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What Does the Future Hold for the Employment-Based Health Benefits System?

By Paul Fronstin, Ph.D., Employee Benefit Research Institute

The author wishes to thank Jon Anderson, Joe Antos, Peter Baxter, Bernadette Branosky, Bob Foley, David Kasiarz, Jon Kessler, and Lori Lucas for useful comments on an earlier draft of this paper.

AT A GLANCE

- The employment-based health benefits system is the most common form of health coverage in the United States, covering 167 million people under age 65 in 2017. Between 2013 and 2017, the percentage of individuals with employment-based coverage has been growing. The increase in employment-based health insurance among workers and their dependents may be due to the increase in the percentage of employers offering such benefits, which may in turn be due to a combination of the strengthening economy, lower unemployment rates, and relatively low premium increases.

- According to the 2018 EBRI/Greenwald & Associates Health and Workplace Benefits Survey (WBS), nearly 60 percent of workers are satisfied with their current mix of health benefits and wages, and most individuals with employment-based health benefits are satisfied with their coverage.

- The employment-based health benefits system has a number of advantages over various alternatives. These advantages may make it difficult to completely move away from the employment-based system. For instance, when it comes to insuring a group of individuals, employment-based groups are often considered "natural groups" in the sense that they were formed for reasons other than the purchase of health insurance. Insurers are more willing to provide insurance for a naturally formed group than for a group that was formed solely for the purpose of buying health insurance because the risks of adverse selection are mitigated. Employers also often act as an advocate for workers during coverage disputes between the insured and insurer, and they frequently involve themselves in matters of quality assessment of care and influencing health care matters in the policy development arena.

- The employment-based health benefits system is far from perfect. One of the shortcomings is that it does not guarantee universal coverage, which a Medicare-for-all system could do. Many employers, especially smaller employers, choose not to offer coverage. Employers that offer coverage also need to continuously justify whether to offer coverage to workers. The percentage of employers offering health benefits ebbs and flows with the economy and other factors. De-linking health insurance from employment may address the shortcomings of the current system.

- Public policies related to the Cadillac tax; Medicare-for-all; proposals that would allow insurance to be purchased in the individual market using employer funding; and market developments, such as the gig economy and high-priced medical advances like specialty medications, may all affect whether there is an employment-based health benefits system in the future.

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- The Congressional Budget Office (CBO) estimates that employer and employee contributions toward health coverage will account for $282 billion in forgone tax revenue during FY 2019 and nearly $3.7 trillion over 2019–2028. In contrast, the FY 2019 mortgage interest deduction is expected to account for $75 billion in forgone tax revenue, while contributions to workplace retirement plans for that same time period are expected to be about $196 billion. The large dollar amounts associated with the tax exclusion of employment-based health benefits makes it an almost inescapable target for policymakers from both a budgetary and a political perspective.

- While employment-based coverage is the largest tax expenditure in the U.S. budget, it is also the least per person when compared to other health-coverage-related subsidies. The average per capita subsidy tax expenditure was $1,722 for individuals with employment-based coverage, compared with an average subsidy of $6,111 among those getting a subsidy in the non-group market and $4,418 among those receiving either Medicaid or coverage through the Children's Health Insurance Program (CHIP).

- Capping, reducing, or eliminating the tax preference could generate additional tax revenue to reduce the budget deficit and/or pay down the federal debt. Or it could be used to pay for a new round of health reform. For instance, during the 2018 election, many democrats noted their support for "Medicare-for-all," and reiterated such support with the introduction of the "Medicare for All Act of 2019" on February 27, 2019. In various single-payer or Medicare-for-all bills, employment-based health insurance would cease to exist as we know it. However, in various Medicare and Medicaid buy-in proposals, employers could continue to offer health coverage. Even the administration's own proposal to expand the use of health reimbursement arrangements (HRAs) could seriously undermine employment-based health benefits.

- The employment-based health benefits system arose not from any deliberate national health care policy but rather from a voluntary, market-driven response by employers to government regulations regarding wages and taxation during World War II. In the absence of more government involvement in health care, employer activism has increased through various types of coalitions. What we do not know is whether employers would trade off more government involvement in health care for less of their own involvement if given the opportunity, especially in a weak economic environment. Thoughtful consideration of policy proposals to expand the number of people with health insurance coverage should not only evaluate their effectiveness in addressing health care costs, quality, and coverage. Policy makers should consider the impact on the voluntary, market-driven, employment-based 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. 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, Employee Benefit Research Institute-Education and Research Fund (EBRI-ERF), or their staffs. Neither EBRI nor EBRI-ERF lobbies or takes positions on specific policy proposals. EBRI invites comment on this research.

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What Does the Future Hold for the Employment-Based Health Benefits System?

By Paul Fronstin, Ph.D., Employee Benefit Research Institute

Introduction

The employment-based health benefits system is the most common form of health coverage in the United States, covering 167 million people under age 65 in 2017. Despite the fact that workers value health insurance more than any other employee benefit, the system faces a number of potential threats in the future. Public policies related to the Cadillac tax; Medicare-for-all; proposals that would allow insurance to be purchased in the individual market using employer funding; and market developments, such as the gig economy and high-priced medical advances like specialty medications, may all affect whether there is an employment-based health benefits system in the future.

There are pros and cons of having an employment-based health benefits system. Furthermore, it is debatable as to whether there is an alternative to the employment-based system that would produce higher-quality care, better service, and lower price, and what that alternative might look like.

This *Issue Brief* summarizes a discussion of these issues by a panel of experts at EBRI's December 2018 Policy Forum held in Washington, DC. The panel was comprised of Paul Fronstin, Director, Health Research and Education Program, Employee Benefit Research Institute; Sabrina Corlette, Research Professor, Center of Health Insurance Reforms, Georgetown University Health Policy Institute; Joseph Antos, Wilson H. Taylor Scholar in Health Care and Retirement Policy, American Enterprise Institute; and was moderated by Tami Simon, Global Corporate Consulting Leader, The Segal Company. See this link to watch the video replay.

Why Do We Have an Employment-Based Health Benefits System?

It was during World War II that many employers began to offer health coverage to workers. Because the National War Labor Board froze wages, employers sought ways to get around the wage controls in order to attract scarce workers (Helms 2008). In 1943, the National War Labor Board (NWLB) ruled that employer contributions to health insurance were not subject to wage controls because of IRS rules that deemed health insurance to not be treated as taxable income. As a result, because of business reasons related to competing for scarce workers and government policies on wages and taxation unrelated to health care, employers began to offer health coverage to their workers, and the number of persons with employment-based health coverage started to increase. After the wage controls ended, the employment-based system continued to expand, in part because income and payroll taxes became more prevalent; the cost of health care began to increase dramatically; and social insurance programs, such as Medicaid and Medicare, did not yet exist.

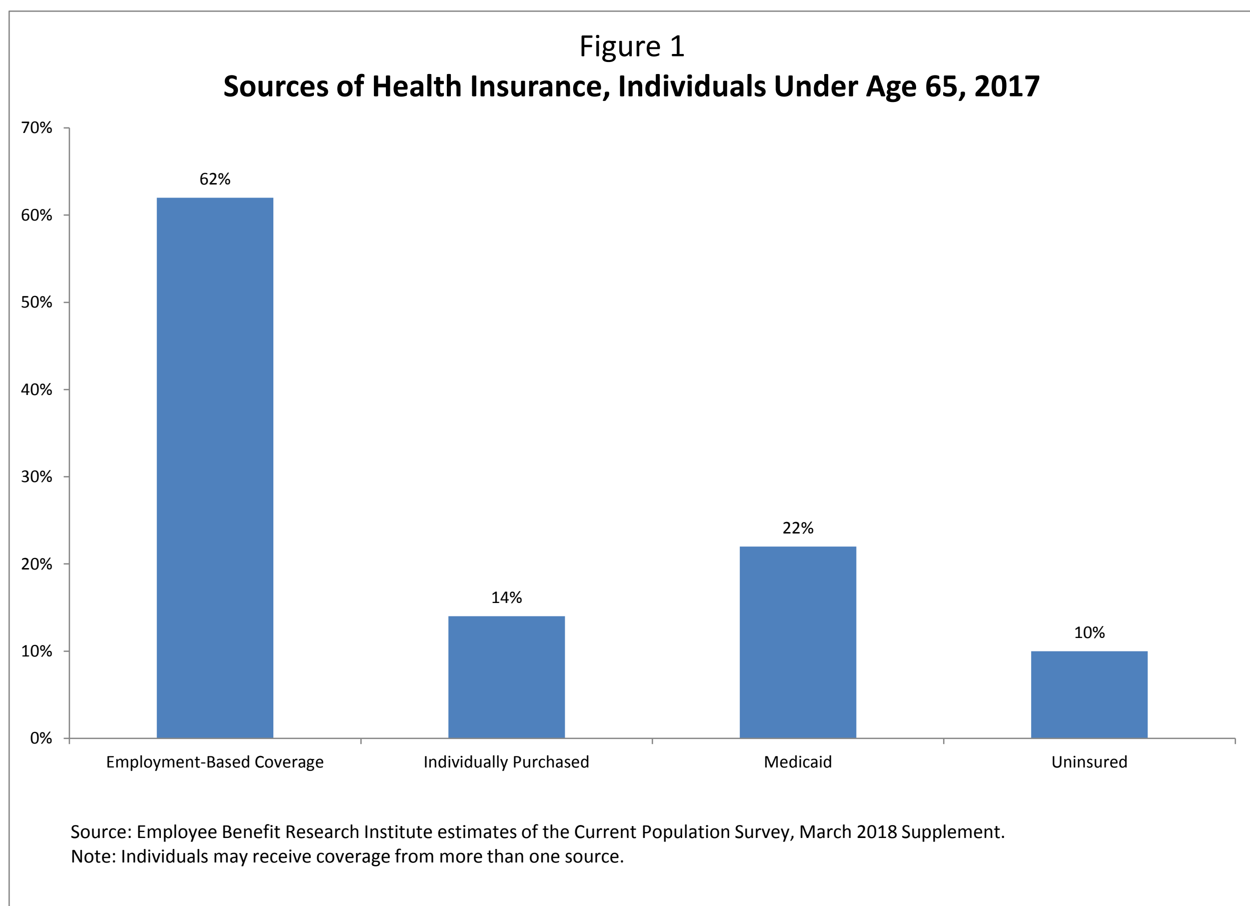
It is often suggested that the tax-preferred status of employment-based health coverage led to the rise in its prevalence and comprehensiveness (Gabel 1999) and that it has encouraged employers to offer it and to provide more comprehensive coverage than they otherwise would have (Sheils and Haught 2004). However, there is still disagreement among historians as to the role of taxation in the growth of employment-based health coverage. According to Helms (2008), the NWLB decision on health benefits mirrored IRS rulings that insurance benefits were not to be treated as taxable income. According to Hacker (2002), it was not until the Revenue Act of 1954 that the Internal Revenue Code made it clear (after a number of conflicting IRS rulings prompted Congress to adopt a blanket exception) that employer spending on employee health benefits was not to be counted as employee income. Lyke (2008) goes so far as to conclude that the "historical argument about the importance of tax and regulatory policies may be overstated."

These disagreements raise a question as to whether it was the tax treatment or scarcity of workers during World War II that led to the employment-based health benefits system we have today. However, whether the decisions regarding taxation of employment-based health benefits made over 60 years ago were explicitly intended to increase coverage or

accidentally led to the widespread coverage we have today, those tax preferences currently provide employers an incentive to offer coverage to workers, and they provide workers an incentive to take coverage when it is offered. It can be concluded that society believes it is more important to have health insurance coverage than to not have it, thus, tax policy incentivizes it over most other goods and services.

Today, employment-based health coverage is by far the most common source of health insurance in the United States. Nearly two-thirds of the population (62 percent) or 167 million individuals under age 65 had employment-based coverage in 2017 (Figure 1). In contrast, 14 percent purchased coverage directly from an insurer, 22 percent had Medicaid, and 10 percent did not have any health insurance. Between 2013 and 2017, the percentage of individuals with employment-based coverage has been edging up (Figure 2).

The increase in employment-based health insurance among workers and their dependents may be due to the increase in the percentage of employers offering such benefits (Figure 3). This, in turn, may be due to a combination of the strengthening economy, lower unemployment rates, and relatively low premium increases. With respect to the economy and the labor market, the unemployment rate has continued to trend down. It was below 5 percent for most of 2016, trending down to 4.1 percent by the end of 2017 (Figure 4). When unemployment is low, recruiting and retaining workers becomes a bigger challenge for employers, including some smaller employers, which in turn often means improving compensation and benefits. With respect to premiums, they have been increasing only modestly for the past decade (Figure 5).



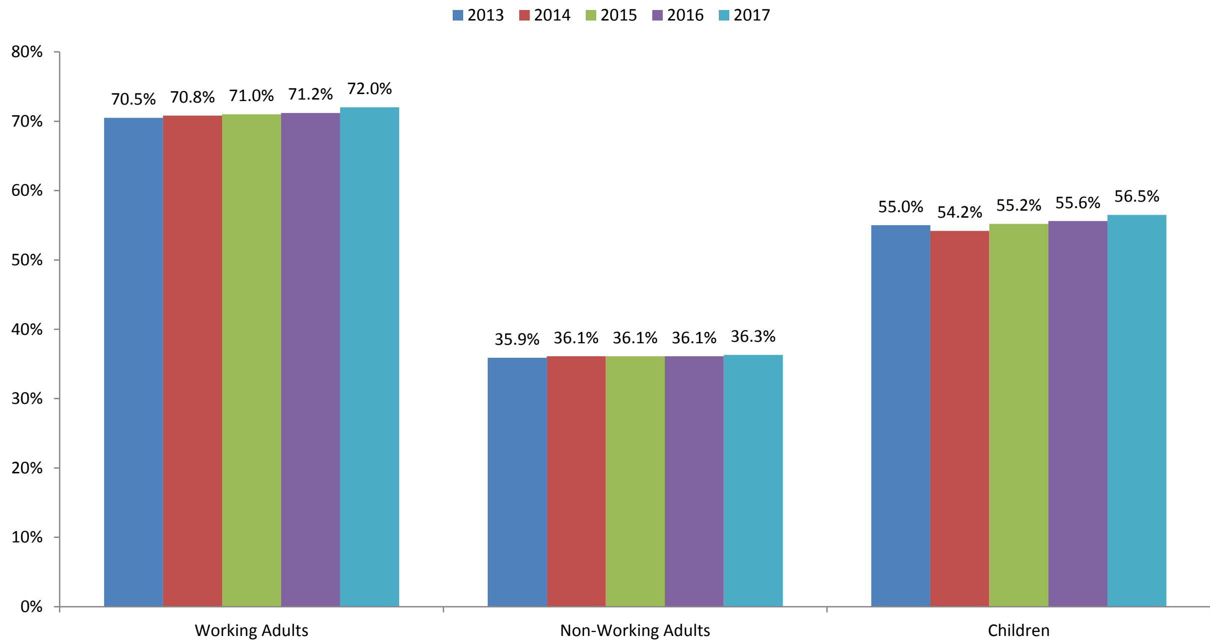


Figure 2
Percentage of Workers, Non-Workers, and Children With Employment-Based Health Coverage, 2013–2017
2013
2014
2015
2016
2017
80%
70%
60%
50%
40%
30%
20%
10%
0%
70.5%
70.8%
71.0%
71.2%
72.0%
35.9%
36.1%
36.1%
36.1%
36.3%
55.0%
54.2%
55.2%
55.6%
56.5%
Working Adults
Non-Working Adults
Children
Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 2014–2018 Supplements.

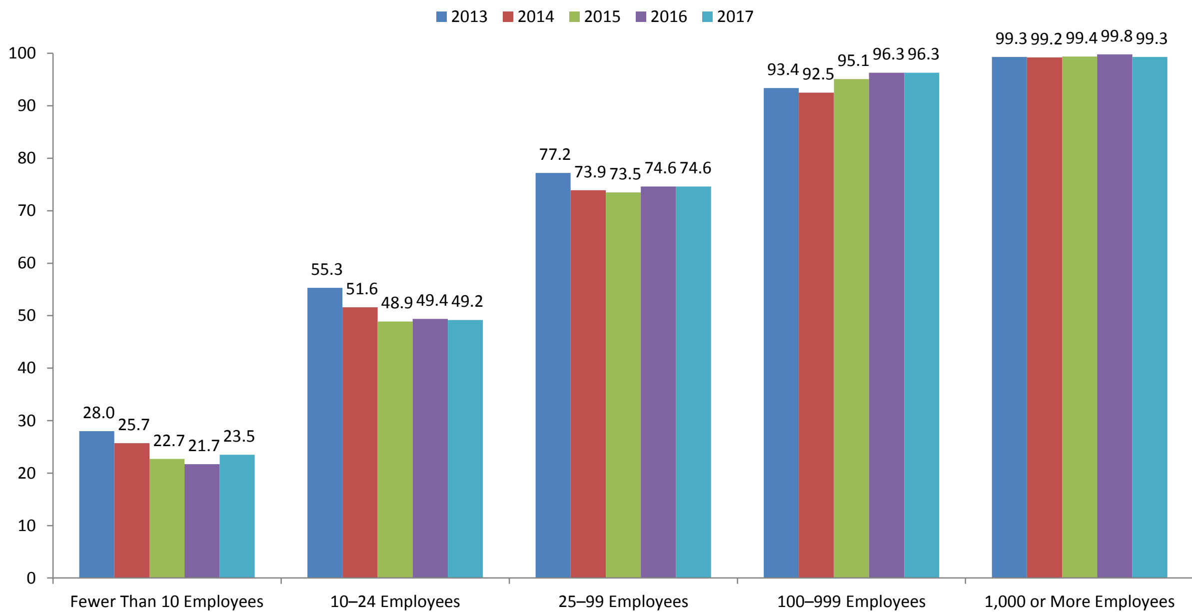
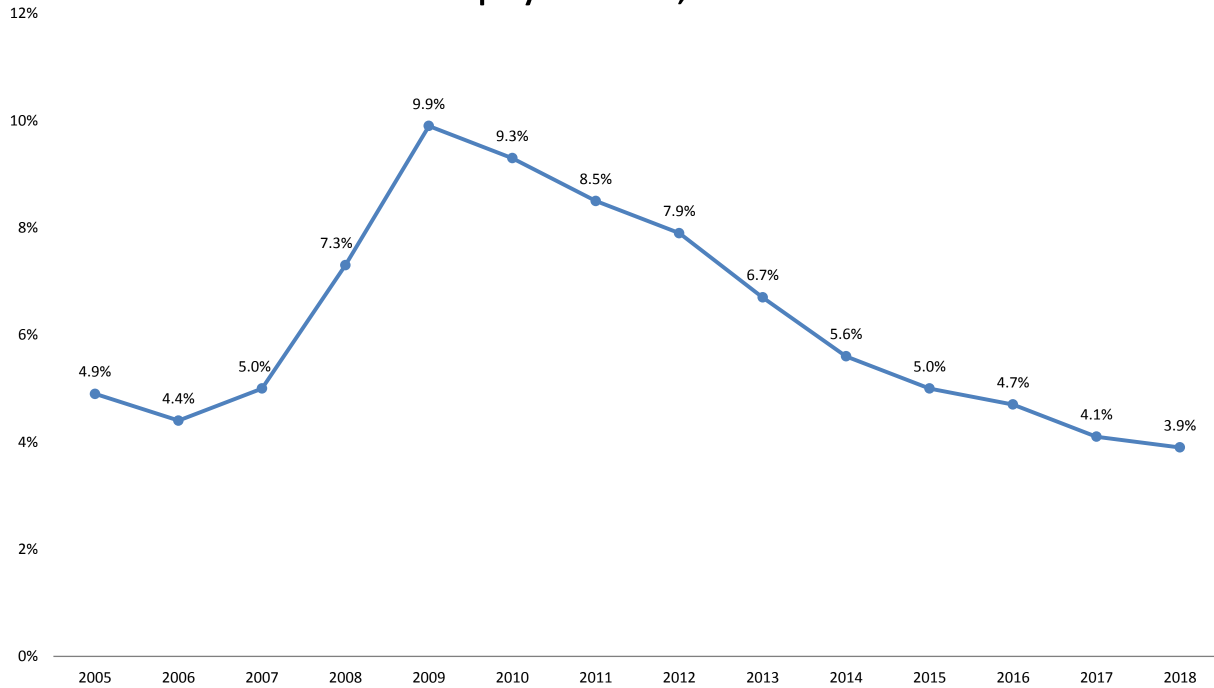


Figure 3
Percentage of Private-Sector Establishments That Offer Health Insurance, by Establishment Size, 2013–2017
2013
2014
2015
2016
2017
100
90
80
70
60
50
40
30
20
10
0
28.0
25.7
22.7
21.7
23.5
55.3
51.6
48.9
49.4
49.2
77.2
73.9
73.5
74.6
74.6
93.4
92.5
95.1
96.3
96.3
99.3
99.2
99.4
99.8
99.3
Fewer Than 10 Employees
10–24 Employees
25–99 Employees
100–999 Employees
1,000 or More Employees
Source: Medical Expenditure Panel Survey - Insurance Component (MEPS-IC).

Figure 4

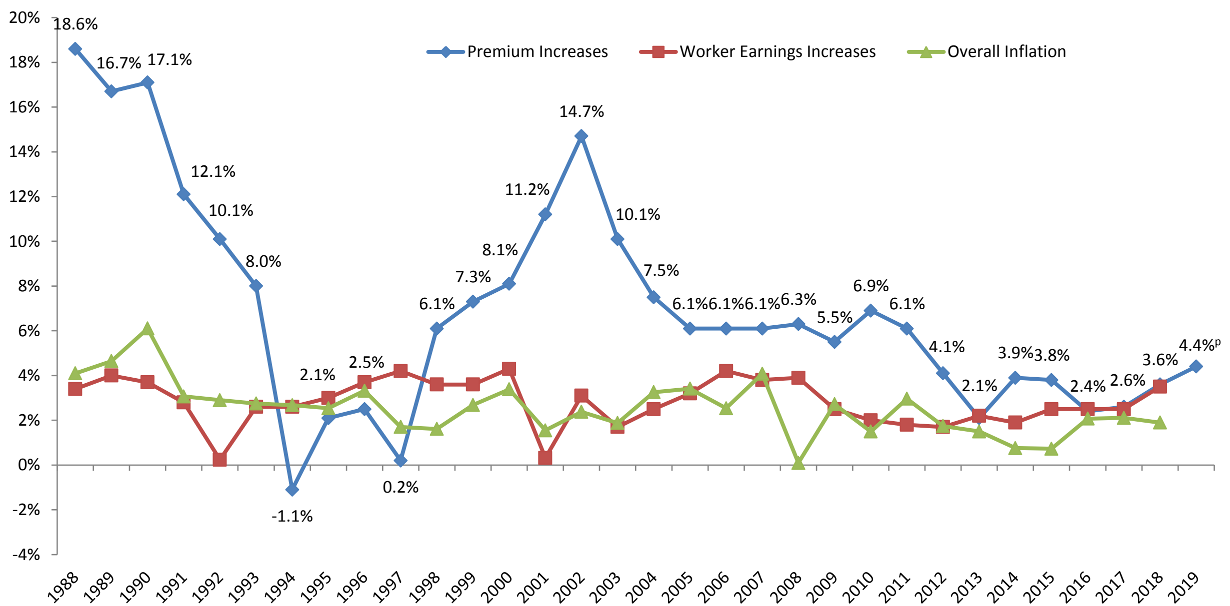
Unemployment Rate, 2005–2018



Source: December unemployment rate from Bureau of Labor Statistics, Series LNS14000000.

Figure 5

Premium Increases Among Employers With 10 or More Employees, Worker Earnings, and Inflation, 1988–2019



Source: Mercer, *National Survey of Employer-Sponsored Health Plans*, and Bureau of Labor Statistics.
p=2019 data is projected.

Employment-Based Health Benefits at Risk?

Despite the fact that employment-based health benefits are the most common source of health benefits and that the percentage of individuals with such coverage is growing, the future of the employment-based system is uncertain. Currently, health insurance premiums for employment-based health coverage are excluded, without limit, from most workers' taxable income. Premiums are not subject to federal income tax, state income tax, or payroll taxes for Social Security and Medicare. This tax break is the largest "tax expenditure" in the federal budget. The Congressional Budget Office (CBO) estimates that employer and employee contributions towards health coverage will account for $282 billion in forgone tax revenue during FY 2019 and nearly $3.7 trillion over 2019–2028.[1] In contrast, the mortgage interest deduction is expected to account for $75 billion in forgone tax revenue, while contributions to workplace retirement plans are expected to account for about $196 billion for FY 2019.[2]

The large dollar amounts associated with the tax exclusion of employment-based health benefits makes it an almost inescapable target for policymakers from both a budgetary and a political perspective. Capping, reducing, or eliminating the tax preference could generate additional tax revenue to reduce the budget deficit and/or pay down the federal debt. Or it could be used to pay for a new round of health reform. For instance, during the 2018 election, many democrats noted their support for "Medicare-for-all." In both Sen. Bernie Sanders' (I-VT) and Rep. Keith Ellison's (D-MI) single-payer or Medicare-for-all bills, employment-based health insurance would cease to exist as we know it. However, in various Medicare and Medicaid buy-in proposals, employers could continue to offer health coverage. Even the Trump administration's own proposal to expand the use of health reimbursement arrangements (HRAs) could seriously undermine employment-based health benefits, as will be discussed in more detail below.

While employment-based coverage is the largest tax expenditure in the U.S. budget, it is also the least costly per person when compared to other health-coverage-related subsidies. The average per capita tax expenditure was $1,722 for individuals with employment-based coverage, compared with an average subsidy of $6,111 among those getting a subsidy in the non-group market and $4,418 among those receiving either Medicaid or coverage through the Children's Health Insurance Program (CHIP) (Figure 6).

There are a number of ways that the subsidy could be used differently while trying to maintain employment-based coverage. First, the subsidy could be limited to only individuals below 400 percent of the federal poverty level (FPL), much like subsidies in the non-group market. Under this scenario, total tax expenditures fall to $125.6 billion (Figure 7). Second, subsidies could not only be limited to individuals below 400 percent FPL but could also be capped at the value of less-comprehensive insurance, such as premiums associated with HSA-eligible health plans. Under this scenario, total tax expenditures fall to $101.9 billion. In contrast, let's assume the subsidy for employment-based coverage is eliminated and individuals with employment-based coverage move to the non-group market. Under this scenario, if the subsidy were limited to individuals below 400 percent FPL, total tax expenditures for this group would increase to $445.7 billion. All of these scenarios assume that individuals do not otherwise change their behavior in response to the change in subsidies.

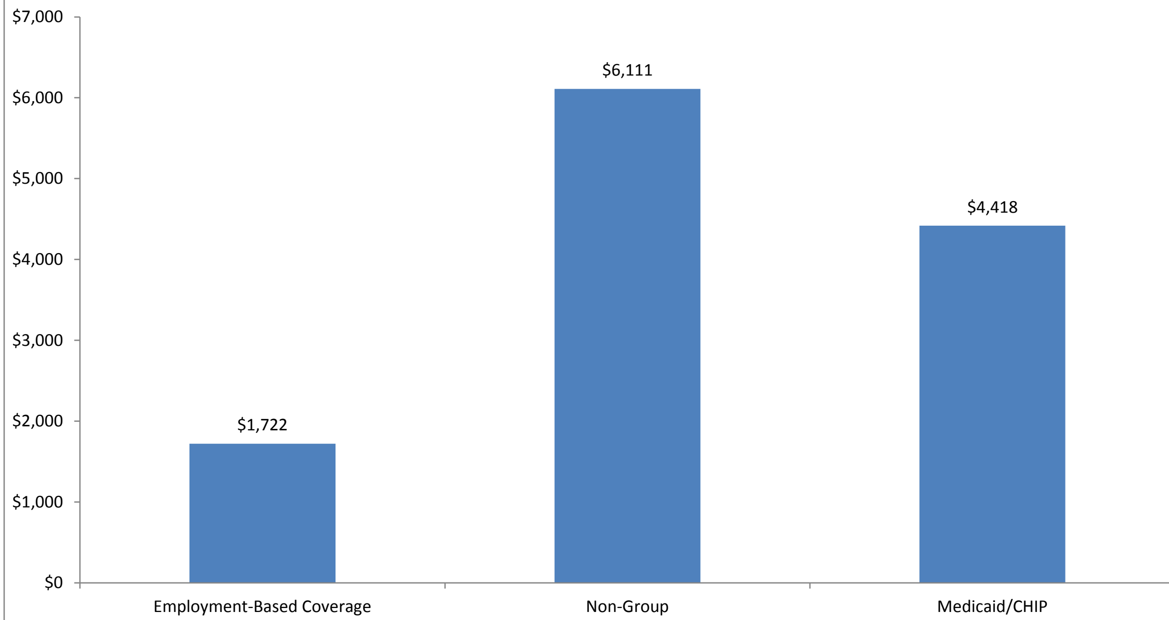
Other changes to the tax treatment of employment-based health benefits may have more profound effects. They include the Trump administration's own proposal to expand the use of HRAs, individual tax credits, and proposals to allow individual premiums to be paid from health savings accounts (HSAs).

Congressional Proposals to Expand Health Insurance Coverage

A number of proposals were introduced in the 115th and 116th Congresses that would have direct and indirect impacts on employment-based health benefits (Figure 8).[3] These bills include single-payer proposals such as Medicare-for-all, a public plan option, and Medicare and Medicaid buy-in proposals. The various proposals for a public plan option and Medicare/Medicaid buy-in would not have a direct impact on the employment-based health insurance system. Employers would continue to be able to offer coverage as they do now. However, these proposals could affect the extent to which employers continue to offer health benefits as well as the manner in which they offer it.

Figure 6

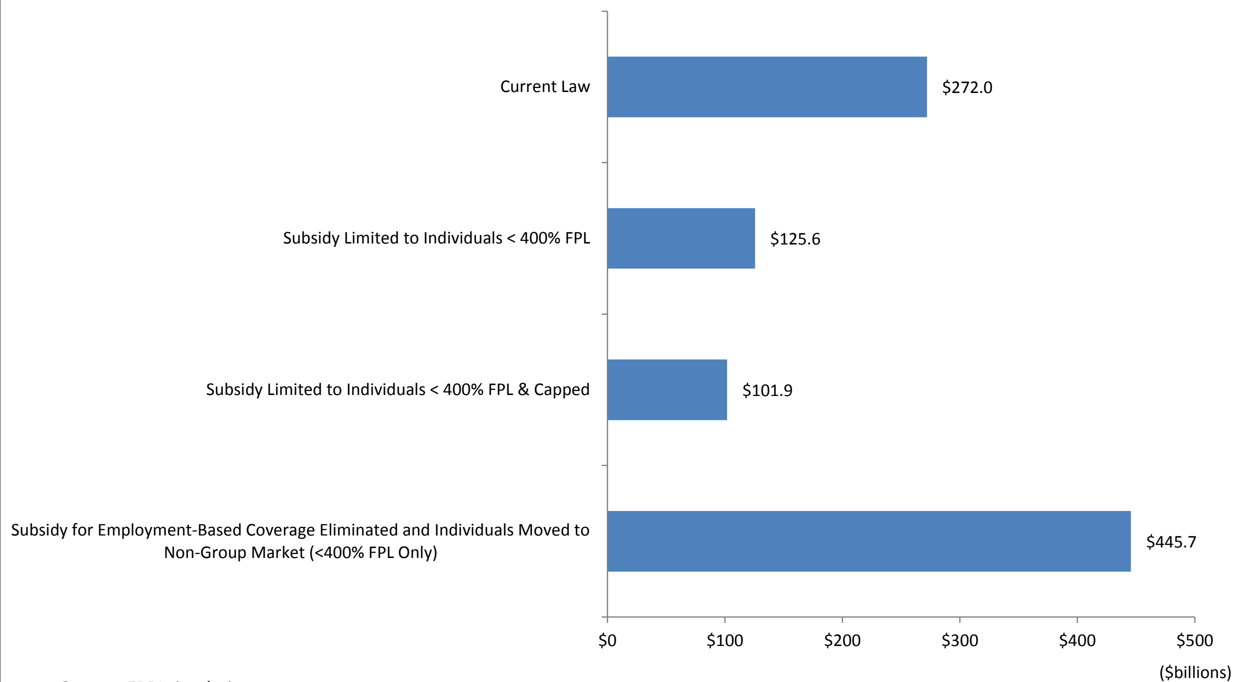
Net Per Capita Federal Subsidies Associated With Health Insurance Coverage for People Under Age 65, 2018



Source: EBRI estimates based on data in https://www.cbo.gov/system/files?file=2018-06/51298-2018-05-healthinsurance.pdf.

Figure 7

Comparison of Subsidies Under Current Law With Various Possible Scenarios



Source: EBRI simulations.

Single Payer or Medicare-for-All

The Sanders and Ellison single-payer proposals would completely overhaul the health care financing and delivery system in the U.S. Both proposals would expand Medicare such that everyone would be covered from birth to death. Both would set provider payment rates, negotiate drug prices, and use global budgets. Their Medicare-for-all proposals would do away with the employment-based health benefits system.

Public Plan Option

Two public plan option proposals, Schakowsky/Whitehouse and Bennet/Higgins, would be available to anyone eligible to participate in the public marketplace. Small employers would also be able to offer the public plan option to their employees via the small group insurance market (aka SHOP marketplace). While large employers could not offer the public plan option, they could drop coverage, which would make their employees eligible for such coverage.

Proponents also believe that the availability of a public plan would be necessary to drive private insurers toward true competition. Opponents view the public plan option as a step toward government-run health care and are wary of cost shifting from public payers to private insurers (Fronstin and Ross 2009). A public plan could have the means to lower costs in a number of ways, but setting provider payment levels at already low Medicare levels is the most likely action in the short run. A public plan with premiums lower than private plans would either drive private plans to reduce costs to be competitive or drive private plans out of business if they could not negotiate the same provider payment levels as the public plan. By contrast, a public plan designed in such a way as to prevent it from exploiting any unfair advantages or perverse incentives might not realize any premium savings as compared to private plans.

A public plan could exacerbate cost shifting from the public sector to private plans. It is well known that premiums for employment-based health benefits are higher than they would otherwise be because the federal government sets prices through Medicare. If this continued under a public plan option in a health insurance exchange for the under-age-65 population, private plans would see costs increase as health care providers increased rates to those plans. As long as premiums in the public plan were lower than those in private plans, individuals would flock toward the public plan, ultimately resulting in fewer private plans. Private plans would drop out of the market as they determined they were unable to compete with the public plan. As private plans drop out and fewer individuals are covered by private plans, cost shifting available from employment-based plans would be reduced or eliminated. This would put undue pressure on the public plan to raise provider reimbursement rates and raises a question as to whether tax rates would need to increase to support such higher rates.

Medicare and Medicaid Buy-In

A number of Medicare and Medicaid buy-in proposals were introduced in the 115th Congress. Sen. Debbie Stabenow (D-MI) and Rep. Clay Higgins (D-NY) both introduced proposals to expand eligibility to Medicare to older individuals not yet eligible for the program, while Sen. Brian Schatz (D-HI) and Rep. Ben Ray Luján (D-NM) introduced a Medicaid buy-in that would allow individuals eligible for the public marketplace to buy into Medicaid. At this point, the Higgins proposal could potentially impact employment-based health benefits given the specificity of the legislative language. Employers would be allowed to pay premiums on behalf of eligible individuals if enrollment is the choice of the individual. While there are many factors to consider, employers could raise premiums or cost sharing to incentivize individuals to enroll in Medicare. Since only older individuals would be eligible for the Medicare program, and because older individuals use more health care than younger individuals, to the degree that older individuals chose the Medicare program, the average cost of health benefits in the workplace would fall.

Think Tank Proposals

Both the Urban Institute and Center for American Progress have offered their own health reform proposals. The Urban Institute's Healthy America proposal would replace current Patient Protection and Affordable Care Act of 2010 (ACA) exchanges and Medicaid/CHIP with a public plan option along with Medicare-Advantage-like private plans for people under age 65.[4] Other than the inclusion of antidiscrimination provisions to prohibit employers from dropping sick

Figure 8
Impact of Various Health Reform Proposals on Employment-Based Health Benefits System

Proposal	Type	Individual Eligibility	Employer Eligibility
Sen. Sanders/Rep. Ellison	Single payer (Medicare-for-all)	All U.S. residents.	Replaces private insurance, including employment-based coverage. Prohibits employers from providing duplicative health benefits.
Sen. Bennet/Rep. Higgins	Public plan option (Federal/Medicare)	All individuals eligible to participate in the marketplace (citizens, lawfully admitted permanent residents, not incarcerated) and not otherwise eligible for Medicare. Medicare-X offered in the individual market beginning in 2020 in areas with one issuer or high costs due to provider shortages, then in all areas by 2023.	Small employers and their employees and dependents have access through the small group insurance market. Medicare-X offered in small group market beginning in 2024.
Rep. Schakowsky/Sen. Whitehouse	Public plan option (Federal/Medicare)	All individuals eligible to participate in the marketplace (citizens, lawfully admitted permanent residents, not incarcerated).	Small employers and their employees/participants have access through the SHOP marketplace.
Sen. Stabenow (D-MI)	Medicare buy-in for older adults	Individuals ages 55 to 64 who are U.S. citizens or nationals residing in the U.S. or lawfully admitted for permanent residence in the U.S., and who are not otherwise entitled to/eligible for benefits under Medicare Parts A or B.	No provision.
Rep. Higgins (D-NY)	Medicare buy-in for older adults	Individuals ages 50 to 64 who are not otherwise entitled to Medicare Part A or eligible to enroll under Medicare Part A or B, who would be eligible/entitled if age 65 or older.	Employers of eligible individuals may pay premiums on their behalf, if enrollment is choice of the individual and not the employer.
Sen. Schatz/Rep. Lujan (D-NM)	Medicaid buy-in	Individuals who are residents of states electing to establish the Medicaid buy-in option, who are eligible to participate in the marketplace, and who are not concurrently enrolled in other health coverage.	No provision.
Urban Institute (Healthy America)	New public plan option, restructured private nongroup insurance market	All lawfully present people younger than 65.	No provision.
Center for American Progress (Medicare Extra)	Medicare buy-in	All lawfully present individuals in the United States would be automatically eligible for Medicare Extra. Newborns and individuals turning age 65 would be automatically enrolled.	Employers would have the option to offer Medicare Extra, and workers would have the option to choose it over employment-based coverage.

Source: Adapted from http://files.kff.org/attachment/Table-Side-by-Side-Comparison-Medicare-for-all-Public-Plan-Proposals, https://www.americanprogress.org/issues/healthcare/reports/2018/02/22/447095/medicare-extra-for-all/, and https://www.urban.org/sites/default/files/publication/98432/2001826_2018.05.11_healthy_america_final_1.pdf

employees from their health plans, it would not make any changes to the employment-based system. Employers would be free to offer coverage as they do now, there would be no employer mandate, and there would be no change to the tax treatment of employment-based health benefits. Provider payment rates would be capped, but employer plans would pay higher rates for their enrollees.

While the Urban Institute argues that employers would continue to provide health benefits because they have historically for business reasons, employers would find discontinuing coverage very attractive. Employers already pay higher fees to providers than do Medicare and Medicaid. To the degree that employers feel that costs are being shifted to them and believe their employees can join health plans that cap provider payment rates, they may decide to drop coverage. Similarly, while the proposal includes antidiscrimination provisions to prohibit employers from dropping sick employees from their health plans, there is nothing stopping employers from dropping coverage for all workers. Employers facing the highest premiums in the group market — those with more costly than average populations — may find dropping coverage appealing. While employers may hesitate to make a major move away from health benefits when the economy is strong, when the economy weakens, employers may decide that they no longer need to offer health benefits to be competitive in the labor market. It would be the first time in history that a recession would be paired with a viable alternative to employment-based coverage, so we should not expect employers to behave as they have in past recessions. The Urban Institute estimates that 18.3 million fewer people will have employment-based coverage under their proposal and assumes the drop in coverage comes from workers opting for the Healthy America program voluntarily rather than because employers dropped coverage. This is an assumption based on the experience of employers not dropping coverage after the ACA went into effect and may not be valid were the U.S. to experience its first recession since then.

Under the Center for American Progress "Medicare Extra" proposal, employers would be allowed to continue to offer coverage.[5] If they do, they must provide coverage with an actuarial value of at least 80 percent, and they are also required to contribute at least 70 percent of the premium. Today, the vast majority of employers already offer plans that meet these requirements.

Workers would have the option of enrolling in Medicare Extra even when their employer offers them a plan directly. Employers would contribute the same amount to Medicare Extra that they contribute to their own coverage when their employees choose the Medicare Extra program.

Employers would have the choice of offering Medicare Extra to their employees. If they did, they would be required to contribute at least 70 percent of the Medicare Extra premium. If employers did not offer health benefits either as they currently do or through the Medicare Extra program, they would be required to make either maintenance-of-effort payments — that is, payments equal to their spending in the year before enactment, adjusted for inflation and firm size changes — or they would be required to pay a percentage of payroll, depending on firm size. Smaller employers, those with fewer than 100 full-time employees, would be exempt from these requirements.

Under Medicare Extra, like the Healthy America proposal, there is no guarantee that employers would continue to offer health benefits.   Employers facing the highest premiums in the group market, because they have a less-healthy population, may find it advantageous to drop coverage. Furthermore, the value proposition for offering coverage — to recruit and retain workers — may change if and when the economy weakens and unemployment rates rise.

Trump Administration Proposal on Health Reimbursement Arrangements

Unlike the Congressional and Think Tank proposals discussed above, the employment-based health benefits system may be impacted by regulations that are working their way through the Trump administration. In October 2018, regulations[6] were issued by the departments of Treasury, Labor, and Health and Human Services — at the direction of an Executive Order[7] by President Trump — to expand the use of stand-alone Health Reimbursement Arrangements (HRAs) by employers of all sizes.

This is another twist in the complicated history of HRAs. HRAs first became available around 2001, when a handful of employers paired such arrangements with high-deductible health plans. These employers offered HRAs under then-existing law — which was unclear at the time. In 2002, the Internal Revenue Service (IRS) released Revenue Ruling 2002-41[8] and Notice 2002-45[9] (published in Internal Revenue Bulletin 2002-28, dated July 15, 2002) to provide guidance clarifying the conditions under which HRAs could be provided to workers on a tax-free basis and addressed questions related to the benefits offered under an HRA, the interaction between HRAs and cafeteria plans, FSAs, COBRA coverage, and other matters. One of the provisions in Notice 2002-45 allowed HRAs to be used on a stand-alone basis to reimburse workers for eligible health insurance premiums, which included premiums for health insurance purchased by workers directly from insurance companies in the individual or non-group market.

Employers never made this provision widely available and, in 2013, the Obama Administration banned the practice in the Department of Labor Technical Release No. 2013-03.[10] Then in December 2016, the 21st Century Cures Act included a provision known as the Qualified Small Employer Health Reimbursement Arrangement (QSEHRA), which allows certain small employers to use HRAs on a tax-preferred basis to reimburse workers for health insurance purchased on the individual market, as well as deductibles, and cost sharing more generally.[11] A year later, President Trump issued his executive order.

Under the newly proposed regulations, two types of HRAs would be allowed:

- A stand-alone HRA that could be used to purchase coverage in the non-group market with no contribution limit. The HRA must be used to purchase ACA-compliant plans and must meet ACA affordability requirements in order for the employer to meet the shared responsibility requirement. The HRA will not be subject to ERISA if certain conditions are met.
- An "excepted benefit HRA," where employers would be able to contribute up to $1,800 that workers could use to pay their out-of-pocket cost sharing and/or certain premiums, such as those for short-term health insurance, COBRA, disability insurance, and dental and vision insurance. When offering an excepted benefit HRA, employers must also offer a group health plan, but workers could decline it and get coverage in the non-group market. Employers are not allowed to offer both the stand-alone HRA and excepted benefit HRA to the same class of workers.

The administration expects around 800,000 employers will offer stand-alone HRAs by 2024 and beyond. As a result, some 10.7 million individuals would be covered by such an HRA by 2027 and 6.8 million fewer workers (and their dependents) would have traditional employment-based health coverage. It is no surprise that there would be fewer people with employment-based health coverage. Employers have been interested in the concept of "defined contribution (DC) health" coverage and giving workers an HRA that they can use to purchase coverage in the non-group market may be an attractive means of moving to DC health. Employers never moved in the direction of giving workers a fixed contribution to purchase health insurance for a number of reasons. Historically, they were hesitant to drop group coverage in favor of offering individual policies because the non-group market was not considered a viable alternative to the employment-based system. And, more recently, even with the advent of private health insurance exchanges, employers did not embrace them as the initial hype would have expected us to believe.[12]

There is no question that the HRA provision gives employers the means to drop traditional health coverage and go to a "DC health"-type plan. One of the concerns is that employers will try to structure their plans in such a way to send high-risk employees to the individual market. The regulations include a number of provisions to prohibit such a discriminatory practice. However, what if only employers facing the highest premiums in the group market adopted HRAs? If such a phenomenon occurred, the non-group market would not become more stable and may see average premiums increase, while the group market would see a reduction in average premiums as higher risk groups left.

Employers may require that there be a viable non-group market for their employees to go to before moving to HRAs. Stability in premiums may be one requirement, which may make it less likely that multi-state employers move to HRAs given the variation in premium growth across states. The quality of the benefits offered is another consideration. For instance, the prevalence of narrow-network plans in the non-group market may be something that continues to hold

employers back from HRAs. And of course there is always the uncertainty of future changes in the non-group market, as employers have no control over that marketplace and would have no control over how workers spent HRAs in the non-group market.

There are a number of unanswered questions. Which employers would go in this direction, under what circumstances, and for which employees? Would it vary by firm size? Do the strength of the economy and labor market conditions factor in? The next recession will be the first recession in history since the insurance market reforms were put into place by the ACA. It will be the first time in history that a recession was paired with the inability of insurance companies to deny people coverage for pre-existing conditions or to charge them more for such conditions. It will also be the first time that health insurance premiums for people under 400 percent of the federal poverty level would be subsidized by the federal government during a recession in a meaningful way. Employers may decide that they no longer need to offer health benefits to be competitive in the labor market during the next recession, and the combination of the insurance market reforms and the ability to give workers tax-free money to purchase health insurance on their own may finally put the future of employment-based health coverage to the test.

The new regulations are expected to be finalized early this year and take effect for plan years beginning on or after Jan. 1, 2020.

Advantages of Employment-Based Health Benefits

The employment-based health benefits system has a number of advantages over various alternatives. These advantages may make it difficult to completely move away from the employment-based system. We will cover the advantages in this section and move to disadvantages in the next.

Less Chance of Adverse Selection

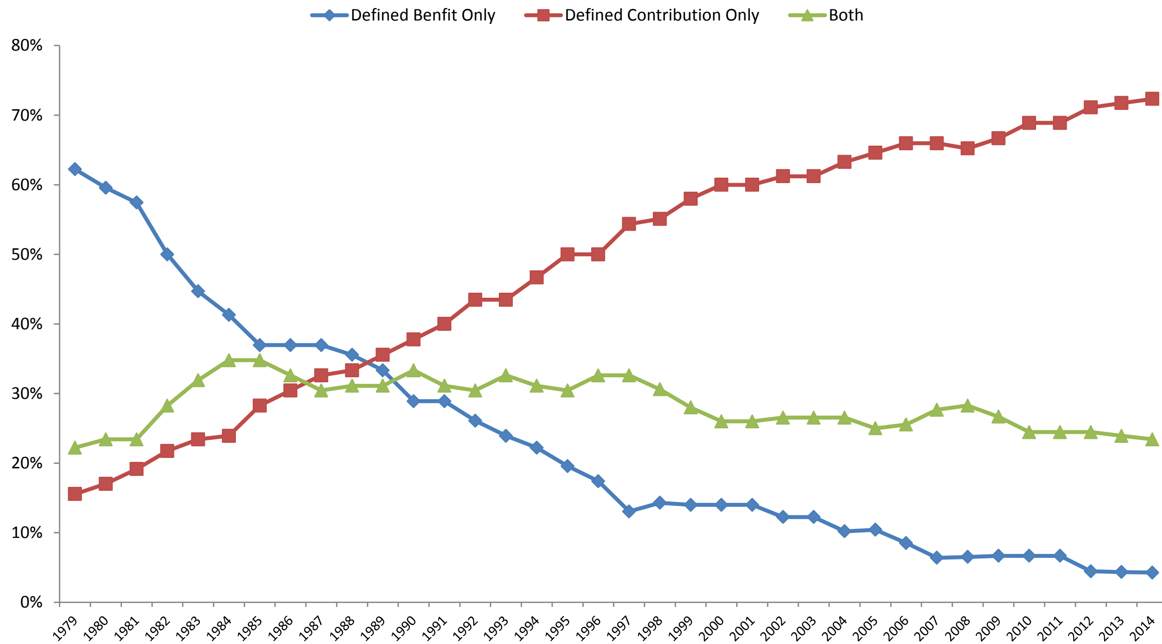
When it comes to insuring a group of individuals, employment-based groups are often considered "natural groups" in the sense that they were formed for reasons other than the purchase of health insurance. Insurers are more willing to provide insurance for a naturally formed group than for a group that was formed solely for the purpose of buying health insurance because the risks of adverse selection are mitigated. In a purely voluntary system, such as the U.S. system, the risk of adverse selection is relatively high because those most likely to seek insurance for health care are also those most likely to need health care. As a result, when insuring groups, insurers are unable to single out higher-risk or unhealthy individuals, allowing those individuals the same opportunity to be covered by a health insurance plan. Hence, employment-based health insurance is a potent means for spreading risk among both healthy and unhealthy individuals. This is an argument against moving away from the current employment-based system, especially as it relates to more individualistic approaches to health insurance.

Worker Preference for Employment-Based Coverage

According to the 2018 EBRI/Greenwald & Associates Health and Workplace Benefits Survey (WBS), nearly 60 percent of workers are satisfied with their current mix of health benefits and wages, and most individuals with employment-based health benefits are satisfied with their coverage (Fronstin and Dretzka 2018). One-half are extremely or very satisfied with their coverage, and another 38 percent are somewhat satisfied. Furthermore, health insurance benefits are by far the most important benefit when workers are considering a job decision. Prior-year surveys have found that workers are much more confident in their employers' ability to select the best available plan than in their own ability to do so. It may take a change in culture before workers are ready to accept something other than an employment-based health benefits system. Employers may still need to offer health benefits to be competitive in the labor market, and the need to offer benefits to be competitive may vary by industry, geographic region, and/or other factors. Workers may prefer that employers offer health benefits simply to take advantage of the tax-preferred status of this form of compensation.

A parallel can be drawn between the culture change required here and the one that has largely taken place in the shift from defined benefit (DB) to defined contribution (DC) in retirement benefits. In 2014, 4 percent of private-sector workers with a retirement benefit were participating in only DB plans, down from nearly 62 percent in 1979 (Figure 9).

Figure 9
Distribution of Private-Sector Participants in an Employment-Based Retirement Plan, by Plan Type, 1979-2014*



Source: U.S. Department of Labor Form 5500 Summaries 1979–1998, Pension Benefit Guaranty Corporation, Current Population Survey 1999–2011.
*EBRI estimates 1999–2014.

In contrast, the percentage of private-sector workers with retirement plans participating in only DC plans increased from 16 percent to 72 percent. The percentage with both DB and DC plans was 22 percent in 1979 and 23 percent in 2014 and peaked at 35 percent in the mid-1980s.

DB plans steadily lost ground as the preferred plan type for a number of reasons:

- Government regulation had a profound impact on plan choice (Clark and Schieber 2000) (Ippolito 2002) (VanDerhei and Olsen 1997).
- Changes in the workplace may have contributed to the rise of DC plans, including increased worker and employer appreciation and demand for DC plans (Gale, Papke and VanDerhei 1999) (Ostaszewski 2001).
- A number of economic explanations have been proposed as well (Brown and Liu 2001) (Ostaszewski 2001) (Salisbury 1997) (VanDerhei and Olsen 1997), including a changing business environment and the risk associated with funding and managing pension plans; issues with firm size; and the increase in global competition faced by employers in recent years, which has led to the subsequent need for more flexibility in retirement plan design.

While many employers did not set out to shift the risks associated with funding retirement onto workers, this has certainly occurred. There may be lessons that can be learned from the experience with the shift from DB to DC retirement plans that apply to a possible similar shift away from employer involvement in health benefits. Notably, over time, DC plans introduced features such as target-date funds, automatic enrollment, and auto-escalation to make DC plans more DB-like — generally in recognition of the fact that many workers were not saving and investing well in their DC plans on their own.

Group Purchasing Efficiencies

The existence of economies of scale in the purchase of group health insurance coverage results in lower average premiums. When economies of scale exist, the average administrative costs of insuring a group make up a smaller percentage of the cost of health insurance. As a result, large firms, which are able to exert market power, are more likely to offer health benefits than small firms because they can purchase the same plan at a lower cost. In addition, employers may be better at searching or negotiating for lower-cost health plans than workers would be in the individual market. Lacking either an employment-based system or universal coverage that mandates participation, this will be one of the more difficult aspects to replicate.

Employer as Advocate

Employers are not only able to find or negotiate lower health insurance costs than workers could in the individual market, but they also often act as an advocate for workers during coverage disputes between the insured and insurer. For example, an employer experiencing widespread dissatisfaction with a specific health plan will either find a new health plan or threaten to find a new health plan if the insurer does not respond to the issues brought up by members of the plan. Insurers are more likely to respond to an employer than to an individual because of the risk of losing a large group contract when that group is not adversely selected.

Delivery Innovation and Health Care Quality

Employers frequently involve themselves in matters of quality assessment of care and influencing health care matters in the policy development arena. With the rise of health care costs in the 1970s and 1980s, large employers began to pay closer attention to health care quality. One aspect of this increased attention was the formation of coalitions of employers to facilitate the sharing of information about health care quality and health care providers among a group of employers in order to allow employers to contract with the best insurers and providers. Many believe that employers are better able to perform the role of monitoring quality of health care than individuals.

Health Literacy Issues

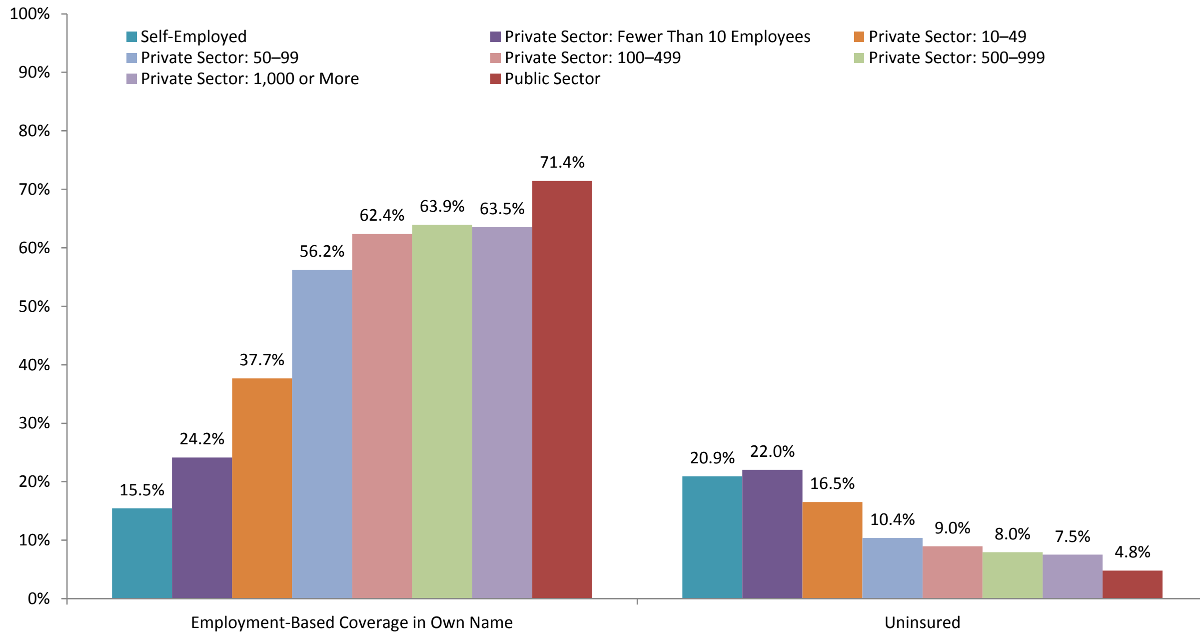
Our research has found that only 39 percent of workers were extremely or very confident that they could choose the best available health plan in the non-group market.[13] The Institute of Medicine (2004) concluded that nearly one-half of all adult Americans were health illiterate. The Institute of Medicine report cited studies that determined that limited health literacy has been shown to be associated with worse health status, higher use of health care services, and worse clinical outcomes. It also found that individuals with limited health literacy and chronic illness have less knowledge of disease management than those with higher health literacy. While the report did not examine the impact of health literacy on knowledge of health insurance and purchasing decisions, the conclusions drawn from the report raise the obvious question of how well served individuals would be in the non-group market and how long it will take for individuals and insurers to match themselves up with appropriate products.

Shortcomings of the Employment-Based Health Benefits System

Of course, the employment-based health benefits system is far from perfect. One of the shortcomings is that it does not guarantee universal coverage, which a Medicare-for-All could do. Employment-based health benefits cover 62 percent of the population under 65 years old, leaving the remainder with either individually purchased coverage or Medicaid, or they remain uninsured (Figure 1). In our voluntary, employment-based system, many employers, especially smaller employers, choose not to offer coverage. Only 23.5 percent of employers with fewer than 10 employees and 49.2 percent of employers with 10–24 employees offered coverage to workers in 2017 (Figure 3). As a result, workers at these companies are much less likely to have coverage through their workplace, and are much more likely to be uninsured than workers in larger companies, where health coverage is much more ubiquitous, though some of these workers will be able to get coverage as a spouse or dependent on another employment-based plan (Figure 10).

Figure 10

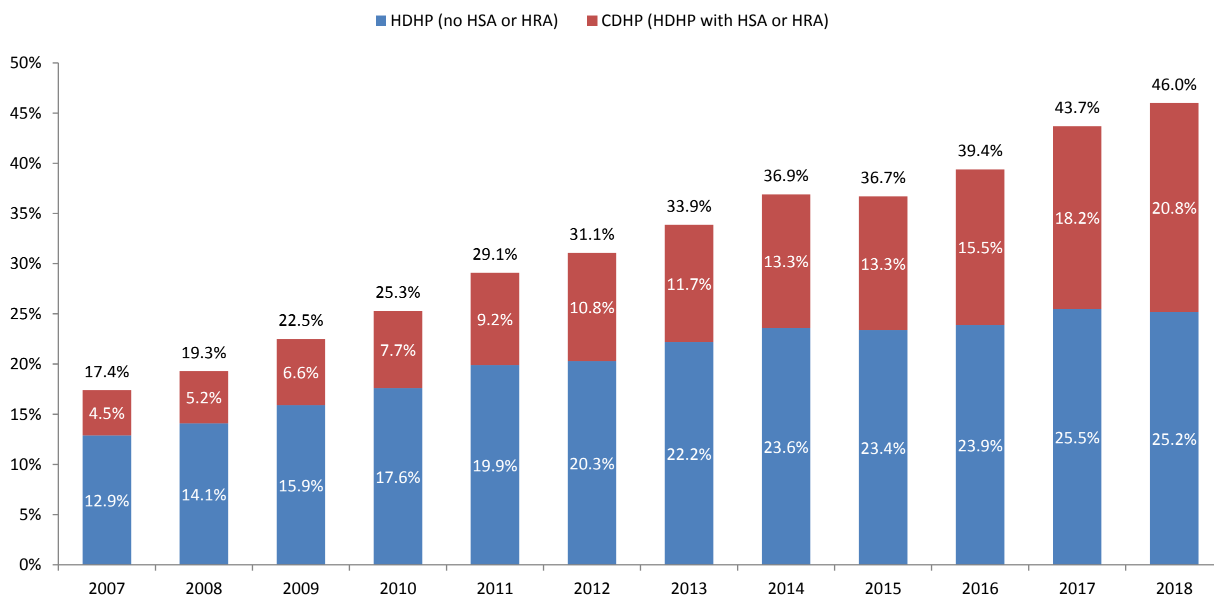
Percentage of Workers With Employment-Based Coverage or Uninsured, Ages 18–64, by Firm Size, 2017



Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 2018 Supplement.

Figure 11

Percentage of Persons With Private Health Insurance Under Age 65 Enrolled in a High-Deductible Health Plan or in a Consumer-Directed Health Plan, 2007–2018



Source: Figure 11 in https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201811.pdf and Figure 3 in https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201306.pdf

Employers also need to continuously justify whether to offer coverage to workers. The percentage of employers offering health benefits ebbs and flows with the economy and other factors. For instance, after years of stability in the percentage of employers offering coverage, it started falling in 2009, in part due to the Great Recession and increasing unemployment rates.[14] In today's economic environment, an increasing percentage of employers are offering health coverage. When unemployment is low, recruiting and retaining workers becomes a bigger challenge for employers, including some smaller employers, which in turn often means improving compensation and benefits.[15]

Employers manage the cost of providing health benefits by changing the design of the benefits plan. High-deductible health plans (HDHPs) are becoming more and more common. HDHPs are health plans with deductibles of at least $1,350 for individual coverage and $2,700 for family coverage in 2019. Between 2007 and 2018, the percentage of individuals with private insurance on a HDHP increased from 17.4 percent to 46.0 percent (Figure 11). Ironically, while there is talk of expanding Medicare either through a buy-in program or via Medicare-for-all, the program also has high deductibles. In 2019, there is a $1,364 deductible for inpatient stays (and $341 copayments per day after 60 days) and a $185 deductible for outpatient office visits. Medicare beneficiaries can cover these deductibles with supplemental coverage either by purchasing that coverage at their own expense or by enrolling in a Medicare Advantage plan that often provides coverage for deductibles by limiting the network of physicians that are covered by the plan. And unlike employment-based health plans, Medicare does not have a maximum out-of-pocket limit for beneficiaries.

Arguments for De-Linking Health Coverage From Employment

De-linking health insurance from employment may address the shortcomings of the current system. For example, health insurance is not portable from job to job, i.e., workers cannot usually continue to participate in their health plan when they change jobs. Workers sometimes stay in their jobs because of health insurance. The Health Insurance Portability and Accountability Act (HIPAA) addressed portability when it comes to coverage for pre-existing conditions for workers changing jobs; however, potential employers may not offer health benefits, the benefits offered may be less comprehensive than were offered in the current job, and the benefits from the potential employer may cost more. HIPAA does not address portability for workers without health insurance coverage through their job, which has implications for the gig economy and contract workers, who are less tied to traditional employment relationships.

Another example regarding de-linking health insurance from employment relates to the lack of choice of a health plan among workers with employment-based coverage: Workers do not have a lot of plan choices through the employment-based system. Nearly 60 percent of workers with health insurance have a choice of health plan, but only 19 percent have a choice of at least three health plans.[16] When workers do have a choice of health plan, it is typically between a health maintenance organization (HMO) and a preferred provider organization (PPO) from the same insurance carrier (or through the same self-insured employer) — although consumer-driven health plans are being increasingly added as an option.

Employers decide which health plan to offer employees and whether to offer a choice of plan at all. The employer choice of plan may not match the employee choice, if given a wider choice of plan options. Moving workers into a health insurance exchange would allow workers to choose from among all of the available health plans. Furthermore, insurers might start to offer a more diverse choice of health plans in the individual market to attract new business and to address increased demand. Medicare-for-all may or may not offer workers a choice of health plans.

Conclusion

The employment-based health benefits system arose not from any deliberate national health care policy but rather from a voluntary, market-driven response by employers to government regulations regarding wages and taxation during World War II. Today, the employment-based health benefits system is the most common form of health coverage in the United States, covering 167 million people under age 65 in 2017, and most individuals with employment-based health benefits are satisfied with their coverage.

One of the shortcomings of the employment-based system is that it does not cover everyone. About 28 million Americans did not have health insurance in 2017, about 14 million lower than what it was in 2013, the year before the major provisions in ACA to expand coverage took effect. Policymakers are considering a number of options to expand the number of people with health insurance coverage. While some proposals would build upon the employment-based system, as the ACA tried to do, proposals such as single-payer would end employment-based coverage as we know it, and those that would move more toward individually purchased private coverage could seriously undermine it.

We know that workers value health benefits more than any other employee benefit offered by employers. In the absence of more government involvement in health care, employer activism has increased through various types of coalitions.[17] What we do not know is whether employers would trade off more government involvement in health care for less of their own involvement if given the opportunity, especially in a weak economic environment. Thoughtful consideration of policy proposals to expand the number of people with health insurance coverage should not only evaluate their effectiveness in addressing their impact on health care costs, quality, and coverage, but should consider the impact on the voluntary, market-driven employment-based system.

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Endnotes

[1] See Table 2 in https://www.cbo.gov/system/files?file=2018-06/51298-2018-05-healthinsurance.pdf

[2] See www.whitehouse.gov/wp-content/uploads/2018/02/ap_13_expenditures-fy2019.pdf. Note that contributions to retirement plans do not receive the same tax preference as spending on health insurance or mortgage interest. In the case of health insurance and mortgage interest, forgone tax revenue is never collected. In the case of retirement plans, tax revenue is forgone in the short term, but income is taxed when distributions are taken by retirees.

[3] See http://files.kff.org/attachment/Table-Side-by-Side-Comparison-Medicare-for-all-Public-Plan-Proposals for more details.

[4] See https://www.urban.org/sites/default/files/publication/98432/2001826_2018.05.11_healthy_america_final_1.pdf

[5] See https://www.americanprogress.org/issues/healthcare/reports/2018/02/22/447095/medicare-extra-for-all/

[6] See https://www.federalregister.gov/documents/2018/10/29/2018-23183/health-reimbursement-arrangements-and-other-account-based-group-health-plans

[7] See https://www.whitehouse.gov/presidential-actions/presidential-executive-order-promoting-healthcare-choice-competition-across-united-states/

[8] See https://www.irs.gov/pub/irs-drop/rr-02-41.pdf

[9] See https://www.irs.gov/pub/irs-drop/n-02-45.pdf

[10] See https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/technical-releases/13-03

[11] See https://www.irs.gov/pub/irs-drop/n-17-67.pdf

[12] See https://www.ebri.org/health/publications/issue-briefs/content/private-health-insurance-exchanges-and-defined-contribution-health-plans-is-it-d%C3%A9j%C3%A0-vu-all-over-again--5092

[13] Unpublished findings from the 2018 EBRI/Greenwald & Associates Health and Workplace Benefits Survey.

[14] See Figure 1 in https://www.ebri.org/docs/default-source/ebri-notes/ebri_notes_07-no8-july16.pdf?sfvrsn=9ec5292f_0

[15] See https://www.ebri.org/docs/default-source/ebri-issue-brief/ebri_ib_455_offerrates-6aug18.pdf?sfvrsn=6958352f_2

[16] See https://www.kff.org/report-section/2018-employer-health-benefits-survey-section-4-types-of-plans-offered/#figure42

[17] Recent examples of relatively new employer coalitions include the Health Transformation Alliance (www.htahealth.com) and the alliance between Amazon, Berkshire Hathaway, and JP Morgan Chase known as Haven (www.havenhealthcare.com). The new coalitions may also be a way to outsource benefits administration as employers are finding health care purchasing and design to be increasingly complex.

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