Employment-Based Health Insurance: Past, Present, And Future

As the inexorable march toward the demise of employer health insurance continues, no one plan has emerged as its likely successor.

by Alain C. Enthoven and Victor R. Fuchs

ABSTRACT: We review the rise, stabilization, and decline of employment-based insurance; discuss its transformation from quasi-social insurance to a system based on actuarial principles; and suggest that the presence of Medicare and Medicaid has weakened political pressure for universal coverage. We highlight employment-based insurance’s flaws: high administrative costs, inequitable sharing of costs, inability to cover large segments of the population, contribution to labor-management strife, and the inability of employers to act collectively to make health care more cost-effective. We conclude with scenarios for possible trajectories: employment-based insurance flourishes, continues to erode, or is replaced by a more comprehensive system. [Health Affairs 25, no. 6 (2006): 1538–1547; 10.1377/hlthaff.25.6.1538]

As health economists, we have been observing and participating in debates about the U.S. health care system for decades. This paper represents a crystallization of our combined thinking on the important issues at stake. It looks to the past to set a context for how the United States got the system it has now; examines present trends; and makes some conjectures about the future, to suggest what it might take for the country to move beyond its employer-based health insurance system to put in place a system that covers nearly all Americans.

The Past

The most familiar aspect of employment-based insurance’s past is its rapid growth in the first three decades after World War II, the relative stability that followed for about a decade, and the decline in coverage since the late 1980s. The exemption of employer payments for health insurance from employees’ taxable income.

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come, combined with substantial efficiency advantages of group over individual insurance, fueled rapid expansion. By the mid-1950s, 45 percent of the population had hospital insurance; coverage soared to 77 percent by 1963. Also, by 1963 more than half of the population had coverage for regular medical expenses, and almost one-fourth had major medical insurance.

Employment-based coverage reached its peak sometime in the 1980s and has been declining since then. According to the Employee Benefit Research Institute (EBRI), coverage of workers ages 18–64 fell 2.8 percentage points between 1987 and 1999. Another EBRI series shows a decline of 3.5 percentage points from 1999 to 2004. Linking the two series indicates a decline of 6.3 percentage points from 1987 to 2004. Data from the Bureau of Labor Statistics, derived from establishment surveys, show a decline for full-time workers in the private sector of fifteen percentage points from 1989–90 to 2003. Regardless of data source, it appears that the best days of employment-based insurance are in the past.

More important but somewhat less familiar than the growth and subsequent decline of employment-based insurance is its transformation from quasi-social insurance to insurance based on actuarial principles. The latter assumes that insurance is to protect against unpredictable risks for individuals or subgroups; if risks are predictable, premiums are adjusted for the differential. Under social insurance, individuals or subgroups who are expected to use more care do not pay a differential premium; the excess costs are shared collectively. In market terms, those with lower risks cross-subsidize those with higher risks.

**Importance of large U.S. firms.** Employment-based insurance started out as quasi-social insurance. During the early post–World War II period, the principal underwriters were nonprofit Blue Cross and Blue Shield plans; they typically followed community rating in pricing their policies. Thus, there was considerable cross-subsidization of insurance across industries and firms in the same community and across workers in the same firm. This cross-subsidization was facilitated by the dominance of large firms in many of the most important industries of the time—firms such as General Motors, U.S. Steel, Alcoa, and Dupont—that enjoyed substantial profit opportunities relatively unconstrained by domestic or foreign competition. In regulated industries, profits were even more secure, enabling firms such as AT&T, the largest private employer, to offer generous health insurance benefits to its employees. When health insurance premiums rose, AT&T, a regulated monopoly with guaranteed profits, could easily pass on the increase to telephone subscribers. Now AT&T is in a competitive struggle with many other companies, and competition in the auto industry is driving General Motors close to bankruptcy.

**Role of unions.** Strong unions also played a role in the spread of employment-based insurance. In industries dominated by a few giant firms, unions used their “countervailing power” to make the firms share some of their potential profits with workers in the form of high wages and generous health insurance benefits. In industries comprising many small firms, such as residential construction or women's
clothing manufacturing, unions organized industrywide labor-management health insurance plans that provided considerable cross-subsidization among firms and among individual employees within firms by charging uniform premiums regardless of expected utilization.

■ **Entry of insurance companies.** Large-scale entry of commercial health insurance companies into employment-based insurance led to a shift from community-rated premiums to those based on actuarial risk. The quasi-social insurance of community rating could not survive when those groups with below-average expected utilization were skimmed off by the offer of lower premiums. The actuarial approach quickly evolved into “experience rating,” where the premium for a group in any given year is based on its use of health services in the previous year, adjusted for changes in the cost of medical care. Larger firms realized that it was cheaper to self-insure, and self-insurance received an additional boost in 1974 when the Employee Retirement Income Security Act (ERISA) prohibited states from applying coverage mandates to self-insured plans. The world of employment-based insurance is now largely one of every firm on its own, and the advent of health savings accounts (HSAs) reduces cross-subsidization even among employees in the same firm.

■ **Impact of Medicare and Medicaid.** The third important feature, not much discussed and in our judgment underappreciated, is the extent to which the survival of employment-based insurance in recent decades has depended upon the existence of Medicare and Medicaid. When these programs were enacted in 1965, job-based insurance was the nation’s principal source of health care coverage; it was clear, however, that it could never come close to covering the entire population. Many advocates of universal coverage supported Medicare and Medicaid, arguing that this legislation was just the first step toward national health insurance. Four decades later, it is obvious that this prediction was far off the mark. Indeed, instead of hastening the coming of national health insurance, a reasonable case can be made that the existence of Medicare and Medicaid has forestalled it.

To see why, let us suppose there were no Medicare and Medicaid. The percentage of uninsured people in 2005 would be much greater than the current 16 percent of the population, probably more than 25 percent. Moreover, a high proportion would be old, sick, or disabled, whereas today more than 60 percent of the uninsured are under age thirty-five. Intense pressure to replace employer coverage with some kind of national health insurance would come from the uninsured and their relatives, state and local governments that bear the brunt of caring for the uninsured, and providers of care. More than half of all spending on hospital care and more than one-third of spending on physician and clinical services is in public programs, with Medicare and Medicaid providing the bulk of these payments.
The importance for employment-based insurance of Medicare and Medicaid in forestalling the enactment of some form of national health insurance becomes particularly salient as these programs face financial crises in the decades ahead.

The Present

Employment-based insurance is now showing its many flaws in sharper relief. The implicit standard by which we analyze job-based insurance is what we believe could be accomplished by a system of universal health insurance based on tax-financed premium support, managed competition, and responsible consumer choice of health plans/delivery systems, broadly resembling the Federal Employees Health Benefits (FEHB) program.6

Administrative costs. First, the administrative costs of employer insurance are very high. The need for more than 850 health insurance companies to sell and contract with millions of employers, underwriting each one, adds greatly to administrative overhead costs.7 Typically, administrative costs are of the order of 11 percent of premium, and this does not include the costs to employers to purchase and manage health care spending, including armies of consultants, benefits managers, and brokers.8 To understand how this could be different, consider that Kaiser Permanente signs one annual contract for the coverage of more than 400,000 employees and dependents with the California Public Employees Retirement System (CalPERS), and CalPERS’ administrative costs are on the order of 0.5 percent of premium.

Allocation of costs. Second, under job-based health insurance, the costs of health care are passed on to workers in a way that many people believe is inequitable. In competitive markets, employers’ contributions to health insurance typically result in lower wages.9 Despite substantial increases in productivity, inflation-adjusted hourly wages have not increased in more than thirty years, and average weekly earnings have declined.10 Before taxes, the cost of $10,000 per year is borne approximately equally by a worker making $30,000 and one whose salary is many times that. After taxes, higher-paid workers actually pay less for health insurance than lower-paid workers, because they are in higher tax brackets. Many people believe that a fairer system would allocate costs more in proportion to income because much of the demand for health care arises from reasons beyond the individual’s control, such as genetic predisposition to heart attack or cancer.

Coverage of the population. Third, employer coverage leaves out many people and cannot provide the basis for comprehensive coverage of the whole population that is not aged, disabled, or poor. Only 60 percent of firms with 3–199 workers offered coverage in 2005.11 About 20 percent of workers in firms that offer insurance are not eligible. (Another 17 percent are eligible but do not participate.) Small employers with mostly low-wage workers often do not offer coverage. People lose their health insurance when they lose their jobs. Just when people need coverage the most, they are likely to have a hard time paying for it, as when the breadwinner dies.
or becomes unable to work, or a marriage breaks up. Job-based insurance leaves out many self-employed, nonpoor, and pre-Medicare widows and retirees or forces them to pay a very high price for individual coverage. The economic insecurity associated with employer coverage is greater than what is measured by the existence of forty-six million uninsured Americans.

**Labor-management relationships.** Fourth, employment-based insurance is an important contributor to labor-management strife and bankruptcies. Such insurance interferes with labor mobility (“job lock”) and distorts labor-market decisions by individuals and firms. As employers attempt to pass on insurance costs to employees, they are forced to do painful things such as reducing coverage or reducing wages. And employment-based insurance leads to insecure and unstable coverage. Forty-one million workers (36 percent of the labor force) work for firms of 100 or fewer workers, much too small for spreading today’s risks.

**Inefficiencies of fee-for-service.** Fifth, employment-based insurance has assigned to employers the responsibility to manage health care purchasing for most Americans. But employers have, at best, weak incentives to act collectively to increase the efficiency of the health care delivery system. Health care purchasing is not a part of most employers’ core competencies. As it has evolved, employer insurance has helped perpetuate the inefficiencies inherent in the fragmented, uncoordinated fee-for-service (FFS) small-scale practice model that still accounts for most of health care delivery. FFS contains incentives for overuse, underuse, and misuse; it pays more to providers who cause complications or are slow to make a diagnosis. FFS pays for volume, not quality. Employers have not been able to create a market in which efficient models can compete and take market share from FFS (the same is true of Medicare).

There are alternatives to wide-access FFS, including integrated delivery systems (IDSs) with salaried doctors, in group practices, with incentives for quality and efficiency. Such systems can set standards, measure and monitor performance, and take corrective action where appropriate. Such systems can accept responsibility to manage cost and quality. Also, there are tiered high-performance networks that separate economical from costly physicians and give patients incentives to choose the former.

Most employers offer a single carrier; their insurance companies give them incentives to do so or even require it. Because, understandably, people want to be able to choose their doctors, delivery systems that limit patients’ choice of doctor are not suitable candidates for the single-carrier role. Many employers who do offer such alternatives contribute much more (like 80–100 percent of the difference) on behalf of the more costly, usually FFS, alternatives. When employers do this, they do not provide an incentive for employees to choose the economical alternative, and it is not possible for the efficient systems to gain market share by superior efficiency. Employers are reluctant to expose employees to full cost differences in tiered networks. In other words, despite appearances, in most of the employer in-
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Insurance market, competition over value for money is ruled out.

- **An alternative.** The federal government, as employer, and a small minority of other employers offer employees choices that include IDSs and other alternatives to FFS, and fixed-dollar contributions so that those who choose less costly systems or providers get to keep the savings. Typically, in these groups, market shares of IDSs are very high. Most employers do not offer such choices. Nor have they been able to sustain a process of cost-reducing innovation in other ways.

  Individual employers, understandably, manage health benefits as a tool in the labor market, not as part of a coordinated strategy to produce an efficient health care system. One employer acting alone to create competition is not rewarded with the competitive health care delivery system that would result if most or all did. The great diversity of interests, circumstances, and views about health insurance among employers has precluded collective action to create a market open to competition from efficient systems.

  Many of the flaws of employer-based insurance discussed here were also present during the 1950s–1970s when the employer system was growing. They became more apparent, however, toward the end of the twentieth century and even more troublesome in recent years as the result of the interaction of rapidly increasing costs of insurance relative to incomes; greater competitive pressures on U.S. firms, making it more important than ever that they pass these costs on to employees; and low general inflation, which makes it more difficult for them to do so. As a result, some employers are dropping coverage, others are scaling back in various ways, and the percentage of workers with employer-based coverage is declining.

**The Future**

Absent a crystal ball to predict dramatic economic, political, social, or medical changes that would affect the future of employer coverage, we discuss three possible trajectories: Job-based health insurance may flourish, may continue to erode, or may be replaced by an entirely different system. We consider scenarios that might lead to these results and offer our judgment regarding their probability and desirability.

- **Scenarios for flourishing.** Employer mandates. The most plausible scenario for job-based insurance to flourish would be the enactment of employer mandates by many large states or the federal government. This would stem erosion, at least for a while, if all or nearly all employees were covered and if employers that failed to comply were subject to large penalties. The recently enacted Massachusetts health plan's employer mandate of $295 per year per employee is too small to have any major effect. Moreover, if the mandates exempt part-time and small-firm workers, the cover-
age increase will be small and will probably cause some unemployment. Minimum-wage workers will be particularly vulnerable because their employers cannot pass on the increased labor costs by reducing wages.

Individual mandates. Individual mandates, with income-related subsidies, might also increase employer-based insurance, at least in the short run. If individuals could satisfy the mandate with employer-based insurance, those currently without insurance but with incomes too high to receive much or any subsidy (about 10–15 million people) might search more aggressively for jobs with health benefits instead of purchasing insurance in the more costly individual market.

Income subsidies. An increase in employer-based insurance, however, is not certain. If low-income workers who currently have insurance through their employer were eligible for an income subsidy, some might find it economically advantageous to accept the subsidy to buy individual insurance and take a better-paying job in a firm that does not offer health insurance. Firms that employ mostly low-wage, subsidy-eligible workers would have an incentive to drop health insurance altogether. If the government decided to extend the subsidies to low-income workers with employer insurance as well as to those who purchase individual insurance, the result could be very costly. Mandate legislation has its best chance for passage when, as in Massachusetts, it does not call for any new taxes.

Tax shelters. Another scenario that might breathe new life into employer-based insurance derives from its tax-shelter advantages. Suppose there were a large expansion of consumer-directed care based on high-deductible policies and HSAs. The option to roll over unspent HSA balances to accumulate tax-free income would be very attractive to high-income workers, who usually have disproportionate influence within firms and in the political arena. Thus, even if employers’ insurance function were to be sharply diminished, employer-based insurance might continue to flourish for tax reasons.

The money in the HSAs can be invested, and the income earned is tax free. The account, with earnings, can be rolled over from year to year until age sixty-five. At that point, the worker or spouse can use the money (tax free) to pay any medical expenses (broadly defined) or premiums for Medicare or supplemental insurance. Thus, HSAs could be a magnificent tax shelter for high-income workers, even though its relevance for meeting the health care needs of low- and average-income workers is dubious.

Because attempts to remove this tax break will encounter fierce resistance, employer insurance may linger and delay the change to a more efficient, more equitable financing system. Also, despite HSAs’ shortcomings as social policy, they, and the accompanying high-deductible policies, could be a commercial success. The reason is adverse selection. When high deductibles and low (or no) deductibles exist side by side in a voluntary system, the high-deductible policy will attract people with below-average expected utilization. Over time, the low- (or no-) deductible policies will be driven out of the market, much as community-rated poli-
cies were driven out by actuarial-based insurance.

Regardless of the short-run effect, in the long run the flaws of employer-based insurance are likely to persist. In particular, the inability of employer coverage in its present form to move the system toward more cost-effective care would invite continued criticism.

**Scenarios for continuing erosion.** Employer insurance’s most likely trajectory is continuing erosion. This scenario, crisply described by Don Moran, involves “thinning out” or “rolling back” of job-based insurance, a process that is already under way. Employers will seek to limit their health insurance premium contributions to a fixed percentage of total compensation. They could gradually increase deductibles and coinsurance and pare back or eliminate coverage for outpatient drugs, hearing, vision, durable medical equipment, and the like. The changes might not expose most employees to great risks to health or financial ruin. Employers could pay fixed amounts for various services, leaving patients liable for the balance, with payments keyed to the charges of low-cost providers. They could adopt “tiered high-performance networks,” separating high- and low-cost (per episode) providers and raising the financial penalty for patients using the former. These models could make the transition to a form of reference pricing in which insurance pays for the cost of low-cost providers in each category and each region, or for the low-priced drug in a therapeutic category. Rates of coinsurance might be adjusted selectively for the degree to which a procedure was thought to be driven by consumers’ preferences. High front-end cost sharing is likely to reduce spending on preventive services. The use of cost sharing is constrained by the necessity for some annual limit on out-of-pocket spending by patients. Raising cost sharing would shift costs from the healthy to the sick. This might be accompanied by a message that much illness is the result of unhealthy lifestyle choices.

The social-welfare implications of this scenario are mixed. To the extent that the tax exemption granted employer-based insurance encourages too much insurance, which, in turn, encourages too much use of care, a more parsimonious approach to insurance might make the system more efficient. On the other hand, it would become less equitable in that the burden of uninsured costs would be felt more heavily by the sick and the poor. If erosion becomes deep enough, the pressure to replace employer-sponsored insurance with a more comprehensive approach will increase.

**Scenarios for replacement by universal health insurance.** For more than half a century, employer-based insurance has been the cornerstone of U.S. health insurance and, despite recent setbacks, still covers almost three of every five Americans. Despite shortcomings in efficiency and equity, it will not be easily replaced. Not only are tens of millions of Americans familiar with and satisfied with this arrangement, but numerous organizations and individuals derive their incomes from it. However, its internal weaknesses or seismic shifts in the external political or economic environment could eventually result in its replacement with some form of
universal health insurance.

One factor contributing to weakening support for job-based insurance is the difficulty employers are finding in passing on to workers the increased cost of health care. When the average annual cost per employee (for a family plan) was $5,000, a 10 percent increase meant that the employer had to reduce the rest of total compensation by $500. In an era of high general inflation, this could be done relatively easily by a slightly smaller increase in nominal wages. A 10 percent increase now means an increase of $1,000–$2,000 in the cost of a family plan, depending on location and generosity of coverage. To pass this on to a low-wage worker in an era of low general inflation requires a cut in the nominal wage, which workers fiercely resist. The alternatives are only slightly more palatable: an increase in the employee’s premium contribution, a larger deductible, or a higher copayment.

Changes in the financial viability of Medicare and Medicaid also threaten the future of job-based insurance. For forty years these programs have protected employer coverage; without them, that coverage would probably already have been replaced by some form of universal health insurance. Now, even optimistic financial projections indicate that Medicare cannot continue for long in its present form, and the states are increasingly restive and vocal about financing Medicaid.

Advocates of universal health insurance have predicted the demise of job-based insurance many times in the past, only to be disappointed. And it could survive again. Part of the problem is the unwillingness or inability of national health insurance supporters to unite behind a particular approach. Some favor comprehensive personal mandates; others prefer single payer; while still others propose a system of universal vouchers, which is a blend of single payer, managed competition, and consumer-directed care.

Even if 75 percent of the population wanted universal health insurance, employer coverage would not be replaced if each approach commanded the support of 25 percent and no compromise was possible. But some external traumatic event—a major war, a depression, large-scale civil unrest, bankruptcy of some key industries, or a public health crisis—could trigger a political upheaval that would increase support for universal health insurance and force a compromise among alternative proposals. Rapid erosion of employer coverage combined with financial crises at Medicare and Medicaid could also precipitate movement to universal health insurance.

“The likely and most desirable outcome is replacement of job-based insurance with some form of universal health insurance.”
We think that the most likely trajectory in the near term is continued erosion, but it is possible that this will be offset by mandates and the use of employment-based insurance as a tax shelter for HSAs. In the long term, we think that the likely and most desirable outcome is replacement of job-based insurance with some form of universal health insurance that encompasses choice, competition, and technology assessment to revitalize social insurance while making care more cost-effective.

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NOTES
2. Ibid., chap. 2.
8. The figure of 11 percent of premiums spent on administrative costs is from Sherlock Company, PULSE, January 2000.