National Center for Policy Analysis

BRIEF ANALYSIS
No. 344
For immediate release:
Friday, December 8, 2000

Myths about Employer-Sponsored Health Insurance

By Greg Scandlen

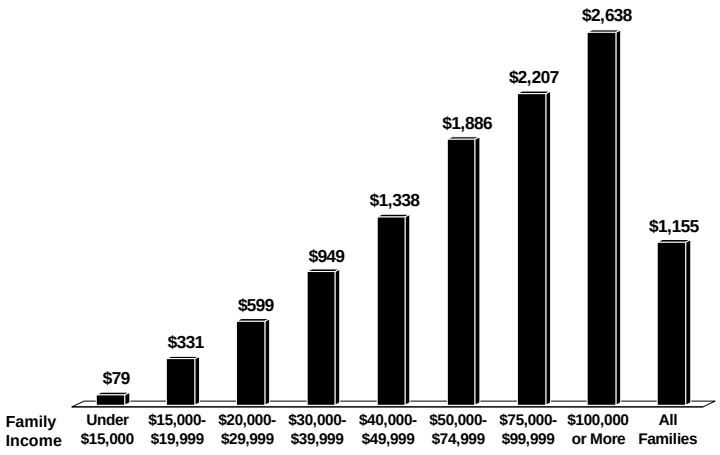
For more than 50 years, America has relied on employers as the primary source of health insurance coverage. For the most part, this has been a successful approach, providing coverage in 1998 to 155 million people, compared to only 15.5 million who purchase their own coverage.

People receiving employer-based health insurance enjoy an enormous tax advantage. The value is free of all state and federal income and payroll taxes.

- This tax advantage is worth about $141 billion in lost state and federal revenue in 2000, according to the Lewin Group.
- This is based on a total cost for employer coverage of $355 billion, amounting to a subsidy of 40 percent of the cost of coverage.

People who buy their own insurance get no tax break unless their medical costs exceed 7.5 percent of their adjusted gross income. Even then they get only a simple deduction and must itemize on their tax return. Importantly, as the figure shows, the exclusion for employer-based insurance is extremely regressive, providing far more benefit to people of higher incomes than to people of lower incomes.

Average Tax Subsidy for Families



Includes subsidy from the income tax exclusion, the Social Security income tax exclusion and the health expenses deduction.

Source: Lewin Group estimates.

With a subsidy of this magnitude, it is small wonder that employer-sponsored coverage is popular. Many people argue that employer coverage has other natural advantages as well. However, these supposed advantages are often myths, or at best overstated.

Myth No. 1: Employer groups make good risk pools. Employers do not in fact make particularly good risk pools, if a risk pool means a large number of people of diverse health care needs who can share the cost of occasional large claims. Very few employers are big enough to manage risk without purchasing reinsurance. Also, workers in a single company tend to be more like one another than like the general population. For one thing, they are able to work. For another, they tend to be from a single geographic area. There are clear gender and ethnic divisions at most work sites — construction workers and print shop employees tend to be male, elementary school teachers and data entry clerks female. The very proximity of the work site means that contagious diseases or environmental hazards easily can affect the entire group. Finally, the nature of the workplace usually means that older members remain in the group for many years while younger members come and go. A large national or regional insurance company makes for a far better risk pool than almost any employer.

Myth No. 2: Employers are effective agents for their workers. Although there are some notable exceptions, employers generally are poor at helping workers navigate the health care financing and delivery system. Very few workers are comfortable in confiding their true health care needs and concerns to their employers. If a worker needs mental health services or has a drug addicted spouse, or a daughter who wants an abortion, or

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a son with AIDS, the employer is close to the last person an employee would confide in. Employers offer no confidentiality protection like that of doctors, attorneys or ministers. And employers are not particularly knowledgeable about either health care financing or medical care services.

Myth No. 3: Employer-based coverage is administratively efficient. Here there is some truth, but it is often overstated. It is true that loss ratios (the percentage of premium paid out in claims) are lower for small employers than for large ones, and lower still for individuals. But a substantial part of this is because larger employers absorb much of the administrative cost that insurers must perform for individuals and small groups. Services such as distributing plan material, answering worker questions, tracking enrollment and collecting premiums are still rendered and paid for, but they show up in the large employer's overhead instead of as part of premium. The one area that makes a big difference is marketing expense. Having a broker explain the product to a single decision maker for 1,000 workers is far more efficient than having the same person explain the product to each of 1,000 individuals. But the prospect of Internet marketing and enrollment or non-employment groups could erode this advantage considerably.

Myth No. 4: Employers allocate costs fairly among workers. It is often argued that, while an employer may be experience-rated, the workers themselves are community-rated within the group. So, a high-risk 50-year-old man pays the same premium as a low-risk 25-year-old. There are two problems with the argument. First, it may not be a good thing, and second, it may be less true than it appears.

Is it fair to treat 50-year-old Fred the same as 25-year-old Sam? Very likely Fred will be making more money than Sam because he is more experienced and has more seniority. But even if that is not the case, Fred may value the coverage more highly than Sam does and be willing to pay more for it. If that is true, we should expect Sam to opt out of the coverage far more frequently than Fred does. And that is exactly what happens. Only 28.6 percent of 25-year-olds have employment-based coverage in their own names, compared to 56.1 percent of 50-year-olds. So, the practice of community rating within a group may contribute to a large number of younger people with no insurance coverage.

Moreover, it is not true that all workers are treated the same. Workers with dependents, for instance, usually receive far more in nominal benefits than do single workers.

Finally, there is at least some evidence that higher-risk workers actually do pay more for their coverage because employers pay them less in wages to offset the added cost of coverage.

Myth No. 5: Employer coverage is cheaper than individual coverage. But is that really true? As we've seen above, some of the difference may be due to marketing costs — which can be reduced through use of the Internet. Some is also due to employers' absorption of administrative costs. But there is a far more profound cause for cost differences. Because of the 40 percent subsidy available exclusively to employer-based coverage, anyone who can possibly obtain workplace coverage will do so, leaving only those who cannot in the individual market. Who are these people? They are often retired or semiretired, or too sick to work, or incapable of holding a job, or employed in seasonal or high-risk jobs. They may come in and out of the insurance market as they can afford it. Insurers in the individual market have huge challenges in retention and premium collection. People are much older, sicker and poorer than those in the employer-group market.

Conclusion. It is no wonder that today's individual insurance market is more expensive than today's employer-group market. But those relative differences would likely quickly disappear if large numbers of the stable and subsidized workforce entered the individual insurance market.

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