

Chapter 4: Employer-Sponsored Health Coverage

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Six out of every 10 individuals in the U.S. had some form of health insurance coverage through an employer in 2007.¹ (See chart, "Sources of Health Coverage 2007.") This is a major contrast to most other countries, where people typically obtain coverage through government programs.

Most employers, both large and small, who offer health benefits do so because in their view, there is a business case for doing so.² These employers think that they must offer health benefits in order to recruit and retain workers in a competitive labor market. They also think that offering health benefits has a positive effect on worker health status and therefore on productivity (a proposition backed up by research).³

Overall, private-sector employers spent \$518 billion on contributions toward employee health insurance premiums in 2007, while the federal government and state governments spent \$134 billion. Individuals contributing to their employer-based premiums or purchasing policies in the non-group market spent an additional \$238.6 billion.⁴ (The true cost for employees was actually higher, however. See text box, "How Much

Do Employees Really Contribute Toward Their Health Insurance?")

Federal and state governments offer a tax incentive for employer-based coverage. Health benefits are a tax-deductible expense for employers and they are excluded from-do not count as-taxable income to employees. This exclusion is estimated to total \$246 billion in federal revenue passed up in 2007, about half of what the government spent on Medicare that year.⁵

Growth in employment-based health benefits accelerated during and after World War II for numerous reasons.⁶ By the end of the war, health coverage in the U.S. had tripled, not because of the favorable tax treatment of premiums (the tax treatment was unclear at the time) but because employers had to compete for labor at a time of labor shortages and government-imposed wage restrictions.⁷ Only with the Revenue Act of 1954 did the Internal Revenue Code make it absolutely clear that employer spending on health benefits was not counted as worker income.⁸

The Employee Retirement Income Security Act of 1974 (ERISA) is the primary federal law governing

FAST FACTS

- 162.5 million individuals under age 65 were covered by employment-based health benefits in 2007.^a
- The percentage of individuals with such coverage was 62.2 percent in 2007, down from 68.4 percent in 2000.^b
- 62 percent of employers with 3 to 199 workers offered health benefits in 2008, down from 68 percent in 2000. The percentage of larger employers offering health benefits has held steady at 98 to 99 percent.^c
- 12.6 million individuals ages 65 and older had some form of employment-based health benefits in 2007 - either as an active worker, retiree, or dependent.^d
- Retiree coverage has been shrinking. In 2008, 27 percent of employers with 500 or more workers offered early retiree coverage as a benefit to new hires, down from 46 percent in 1993.^e
- In 2008, premiums for employee-only coverage averaged \$4,704 (\$721 from the worker, \$3,983 from the employer). For family coverage, the average premium was \$12,680 (\$3,354 from the worker, \$9,325 from the employer).^f
- Workers paid an average of 16 percent of the total cost of employee-only coverage in 2008, and 27 percent for family coverage.^g
- For 2009, per employee health costs are projected to grow by 6.4 percent, similar to the 6.3 percent uptick in 2008.^h

For story ideas on employer-sponsored coverage, see page 50. A list of experts and websites also begins on page 50.

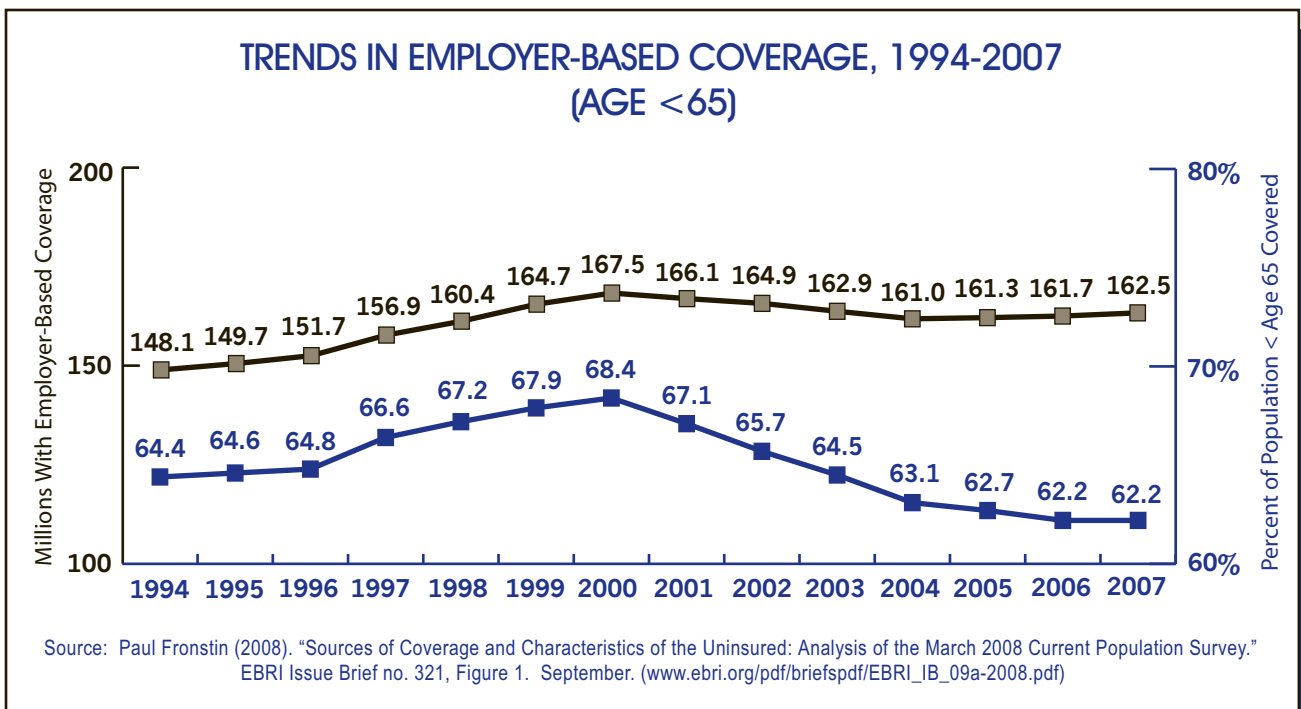
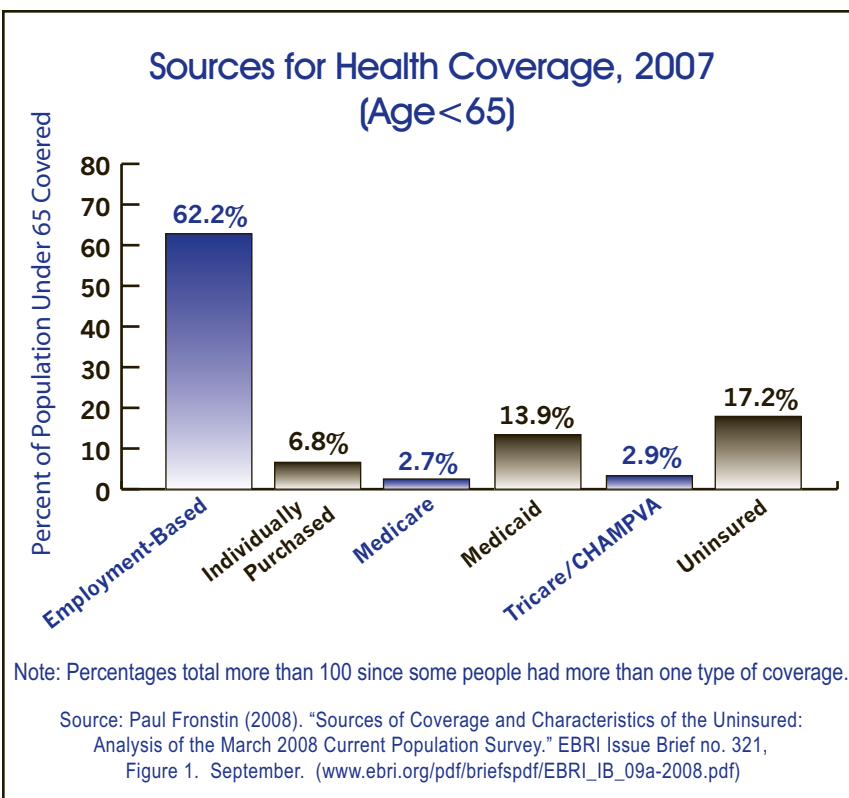
employment-based health benefits in the private sector.⁹ Under ERISA, the regulation of employment-based health benefits has evolved into a system in which both federal and state laws play important roles.

ERISA relieves employers of the need to meet state-imposed mandates governing health benefits, so long as the benefits are "self-funded." Self-funded employers pay for employees' health expenses directly, rather than buying insurance to cover these expenses.

ERISA has been seen as a barrier to state-level health reform that would, for example, require employers to help pay for coverage for their workers. It would presumably not interfere with national health reform, however, if national reform imposed the same requirements regarding employer-sponsored coverage in all states.

There are a number of advantages associated with using employment-based coverage as the primary means for providing health benefits. It is generally cheaper for a worker to receive the same covered services through employment-based benefits than to

shop for coverage on his or her own. An employer, representing many workers, naturally has more clout in negotiating prices with insurers than any individual. Insuring a group of employees also represents less overhead cost per person for insurers than insuring an individual.



How Much Do Employees Really Contribute Toward Their Health Insurance?

For many years, employees receiving health coverage through their employer have paid about 16 percent of the total premium out-of-pocket for single (employee only) coverage and about 27 percent of the total premium for family coverage.¹

But employees' true contribution toward their premium is actually higher. Studies have found that employers offering health coverage, consciously or not, pay less in cash wages to help pay for workers' coverage.

One study estimates that an employer's expenses for health benefits are offset by a 9 percent reduction in wages.² The study's authors, Patricia Ketsche and William Custer of Georgia State University, conclude that "Wages adjust downward at firms offering health insurance."

Another study found that in firms offering health coverage, obese employees are paid significantly less than employees of normal weight doing the same jobs. The authors' conclusion: employers expect obese workers to have higher health care costs. Since employers are prohibited from charging some employees more for coverage than others, they compensate by paying obese employees less.³ For obese women, but not obese men, the wage reduction was more than the employer's expected increase in health costs.⁴

And even though employees' contribution to their premiums as a share of the total has remained relatively stable, that coverage has gotten much less affordable for lower-income employees. Families premiums have risen so much that employer-sponsored coverage is now less affordable for families at 300 percent of the federal poverty level (FPL) than it was for families at 200 percent of FPL in 1996, according to a study by the Urban Institute, sponsored by the Robert Wood Johnson Foundation.⁵

¹ Kaiser Family Foundation and Health Research and Educational Trust (2008). "Employer Health Benefits: 2008 Annual Survey." Exhibit 6.1. (<http://ehbs.kff.org/pdf/7790.pdf>).

² Patricia G. Ketsche and William S. Custer (2004). "Impact of Health Insurance Benefits on Wages." Presentation at AcademyHealth conference, San Diego, no. 21, abstract no. 960. (<http://gateway.nlm.nih.gov/MeetingAbstracts/ma?f=103623994.html>)

³ Selis, Sarah (2005). "Obese workers paid less due to health costs, not prejudice, study finds." News release, May 6. (<http://psychcentral.com/blog/archives/2005/05/09/obese-workers-pay-lower-due-to-health-costs-stanford-study-finds/>).

⁴ Bhattacharya, Jay and Bundorf, M. Kate (2005). "The Incidence of the Healthcare Costs of Obesity." National Bureau of Economic Research Working Paper No. 11303. May. (<http://www.nber.org/papers/w11303>).

⁵ Kenney, Genevieve and Pelletier, Jennifer (2009). "Setting Income Thresholds in Medicaid/ScHIP: Which Children Should be Eligible?" January. (<http://www.rwjf.org/files/research/coveragequickstrikejan2009.pdf>).

In addition, buying coverage for a group of workers means spreading the insurer's financial risk. Most people in the group will have minimal medical expenses, balancing the small number who will need expensive care. This generally leads to lower insurance rates for groups. (And of course, the same risk sharing helps lower per-beneficiary costs for self-funded employers paying for employee health expenses directly.)

But there are disadvantages to employer-sponsored coverage as well. Because employers are not required to offer coverage, not all workers have access to it. Losing a job or deciding to start one's own business could result in loss of coverage, as could retirement or a shift to part-time status. (See text box, "Retiree Coverage.")

The number and percentage of people with employment-based health benefits has fallen considerably from the peak year of 2000.¹⁰ (See

chart, "Trends in Employment-Based Coverage 1994-2007.") Likewise, the percentage of smaller employers (those with fewer than 200 employees) offering coverage is down since 2000, especially noticeable among employers with three to nine workers.¹¹ (See chart, "Percent of Employers Offering Health Benefits, by Firm Size, 1999-2008.")

RESPONSES TO PREMIUM INCREASES

Premiums have been increasing faster than inflation, workers' earnings and the gross domestic product (except for 2006, when GDP grew at a slightly faster pace). (See chart, "Percent Increase in Health Insurance Premiums Compared to Other Indicators, 2001 - 2008.") Between 2001 and 2008, the average cost of health premiums increased by 75 percent for employee-only coverage and 80 percent for family coverage,¹² while the Consumer Price Index increased 20 percent.¹³

Retiree Coverage

About 2.5 million retirees ages 55-64 have health coverage through their former employers.¹ Furthermore, 12.6 million individuals ages 65 and older have some form of employment-based health benefits - either as an active worker, retiree, or dependent.² But this benefit is becoming less common. In 1993, 46 percent of employers with 500 or more workers offered health benefits to early retirees and 40 percent to Medicare-eligible retirees. By 2008, only 27 percent offered them to early retirees and 19 percent to Medicare-eligible retirees.³

Employers have cut back on retiree health benefits in part because the Financial Accounting Standards Board⁴ requires that firms account for retiree health benefits on an accrued basis: They must estimate their total future obligations to retirees, and place this potentially considerable figure on the balance sheet. Public sector employers are in the process of complying with a similar standard from the Governmental Accounting Standards Board⁵ that is expected to trigger a comparable decline in availability of retiree health benefits among public sector workers.

To make spending more predictable and affordable, employers have been imposing "caps" - limits on their obligations even in the face of steadily rising costs each year. Roughly one-half of large employers have caps on the share they will spend for the retiree's health coverage for at least one of the plans they offer retirees.⁶

When a retiree reaches age 65, Medicare helps cover the majority of health care costs. If the employer continues coverage for the retiree, it typically "wraps around" Medicare, paying for copays, deductibles, and services Medicare does not cover. Thus, post-65 retiree costs are lower for most employers.

Historically, the cost of outpatient prescription drugs for retirees has concerned employers. Medicare prescription drug benefits provided through Medicare Part D will ease some of this burden.⁷

¹ Fronstin, Paul (2007). "Health Insurance Coverage of the Near Elderly." EBRI Notes 28(1), January. (http://www.ebri.org/pdf/notespdf/EBRI_Notes_01-20071.pdf).

² U.S. Census Bureau (2008). "Table HIA-2. Health Insurance Coverage Status and Type of Coverage All Persons by Age and Sex: 1999 to 2007." (www.census.gov/hhes/www/hlthins/historic/hihist2.xls).

³ Mercer (2008). "So what happens in next year's tough business environment?" (news release)(Nov. 19). (www.mercer.com/print.htm?indContentType=100&idContent=1328445&indBodyType=D&reference=).

⁴ The Financial Accounting Standards Board (FASB) is the designated organization in the private sector for establishing standards of financial accounting and reporting. Those standards govern the preparation of financial reports.

⁵ The Governmental Accounting Standards Board (GASB) is the designated organization in the public sector for establishing standards of financial accounting and reporting.

⁶ Kaiser Family Foundation and Hewitt Associates (2006). "Retiree Health Benefits Examined: Findings from the Kaiser/Hewitt 2006 Survey on Retiree Health Benefits." Exhibits 12 and 13. December. (<http://www.kff.org/medicare/upload/7587.pdf>).

7

As premiums have risen over the years, employers have tried different strategies to curb the growth in their health care costs. One way is to have employees pay more out-of-pocket for deductibles and co-payments. (See glossary for definitions.) This means less expense for insurers (and self-insured employers) and, theoretically at least, lower premiums.

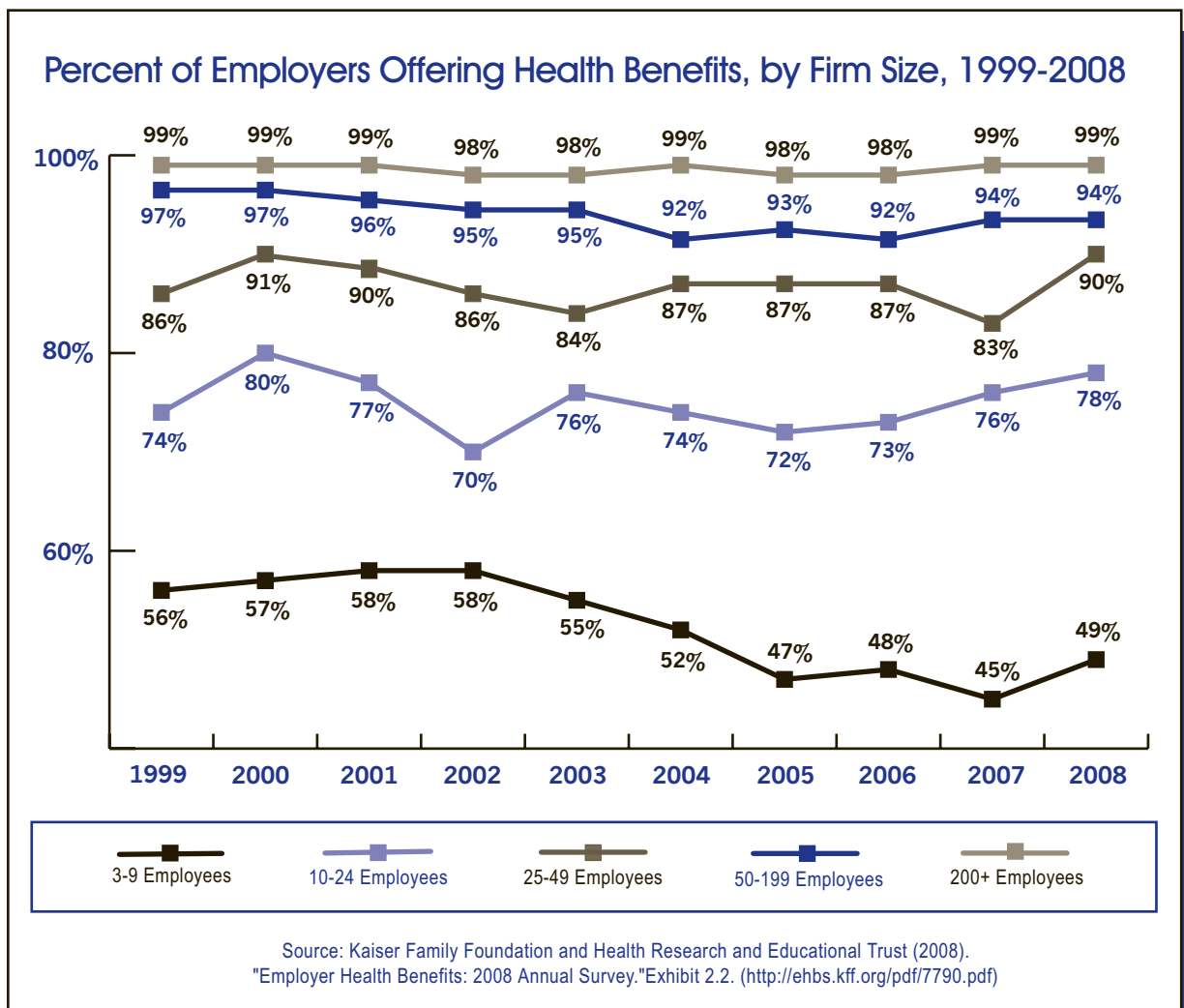
For instance, workers in preferred provider organizations having a general annual deductible for single coverage saw their yearly deductible almost double from 2003 to 2008 - from \$275 to \$560.^{14,15}

Among their cost containment strategies, employers have not made employees pay a noticeably higher portion of the premium. Workers have been paying about 16 percent of the premium for single coverage since 2002, and between 26 and 28 percent of the family premium.¹⁶

The year 2009, despite being a recession year, probably won't see any slackening in the pace of employer health costs. A survey of large employers by the Mercer company projects a 6.4 percent growth in per-employee costs, similar to the 6.3 percent uptick in 2008. One change: more employers will be giving employees incentives to take part in health management programs.¹⁷

To help reduce costs, employers have also shown interest in a relatively new type of health plan. Frequently referred to as consumer-directed health benefits, these plans combine higher deductibles with tax-preferred accounts that can be used for out-of-pocket health care expenses. (See text box, "Consumer-directed health plans.") The plans encourage employees to be more cost conscious about their health care spending, since they feel as if they are spending their own money for expenses up to the deductible amount. For 2009, the minimum deductibles for such plans to qualify for a tax preference are \$1,150 for self-only coverage and \$2,300 for family coverage.¹⁸

Enrollment in consumer-directed plans is growing slowly. A report by the Employee Benefit Research Institute found that in 2008, 3



percent of privately insured people aged 21 - 64 were enrolled in a health savings account (HSA) or health reimbursement arrangement (HRA) linked to a high-deductible health plan. This compared with 2 percent in 2007.¹⁹

LIKELY POLICY DEBATES

TAX TREATMENT OF HEALTH BENEFITS

Various proposals to change the way health benefits and health care costs are treated under the tax code have one thing in common: They would eliminate or curtail the current preferential tax treatment for employment-based health benefits and replace it with some form of a flat tax credit or tax deduction for all taxpayers with qualifying private health insurance. During the 2008 presidential campaign, Sen. John McCain made changes to the tax treatment of health premiums a cornerstone of his health reform plan.

From both a budgetary and political perspective, the

tax treatment of employment-based health benefits is an almost inescapable target. As noted earlier, this treatment meant that the federal government passed up an estimated \$246 billion in tax revenue in 2007, according to the Joint Committee on Taxation in Congress.²⁰

Changing the way health benefits are taxed would have far-reaching implications for employer health plan design, including the viability of many of the newer consumer-directed health plans that use HRAs or HSAs to increase worker engagement. Such tax proposals, if enacted, could also raise questions about the future of employment-based health benefits generally.

EMPLOYER AND OTHER MANDATES

Some policymakers would mandate coverage for all individuals nationwide, while others would only mandate it for children. Similarly, some would mandate that all employers offer coverage,

Consumer-directed health plans

If consumers have to pay more out-of-pocket for services, the thinking goes, they will think twice before seeking care that isn't really necessary and will try to find the best deal for care that is necessary. The result would be to help restrain rising health care costs.

Consumer-directed health plans work off this premise. They have high deductibles (an average of \$2,040 for single coverage and \$4,120 for family coverage in 2008 when offered through employers).¹ Insured individuals must pay for services out-of-pocket until the deductible amounts are reached each year, at which point the health plan begins paying for covered services.

To help consumers set aside the money for their initial out-of-pocket expenses, high-deductible plans can be combined with health savings accounts (HSAs). Money deposited into the HSA is subtracted from a person's taxable income. Earnings on these funds accrue tax free. Withdrawals aren't subject to taxes as long as they are used for medical expenses.²

High-deductible plans and HSAs are available both through employers and in the non-group insurance market. (Health reimbursement arrangements - HRAs - are similar to HSAs but are available only through employers.)

Advocates of consumer-directed health policies want to establish more affordable health insurance options and create financial incentives for people to shop wisely for both health insurance and health care. HSAs are also appealing, according to proponents, because they encourage cost sensitivity, are owned by the individual and are fully portable.

Critics say that high-deductible policies are not attractive to low-income uninsured people, who can't afford substantial out-of-pocket costs.³ High-deductible plans can also be a problem for people with chronic illnesses. Studies have shown that such patients, faced with large out-of-pocket payments for prescription drugs, often forgo maintenance drug therapy.⁴

A January 2009 study by the Urban Institute, supported by the Robert Wood Johnson Foundation, notes that high-deductible plans and HSAs are likely to be attractive to people with high incomes and those with expected low use of health care services. But the plans are unlikely to significantly decrease the number of uninsured, who often can't afford the large deductibles required and don't benefit from the plans' tax advantages.⁵

For more information, see these reports: "Availability, Contributions, Account Balances, and Rollovers in Account-Based Health Plans" by the Employee Benefit Research Institute (Dec. 2008). (www.ebri.org/publications/notes/index.cfm?fa=notesDisp&content_id=4128).

"Health Savings Accounts and High-Deductible Health Insurance Plans: Implications for Those with High Medical Costs, Low Incomes, and the Uninsured" by the Urban Institute (Jan. 2009). (www.rwjf.org/files/research/20090203qsstudyfinal.pdf).

¹ Blumberg, Linda and Clemans-Cope, Lisa (2009). "Health Savings Accounts and High-Deductible Health Insurance Plans: Implications for Those with High Medical Costs, Low Incomes, and the Uninsured." Urban Institute, p. 3, January. (www.rwjf.org/files/research/20090203qsstudyfinal.pdf)

² Blumberg, Linda and Clemans-Cope, Lisa (2009). "Health Savings Accounts and High-Deductible Health Insurance Plans: Implications for Those with High Medical Costs, Low Incomes, and the Uninsured." Urban Institute, p. 2, January. (www.rwjf.org/files/research/20090203qsstudyfinal.pdf)

³ Glied, Sherry; Callahan, Cathi; Mays James and Edwards, Jennifer N. (2002). "Bare Bones Plans: Are They Worth the Money?" Commonwealth Fund issue brief, May. (http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=221524).

⁴ Yegjian, Jill (2006). "Coordinated Care In A "Consumer-Driven" Health System." Health Affairs Web Exclusive, Oct. 24, p.w532. (www.healthaffairs.org).

⁵ Blumberg, Linda and Clemans-Cope, Lisa (2009). "Health Savings Accounts and High-Deductible Health Insurance Plans: Implications for Those with High Medical Costs, Low Incomes, and the Uninsured." Urban Institute, p. 2, January. (www.rwjf.org/files/research/20090203qsstudyfinal.pdf)

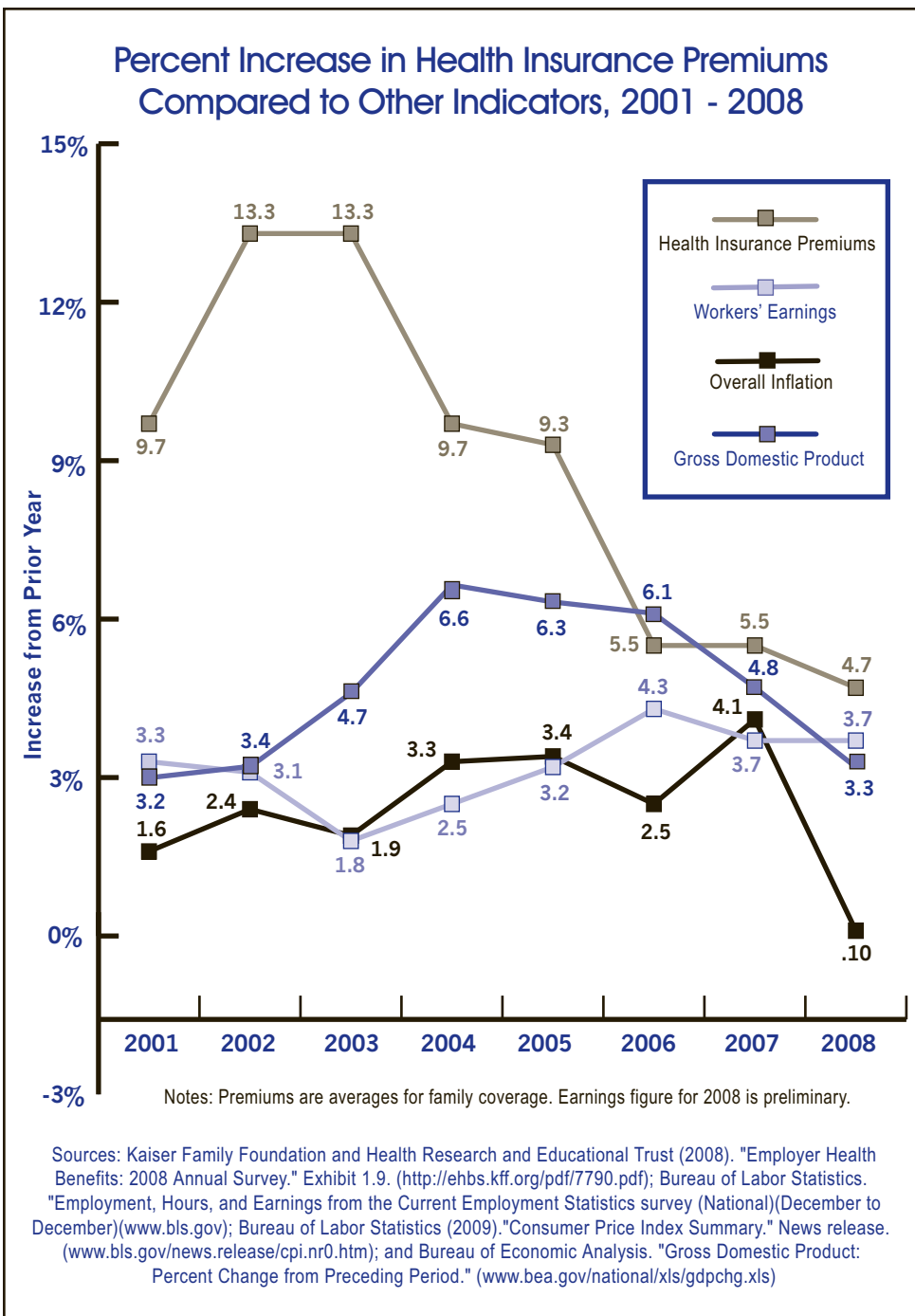
regardless of size, while others would exempt small businesses. Some would provide subsidies to small businesses.

Massachusetts has implemented both individual and employer mandates. The Massachusetts reform law requires most adults to have health coverage, or to pay a penalty. Employers with 11 or more employees

must provide health coverage to their employees, or pay a "fair share" assessment. As a result, 439,000 people gained coverage between the time the law was passed in April 2006 and the end of March 2008.²¹

CONSUMERISM

Employers and health plans have embraced



consumerism in health care and have been implementing consumer-directed health plans with health reimbursement arrangements (HRAs) and health savings accounts (HSAs) as a way to address rising health coverage costs. Participants in these plans need detailed information on cost, quality and outcomes in order to make informed decisions about their health care, information which plans could be required to provide.

sources of coverage, recent trends, etc. (Statehealthfacts.org, a service of the Kaiser Family Foundation, has a wealth of information for your state.)

- Identify and keep in close touch with state officials (legislative and executive) who work on health issues. State lawmakers often are among the first to know when a major health issue is developing in a state.

TIPS FOR REPORTERS

- Keep in contact with your state medical association, state business groups (Chamber of Commerce, NFIB) active in coverage issues, and health consumer groups.

- Remember that AARP has an interest in employment-based health benefits as well as in Medicare. State chapters can be helpful in providing reaction to private-sector or government health proposals.

- Do not overlook your state insurance department.

- Take an insurance agent out to lunch. Learn how they think about "managing risk," and why it's important to have enough people in an insurance pool who won't need expensive services anytime soon, to offset those who will.

- Build and update a data resource bank for your state with the number of insured/uninsured,

- Keep an eye on the docket for the state supreme court in your state for health issues that may result in important judicial opinions.

STORY IDEAS

- Find local people who are employed but who do not have employment-based health benefits, and explain the reasons why they do not.
- Do the same with the so-called "underinsured," those who have skimpy coverage.
- Check with local businesses to see if and how they are active in health care debates in the local community.
- Check with consumer groups to see what initiatives may be in progress to expand the number of people with health benefits.
- Be on the lookout for two key reports each year on trends in employer-sponsored coverage: the Kaiser/HRET Annual Employer Health Benefits Survey (www.kff.org), usually released in September, and the annual report on health benefits from Mercer Consulting (www.mercer.com), usually released in November. Both give you a hook for stories about local trends.
- Business groups usually oppose coverage mandates. What are they doing to promote their agenda and how does that fit in with the goal of expanded coverage?
- What do local people who now have coverage through their job think of the idea of receiving a tax break that would help them to buy their own insurance apart from their employer?

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Georgetown University Health Policy Institute
http://ihcrp.georgetown.edu/

Georgia State University Department of Risk Management and Insurance
http://www.rmi.gsu.edu/

Government Accountability Office
www.gao.gov

Health Policy and Strategy Associates
www.healthpol.com

Health Policy R & D
www.hprd.net

Health Research and Educational Trust
www.hret.org

Heritage Foundation
www.heritage.org

Institute for Health Policy Solutions
www.ihps.org

Kaiser Family Foundation
www.kff.org

Kaiser Foundation Health Plan Inc.
www.kaiserpermanente.org

Mathematica Policy Research
www.mathematica-mpr.com

National Association of Health Underwriters
www.nahu.org

National Association of Insurance Commissioners
www.naic.org

National Center for Policy Analysis
www.ncpa.org

National Coalition on Health Care
www.nchc.org

National Women's Law Center
www.nwlc.org

New America Foundation
www.newamerica.net

Rollins School of Public Health, Emory University
www.sph.emory.edu

UnitedHealth Group
www.unitedhealthgroup.com

Websites

Alliance for Health Reform
www.allhealth.org

Alliance of Community Health Plans
www.achp.org

American Enterprise Institute
www.aei.org

American Medical Association
www.ama-assn.org

America's Health Insurance Plans
www.ahip.org

Blue Cross Blue Shield Association
www.bcbs.com

Cato Institute
www.cato.org

Center for Studying Health System Change
www.hschange.org

Center on Budget and Policy Priorities
www.cbpp.org

Commonwealth Fund, The
www.commonwealthfund.org

Consumers for Health Care Choice
www.chcchoices.org

Council for Affordable Health Insurance
www.cahi.org

Employee Benefit Research Institute
www.ebri.org

Families USA
www.familiesusa.org

Federation of American Hospitals
www.fah.org

Galen Institute
www.galen.org

Urban Institute
www.urban.org

US Census Bureau, Health Insurance Data
<http://www.census.gov/hhes/www/hlthins/hlthins.html>

ENDNOTES

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