

# **THE FUTURE OF EMPLOYER-BASED HEALTH INSURANCE FOLLOWING HEALTH REFORM**

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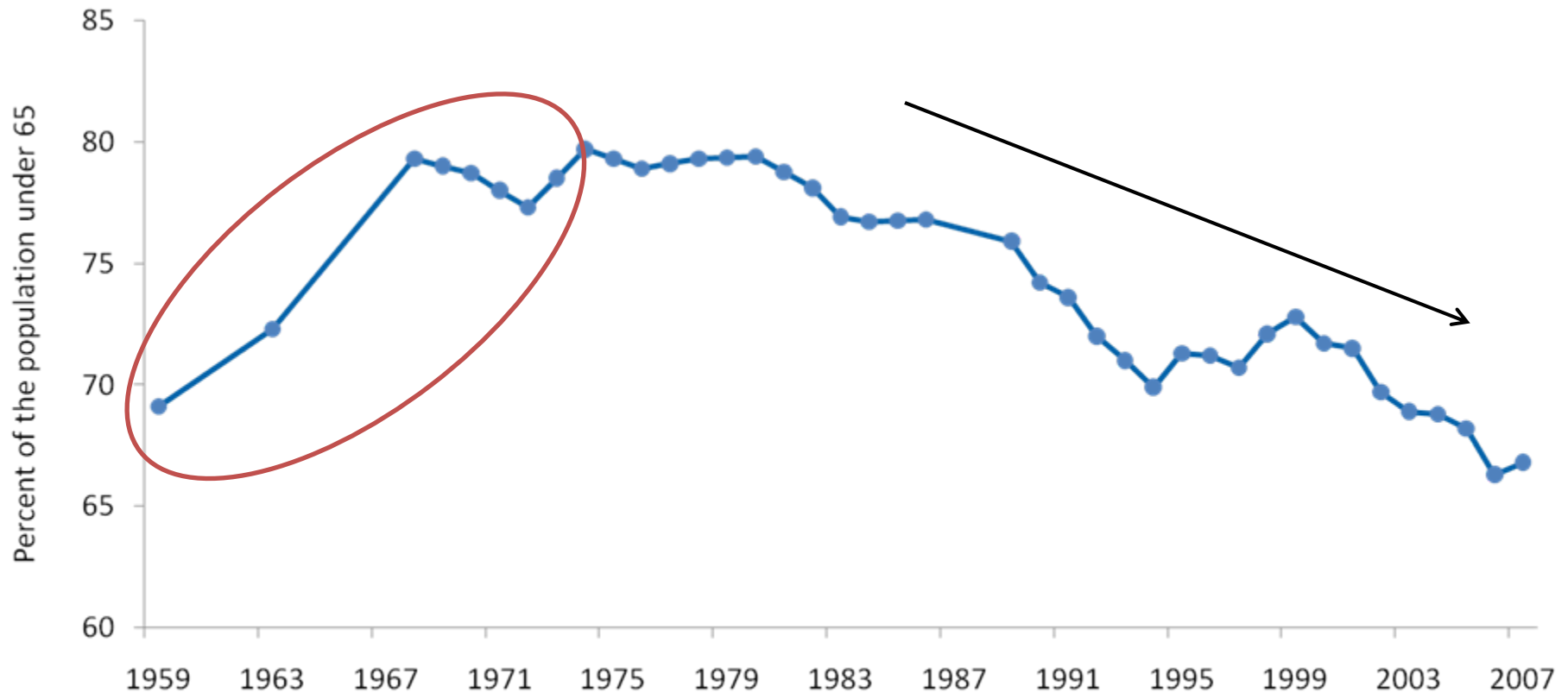
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# Brief history of employer-sponsored health insurance

- Government policies created incentives in the 1940s and 50s that stimulated provision of health insurance through the workplace
  - fringe benefits not counted against wage freezes during WWII: used to attract workers
  - preferred tax treatment of health premiums: used to attract healthy enrollees and form stable and sustainable risk pools
- As a result, ESI flourished

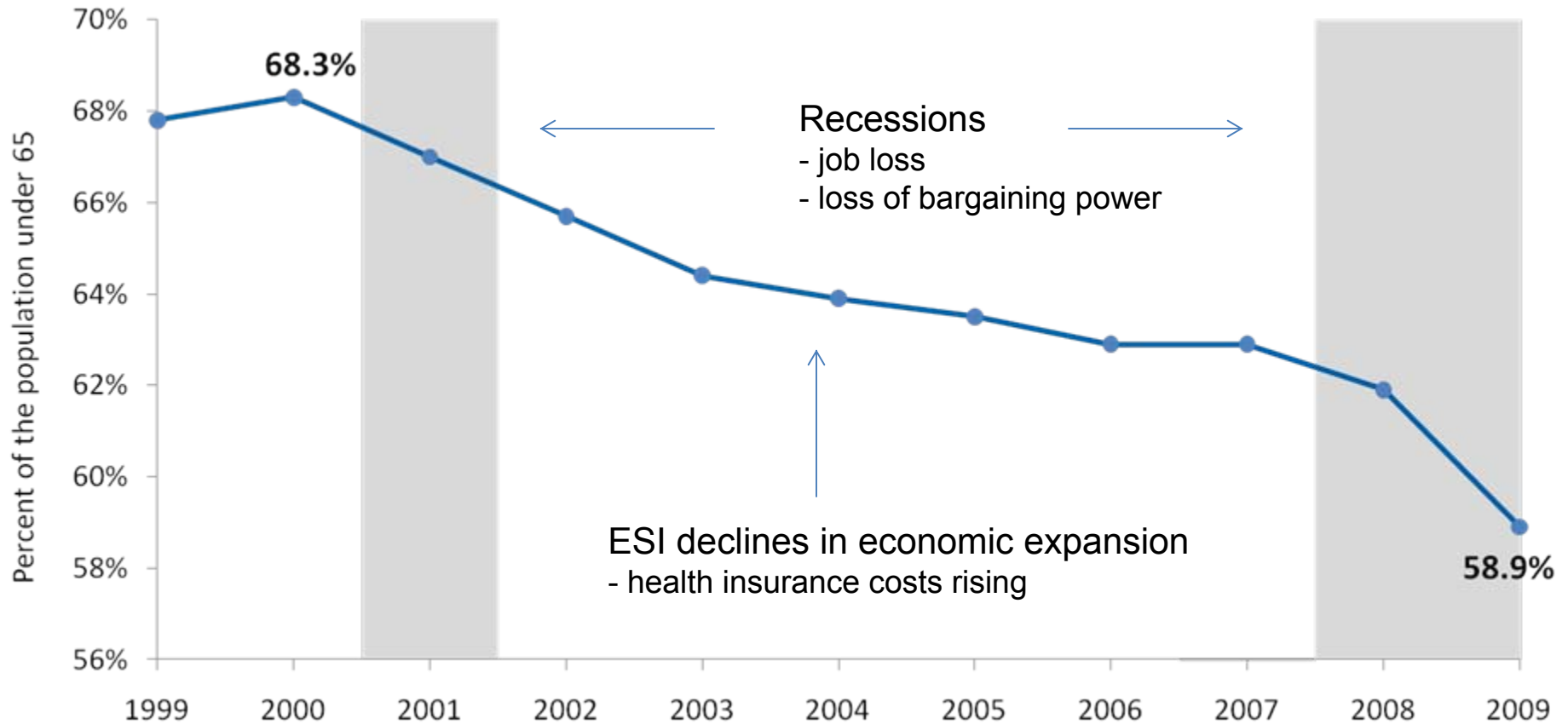
# Share of under-65 population with any kind of private health insurance coverage, 1968-2007



Note: First 2 data points (1959, 1963) refer only to coverage for hospital insurance. Missing data graphed using linear extrapolation.

Source: Cohen et al. (2009).

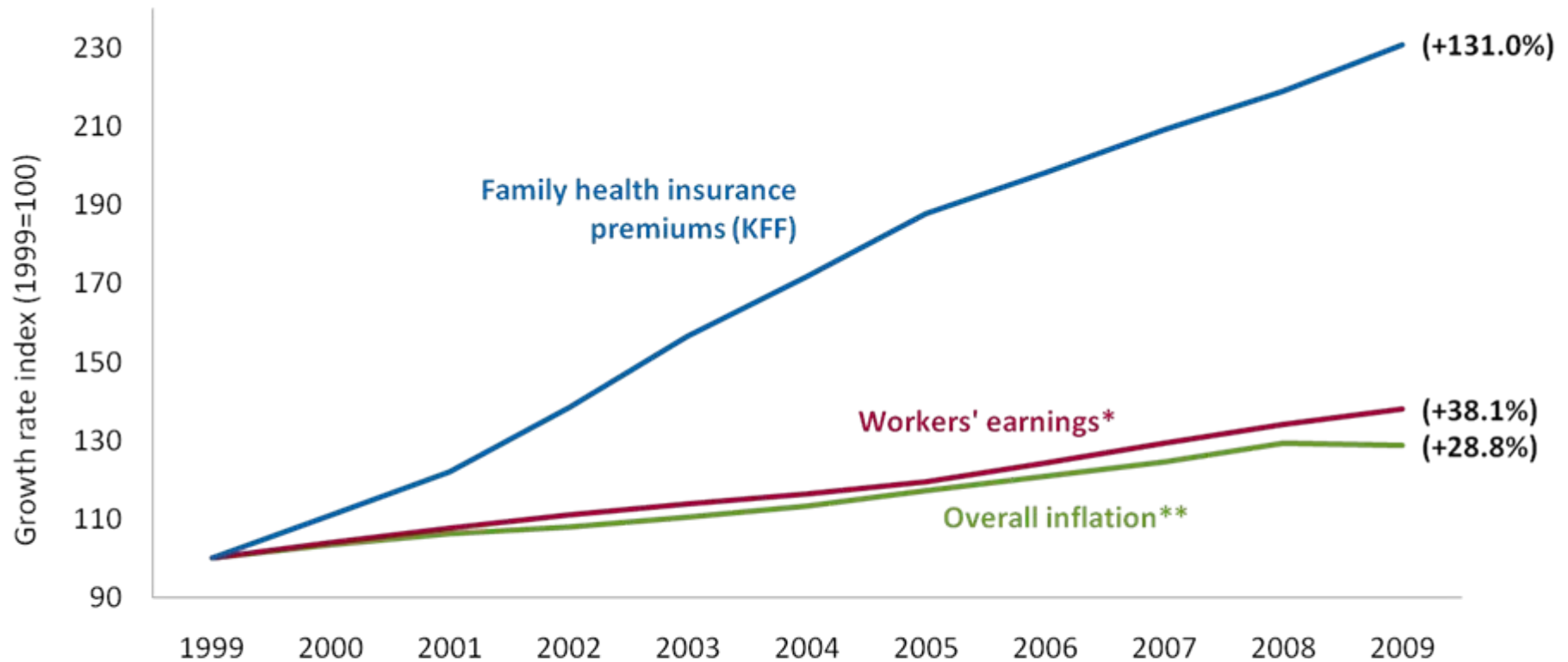
# Share of the under 65 population with employer-sponsored insurance, 1999-2009



Source: EPI analysis of Current Population Survey, Annual Social and Economic Supplement, 2000-2010

# Growth of health insurance premiums far outpaces workers' earnings or overall inflation

Growth rate index of family health insurance premiums, workers' earnings, and overall inflation, 1999-2009



\* Workers' earnings as measured by average hourly earnings for private sector production workers.

\*\* Overall inflation as measured by the Consumer Price Index for All Urban Consumers (CPI-U).

Source: EPI analysis of Kaiser Family Foundation and Bureau of Labor Statistics data.

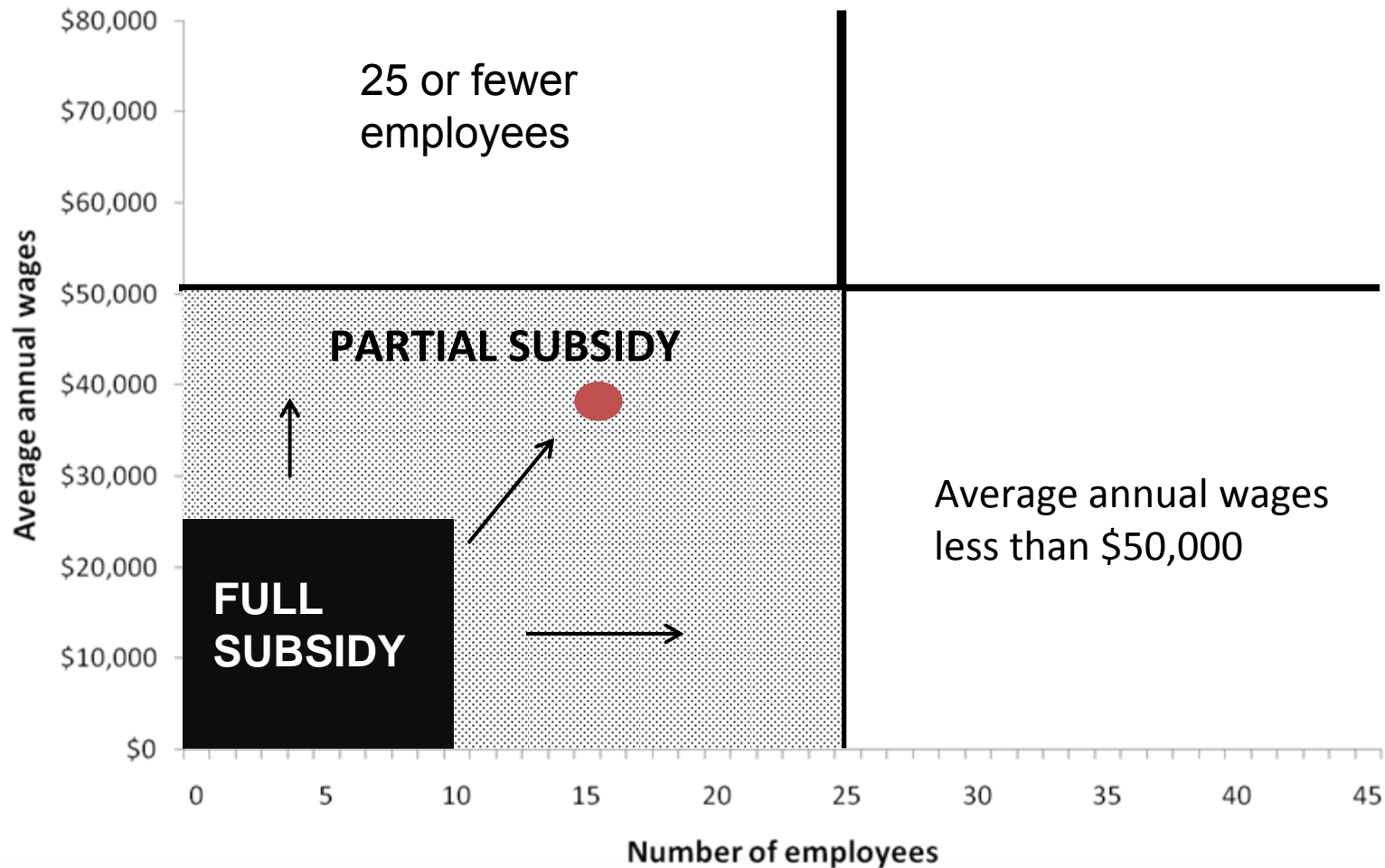
# What will health reform do to these trends in employer-sponsored insurance?

- Subsidies to small employers: ↑ ESI
- Dependent coverage up to age 26: ↑ ESI
- Regulatory reform of individual market: ↓ ESI
- Subsidize premiums and medical expenses of individuals who purchase health insurance through exchanges: ↓ ESI
- Employer requirement: ↑ ESI
- Individual mandate: ↑ ESI

# Subsidies to employers (1)

- Subsidies to offer insurance
  - tax credits for small employers to offer coverage (2010-15)
    - up to 35% of the employer's contribution toward the premium if the employer contributes at least 50% of the total cost (2010-2013)
    - up to 50% of the employer's contribution (2014-2015)
  - reinsurance for Medicare-ineligible retirees (2010-14)

# Subsidies to employers (2)





# Health insurance exchanges (1)

- Regulatory reform of individual market (2010)
  - Quality measurements, consumer protections (e.g. guaranteed issue, community ratings, end rescissions, set medical loss ratios), standardize health plans
- Subsidize premiums and medical expenses of exchange enrollees (2014)
  - premium contributions limited to 2% of income for those below 133% of poverty up to 9.5% of income at 400% of poverty
  - cost-sharing subsidies increase the actuarial value of a plan to 94% for those below 150% of poverty down to 70% for those at 400% of poverty

# Health insurance exchanges (2)

- Create new state/regional exchanges to pool individuals and (initially) small employers (2014)
  - Does not replace individual market
- Small employers eligible to participate in insurance exchanges (2014)
  - Individuals and small businesses with up to 100 workers could enroll in exchange
    - until 2016 states could limit enrollment to companies with 50 or fewer workers
    - in 2017 states can expand eligibility to all firms

# Employer responsibility (1)

- Employer requirements for those who offer
  - Employers who offer dependent health insurance coverage must allow child dependents up to age 26 (2010)
    - amends the tax code to still get full tax exclusion when covering these older dependents
  - End rescissions of coverage; eliminate waiting periods greater than ninety days; eliminate lifetime limits; sets annual limits no less than \$750,000
- Employer penalties (2014)
  - Introduce a penalty on large employers that do not offer coverage, provide low quality coverage, or require high individual premium contributions and have individuals who receive subsidies through the exchange

# Employer responsibility (2)

## More than 50 employees

### Does not offer coverage

- One FTE receives a premium tax credit
  - Any one employee has income less than 400% FPL and gets subsidy in the exchanges
- Penalty: \$2,000 per FTE (excluding the first 30 employees)

e.g.: 100 employees, 50 with credit

**Penalty = \$140,000**

### Offers coverage

- One FTE receives a premium tax credit
  - Plan offered is either low quality (60% actuarial value) or too expensive (more than 9.5% income)
- Penalty: \$3,000 per employee with credit, capped at \$2,000 per FTE (excluding the first 30 employees)

e.g.: 100 employees, 10 with credit

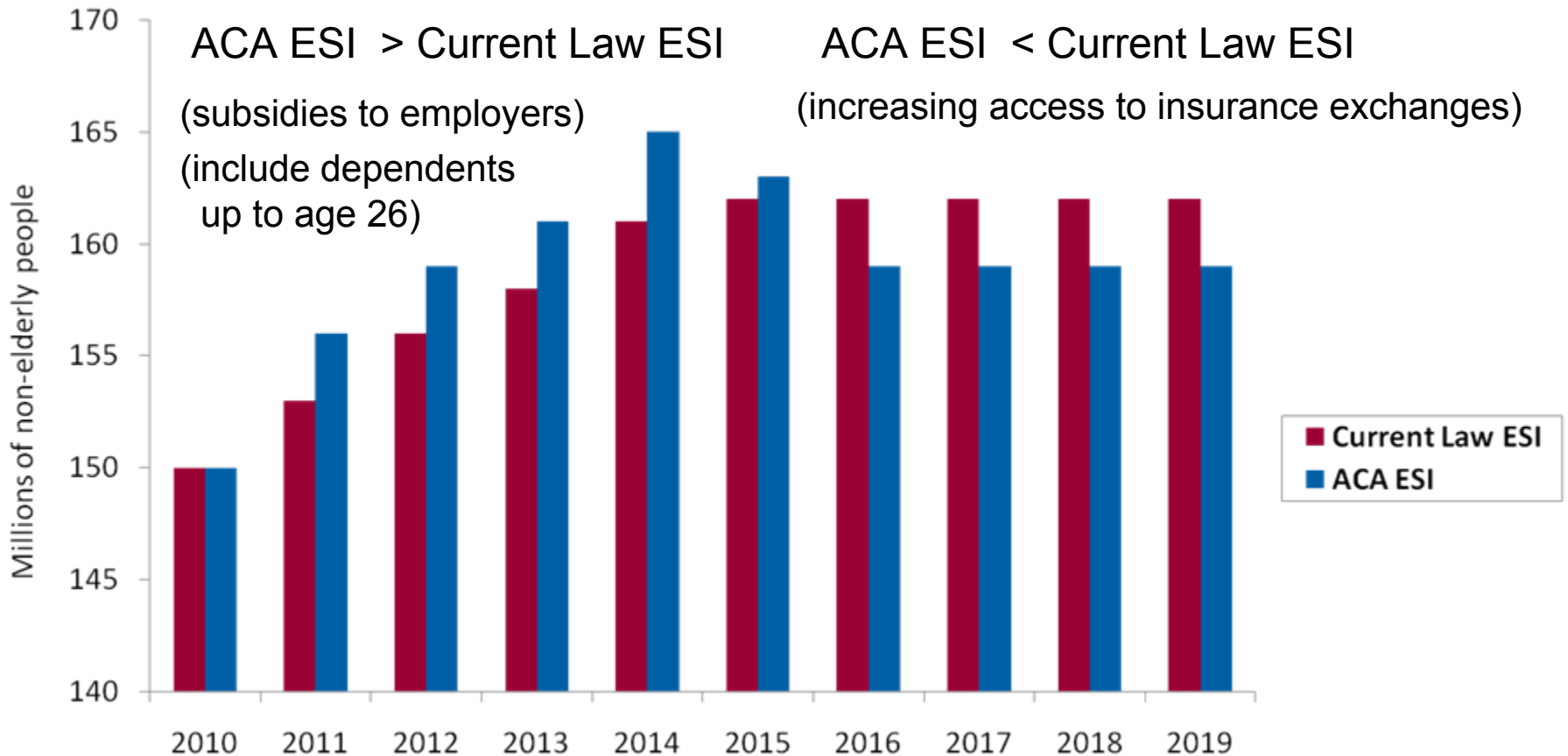
**Penalty = \$30,000**

# Employer responsibility (3)

- Exceptions

- Free choice vouchers: require employers that offer coverage to their employees to provide a free choice voucher to employees with incomes <400% FPL whose share of the premium is between 8% and 9.8% of their income and go to the Exchange.
  - The voucher amount is equal to the employer contribution.
  - Employers providing free choice vouchers are exempt from penalties.
- Grandfathered plans: Individual and group plans in which an individual was enrolled at the time of enactment
  - Renewal for individual and their dependents allowed
  - Counts as minimum essential coverage for the mandates

# Affordable Care Act of 2010: Effect on employer-sponsored health insurance, 2010-2019



Source: Congressional Budget Office (2010)

# CBO estimates of coverage effects

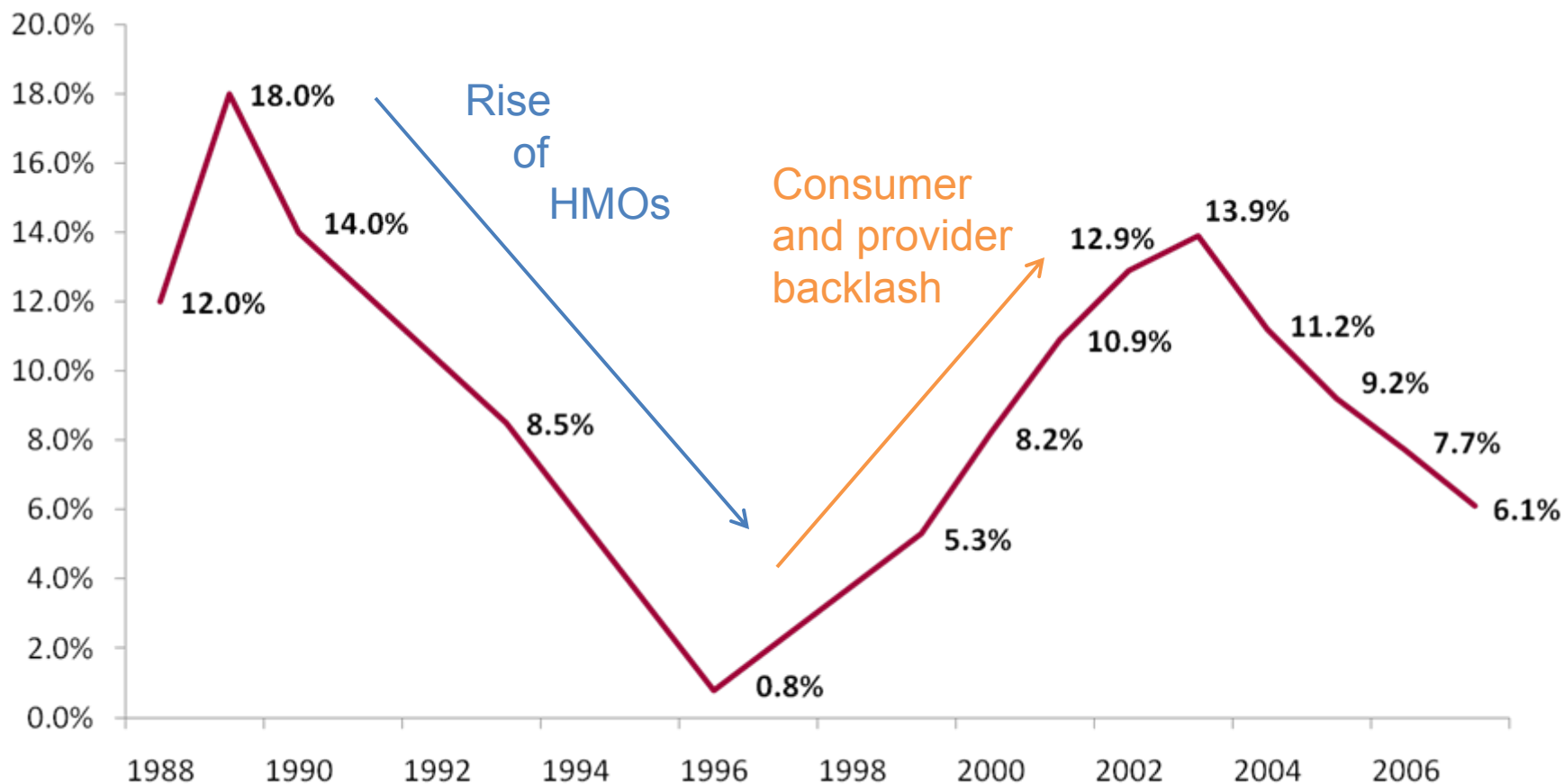
- 3 million net decline in ESI coverage in 2019
  - 6-7 million *increase* in ESI from *new* ESI offers
  - 8-9 million *decline* in ESI from employers dropping coverage or a lack of new coverage (coverage declines mostly in small and/or low-wage firms)
- 29 million enrolled in exchanges in 2019
  - 5 million who would have otherwise had ESI

# Cost containment strategies

- If rising costs is the driving force behind employment based insurance losses in an economic expansion, then what does health reform do about cost containment?
  - Independent Payment Advisory Board (IPAB)
  - Excise tax on premiums above a set value
- Brief look at what has contained costs
  - Insurance design: HMOs
  - Administrative costs: Large firms/Medicare

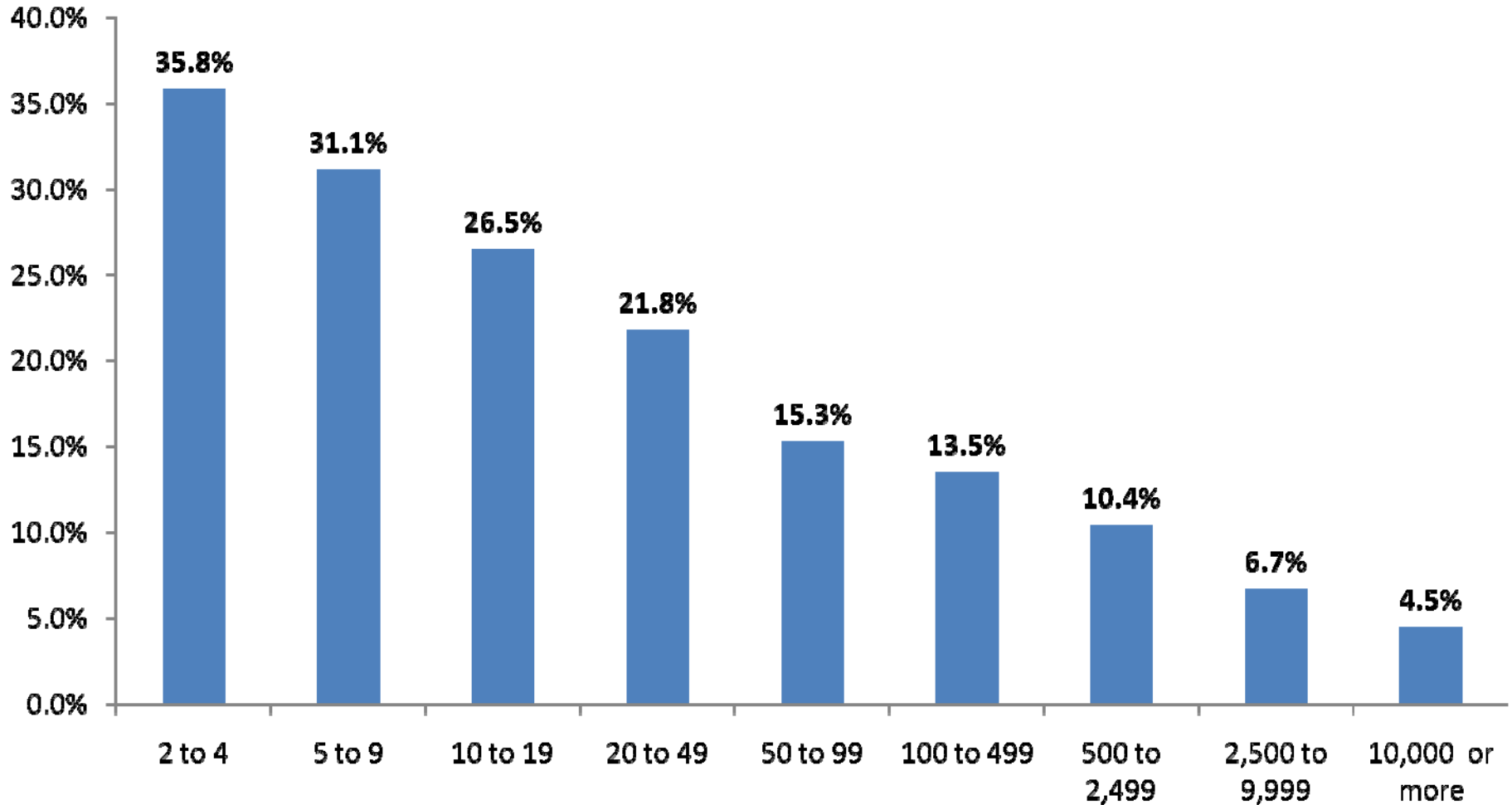


# Average percentage increase in health insurance premiums, 1988-2007



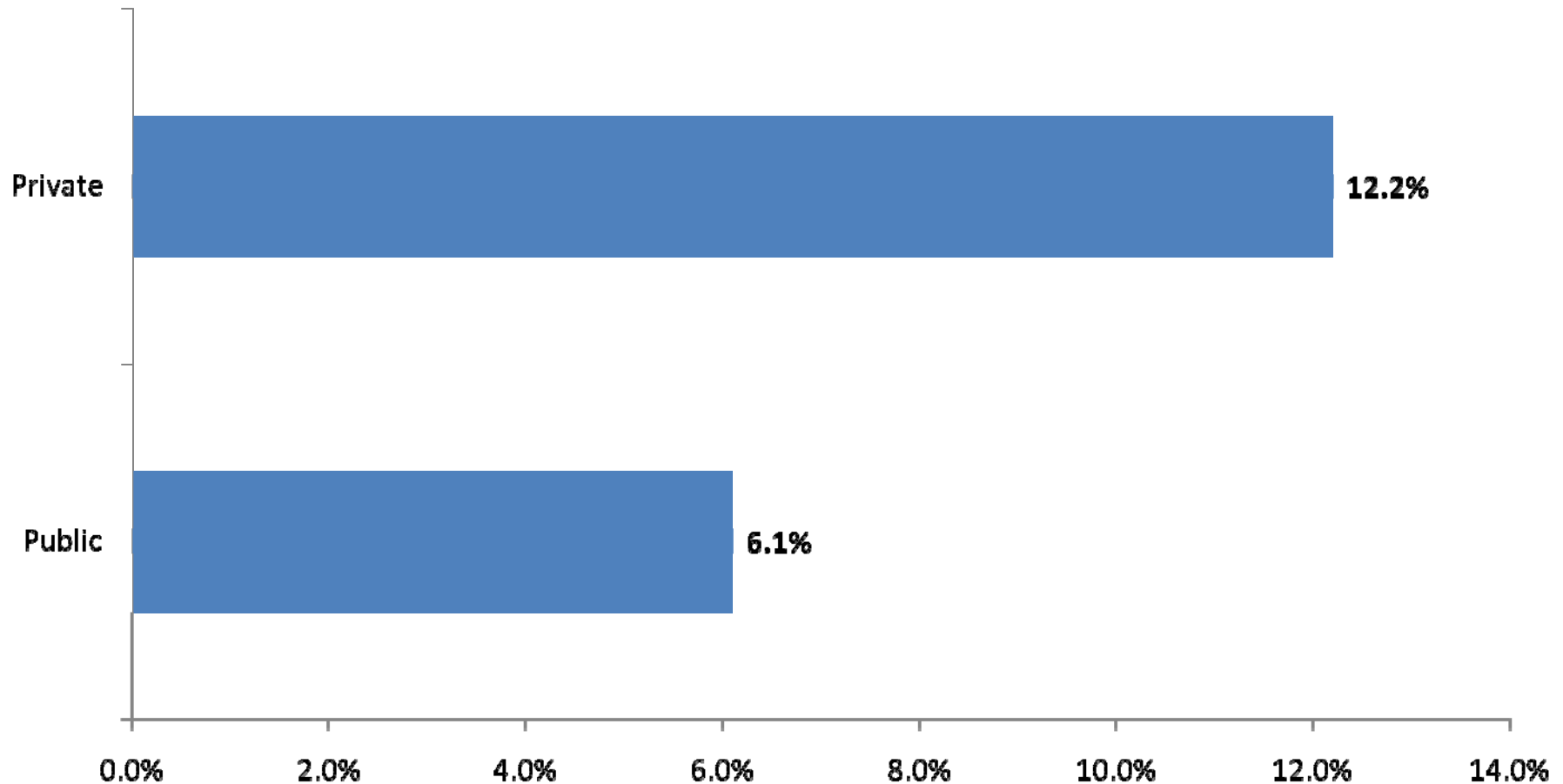
Source: Kaiser Family Foundation, *Employer Health Benefits 2007 Annual Survey*

# Administrative costs for health insurance by firm size



Source: Lewin Group analysis of Hacker (2006) *Health Care for America*.

# Administrative expenses as a percent of insured personal health spending



Source: Calculations from M. Hartman, A. Martin, P. McDonnell et al., "National Health Spending in 2007: Slower Drug Spending Contributes to Lowest Rate of Overall Growth Since 1998." *Health Affairs*, Jan/Feb. 2009 28(1):246-61.

# Cost containment provisions: IPAB

- Established by ACA to reduce *growth* in per capita Medicare costs
  - Establishes **targeted** growth rate in Medicare program spending over five-year period and tracks **actual** growth rate
  - If actual growth is higher, the fifteen-member panel gives Health and Human Services a savings plan to implement
- Required to make (nonbinding) recommendations regarding ways of slowing the growth in private national health care expenditures

# Cost containment provisions: Excise tax (1)

- Excise tax (40% of plan value) on insurers (or employers that self-insure) with ESI plans that exceed
  - \$10,200 for individual coverage (2018)
  - \$27,500 for family coverage
- Threshold amounts higher for:
  - retired individuals age 55 and older who are not eligible for Medicare
  - employees engaged in high-risk professions
  - firms that may have higher health care costs because of the age or gender of their workers.

# Cost containment provisions: Excise tax (2)

- Whose costs are contained?
  - Federal government costs ↓
    - 32 billion in savings (2010-2019)
  - Employers ↓↑?
    - JCT assumes employers will put savings into wages *OR* profits. Which is more realistic?
  - Individuals ↓↑?
    - premiums incorporate higher costs of the tax *OR* individuals choose to purchase less expensive plans and take on higher out-of-pocket rates

# Cost containment provisions: Excise tax (3)

- Does the purchase of less expensive plans and the additional shift in costs onto consumers lead to lower overall system costs?
  - Standard economic theory dictates that higher prices lead to lower levels of consumption
  - Less consumption for who and of what?
    - For some – those with chronic conditions, for instance – lower consumption or delayed care can actually lead to worse health and higher system-wide costs
      - e.g. high coinsurance for drugs lead to lower consumption and higher rates of hospitalization

# Conclusions

- What makes ESI go up under health reform?
  - Subsidies to small employers
  - Dependent coverage up to age 26
  - Employer requirement
  - Individual mandate
- What makes ESI go down under health reform?
  - Additional insurance regulations on the ESI marketplace
  - Subsidies to individuals in the health insurance exchanges
- What else can happen?
  - Repeal of the individual mandate: ↓ ESI
  - Increasing access to the insurance exchanges for employers of all sizes: ↓ ESI
  - More efficient cost containment in the insurance exchanges (public option): ↓ ESI
  - Deeper recession: ↓ ESI
- Is ↓ ESI a bad thing in the long run?
  - Not necessarily if we find more effective pooling functions to increase coverage and control costs in the future



# For more information

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