America honors four presidents with monuments on the National Mall in Washington, DC, and Franklin D Roosevelt didn’t get his by chance. Leadership out of the Depression, triumph in World War II, and the New Deal are just part of his immense legacy.

But President Roosevelt didn’t do it all. In 1935, forced to choose between his highest domestic policy priorities—a minimum guaranteed income for the elderly and a national health insurance program—he picked the former (ie, Social Security) putting medical coverage on temporary hold. (“Temporary” stretched to 30 years until the passage of Medicare legislation in 1965.)

President Roosevelt’s dream of a national health insurance program was never realized as the next decade brought World War II and a severe domestic labor shortage. The resultant inflation spawned wage controls and, to remain competitive, employers offered health insurance as a substitute for salary increases.

That precedent and a post-war economic boom contributed to enormous growth in employer-based health insurance. Between 1940 and 1950, the number of Americans with such coverage grew from 21 million to 142 million.1,2

In 1954, the pre-eminence of employer-provided health coverage was further cemented by the Internal Revenue Service decision confirming the tax deductibility of such premiums.1 A tax break, a popular employee benefit, a distinguishing feature in recruitment and retention… all at a modest cost. What was not to like for American business?

Unfortunately, the moderate costs didn’t last. And now, with the relentless growth of health care expenditures, many American companies, faced with increasing competition due to globalization, have had to restrict or even jettison medical insurance coverage for their employees and retirees.

Every fall, in an unwelcome annual rite, corporate benefit managers nervously await the survey of premium increases. On September 26, 2006, right on cue, the Kaiser Family Foundation delivered this year’s bad news:3 Between 2000 and 2006, premiums had risen 87% while wages had increased 20% and inflation 18% (Figure 1). Overwhelmed by these costs, for the first time the percentage of employees receiving insurance coverage dropped below 60% to 59% (Figure 2).

No employers, not even corporate giants and governments, escaped the squeeze. General Motors, Intel, Costco; the states of New York, Maryland, and Nevada; San Diego county and the city of Arlington, Texas all...
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went public with their plight.4 What steps has the business community taken to mitigate this escalation in expenses?

One mechanism employers, particularly large companies, have used to rein in costs is the self-funding of health insurance coverage. In this strategy, the employer accepts the financial risk (and reward) and pays insurance companies a straightforward, fixed management fee.

Self-funding has two big attractions: The first is straight out of Economics 101. In California, Kaiser Permanente has an overhead of 7% (93% of premiums go directly to patient care) compared to 21.1% for Blue Cross, or WellPoint.5 This difference allows, at least in theory, for savings of 14% in medical expenses to go directly to the employer.

Secondly, thanks to the passage on the Employer Retirement Income Security Act (ERISA) in 1974, self-funded plans are exempt from the myriad state coverage mandates. These statutory requirements include acupuncture (11 states), Wilm’s tumor screening (1), temporomandibular joint surgery (19), port-wine stain therapy (2), overnight maternity stays (all fifty states) and more than sixty other measures.6 The savings from avoiding these mandates (estimates range from 20-50%) go directly to the employer.

There is, however, a down side. With just about every employer large enough to participate in such plans already doing so, most of the costs have already been rung out of the system and, at this point, there is only room for marginal benefit. If self-funded insurance was to be the salvation of large companies, small employers put their hopes into the notion of consortia. A consortium is a mechanism through which companies could band together to purchase health care insurance, thereby gaining economies of scale and negotiating clout in the marketplace.

Among the first and largest such efforts was the Health Insurance Plan of California (HPIC).8 At the time of its founding in 1993, Governor Pete Wilson proclaimed, “The promise is of a new way, a better way, a less expensive way for small business to buy health insurance.”9

Not everyone was as optimistic. Some underwriters predicted that, with only voluntary rather than firm contractual ties, such alliances would founder over time as individual businesses understandably placed their own interests ahead of the group.

Early on, HPIC looked like a winner, dramatically increasing, sometimes tenfold, the number of health plans available to companies with 2-50 employees. But the anticipated purchasing clout and administrative savings proved more imagined than real.8

And 13 years later, the skeptics finally proved correct. In spite of a peak participation of 147,000 clients in 2002, HPIC fell victim to the bane of such efforts—adverse selection bias as employers with healthier workers inevitably left the cooperative.

On August 12, 2006, HPIC, by then doing business as PacAdvantage, closed its doors with considerably less fanfare and press than when it started.

Parenthetically, despite this history, another state has its eye on the consortium concept, albeit with a different population. In April 2006, the commonwealth of Massachusetts passed legislation that assures health insurance coverage to all its citizens. For companies with fewer than 50 employees, one element of this plan is a new, private, state-chartered clearinghouse called the Commonwealth Care Health Insurance Connector, or simply the Connector.10

Unlike HPIC, which functioned as an insurance underwriter, the Con-

Figure 2. Percentage of all workers covered by their employers’ health benefits in firms both offering and not offering health benefits, 1999-2006.4

* Tests found no statistical difference from estimates for the previous year shown at p < .05. Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2006. Kaiser Family Foundation, 2006.5
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nector will act as a stock exchange—matching buyers and sellers, collecting premiums and billing employers. Time will tell whether this iteration of a purchasing cooperative will be successful.

The third and newest mechanism employers have used to constrain costs is consumer-directed health care.

Consumer-directed health care is somewhat of a catchall, a term that includes high-deductible and high copay policies as well as health savings accounts, a tax-free vehicle for accumulating funds for out-of-pocket medical expenses.

The principle of such plans is that consumers, forced to spend their own money up to the deductible limit, will be prudent shoppers for discretionary health care thereby lowering overall societal costs.

Because of the high deductible (as much as $5000 a year), the overall costs and employee share of premiums can be held very low. As an example, Wal-Mart's newly announced Value Plan will cost individual workers as little as $22 a month.

Though untested, the policies have gained great favor among conservative economists and the Bush administration. Employers seem to be more timid in their response. In the 2006 Kaiser Family Foundation survey, fewer than 7% offered high-deductible or health savings accounts or both in 2006 and only 6% planned such programs in 2007. The much more common strategy (21%) was to simply charge employees more for the traditional coverage.

Similarly disquieting, in a Government Accountability Office survey of health savings accounts and high-deductible insurance plans, a minority of employees acknowledged shopping around for the most cost-effective medical services or even funding their savings accounts.

Though self-funding, purchasing cooperatives and consumer-directed health care are the predominant strategies used by employers, there are others.

Some employers, including Wal-Mart, Freddie Mac and Capital One, have taken things into their own hands and opened workplace medical clinics. As many as one-quarter of the Fortune 1000 are planning similar steps. In 2003, General Motors, staggering under a $5.3 billion yearly health care expense, seriously considered building its own hospitals in six cities with large concentrations of employees and retirees.

So what is the future of employer-based medical insurance? On one hand, not so good. At the current rate, about a 1% loss per year, by 2015 fewer than half of Americans younger than age 65 years will receive health insurance through their employer.

On the flip side, employers like the competitive advantage and control that providing health care coverage allows, not to mention the $126 billion annual tax break. And in the absence of a proven alternative, the 160 million Americans with employer-based coverage are unlikely to have much taste for political experimentation.

References

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