
# The Effects of Rising Health Care Costs on Middle-Class Economic Security

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AARP

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At the request of CEO Barry Rand, the AARP Public Policy Institute (PPI) conducted a year-long, multi-disciplinary exploration of the well-being of America's middle class with a focus on prospects for financially secure retirement. The Middle Class Security Project offers insight, analysis, and an agenda for policymakers to consider. The project team included:

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***Harriet Komisar***
***Georgetown University***

AARP's Public Policy Institute informs and stimulates public debate on the issues we face as we age. Through research, analysis, and dialogue with the nation's leading experts, PPI promotes development of sound, creative policies to address our common need for economic security, health care, and quality of life.

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## EXECUTIVE SUMMARY

Health care costs, including costs for long-term services and supports, are a growing burden for middle-class families across all age groups. Wages have not kept up with increases in health care costs, and more middle-class families are struggling to cope with higher health insurance premiums and higher out-of-pocket expenses when they have an illness. Rising health care costs are crowding out other important priorities for workers, such as saving for their own retirement or for their children's college education. Employers have responded to higher health care costs by scaling back wage increases, shifting cost increases to their employees, or changing the type of insurance they offer.

If these trends continue, many people who had been middle-class throughout their working years will be at risk of not having enough financial resources to maintain a middle-class lifestyle during their retirement years. Increased out-of-pocket costs to Medicare beneficiaries and the often catastrophic costs of long-term services and supports are major threats to middle-class security for retirees and family members, who often end up in caregiving roles.

### Key Findings

This report documents the impact of rising health care and long-term services and supports costs for middle-class workers and retirees. Some key findings are as follows:

- National health care spending in the United States averaged $8,402 per person in 2010—72 percent higher than a decade earlier when it was $4,878, and nearly triple the 1990 level of $2,854.
- Health care spending has been growing faster than inflation and the overall economy. Between 2000 and 2010, health care spending per person grew at an average rate of 5.6 percent per year, outpacing inflation (2.4 percent per year) and the growth in gross domestic product per person (2.9 percent per year).
- Over the past decade, the average amount that middle-income households spent on health care increased by 51 percent—nearly double the growth in their incomes (30 percent) and three times the rate of growth in their spending for all other products and services.
- With rising health care costs, more people under 65 are burdened with high health care spending. In 2009, 21 percent of middle-income people under 65 reported spending more than 10 percent of their incomes on health care expenses, compared to 15 percent in 2001.
- One in five people are in families that have problems paying medical bills. Many of these families have experienced serious financial stress, such as problems paying for other necessities (e.g., food, clothing, and housing) or medically related bankruptcy.
- Health insurance premiums for employer-sponsored insurance nearly doubled over the past decade, with total premiums (employer's and worker's shares) increasing from an average of $7,601 per year in 2001 to $15,073 in 2011 for family coverage. Rising premiums contributed to a rise in the proportion of people without health insurance.

- Employers have responded to rising health care costs by shifting more health insurance costs to employees, offering high-deductible health plans with lower premiums but higher cost sharing, and limiting wage growth.
- Health-related expenses absorb a large share of incomes for people age 65 and older, and that share is projected to grow over time. The share of household income spent on health care expenses is projected to reach 18 percent for future retirees, compared to 8 percent for today's retirees.
- Expenses for long-term services and supports (LTSS) are a major risk to economic security in retirement for middle-class families, since such expenses are not covered by Medicare and few people have private insurance to cover such costs.
- Family caregivers providing unpaid assistance to family members needing LTSS do so at a cost to their own economic security. Of those who worked while caregiving, two-thirds made some adjustments to their employment and one in ten quit a job or took early retirement—issues that especially affect the future financial security of women, who are most often the primary caregivers.

## INTRODUCTION

Rising health care costs and declining health insurance coverage are jeopardizing the health and financial security of increasing numbers of middle-class families. A report for the White House Middle Class Task Force noted, "Extra medical bills or higher family expenses for child care or elder care can easily make a middle class lifestyle unattainable." As that report notes, rising health care costs are an important part of a larger picture where the costs for basic needs of middle-class families are rising faster than their incomes: "Most important, prices of three big expenditure items—housing, health care, and college—have gone up faster than incomes. These factors make attaining a middle class lifestyle harder today than it was two decades ago."[1]

This report examines the research on recent trends in health care and insurance costs and how they are contributing to the financial stress and insecurity experienced by middle-class American households during their working and retirement years. The focus of the brief is on trends affecting middle-class economic security during the past decade, many of which are a continuation of longer historical trends.

National health care spending in the United States averaged $8,402 per person in 2010, 72 percent higher than a decade earlier, when it was $4,878, and nearly triple the 1990 level of $2,854.[2] Between 2000 and 2010, health care spending per person grew at an average rate of 5.6 percent per year, outpacing inflation (2.4 percent per year[3]) and the growth in gross domestic product (GDP) per person (2.9 percent per year[4])—and continuing a decades-long trend of the health sector expanding as a share of the economy. In 2009 and 2010, health care spending represented 17.9% of GDP—more than one-sixth of the value of all goods and services produced in the U.S. economy—up from 13.8 percent in 2000 and nearly double its share of 9.2 percent in 1980.[5]

These rising health care costs affect middle-class households in several ways. Not only do households face the direct costs of escalating health insurance premiums and out-of-pocket expenses for services, but rising health costs have also contributed to declines in private health insurance enrollment, to the increasing risk of incurring high out-of-pocket expenses, and to the stagnation of wages for middle-class households. For both working-age and retirement-age middle-class households, rising health care expenses are taking up a growing share of financial resources, leaving less for other priorities.

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1 U.S. Department of Commerce, *Middle Class in America*, January 2010, p. 1, http://www.commerce.gov/news/fact-sheets/2010/01/25/middle-class-america-task-force-report-pdf.

2 Anne B. Martin et al., Growth in US Health Spending Remained Slow in 2010; Health Share of Gross Domestic Product was Unchanged from 2009, *Health Affairs* 31(1) (2012):208–19.

3 Based on the Consumer Price Index (for all urban consumers, all items) as reported in the *Economic Report of the President*, 2012, Table B-60, http://www.gpo.gov/fdsys/pkg/ERP-2012/pdf/ERP-2012-table60.pdf.

4 Kaiser Family Foundation, *Health Care Costs: A Primer*, May 2012, http://www.kff.org/insurance/upload/7670-03.pdf.

5 Martin et al., 2012.

### 1. Health care expenses are a major and expanding share of middle-class households' budgets

Health care expenses—consisting of insurance premiums and out-of-pocket expenditures—are a major budget item for most middle-class households. In this brief, the term "middle class" refers to households in a middle part of the income distribution.[6] The research studies cited in this report employ varying approaches to defining income groups, and therefore the findings presented in this brief are based on varying definitions of middle-income households.[7] Although a majority of Americans consider themselves to be middle class even if their incomes are significantly lower or higher than the middle, analysis of the experiences of a middle-income group provides a reasonable approximation of "middle-class" experiences.

National survey data on consumer spending document the growth in household spending for middle-income households. Over the past decade, the average amount households in the middle income quintile spent on health care increased by 51 percent (from $2,199 in 2001 to $3,319 in 2011) (see table 1).[8] Health spending grew even more for households in the fourth quintile, rising by 60 percent over the decade. These rates of increase were nearly double the growth in household average income (30 percent) for these middle-class families and more than three times the rate of growth for all other spending on products and services. In contrast to health care, middle-class households' spending on all other products and services grew by 16 percent (fourth quintile) to 17 percent (middle quintile) over the decade (not shown).[9]

### 2. A growing share of middle-income households are experiencing high burdens from health care expenses

As health care spending has increased, more middle-income families of all ages are facing higher levels of health care expenses. In 2009, nearly one-fifth (19 percent) of people under age 65 were in families that experienced a high burden of health care

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6 Brian W. Cashell, *Who Are the "Middle Class"?* Congressional Research Service, 28 September 2009.

7 Examples include analyses of the middle one-third of the income distribution and the middle and fourth income quintiles (from the 40th percentile to the 80th percentile of the income distribution). Other research uses the ratio of income to the federal poverty threshold (FPL) for the household's size; using this approach, analysts often focus on people with incomes between 200 percent and 399 percent of FPL (e.g., about $36,000 to $72,000 for a family of three in 2011). In 2011, 33 percent of people had income between 200 percent and 399 percent of FPL; 34 percent had income of less than 200 percent of FPL; and 33 percent had income of 400 percent or more of FPL. For population with income below 200 percent of poverty: Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica C. Smith, *Income, Poverty, and Health Insurance Coverage in the United States: 2011*, U.S. Census Bureau, Current Population Reports, P60-243 (Washington, DC: U.S. Government Printing Office, 2012), http://www.census.gov/prod/2012pubs/p60-243.pdf. For population with income of 400 percent or more of FPL: Kaiser Family Foundation, statehealthfacts.org, Distribution of Total Population by Federal Poverty Level, U.S., 2011, http://www.statehealthfacts.org/comparebar.jsp?ind=9&cat=1.

8 Health care expenses in table 1 are direct out-of-pocket payments for insurance premiums and services. It is beyond the scope of this brief to examine the indirect effects of publicly financed health care programs on the taxes of middle-income households. For a recent study of direct and indirect health care costs that includes estimated taxes, see David Auerbach and Arthur L. Kellerman, "A Decade of Health Care Cost Growth Has Wiped Out Real Income Gains for an Average US Family," *Health Affairs* 30(9): 1–7.

9 Based on data from Bureau of Labor Statistics, U. S. Department of Labor, Consumer Expenditure Survey, 2001 and 2011, http://www.bls.gov/cex/#tables.

**Table 1**
**Health Care Spending of Middle-Income Households of All Ages Grew by More than 50 Percent between 2001 and 2011**

| | Income Quintiles | | | | |
|---|---|---|---|---|---|
| | Lowest | Second | Middle | Fourth | Highest |
| **Health care expenditures** | | | | | |
| 2001 | $1,422 | $2,074 | $2,199 | $2,494 | $2,921 |
| 2011 | $1,489 | $2,611 | $3,319 | $3,994 | $5,149 |
| Percent increase | 4.7% | 25.9% | 50.9% | 60.1% | 76.3% |
| **Income before taxes** | | | | | |
| 2001 | $7,946 | $20,319 | $35,536 | $56,891 | $116,666 |
| 2011 | $9,805 | $27,117 | $46,190 | $74,019 | $161,292 |
| Percent increase | 23.4% | 33.5% | 30.0% | 30.1% | 38.3% |

Note: The table shows average health care spending and income for consumer units in each quintile.

Source: Bureau of Labor Statistics, U. S. Department of Labor, Consumer Expenditure Survey, 2001 and 2011, http://www.bls.gov/cex/#tables.

spending, defined as spending more than 10 percent of before-tax family income on health care services and insurance premiums.[10] In comparison, in 2001, 14 percent of people under age 65 were in families with a high burden of health spending.[11] (Health care expense burdens for people age 65 and older are discussed in section 8.)

The proportion of people with high burden varies among income groups. Although a greater share of lower-income families have high burdens, middle-income and higher-income families experienced steeper increases in the past decade in the proportions of people with high health care burdens. The proportion of people under age 65 in middle-income families (with income between 200 percent and 399 percent of the federal poverty level, or FPL) that experienced high burdens from health care expenses increased by more than one-third, from 15 percent in 2001 to 21 percent in 2009 (see figure 1).

### 3. One in five people are in families that have problems paying medical bills

A significant illness or injury can lead to sizable medical bills for people who are uninsured and for people who have health insurance but incur high deductible or other uncovered expenses. In the first half of 2011, one-third of people (of all ages) were in a family experiencing a financial burden from medical care, including families that had problems paying medical bills (20 percent) or are currently paying bills over time.[12] One in ten people are in a family with medical bills it cannot pay at all.

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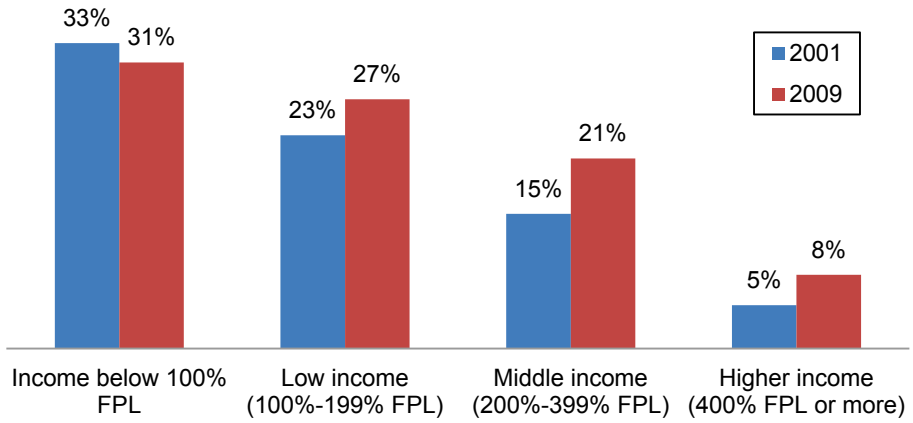
[10] Peter J. Cunningham, "Despite the Recession's Effects on Incomes and Jobs, The Share of People with High Medical Costs was Mostly Unchanged," *Health Affairs* (2012): doi: 10.1377/hlthaff.2012.0148.

[11] Peter J. Cunningham, "The Growing Financial Burden of Health Care: National and State Trends, 2001–2006," *Health Affairs* (2010).

[12] Robin A. Cohen et al., *Financial Burden of Medical Care: Early Release of Estimates from the National Health Interview Survey, January-June 2011*, National Center for Health Statistics, March 2012, http://www.cdc.gov/nchs/data/nhis/earlyrelease/financial_burden_of_medical_care_032012.pdf.

**Figure 1**
**More Than One-Fifth of Middle-Income People under Age 65 Have a High Burden from Health Care Expenses**

***Percentage of people under age 65 in families with health care expenses higher than 10% of income***




FPL = federal poverty level.

Sources: Peter J. Cunningham, The Growing Financial Burden of Health Care: National and State Trends, 2001–2006, *Health Affairs* 2010; Peter Cunningham, unpublished analysis of data from the 2009 Medical Expenditure Panel Survey, November 2012.

The proportion of people in families with problems paying medical bills increased from 15 percent in 2003 to 21 percent in 2010—an increase of nearly one percentage point per year.[13] The findings indicate that problems with medical bills are more likely among people under age 65, affecting more than one in five (22 percent) younger people in 2010, compared with 10 percent of people age 65 and older.[14]

Most people with problems paying medical bills experienced serious financial stress: Two-thirds had problems paying for other necessities (such as food, clothing, and housing), nearly two-thirds had been contacted by a collection agency, and half had borrowed money. One in four considered filing for bankruptcy, and 5 percent actually did file for bankruptcy.[15] Among people with problems paying medical bills, the average medical debt was $6,500 in 2010, and more than half the people (55 percent) with medical debt reported that they had so far paid off "none or a little" of it.

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[13] Anna Sommers and Peter J. Cunningham, *Medical Bill Problems Steady for U.S. Families, 2007–2010*, Center for Studying Health System Change, Results from the Community Tracking Study, No. 28, December 2011, http://www.hschange.com/CONTENT/1268/1268.pdf; Peter J. Cunningham, *Trade-Offs Getting Tougher: Problems Paying Medical Bills Increase for U.S. Families, 2003–2007*, Center for Studying Health System Change, Results from the Community Tracking Study, No. 21, September 2008, http://www.hschange.com/CONTENT/1017/1017.pdf.

[14] Sommers and Cunningham, 2011. Another national study, using a somewhat broader definition of medical bill problems, found that 41 percent of adults ages 19–64 had medical bill problems in 2007. In this study, people were considered to have medical bill problems if they had problems paying medical bills in the past 12 months, had to change their way of life because of medical bills, had been contacted by a collection agency, or had medical debt they were paying off over time. Michelle M. Doty et al., *Seeing Red: The Growing Burden of Medical Bills and Debt Faced by U.S. Families*, The Commonwealth Fund, August 2008, http://www.commonwealthfund.org/usr_doc/Doty_seeingred_1164_ib.pdf?section=4039.

[15] Sommers and Cunningham, 2011.

### 4. Health insurance premiums more than doubled over the past decade

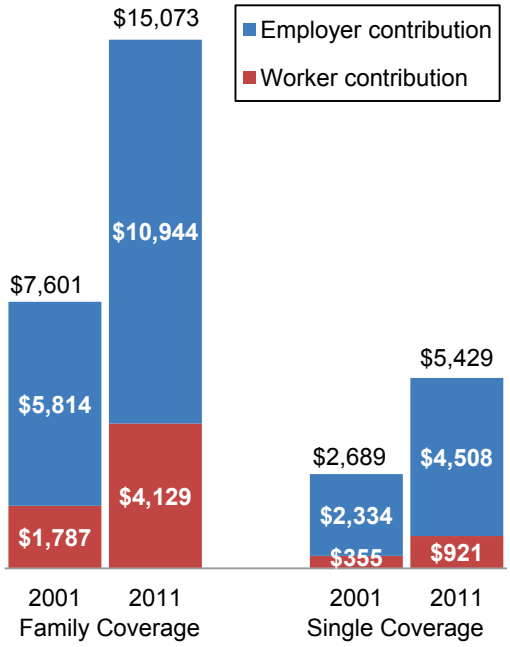
Health insurance is a key component of middle-class economic security. Because medical care is potentially so costly, health insurance provides financial protection and improves access to medical care. Most middle-income working-age families obtain health insurance through a family member's employment, so trends in employer-sponsored health insurance have a major effect on middle-class households. In 2011, 73 percent of people under 65 in households with incomes between 200 percent and 399 percent of the FPL (that is, with income of $44,700 to $89,400 for a family of four) had private insurance[16]—approximately 67 percent with employer-based insurance and 6 percent with individually purchased, nongroup insurance.[17] A sizable minority of middle-income households is uninsured; in 2011, 15 percent of people under 65 in middle-income households with incomes between 200 percent and 399 percent of FPL were uninsured.

Over the past decade, health insurance premiums increased even faster than national health care spending per person. For employer-sponsored health insurance, premiums typically consist of the employee's share paid directly by the worker (typically as a deduction from pay) and the employer's share. Looking at total premiums (employer's and employee's shares) for employer-sponsored insurance, the average annual premium for workers with family coverage nearly doubled in the past decade, increasing from $7,601 in 2001 to $15,073 in 2011 (an average increase of 7.9 percent per year)(see figure 2).[18]

Average worker contributions grew faster than total premiums, as employers increased their workers' share of premiums.[19] Between 2001 and 2011, the amount workers pay

**Figure 2**
**Premiums for Employer-Sponsored Health Insurance Doubled between 2001 and 2011**

***Average annual premiums for employer-sponsored health insurance***




Source: Kaiser Family Foundation and Health Research & Educational Trust , *Employer Health Benefits: 2011 Annual Survey*, 2011, http://ehbs.kff.org/pdf/2011/8225.pdf.

[16] Sonya Streeter et al., *The Uninsured: A Primer*, The Kaiser Commission on Medicaid and the Uninsured, October 2012, http://www.kff.org/uninsured/upload/7451-08.pdf.

[17] Author's estimate based on data from Sonya Streeter et al., 2012.

[18] Because these averages are based on insurance plans in which workers are enrolled, the change in premiums over time reflects shifts in the characteristics of these plans as well as increasing prices, and therefore may differ from changes over time in prices for the same or equivalent plans or for all plans available to workers.

[19] Kaiser Family Foundation and Health Research & Educational Trust (KFF-HRET), *Employer Health Benefits: 2011 Annual Survey*, 2011, http://ehbs.kff.org/pdf/2011/8225.pdf.

directly for premiums for family coverage more than doubled, from $1,787 in 2001 to $4,129 in 2011 (an average increase of 8.7 percent per year). For workers with single coverage, the average premium increased even more steeply, rising at an average rate of 10.0 percent per year, from $355 in 2001 to $921 in 2011.

### 5. Rising premiums contributed to a rise in the proportion of people without health insurance, putting more middle-class families at risk of unaffordable medical bills

Rising premiums influence both employers' and workers' decisions about health insurance. Employers must decide which health insurance options, if any, they offer. Workers must then decide whether or not to buy insurance if offered and which plan to choose if alternative plans are available. Rising premiums have led some employers to drop or not offer insurance. Other employers have modified the types and features of plans available to their employees or increased the portion of the premium employees must pay. Steep increases in the premiums workers pay have led more workers to forego insurance or to move to plans with relatively lower premiums and less comprehensive coverage—trends that have eroded middle-class income security by putting more people at risk of incurring unaffordable medical expenses. These trends have amplified the declines in employer-sponsored health insurance coverage that occurred due to job losses during the recession and slow recovery, which reduced both access to employer-sponsored insurance and the income to pay for it.

Among all workers (including those whose employers do and do not offer insurance), the percentage enrolled in insurance offered by their employers declined from 65 percent in 2001 to 58 percent in 2011.[20] This trend reflects both a decline in the proportion of workers who have the option of insurance at work and a decline in "take-up" of insurance among eligible employees.[21]

Looking at the population under age 65, the proportion with employer-sponsored insurance (as a worker or family member of a worker) fell from 67.8 percent in 2001 to 58.4 percent in 2011, a relative decline of 14 percent.[22] In 2011, 12.3 million fewer people had employer-sponsored insurance than in 2001. The proportion buying individually purchased insurance dropped slightly, from 7.3 percent to 7.1 percent. Public insurance programs, especially Medicaid, expanded enrollment significantly, buffering the drop in employer-based coverage for people with low incomes and limited savings. Still, the proportion of the population under age 65 who are uninsured increased by nearly one-fifth, from 15.2 percent in 2001 to 18.0 percent in 2011, putting millions more households at risk of incurring unaffordable health care costs.

Households at all income levels experienced increases in the proportion of adults without health insurance during the past decade. In middle-income families, the

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[20] KFF-HRET, 2011.

[21] KFF-HRET, 2011; and Paul Fronstin, *Employment-Based Health Benefits: Trends in Access and Coverage, 1997–2010*, Issue Brief no. 370, Employee Benefits Research Institute, April 2012, http://www.ebri.org/pdf/briefspdf/EBRI_IB_04-2012_No370_HI-Trends.pdf.

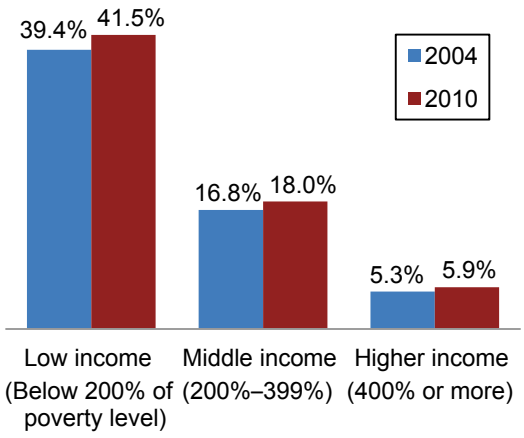
[22] Paul Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2012 Current Population Survey*, Issue Brief no. 376, Employee Benefit Research Institute, September 2012, http://www.ebri.org/pdf/briefspdf/EBRI_IB_09-2012_No376_Sources.pdf.

proportion of adults who are uninsured increased from 16.8 percent in 2004 to 18.0 percent in 2010 (see figure 3).[23]

Lack of health insurance is a major risk to middle-class economic security, as well as to quality of life. For people who incur high health care expenses, lack of insurance can lead to out-of-pocket expenses that increase medical debt and displace other priorities that are important to future economic security, such as saving for retirement, investing in education, and increasing home equity. Even among people who do not incur large health care bills, a lack of health insurance can have indirect but potentially serious and long-lasting effects on health and economic security.[24] Chronic conditions that are not well controlled may mean missed workdays and lower income—consequences that may, over time, have implications such as earlier retirement, lower savings, and diminished financial security.

**Figure 3**
**The Proportion of Middle-Income Adults without Insurance Increased During the Past Decade**

***Percent of adults under age 65 who are uninsured***




Sources: John Holahan & Allison Cook, The U.S. Economy and Change in Health Insurance Coverage, 2000–2006, *Health Affairs* 27(2)(2008):w135–w144;. John Holahan & Vicki Chen, Changes in Health Insurance in the Great Recession, 2007–2010, Kaiser Commission on Medicaid and the Uninsured, December 2011.

Cutbacks in the availability of workplace insurance also can have the effect of "job lock" for workers who have insurance at work—that is, staying in a job because other employment opportunities do not have health insurance benefits or have a lengthy waiting period. Research has found that employees who rely on employer-sponsored health insurance are less likely to switch jobs or become self-employed than people who have access to alternative sources of health insurance (such as through their spouse's employer).[25] Overall, job lock can detract from households' long-run income and economic security, as well as job satisfaction, by preventing workers from taking advantage of other opportunities. Job lock also detracts from the overall flexibility of the labor force, a factor that can affect long-run productivity and economic growth of the nation.

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[23] John Holahan and Allison Cook, "The U.S. Economy and Change in Health Insurance Coverage, 2000–2006," *Health Affairs* 27(2) (2008):w135–w144; John Holahan and Vicki Chen, *Changes in Health Insurance in the Great Recession, 2007–2010*, Kaiser Commission on Medicaid and the Uninsured, December 2011.

[24] For a discussion of recent research on this topic, see: Sarah Kliff, "Yes, insurance status does matter," *Ezra Klein's Wonkblog, The Washington Post*, October 11, 2012, http://www.washingtonpost.com/blogs/ezra-klein/wp/2012/10/11/yes-insurance-status-does-matter-for-your-health/; and Sarah Kliff, "Study: When health insurance costs rise, productivity drops," *Ezra Klein's Wonkblog, The Washington Post*, October 9, 2012, http://www.washingtonpost.com/blogs/ezra-klein/wp/2012/10/11/yes-insurance-status-does-matter-for-your-health/ and http://www.washingtonpost.com/blogs/ezra-klein/wp/2012/10/09/study-when-health-insurance-costs-rise-productivity-drops/.

[25] Government Accountability Office, *Health Care Coverage: Job Lock and the Potential Impact of the Patient Protection and Affordable Care Act*, GAO-12-166R, December 2011, http://www.gao.gov/assets/590/586973.pdf.

### 6. A dramatic increase in high-deductible health plans means more insured families face the risk of high medical bills

To constrain rising health insurance premiums, employers, employees, and people buying insurance in the individual market increasingly have been attracted to high-deductible health plans (also referred to as consumer-directed health plans) because they typically have lower premiums than other types of health insurance. Definitions of high-deductible plans differ. Studies often define them as plans with a deductible of least $1,000 for single coverage and at least $2,000 for family coverage. Other studies focus on high-deductible plans that are either paired with a Health Reimbursement Account, or that meet the qualifying criteria for a Health Savings Account (HSA) (see box for a discussion of types of high-deductible plans).

In 2011, more than one in five (22 percent) adults age 21–64 with private health insurance had a high-deductible health plan (defined as a plan with a deductible of at least $1,000 for single coverage and at least $2,000 for family coverage).[26] The share of working-age households with high-deductible insurance has grown rapidly, doubling between 2005 and 2011.[27] Enrollment under such plans is expected to continue expanding; some experts have suggested that high-deductible plans may grow to half of the employer-sponsored insurance market over the coming decade.[28]

Although premiums are typically lower, high-deductible plans put enrollees at elevated risk for high out-of-pocket expenses. In 2011, the family deductible was $4,000 or more for nearly half (46 percent) of workers who had an HSA-qualified high-deductible plan with family coverage.[29] The combination of a high deductible and cost sharing for health services means that individuals and families who need significant health care incur thousands of dollars in medical bills on top of their health insurance premiums.

Some observers consider increased cost-consciousness among consumers to be a benefit of high-deductible plans because they cause people to "think twice" before obtaining services. Research findings suggest high-deductible plans have reduced health care use and spending.[30] However, evidence also indicates that some people facing high out-of-pocket expenses forego needed care, potentially leading to more serious problems and higher costs down the road.[31] Research findings indicate that people with high-

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[26] Paul Fronstin, *Findings from the 2011 EBRA/MGA Consumer Engagement in Health Care Survey*, Issue Brief no. 365, Employee Benefit Research Institute, December 2011, http://www.ebri.org/pdf/briefspdf/EBRI_IB_12-2011_No365_CEHCS.pdf

[27] Ibid.

[28] Amelia M. Haviland et al., "Growth of Consumer-directed Health Plans to One-half of All Employer-Sponsored Insurance Could Save $57 Billion Annually," *Health Affairs* 31(5) (2012):1009–15.

[29] KFF-HRET, 2011.

[30] M. Kate Bundorf, *Consumer-directed health plans: Do they deliver?* Research Synthesis Report no. 24, The Synthesis Project, Robert Wood Johnson Foundation, October 2012, http://www.rwjf.org/content/dam/farm/reports/reports/2012/rwjf402405.

[31] Steffie Woolhandler and David U. Himmelstein, "Consumer Directed Healthcare: Except for the Healthy and Wealthy It's Unwise," *Journal of General Internal Medicine* 22(2007): 879–881. See also Rand Health, *Skin in the Game: How Consumer-Directed Plans Affect the Cost and Use of Health Care*, Research Highlights, 2012, http://www.rand.org/content/dam/rand/pubs/research_briefs/2012/RAND_RB9672.pdf.

### Types of High-Deductible Health Plans

There are different types of high-deductible health plans. One type, referred to as Health Savings Account (HSA) qualified, allows policyholders the option of establishing a Health Savings Account, which offers tax incentives for savings that are used to pay out-of-pocket health care expenses. To be has qualified, a health plan must meet certain requirements, including an annual deductible of at least $1,200 for single coverage and $2,400 for family coverage in 2012.[32] Employers can also offer high-deductible heath plans (which do not have to be HSA-qualified) paired with a Health Reimbursement Account, an account funded by the employer that the employee can draw upon for health care expenses.[33] There are also high deductible plans that are neither HAS-qualified nor paired with a Health Reimbursement Account.

In 2011, about one-third of adults with a high-deductible health plan also had an HSA or Health Reimbursement Account; another third had an HSA-qualified plan but did not have an HSA; and the remaining third had a high-deductible health plan that was neither HSA-qualified nor paired with a Health Reimbursement Account.[34] Among people with HSA-qualified high-deductible plans, about one-fifth purchased them in the individual market.[35]

The annual Employer Benefits Survey, conducted by the Kaiser Family Foundation and Health Research & Educational Trust, collects information on "high deductible health plans with a savings option" (that is, plans that are either HSA-qualified or paired a Health Reimbursement Account) offered by employers. In 2011, annual premiums (the sum of the employer's and employee's shares) for these plans were 9 percent (or $1,369) less, on average, for family coverage and 12 percent (or $636) less for single coverage, compared with the overall average premiums of workers with any type of employer-based insurance.[36] For about half of the 17 percent of workers enrolled in high-deductible plans with a savings option in 2011, the high-deductible plan was the only insurance option available at their workplace.[37]

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[32] The minimum deductible amounts adjust annually for inflation. For 2013, the deductible must be at least $1,250 for self-only coverage and $2,500 for family coverage. Sally P. Schreiber, "HSA Inflation Adjustments for 2013," *Journal of Accountancy*, April 27, 2012, http://www.journalofaccountancy.com/News/20125614.htm.

[33] KFF-HRET, 2011.

[34] Paul Fronstin, *Findings from the 2011 EBRA/MGA Consumer Engagement in Health Care Survey*, Issue Brief no. 365, Employee Benefit Research Institute, December 2011, http://www.ebri.org/pdf/briefspdf/EBRI_IB_12-2011_No365_CEHCS.pdf

[35] America's Health Insurance Plans, Center for Policy and Research, *January 2012 Census Shows 13.5 Million People Covered by Health Savings Account/High-Deductible Health Plans (HAS/HDHPs)*, May 2012, http://www.ahip.org/AHIPResearch/.

[36] Computed from KFF-HRET, 2011, Exhibit B.

[37] KFF-HREF, 2011.

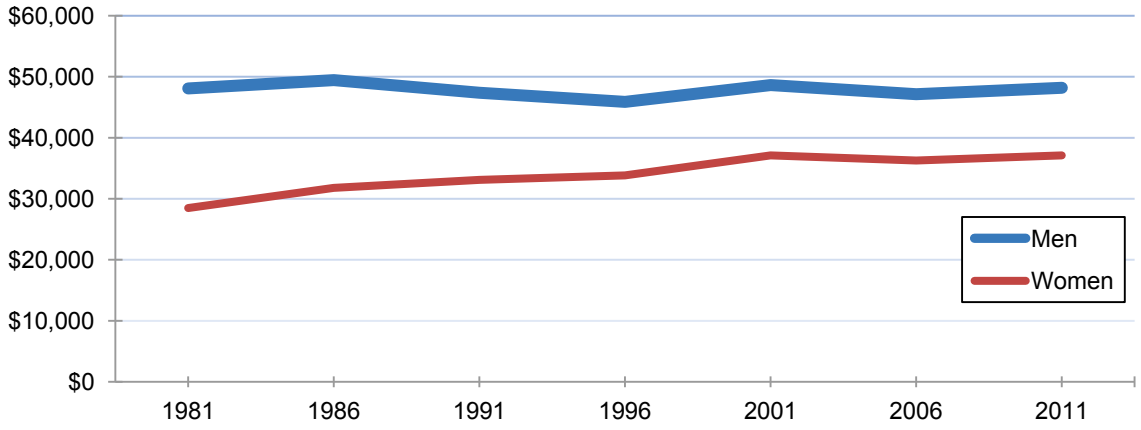
deductible health plans are more likely than people with other types of health insurance plans to skip preventive care,[38] forego or delay care because of cost,[39] and have unmet medical care needs or prescription drug needs because of cost.[40]

### 7. Rising health care costs have slowed growth in middle-class wages

Wage growth in the United States has been remarkably slow in recent decades, despite continuing increases in worker productivity.[41] After adjusting for inflation, median full-time earnings of men have been virtually unchanged—not only over the past decade, but over the past 40 years (see figure 4).[42] Earnings of women employed full-time have also been nearly flat during most of the past decade, after adjusting for inflation. Median annual earnings of women employed full-time, year-round were $37,118 in 2011, nearly the same as in 2001 ($37,114, in 2011 dollars).

**Figure 4**
**Median Inflation-Adjusted Wages of Full-time Workers Have Not Changed Over the Past Decade**

***Median annual earnings of full-time, year-round workers (in 2011 dollars)***




Sources: Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica C. Smith, *Income, Poverty, and Health Insurance Coverage in the United States: 2011*, U.S. Census Bureau, Current Population Reports, P60-243 (Washington, DC: U.S. Government Printing Office, 2012), http://www.census.gov/prod/2012pubs/p60-243.pdf.

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38 Melinda Beeuwkes Buntin et al., "Healthcare Spending and Preventive Care in High-Deductible and Consumer-Driven Health Plans," *American Journal of Managed Care* 17(3) (2011):222–30.

39 Alison A. Galbraith et al., "Delayed and Forgone Care for Families with Chronic Conditions in High-Deductible Health Plans," *Journal of General Internal Medicine (Online First),* published online January 18, 2012, http://www.springerlink.com/content/k884422j8t75p076/.

40 Robin A. Cohen, *Impact of Type of Insurance Plan on Access and Utilization of Health Care Services for Adults Aged 18–64 Years with Private Health Insurance: United States, 2007–2008*, Data Brief no. 28, National Center for Health Statistics, February 2010, http://www.cdc.gov/nchs/data/databriefs/db28.pdf.

41 Steven A. Nyce and Sylvester J. Schieber, *How Rising Health Costs Slow Wage Growth* (Washington, DC: Progressive Policy Institute, March 2012).

42 Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica C. Smith, *Income, Poverty, and Health Insurance Coverage in the United States: 2011*, U.S. Census Bureau, Current Population Reports, P60-243 (Washington, DC: U.S. Government Printing Office, 2012), http://www.census.gov/prod/2012pubs/p60-243.pdf.

While numerous aspects of our economy have influenced the trend in wages, rising health care costs have been an important factor in slowing growth. Experts note that employers focus on total compensation costs—that is, the combination of wages and benefits—so increases in health benefits will result in lower wage increases than would occur if health benefits did not increase.[43] The Council of Economic Advisers reports that between 2000 and 2009, workers' average total compensation (wages and benefits) grew by 1.3 percent per year (after adjusting for inflation).[44] The growth rate of premiums for employer-sponsored coverage was much faster, however, averaging 5.1 percent per year (after adjusting for inflation) during this period. As a result, the portion of workers' total compensation going toward employer-sponsored health insurance premiums expanded from 7.4 percent in 2000 to 10.3 percent in 2009. The average wages workers received net of insurance premiums (that is, after subtracting the employees' premiums) grew by only 0.7 percent per year (adjusted for inflation) between 2000 and 2009.[45]

Although the main effect of rising premiums is slower wage growth, research evidence indicates that rising premiums have also led to cutbacks in the number of jobs and more part-time positions (which tend to not have health insurance) relative to full-time ones.[46] Because it is difficult for employers to actually lower individual workers' wages, when premiums grow faster than productivity gains and inflation, the increases cannot be fully offset with lower wage growth. Employers therefore take other actions, such as reducing the number of full-time jobs, to control costs.

In addition, evidence suggests that rising health insurance costs have contributed to increasing inequality in income.[47] An employer's contribution toward health premiums is roughly similar for all workers, but it usually accounts for a larger share of the total compensation for workers earning low and middle wages than it does for higher-wage workers.[48] Thus, as employer contributions toward premiums increased over time, they absorbed a larger share of total compensation gains for low- and middle-income workers than for high-wage workers, contributing to the widening differences in take-home pay across the wage distribution. A recent study estimated that, for workers in the middle 40 percent (middle four deciles) of the earnings distribution, increases in health care benefits paid by employers represented 26 percent to 37 percent of total compensation

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43 Ezekiel J. Emanuel and Victor R. Fuchs, "Who Really Pays for Health Care? The Myth of 'Shared Responsibility,'" *Journal of the American Medical Association* 299(9) (2008):1057–9.

44 Christina Romer and Mark Duggan, *Exploring the Link between Rising Health Insurance Premiums and Stagnant Wages*, Council of Economic Advisers, March 12, 2010, http://www.whitehouse.gov/blog/2010/03/12/exploring-link-between-rising-health-insurance-premiums-and-stagnant-wages.

45 Assuming these growth rates in total compensation and premiums continue, the Council of Economic Advisors estimates that total premiums will constitute 15 percent of total compensation by 2019. Ibid.

46 Katherine Baicker and Amitabh Chandra, "The Labor Market Effects of Rising Health Insurance Premiums," *Journal of Labor Economics* 24(3)(2006):609–34; Neeraj Sood, Arkadipta Ghosh, and Jose J. Escarce, "Employer-Sponsored Insurance, Health Care Cost Growth, and the Economic Performance of U.S. Industries," *Health Services Research* 44(5) (2009):1449–64.

47 Nyce and Schieber, 2012; Gary Burtless and Sveta Milusheva, *Effects of Employer Health Costs on the Trend and Distribution of Social-Security Taxable Wages* (Washington, DC: The Brookings Institution, February 2010).

48 Nyce and Schieber, 2012.

gains between 2000 and 2009.[49] In comparison, increases in health benefits represented 9 percent of total compensation gains for workers in the top decile of the earnings distribution.

### 8. Health-related expenses absorb a large, and growing, share of incomes for people age 65 and older

Many older people see the middle-class security they built during their working years eroded by high health-related expenses. The federal Medicare program provides health insurance for nearly all people over age 65 and for some younger people with disabilities or end-stage renal disease. While Medicare provides considerable insurance coverage for a range of health care services, enrollees pay for Medicare premiums and cost-sharing requirements. To help pay for Medicare's cost-sharing requirements, most middle- and higher-income Medicare enrollees have some type of private supplemental insurance, such as: employer-sponsored retiree health coverage, a Medigap policy, or enrollment in a Medicare Advantage plan. Low-income Medicare enrollees are eligible for assistance paying for Medicare's optional prescription drug coverage. Many low-income Medicare enrollees qualify for Medicaid benefits, which cover Medicare's premiums and cost-sharing requirements, as well as some services not covered by Medicare, such as dental, vision, and long-term services and supports.

Even with supplemental coverage, however, most middle-income Medicare enrollees have sizable out-of-pocket expenses, including premiums for Medicare Part B and Part D (for those who choose to enroll), premiums for supplemental insurance, cost sharing for Medicare-covered services, and expenses for services not covered by Medicare. In 2012, Medicare's standard Part B premium ($99.90 per month) and an average-priced drug plan (about $40 per month) total nearly $1,700 for the year for an individual or $3,400 for a couple.[50]

When out-of-pocket spending on health care services, as well as insurance premiums, is taken into account, many retirees spend large shares of their income on health-related expenses. Among Medicare enrollees age 65–69, half spent more than 11 percent of their incomes on health care expenses (including nursing home services) in 2007 (see table 2). Median out-of-pocket spending and the share of income taken up by out-of-pocket spending increase with age; among Medicare beneficiaries age 85 and older, half spent more than 28 percent of their income on health care.[51]

These levels of spending mean that many middle-income retirees must draw from savings in order to pay for health-related expenses—and numerous retirees exhaust their

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[49] Ibid.

[50] Harriet Komisar, Juliette Cubanski, Lindsey Dawson, and Tricia Neuman, *Key Issues in Understanding the Economic and Health Security of Current and Future Generations of Seniors* Kaiser Family Foundation, March 2012, http://www.kff.org/medicare/upload/8289.pdf.

[51] For another analysis of health care expense burden of people age 65 and older, see Jessica S. Banthin and Didem Bernard, "Incorporating Data on Assets into Measures of Financial Burdens of Health," in *Medical Care Economic Risk: Measuring Financial Vulnerability from Spending on Medical Care*, ed. Michael J. O'Grady and Gooloo S. Wunderlich (Washington, DC: National Academies Press, pre-publication copy, September 2012).

savings.[52] Rising health care costs make it increasingly difficult for retirees to have adequate savings to pay for out-of-pocket health expenses throughout retirement. One study estimated that, in 2010, a married couple with Medicare who purchased both supplemental insurance (Medigap) and Part D drug coverage would need savings at age 65 of $158,000 to cover the median projected insurance premiums and other health care expenses in retirement. However, because longevity and health care expenses are unpredictable, there is a substantial probability that this couple's expenses would exceed the median level. Taking into account the unpredictable variation in expenses, the study estimates that they would need to $271,000 in savings to have a 90 percent chance of having enough money to cover insurance premiums and other health care expenses in retirement.[53] These estimates do not include any additional costs of long-term care services.

**Table 2**
**Out-of-Pocket (OOP) Health Care Expenses Take Up a Sizable Share of the Incomes of Most People Over Age 65**

| Age | Out-of-Pocket Health Care Spending by Medicare Beneficiaries Age 65 and Older in 2007 | |
|---|---|---|
| | Total OOP Spending (median) | OOP Spending as a Percentage of Income (median) |
| **65–69** | $2,676 | 11.0% |
| **70–74** | $3,236 | 16.8% |
| **75–79** | $3,572 | 19.2% |
| **80–84** | $3,817 | 23.0% |
| **85 and older** | $4,237 | 27.8% |

Source: Claire Noel-Miller, *Medicare Beneficiaries Out-of-Pocket Spending for Health Care*, AARP Public Policy Institute, May 2012, http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/medicare-beneficiaries-out-of-pocket-spending-AARP-ppi-health.pdf.

Because of rising health care costs, health care expenses are projected to absorb an increasing share of retirees' incomes in the future. A new study by the Urban Institute projects the retirement prospects for current working-age (ages 25–54) middle-income adults and compares them to today's retirees (ages 69–71). In the study, "middle income" is defined as the middle one-third of the distribution of household income per person in the household. The projections indicate that out-of-pocket expenses for health care (insurance premiums and services), excluding long-term services and supports, will absorb a larger share of retirement income for future middle-class retirees. At age 70, the median working-age (age 25–54 in 2012) middle-income person will spend an estimated 18 percent of household income on health care expenses, compared with 8 percent for the median middle-income person among today's retirees (ages 69–71 in 2012). Although the median income at age 70 for people in the younger cohort will be higher than for the older cohort, nearly all of the income gain will go to higher out-of-pocket health expenses.[54]

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[52] James M. Poterba, Steven F. Venti, and David A. Wise, *Were They Prepared for Retirement? Financial Status at Advanced Ages in the HRS and AHEAD Cohorts*, NBER Working Paper No. 17824, February 2012, http://www.nber.org/papers/w17824.

[53] This estimate assumes median prescription drug expenses. Paul Fronstin, Dallas Salisbury, and Jack VanDerhei, *Funding Savings Needed for Health Expenses for Persons Eligible for Medicare*, EBRI Issue Brief, No. 351, December 2010, http://www.ebri.org/pdf/briefspdf/EBRI_IB_12-2010_No351_Savings3.pdf.

[54] Barbara Butrica and Mikki Waid, *What Are the Retirement Prospects of Middle Class Americans* Research Report (Washington, DC: AARP Public Policy Institute, 2013).

### 9. Expenses for long-term services and supports are a major risk to economic security in retirement for middle-class families

Many people who had been middle class throughout their working years are at risk of not having enough financial resources to maintain a middle-class lifestyle during their retirement years. One estimate of "retirement readiness" projects that nearly half (47 percent) of people currently ages 56–62—including two-fifths (41 percent) of middle-income people in this age group—are at risk of not being able to pay for basic living expenses and out-of-pocket health care costs in retirement, including nursing home and home health care expenses.[55] Another report found that 46 percent of people die with virtually no assets, often because they had inadequate resources to pay for unanticipated expenses related to health and long-term services and supports (LTSS).[56]

An especially high, unpredictable risk to middle-class security is the potential cost of long-term services and supports (also called long-term care). These services consist primarily of ongoing personal assistance with routine activities (such as bathing, dressing, and managing medications) in many settings, including at home, in an adult day center, in assisted living, and in nursing homes.

The need for LTSS is uncertain and varies widely among individuals. Some people will not need any long-term care services during their lives; others will need extensive assistance for an extended period of time.[57] Most people who need LTSS reside at home, not in nursing homes or assisted living facilities, and rely solely on unpaid personal assistance from family and friends.[58] Family caregivers cannot always, however, provide the intensity, type, or full amount of needed care.

When an individual needs extensive LTSS, the costs can add up quickly. The cost of hiring a home care assistant averages about $21 an hour in 2012, or about $22,000 annually for 20 hours per week of assistance.[59] Adult day center services cost $70 per day, on average, or about $18,000 annually for five days per week. The annual cost of assisted living services is about $43,000 for a basic package of services, which many

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55 Jack VanDerhei and Craig Copeland, *The EBRI Retirement Readiness Rating: Retirement Income Preparation and Future Prospects*, EBRI Issue Brief, No. 344, July 2010, http://www.ebri.org/pdf/briefspdf/EBRI_IB_07-2010_No344_RRR_RSPM1.pdf. See also Alicia H. Munnell, Anthony Webb, and Francesca Golub-Sass, *That National Retirement Risk Index: After the Crash*, Center for Retirement Research at Boston College, October 2009, http://crr.bc.edu/wp-content/uploads/2009/10/IB_9-22.pdf; and Alicia H. Munnell, Anthony Webb, Francesca Golub-Sass, and Dan Muldoon, *Long-Term Care Costs and the National Retirement Risk Index*, Center for Retirement Research at Boston College, March 2009, http://crr.bc.edu/wp-content/uploads/2009/04/IB_9-7.pdf.

56 Poterba, Venti, and Wise, 2012.

57 Peter Kemper, Harriet L. Komisar, and Lisa Alecxih, "Long-Term Care Over an Uncertain Future: What Can Current Retirees Expect?" *Inquiry* 42(4) (Winter 2005–2006):335–50.

58 H. Stephen Kaye, Charlene Harrington, and Mitchell P. LaPlante, "Long-Term Care: Who Gets It, Who Provides It, Who Pays, and How Much?" *Health Affairs* 29(1) (January 2010):11–21.

59 MetLife Mature Market Institute and LifePlans, Inc., *Market Survey of Long-Term Care Costs: The 2012 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs*, November 2012, https://www.metlife.com/assets/cao/mmi/publications/studies/2012/studies/mmi-2012-market-survey-long-term-care-costs.pdf.

people need to supplement with additional services that increase the price. The average price of nursing home care is nearly $91,000 per year for a private room.

Medicare and private health care insurance do not pay for ongoing LTSS, and only a small portion of middle-income households buy private long-term care insurance.[60] While Medicare provides limited coverage of home health care and skilled nursing facility services in certain situations, these benefits are focused on postacute, rehabilitative skilled nursing and therapy services. Medicaid benefits include LTSS, but only people with low incomes and limited savings are eligible for Medicaid, including people who have exhausted their resources paying for medical care and LTSS. Because Medicaid steps in when financial resources are used up, it is vital safety net for middle-class households.[61]

The costs of extensive paid services are beyond the incomes of middle-class retirees, and could quickly exhaust the savings of most of them. Among middle-income (middle three income quintiles) households age 75 and older (the age range at highest risk of needing LTSS), median financial assets were $64,000 in 2010,[62] an amount that could cover less than nine months in a private room in a nursing home (at the national average price of $7,543 per month) or less than 14 months of dementia care in an assisted living facility (at an average cost of $4,807 per month in 2012).[63]

Medicaid's safety net is essential to middle-class families because it ensures access to services for people with high levels of need who have exhausted their own resources. However, relying on Medicaid means a loss of financial independence, a situation most middle-class retirees dread. Individuals who are eligible for Medicaid must apply all of their resources except for certain allowances to their medical and long-term care services. Medicaid recipients receiving nursing home care are required to spend all of their financial resources on their nursing home care (with limits for residents with spouses at home), except for a small "personal needs allowance" of about $30 to $60 per month in most states.[64] To avoid relying on Medicaid, or to delay it as long as possible, households often have to make difficult choices. Too often, personal assistance needs are not fully met, financial resources are diverted from other priorities, and family members take on large caregiving responsibilities.

Further, while Medicaid pays for nursing home services in all states, Medicaid coverage of home care services, assisted living, and other community-based services varies widely by state, and many individuals who prefer these types of services are not

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60 LifePlans, Inc., *Who Buys Private Long-Term Care Insurance in 2010–-2011? America's Health Insurance Plans*, March 2012.

61 Wendy Fox-Grage and Donald L. Redfoot, *Medicaid: A Program of Last Resort for People Who Need Long-Term Services and Supports*, AARP Public Policy Institute, May 2011, http://www.aarp.org/health/medicare-insurance/info-05-2011/fs223-medicaid.html.

62 AARP Public Policy Institute analysis of the Survey of Consumer Finance, Federal Reserve, 2012.

63 MetLife Mature Market Institute and LifePlans, Inc., 2012.

64 Lina Walker and Jean Accius, *Access to Long-Term Services and Supports: A 50-State Survey of Medicaid Financial Eligibility Standards*, AARP Public Policy Institute, September 2010, http://assets.aarp.org/rgcenter/ppi/ltc/i44-access-ltss_revised.pdf.

able to obtain them through Medicaid.[65] Budget pressures are forcing states to make important decisions about their Medicaid programs, limiting expansion of home and community-based services in some states but spurring others to accelerate the transformation of their systems to promote more home and community-based services in order to control costs.[66]

### 10. Family caregiving affects the economic security of families in complex ways

Most individuals who need LTSS rely solely on unpaid assistance from family caregivers and receive no paid services. Family caregivers also typically have a significant role in assisting individuals who receive paid services at home or in an assisted living or nursing home setting. The types and amounts of assistance vary widely, like individuals' needs. Caregiving is undoubtedly of major value to families, and the availability of family or close friends can contribute greatly to the care recipient's well-being and economic security. One study estimated unpaid work of family caregivers to have a national economic value of $450 billion in 2009, underscoring the magnitude of these unpaid contributions to society.[67] But the value of caregiving goes beyond national cost savings or savings for care recipients, because these unpaid services also reflect the type of assistance that individuals with disabilities often prefer.

A recent survey documents the varied, complicated, and skilled work that family caregivers perform in the home—often with little training or supervision from health care professionals. Family caregivers have always provided personal assistance with activities such as bathing, preparing meals, shopping, and managing finances. Increasingly, family caregivers are also performing medically related nursing tasks, including managing multiple medications, providing intravenous medications and injections, helping with assistive devices used for mobility, preparing food for special diets, providing wound care, and using monitors and specialized medical equipment.[68]

While caregiving arrangements can have a positive effect on the economic security and well-being of the care recipient, such responsibilities often reduce the economic security of the caregiver. Most caregivers are employed full-time or part-time, or were

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[65] Judy Feder and Harriet L. Komisar, *The Importance of Federal Financing to the Long-Term Care Safety Net*, The Scan Foundation, February 2012, http://www.thescanfoundation.org/sites/thescanfoundation.org/files/Georgetown_Importance_Federal_Financing_LTC_2.pdf.

[66] Mike Cheek, Martha Roherty, Leslie Finnan, Eunhee Cho, Jenna Walls, Kathleen Gifford, Wendy Fox-Grage, and Kathleen Ujvari, *On the Verge: The Transformation of Long-Term Services and Supports*, AARP Public Policy Institute, February 2012) http://www.aarp.org/health/health-care-reform/info-02-2012/On-the-Verge-The-Transformation-of-Long-Term-Services-and-Supports-AARP-ppi-ltc.html.

[67] Lynn Feinberg, Susan C. Reinhard, Ari Houser, and Rita Choula, *Valuing the Invaluable: 2011 Update, The Growing Contributions and Costs of Family Caregiving*, Insight on the Issues 51, AARP Public Policy Institute, June 2011) http://assets.aarp.org/rgcenter/ppi/ltc/i51-caregiving.pdf.

[68] Susan C. Reinhard, Carol Levine, and Sarah Samis, *Home Alone: Family Caregivers Providing Complex Chronic Care, AARP and the United Hospital Fund*, October 2012, http://www.aarp.org/home-family/caregiving/info-10-2012/home-alone-family-caregivers-providing-complex-chronic-care.html.

employed sometime while also caregiving.[69] A national survey of caregivers (of adults age 50 and older) found that among those who had worked while caregiving, two-thirds had made some adjustments to their employment because of their caregiving responsibilities, such as taking time off, taking a leave of absence, cutting back work hours, or turning down a promotion. One in ten caregivers quit a job or took early retirement.[70]

Caregivers who make adjustments in their work may experience a range of effects that reduce their income and economic security, both during their working years and in retirement. During their working years, adjustments in work (such as choosing to work part-time) can affect job security and future job opportunities, as well as access to employment-related benefits such as health insurance and retirement benefits. One study estimated that family caregivers (age 50 and older) who leave the workforce to care for a parent lose, on average, nearly $304,000 in wages, Social Security, and pension benefits over their lifetimes.[71] Caregiving responsibilities can affect retirement security because lower earnings can result in lower Social Security benefits, pension income, and retirement savings. One study found that assuming the role of caregiver for aging parents in midlife may substantially increase a woman's risk of living in poverty and receiving public assistance in old age.[72]

## CONCLUSION

Rising out-of-pocket costs for health insurance and health care services, and the increasing exposure to a risk of high out-of-pocket costs for health-related services not covered by insurance, are major concerns for middle-class households of all ages. The trends of the past decade described here document the ways in which rising health care costs have adversely affected the economic security of middle-class families during their working and retirement years.

The Affordable Care Act will make an important difference by expanding the number of people with health insurance protection, but the trend toward high-deductible health plans may mean that many currently and newly insured households face a significant risk of high medical bills. Increasing consumer awareness of how these plans (and health insurance in general) work may be beneficial, along with providing information about savings options that can be paired with high-deductible plans. Other strategies to help consumers include requiring clear information on the price of services and out-of-pocket

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[69] Lynn Feinberg and Rita Choula, *Understanding the Impact of Family Caregiving on Work*, Fact Sheet 271, AARP Public Policy Institute, October 2012, http://www.aarp.org/home-family/caregiving/info-10-2012/understanding-the-impact-of-family-caregiving-and-work-fs-AARP-ppi-ltc.html.

[70] National Alliance for Caregiving (NAC) and AARP, *Caregiving in the U.S. 2009* (Bethesda, MD: NAC, and Washington, DC: AARP, November 2009).

[71] MetLife Mature Market Institute, National Alliance for Caregiving, and Center for Long Term Care Research and Policy at the New York Medical College, *The MetLife Study of Caregiving: Costs to Working Caregivers: Double Jeopardy for Baby Boomers Caring For Their Parents* (New York, NY: MetLife Mature Market Institute, June 2011).

[72] Chizuko Wakabayashi and Katharine M. Donato, "Does Caregiving Increase Poverty among Women in Later Life? Evidence from the Health and Retirement Survey," *Journal of Health and Social Behavior* 47(3) (2006):258–74.

expenses, as well as information on the quality of care. Policy proposals that would increase out-of-pocket health care expenses for Medicare enrollees are a concern, given the high proportion of middle-class retirees for whom health care costs are already burdensome.

The possibility of needing LTSS in the future is an especially large risk to the economic security of older adults in retirement. Policies to assist family caregivers would benefit numerous families. Proposals include providing tax credits to defray some of the costs of caregiving, Social Security credits for family caregivers, promoting workplace practices that provide more flexibility to workers in their schedules and use of leave, and expanding the categories of workers covered by the Family and Medical Leave Act to allow more workers to take unpaid leave for caregiving.

Without a major change in policy, Medicaid will continue to play a large, essential role in LTSS, not only for people with low incomes but also for people who were middle class during their working years and have exhausted their financial resources on medical care and LTSS. Policies to improve the availability in Medicaid of quality LTSS in home and community settings, along with improved support for family caregivers, would improve the quality of life for many retirees who need long-term care, as well as their caregivers. Even with substantial improvements, however, Medicaid is a "safety net" program requiring people to deplete their financial resources before qualifying. Protecting middle-class security in retirement against this risk will require widespread insurance protection for LTSS. Achieving this goal is a significant policy challenge. But a more adequate solution to helping middle-class families pay for long-term services and supports could yield benefits to economic security, health, and well-being for the millions of people who need these services and for their families.

A recent slowdown in health care spending growth is welcome news. Although the recession and struggling recovery are likely the most important factors in the historically slow growth seen in 2009 and 2010, some experts suggest that fundamental changes in health care delivery are also occurring. The future economic health of the nation will depend on constraining the growth in health care spending. But spending constraints must be accompanied by a focus on improving the value of health care—that is, using health care resources efficiently to achieve affordable insurance coverage and quality care. Gains in the productivity and effectiveness of health care are possible in a variety of areas: organization of care delivery; care coordination for patients with complex needs; workforce development and training; technology (including information technology); administrative systems; and patient information and involvement in decision making.[73] While the Affordable Care Act included provisions to constrain Medicare spending and improve the coordination and efficiency of service delivery, a number of additional policy options could be adopted to stimulate advances in cost-effectiveness by altering incentives and addressing the sources of health spending growth.

[73] For some specific policy proposals, see Ezekiel Emanuel et al., "A Systematic Approach to Containing Health Care Spending," *New England Journal of Medicine*, published August 1, 2012, http://www.nejm.org/doi/full/10.1056/NEJMsb1205901#t=article.