Employment-Based Health Benefits Under Universal Coverage

It is premature to abandon the employer role until insurance exchanges have proved that they can do a better job.

by Paul B. Ginsburg

ABSTRACT: In the context of proposals for universal coverage, a key emerging issue is the role of employer-sponsored coverage. Such coverage has been slowly eroding and has been criticized for providing little meaningful plan choice. Increased reliance on the individual insurance market in its present form is unlikely to meet society's goals, but directing those without access to employer coverage who receive subsidies to regional insurance exchanges could make such coverage much more attractive. But real-world experience with such a reform is needed before considering the substitution of individual coverage for employer-based coverage. [*Health Affairs* 27, no. 3 (2008): 675–685; 10.1377/hlthaff.27.3.675]

Leading up to the 2008 presidential election, public policy initiatives to expand the number of Americans with health insurance are receiving more attention than at any time since 1993, when President Bill Clinton delivered a comprehensive proposal to Congress. Many attribute today's attention to the return of conditions that motivated interest in the early 1990s, when many years of rapid health insurance premium growth—well in excess of earnings trends—fed fears about inability to continue to afford coverage.

Although cost concerns are as serious now as they were in 1993, much has changed since then. A managed care revolution blossomed and faded. Shortfalls in the quality of care have engaged the health care field. Consumerism has become the vision of many large employers and some policy leaders for addressing the high costs and uneven quality of care. These changes may lead to a different discussion of an issue raised in the 1993 Clinton plan: employers' role as purchasers of health insurance for employees and their dependents.

Today, three main viewpoints question whether employer-based coverage should continue as the dominant coverage source for people under age sixty-five. The most broad based is concern about the viability of employer coverage in a context of decreasing affordability for employers and employees, the challenge of in-

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ternational competitiveness, and changes in the structure of employment. The other two views come from distinct camps. One champions a much greater role for markets in health care and perceives employer coverage as an impediment to market forces because few people have a broad choice of health plans and suitable incentives to economize. The other rejects markets in health care and advocates a single-payer system, which might take the form of Medicare for all.

Serious thinking about the future role of employers in the provision of health insurance coverage is emerging in proposals for universal coverage. Sen. Ron Wyden (D-OR) and Sen. Bob Bennett (R-UT) have cosponsored a bipartisan bill (S 334) under which employees and other individuals would choose a private health plan through a statewide Health Help Agency. Employers would not provide coverage but would contribute funding based on premiums in the state and on firm size and revenue. Insurers would have to enroll all who apply and not vary premiums based on health status. Likewise, the Committee for Economic Development (CED), a research and policy organization of business leaders and educators, developed a proposal for universal coverage that is built on individuals' accessing regional insurance exchanges to choose from competing health plans.[1]

This paper examines the role of employers under universal coverage in today's context. I discuss the advantages and shortcomings of employer-based coverage, what is needed to create a system in which individual coverage is a viable alternative to employer-based coverage, and why care should be taken not to undermine employers' role in providing coverage.

Factors Driving An Employer-Based System

Although analysts occasionally describe the origin of the U.S. employer-based health insurance system as accidental—a mechanism to evade wage controls during World War II—such a system would not have persisted and grown so long after wage controls in the absence of continuing compelling reasons. Three factors stand out as most important.

■ **Tax treatment.** Employer contributions are not taxable to the employee as income and are deductible to the employer as a business expense. This applies to federal and state income taxes and to federal payroll taxes. Many self-employed people also can deduct the cost of health insurance from their federal and state income taxes but not from their payroll taxes. Ultimately, insurance purchased outside of employment, however, does not gain any of this favored tax treatment, with the exception of the ability to deduct from income taxes any health care costs in excess of 7.5 percent of adjusted gross income (AGI).

The magnitude of the tax incentive related to employer coverage probably has declined over time as federal marginal tax rates have declined. During the 1950s, when employment-based coverage grew particularly rapidly, the top marginal tax rate was as high as 92 percent. But the recent proliferation of Section 125 plans, which permit employees' premium contributions to be excluded from taxation as

well, has increased the incentive. The fact that the tax treatment is more valuable to employees with high incomes—who are in higher tax brackets and who tend to purchase more-expensive coverage—likely contributes to the current pattern of high-wage firms' offering the most comprehensive coverage.[2]

■ **Large economies of scale.** The costs of distributing health insurance to individual purchasers (marketing, sales, underwriting, billing) are a major portion of premiums, providing the opportunity for much lower costs per covered employee when employers, especially large ones, purchase coverage for most employees and their families. Charles Phelps reports that loading charges (the portion of the premium not going to paying medical claims) range from 60–80 percent of benefits for individual policies to 15–20 percent of benefits for medium groups (100–200 employees) and 5–8 percent of benefits for very large groups (more than 1,000). However, some of this variation is probably a reflection of richer coverage obtained by the larger firms (fixed distribution costs spread across more medical benefits).[3] This cost advantage provides large employers with an advantage in the labor market.

Employers also provide value to employees by negotiating the purchase of a complex financial product on their behalf. Not only do health insurance policies have complex benefit structures, but aspects such as which services are covered, the quality of the provider network, and the extent of utilization controls are difficult for consumers to assess. Having a professional handle this transaction is a relief to many employees, as demonstrated in employee surveys.

■ **Employers' desire to have a covered workforce.** Employers believe that there is a link between access to health care and productivity; indeed, this is driving recent strategies in wellness promotion.[4] Having most employees covered is a key factor behind employers' pooling employees' coverage and not varying employee contributions by expected health care use—long before they were required to under the Health Insurance Portability and Accountability Act (HIPAA). If employers instead made a uniform defined contribution for each employee and then charged them the difference between this and their expected costs on the basis of factors such as age or chronic disease history, many of those likely to have the largest needs for health care could not afford coverage. Pooling enables those at high risk to obtain coverage, perhaps with some loss of take-up by young and healthy employees.

Erosion Of Employment-Based Coverage

Much of the concern about the future role of employers in providing coverage comes from the slow decline in the proportion of Americans with employer-based coverage. Census tabulations show that in 2006, 59.7 percent of the population obtained health insurance through employment, compared with 62.8 percent in 1999, a year at a similar stage in the economic cycle. Long-term trends are difficult to discern because year-to-year trends are dominated by changes in the number of people employed and the size of the gap between premium trends and income trends. But a number of factors are leading to a smaller proportion of working

people having employment-based coverage.

■ **Decreasing affordability.** As premium trends exceed earnings trends, the cost of insurance, whether borne by the employer or the employee, becomes untenable for more workers, and this difficulty is moving up the income scale. According to the Henry J. Kaiser Family Foundation/Health Research and Educational Trust (KFF/HRET) annual employer benefits survey, from 1999 to 2007, premiums for employer-based coverage increased 114 percent while earnings increased only 27 percent, a gap of 6.7 percentage points per year.

■ **Changed attachment to employers.** Changes in employees' attachment to employers also have contributed to the erosion of employer coverage. From 2001 to 2005, increases in the percentage of the workforce that is self-employed and the percentage of employees who were in part-time or contract status and who worked in industries that are less likely to provide coverage all contributed to declining rates of employment-based coverage.[5]

■ **Declining retiree coverage.** Likewise, the prevalence of retiree health coverage continues to decline, a victim of a dynamic economy. According to the KFF/HRET survey, the proportion of employers with 200 or more workers offering coverage to active employees that also offer retiree coverage declined from 66 percent in 1988 to 33 percent in 2007.[6] Few firms with fewer than 200 workers offer retiree coverage. New accounting standards related to reporting liabilities for retiree coverage accelerated employers' recognition of the incongruity of making commitments decades into the future, given the uncertainty of the future size of their workforce, life expectancies, and health care costs.

■ **Addressing the erosion of job-based insurance.** Policies discussed to address the erosion of employer-based coverage emphasize tools that directly motivate employers to provide coverage—or employees to take it up. Examples include mandating that employers (except for small employers) provide coverage and offering subsidies to employers or employees to offer or take up coverage.

Much of today's discussion about expanding coverage seeks to develop complements to the employer system. For example, proposals by leading candidates for the Democratic presidential nomination include both expansions of public insurance for low-income adults and children and subsidies for individuals to purchase private coverage. Although these proposals seek to address populations that might not have access to employer coverage, each one is likely to lead some people who might have obtained such coverage to obtain it elsewhere.

Expansions of public coverage for low-income people can be seen as drawing on a single-payer approach for situations in which market-based coverage is least likely to be effective. President George W. Bush's veto of the State Children's Health Insurance Program (SCHIP) expansion reflected an acceptance of a role for public coverage but resistance to expanding it to income levels where he believes public coverage would "crowd out" market-based approaches.

Proposals for subsidies for individuals to purchase private coverage also need to

include strategies to develop a marketplace to make such purchases that has low distribution costs and is able to accommodate those whose age or medical history would lead to either very high premiums or no offer of coverage at any price (discussed below). The analogue of crowd-out in subsidizing people directly is the potential for young and healthy employees to opt out of an employer-based plan and instead seek individual insurance. In the short run, this would lower aggregate health benefits costs for employers but would also make employers' offerings of a package of cash wages and health benefits less attractive to a portion of the labor market, raising issues for some employers about the attractiveness of continuing to offer health benefits.

Arguments For Greater Use Of Individual Coverage

In contrast to approaches designed to support employment-based coverage by targeting those least likely to have access to it, some see merit in extensive replacement of employer coverage with individual coverage. Often this is driven by criticism of the nature of coverage that employers offer. For example, consumer-driven health care advocates believe that more people would choose consumer-directed plans—high-deductible plans coupled with a health savings account (HSA)—if such options were available.

■ **Greater choice of plans.** Usually, only large employers offer a choice of plans, and there has been a recent trend among those that do offer choice to offer fewer choices, increasingly through a single carrier. To the degree that employees have different attitudes about their willingness to accept less provider choice or more administrative controls to save money, a single plan for the entire group leads to some employees' not getting the type of plan they prefer. Indeed, lack of plan choice may be a barrier to innovation, since changes that do not appeal to a large enough portion of a company's workforce are unlikely to be adopted, even if they might be attractive to a minority, such as those with low incomes.

■ **Benefits tailored to expected use of care.** Much of the recent discussion of health plan choice emphasizes tailoring the richness of benefits to different enrollees' expected use of medical care. Indeed, in Medicare Part D, the program is providing tools to support beneficiaries' efforts to do this. But to the extent that employees choose benefit structures on the basis of their expected use of health services—as opposed to attitudes toward bearing part of the financial risk—the result is to support risk selection, potentially undoing some of the advantages of pooling risk. This poses a conflict between individual interest in such choice and societal interests in maintaining pooling. In contrast, choice on the basis of features such as differences in provider networks, penalties for going out of network, or providers' efficiency and quality have societal benefits as well.

■ **Union-negotiated benefits.** The design of health benefits collectively bargained by unions has long been distinct from that found outside of collective bargaining. Union members tend to have more-extensive health benefits, even after ad-

justing for their higher wage rates.[7] Economists have suggested that this reflects the political structure of unions. The implication is that many union members might prefer less-costly health benefits and higher wages—or stronger international competitiveness on the part of their employer.[8]

■ **Recruitment and retention above all.** Interviews with employers make clear that recruitment and retention are the dominant forces driving decisions about benefit design.[9] In the abstract, this can be entirely consistent with making choices on behalf of employees that reflect their preferences. But the real world is more complex. Take, for example, the fact that employers have more difficulties recruiting workers at higher education and skill levels. If all are to have the same health benefits, then employers are going to give greater weight to the preferences of those in categories most difficult to recruit. This may have been a factor in the rapid retrenchment from aspects of managed care in the late 1990s, which set up the spike in health spending trends early in this decade.

■ **Employers' international competitiveness.** Some proponents of replacing employment-based coverage with individual coverage raise the issue of international competitiveness. Although most economists believe that in the long run, employers' share of health benefits costs is borne by employees through lower wages, most industrial leaders believe that high health costs increase their overall compensation costs and make it more difficult to compete with companies for which health care costs are financed by governments. This omits the question of how foreign governments raise the revenue for their health benefits, which can be gotten through higher taxation overall (including corporations) or payroll taxes dedicated to health benefits.

But more economists today are suggesting that the "long run" is many years and that health care costs do come into the competitive equation.[10] If this view is correct, replacing employer-based coverage with individual coverage and restructuring the tax treatment of health insurance offer the opportunity to relieve some companies with older workforces in areas with high health care costs of some of this burden—an important component of the Wyden-Bennett proposal.[11]

Can Individual Coverage Meet Society's Objectives?

A key part of any discussion about employers' future role in providing health benefits is to assess what would replace it. With virtually all of the mainstream political leaders judging that single-payer systems are not a feasible choice at this time, this paper does not delve into that option. This leaves having individuals purchase private insurance as the alternative. This need not preclude either continuation or expansion of public programs (Medicaid and SCHIP).[12] Even some of the most enthusiastic advocates of the individual insurance market see merit in covering those with the lowest incomes through public insurance.

Most recognize that today's individual market is not an attractive alternative to employer-sponsored coverage. The presence of underwriting based on medical history and age would make insurance unaffordable for many who now obtain

coverage through employment. And the very high loading charges in the individual market are another barrier.

Although most states regulate their small-group insurance markets by requiring that coverage be renewed and by limiting the magnitude of variation in rates charged different employers, few have attempted to apply similar regulation to the individual market. With individuals deciding whether or not to purchase coverage at all, regulation that forced insurers to sell to all for a similar premium (sometimes referred to as "community rating") would lead to extensive adverse selection. This, in turn, would drive premiums so high as to preclude a viable market. This happened in Washington State during the 1990s, when new individual-market regulation designed to accompany universal coverage was not abandoned when the universal coverage initiative fell through.[13]

■ **Major expansion of the individual market.** Some individual-coverage enthusiasts believe that a large-scale expansion of the individual market could make community rating feasible, since the potential magnitude of adverse selection would be lower.[14] For example, if a combination of extensive subsidies to low-income people to purchase insurance were coupled with an effective individual mandate, then a ban on medical underwriting and limits on the degree to which rates could vary by factors such as age and sex might be compatible with a viable individual insurance market. This is what Massachusetts has done as part of its universal coverage initiative (see below). Insurers would still have incentives to attempt to insure those in the best health and likely would have some success (individually, if not collectively), but regulation might be effective enough to meet society's goals about affordability of coverage for those whose expected medical spending is high. Although this would not directly address the high overall costs in the individual market, the combination of no resources going to medical underwriting and increasing use of the Internet for distribution, a trend already well under way, might make the individual insurance market more capable of meeting society's evolving needs.

■ **Insurance exchanges.** I believe that the only way to create an individual insurance market that would be a vehicle for universal coverage is through government creation of or support for insurance exchanges. This idea has been advocated most forcefully by Alain Enthoven, who has worked with the CED on its universal coverage proposal based on this concept, and by the Heritage Foundation, which advised Gov. Mitt Romney on incorporating elements of these ideas into the Massachusetts reform.[15] Focusing on the concept, rather than on specific parameters specified by some advocates, an exchange is a marketplace managed by government (or by a private entity operating under rules established by government) in which individuals choose among health insurance products offered by competing carriers.

Many point to the Federal Employees Health Benefits (FEHB) program as a model for an insurance exchange, although it is more properly labeled as employment-based health benefits with plan choice. Key aspects of the FEHB program that may or may not be replicated in an insurance exchange are as follows: (1) fed-

eral employees who want health benefits must choose a plan through the program; they cannot use the federal employer contribution outside of the program; (2) risks are pooled so that employee contributions for any particular plan vary only by whether the coverage is for an individual or a family; (3) employee contributions are collected efficiently through payroll deduction; (4) health plan benefit structures vary, but they are subject to approval by the Office of Personnel Management (OPM); and (5) employees choose a plan through the OPM once a year during an open-enrollment period.

Of these aspects, the first is probably the most critical for success of an insurance exchange. If an exchange is to create a pool of individuals with different risks of having high medical expenses, it needs a mechanism to ensure that both sick and healthy people enroll. As part of a universal coverage program, the federal government could accomplish this by offering the extensive tax benefits of purchasing health insurance only to those purchasing through the designated exchange for their region. Without such incentives, the healthiest people are likely to obtain coverage outside of the exchange, threatening it with an adverse-selection spiral. To date, I have seen little public understanding of this issue on the part of political leaders advocating a larger role for individual insurance.

Charging people rates that are not heavily dependent on their age or medical history (pooling) could be facilitated by something that is still not done in the FEHB program: risk adjustment. The FEHB program has been negatively affected by risk selection, sometimes losing participating plans that have experienced adverse selection, but it has addressed the dynamic only through preventing plans from offering benefit structures that might generate too much favorable risk selection. An insurance exchange could shift funds from insurers attracting healthier-than-average enrollees to those attracting sicker-than-average ones.

The Medicare Advantage (MA) program has the most experience with sophisticated risk adjustment and could serve as a model. The payments received by the plans from Medicare reflect the risks of those who enroll, but all beneficiaries enrolling in a plan pay the same premiums. Indeed, MA is probably the closest thing we have to an effective insurance exchange.

The Massachusetts Connector has some characteristics of an insurance exchange but lacks others. It provides plan choice to both individuals and employees of small firms that have opted to purchase through the Connector. Individuals receiving subsidies to purchase insurance must use the Connector. With an individual mandate and pooling of the small-group and individual markets, the Connector is able to bar medical underwriting.

If insurance exchanges are to be a mechanism to replace employer-based coverage, a key design feature will be the types of plans that can be offered. Discussions two decades ago emphasized standardization of benefit structures, both to keep choices simple for enrollees and to limit risk selection. But today, many are looking to plans to innovate on benefit designs, which have the potential to change the in-

centives in the delivery system, for example, by encouraging patients to choose providers on the basis of measured quality of care and efficiency. Many are also looking to plans for value-based benefit designs, which target patient cost sharing toward more elective services and away from services that are part of accepted regimens for chronic disease management.

Indeed, with the state of risk adjustment having progressed, risk selection that occurs when differences in benefit design are offered would not be as large a problem. Designs that appear to be constructed primarily to attract favorable risks would still have to be barred, but a lot more variation could be accepted. Encouragement of innovative benefit designs is potentially a key attraction of substituting individual choice of health plans for employer choice.

Exchanges have the potential to support a range of valuable choices in plan designs, but also have the potential to retard it. Having exchanges associated with state government gives one pause because of the political process in many states that has resulted in mandates reflecting the narrow interests of particular professional groups to force their services into a benefit design. Massachusetts' mandates, which include coverage of in vitro fertilization, were maintained when it adopted its universal coverage reform and undoubtedly are contributing to its problems of not having sufficient state resources to subsidize all of those who otherwise are unable to afford coverage.

Key Considerations In Choosing A System

With employer-based coverage eroding and single-payer approaches limited to expansions of Medicaid and SCHIP for low-income people, what should the role be for individual insurance as part of a universal coverage program for the United States? I see two options.

■ **Insurance exchanges for those without access to employer coverage.** The first would create insurance exchanges to serve those without access to employer-based coverage, so that the individual insurance market serves them more effectively than what is out there today can do. Presumably, all receiving subsidies (including tax credits or deductions) to purchase private coverage would be directed to obtain their coverage through the exchange. This is the model that Massachusetts has pioneered in its reform.

Under this first option, care should be taken to limit the degree to which the individual market (outside of insurance exchanges) attracts healthy people away from their employer coverage. As long as those receiving tax benefits or subsidies are required to use the exchange, then plans could be directed to vary premiums on the basis of age and medical history by only limited amounts. So a person who is contemplating leaving an employment-based plan would not have an option of being rated on the basis of individual characteristics. In a sense, such a person would go from one pool with a mix of enrollee characteristics to another. Efforts to limit attrition of healthy people from employer plans could be seen as parallel-

ing the efforts that the federal and state governments have made to limit the extent to which expansions of Medicaid and SCHIP crowd out private (mostly employer-based) coverage.

■ **Replace employer insurance with individual insurance.** The second option would go much farther by also replacing employer-based coverage with individual insurance obtained through insurance exchanges—along the lines of the Wyden-Bennett or CED approaches. Although this approach has some attractive features, I believe that it is premature to abandon employer-based coverage with a strategy that is so untested in the real world. At this point, insurance exchanges are, for the most part, an attractive concept developed by thought leaders. Many design issues will have to be thrashed out in the policy process, and many operational problems are likely to be encountered and will need to be worked through. It would be better to do this learning with the tens of millions of people without access to employer-based coverage than with the entire privately insured population. This would both limit the numbers involved and engage only those with the most to gain from reforming individual insurance markets. It is not yet clear whether insurance exchanges can achieve the low distribution costs of employers or the value that a benefit manager brings to this complex marketplace. Framers of universal coverage proposals believe that they have learned from experience about the perils of threatening large numbers of people who are happy with their health insurance with major changes in how what is available and how they obtain it.

The most important unknown is whether individual insurance markets will develop and distribute products that are innovative and have the best chance of addressing the health care system's large problems in terms of the cost and quality of care. The upside of a greater role for individual insurance is the potential to more quickly develop and roll out improved products. The downside is the possibility that we could have even less of this innovation than we do with the employer-based system.

When one looks at the innovations in insurance coverage in recent years, most were initiated through large employers' directing their carriers to develop and implement them. This includes wellness and health promotion initiatives, high-performance networks, pay-for-performance, tiered cost sharing for prescription drugs, centers of excellence, value-based benefit designs, and HSAs. Since the same carriers that administer insurance for large employers sell insurance to small employers, the most successful have also become available to the latter. Only HSAs developed more rapidly in the individual insurance market, and this is likely because such products are the only option for tax benefits for those obtaining coverage other than through employment and because the benefit structures are closest to products already sold in that market. Although large employers can certainly be faulted for not pursuing innovations aggressively enough, replacing health benefits from large employers with individual purchasing could cut off a lot of the potential for innovation.

Policymakers should be spending their energy today on developing viable structures, such as insurance exchanges, that have the promise of offering and distributing individual coverage efficiently and with sufficient pooling that it is accessible to the broad population without access to employer-based coverage, including those with low incomes who will be subsidized under a possible program of universal coverage. The experience with a reformed individual market should then be evaluated to make a judgment down the road about whether it should be expanded to replace employer-based coverage.

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