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Is There a Future for Employer-Sponsored Health Insurance?

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With approximately 150 million Americans obtaining insurance through their employer, traditional employer-provided health insurance remains the cornerstone of the American health insurance market for the non-elderly, non-poor population.

The federal and state health insurance exchanges, while generating a great amount of attention and controversy, still only represent a small fraction of the marketplace.

But will it stay this way? Will the new rules and incentives embodied in the Affordable Care Act—especially after the employer mandate is fully put into place—cause significant changes in the use of employer-based group health insurance for this population? In the short run, my answer to this second question is no. But in the longer run, there is greater potential for erosion from employer-sponsored insurance, depending on how firms themselves respond to the subsidies available on the exchanges for low-wage workers.¹

ASSUMPTIONS

As an economist, there are a few commonly-held assumptions that underlie my own thoughts on the future of employer-sponsored health insurance:

Assumption #1: Employees pay for all their health insurance. With few exceptions, it is the employees, not their employers, who will always bear the benefits

SUMMARY

- Over the next five years, the effects of the ACA on employer-sponsored insurance will be modest. In the longer run, there is greater potential for disruption, depending on how firms respond to the subsidies available on the exchanges for low-wage workers. In all, only about 15% of the workforce likely will be affected.
- The impacts of the ACA on firms will vary widely based on three main factors: 1) the size of the firm, 2) the average compensation within the firm, and 3) the degree to which wages within the firm are homogenous or heterogeneous.
- Keeping in mind that employees pay for all their health insurance, group insurance is not intrinsically superior to private exchanges, and cost trumps choice for consumers, firms will choose the option that maximizes benefits to their workers, takes advantage of the best available subsidies while avoiding tax penalties, and results in the lowest administrative costs.
- Making all low-wage workers eligible for the same subsidies, whether they acquire coverage on the exchanges or in group plans, would be reasonable and involve less distortions.



and costs of health insurance, whether they shop on the exchanges or pay premiums from wages for group insurance. Insurance premiums paid by employers are part of compensation, and offset money wages. By the same token, employers cannot shift the burden of health insurance premiums to workers, because if they do, they would have to compensate them more in money wages.

Assumption #2: Group insurance is not intrinsically superior. The value of an insurance arrangement is derived from the ability of workers to choose insurance that is efficiently priced, reflective of the benefits received, and appropriate to their needs. If these are the chief criteria of evaluating the efficiency of a system of coverage, there is no inherent value in preserving group insurance if private exchanges can provide the same services at lower costs.

Assumption #3: Cost trumps choice. Surveys show that health-care consumers favor having more insurance plan options, but what those surveys don't address is how much more those people are willing to spend to have additional options available. Employees may accept a small increase in cost in order to move to the greater number of choices on the

exchanges, but it's safe to assume that people who aren't sufficiently dissatisfied with their current plan would not accept significantly higher premiums than what they pay in group insurance in order to have more choices on the exchanges.

With these factors of cost and choice in mind, we conclude that the interests of the employers and employees should run parallel to each other: both should want employees to have access to those attractive, efficiently managed and priced insurance plans that employees prefer at those prices. It then stands to reason that firms will choose the option that a) maximizes benefits to their workers, b) takes advantage of the best available subsidies while avoiding tax penalties, and c) results in the lowest administrative costs. Therefore, in order to predict the most likely response of employers to the ACA, we must determine whether and how the ACA changes what is in the best interests of their employees.

ANALYSIS

The impacts of the ACA on firms will vary widely based on three main factors: 1) the size of the firm, 2) the average compensation within the firm,

and 3) the degree to which wages within the firm are homogenous (all workers earning roughly the same amount) or heterogeneous (a mix of high-, medium-, and low-wage workers). Though this distinction is not specified in law, for our purposes we will describe small firms as having fewer than 50 employees, and medium firms as employing between 50 and 200.²

To begin to understand the effects of the ACA, we will start by examining the two extremes of this spectrum: small low-wage firms (i.e., worker incomes below 200% of the poverty line) providing insurance, and large high-wage firms (i.e., worker incomes above 500% of the poverty line) providing insurance.

Small Low-Wage Firms: These firms will likely be among the most heavily impacted by the ACA, and the American workers they employ are prime candidates for moving to exchanges. Small businesses were unlikely to be providing insurance before the ACA, but if they were, the only subsidy they would have received would have been a small tax exclusion worth approximately 15% of the provided benefits. Since these firms are typically homogenous with respect to wages, employers who did offer insur-

NOTES

¹ This brief builds on key points made by Mark Pauly during an October 9, 2014 conference co-sponsored by the Penn Wharton Public Policy Initiative and Leonard Davis Institute of Health Economics entitled, "Health Care Reform 2015: What the Research Tells Us."

² The U.S. Census Bureau Statistics of U.S. Business Annual Data for 2011 indicates that the 96.2% of employer firms with fewer than 50 employees in 2011 accounted for 27.6% of all non-self-employed workers.



ance likely would only have offered a single plan, and their employees who bought insurance in the small group market often faced unappealing and volatile premiums.

Post-ACA, I would expect to see a dramatically different landscape. Businesses with fewer than 25 workers are now potentially eligible for Supplemental Health Options Policy (SHOP) benefits, although their implementation has been slow. Employees at 200% of the poverty line can receive Silver Plans with a generous 50% subsidy. Or they can buy plans through the exchanges with loadings (extra fees added to basic premiums to insure higher-risk individuals) of about 15%. Given that the net change in subsidy is about 35% (from 50% to 15%) or about \$1400 on a typical \$4000 premium, the additional subsidies available in exchanges will incentivize employers who were offering insurance to stop paying their part of the premium and instead pay the money as wages to let their employees seek better options through the exchanges. Since there is little efficiency advantage at the small group level, these firms have little to lose in making the switch. However, because the number of workers in low-wage small firms previously obtaining employment-based coverage was small, the main effect will not be erosion of group insurance, but rather initiation of insurance purchase by the formerly uninsured.

Large High-Wage Firms: I expect these firms to exhibit the smallest degree of change from the ACA. Before the ACA, more than 95% of the employees at these firms already had self-insured group

coverage with loadings of about 5%. Moreover, they often had three or four plan options from which employees could choose, with coverage far more generous than that of a Silver Plan, although offerings typically would decrease as the company size shrinks. If the marginal income tax rate is 25%, the overall marginal federal tax including payroll taxes would be about 30-40% (depending on the maximum Social Security tax).

Although the regulations of the ACA may slightly increase premiums because of required coverage of preventive care and dependents up to age 26, there is no reason to anticipate any drastic change in the employer-sponsored insurance offered by these large, high-wage firms. Incentives for switching to the exchanges simply are not there. Employees in this category would not be eligible for any sizeable premium subsidies, and any replacement of employer premium payments with wages would be taxed at 30-40%. If the firm has a lower-than-average risk, exchange premiums actually could become higher. The employer mandate penalty for failing to offer insurance is irrelevant in this case because the firm is assumed to offer coverage, but it would still be there to remind employers not to do anything foolish. Because of the high offerings already provided, group insurance would be the preferred option of these firms even without the penalty. Because the subsidy is lower in the exchanges, there will be no switching to the exchanges. We may see small effects on the tiny fraction of uninsured working in large firms as they switch from being uninsured into having group coverage.

Firms between the Poles: The effects of the ACA on other types of firms would fall between these two polar extremes. The ACA's mandate penalty is likely to have a modest deterrent effect on large, low-wage firms, which might consider dropping employer-sponsored coverage, if the subsidy available on the exchanges is larger than the tax subsidy their workers currently receive. By contrast, small, high-wage firms likely provided insurance coverage to their employees prior to the ACA; they would have little incentive to switch to the exchanges now. The exchanges might offer more insurance plan choices, but at the cost of a lost tax subsidy, typically in the range of 20 to 50%, depending on income. As there is little evidence to suggest that workers are interested in paying more for increased choice, I expect these small, high-wage firms will stay off the exchanges.

Similarly, medium-sized firms are likely to continue offering employer-sponsored health insurance and may actually offer new, expanded coverage because of the employer mandate—that is, unless the average wage at such a firm is so low (below 200% of poverty) that the exchange subsidy exceeds the amount of the penalty (\$2000) plus the tax exclusion (at least \$450). Medium-sized firms also tend to be heterogeneous in terms of wages, with some high-wage workers and some low-wage earners, and that heterogeneity will help keep these firms nailed to the employer-based setting. While low-wage workers at these firms might be better off switching to the exchanges, where they could benefit from larger subsidies, high-wage workers would be worse off, as



they would lose their tax exclusion while being ineligible for any compensatory exchange subsidy. As firms tend to respond more to the interests of their high-wage workers, who are more expensive to train and harder to replace, we should expect medium-sized firms with greater wage heterogeneity to heed the interests of their high-wage workers by sticking with employer-sponsored insurance.

Table 1 illustrates the distribution of insurance status (e.g., uninsured vs. individuals with public insurance, private insurance, or a combination of public and private insurance; and whether they obtained the private insurance through their employer or individual market) for individuals between 138% and 400% of the Federal Poverty Level, who are eligible for subsidies to purchase insurance through the exchanges, as well the same breakdown for individuals between 138% and 350% of the Federal Poverty Level, for whom the value of the exchange subsidy roughly equals the value of the tax exemption for employer-sponsored insurance.

CONCLUSIONS

Over the next five years, the effects of the ACA on employer-sponsored insurance will be modest. Any erosion in group coverage is likely to be limited to low-wage workers currently offered insurance in smaller firms, who are prime pickings for moving to the exchanges. However, there are relatively few such workers. The only other vehicle would be conversion of full-time low-wage workers in larger firms to part-timers who are exempt from the employer mandate penalty,

but there are serious limits on a firm's ability to manage with part-time workers. And any erosion will be offset to a considerable extent by the expansion of employment-based cov-

onto the exchanges. If such reconfigurations occur, the erosion of employer-based insurance would increase significantly. And if this means that large numbers of low-wage workers

TABLE 1: ESTIMATED NUMBERS OF AMERICANS YOUNGER THAN 65 YEARS OF AGE, ACCORDING TO INSURANCE STATUS, INCOME, AND EMPLOYER SIZE, 2012.*

Insurance Status	Income 138-400% of the Federal Poverty Level	Income 138-350% of the Federal Poverty Level
All	98,739,165	84,483,590
Public insurance only	8,824,391	8,332,361
In firms with >=50 employees	1,888,627	1,737,043
Private insurance only	68,900,566	56,929,424
Employer-sponsored insurance	62,386,415	51,215,185
In firms with >=50 employees	55,942,112	45,672,517
Individual market	6,514,151	5,714,239
In firms with >=50 employees	3,236,450	2,918,676
Private and public insurance	5,811,337	5,078,155
Employer-sponsored insurance	4,876,367	4,210,647
In firms with >=50 employees	3,787,388	3,286,568
Individual market	934,971	867,508
In firms with >=50 employees	346,024	304,923
Uninsured	15,202,871	14,143,650
In firms with >=50 employees	7,745,201	7,225,688

* Data are from an analysis of the Current Population Survey, 2013 Annual Social and Economic Supplement.

erage to previously uninsured workers in medium and large firms, which are much less likely to send workers to the exchanges. In all, I estimate that only 15% of the workforce will be affected.

The long-term picture is murkier, and depends greatly on how creative workers and firms are in responding to the incentives of the ACA. Since low-wage workers are better off in the exchanges, where they are eligible for a relatively generous subsidy, one could imagine firms spinning off their low-wage workers into small, low-wage firms that would send workers

are spun out of less expensive and highly efficient employer-based group plans, then that would not be a good economic outcome.

My personal recommendation as an economist would be to make all low-wage workers eligible for the same subsidies, whether they acquire coverage on the exchanges or in group plans. That type of scenario would be reasonable and involve less distortions and would leave the future of employer-sponsored insurance looking much as it is today.



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Mark V. Pauly holds the position of Bendheim Professor in the Department of Health Care Management at the Wharton School of the University of Pennsylvania, where is a Professor of Health Care Management and Business Economics and Public Policy. Dr. Pauly is a former commissioner on the Physician Payment Review Commission and an active member of the Institute of Medicine. One of the nation’s leading health economists, Dr. Pauly has made significant contributions to the fields of medical economics and health insurance. His classic study on the economics of moral hazard was the first to point out how health insurance coverage may affect patients’ use of medical services. Subsequent work, both theoretical and empirical, has explored the effect of conventional insurance coverage on preventative care, on outpatient care, and on prescription drug use in managed care. In addition, he has explored the influences that determine whether

insurance coverage is available and, through several cost-effectiveness studies, the influence of medical care and health practices on health outcomes and cost. His work in health policy deals with the appropriate design for Medicare in a budget-constrained environment and the ways to reduce the number of uninsured through tax credits for public and private insurance. Dr. Pauly has served on the Institute of Medicine panels on improving the financing of vaccines and on public accountability for health insurers under Medicare. He also is a former member of the U.S. Department of Health and Human Services National Advisory Committee to the Agency for Healthcare Research and Quality.

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