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Statement for the

ERISA Advisory Council
Working Group on Challenges to the Employment-Based Health Care System

by
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Chairman Camden and members of the working group, I am pleased to appear before you today to discuss uninsured Americans. My name is Paul Fronstin. I am a senior research associate and director of the Health Security and Quality Research Program at the Employee Benefit Research Institute (EBRI), a private, nonprofit, nonpartisan, public policy research organization based in Washington, DC. EBRI has been committed, since its founding in 1978, to the accurate statistical analysis of economic security issues. Through our research we strive to contribute to the formulation of effective and responsible health and retirement policies. Consistent with our mission, we do not lobby or advocate specific policy solutions.

Introduction

Health insurance provides Americans with financial security against losses that often accompany unexpected serious illness or injury. Employers offer health insurance as an employee benefit for a number of reasons. Besides providing financial security to workers and their families, employees are offered health benefits to promote health and to increase worker productivity. Health benefits are also a form of compensation used to recruit and retain workers.

Health insurance is the benefit most valued by workers and their families. Sixty-five percent of workers responding to a recent survey rated health insurance as the most important employee benefit (Salisbury and Ostuw, 2000).

It was during World War II that many employers began to offer health benefits, and subsequently the number of persons with employment-based health insurance started to increase. Because the National War Labor Board froze wages, employers sought ways to get around the wage controls in order to attract scarce workers. In 1943, the National War Labor Board ruled that employer contributions to insurance did not count as wages. Health insurance benefits were an attractive means to recruit and retain workers. Unions supported the provisions of employment-based health insurance benefits, and workers' health benefits were not subject to income tax (or Social Security payroll taxes), as were cash wages.

Historians often suggest that the tax-preferred status of employment-based health insurance benefits led to the rise in its prevalence. However, employer interest in the workers' health actually started long before the tax treatment of health benefits became an incentive. Early examples of employment-based health programs include the mining, lumbering, and railroad industries during the late 1800s (Institute of Medicine, 1993). Employers in these industries provided company doctors funded by deductions from workers' wages. Employers had a practical interest in providing health services to injured or ill workers, who often worked in remote geographic regions. Early employment-based programs occasionally covered general medical care for workers, their families, and the community as well.

World War II, though, did accelerate the growth in employment-based health insurance benefits. By the end of the war, health insurance coverage had tripled (Weir et al., 1988). However, it was not until 1954 that the Internal Revenue Code made it clear that employer spending on employee health benefits was not counted as employee income.

Today, employment-based health insurance benefits are the most common source of health insurance in the United States. Nearly 160 million Americans under age 65, representing about two-thirds of the population, are covered by the employment-based health insurance system (Fronstin, 2000). An additional 11 million individuals ages 65 and older have employment-based health insurance coverage, mostly as supplements to Medicare benefits. Because of double-digit health benefit cost increases during the late 1980s and early 1990s, employment-based health benefit plans began to move workers into managed care arrangements. Between 1992 and 1999, the percentage of workers enrolled in traditional indemnity plans declined substantially.

While the movement to managed care brought about declines in the rate of health benefit cost inflation, at least temporarily, this movement has not occurred without controversy. Not only are health benefit costs rising again,

but policymakers are considering legislation that would provide consumers with certain rights. These "rights" would likely increase the cost of health benefits.

Employers are once again examining changes to employment-based health insurance benefits to control future health benefit cost increases, respond to employee demands for more choice and, in some cases distance themselves further from care decisions. This paper discusses recent trends in and the future of employment-based health insurance benefits. The next section presents recent trends in sources of health insurance, access to health benefits, changes to benefit packages, and retiree health benefits. The third section discusses the reasons underlying the trends in employment-based health insurance benefits. The fourth section presents the outlook for employment-based health insurance benefits, and includes a discussion of defined contribution health benefits.

Recent Trends

The percentage of Americans under age 65 covered by employment-based health benefits has been increasing since 1994 (table 1). Overall, the increase in coverage was due in large part to a higher likelihood that children were covered by an employment-based health plan. Between 1994 and 1999, the percentage of children covered by an employment-based health plan increased from 58.1 percent to 61.5 percent (chart 1). For adults, it rose from 66.1 percent to 67.6 percent, with the increase mainly occurring between 1997 and 1999 (chart 2).

The likelihood of a child being covered by employment-based health insurance benefits increased for a number of reasons (Fronstin, 1999b). The percentage of children with a working parent increased, the percentage of children in families with incomes below the poverty level decreased, and more children had a working parent employed in a large firm. The increase in employment-based coverage among children can in part be attributed to a combination of welfare reform and the strong economy, both of which resulted in fewer adult women on welfare and more adult women working.

Between 1994 and 1997, the percentage of working adults with employment-based health insurance coverage held steady at roughly 72.3 percent (chart 3). During this period, health care cost inflation was essentially nonexistent. Working adults finally experienced an increase in the likelihood of having employment-based health benefits in 1998. Between 1997 and 1999, the percentage of working adults with employment-based health insurance increased from 72.2 percent to 73.3 percent, despite the apparent return of health care cost inflation in 1998 and 1999.

An examination of total employment-based insurance benefits among workers can mask important differences in trends for the sources of that coverage. Workers can be covered by employment-based insurance benefits through their own employer, through a spouse's employer, and sometimes through a parent's employer.[1] It turns out that the trend for workers' coverage from various sources of employment-based health benefits follows the trend for total employment-based health benefits. The percentage of workers receiving health benefits from their own employer (own name coverage) increased from 55 percent in 1997 to 55.5 percent in 1998 (chart 4). Similarly, the percentage of workers receiving health benefits from a family member's employer (dependent coverage) increased from 17.3 percent in 1998 to 17.7 percent in 1999. Overall, the likelihood of a worker having coverage from his or her own employer increased only 1 percent between 1994 and 1999 because of an initial drop in coverage between 1994 and 1997. The likelihood that a worker had dependent coverage increased 4 percent between 1994 and 1999. It is likely that the changing composition of the labor force accounted for some of the increase in the percentage of workers covered by employment-based health insurance benefits. For example, between 1997 and 1999, the percentage of workers who were self-employed declined, the percentage of workers employed at firms with 1,000 or more employees increased, and the percentage of workers employed on a part-time or part-year basis decreased (chart 5).

Despite rising health insurance costs, employers increasingly have been offering health benefits to workers—because of the tight labor market. Between 1998 and 2000, the percentage of small firms offering health benefits increased from 54 percent to 67 percent, with much of that increase occurring among the smallest of the small firms (chart 6). Most small employers report that offering health benefits helps with recruitment and retention

and keeps workers healthy, which ultimately reduces absenteeism and increases productivity (Fronstin and Helman, 2000). Clearly, many employers realize there is real business value in providing health care coverage to their workers. Overall, offer rates to employees increased between 1997 and 1999, although employee take-up rates remained unchanged (chart 7).

The increase in the percentage of employers offering health benefits and the increase in the percentage of workers and their dependents covered by employment-based health benefits between 1997 and 1999 are both not surprising and surprising. They are not surprising because the strong economy and low unemployment rates caused more employers to provide health benefits in order to attract and retain workers, and also may have resulted in more workers being able to afford health insurance. They are surprising because 1998 saw the return of health care cost inflation, and this inflationary trend accelerated in 1999. In the late 1980s and early 1990s, the percentage of Americans covered by an employment-based health plan declined in large part because of health care cost inflation. In the late 1980s, health care costs increased at an average rate of between 15 percent and 20 percent annually. However, between 1994 and 1997, these costs barely changed. In 1998, they started to increase again, but the increase does not appear to have affected the percentage of Americans with employment-based health benefits. More research needs to be conducted in this area to understand the trade-offs employers face between rising health benefit costs and the other costs of operating a business.

The Uninsured

In 1999, for the first time since at least 1987, the percentage of Americans with health insurance increased: 82.5 percent of Americans under age 65 were covered by some form of health insurance, up from 81.6 percent in 1998 (calculated from table 1). As a result, 198.6 million Americans under age 65 had health insurance coverage in 1999, while 42.1 million were uninsured. The percentage of Americans under age 65 without health insurance coverage declined from 18.4 percent in 1998 to 17.5 percent in 1999 (table 1 or chart 8). Not only is this the first significant decline in the percentage of uninsured Americans since at least 1987, but it is also the first time that the number of uninsured Americans has declined.

The main reason for the decline in the number of uninsured Americans appears to be the strong economy and low unemployment. More workers and their dependents are being covered by employment-based health insurance because of a strong economy. Between 1998 and 1999, the overall percentage of Americans under age 65 covered by employment-based health insurance increased from 64.9 percent to 65.8 percent, continuing a longer-term trend that started between 1993 and 1994 (table 1).

While the majority of Americans under age 65 with health insurance in 1999 received coverage through an employment-based health plan, 34.1 million Americans received health insurance from public programs, and an additional 15.8 million purchased it directly from an insurer. Twenty-five million Americans participated in the Medicaid program,[2] and 6.5 million received their health insurance through the Tricare and CHAMPVA[3] programs and other government programs designed to provide coverage for retired military members and their families.

Prior to 1999, the uninsured population grew for a number of reasons. For instance, between 1987 and 1993, this increase can be attributed to the erosion of employment-based health benefits.[4] While public programs covered an increasing percentage of Americans prior to 1993, the growth in these programs was not enough to offset the erosion in employment-based health insurance, so more individuals were uninsured. In contrast, between 1993 and 1998, the portion of Americans covered by employment-based health insurance increased, but the percentage of those without health insurance coverage also continued to grow. During this period, the decline in *public* sources of health insurance would mostly explain the increase in the uninsured population.

For example, the percentage of nonelderly Americans covered by Tricare or CHAMPVA declined from 3.8 percent to 2.9 percent between 1994 and 1998, and continued down to 2.7 percent in 1999, in large part due to downsizing in the military. Similarly, between 1993 and 1998, the percentage of nonelderly Americans covered by Medicaid (the federal-state insurance program for the poor) declined from 12.7 percent to 10.4 percent as welfare reform,

coupled with the strong economy, resulted in fewer people on the welfare roles and more former welfare recipients moving into private- and public-sector employment.

Despite expansions in the State Children's Health Insurance Program (S-CHIP), public health insurance coverage did not increase overall between 1998 and 1999. The percentage of nonelderly Americans covered by Medicaid and other government-sponsored health insurance coverage did not change between 1998 and 1999—remaining at 10.4 percent in 1999. While the data used in this paper currently do not allow researchers to count the number of children enrolled in S-CHIP, it appears that some children benefited from expansions in government-funded programs. Findings from the U.S. Census Bureau's Current Population Survey (CPS) indicate that the percentage of children in families just above the poverty level without health insurance coverage declined dramatically, from 27.2 percent uninsured in 1998 to 19.7 percent uninsured in 1999. Some of the decline can be attributed to expansions in Medicaid and S-CHIP. Between 1998 and 1999, the percentage of near-poor children covered by these programs increased from 39.3 percent to 40.5 percent. However, it appears that expansions in employment-based health insurance and individually purchased coverage had an even larger effect than expansion of S-CHIP. Specifically, the percentage of near-poor children covered by an employment-based health insurance plan increased from 30.5 percent to 34.5 percent between 1998 and 1999, while the percentage of near-poor children covered by individually purchased plans increased from 7.8 percent to 10.3 percent.

Benefits Package

It is notable that the decline in the uninsured occurred at a time when health insurance costs were going up. Health insurance cost inflation has been increasing since 1998. According to data from a recent study (Gabel et al., 2000), health insurance costs increased 8.3 percent for all firms between spring 1999 and spring 2000, and they increased 10.3 percent for smaller firms (with 3–199 workers) (chart 9). When health care costs increase, the percentage of Americans covered by an employment-based health insurance plan is expected to decline, with employers shifting the cost of coverage onto workers or even dropping coverage completely. But as discussed above, more workers and their dependents were covered by employment-based health insurance coverage in 1999 than in 1998. In fact, employers have not been shifting the cost onto workers. An annual survey by William M. Mercer indicates that the worker share of the premium has been unchanged since 1993 (table 2). In contrast, an annual survey by the Kaiser Family Foundation and the Health Research and Educational Trust (Gabel et al., 2000) found a slight reduction between 1996 and 2000 in the percentage of the premium workers were required to pay (chart 10). While the two studies report different findings, both support the observation that employers have not started to shift recent cost increases onto workers by decreasing the employer share of the premium.

The strong economy and low unemployment have had an affect not only on the likelihood that an employer offers health benefits and the percentage of the premium that workers pay but also on certain aspects of the benefits package. According to data from the Bureau of Labor Statistics, employers and insurers have been raising lifetime benefit limits. The percentage of workers with a lifetime limit under $1 million has declined, while the percentage with a lifetime limit either at $1 million or above $1 million has increased (chart 11). Furthermore, the percentage of workers with no lifetime limit also has increased. Employers and insurers also have been increasing their share of coinsurance and lowering deductibles. The percentage of workers in non-health maintenance organization (HMO) plans with 80 percent coinsurance has declined while the percentage with 90 percent coinsurance or no coinsurance has increased (chart 12). Similarly, the percentage of workers in non-HMO plans with no deductible has increased (chart 13). More recent data than that provided in charts 11 through 13 show that the trend toward lowering deductibles has continued through 2000, except for point of service (POS) and preferred provider organization (PPO) out-of-network deductibles (chart 14).

Retiree Health Benefits

Retiree health benefits were originally offered in the late 1940s and the 1950s, when business was booming and there were very few retirees in relation to the number of active workers. The benefits emerged as part of collective bargaining agreements, and employers were willing to provide them because the cost was such a small proportion of total compensation.

With the enactment of Medicare in 1965, the employer's cost obligation declined significantly, because employers were able to integrate their retiree health benefit programs with Medicare. In more recent years, however, the changing demographics of the work force, coupled with increasing life spans and rising health care costs, have left many employers with rising retiree-to-active-worker ratios, and have increased employers' retirement liabilities. In December 1990, the Financial Accounting Standards Board (FASB) approved Financial Accounting Statement No. 106 (FAS 106), "Employers' Accounting for Postretirement Benefits Other Than Pensions." FAS 106 dramatically changed the way most private companies accounted for their retiree health benefits. It required companies to record unfunded retiree health benefit liabilities on their financial statements in order to comply with generally accepted accounting standards, beginning with fiscal years after December 15, 1992. FAS 106 also required employers to accrue and expense certain future claims' payments as well as actual paid claims. The recognition of new liabilities and expenses was unappealing to many companies.

As a result of FAS 106, many employers began a major overhaul of their retiree health benefits program. Some dropped the benefits completely. An annual survey of employers with 500 or more workers shows that the percentage offering health benefits to early retirees declined from 46 percent in 1993 to 35 percent 1999 (chart 15). In addition, a survey of employers with (mostly) 1,000 or more workers shows that the percentage offering health benefits to early retirees declined from 88 percent in 1991 to 76 percent in 1998 (chart 16). The rate at which retiree health benefits are offered is higher in chart 16 than in chart 15 because larger firms are more likely to offer retiree health benefits. In fact, the "drop" rate is lower among employers with 1,000 or more employees than among the sample with 500 or more employees.

The data presented in charts 15 and 16 actually overstate the extent to which employers are dropping retiree health benefits. When broad cross sections of employers are studied over time, it appears that employers are dropping retiree health benefits. However, new large employers most likely never offered retiree health benefits in the first place. Thus, the cross sections that include these new employers are not examining employer behavior over time as much as they are providing snapshots of the availability of retiree health benefits.

An analysis of a constant sample of employers (Hewitt, 1999) shows that there has been a decline in the availability of retiree health benefits, but it was not as large as that portrayed in chart 16. The important point is that although employers are not necessarily dropping retiree health benefits, fewer workers will have them available when they retire because the work force appears to be moving away from firms that offer benefits to firms that do not.

Most employers continuing to offer retiree health benefits have made changes in the benefit package. The most common change is in cost-sharing provisions, with employers asking retirees to pick up a greater share of the cost of coverage. In 1999, 42 percent of employers with 500 or more workers offering retiree health benefits required retirees to pay 100 percent of the premium for coverage, up from 31 percent of employers in 1997 (chart 17). While there is no doubt that fewer employers offer retiree health benefits today and that the percentage of those offering coverage continues to decline, it is not clear that fewer retirees are covered by health insurance. According to data from the Current Population Survey (CPS), the percentage of early retirees covered by retiree health benefits may have increased slightly between 1994 and 1999 (chart 18).[5] Overall, there have been no statistically significant changes in sources of health insurance coverage for early retirees since 1994. In addition, the likelihood of their being uninsured remains statistically unchanged since 1994.[6]

The apparent inconsistency between fewer employers offering retiree health benefits and workers not necessarily losing retiree health benefits can be explained, in part, by recent changes in the labor force. Contrary to popular belief, the percentage of workers employed by large firms has not been declining. In fact, it may be rising. According to the data in chart 5, the percentage of workers employed by firms with 1,000 or more workers increased from 27 percent in 1994 to 29 percent in 1999. It is true that small employers are creating jobs and that large employers have downsized, but when small employers create jobs they often become large employers and thus are able to add employee benefits to their compensation packages. On the other hand, when large firms downsize, they often remain large firms, and former employees from these firms often take jobs with other large employers. So while

fewer employers are offering retiree health benefits, the decline may be offset by the movement of workers from small firms to large firms.[7]

Ultimately, it may be a few more years before we truly understand how workers and retirees will be affected by cutbacks in retiree health benefits. Many workers may never qualify for retiree health benefits because their employers offer them only to workers hired before a specific date.

Trend Drivers

Two factors will likely play primary roles in driving the future of the employment-based health benefits system: health benefit costs and labor market conditions.

Health Benefit Costs

During the late 1980s and early 1990s, health care costs increased faster than the overall consumer price index (CPI) and faster than the medical portion of the consumer price index (MCPI). In some years, these costs increased nearly 20 percent for some employers, cost increases that many private employers simply did not want to pay (Fox, 1998). For example, in 1988 overall inflation according to the CPI was 4 percent, the MCPI was 7 percent, but employer spending on health benefits rose 19 percent (chart 19).

Health care costs increased for a number of reasons. Under the traditional fee-for-service system, health care providers had no financial incentive to provide health care services in the most efficient setting. Furthermore, technological innovation, improved treatments, consumer activism, quality shortfalls, administrative inefficiencies, and an aging population all contributed to rising costs. While the growth rate in employer spending on health benefits declined after 1988, it continued to outpace the CPI and the MCPI, and remained above 10 percent. As a result, employers looked for alternatives to fee-for-service health benefits. Managed care (which by then had existed for decades, although mostly in the West and Pacific Northwest) promised to control costs through improved coordination and efficiency by reducing the inappropriate or unnecessary use of health care services, reviewing proposed health care services before they were provided, increasing access to preventive care, and maintaining and improving the quality of care.

Managed care, it seems, was able to reduce the rate at which health care costs were increasing. According to chart 19, employer costs for health benefits barely changed between 1994 and 1997. One major factor that led to the reduction in health benefit cost increases was migration to lower-cost managed care plans. Managed care plans also altered the incentive structure from a fee-for-service or cost-plus reimbursement scheme to a payment scheme in which health care providers were paid either a salary, a fixed amount per patient (a “capitated” basis), or a prenegotiated discount on fee-for-service charges. In return, health care providers were guaranteed high volume because they would be providing health care services to a large group of subscribers. Also, health providers accepted more ”risk” because they had to compete with an oversupply of both physicians and hospital beds. Managed care plans also shifted some types of care from costly inpatient settings to less costly outpatient settings. Currently, health benefit costs are once again rising faster than the CPI and MCPI, and many employers are reluctant to absorb the cost increases. Health benefit costs are increasing nearly 10 percent annually (chart 19), and are expected to continue increasing at this rate (if not more) in the future. There are several reasons why these costs will continue to increase:

First, the U.S. population is aging. While this does not have a major impact on health benefit costs on a year-to-year basis, it will affect spending over time because health care use increases with age (chart 20).

Second, new technology, including pharmaceuticals and imaging, will continue to be developed. New technology for the delivery of medical services either replaces existing technology, which was usually less expensive, or brings something new to the medical field that did not exist in the past, thereby adding costs which also did not exist. Third, demand for services continues to increase. Consumers and providers tend to demand the “latest and

greatest" services, and information provided on the Internet about previously "unknown" treatments and direct-to-consumer advertising have also induced demand for health care services.

Fourth, health care providers and insurers have been consolidating. Health care providers are now in a better position to negotiate fees with insurers and employers, and insurers are also in a better position to negotiate with employers.

Fifth, the managed care backlash may have resulted in health insurers relaxing restrictions on access to health care services.[8] Furthermore, in 1998, growth in health HMOs ceased, and POS plans lost market share. It appears that consumers and employers are voting with their feet. The combination of the managed care backlash and the return of health care cost inflation is in part to blame for the stagnation of HMOs and POS plans. Finally, the strong economy likely had an impact on enrollment and health care spending, resulting in more employees enrolled in less-restrictive PPOs as they enjoy rising real income and become able to pay for better benefits and additional health care services. Employers offer health benefits as a form of compensation in order to recruit and retain qualified employees and as a way to improve employee productivity. Locking employees into a plan that limits choice and perhaps reduces their satisfaction may be less costly, but it may not be cost-effective in terms of an employer's recruitment, retention, and lost productivity costs.

Rising health benefit costs will impact the percentage of workers (and dependents) with health benefits in two ways. It is likely that small employers that cannot afford health benefits will simply drop them. In contrast, large employers will probably not drop health benefits, but they will respond in other ways. They may increase the employee share of the premium, or they may reduce the benefits package. This likely will result in fewer workers taking health benefits that are offered to them.

Recent evidence, discussed above and presented in chart 6, shows that the percentage of small employers (with fewer than 200 employees) offering health benefits has been increasing. While the percentage of large employers offering health benefits has remained essentially unchanged, that is because nearly all large employers already offer health benefits. In addition, the percentage of the premium that workers have been asked to pay has declined or remained constant (chart 10 and table 2), while the benefits package has been improving (charts 11–14). Other recent evidence, also discussed above and presented in charts 9 and 19, shows that the cost of providing health benefits to employees has been increasing. Economists, and others, assume that when the price of a product increases, consumers will demand less of that product. If this is true, then why would more small employers offer health benefits and make the benefits package richer at a time when the cost of providing those benefits was increasing? The answer is that the relationship between the provision of health benefits to employees and the cost of providing those benefits is not simple. It is complicated by other factors, such as labor market conditions.

Labor Market Conditions

The unemployment rate has been declining since 1992. In that year, the unemployment rate was 7.5 percent, compared with 4 percent in 2000 (chart 21). Low unemployment drives more employers to offer health benefits and to improve the benefits package they offer, t in order to attract employees. As mentioned in the introduction, health benefits were first offered to employees as a means of recruitment and retention during the labor market shortage of World War II. Health benefits can be thought of as just one form of total compensation. When employers are competing for employees, total compensation is bid up. As a result, health benefits, a major part of total compensation, are changed to attract and retain workers. Today, many small employers understand the value of offering health benefits. A recent study found that roughly three-quarters of small employers offering health benefits reported that these benefits had a positive impact on recruitment, retention, employee attitude, and performance (chart 22).

Between 1998 and 1999, the percentage of Americans with employment-based health insurance benefits increased, and the benefits package improved, despite the fact that the cost of providing those benefits was rising. It is likely that low unemployment rates had a stronger impact on employer behavior toward health benefits than the cost of providing these benefits.

Outlook

As long as health benefit costs continue to increase, employers will seek ways to reduce these costs. However, as long as unemployment remains low, employers will likely be unable to significantly modify existing health benefit programs. With low unemployment, the cost of not providing health benefits, such as the cost of recruiting and retaining employees, often outweighs the cost savings that can be attributed to cutting back on health benefits.

The Economy

Whether the slowing economy has an impact on employment-based health benefits depends on a number of factors. Massive layoffs have yet to have a substantial impact on the unemployment rate. While the unemployment rate jumped from a 30-year low of 3.9 percent in October 2000 to 4.2 percent in January 2001, it remained at 4.2 percent in February—still a very low level of unemployment. In contrast, the combination of a slowing economy, rising health care costs, and worker uncertainty about the future may make it easier for employers to modify health benefit programs. Even with low unemployment, if employees fear that they could lose their jobs, employers may have more flexibility to reduce health benefits (and other components of total compensation) in order to reduce costs in a slowing economy.

The release of the March 2001 CPS in Fall 2001 may add to the confusion over the impact of rising health benefits costs on employment-based health benefits. When these findings are released, the data for 2000 are expected to show that the number of uninsured Americans continued to decline. The drop may even be larger than the 1.7 million decline experienced between 1998 and 1999. As mentioned above, between 1998 and 2000, the percentage of firms with 3–199 employees that offered health benefits increased (Gabel et al., 2000). In addition, S-CHIP will continue to expand health insurance coverage. This combination of more employers adding health benefits and more children covered by S-CHIP will result in continued expansion of health insurance coverage. This decline in the uninsured and rise in employment-based health insurance benefits may be confusing because the data are often misinterpreted as representing the current time period rather than the period nearly two years prior to its release.

The Uninsured

It is also worth noting that while the uninsured declined between 1998 and 1999, more than 42 million Americans continue to be uninsured. Even if the number drops again later this year, when the 2000 data are released, it is likely that 40 million Americans will still be uninsured—more than 15 percent of the population. As long as the economy is strong and unemployment is low, employment-based health insurance coverage will expand and the uninsured population will gradually decline. However, even if the United States experiences five more years of declines in the uninsured similar to the decline that occurred between 1998 and 1999, 34 million Americans would still be uninsured in 2005 (chart 23). In contrast, if the economy continues to weaken and health benefit costs continue to increase, the uninsured population is likely to start to increase again. Even those who keep their jobs would be affected, as small employers are likely to drop health benefits and large employers are likely to shift the cost of coverage onto workers, resulting in fewer workers accepting coverage. If the uninsured rate returns to its 1999 level of 17.5 percent of the nonelderly population, 45 million Americans would be uninsured in 2005. In contrast, if the downturn in the economy is severe and uninsured individuals represent 25 percent of the population under age 65, 63 million Americans would be uninsured.

Public Policy

The rising cost of health benefits may not be the only factor resulting in the future erosion in employment-based health insurance benefits. Public policy can play a strong role as well. For the past few years, Congress has been debating proposed legislation known as the “Patient Bill of Rights.” Employers and insurers generally agree that most of the proposed provisions would not have a significant impact on benefit costs; however, provisions that would make insurers, and potentially employers, liable for medical decisions have raised many questions about how this increased liability and the possibility of resolving many medical decisions and benefit issues in state or federal courts will impact health benefit costs.

The Employee Retirement Income Security Act of 1974 (ERISA) established the federal government as the primary regulator of private-sector employee benefit plans (Copeland and Pierron, 1998). The number of individuals under age 65 with health benefits subject to ERISA was approximately 128.2 million in 1999 (Copeland, 2001). Patient protection legislation, if passed, would significantly modify ERISA. Managed care plans have been criticized because of the way in which they are able to operate under ERISA. Under traditional fee-for-service plans, the most prevalent type of plan at the time ERISA was enacted, the denial of a claim is typically not as critical as it is in a managed care setting, because claims are generally paid or denied after the treatment has taken place. In a managed care setting, the dominant form of health plan enrollment today, most claims decisions are made prospectively through the utilization review process. This leads many to believe that a denial of coverage by a plan is the denial of care. Courts appear to be making distinctions between benefit determinations and administration, which are pre-empted by ERISA, and medical decisions outside of benefit determinations, which have increasingly not been pre-empted, although the courts have not settled the issue. In fact, the Supreme Court is currently seeking advice from the solicitor general on whether state laws requiring an independent review of medical necessity decisions made by a health plan conflict with ERISA.

Critics of ERISA believe that denial of coverage is equivalent to the denial of care, and that administrators of health plans make medical decisions and thus should be held responsible for those decisions through malpractice liability (Copeland and Pierron, 1998). Once health plans are held liable, critics argue that the quality of care provided will improve. Sponsors of health plans counter that when a health plan makes a benefit determination, it is interpreting a contract between the health plan and the plan sponsor on what benefits are covered under that contract. The health plan is not preventing that participant from receiving care or telling the participant not to get the care but simply stating whether the contract covers the benefit. Therefore, malpractice law would usually not apply.

Defined Contribution Health Benefits

Defined contribution (DC) health benefits are emerging as an alternative to the current employment-based health benefits system.[9,10] DC health benefits often are mentioned in the context of enabling employers to control their outlay for health benefits by avoiding increases in health care costs. DC health benefits are also often mentioned in the context of giving individuals more control of their health care dollar and the design of their benefits. These benefits have also been discussed in terms of e-commerce: The growth of the Internet can enable employers to move to a benefits structure that takes full advantage of new technology.

Employers already are considering using a DC approach to health benefits in response to rising health care costs. Furthermore, consideration of a DC approach may accelerate if Congress were to pass patient protection legislation. These plans essentially would change employer thinking from trying to manage the range of covered health care services and utilization through the way benefits are designed to setting limits on employer contributions, and, in some cases, requiring employees to design their own benefit plans. Thus, DC health benefits could be an effective way of controlling health care costs for an employer.

DC health benefits are also often mentioned as a means of giving individuals more control of their health care dollar and the design of their benefits. As a result, under this type of plan, individuals (and providers) should have more control over medical necessity decisions. While there are several types of DC arrangements, the most important difference among them is whether the employer or employee controls how contributions are used to pay for health care services. One option would have employers provide employees with a defined amount of money, which the employee would then use to purchase benefits from a range of plans chosen by the employer. Under another option, an employer would create an account and the employee would buy services with funds from the account. A person could supplement the employer's contribution with his or her own funds and, depending on the type of plan, purchase a richer benefit plan or more services.

DC-type health plans have existed as cafeteria plans since the 1980s. A cafeteria plan gives each employee the opportunity to determine the allocation of his or her total compensation (within employer-defined limits) among

the various employee benefits that are offered (primarily retirement or health). The Federal Employees Health Benefits Program (FEHBP) has operated as a DC-type health plan for years.

Today, most types of DC health plans currently being discussed could be provided within the current employment-based health insurance system, with or without the use of cafeteria plans. They could also allow employees to purchase health insurance directly from insurers, or they could drive new technologies and new forms of risk pooling through which health care services are provided and financed.

DC health plans have also been discussed in the context of e-commerce: The growth of the Internet can enable employers to move to a benefits structure that takes full advantage of new technology. The Internet would facilitate plan selection during open enrollment season, and would also provide tools and resources that would enable employees to make informed decisions about health plans and health care providers. These new technologies may also give rise to new types of products and may enable employers to assume new roles more in line with emerging health consumerism. New technology may also enable new types of health plans to emerge, much as the Internet already is giving individuals information about various health care services that they are using to challenge medical and benefit decisions made by health care providers and health plans.

Health care costs could either decline or increase in a DC health care environment. For instance, some employees may choose less extensive benefits than those currently provided by their employer. If health insurance currently acts to induce demand for health care services, utilization of services could decline. Employees may choose health plans that forgo preventive and routine health care in order to save money. However, it should be noted that preventive and routine health care services sometimes detect conditions and diseases at early stages, when both the treatments and costs are less intense. If conditions and diseases are first being treated at later stages, the cost of providing health care may actually be higher in the long run. Furthermore, if it is less costly to treat a disease in its early stage, there is an opportunity cost of late detection in the form of resources being devoted to health care that could be more productive elsewhere.

On the other hand, some employees might choose more extensive benefits and ultimately pay more for health insurance. If health insurance currently acts to induce demand for health care services, utilization of services could increase. This concept is known as moral hazard—meaning individuals demand a greater quantity of health care services when health insurance pays for at least part of the cost of receiving care. Findings from the RAND Health Insurance Experiment indicate that as coinsurance rates increased, utilization and expenditures for health care services declined (Manning et al., 1987). In addition, a more recent study found that Medicare beneficiaries will forgo medically necessary drugs when out-of-pocket costs for those drugs increase (Adams et al., 2001). Employers might benefit from DC health plans if they use them to cap their cost. If the cost of health insurance increases faster than real wages, or faster than employer contributions, employers might save money in the long run but the increased use of DC health plans might also result in care being deferred, lost productivity and economic output, and higher costs in the long run.

Conclusion

The provision of health care services may have advantages that go beyond simply improving health. Research has shown that advances in medical technology that have improved life expectancy have had a significant positive impact on the economy. Murphy and Topel (2000) found that improvements in life expectancy due to technological innovations in medical care added $2.4 trillion per year (in 1992 dollars) to national wealth between 1970 and 1990. There could be a cost to society in the form of forgone economic output if mortality is higher because fewer Americans receive quality health care services.

The degree to which employers can shift the cost of coverage onto employees will vary with the strength of the economy and the labor market. Because health benefits are a form of total compensation, employers will not be able to cut benefits, thereby cutting total compensation, when unemployment levels are low. Today, unemployment rates are running just over 4 percent, and more small employers are adding health benefits to recruit and retain

employees even when their health care costs are increasing more than 10 percent annually (KFF/HRET, 2000). This is further evidence that employers cannot simply cut back on their contributions to health benefits when health care expenditures are increasing, because any savings from reducing health benefit costs will likely be offset by higher recruitment and retention costs.

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Endnotes

[1] A 20-year-old student working part-time could be covered by their parent's employment-based health benefits plan.

2 The estimate for Medicaid likely also includes children enrolled in the S-CHIP program. It is currently impossible to obtain

separate estimates of Medicaid and S-CHIP from the CPS. Medicaid (and Medicare) estimates are under-reported in the CPS, according to comparisons of these data with enrollment and participation data provided by the Health Care Financing Administration (HCFA) (Bennefield, 1998).

[3] Tricare (formerly known as CHAMPUS) is a program administered by the Department of Defense for military retirees as well as families of active duty, retired, and deceased service members. CHAMPVA, the Civilian Health and Medical Program for the Department of Veterans Affairs, is a health care benefits program for disabled dependents of veterans and certain survivors of veterans.

[4] See Fronstin and Snider (1996/97) for an analysis of the decline in employment-based health insurance between 1988 and 1993.

[5] The change in the likelihood of being covered by retiree health benefits was not statistically significant; furthermore, the survey does not allow researchers to distinguish between retiree health benefits and coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) coverage.

[6] Some persons in the CPS report their main activity as “Ill or Disabled” when they may in fact be retired. Similar to the findings for retirees, there was no significant change in insurance coverage for the ill and disabled between 1994 and 1999.

[7] The seemingly inconsistent trends may also be due to more retirees accepting COBRA coverage. As mentioned already, it is impossible to distinguish between COBRA coverage and retiree health benefits in the March CPS.

[8] Unitedhealthcare, as an example, ended its practice of requiring pre-authorization for certain types of care in 1999. See www.unitedhealthcare.com/press/991109ccoord.html

[9] Defined contribution health benefits have also been referred to as “defined care,” “consumer driven,” and “consumer-centric.”

[10] For a more detailed treatment of changes to the employment-based health insurance benefits system see Fronstin (2001a) and Fronstin (2001b).

Table 1

Nonelderly Americans with Selected Sources of Health Insurance Coverage, 1987–1999

	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
							(millions)						
Total Population	214.4	216.6	218.5	220.6	222.9	225.5	228.0	229.9	231.9	234.0	236.2	238.6	240.7
Employment-Based Coverage	148.5	149.4	149.8	147.7	147.7	145.9	144.9	146.3	147.9	149.8	151.7	154.8	158.4
Own name	72.5	73.5	74.0	73.1	73.1	71.7	74.9	75.2	75.9	76.9	77.4	79.1	80.3
Dependent coverage	75.9	75.9	75.8	74.7	74.6	74.3	69.9	71.1	72.1	72.9	74.3	75.7	78.1
Individually Purchased	14.3	13.5	14.5	14.3	13.6	14.6	16.6	16.4	16.0	16.0	15.8	15.5	15.8
Public	28.5	28.8	28.7	31.9	34.4	36.0	38.1	38.9	38.4	37.4	34.9	34.2	34.1
Medicare	3.1	3.2	3.2	3.4	3.5	3.9	3.7	3.7	4.1	4.6	4.7	4.8	4.8
Medicaid	18.4	18.9	19.2	22.4	24.8	26.5	29.0	28.7	29.0	28.2	26.0	24.9	25.0
Tricare/CHAMPVA[a]	8.5	8.2	7.9	7.9	7.9	7.5	7.4	8.7	7.4	6.8	6.6	6.8	6.5
No Health Insurance	31.8	33.6	34.3	35.6	36.3	38.3	39.3	39.4	40.3	41.4	43.1	43.9	42.1
							(percentage)						
Total Population	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Employment-Based Coverage	69.2	69.0	68.6	67.0	66.3	64.7	63.5	63.6	63.8	64.0	64.2	64.9	65.8
Own name	33.8	33.9	33.9	33.1	32.8	31.8	32.9	32.7	32.7	32.9	32.8	33.1	33.4
Dependent coverage	35.4	35.0	34.7	33.8	33.5	32.9	30.7	30.9	31.1	31.2	31.5	31.7	32.4
Individually Purchased	6.7	6.3	6.6	6.5	6.1	6.5	7.3	7.1	6.9	6.8	6.7	6.5	6.6
Public	13.3	13.3	13.2	14.5	15.5	16.0	16.7	16.9	16.6	16.0	14.8	14.3	14.2
Medicare	1.4	1.5	1.5	1.6	1.6	1.7	1.6	1.6	1.8	2.0	2.0	2.0	2.0
Medicaid	8.6	8.7	8.8	10.2	11.1	11.8	12.7	12.5	12.5	12.1	11.0	10.4	10.4
Tricare/CHAMPVA[a]	4.0	3.8	3.6	3.6	3.5	3.3	3.3	3.8	3.2	2.9	2.8	2.9	2.7
NoHealthInsurance	14.8	15.5	15.7	16.1	16.3	17.0	17.3	17.1	17.4	17.7	18.3	18.4	17.5

Source: Employee Benefit Research Institute Analysis of the March 1988-2000 Current Population Survey.
Note: Details may not add to totals because individuals may receive coverage from more than one source.
[a]TRICARE (formally known as CHAMPUS) is a program administered by the Department of Defense for military retirees as well as families of active duty, retired, and deceased service members. CHAMPVA, the Civilian Health and Medical Program for the Department of Veterans' Affairs, is a healthcare benefits program for disabled dependents of veterans and certain surivors of veterans.

Table 2

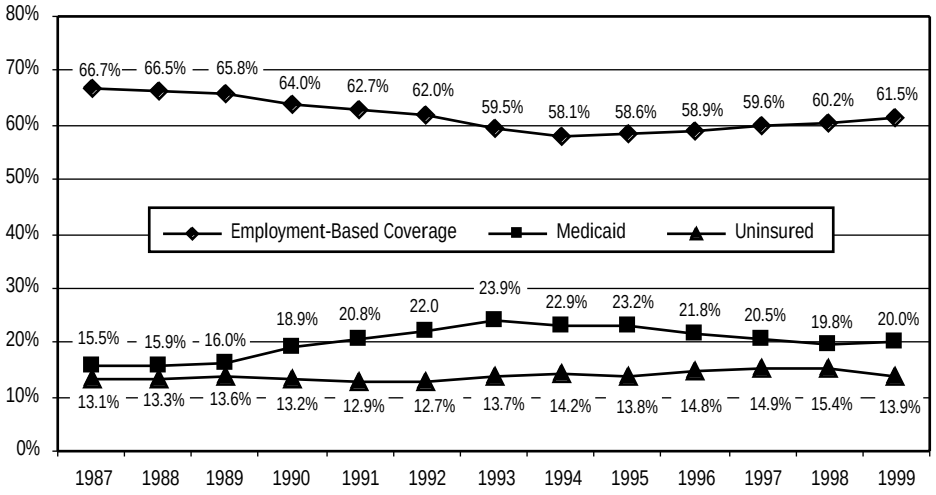
Average Percentage of Medical Plan Premium Paid by Employee in Firms of 500 or More Employees, by Plan Type, 1993–2000

	1993	1994	1995	1996	1997	1998	1999	2000
Indemnity								
Employee-only coverage	24%	20%	23%	24%	24%	22%	24%	23%
Family coverage	33	25	33	32	32	29	35	30
Health Maintenance Organization								
Employee-only coverage	23	22	22	22	23	23	22	22
Family coverage	33	29	35	33	34	36	34	33
Preferred provider organization								
Employee-only coverage	24	20	25	24	23	24	24	23
Family coverage	31	28	41	36	36	38	36	36
Point-of-Service								
Employee-only coverage	19	20	20	22	22	24	22	22
Family coverage	35	29	32	34	31	33	33	32

Source: William M. Mercer.

Chart 1

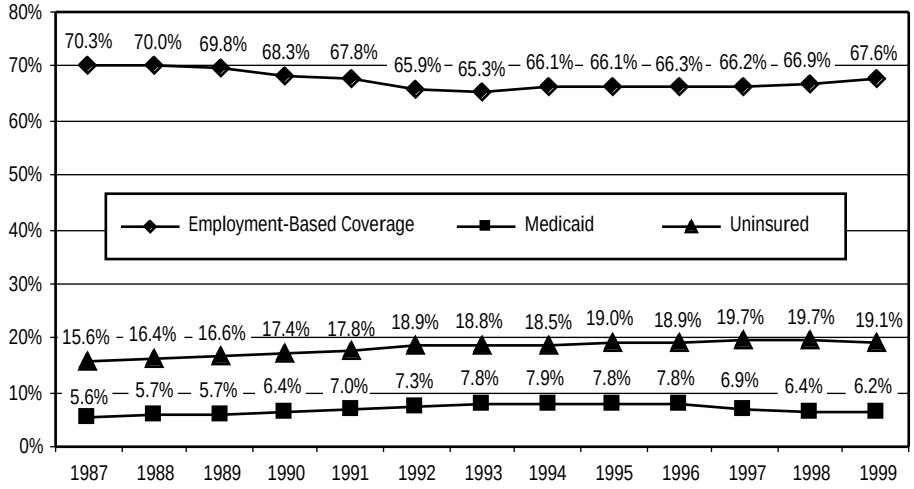
Percentage of American Children, Ages 0-17, With Employment-Based Health Benefits, Medicaid, and Without Health Insurance, 1987–1999



Source: Employee Benefit Research Institute estimates from the March 1988-2000 Current Population Survey.

Chart 2

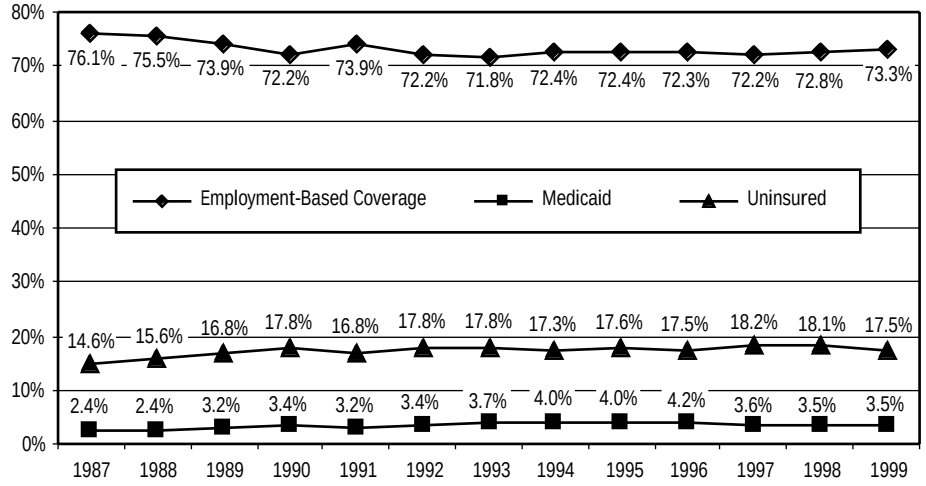
Percentage of American Adults, Ages 18–64, With Employment-Based Health Benefits, Medicaid, and Without Health Insurance, 1987-1999



Source: Employee Benefit Research Institute estimates from the March 1988–2000 Current Population Survey.

Chart 3

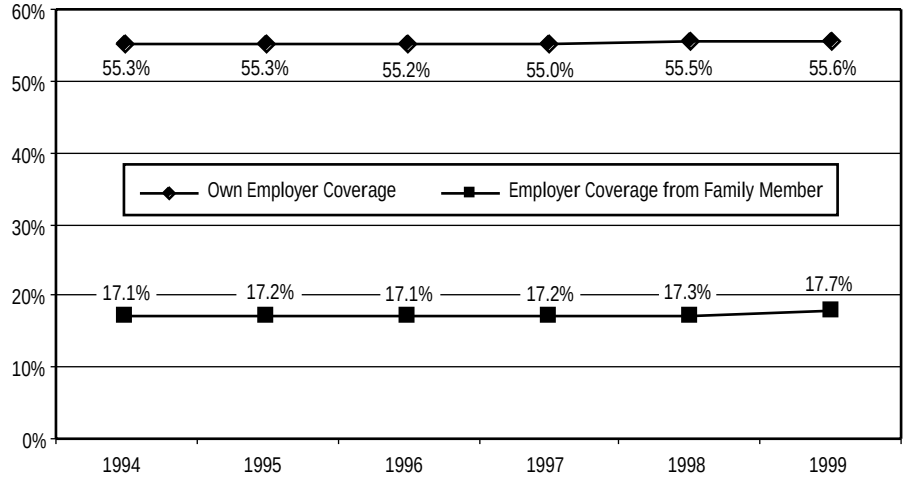
Percentage of Workers, Ages 18–64, With Employment-Based Health Benefits, Medicaid, and Without Health Insurance, 1987–1999



Source: Employee Benefit Research Institute estimates from the March 1988-2000 Current Population Survey.

Chart 4

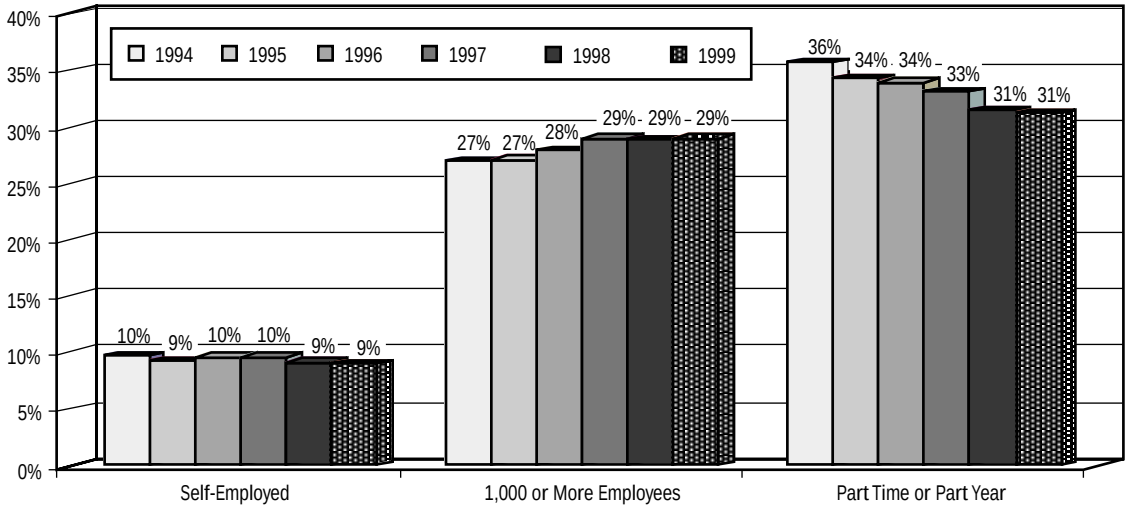
Percentage of Workers Ages 18–64 With Employment-Based Health Insurance Benefits, by Source of Coverage, 1994–1999



Source: Employee Benefit Research Institute estimates from the March 1995-2000 Current Population Survey.

Chart 5

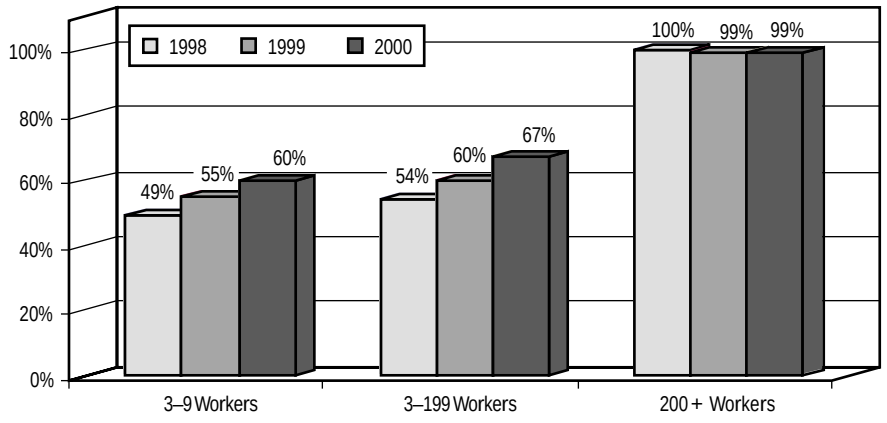
Percentage of Workers Employed in Large Firms, Self-Employed, Part-Time or Part-Year, 1994–1999



Source: Employee Benefit Research Institute estimates from the March 1995–2000 Current Population Survey.

Chart 6

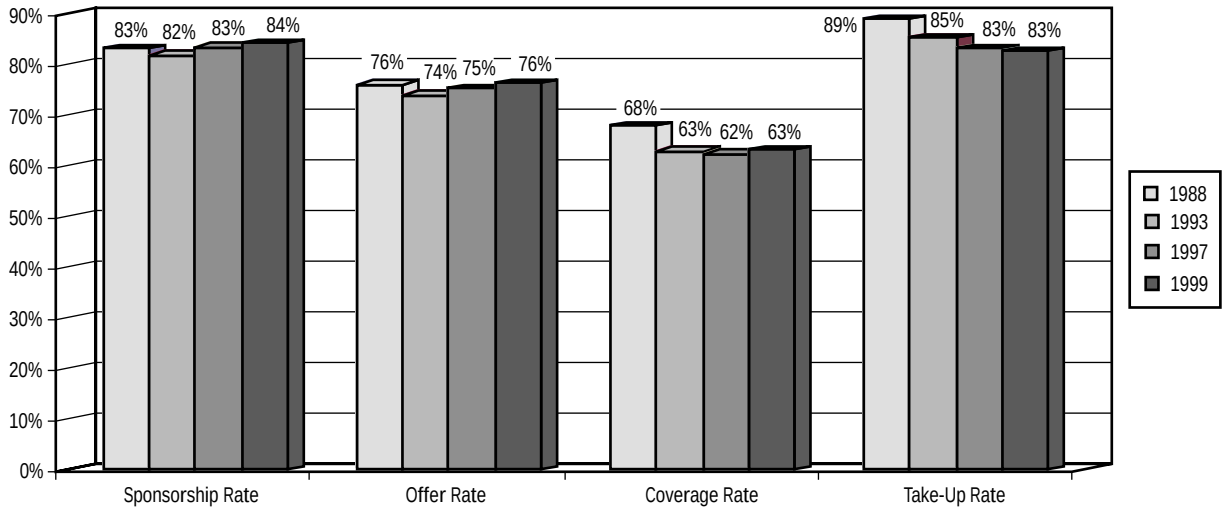
Percentage of Employers Offering Health Benefits, by Firm Size, 1998–2000



Source: Gabel et al., 2000.

Chart 7

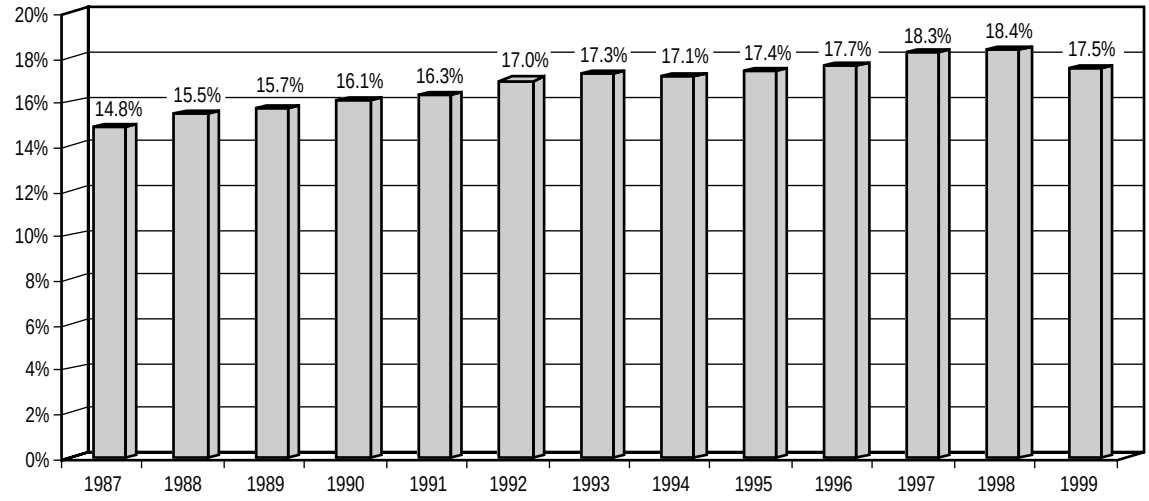
Employment-Based Health Insurance Benefits Sponsorship, Offer, Coverage, and Take-Up Rates among Wage and Salary Workers, Ages 18–64, 1988–1999



Source: Employee Benefit Research Institute estimates from the May 1988, April 1993, February 1997 and February 1999 Current Population Survey.

Chart 8

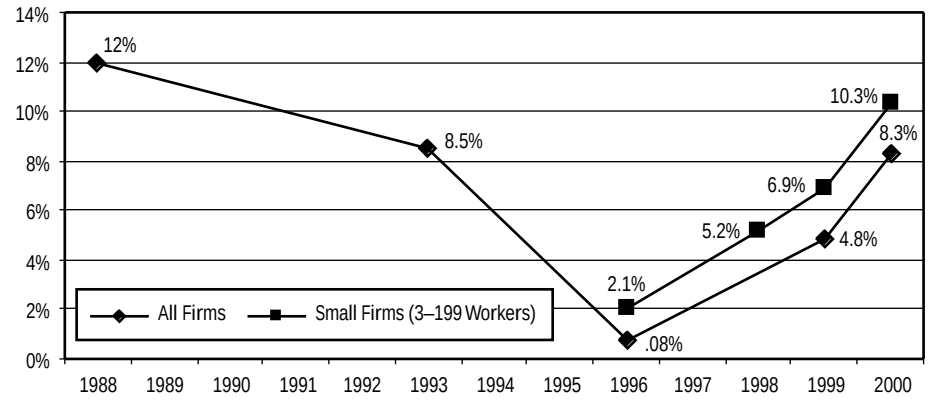
Percentage of Nonelderly Americans without Health Insurance, 1987–1999



Source: Employee Benefit Research Institute estimates from the March 1988–2000 Current Population Survey.

Chart 9

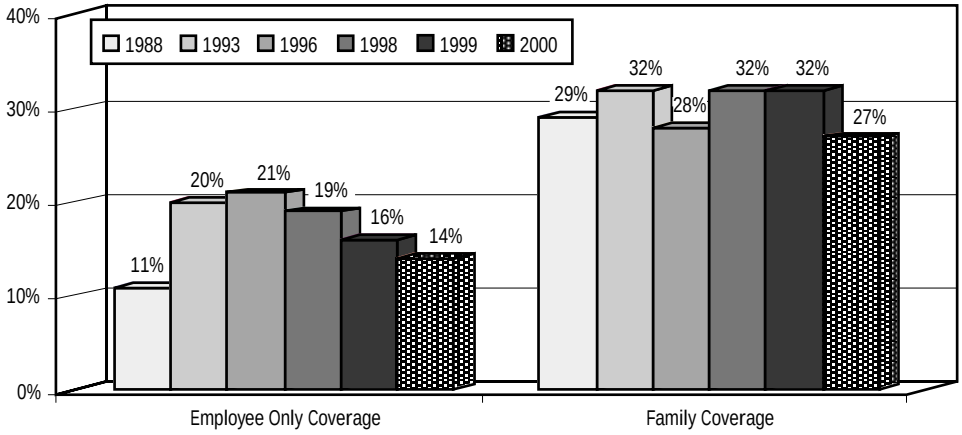
Premium Increases by Firm Size, 1988–2000



Source: Gabel et al. 2000.

Chart 10

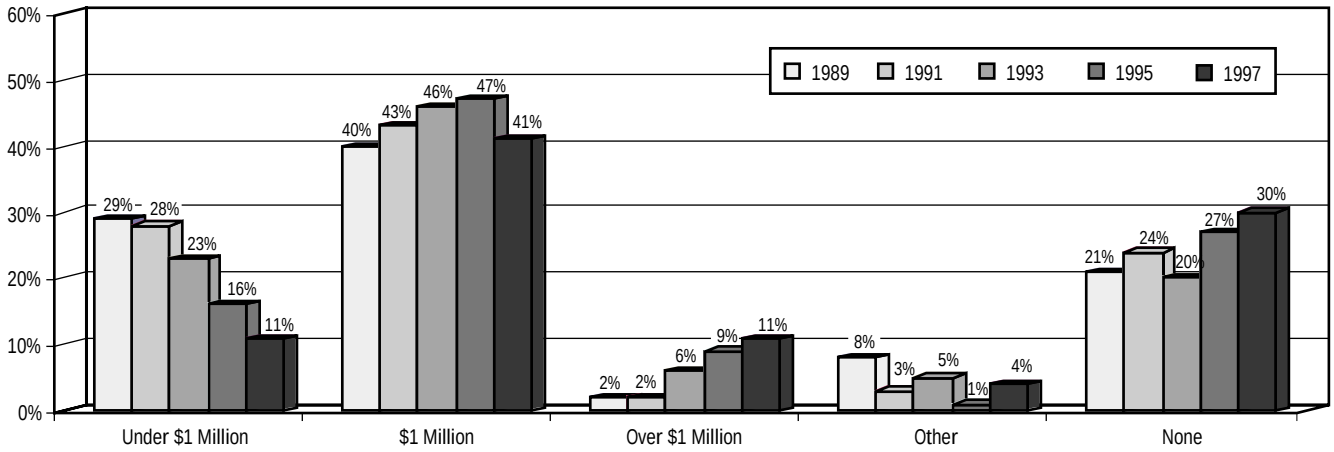
Percentage of Premium Paid by Workers for Health Benefits, 1988–2000



Source: Gabel et al. 2000.

Chart 11

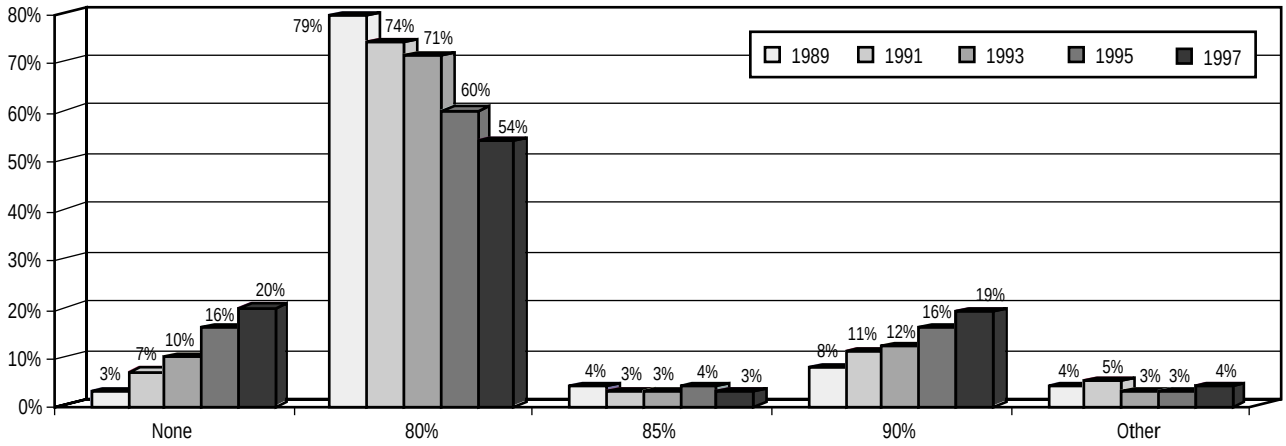
Percentage of Full-Time Employees in Medium and Large Private Establishments, Participating in Non-Health Maintenance Organization Plans, by Lifetime Maximum Limit Amount, 1989–1997



Source: Bureau of Labor Statistics.

Chart 12

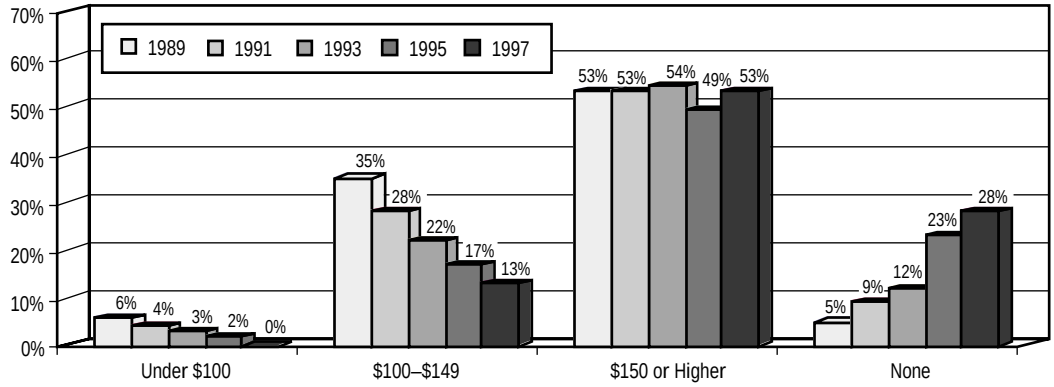
Percentage of Full-Time Employees in Medium and Large Private Establishments, Participating in Non-Health Maintenance Organization Plans, by Coinsurance Rate, 1989–1997



Source: Bureau of Labor Statistics.

Chart 13

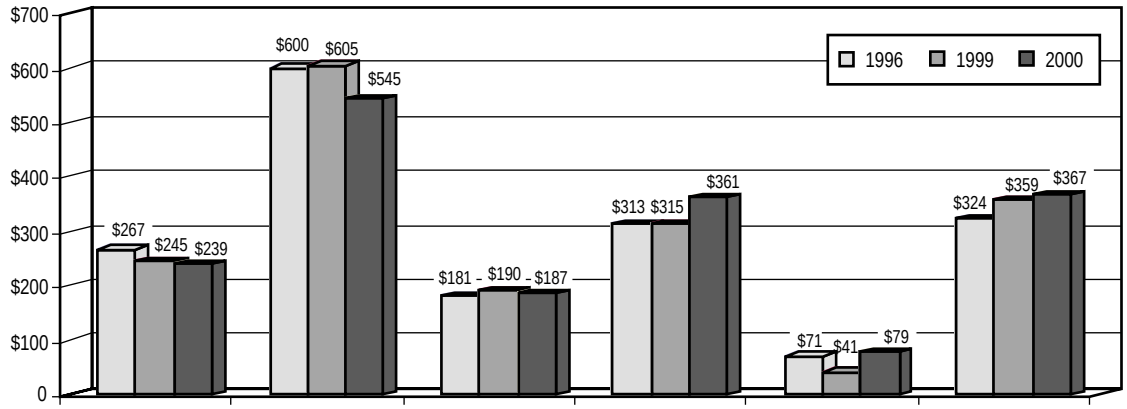
Percentage of Full-Time Employees in Medium and Large Private Establishments, Participating in Non-Health Maintenance Organization Plans, by Deductible Amount, 1989–1997



Source: Bureau of Labor Statistics.

Chart 14

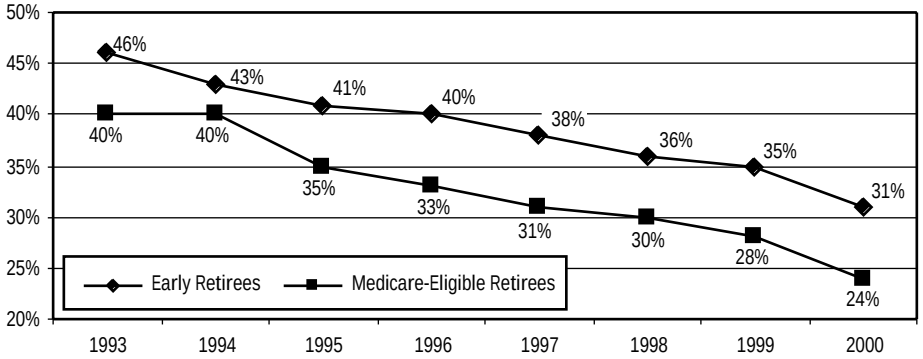
Average Annual Deductibles, by Plan Type, 1996–2000



Source: Gabel et al. 2000.

Chart 15

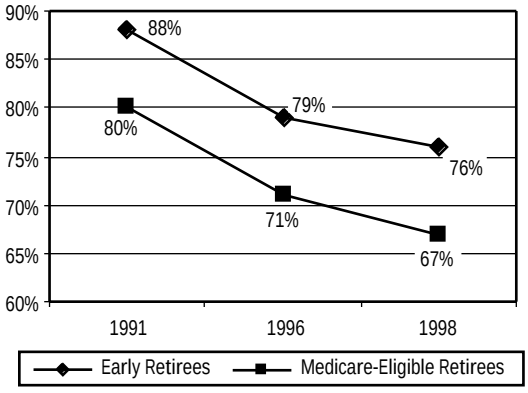
Provision of Retiree Health Benefits by Employers With 500+ Employees, 1993–1999



Source: William M. Mercer.

Chart 16

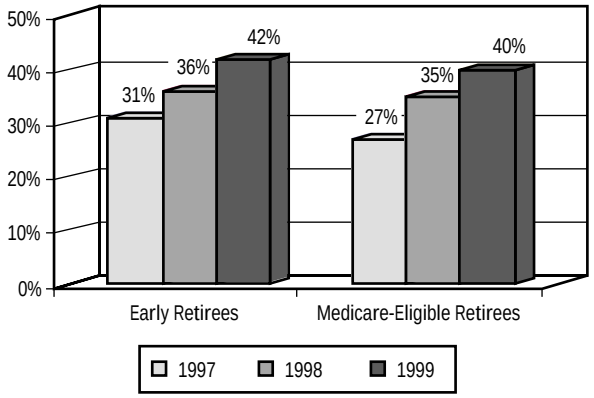
Provision of Retiree Health Benefits by Employers With 1,000+ Employees, 1991, 1996, and 1998



Source: McArdle et al., 1999.

Chart 17

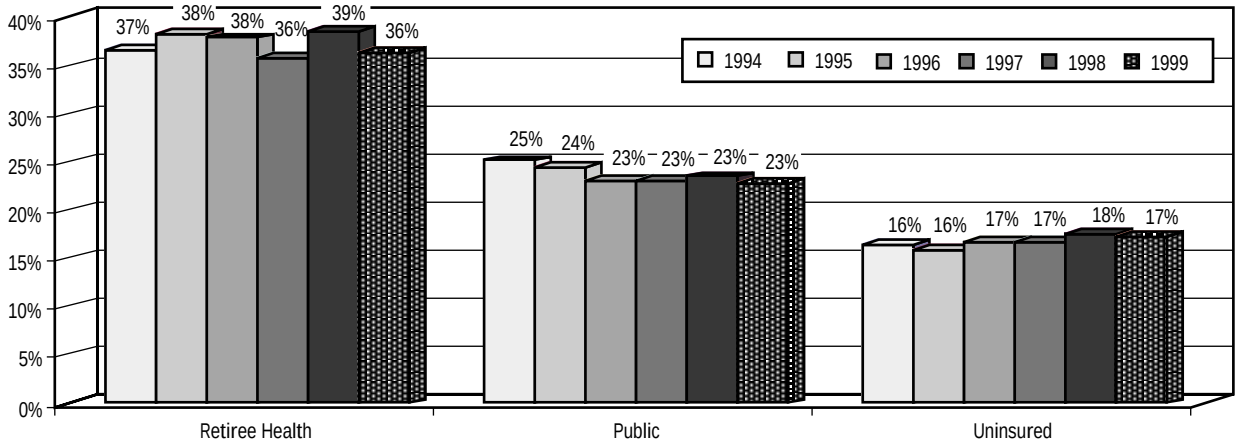
Percentage of Large Employers Requiring Retiree to Pay Full Cost of Retiree Health Benefits, 1997– 1999



Source: William M. Mercer.

Chart 18

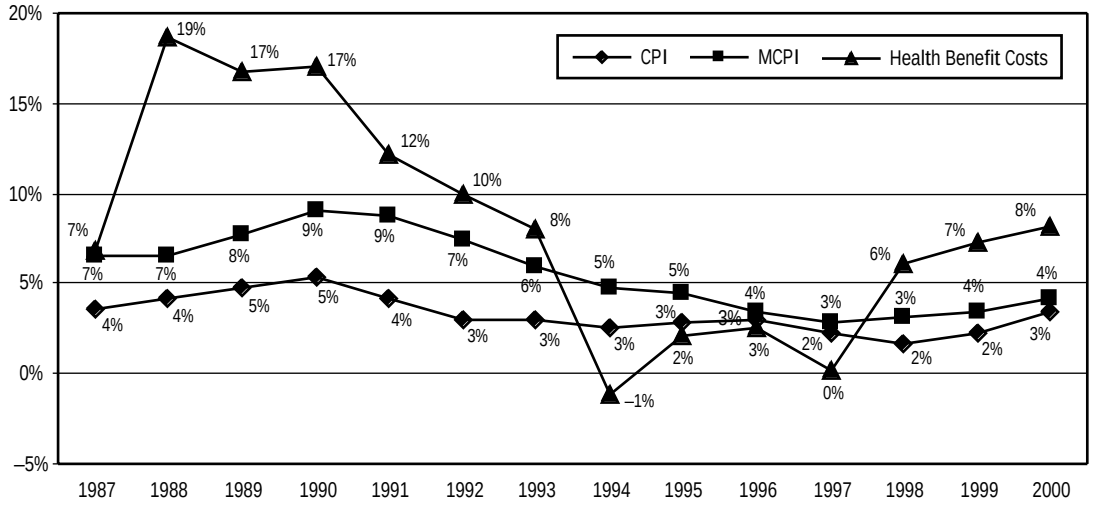
Percentage of Retirees Ages 55–64 With Retiree Heath Benefits, Public Coverage, or Uninsured, 1994 –1999



Source: EBRI estimates from the March Current Population Survey, 1995–2000.

Chart 19

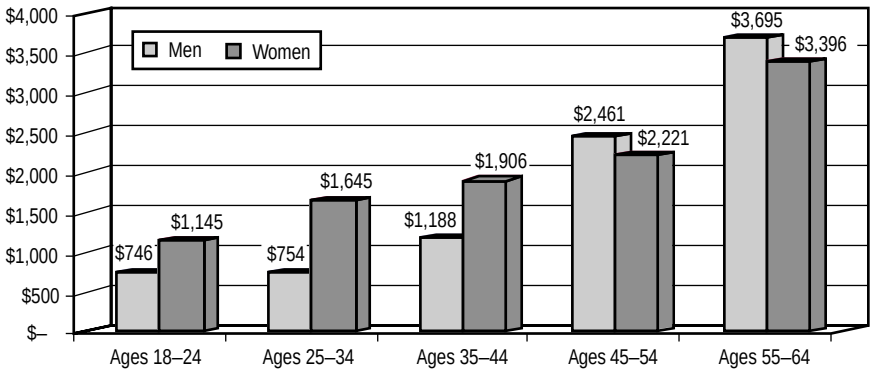
Health Care Cost Inflation, 1987–2000



Source: Economic Report of the President (2001) and William M. Mercer (2001).

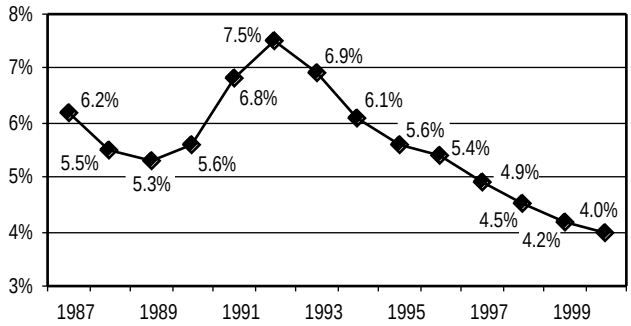
Chart 20

Health Care Spending, by Age and Gender, 1996



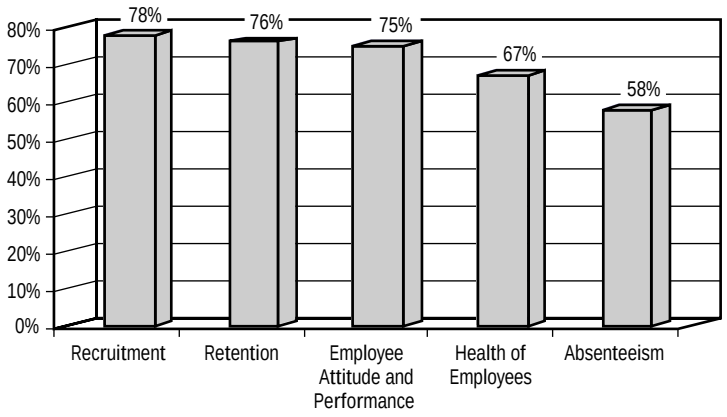
Source: EBRI estimates from the 1996 Medical Expenditure Panel Survey.

Chart 21
Unemployment Rate, 1987–2000



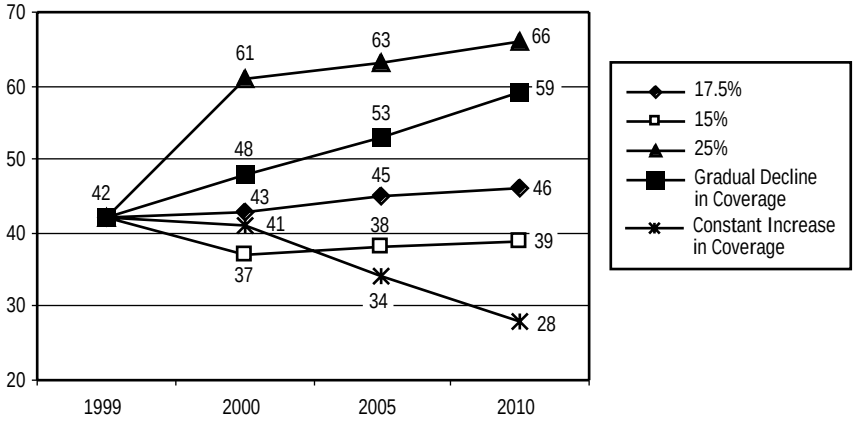
Source: Bureau of Labor Statistics.

Chart 22
Percentage of Small Employers Reporting Health Benefits Positive Impact on Various Aspects of their Business



Source: Fronstin and Helman (2000).

Chart 23
Number of Uninsured Americans, Ages 0–64, Various Assumptions About Percentage Uninsured, 1999–2010



Source: EBRI.