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Employer-Provided Health Insurance: Why Does It Persist, and Will It Continue after 2014?

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Employer-sponsored health benefits cover 56% of the population under the age of 65 and have been the primary source of Americans' health insurance for most of the past century. (http://kaiserfamilyfoundation.files.wordpress.com/2013/08/8465-employer-health-benefits-20131.pdf) Firms began offering coverage in force in the 1940s, partly in response to wartime federal limits on wage increases. (http://www.nejm.org/doi/full/10.1056/NEJMhpr060703) Because health benefits were exempt from these limits, employers could better compete for workers by providing health insurance. Later decisions to exempt employer-provided health insurance from federal income and payroll taxes solidified health benefits as a requisite part of compensation for most workers. (http://www.nber.org/papers/w7543) The tax exemption does not extend to health insurance purchased individually on the private market.

Firms also bring a diverse group of people together for reasons that are not health-related, creating a reliable risk-pooling mechanism. Because firms pay the majority of the premium, healthy employees are encouraged to enroll. In contrast, plans on the nonemployer market have traditionally been limited by adverse selection, in which sicker persons who are heavy utilizers are more likely to enroll. Adverse selection increases premiums, and—without regulation—can cause insurers to screen out applicants who may be expensive. Many state and federal regulations aim to prevent adverse selection, but before the Affordable Care Act (ACA), these regulations applied mostly to the employer market. Even under the ACA, requirements differ for employer and individual insurance policies, and in the employer market depend on firm size and whether firms offer self-insured or fully insured plans (Table 1).

Although the incentives for employers to provide health insurance are strong, the system has been increasingly strained by rising health care costs. According to the Kaiser Family Foundation, employer premiums for family coverage increased by 80% between 2003 and 2013. (http://kaiserfamilyfoundation.files.wordpress.com/2013/08/8465-employer-health-benefits-20131.pdf) While the offer rate among large employers (those with 200 or more workers) remained virtually unchanged over this period, the share of small firms offering coverage declined from 65 to 57%.

Most economists agree that the burden of rising health care costs falls largely on workers rather than employers. That is, employers offer workers a compensation package that includes wages, health insurance, and other benefits. If the cost of health insurance increases, wages and other benefits must fall, to ensure that workers' total compensation reflects their market value. However, the ability to reduce wages in response to rising health care costs most likely occurs over the long run, since it is easier to limit wage growth than to reduce workers' pay. Minimum-wage laws and the bargaining power of labor unions may further reduce firms' ability to trade wages for health insurance. For these reasons, U.S. industries that provide a large percentage of their workers with health insurance have experienced slower growth over time than other U.S. industries and than their counterparts in Canada. (http://www.rand.org/pubs/research_briefs/RB9465/index1.html)

Table 1. Affordable Care Act Requirements Affecting Employer and Individual Exchange Plans.*

	Individual (Non-Employer) Exchange Plans	Small, Fully-Insured Employers	Large, Fully-Insured Employers	Self-Insured Employers
Premium Rating Requirements	Premiums can vary only on the basis of age, tobacco use, family size, plan generosity, and geographic region	Premiums can vary only on the basis of age, tobacco use, family size, plan generosity, and geographic region	None	None
Tax Rules	Tax credits available to individuals with incomes between 100 and 400% of FPL, if no affordable employer offer	Not subject to income and payroll taxes	Not subject to income and payroll taxes	Not subject to income and payroll taxes
Penalty for not offering	Not applicable	None, if firm has fewer than 50 full-time employees	Yes	Yes, if firm has 50 or more full-time employees

*Data are from the Patient Protection and Affordable Care Act of 2010 as modified by the Health Care and Education Reconciliation Act of 2010 (P.L. 111–148 and P.L. 111–152). Premium-rating requirements apply to small employers with 100 or fewer employees, although in 2014 and 2015 states may limit these requirements to firms with 50 or fewer employees. Employer penalties take effect in 2015 and apply to firms with 50 or more workers. Fully-insured employers purchase health insurance from a health insurance issuer; self-insured employers pay for employee's health costs out of assets or general revenue.

Paradoxically, the tax advantage that encourages the employer system may also contribute to unsustainable cost growth. The current tax structure creates an incentive for plans to impose few cost-sharing requirements and to cover a broad range of services, since a dollar spent on health care goes farther when it is paid with untaxed employer insurance. These features encourage consumption of both necessary and unnecessary health care. Although recent trends toward high-deductible health plans demonstrate that there remain incentives to reduce spending, high-deductible plans represent only 20% of the current market. (http://kaiserfamilyfoundation.files.wordpress.com/2013/08/8465-employer-health-benefits-20131.pdf)

The ACA makes changes that reduce the tax advantage associated with employer coverage relative to nonemployer coverage and will eventually reduce incentives to provide generous plans. Starting on January 1, 2014, the tax advantage for employer coverage will be counterbalanced by tax credits for individuals without affordable employer coverage whose incomes are between 100 and 400% of the federal poverty line (FPL). The tax credits become less generous as income rises, phasing out completely at 400% of FPL, or about $46,000 for a single person. While the tax advantage for employer plans remains unchanged in the short run, in 2018, a new tax will be levied on high-cost plans—those with premiums above $10,200 for single coverage or $27,500 for family coverage (premiums that are 70% higher than today's average).

Tax credits for nonemployer coverage, and new regulations requiring nonemployer plans to offer coverage to all comers, make nonemployer plans a more viable option for consumers and reduce the value of employer insurance as a benefit. The availability of affordable nonemployer options may also encourage entrepreneurship, making it possible to pursue promising self-employment opportunities without fear of losing health insurance.

Nevertheless, the Congressional Budget Office and other modelers predict that employer coverage will remain the dominant source of health insurance for the foreseeable future. (http://www.ncbi.nlm.nih.gov/pubmed/24019355) A key reason is that the tax advantage associated with employer-sponsored coverage continues to exist and—despite other changes—continues to make employer coverage the best option for higher-income workers. Figure 1 shows that over 40% of full-time workers have incomes above 400% of FPL, making them ineligible for exchange tax credits. Over half of full-time workers have incomes above 300% of FPL, a range in which the value of the exchange tax credit is most likely overshadowed by the tax advantage associated with employer cover-

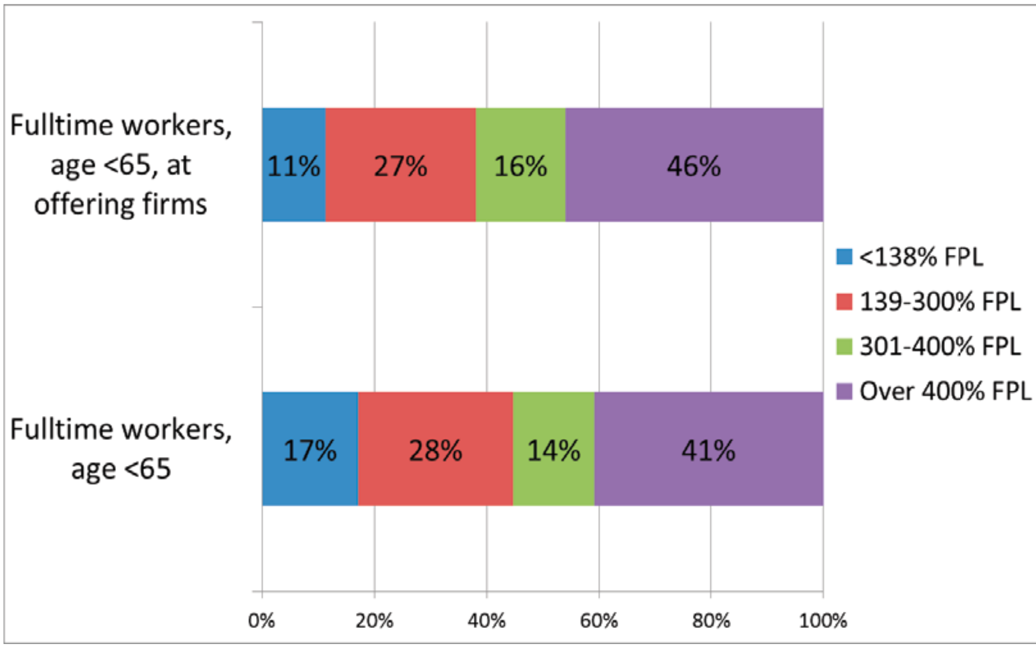

Figure 1. Distribution of Full-Time Workers by Income, All Firms and Firms Offering Health Insurance, April 2010.
Data are from the U.S. Census Bureau, Survey of Income and Program Participation, April 2010.
Full-time status is defined as working 30 or more hours in an average week.

age. Because firms must make one decision about offering health insurance for all workers, many will continue to offer insurance. The incentive to offer will be further strengthened when employer-mandate penalties take effect in 2015.

Although it seems unlikely that employer coverage will disappear in the short run, there is evidence that employers are exploring ways to avoid some of the ACA's requirements and to take advantage of new, federally-subsidized options for lower-wage workers. Regulatory avoidance is possible, in part, because the ACA's rules are different for small firms, large firms, self-insured firms, and private, nonemployer plans. Larger firms might outsource lower-wage jobs and reduce worker hours to avoid mandate penalties while enabling lower-wage workers to take exchange tax credits. Small firms with healthier workers might self-insure to avoid the ACA's small-employer rating regulations, since these regulations could increase premiums for firms with healthy enrollees. Some firms might downsize to avoid employer-mandate penalties (which affect firms with 50 or more workers), or grow to avoid rating regulations (which affect firms with 100 or fewer workers).

These strategic responses can be distortionary, in that the optimal response for the firm may be suboptimal for society. Economic growth, for example, is hindered if firms limit hiring simply to avoid mandate penalties. Alternative regulatory regimes can also lead to inequities, such as when a low-wage worker at a firm that offers health insurance is disqualified from exchange tax credits, while a comparable worker at a non-offering firm is allowed these credits.

As the ACA is implemented, policy makers should be attuned to potential inefficiencies and inequities created by a system with different regulatory and tax rules for small employers, large employers, and individual health plans. Attempts to equalize the playing field may be difficult, given that the employer-provided insurance is a long-standing part of U.S. health care and that a core promise of the ACA was that Americans could keep their current coverage. Nevertheless, a more uniform approach could lead to more equitable treatment for consumers and reduce distortionary behavior among firms.