Subject: Trends in Employer-Sponsored Health Insurance

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Despite slower growth in the past four years, health care costs continue to outstrip inflation which makes purchasing insurance more challenging for families and business. With more than 158 million individuals receiving health insurance through an employer, a seemingly small percentage change in employer-sponsored coverage can have a significant impact on the number of the uninsured. In its continuing effort to advocate for an expansion of health insurance coverage, the Council on Medical Service studied trends in employment-based health insurance.

This report reviews key trends in employer-sponsored health insurance, identifies employer strategies to contain health care costs and achieve greater value for health spending, reviews federal and state actions regarding employer-sponsored insurance, discusses the Employee Retirement Income Security Act, and offers strategies directed to small employers that further support patient access to continuous health care coverage.

TRENDS IN EMPLOYER-SPONSORED HEALTH INSURANCE

In September 2007, the Employer Health Benefits Survey by the Kaiser Family Foundation (KFF) and the Health Research and Educational Trust (HRET) published its most recent annual report on trend data related to employer health insurance. According to the report, the percentage of firms offering health benefits fell from 69% in 2000 to 60% in 2007. Between 2001 and 2007, health insurance premiums for employer-sponsored insurance increased 78%, compared with cumulative inflation of 19% and cumulative wage growth of 22%.

The overall recent decrease in the number of firms offering health benefits was driven primarily by companies with fewer than 200 workers. In 2007, nearly all large firms with 200 or more workers offered health benefits (99%), while the percentage of small to mid-sized firms offering health insurance varied considerably. Only about half (45%) of the smallest companies (3 – 9 workers) offered health benefits as compared to nearly three-fourths of firms (76%) with 10 to 24 workers, 83% of firms with 25 – 49 workers, and more than 95% of firms with 50 or more workers.

The likelihood of employees opting out of health insurance coverage rises with increased cost of premiums. Proportionally, employers’ contributions to premiums has remained steady, however, the dollar amount paid in premiums by both employers and employees has increased. According to a Kaiser Commission on Medicaid and the Uninsured (KCMU) study entitled “Changes in Employees’ Health Insurance Coverage, 2001-2005,” annual worker contributions increased by $293 for single coverage and by $1,354 for family coverage since 2000. The September 2007 KFF/HRET survey estimated that the average annual premium in 2007 totaled $4,479 per year for single coverage (roughly $3,785 contributed by the firm, and $694 contributed by the employee).
and $12,106 per year for family coverage ($3,281 contributed by the employee, and $8,824
contributed by the employer). Approximately 10% of employees experienced substantial premium
increases (greater than 15%), while 46% of covered workers experienced modest premium
increases (less than or equal to 5%).

Loss of eligibility of health insurance can occur in a number of ways. For instance, some
employers have modified their plans to exclude family coverage. According to the Kaiser Family
Foundation (KFF) study “Change in Percentage of Families Offered Coverage at Work,” during the
period from 1998 to 2005, the number of families that include an adult worker who is offered job-
based health coverage has fallen 3 percentage points from 80% to 77%, with lower income families
seeing a larger change than the highest income group.

PUBLIC SECTOR INSURANCE

Discussions about the eligibility levels of public sector health insurance have often raised the
concern that employers may drop coverage if their employees become eligible for public coverage
under Medicaid or the State Children’s Health Insurance Program (SCHIP). Such concerns are
intensified as employers continue to struggle with rising health care costs. “Crowd-out” describes
this phenomenon whereby employees drop existing private coverage and enroll in public coverage,
or employers change their insurance offerings in response to the availability of public coverage.
Throughout 2007, the reauthorization debate for the SCHIP program focused on the extent to
which SCHIP would substitute or “crowd out” private coverage for higher income families.

Determining the extent to which “crowd out” occurs is difficult because there are a variety of
reasons that employers and individuals modify their offering or acceptance of employer-sponsored
insurance. Despite the difficulty of measuring “crowd out,” the Congressional Budget Office
estimated in May 2007 that the availability of SCHIP resulted in at most a 10% decline in
employer-sponsored coverage among SCHIP-eligible children, and a 2% decline in employer-
sponsored coverage among all children.

RETIREE HEALTH INSURANCE BENEFITS

More than three million retirees between the ages of 55 and 64 rely on employer-sponsored health
insurance from their former employers to bridge coverage until they are eligible to receive
Medicare. In recent years, several large national firms have eliminated retiree health benefits.
According to the September 2007 report from KFF/HRET, coverage for retirees nationally dropped
from 66% in 1988 to 33% in 2007. During a time when their health expenses are likely to increase,
an increasing number of retirees are facing a greater share of their health care costs, an increased
number of eligibility restrictions, and benefit limitations.

The Medicare system relies on taxes paid by current workers to fund the benefits provided to
current retirees. The ratio of working tax-payers to the number of beneficiaries is expected to
decline steadily as “baby boomers” become eligible for Medicare, life expectancy continues to
improve, and future birth rates stay at levels similar to those of the last two decades. For this
reason, the long-term financing and benefits structure of the current Medicare program is
the Medicare Program,” presents strategies for stabilizing the fiscal strength of Medicare.
The sustained erosion of retiree health benefits is likely to have the greatest impact on those who
are currently employed. Compounding the demographics problem is the continual increase in
health care costs across all segments of the population. In its 2007 report to Congress, the Medicare Trustees noted that Hospital Insurance (HI) tax revenues currently cover approximately 99% of HI costs. The Trustees project that taxes will cover only 79% of costs in 2019, the same year in which the Trustees project exhaustion of HI Trust Fund assets. An April 2007 study by the Employee Benefit Research Institute calculated that couples will need about $300,000–$500,000 to cover health expenses in retirement.

EMPLOYER ACTIONS TO CONTAIN COSTS AND INCREASE VALUE

Employers have always looked for ways to contain the cost of health insurance premiums. In 2006, about two-thirds of large employers focused on strengthening care management and consumerism programs. In 2007, large firms reported that they are likely to increase cost-sharing for premiums, office visits, deductibles, and prescription drugs according to the September 2007 KFF/HRET survey. Regardless of the aggregate action of employers, individual employer strategies vary greatly depending on the structure of their current employee health insurance benefits, recruiting needs, employee demands, and cost trends specific to their region or industry.

Some employers have focused on increasing the value of their health care spending by supporting a number of initiatives such as:

- Health insurance plans that include tiered benefits (e.g., tiered network PPOs, narrow or high performance networks, or plans with enrollee incentives to select high value performers, including medical “centers of excellence”);
- Pay-for-performance and incentive programs (e.g., Bridges to Excellence); and
- Wellness and disease management programs.

Large employers have been particularly enthusiastic about wellness programs to reduce demand for medical services, absenteeism, on-the-job injuries, worker compensation costs, and disability-management costs. The AMA has developed detailed responses to these initiatives to ensure that they do not disrupt patient/physician relationships.

A strategy used by some employers is to avoid hiring workers with potentially costly preexisting conditions by implementing long waiting periods before employees become eligible for the company’s health benefits plan, rather than changing the benefits offered. Some employers avoid providing health coverage by relying on workers that are not eligible for company benefits (i.e., contract, seasonal, or part-time employees).

For the past several years, some employers with low income and hourly workers have offered bare-bones policies, known as “limited-benefit” or “mini-medical” plans as a way to reduce insurance premiums. Recently, a broad mix of employers has started to offer such plans. So-called “mini-medical” plans control costs by limiting physician visits, laboratory tests, and hospital care. Annual coverage for “mini-medical” plans may contain caps as low as $1,000/year and rarely covers services costing more than $20,000 per year.
In addition to traditional cost containment methods, employers are seeking alternative health insurance products that will provide incentives for employees to manage their own costs. Consumer driven health plans (CDHPs) include health savings accounts (HSAs), high deductible health plans (HDHPs), and health reimbursement arrangement (HRAs). CDHPs offer a high degree of individual choice regarding physicians and other health care providers, treatment decisions, and/or health insurance coverage. HDHPs are a type of health insurance plan with a deductible that is higher than typical deductibles seen in the group insurance market. HSAs are a form of health insurance coverage that includes a HDHP coupled with a tax-advantaged personal savings account to be used for qualified medical expenses. For HRAs, the employer agrees to reimburse qualified medical expenses. HRAs are similar to HSAs, but employees have greater flexibility in that they can use the money in an HRA to buy health insurance. However, unlike HSAs, HRA balances typically remain with the employer and are not portable. Council on Medical Service Report 3 (I-05), “Update on HSAs, HRAs, and Other Consumer-Driven Health Care Plans,” provided a detailed description of these insurance models.

According to an April 2007 survey conducted by the consulting firm Mercer, employers’ offerings of account-based, high-deductible CDHPs grew from just 1% to 3% nationally in 2006. Among large employers (20,000 or more employees), such offers jumped from 22% to 37%. Among small employers (fewer than 500 employees) the offering of CDHPs rose from 2% to 5%. In addition, the Mercer study notes that small employers prefer HSA-based plans because HSAs do not require an employer contribution.

These new models of health insurance coverage, which provide incentives for individual patients to make more of their own health care decisions, can be particularly appropriate for small businesses. The Mercer study found that the cost of an average CDHP is $5,770 for single coverage, which is 17% less than Mercer’s estimate of a $6,932 premium for traditional preferred provider organization (PPO) plans for individuals. Firms offering health savings accounts and other forms of consumer-directed health coverage have lowered their health care costs. However, these plans may attract healthier individuals with lower overall health care costs.

In a May 2003 Health Affairs article, economist Alain Enthoven urged public and private partnerships to create exchanges for small employers to manage health benefits in regional markets. To create exchanges, employers would have to agree to undergo the costs of transitioning to fixed-dollar contributions. People with low incomes could be subsidized by federal and state governments to enable them to obtain coverage through the exchanges. Similar to the concept of health exchanges, “HealthMarts” are private organizations that serve as clearinghouses of health insurance products that can be purchased by employers and employees within a geographic region.

Entrepreneur Paul Zane Pilzer was featured on the front page of the July 30, 2007, Wall Street Journal for enlisting more than 300 employers in a health exchange that aids employees with purchasing individually owned health insurance policies instead of group health insurance policies. Zane encourages individuals to choose HRAs through their employers and use the accounts to purchase individual health insurance. Zane’s approach has been criticized because the current individual market is closed to many individuals with existing or chronic conditions. Council on Medical Service Report 2 (I-07), “Health Insurance Coverage of High Risk Patients,” discusses coverage options specific to the needs of these individuals.
In addition to alternative coverage options, innovative new tools are being developed for employers that choose to offer health benefits to their employees. For example, the consulting firm Bowers & Associates developed a “Health Plan Evaluator” tool that allows employees to compare the plans offered by their employers using their personal previous claims data. According to Bowers & Associates, a pilot study of this tool demonstrated a “significant migration into leaner designs,” with HSA participation increasing by 30%, and enrollment in less costly PPOs increasing by 25%.

FEDERAL AND STATE PROPOSALS

The Bush Administration’s 2008 budget proposed revoking the employee tax exclusion for employer-sponsored health insurance. President Bush proposed using the revenue from eliminating the income tax exclusion to provide standard tax deductions to all taxpayers for the purchase of health insurance coverage. Council on Medical Service Report 5 (I-07), “Health Insurance Subsidies: Tax Deductions and Credits,” provides a comparison of the Bush Administration proposal with the AMA proposal, both of which favor eliminating the income tax exclusion for employer-sponsored health insurance. In addition to the Administration’s proposal to restructure the tax exclusion, the Senate passed the June 2007 Small Business Health Insurance Options Act, to grant Small Business Development Centers funds to provide regional information about health insurance options available to them. The introduction of this legislation is based on research showing employers are 33% more likely to offer health insurance to their employees with the availability of information on coverage options.

Employee Retirement Income Security Act

In order to understand recent policy proposals regarding employer-sponsored health insurance, it is important to understand the Employee Retirement Income Security Act (ERISA). Enacted in 1974, ERISA was originally developed to address irregularities in the administration of certain large pension plans. There have been a number of amendments to ERISA, expanding the protections available to health benefit plan participants and beneficiaries (including the Consolidated Omnibus Budget Reconciliation Act [COBRA] and the Health Insurance Portability and Accountability Act [HIPAA]). Today, ERISA sets minimum standards for most voluntarily established pension and “self-insured” health plans in private industry to provide protection for individuals in these plans. Hawaii’s Prepaid Health Care Act of 1974, pre-dated ERISA and remains as the only state employer mandate.

Recently, both federal and state legislators have considered enforcing employer responsibility as a way to reduce the number of uninsured residents despite the ERISA statute. For example, so-called “pay or play” proposals would require employers to either pay a percentage of their payroll into a fund to subsidize health insurance or provide coverage for their workers. Most “pay or play” proposals typically exempt smaller firms (ranging from 10 to 50 employees), and part-time employees (20 hours per week).

Both Vermont and Massachusetts health insurance reform laws required all employers that do not offer insurance to pay into state pools. In January 2006, Maryland passed an employer mandate that was later struck down by the courts on the grounds that it was preempted by ERISA. The likelihood that “pay or play” mandates are challenged for violating ERISA laws depends on the size of the penalty. For instance, state lawmakers in California, Illinois and Pennsylvania are debating “pay or play” proposals. In an effort to avoid conflicting with ERISA, Pennsylvania and
Illinois are considering broad-based taxes on employers to be coupled with tax credits for employers that already spend a certain amount on health coverage.

At the federal level, lawmakers are considering whether to grant states ERISA waivers or help states include employer requirements as part of their comprehensive health reform efforts. Senator Ronald Wyden (D-OR) has introduced The Healthy Americans Act (S. 334), which would require employers to either raise wages for employees to purchase insurance of their own, or make “employer shared responsibility payments” to the federal government to help subsidize the cost of covering the uninsured.

**AMA POLICY**

In 2000, in order to be consistent with newly adopted policy favoring individually owned insurance allowing for portability and patient choice, the AMA formally rescinded policy supporting an employer mandate to provide health insurance. In 1998, the AMA adopted policy supporting the revoking of the employee income tax exclusion for employer-sponsored health insurance (Policies H-165.865[1] and H-165.920[11], AMA Policy Database). In 2004, the AMA adopted policy supporting capping the employer-sponsored health insurance tax exclusion as an incremental step toward implementation of the AMA proposal for expanding coverage (Policy H-165.851[2]). The AMA strongly advocates for a pluralistic approach to financing health care, and for the right of individuals to select health insurance plans of their choice. While individually selected and owned health insurance is the preferred method for people to obtain health insurance coverage, the AMA supports and advocates a system where employer-provided coverage is still available to the extent the market demands it (Policy H-165.920[3]). AMA policy promotes health coverage choice through fixed-dollar, refundable tax credits for the individual purchase of health coverage (Policy H-165.865[1f]) and through employer defined contributions toward employee-selected health insurance coverage (Policy H-165.881).

**DISCUSSION**

Although employer-sponsored health insurance coverage remains a key component of insuring Americans, rising costs to both employers and employees has caused it to decline in recent years, with the rate of decline easing in the past four years. Employees of small firms, which are particularly sensitive to changes in premium costs, are much more likely to be uninsured than employees of large firms. Larger firms are less sensitive to increases in costs, but some are limiting benefits to retirees.

The Council on Medical Service believes that employers, particularly small business coalitions, could implement elements of the AMA proposal as they seek ways to provide their otherwise uninsured employees with health care coverage. The AMA’s broad proposal for expanding health insurance coverage favors market-based approaches and includes three key elements: (1) a preference for individual ownership and selection of health insurance; (2) the use of income-related, refundable, advanceable tax credits toward the purchase of health insurance; and (3) improved health insurance market regulation based on “fair rules of the game.”

There is growing bipartisan acknowledgement that the current tax exclusion of employee health benefits is regressive. With increased attention on the uninsured, the AMA has the opportunity to engage small employers in collaborative and supportive efforts to expand health insurance coverage through the individual market. The Council has developed an extensive body of reports.
that could provide a basis for targeting small employers interested in offering a defined contribution for the purchase of health insurance, pooling resources with other employers, and advocating for fairer and more uniform market regulations.

A number of recent coverage innovations have increased individual choice and infused greater patient responsibility in making health care decisions. Despite efforts to provide price transparency, consumerism, and consumer-directed plan designs, the numbers of employers and employees offering and enrolling in consumer directed plans remains modest. There is persistent reluctance to make information on comparative cost and quality to consumers easily available. For this reason, tools that assist employees in projecting their future health care costs are likely to prove helpful in advancing the consumer market. Such tools are particularly necessary for patients, especially those with high-deductible plans, to alleviate potential complications with physician payment from patients.

Finally, consistent data indicates that individuals are not prepared for the future costs of health care, especially as employers limit retiree benefits to their current employees and Medicare faces financial uncertainty. Employers should be encouraged to educate employees about the potential for escalating costs for health care and long-term care. In addition, employers should provide incentives to individuals to pre-fund future costs related to health care and long-term care. Opportunities for those ages 55-64 to purchase coverage through the individual market could significantly reduce the projected increase in uninsurance for this age group.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and that the remainder of the report be filed:

1. That our American Medical Association encourage employers to:

   a) Promote greater individual choice and ownership of plans;

   b) Enhance employee education regarding how to choose health plans that meet their needs;

   c) Offer information and decision-making tools to assist employees in developing and managing their individual health care choices;

   d) Support increased fairness and uniformity in the health insurance market; and

   e) Promote mechanisms that encourage their employees to pre-fund future costs related to retiree health care and long-term care. (Directive to Take Action)

References for this report are available from the AMA Division of Socioeconomic Policy Development.

Fiscal Note: No Significant Fiscal Impact.