EBRI
EMPLOYEE BENEFIT RESEARCH INSTITUTE®

Issue Brief

No. 312

December 2007

The Future of Employment-Based Health Benefits: Have Employers Reached a Tipping Point?

By Paul Fronstin, EBRI

- ***Death of employment-based benefits?*** There have been numerous references in recent reports to the death of employment-based health benefits. This *Issue Brief* examines the notion that employers have reached a "tipping point" where they will stop offering health benefits.
- ***Data do not show health benefits are disappearing:*** Evaluation of recent data does not suggest that employment-based health benefits are vanishing. The percentage of small employers offering health benefits in 2007 was about the same as it was in 1996, though it expanded between the mid-1990s and 2000, before declining through 2005. Between 2005 and 2007, the percentage of small employers offering health benefits was stable.
- ***Long-term access to health benefits is stable:*** The percentage of workers reporting that they have access to health benefits through their job is largely unchanged from the mid-1990s and down only slightly from the late 1980s. In 2005, 74 percent of workers who were not self-employed reported they were eligible for health benefits through their own job, up slightly from 73.6 percent in 1995.
- ***Take-up rates are falling:*** Take-up rates for employment-based health benefits have fallen from nearly 88 percent in 1988 to 83.5 percent in 2005 among workers with benefits from their own employer, but fewer than 5 percent of workers eligible for health benefits are uninsured.
- ***Employment-based health coverage has fallen, but not sharply:*** Between 1994 and 2000, the percentage of workers with health benefits through an employer held steady at between 73 percent and 75 percent. Since 2000, the percentage of workers with health benefits has fallen to about 71 percent.
- ***Business supports employment-based coverage, but not the status quo:*** The message from most associations representing employers is that the existing employment-based system must be reformed. Most individual employers, including leaders in the field, appear to share this vision. Individual employers believe that there is a business case for offering health benefits to their workers and they continue to invest in improving their health programs.
- ***Mixed views by plan sponsors:*** Employers interviewed for this study had mixed opinions concerning whether the employment-based health benefits system is the most viable model for providing health insurance. Some think it is the best system available, though they also think that the current system is both "inefficient" and "not intelligent" and that "if we could start over with a clean slate, we would not have the current system." Some think that an improved version of the current system would be the best system. Others go so far as to say that the current system is not the best system because it is inefficient and because transparencies are lacking.
- ***Waiting to take the plunge:*** The employers interviewed for this study tend to agree that if one major employer were to drop health benefits, others would follow. And they tend to agree that public policy changes, such as the erosion or elimination of ERISA (federal) pre-emption of state insurance regulation, could result in the complete elimination of employer support for a voluntary employment-based health benefits system.

Paul Fronstin is director of the Health Research and Education Program at the Employee Benefit Research Institute (EBRI). This *Issue Brief* was written with assistance from the Institute's research and editorial staffs. The author would like to thank Robert Crane, Robert Dickler, Christopher De Rosa, Dave Guilmette, Mike Langan, Jane Lassner, Jeff McGuiness, Marisa Milton, Christina Nyquist, Dallas Salisbury, Laura Tollen, Mark Ugoretz, Ray Werntz, and Steve Wetzell for reviewing an earlier version of this paper. Any views expressed in this report are those of the author and should not be ascribed to the officers, trustees, or other sponsors of EBRI, EBRI-ERF, or their staffs. Neither EBRI nor EBRI-ERF lobbies or takes positions on specific policy proposals. EBRI invites comment on this research.

Table of Contents

Figures

Introduction

Malcolm Gladwell (2003), a best-selling author, describes reaching a "tipping point" as when something unusual becomes common, and fundamental change occurs. The question of whether the U.S. health care financing and delivery system has reached a tipping point has been asked frequently,[1] and in some cases is simply implied (Porter and Teisberg, 2006). A natural extension of this question applies to employers: Is the employment-based health benefits system—the primary means by which the vast majority of Americans receive health insurance coverage[2]—going through or *about* to go through a fundamental change that could be characterized as a tipping point?

There have been numerous references to the death of employment-based health benefits. The employment-based system of providing health benefits has been described as follows: "vanishing,"[3] "failing,"[4] "[employers] are fleeing the system,"[5] "employer-based health care is ending. It is dying in front of our very eyes."[6] "Employer-based health coverage is melting away like a popsicle on the summer sidewalk."[7] Furthermore, while some organizations and policymakers do not go so far as to say that employment-based health benefits are dying, vanishing, or have reached a tipping point, they promote policies that would effectively end employment-based health benefits as we know them (Fronstin and Salisbury, 2007).[8] The various presidential candidates have proposals for reforming the health care system, and proposals from both sides of the aisle could directly or indirectly erode or even end employment-based health benefits.[9]

Whether employers have reached a tipping point with health benefits may depend on the definition of a tipping point. The quotes above would suggest that employers have reached a threshold in the sense that the employment-based health benefits system is going to cease to exist. Alternatively, the tipping point could be described as the point at which employers decide to become much more proactive in controlling health costs through every vehicle possible in order to "redefine" what is meant by an employment-based health benefits system. This would include changes to current benefit programs as well as public policy proposals that would allow employers to operate programs in different ways than they have been doing.

In both cases, questions are being asked regarding whether the current system is unsustainable without fundamental reform and what changes are needed in order to shore up and strengthen the employment-based health benefits system. Questions are also being asked with respect to the role of employers, individuals, insurers, providers of health care services, and the government.

This *Issue Brief* examines the notion that employers have reached a tipping point over health costs and will cease offering health care benefits to their workers. In the end, an evaluation of recent data does not suggest that the end of employment-based health benefits is upon us. However, the message from some associations representing employers is that the existing employment-based system must be reformed because the status quo is unsustainable. Some individual employers, including leaders in the field, appear to share this new vision. However, many individual employers believe that there is a business case for offering health benefits to their workers, and they continue to invest substantial amounts of money in their health programs. They also tend to agree that if one major employer were to drop health benefits, others would follow. And they tend to agree that public policy changes, such as the erosion or elimination of ERISA (federal) pre-emption of state insurance regulation, *could* mean the end of voluntary employment-based health benefits.[10]

The first section of this report examines recent trends in health benefits. It then discusses whether employers have reached a tipping point with health benefits. This is followed by a discussion of what is driving employers to a tipping point with respect to retiree health benefits.

Recent Trends in Employment-Based Health Benefits

Are employment-based health benefits vanishing? The question of whether employers have reached a tipping point is driven by the rising cost of providing health benefits to workers. Between 2000 and 2007, the cost of providing health benefits doubled, while workers' wages and overall inflation increased only 25

and 21 percent, respectively (calculated from Figure 1). While the growth rate in the cost of providing health benefits fell between 2003 and 2007 from 13.9 percent to 6.1 percent (Figure 1), growth in the cost of providing health benefits to workers continues to run double the growth in workers' earnings and is also double the rate of overall inflation. This section addresses the question of whether the employment-based system is vanishing. Whether employers have reached a tipping point is a different kind of question that will be addressed in the next section.

Despite the continued rising cost of providing health benefits to workers relative to workers' earnings and overall inflation, an examination of recent history suggests that the employment-based system is not vanishing, although there has been some erosion in the availability of health insurance through smaller employers. In fact, the percentage of small employers offering health benefits in 2007 was about the same as it was in 1996. In 2000, 68 percent of employers with fewer than 200 employees offered health benefits (Figure 2). By 2005, only 59 percent offered it. Between 2005 and 2007, the percentage of small employers offering health benefits was stable. The erosion in availability among small employers between 2000 and 2005 followed an expansion in availability of health benefits that occurred between 1996 and 2000.

While there has been an erosion of availability of health benefits at the *small employer* level since 2000**,** the percentage of workers reporting that they *have access* to health benefits through their job is largely unchanged from the mid-1990s and down only slightly from the late-1980s. In 2005, 74 percent of workers who were not self-employed reported that they were eligible for health benefits through their own job, up slightly from 73.6 percent in 1995, but down from 77.8 percent in 1988 (Figure 3). And while *take-up rates* for employment-based health benefits have fallen from nearly 88 percent in 1988 to 83.5 percent in 2005, fewer than 5 percent of workers who are eligible for health benefits from their own employer but decline them are uninsured, as most workers who decline coverage do so because they have coverage from another source (Fronstin, 2007).

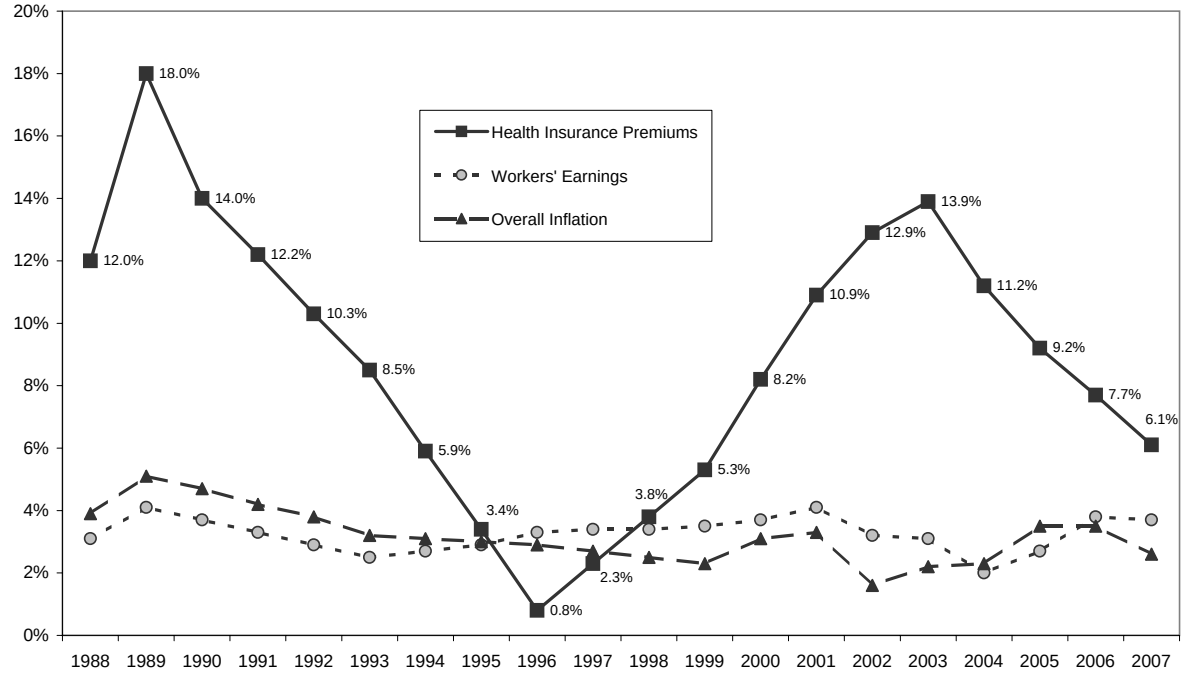
In terms of whether workers *have* health insurance coverage, for the most part, the percentage of workers with coverage either from their own employer or from someone else's employer has been remarkably stable, considering what has happened with the cost of providing health benefits and the fact that fewer small employers have offered coverage since 2000. Between 1994 and 2000, the percentage of workers with health benefits through an employer held steady at between 73 percent and 75 percent (Figure 4). Since 2000, the percentage of workers with health benefits has fallen to about 71 percent. While a 4 percentage point drop in the number of workers with health benefits may be significant, it does not imply that these benefits are vanishing.

Another way to examine whether employment-based health benefits are vanishing is to look at trends in the benefits package. While workers and their families continue to have coverage, if the composition of that coverage is eroding, it might be concluded that benefits are vanishing.

Workers are definitely paying more for health benefits today than they were in 2000. Premiums for employee-only coverage increased from $28 to $52 per month between 2000 and 2006, an 86 percent increase, and family coverage premiums increased from $138 to $248 per month, an 80 percent increase (Figure 5). In contrast, the consumer price index (CPI) increased by 17 percent between 2000 and 2006. While premiums have increased more than four times the rate of inflation, it cannot be concluded that, because workers are paying more, their health benefits are at least as comprehensive as they used to be. In order to determine whether health benefits are vanishing, it is necessary also to look at the services that are covered by the benefits package and the cost of obtaining those services when needed.

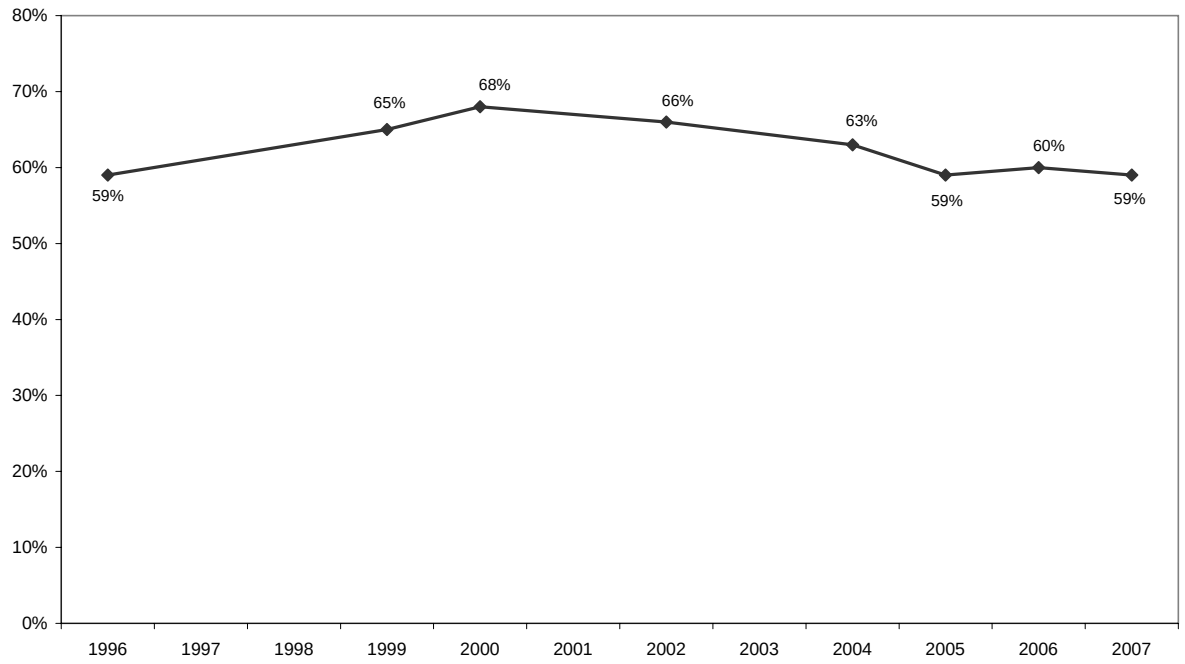
Worker cost-sharing for health care services *has* been increasing and *has* been outpacing overall inflation. Between 2000 and 2006, the percentage of workers in a preferred provider organization (PPO) with a deductible of at least $500 increased from 14 percent to 38 percent (Figure 6) and the percentage of workers with an office visit co-payment of at least $20 increased from 39 percent to 53 percent (Figure 7). Overall, the average deductible among workers with employee-only coverage in a PPO increased from $187 in 2000 to $327 in 2006, an increase of 75 percent, compared with the 17 percent increase in the CPI as mentioned above.[11] Co-payments for prescription drugs have also increased at a rate outpacing inflation. For example, between 2000 and 2006, the average co-payment for brand name (preferred) drugs on the formulary increased from $13 to $24, an 85 percent increase, while the average co-payment for nonformulary

Figure 1
Growth in Cost of Health Benefits, Worker Earnings, and Overall Inflation, 1988–2007



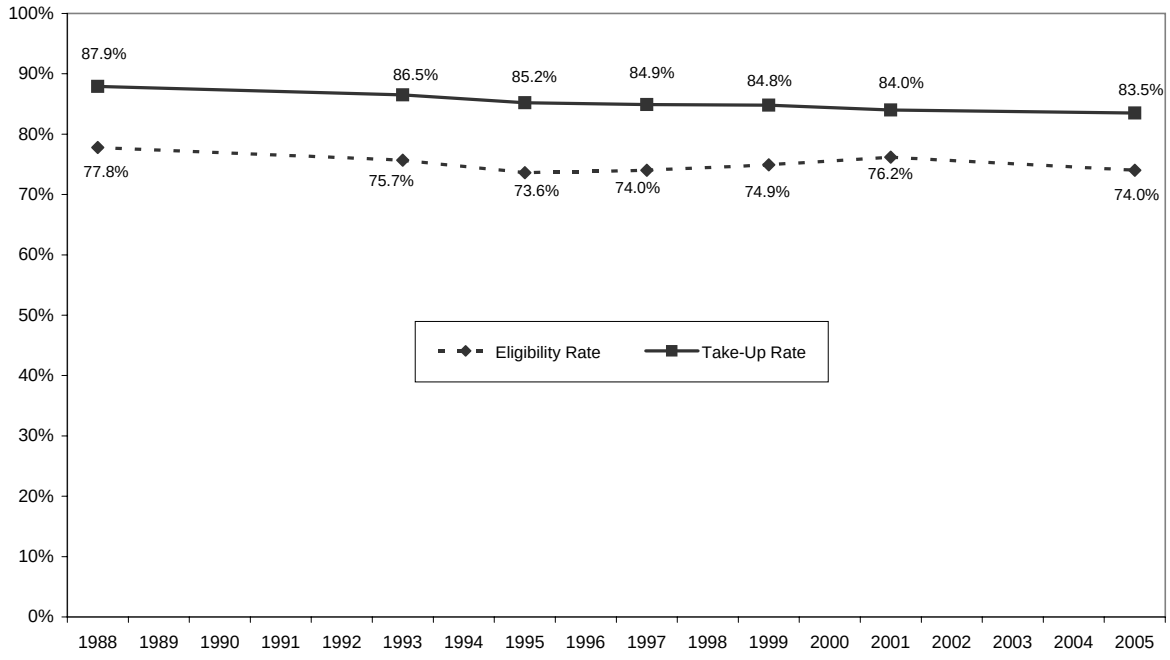
Source: Kaiser Family Foundation.

Figure 2
Percentage of Employers With 3–199 Employees Offering Health Benefits, 1996–2007



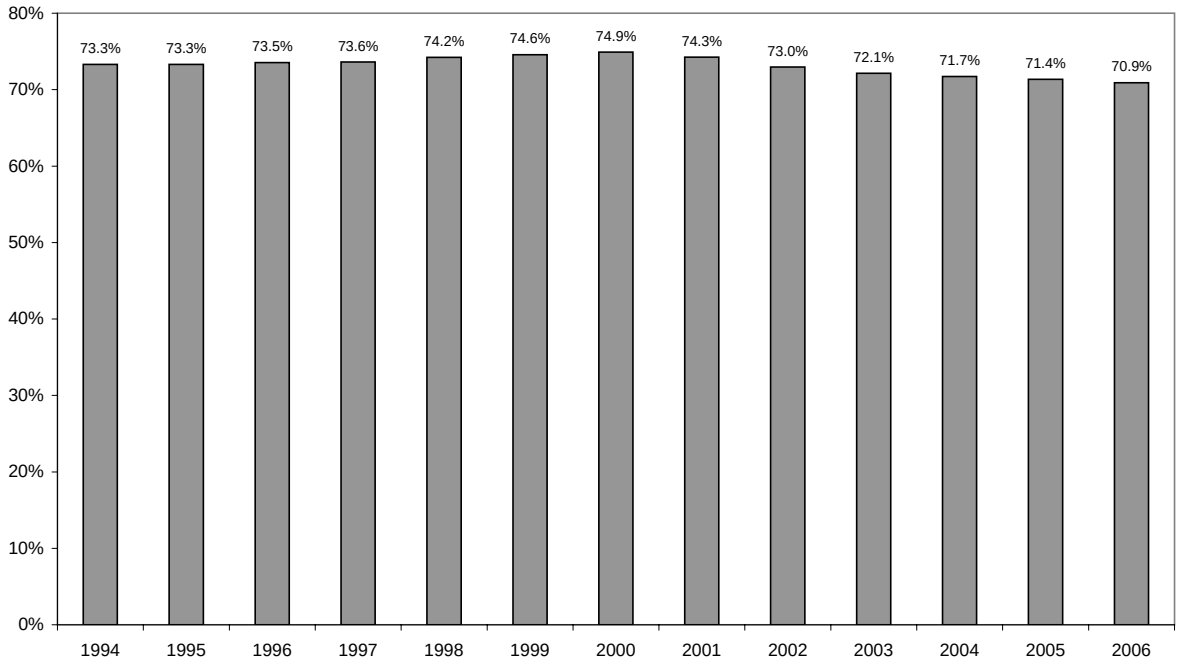
Source: Kaiser Family Foundation.

Figure 3
Worker Eligibility and Take-Up Rates for Own-Employer Health Benefits, Wage and Salary Workers Ages 18–64, 1988–2005



Source: Employee Benefit Research Institute estimates based on data from the Current Population Survey.

Figure 4
Percentage of Workers, Ages 18–64, With Employment-Based Health Benefits, 1994–2006



Source: Employee Benefit Research Institute estimates based on data from the Current Population Survey, March Supplement.

(nonpreferred) brand name drugs increased 124 percent (Figure 8). The average co-payment for generic drugs also increased faster than inflation, up 57 percent between 2000 and 2006.

Despite the fact that more workers are subject to higher deductible and co-payments, the percentage of consumer health care expenses paid out-of-pocket is at an all-time low. In the mid-1990s, more than 30 percent of consumer health care expenses were paid out of pocket (Figure 9**).** By 2005, out-of-pocket spending as a percentage of total consumer spending was down to 26 percent. Furthermore, the percentage of the premium paid by employees for employee-only coverage is down from the mid-1990s and is essentially unchanged for family coverage. In 1993, workers paid an average of 20 percent of the premium for employee-only coverage (Figure 10). By 2007, workers were paying 16 percent. The percentage that workers pay for family coverage has been bouncing around between 26 percent and 28 percent since 1996.

For the most part, the percentage of the population with *access* to employment-based health benefits and the percentage *covered* by them are little changed since the mid-1990s. In addition, services covered have increased, although often with restrictions. Nevertheless, there has been erosion in the benefits package in that cost-sharing has not kept up with inflation. Hence, the employment-based health benefits system is not vanishing and is not dying. Some would go so far as to say that employment-based health benefits are "not falling off a cliff."[12]

Some might posit that employers have been making major changes to health benefits in order to avoid falling off a cliff and to maintain some form of health benefits for their workers. A case in point is the movement to consumer-driven health benefits (CDHBs) (high-deductible account-based health plans such as plans with health savings accounts (HSAs) or health reimbursement arrangements (HRAs)).[13] On the one hand, it can be argued that moving to CDHB is simply a cost shift from employers to employees or that it is intentionally pushing employment-based health benefits toward the cliff. On the other hand, the movement to CDHB can be seen as a response by employers to maintain some form of health benefits for workers in the face of the ever-increasing costs of providing these benefits.

Regardless of one's point of view on CDHB, some employers are investing resources in efforts to improve or shore up employment-based health benefits. In other words, employers are moving more toward consumerism, of which CDHBs are only one part. Most efforts around increased consumerism involve attempts to bring more "transparency" to the health care system (regarding health care quality and costs) so that workers and their families can make informed health care decisions.

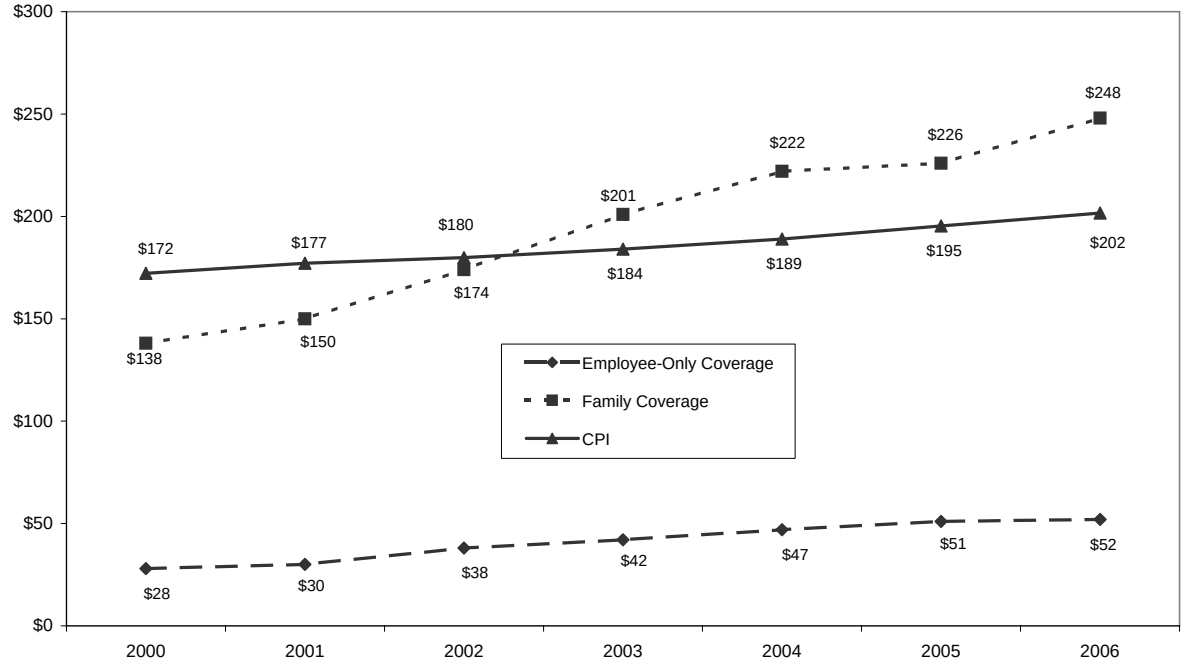
For example, in 1998 a group of large employers formed The Leap Frog Group in an effort to improve the quality and affordability of the health care that they purchase.[14] In 2001, employers formed what is now known as the Consumer-Purchaser Disclosure Project in order to report health care provider quality measures.[15] Today, the group is composed of not only employers but also consumer groups and organized labor. The HR Policy Association recently formed a coalition to bring greater transparency to the way employers purchase pharmaceutical benefits. The coalition uses a comprehensive certification process to identify pharmacy benefit managers (PBMs) willing to meet its transparency standards.[16] Employers are also working with health care providers, insurers, and the federal government to determine how to most effectively and efficiently improve performance measurement, data aggregation, and reporting in all areas of physician practices.[17]

While employers do continue to offer benefits to workers, and while erosion in the benefits package has been modest, and while employers continue to invest in strengthening and improving health benefits, it must be acknowledged that there are very real issues with the employment-based system. The current employment-based system has distinct advantages over other alternatives, but de-linking health insurance from employment might address the shortcomings (Fronstin and Salisbury, 2007).

For example, health insurance is not portable from job to job—i.e., workers can rarely continue to participate in the same health plan when they change jobs. Health insurance is an incentive for workers to stay in their jobs. In 2004, 27 percent of adults reported that they or an immediate family member had passed up a job opportunity, or stayed in a job they would have otherwise left, in order to maintain health insurance (Helman and Fronstin, 2004). The Health Insurance Portability and Accountability Act (HIPAA) addressed portability when it comes to coverage for pre-existing conditions for workers changing jobs, but changing jobs is still risky: Potential employers may not offer health benefits, the benefits offered may be less comprehensive than those offered in the current job, and the benefits from the potential employer may

Figure 5

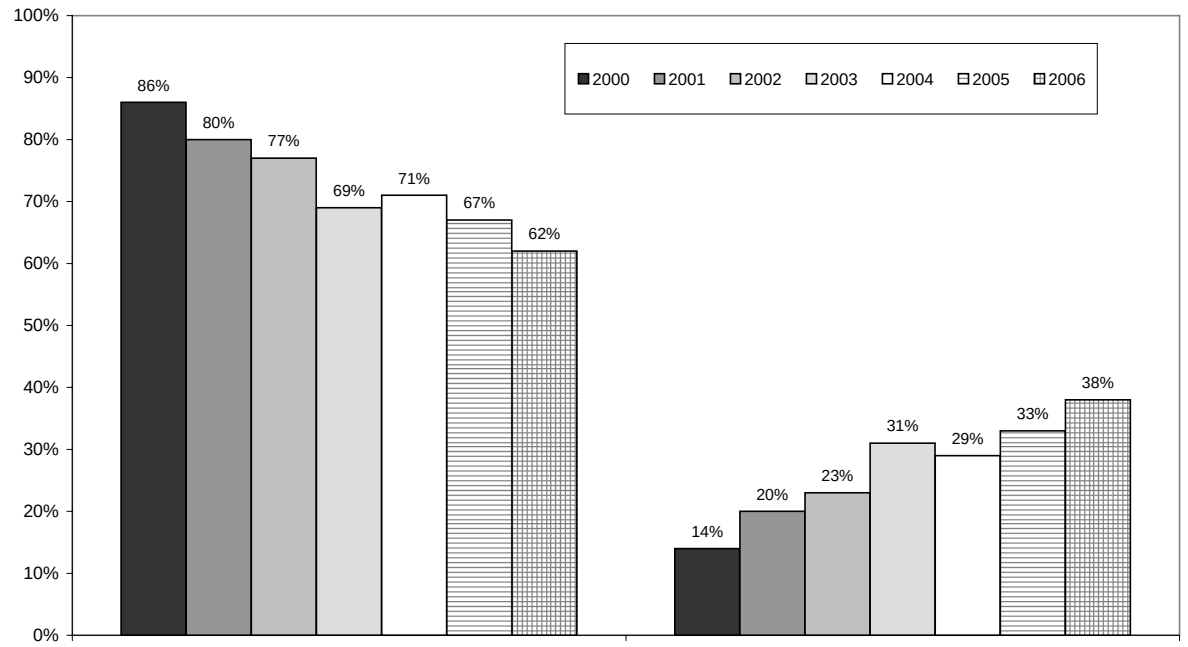
Average Monthly Premiums for Employee-Only Coverage and Family Coverage, and Consumer Price Index (CPI), 2000–2006



Source: Kaiser Family Foundation and Bureau of Labor Statistics (BLS).

Figure 6

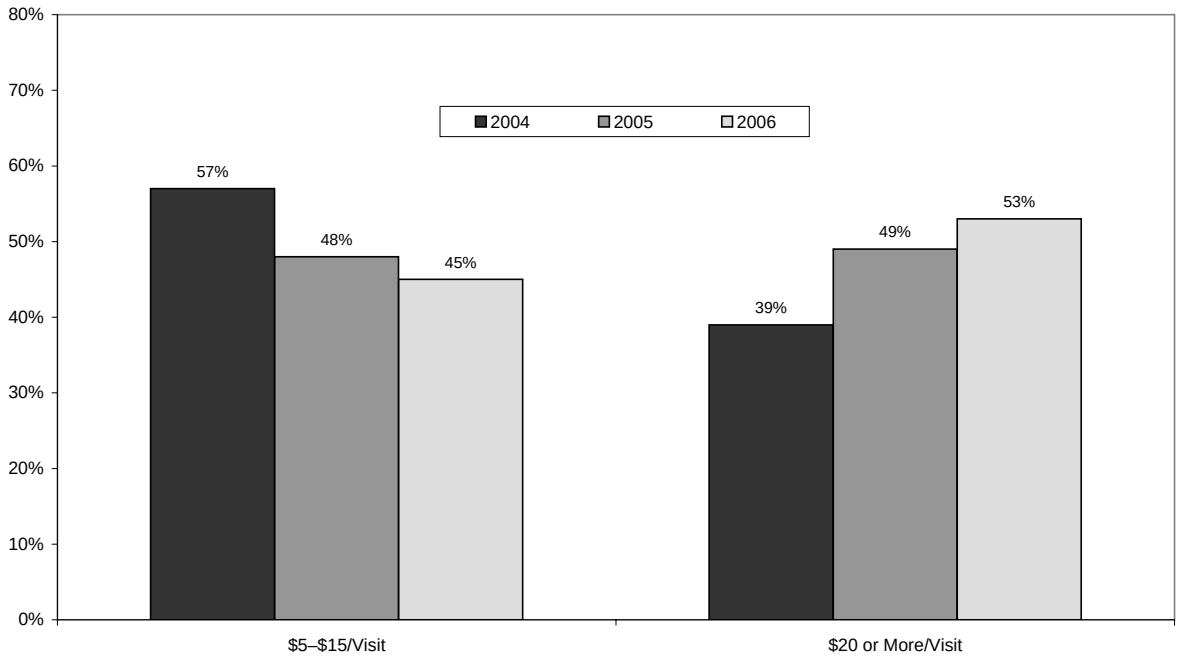
Distribution of Deductibles for Employee-Only PPO[a] Coverage, 2000–2006



Source: Kaiser Family Foundation.

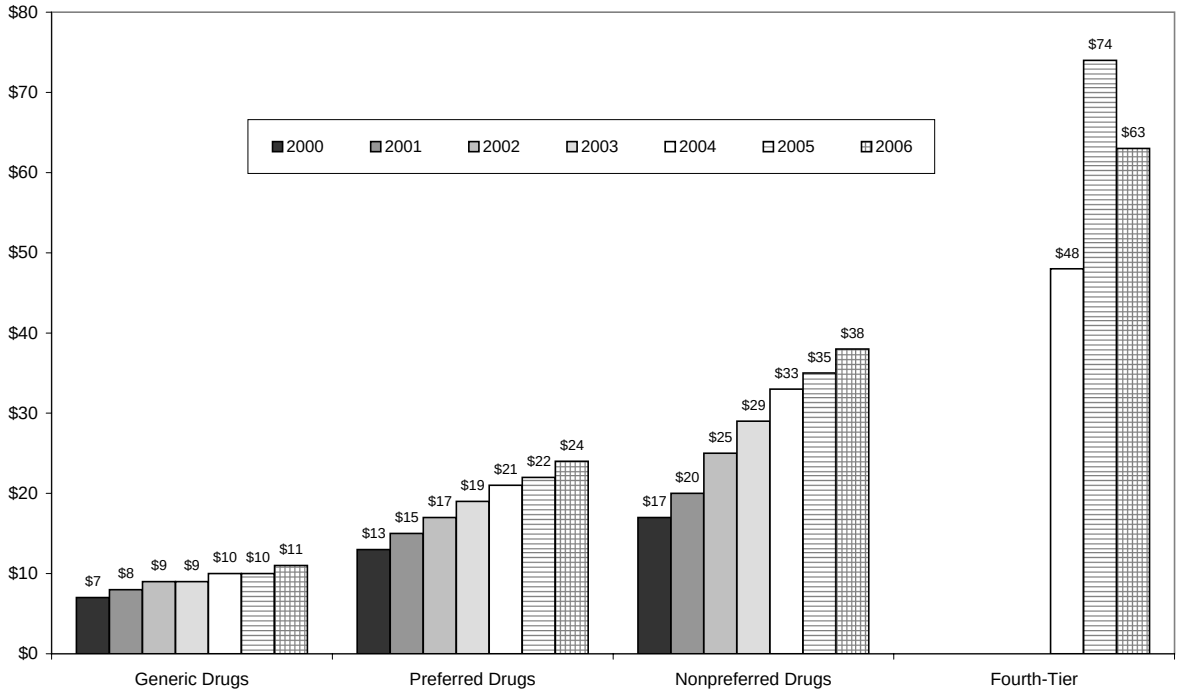
[a] Preferred provider organizaiton.

Figure 7
Distribution of Physician Office Visit Co-payments, All Plan Types, 2004–2006



Source: Kaiser Family Foundation.

Figure 8
Average Co-Payment for Prescription Drugs, 2000–2006



Source: Kaiser Family Foundation.

cost more. And while the continuation-of-coverage provision of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers with 20 or more employees to make available continued health care coverage for a specified period to employees (and/or their qualified dependents) who terminate employment for reasons other than gross misconduct, COBRA coverage is often unaffordable. COBRA beneficiaries are required to pay the full premium, and a 2 percent administrative fee, on an after-tax basis.[18]

Workers do not have a lot of plan choices through the employment-based system. Roughly one-half of workers with health insurance are employed by a firm that offers only one choice of health plan.[19] Of the roughly one-half of workers with health insurance who are employed by a firm that offers more than one choice of health plan, this does not necessarily translate into a choice of those plans for those workers. When workers have a choice of health plans, it is typically between a health maintenance organization (HMO) and PPO from the same insurance carrier or through the same self-insured employer.

Finally, large employers have distinct advantages over small employers when it comes to health benefits. Large employers are usually able to offer health benefits for less than it would cost small employers to offer the same benefits. Furthermore, large employers usually self-insure their health benefits, which means that those plans are exempt from potentially costly state mandates. This compounds the competitive disadvantage faced by small employers.

Have Employers Reached a Tipping Point With Health Benefits?

Despite the fact that health benefits have not "fallen off a cliff," various associations representing the interests of employers have suggested major reforms to the current system of employment-based health benefits. These initiatives indicate that employer associations are positioning themselves for the health care debate tied to a new presidency in 2009, and the prominence of the issue leading up to the 2008 election. The various associations have much in common, as all suggest that the status quo must change in the next few years. The fact that all of the proposals move significantly away from the status quo suggests that employers *have* reached a tipping point with their willingness to sustain the current employment-based health benefits system.

The HR Policy Association, representing the chief human resource officers in the largest corporations in the United States, is currently developing a comprehensive position on health care reform. The Association's members are committed to maintaining the nation's system of employment-based health insurance *if and only if* major reforms can be achieved. Their commitment is contingent on near-term adoption of *dramatic* improvements that can help contain skyrocketing costs, improve efficiency and value, and improve overall quality.

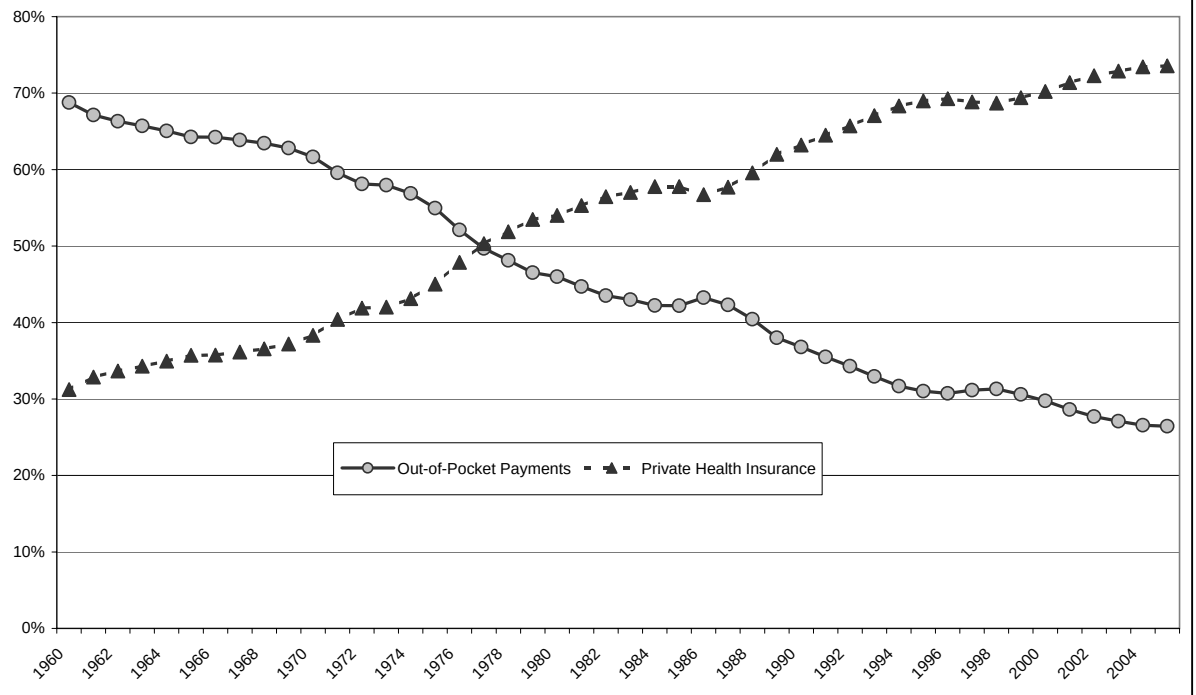
In November 2006, the Committee for Economic Development (CED), an organization of business leaders and educators, released its recommendations for continuing to maintain some form of an employment-based health benefits system.[20] After explaining in great detail why neither CDHB nor single-payer (nationalized) options will solve the health care problems in the United States, the report discusses how the following ideas are being "oversold as solutions in themselves":

- Information technology.
- Electronic medical records.
- Pay for performance.
- Disease management.
- Evidence-based medicine.
- Tort reform.
- Tiered high performance networks.
- Transparency.

The report then discusses the characteristics of a health care system that could respond to the country's needs.

Figure 9

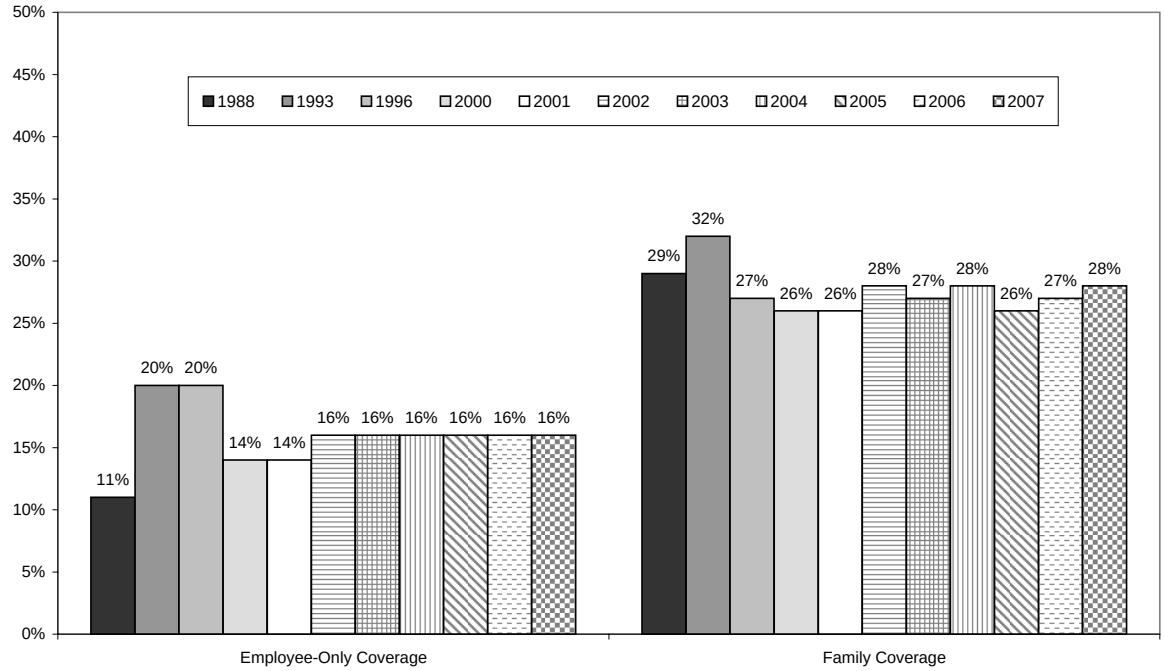
Percentage of Private Consumer Health Care Expenditures That Are Out-of-Pocket and Private Health Insurance Payments, 1960–2005



Source: Centers for Medicare and Medicaid Services.

Figure 10

Average Percentage of Premium Paid by Covered Workers for Employee-Only and Family Coverage, 1988–2007



Source: Kaiser Family Foundation.

Ultimately, CED recommends moving to some type of health insurance exchange from which individuals, who would be given a fixed contribution, could purchase health insurance. The federal government would establish independent regional exchanges that would make available many competing private insurance plans. The exchanges would set standards for the insurers and each year conduct an open enrollment season when individuals could change health plans. The exchanges would manage risk adjustments for insurers, but no one could be denied coverage because of age or prior illness. Every family would receive a fixed-dollar tax credit, sufficient to pay the premium on the basic, low-cost plan in its region, so the family could be insured without cost to them. Any higher-cost policy would be paid by individuals with after-tax dollars. The current tax preference for employer-financed health care would end. As a result, employers would also no longer need to offer health benefits to be competitive in the labor market. Ultimately, some form of broad-based tax on payroll, income, or purchases would finance the universal insurance payments.

The CED recommendations are described in much greater detail in *Quality, Affordable Health Care for All: Moving Beyond the Employer-Based Health-Insurance System,* a report released by the CED on Oct. 15, 2007.[21] This most recent CED report takes a stronger stance on the employment-based health benefits system, now suggesting that it be replaced and going so far as to suggest that it is "dragging down the entire health-care delivery system."

In June 2007, the ERISA Industry Committee (ERIC), a membership organization representing the employee benefit plans of the largest corporations in the United States, released its position, entitled "New Benefit Platform for Life Security."[22] In it, ERIC outlines its proposed structure that employers could use as an alternative to the current way in which they provide both health and retirement benefits. This proposal has some similarities to the CED proposal, such as the use of an exchange combined with a fixed contribution from employers. The structure provides for portability of health insurance and permits individuals and small businesses to buy into a much larger pooling arrangement than exists today. A "benefit administrator" would take on most, if not all, of the administrative responsibilities now borne by employers, and employers would pay for benefits chosen by their employees through the fixed contribution mentioned above. Employers would continue to be responsible for due diligence and monitoring of the benefits offering by competing benefits administrators.

Business coalitions have also partnered with other coalitions to promote various positions on health care reform. For example, the Business Roundtable and the National Federation of Independent Business (NFIB) have partnered with AARP and the Service Employees International Union (SEIU) to promote the "Divided We Fail Partnership." The partnership has four guiding principles:

- *Need for health care and financial security.* All Americans have a need for access to health care and long-term financial security.
- *Access to affordable coverage.* All Americans should have access to affordable health care, including prescription drugs, and these costs should not burden future generations.
- *Focus on prevention*. Wellness and prevention efforts, including changes in personal behavior such as diet and exercise, should be top national priorities.
- *Choices for long-term care.* Americans should have choices when it comes to long-term care, allowing them to maintain their independence at home or in their communities with expanded and affordable financing options.

The partnership does not, however, suggest a path to achieving the guiding principles.[23]

Another coalition of employers and insurers, the "Coalition to Advance Health Care Reform," is more specific in its recommendations for market-based solutions to address the uninsured and health care quality. It supports transparency, electronic medical records, an individual mandate, subsidies for the low-income population, and fundamental reform of the way health insurance is taxed.[24]

This *Issue Brief* does not do justice to the various proposals mentioned above. The reader should refer to the specific proposals for those details. But their significance is that all the proposals have a common message that employers have reached a tipping point with health benefits and are either proposing alternatives to the status quo or are on the verge of releasing such a proposal.

While these employer associations are releasing positions on health care reform that suggest that employers are demanding fundamental change in health benefits, some individual employers do not think that they or other employers have reached this point. EBRI interviewed 10 employers for this report. Benefit directors and vice presidents of human resources were included in the interviews, as was one chief financial officer. These individuals often had different perspectives from each other as well as different perspectives from senior management.

All of these managers worked for "jumbo" employers, ranging in size from 18,000 to more than 200,000 employees. Collectively, these employers covered more than 650,000 workers, not including dependents. Combined employer and employee spending for these 10 employers totaled over $4 billion in 2006, accounting for nearly one-half of 1 percent of private health care spending in the United States. These 10 employers are based in different parts of the country and represent employers in financial services, various manufacturing sectors, transportation, the service sector, and the public sector. While these employers are not necessarily nationally representative, and not necessarily representative of senior management, their points of view are informative, as they can exert strong influence over policymakers as well as their associations and association members.

Role of the Employer

The employers interviewed for this study offer benefits because in their view there is a business case for offering them: All of them think that they must offer health benefits in order to recruit and retain workers in a competitive labor market. Most also think that offering health benefits has a positive effect on worker health status—through prevention and wellness programs and disease management—and therefore productivity, which affects the bottom line. Some employers mentioned the issues of tax effectiveness and collective purchasing and the economies of scale that employers can realize when offering health benefits. But while they think that health benefits have a positive impact on the bottom line through wellness, disease management, and worker productivity, they do not think that it is the role of the employer to ensure that workers have *coverage.* Instead, they believe that their role is to provide *access* to an affordable health plan.

Nearly all of these employers also believe that making health care more affordable for both employees and employers is a top business priority, although they vary in their approaches toward addressing affordability. Some employers equate affordability with controlling overall health spending in the benefits package through cost-sharing incentives, such as deductibles, co-payments, and increased consumerism. Some focus on managing health care quality, while investing in employee health through healthy worksite and wellness initiatives and health coaches. Some have addressed affordability through provider network design. One employer owned its own HMO and primary care clinics. And one employer reported that it was trying to shape the market through public policy.

When employers were asked what they were doing that was innovative or unique in the provision of health benefits, it became clear that these employers were not on the verge of dropping these benefits, although it can be argued that they have reached a tipping point with the status quo. These employers noted what could be described as investments in their health benefit programs, as follows:

- The availability of health coaches to both healthy and unhealthy employees.
- Educational campaigns.
- Increased emphasis on preventive care and enhanced wellness programs.
- Increased innovation in disease management programs.
- Elimination of employee and family premiums when choosing a high-performing health plan.
- Elimination of cost-sharing when choosing in-network health care providers.
- No-cost, on-site health screenings.
- Quarterly scorecards of health plans.
- Requests for proposals from health plans every two or three years.

When asked what would cause an employer to stop offering health benefits, the employers interviewed for this study provided mixed responses. Although it is clear that these employers are not on the verge of dropping benefits, if they were to do so, none of them would be the first to drop benefits. Being the first to

drop benefits was described by one employer as "insane." Another employer reported that it would be the *last* to drop benefits. But these employers gave a cadre of collective reasons as to what it would take to cause them to stop offering health benefits. They mentioned the elimination of the employer tax deduction, movement to a universal system, and erosion and/or elimination of ERISA pre-emption.

They also said that, if other employers dropped coverage, for competitive reasons they would be forced to reconsider their decision to offer benefits. But they do not think other employers are on the verge of dropping health benefits: There is too much risk in being the first employer to drop benefits. And while some employers have been talking about it for years, many employers think that the talk of dropping health benefits is an empty threat. The exception, though, is that these large employers all think that small employers might be on the verge of dropping benefits.

These employers have mixed opinions when it comes to whether the employment-based health benefits system is the most viable model for providing health insurance. Some think it is the best system available, although they also think that the current system is both "inefficient" and "not intelligent" and that "if we could start over with a clean slate we would not have the current system." They believe that it is a market-based system where employers can bring about reform to a critical mass of the market easier than individuals can. They believe that employer pooling and leverage is significant. Some think that an improved version of the current system would be the best system. Others go so far as to say that the current system is not the best system because it is inefficient and it lacks transparency.

The employers who think the current employment-based system is not the best model do not know what a better model would be, but do think that a better model could be designed. While employers have numerous recommendations for improving the current system, they are not suggesting changes that imply the United States should adopt a completely new system of health care financing and delivery. They were nearly unanimous in thinking that the next generation of worker health benefits will have a much greater focus on shared responsibility and accountability.

Role of the Individual

The employers interviewed for this study think that individuals do not play a big role in health care. They think individuals are "disengaged," have an "entitlement mentality," and have made lifestyle choices that had led to poor health. At the same time, employers also think that they have contributed to the current negative role of individuals by creating plan designs that disengage individuals from the true cost of health care and health status. Furthermore, while they believe that individuals need to be become more engaged and should make informed decisions, they admit that individuals have not been provided sufficient information to do so.

Role of the Government

Employers think that the government should be a partner when it comes to health care and benefits. They want the government to establish quality standards through some type of national forum; they want the uninsured covered—although not necessarily through mandates; and they want the government to continue in its role of safety net provider. Employers understand why the states are challenging ERISA but are for the most part against states having more regulatory authority over employment-based health benefits. They think the government should be more focused on provider reimbursement issues as well as cost and quality transparency issues, and should let employers continue to be innovative in the provision of health benefits. Ultimately, though, employers believe that they have an obligation to employees to improve health care quality, and think that they will need to drive efforts to bring more transparency to health care quality.

Retiree Health Benefits

While it is still debatable whether employers have reached a tipping point with health benefits for *active workers*, there is no question they have reached it for *retirees*; in fact, they reached it in the mid-1990s. Research has consistently found that fewer employers are offering retiree health benefits than in the past, and that when retiree health benefits are offered, retirees are experiencing various combinations of rising premiums, higher out-of-pocket expenses, and more stringent eligibility requirements. In fact, most active

workers will never be eligible for health insurance in retirement through a former employer. The Agency for Healthcare Research and Quality (AHRQ) reports that only 13 percent of private-sector establishments offered health benefits to early retirees in 2005, down from 22 percent in 1997 (Figure 11). Furthermore, 13 percent of private-sector establishments offered health benefits to Medicare-eligible retirees in 2005, down from 20 percent in 1997. The trend among large employers—those most likely to offer health benefits—has been down as well (Figure 12).

One of the most important factors (if not the most important) that led to the erosion in retiree health benefits was a 1990 accounting rule change issued by the Financial Accounting Standards Board (FASB). Known as Financial Accounting Statement No. 106 (FAS 106), "Employer's Accounting for Postretirement Benefits Other Than Pensions," it required employers to report retiree health liabilities on the balance sheet. The accounting rule change was issued in December 1990 and triggered many of the changes that private-sector employers have made to retiree health benefits since the early 1990s. But even in the late 1980s, before FAS 106 was approved, studies were examining how the proposed changes would cause employers to reconsider their sponsorship of these benefits, and some employers made changes to retiree health benefits in anticipation of FAS 106 (Employee Benefit Research Institute, 1987). While FASB is not on the verge of an accounting rule change that would affect active worker health benefits, public policy proposals—for example, those that would remove ERISA pre-emption or fundamentally change the tax treatment of health insurance—could have the same impact on active worker health benefits as FAS 106 had on health benefits for retirees.[25]

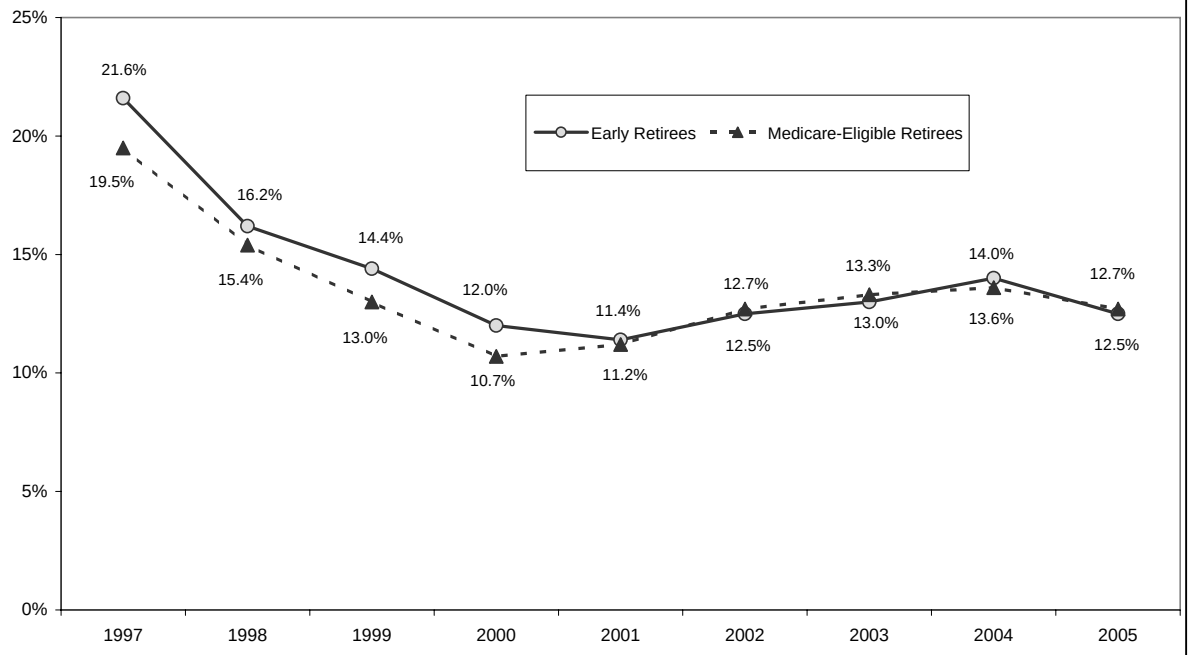
Conclusion

The employment-based based system of providing health benefits has been described a number of different ways. As mentioned and cited above, it has been characterized as "vanishing" and "failing." It has been suggested that "[employers] are fleeing the system," "employer-based health care is ending. It is dying in front of our very eyes," and that "employer-based health coverage is melting away like a popsicle on the summer sidewalk." Some organizations and policymakers do not go so far as to say that employment-based health benefits are dying, vanishing, or have reached a tipping point, but they promote policies that would effectively end employment-based health benefits as they currently exist.

Evaluation of recent data does not suggest that employment-based health benefits for active workers are vanishing, although employers have clearly moved away from providing health benefits to retirees. The percentage of employers offering health benefits has fallen from its 2000 peak, but it is about where it was in the mid-1990s and has been stable since 2005. Between the mid-1990s and 2005, the percentage of workers with *access* to health benefits through their own job has been stable, and, while the percentage of workers *taking coverage* when offered is down slightly from mid-1990 levels, very few workers who are offered health benefits are uninsured—only about 5 percent. Roughly 71 percent of workers have health benefits through an employer, and this number has been in the low 70 percent range since 1994.

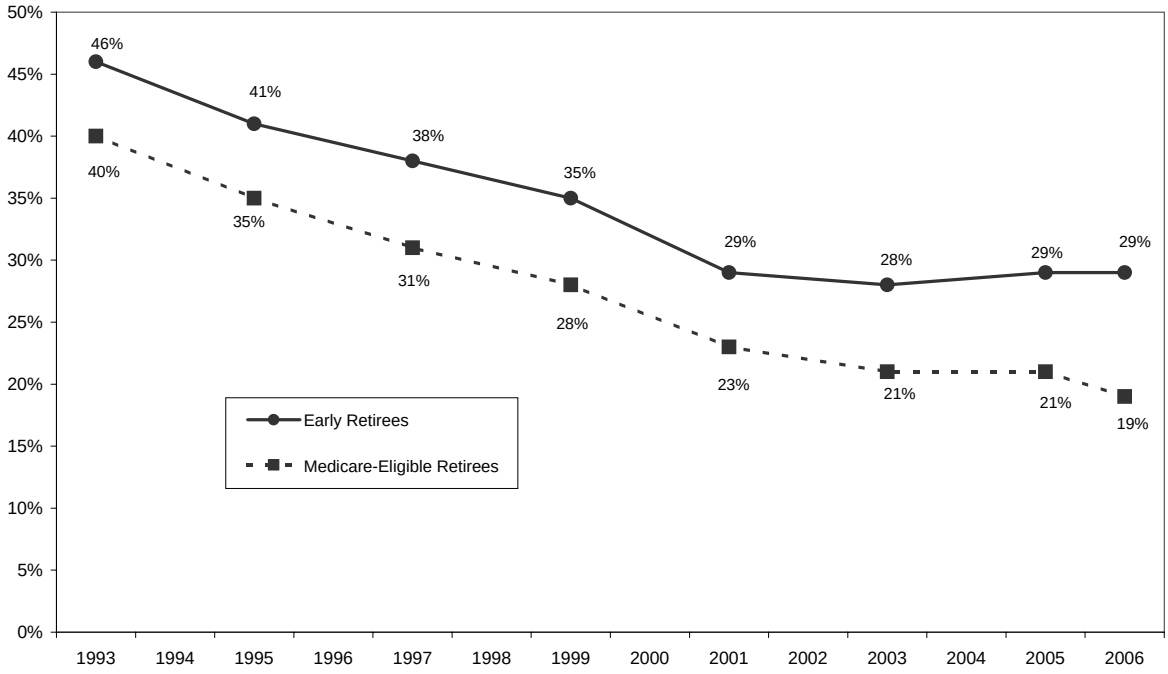
There is no question, however, that workers are paying more for health benefits and that the level of cost-sharing (i.e., deductibles and co-payments) has increased much faster than inflation. There is also no question that there are shortcomings with the employment-based system and that the message from associations representing employers is that the existing employment-based system must be replaced with something else. Individual employers agree that the status quo must change, but they believe that there is a business case for offering health benefits, and they continue to invest in their programs. They think that health benefits must evolve to include greater shared responsibility and accountability on the part of workers and their families. They all agree that if one major employer were to drop health benefits, others would immediately begin to assess whether or not they should follow, on the one hand, or take advantage of others dropping the benefits to enhance talent acquisition. They also agree that public policy changes, such as the erosion or elimination of ERISA pre-emption, could mean the end of large employer self-funded employment-based health benefits as we know them.

Figure 11
Percentage of Private-Sector Establishments Offering Health Insurance to Retirees, 1997–2005



Source: Various tables at www.meps.ahcpr.gov/Data_Pub/IC_Tables.htm.

Figure 12
Percentage of Employers With 500 or More Employees Offering Health Insurance to Retirees, 1993–2006



Source: Mercer Human Resources Consulting, 2006.

RESOURCES

For more information about the various associations mentioned in this report as well as other organizations with positions on health care reform, see the links below.

AFL-CIO
www.aflcio.org/aboutus/thisistheaflcio/ecouncil/ec03062007.cfm?RenderForPrint=1

America's Health Insurance Plans (AHIP)
www.ahipbelieves.com/AVisionforReform/tabid/57/Default.aspx

Better Health Care Together
www.americansforhealthcare.org/index.cfm

Bipartisan Group of 10 Senators
www.wyden.senate.gov/media/2007/02132007_Health_Care_Letter.htm

Coalition to Advance Health Care Reform
www.coalition4healthcare.org

Committee for Economic Development (CED)
www.ced.org/docs/report/report_healthcare200710.pdf

Divided We Fail Partnership
http://www.aarp.org/issues/dividedwefail/

ERISA Industry Committee (ERIC)
www.eric.org

Federation of American Hospitals
http://www.fah.org/passport/HCP%20PPT%20Designed%202-16-07.pdf

Health Coverage Coalition for the Uninsured
www.coalitionfortheuninsured.org/

HR Policy Association (HRPA)
www.hrpolicy.org

References

Cannon, Michael F. "Combining Tax Reform and Health Care Reform With Large HSAs." *Tax & Budget Bulletin*. No. 23 (May 2005), http://www.cato.org/pubs/tbb/tbb-0505-23.pdf.

Claxton, Gary, Jon Gabel, Isadora Gil, Jeremy Pickreign, Heidi Whitmore, Benjamin Finder, Bianca DiJulio, and Samantha Hawkins. "Health Benefits In 2006: Premium Increases Moderate, Enrollment In Consumer-Directed Health Plans Remains Modest." *Health Affairs* Web Exclusive, September 26, 2006, http://content.healthaffairs.org/cgi/reprint/25/6/w476?ijkey=gU80Qa01mo8pg&keytype=ref&siteid=healthaff.

Employee Benefit Research Institute. *Measuring and Funding Corporate Liabilities for Retiree Health Benefits*. Washington, DC: Employee Benefit Research Institute, 1987.

Fronstin, Paul. "Employment-Based Health Benefits: Access and Coverage, 1988–2005." *EBRI Issue Brief*, no. 303 (Employee Benefit Research Institute, March 2007).

_____. "Health Savings Accounts and Other Account-Based Health Plans." *EBRI Issue Brief*, no. 273 (Employee Benefit Research Institute, September 2004).

_____. "Savings Needed to Fund Health Insurance and Health Care Expenses in Retirement." *EBRI Issue Brief*, no. 295 (Employee Benefit Research Institute, July 2006).

Fronstin, Paul, and Dallas. L. Salisbury. "Health Insurance and Taxes: Can Changing the Tax Treatment of Health Insurance Address Challenges in Our Health Care System?" *EBRI Issue Brief*, no. 309 (Employee Benefit Research Institute, September 2007).

Gladwell, Malcolm. *The Tipping Point: How Little Things Can Make a Big Difference*. Rockland, MA: Wheeler Publishing, 2003.

Goodman, John C. "Characteristics of an Ideal Health Care System." *NCPA Policy Report.* No. 242 (April 2001), http://www.ncpa.org/pub/st/st242/st242.pdf

Helman, Ruth, and Paul Fronstin. "Public Attitudes on the U.S. Health Care System: Findings from the Health Confidence Survey." *EBRI Issue Brief*, no. 275 (Employee Benefit Research Institute, November 2004).

Mercer Human Resource Consulting. *National Survey of Employer-sponsored Health Plans: 2006 Survey Report*. New York: Mercer Human Resource Consulting, 2007.

Porter, Michael E., and Elizabeth Olmsted Teisberg. *Redefining Health Care: Creating Value-Based Competition on Results*. Boston, MA: Harvard Business School Press, 2006.

Tanner, Michael. "What's Wrong with the Present System." In G. Arnett, ed. , *Empowering Health Care Consumers Through Tax Reform*. Ann Arbor, MI: University of Michigan Press, 1999.

Endnotes

[1] See http://www.pnhp.org/news/2006/april/the_healthcare_tipp.php, http://www.consumerwatchdog.org/healthcare/co/?postId=5208, http://www.businessweek.com/adsections/2005/pdf/0525_healthcosts.pdf and http://www.msnbc.com/id/9816109/

[2] See Fronstin (2007).

[3] http://www.americanprogress.org/events/2007/04/business_healthcare.html

[4] See page xi in http://www.ced.org/docs/report/report_healthcare200710.pdf

[5] See page 11 in http://www.brook.edu/comm/events/20060616.pdf

[6] See page 12 in http://www.brook.edu/comm/events/20060616.pdf

[7] See http://wyden.senate.gov/

[8] Also see Cannon (2005), Goodman (2002), Tanner (1999), and http://www.reason.org/phprint.php4

[9] See http://www.health08.org/sidebyside.cfm and http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=469753

[10] ERISA supersedes, or "pre-empts," state laws that "relate to" employer-sponsored benefits, although ERISA preserves the states' ability to regulate the "business of insurance." ERISA is coming under intense scrutiny from consumer advocates and state and federal lawmakers who believe that it prevents the states from carrying out comprehensive health insurance reform. In short, their complaint is that ERISA prevents the states from regulating employment-based group health plans.

[11] See http://www.kff.org/insurance/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13512 for 2000 data, and Claxton et al. (2006) for 2006 data.

[12] See Jon Gabel, "Trends in Employer Based Health Insurance," presentation to the Colorado Health Care Foundation, July 26, 2007, in Beaver Creek, CO.

[13] See Fronstin (2004) for more information about account-based health plans.

[14] See www.leapfroggroup.org

[15] See http://healthcaredisclosure.org/

[16] See http://www.hrpolicy.org/initiatives/pharma_1.asp

[17] See http://www.aqaalliance.org/ and http://www.hrpolicy.org/initiatives/hcqi.asp

[18] While the 2 percent administrative fee on top of full premiums on an after-tax basis may not be affordable for employees, research has shown that employers bear part of the burden of COBRA in that the 2 percent fee does not come close to covering the cost of administration and adverse selection.

[19] See Exhibit 4.2 in http://www.kff.org/insurance/7527/upload/7527.pdf

[20] See http://www.ced.org/docs/report/report_2007healthcare_ebi.pdf

[21] See http://www.ced.org/docs/report/report_healthcare200710.pdf

[22] See http://maxx.eric.org/uploadFiles/B86A00000009.filename.ERIC_New_Benefit_Platform_FL0614.pdf This proposal also provides for a retirement plan for all workers and calls for subsidies for low-income workers who cannot afford to save for retirement.

[23] See http://www.aarp.org/issues/dividedwefail/

[24] See www.coalition4healthcare.org

[25] For a more detailed treatment of trends in retiree health benefits, see Fronstin (2006).

EBRI Issue Brief

EBRI Employee Benefit Research Institute Issue Brief (ISSN 0887–137X) is published monthly by the Employee Benefit Research Institute, 1100 13th St. NW, Suite 878, Washington, DC, 20005-4051, at $300 per year or is included as part of a membership subscription. Periodicals postage rate paid in Washington, DC, and additional mailing offices. POSTMASTER: Send address changes to: *EBRI Issue Brief,* 1100 13th St. NW, Suite 878, Washington, DC, 20005-4051. No. 312.

Who we are

The Employee Benefit Research Institute (EBRI) was founded in 1978. Its mission is to contribute to, to encourage, and to enhance the development of sound employee benefit programs and sound public policy through objective research and education. EBRI is the only private, nonprofit, nonpartisan, Washington, DC-based organization committed exclusively to public policy research and education on economic security and employee benefit issues. EBRI's membership includes a cross-section of pension funds; businesses; trade associations; labor unions; health care providers and insurers; government organizations; and service firms.

What we do

EBRI's work advances knowledge and understanding of employee benefits and their importance to the nation's economy among policymakers, the news media, and the public. It does this by conducting and publishing policy research, analysis, and special reports on employee benefits issues; holding educational briefings for EBRI members, congressional and federal agency staff, and the news media; and sponsoring public opinion surveys on employee benefit issues. **EBRI's Education and Research Fund** (EBRI-ERF) performs the charitable, educational, and scientific functions of the Institute. EBRI-ERF is a tax-exempt organization supported by contributions and grants.

Our publications

EBRI Issue Brief is a periodical providing expert evaluations of employee benefit issues and trends, as well as critical analyses of employee benefit policies and proposals. ***EBRI Notes*** is a periodical providing current information on a variety of employee benefit topics. EBRI's ***Pension Investment Report*** provides detailed financial information on the universe of defined benefit, defined contribution, and 401(k) plans. EBRI ***Fundamentals of Employee Benefit Programs*** offers a straightforward, basic explanation of employee benefit programs in the private and public sectors. The ***EBRI Databook on Employee Benefits*** is a statistical reference work on employee benefit programs and work force-related issues.

Orders/ subscriptions

Contact EBRI Publications, (202) 659-0670; fax publication orders to (202) 775-6312. Subscriptions to *EBRI Issue Briefs* are included as part of EBRI membership, or as part of a $199 annual subscription to *EBRI Notes* and *EBRI Issue Briefs.* Individual copies are available with prepayment for $25 each (for printed copies) or for $7.50 (as an e-mailed electronic file) by calling EBRI or from www.ebri.org. ***Change of Address:*** EBRI, 1100 13th St. NW, Suite 878, Washington, DC, 20005-4051; (202) 659-0670; fax number, (202) 775-6312; e-mail: subscriptions@ebri.org ***Membership Information:*** Inquiries regarding EBRI membership and/or contributions to EBRI-ERF should be directed to EBRI President/ASEC Chairman Dallas Salisbury at the above address, (202) 659-0670; e-mail: salisbury@ebri.org

EBRI Issue Brief is registered in the U.S. Patent and Trademark Office. ISSN: 0887–137X/90 0887–137X/90 $ .50+.50