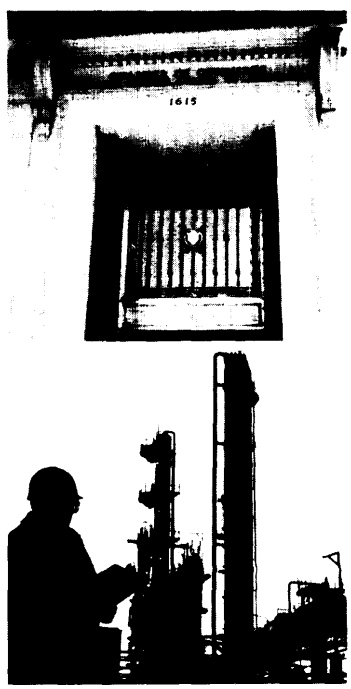
Impacts on Employers 4

INTRODUCTION

Health insurance in the United States is provided in large part through groups sponsored by employers. Employment-based insurance covered the majority (64 percent) of insured persons under age 65 in the United States in 1990 (89). Thus, employment-based coverage is the source of a considerable portion of national health care expenditures in the United States (34 percent in 1991) (19). Yet most of the uninsured people in the United States are employed, either full-or part-time (89).

Many of the uninsured workers are employed in small businesses (usually defined in reform proposals as no more than 100 employees, but sometimes defined as 25 or fewer). Due primarily to higher administrative charges and the increased underwriting risk to insurers, insurance coverage expenditures for small groups tend to be even higher than those for large groups.[1] To the extent that these factors increase small employers' costs beyond what they deem as affordable, they may not offer to sponsor insurance at all.

The problem for groups sponsored by large employers (usually defined as having more than 100 employees but sometimes as having more than 1,000) is somewhat different, insofar as they



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[1] Definitions of "large" versus "small" employers vary considerably in proposed legislation and illustrative reform proposals. Since employer size is an issue with respect to the application of certain provisions of some reform proposals, the specific definition used in a proposal is generally quite important (e.g., an employer mandate which includes all employers will have a different impact on employers, overall and by size, than one which excludes or subsidizes employers based on size).

are better able to control their total health plan costs.[2] Nevertheless, large employers have expressed concern with the issue of increasing health care costs (e.g., in terms of their groups' share of the financing burden and the impact of financing on their business or budget) (See also chapter 7).

While analyses of the impact of the various reform approaches on employers, both large and small, make many assumptions to project potential effects, the key ones pertain to:

- the extent to which the particular approach or proposal requires employers to finance health care coverage, either directly (e.g., to contribute to employees' health insurance premiums) or indirectly (e.g., to finance coverage through taxes);
- employer behavior, when employers are presented with choices between direct (e.g., to purchase private insurance for employees) and indirect (e.g., to pay into a public plan through which employees secure coverage) coverage; and
- the employers to whom any mandate applies.

It is important to note here that the idea that health care costs have an impact on a business's (or other employer's) bottom line is antithetical to economic theories of total compensation costs (69). According to economic theory, "employer-purchased" health insurance is actually part of the employee's total compensation package. That is, the employee trades off wages in exchange for the noncash benefit of health insurance. Thus, any costs or savings ''to the employer' for health insurance (e.g., the employer's "share" of the health insurance premium) is in reality a cost or savings to the employee.[3] Employers (i.e., management), employees (e.g., organized labor) and policy analysts rarely speak of health insurance costs in these terms, however. This report also uses the language of impacts on employers although it is important to note that the actual impacts may be broader.

IMPACTS OF SINGLE PAYER APPROACHES

Approaches that render government the sole payer for services would remove employers from direct involvement in the funding of health care. Businesses could, however, continue to fund health care coverage indirectly through broad-based Federal and State taxes. The impact of these taxes on employers would depend upon the specific tax system devised to implement the plan (55). For example, while employers' corporate income or payroll taxes may increase, if such increases are less than their current health care coverage payments, they will experience a net gain.

As summarized in table 3 in chapter 1, only one group of analysts has projected what the impact of a Single Payer system on employers might be. This one analysis estimated that a Canadian-style system would result in pretax *savings*[4] to employers in 1991 ranging from $76.0 to $136.0 billion (43). Estimates of cumulative pretax *savings* to this group ranged from $2.2 to $3.0 trillion in current dollars from 1991 through the year 2000 (43) (table 3). Behind the range in these estimates

[2] Large employers' health benefit plans tend to be larger in size, in terms of numbers of enrollees and, therefore, able to take advantage of many economies of scale to control administrative costs and to spread the risk. Furthermore, many large employers are self-funded (self-insured), which also allows them to self-administer their benefit plans or to contract for the administrative services portion of their plan with a private insurer or other entity. Whether self-administered or contracting for administrative services only, a self-funded insurer can have greater and/or more direct control over its health benefit plans' expenses.

[3] Employees without health insurance, under this theory, are or should be receiving alternative compensation. Thus, it is really the employees of small employers who are incurring the costs of higher health insurance premiums resulting from being part of a small group or being affected by the nonaffordability of insurance to the small group. The issue of total compensation is discussed further in ch. 5.

[4] Pretax savings are defined as savings before employers' liability for increased income taxes, due on increased income resulting from a decrease in deductible health care expenditures, has been met (43).

were the authors' assumptions about the degree to which the system would control the rate of growth in health care spending; that is, health care spending was capped at its current share of GDP after including the cost of covering uninsured persons (lower savings estimates), or health care spending was assumed to not exceed 8.7 percent of GDP (higher savings estimates). Thus, the greater the savings to the Nation overall, the greater would be the likely savings to employers in terms of taxes required to finance the system.

IMPACTS OF PLAY-OR-PAY APPROACHES

A major issue in the context of a proposal to mandate that an employer offer and contribute toward employees' health insurance is: Would such a mandate apply to all employers and employees and, if so, would it do so uniformly? If not, what are the criteria for not applying the mandate or for varying its application? Underlying the relevant policy decision is the fact that if a scheme does not require all employers to participate, the intent to achieve universal coverage primarily through an employment-based health insurance coverage system is subverted. A parallel dilemma is that if the system does not require all employers to participate what, if any, backup system is appropriate?

The impact of Play-or-Pay proposals on specific employers could vary considerably by the number of workers employed. Currently, larger firms are more likely to offer health insurance (38) and, therefore, are more likely to experience net savings due to shifts in the covered population and potential reductions in cost-shifting from uncompensated care and Medicaid (75). Smaller fins, which are less likely to offer health insurance, are more likely to experience a net increase in costs under this type of system. The impact of such an approach on both large and small employers will vary according to:

- the size of the employer to which the mandate applies;
- the length and design of any phase-in period;
- the payroll tax levied on employers (including provisions for its adjustment);
- the content of the benefit package; and
- any requirements regarding payment for dependent coverage (75).

Also relevant to employers' costs is any impact of the approach on the rate of growth in health care costs (see chapter 2 in this report).

All quantitative estimates of the impact of the Play-or-Pay approach projected *increased spending* by employers (37,75,100), ranging from $14.7 billion in 1990 (75) to $44.4 billion in 1989 (100) (table 3 in chapter 1). The estimates at the extremes assumed, respectively, a 7- and 9-percent payroll tax rate but there were also other differences in assumptions (See appendix B).

IMPACTS OF APPROACHES EMPLOYING INDIVIDUAL VOUCHERS OR TAX CREDITS

The impact on employers of reforms that focus on providing individuals with tax incentives depends, at least in part, upon whether an approach:

- continues to rely on employment-based insurance;
- preserves or modifies the current tax benefit for employment-based health insurance coverage;
- requires that individuals purchase insurance; and
- achieves a decrease in both health insurance premiums and health care spending.

As summarized in table 3 in chapter 1, estimates of the impact of Individual Vouchers or Tax Credits approaches ranged from *savings* to employers of $2.0 billion in 1994 under the Bush plan (65) to *increased spending* of $7.8 billion in 1991 under the Heritage Foundation plan (35).

Silow-Carroll's analysis of the Bush Administration plan projected cumulative savings to employers for the period from 1994 through 2003 (65). Depending upon the model used regarding

the distribution of savings to employees,[5] as well as on other factors such as the rate of growth in health care spending, the estimates of the cumulative impact of the Bush Administration plan ranged, in 1994 aftertax dollars, from *savings* of $4.0 billion to *savings* of $84.0 billion for 1994 through 2003 (65).

The Heritage Foundation plan assumed that employers would no longer make premium contributions on behalf of their employees but would convert the value of the employer share of any premium to wages, in at least the transition year. The estimated increase in employers' spending under the Heritage Foundation plan was attributed to increased OASDI (Old Age, Survivors and Disability Insurance) and HI (Hospital Insurance Trust Fund) payroll taxes less employers' reduced corporate income taxes (35). Since estimates were provided for the frost year of the plan only, it is not possible to tell what the long-term impact of the Heritage Foundation plan on employers would potentially be.

The estimates of the impact on employers of the Bush Administration plan depended in large part upon the author's assumptions about the plan's impact on the rate of growth in health care spending. Thus, the study's ''Pessimistic Scenario, which assumed that 'much of the savings in the Bush plan are one-time in nature, and that after these efficiencies are achieved, the cost curve returns to its present course, ' estimated no initial but some cumulative savings (65). The "Optimistic Scenario" assumed that in the first 5 years, "the plan's cost containment features are relatively successful in both reducing current expenditures. . and slowing down the rate of spending growth' (65); therefore, the analysis projected some initial as well as greater cumulative savings under this scenario. The study noted, however, that [a]s a result of the incentive nature of the reforms, assumptions about the success of access expansion and cost containment under the Bush plan are more speculative than corresponding assumptions used in alternative proposals" (65), leaving questions about the long-term impact on employers (as well as on other areas of the economy) of the Bush Administration proposal.

IMPACTS OF MANAGED COMPETITION APPROACHES

In-depth studies of the impact of Managed Competition on employers were not available for this report. However, some Managed Competition approaches would use a Play-or-Pay approach to help achieve universal coverage. To the extent that this feature operates as suggested in studies of Play-or-Pay approaches to reform, employer health care spending would likely increase. However, there may be other changes in the system, for example, more extensive use of managed care, which may reduce such increased costs.

In a recent analysis of a Managed Competition approach, Long and Rodgers estimated that business private insurance costs would *increase* by *$8.0* billion in 1993 (40) (table 3 in chapter 1). This estimate, based on a draft of the analysis by Sheils and his colleagues of a Managed Competition proposal (41), was for a plan incorporating an employer mandate with a 7 percent cap on employers' costs, and assumed savings from Managed Competition of 8 percent based upon the experience of group-model health maintenance organizations or administrative savings. While Sheils and colleagues' analysis of a like plan did not estimate the impact on employers of Managed Competition, it assumed a 2 percent savings from Managed Competition based upon the experience of all types of health maintenance organizations (63), which would likely lead to a greater increase in business's private insurance costs.

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5 Employers are assumed to distribute 80 or 50 percent of savings to labor, respectively (65).

SUMMARY

In summary, the impact on employers of the competing approaches to health care reform rests on the extent to which the system selected requires employers to contribute toward health care coverage and the means by which employers contribute (e.g., taxes versus purchase of insurance coverage on behalf of employees). Not surprisingly, approaches that require employers to offer and support coverage for their employees have been estimated to cost employers more than would government-financed or individually-financed approaches (table 3 in chapter 1). However, vastly different analytic models' assumptions have been applied across approaches (table 3) and it remains unclear who would eventually pay any costs or save money. Furthermore, control of the rate of growth in health care spending will also affect employers' share of health care spending.