Employer-Sponsored Health Insurance and the Low-Income Workforce

Limitations of the System and Strategies for Increasing Coverage

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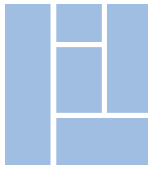

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Contents

Employer-Sponsored Health Insurance and the Low-Income Workforce

Limitations of the System and Strategies for Increasing Coverage

As the number of uninsured grows, and the share with employer-sponsored insurance (ESI) falls, questions are raised about the future viability of our largely employer-based health insurance system. Premium growth has far outstripped that of earnings and overall inflation, leading to declines in the shares of employers offering insurance and of workers taking up coverage that is offered. The decline in ESI is occurring among low-income workers, with coverage among high-income workers remaining steady.

Significant weaknesses exist in the employer system, and these are heightened for the low-income working population and their employers. One example can be seen in examining the employers' decision whether to offer ESI. Consider the employer's offer decision as a function of the preferences of the firm's workers, how many similar firms offer insurance, and the insurance price that the firm faces. So, if workers in a particular firm have a low demand for health insurance (e.g., many low-income employees that receive little from the tax subsidy for employer insurance contributions, low-income employees that prefer to maximize wage compensation), then the employer is less likely to offer insurance. Likewise, in labor markets where ESI is rare, the pressure to offer is lessened.

As health insurance premiums rise, the necessary wage trade-off for receiving ESI becomes increasingly great. Strategies for containing costs have met with little success, leading to frustration even among employers that continue to offer coverage. In response, employers are shifting more of the financing burden to the highest users of care (through increased cost-sharing requirements), creating greater barriers to low-wage workers obtaining affordable care.

Both public- and private-insurance-centered strategies can be used to address the problems experienced under the current system. But, it is unrealistic to expect significant

progress in expanding coverage without government intervention. Because most uninsured workers are low income, subsidies for the purchase of coverage will be required to have a significant impact. While the political hurdles are substantial, expanding existing public programs (e.g., Medicaid and SCHIP) may be the most efficient and easily administered mechanisms for expanding coverage at the state level. Enrolling individuals in private plans outside public programs has more political appeal in some sectors, even with some public subsidization of these plans.

A menu of policy options is available for expanding coverage, and significant expansions will require a combination of approaches: providing income related subsidies and perhaps health status–related subsidies for coverage, providing a guaranteed source (such as a purchasing entity) for all individuals to obtain coverage, requiring individuals to have at least a minimum level of insurance, requiring employers to contribute to the costs associated with health insurance coverage, increasing enrollment and retention in existing insurance option, and increasing the system's ability to contain health care spending and its rate of growth over time.

Financing reform is always the most difficult hurdle to surpass. While any comprehensive reform will require some redistribution of current spending, one cannot prudently assume that universal coverage can be achieved by redistribution of current spending alone.

Introduction

Recent trends related to employer-sponsored health insurance do not inspire much optimism, particularly concerning the low-income population. Employment-based coverage among low-income workers continues to fall while the share of those workers without any insurance continues to climb. Some have portended the near-term demise of the employment-based insurance system. This paper outlines the problems with employer-sponsored insurance from the perspective of employers, specifically those employing low-income workers, and discusses potential strategies for addressing them.

While the trends to which I have alluded are clearly a cause for concern and may reasonably be a catalyst for policymakers, are we witnessing the beginning of the end of employer-sponsored insurance? As of 2005, more than three-quarters of employees were covered by ESI, either via their own employer or that of a family member (Clemans-Cope et al. 2006). Even among near-poor workers (those with family incomes between 100 and 199 percent of the federal poverty level), more than half had ESI in 2005.

Thus, eradication of ESI does not appear on the immediate horizon. In truth, the biggest concern from a coverage standpoint today is for the modest-income workers and for those with substantial health care needs. And while many employers may wish to be out of the business of purchasing health insurance for their workers, for many, doing so

is an important tool for attracting and retaining their desired types of employees (Galvin and Delbanco 2006). Such a degree of stability and inertia is critical at this time, since there is no effective safety net that would provide access to adequate and affordable coverage if a significant share of people with ESI coverage were to suddenly find themselves without it.

But if the news of ESI's death has been somewhat premature, we should not minimize or ignore its weaknesses and shortcomings. These problems are heightened for the low-income working population and their employers. The background section of this paper provides further details on recent trends in ESI. Next I outline the problems and issues associated with ESI from the employer perspective and then present strategies for addressing the shortcomings of the current system.

Background

Between 2001 and 2005, the share of nonelderly employees with incomes below the federal poverty level (FPL) covered by ESI dropped from 37 percent to 30 percent (Clemans-Cope et al. 2006), while the share with no coverage at all rose from 47 percent to 54 percent. For workers with incomes between 100 and 199 percent of FPL, ESI dropped from 59 percent to 52 percent during the same period. In contrast, ESI coverage for those employees with incomes at or above 400 percent of FPL remained quite steady, dropping less than a percentage point from about 93 percent over this timeframe. The stability in ESI among higher-income workers is at least partly due to the substantial value workers receive from the tax exemption for employer contributions to health insurance. Because this tax subsidy increases with increasing income, it is of little to no value for those at the low end of the income distribution.

Between 2000 and 2006, family premiums grew by a cumulative 87 percent, on average, compared with a cumulative 20 percent for worker earnings and 18 percent for overall inflation (Kaiser Family Foundation and Health Research and Educational Trust 2006). As of 2005, approximately 70 percent of workers without health insurance had no access to ESI, through their own employer or through the employer of a family member (Clemans-Cope et al. 2006). Among poor workers (those with incomes below the FPL) with no health insurance, 81 percent had no access to ESI; the same was true for 73 percent of near-poor workers.

In addition to rapidly growing premiums, recent changes in benefit design have tended to increase the share of health care costs that is placed upon those that use health care the most (Blumberg et al. 2005). As out-of-pocket requirements increase and benefits become defined more narrowly, the nature of what is considered insurance changes as well. Such trends put high users of medical care and those with low and modest incomes at risk for overwhelming financial burdens and decreased access to necessary medical care.

In addition to the trends in health insurance premiums and benefits, there has been a shift in employment: more workers are employed in the types of firms that are less likely than average to offer health insurance to their workers. During the 2001 to 2005 period, a greater share of the workforce could be categorized as self-employed, working part time, or holding temporary or contract positions (Clemans-Cope et al. 2006). In addition, there was a shift in employment toward the smallest employers (fewer than 10 workers) and away from firms of 100 or more workers. It is well documented that workers in these types of employment situations are significantly less likely than other workers to receive employer-based offers of insurance (Clemans-Cope and Garrett 2006, Nichols, et al. 1997, Cooper and Schone 1997).

The decline in coverage among all workers between 2001 and 2005 was attributable to (Clemans-Cope et al 2006)[1]

- a decline in the share of workers receiving offers of insurance from their employers (accounting for 62 percent of the decline in coverage);
- a decline in the share of workers taking up an employer offer (27 percent of the decline); and
- an increase in the share of with dependent coverage (11 percent of the decline).

Declining rates of employer offers and worker take-up can both be attributed largely to increasing premiums. Among the low-income working population, however, the decline in take-up of employer coverage that is offered is even more significant, with

- 47 percent of the ESI decline among poor workers attributable to a decline in take-up;
- 43 percent attributable to a decline in the share of low-income workers receiving an offer; and
- 10 percent attributable to a decline in dependent coverage.

This highlights that low-income workers are suffering the greatest declines in ESI as a consequence of two related trends: first, the declining rates of employers making coverage available; and second, a decreasing affordability of the policies that are available to them.

Meanwhile, some employers that offer health insurance, particularly those in manufacturing industries that compete with firms operating from other countries, report that providing health insurance significantly impedes their ability to compete globally (Freudenheim 2007; USA Today Editorial Staff 2007). These significant trends, all pointing in the direction of reduced employer offers, reduced worker take-up, and reduced coverage, and which portend further declines, have led some to predict the end of the employer-sponsored health insurance system as we know it (Enthoven 2006; Stern 2006).

Problems and Issues through the Employer's Lens

Employers must decide whether they will offer health insurance to their workers and, if they offer, which workers will be made eligible to enroll. Obviously other decisions also have to be made, such as what type of insurance to provide (plan type, benefits, cost-sharing, etc.), how much of the premium to require workers to contribute, and so on, but here I focus on how employers make the two central decisions of offer and eligibility. In addition, I will delineate the reasons many of those employers that have decided to offer coverage to their workers remain dissatisfied with the current system.

Why do some employers offer coverage while others do not?

Economists generally assume that employers care about providing health insurance to their workers simply because their workers value health insurance. In other words, employers are willing to pay a certain level of compensation to each worker, with that amount determined by the marginal value of that worker to the firm. Employers want to attract a certain type of worker to their employ, and if that type of worker would prefer some compensation be paid in benefits like health insurance instead of purely through wages, then employers will have an interest in doing so.[2]

As a consequence, one can think of the employer's offer decision as a function of the aggregated preferences of the firm's workers, how many other employers in the area trying to hire similar workers offer insurance, and the price the firm faces for health insurance. If, as classic economic theory states, that employer's contributions to health insurance are all in actuality passed back to workers through reduced wages, then the price of insurance faced by the firm is zero. However, if there are administrative or other costs that, for some reason, cannot be fully recaptured by the employer, then the firm might face a positive price for providing coverage.

For example, if workers in a particular firm had a relatively low demand for health insurance (e.g., many employees with health insurance through another source; largely young, healthy employees; or predominantly low-income employees that receive little from the tax subsidy for employer contributions to insurance), the employer would be less likely to decide to offer insurance. If, on the other hand, the firm's employees had a high demand for health insurance (e.g., largely middle-aged workers, individuals with families, higher-income individuals who would gain greater value from the tax exemption for employer contributions to premiums), then the employer would be more likely to offer coverage. In addition, when employers competing for the same pool of workers tend to offer health insurance, then the pressure to offer such benefits increases for the other employers in that labor market. Likewise, in markets where ESI is not common, the pressure to offer it is significantly lessened.

One of the more controversial and complex issues related to the employer decision to offer insurance is whether the incidence of employer premium contributions falls

upon the employer or upon the worker. While the best empirical evidence available indicates that, at least in large part, employer payments are passed back to workers via reduced wages (Gruber 2000; Blumberg 1999; Gruber 1994), most employers do not believe this is the case. This is also a concept that has not seen wide acceptance among workers or the advocacy community. At least part of the disconnect between employer perceptions and empirical evidence may be the length of time required for the employer contributions to be recouped through wage adjustments. Economists do not have much evidence on the path of the wage adjustment process, but it is likely not instantaneous. It is possible that the wage adjustment takes place over the course of a year or more, while employers are focused on their profitability over a shorter time horizon.

However, if the economists and the weight of empirical analysis are correct, then full or even high-wage incidence implies that firms employing significant numbers of modest-wage workers will not be able to offer health insurance to their workers. This is because low-income workers will tend to prefer employment that provides additional wages as opposed to health insurance benefits to a significantly greater extent than will high-income workers. And even for those who would prefer the insurance benefits, their wages may be too close to the minimum wage to be able to absorb such an offset. Consistent with this scenario, there is clear evidence that low-wage workers are substantially less likely to have jobs through which they are offered health insurance.

Another aspect of the price of health insurance to employers is labor turnover. The administrative costs associated with health plan enrollment and disenrollment are higher for employers with high-turnover workforces. If these cost differences cannot be recouped completely, employers with high-turnover workforces will face disincentives to offer coverage to their workers. In addition, high-turnover workers tend to be less productive than stable employees and lead to higher recruitment and training costs. Lower pay related to this lower productivity and higher associated costs may make a wage-fringe benefit trade-off less desirable for the workers as well. Survey data suggest a significant link between offer status and employee turnover (Kaiser Family Foundation and Health Research and Educational Trust 2006).

Why do employers make some workers eligible for insurance and not others?

Employers have some flexibility to limit the types of individuals eligible for the health plans that they offer, but this flexibility is constrained by antidiscrimination laws. Employers must treat workers in the same class in the same way. For example, full-time workers can be treated differently from part-time workers or contract workers. But workers within the same class cannot be charged different premiums as a function of their health status or use of services. Most frequently, employers restrict health plan eligibility by requiring waiting periods and by denying eligibility to part-time workers.

The eligibility rate has fallen in recent years, however, and this decline was estimated to account for approximately 14 percent of the drop in coverage between 2001 and 2005. Eligibility for ESI (conditional on working for an employer offering health insurance to at least some workers) fell from 66.7 percent to 63.2 percent for workers employed less than 20 hours a week, from 86.8 percent to 83 percent for workers employed 20 to 34 hours a week, and by 1 percentage point for contingent workers. There is no reason to expect that the preference for insurance among part-time or contingent workers might be changing over time, but there is no real research on the employer's eligibility decision to shed greater light on what could be happening here.

Why even employers that currently offer insurance are unhappy

Employers that do offer coverage to their workers today still face substantial concerns with the system as it is. Chief among them is that rapid increases in private insurance premiums present a no-win situation for employers. The growth in fringe benefit costs will tend to crowd out wage growth, and this is obviously frustrating for workers. If the employer attempts to control premium growth in order to allow for greater wage growth, workers are dissatisfied by the consequent reduction in benefits.

In addition, many employers believe that they, not their workers, pay for these health insurance benefits, and that the rising costs are harming their ability to compete internationally (Pauly 1997). And while the weight of research evidence is to the contrary, this is of little comfort to the employers. And given that decisions regarding the purchase of health insurance will be made based upon the employers' perceptions of reality, these perceptions, right or wrong, have important implications for the future of employer-based insurance coverage.

Even large self-insuring employers and large commercial insurers appear to have very little success in containing costs and the rate of growth in premiums/spending over time. Many factors may be contributing to this failure. For example, it is possible that many large self-insuring employers or their third-party administrators still do not have sufficient market power to negotiate from a position of strength with providers. Plus, employers offering health insurance to their workers are caught in the difficult position of attempting to balance the competing interests of their workers over their health coverage. Workers want to contain the rate of growth in their premium contributions each year, while being reticent to accept plans with tighter review and controls on use of services.

These strong but conflicting preferences make it difficult for employers to satisfy their workers. Employers may find it politically more palatable within their firms to, over time, place more of the health care financing burden on the highest users of care (through higher deductibles and other cost-sharing tools) because many more workers will be healthy. Satisfying the needs of those that are less healthy may not make economic sense from the perspective of a single firm.

Strategies for Addressing the Shortcomings of the Current Employer-Based System

Both public- and private-insurance-centered strategies can be pursued in an effort to address the problems experienced under the current system. However, it is unrealistic to expect significant progress to be made in meaningfully expanding health insurance coverage without government intervention. The emphasis on expanding that coverage through public versus private insurance plans is a highly politicized decision.

Proposals to expand existing public programs find strong resistance in some sectors opposed to "big government" programs and the associated tax increases that they imply. Expanding Medicaid and State Children's Health Insurance Program (SCHIP) eligibility also touches off the political "hot button" of provider payment rates, which are perceived by some stakeholders as too low. Providers may be unwilling to support further public expansions without payment rate increases under these programs. In addition, public program expansions more frequently raise political and financing concerns related to the displacement of private insurance with public insurance, the so-called "crowd-out" effect.

While the political hurdles are substantial, the Medicaid and SCHIP programs may often be the most efficient and most easily administered mechanisms for expanding coverage at the state level. This is particularly true for states that would be entitled to additional federal matching funds for further enrollment and eligibility expansions because they have not exhausted their federal funding allotments. Medicaid and SCHIP also provide existing administrative mechanisms for determining eligibility and enrolling individuals and families in coverage. Particular states have also identified mechanisms for achieving very high participation rates, and other states can learn from these successes (Dubay et al. 2006).

Providing a new guaranteed source for purchasing private plans state has more political appeal in some sectors than does expanding coverage through existing public programs, even if enrollment of many would require public subsidization. Massachusetts's Connector is one example of such a state-based purchasing entity that contracts with private insurers, is open to all individual purchasers as well as small employers, and provides financial assistance for low-income enrollees. This type of approach requires new administrative mechanisms to be developed, such as those for determining eligibility, delivering subsidies in a timely manner, and making payments to health plans. In addition, when multiple private plans are used in this type of context, concerns arise related to the distribution of risk across plans. The process of spreading risk broadly becomes more complex if private plans are allowed or required to offer different benefit packages or different levels of cost-sharing to enrollees. While aggregate payments to insurers (from individuals, employers, and government) must reflect differentials in the costs of enrollees, maintaining the viability and competitiveness of com-

prehensive plans will require either direct subsidization of the excess costs associated with the unhealthy or another mechanism for spreading those costs more broadly than over enrollees in a single plan.

The private-centered approach also requires some mechanism for promoting efficiency and cost-consciousness within the plans under contract, while simultaneously ensuring sufficient capacity within the plans for all eligibles. While draconian cost controls may hamper the willingness of private plans to participate, thereby limiting the number of individuals that can be enrolled, avoiding such oversight will lead to higher government and private financial burdens that could impede a program's long-term feasibility.

Regardless of whether a public- or private-centered approach is taken, achieving universal coverage requires a mechanism through which all individuals in the population of interest are automatically enrolled, or the imposition of an individual mandate. An individual mandate is simply a requirement that all individuals be enrolled in a health insurance plan that meets the minimum determined standards of coverage. While generous subsidization and other incentives provided voluntarily can significantly increase coverage, there will always be some individuals who do not enroll of their own volition, hence the role for a mandate.

While employer mandates are another policy tool being seriously considered in some quarters, an employer mandate without an individual mandate cannot achieve universal coverage. Even if employers are required to offer and contribute to coverage on behalf of their workers, some workers will decline to enroll voluntarily, and those without connection to the workforce would not be covered by such an approach.

Not all policy proposals are intended to achieve universal coverage, however, and some might include limited mandates (e.g., for adults only, for those above a defined income threshold) or a mandate that is conditional on products being available that meet a defined affordability standard. Regardless of whether a mandate is included, a menu of policy options is available for expanding health insurance coverage, and significant increases in insurance will require combinations of such approaches.

Policy options

Providing government subsidies for insurance coverage. It is indisputable that significant inroads cannot be made in reducing the number of uninsured without providing some financial assistance to those with low and modest incomes. Such assistance can take the form of subsidies (e.g., refundable tax credits or vouchers) for the purchase of private insurance policies, or it may take the form of publicly provided health insurance coverage (e.g., Medicaid, SCHIP) either for free or at reduced cost.

Subsidies related to an individual's health care risk may be necessary, depending upon the structure of a reform. Under the current system, private insurance premiums

are determined as a function of the expected health care expenditures of those enrolled in a particular insurance risk pool. As a consequence, plans that tend to attract a higher-cost group of enrollees will tend to have higher premiums than plans that attract a lower-cost group.

As a consequence, ensuring that individuals with above-average health care needs have access to adequate and affordable health insurance coverage may require additional financial assistance relative to those of lower risk. This is particularly true when reforms are structured through private insurance plans or when individuals retain partial financial responsibility for the costs of their care. Without extra assistance, premiums for high-need individuals may be so high as to make coverage unaffordable, or individuals may be forced into substantially less comprehensive insurance plans (in order to get lower premiums) that force their out-of-pocket payment requirements to levels high enough to impinge on their access to needed care.

Additional financial assistance for the high-health-care-need population can be provided through subsidies that are related to health status, although this is likely to be administratively onerous. Alternatively, a system could be designed where the premium charged for a guaranteed issue insurance policy, or an array of such policies, is unrelated to the particular health care risk of the individuals who actually enroll in it. The premiums could be set as a function of the health care needs of a broader population. The difference between the premiums charged in the insurance pool and the costs of the individuals actually enrolled could be made up by government funds or by premium surcharges to premiums payments made by enrollees in other insurance pools.

Providing a guaranteed source for private purchase of insurance. In the U.S. health care system, there is no guarantee that all individuals will have a source for purchasing health insurance coverage, even if they have the resources sufficient to do so. Only a small fraction of the population is eligible for publicly provided insurance, and a growing share has no offer of employer-sponsored insurance coverage. Plus the direct purchase or nongroup market is not conducive to providing insurance coverage to those with above-average health care needs or those at elevated risk for such needs. In most states, the private nongroup insurance market can refuse to sell insurance coverage to individuals based on their health care risk. In many states, nongroup insurers can exclude coverage for particular body parts and body systems in the policies that they do offer, based on an individual's health history. The market is very small, with estimates from national surveys indicating that only about 5 percent of the population is currently enrolled (Holahan and Cook 2006) and indications from state data that this figure may be a significant overestimate.

As a consequence, the existing private nongroup market cannot effectively form the basis of providing coverage for a significant insurance expansion. Yet several viable options for providing a guaranteed source of coverage are available. These include existing public and semi-public options, as well as purchasing entities that could be newly

established to serve such a role. For example, individuals could be allowed to enroll in or "buy into" Medicaid, SCHIP, or Medicare. These programs all do considerable contracting with private insurance plans for their enrollees. State governments and the federal government all contract with private insurers for the purchase of health insurance plans for their employees. Individuals could be allowed to buy insurance through these government employee benefit plans, either through a separate risk pool or one that includes the government employee enrollees.

Some states also have high-risk pools that provide coverage for certain individuals unable to access plans through the private nongroup market because they have particular health conditions. These high-risk pools contract with private insurers to provide this coverage. While many high-risk pools face limitations that inhibit their ability to meet the comprehensive health care needs of high-cost populations (Chollet 2002), they are experienced at contracting with private insurers, screening individuals for eligibility, and performing enrollment functions. Such experience can be effectively built upon for creating a more extensive system of coverage. Alternatively, new purchasing entities can be set up to contract for coverage with private insurers or to offer coverage through a government self-insured plan. Any of these options can be used to provide coverage to individuals and also to employer groups if desired.

Requiring all residents to obtain a minimum level of insurance: individual mandates. Successful implementation and acceptability of an individual mandate requires that subsidies be sufficient to make the requirements reasonable. In particular, the mandate cannot be overly burdensome to low- and middle-income individuals and families. But while its legal requirements fall upon individuals, it is important to recognize that an individual mandate does not imply the end of employer-sponsored insurance, nor would it necessarily lead to substantial declines in such coverage.

Depending upon how the reform is designed, incentives for employers to offer coverage to their workers may stay relatively constant, and may even strengthen. Administrative economies of scale and risk pooling (in larger firms), the tax exemption for employer-sponsored insurance, ease of enrollment and payment of contributions, and benefit design being tailored to worker preferences are all reasons workers might prefer employer-based coverage over other private plans. A reform incorporating an individual mandate need not change any of these incentives. And once individuals are required to purchase insurance of some type, some may decide that getting it through their employers would be the most attractive option, and thus be willing to trade off some wages for new provision of health insurance.[3]

Requiring employers to participate in the financing of health insurance coverage for their workers: employer mandates. The Employee Retirement Income Security Act (ERISA) of 1973 prohibits states from requiring employers to provide health insurance to their workers. As a consequence, all employer mandates legislated at the state level are likely to be challenged in the courts. One approach, how-

ever, has the greatest chance of surviving an ERISA challenge—"pay or play" (Butler 2002). Under a pay-or-play approach, employers are required to pay a payroll tax but are not required to provide actual health insurance to their workers. However, if an employer voluntarily makes contributions toward health insurance on behalf of its workers (as many employers do today), then the payroll tax requirement is reduced by the amount of those contributions. A recent judicial challenge to Maryland's pay-or-play legislation found the state's law did violate ERISA; however, this particular law was structured very narrowly and would have affected only one very large employer in the state. As a consequence, it is difficult to know whether the ruling is generalizable to future possible state laws that have a broader intent and would have a wider impact on a state's employers. Of course, employer-mandate legislation generated at the federal level could preempt ERISA.

In addition to legal challenges, employer mandates of any type will face vigorous opposition from an employer community that often does not believe that it can pass back the costs of coverage or new payroll taxes to workers. The impact of employer mandates will always fall upon those employers and their workers that do not offer health insurance coverage, and these tend to be smaller firms and firms employing lower-wage workers. Meanwhile, some large employers that offer health insurance resent what they see as cost shifting from small employers that do not offer coverage.

As employers have strong reactions over the prospect of employer mandates, so do advocates for the low-income population. Many feel that an employer mandate is the most attractive private insurance–based approach, since the economists' notion that the incidence of employer contributions to health insurance ultimately falls on the workers themselves is not widely held within this community either.

Regardless of the strength of the economic research on the matter, the politics surrounding employer mandates are driven and complicated by the perceptions of the employers, workers, and their advocates. The compromise achieved under the Massachusetts legislation was to maintain some employer responsibility for insurance coverage, via an employer mandate with a low financial requirement, coupled with an individual mandate and significant subsidies to the low-income population. The employer community was able to support the proposal because their responsibility was not too great. Advocates for the low-income accepted it because employers were required to participate to some extent, and government financial assistance for the low-income was significant.

Increasing enrollment and retention in existing insurance options. Both premium assistance programs and the provision of wraparound services have been used by states to help families maintain their employer-sponsored insurance with the assistance of public funding. Depending on the state, premium assistance options would be available for workers who are themselves eligible for Medicaid or SCHIP or who have children who are eligible for one of these programs. Under premium assistance programs, states

subsidize the worker's share of the employer-sponsored insurance premium using either Medicaid or SCHIP funds. Alternatively, states can provide benefits, such as dental care or prescription drugs to "wrap around" private policies in order to ensure enrollee access to all the services covered through the public program and to compensate for higher cost-sharing in the private plans—under current policy, this is permitted for children eligible for Medicaid but not for those eligible for SCHIP.

Premium assistance programs allow states to subsidize certain workers' purchase of employer-sponsored insurance using Medicaid or SCHIP funds. This program is available for workers who are themselves eligible for Medicaid or SCHIP or who have children eligible for one of these programs. States take one of two approaches in providing premium assistance: (1) subsidizing the worker's share of the employer-sponsored insurance premium or (2) providing benefits to "wrap around" private policies in order to ensure enrollee access to all the services covered through the public program and to compensate for higher cost-sharing in the private plans.

Premium assistance programs represent an effort by states to integrate public coverage and employer-sponsored health insurance. These programs are also an attempt to maintain employer contributions to health insurance for workers who are eligible for Medicaid or SCHIP. While these programs hold a considerable amount of political attractiveness, their reach has been extraordinarily limited (Shirk and Ryan 2006). In large part, this is because most low-income workers eligible for public insurance do not have an offer of private insurance from their employers. And the assistance provided through the programs will not have an effect on employers sufficient to induce them to begin offering coverage when they have not done so previously. However, premium assistance may allow some low-income workers who do have employer-based coverage to maintain the insurance over time, particularly in the face of increasing premiums and decreasing take-up rates.

Research has shown that approximately two-thirds of uninsured children and poor uninsured parents are eligible for public insurance but not enrolled (Dorn and Kenney 2006). Allowing these eligible individuals to be enrolled automatically by virtue of their eligibility and enrollment in other nonhealth programs could lower the rate of uninsurance in these groups significantly (Dorn and Kenney 2006). A particularly promising avenue for identifying children and parents for auto-enrollment is the various nutrition programs: the national school lunch program, food stamps, and the special supplemental program for women, infants, and children.

Two practical reforms would be required to successfully implement such auto-enrollment policies. First, investments are necessary in developing state information technology systems for allowing communication and data sharing between the nutrition programs and the health programs. Second, modifications to federal law are necessary to allow states to disregard small differences between health and nutrition programs in the ways that they count income for purposes of determining program

eligibility. Auto-enrollment for other programs, both public and private, have been demonstrated to substantially increase participation.

Approaches for controlling health care costs. Strategies for containing health care spending and its rate of growth over time are a high priority for reform among many stakeholders. For reasons already discussed related to wage growth, worker satisfaction with compensation, and the perceived incidence of costs, employers involved in the purchase of health insurance for their employees have strong preferences for cost containment. More individuals face affordability constraints in the purchase of health insurance through their employers or through the individual market. Policymakers sensitive to other government priorities being crowded out by continuously expanding public health programs also find the need for some type of cost containment compelling.

While the motivations are seemingly compelling, imposing measures that would significantly decrease either health care spending or the rate of growth in such spending is politically very difficult. Successful measures would require a decrease in prices paid to providers and/or a decrease in use among those spending the most on health care. It is extremely important to recognize that reducing spending among those at the lower end of the health care spending distribution cannot significantly impact overall spending because of the highly skewed nature of the spending distribution. Seventy percent of health care costs are attributable to the top 10 percent of spenders; only 3 percent of spending is attributable to the lowest 50 percent of spenders (Berk and Monheit 2001). Even if every individual in the country was enrolled in an insurance policy with a deductible as high as those associated with health savings accounts (HSAs)[4] ($1,100 for a single policy and $,2200 for a family policy), and even if such high levels had an impact in reducing spending below the deductible level (and it is not clear that they do have this effect in reality), this change still could not substantially affect overall health care spending. This is because 97 percent of health care spending is attributable to individuals spending over these deductible levels, and 82 percent of spending occurs after the level of these deductibles has been exceeded (author's calculations using the MEPS-HC).

Significant reductions in spending therefore require provider price reductions and/or significant changes in use among individuals with the greatest medical needs. The former will be resisted politically by the provider community and may have important implications for access to providers over time. The latter will require changing patterns of practice and use for the high-need segment of the population. Doing so in a way that protects access to needed care for those with medical needs will be a difficult task to be sure.

Some potential tools for cost containment include promoting managed competition via purchasing pools, management of high-cost cases to promote cost-effective care; investment in cost-effectiveness analyses of new and existing technologies and treatment regimes, further development and dispersion of health information technology to promote cost-effective care, and provider payment reform.

Conclusions

Increasing health insurance coverage and ensuring security of that coverage is a priority for employers and their workers. Numerous practical policy tools are available for achieving such ends, although the administrative costs and the financial redistribution required will vary as a function of the details of the policy approaches adopted. From the experience in passing legislation in the state of Massachusetts, any successful policy adoption will require political compromise, as no group's ideal is likely to be acceptable to all the other stakeholders in the health care system.

Financing reforms is always the most difficult hurdle to surpass. While any comprehensive reform will require some redistribution of current spending, one cannot prudently assume that universal coverage can be achieved by redistribution of current spending alone. Providing benefits for necessary services at an affordable price for an entire population will surely cost more government dollars and more system-wide dollars (government plus employer plus individual expenditures) than is the case today. Even if cost-containment policies are put in place that slow the rate of growth in spending relative to current trends, early years of such a program should be expected to be higher than current experience. Finding new sources of revenue to finance such a system is always a political challenge. Action will most certainly require that employers, individuals, and providers speak with a unified voice about their need and willingness to explore new avenues of compromise.

Notes

1. Here, an individual is deemed to have an offer from an employer if the employer offers health insurance to any of the firm's workers *and* the particular worker is eligible to enroll in the coverage that is offered.
2. This section draws liberally from a discussion on this topic from Blumberg and Nichols (2004).
3. It is worth noting here that a number of recent proposals (Massachusetts and California) include requirements that all employers provide workers with Section 125 plans. These plans allow workers to put pretax dollars into an account that could then be used to pay for health insurance premiums through a state-run purchasing pool. Because these provisions will lower the effective cost of buying insurance as individuals (as opposed to as a member of an employment-related group), the provisions may have the unintended effect of reducing employer-based coverage.
4. HSAs are tax-free savings accounts for people who are covered by a high-deductible insurance plan, either purchased independently or on their behalf by an employer. Contributions to HSAs up to the deductibles are excluded from income and payroll tax if made by an employer, and deductible from income tax if made by the individual. Withdrawals are tax-free if used to pay for qualifying medical expenses. Other withdrawals are subject to income tax, plus a 10 percent penalty if taken before age 65, death, or disability. Some believe that HSAs will discourage unnecessary medical spending because individuals will make more careful decisions if they, rather than an insurer, are paying for their care.

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