



**Most nonelderly Americans — 161.8 million workers and their dependents — received health coverage through the workplace in 2003. But this means that the share of the nonelderly population with employment-based coverage is at its lowest level since 1996. The number of Americans with coverage on the job has shrunk each year since 2000, despite a steadily increasing national population.<sup>1</sup>**

One main reason: higher health insurance costs. Rapidly rising health care costs are severely affecting the private and public sectors, including the business world. For employers and workers alike, rising health care costs threaten profits, the ability to meet out-of-pocket expenses, and perhaps the ability to afford coverage at all.

### KEYFACTS

- In 2003, 161.8 million Americans under age 65 — about two-thirds of the nonelderly population — had employment-based health insurance. This figure includes workers and their dependents.<sup>a</sup>
- The average annual premium cost for job-related coverage in 2003 was \$3,383 for a single employee (\$508 from the worker, \$2,875 from the employer). For family coverage, the average premium was \$9,068 in 2003 (\$2,412 from the worker, \$6,656 from the employer).<sup>b</sup>
- Considerable change occurs in the employer health insurance market: 62 percent of all companies said they shopped for a new health plan in 2003, and 33 percent changed the types of plans they offered or switched insurance carriers.<sup>c</sup>
- More than half of retirees age 55 - 64 had employer-sponsored health benefits in 2003. Among persons age 65 and older with Medicare in 2000, a third also had employer-sponsored coverage.<sup>d</sup>
- Only 38 percent of firms with 200 or more workers provided retiree health benefits in 2003, down from 66 percent in 1988.<sup>e</sup>
- More than 3,000 employers, including members of the Fortune 500, and some state and city governments, provide health care benefits to domestic partners of workers.<sup>f</sup>

For key fact sources, see endnotes.

According to a 2004 study, almost two-thirds of the declining number of people insured through an employer, especially dependent children, was attributed to fewer people signing up for coverage offered on the job.<sup>2</sup> Higher costs could be a key factor in this decision. Researchers estimated another 29 percent of the drop in employer-sponsored coverage numbers was due to people being out of work.

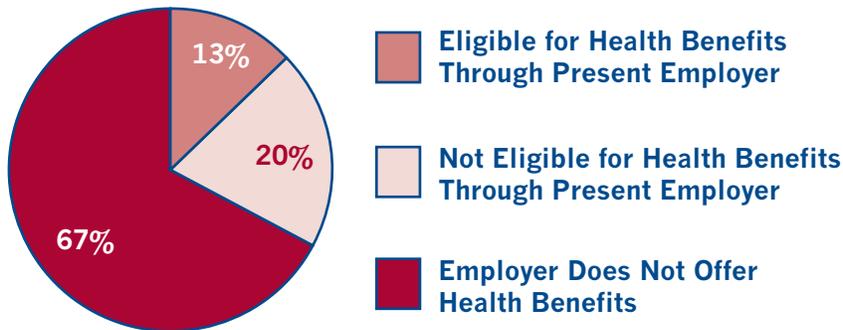
Despite the rising costs, however, employers are not seriously considering dropping sponsorship of health insurance and telling workers to find coverage on their own. Employers and workers alike regard health insurance as a bedrock benefit, an indispensable part of virtually any good job.

Coverage is so valuable, in fact, that workers believe it is worth walking the picket lines to preserve. Strikes today are often about health care, not wages. The Federal Mediation and Conciliation Service (FMCS) helped labor and management negotiate more than 6,000 disputes in 2003. Health benefits were an issue in 46 percent of those cases.<sup>3</sup>

Health care "is the single issue most likely to cause friction between workers and companies all over the country in coming months," according to Peter J. Hurtgen, head of FMCS. He helped resolve a bitter, four-month-long strike and lockout in early 2004, by grocery workers and supermarkets in southern California. The workers ultimately kept their benefits but agreed to cutbacks for future hires in the grocery industry.<sup>4</sup>

The majority of employers—59 percent in a recent Commonwealth Fund study—believe it is very important to make health insurance available to their workers, either by providing it directly or helping workers pay for it.<sup>5</sup> "The message from employers is that they want to do the right thing for their employees, but are struggling to manage the

## MOST UNINSURED WORKERS AREN'T OFFERED HEALTH BENEFITS



Source: Employee Benefits Research Institute estimates from the Current Population Survey, February 2001 supplement

rising costs of providing health coverage," said Commonwealth Fund president Karen Davis.<sup>6</sup>

The consensus is that the traditional system of on-the-job coverage, in place for more than a half-century, will continue to be the standard for America for the near future. Employer-sponsored health insurance plans were first developed and offered by Blue Cross hospital insurance plans during the 1930s. At about the same time, Henry J. Kaiser started a prepaid group health plan for employees of his construction company in the West. This plan was the forerunner for today's health maintenance organizations (HMOs).

On-the-job coverage became more appealing during World War II. The labor market was very tight because so many men and women were serving in the military. The government froze wages to help control inflation, but decided not to consider health benefits as earnings. Providing health coverage for employees became a popular tool for recruiting and keeping employees.

After World War II, unions, which at their peak represented as much as a third of the US work force, insisted on health care as an important bargaining benefit in their contracts. It spread throughout the economy, to union and non-union companies alike.

Firm size and coverage through the job are directly

related: the larger the firm, the more likely it is that workers will have health insurance coverage through their jobs. In 2003, about 39 percent of workers in firms with three to nine employees got coverage through their own jobs; 49 percent in firms with 10-24 workers; 59 percent with 25-49 workers; 61 percent with 50-199 workers; and 68 percent are covered at firms with more than 200 employees.<sup>7</sup>

Congress made health insurance a favored part of the economic structure with large tax subsidies. The IRS does not include employers' contributions for health insurance in workers' taxable income. That means a

dollar for health insurance is a full 100-cent dollar to the worker, rather than a dollar reduced by income, Social Security and Medicare taxes.

There are other advantages to job-based coverage. It is generally cheaper for the same covered services than if the employee were to purchase coverage on his or her own. An employer, representing many employees, has more clout than an individual in negotiating prices with health plans. Insuring a group of employees also represents less overhead cost per person for health plans than insuring an individual.

In addition, buying health coverage for a group of employees makes it more likely there will be many people with minimal medical expenses, balancing the small number who will need expensive care. This mix of people with different levels of risk spreads an insurer's financial risk, another factor that generally leads to lower insurance rates for groups. (See box, "Is Your Health Insurance Really Insurance?")

There are disadvantages to voluntary job-based coverage as well. Since employers aren't required to sponsor coverage, not all workers have access to it. Two-thirds of uninsured workers in 2001 held jobs where no health benefits were offered. (See chart, "Most Uninsured Workers Aren't Offered Health Benefits.")<sup>8</sup> Losing a job, deciding to start one's own business,

divorce, retirement or a shift to part-time status could all mean loss of coverage. And when coverage is offered, some workers simply can't afford their share of premiums and other cost-sharing.

## RESPONSES TO PREMIUM INCREASES

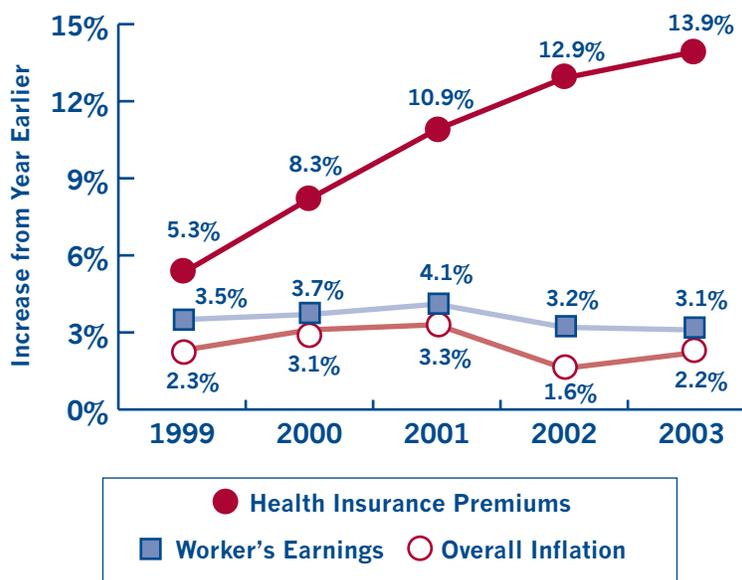
Premium increases for health insurance through the workplace totaled 13.9 percent for the 12 months ending in spring 2003, the third straight year of double-digit increases. The increase was the biggest for a single year since 1990. Premiums are dramatically outpacing inflation (2.2 percent) and wages (3.1 percent). (See chart, "Cost of Health Insurance Premiums is Rising Faster than Earnings or Inflation.")<sup>9</sup> This means that health costs consume a bigger share of corporate spending and a bigger share of the average household budget.

The average premium increase for 2003 would have been even higher if a large number of employers had not chosen to reduce coverage. The Center for Studying Health System Change estimates that such reductions brought about a savings of 3 percentage points in 2003.<sup>10</sup> Analysts predict double-digit increases again for 2004 and 2005, and probably for years to come.<sup>11</sup> (For more information, see Chapter 8, Health Care Costs.)

Health insurance is now a major expense for both workers and employers. The average premium for 2003 was \$3,383 for a single worker, with the worker's share at \$508, and the company paying \$2,875. The average cost of family coverage for the year was \$9,068, with the worker paying \$2,412 of the premium, and the employer paying \$6,656.<sup>12</sup>

During the strong economic growth and tight labor markets of the late 1990s, most employers were willing to absorb the cost of increasing premiums. But the economic slowdown that began in 2000 led companies to believe they could no longer absorb the increases unilaterally.

## COST OF HEALTH INSURANCE PREMIUMS IS RISING FASTER THAN EARNINGS OR INFLATION



Source: Kaiser Family Foundation and Health Research and Educational Trust (2003). "Employer Health Benefits: 2003." Chart pack, p.2. (<http://www.kff.org/insurance/ehbs2003-abstract.cfm>)

More employers are beginning to selectively shift the cost burden to their workers. They usually do not increase the worker share of premiums significantly, at least not for employee-only coverage, because that might deter enrollment. Insurers often require high levels of participation in a given firm, to avoid insuring only the sickest workers. If the required level of participation is not met, the insurer may decline to offer a policy to the company.

A 2003 study by Mercer Human Resources Consulting found no increase between 2002 and 2003 in the percent of the total premium employees had to pay to cover themselves alone in a preferred provider organization (PPO), and a 4 percent increase for employee-only HMO coverage. The employee contribution for family PPO coverage went up from 53 percent of the total premium in 2002 to 58 percent in 2003, and for HMO family coverage from 50 percent in 2002 to 57 percent in 2003.<sup>13</sup>

Rather than raising employee premium contributions dramatically, employers have been structuring policies

## IS YOUR HEALTH INSURANCE REALLY INSURANCE?

Most workers' health insurance is not, strictly speaking, insurance. About 52 percent of those with coverage through their jobs work for firms that "self-insure." That is, the companies pay health care bills directly, instead of buying coverage from an insurer for a set premium. Thus the employers bear the financial risk, and they typically hire an insurer to process claims. This allows the employer to avoid most state insurance regulations and premium taxes, and allows multi-state companies to offer the same coverage to their employees in any part of the country. The bigger the company, the more likely it is to be self-insured. Self-insured companies often limit their overall financial exposure by purchasing reinsurance for claims above a given amount.

Source: The Kaiser Family Foundation and Health Research and Educational Trust (2003). "Employer Health Benefits: 2003 Annual Survey," p. 124. (<http://www.kff.org/insurance/ehbs-archives.cfm>) Retrieved April 27, 2004.

so that the worker must spend more of his or her own money when using the health care system, usually through increases in copayments and deductibles. Among the nearly 3,000 employers polled in the Mercer survey mentioned earlier, 34 percent said they required employees to pay a deductible of \$1,000 or more for PPO network care in 2003, compared with 20 percent in 2002.<sup>14</sup>

Traditionally, in most health plans a hospital stay had a negligible deductible, or none at all. Now, the deductibles for many workers are hefty. About 36 percent of all workers with health insurance have separate deductibles when they go to the hospital, with the deductible averaging \$202 in 2003.<sup>15</sup>

Companies have also adopted drug formularies, lists of medications approved by the health plan. For those who use a medication outside the approved list, there is a higher copayment. The percentage of workers enrolled in a health plan using a drug formulary was 71 percent in 2003, compared with just 46 percent in the year 2000.<sup>16</sup>

## RETIREE COVERAGE

About 12 million non-federal retirees have health coverage through their former employers.<sup>17</sup>

But this is a rapidly disappearing benefit. As recently as 1988, 66 percent of companies with 200 or more workers provided retiree health benefits. By 2003, the figure had dropped to 38 percent and is expected to keep falling.<sup>18</sup> Noted health economist Uwe Reinhardt of Princeton University believes that "twenty years from now, no company will offer retiree health care."<sup>19</sup>

The Financial Accounting Standards Board requires that firms account for retiree health benefits on an accrued basis: they must estimate their total future obligations to retirees, and place this potentially huge amount on the balance sheet. To make spending more predictable and affordable, companies have been imposing caps, which will limit their obligations even in the face of steadily rising costs each year. The cap is typically a limit on how much the company will contribute to the health care premium for each worker. When the costs exceed the cap, any additional expenses must be borne solely by the retired worker. Some 46 percent of all employers have caps on the share they will spend for the retiree's health coverage.<sup>20</sup>

When a retiree reaches age 65, Medicare covers most of their health care bills. If the employer continues coverage for the retiree, it typically complements or "wraps around" Medicare, paying for co-pays, deductibles, and services Medicare doesn't cover. Thus post-65 retiree costs are lower for most employers. The average monthly health insurance premium in 2003 for retirees under 65 was \$427—\$166 paid by the retired worker and \$261 by the former employer. For retirees 65 and over, the average premium was \$212 a month, with \$83 paid by the worker and \$129 by the company.<sup>21</sup>

The most noticeable gap in Medicare has been coverage for outpatient prescription drugs. The cost of outpatient drugs has been rising at a double digit rate for the last several years.<sup>22</sup> The new Medicare prescription drug law will ease some of the burden on employers. It has special subsidies to corporations to encourage them to retain their retiree health benefits. The law provides \$71 billion in direct subsidies between the years 2006 and 2013 and another \$17.8 billion in tax benefits during the same period to cover the cost of prescription drugs for retirees.<sup>23</sup>

## WHAT'S ERISA?

ERISA — the Employee Retirement Income Security Act — was enacted by Congress in 1974, mainly to protect workers' pensions. But the law also sets uniform standards for private multi-state, employer-sponsored health plans. The intent was to give workers some minimum procedural protection, while allowing large employers to offer the same health insurance package in multiple states by clearing away the obstacles posed by conflicting state laws. Roughly 120 million Americans belong to ERISA-regulated health plans.

Its supporters credit ERISA with helping to expand health insurance to millions of workers by easing administrative and regulatory burdens on large employers. Yet some policy makers view a number of provisions in ERISA as anti-consumer.

For example, if a worker covered by an ERISA-regulated plan thinks he or she has been wrongly denied a benefit, such as a cancer test, and is subsequently diagnosed with cancer, they cannot sue for resulting damages in state court. That's because ERISA preempts any state law related to the wrongful denial or delay of health benefits in a health plan sponsored by a private employer.

ERISA does allow suits against health insurers and employers, but only in federal court, and only for the immediate value of the medical care denied, not for resulting economic loss, or for non-economic or punitive damages. Given the expense and difficulty of the legal process, those provisions have effectively prevented liability lawsuits against health plans, insurers, and employers covered under ERISA.

Legislation has been introduced regularly in recent years to give workers more room to seek redress from their ERISA-regulated plans, but has not advanced to enactment.

Source: Butler, Patricia A. (2002). "Regulation of ERISA Plans: The Interplay of ERISA and California Law." California HealthCare Foundation, June. (<http://chcf.org/documents/insurance/ERISAREgulationFullReport.pdf>) Retrieved August 3, 2004.

## CONTROLLING FUTURE COSTS

In an attempt to control future health care costs, some employers are turning to a relatively new concept, so-called consumer-driven health plans, which put cash and much of the responsibility for health care spending into the hands of employees. While many firms have shown interest, by January 2003 only about 470,000 workers were enrolled in such plans. (Unpublished estimates in early 2004 put the figure at about 1 million.)<sup>24</sup> But many firms, especially large employers, have indicated they will add these plans to the list of choices for workers in the near future. (For more information on consumer-directed health plans, see Chapter 8, Health Care Costs.)

## DOMESTIC PARTNERS

An increasing number of companies offer domestic partner benefits. The same workplace benefits—including health insurance—that are offered to the spouses of married workers are made available to the domestic partners of unmarried workers. These may be either same sex or opposite sex partners; each company decides its own policy. Typically, the employee would sign a statement that the domestic partners have lived together for at least six months and are in a committed relationship.

Domestic partner coverage has grown rapidly since the Village Voice newspaper first offered it to its workers in 1982. Now, more than 5,600 private and public employers provide the benefits, including 182 of the Fortune 500, and the states of California, New York, New Jersey, Connecticut, Maine, Minnesota, Rhode Island, Oregon, Vermont and Washington.<sup>25</sup> According to the Society for Human Resource Management, about 23 percent of companies offer domestic partner benefits to same-sex couples.<sup>26</sup>

There is a difference in the federal tax status of domestic partners. They are not considered spouses under the tax code. For married couples, the value of the spouse's health insurance is not considered income to the worker. However, the value of the benefit for an unmarried domestic partner is counted as income for the worker.

For example, suppose coverage costs \$100 a month for a single worker and \$200 a month for a married couple. In both cases, the value of the premium for the worker is excluded from income. However, if the worker has a domestic partner, the additional \$100 a month in premiums for coverage for the couple would be counted as wages, meaning the worker must pay taxes on the money. The money is non-taxable only if the domestic

partner is a dependent, defined as someone who lives in the worker's home and gets at least half their support each year from the worker.<sup>27</sup>

## STORY IDEAS

- Contact major employers and unions in your area to see what changes are being made in health plans to control rising costs. Is their preferred method to raise the share of the premium paid by the employees? Do they find it more acceptable to increase the copayments and deductibles? Do they use a three-tier system for prescription drug coverage? (Lowest copayment for generic drugs; a larger payment for brand-name drugs on the approved list, and the highest payment for brand name drugs outside the approved list.)
- Talk to owners and operators of small businesses, and to the state chapters of organizations such as the National Federation of Independent Business. Are they or their members dropping coverage because of rising costs, picking up the increased costs themselves, or, are they requiring workers to pay more for coverage?
- Talk to administrators at clinics and community health centers and hospital emergency rooms? Are they seeing a caseload increase? Does this represent people who lost their coverage at work? Or people who have coverage but can't afford to use it?
- Contact health insurance firms about their changing products. Are they selling more high-deductible policies to keep down the overall premium expense? Are they beginning to market policies combined with the Health Savings Accounts authorized under the new Medicare law?
- Ask local HMOs in the Medicare market if they expanded and improved their benefits this year because of the additional money granted to them by the new Medicare law. Many HMOs strengthened their coverage of brand name prescription drugs, some reduced their monthly premiums, and some raised provider payments in response to the infusion of extra cash from the federal government.
- If Congress were to change the ERISA law (see box) to make it easier for people to sue their

## CANDIDATES' VIEWS

President Bush and Senator Kerry offer contrasting visions of the role that government can play vis-à-vis employer-based health care coverage.

President Bush relies on two main approaches: tax incentives to encourage people without coverage to buy individual private insurance and Association Health Plans that would make it easier for small businesses to sponsor coverage. These plans would allow chambers of commerce and other groups to sponsor regional and national health insurance plans without having to comply with most state insurance regulations, including state-mandated benefits. This, backers say, will significantly lower costs and, therefore, expand coverage for workers at small businesses.<sup>28</sup>

Senator Kerry proposes to cover more of the uninsured, with major expansions of public programs. He would encourage more employment-based coverage by offering a choice of policies, in a structure similar to the Federal Employee Health Benefits Program, for small businesses and some individuals.

Senator Kerry would also create a premium rebate pool to help companies deal with catastrophic health care costs. Under this arrangement, the pool would reimburse employer-sponsored health plans for 75 percent of the costs they incur above \$50,000 per person, as long as the resulting savings are used to reduce the cost of workers' health premiums.<sup>29</sup> To be eligible for reimbursement from the pool, an employer would have to provide health coverage to all workers and would have to offer chronic disease management programs.<sup>30</sup>

employer-sponsored health plans, how would this affect employers in your state?

## SOURCES AND WEBSITES

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