

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4 - I-07

Subject: Trends in Employer-Sponsored Health Insurance

Presented by: Georgia A. Tuttle, MD, Chair

Referred to: Reference Committee K
(M. Leroy Sprang, MD, Chair)

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

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

13 TRENDS IN EMPLOYER-SPONSORED HEALTH INSURANCE

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

22
23 The overall recent decrease in the number of firms offering health benefits was driven primarily by
24 companies with fewer than 200 workers. In 2007, nearly all large firms with 200 or more workers
25 offered health benefits (99%), while the percentage of small to mid-sized firms offering health
26 insurance varied considerably. Only about half (45%) of the smallest companies (3 – 9 workers)
27 offered health benefits as compared to nearly three-fourths of firms (76%) with 10 to 24 workers,
28 83% of firms with 25 – 49 workers, and more than 95% of firms with 50 or more workers.

29
30 The likelihood of employees opting out of health insurance coverage rises with increased cost of
31 premiums. Proportionally, employers' contributions to premiums has remained steady, however,
32 the dollar amount paid in premiums by both employers and employees has increased. According to
33 a Kaiser Commission on Medicaid and the Uninsured (KCMU) study entitled "Changes in
34 Employees' Health Insurance Coverage, 2001-2005," annual worker contributions increased by
35 \$293 for single coverage and by \$1,354 for family coverage since 2000. The September 2007
36 KFF/HRET survey estimated that the average annual premium in 2007 totaled \$4,479 per year for
37 single coverage (roughly \$3,785 contributed by the firm, and \$694 contributed by the employee)

1 and \$12,106 per year for family coverage (\$3,281 contributed by the employee, and \$8,824
2 contributed by the employer). Approximately 10% of employees experienced substantial premium
3 increases (greater than 15%), while 46% of covered workers experienced modest premium
4 increases (less than or equal to 5%).

5
6 Loss of eligibility of health insurance can occur in a number of ways. For instance, some
7 employers have modified their plans to exclude family coverage. According to the Kaiser Family
8 Foundation (KFF) study “Change in Percentage of Families Offered Coverage at Work,” during the
9 period from 1998 to 2005, the number of families that include an adult worker who is offered job-
10 based health coverage has fallen 3 percentage points from 80% to 77%, with lower income families
11 seeing a larger change than the highest income group.

12 13 PUBLIC SECTOR INSURANCE

14
15 Discussions about the eligibility levels of public sector health insurance have often raised the
16 concern that employers may drop coverage if their employees become eligible for public coverage
17 under Medicaid or the State Children’s Health Insurance Program (SCHIP). Such concerns are
18 intensified as employers continue to struggle with rising health care costs. “Crowd-out” describes
19 this phenomenon whereby employees drop existing private coverage and enroll in public coverage,
20 or employers change their insurance offerings in response to the availability of public coverage.
21 Throughout 2007, the reauthorization debate for the SCHIP program focused on the extent to
22 which SCHIP would substitute or “crowd out” private coverage for higher income families.

23
24 Determining the extent to which “crowd out” occurs is difficult because there are a variety of
25 reasons that employers and individuals modify their offering or acceptance of employer-sponsored
26 insurance. Despite the difficulty of measuring “crowd out,” the Congressional Budget Office
27 estimated in May 2007 that the availability of SCHIP resulted in at most a 10% decline in
28 employer-sponsored coverage among SCHIP-eligible children, and a 2% decline in employer-
29 sponsored coverage among all children.

30 31 RETIREE HEALTH INSURANCE BENEFITS

32
33 More than three million retirees between the ages of 55 and 64 rely on employer-sponsored health
34 insurance from their former employers to bridge coverage until they are eligible to receive
35 Medicare. In recent years, several large national firms have eliminated retiree health benefits.
36 According to the September 2007 report from KFF/HRET, coverage for retirees nationally dropped
37 from 66% in 1988 to 33% in 2007. During a time when their health expenses are likely to increase,
38 an increasing number of retirees are facing a greater share of their health care costs, an increased
39 number of eligibility restrictions, and benefit limitations.

40
41 The Medicare system relies on taxes paid by current workers to fund the benefits provided to
42 current retirees. The ratio of working tax-payers to the number of beneficiaries is expected to
43 decline steadily as “baby boomers” become eligible for Medicare, life expectancy continues to
44 improve, and future birth rates stay at levels similar to those of the last two decades. For this
45 reason, the long-term financing and benefits structure of the current Medicare program is
46 increasingly unsustainable. Council on Medical Service Report 6 (I-07), “Strategies to Strengthen
47 the Medicare Program,” presents strategies for stabilizing the fiscal strength of Medicare.
48 The sustained erosion of retiree health benefits is likely to have the greatest impact on those who
49 are currently employed. Compounding the demographics problem is the continual increase in

1 health care costs across all segments of the population. In its 2007 report to Congress, the
2 Medicare Trustees noted that Hospital Insurance (HI) tax revenues currently cover approximately
3 99% of HI costs. The Trustees project that taxes will cover only 79% of costs in 2019, the same
4 year in which the Trustees project exhaustion of HI Trust Fund assets. An April 2007 study by the
5 Employee Benefit Research Institute calculated that couples will need about \$300,000–\$500,000 to
6 cover health expenses in retirement.

7
8 EMPLOYER ACTIONS TO CONTAIN COSTS AND INCREASE VALUE
9

10 Employers have always looked for ways to contain the cost of health insurance premiums. In
11 2006, about two-thirds of large employers focused on strengthening care management and
12 consumerism programs. In 2007, large firms reported that they are likely to increase cost-sharing
13 for premiums, office visits, deductibles, and prescription drugs according to the September 2007
14 KFF/HRET survey. Regardless of the aggregate action of employers, individual employer
15 strategies vary greatly depending on the structure of their current employee health insurance
16 benefits, recruiting needs, employee demands, and cost trends specific to their region or industry.

17
18 Some employers have focused on increasing the value of their health care spending by supporting a
19 number of initiatives such as:

- 20
21 • Health insurance plans that include tiered benefits (e.g., tiered network PPOs, narrow or
22 high performance networks, or plans with enrollee incentives to select high value
23 performers, including medical “centers of excellence”);
24 • Pay-for-performance and incentive programs (e.g., Bridges to Excellence); and
25 • Wellness and disease management programs.
26

27 Large employers have been particularly enthusiastic about wellness programs to reduce demand for
28 medical services, absenteeism, on-the-job injuries, worker compensation costs, and disability-
29 management costs. The AMA has developed detailed responses to these initiatives to ensure that
30 they do not disrupt patient/physician relationships.
31

32 A strategy used by some employers is to avoid hiring workers with potentially costly preexisting
33 conditions by implementing long waiting periods before employees become eligible for the
34 company’s health benefits plan, rather than changing the benefits offered. Some employers avoid
35 providing health coverage by relying on workers that are not eligible for company benefits (i.e.,
36 contract, seasonal, or part-time employees).
37

38 For the past several years, some employers with low income and hourly workers have offered bare-
39 bones policies, known as “limited-benefit” or “mini-medical” plans as a way to reduce insurance
40 premiums. Recently, a broad mix of employers has started to offer such plans. So-called “mini-
41 medical” plans control costs by limiting physician visits, laboratory tests, and hospital care.
42 Annual coverage for “mini-medical” plans may contain caps as low as \$1,000/year and rarely
43 covers services costing more than \$20,000 per year.

1 COVERAGE INNOVATIONS

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3 In addition to traditional cost containment methods, employers are seeking alternative health
4 insurance products that will provide incentives for employees to manage their own costs.
5 Consumer driven health plans (CDHPs) include health savings accounts (HSAs), high deductible
6 health plans (HDHPs), and health reimbursement arrangement (HRAs). CDHPs offer a high
7 degree of individual choice regarding physicians and other health care providers, treatment
8 decisions, and/or health insurance coverage. HDHPs are a type of health insurance plan with a
9 deductible that is higher than typical deductibles seen in the group insurance market. HSAs are a
10 form of health insurance coverage that includes a HDHP coupled with a tax-advantaged personal
11 savings account to be used for qualified medical expenses. For HRAs, the employer agrees to
12 reimburse qualified medical expenses. HRAs are similar to HSAs, but employees have greater
13 flexibility in that they can use the money in an HRA to buy health insurance. However, unlike
14 HSAs, HRA balances typically remain with the employer and are not portable. Council on Medical
15 Service Report 3 (I-05), "Update on HSAs, HRAs, and Other Consumer-Driven Health Care
16 Plans," provided a detailed description of these insurance models.

17
18 According to an April 2007 survey conducted by the consulting firm Mercer, employers' offerings
19 of account-based, high-deductible CDHPs grew from just 1% to 3% nationally in 2006. Among
20 large employers (20,000 or more employees), such offers jumped from 22% to 37%. Among small
21 employers (fewer than 500 employees) the offering of CDHPs rose from 2% to 5%. In addition,
22 the Mercer study notes that small employers prefer HSA-based plans because HSAs do not require
23 an employer contribution.

24
25 These new models of health insurance coverage, which provide incentives for individual patients to
26 make more of their own health care decisions, can be particularly appropriate for small businesses.
27 The Mercer study found that the cost of an average CDHP is \$5,770 for single coverage, which is
28 17% less than Mercer's estimate of a \$6,932 premium for traditional preferred provider
29 organization (PPO) plans for individuals. Firms offering health savings accounts and other forms
30 of consumer-directed health coverage have lowered their health care costs. However, these plans
31 may attract healthier individuals with lower overall health care costs.

32
33 In a May 2003 *Health Affairs* article, economist Alain Enthoven urged public and private
34 partnerships to create exchanges for small employers to manage health benefits in regional
35 markets. To create exchanges, employers would have to agree to undergo the costs of transitioning
36 to fixed-dollar contributions. People with low incomes could be subsidized by federal and state
37 governments to enable them to obtain coverage through the exchanges. Similar to the concept of
38 health exchanges, "HealthMarts" are private organizations that serve as clearinghouses of health
39 insurance products that can be purchased by employers and employees within a geographic region.

40
41 Entrepreneur Paul Zane Pilzer was featured on the front page of the July 30, 2007, *Wall Street*
42 *Journal* for enlisting more than 300 employers in a health exchange that aids employees with
43 purchasing individually owned health insurance policies instead of group health insurance policies.
44 Zane encourages individuals to choose HRAs through their employers and use the accounts to
45 purchase individual health insurance. Zane's approach has been criticized because the current
46 individual market is closed to many individuals with existing or chronic conditions. Council on
47 Medical Service Report 2 (I-07), "Health Insurance Coverage of High Risk Patients," discusses
48 coverage options specific to the needs of these individuals.

1 In addition to alternative coverage options, innovative new tools are being developed for employers
2 that choose to offer health benefits to their employees. For example, the consulting firm Bowers &
3 Associates developed a “Health Plan Evaluator” tool that allows employees to compare the plans
4 offered by their employers using their personal previous claims data. According to Bowers &
5 Associates, a pilot study of this tool demonstrated a “significant migration into leaner designs,”
6 with HSA participation increasing by 30%, and enrollment in less costly PPOs increasing by 25%.

7
8 FEDERAL AND STATE PROPOSALS

9
10 The Bush Administration’s 2008 budget proposed revoking the employee tax exclusion for
11 employer-sponsored health insurance. President Bush proposed using the revenue from
12 eliminating the income tax exclusion to provide standard tax deductions to all taxpayers for the
13 purchase of health insurance coverage. Council on Medical Service Report 5 (I-07), “Health
14 Insurance Subsidies: Tax Deductions and Credits,” provides a comparison of the Bush
15 Administration proposal with the AMA proposal, both of which favor eliminating the income tax
16 exclusion for employer-sponsored health insurance. In addition to the Administration’s proposal to
17 restructure the tax exclusion, the Senate passed the June 2007 Small Business Health Insurance
18 Options Act, to grant Small Business Development Centers funds to provide regional information
19 about health insurance options available to them. The introduction of this legislation is based on
20 research showing employers are 33% more likely to offer health insurance to their employees with
21 the availability of information on coverage options.

22
23 Employee Retirement Income Security Act

24
25 In order to understand recent policy proposals regarding employer-sponsored health insurance, it is
26 important to understand the Employee Retirement Income Security Act (ERISA). Enacted in 1974,
27 ERISA was originally developed to address irregularities in the administration of certain large
28 pension plans. There have been a number of amendments to ERISA, expanding the protections
29 available to health benefit plan participants and beneficiaries (including the Consolidated Omnibus
30 Budget Reconciliation Act [COBRA] and the Health Insurance Portability and Accountability Act
31 [HIPAA]). Today, ERISA sets minimum standards for most voluntarily established pension and
32 “self-insured” health plans in private industry to provide protection for individuals in these plans.
33 Hawaii’s Prepaid Health Care Act of 1974, pre-dated ERISA and remains as the only state
34 employer mandate.

35
36 Recently, both federal and state legislators have considered enforcing employer responsibility as a
37 way to reduce the number of uninsured residents despite the ERISA statute. For example, so-called
38 “pay or play” proposals would require employers to either pay a percentage of their payroll into a
39 fund to subsidize health insurance or provide coverage for their workers. Most “pay or play”
40 proposals typically exempt smaller firms (ranging from 10 to 50 employees), and part-time
41 employees (20 hours per week).

42
43 Both Vermont and Massachusetts health insurance reform laws required all employers that do not
44 offer insurance to pay into state pools. In January 2006, Maryland passed an employer mandate
45 that was later struck down by the courts on the grounds that it was preempted by ERISA. The
46 likelihood that “pay or play” mandates are challenged for violating ERISA laws depends on the
47 size of the penalty. For instance, state lawmakers in California, Illinois and Pennsylvania are
48 debating “pay or play” proposals. In an effort to avoid conflicting with ERISA, Pennsylvania and

1 Illinois are considering broad-based taxes on employers to be coupled with tax credits for
2 employers that already spend a certain amount on health coverage.

3
4 At the federal level, lawmakers are considering whether to grant states ERISA waivers or help
5 states include employer requirements as part of their comprehensive health reform efforts. Senator
6 Ronald Wyden (D-OR) has introduced The Healthy Americans Act (S. 334), which would require
7 employers to either raise wages for employees to purchase insurance of their own, or make
8 “employer shared responsibility payments” to the federal government to help subsidize the cost of
9 covering the uninsured.

10 11 AMA POLICY

12
13 In 2000, in order to be consistent with newly adopted policy favoring individually owned insurance
14 allowing for portability and patient choice, the AMA formally rescinded policy supporting an
15 employer mandate to provide health insurance. In 1998, the AMA adopted policy supporting the
16 revoking of the employee income tax exclusion for employer-sponsored health insurance (Policies
17 H-165.865[1] and H-165.920[11], AMA Policy Database). In 2004, the AMA adopted policy
18 supporting capping the employer-sponsored health insurance tax exclusion as an incremental step
19 toward implementation of the AMA proposal for expanding coverage (Policy H-165.851[2]). The
20 AMA strongly advocates for a pluralistic approach to financing health care, and for the right of
21 individuals to select health insurance plans of their choice. While individually selected and owned
22 health insurance is the preferred method for people to obtain health insurance coverage, the AMA
23 supports and advocates a system where employer-provided coverage is still available to the extent
24 the market demands it (Policy H-165.920[3]). AMA policy promotes health coverage choice
25 through fixed-dollar, refundable tax credits for the individual purchase of health coverage (Policy
26 H-165.865[1f]) and through employer defined contributions toward employee-selected health
27 insurance coverage (Policy H-165.881).

28 29 DISCUSSION

30
31 Although employer-sponsored health insurance coverage remains a key component of insuring
32 Americans, rising costs to both employers and employees has caused it to decline in recent years,
33 with the rate of decline easing in the past four years. Employees of small firms, which are
34 particularly sensitive to changes in premium costs, are much more likely to be uninsured than
35 employees of large firms. Larger firms are less sensitive to increases in costs, but some are
36 limiting benefits to retirees.

37
38 The Council on Medical Service believes that employers, particularly small business coalitions,
39 could implement elements of the AMA proposal as they seek ways to provide their otherwise
40 uninsured employees with health care coverage. The AMA’s broad proposal for expanding health
41 insurance coverage favors market-based approaches and includes three key elements: (1) a
42 preference for individual ownership and selection of health insurance; (2) the use of income-
43 related, refundable, advanceable tax credits toward the purchase of health insurance; and (3)
44 improved health insurance market regulation based on “fair rules of the game.”

45
46 There is growing bipartisan acknowledgement that the current tax exclusion of employee health
47 benefits is regressive. With increased attention on the uninsured, the AMA has the opportunity to
48 engage small employers in collaborative and supportive efforts to expand health insurance
49 coverage through the individual market. The Council has developed an extensive body of reports

1 that could provide a basis for targeting small employers interested in offering a defined
2 contribution for the purchase of health insurance, pooling resources with other employers, and
3 advocating for fairer and more uniform market regulations.

4
5 A number of recent coverage innovations have increased individual choice and infused greater
6 patient responsibility in making health care decisions. Despite efforts to provide price
7 transparency, consumerism, and consumer-directed plan designs, the numbers of employers and
8 employees offering and enrolling in consumer directed plans remains modest. There is persistent
9 reluctance to make information on comparative cost and quality to consumers easily available. For
10 this reason, tools that assist employees in projecting their future health care costs are likely to prove
11 helpful in advancing the consumer market. Such tools are particularly necessary for patients,
12 especially those with high-deductible plans, to alleviate potential complications with physician
13 payment from patients.

14
15 Finally, consistent data indicates that individuals are not prepared for the future costs of health
16 care, especially as employers limit retiree benefits to their current employees and Medicare faces
17 financial uncertainty. Employers should be encouraged to educate employees about the potential
18 for escalating costs for health care and long-term care. In addition, employers should provide
19 incentives to individuals to pre-fund future costs related to health care and long-term care.
20 Opportunities for those ages 55-64 to purchase coverage through the individual market could
21 significantly reduce the projected increase in uninsurance for this age group.

22 RECOMMENDATIONS

23
24
25 The Council on Medical Service recommends that the following be adopted and that the remainder
26 of the report be filed:

- 27
28 1. That our American Medical Association encourage employers to:
- 29 a) Promote greater individual choice and ownership of plans;
 - 30 b) Enhance employee education regarding how to choose health plans that meet their
31 needs;
 - 32 c) Offer information and decision-making tools to assist employees in developing and
33 managing their individual health care choices;
 - 34 d) Support increased fairness and uniformity in the health insurance market; and
 - 35 e) Promote mechanisms that encourage their employees to pre-fund future costs
36 related to retiree health care and long-term care. (Directive to Take Action)
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References for this report are available from the AMA Division of Socioeconomic Policy
Development.

Fiscal Note: No Significant Fiscal Impact.