Statement for the

Senate Finance Committee

Health Reform Summit 2008

June 16, 2008
Library of Congress, Washington, DC

Submitted by:

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Employee Benefit Research Institute (EBRI)
T-152

"Trends in Employment-Based Health Benefits for Workers and Retirees"

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Trends in Employment-Based Health Benefits for Workers and Retirees

By Paul Fronstin, EBRI

Highlights

- ***Small employer coverage:*** Recently, there has been some erosion in the availability of health insurance through smaller employers. In 2000, 68 percent of employers with 3-199 employees offered health benefits. By 2005, only 59 percent offered it. Between 2005 and 2007, the percentage of these employers offering health benefits was stable. Employers with 3–9 workers experienced the largest decline in offer rates, with the percentage offering coverage falling nearly steadily from 58 percent in 2001 to 45 percent in 2007.
- ***Total coverage rates:*** The percentage of workers reporting that they have access to health benefits through their job is largely unchanged from the mid-1990s and down only slightly from the late-1980s. In 2005, 74 percent of workers who were not self-employed reported that they were eligible for health benefits through their own job, up slightly from 73.6 percent in 1995, but down from 77.8 percent in 1988.
- ***Employment-based coverage:*** The percentage of workers with coverage either from their own employer or from someone else's employer has been remarkably stable**.** Between 1994 and 2000, the percentage of workers with health benefits through an employer held steady at between 73 percent and 75 percent. Since 2000, the percentage of workers with health benefits has fallen to about 71 percent.
- ***Worker health costs going up:*** Workers are paying more for health benefits today than they were in 2000. Average premiums for employee-only coverage increased from $28 to $58 per month between 2000 and 2007, a 107 percent increase, and average family coverage premiums increased from $138 to $273 per month, a 98 percent increase. In contrast, the consumer price index (CPI) increased by 20 percent between 2000 and 2007.
- ***Cost-sharing going up but out-of-pocket share still low:*** Worker cost-sharing for health care services *has* been increasing and *has* been outpacing overall inflation. Deductibles are increasing and co-payments are increasing. Despite the fact that more workers are subject to higher deductible and co-payments, the percentage of consumer health care expenses paid out-of-pocket is at an all-time low. In the mid-1990s, more than 30 percent of consumer health care expenses were paid out-of-pocket**.** By 2005, out-of-pocket spending as a percentage of total consumer spending was down to 26 percent.
- ***Premium share relatively stable:*** The percentage of the premium paid by employees for employee-only coverage is down from the mid-1990s and essentially unchanged for family coverage. In 1993, workers paid an average of 20 percent of the premium for employee-only coverage. By 2007, workers were paying 16 percent. The percentage that workers pay for family coverage has been bouncing around between 26 percent and 28 percent since 1996.

- ***Employer cost-control efforts:*** Employers have also been changing the structure of health benefits in order to control the cost of providing health benefits. In 2007, 10 percent of employers offering health benefits were offering a high-deductible health plan with either a health reimbursement arrangement or a health savings account. An estimated 7.5 million adults ages 21–64 with private health insurance were either in an account-based plan or were in a high-deductible health plan that was eligible for an HSA, but had not opened the account. Some employers are investing resources in an attempt to bring more transparency to the health care system so that workers and their families can make informed health care decisions.
- ***Retiree health benefits:*** With respect to health benefits for retirees, research has consistently found that fewer employers are offering retiree health benefits than in the past, and that when retiree health benefits are offered, retirees are experiencing various combinations of rising premiums, higher out-of-pocket expenses, and more stringent eligibility requirements. Most workers will never be eligible for health insurance in retirement through a former employer.

Trends in Employment-Based Health Benefits for Workers and Retirees

Recent Trends in Employment-Based Health Benefits for Workers

Employment-based health benefits are by far the most common source of health coverage in the United States. In 2006, 161.7 million individuals under age 65 had some form of employment-based health coverage, representing 62.2 percent of that population (Fronstin, 2007). The number and percentage of persons under age 65 with employment-based health benefits has fallen from 167.5 million in 2000, representing 68.4 percent of the under age 65 population. Fewer people have this coverage for a number of reasons. Public sources of health insurance picked up some of the decline in employment-based health coverage, while the uninsured as a percentage of the under age 65 population increased from 15.6 percent in 2000 to 17.9 percent in 2006.

Are employment-based health benefits eroding? This question is driven by the rising cost of providing health benefits to workers. Between 2000 and 2007, the cost of providing health benefits doubled, while worker wages and overall inflation increased only 25 and 21 percent, respectively (calculated from Figure 1). While the growth rate in the cost of providing health benefits fell between 2003 and 2007 from 13.9 percent to 6.1 percent (Figure 1), growth in the cost of providing health benefits to workers continues to run 50 percent higher than growth in worker earnings and is double the rate of overall inflation.

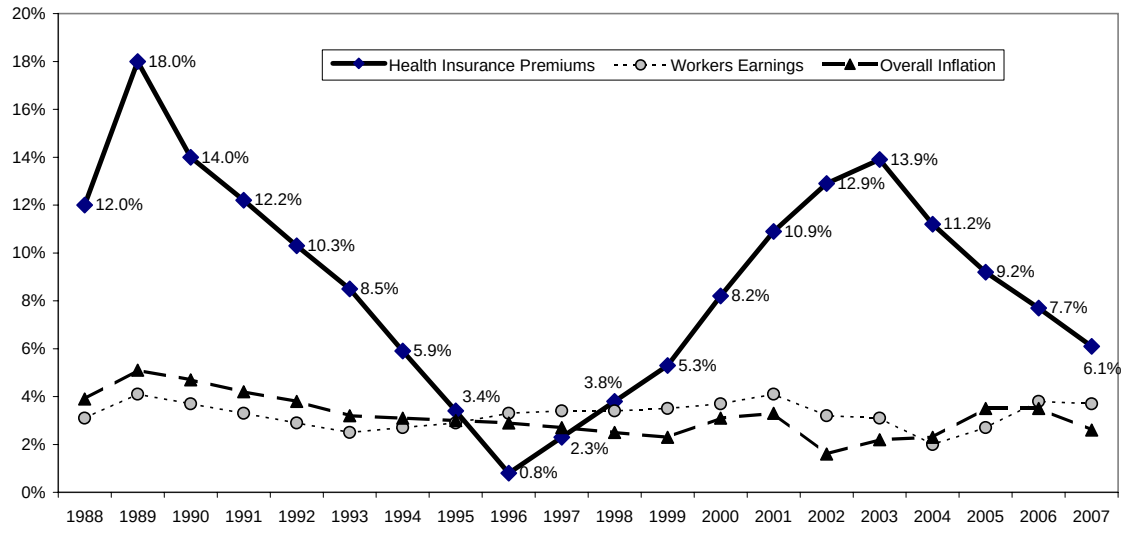
Recently, there has been some erosion in the availability of health insurance through smaller employers. In 2000, 68 percent of employers with 3-199 employees offered health benefits (Figure 2). By 2005, only 59 percent offered it. Between 2005 and 2007, the percentage of these employers offering health benefits was stable. The erosion in availability among small employers between 2000 and 2005 followed an expansion in availability of health benefits that occurred between 1996 and 2000.

Upon further examination, the erosion in the availability of health benefits through small employers that occurred was confined mainly to the smallest employers. Between 2000 and 2007, the percentage of employers with 50–199 workers that offered health benefits bounced around between 92 percent and 97 percent (Figure 3). Among employers with 25–49 workers, the percentage offering health benefits fell from 91 percent in 2000 to 83 percent in 2007, though it bounced around in the intervening years. Among employers with 10–24 workers, the percentage offering coverage fell from 80 percent to 70 percent between 2000 and 2002, but then increased and reached 76 percent by 2007. Finally, employers with 3–9 workers experienced the largest decline in offer rates, with the percentage offering coverage falling nearly steadily from 58 percent in 2001 to 45 percent in 2007.

While there has been an erosion of availability of health benefits at the small employer level since 2000**,** the percentage of workers reporting that they have access to health benefits through their job is largely unchanged from the mid-1990s and down only slightly from the late-1980s. In 2005, 74 percent of workers who were not self-employed reported that they were eligible for health benefits through their own job, up slightly from 73.6 percent in 1995, but down from 77.8 percent in 1988 (Figure 4).

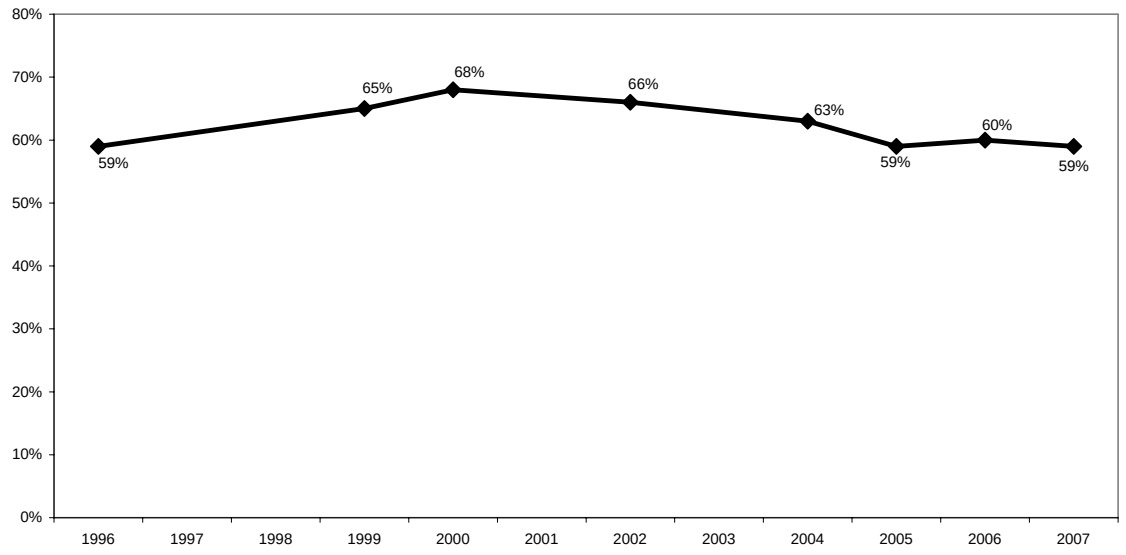
In terms of whether workers *have* health insurance coverage, for the most part, the percentage of workers with coverage either from their own employer or from someone

Figure 1
Growth in Health Insurance Premiums,
Worker Earnings and Overall Inflation, 1988-2007



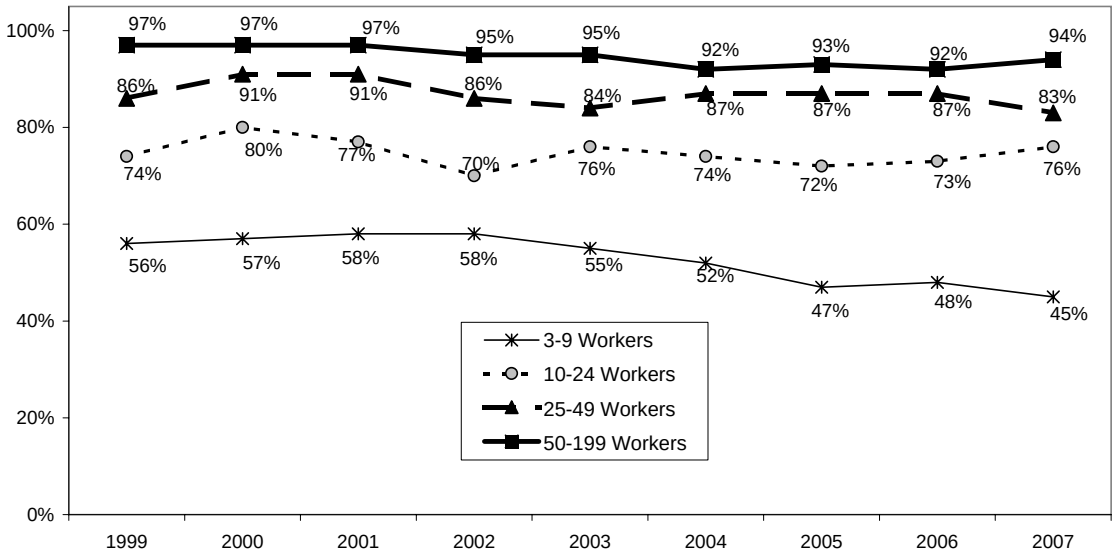
Source: Kaiser Family Foundation.

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



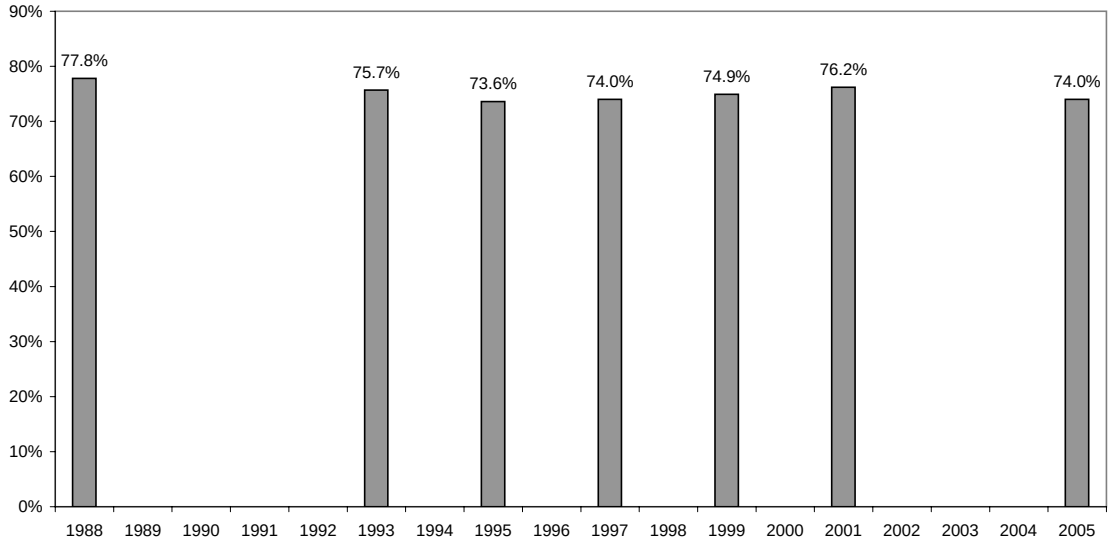
Source: Kaiser Family Foundation.

Figure 3
Percentage of Employers With 3–199 Employees Offering Health Benefits, by Firm Size, 1999–2007



Source: Kaiser Family Foundation.

Figure 4
Worker Eligibility for Own Employer Health Benefits, Wage and Salary Workers Ages 18–64, Selected Years, 1988–2005



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

else's employer has been remarkably stable, considering what has happened with the cost of providing health benefits and the fact that fewer small employers offer coverage since 2000**.** Between 1994 and 2000, the percentage of workers with health benefits through an employer held steady at between 73 percent and 75 percent (Figure 5). Since 2000, the percentage of workers with health benefits has fallen to about 71 percent.

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

Workers are definitely paying more for health benefits today than they were in 2000. Premiums for employee-only coverage increased from $28 to $58 per month between 2000 and 2007, a 107 percent increase, and family coverage premiums increased from $138 to $273 per month, a 98 percent increase (Figure 6). In contrast, the consumer price index (CPI) increased by 20 percent between 2000 and 2007. While premiums have increased over four times the rate of inflation, we cannot conclude that because workers are paying more that their health benefits are at least as comprehensive as they used to be. It is also necessary to look at the services that are covered by the benefits package and the cost of obtaining those services when needed.

Worker cost sharing for health care services *has* been increasing and *has* been outpacing overall inflation. Between 2000 and 2007, the percentage of workers in a PPO with a deductible of at least $500 increased from 14 percent to 36 percent (Figure 7) and the percentage of workers with an office visit co-payment of at least $20 increased from 39 percent in 2004 to 58 in 2007 percent (Figure 8). Overall, the average deductible among workers with employee-only coverage in a PPO increased from $187 in 2000 to $327 in 2006, an increase of 75 percent, as compared to the 17 percent increase in the CPI.[1] Co-payments for prescription drugs have also increased at a rate outpacing inflation. For example, between 2000 and 2007, the average co-payment for brand name drugs on the formulary increased from $15 to $25, a 67 percent increase, while the average co-payment for non-formulary brand name drugs increased 48 percent (Figure 9). The average co-payment for generic drugs also increased faster than inflation, up 38 percent between 2000 and 2007.

Despite the fact that more workers are subject to higher deductible and co-payments, the percentage of consumer health care expenses paid out-of-pocket is at an all-time low. In the mid-1990s, over 30 percent of consumer health care expenses were paid out-of-pocket (Figure 10**).** By 2005, out-of-pocket spending as a percentage of total consumer spending was down to 26 percent. Furthermore, the percentage of the premium paid by employees for employee-only coverage is down from the mid-1990s and essentially unchanged for family coverage. In 1993, workers paid an average of 20 percent of the premium for employee-only coverage (Figure 11). By 2007, workers were paying 16 percent. The percentage that workers pay for family coverage has been bouncing around between 26 percent and 28 percent since 1996.

For the most part, the percentage of the population with access to employment-based health benefits and the percentage covered by them is little changed since the mid-1990s. In addition, services covered have increased, though often with restrictions. Nevertheless, there has been erosion in the benefits package in that cost sharing has not kept up with inflation.

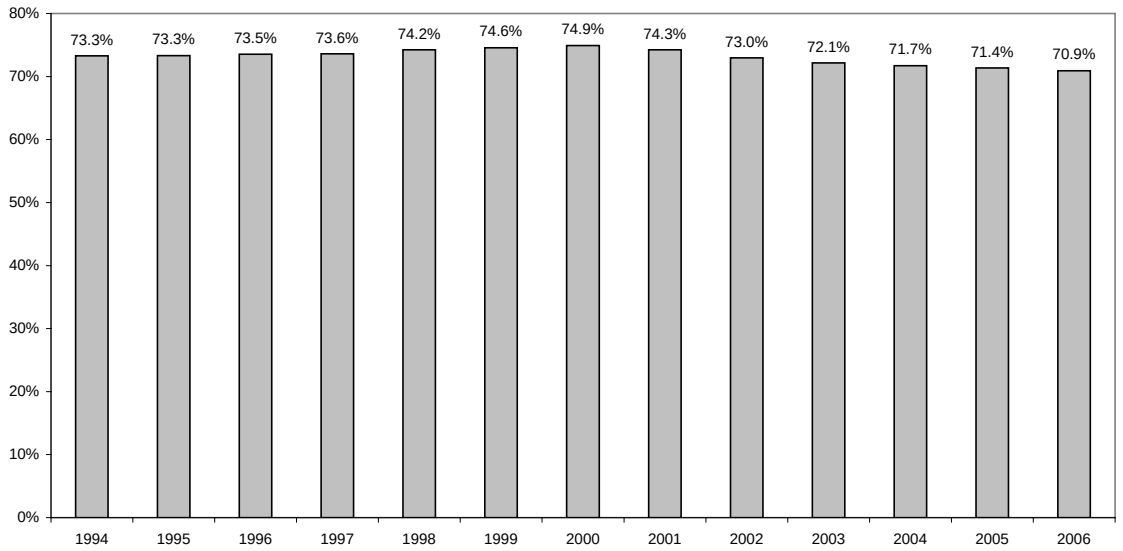
Employers have also been changing the structure of health benefits in order to control the cost of providing them. The movement to consumer-driven health benefits (CDHBs)—high-deductible health plans combined with a tax-preferred savings or spending account—is a case in point.[2] Employers first started offering account-based health plans in 2001, when a handful of employers began to offer health reimbursement arrangements (HRAs). In 2004, employers started to offer health plans with health savings accounts (HSAs). By 2007, 10 percent of employers offering health benefits were offering one or both of these options to workers, and an estimated 7.5 million adults ages 21–64 with private health insurance were either in an account-based plan or were in a high-deductible health plan that was eligible for an HSA, but had not opened the account (Fronstin and Collins, 2008).

Some employers are investing resources in an attempt to bring more transparency to the health care system so that workers and their families can make informed health care decisions. For example, in 1998 a group of large employers formed The Leap Frog Group in an effort to improve the quality and affordability of the health care that they purchase.[3] In 2001, employers formed what is now known as the Consumer-Purchaser Disclosure Project in order to report health care provider quality measures.[4] Today, the group is composed not only of employers but also consumer groups and organized labor. The HR Policy Association recently formed a coalition to bring greater transparency to the way employers purchase pharmaceutical benefits. The coalition uses a comprehensive certification process to identify pharmacy benefit managers (PBMs) willing to meet its transparency standards.[5] Employers are also working with health care providers, insurers, and the federal government to determine how to most effectively and efficiently improve performance measurement, data aggregation, and reporting in all areas of physician practices.[6]

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

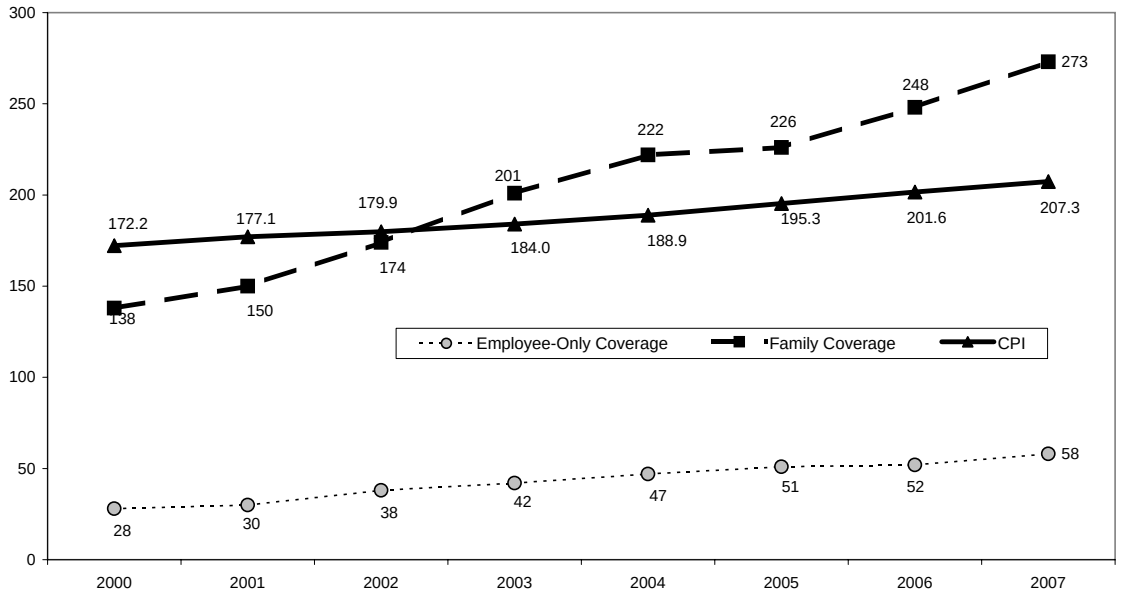
For example, health insurance is not portable from job to job—i.e. workers can rarely continue to participate in the same health plan when they change jobs. Health insurance influences workers staying in their jobs. In 2004, 27 percent of adults reported that they or an immediate family member had passed up a job opportunity or stayed in a job they would have otherwise left to maintain health insurance (Helman and Fronstin, 2004). The Health Insurance Portability and Accountability Act (HIPAA) addressed portability when it comes to coverage for pre-existing conditions for workers changing jobs, but changing jobs is still risky: potential employers may not offer health benefits, the benefits offered may be less comprehensive than those offered in the current job, and the benefits from the potential employer may cost more. And while the continuation of coverage provision of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers with 20 or more employees to make available continued health care coverage for a specified period to employees (and/or their qualified dependents) who terminate employment for reasons other than gross misconduct,

Figure 5
Percentage of Workers, Ages 18–64,
With Employment-Based Health Benefits, 1994–2006



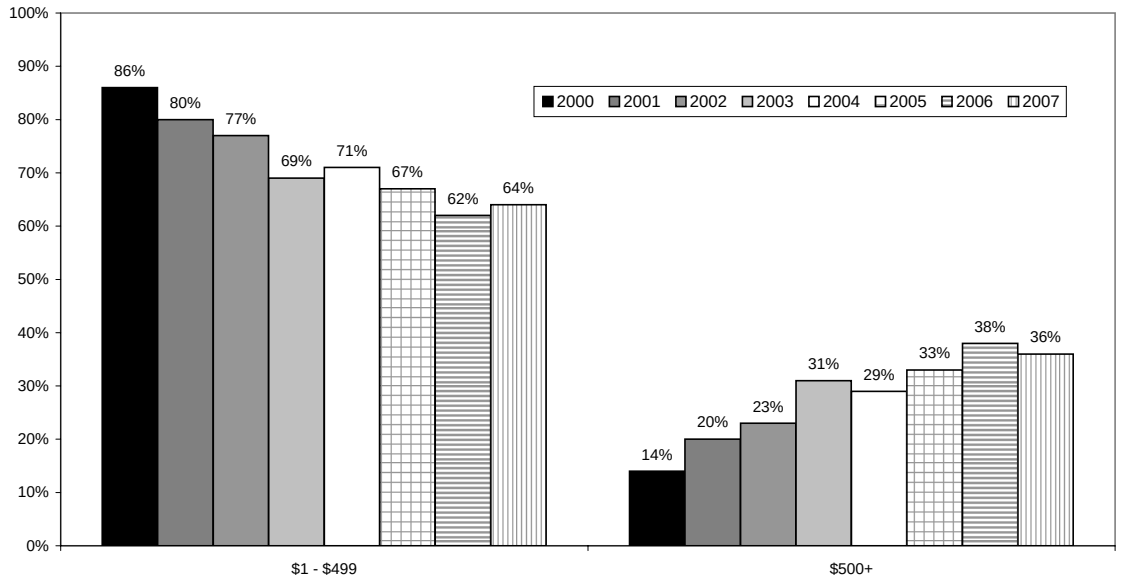
Source: Employee Benefit Research Institute estimates based on data from the Current Population Survey, March Supplement.

Figure 6
Average Monthly Premiums for Employee-Only Coverage
and Family Coverage, and Consumer Price Index (CPI), 2000–2007



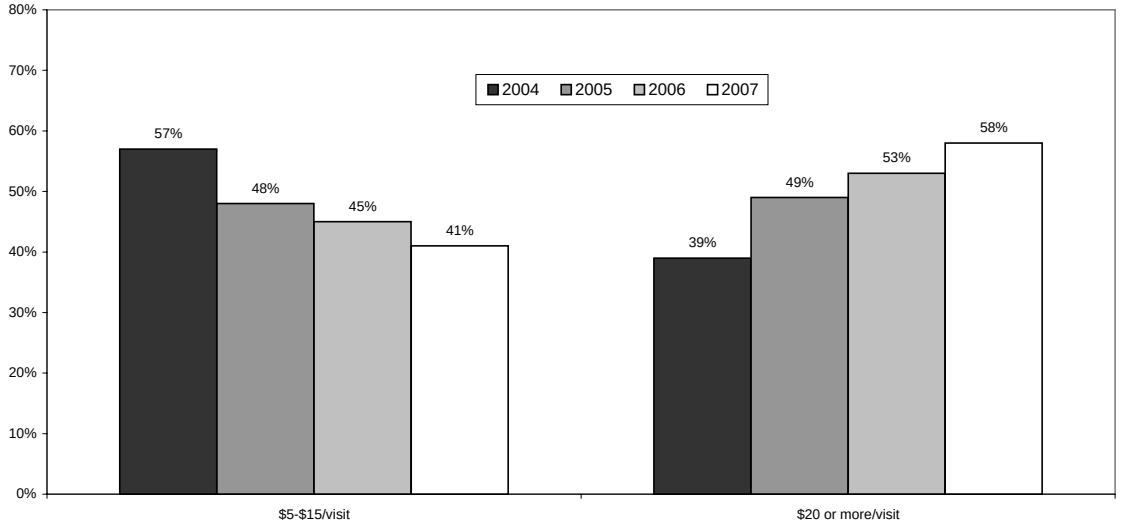
Source: Kaiser Family Foundation and Bureau of Labor Statistics (BLS).

Figure 7
Distribution of Deductibles for Employee-Only PPO Coverage, 2000–2007



Source: Kaiser Family Foundation.

Figure 8
Distribution of Physician Office Visit Co-payments, All Plan Types, 2004–2007



Source: Kaiser Family Foundation.

COBRA coverage is often unaffordable. COBRA beneficiaries are required to pay the full premium and a 2 percent administrative fee, on an after-tax basis.[7]

Workers do not have a lot of plan choices through the employment-based system. Roughly one-half of workers with health insurance are employed by a firm that offers only one choice of health plan.[8] Of the roughly one-half of workers with health insurance who are employed by a firm that offers more than one choice of health plan, this does not necessarily translate into a choice of those plans for those workers. When workers have a choice of health plans, it is typically between an HMO and PPO from the same insurance carrier or through the same self-insured employer.

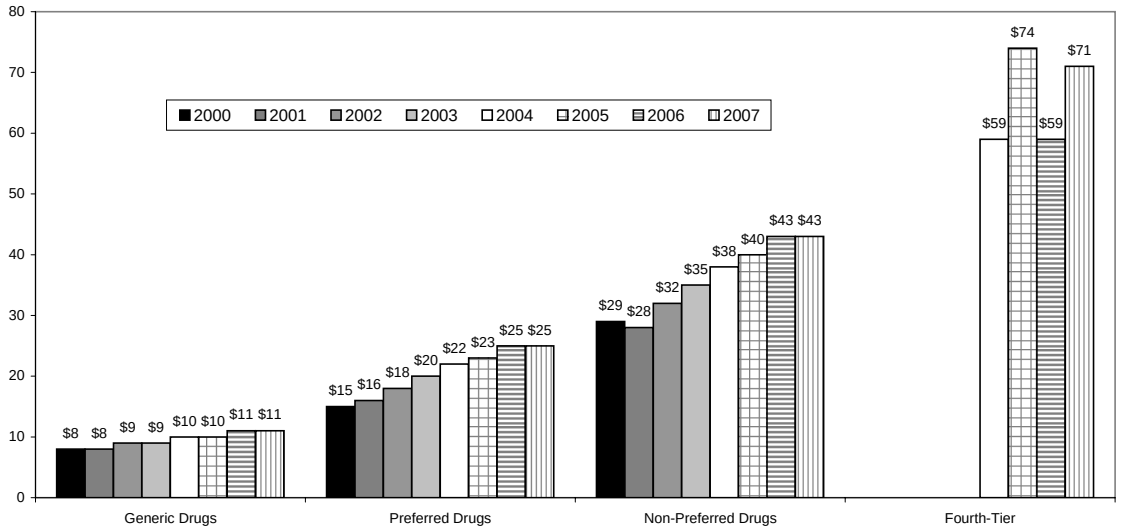
Finally, large employers have distinct advantages over small employers when it comes to health benefits. Large employers are usually able to offer health benefits for less than it would cost small employers to offer the same benefits. Furthermore, large employers usually self-insure their health benefits,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

Trends in Retiree Health Benefits

It can be argued that employers have not only reached a tipping point with health benefits for retirees, but that they reached it in the mid-1990s. Research has consistently found that fewer employers are offering retiree health benefits than in the past, and that when retiree health benefits are offered, retirees are experiencing various combinations of rising premiums, higher out-of-pocket expenses, and more stringent eligibility requirements. In fact, most workers will never be eligible for health insurance in retirement through a former employer. The Agency for Healthcare Research and Quality (AHRQ) reports that only 13 percent of private-sector establishments offered health benefits to early retirees in 2005, down from 22 percent in 1997 (Figure 12). Furthermore, 13 percent of private-sector establishments offered health benefits to Medicare-eligible retirees in 2005, down from 20 percent in 1997. The trend among large employers—those most likely to offer health benefits – has been down as well (Figure 13).

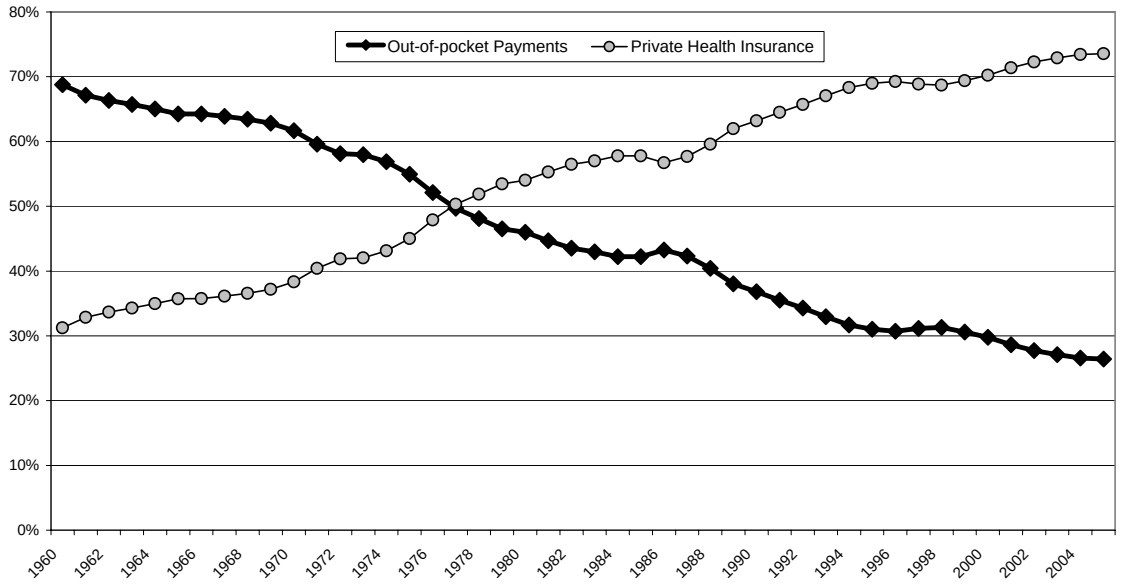
One of the most important factors (if not the most important) that led to the erosion in retiree health benefits was a 1990 accounting rule change issued by the Financial Accounting Standards Board (FASB). Known as Financial Accounting Statement No. 106 (FAS 106), "Employer's Accounting for Postretirement Benefits Other Than Pensions," it required employers to report retiree health liabilities on the balance sheet. The accounting rule change was issued in December 1990 and triggered many of the changes that private-sector employers have made to retiree health benefits since the early 1990s. But even in the late-1980s, before FAS 106 was approved, studies were examining how the proposed changes would cause employers to reconsider their sponsorship role of these benefits and some employers made changes to retiree health benefits in anticipation of FAS 106 (Employee Benefit Research Institute, 1987). While we are not on the verge of an accounting rule change that would affect active worker health benefits, public policy proposals—for example, those that would remove ERISA pre-emption or fundamentally change the tax treatment of health insurance—could have the same impact on active worker health benefits as FAS 106 had on health benefits for retirees.[9]

Figure 9
Average Co-Payment for Prescription Drugs, Among Workers With Three- or Four-Tier Co-Payments, 2000–2007



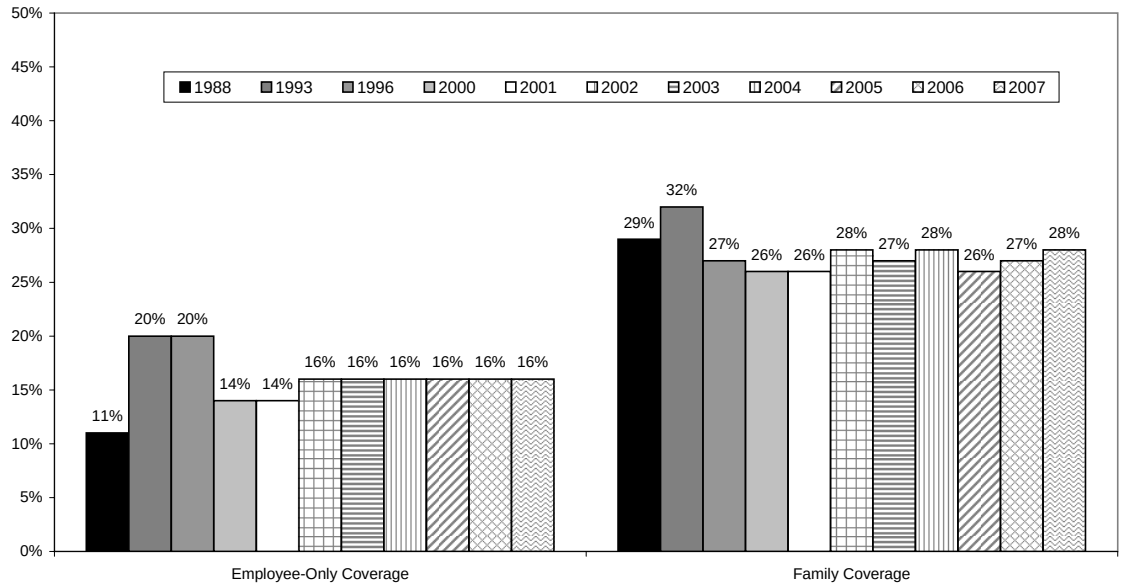
Source: Kaiser Family Foundation.

Figure 10
Percentage of Private Consumer Health Care Expenditures That Are Out-of-Pocket, and Private Health Insurance Payments, 1960–2005



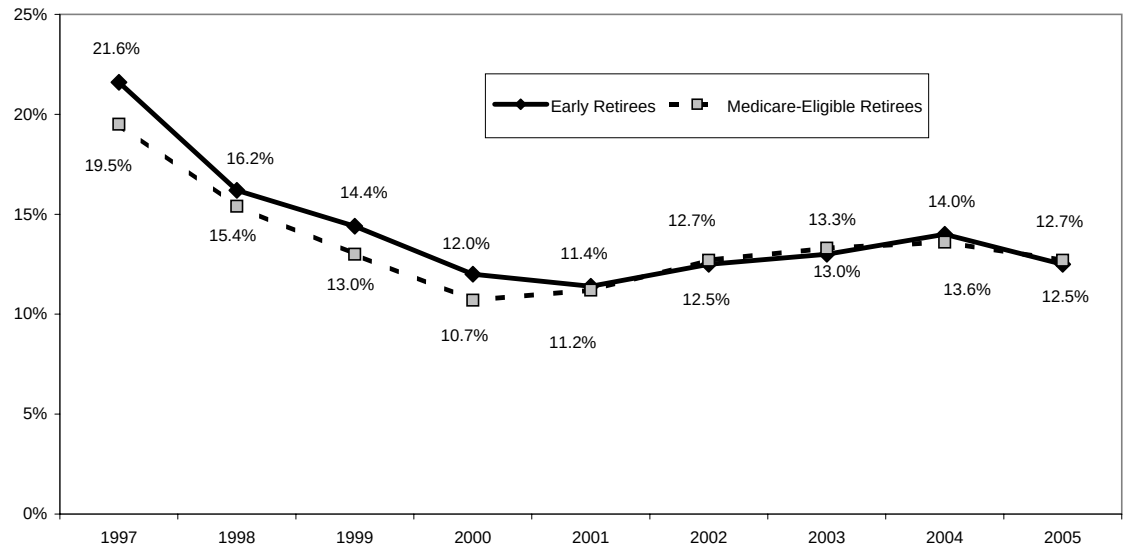
Source: Centers for Medicare and Medicaid Services.

Figure 11
Average Percentage of Premium Paid by Covered Workers for Employee-Only and Family Coverage, 1999–2007



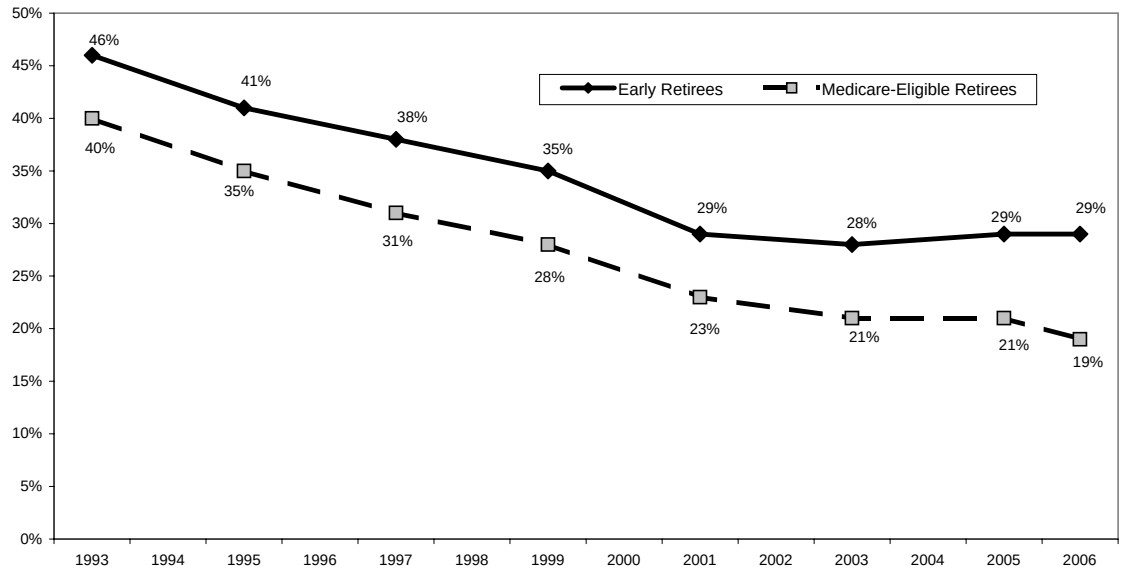
Source: Kaiser Family Foundation.

Figure 12
Percentage of Private-Sector Establishments Offering Health Insurance to Retirees, 1997–2005



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

Figure 13
Percentage of Employers With 500 or More Employees Offering Health Insurance to Retirees, 1993–2006



Source: Mercer Human Resources Consulting, 2006.

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Endnotes

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

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

[3] See www.leapfroggroup.org.

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

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

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

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

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

[9] For a more detailed treatment of trends in retiree health benefits see Fronstin, Salisbury, and VanDerhei (2008).