- and middle-income households turn to credit cards to pay for medical care (Zeldin and Rukavina, 2007). Based on a national telephone survey of more than 1,100 low- and middle-income households, the report found that nearly a third (29%) respondents stated that medical expenses contributed to their current level of credit card debt. In households with medical debt, the average credit card debt was significantly higher (46%) than in those households that do not have medical expenses as a contributing factor to their overall credit card debt. Although uninsured respondents had the highest level of credit card debt, even respondents with health insurance were not completely protected from the problem of medical debt. Access also carried out research on the problem of medical debt. For example, Kohn et al. (2005) examines the scope and consequences of medical debt for people in Kansas, and it turns out that medical bills can run out of family savings, health insurance may not protect families from crushing debt problems, and medical debt can create barriers to people's access to future medical services. Another report from Massachusetts shows that people can accumulate medical debt, which causes them to forgo further care, damage their loans and create housing and employment problems (Pryor and Gurewich, 2004). Rising health insurance costs can affect labour market performance. As mentioned earlier, Baicker and Chandra (2005) estimate that a 10% increase in health insurance premiums reduces the likelihood of employment by 1.6%, and that if employed, it increases the likelihood of part-time work by 1.9%. Johnson et al. (2003) believes that insurance costs significantly reduce pension rates for workers aged 51 to 61. Rising healthcare costs mean less money for consumption outside healthcare, other benefits and retirement. Johnson and Penner (2004) that in 2030, health care costs will take about a third of the after-tax income for the elderly out of pocket, up from around 16% in 2000. Follette & Sheiner (2005) estimates that a 2% increase in health care spending per capita relative to GDP per capita will lead to a decrease in non-health-related consumption by 2040 and leave over 75 years. A recent report suggests that a 65-year-old couple retiring in 2007 will need about $215,000 to cover medical expenses in retirement, up 7.5 percent from the previous year. For about 40 percent of retirees whose main source of income is Social Security, health spending can eat up to half of their retirement benefits (Hamilton, 2007). Goldman, Sood and Leibowitz (2005) show that workers facing rising health insurance prices react by lowering insurance levels. However, workers do not completely push back the increase in health insurance spending — in fact, rising prices lead to an increase in health insurance spending. These increases are taken into account by reducing both household income and other benefits such as life insurance, disability insurance, dental insurance and retirement benefits. For example, they estimate that a $1 increase in premiums leads to a 52-cent increase in health insurance spending. About two-thirds of this increase is financed by reduced wages and 1/3 of other benefits. These results suggest that rising health insurance prices not only reduce resources for current consumption, but also reduce insurance purchases for various risks. Consumers are concerned about rising healthcare costs. Rising health insurance costs are causing anxiety among voters. The results of the annual health trust survey show that more than half of those surveyed were dissatisfied with the cost of health insurance. The results of the ABC/Washington Post poll showed that 75% of people would prefer to have employer-sponsored health insurance rather than a $6,700 raise (Alonso-Zaldivar, 2006). 2006).