THE FUTURE OF EMPLOYER-BASED HEALTH INSURANCE FOLLOWING HEALTH REFORM

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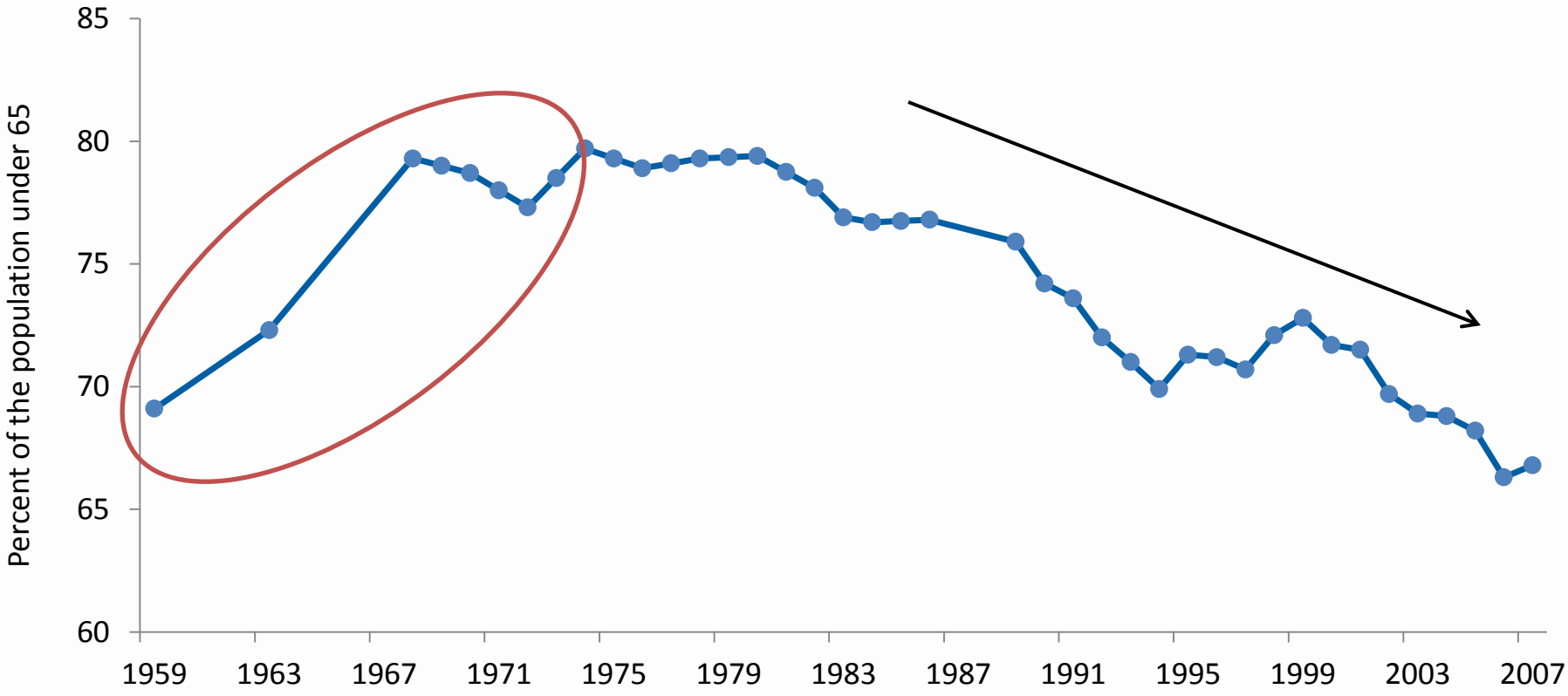
Brief history of employer-sponsored health insurance

- 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

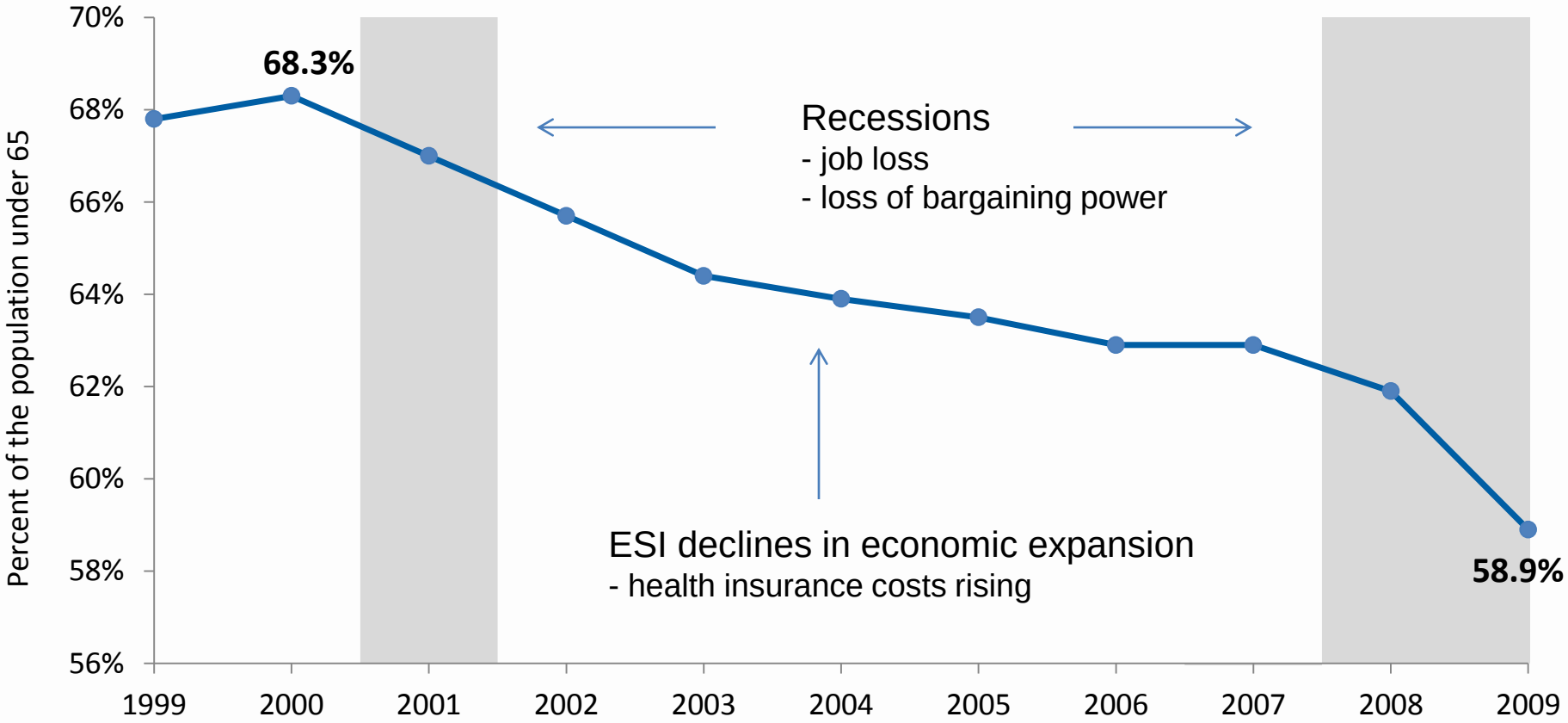
Share of under-65 population with any kind of private health insurance coverage, 1959-2007



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).

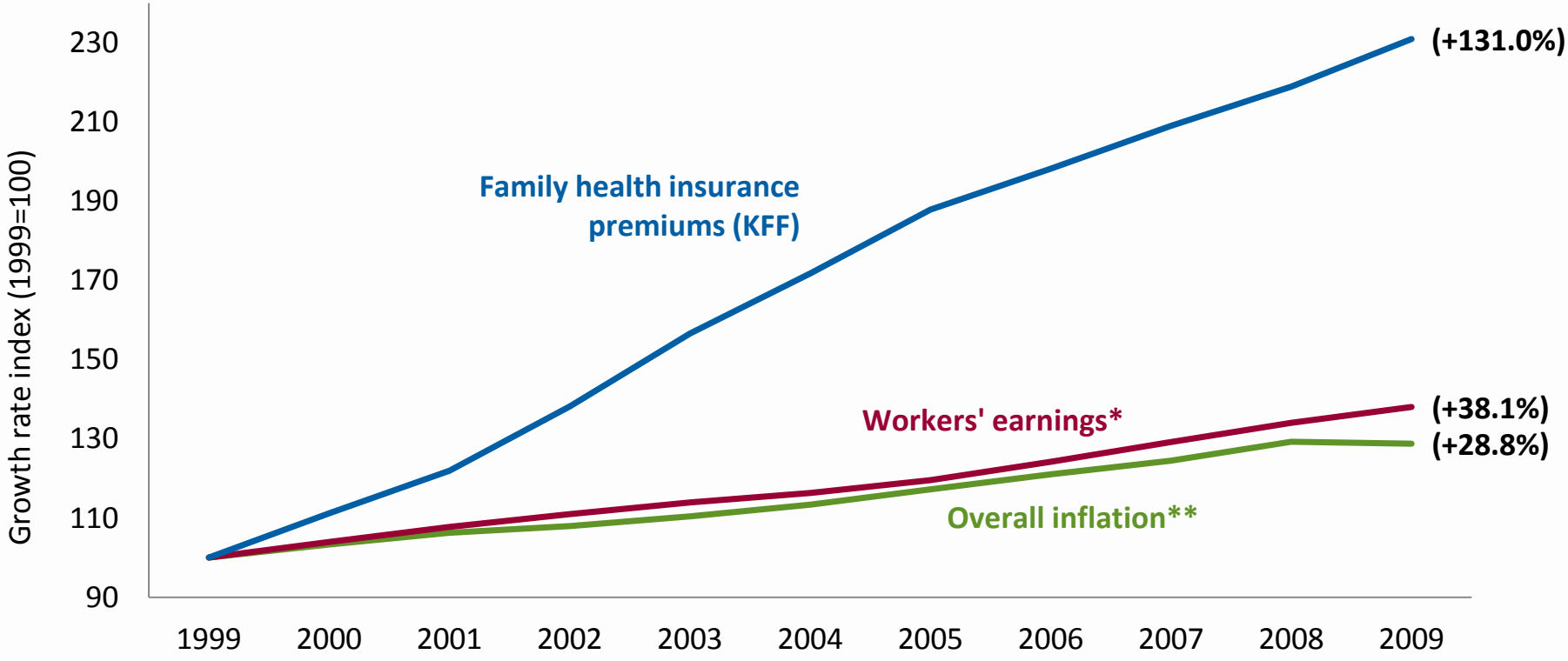
Share of the under 65 population with employer-sponsored insurance, 1999-2009



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.

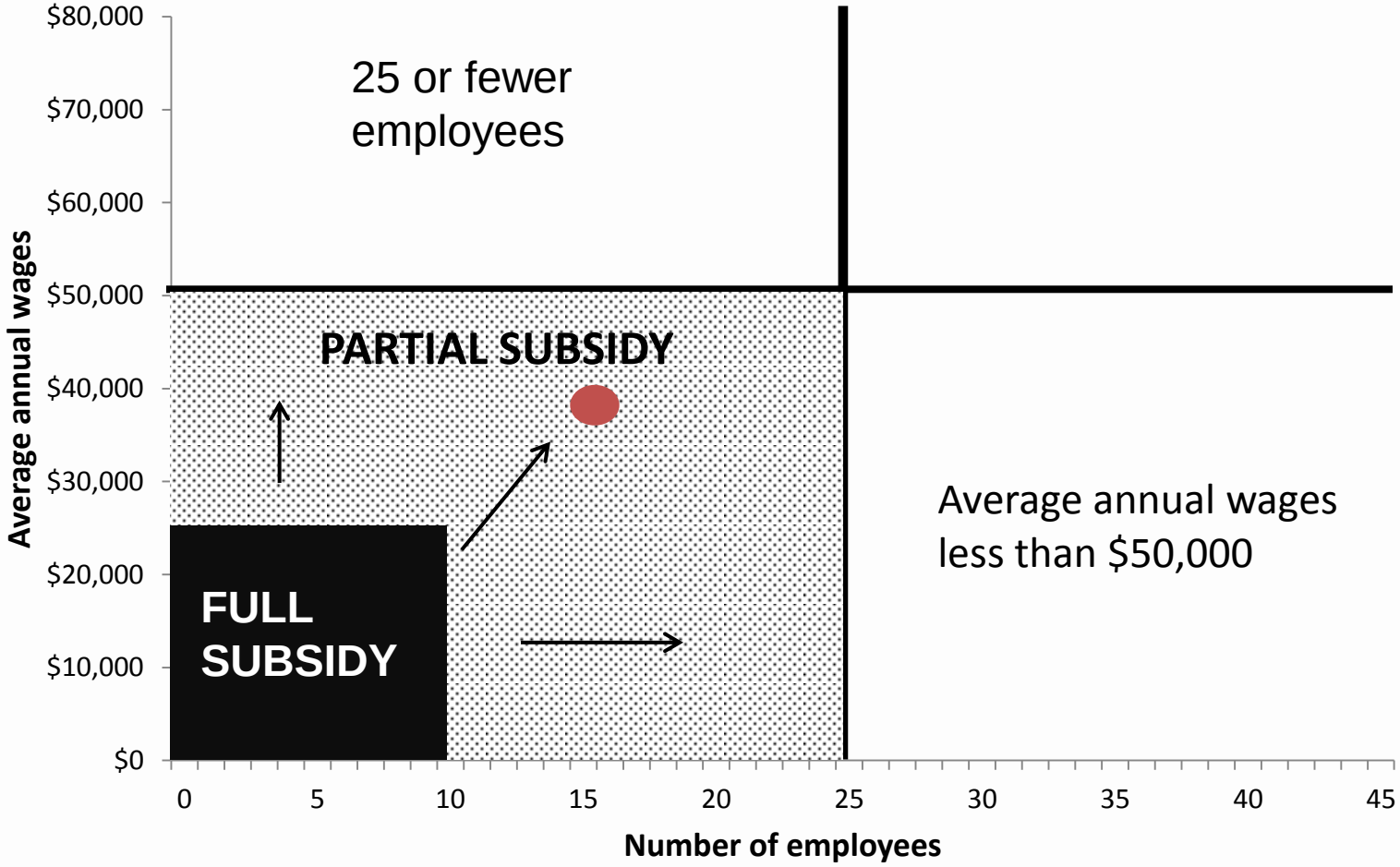
What will health reform do to these trends in employer-sponsored insurance?

- 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)

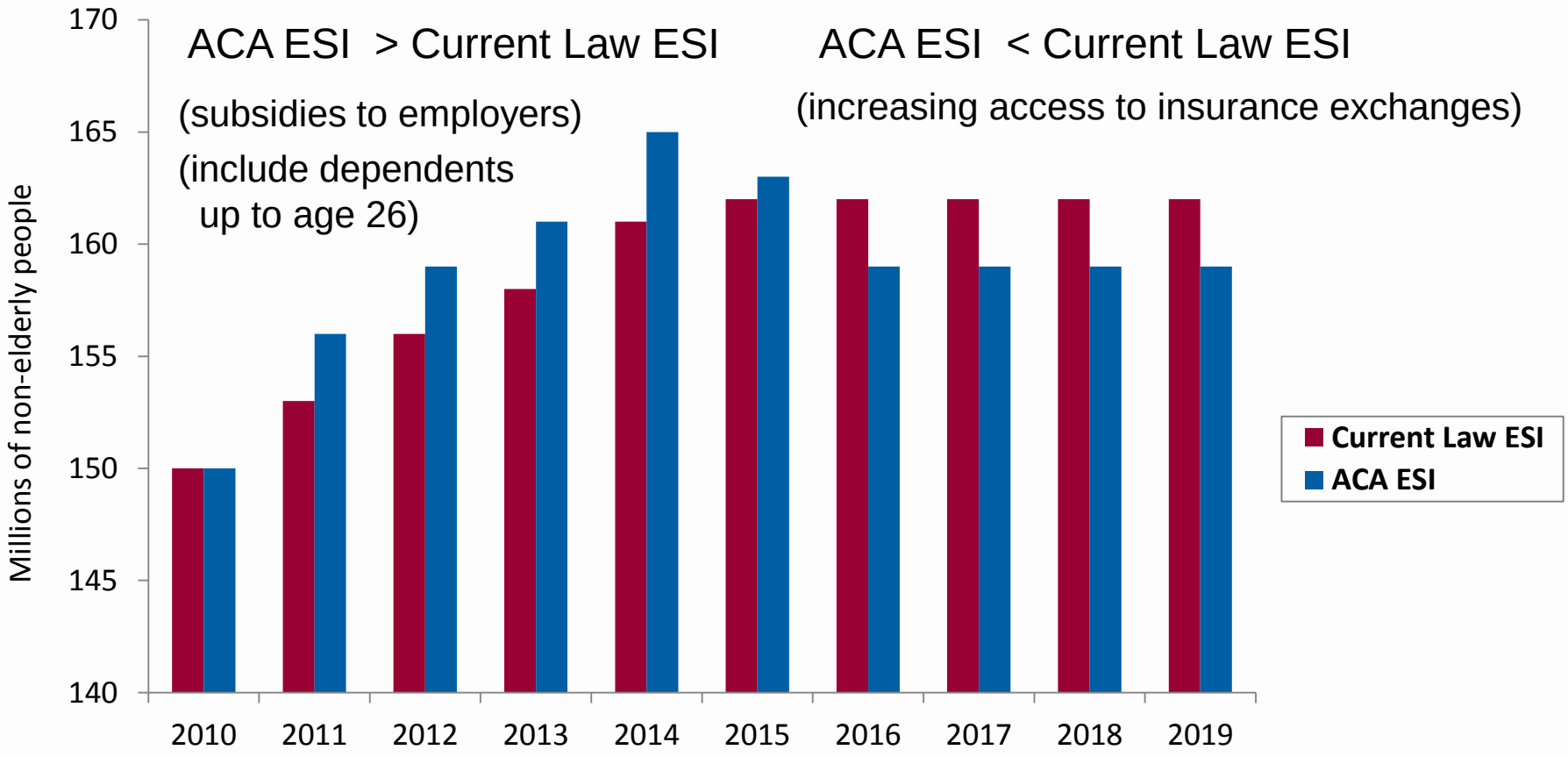
e.g.: 100 employees, 10 with credit

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

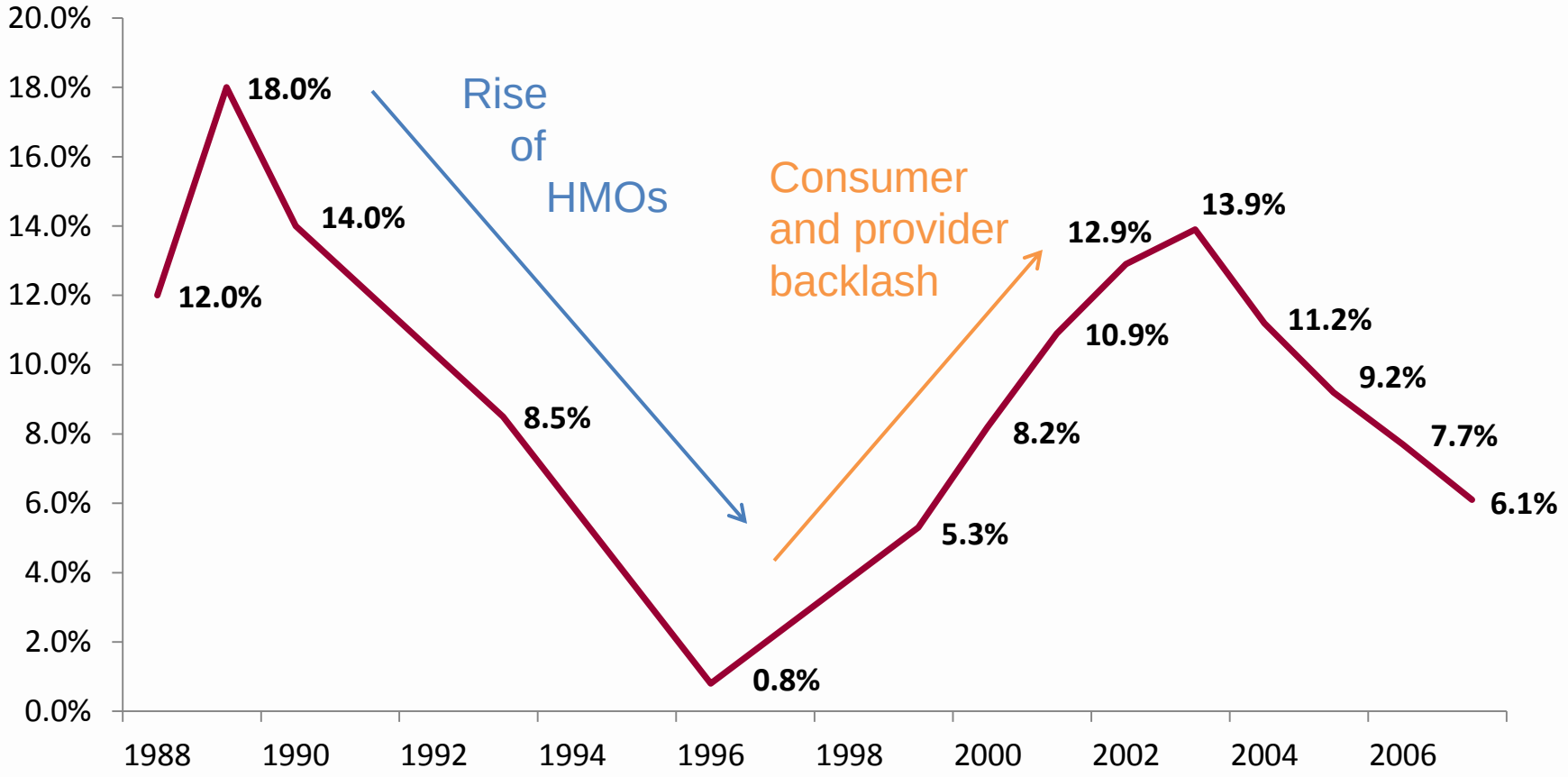
- 3 million net decline in ESI coverage in 2019
  - 6-7 million *increase* in ESI from *new* ESI offers
  - 8-9 million *decline* in ESI from employers dropping coverage or a lack of new coverage (coverage declines mostly in small and/or low-wage firms)
- 29 million enrolled in exchanges in 2019
  -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

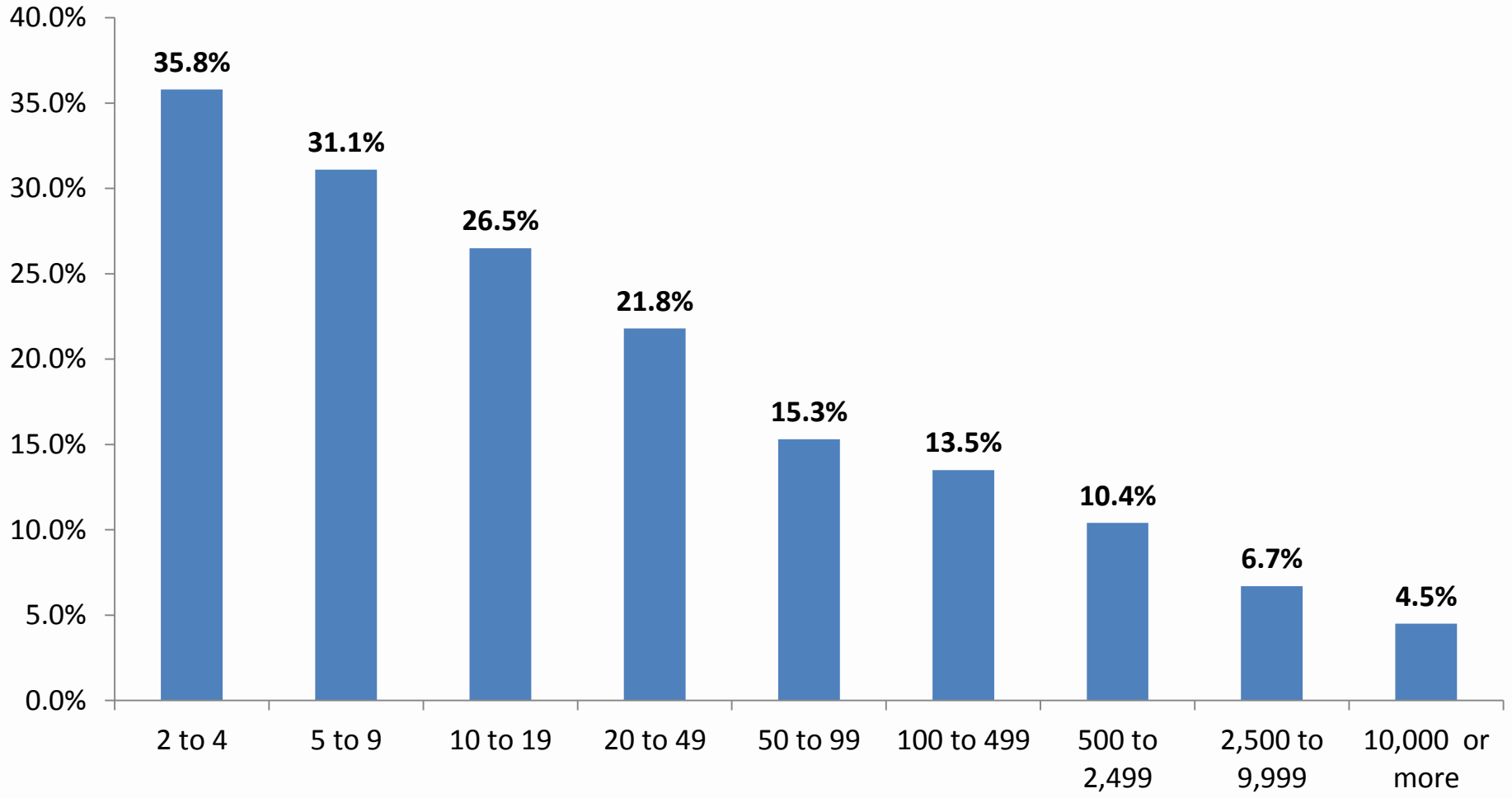
- Brief look at what has contained costs
  - Insurance design: HMOs
  - Administrative costs: Large firms/Medicare

Average percentage increase in health insurance premiums, 1988-2007



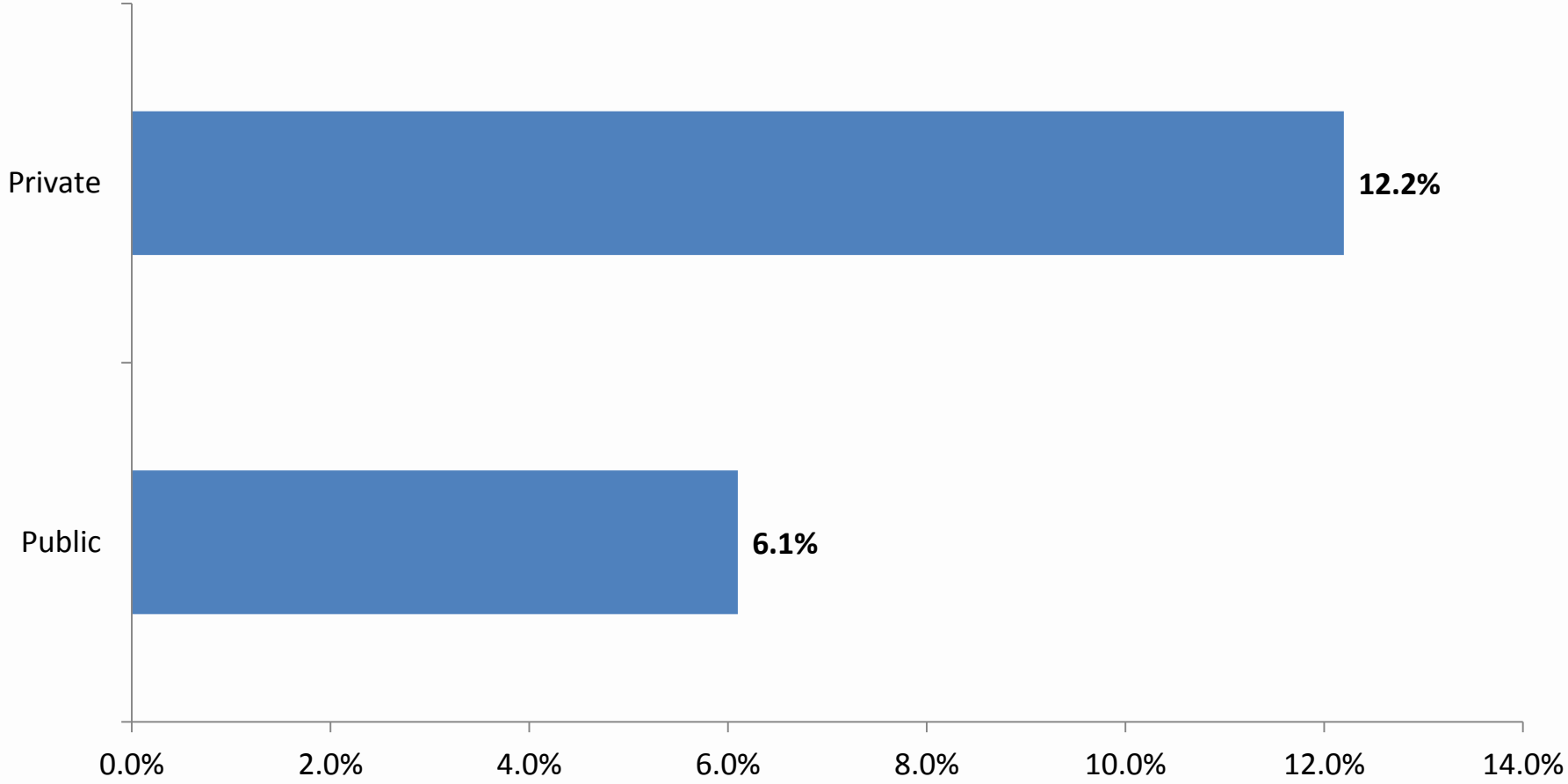
Source: Kaiser Family Foundation, *Employer Health Benefits 2007 Annual Survey*

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
  - $27,500 for family coverage (2018)

  – 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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