



The Governor Scott M. Matheson Center for Health Care Studies Health Policy Report

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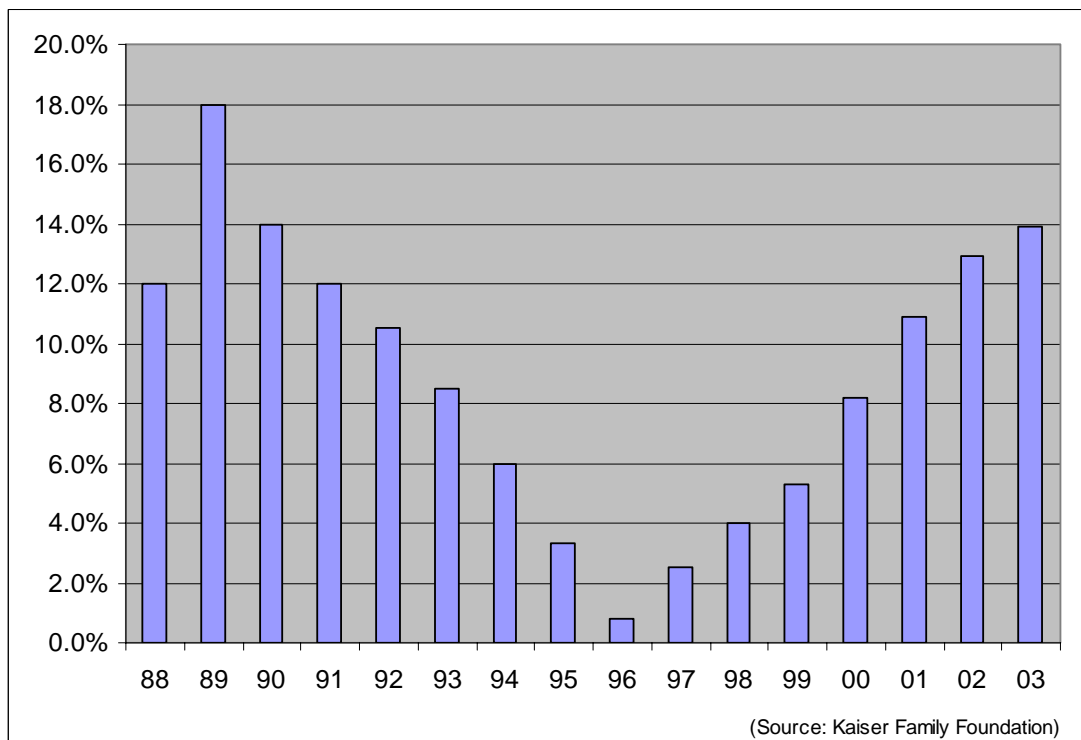
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Health Care Insurance

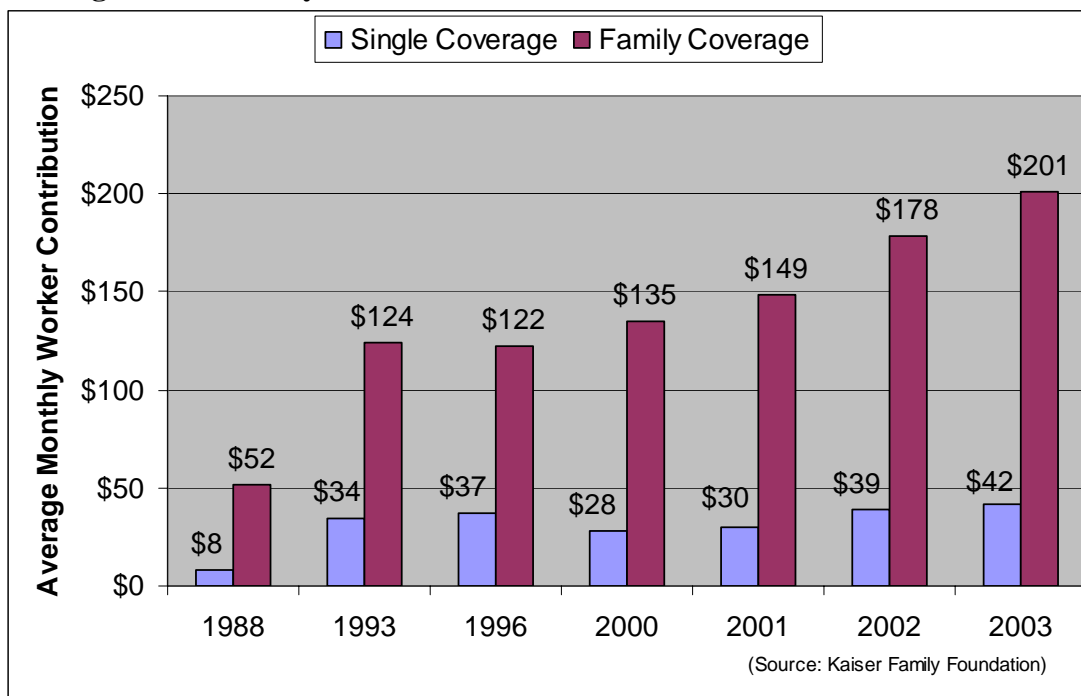
Health insurance premiums continue to rise at a significant pace. Between 2002 and 2003, the average premium for employer sponsored health insurance increased 13.9%. This increase continued the upward trend in annual premium increases that began in 1997. The average annual increase for each year from 1998 through 2003 is shown in Figure 1.

Figure 1. Average Annual Increase in Health Insurance Premiums



General economic inflation between 1988 and 2003 ranged approximately between 2% and 4%. Thus, except in the years 1995, 1996 and 1997, health insurance premium inflation outpaced general economic inflation, and usually by a very significant margin. In 2003, the average annual premium for employer sponsored health insurance was \$3,383 for single coverage and \$9,068 for family coverage. Payment for employer sponsored health insurance comes from two sources: 1) worker contribution (after tax, pay check deductions) and, 2) employer contribution (a non-taxable benefit that ultimately also comes out of the worker's pocket). The average monthly worker contribution for single coverage plans and for family coverage plans for selected years between 1988 and 2003 are shown in Figure 2.

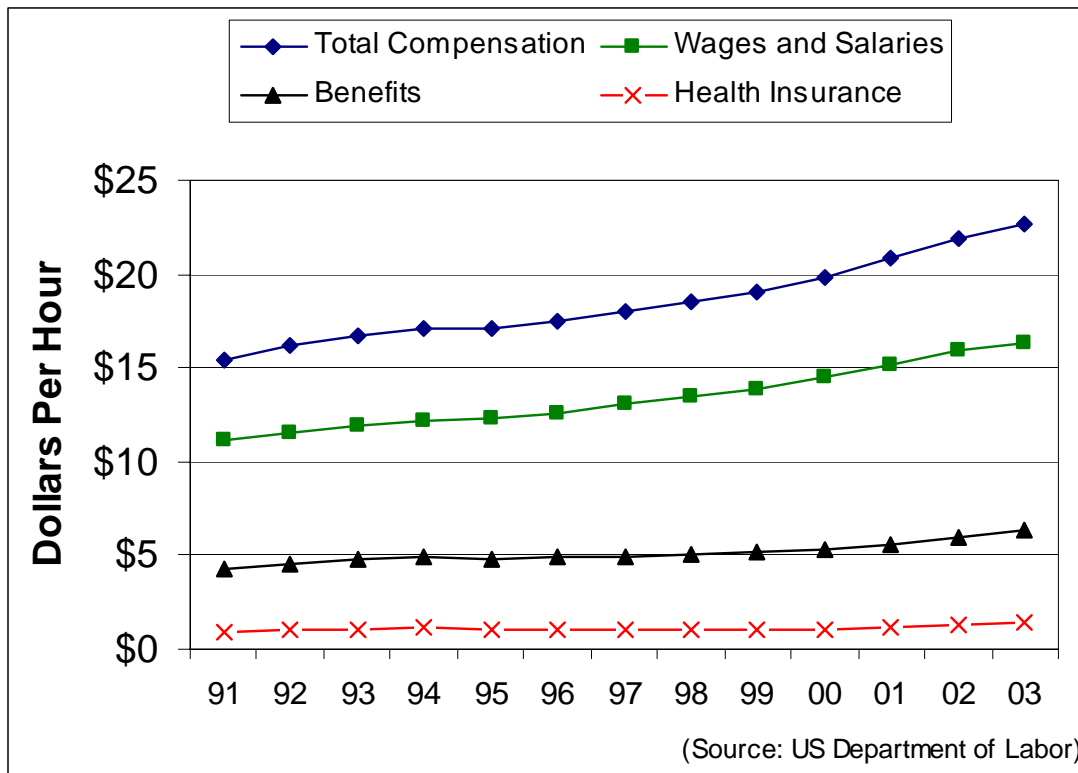
Figure 2. Monthly Worker Contribution to Health Insurance Premium



In 2003, the average worker paid 14% of the premium for single coverage with after tax dollars and 26% of the premium for family coverage with after tax dollars.

The employer portion of the health insurance premium is the largest portion for both single and family coverage. In 2003 the employer paid an average of \$2,879 for single coverage and \$6,656 for family coverage. It is, however, very important to keep the price of health insurance premiums in perspective. Health insurance is a relatively small portion of a workers total compensation (see Figure 3). In the third quarter of 2003, the average hourly total compensation for private sector workers in the US was \$22.61, wages and salary \$16.31, total benefits \$6.30, and health care insurance \$1.45.

Figure 3. Average Hourly Compensation of Private Sector Workers



The total cost of an employee to an employer is the sum of total compensation plus payroll taxes. Payroll taxes are the employer portion of Social Security and Medicare taxes, unemployment taxes, and worker's compensation (these taxes amount to approximately \$3,000 per year or about \$1.49 per hour for the average worker). Thus, the average employer portion of

the health care insurance premium in 2003 was approximately 6% of the total employee cost. This fact buffers the impact of increasing health insurance premiums on the total cost of an employee to an employer. A 14% increase in the employer's share of a worker's health insurance premium translates to less than 1% increase in total employee cost. This is not a trivial cost to an employer. However, the employer generally does not take a hit to the bottom line because the yearly wage increase (a workers pay raise) is adjusted to account for the increase in health insurance premiums. Except in unusual circumstances the cost of health insurance is born by the worker in the form of reduced wages.

Employers may use various strategies to moderate the impact of increasing health insurance premiums on total employee cost. The five most common strategies are: 1) shop around for a new (less expensive) insurance provider; 2) opt for an insurance product that has fewer benefits; 3) increase the employee after-tax contribution to the premium; 4) increase employee cost sharing at the time of service; and, 5) drop health insurance coverage altogether.

Employers use all five strategies. In 2003, 62% of employers reported that they shopped for an alternative insurance provider or plan and 33% actually changed their provider or plan (reported by the Kaiser Family Foundation). Employee contribution, at least for family coverage, has also increased over time (see Figure 2). However, the most common strategy to decrease health insurance costs has been to increase employee cost sharing at the time of service. Increased cost sharing takes the form of increased deductibles, co-insurance or co-payments for physician visits, for hospitalizations, and particularly for drugs.

Sadly, some firms have not been able to adapt to increased health insurance premiums and have opted to drop health insurance coverage as a benefit. An employer will drop coverage when workers cannot be hired at a sufficiently low wage that the employer can also afford to

contribute money to health insurance. Payroll taxes are mandatory, so an employer can only adjust total compensation (wages plus benefits) to balance the books. Wages are the most visible part of compensation to prospective employees and they are also regulated by minimum wage laws. If an employer is to stay in business she must offer sufficient compensation to attract workers and comply with the law, yet not allow worker compensation to exceed available resources. Health insurance is jettisoned in favor of wages in order to balance total compensation against available resources. Low wage jobs in industries with a very thin margin tend to be at greatest risk for losing health insurance coverage. In 2003, 66% of all firms offered health insurance coverage (basically unchanged from 2002, but down from a pre-recession high of 69% in 2000).

It should not be ignored that firms can offer health insurance but make it impossible for low wage workers to obtain by employing the worker as a part time employee, or by making the after-tax worker contribution to health insurance sufficiently high that it is out of reach for the low wage workers. These two strategies, while morally distasteful, achieve the same goal for the employer as the strategy of not offering health insurance at all.

Too many people in the U.S. are without health insurance. Numerical estimates vary, but a working number is 40 to 43 million (about 15% of the U.S. population). While 15% may not seem very large, it is greater than the number of seniors in the U.S. (about 12%). Counting the number of uninsured is difficult. Some are uninsured only briefly during the year, some are uninsured for most of the year while they are in between jobs, and yet others are chronically uninsured.

It is significant that 80% of those who are poor and without insurance are employed and either do not have the opportunity to obtain insurance at work (because it is not offered or

because they do not qualify) or else do not accept the insurance offered by their employer (presumably because they can't afford the employee contribution).

Most uninsured individuals receive some medical care during the course of the year. The sources of payment for that care are quite variable. Some are insured for part of the year and so may actually have third-party reimbursement for much of their health care. Others pay out of pocket for care, while many rely on charity. When taking all sources of payment for care into account, the uninsured individual receives only about 50% of the amount of care received by the privately insured individual. It is estimated that physicians contribute between \$5 billion and \$10 billion of uncompensated care annually. (See Hadley and Holahan: How Much Medical Care Do The Uninsured Use, And Who Pays For It? *Health Affairs*, 2003)

When the Kaiser Family Foundation asked employers what they plan do with health insurance in 2004, their responses were similar to their responses in 2003. A significant number plan to increase worker contributions to the health insurance premium but more employers plan to increase cost sharing at the point of service. Very few report that they plan to reduce eligibility or drop coverage. However, employer interest in alternative health benefit design is increasing indicating that we may see novel types of insurance plans in the future. Unfortunately, we may also see an erosion of employer based insurance.

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