

**The State of Employment-
Based Health Coverage**
and
**Business Attitudes About
Its Future**

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Economic and Social Research Institute (ESRI) is a nonprofit organization that conducts research and policy analysis in health care and in the reform of social services. ESRI specializes in studies aimed at enhancing the effectiveness of social programs, improving the way health care services are organized and delivered, and making quality health care accessible and affordable.

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SUMMARY

This report by the Economic and Social Research Institute reviews the history and trends of the employment-based health coverage system, assesses its strengths and weaknesses, and explores how employers themselves feel about continuing their current roles in that system and about various options to reform it. We conducted in-depth interviews with employers from a wide range of firm sizes, industries, and geographic locations. The findings reveal employers' attitudes about what needs to be "fixed" in the current health care system, and their willingness to consider changes and alternatives to that system.

STRENGTHS AND WEAKNESSES OF CURRENT EMPLOYMENT-BASED HEALTH SYSTEM

Among its strengths, the employment-based system of providing health coverage provides a convenient and accessible vehicle for enrollment and for pooling risk. About nine out of ten workers who are eligible for employment-based coverage sign up, with a minimum of paperwork and automatic deductions of premium contributions from their paychecks. Federal tax treatment of health insurance, while costly, has encouraged the spread of health coverage and now 172 million people—including the majority of nonelderly Americans — get their coverage through the workplace.

The employment-based system also encourages innovation in the areas of cost control and quality initiatives, while giving employees an intermediary with greater bargaining power and generally more expertise and resources to dedicate to complicated administrative and negotiation responsibilities. Employer- sponsored coverage makes health coverage affordable to a great number of people who would be priced out of the individual market.

Among its weaknesses, this system excludes millions who are not tied to the work force, along with a significant number of working Americans and their dependents who are not offered or are ineligible for employer-sponsored benefits, or cannot afford their share of premiums. The tax incentives that encourage participation also reflect a regressive financing system in which lower-income workers pay a relatively higher percentage of their income and receive less tax benefits for health insurance than higher-wage workers; those without work-based coverage do not get these tax benefits at all.

The system favors larger and younger firms, forcing small employers and those with older, sicker work forces to pay significantly more for health coverage. The high costs and management functions are particularly burdensome to small firms. The system also

limits individual choice of health plan and may hurt productivity if it locks workers into jobs, while at the same time disrupting continuity of medical care for workers who do change jobs, or work for a firm that changes health plans.

Some of these problems are related to the way employers currently finance and/or manage health coverage and can be addressed by changing employer practices. For example, many employers who contribute to health benefits offer only one plan, and many companies do not structure their contributions in a way that encourages cost control. Access and portability problems, however, are inherent in a voluntary system where coverage is tied to one's job.

FINDINGS FROM INTERVIEWS

Employers have a first-hand understanding of the practical advantages and difficulties of an employment-based financing system, and their knowledge and support can be critical to devising workable solutions to the problems with that system.

ESRI conducted in-depth interviews with 56 U.S. business representatives to explore their opinions about health coverage issues and policy reforms. We did not set out to conduct a formal survey of a fully representative sample of employers, but rather chose "depth" over "breadth." Although our sample is not large enough to draw statistically valid conclusions about the views of American employers as a whole, we believe that it captures the diversity of American employers and provides the range of concerns and preferences in the business community. To build some diversity into our sample, we interviewed roughly an equal number of employers from four firm size categories: very small firms (2 to 15 full time employees [workers]), small firms (20 to 70 workers), mid-sized firms (100 to 500 workers), and large firms (900 or more workers). We included companies from all geographic regions and from a variety of industries.

Key Themes

The respondents conveyed a diversity of opinions; nevertheless, there was consensus among most interviewees on a few important issues. Following are the key themes that emerged:

- Despite current rhetoric that most employers want to relinquish their involvement in providing health coverage, most respondents in our sample desire to maintain their role in both financing and managing health benefits.
- There is wide-spread acknowledgement across all firm sizes of the obstacles facing smaller firms and the need to expand their options for obtaining affordable health insurance.
- While all respondents believed that everyone should have health coverage, *choice* in both whether to obtain insurance and in selecting a health plan is highly valued over mandates.

- There is strong antagonism toward HMOs and managed care, particularly related to taking decisions away from physicians, rising premiums, administrative hassles, and inadequate reimbursement to providers.
- Most respondents strongly distrust government, which is viewed as interfering with personal freedom, and/or incapable of operating a program effectively or efficiently; private sector solutions are preferred.
- Despite anti-government attitudes, most respondents supported expansion of government health coverage programs (Medicaid, S-S-CHIP) and further regulation of the managed care industry.
- Some conflicting views about the role of government and the private sector reflect a degree of “cognitive dissonance” among employers.

Role in Financing and Managing Health Benefits

In our discussions we distinguished between two types of responsibilities currently taken on by the majority of employers: *financing* health coverage by contributing toward workers’ and dependents’ premiums; and *managing* health coverage by selecting and designing benefit packages, negotiating with health plans on behalf of employees, and trying to control costs or improve the quality of care delivered.

The prevalent view among the respondents was that employers should *finance* health benefits, for the following reasons:

- Employers have a moral responsibility / obligation to workers.
- Health benefits are a tool to recruit and/or retain workers.
- Providing coverage is a necessary cost of doing business.

Among the minority who expressed the view that employers should *not* finance health benefits, the primary reasons were:

- Many employers cannot afford to provide health benefits.
- Obtaining coverage should be the responsibility of individuals.

The majority of respondents stated that employers should *manage* health benefits, for the following reasons:

- Employers are better equipped than workers to conduct management functions (research health plans, negotiate with insurers, administer benefits).
- Employers can make better choices than workers.
- Employers have a stake in maintaining control and ensuring that money is being spent wisely.

Among the minority who felt that employers should not manage health benefits, the key reasons were:

- Many employers are not equipped to conduct management functions.
- Individuals can better choose what is best for them.

Reforming the Health Care System

All respondents acknowledged flaws in the health coverage system. The three greatest concerns about the future of health care were (in decreasing order of prevalence):

- rising costs, with some employers citing prescription drug costs specifically, and many claiming that insurance is becoming unaffordable;
- abuses by HMOs and managed care, particularly removing decisions from the doctors, continually increasing premiums, not reimbursing providers adequately, and other complaints; and
- access, problems facing uninsured people.

When asked about specific reform strategies to improve the health care system, the following reforms are *avored* by a majority of respondents (order reflects decreasing level of support among those expressing opinions):

- new purchasing cooperatives for small businesses;
- small firm “buy-ins” to existing group health plans (e.g., state employee health plan, Federal Employees Health Benefit Program (FEHBP));
- subsidies for employers offering health coverage to workers for the first time;
- expansion of Medical Savings Accounts;
- expansion of public health coverage programs (e.g., Medicaid, S-CHIP); and
- government-backed reinsurance of private health plans.

Reform strategies *opposed* by a majority of respondents were:

- employer mandate;
- individual mandate;
- single payer, national health system; and
- replacement of tax exclusion with targeted tax credit.

Differences in Attitudes Across Firm Size

On most issues discussed, attitudes and preferences were similar across firm size. There were some noteworthy differences, however:

- Employers of very small firms (2 to 15 workers) were somewhat less likely than other size firms to support the employers’ role in *financing* health coverage for workers and much less likely to support their role in *managing* health benefits. This group was more likely to favor an individual mandate to purchase health coverage (slightly more than half of respondents in this group favored the mandate).
- Employers of small firms (20 to 70 workers) were the most supportive of the employer role in managing health benefits, generally because they felt that they could do the job better than individual workers. Yet this was the only group in which a majority favored reform that would establish a single payer system, and reform that would institute an employer mandate. While all groups were

unanimous in supporting the ability of small firms and individuals to purchase coverage through new, large purchasing cooperatives, small employers were the most vehemently opposed to a *requirement* that small firms obtain insurance through these large pools. This group was most likely to consider using defined contributions to fund employee coverage in the future.

- While the majority in each size group favored expansion of Medical Savings Accounts (MSAs) to promote affordable coverage in the workplace, employers from medium-sized firms (100-500 workers) were the only group in which a majority said that they themselves would consider instituting MSAs at their businesses.
- Respondents from large firms (900 or more workers) were unanimous in supporting two reforms that help put *smaller* businesses on an even playing field with them: allowing small firms to buy in to existing large group plans (e.g., state employee health plan, FEHBP); and expansion of large purchasing cooperatives.

POLICY IMPLICATIONS AND CONCLUSIONS

Employers acknowledge that the current system has both positive and burdensome features for them. They also apparently understand that there are major flaws in a system that leaves so many people without access to affordable health coverage. The following messages for policymakers emerged from this study.

- Employers are not abandoning the U.S. health care system. At least for the near future, employers want to remain actively involved in providing coverage to workers and dependents. Many employers seem to feel a deep sense of responsibility for their workers, independent of unemployment rates and profits. Despite experiencing a recent acceleration of premiums and foreseeing a downturn in the economy, they called for better controls on cost rather than opting out of the system.
- Reform should include efforts to level the playing field for small businesses. Employers are likely to favor an expansion of purchasing cooperatives on a voluntary basis, and would likely support government assistance to these entities to help them get established. They do not seem to be aware, however, of the difficulties faced by many such cooperatives in achieving a “critical mass” to become viable. Enrolling workers from small firms in public sector workers’ insurance plans, direct government premium subsidies to small businesses or to employers offering insurance for the first time, and to low-income individuals are also likely to be supported.
- Employers are torn between (potentially) conflicting desires to control costs and to remove restrictions on access to health care. Demands for regulation on HMOs to both keep premiums down *and* to stop tying the hands of physicians and patients

illustrate unrealistic expectations that they can cut costs even as realistic cost-cutting mechanisms are weakened. A challenge for policymakers is to develop ways to curtail the most onerous restrictions by managed care plans while allowing them to maintain some of the incentives and mechanisms aimed at reducing inappropriate care and keeping costs in check.

- Employers could support an expanded but limited role for government in health care. Employers seem to understand that both private and public sources of coverage must expand to cover those left out of our system. Government could likely garner business support for: expanding subsidy programs such as Medicaid and S-S-CHIP, as well as for subsidies to workers and employers to help expand coverage in the workplace; regulatory measures to limit insurers' ability to practice risk selection among smaller companies and to enable small firms to buy into large insurance pools; and other measures that would allow employers and employees to maintain a certain level of autonomy while helping to provide coverage for those workers excluded from the current employment-based system.
- Businesses are more likely to support a combination of incremental approaches over a bold, comprehensive reform initiative. To be effective, such an approach would require that new subsidies be large enough, and the insurance pools broad enough, to keep the financial contribution made by a large number of lower-income workers and employers reasonable. These strategies should be combined with an expansion of public programs for those who still fall between the cracks. The challenge for policymakers who pursue this direction is to avoid a piecemeal collection of unrelated reforms, and instead develop a carefully thought out, well-integrated strategy to restrain the growth in costs and make coverage available for those people left out of the current system.

INTRODUCTION

Employment-Based health coverage remains the dominant form of health insurance for people under age 65 in the United States. More than 170 million Americans, or two-thirds of the nonelderly population, obtain health care coverage through their jobs or the job of a family member. This system places two types of responsibilities on the shoulders of employers who choose to take part: *financing* health coverage by contributing to health insurance premiums for workers, and in most cases their dependents; and *managing* health coverage by designing and selecting benefit packages, negotiating premiums with health plans, and trying to improve the quality of care delivered.

While it clearly has its strengths, the current employment-based system is showing cracks and flaws that make some people question whether it is appropriate to place so much reliance on this source. The purpose of this report is to fully assess the strengths and weaknesses of employment-based coverage, and explore how employers themselves feel about continuing their current roles in financing and managing coverage, and about various options to reform the health care system.

The Economic and Social Research Institute has conducted in-depth interviews with employers from a wide range of firm sizes, industries, and geographic locations to provide up-to-date information about how employers think about the health coverage system they oversee and partially finance. Understanding their perspective is important both for their insights about the strengths and weaknesses of our current system and to gauge their willingness to consider major reforms and alternative systems. We explore, for example, employers' opinions on the critical issue of whether to try to fix the employment-based system (and how to do this) versus starting over with a very different approach. Further, we try to determine their views on what would be the best alternative, and the reasons behind their choices.

Employers have a first-hand understanding of the practical advantages and difficulties of an employment-based financing system, and their knowledge can be critical to devising workable solutions to the problems with that system. Moreover, many employers have a vested interest in the present system: they have invested time, money, and personnel in making it serve their needs. Anyone who proposes to reform the system, especially if the reform would dramatically alter the employer's role, needs to understand how employers would react to the proposed alternatives. Their political opposition could be a major element in determining the viability of legislation that would change the system, and their attitudes toward reform could be crucial in determining whether those reforms will succeed.

In Section 2, we describe the employment-based health insurance system in an historical context. A brief history illustrates how the employers' current role in

financing and managing health coverage in part from conscious health care polling decisions, but also from social, economic, and political forces outside the health care system. We then present a snapshot of the employment-based system today, showing how this mechanism provides coverage to the majority of nonelderly Americans, but excludes millions of both non-working and working individuals and families. Citing major research studies and national surveys, we then present evidence on *trends* emerging in key dimensions including: rates of employee and retiree coverage; offering, eligibility, and take-up rates; costs and premiums; employer and employee contributions; range of benefits; choice of health plans; managed care enrollment; and purchasing practices.

This review of trends sets the stage for an analysis of the key strengths and weaknesses of the employment-based coverage system, presented in Section 3. We then assess the key challenges for reforming the current system, and present the major reform options that have been proposed to address existing flaws. Some of these proposals would build upon the existing employer roles in financing and managing health coverage; some would alter some aspect of these roles; and some would eliminate the employment-based system entirely.

Section 4 focuses on our interviews with 56 employers nation-wide. After summarizing past research on employer attitudes toward their role in health care and toward reform options, we discuss the need for a new understanding of business' views, given the ongoing gaps in coverage, and the recent and projected budget surpluses that make large-scale reform more feasible than in prior decades.

We then present our findings from in-depth discussions with employers. We focus on the employers' attitudes toward their future role in financing coverage for workers and in managing health benefits. We ascertain their greatest concerns about the future of health care, and describe their reactions to a variety of health reform options. We gauge not only the degree of respondents' support for or opposition to specific proposals, but also the *reasons behind* their positions, and present major themes that emerge.

Finally, Section 5 concludes with a discussion of the policy implications of our analysis. We try to translate our findings into a set of practical policy reforms that might garner the active support of employers, or at least avoid their determined opposition.

HISTORY AND TRENDS OF EMPLOYMENT-BASED HEALTH INSURANCE

HISTORICAL PERSPECTIVE

While nearly all other developed nations have some form of government-mandated health care coverage for virtually all of their citizens, about 65 percent of nonelderly Americans are protected by voluntary, employer-sponsored health insurance. U.S. employers, individually and collectively, have a primary role in both the financing and management of health coverage. To some extent this system evolved “accidentally” in response to social, economic, and political forces over the past century. In other cases it emerged from purposeful decisions to encourage job-based coverage for the working population. Understanding this evolution is critical to understanding the current debate over reforming or replacing the employment-based health insurance system.

The industrial revolution beginning in the mid-nineteenth century contributed to greater need for protection against the costs of illness and increased reliance on care provided by physicians and hospitals. In response, three general approaches to health coverage were proposed during the late nineteenth and early twentieth centuries: company medical programs, voluntary, non-employer benefits, and government-mandated insurance. But each of these was rejected. Worker and physician opposition led to curtailment of company medical care. Private organizations including trade unions, fraternal orders, and mutual aid societies provided cash benefits to the sick, but this practice declined due to financial difficulties. Numerous state proposals calling for compulsory health insurance financed jointly by employers, employees, and the state were defeated due to strong opposition by employers and physicians. The anti-socialist mood at the outbreak of World War I contributed to public wariness about mandated insurance. Even the labor unions were ambivalent, with some viewing compulsory insurance as usurping unions’ role.¹

The period between the two world wars helped define the voluntary, employment-based approach to health coverage that dominates today. The primary forces behind

¹ Silow-Carroll, Sharon, Jack Meyer, Marsha Regenstein and Nancy Bagby, *In Sickness and in Health? The Marriage Between Employers and Health Care*, Economic & Social Research Institute, Washington, D.C., 1995; Starr, Paul, *The Social Transformation of American Medicine*, Basic Books, Inc. New York, 1982; Stevens, Beth, *Complementing the Welfare State: The Development of Private Pension, Health Insurance and Other Employee Benefits in the United States*, International Labor Office, Geneva, 1986; Field, Marilyn J. and Harold T. Shapiro, eds. *Employment and Health Benefits: A Connection at Risk*, Institute of Medicine, National Academy Press, Washington, D.C., 1993.

this development were: ²

1. The commercial insurance industry “discovered” employee group insurance; after the 1912 establishment of group coverage for life insurance, the sharing of risk was expanded to sickness benefits and other types of insurance.
2. Employers embraced insurance benefits as a way to attract and retain workers and to avoid unionization.
3. Escalating medical costs and reduced ability to pay (during Depression era) spawned the establishment of Blue Cross hospital insurance (1929) and Blue Shield physician coverage (1939); the Blues’ viability led to commercial insurers offering of indemnity coverage to employers.
4. Physicians held the line against corporate and “socialized” medicine, successfully lobbying for state laws prohibiting consumer-controlled medical plans and requiring free choice of physician.

The labor shortage during World War II was the major factor leading to employment-based health insurance. The National War Labor Board, created in 1942 to control wages and prices under the inflationary pressures generated by the war effort, ruled that employer contributions to employee insurance and pension plans that did not exceed 5 percent of wages were exempt from wage restrictions. Also, a 1940 “excess profits” law that meant that 85 to 90 percent of “excess” corporate earnings would be taxed, encouraging employers to devote a portion of their profits to employer-sponsored health insurance rather than to the government. Employers turned to health and other benefits as a recruitment and retention tool in the tight civilian labor market. Treating employer health insurance contributions as a tax-deductible business expense and tax-free employee compensation was written into the Internal Revenue Code in 1954.³

The Taft-Hartley Act of 1947 and the National Labor Relations Board reconfirmed that benefits were “conditions of employment” and thereby subject to collective bargaining. Unions began to negotiate aggressively for improved health plans. By 1958, about 75 percent of Americans with private health insurance were covered by job-based plans. Employer-sponsored health coverage was entrenched as the leading form of protection against the costs of illness.

Certain features of the early system that made sense *at that time* planted seeds of cost problems that would emerge later. Blue Cross plans paid physicians and hospitals on what was essentially a cost-plus basis, creating a built-in cost escalator as providers raised fees and insurers underwrote the increases. The enactment of Medicare and Medicaid in 1965 further entrenched this practice. State mandated benefit laws geared to expand the scope of protection in terms of benefits offered and types of providers covered have also resulted in increased cost of insurance. And the tax exclusion that

² *Ibid.*

³ *Ibid.*

helped to spur the broadening of coverage is now blamed for insulating workers and firms from the cost consequences of their selection of health plans.⁴

The decades between 1970 and 1990 were marked by dramatic increases in health care spending, as employers health spending grew from 3.5 to 8.5 percent of workers' wages and salaries, and national expenditures on health care increased from 7.3 to 12.2 percent of the gross national product. Concerns over competing domestic priorities and the alleged negative impact of rising health costs on U.S. global competitiveness led to proposals for national health insurance, but these were rejected as too costly in an era of recession and inflation.

Instead, a series of less radical, incremental actions were taken, including:

- HMO Act of 1973, which paved the way for managed care, currently the major source of job-based coverage;
- Employee Retirement Income Security Act (ERISA) (1974), which opened the way for large employers to self-insure and be free of state insurance regulations such as mandated benefits, reserve requirements, and requirements to contribute to state indigent care pools; and
- Diagnostic Related Groups (DRGs) (1983), establishing diagnosis-based prospective payments for hospitals under Medicare, which served as a model for hospital and physician reimbursement policies in the public and private sectors.

Additional cost control devices implemented by private employers and by individual states included cost-sharing (passing more of the cost to employees), utilization controls, and insurance reform. Many individual employers and business coalitions began to innovate with cost control measures such as selective provider contracting, fixed employer premium contributions, and value-based purchasing.

Meanwhile, to reduce costs and thereby keep premiums competitive, insurers would exclude groups and individuals deemed more likely to need medical care. This process splintered the risk pool across which health care costs were spread, and made it increasingly difficult for some businesses and individuals to obtain affordable coverage.

The past decades have brought growing awareness of the gaps in employment-based insurance that left millions of individuals without protection. Attempts to address these gaps include: the Consolidated Omnibus Reconciliation Act of 1986, which provides opportunities to continue employer-sponsored group health coverage upon termination of employment; and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which prohibits insurers from denying coverage to small employers, requires insurers to offer coverage to workers entering the individual market from group plans, and places limits on pre-existing condition exclusions. Also, Medicaid expansion, the State Children's Health Insurance Program (S-S-CHIP), state small

⁴ *Ibid.*

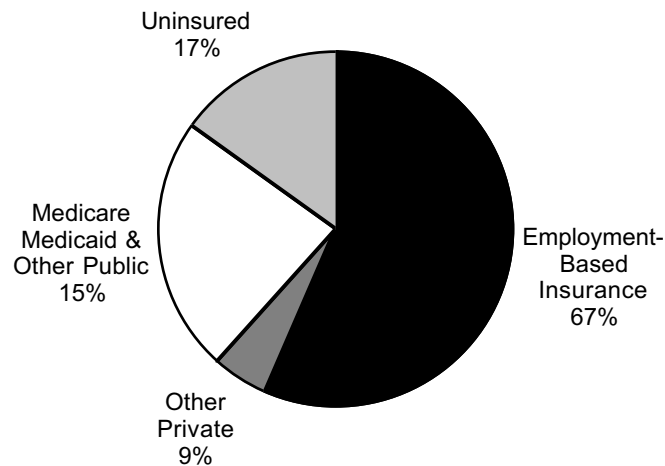
group insurance reform, state risk pools, purchasing cooperatives, and a variety of public and private efforts have been geared to expand coverage to the uninsured.

EMPLOYMENT-BASED COVERAGE TODAY

In 1999, more than 172 million individuals—88 percent of all privately insured Americans—were covered through employment-based health insurance.⁵ The following highlights the state of employment-based coverage:

- Among nonelderly Americans, 67 percent were covered by employment-based coverage, 2 percent by Medicare, 10 percent by Medicaid, and 9 percent by other coverage including individual insurance, association plans and others sources in 2000. Seventeen percent of the nonelderly population—42.1 million people — were uninsured for the whole year from March 1999 through March 2000. A greater number were without health insurance for some portion of that time.⁶ (See figure 1.)

FIGURE 1: SOURCES OF HEALTH INSURANCE FOR NONELDERLY AMERICANS, 1999



* Percentages may not add to 100 percent because of multiple sources of coverage.
Source: U.S. Census, CPS

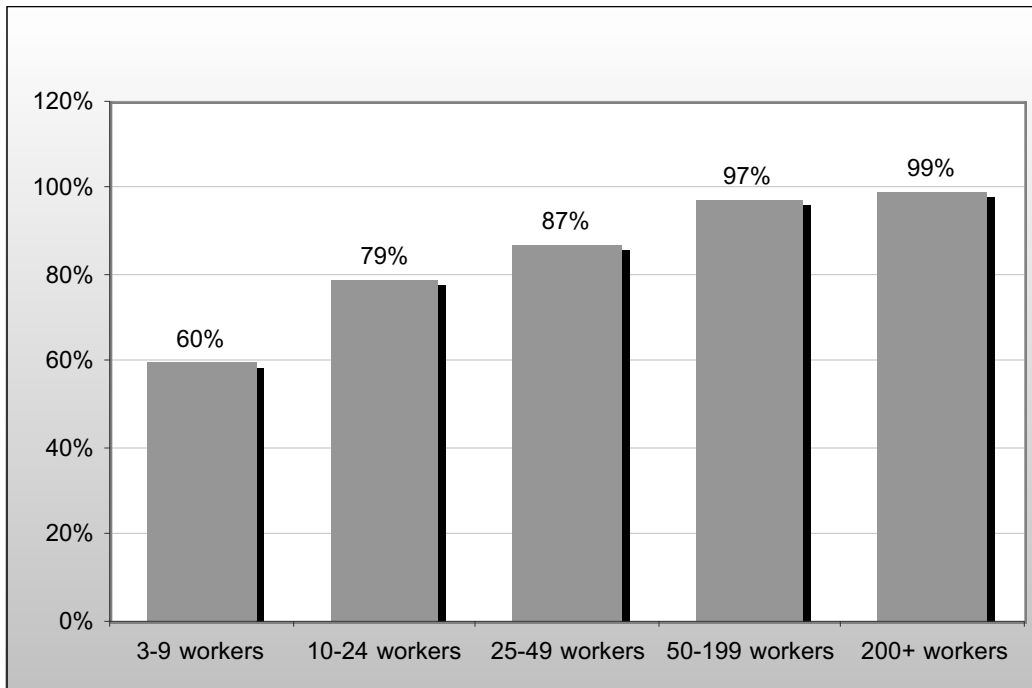
- There were wide variations in offer rates based on size of firms. In 2000 firms with 3 to 9 workers had an offer rate of 60 percent; this rate grew significantly as firm size increases. Virtually all firms with 200 or more workers offered health benefits.⁷ (see Figure 2)

⁵ U.S. Census Bureau, March 1999 Current Population Survey.

⁶ U.S. Census Bureau, March 2000 Current Population Survey. The total of these percentages is greater than 100 percent because some people reported more than one source of coverage (e.g., Medicare and some type of private, supplemental coverage).

⁷ Gabel, Jon. Employer Health Benefits: 2000 Annual Survey, The Kaiser Family Foundation and Health Research and Educational Trust, 2000.

FIGURE 2: PROPORTION OF FIRMS OFFERING HEALTH COVERAGE, BY FIRM SIZE, 2000



Source: Gabel 2000

- Total spending for employer-sponsored coverage in 2000 was estimated at \$356 billion; of this, an estimated 83 percent (\$297 billion) was paid by employers, and 17 percent (\$59 billion) was paid by employees and retirees.⁸
- The average monthly premium cost per worker in 2000 was \$202 for single coverage and \$529 for family coverage. The average contribution by employees was 14 percent of the premium for single coverage (\$28 per month), and 27 percent of the premium for family coverage (\$138 per month).⁹
- Conventional (indemnity) plans constituted only 8 percent of enrollment in job-based health plans in 2000. Twenty-nine percent of enrollment was in Health Maintenance Organizations (HMOs), 41 percent in Preferred Provider Organizations (PPOs), and 22 percent in Point of Service (POS) plans.¹⁰
- The tax subsidy for employment-based health insurance was estimated to be worth \$141 billion in 2000—arguably the most expensive tax expenditure in the tax code. The subsidy resulted from the health benefits exclusion from federal income taxes (\$75 billion), the exclusion from Social Security and Medicare HI taxes (\$49 billion), the exclusion for reimbursement accounts (\$6 billion), and the deduction for

⁸ Sheils, John, Paul Hogan, and Randall Haught. "Health Insurance and Taxes: Impact of Proposed Changes in Current Federal Policy." Prepared for the National Coalition on Health Care, October 19, 1999.

⁹ Gabel 2000.

¹⁰ *Ibid*.

out-of-pocket health spending (\$5 billion). State tax subsidies were worth an additional \$15 billion.¹¹

To put this current “snapshot” of employment-based health insurance into context, one must examine the *trends* and *direction* of the various elements. The following section reviews trends emerging from major research studies and national surveys, which in turn allows for an objective analysis of the system’s strengths and weaknesses.

TRENDS: REVIEW AND SYNTHESIS OF RESEARCH FINDINGS

Employee Enrollment

Depending upon how one measures the data, either an optimistic or pessimistic view of the ability of employment-based coverage to continue protecting American workers and their families emerges. Reputable researchers have documented varying trends regarding the direction of health coverage through the workplace, and each is “correct” according to the period they studied. Following are a few examples:

- The U.S. Census Bureau reports that the percentage of nonelderly people covered by employment-based insurance dropped from 66 percent in 1987 to a low of 60 percent in 1993, but then rose back up to about 67 percent by 1999. However, the percentage of nonelderly people who lacked insurance rose from 14 percent in 1987 to over 17 percent in 1999.¹² (See figure 3)
- Based on national household surveys, Gabel found that the percentage of nonelderly Americans covered by employment-based insurance remained stable from 1977 to 1988, but then fell from 71 percent (1988) to 64 percent in 1996. The decline occurred primarily among less educated Americans, particularly those without high school diplomas. The portion of workers with coverage from their employers appeared to decline throughout the entire period: 67 percent in 1977, 64 percent in 1988, and 60 percent in 1996.¹³

¹¹ Sheils, et. al., 1999. These estimates are consistent with the U.S. Treasury Department’s \$86 billion estimate of the value of the federal tax exclusion excluding forgone Social Security and Medicare HI payroll taxes.

¹² Census, September 2000.

¹³ Gabel, Jon R. “Job-Based Health Insurance, 1977-1998: The Accidental System under Scrutiny.” *Health Affairs* 18:6, November/December 1999.

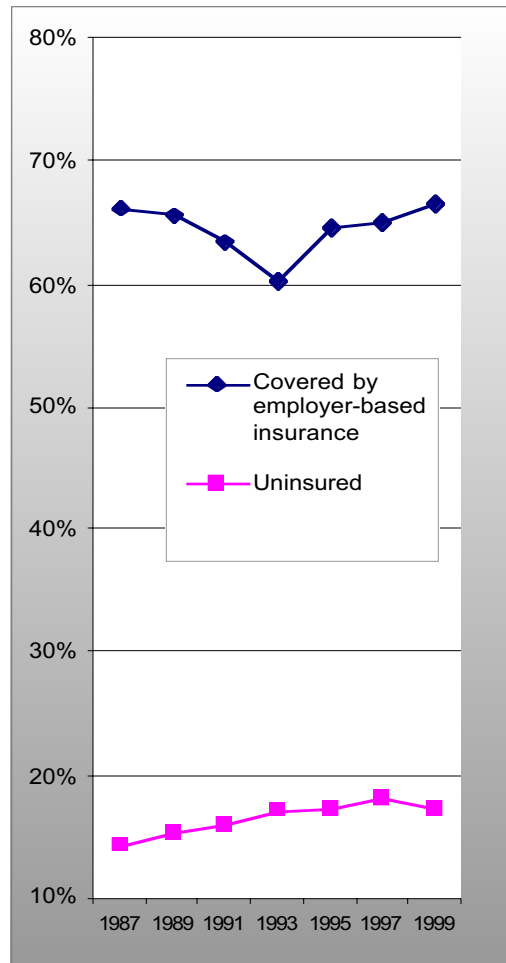
- Gabel also found that the portion of employees *eligible* for coverage from their employer fell precipitously from 83 percent in 1977 to 73 percent in 1988, but then improved slightly to 75 percent in 1996. The portion of eligible workers taking up coverage increased from 81 percent (1977) to 88 percent (1987), but the trend then reversed and the proportion fell to 80 percent by 1996.¹⁴

- Long and Marquis (Rand) examined coverage patterns from 1993 to 1997, and found stable enrollment in employment-based plans over this period. Comparing multiple national surveys, they found stable or slightly increased enrollment by one's own employer: 58 percent in 1993 to 60 percent in 1997. Further, Long and Marquis found stability from 1993 to 1997 in the portion of employees in firms that sponsor insurance, the portion of workers eligible to enroll, and the participation, or take-up rates.¹⁵ This view is consistent

with Gabel's and others' findings that the erosion from 1988 to 1996 occurred during the first half of that period and not during the second half.

- Based on EBRI estimates and the 1997 Current Population Survey, Fronstin found that employer offer rates remained stable from 1988 to 1997 at about 83 percent, but that eligibility changed markedly, falling from 82 percent of workers eligible for coverage through their employer in 1988 to 75 percent in 1997 (see Figure 4). The overall rate of workers participating in employment-based health plans dropped from 68 percent to 62 percent over this period.¹⁶
- The flip side of employment-based coverage trends is the rate of uninsurance. Over the past twenty-five years the ranks of uninsured Americans has swelled, from 23

FIGURE 3: PEOPLE COVERED BY EMPLOYMENT-BASED PLANS AND PEOPLE LEFT UNINSURED, 1987-1998



Source: U.S. Census, CPS

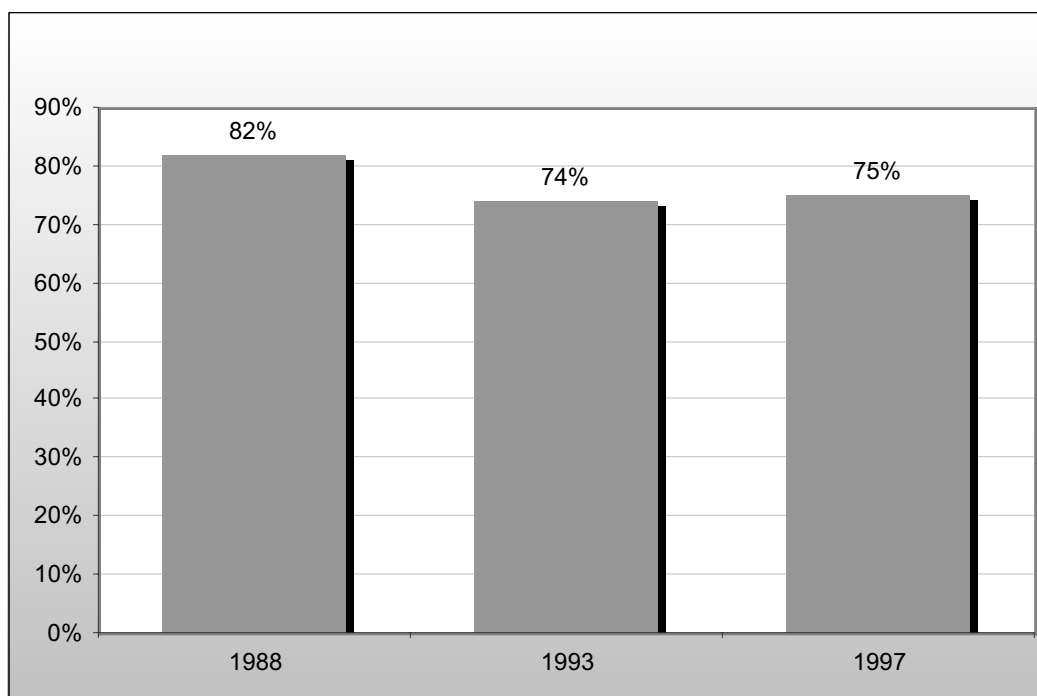
¹⁴ Gabel 1999.

¹⁵ Long, Stephen H. and M. Susan Marquis. "Stability and Variation in Employment-Based Health Insurance Coverage, 1993-1997." *Health Affairs* 18:6, November/December 1999.

¹⁶ Fronstin, Paul. "Employment-Based Health Benefits: Who is Offered Coverage vs. Who Takes It," *Employee Benefit Research Institute Issue Brief #213*, September 1999.

million individuals in 1976 to nearly 44 million in 1998. Despite almost a decade of unprecedented economic growth, 1999 was the first year to see the number of people without health insurance drop (still 42 million people were uninsured).¹⁷

FIGURE 4: ELIGIBILITY RATES FOR EMPLOYER -SPONSORED COVERAGE 1988-1997



Source: Fronstin 1999

The fall in employer-sponsored coverage in the late 1980s and early 1990s can be attributed to the escalation of premiums, and the movement of workers into part-time jobs, non-unionized jobs, and service jobs.¹⁸ The rising premiums likely led some employers to not offer coverage or to shift more of the cost to workers. Slow wage growth and higher cost-sharing also may have led some lower-income workers to decline coverage, or at least dependent coverage.

The more recent stability of enrollment and decline in the number of uninsured likely stems from the interaction of various forces: the leveling off of premiums in the mid-1990s (attributed to managed care and the suppression of premiums by insurers to gain market share); the economic boom that left many businesses “flush;” and a very tight labor market. As a result, employers are apparently more willing and able to use health benefits to attract and retain workers. Whether this reflects a long-term

¹⁷ Karen Davis’ presentation for The Commonwealth Fund, Taskforce on the Future of Health Insurance, December 2000. Sources, 1976, National Health Interview Survey; March 1987—March 2000 Current Population Survey

¹⁸ Long and Marquis (1999); and Fronstin, Paul and Sarah C. Snider. “An Examination of the Decline in Employment-Based Health Insurance Between 1998 and 1993.” *Inquiry*, Winter 1996-1997.

reversal or a temporary reprieve will likely depend upon the direction of the economy over coming years.

The research also indicates that the key to expanding worker enrollment is not merely getting more employers to *sponsor* coverage. While there are conflicting reports of trends in sponsorship rates, it appears that declining enrollment in employment-based health plans is largely due to: 1) declining number of workers *eligible* for the coverage sponsored by their employers; and 2) declining *take-up* rates by employees, attributed to lack of affordability to low-wage workers.

Retiree Coverage

Whereas one may be cautiously optimistic about active employee enrollment in job-based health plans, employer-sponsored retiree coverage has clearly eroded since the mid-1980s. This is due in part to 1992 accounting changes that required companies to account for the present value of their future commitment to fund retiree health benefits on balance sheets. The exact pattern of retiree coverage varies among surveys:

- Mercer/Foster Higgins surveys document a decline in the proportion of large employers contributing to retiree coverage for the 65 and over population from 40 percent in 1993 to 30 percent in 1998, and a further drop to 28 percent in 1999. Further, employers are increasingly requiring early retirees to pay the full cost of coverage.¹⁹
- The Kaiser/HRET survey found that among large firms (200+ employees), the portion of employers offering retiree health benefits fell from 66 percent in 1988 to 36 percent in 1993, but then grew to 41 percent in 1999. Small businesses, employers with high percentages of low-income workers, and businesses in retail and high-tech industries are much less likely to offer retiree health benefits. A majority of very large firms (at least 5,000 employees) have made changes to their retiree coverage between 1997 and 1999 to control costs; changes include capping the maximum employer contribution, increasing the share of premium contributions by retirees, and introducing Medicare-risk HMOs to retirees. Nearly half (46 percent) of very large firms terminated conventional plan coverage for retirees during this two-year period.²⁰

The erosion of employer-sponsored retiree coverage has wide ramifications. It is leading to demands to lower the eligibility age under Medicare so that early retirees can be covered, a step that without designating new financing mechanisms, could exacerbate the already serious long-term solvency problems associated with this

¹⁹ *Decline in Employers Offering Retiree Health Coverage, 1993-1998* Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans 1998: Report of Survey Findings; and *The Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans 1999* [Note: the 1999 survey included 3,166 respondents; results were weighted to reflect the demographics of all employers in the US with 10 or more employees that offer health coverage to represent about 600,000 employers and over 90 million full- and part-time employees.]

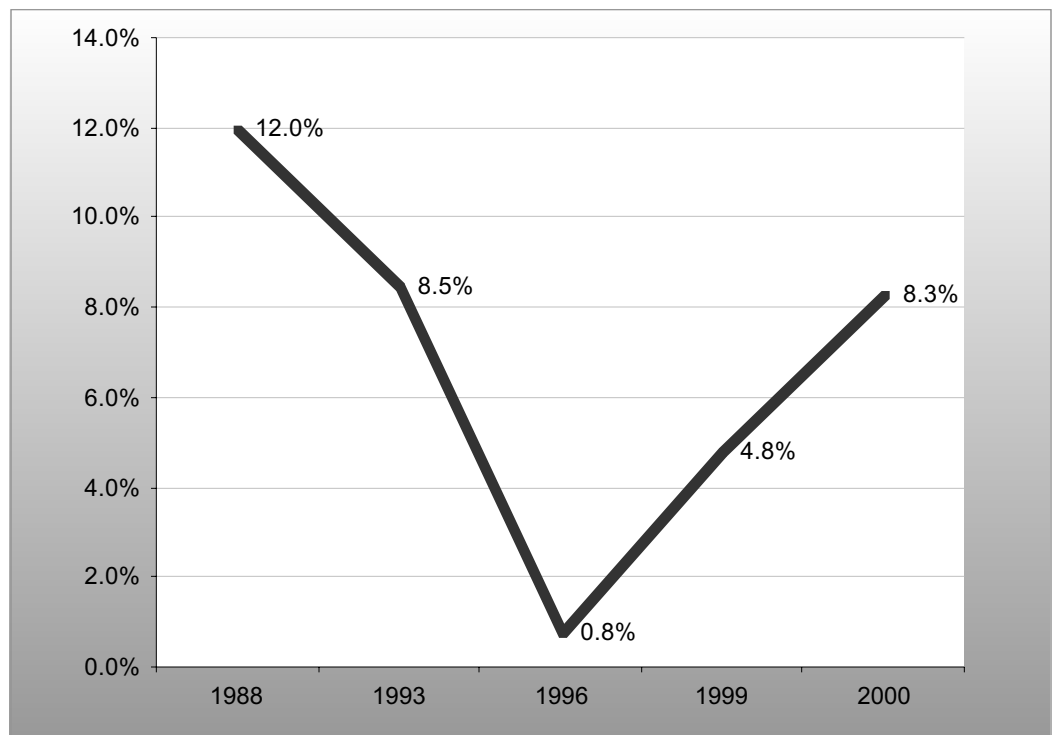
²⁰ Gabel 2000.

program. Some proposals call for early retirees to “buy in” to Medicare. The cost of private, individual coverage for persons in this age group can be prohibitive.

Cost

Researchers and market analysts agree that after several years of level or modest health plan premium increases, premiums began to accelerate in the late 1990s, despite low general inflation.(see Figure 5). This re-acceleration in health costs has outpaced workers’ earnings, representing a return to an earlier pattern in which wages appear to be “squeezed” by sharply rising health costs.

FIGURE 5: INCREASE IN HEALTH PREMIUMS, 1988-2000



Source: Gabel 2000

Health benefit cost escalation was very modest over the 1993-1998 period, reflecting shifts to managed care, increased use of utilization review, cutbacks in retiree health benefits, and premium cuts or freezes by health plans to gain market share. Part of the current surge in prices is attributed to health plans trying to make up for losses in recent years.²¹ One market analyst explained the surge as part of the underwriting cycle in

²¹ *Employer Health Benefits: 1999 Annual Survey*. The Henry J. Kaiser Family Foundation, Menlo Park, CA. and the Health Research and Educational Trust, Chicago, IL. 1999.

health insurance, as the industry is attempting to “normalize” profits after an era of artificially low prices to gain market share.²²

Health plan premiums grew by an average of 6 to 7 percent in 1999, and market analysts predict that this trend will continue into 2001 or 2002. Three recent surveys indicate that employers are now facing the largest premium increases since the early 1990s, and small employers are facing the greatest price hikes:

- A survey by Hewitt Associates LLC concludes that companies can expect a 10 to 13 percent increase in premiums for the year 2001. It found a 9.4 percent hike in premiums in 2000, and projects an average health plan cost of \$4,707 per employee in 2001.²³
- A survey by William Mercer/Foster Higgins found that insurance premiums increased 7.3 percent in 1999, nearly three times the rate of inflation. According to this survey, premiums were expected to rise 7.5 percent in 2000, marking the third straight year of significant premium hikes. Average cost per active employee rose from \$3,817 in 1998 to \$4,097 in 1999. Small firms were hit hardest; firms with fewer than 50 employees faced a 13.8 percent increase, while large firms (at least 500 workers) faced a 7.0 percent increase.²⁴
- A survey by the Kaiser Family Foundation and the Health Research and Educational Trust found an 8.3 percent premium hike from 1999 to 2000. Like the Mercer/Foster Higgins survey, the smallest firms reported the highest premium increase (10.3 percent among firms with 3 to 9 employees), indicating that it will be even harder for small firms to offer coverage in the future.²⁵

Underlying medical costs are increasing by about 5 to 7 percent a year—higher than in the recent past, but slower than premium increases. The principal force driving health care costs (accounting for about half the cost growth) is the increase in pharmaceutical costs. Rising hospital outpatient costs are the second largest factor in cost increases, with physician costs and inpatient hospital costs maintaining minimal growth.²⁶

Retiree coverage has been subject to much more modest price increases. One survey found that the cost of covering a pre-Medicare-eligible retiree increased 4.5 percent from 1998 to 1999, and the cost of providing supplemental coverage to Medicare-eligible retirees increased only 3.2 percent.²⁷

The implications of health cost increases depend upon interactions with other factors such as the labor market and economic growth. For example, the tight labor market and

²² Center for Studying Health System Change. *Wall Street Comes to Washington: Analysts' Perspectives on the Changing Health Care System*, Issue Brief 21, September 1999.

²³ Hewitt Associates LLC. *U.S. Health Care Costs to Increase into the Double Digits for Second Consecutive Year*. Press Release, October 23, 2000.

²⁴ Mercer/Foster Higgins, 1999.

²⁵ Gabel 2000.

²⁶ HSC Issue Brief 21, September 1999.

²⁷ Mercer/Foster Higgins, 1999.

strong economy led employers to maintain coverage and economize in other ways in 1999, despite the significant premium hike (discussed further below). If the more recent downturn in the economy continues or worsens, however, premium escalation would likely lead to some combination of cutbacks in health coverage and slower wage growth.

Employer/Employee Contributions

Employee contributions include premium payments, co-payments and deductibles. In the past, employers shifted more costs to workers in an attempt to contain rapidly rising health benefit expenses. This shift clearly contributed to more workers turning down work-based coverage because they could not afford their share of the cost. Indeed, as mentioned above, the rise in uninsured workers from 1987 to 1996 can be attributed to a declining take-up rate among workers, rather than a decline in the number of workers offered health coverage.²⁸

But this cost shift to workers leveled off in the late 1990s as health costs moderated and employers needed to attract and retain workers in a strong economy with very low unemployment. Surveys show that increases in employee contributions lagged behind increases in plan cost in 1999, and employers were reluctant to increase worker contributions in 2000 despite the acceleration in plan cost.²⁹

The increase in financial burden to workers over past decades is dramatic. In 1998 dollars, workers paid 3.5 times more for coverage in 1998 (\$91 per month average) than in 1977 (\$26 per month), while real weekly wages fell during that period. (see Figure 6) The portion of premium paid by workers increased over this period from 20 percent to 27 percent in 1998. Unlike premiums, deductibles did not increase significantly, due to the shift from indemnity plans to managed care, which generally offers no or small co-payments and deductibles for physician visits and hospital care if in-network providers are used. Average deductibles for out-of-network providers declined from \$259 in 1977 to \$216 in 1988, but then increased to \$325 in 1998 (in 1998 dollars).³⁰

One study found the average worker contributed \$28 to single and \$138 to family coverage in 2000, or 14 percent and 27 percent of the premium, respectively. There are variations, however, in average contributions across region, industry, type of coverage, firm size, and wage level. For example:³¹

- Workers in lower-wage firms pay more toward premiums on average for family coverage than do workers in higher-wage firms.
- Workers in very large firms (5,000 plus) pay more toward premiums for single

²⁸ Gabel 1999.

²⁹ Mercer/Foster Higgins, 1999.

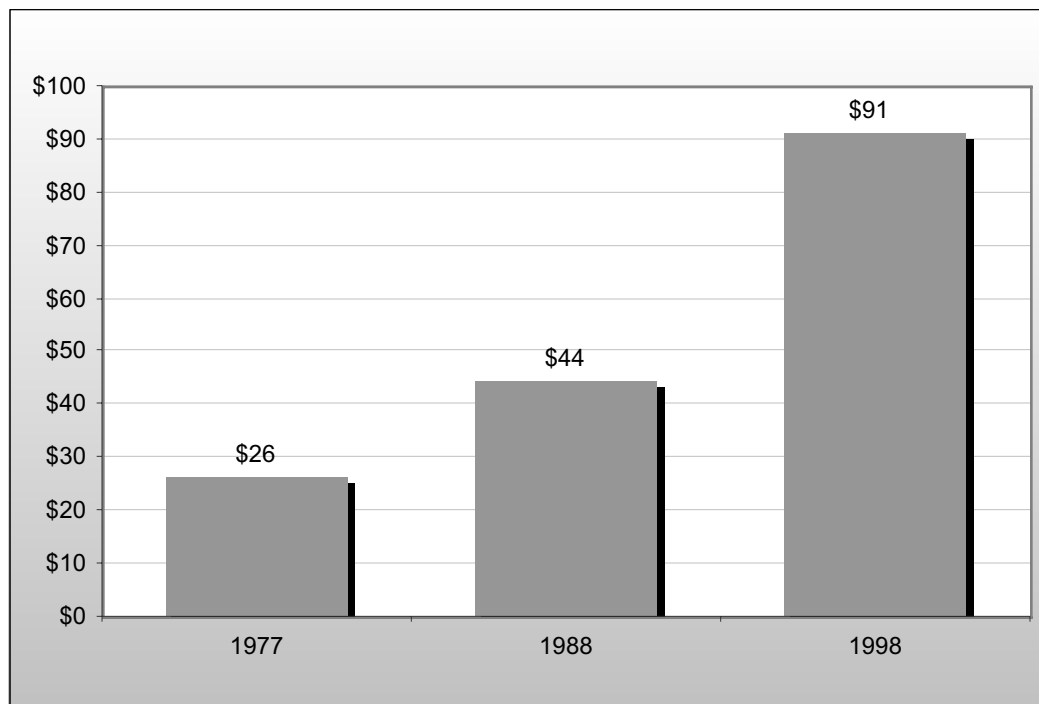
³⁰ Gabel 1999.

³¹ Gabel 2000.

coverage than employees in smaller firms (3-199).³² Contributions to family coverage are similar across firm size.

- Workers in smaller firms face larger deductibles for single and family coverage in PPO, POS, and conventional plans.

FIGURE 6 : EMPLOYEE MONTHLY INSURANCE CONTRIBUTION (1998 DOLLARS), 1977-1998



Source: Gabel 1999

Benefits

The shift to managed care over the past two decades has been one of the factors contributing to an expansion in covered benefits. Specifically, there has been large growth in the portion of employees covered for routine physicals (6.3 percent in 1977 to 84 percent in 1998), outpatient mental health care (75 percent in 1977 to 96 percent in 1998), and prescription drugs (87 percent in 1977 to 97 percent in 1998).³³

Whereas one survey indicated that the scope of benefits did not change significantly from 1998 to 1999 (Kaiser/HRET 1999), another (Mercer/Foster Higgins 1999) found an increase in employers offering dental benefits in 1999, while many large businesses added vision plans or long-term care insurance, and non-traditional benefits such as health club subsidies. Large firms tend to provide more generous benefit packages than

³² The grouping of firms with 3 to 199 employees may mask differences in average employee contribution between different size subgroups within this category.

³³ Gabel 1999.

do smaller businesses, and the recent expansion in covered services is attributed to employers' efforts to attract and retain workers.³⁴

While generally expanding the range of benefits, however, the shift to managed care also brought new kinds of service *limitations* to millions of workers and their families, in the form of limited provider networks, required referrals for specialty care, pre-admission reviews, and other strategies aimed to control costs and unnecessary use of services.³⁵ For example, among employers with at least 500 workers, 32 percent made changes to their drug benefit design in 1999, adding or expanding financial incentives to use generic drugs or those listed on the plan's formulary. A smaller but significant portion of businesses limited or excluded coverage for certain new prescription drugs, tests, or medical treatments. Some expansions in covered benefits in 1999, such as increased coverage for chronic disease management programs, chiropractic care, and acupuncture, can also be viewed as efforts to substitute lower-priced services for more costly traditional treatments.³⁶

Choice

There has been increased interest over recent years not merely *whether* workers are offered coverage by their employers, but also to what degree workers are given a *choice* of health plans. Many policy analysts contend that giving individuals a choice enhances competition among health plans, thereby increasing efficiency in the market, and also enhances satisfaction by allowing people to select plans that meet their specific needs. Indeed, there is some evidence that individuals with a choice of health plans are more satisfied along certain dimensions. They are more likely to: be insured; have higher take-up rates of coverage when it is offered; have a usual source of care; and have had basic preventive services.³⁷

Research has revealed increasing choice of health plans among employees through the 1980s and early 1990s, with little change since the mid-1990s (one study found a decline in choice among large firms between 1993 and 1997)³⁸. The early expansion of choice is likely related to the entry of managed care plans into the marketplace. Previously, when fee-for-service was the norm, there was less need for choice in plans, since there was free access to providers. As HMOs, PPOs, and POS plans entered the market, with each health plan associated with specific, limited networks of participating providers, there was greater meaning to having a choice of plans.

³⁴ Mercer/Foster Higgins 1999.

³⁵ Gabel 1999.

³⁶ Mercer/Foster Higgins, 1999.

³⁷ Gawande, et al., "Does Dissatisfaction with Health Plans Stem from Having No Choice?," *Health Affairs*, September/October 1998; and Schone, Barbara Steinberg and Philip F. Cooper, "Assessing Health Insurance Plan Choice in the United States" Agency for Health Care Policy and Research, November 1999.

³⁸ The portion of firms with 500 or more employees that offered a choice of health plans fell from 43 percent in 1993 to 35 percent in 1997, based on National Employer Health Insurance Survey and 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey, (Marquis, M. Susan and Stephen H. Long. "Trends in Managed Care and Managed Competition, 1993-1997," *Health Affairs* 18:6, November/December 1999).

The following trends apply to workers who are offered insurance coverage by their employers:³⁹

- The proportion offered more than one plan increased from 18 percent in 1977, to 53 percent in 1988, to 65 percent in 2000.
- By 2000, 50 percent of workers in firms with coverage were offered a choice of at least 3 plans.
- Over the 1988 to 2000 decade, the proportion offered an indemnity plan fell from 90 percent to 21 percent, while the proportion offered various types of managed care plans rose significantly.
- PPOs have become the most common type of managed care plan offered; in 2000, 66 percent of covered workers had a choice including a PPO plan, 55 percent of covered workers had a choice including an HMO plan, and 44 percent of covered workers had choice including a POS plan.

A study of all workers—including those whose employers do not offer any coverage, and considering choices available through the job of a family member—reveals that 55 percent of wage earners have some choice of health plans.⁴⁰ These results can be taken two ways. On one hand, there has been much progress toward greater choice in the workplace over the years. On the other hand, we still remain a long way from a consumer-choice health care model, with nearly half of all workers still lacking a choice of work-based health plans.

Furthermore, the overall expansion in choice masks the extreme disparity in choice by firm size, with choice increasing with size of business. In 2000, among small businesses (3 to 199 workers) that provide health coverage, only 9 percent offer a choice of plans. This increases to 53 percent among midsize firms (200 to 999 workers), 68 percent among large firms (1000 to 4999 workers) and 84 percent for very large firms (at least 5,000 workers). (see Figure 7) The major obstacles to offering more than one plan cited by smaller firms are: 1) the expense; 2) insurance rules requiring all employees to be in the same plan; and 3) the administrative burden.⁴¹

A final note of caution reflects the extent to which workers and their families are provided with *meaningful* choices. In recent years, managed care organizations have broadened their networks of providers. This has occurred in the past because employees have pressed for broad networks that offer their workers as much choice of *providers* as possible. Focus groups with employees have shown that workers are at least as concerned with having a choice of physicians as they are with having a choice of health plans.⁴² As “competing” health plans have moved toward offering

³⁹ Gabel 2000.

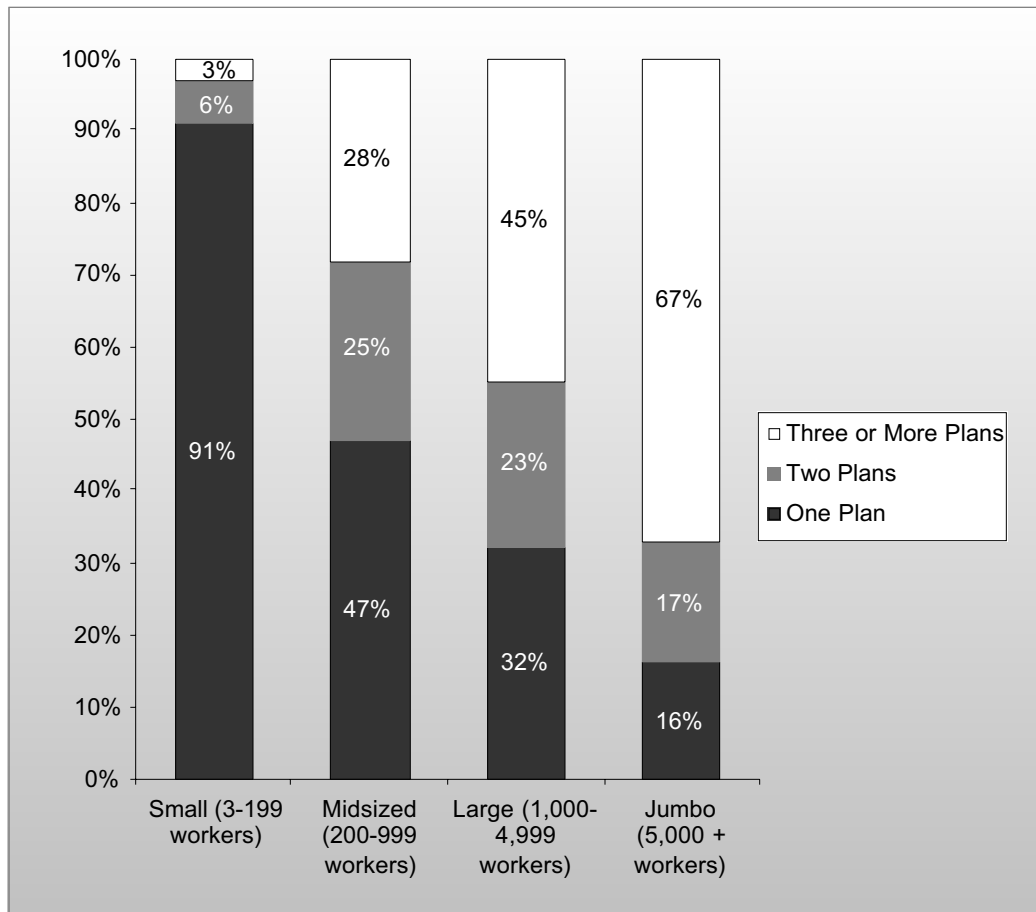
⁴⁰ Schone et. al., 1999.

⁴¹ Gabel 2000.

⁴² Wicks, Elliot, Jack A. Meyer, Lise Rybowski, and Michael Perry. “Using Report Cards to Assess Health Plans.” Economic & Social Research Institute, April 1999.

virtually the same, overlapping, and wide-open networks of providers, the choice of plans may take on less significance than has been envisioned under a consumer-choice model in which consumers' choice of health plan would reflect their desire to work with a specific panel of doctors or practice style.

FIGURE 7: CHOICE OF PLANS AMONG EMPLOYERS PROVIDING COVERAGE IN 2000, BY FIRM SIZE



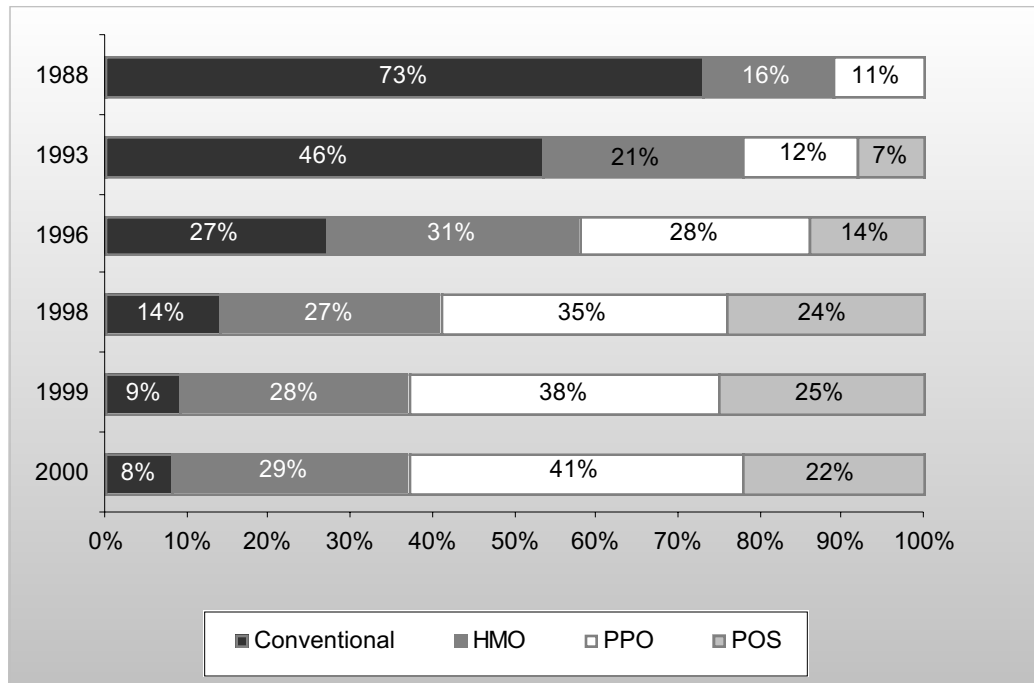
Source: Gabel 2000

Managed Care Enrollment

Health plan enrollment has mirrored the trends in plan choice, described above. According to one survey of covered workers, enrollment in indemnity plans plummeted from 73 percent in 1988 to 8 percent in 2000. During that period, PPO enrollment grew from 11 percent in 1988 to become the dominant managed care form at 41 percent market share in 2000. POS plans emerged over the decade and captured 22 percent of the market in 2000. And HMO enrollment grew steadily but then leveled off and slightly

declined in the late 1990s to 29 percent in 2000, as PPO and POS plans gained market share.⁴³ (see Figure 8)

FIGURE 8 : MARKET SHARE OF VARIOUS TYPES OF PLANS, 1988-2000



Source: Gabel 2000

Researchers note that the changes in HMO enrollment reflect health care inflation. Rapid growth in premiums during the 1980s and early 1990s resulted in employers shifting to HMOs, generally most restrictive and least costly of the managed care models. Moderation in premium growth during the late 1990s, along with a consumer “backlash” against HMOs, is reflected in growth of the less restrictive PPO and POS plans.⁴⁴

Purchasing Practices

Over the past decade, there has been a growing effort to measure the performance of health plans and providers, and to make this information available to employers and consumers. Numerous studies suggest, however, that despite the large resources devoted to these efforts, the *use* of this information by employers and consumers in their purchasing decisions remains quite limited. As can be expected, very large firms and members of business coalitions are much more likely than smaller firms and non-

⁴³ Gabel 2000. Other surveys reveal similar trends; for example, a 1999 Mercer/Foster Higgins survey found 11 percent of workers enrolled in indemnity plans, 30 percent in closed-panel HMOs, 16 percent in POS plans, and 43 percent in PPOs.

⁴⁴ Gabel 2000.

coalition members to use performance-related considerations in their selection and management of health benefits. But most employers do *not* use quality performance indicators in selecting health plans, provide employees with comparative performance data on health plans offered, or give workers incentives to make cost-conscious choices. When employers do induce workers to make cost-conscious choices, it is not clear that this results in long-term savings. Finally, when employees do receive comparative performance information, it is generally not in a form that employees find useful. For instance:

- Hibbard and colleagues found that among 33 very large businesses, purchasers were often not aware of performance information available, and frequently did not use the data when it was available. Seventy percent reported that they sought a balance between cost and quality, but had concerns about the relevance or validity of the performance data. Only 31 percent provided performance information to their employees.⁴⁵
- Legnini and colleagues found, based on focus groups, that neither employers of small firms nor their insurance agents compare health plan performance information when selecting health plan(s). Most are primarily concerned that their workers remain satisfied with the plan, and that the price is right. Small employers lack resources to measure comparative performance, and are skeptical about claims of important differences among plans and providers.⁴⁶
- Studies by both the Minnesota Health Data Institute and Hibbard and Jewett found that information given to employees on the comparative performance of health plans is often not in a form that employees find useful. Hibbard and Jewett concluded that consumers do not fully understand many performance indicators, and do not view many indicators as important.⁴⁷
- The Kaiser/HRET employer survey found that NCQA accreditation and HEDIS indicators—both objective, multi-faceted measures of health plan performance—play a relatively minor role in employers’ purchasing decisions. Using NCQA accreditation as a criterion for HMO and POS selection is rare, except among firms with at least 5,000 employees. Employers are most likely to make health plan selections based on the number of physicians in the network, the reputation and credentials of the physicians, and the cost of the plan. Interestingly, cost is found to be less important among small firms than among mid-size and large firms.⁴⁸

⁴⁵ Hibbard, Judith H., Jacquelyn J. Jewett, Mark W. Legnini, and Martin Tusler. “Choosing a Health Plan: Do Large Employers Use the Data?” *Health Affairs*, 16:6, November/December 1997.

⁴⁶ Legnini, Mark W., Laurie E. Rosenburg, Michael J. Perry, and Neil J. Robertson. “Where Does Performance Measurement Go From Here?” *Health Affairs*, 19:3, May/June 2000, p. 174.

⁴⁷ Hibbard, Judith H. and Jacquelyn J. Jewett. “Will Quality Report Cards Help Consumers?” *Health Affairs*, 16:3, May/June 1997.

⁴⁸ Gabel 2000.

- Marquis and Long found that in 1997, only 28 percent of employers offering multiple plans made a fixed-dollar contribution toward single coverage, a practice that is meant to encourage cost-conscious decision-making among employees; 34 percent of employers paid a fixed *percent* toward all plans; 31 percent of employers paid the full cost of the premium regardless of the plan selected by the worker, and 7 percent of employers required a fixed contribution from the worker regardless of the plan selected. Employees given the fixed-dollar contribution were most likely to select the lowest-price plan (51 percent of employees versus 37 percent of employees whose employer pays the full premium). However, employers offering strong financial incentives to select lower-priced plans did not enjoy lower average premiums or slower growth in costs. Only 22 percent of large firms in the study offering a choice of plans provided performance-related indicators to workers to help them make quality-based decisions.⁴⁹
- Lo Sasso and colleagues found in a 1997 survey that the vast majority (86 percent) of employers providing coverage to workers stated that assessing quality was the workers' responsibility. However, firms relied more on cost factors, geographic coverage, and member access than on "responsible purchasing" information (performance indicators) in selecting health plans. In a 1999 follow-up survey, responsible purchasing practices were found to be most likely practiced by large employers, members of business coalitions, firms with predominantly managed care enrollment, and firms that require employee contributions. Barriers to responsible purchasing practices included difficulties in measuring incremental changes in quality, health plan consolidation and reorganization, differences between employee preferences and external measures of quality, and growth in POS and PPO plans not associated with HEDIS measures and National Committee on Quality Assurance (NCQA) accreditation.⁵⁰

⁴⁹ Data came from the 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey (Marquis, M. Susan and Stephen H. Long. "Trends in Managed Care and Managed Competition, 1993-1997." *Health Affairs*, 18:6), November/December 1999.

⁵⁰ Researchers analyzed two data sets: the Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans (1997), and the 1999 Northwester/Midwestern Business Group on Health Employer Health Care Purchasing Policies and Practices Survey. (Lo Sasso, Anthony T., Linda Perloff, Jill Schield, James J. Murphy, James D. Mortimer, and Peter P. Budetti. "Beyond Cost: Responsible Purchasing of Managed Care Plans by Employers." *Health Affairs*, 18:6, November/December 1999.)

STRENGTHS AND WEAKNESSES, CHALLENGES, AND REFORM OPTIONS

After reviewing the myriad statistics and trends of the many facets of employment-based health insurance (previous section), one can better and more fully assess the system’s strengths and weaknesses. Following we present an analysis of the benefits that we may want to expand or build upon, as well as the drawbacks that we may want to minimize or eliminate. Taken together (summarized in Figure 9), these positive and negative attributes of the current employment-based system provide the framework for formulating challenges for reform.

FIGURE 9: STRENGTHS AND WEAKNESSES OF THE EMPLOYMENT-BASED HEALTH INSURANCE SYSTEM

Strengths	Weaknesses
<ul style="list-style-type: none"> • Insures the majority of nonelderly • Provides vehicle for spreading and sharing risk • Reduces employee turnover in firms that provide coverage, thereby reducing those employers’ costs • Encourages individuals and families to obtain health coverage through tax subsidies and employer contributions • Encourages employer innovations re: cost control, quality initiatives • Provides workers with intermediary who provides oversight, screens products, and conducts administrative tasks • Fits with strong aversion by business and others to government regulations, high taxes, and major public role 	<ul style="list-style-type: none"> • Excludes millions not tied to workforce • Voluntary nature leaves millions of workers/dependents without access to affordable coverage, including retiree coverage • Lack of portability leaves those who lose or change jobs vulnerable, creating job lock, hurting productivity and jeopardizing continuity of patient care • Limits choice of health plans for individual workers • Reflects regressive financing — low-income people pay proportionately more of their income for coverage, and get less in tax benefits than wealthier people • Results in employers with older, sicker workers paying higher premiums, giving employers incentive to discriminate against higher-risk job applicants and hurting productivity • Leads to small firms paying higher administrative/marketing/load costs • Places extra responsibilities on firms that do not have expertise to select/manage health plans • Dilutes cost control when individual firms do not have purchasing power to keep costs down • Frequently leaves employees with burdensome share of the premium

Strengths

Insures majority of nonelderly: As noted above, private and public employers provide health insurance coverage for 67 percent of the nonelderly population. Proponents argue that the system is working for the majority of the population and therefore efforts should be made to fill the gaps rather than dismantle and replace a major institution.

Provides vehicle for spreading and sharing risk: Work establishments provide natural vehicles for grouping individuals into insurance pools, which allows premium averaging, or cross subsidization, across individuals of varying age and health conditions. In other words, people with low health care costs subsidize people with high health care costs. Other advantages of group coverage over individual coverage include lower administrative costs and less risk to insurers.

Reduces employee turnover: Since some jobs provide health coverage while others do not, employers that offer health coverage are likely to experience lower employee turnover than those who do not. If offering health insurance helps companies retain highly-valued workers it will lower firms' costs relative to paying only cash wages.⁵¹ One study found that health insurance coverage reduces the probability that a worker will change jobs by 26 to 31 percent.⁵²

Encourages coverage through subsidies and employer contributions: The tax exclusion provides about \$125 billion in subsidies to workers and their families. In addition, the vast majority of employers that make health insurance available to employees also contribute toward premiums—generally the bulk of the premium for workers, and a significant portion for dependents—thereby making coverage affordable to most families. Economists argue, however, that such contributions are merely a form of total compensation that is determined by market forces, and if health benefits were cut, then wages or other benefit contributions would rise.

Encourages employer innovation: The rapid escalation in premiums during the 1970s and 1980s motivated some employers to become involved in efforts to control costs, improve quality, and thereby enhance the value of the health care they purchase for their employees. Many large companies and business coalitions have been active in developing and implementing new techniques such as selective contracting, comparison of provider / plan performance including use of outcomes data, and fixed contribution policies. Once pioneered by the leaders, these innovations have been adopted by other firms as well.

Provides employees an intermediary: Benefits managers screen health plans, conduct administrative tasks, negotiate rates, and provide oversight —services valued by many employees and their families who do not have any expertise or experience in such

⁵¹ Buchmueller, Thomas. "The Business Case for Employer-Provided Health Benefits: A Review of the Relevant Literature." Prepared for the California Health Care Foundation, March 2000.

⁵² Macluan B. "Employment-Based Health Insurance and Job Mobility—Is there evidence of Job-Lock?" *Quarterly Journal of Economics* 109(1): 27-54, 1994.

matters. This employer role as intermediary and agent is an important part of the “social contract” between employees and employers.

Fits with aversion to “Big Government”: The current reliance on private employers to purchase private insurance for a large portion of the population fits well with American culture and preferences. It is “in synch” with the business community’s aversion to government regulation, consumers’ widespread rejection of tax increases, and the historical American view that government should provide a safety net rather than serve as the primary provider of a good or service.⁵³ It gives employers the flexibility that they may not have under a government-mandated system.

Weaknesses

Excludes millions not tied to workforce: The primary disadvantage of the employment-based health insurance system is that it does nothing for millions of Americans who are outside the formal workforce. This includes unemployed and unemployable adults and their dependents, many self-employed people, early retirees, and countless individuals—primarily immigrants and migrant workers—who are employed “off the books.”

Leaves millions of workers and dependents without access to affordable coverage, including retiree coverage: Due to the voluntary nature of insurance sponsorship by employers, employment in the formal workforce alone does not guarantee health coverage. Nearly half of very small firms (less than 10 employees) choose not to sponsor health insurance. Seventy five percent of workers in firms offering insurance were eligible. Further, lack of dependent coverage leaves many children of workers without protection. And as employers pull back on retiree coverage, older workers who retire before they are eligible for Medicare may become uninsured, and those eligible for Medicare must purchase supplemental coverage on their own or be at risk of paying substantial costs out of pocket.

Lack of portability leaves workers vulnerable if they lose or change jobs: Insurance tied to one’s workplace means that people who lose their jobs or who move to a new job have their insurance interrupted, and many people go long periods of time without any coverage. While COBRA rules help some workers by giving them access to their former employers’ health plans for a limited period, workers have to pay the full premium plus a small fee. And while the Health Insurance Portability and Accountability Act (HIPAA) helps by requiring insurers to offer coverage to workers entering the individual market and placing limits on pre-existing condition exclusions, it does not limit premiums, which are too expensive for many unemployed people. This lack of portability induces some people to remain in their jobs solely to keep their health insurance (“job lock”), which hurts productivity if they are better suited for other positions.

⁵³ Silow-Carroll, et.al., 1995.

When employees do move between jobs, even jobs with health benefits, they are often forced to change insurance plans and provider networks, and may be asked to change their primary care physician. This disrupts the continuity of patient care and can be detrimental to the doctor/patient relationship. Even those who stay employed at the same firm are sometimes required to change plans and/or providers because either their physician no longer has a relationship with their insurer or because their employer decides to change carriers for financial or other reasons. Continuity of care is known to be an important indicator of quality health care.

Limits choice for individual workers: The down side of employers' ability to select health plans is the limitation on individual choice, which is especially important now that most people are enrolled in managed care plans, with their rules for controlling utilization and restrictions on choice of providers. Yet as noted above, only 55 percent of wage earners have some choice of health plans. Insured workers who are given no choice of health plans tend to be lower-wage and employed in smaller firms. If a goal is a "managed competition" model where individuals may choose among competing health plans, then the current system is sorely lacking.

Reflects regressive financing: The current financing of employment-based health coverage is regressive. Low-income people generally pay a higher share of their income toward coverage. Also, low-wage workers receive less in tax benefits than do wealthier people: since they are in lower tax brackets, the tax exclusion has less value than it does for people in higher tax brackets. Further, the tax exclusion does not provide any benefit to people with such low incomes that they do not owe federal taxes.

Results in employers with older, sicker workers paying higher premiums: Particularly in smaller firms, experience rating (even with rate bands) results in employers with older and sicker workers incurring higher health benefit costs. In addition to the questionable fairness of this situation, it gives employers an incentive to discriminate against higher-risk job applicants. Selecting workers on the basis of their likely impact on insurance costs—rather than on qualifications related to the job itself—may hurt productivity.

Leads to small firms paying higher administrative/marketing/load costs: Without the ability to attain economies of scale enjoyed by large businesses, smaller firms pay more toward their health insurance in administrative, marketing, and other fees. They also face greater volatility in premiums than do large firms.

Places extra responsibilities on firms that do not have expertise to select/manage health plans: Whereas most large corporations have developed health benefits departments that effectively and efficiently choose and administer health benefits for their workers, the vast majority of companies are relatively small and do not have this luxury. Their expertise lies in producing products or providing services unrelated to health care, and they do not have the resources to skillfully select and manage health care plans.

Dilutes cost control when individual firms do not have purchasing power to keep costs down: Individual small and medium-sized businesses typically do not have the leverage to effectively negotiate prices with health plan providers. This has contributed to the lack of cost containment and is inherent in an employer-managed structure. Purchasing coalitions that pool purchasing power attempt to reduce this problem, but to date they have had only limited success, and only a small fraction of firms have joined such collectives.

Frequently leaves employees with burdensome share of premiums: Under the present system, companies have the incentive to reduce their own health care costs; they do not have a direct stake in total health care spending. One way employers have moderated their own costs has been by passing more of the burden to employees.⁵⁴ Trends discussed in the previous section show the rise in required contributions by employees.

KEY CHALLENGES FOR REFORMING THE EMPLOYMENT-BASED SYSTEM

The strengths and weaknesses described in the preceding section present serious challenges to those hoping to improve the health care system. Policymakers and analysts on all sides of the political and philosophical spectrum are faced with the challenge of addressing the key flaws of the existing employment-based insurance system, while building upon its strengths or finding new ways to attain those benefits in an alternative system. Whether by repairing the employment-based system or completely replacing it, the key challenges are the following:

Covering the Uninsured

A primary challenge is to provide affordable coverage to those left out of the employment-based health insurance system. This includes making coverage available and affordable to employers and to employees, particularly low-wage workers in small firms, whose employers do not sponsor health benefits, and those who are ineligible for coverage sponsored by their employers. It also must reach people not tied to the traditional workforce, and children of workers for whom dependent coverage is unavailable or too expensive. Expanding coverage could involve providing incentives or mandating individuals to obtain coverage, and/or offering incentives or mandating employers to contribute toward insurance. Most reform proposals include public subsidies to help to make insurance more affordable to vulnerable individuals.

Assuring Vehicles for Pooling Risk

One of the key advantages of the current system is the use of the workplace as a vehicle for group coverage, with its pooling of risk and administrative efficiencies compared

⁵⁴ Silow-Carroll, et.al., 1995.

with individual insurance. A reform strategy could build upon this advantage by grouping small businesses into viable purchasing units to reduce administrative costs and expand the risk pool. Alternatively, a move away from group coverage could use risk-related subsidies or insurance rate reform (rate bands or community rating) to address variation in risk-related insurance costs.

Making Coverage Portable at Affordable Prices

A related challenge is to find an effective way to make coverage truly *portable at affordable rates*, to protect people who lose their jobs or change jobs, and reduce the incidence of job lock. The HIPAA law and various state reforms noted earlier have helped reduce the problems of portability, but these reforms still provide only limited help to people who have to buy individual coverage. They only assure that a worker losing group coverage can get coverage at some rate, which may be very high, rather than providing ways to continue coverage at affordable rates.

Addressing the Needs of Older Workers

With many companies scaling back or discontinuing retiree health benefits, there is a need to protect early retirees (some of whom may not be truly voluntary retirees) who are not yet eligible for Medicare, as well as traditional Medicare eligibles who cannot afford to purchase supplementary coverage. This may involve encouraging older workers to remain in the work force (with private health insurance), in order to assure that Medicare remains a viable program for older retirees, and/or implementing a “buy-in” to Medicare for early retirees.

Enhancing Fairness and Equity

Reform should address the many inequities embedded in our current system. First, it should reverse the regressivity of the current employee contribution and tax policies whereby low-income people pay a higher share of compensation toward health coverage but receive less in tax benefits than do wealthier workers. Second, reform should address the fact that people without employer-sponsored insurance, including many purchasing individual coverage and those without insurance, do not receive tax subsidies. This could involve extending the current tax exclusion to people purchasing coverage in the individual market, or replacing the existing tax exclusion with a tax credit (universal or income-related) that could be used toward the purchase of health insurance. Third, reform should address the unfairness related to employers with older, sicker workers paying higher health benefit costs. Fourth, reform should help “level the playing field” so that special interests with tremendous resources do not have a monopoly on influence and power.

Finding Efficiencies and Controlling Costs

To achieve and maintain affordable coverage options, reform should promote cost control through *real efficiencies* in the financing and delivery of care rather than

through simply *shifting costs* to other businesses (e.g., large companies shift to small firms), to workers, or to other insurers through risk selection. Employers can introduce more efficiency in the *financing* of care by making greater use of fixed contributions pegged to the cost of the best-performing health plans. Cost control may also involve maximizing administrative efficiencies, and enhancing purchasing power of employers or consumers (e.g., by increasing the size of purchasing pools). Improvements in the delivery system involve incentives to reduce unnecessary and inappropriate care, and to increase the use of effective preventive care services.

Offering Workers Choices and Appropriate Incentives

Another challenge for reform is greater choice of health plans to individuals, with incentives promoting cost-conscious selections. Consumer choice is an important ingredient of a cost-effective health care system, yet many workers are offered only one plan or no plans by their employer.

Providing Good Information in a Competitive Environment

Another key ingredient of a well-functioning health care system is good information on the cost and quality of competing suppliers. A reform strategy should promote the collection and use of reliable information on quality and cost of health plans and providers. It should also ensure that entities supplying services compete with one another for the purchasers' dollars—an increasingly difficult challenge in light of the wave of mergers and consolidations among hospitals and health plans in recent years.

Avoiding Adverse Incentives to Employers

Reform should reduce or eliminate the current incentive to employers to discriminate against higher-risk job applicants, a danger especially in smaller firms where the risk profile of one or a few workers more directly affects insurance premiums. Also, reform should reduce the incentive for employers to shift their health care costs to workers, which leads to higher turndown rates among employees who cannot afford their share of premiums, co-payments, or deductibles.

Maintaining Employer Flexibility while Protecting Workers

Those trying to improve the health care system are faced with a challenge of balancing flexibility for employers with protection for workers. Employers have the ability to choose their level of involvement in both managing and financing health care benefits. Some larger firms have taken a very active role in controlling health care costs and improving quality of care through selective contracting, outcomes data, and fixed contributions. This is one of the key strengths of the employment-based system. Conversely, many firms do not have the expertise to select and manage health plans, and choose to play a smaller role or opt out completely. While employers value the flexibility to make these decisions, employees are directly affected—they suffer the consequences when their firms choose not to offer any health insurance.

PROPOSALS TO CHANGE THE SYSTEM

There are many dimensions to reforming the health coverage system. The options cannot be arrayed along a single dimension, and many combinations of reforms are possible. Some reform options are relatively sweeping and move the system far from its present course, eliminating the current role of employers in financing or managing health coverage. Others are more incremental in nature, altering some elements, abandoning others, and adding new ones. We now briefly describe some of the options, which formed the basis for our discussions with employers (Section 4).

Single Payer /Medicare for All

Often referred to as a “single payer” system, this approach would do away with the employment-based system, eliminate subsidies based on tax exclusions, deductions, or credits, and have everyone more-or-less automatically covered as a matter of right. In essence, all Americans would be enrolled in a Medicare-type program, since Medicare already follows this approach for the aged and people with certain conditions. Financing could be a combination of government tax revenues (a variety of forms are possible) and perhaps some enrollee premium payments. Presumably an individual’s premium payment would be based on income, to ensure that lower-income people could afford their share of the premium. The role of insurers would clearly be altered but would not necessarily be eliminated, since people might be given the option of choosing among a variety of managed care plans.

Extending Public Coverage Programs

Large numbers of people who do not have the financial resources to pay for coverage are now protected by public insurance programs, most notably Medicare, Medicaid, and the S-CHIP. Over the years, eligibility standards have been relaxed to include more lower-income people in some of these programs and new programs like S-CHIP have been developed to cover more children. This kind of incremental reform could be extended further. For example, S-CHIP could be expanded (as is being pursued in a few states) to include the parents of S-CHIP-eligible children. Uninsured older people not yet eligible for Medicare could be allowed to “buy-in” to Medicare at subsidized rates, depending on their income. This set of approaches leaves the rest of the system largely intact—employer-sponsored coverage would continue to be the source of coverage for most people, and the tax-exclusion of employer contributions would be unchanged.

Tax Reform

The idea of providing subsidies through tax credits seems attractive to many policy makers. Under this approach, government would subsidize private insurance to make it more affordable by allowing individuals to reduce their federal tax liability by some portion of the cost of the expense they incur in purchasing coverage. Tax credits for

individuals would make coverage more affordable and presumably induce many people who are currently uninsured to buy coverage at the now-lower net price.

The impact of tax credit reform on the number of uninsured and the role of employers would vary widely, depending upon a number of key elements: treatment of the current tax exclusion, amount and timing of credits, and eligibility criteria. Economist Ken Thorpe divides tax credit proposals into three general categories:⁵⁵

- Incremental reform—retains the current tax treatment of health insurance benefits.
- Structural reform—expands the current favorable tax treatment of insurance (exclusion of employer and employee premium contributions from taxable income) beyond employer-sponsored coverage.
- Comprehensive reform—eliminates current tax treatment of employer-sponsored coverage.

According to this categorization, the “incremental” reforms target tax credits to a portion of the uninsured, while retaining the current tax exclusion. The subsidy may be geared to low-income individuals/families or small firms (which are most likely to have uninsured workers).⁵⁶ This approach would not likely alter significantly the current role of employers in managing or financing health benefits.

The “structural” tax reforms, which expand the current tax benefits to individual insurance coverage and other types of arrangements, have greater potential to alter the employment-based insurance system. These proposals let workers decide whether to obtain insurance through the employer or in the individual market⁵⁷, which would now have comparable tax advantages. The extent to which workers “opt out” of employer-sponsored coverage would depend on the “cash-out” amount provided by the employer, and the relative price of coverage in the various settings. For example, a young, healthy worker may find it beneficial to pull out of work-based coverage and purchase an inexpensive, experience-rated individual policy. Some fear that if only high-risk workers remain in employer-sponsored plans, these plans would become unaffordable and eventually dropped by employers.

The “comprehensive” tax credit proposals would have the greatest impact on employers, by removing the current tax benefit of obtaining employer-sponsored health benefits, and providing tax credits to help people purchase either group or individual coverage.⁵⁸ This represents a more equitable method of government subsidization, but has greater chance of reducing or perhaps even ending the employer’s role in managing

⁵⁵ Thorpe, Kenneth E. “Changing the Tax Treatment of Health Insurance: Impacts on the Insured and Uninsured” in *Severing the Link Between Health Insurance and Employment*, Employee Benefit Research Institute 1999.

⁵⁶ Examples of incremental tax reform strategies are those proposed by the American College of Physicians, American Society of Internal Medicine, and the Blue Cross and Blue Shield Association.

⁵⁷ Or through another arrangement such as a “HealthMart” or Medical Savings Account.

⁵⁸ Examples of comprehensive tax reform strategies are those proposed by Mark Pauly (1992) and by Eugene Steuerele (1997).

and financing health coverage. (This latter type of tax reform is the type discussed with employers in the interviews, Section 4.)

Mandates

Mandates can apply to either employers or individuals, but they have somewhat different purposes. In years past, there was much interest in an employer-mandate—that is, a requirement that all employers offer and pay for (some portion) of coverage for their employees and employees’ dependents. The idea was to build on the employment-based system: requiring every employer to subsidize coverage would make coverage available to all workers and affordable for many who cannot pay their share of the premium currently. From a practical standpoint, this approach would almost certainly require some subsidies be made available to low-wage employers, especially to those that employ primarily minimum-wage workers. Otherwise, some employers would be forced out of business and some employees would be laid off because they are not productive enough to justify the increase in the costs of providing their compensation including health insurance.

Individual mandates have a different purpose and would probably produce a different result. The main purpose of an individual mandate is to ensure that everyone acquires coverage. This would address the problem created when some people fail to take up their employer’s coverage offer or fail to buy coverage on their own. But since a simple mandate does nothing to make coverage more affordable for lower-income people, proposals generally include some kind of subsidy such as a voucher or a refundable tax credit. This individual mandate approach might encourage some movement away from employer-sponsored coverage *if* it were combined with comprehensive tax reform described above. Otherwise, employment-based coverage would likely continue as most people could meet the mandate requirement simply by taking up employer-offered coverage.

Buy-Ins or Purchase Through Existing or New Groups

One reason insurance coverage for both small groups and individuals is expensive is that administrative costs are high because it is costly to market to and service many small purchasers. It would seem possible to realize economies of scale and reduce coverage costs by arranging for small employers and individuals to purchase coverage through some larger group. Several possibilities exist to accomplish this objective. Some proposals would have small groups and individuals purchase coverage by “buying in” to something like a state employees plan or the Federal Employee Health Benefits Program. Other proposals would establish new entities, such as health insurance purchasing cooperatives (HIPCs), that would purchase on behalf of small groups and individuals.

Having such options would presumably allow people to buy coverage at lower cost than they could do on their own (though the evidence indicates that the buying

organizations would have to be big to achieve expected economies of scale). There is a danger, however, that the people who choose coverage through these groups would be people with higher-than-average risk, especially if there were no mandate requiring individuals to purchase coverage. Steps would be necessary to protect the purchasing entities against this kind of adverse selection.

Medical Savings Accounts

Medical Savings Accounts (MSAs) build upon the basic Flexible Spending Account (FSA) model, in which employees are given the option to contribute pretax dollars to an account that can be used to cover out-of-pocket medical costs not paid by their insurance.

An employer that chooses the MSA approach would purchase a low-cost catastrophic policy to cover employees for only the most costly major medical services—hospitalization, surgeries, emergency room visits, etc. Either the employee, the employer, or both, would then contribute money to an MSA to cover the high deductible and the cost of basic and preventative services. Unlike FSAs, any money left in the account at the end of the year would carry over to the following year, although it would be reserved for medical expenditures only. Theoretically, this approach gives employees strong incentives to economize in utilizing health care services because they are spending “their own” money, rather than the insurer’s money, when they consume care; yet with catastrophic coverage they are financially protected if they experience a very expensive episode of care.

Miscellaneous Incentive-based Proposals

While we cannot cover all variations of health care reform proposals here, we include a few incentive-based reforms that are currently being initiated on a small-scale, in individual businesses, communities, or states. In our interviews with employers, we obtain their reactions to these approaches, which could be expanded to a larger scale, perhaps even nation-wide. These reforms would maintain and build upon the current employer role in financing and managing health coverage.

One approach is to provide *subsidies to employers who begin to offer health coverage to employees*. This approach, being used in the communities of Muskegon County, MI, San Diego, CA, Wayne County, MI, Denver, CO, and state-wide in Kansas, encourages employers who want to provide coverage to their workers, but need some financial assistance.⁵⁹ This approach efficiently targets firms without coverage, but is criticized because it does not provide assistance to businesses that have been providing coverage but were struggling to do so.

Another approach, being explored in New York and elsewhere, involves providing *government-backed “reinsurance” to private health plans and insurers*. Government

⁵⁹ See Silow-Carroll, Sharon, Stephanie Anthony, and Jack Meyer. *State and Local Initiatives to Enhance Health Coverage for the Working Uninsured*. Prepared for the Task Force on the Future of Health Insurance, The Commonwealth Fund, October 2000.

would reimburse private health plans for very large claims (above a designated dollar figure) or for losses exceeding a certain amount. This “stop-loss” protection would in theory allow insurers to reduce premiums, thereby keeping coverage more affordable for employers and individuals.

Finally, a device used by some large businesses providing health benefits is called *defined contributions*. Although there are many variations applied to this term, the most common one (and the one we discussed in our interviews) involves employers offering a choice of health plans, and providing a certain dollar amount toward each worker’s health coverage. If an employee selects a less expensive option, he/she contributes a relatively small amount or nothing at all. If the worker selects a more expensive option, he/she must contribute a larger amount. This approach both allows employers to better control their health benefit budget, and provides incentives to workers to make more cost-conscious health plan selections.

EMPLOYER INTERVIEWS

PAST RESEARCH ON EMPLOYER ATTITUDES

Public opinion polls track the general public's and workers' attitudes regarding the health care system and potential reforms. Surveys that explore workers' views on the provision of health benefits, for example, have found that employees are generally satisfied with the current employment-based system.⁶⁰ One recent study found that 73 percent of workers who have insurance think that employers do a good job of selecting and providing quality benefits. Another reports that 64 percent of people think that employment-based health insurance is the most important non-wage benefit workers receive. The same research revealed a nearly four-to-one preference for employment-based coverage over a plan to give employees an equivalent cash sum and allow them to purchase their own insurance. Even when asked what their view would be if fringe benefits were to become a part of an employee's taxable earnings, more than half favored retaining employment-based coverage.

Rather than looking at attitudes, surveys of *employers* generally focus on current business practices in providing health benefits and on controlling benefit costs. The Economic and Social Research Institute (ESRI) has, however, conducted several surveys that look specifically at how employers' *think* about financing and managing health benefits. In 1995, ESRI conducted in-depth interviews with 40 business executives about the role of employers in financing and administering health care and about various reform proposals. Most employers interviewed by ESRI in 1995 held the view that reform was needed to contain health care costs and expand access. While not a representative sample of all private employers, respondents from large companies expressed a clear desire to continue or strengthen the employer's role in managing and financing health care benefits, while those from small businesses had mixed views. A majority of employers interviewed expressed:

- skepticism about government's ability to improve the health care system, and a belief that employers should drive any reform efforts;
- a strong desire for employers to retain control over health benefits;
- preference for state reforms over federal reforms; and
- preference for employer premium contributions over a payroll tax for financing

⁶⁰ See: Schoen, Cathy, Erin Strumpf, and Karen Davis, "A Vote of Confidence: Attitudes toward Employer-Sponsored Health Insurance," The Commonwealth Fund, January 2000.

See also: Fronstin, Paul, Employer Based Health Insurance, A Look at Tax Issues and Public Opinion," EBRI Report, July 1999.

health benefits.⁶¹

In 1996, ESRI surveyed 600 small, medium, and large businesses regarding their attitudes on health care, with a particular emphasis on providing coverage for children. This survey found an overall desire by employers of all sizes to maintain and even strengthen our employment-based health insurance system, favoring a system in which both employers and employees contribute toward coverage. The majority of employers were not in favor of an employer mandate; they preferred tax incentives to encourage employers to contribute toward workers' coverage. While acknowledging employer responsibility toward their own workers and their families, most viewed government as being responsible for providing coverage to the uninsured.⁶²

In 1998, ESRI surveyed low-wage businesses offering health coverage, and found an almost universal sense of obligation by employers to provide and contribute toward health insurance for their employees and their children under the current employment-based system. This study did not examine attitudes toward the appropriate future role of employers or toward reform.⁶³

A more recent survey of more than 300 businesses, conducted by the National Association of Health Underwriters, found that more than three-quarters of employers favored federal legislation that would provide low-income employees with tax credits to help pay for health insurance premiums.⁶⁴

Need for New Understanding of Employers' Views

The last few years have brought a combination of economic prosperity and, with the exception of the most recent year, rising numbers of uninsured people. These conditions raise new concerns about the ability of the employment-based system to provide adequate coverage to Americans. For that reason, and because budgetary constraints that have inhibited reform in the past are less severe, there is renewed interest in reforming the health care system. At the same time, it is unlikely that reform would transpire without the support of the business community. It is therefore essential to ascertain employers' current views about their role in health care and the degree to which they support or oppose various reform proposals. Understanding employers' views will likely help policymakers be more successful in their reform efforts.

To capture these views, we developed an interview guide that reflected our assessment of the strengths and weaknesses of the current employment-based insurance system as well as our categorization of major reform proposals (Section 3). The guide was designed

⁶¹ Silow-Carroll, et al. ,1995.

⁶² Meyer, Jack A., Diane H. Naughton and Michael J. Perry. *Assessing Business Attitudes on Health Care*. Economic and Social Research Institute and Mathew Greenwald & Associates, October 1996.

⁶³ In this survey, ESRI gauged business and employee attitudes toward the new State Children's Health Insurance Program (SS-CHIP). (Meyer, Jack A., Elliot K. Wicks, Stephanie E. Anthony, Laurie E. Rosenberg, and Michael J. Perry. *Business and Employee Attitudes Toward the New State Children's Health Insurance Program*. Economic and Social Research Institute, May 1999).

⁶⁴ National Association of Health Underwriters, Employers Study 2001.

to elicit opinions about the role of employers in financing and managing health care benefits and about the acceptability of various alternatives to the current system. Our interviews explored issues such as the following:

- Do employers see administration of health coverage as important and relevant to their business objectives, or as a distraction and a burden they would like to relinquish?
- What are the major problems and benefits of an employment-based financing system? Is that system the best way to accomplish the objectives of providing cost-effective care for the employed population?
- Is it appropriate for employers to play such an important role in determining the kinds of health plans that are available to employees and, in the longer term, determining how the health care system will be structured? Are employers the appropriate actors to be making these decisions?
- Should employers be expected to pay for a large part of health coverage (even if the burden ultimately is borne by workers in the form of lower cash wages)? How should the costs of coverage be divided up among employers, employees, and government (taxpayers)?
- How do employers feel about “cashing out” health benefits by paying workers more cash wages and letting them make their own arrangements for health coverage?
- How would employers react to various alternatives that have been proposed to reform the health care system?
- What adjustments or adaptations in reform proposals to build on or replace the employment-based system would be acceptable to the business community?

The interview guide was designed to assess respondents’ reactions to policy alternatives, and allow us to identify those that seem palatable, desirable, and feasible as well as those that are not acceptable from the perspective of the business community. We analyze the findings, draw out major themes, and assess implications for public policy in following sections.

METHODOLOGY

Between October 2000 and January 2001, the Economic and Social Research Institute conducted interviews with 56 employers from businesses ranging in size from 2 to 8,200 full-time employees. The interviewers followed a guide (Appendix) designed to elicit employers’ attitudes and opinions on several proposals aimed at changing the way health benefits are offered and financed, as well as to prompt comments on their role in sponsoring and managing health benefit programs for their employees.

When conducting interviews, researchers face tradeoffs. A large sample size allows the researchers to generalize from the findings but usually requires that interviews be relatively short and that those being interviewed choose from a limited number of responses. It also requires interviewers to “stick to the text,” and avoid additional conversation that might shed some light on the reasoning behind the answers that are being coded. Our intent was to gain a greater understanding of the range of employers’ attitudes, and the factors that underlie their opinions. Given that goal, we concluded that a smaller set of interviews would allow for more in-depth probing and conversation.

The interviews were conducted by ESRI staff and consultants from the Severyn Group, all of whom are familiar with health policy issues and have a working knowledge of the proposals included in the survey. Because of the conversational format of the interview and the complex nature of the proposals, it was important for interviewers to have some degree of expertise to ensure that respondents understood the implications of each proposal and could ask for clarification and/or additional information. Their expertise also allowed interviewers to probe more deeply and to examine employers’ reasoning more thoroughly than would have been possible with a standard interview format administered by questioners with little or no knowledge of the subject.

Every attempt was made to ensure a diverse interview pool. ESRI drew its sample from a Dun & Bradstreet list of public and private employers for which a human resources contact was available. Because of the limited sample size and ESRI’s desire to tap firms of varying sizes, we divided the businesses into four groups: very small firms (2 to 15 full time workers), small firms (20 to 70 workers), mid-sized firms (100 to 500 workers), and large firms (900 or more workers). We completed interviews with representatives of 12 very small firms, 18 small firms, 10 mid-size firms, and 16 large firms.

The location of businesses varied, with more or less equal numbers coming from the northeast, south, west, and midwest United States. They represented a wide range of industries, including financial services, manufacturing, retail, shipping, hospitality, construction, health services, and other industries. Although our sample is not large enough to be statistically representative of employers nationwide, we believe that it captures the diversity of American employers.

When arranging the interviews, we requested to speak with the person who makes decisions regarding health benefits for employees. For most of the very small and small firms, we spoke directly with the owner/proprietor. For the medium and large firms, we generally spoke with the benefits manager or director of human resources. Sometimes, the respondent gave two answers to certain questions, one from the perspective of the “employer,” another from the perspective of a working person. We tried to capture the reasoning behind these dual responses when this occurred.

We coded interview responses in two ways. Those questions that elicited a Yes/No, “favor/oppose” or multiple choice response were coded numerically, and frequencies

were generated for total respondents and by employer group size. Many questions were of an open-ended nature, however, to encourage respondents to talk freely and express their views in an unrestricted manner. Responses to these open-ended questions were categorized and coded according to themes. Most responses were captured by this method. Given the small sample size, we were able to keep track of responses that did not fit neatly into categories, and we note some of these responses in the Findings section. To the extent that there were major differences in responses among firms of different sizes, we discuss this in the Findings section as well, but again with the caveat that we cannot generalize to all employers of a particular size.

In addition to recording the responses to questions, the interviewers carefully noted additional themes, personal anecdotes, and inconsistencies that emerged during the interviewing process. This allowed us to assess specific trends in the respondents' thinking, while at the same time recognizing the unique concerns of individual employers. While we do not claim that our findings are fully representative of the employer community in the sense of meeting tests of statistical significance, we think that the views elicited provide useful insights into the variety of employers' attitudes toward their role in providing health benefits and toward health care reform.

FINDINGS

Health Care Coverage Offered by Respondents

Firms in our sample provide health benefits to their employees, dependents, and retirees in a pattern that is similar to coverage rates seen in larger employer benefits surveys.⁶⁵ Health benefits are offered in all of the large and mid-size firms in our sample, the vast majority (nearly 95 percent) of firms with 20 to 70 workers, and just more than half of the very small firms (2 to 15 workers).

Although less likely to offer coverage, the small and very small firms that do offer health benefits are the most likely to pay the full cost of employees' premiums. On average, the employers we interviewed contribute about three-fourths of the cost of workers' coverage. One very small firm makes a group-rated plan available—which saves the employee from having to enter the individual market—but does not contribute any dollars toward the premium.

Nearly all respondents that provide benefits to employees also offer some form of dependent coverage. However, firms that offer a dependent benefit sometimes pay a smaller percentage of the premium for family coverage than for individual coverage. A number of employers (most often in small firms) pay nothing toward dependents' premiums, but make the coverage available at the employee's expense. Others, especially larger firms, pay the same percentage toward an individual or family

⁶⁵ See The Kaiser Family Foundation, & Health Research and Educational Trust, "Employer Health Benefits: 2000 Annual Survey."

policy. For employers offering dependent coverage, the average employer contribution for that coverage is just under 50 percent, ranging from 100 percent coverage for dependents to the offer of dependent coverage with no additional contribution above what the employer gives for an individual employee.

Only one-third of employers in our sample provide health benefits for retirees. Even among the large firms—which are most likely to offer retiree coverage—fewer than half provide health benefits to retirees. None of the very small firms provides retiree coverage, in part because smaller firms are much less likely than larger firms to have retirees.

Most larger firms offer employees a choice of plans, generally at least one HMO and a PPO, while smaller firms tend to offer only one plan. None of the employers we spoke with offers a cafeteria-style benefits package, where employees are given a standard dollar amount for a variety of fringe benefits and are allowed to allocate money as they see fit. This finding, however, could be due to our small sample size and the fact that it is generally only larger employers who are able to offer this type of package.

Role of Employers

During the interviews, we were careful to distinguish between the role of *financing* health coverage and *managing* health coverage for workers. *Financing* was defined as contributing toward health insurance premiums for workers, dependents, or retirees. *Managing* health coverage was defined as selecting and designing benefit packages, negotiating with health plans on behalf of employees, trying to control costs or improve the quality of care delivered, and administering/maintaining the benefit plan. These two roles were separated to help the respondents consider the relative importance of each and to help them articulate why they believed each role was either beneficial or detrimental to employers and employees. Their answers revealed how strongly they feel about maintaining or eliminating the different kinds of employer responsibilities and helped to prepare the respondents for later questions about reforms that would alter some aspects of their roles in managing or financing coverage.

Financing Coverage for Workers

The vast majority of respondents expressed that employers *should be financing* health care by contributing toward their workers' health insurance premiums. This support for their financing role was nearly universal among firms of all sizes, except for the very small ones. But even among the smallest companies, three-quarters of respondents expressed support for this role.

When asked to articulate why they thought employers should be financing health benefits, respondents gave one or more reasons. The most common reason was that it is employers' *responsibility* to provide coverage, and they felt a sense of *obligation* to their workers. As one employer at a small firm said, "We take care of [our employees]—it's a team and family." Another common reason was that providing

health benefits is an important tool for recruiting and retaining employees. A significant minority of respondents felt employers should contribute toward worker’s health insurance because it is a necessary cost of doing business. Only a few employers pointed out the ultimate benefits to employers of promoting a healthy workforce, in terms of increased productivity and reduced absenteeism. (see Figure 10.)

A number of respondents qualified their support for financing health benefits by asserting that employers should finance coverage if they *are able*; that is, this role is ideal but it should not be mandatory. Many employers who supported financing health coverage acknowledged that some employers face financial obstacles. An employer at a mid-size social service organization stated,

Ideally, yes [employers should finance health benefits], but it can’t always be done. While there’s a direct relationship to employees’ happiness and productivity, employers can’t always afford it. We’re looking for ways to share the costs with employees and to lower the overall costs by pooling lives with a similar organization.

One representative of a large, non-profit hospital stated that financing workers’ health coverage “should be an option,” and employers’ decisions should “depend on what the market requires—a function of competitive forces.”

Not surprisingly, three respondents who did *not* think employers should be financing health coverage represent very small firms that are not currently providing coverage to their workers. Two cited the fact that many employers cannot afford to provide coverage, and one asserted that obtaining coverage should be up to the individual: “I do not think it’s my responsibility; it’s like house or utility payments—that’s up to them [employees].” An employer of a small firm stated, “Small employers should help *facilitate* coverage, but the primary responsibility is up to the employee.”

Interestingly, another four respondents from small and very small firms that do *not* currently offer health benefits responded that employers *should* be financing coverage. Apparently, these employers would like to provide insurance but cannot afford to do so. This suggests that mechanisms that make coverage more affordable to small firms would in fact be welcomed and used by these employers.

FIGURE 10: EMPLOYERS’ ATTITUDES TOWARD FINANCING HEALTH BENEFITS FOR WORKERS

Prevalent View: Employers <i>should</i> finance health benefits because...	Minority View: Employers <i>should not</i> finance health benefits because...
<ul style="list-style-type: none"> • Employers have a moral responsibility/obligation to workers • Health benefits are a tool to recruit and/or retain workers • Providing coverage is a necessary cost of doing business 	<ul style="list-style-type: none"> • Many employers cannot afford to provide health benefits • Obtaining coverage should be the responsibility of individuals

Financing Coverage for Dependents

While the vast majority of the respondents supported the view that employers have a responsibility to provide workers with health coverage, a smaller majority extended that responsibility to workers' *dependents*. One employer of a large firm pointed out that, "For us, [coverage for dependents] affects absenteeism if workers have to stay home to take care of someone." This respondent also viewed dependent coverage as a recruiting tool.

The disparity in employer responsibility toward workers versus dependents was most pronounced among employers of small firms. All respondents from firms with 20 to 70 workers thought employers should finance workers' coverage, but less than half expressed that employers should finance coverage for dependents. There are two factors at work. For some employers, it is a financial issue: they just do not have the funds to contribute toward dependent coverage. For others it is a philosophical issue: they believe that employers do not have the moral obligation to cover family members. Most of these respondents were from firms that make coverage *available* to workers' dependents, but do not contribute toward dependent coverage. That is, they see the value in making group coverage accessible to families, but believe that individual workers should be responsible for paying for that coverage.

Interestingly, this large disparity in feelings of financial responsibility toward workers versus dependents was not seen among employers of very small firms (2 to 12 workers), perhaps reflecting closer relationships between these employers and their few employees. That is, the employers are more likely to have a personal relationship with each employee when there are only a few employees, and therefore have greater familiarity with and greater sense of responsibility for workers' family members.

Financing Coverage for Retirees

There was significantly less support for employers financing health benefits for retirees than for dependents. Fewer than a third of total respondents expressed that employers should be contributing toward retiree health care. (Among those who answered the question definitively, it is about evenly split among those who think employers *should* and *should not* finance health insurance for retirees.) This view is consistent with the overall decline in employer coverage for retirees over the past decade. Even among respondents from large firms—which historically have been most generous with retiree coverage—only half favored employer sponsorship of this type of coverage.

Employer Role in Managing Workers' Coverage

Overall, respondents felt strongly that employers should be *managing* (selecting, negotiating, administering) health coverage for their workers, although this support was not as prevalent as for employers' financing coverage (Figure 11). Virtually all who favored involvement in managing coverage said they feel that employers are better equipped than employees to manage coverage, and can make better health plan choices. While many respondents suggested that employees should also be involved in

the process, there was general agreement that employers are in a better position to negotiate with insurers, compare health plan options, make rational choices, ensure premium payment, and conduct other administrative functions. Many employers expressed the view that individual employees would be, as one respondent put it, “lost out there.” They want to make sure the money is being spent wisely, implying that employees on their own would or could not spend premium dollars appropriately. They also feel it important to “maintain control.” A respondent from a large firm said, “We’re the ones paying the bills so we want the most bang for the buck.”

A few employers supported their management role, but admitted that it is an administrative burden. As with financing coverage, many thought that employers *should* manage benefits “if they *are able*.” They also stressed that employers should have the option: “Some small companies are better off managing health benefits themselves, others are not; employers should be able to choose.”

The view that managing coverage should *not* be the employer’s responsibility was the (slight) majority view only among respondents from very small firms (2 to 12 workers). This is not surprising given that very small firms are least likely to have personnel dedicated to health benefits functions. Yet curiously, in the next largest category of firms (20 to 70 workers), all of those interviewed supported a management role for companies. (A sizable majority of larger firms also favor a role for employers in managing health benefits.)

Respondents who opposed a management role offered both practical and philosophical reasons: employers cannot afford or are not equipped to conduct the management functions, and individuals can better choose what is best for them.

FIGURE 11: EMPLOYERS' ATTITUDES TOWARD MANAGING HEALTH BENEFITS FOR WORKERS

Prevalent View: Employers should manage health benefits because...	Minority View: Employers should not manage health benefits because...
<ul style="list-style-type: none"> • Employers are better equipped than workers to conduct management functions (research health plans, negotiate with insurers, administer benefits) • Employers can make better choices than workers • Employers have a stake in maintaining control and ensuring that money is being spent wisely 	<ul style="list-style-type: none"> • Many employers are not equipped to conduct management functions • Individuals can better choose what is best for them

Employers' Concerns About and Goals for Reform

Greatest Concern About Future of Health Care

When asked about their greatest concern about the future of health care, *rising costs* was cited most often across all size firms, among nearly two-thirds of respondents. One employer of a small business reported a 30 percent increase in premiums last year, and many claimed that insurance is becoming unaffordable. A number of employers cited rising prescription drug costs specifically as their greatest concern, which is consistent with analyses showing pharmaceuticals as the fastest growing component of health care costs.

The second most common concern, cited by one-fifth of the respondents, is related to HMOs and managed care. Many employers expressed strong anger toward HMOs and other insurers, which they claim remove decisions from the doctors, continually increase premiums, do not reimburse providers adequately, and have generally ruined the health care system. A respondent from a small firm said his greatest concern is "...HMOs and what they've done, regarding quality, administration. You have to fight for services, they aren't paying providers correctly, there are reams of forms and papers; it's a struggle." According to one pharmacist and small employer, "There won't be any providers left because the [HMOs'] reimbursement rates are not fair."

While many employers expressed that HMOs have too much control in the health care system, only one employer of a large firm believes that HMOs did not have enough control. This employer's greatest concern is "...boundaries of the government's regulation over HMOs; HMOs should be able to do more to control costs without government interference."

Access to insurance was the third most common concern among employers, who complained that there are too many uninsured people. Other concerns included:

- Waste and the declining quality of care;
- over-regulation by government;
- too much paperwork/administrative burden; and
- limited number of choices.

There were no major differences in concerns across firms of various sizes.

Primary Goal of Reform

The primary goal of reforming the health coverage system was generally correlated with employers' major concerns over the future of health care. Just over half of respondents stated that reform should be geared to control costs and improve affordability of health coverage. A related goal, cited by 22 percent of respondents, is to expand coverage to the uninsured.

The anger toward HMOs was expressed in the need for reforms to regulate HMOs and give control back to doctors. One employer of a small firm stated, "We must deal with

HMOs—they're out of control!" Another expressed that the goal of reform should be to "move away from HMOs that decide what care people get. The HMO idea is not good for anyone except HMOs."

A few employers cited the goal to reduce administrative burden and government intervention. Only a couple of respondents felt that the primary goal of reform should be to improve the quality of care.

Reactions to Specific Reform Proposals

The employers were asked their views on a number of specific kinds of reform strategies, based on the proposals described earlier. The interviewers prefaced this discussion by reminding respondents that some of the proposals would maintain the employer's role in financing and managing health coverage, some would change certain aspects of that role, and others would eliminate employment-based insurance entirely. The interviewers read a brief description of each type of reform.⁶⁶ Given the diversity of businesses in the sample, there was wide variance in the level of previous knowledge and understanding of the strategies. Many respondents were already aware of the major implications of the proposals, while others were learning about the strategies for the first time and had not necessarily thought them through before. If the respondent seemed confused or asked questions, the interviewers were prepared to clarify and expand on the strategies, careful to present both "pros" and "cons" of the proposals.

The reform strategies are presented in decreasing order of support in Figure 12. Among respondents who had opinions about the reforms, the proposals most favored are those geared to reducing coverage costs for small businesses. These include establishing new entities that purchase coverage on behalf of small businesses, allowing small firms to "buy in" to an existing large group plan such as a state employee health plan or the Federal Employee Health Benefits Program, and subsidizing employers offering coverage to workers for the first time.

Such high degree of support for these strategies reflects acknowledgement by employers in firms of *all* sizes that small businesses have difficulty obtaining affordable coverage and need a mechanism to bring them onto a level playing field with larger firms.

There was also a high degree of support for Medical Savings Accounts, despite the fact that many employers were learning about MSAs for the first time. Yet while the majority of employers favored the idea of MSAs and thought they should be available on a wider scale, fewer than half of respondents thought they would incorporate MSAs into their own firm's benefit structure.

About three-quarters of respondents favored expanding public programs to help fill the gaps in coverage. And a majority of respondents supported an indirect route to coverage

⁶⁶ See Interview Guide in Appendix for descriptions of reform proposals.

expansion involving government-backed reinsurance for private insurers to help slow down the rise in premiums.

There was less support for reforms that can be considered more sweeping in scope and/or that involve limiting choices. An employer mandate, a single-payer system, an individual mandate, and replacement of the tax exclusion with a tax credit were all opposed by a majority of respondents.

The following section describes the reactions to each of the proposals discussed in the interviews.

FIGURE 12: EMPLOYERS’ SUPPORT FOR HEALTH CARE REFORM STRATEGIES
(Order reflects decreasing level of support among respondents expressing opinions)

Supported by a majority of respondents...	Opposed by a majority of respondents...
<ul style="list-style-type: none"> • New purchasing cooperatives for small businesses • Small firm “buy-ins” to existing group health plans (e.g., state employee health plan, FEHBP) • Subsidies for employers offering health coverage to workers for the first time • Expansion of Medical Savings Accounts • Expansion of public health coverage programs (e.g., Medicaid, S-CHIP) • Government-backed reinsurance of private health plans 	<ul style="list-style-type: none"> • Employer mandate • Individual mandate • Single payer, national health system • Replacement of tax exclusion with targeted tax credit

Grouping Small Businesses to Purchase Health Coverage

Two reform strategies that were very popular among the respondents involved allowing small businesses and individuals to buy health coverage through some larger group. Across-the-board support for these proposals suggests that employers of all sizes are aware of the difficulties and disadvantages facing small firms in obtaining affordable health coverage. Even employers of large companies favored methods that would level the playing field, bringing smaller businesses the advantages that they enjoy in terms of spreading risk and negotiating from a position of relative strength. Further probing revealed important qualifications, however, which reflect employers’ attitudes toward government involvement and toward the importance of choice.

Health Insurance Purchasing Cooperatives (HIPCs)

All respondents who had an opinion about this proposal were in favor of the formation of new entities, such as health insurance purchasing cooperatives (HIPCs), that

purchase health coverage on behalf of smaller businesses and individuals—making this the most popular reform proposal discussed.⁶⁷ The prevailing attitude is summed up by one employer of a small firm, who stated that purchasing cooperatives will “allow some employers that currently can’t afford group coverage to have an option that would work for them.” Nearly all of the respondents reasoned that pooling allows for economies of scale, or enables small firms to negotiate better deals with insurers, thereby leveling the playing field with larger firms. Only one employer based his support on the fact that HIPCs remove the burden from employers to manage health benefits.

These findings are interesting, but may suggest unrealistic expectations. Other studies by ESRI found that most purchasing cooperatives have had good results in increasing choice, but very limited success in lowering costs.⁶⁸

A few respondents added the caveat that they would support cooperatives if they were *privately* managed, but not if they were government-run institutions. A couple of employers were concerned that HIPCs would establish new bureaucracies, and one feared that HIPCs would *limit* an employer’s choice of health plans, rather than expand the number of options.

Support for HIPCs plummeted when the HIPC idea was combined with a stipulation that all small employers that wish to provide coverage for their workers *must* purchase that coverage through a HIPC. Maintaining the option to buy coverage outside the cooperative was deemed critical by the vast majority of respondents, with many employers expressing the opinion that “no one should be telling me what to do.” The few employers who favored the proposal with the stipulation did so reluctantly only because they felt that it would help everyone in the long run by strengthening the pooling mechanism and not because they supported the principle of mandated participation.

Most respondents appeared unaware of the reasoning that is used to support the proposal that all small employers providing health benefits must do so through a HIPC—that the mandate may be necessary, at least in early stages, to assure the “critical mass” needed to provide HIPCs with sufficient bargaining clout to lower costs.⁶⁹ One respondent discounted this notion by saying that if purchasing cooperatives really work, there will be no need for a mandate and the HIPCs will essentially “sell themselves.” He feels that a government mandate would do little more than create further unnecessary regulation. Evidence has shown, however, that HIPCs do need help in generating enrollment. Studies by both ESRI and others have found that both privately- and publicly-run HIPCs have had difficulty achieving sufficient enrollment

⁶⁷ Of the total sample, 84 percent supported the expansion of HIPCs, none opposed the idea, and 16 percent had no opinion.

⁶⁸ See: Wicks, Elliot, Mark Hall and Jack Meyer “Barriers to Small-Group Purchasing Cooperatives,” Economic and Social Research Institute, March 2000.

⁶⁹ Wicks, Elliot and Mark Hall, “Purchasing Cooperatives for Small Employers: Performance and Prospects”, *Milbank Quarterly*; Volume 78 (4), 2000: pp. 511-46.

to provide benefits comparable to large-group coverage at a low cost.⁷⁰ The employers in our survey, however, were either unaware of this evidence or were not swayed by it, and overwhelmingly disapprove of any mandate that diminishes employers' ability to choose and that forces them to buy coverage from a single source.

Small Firm “Buy-ins” to Existing Group Health Plans

There was also much support for allowing small businesses and individuals to “buy in” to an existing large group such as a state employee health plan or FEHBP. Three-quarters of all respondents favored this strategy for extending the advantages of large-group purchasing to small firms and those without access to any group coverage. Only one-quarter oppose this particular proposal or had no strong opinion one way or the other.

Interestingly, many respondents reacted positively to the idea of taking advantage of *publicly-sponsored* government employee groups despite the substantial amount of anti-government sentiment they expressed throughout the interviews (discussed further below). FEHBP allows federal employees to participate in plans offered by a number of private insurers, so it is possible that employers did not view this option as a public sector reform, but rather as an opportunity for smaller employers to benefit from economies of scale in the private market. More than one person favored buying into FEHBP and state employee benefit programs only after we discussed the fact that these plans allow for coverage by private insurers rather than state or federally-run insurance programs. Those who favored a buy-in arrangement generally thought government employees receive a decent benefit package at a reasonable cost, and that many employers and employees from small firms would like to be able to take advantage of such a program.

Even though the respondents were favorably disposed to the idea of pooling, deeper probing revealed a general ambivalence toward government's role in such a plan. One respondent captured the spirit of this ambivalence quite well when he says that he would like to be a part of any system that was created “*by a government employee for government employees,*” but that he distrusts the efficacy of public programs intended for workers in the private sector. The few employers who responded negatively to the state/federal plan buy-in cited a distrust of government involvement as a primary reason for their disapproval, even though they generally supported the idea of small firms joining a larger group. They expressed either a philosophical objection to “government control,” or skepticism that government can provide a program that is worthwhile and well-run. As one employer put it, “In government programs you're going to get less and less care and attention; you're just a number.”

⁷⁰ Wicks, et. al., 2000.

Medical Savings Accounts

Another popular reform strategy is the promotion of Medical Savings Accounts (MSAs). Under this approach, rather than purchasing comprehensive coverage, employers, or in some cases workers themselves, purchase less expensive high-deductible, “catastrophic” insurance to pay for very large health care expenses; they then put the savings on a tax-free basis into a special account, which the worker can use for routine and lower-cost care.

Forty-three out of 53 respondents who had an opinion supported this approach, at levels fairly consistent across firm size and despite that fact that many employers from smaller firms were not previously familiar with the MSA concept. MSAs were supported primarily because they allow employers and employees to retain control, and permit employers to budget their contribution toward health care at a level they deem appropriate. Another group of respondents believed that sharing directly in the decision-making process and having a stake in “conserving” dollars will encourage employees to be more *cost-conscious*, if not more health-conscious. According to one respondent, “MSAs empower the individual to provide for his own health care, allowing people to enjoy more options.” Another employer emphasized his strong preference for MSAs over managed care: “[MSAs] keep with the private system, and keep people in control of their own medical purchasing. They’ll be wise consumers, versus managed care, where it’s out of our control and will wind up costing more.”

Some respondents from mid-sized and large firms likened the MSA approach to their experiences with flexible spending accounts (FSAs),⁷¹ and complained that they have trouble getting employees to use FSAs. In fact, research indicates that very few people who are offered an FSA option take advantage of it, and of those who do, it is questionable whether the majority use them in an appropriate way.⁷²

Some said that, even though they favor MSAs, maintenance and management of such arrangements could be difficult, especially for smaller employers. While respondents reacted favorably to this proposal, they saw it primarily as a tool that employers and employees could use to help manage the steadily increasing cost of health coverage, *not* as a solution to the problem of uninsured workers.

Among those who opposed promotion of MSAs, there was a common concern that employers and/or employees would never be able to save enough money to cover skyrocketing medical costs. Nearly half of this group expressed a concern for lower-income workers who might not be able to contribute sufficient money to the accounts to pay for even the most basic medical expenses. There was also a feeling that people need

⁷¹ FSAs, however, generally work in tandem with more comprehensive insurance programs than the catastrophic coverage plans advocated by some supporters of MSAs.

⁷² Schweitzer, Hershey & Asch, “Individual Choice in Spending Accounts. Can We Rely on Employees to Choose Well?” *Medical Care* June 1996; 34(6):583-93, as well as Schweitzer and Asch, “The Role of Employee Flexible Spending Accounts in Health Care Financing.” *American Journal of Public Health*, Aug 1996;86(8 Pt 1):1079-81.

more comprehensive insurance than catastrophic coverage offers. If employers and employees suddenly become responsible for the total cost of all medical expenses up to the point that catastrophic coverage kicks in, some people worried that the amount of basic preventive care people receive will decline. One respondent addressed this issue by saying that what most people need is coverage for basic medical services. She felt that catastrophes happen very rarely, and that people need insurance that covers preventive care and services for chronic conditions, which might mitigate the occurrence of catastrophes in the first place. Others who opposed MSAs felt that they are too complicated, and that employees would not take advantage of them.

Expanding Public Programs

One of the most striking, though perhaps not unexpected, findings is that employers tend to favor private-sector reforms over those that have a strong element of government involvement, with a few notable exceptions. About three-fourths of respondents, for instance, favored the expansion of publicly-subsidized programs to cover low-income working adults and their children. This support was expressed by a majority of respondents from firms of all sizes.

We consistently heard that employers favor private-sector solutions to the problems plaguing the health care system, and that they do not think the federal government is equipped to provide the best services in the most cost-effective way. Despite this, most respondents seemed to think that, for workers at the lowest end of the economic ladder, federal programs like Medicaid, Medicare, and S-CHIP are useful, if not absolutely necessary. Even if they are apprehensive about government involvement in the financing and management of health coverage, respondents generally felt that expanding public programs is favorable as long as the end result is an increase in the number of people covered. “Health coverage needs to be available to everyone,” according to one representative of a small business.

Some respondents stated specifically that it is government’s responsibility to act as a “back up” to the private sector, filling the gaps in coverage for those who cannot obtain employment-based or individual private insurance. According to a respondent from a large firm, expansion of government programs is “exactly what needs to take place; the employment-based system isn’t broken — the issue is to cover the uninsured.” A couple of employers supported expansion of public programs because they feel “the more options [available], the better.”

Among the minority of respondents who opposed the expansion of public health coverage programs, the reasons most commonly cited were cost, which is ultimately borne by taxpayers, and opposition to giving government a bigger role in health care. A few respondents objected to expansion of public programs because provision of health benefits is the responsibility of the employer. This view is consistent with the sentiments of a large number of respondents, discussed earlier, who believe that health coverage is a responsibility, perhaps even a “moral obligation,” that employers have to their workers.

So, while respondents generally did not favor government-run programs, they were also pragmatic in that they saw a need for government programs to cover low-income workers and other poor people when employers and the private market fail to do so. Another view was expressed by those who feel that expansion of public programs is defensible *only* for the *working* poor, and not for non-workers, who some feel are not “earning” their coverage. This relatively small group regards health coverage as a “benefit” of employment (whether it was supplied by the employer or not), as opposed to the majority who tend to think of it in terms of a “right” or “necessity.”

One employer of a small firm opposed expansion of public assistance programs, claiming that people who do not have coverage should find another job that does offer health benefits.

Other Incremental Proposals

Many of the proposals covered in our survey are far reaching in that they demand a certain amount of reorganization of the current employment-based system of providing health coverage. We also asked the employers about a few reform proposals, generally less expansive in nature, that rely more on incremental adjustments and incentives, rather than systemic changes and mandates or requirements, to improve access to coverage or contain costs. These strategies were generally supported by a majority of respondents.

Subsidies/Tax Credits to Employers Who Begin to Provide Health Coverage to Workers

Forty-four out of 51 respondents who had an opinion favored giving tax credits or subsidies to employers who begin providing health coverage to employees. The subsidy would, theoretically, encourage employers who are currently unable or unwilling to provide benefits to do so, knowing that at least part of the cost would be defrayed by the government contribution. The model we described would not, however, provide subsidies to employers that currently provided benefits, regardless of size or earnings.

Strong support for this approach—among firms of all sizes—may mean that employers recognize health benefits as an important and desirable outcome in and of itself—that is, a public good for society as a whole—and not merely as an instrument of competition in the marketplace. It also suggests that employers believe mechanisms that make coverage more affordable to businesses will be welcomed and used. It may also reflect employers’ view that they are indeed “paying for” health care, so that the assistance should go to them, as opposed to the prevailing view of economists that employees are ultimately paying for most or all of their health coverage, regardless of who writes the check.

As expected, all respondents who opposed this approach currently provide insurance to their employees. Among these few respondents, the subsidy was interpreted as being unfair to employers already providing coverage. As one respondent from a small firm noted, “[the subsidy] penalizes us for being good guys, for doing the right thing all

along.” Another employer echoed this sentiment, saying that the subsidy would “penalize people who are trying to do the right thing and reward people who aren’t.”

Government Backed “Reinsurance” to Health Plans

Slightly more than half of respondents favored the creation of government-backed “reinsurance” programs that would help private health plans pay for high claims. In essence, this approach would limit the liability of health plans, covering a proportion or all of the cost of claims over a certain set dollar amount. The cost savings realized by the plans would presumably be passed along to consumers in the form of lower premiums, thereby keeping health insurance more affordable. Some hope that the lower premiums will draw some firms into offering health coverage for the first time. A few respondents correctly noted that insurance companies already have the ability to purchase this type of “stop-loss” coverage in the private market.

Among those who opposed the plan, and to a small degree also among those who approve, there was a sense that the government should not be providing assistance to the insurance industry. A few people were skeptical as to whether the insurance companies would actually pass the savings along to consumers. Some also noted the potential for abuse by insurers. The lukewarm reception to this proposal may be a reflection of the fact that many people with whom we spoke have an aversion to insurance companies in general and HMOs in particular.

Defined Contributions

We inquired as to whether the respondents currently engage in or would consider using a “defined contribution” strategy. We used the most common meaning of this term, whereby an employer offers a variety of health plan options, and contributes a set dollar amount toward the premium. If an employee chooses a less expensive plan, his/her share of the premium is small or zero. If the employee selects a more expensive plan (reflecting more comprehensive benefits, lower cost-sharing requirements, a wider selection of providers, or inefficiency in administration or care management), he/she must contribute more to cover the premium. This approach provides an incentive for employees to be more cost-conscious in their selection of health plan, allows them to have more control over their coverage and meet their personal needs, and enables employers to budget and limit their health benefit costs.

Only about one-fifth of the employers with whom we spoke currently make defined contributions for health benefits, with large firms most likely to use this method. This is not surprising since the size of the group represented by large employers allows for economies of scale not available to smaller employers. Also, the terms of many smaller employers’ policies prohibit them from further subdividing their already small pool of enrollees.

However, about three-fourths of employers who are not using defined contributions say that it is something they would consider in the future if it were a real option. Also, at

least one employer from each size category uses some variation of this arrangement (for example, offering a choice of plans and contributing a set *percentage* of premium). A respondent from a small firm emphasized the value of her defined contribution policy in terms of *individual choice*: “We like having a choice; that’s real important to us... [one’s selection] depends on what your priorities are; we choose to spend more on a more expensive plan; others do not put as much importance on it and spend less; that’s how it should be.”

Mandates

The majority of respondents oppose reform proposals that involve *mandates* of any kind. There is consistent and strong aversion to government “telling us what to do,” with many respondents emphatic in their desire for *choice* as employers and as individuals. There are a few notable exceptions, however, described below.

Employer Mandate

A small majority of all respondents opposed a strategy to expand coverage through legislation that would require all employers to provide health benefits to workers and contribute a certain portion of the premium. The overwhelming reason across all size firms was practical: many employers cannot afford to provide coverage. However, most respondents said that they would find employer mandates more acceptable if either small businesses were able to purchase group coverage through a pool or cooperative, or if firms with many low-income workers were given some form of financial assistance to help provide their employees with coverage. Fewer but still a small majority of respondents found an employer mandate more acceptable if employers are given the option of providing coverage directly or contributing toward a fund that would provide coverage to workers (an approach sometimes referred to as “pay or play”). The second most commonly cited reason for opposing an employer mandate is philosophical: “government should not tell us what to do.” Employers from firms of all sizes gave this response. One employer’s greatest concern was that the government is going to “rev it down [employers’] throats.”

We were surprised to find that the option of an employer mandate was not opposed by a much larger portion of respondents. A sizable minority (23 out of 54 respondents who had opinions) favored an employer mandate, including the majority of respondents from *small* firms (about 60 percent). This contrasts with only about one-fourth of respondents from *very small* firms supporting the mandate. This disparity may be explained by the fact that nearly all of the small firms are currently providing health benefits (whether to attract employees or out of moral obligation), but with some hardship, and at times placing them at a competitive disadvantage relative to businesses that have lower costs because they do not provide coverage. An employer mandate would not place any new burdens on them and would help to level the playing field by requiring their competitors to pay their share.

Among the very small firms, however, nearly half in our sample are not currently providing health coverage to their workers. For these employers, a mandate would place on them a new, significant administrative and financial burden—although many economists would argue that the financial burden is ultimately borne by employees, except perhaps for those already earning the minimum wage. Even among those employers that currently provide health benefits, a mandate would prohibit them from eliminating that benefit if finances became tight.

Among all respondents who favored an employer mandate, the most common reason was that it would expand access to insurance, resulting in more people covered. A number of respondents, particularly in large firms, supported a mandate because they regard health benefits as a cost of doing business, so a mandate would spread that cost more broadly. A few respondents favored the mandate because they believe that providing coverage is an employer's responsibility.

Ambivalence among some employers can be summed up with the words of one employer, who acknowledged that an employer mandate would “level the playing field,” but opposed the idea of government telling employers what to do.

Individual Mandate

Another reform strategy discussed with respondents was a mandate that every individual must acquire coverage from some source, either through their employer or by buying an individual policy. Lower-income people, and perhaps others, would receive some type of subsidy to help them afford it.

Overall opposition to an individual mandate was slightly stronger than opposition to an employer mandate. Among the 32 respondents who opposed the mandate (out of 52 respondents who had an opinion), the overwhelming reason was that a mandate impinges on individual freedom. Respondents state emphatically that government should not tell us what to do, and that whether to obtain coverage should be up to the individual. The emphasis on individual choice is exemplified in these quotes:

“I hate to see people mandated to do anything; insurance should be a matter of choice.”—Employer at a small firm.

“[An individual mandate] would limit individual rights. It's against the Constitution. Obtaining health coverage should be a personal decision.”—Employer at a very small firm.

“If people for whatever reason do not want coverage, they should not have to buy it... Even though I think it's important for everyone to have it.”- Employer at a small firm.

Some respondents opposed the individual mandate not on philosophical grounds, but because they think it is unenforceable. A couple of these respondents liked the mandate in theory, but feared that there is no effective way to ensure compliance. One employer stated that “there would be still be so many people without coverage.” A few

respondents said they oppose the mandate because many people cannot afford coverage, despite being told that the strategy would include a subsidy for lower-income people.

Among the 20 respondents who favored an individual mandate, the primary reason was that the mandate expands coverage by requiring everyone to show proof of having health insurance. The second most common reason was that individuals should be accountable for obtaining health coverage. A couple of respondents noted that the mandate makes health care more affordable by spreading the cost.

Interestingly, there was disparity in support for an individual mandate between small and very small firms—in an opposite direction of the disparity in support for the employer mandate. A small majority of respondents from *very* small firms (2-15 workers) favored an individual mandate, whereas only about one of four respondents from *small* firms (20-70 workers) favored this approach. Looking across all firm sizes, employers of very small firms were most likely to support an individual mandate and oppose an employer mandate, while employers of small firms were most likely to support an employer mandate and oppose an individual mandate. This finding can be interpreted as consistent thinking by respondents: very small firms are less likely to provide health benefits and do not want to be forced to start; they place more responsibility for obtaining coverage on the individual. Conversely, nearly all of the employers that we interviewed from small firms are already providing health benefits. They may view coverage more as an employer's obligation than an individual's obligation; also, an individual mandate would not likely change their situation, whereas an employer mandate may benefit them by leveling the playing field.

Single-Payer System

During the interviews, we discussed one type of health care reform that would completely eliminate job-based health coverage by enrolling everyone in a publicly-funded and publicly-managed health insurance program like Medicare. The overall level of support for a single-payer system is relatively low—at a level comparable to support for an individual mandate—with 20 respondents in favor and 33 respondents opposing it. The two most common reasons given for opposing this strategy were related to the desire for choice and anti-government sentiment. The reason cited most often was that a single-payer system limits choice of health plans, and that “one size doesn't fit all.” The second most common reason was based on philosophical grounds: this approach gives government too much control. Another group of respondents objected because they assume government incompetence and bureaucracy. A few claimed that national health plans do not work in other countries (though some wished it could work), and one respondent cited a fear of rationing of health care services. Others do not want to pay the taxes that would be necessary to finance such a program. One respondent from a large firm opposed a single-payer system because he wants to retain job-based health benefits as a recruiting tool.

Among the roughly one-third of respondents who favored the single-payer reform, the primary reason was access expansion; with broad acknowledgment that a national health plan ensures coverage for everyone. A few respondents thought it would cut overall health care costs, and a couple favored it because it relieves employers from the burden of providing health benefits. A few employers favored this approach but expressed some doubt that it could work.

Reactions to a single-payer strategy differ by firm size. A large majority of respondents in every size category opposed a single-payer system, with the notable exception of small companies (20 to 70 employees). Ten respondents out of 17 who had an opinion in this firm-size category actually *favored* a single-payer system. One way to interpret this finding is that small employers, which generally provide coverage but usually with difficulty, favor an alternative system that would relieve them of this burden. Their desire for such relief may outweigh their aversion of government intervention. One small employer who does *not* currently provide coverage to workers favored the single-payer plan because the current voluntary employment-based system puts him at a competitive disadvantage. Thus, while the majority oppose a single-payer approach, a sizable minority seem to have some interest in this option.

During the interviews, we inquired how a single-payer system should be *financed* if it were enacted. The most common responses were about equally divided among payroll taxes, income taxes, and a combination of sources. Support for payroll taxes and a combination approach may indicate the respondents' feelings that employers should continue to contribute toward health care financially even if their role in managing health benefits is eliminated. Many expressed their desire to spread the cost of health care across society. Less common suggestions for financing included reducing funding for other government programs and using the federal government's budget surplus.

Replacement of Federal Tax Exclusion with Targeted Tax Credit

We discussed one reform strategy that would use the tax system to redirect public subsidies for health insurance so that the subsidies would be available to people purchasing coverage in the individual market. This approach would eliminate the current "tax exclusion," whereby employer contributions toward premiums are not counted as part of employees' taxable income. Including reductions in both federal and state revenues, the value of this "subsidy," combined with smaller tax breaks related to health care, has been estimated at \$141 billion for the year 2000. Many economists and others have complained that this tax treatment favors higher-income people and leaves out others—most often lower-income workers and their families who do not have access to job-based health coverage. The type of tax reform strategy described during the interviews would make employer contributions to health benefits taxable income for workers and redirect some or all of the new government revenue into a tax credit that would help low- and moderate-income people buy health insurance.

Interestingly, this tax reform was among the least popular of all of the proposals discussed, with only about one-third of all respondents reacting favorably. (The level

of opposition was comparable to the levels of opposition to the employer mandate, individual mandate, and single-payer proposals.) However, discussions with many respondents (particularly those from very small firms) revealed a lack of understanding of both the current tax exclusion and the implications of the proposal. The primary reason given for opposing tax reform was that it seems too complicated. It is possible that a lengthier discussion that carefully laid out the advantages and disadvantages of both the current tax treatment and the reform proposal may lead to greater support for the program.

However, since many respondents were knowledgeable about the issues involved, lack of understanding cannot explain all of the opposition to this reform. Many opposed the proposal because it would take away from middle- and upper-income people. They expressed the view that it is not fair to subsidize lower-income people only, and that we should not remove a current tax benefit. A smaller number of respondents objected because the reform was seen as too much government interference.

The one-third of respondents who favor the tax reform proposal generally think that targeting tax subsidies to lower-income people would be more fair than the current system.

Since the tax reform we described would remove the tax advantage of obtaining health coverage through the workplace versus the individual insurance market, we asked the respondents about how employers' behavior may change under this approach. The majority of respondents with an opinion think that employers would continue to provide health benefits to employees, as opposed to giving workers the equivalent in cash and letting them buy coverage on their own. A substantial majority of those who currently provide coverage say that *they* would continue to do so. This is consistent with the prevailing attitude that employers have an obligation to provide coverage to their workers. To some extent, however, these responses may reflect a lack of understanding among some that the reform would remove the current tax advantage of job-based insurance.

Finally, we asked whether the respondents thought that under the tax reform, workers would prefer to continue to have job-based coverage or to get the cash equivalent to buy coverage on their own. Most who have a opinion think, somewhat paternalistically, that workers would rather continue receiving insurance through the workplace. According to one employer of a small firm, "Lots of people aren't good with their money. If they need the money for other reasons, they'd use it for car payments, to feed the kids, etc. So coverage should be [automatic] through one's job, rather than giving cash."

Preference for Reform

At the end of the interview, after discussing each reform strategy and ascertaining the respondent's support or opposition, we asked respondents for their preference for

reforming the health care system. The respondent was given the latitude to choose from among the proposals discussed or other strategies, or some combination of approaches.

There was no one overwhelming preference for reform. Rather, most of the respondents who answer this question reply that a *combination* of reforms is necessary. They view the problems as multi-faceted and in need of more than one solution. Many employers do not offer specific strategies but stress that solutions should be within the *private* domain without government involvement—despite often supporting expansion of public programs and other government activities earlier in the interview. Only one respondent—who ran a small social service agency—prefers “*more* involvement by government, as well as better buying power for individuals and small companies, to help everyone get coverage.”

THEMES

During the course of the interviews, a number of themes emerged from the comments and anecdotes offered by respondents:

- Respondents desire to maintain the employer role in financing and managing health benefits;
- There is wide-spread acknowledgement of the need to level the playing field for smaller businesses;
- Choice is highly valued over mandates;
- There is strong antagonism toward HMOs and managed care;
- Respondents distrust government and prefer private-sector solutions;
- Some conflicting views reflect a degree of “cognitive dissonance.”

Below we discuss each of these themes in turn.

Maintain Role in Financing and Managing Health Benefits

Despite major concerns about rising premiums, most respondents did *not* wish to relinquish their role in financing or managing health benefits for workers. They took these responsibilities very seriously, viewing the provision of health benefits as either a moral obligation toward their workers or an important tool to attract and retain workers. There was a protective, at times paternalistic, attitude toward employees, whom many respondents viewed as incapable of effectively choosing or managing health coverage on their own.

The subgroup of employers from very small firms was the only one where a majority did not support the employers’ management role. This is not surprising, given that very small businesses generally do not have the personnel or resources to devote to management functions. Yet three-fourths of respondents in this subgroup thought employers should contribute toward health benefits, and should remain involved at

least financially. Clearly, there was not much interest in eliminating the employment-based health coverage system.

Level the Playing Field for Smaller Firms

Employers running small and very small firms voiced many complaints about the obstacles they face in obtaining and keeping affordable coverage. A number of these respondents described how employing one or two high-risk workers has resulted in huge premium hikes and/or precluded them from switching health plans. One employer complained that premium increases caused her to switch health plans every year, which is an administrative burden to the firm, and especially disruptive to the workers who must change doctors and benefits each year.

Yet concern for smaller businesses was not limited to those experiencing these difficulties first hand. Respondents from firms of every size acknowledged that smaller firms lack negotiating clout and face higher administrative costs and premiums than larger firms. Respondents across the board supported pooling arrangements—such as establishing purchasing cooperatives or “buying in” to larger group plans—that would put smaller firms on a level playing field.

Value Choice over Mandates

Maintaining *choice* was a theme that recurred throughout the interviews. This included a desire for individuals to decide whether or not to obtain health coverage (despite opinions that everyone *should* have coverage) and a desire for employers to decide whether to finance and manage health benefits (despite nearly all respondents fulfilling both roles). And despite universal support for enabling smaller firms to purchase health coverage through large cooperatives, there was near universal insistence that the firms have the *option* to join and that they not be *mandated* to do so. Also, there was a desire that everyone have the ability to choose the most suitable health plan versus a “one-size-fits-all” plan that was often associated with government-financed programs.

Not surprisingly, the majority of respondents expressed strong opposition to government mandates. One employer of a small firm captured the sentiment expressed by many respondents, stating, “I do not think the government should mandate anything; it goes against what America is all about.” However, the responses may point to an acceptance by employers of a level of government intervention in the realm of business that they are not willing to tolerate in their private lives. While many employers rejected the idea of mandates on both individuals and businesses, they often did so for quite different reasons. For example, of those who opposed the *individual* mandate, more than three in four said that they felt *it* impinged on individual freedom, and only about one in nine said that they felt many people would not be able to afford coverage. Of those who opposed the *employer* mandate, however, nearly three-quarters said

that they felt many employers would not be able to afford it, while only about one-third said that the government should not be telling businesses what to do.

While the anti-mandate view was voiced forcefully, a significant minority of respondents acknowledged (sometimes grudgingly) that mandates might be necessary to expand coverage. Among all respondents, a sizable minority favored an employer mandate, and just over one-third favored an individual mandate. For these employers, the desire to expand access so that more people have health coverage was the overriding motivation. The majority of respondents favored such accommodations as pooling smaller businesses or subsidizing employers with low-income workers, and felt that they would make an employer mandate more palatable.

Anti-HMO and Managed Care Sentiment

One conclusion from these interviews was that the “managed care backlash” continues to be strong. Many employers were emphatic in their anger and frustration toward managed care in general and HMOs in particular, recounting negative experiences with rate hikes and efforts to get services approved. Respondents also complained that HMOs take health care decisions out of the hands of doctors and do not reimburse health care providers adequately.

Problems related to HMOs and managed care constituted the second most common concern for the future of health care, after rising costs. Numerous respondents called for reform that would involve government regulating HMOs and “giving control back to doctors.” These feelings did not, however, diminish the overriding preference for private-sector solutions over public-sector solutions. (This apparent inconsistency is discussed at length below.)

Distrust of Government and Preference for Private Sector

Two different but related themes came up consistently during the interview process. The first was a distrust of government and government programs. The second was a conviction that any reform, if it were to work, would have to be implemented through the private sector. These dual convictions cut across firm size, industry, and geography, with the majority of respondents mentioning one or the other, and very often both, at some point during the course of the conversation. While this view was not expressed by *all* of the respondents, those that verbalized such sentiment tended to do so with much intensity.

There seemed to be two underlying reasons behind the anti-government stance. One was a philosophical distrust of government, which is seen as interfering with personal freedom. Second was a belief that government is incapable of operating a program effectively or efficiently. Respondents viewed public programs as overly bureaucratic and/or wasteful and were skeptical that new public initiatives would work. Both of these factors were behind a prevailing preference for “private-sector solutions” to current problems plaguing the health care system.

“Cognitive Dissonance”

A few of the themes discussed above appear to be at odds with each other. In this section we address the apparent internal inconsistency that emerged during many interviews—what Professor Robert Blendon refers to as “cognitive dissonance” applied to health care. Specifically, we attempt to describe the prevalent attitudes toward government and the private sector, the central precepts on which those attitudes are based, and related values and beliefs. Then we speculate as to how to rationalize or accommodate the dissonance between the two belief systems.

We were not surprised to see how often respondents, unprompted by the interviewer, related their distrust of government programs and their abiding faith in private sector reform. We have heard these same themes from business associations and lobbyists, as well as from many politicians, pundits, economists, and lay people for many years. What did seem surprising initially is the fact that we also nearly as often heard viewpoints—from the same individuals—that seem incompatible: respondents largely distrusted private HMOs and insurers, and they favored some reforms that involve considerable government intervention.

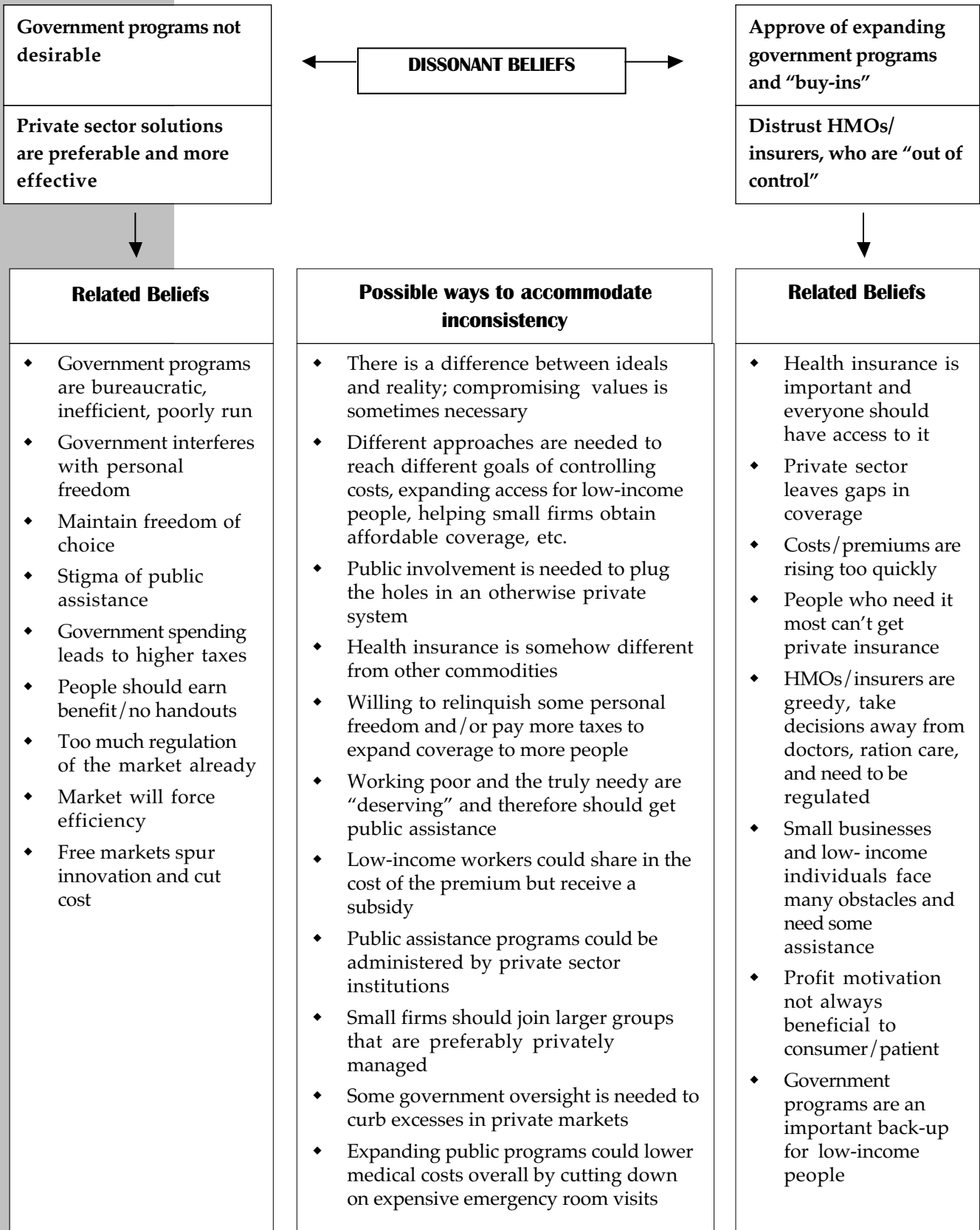
Figure 13 illustrates this dichotomy in thinking and possible ways of understanding or rationalizing it. The left side of Figure 13 displays the overarching views that government involvement is undesirable and that private-sector solutions are preferable. Related to these views are beliefs and values, expressed during the interviews, such as: government programs are inefficient, interfere with personal freedom, and raise taxes; public assistance gives “handouts” to the undeserving; and the private market is more efficient and spurs innovation.

Views that seem incompatible with those described above are illustrated on the right-hand column of Figure 13. The majority of respondents felt that existing public assistance programs like Medicaid, S-CHIP, and Medicare should be expanded because the private-sector system leaves gaps, and they believe that everyone should have access to coverage. Also, there was overwhelming support for small-employer buy-ins to state and federal employee benefit programs to overcome obstacles facing small businesses in the private small-group insurance market.

A different but related view was a distrust of HMOs and private insurers. HMOs (and in some cases insurers in general) were accused of placing too many restrictions on doctors and patients, excluding people who need coverage most, raising premiums too high, and being overly bureaucratic. To some extent, employers view them as the private-sector counterpart of government, or at least as sharing the same defects. Some seemed to acknowledge that the profit motive is not always beneficial to consumers/patients.

One employer displayed inconsistency when he supported a single-payer approach, where “all workers contribute into a national health care program,” but when asked for his preferred reform, responded, “Free enterprise! Private ownership of programs and services is a must.” For most respondents, the dissonance was more subtle. These findings, though, are not dissimilar to those of other researchers who have

Figure 13: Accommodation of Dissonant Beliefs



interviewed Americans about their views on health care and health financing,⁷³ suggesting that, as a nation, our thinking on this subject is ambiguous.

To help understand how people can hold apparently disparate beliefs, we offer some possible ways that employers may reconcile their two sets of values. Below we describe two general types of “accommodations” (summarized in the middle column of Figure 13).

Compromise to Achieve Important Goals

Respondents—and employers in general—may understand that ideals differ from reality, and a certain amount of compromise is necessary to achieve a more important end. For instance, a number of respondents who said that they favored private sector reforms and distrusted the government to run an efficient program were nonetheless willing to support expansion of programs like Medicare and Medicaid because they felt that insuring the working poor is an admirable and important goal. A few expressed support even if it meant that they would have to pay for this coverage in the form of higher taxes. Others were willing to sacrifice some personal freedom and support a mandate that would expand coverage to more people.

Employers in this group may have also felt, as was expressed by at least one respondent, that health insurance is essentially different from other products that are available through private markets, and that perhaps it should not be looked at solely in terms of profit and cost-benefit analyses. They view the working poor and the truly needy as “deserving”—people who simply need a little extra help. They acknowledge that the private sector is not perfect and leaves some people out, and that the government should be responsible to fill the gaps.

Accommodate Through Public/Private Sharing of Responsibility

We also speculate that when certain respondents expressed support or opposition to individual reform proposals, they understood that different approaches are needed to reach different goals, such as controlling costs, expanding access for low-income people, and helping small firms obtain affordable coverage. They likely envisioned a reform strategy with multiple components, involving action on the part of private markets as well as government agencies. In fact, when asked about their preferred strategy for reforming the health benefits system, the overwhelming majority of respondents who had any preference at all said that they favored some combination of approaches. Most did not believe that any single proposal, whether it involved primarily private-sector reforms or government-initiated and managed measures, was sufficient to fix the problems that currently exist in the system.

Some respondents may also see benefits from the *interaction* of private and public sector activities. A few suggested that public programs should be administered through employers and other private agents that would have an incentive to be efficient; this

⁷³ See for example, Robert Blendon, et.al. “Health Care in the Upcoming 2000 Election.” *Health Affairs*, 19:4, July-August 2000.

approach could also help to remove some of the stigma associated with public insurance. Similarly, some suggested that small firms should join larger group purchasing cooperatives or large, government employee health plans that are privately managed.

Some respondents, despite their support for the free market system, also pointed to a need for government oversight of private markets (particularly HMOs and insurance companies) to curb excesses and ensure that they are run in a fair and equitable way. Others understood that expanding public programs could lower medical costs overall by cutting down on expensive emergency room visits. In summary, while employers were philosophical about some issues, they were, in the main, rather pragmatic, and seemed willing to mix and match public and private strategies to expand access to health care coverage.

POLICY IMPLICATIONS AND CONCLUSIONS

When we review the strengths and weaknesses of the employment-based health coverage system in light of the findings from our interviews with employers, we see some important implications for public policy. Employers acknowledge that the current system has both positive and burdensome features for them. They also apparently understand that there are major flaws in a system that leaves so many people without access to affordable health coverage. The success of efforts to change that system will depend upon the ability of policymakers to craft strategies that the business community can support. Following are some messages that emerged from this study.

Employers are not abandoning the U.S. health care system.

The conventional wisdom today is that employers are anxious to relinquish their role in the health care system. Many observers herald the advent of “defined contributions” or vouchers as an interim route to an eventual exit for employers from direct provision of health benefits. What we found was quite different. Our interviews suggest that, at least for the near future, employers want to remain actively involved in providing coverage to workers and dependents. Business representatives participating in our study indicate overall satisfaction with their role in both financing and managing health benefits.

While this attitude reflects to some degree the desire to use health coverage as a tool to recruit and retain workers in a strong economy, the rationale for an active employer role went beyond economic factors. Many employers seem to feel a deep sense of responsibility for their workers, independent of unemployment rates and profits. Despite experiencing a recent acceleration of premiums and foreseeing a downturn in the economy, most respondents nevertheless supported their role in providing health benefits. They called for better controls on cost rather than opting out of the system.

Reform should include efforts to level the playing field for small businesses.

Respondents almost universally acknowledged the obstacles small businesses face in obtaining affordable health insurance and the need to make more options available. Employers are likely to favor an expansion of purchasing cooperatives on a voluntary basis, and would likely support government assistance to these entities to help them get established. They do not seem to be aware, however, of the difficulties faced by many such cooperatives in achieving a “critical mass” to become viable. Yet our study indicates that business support for these cooperatives would dwindle if participation were mandatory.

An alternative or additional option that would likely have business support is to enable workers in small firms, and perhaps other uninsured people, to enroll in public

sector workers' insurance plans. This seemed to be an acceptable way to extend the advantages of large group coverage without the burden of building new bureaucracies.

Direct government premium subsidies to help small employers in particular afford their health care contributions are also likely to be supported, based on our interviews. This could include a companion plan to assist workers with their share of the premium. Some mechanism might be needed to target assistance to companies that need it most, such as providing federal tax credits to employers with average wage levels below a certain predetermined floor.

Employers are torn between (potentially) conflicting desires to control costs and provide open access to care.

The business community is quite concerned about both renewed cost pressures and the restrictions on access to care imposed by managed care plans. But the bottom line is that employers' desire to "reign in" HMOs and their desire to control costs may be working at cross-purposes. This reflects a certain denial on the part of employers of some of the factors that have been pushing up health care premiums and perpetuating the large number of uninsured. The deceleration in health care inflation in the mid-1990s was due in part to insurers holding down rates in an attempt to gain market share, and in part to the shift of large numbers of employees from the old indemnity plans into managed care organizations. Whether the cost savings from the movement into HMOs was "one time" in nature or long term is subject to debate. Nevertheless, there is little question that those savings largely grew out of restricted choice of providers, less access to specialists, stricter review of physician decisions, and incentives aimed at avoiding unnecessary or inappropriate tests and hospital admissions.

The strong opposition by employers (and consumers) to these restrictions are central to the HMO "backlash." This has led to the growth of PPO and POS plans that have much looser forms of cost control than HMOs, and are therefore more expensive. Thus, many employers, catering to their workers' pursuit of wide-open choice, have undercut one major source of cost control in a system with few government limits on new technology or government controls on prices, which are common in many other industrial nations. The unrealistic desire by employers to have their cake and eat it too is reflected in our respondents' demands for regulation of HMOs to simultaneously keep premiums down *and* stop tying the hands of physicians and patients.

The fact that employers have these dual, conflicting demands makes it difficult for policymakers to be responsive. A challenge for policymakers is to develop ways to curtail the most onerous restrictions by managed care plans, while allowing them to maintain some of the incentives and mechanisms aimed at keeping costs in check.

Employers could support an expanded but limited role for government in health care.

The business representatives with whom we spoke revealed the same types of internal conflicts and tensions that other researchers have found among the general public. They displayed a serious distrust of government and strong opposition to mandates, yet welcomed government interventions to police insurance companies and discipline the managed care industry. They were also comfortable with expanding public programs to reach more of the lower-income population. This apparent incongruity suggests that, despite the fierce independence of the business community, employers see a place for greater but still limited government involvement in the health care arena.

Based on these findings, we believe that the business community could be successfully encouraged to back some bridge-building between the employment-based health care system and government health care programs. Employers seem to understand that each of these sources of coverage must expand to cover those left out. Government could garner business support for a stepped up effort to enroll people already eligible for programs such as Medicaid and S-S-CHIP, as well as for subsidies to workers and employers to help expand coverage in the workplace. There could also be business support for government expansions of public programs to cover more low-income adults. Regulatory measures to limit insurers' ability to practice risk selection among smaller companies and to enable small firms to buy into large insurance pools would be welcomed. Most respondents also supported government-backed reinsurance of private health plans.

All of these types of "public/private partnerships" would allow employers and employees to maintain a certain level of autonomy while helping to provide coverage for those workers who are left out by the current employment-based system.

Our interviews indicate, however, that replacing the current tax exclusion with a targeted tax credit would face much opposition by the business community. Any type of tax reform may be viewed as too complex and should be accompanied by a major public education campaign.

Businesses are more likely to support an incremental, mixed public/private approach over bold, comprehensive reform.

Throughout our interviews with employers, we detected notable dissatisfaction with many aspects of the current health care system and strong desire for reform. Yet the respondents generally favored incremental policy reforms to expand coverage to the uninsured and contain costs rather than a restructuring of the current employment-based system or mandatory participation in that system. For example, employers expressed interest in medical savings accounts as vehicles to enable them to make limited, tax-sheltered contributions to "catastrophic level" coverage. (While MSAs have had a very low take-up rate, it is not clear whether this is due to lack of familiarity, lack of availability, or lack of interest.)

There was a strong preference that neither firms nor workers be *forced* to purchase coverage. The employers with whom spoke like the freedom to “shop around” and design their own health coverage. They want their workers to have choices as well, including the choice of whether to be covered at all for health care expenses. Yet as long as employers’ and workers’ decisions about health coverage are voluntary, we are likely to have a large number of uninsured people. Similarly, most of the respondents opposed a single-payer, or “Medicare-for-all” type of reform that would expand health coverage to virtually everyone while eliminating the employment-based system.

In the absence of these more sweeping reforms, the U.S. will not likely approach universal coverage. But a reform plan could be devised with a mix of public and private measures that could achieve a substantial reduction in the number of the uninsured. The major force driving high rates of uninsurance is clearly a lack of affordability, or at least the perception of certain people that the benefits of health insurance are not worth the cost. A combination of approaches that makes insurance more affordable and provides employers and individuals with incentives to obtain coverage is more likely to be supported by the business community. For example, both Medicaid and S-S-CHIP could be expanded to reach more low-income, vulnerable people, while pooling mechanisms for small firms and federal income tax credits for employees *and* employers could help shore up job-based coverage.

To be effective, a combination approach would require that new subsidies be large enough, and the insurance pools broad enough, to keep the financial contribution made by a large number of lower-income workers and employers reasonable. As noted above, these strategies should be combined with an expansion of public programs for those who still fall between the cracks. The challenge for policymakers who pursue this direction is to avoid a piecemeal collection of unrelated reforms, and instead develop a carefully thought out, well-integrated strategy to restrain the growth in costs and make coverage available for those people left out of the current system.

APPENDIX

INTERVIEW GUIDE