THE COMMONWEALTH FUND

ISSUE BRIEF

EROSION OF EMPLOYER-SPONSORED HEALTH INSURANCE COVERAGE AND QUALITY

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Workers and their dependents are increasingly at risk of being uninsured, inadequately insured, or lacking in choices among health plans. Although employer-sponsored health insurance remains the foundation for coverage of working families, it has eroded steadily during much of the past decade, and all indicators point to further decline in the next century.

Reduced employer commitment to health benefits for workers reflects economic pressures to cut labor costs and compete in an international market, as well as the impact of international competition on the composition of U.S. jobs. The resulting economic pressures on workers—especially unskilled and low-wage workers—are severe. If employers do not offer health insurance coverage or pay a significant share of the premium, low-wage workers often cannot afford insurance and risk going without coverage.

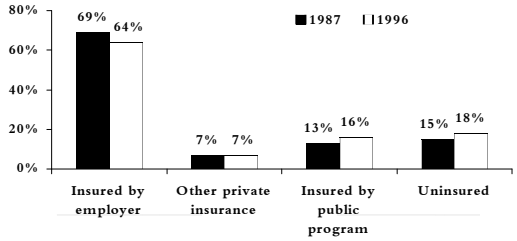
To a large extent, the erosion of employer-based insurance has been greeted with silence from public policymakers, despite the widespread concern expressed by working families. Little public attention has been paid to factors contributing to the decline in coverage, and implications for the future have been ignored. Also lacking has been public debate on potential strategies for reversing the downward trend.

The following essay examines the factors contributing to the erosion of coverage for working families and the range of approaches that could improve their coverage, quality of care, and choices among health insurance plans.

RANKS OF UNINSURED WORKERS INCREASING

Despite a robust economy and expansions of public coverage for children, the proportion of the under-age-65 population without insurance increased from 15 percent in 1987 to 18 percent in 1996. A total of 41 million people in this group were uninsured by 1996—10 million more than were uninsured a decade earlier.[1] The decline in employer-based coverage has resulted in 12 million fewer men, women, and children being covered by employer plans in 1996 than if coverage had been maintained at 1987 levels.

Trends in Insured and Uninsured
Under-Age-65 Population

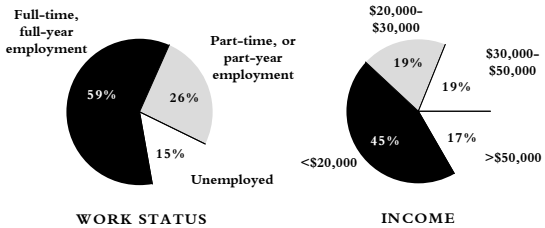


Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1997 Current Population Survey,Employee Benefit Research Institute, Issue Brief 192, December 1997.

The counts of those currently uninsured understate the problem—they do not include those who have had gaps in coverage over time or who have inadequate insurance. The *Kaiser/Commonwealth 1997 National Survey of Health Insurance* found that 13 percent of currently insured adults ages 18 to 64 had experienced a gap in coverage at some point during the past two years.[2] Among all adults under age 65, one-third, or 52 million women and men, were either uninsured (19%) or had a gap in coverage in the previous two years (13%).

The vast majority of the uninsured work and live on low wages. More than 80 percent of the uninsured are workers or dependents of workers. Typically, the family is uninsured despite full-time, year-round work efforts: three of five uninsured people live in families headed by such a worker. Families living on low or modest wages dominate the ranks of uninsured, with two-thirds having annual incomes of less than $30,000.

Most Uninsured People Live in Working Families and Have Low or Modest Incomes



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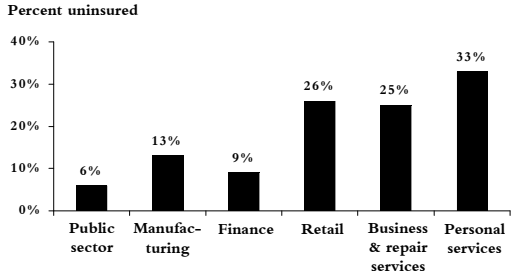
Fund-sponsored surveys and studies have found that several factors put working people at risk for lack of insurance: working in service industries or small firms; unstable, short-term employer-employee relationships; increased employee share of premium payments; and flexible benefit packages and stagnant wages that force families to choose between insurance coverage and other benefits. In addition, most workers lack a choice of health plans offered by employers, many lack continuity of coverage, and further erosion of coverage is likely.

Workers in Service Industries or Small Firms Are at High Risk

The nation's ongoing shifting mix of jobs and industries is a major factor contributing to the decline in employer-based coverage and the increase in uninsured workers and dependents. One of four or more workers in various service industries was uninsured in the most recent *Current Population Survey* by the U.S. Census Bureau, double or more the rate for those in manufacturing or public-sector jobs.

Uninsured Workers, by Industry



Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1997 Current Population Survey,Employee Benefit Research Institute, Issue Brief 192, December 1997.

Increased reliance on work contracted to self-employed workers and small employers, as well as a concentration of lower-wage jobs offered by small employers, has also contributed to the rising ranks of the uninsured. One-fourth of the self-employed and one-third of workers employed by small employers are uninsured. When these workers are covered by employer-based insurance, it is usually through their spouse who has a family plan. Only 26 percent of the self-employed or those working for firms with less than 10 employees have employer coverage in their own name. In contrast, two-thirds or more of those working for firms with 500 or more employees are covered through their own employer.

Unstable, Short-Term Employer-Employee Relationships Undermine Benefits

Shifts in employment relationships have further undermined the likelihood that workers will have employer-sponsored health plans. The most recent estimates suggest that 25 to 33 percent of current employees are working on a part-time, temporary, self-employed, contract, or seasonal basis.[3] Many part-time or temporary workers work full-time hours, but for multiple employers: 6 percent of working men and women hold multiple jobs.[4]

Such job arrangements typically do not offer health benefits: only 20 percent of part-time workers have employer-sponsored health plans in their own name, compared with 63 percent of full-time workers.[5] Temporary and seasonal workers rarely qualify for coverage even if working full-time shifts.

Employees' Share of Premium Costs and Deductibles on the Rise

Declines in the share of premiums paid by employers and increased cost-sharing of benefits have made coverage less affordable. From 1988 to 1996, the average employee premium share for a single-person plan offered by employers with less than 200 workers almost doubled from 12 to 22 percent. Premium shares for family coverage paid by employees jumped from 34 to 44 percent, and family deductibles nearly doubled.[6] These increases in health plan costs to working families far outpaced wage growth for lower-income workers during the same time period. Not surprisingly, recent studies find that fewer low-wage workers are participating in plans offered by their employers.[7]

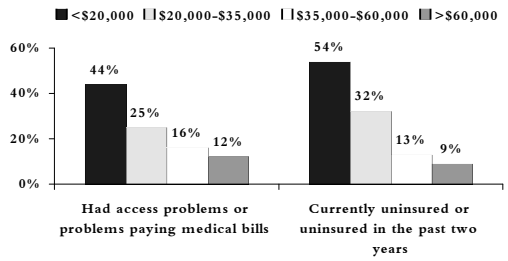
At today's premium costs, employers would need to pay a substantial share for workers with incomes at or near poverty to make coverage affordable. Nationally, the average annual premium for employer group coverage came to more than $5,000 for a family policy and $2,000 for a single-person policy in 1996. At these rates, a family of four earning poverty wages would have to pay 32 percent of their pre-tax income to buy coverage on their own. Even at 200 percent of poverty ($32,000 annually for a family of four), the premium would come to 13 percent of income.

Flexible Benefits and Stagnant Wages Make Affordability a Central Concern

Changes in the structure of employee benefit packages may further discourage enrollment by low- and moderate-wage families. When employers shift to flexible benefit packages with fixed contributions to cover an array of living expenses, families on tight budgets must choose between paying child care expenses, other family living expenses, and health benefits. Such arrangements provide financial incentives for families with no immediate health care needs to forgo relatively expensive family health insurance benefits to meet pressing basic living needs. Some employers have also started basing family premiums on family size, further discouraging dependent coverage.[8]

The decline in employer payments for health benefits and the shift to direct payments by workers and families has occurred during a time of relatively stagnant wage and salary growth for those employed

Low- and Moderate-Wage Families Face Access and Cost Problems, and Often Lack Insurance



The Kaiser/Commonwealth 1997 National Survey of Health Insurance.

in lower-wage jobs. Recent research has found that while the average income of high-wage families increased by 30 percent over the last two decades, low-wage families saw their incomes fall by more than 20 percent, and the salaries of middle-income families remained stagnant.[9] Fund-supported surveys have found that the lower the wage, the less likely the working family will be insured or have a choice of plans, and the more likely the family will face access and cost problems.

Most Workers Lack Choice Among Health Plans

Managed care plans enroll the vast majority of those covered by employer-sponsored plans, accounting for four of five of those employed by medium or large employers. Choosing a health plan increasingly dictates choice of physician network, hospitals, and specialists. As a result, having a choice of health plans influences workers' ability to find medical care that meets their specific needs.

Most workers, however, do not have a choice of employer-offered plans. Less than half (41 percent) of workers report that their employer offers more than one health plan. The lower the wage, the less likely that choice of plans, or any plan, will exist: less than one of four workers with incomes of $20,000 a year or less has a choice of health plans, and more than one-third (37 percent) are not offered a plan at all. In contrast, more than half of workers with family incomes above $60,000 have a choice of plans.[10]

Having a choice appears linked to the quality of health care and access to care. Among those with insurance, families with no choice of plans are more likely to report access problems and negative ratings of the quality of care they receive.[11] In addition, the link between lower satisfaction, access problems, and plan choice is likely to reflect the quality of health insurance coverage. Small employers are notably less likely to offer a choice than are firms with 500 or more employees. These employers are also more likely to offer plans with fewer benefits and higher deductibles and copayments. Lack of choice among health plans may thus be an indicator of insurance with inadequate financial protections and more restrictions on access to physicians and services.

Workers Face Unstable Coverage and Lack Continuity of Care

In this era of managed care, unstable coverage as well as gaps in insurance can undermine quality of care. To the extent that changing health plans means changing physicians and care arrangements, frequent changes in plans reduce continuity of care. Unless changes are voluntary and reflect patient and family preferences for care arrangements, unstable coverage is also likely to undermine trust in doctors and sources of care.

Fund-supported surveys indicate considerable instability of coverage.[12] One-third of all insured adults under age 65 reported being in their current health plan for less than two years. A significant majority reported that they had changed plans involuntarily as a result of their employer changing plans (21%), a change in jobs (34%), or a change in their eligibility for health benefits (14%).

Low-income adults and those covered by Medicaid are particularly at risk for unstable coverage. Overall, half of insured adults with incomes under $20,000 changed plans within the past two years. Among low-income women insured by Medicaid, 28 percent have been covered for less than one year. Nearly two-thirds of low-income women leaving Medicaid become uninsured.[13]

Continued Erosion of Employer-Based Insurance Likely

Absent new public policy initiatives, current trends indicate further deterioration in affordability of coverage for low- and modest-wage families, and rising concern about health plan choices, quality of care, and adequacy of benefits. Increased cost-sharing arrangements and restricted choices are likely to make coverage less tenable for low-wage workers, and forecasts for continued growth of shorter-term, more contingent job arrangements are likely to mean that fewer workers are eligible for benefits at all.

STRATEGIES AND OPTIONS FOR IMPROVING COVERAGE AND QUALITY OF PLAN CHOICES

A range of approaches to improving coverage and quality of plan choices hold promise for making incremental progress.

- **Expansion of public programs to low-wage adults.** Building on the momentum of expansions to children, new state programs could be extended incrementally to adults in working families. Options for early retirees to buy into Medicare could expand access to coverage for older adults.

- **Tax policies.** Businesses may deduct the full cost of health premiums for workers, and self-employed individuals may deduct partial costs. Permitting self-employed and unemployed individuals to

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deduct full premiums would make current tax subsidies for health insurance more equitable. In addition, tax credits could encourage low-wage employers to provide affordable coverage.

- **Pooling and structural options for small employers and self-employed workers.** Small employers lack larger employers' ability to pool risk, purchase at reduced group rates, and contain administrative overhead. Allowing small employers and self-employed workers to buy into purchasing groups, large public-sector benefit programs, or publicly supported insurance programs could make their coverage more affordable and increase their range of plan choices.

- **Integration of private and public programs.** A few states are experimenting with ways to integrate public programs or subsidies with existing employer-based coverage. Options include credits and vouchers to pay worker premium shares for plans offered through employers.

- **Existing regulatory tools or work-related programs.** The Employee Retirement Income Security Act (ERISA) gives the federal government exclusive oversight over employer-provided employee benefits—including health insurance—and preempts states from influencing the quality or scope of benefits. The law offers a potential base on which to improve the quality of health insurance benefits.

- **Revenue options.** Tax policy could also be explored for new sources of revenue to finance coverage expansions or subsidized coverage of specified groups of working families who are most at risk of being uninsured. A portion of the Earned Income Tax Credit could be earmarked for partial premium contributions for low-income working families to purchase Medicaid or other coverage, and existing direct subsidies for health care to the uninsured—such as disproportionate share hospital payments under Medicare and Medicaid—could be used to finance expanded coverage.

SUMMARY

The pervasive feeling of insecurity and concerns about the quality of health insurance as well as continuity of coverage is renewing a demand for change. Congress and state legislators are under pressure from voters to act and set standards for managed care plans and health insurance.

The Commonwealth Fund, through the creation of a new Task Force on Health Insurance for Working Families, hopes to create a greater awareness of the factors underlying erosion of employer-sponsored health insurance. Over a period of five years, the Task Force will analyze the decline of coverage and quality of health insurance for working families; examine the affordability and extent of choices of employer-sponsored health insurance; and design and assess alternative approaches to improving coverage and plan choices. Comprising public- and private-sector leaders, the Task Force will provide a forum for debate and a vehicle for an independent, national exploration of incremental approaches toward improving coverage.

NOTES

[1] Paul Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1997 Current Population Survey,* Employee Benefit Research Institute, Issue Brief 192, December 1997.

[2] Cathy Schoen, Cathy Hoffman, Diane Rowland, Karen Davis, and Drew Altman, *Working Families at Risk: Findings of The Kaiser/Commonwealth 1997 National Survey of Health Insurance,* The Commonwealth Fund, April 1998.

[3] Computed based on data in Thomas Navolone, Jonathan Veum, and Julie Yates, "Measuring Job Security," *Monthly Labor Review* 120 (June 1997):26–33.

[4] John F. Stinson, Jr., "New Data on Multiple Jobholding," *Monthly Labor Review* 120 (March 1997):3–8.

[5] Paul Fronstin, *Trends in Health Insurance Coverage,* Employee Benefit Research Institute, Issue Brief 185, May 1997.

[6] Jon Gabel, Kelly Hunt, and Jean Kim, *The Financial Burden of Self-Paid Health Insurance on the Poor and Near-Poor,* The Commonwealth Fund, April 1998.

[7] Philip F. Cooper and Barbara Steinberg Schone, "More Offers, Fewer Takers for Employer-Based Health Insurance: 1987 and 1996," *Health Affairs* 16 (November/December 1997):142–149.

[8] U.S. General Accounting Office, *Employment-Based Health Insurance: Cost Increases and Family Coverage Decreases,* GAO-HEHS (97–71), February 24, 1997.

[9] Kathryn Larin and Elizabeth McNichol, *Pulling Apart: A State-by-State Analysis of Income Trends,* report to The Center on Budget and Policy Priorities, December 1997.

[10] Cathy Schoen et al., 1998.

[11] Claudia Schur and Mark Berk, "Does Choice of Health Plan Matter? Implications for Access and Satisfaction," draft report to The Commonwealth Fund, January 1998; and Karen Davis, Karen Scott Collins, Cathy Schoen, and Cynthia Morris, "Choice Matters: Enrollees' Views of Their Health Plans," *Health Affairs* 14 (Summer 1995):99–112.

[12] Karen Davis and Cathy Schoen, "Assuring Quality, Information, and Choice in Managed Care," *Inquiry* 35(Summer 1998):104–114.

[13] Pamela Farley Short, *Medicaid's Role in Insuring Low-Income Women,* The Commonwealth Fund, May 1996.

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