

Congressional Health Care Reform Education Project
September 26, 2008
Employer-Sponsored Insurance

Senate Summary

Jim Reschovsky, senior researcher at the Center for Studying Health System Change, provided background on employer-sponsored health insurance in the U.S. The employer-sponsored insurance (ESI) system is eroding. Sixty-eight percent of non-elderly individuals had ESI in 1999 compared to 63 percent in 2007. ESI has been so popular for several reasons: workers enjoy tax the benefit of preferential tax treatment of employer payments for ESI; there are advantages to group purchasing such as economies of scale; and employers benefit by using it to attract workers and keep their employees healthy. But ESI has its limits, in his view. Tax incentives encourage the purchase of overly generous plans. In addition, some do not have access to ESI, either because they don't have a worker in the family or the workers at their place of employment aren't offered subsidies.

Employee benefit plans are regulated by the Employee Retirement Income Security Act (ERISA). Most large insurers are self insured; they contract with insurers for claims administration but they bear the risk themselves. States, by contrast, regulate insurers and have the power, among other things, to mandate benefits. The main reason for declining ESI rates are premiums that are increasing faster than worker earnings and overall inflation. The average annual premium cost for covered workers has nearly doubled since 2000. Reschovsky believes that over time, employers will eventually shift health care cost increases to workers in the form of lower wage increases, though it may take some time for the shift to be completed.

Workers in small firms are significantly less likely to be offered insurance than those in larger firms. And even within large firms, low wage workers are significantly less likely to have health insurance offered to them than higher wage workers. He offered four take-away points for congressional staff to consider during health reform: (1) coverage gaps largely exist because low income workers can't afford ESI; (2) firm behavior is mostly driven by worker demand for insurance; (3) workers ultimately pay for their health insurance costs, and (4) ESI reform without parallel efforts to lower costs and increase value in medical care will fail.

Michael Morrisey, Lister Hill Center for Health Policy, University of Alabama-Birmingham outlined trends that show where ESI is headed. Modern insurance reduces the financial risk of large, relatively rare events and it negotiates lower prices for health services than what individuals can negotiate. He believes the market is evolving to provide higher deductibles with more catastrophic coverage. He believes that we will see more selective contracting with providers and more focus on discounts on drugs and physician visits. He also believes there will be a return to tighter provider networks to improve leverage but with less gatekeeping and utilization management – features that consumers rejected in the 90s. To help consumers deal with the higher deductibles he believes that insurers will negotiate for discounts with providers and pharmacies to help consumers keep their cost down. He thinks there will be innovation in ways to provide coverage for two earner families so that they can use the health benefits of one employer while gaining wage increases in the work setting where the spouse declines coverage. He also believes that employers will start to structure health insurance coverage in such a ways

that show their employees the real cost of their health insurance. Employees view the price of ESI as the amount of their out-of-pocket premium costs, but the real price is the full cost of their premiums.

He advises Congress in developing a reform plan to maintain choice, cap the tax exclusion for ESI to avoid over-insurance and to provide a tax credit for lower income workers to compensate for lower tax subsidy loss and encourage them to buy insurance.

Jeanne Lambrew, Associate professor of the LBJ School of Public Affairs, University of Texas, described some of ESI's benefits as a source of coverage. It spreads risk well because workforce choice is generally not related to health risk. It leverages consumer demand, creating greater negotiation power with providers than individuals would have on their own. This helps counter strong supply side forces in this country where doctors and hospitals have great power. ESI also keeps administrative costs low because of economies of scale, lack of individual underwriting and marketing and easy collection of premiums. Administrative costs are considerably lower for large firms than for small firms.

Employers are also trusted as agents for their workers. Over time benefits have changed to reflect what people want. ESI makes enrollment in health insurance products easy for workers. A study by The Commonwealth Fund found that given a choice between having to go out and buy insurance for themselves with a set amount of money or have a limited set of options provided by an employer, people chose the latter option.

ESI also uses government money in the form of \$200 billion dollars a year in tax breaks to leverage significant employer and worker contributions to finance the health care system.

Some options for strengthening ESI in health reform include: creating an employer mandate, employer pay-or-play (provide insurance or be assessed a fee -- the Massachusetts plan and the failed California plan both included pay-or-play provisions); and creating an individual mandate, which has increased take-up of employer coverage in Massachusetts.

In addition to approaches that would make ESI a part of health reform, elements of ESI can be used without salvaging the entire system. For example you can use corporate and payroll taxes collected by employers to finance the system while using other means to provide coverage. A bill sponsored by Senators Wyden and Bennett is an illustration of this approach. Another way employers can be tapped in a system other than ESI is to have employers collect premiums and/or to have employers coordinate health plan choices without sponsoring them.

Issues to keep in mind in choosing to build on ESI include: small businesses face special challenges and alternatives to employer sponsor system will be needed for individuals who have loose connection to the labor force.

The panel was followed by a Q & A session. Mr. Reschovsky explained to a questioner that administrative costs are much higher in a small group than a large group because functions are distributed over a larger group of people providing economies of scale.

In response to a question about how long it takes for wages to adjust for rising health premiums, noted that a lot depended on labor conditions. If labor markets are tight it will be harder for employers to pass along premiums to their workers. If there is a lot of slack in the labor market than employers can increase wages more slowly and complete shifting the cost of premiums more rapidly.

A question arose about why the Massachusetts connector is not enrolling small group market. Mr. Reschovsky said it was scheduled to launch as a pilot soon, eventually ramping up to full capacity. A staff member familiar with the situation commented that Massachusetts is seeing some moderation of premium increases (even though employers are seeing their total premium cost go up as more participate in ESI) because younger, healthier employees are entering the risk pool.

The conversation turned to the question of stop-loss insurance and a commenter noted that you can get reinsurance at a low attachment point (the point at which reinsurance kicks in). The commentator wondered if insurers could get around state mandates by buying reinsurance (which is not subject to health insurance regulation) at a low attachment point. Ms. Lambrew answered that stop-loss that kicked in quickly would be costly and doubted that the cost of avoided mandates would offset the purchase of the expensive stop-loss.

In response to a comment on employers role as innovators, Mr. Morrissey and Mr. Reschovsky agreed that employers don't innovate that much when it comes to payment. But one commenter noted that wellness programs are one way employers think they are innovating to drive value in the market place.

Mr. Reschovsky believes that payment policy reform must be pioneered in the public programs and that the private market will follow because otherwise private payers will be afraid to offend providers.

Ms. Lambrew suggested that comparative effectiveness research, drug pricing, IT issues and the development of better quality data measures may be ways to improve value that private payers will need government help to achieve.

Morrissey suggested ways that insurers could craft financial incentives to improve patient behavior as another way of improving the value of the care we are purchasing. Lambrew cautioned that you have to be careful not to craft these tools in such a way to discourage or prevent those that need most (such the obese or smokers) from accessing care.