Testimony to the House Committee on Education and the Workforce on behalf of the Employee Benefit Research Institute

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Committee on Education and the Workforce
Subcommittee on Health, Employment, Labor, and Pensions

ERISA's 50th Anniversary: The Value of Employer-Sponsored Health Benefits

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Chairman Good, Ranking Member DeSaulnier, and Members of the subcommittee, I am Paul Fronstin, Director of Health Benefits Research at the Employee Benefit Research Institute (EBRI). I am pleased to appear before you today to testify on ERISA's 50th Anniversary: The Value of Employer-Sponsored Health Benefits. Established in 1978, EBRI is committed exclusively to data dissemination, policy research, and education on financial security and employee benefits. Consistent with our mission, EBRI does not lobby or advocate specific policy recommendations: The mission is to provide objective and reliable research and information. All of EBRI's research is available on the internet at www.ebri.org.

Employers' commitment to worker health established its roots many years ago. Early examples of employment-based health programs include the mining, lumbering, and railroad industries during the late 1800s (Institute of Medicine, 1993). Employers in these industries provided company doctors funded by deductions from workers' wages. Employers had a practical interest in providing health services to injured or ill workers, who often worked in remote geographic regions.

It was during World War II that employers began to offer more formal health coverage. Because the National War Labor Board (NWLB) froze wages, employers sought ways to get around the wage controls to attract scarce workers (Helms, 2008). In 1943, the NWLB ruled that employer contributions to insurance did not count as wages and thus did not increase taxable income, and they were not subject to the wage freeze. As a result, health insurance became an attractive means to recruit and retain workers. Employers began to offer health coverage to their workers to be competitive in the labor market, and the number of persons with employment-based health coverage started to increase. By the end of the war, health insurance coverage in the United States had tripled (Weir, Orloff, and Skopol, 1988).

It has also been suggested that the tax-preferred status of employment-based health coverage led to the rise in its prevalence and comprehensiveness (Gabel, 1999) and that the tax-exempt status of health coverage has encouraged employers to offer it and to provide more comprehensive coverage than they otherwise would have (Sheils and Haught, 2004).

Employers today offer health coverage because of their belief that offering it has a positive impact on the overall success of the business. And it can be argued that the Employee Retirement Income Security Act of 1974's (ERISA's) pre-emption of state law has created an environment of national uniform standards for employee benefit plans, thus giving employers the regulatory means to continue to offer health benefits as they do today.

There were questions as to whether employers had reached a tipping point with health benefits in 2007 (Fronstin, 2007). At the time, there were numerous references to the "death" of employment-based health benefits. Not long after, the Patient Protection and Affordable Care Act of 2010 (ACA) was passed, and similar debate ensued on whether employers would stop offering coverage. There were also contrary views at the time.

In this testimony, I examine trends in the availability of employment-based health coverage. I also examine employer sponsorship of coverage and employee eligibility for coverage, as well as other questions.

Employment-Based Health Benefits System Most Common Source of Health Coverage

There is no comprehensive dataset on employment-based health benefits that allows us to go back to the days around the passage of ERISA. However, two data sources allow us to track one data point — the percentage of people under age 65 (the non-Medicare population) going back to 1970. The percentage of the nonelderly population with employment-based health benefits was at or near 70 percent from 1970 to 1989 (Figure 1). Between 1989 and 2007, it varied between 68 percent and 62 percent. Since 2007, it has varied between 62 percent and 58 percent, and it was 61 percent in 2022.

The declines in coverage that occurred in the 1990s and early 2000s coincided with relatively high increases in health insurance premiums, though there were years, such as 1997–2000, when the correlation was far from perfect.

The more recent stability in premiums coincided with stability in the percentage of the nonelderly population with employment-based health coverage. In 2022, employment-based health coverage continued to be the most common source of health coverage, whether examining the entire population (55 percent covered) or the population under age 65 (61 percent covered) (Figure 2). Among the population under age 65, 21 percent had Medicaid, while 8 percent had private, non-group coverage, which includes marketplace coverage.

Employer Sponsorship of Health Benefits

When examining the period of 1996–2023, the percentage of employers offering health benefits was at a near record low in 2023, with less than one-half of employers offering health benefits at that point (Figure 3). However, it is important to put this number in context. During the same period, 2000 was the year with the greatest percentage of employers offering coverage — 59 percent. And the percentage has ebbed and flowed over time.

The overall percentage of employers offering coverage is heavily influenced by the fact that small employers are in large part responsible for the decline in coverage. Most employers in the United States are small, while most employees work in large firms (Figure 4).

The diminishing percentage of employers offering health coverage has been limited to small employers. Between 1996 and 2023, among employers with fewer than 10 employees, it decreased from 34.2 percent to 22.5 percent. It decreased from 64.9 percent to 51.8 percent among employers with 10–24 employees, and it decreased from 80.8 percent to 76.7 percent among employers with 25–99 employees (Figure 5). In contrast, when we look at larger employers, we find that the percentage with 100–999 employees offering health benefits

increased from 92.7 percent to 95.6 percent. Similarly, the percentage of employers with 1,000 or more employees offering health benefits increased from 96.7 percent to 97.6 percent.

Worker Eligibility for Health Benefits

Despite the overall decline in the percentage of smaller employers offering health coverage, the percentage of workers employed by private-sector employers who were eligible for health benefits (the eligibility rate) has been mostly constant since 1996, varying from a low of 75.4 percent in 2014 to a high of 81.3 percent in 1996 (Figure 6). The eligibility rate has not changed much because of the distribution of workers skewing toward larger employers.

The percentage of workers eligible for health coverage by establishment size is shown in Figures 7 and 8. While eligibility rates trended downward in all firm sizes between 1996 and 2013 (Figure 7), they have been trending upward since (Figure 8). Workers in large firms were most likely to be eligible for health benefits. However, even though small employers were least likely to offer health benefits, workers in smaller firms were almost as likely as workers in large firms to be eligible for health benefits when they were offered. This phenomenon is due to historical minimum participation and minimum contribution requirements in the states. States generally require that a minimum percentage of workers offered coverage must enroll or have coverage from another source. As a result, it is common for small employers to offer coverage to all workers, and it is also more common than in larger firms for the employer to pay the entire premium for employee-only coverage.

Worker Opinions About Health Coverage

Workers have historically rated their own health coverage as favorable and have continued to do so through 2023. Just over one-half (55 percent) of those with health coverage were extremely or very satisfied with their current plan in 2023, and 33 percent were somewhat satisfied (Figure 9). Only 12 percent said they are not too satisfied or not at all satisfied. These figures are essentially unchanged since the late 1990s.

Generosity of Health Coverage

EBRI explored trends in actuarial value (AV) — or relative generosity of health plans — in the employment-based health coverage market since 2013 (Fronstin, Hagen, et al., 2021). The ACA required employers with 50 or more full-time-equivalent employees to offer health plans that provided a minimum value of at least 60 percent. In other words, these employers had to provide health plans with at least a 60 percent AV.

When the ACA passed, there was concern that the requirement for employers offering health coverage to provide plans with at least 60 percent AV would incentivize employers to reduce the generosity of their plans to the 60 percent floor. Using data from mostly the large group market, EBRI research showed that, as of 2019, this has not happened. Both the average and median AV were about 83 percent in each year from 2013–2019.

As opposed to group coverage, health insurance purchased in the individual market tends to be somewhat less generous. Plans purchased in the individual market average an actuarial value of 76 percent (Fronstin, Hagen, et al., 2021).

Several factors may explain the slightly lower AV typically seen in the individual market. First, consumers may have more choices in the individual market than would typically be offered by an employer, including benefit offerings with lower actuarial values. Second, while the tax credit is linked to the consumer's income, it is also based on the second lowest cost silver policy, meaning that it is a fixed number of dollars. Consumers can use their tax credit to purchase a policy of any metal tier, and while many choose silver, a sizable number purchase bronze, because the premium after applying the tax credit is often zero or close to it. Third, because the tax credit is based on a silver policy with an actuarial value of 70 percent, it is typically the case that the consumer purchases either a silver or a bronze policy and only rarely trades up to a gold policy. Fourth, even under the American Rescue Plan Act (ARPA) credits, but certainly under the original ACA tax credit income levels, some people simply did not qualify for a tax credit and had to pay the entire premium amount. They have been more likely to purchase a lower AV policy.

ERISA at 50

ERISA effectively preempts state and local regulation of self-funded, employer-provided health benefits. The scope of this has generated some degree of debate. Proponents of ERISA preemption point to the creation of a uniform and predictable regulatory environment for employers concerning their ERISA-governed benefit offerings, while its detractors believe that state and local governments ought to have a greater role in pursuing health care reform beyond their current ability to regulate health insurance.

On Thursday, September 12, 2024, EBRI is releasing the findings from a series of focus groups with benefits decision makers at large employers (Spiegel and Fronstin, forthcoming). Three main themes emerged in the roundtable discussions. First, under ERISA preemption, there is a uniform landscape of regulations, rather than a patchwork of state-level regulations, which makes it possible for an employer operating in more than one state to administer and offer benefits equitably to their employees. Employers view the consistent benefits made possible by ERISA preemption as a tool for increasing work force mobility. If a worker for a firm with operations in multiple states moves from a satellite office in one state to the company headquarters in another, they know they will have access to a similar menu of benefits. Second, ERISA preemption reduces administrative costs and burdens, thus enabling employers to deliver richer benefits and lower-cost coverage to their workers. Third, ERISA preemption fosters innovation that would otherwise be stifled by different states requiring different coverages or administrative rules.

Employers remain committed to providing health benefits to employees and their families. If ERISA preemption were eroded, however, benefits executives would worry about higher costs

for providing health benefits and would likely closely watch their competitors to determine next steps.

Conclusion

The commitment of employers to worker health was initially driven by practical needs. The formalization of health coverage during World War II, facilitated by wage controls and subsequent tax regulations, set the stage for the widespread adoption of health benefits by employers. This framework was reinforced by the passage of ERISA, which provided a consistent regulatory environment for employee benefit plans.

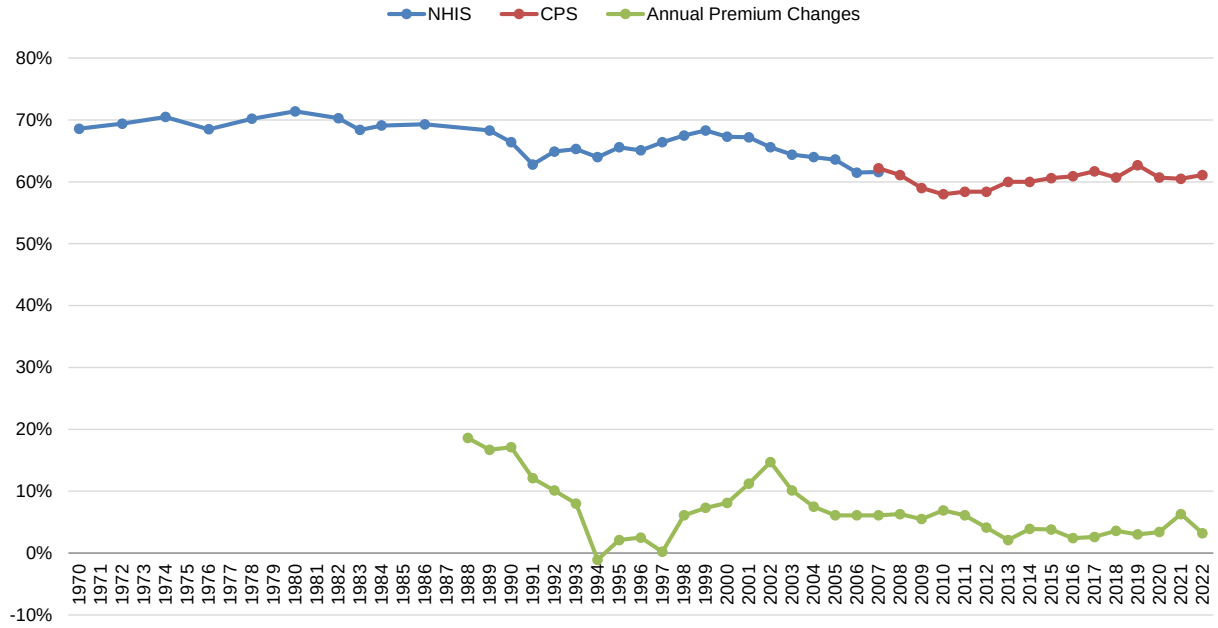
Despite predictions of a decline, the employment-based health coverage system has demonstrated continued resilience. The ACA prompted a debate about its potential impact, yet predictions that employers would reduce their health benefits offerings have not fully materialized. The recent data indicate that, although the percentage of employers offering health benefits has declined, the eligibility rates for coverage among workers have remained relatively stable. This stability is largely due to the continued prominence of large firms, which are more likely to offer health benefits.

While the landscape of employment-based health benefits is evolving, it remains a cornerstone of the American health insurance system.

Chairman Good, Ranking Member DeSaulnier, and Members of the subcommittee, thank you for the opportunity to appear before you today.

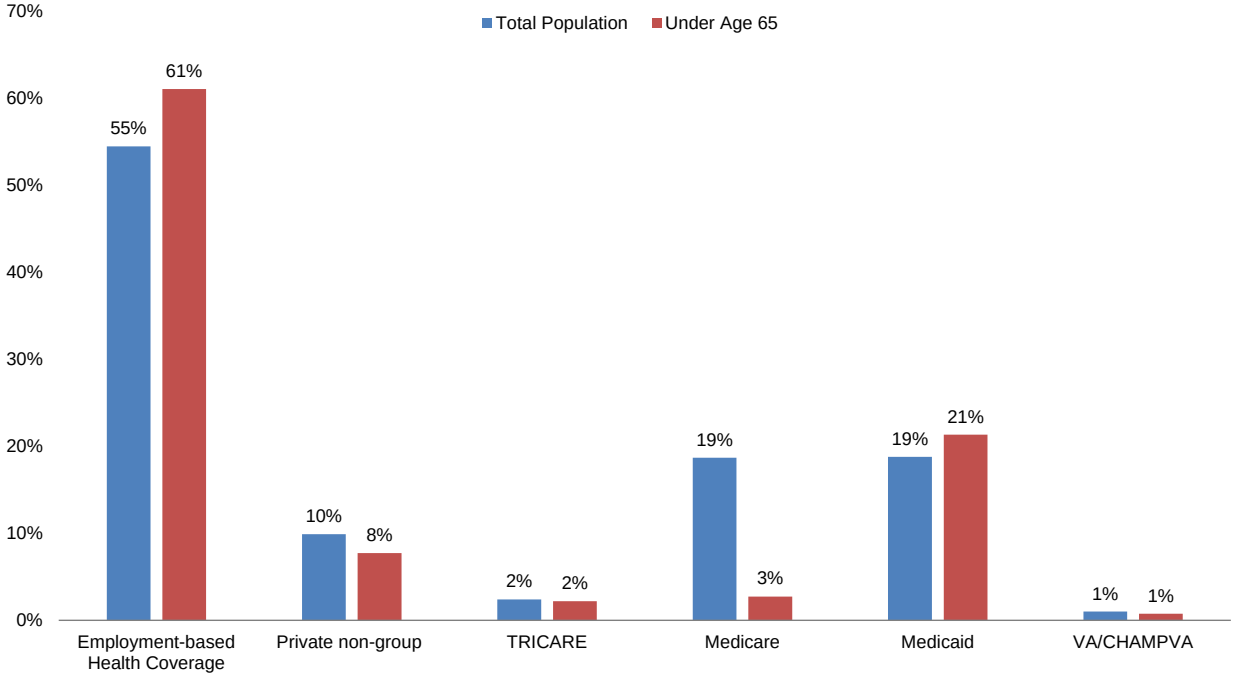
Appendix: Figures

Figure 1
Percentage of Persons Under Age 65 With Employment-Based Health Coverage, 1970–2022



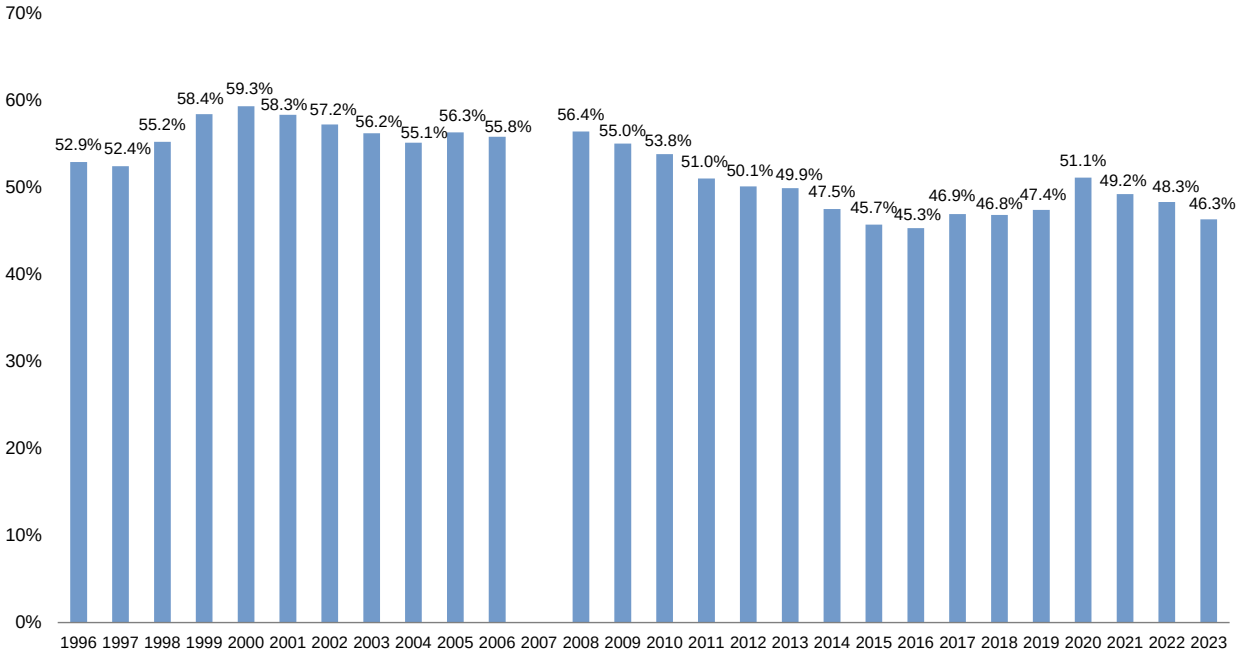
Source: www.cdc.gov/nchs/data/nhsr/nhsr017.pdf and Employee Benefit Research Institute estimates from the Current Population Survey.

Figure 2
Percentage of Population, by Health Insurance Source, 2022



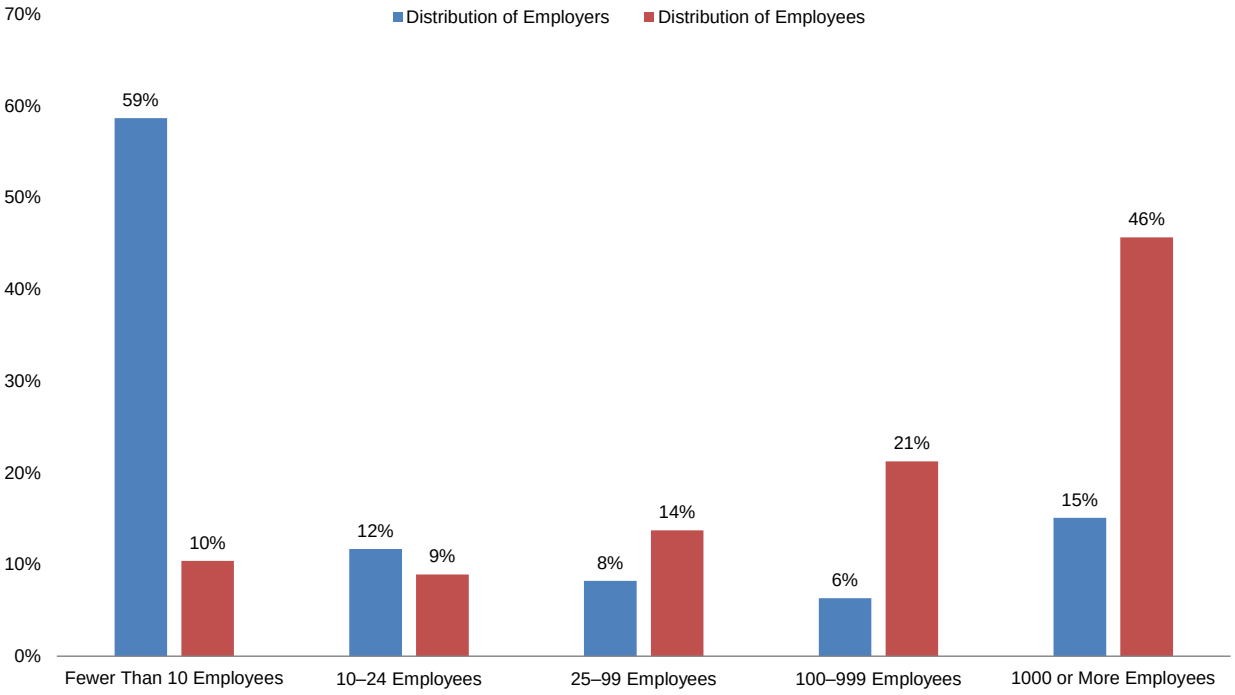
Source: Employee Benefit Research Institute estimates from the Current Population Survey.
Note: The estimates by type of coverage are not mutually exclusive; people can be covered by more than one type of health insurance during the year.

Figure 3
Percentage of Private-Sector Establishments That Offer Health Insurance, 1996–2023



Source: Medical Expenditure Panel Survey - Insurance Component (MEPS-IC).

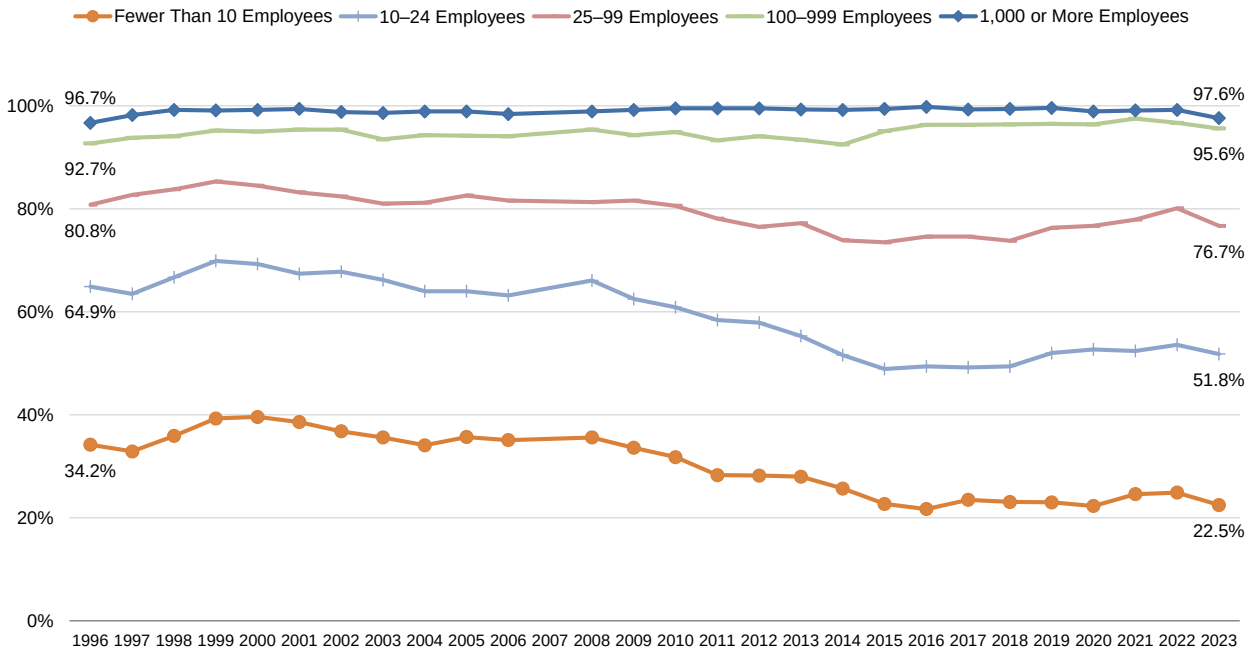
Figure 4
Distribution of Private-Sector Establishments and Their Employees, 2023



Source: Medical Expenditure Panel Survey - Insurance Component (MEPS-IC).

Figure 5

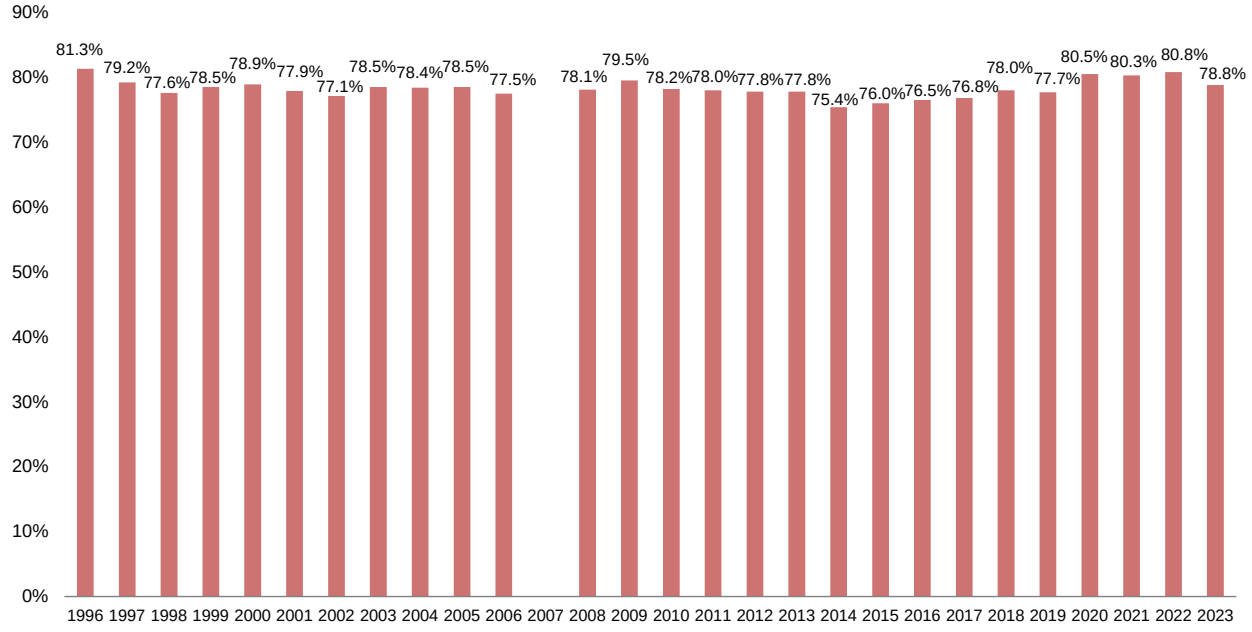
Percentage of Private-Sector Establishments That Offer Health Insurance, by Establishment Size, 1996–2023



Source: Medical Expenditure Panel Survey - Insurance Component (MEPS-IC).

Figure 6

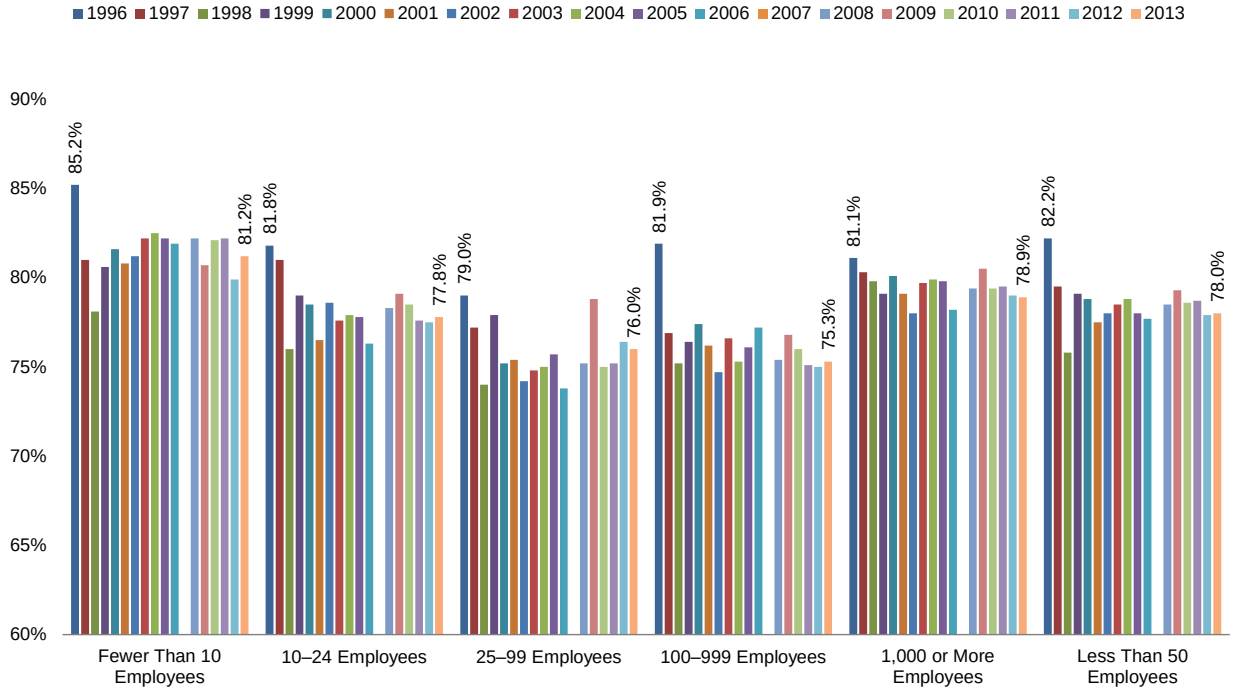
Percentage of Private-Sector Workers Eligible for Health Coverage, 1996–2023



Source: Medical Expenditure Panel Survey - Insurance Component (MEPS-IC).

Figure 7

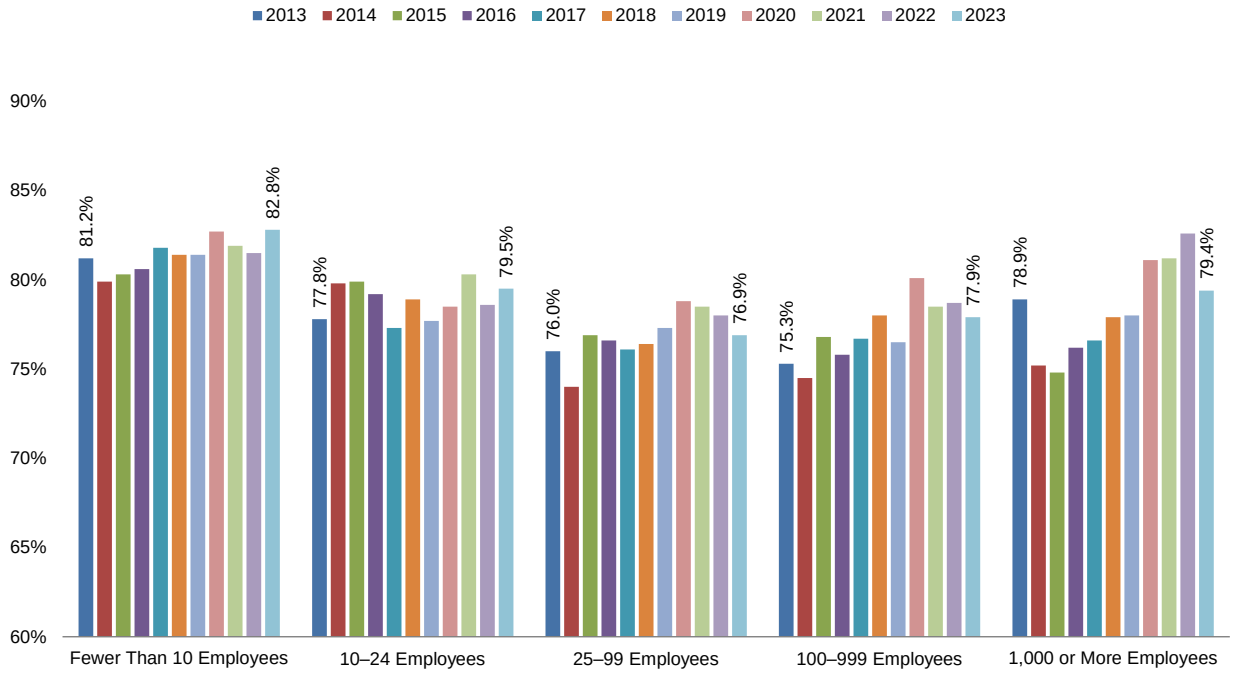
Percentage of Private-Sector Workers Eligible for Health Insurance, by Establishment Size, 1996–2013



Source: Medical Expenditure Panel Survey - Insurance Component (MEPS-IC).

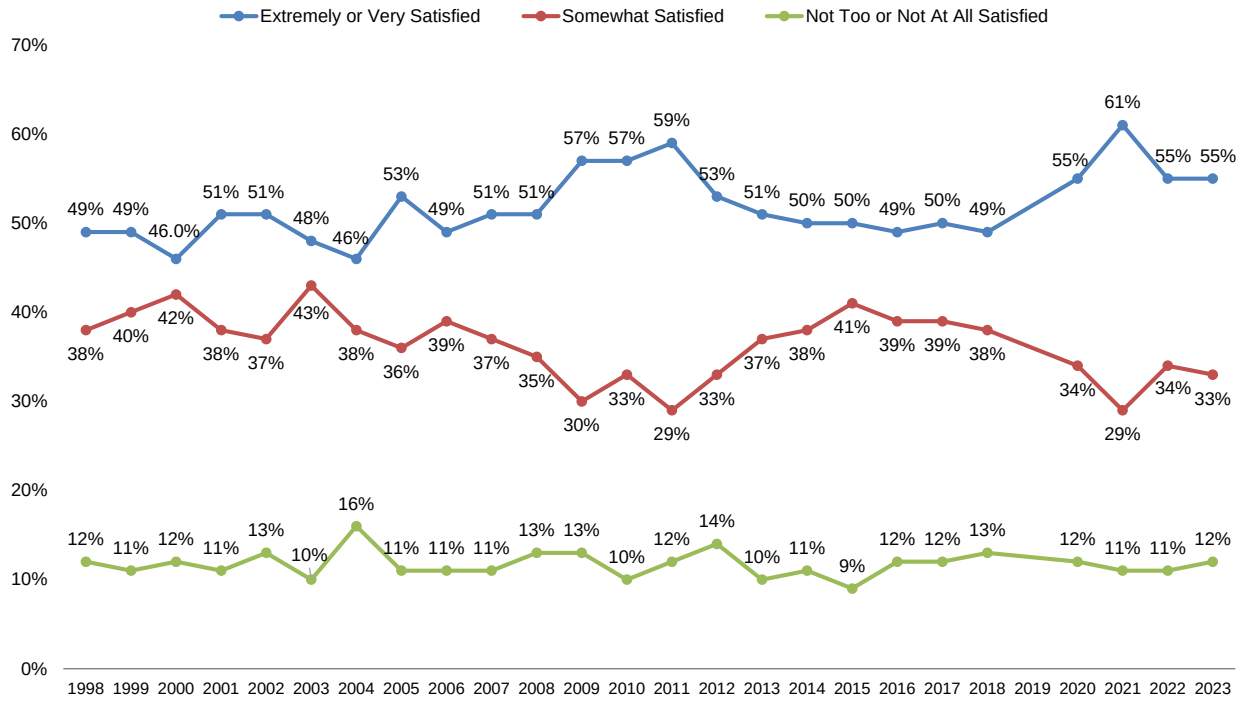
Figure 8

Percentage of Private-Sector Workers Eligible for Health Insurance, by Establishment Size, 2013–2023



Source: Medical Expenditure Panel Survey - Insurance Component (MEPS-IC).

Figure 9
Overall Satisfaction With Current Health Insurance Plan, 1998–2023



Source: Various Employee Benefit Research Institute surveys.

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