

Employer-Sponsored Coverage: Shape It Up? Ship It Out?

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ALLIANCE FOR
HEALTH REFORM

Six out of 10 nonelderly Americans—about 160 million in all—get health insurance through their job or their family member's job. But the gradual erosion of employer-based coverage in recent years has called into question its sustainability as the dominant insurance model for working Americans.

Policymakers and presidential candidates have begun what may become a wide-ranging national discussion about the viability of employer-sponsored insurance (ESI) in its current form, and any changes that may be needed either to strengthen it or to replace it entirely.

A Troublesome Trend?

Growth in ESI has been fueled by its usefulness in helping employers recruit and retain workers, and by its favorable tax treatment (employers may deduct the amount they pay for their employees' health insurance premiums, and workers need not include it as part of their taxable incomes). The number of nonelderly individuals enrolled in employer-sponsored plans peaked at 167.5 million in 2000 (68.4 percent) and dropped to 161.7 million by 2006 (62.2 percent). Analysts attribute this decline more to new employers failing to offer coverage than to established employers cutting existing offers of coverage.

This decline seems dramatic, but over the last few decades, ESI coverage has been relatively stable. Looking back to 1994 (the first year for which comparable data are available), 64.4 percent of nonelderly Americans received employment-based coverage compared to 62.2 percent today.

The sharper decline in employer-sponsored coverage since 2000 has largely been

driven by a decline in the number of small firms offering health insurance. Since 1999, approximately 99 percent of firms with 200 or more workers have offered health benefits to their employees. Among small firms with three to 199 workers, 68 percent offered coverage in 2000; but by 2007, only 59 percent of these firms offered coverage, the same percentage as in 1996, before the height of the Internet boom.

Said Paul Fronstin of the Employee Benefit Research Institute (EBRI), "One of the reasons why coverage expanded, [and] offer rates expanded among employers, was because we had unemployment rates around four percent. And small businesses were doing what they had to do to compete for workers. They were adding health benefits."

A Greater Burden for Employees

The decline in the number of people covered through employment is only one measure of the health of the employer-based system. There is some evidence that at the same time that the prevalence of ESI is gradually eroding, the value of that coverage to employees may be eroding also.

Health insurance premiums have been increasing significantly faster than overall inflation and workers' earnings for nearly a decade. Between 1999 and 2007, the average monthly worker premium contribution for individual coverage rose 115 percent, from \$27 to \$58. The monthly worker contribution for family coverage rose 112 percent, from \$129 to \$273. In contrast, overall inflation increased 24 percent over the same time period. (See chart on page 2.)

Furthermore, employees have faced ris-

Fast Facts

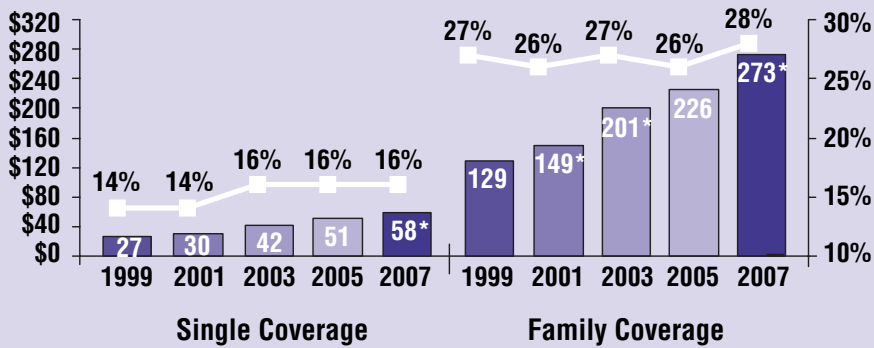
- ▲ Six out of 10 nonelderly Americans get health insurance through employer-sponsored coverage.
- ▲ The portion of nonelderly individuals enrolled in employer-sponsored plans dropped from 68.4 percent in 2000 to 62.2 percent in 2006.
- ▲ While the percentage of large employers offering coverage has remained stable at 98 to 99 percent since 1999, the percentage has dropped among small employers (68 percent in 2000 vs. 59 percent in 2007).
- ▲ Average health insurance premiums have increased faster than overall inflation or workers' earnings for 19 of the past 20 years. The exception was 1996.
- ▲ In 2008, more than half of employers surveyed plan to require employees to pay a larger percentage of the total premium than in 2007.

In September 2007 the Alliance for Health Reform, with support from the Robert Wood Johnson Foundation, held a Capitol Hill briefing to examine the state of employer-based coverage. Panelists were Paul Fronstin, Employee Benefit Research Institute; Robert Galvin, General Electric; Gerald Shea, AFL-CIO; and Len Nichols, New America Foundation. This issue brief incorporates material from that briefing.



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Amount and Percent of Average Monthly Worker Premium Contribution, Selected Years



SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2007.

ing out-of-pocket costs in tandem with rising premiums. Since 2001, an increasing number of firms have been requiring deductibles for PPO in-network care and HMO inpatient hospital services. Employers have also significantly increased the amount of annual deductibles. In 2000, only 14 percent of workers had a deductible of \$500 or more; by 2006, 38 percent did.

Although total premiums have risen, the share of premiums paid by workers has been relatively stable since 1999 (between 14 and 16 percent for individuals, and 26 and 28 percent for families). (See chart.)

There are signs, however, that workers may have to pick up a greater share in the future. A Mercer health benefits survey found that 56 percent of employers planned on requiring employees to pay a larger percentage of premiums in 2008 than they had previously.

Reasons for Cost Increases

Rising health premiums largely reflect rising health care costs, and the rise in the cost of care has many causes. Advancements in medicine and technology have lengthened the lives of Americans, but they have contributed to rising health costs. Some studies suggest that half or more of all medical cost growth may be attributable to the increased use of technology.

Insurer behavior also may have contributed to higher costs. Some insurers have shifted market strategy from maximizing enrollment to charging higher premiums, with attendant enrollment declines, for the sake of profitability.

Analysts also cite third-party payment (which insulates consumers from costs), backlash to managed care cost containment, the aging of the population, lifestyle changes and a growing

prevalence of high-cost treatments. Consumer demand, administrative costs and malpractice claims may also factor into high health care spending. Estimates of the impact of each of these factors differ.

Impact of Employee Choices

The behavior of employees and employers in the context of rising premiums has also contributed to declines in ESI. Worker take-up rates—the proportion of workers actually enrolling in ESI when it’s available to them—have fallen, from 88 percent in 1988 to 83.5 percent in 2005. Still, of the 16 percent or so of workers who don’t take coverage from their employer when it’s offered, more than two-thirds get insurance from another source, usually a spouse’s place of employment.

Some analysts believe that changes in the structure of employment arrangements are one factor behind declining ESI rates. In recent years the share of self-employed and contingent (or part-time) workers has risen. Contingent workers are less likely to receive health care benefits from their employers than full-time employees.

How Much Should We Worry?

The degree to which the downturn in ESI is a cause for concern is a matter of debate. On the one hand, proponents of ESI note that employment-based insurance helps keep costs down by pooling insurance risk for unhealthy workers (and their family members) with a larger number of healthy workers (and family members). Without risk pooling, sicker beneficiaries might gravitate to certain insurance products, causing the premiums to go up and driving healthier individuals away.

Also, administrative costs associated with ESI are generally lower than in the non-group market, where insurers have the cost of individually marketing to and enrolling members. Larger employers also have the resources to employ human resources personnel with the expertise to evaluate insurance plans and negotiate for better quality and pricing.

“[ESI] has led to some innovations,” GE’s Robert Galvin said. “[In] other countries, the number of integrated delivery systems, like Kaiser Permanente or Group Health of Puget Sound, is much smaller. The whole value purchasing agenda...not just focusing on cost containment, but really...thinking about value...payment reform efforts...are all examples of some unique contributions that employers bring.”

Move beyond Employer-Sponsored Coverage?

On the other hand, some argue that ESI puts healthier workers at a disadvantage. Such workers pay more for their premiums, since they are in effect subsidizing the cost of insurance for high risk individuals. Some analysts claim that these high risk individuals fare better in the individual market than is commonly assumed.

To critics, ESI also has structural flaws that go beyond enrollment declines. Some argue that employers do not necessarily share the same interests as their employees in judging the quality and cost of plans, and that individuals are best suited to judge their own health care needs.

Employment-based coverage is not portable for workers who switch jobs. And some analysts believe that American businesses will have a tough time staying competitive internationally if they continue to be burdened by high health care costs.

These weaknesses, along with the erosion of employer coverage caused mainly by cost increases, have led to a host of new proposals that would either strengthen ESI or do away with it altogether. For example, a proposal by Sens. Ron Wyden (D-OR) and Bob Bennett (R-UT) would impose an individual mandate for the purchase of insurance in the non-group market, and require employers to convert their workers' premiums to higher wages. Employers that do not currently provide health insurance would pay "shared responsibility payments." Persons beneath the federal poverty line would be fully subsidized, with sliding scale premium assistance for those between 100 percent and 400 percent of the federal poverty line.

Other proposals are modeled on Massachusetts' reform initiative that features a health insurance exchange (called a connector), a mandate on individuals to buy insurance and a mandate on employers. They must either provide coverage (which in Massachusetts can be fulfilled by setting up a Section 125 cafeteria account and allowing employees to purchase coverage via the connector) or pay a surcharge to offset costs for the uninsured. This approach effectively attempts to move employers away from being purchasers of care toward being facilitators of care.

Single payer proposals are another policy option for expanding coverage. Single payer, as the name suggests, means that one payer—the government—would solely finance health care in the U.S. or in a given state, much like the Canadian system. "Medicare for all" proposals

are examples of single payer plans.

Other proposals that assume continuance of employment-based coverage in a mixed public-private system include reforms such as expansion of the government-funded State Children's Health Insurance Program and proposals to allow people to buy into Medicare.

Changes to the Tax Code

President Bush's health care proposal is neutral with respect to ESI. It would "level the playing field" between employer-sponsored and individually purchased health insurance with respect to tax treatment, by providing a \$15,000 standard deduction for health insurance for any family covered by a basic health insurance policy, whether purchased on the individual market or by an employer.

Under current law those who purchase individual insurance must pay for it with after-tax dollars, making insurance considerably more expensive for those who purchase individually than for those whose employers cover them.

Some critics fear that when workers need not get their care through an employer to gain a tax advantage, employers may decide to drop coverage altogether. Critics fear that this may force individuals into the individual market where they will not benefit from risk pooling and where administrative costs are substantially higher. Further-more, individuals often find it difficult to get coverage at all in the individual market because of chronic pre-existing conditions; a study by The Commonwealth Fund found that 21 percent of respondents were turned down or charged a higher price because of a preexisting condition.

What Does the Future Hold?

With mounting health care costs and the weight of the administrative burden, it would seem that employers would be racing to the exits, embracing alternatives to ESI. Many large employers seem wary of relinquishing responsibility for providing health insurance.

It's a mixed picture for small businesses. A recent survey of more than 500 California small businesses found 80 percent of those who expressed an opinion believed employers should contribute something to health care; 57 percent felt health care was a shared individual, employer and government responsibility.

However, small business owners are far from monolithic in their views on health care reform. The National Federation of Independent Business



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reports that its membership largely wants the health care system that we have today with some reform, such as a tax credit and standard deduction for the purchase of private insurance. Fifty-eight percent of NFIB members think employers' provision of health care should be voluntary compared to only seven percent that think it should be mandatory.

For the present, businesses and even some unions seem inclined to maintain the present employer-based system. As the AFL-CIO's Gerald Shea said at the September briefing, "A lot of us...if we had our druthers, would be in a single payer kind of system. It's not going to happen [politically]. But on the other hand, there is a way of looking at policies that reinforce and strengthen the coverage that we now have, through things like large pools."

How long can this support for ESI be sustained? Economist Len Nichols of the New America Foundation believes that much of corporate America is expressing real concern about this issue:

"International competition prevents you from going forward in the prices," Nichols said. "So if you can't go backward into the wages, and you can't go forward into the prices, in the short run, what's happening?"

It's coming out of profits...that's why employers and CEOs are really focused on this problem."

Even as policy makers consider various health care reform policies in the context of the presidential campaign debate, fundamental changes to ESI are occurring on the ground. Recent United Auto Workers agreements with General Motors, Ford and Chrysler shift responsibility for union members' retiree health benefits to a union-run trust in exchange for a contribution from the company. Other large non-auto companies have reportedly considered similar arrangements for their retirees. Only time will tell whether this movement away from employer-sponsored coverage to new models of care will be unique to the auto workers, or is a sign that the nature of worker coverage is fundamentally changing.

For the sources used in writing this issue brief, please send an email to info@allhealth.org

To download the webcast, transcript, podcast and resource materials from the briefing on which this paper was based, go to www.allhealth.org/briefing_detail.asp?bi=113

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The Alliance is a nonpartisan, not-for-profit group committed to the education of journalists, elected officials and other shapers of public opinion, helping them understand the roots of the nation's health care problems and the trade-offs posed by various proposals for change.

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