Employment-Based Health Care Benefits and
Self-Funded Employment-Based Plans: An Overview

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This fact sheet provides an overview of the status of employment-based health care benefits and the self-funding of employment-based health plans. The data presented are the latest available on these topics from the most recognized sources and include EBRI's analysis of the March 1999 Current Population Survey. The first part of the fact sheet covers employment-based coverage in general, while the second part focuses on self-funding of employment-based health care coverage.

Definitions

• Employment-based health care benefits consist of any health care coverage provided to an individual conditioned upon that individual being an employee or member of the offering employer or union or a dependent of an employee or member. The sponsor may offer either a single plan or a choice of plans.

• Other private health insurance is individual or group coverage not offered through an individual's current or former employer or union. This category consists primarily of individually purchased private insurance bought directly from an insurer, health maintenance organization (HMO), or other managed care organization for one's self and/or family. Unlike employment-based health benefits, the cost of other private insurance is not excludable from taxable income.

• The federal government—under the Employee Retirement Income Security Act of 1974 (ERISA)—has primary regulatory authority over health care benefits provided by private-sector employers, while states regulate other private health insurance plans.

• Under ERISA, employers or unions offering health care benefits must provide each participant with a summary plan description, establish an appeals procedure for any denied claim, and require plan fiduciaries to act in the sole interest of the plan participants and beneficiaries. ERISA also provides remedies to recover wrongfully denied benefits. However, ERISA does not require an independent appeal review of denied claims, and it limits the value of recoverable damages to the value of the wrongfully denied benefit(s).

• Employment-based health care coverage helps spread the risk that an individual will need health care services by including individuals who are at less risk and who, without employer coverage, would ordinarily not purchase the coverage individually. Including more individuals who are less likely to need health care services lowers the cost per individual of health care coverage. As a result, employment-based health benefits are less costly than other private health insurance on a per-person basis for the same benefit package.

• Employers' movement into HMOs and other managed care plans and their adoption of innovative methods of providing health benefits, such as health promotion and disease prevention programs, have helped to slow increases in health care costs in recent years. However, some analysts argue that the preferential tax treatment afforded employment-based health plans has led to the overconsumption of health care services. In addition, employment-based, tax-preferred health insurance plans limit participants' choice of plans to the employer's discretion.
Among nonelderly Americans, 65 percent (154.8 million) had employment-based health care coverage in 1998. Seven percent of the nonelderly had other private or individually purchased health care coverage, and 14 percent of the nonelderly population had health care coverage through a public program. Eighteen percent of the nonelderly population was uninsured.

Health Care Spending by Employment-Based Plans

- According to the Health Care Financing Administration, $1.149 trillion was spent on health care in 1998, with 46 percent paid by public-sector funds and 54 percent paid by private-sector funds.
- Almost one-third of all payments made to hospitals, or $118 billion, came from private health care coverage.
- Private health care coverage paid $116 billion for physician services, or one-half of all payments to physicians.
- Personal out-of-pocket spending accounted for 17 percent of total expenditures, or $199.5 billion.

Source: Health Care Financing Administration, Office of the Actuary; Health Affairs, March-April 1999; and EBRI Health Benefits Databook.)
Workers and Health Care Coverage

- Seventy-three percent of workers received health care coverage through an employer in 1998.
- Combined nonemployment-based public sources of coverage (Medicare, Medicaid, and CHAMPUS/VA) and other private or individual health care coverage covered 12 percent of workers, while 18 percent of workers were uninsured.

Worker Participation in Employment-Based Plans

- Among wage and salary workers ages 18–64, 75 percent (81.2 million workers) were offered health care coverage by their own employer in 1997.
- Of the 81.2 million workers offered coverage, 67.5 million, or 83 percent, accepted the coverage.
Benefits Covered by Employment-Based Health Plans

- Virtually all full-time employees enrolled in employment-based health plans are covered for hospital services and physician visits. Many enrollees also have coverage for other benefits.

Enrollment by Plan Type

- Traditional indemnity plans accounted for 9 percent of employees enrolled in employment-based health plans, while managed care plans accounted for 91 percent of employees in employment-based plans.
- Managed care plan enrollees include the 38 percent of employees enrolled in preferred provider organizations (PPOs), the 28 percent enrolled in HMOs (in-network only), and the 25 percent enrolled in point-of-service (POS) arrangements (out-of-network).
- Managed care techniques used by employers, commercial insurance plans, and HMOs to control costs and ensure quality consist of utilization review, provider panels, discounted payments, and capitated payments.
Funding of Health Benefits

• Health benefits can be funded in a variety of methods. Employers may choose to self-fund, purchase coverage from a commercial insurer, or contract with an HMO to provide health care benefits.
• A self-funded plan (also called self-insured) is one in which an employer pays for its participants’ health care claims directly out of its own income or assets. Employers may require workers to contribute toward part of the plan’s cost. The type of coverage, or the way the benefits are administered, is then provided either through an indemnity system or through the use of managed care techniques.
• Most self-funded plans purchase stop-loss insurance coverage to protect the plan from unusually large claims. Stop-loss coverage will reimburse the plan if expenditures exceed certain dollar limits, on a per-person basis, on an aggregate basis, or both.
• A commercial insurance plan is one in which an employer pays premiums to purchase health insurance coverage directly from an insurer, which assumes the risk for the plan participants’ health care services.
• When an employer contracts with an HMO, the HMO provides health care benefits to the participants. Unlike commercial insurance plans, HMOs may share the risk of plan participants’ health care services with providers.

Benefits Vs. Drawbacks of Self-Funding Health Plans

• ERISA pre-empts specific state regulation of self-funded plans provided by private-sector employers. This allows multi-state employers to provide uniform benefits across all states without potentially having to conform to 51 different state and district regulatory environments.
• Employers that self-fund can offer only the benefits they feel their employees need or prefer, and pay only for the claims their participants actually experience when they occur, instead of paying premiums prior to the participants’ claim experience. Furthermore, employers that self-fund can implement innovative, cost-effective health care prevention or treatment techniques through disease management programs.
• Self-funded plans provided by private-sector employers are criticized by some because the dual federal-state regulatory structure creates uneven regulations for health plan enrollees within a state. Under ERISA, self-funded plans do not face solvency requirements. Also, oversight at the federal level is less stringent than that of most states for commercially insured plans and HMOs.

Self-Funding by Firm Size

• For smaller firms, 4 percent of the participants in plans offered by firms with fewer than 50 employees are in self-funded plans. This number increases to 8 percent for those working for firms with 50–99 employees.
• For larger firms, the percentages increase significantly. Twenty-nine percent of firms with 100–499 employees are in self-funded plans. This number increases to 60 percent for firms with 500 or more employees.

Extent of Self-Funding in Employment-Based Plans

- Approximately 55 million out of 152 million participants in employment-based plans (36 percent) were in self-funded plans in 1997.
- Among participants in private-sector plans, 47.9 million (39 percent) were in self-funded plans.
- Among participants in public-sector plans, 6.9 million (24 percent) were in self-funded plans.
- Approximately 23 percent of the nonelderly population in the United States was in a self-funded plan sponsored by either a private or public employer or a union.

Percentage of Employees in Self-Funded Plans by Plan Type

- For all plan types except for HMOs, approximately 50 percent of the enrollees in employment-based health plans offered by employers are in self-funded plans.
- Nineteen percent of those enrolled in HMOs offered by employers are in self-funded plans. Consequently, the majority of individuals in self-funded plans are not in HMOs but are in other forms of health care plans.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits.