

No. 32, April 2015

Crowding Out of Long-Term Health Insurance by the Institutional Setting of the U.S. Health Insurance System*

By Ines Läufer[†]

Introduction

In the U.S., prior to the introduction of the 'Affordable Care Act' by President Obama, 50 million people under the age of 65 were neither covered by private health insurance nor by the social health care system 'Medicaid'. The key focus of President Obama's reform is the reduction of the number of uninsured people. The main elements of the reform are a health insurance mandate and the strict regulation of private insurance premiums. Right from the beginning, this initiative was accompanied by strong protests and led to controversial discussions in the public and political arenas. The debate about the reform seems to shift the attention away from the fundamental question regarding the reasons that have led to the current level of uninsured people.

Two observations are striking: first, not all of today's uninsured persons have been without health insurance all the time. Many of them have had health insurance at some point in life through the group insurance of their employer, which they lost either as a result of a job change or a job loss. The '[Commonwealth Fund Health Insurance Tracking Survey of U.S. Adults, 2011](#)' concluded that 'losing or changing jobs was the primary reason people experienced a gap' (Collins *et al.* 2012). Second, the income level of many of those uninsured people is well above the poverty threshold of the U.S. Even in households with incomes above 300 percent of the poverty line, 11.6 million people have been uninsured, corresponding to 26 percent of the total uninsured (Pauly, 2010, p. 11). Therefore, it is obviously not just the poor or people with a minor income who have no health-care coverage (Kunreuther *et al.* 2013, pp. 246–250). It is worth noting however, that health insurance premiums can be unaffordable even for people with a higher income in case of pre-existing conditions. If individual health insurance premiums are risk-dependent, those pre-existing conditions go along with high premiums. But in this case, there remains the question why this premium risk has not been covered by a health insurance contract earlier in life. Of course, foregoing long-term health insurance could just be classified as reckless or irrational and driven by the underestimation of potential risks (Kunreuther *et al.* 2013, p. 246 f.). But this short article focuses on another explanation: It considers the institutional factors in the U.S. health insurance system which could make a long-term health insurance unattractive for many individuals.

Options for health insurance in the U.S.

When seeking insurance of the health cost risk under the age of 65, American residents have two options: Employer-sponsored health insurance and/or individual long-term health insurance. These alternatives differ in terms of insurance of the premium risk or the 'reclassification' risk: an illness can induce a long-term condition such as cancer or heart disease, which leads to an increase in current and future health costs. If health insurance was short term and a person wanted to acquire a new insurance contract after the former insurance contract expires, one would have to accept a permanently higher insurance premium to insure the same health benefit catalogue.

As employer-sponsored insurance is job-dependent, and job loss goes along with losing health insurance.¹ Having lost group health insurance and falling back on the individual insurance market, those pre-existing conditions imply

* An elaborate analysis of this only briefly examined issue will be published this year in the journal: *Sozialer Fortschritt/German Review of Social Policy*.

[†] Institute for Economic Policy at the University of Cologne.

a (prohibitively) high individual insurance premium. Therefore, employer-group insurance can only provide an incomplete protection, as the premium risk is not completely insured and depends on the risk of losing the job.

In contrast to that, long-term protection which includes premium risk insurance can allow for a risk-independent premium over time (Pauly *et al.* 1995; Cochrane 1995). In this case, health conditions developed in the course of life do not go along with rising premiums. The individual premium can either be independent of changes of individual health risks which occur after the insurance contract has been signed (Pauly *et al.*, 1995; Cochrane 1995), but increase with age, or it could be independent of risk factors and age if ageing provisions are included (Arentz *et al.* 2012).

Crowding out of individual long-term contracts by employer-provided insurance

In a competitive labour market, one expects employers to adapt wage-fringe benefits packages to workers' preferences. An employee could consider health insurance options during the job search and purposely seek an employer offering health insurance, preferring him over other employers without health insurance. Under this assumption, seeking insurance via employers could be modelled as an individual decision to be insured via the employer instead of purchasing individual insurance. Monheit and Vistnes (1999) conclude in their empirical analysis of workers' job choice that the sorting of workers to different employers, offering or non-offering health insurance reflects their preferences for health insurance. If employers offer health insurance to attract workers, the costs of health insurance reduce the potential of wages in cash. In consequence, explaining foregoing long-term protection requires analysing the potential advantages of group insurance for employees over the alternative of higher cash wages in combination with the closure of a long-term individual health insurance contract.

Premiums of employer group insurance are community rated. Employers are not allowed to consider an employee's risk factors (including age), neither in the premium setting nor in wage setting.² This setting seems at first glance unattractive to low-risk persons since the resulting average premium is too high compared to their expected health costs. However, several factors can create a large price gap between individual and group insurance even for persons with low risks. First, a large employer may benefit from the linkage of employment and insurance group as the insurance pool can be large enough to reduce risk variation. Therefore, the insurer's risk of deviation of expenditures from the expected value of expenditures for this group is reduced (Zweifel and Eisen 2003, p. 240 ff.) and therefore, less risk management in terms of building financial reserves and risk pooling is needed than in case of insuring a small group or an individual (Blumberg and Nichols, 2004, p. 47). Furthermore, insuring groups instead of individuals can allow foregoing individual risk assessment. In case of (a large) group insurance, the marginal effect of an individual employee's risk is low. Therefore, it can be sufficient for a private insurer to consider general group characteristics (such as industry) to calculate the expected costs of the group. In consequence, especially large firms can benefit from saving the costs of individual risk underwriting.

Second, group insurance via the employer saves the transaction costs resulting from searching for and contracting with an insurer: Only one person, namely the employer, acts on behalf of his employees and spends time for searching and contracting with the insurer (Blumberg and Nichols, 2004, p. 47). Administration costs can be 25–30 percent lower than for an individual insurance contract (Blumberg and Nichols 2004, p. 47). Due to those economies of group insurance, premiums can be lower than individual insurance premiums, even for lower-than-average risks.

¹ The 1985 enacted COBRA (Consolidated Omnibus Budget Reconciliation Act) allows employees having lost employer insurance to keep their insurance policy for up to 18 months, paying 102 percent of the employer's premium. Therefore no individual risk equivalent premiums may be required during this period (Madrian, 1994, p. 29).

² The empirical question, if and to what extent wages are age dependent to compensate for age dependent health care costs remains unclear (Bundorf *et al.* 2010, footnote 7). Empirical studies of Sheiner (1999) and Pauly and Herring (1999) conclude that health insurance wage deductions vary with age. But even if this result was representative and reflecting different health costs risks, a further premium differentiation would contravene with the 'Americans with Disabilities Act' (1990) and the Federal 'Health Insurance Portability and Accountability Act' (HIPAA) introduced in 1996. Therefore, the assumption of group, average health insurance premiums is consistent (Bundorf *et al.*, 2010, footnote 7; Cochrane, 1995, p. 458).

Beside the cost advantages of employer-sponsored group insurance due to the combination of workplace and insurance, a price advantage of employer health insurance is created by the exclusive tax advantage for employer-group insurance. Premiums paid by an employer for his employees are exempted from all employees' taxes, federal and state income tax and social security contributions (Monahan and Schwarcz, 2010, pp. 14–15). Additionally, the employer can save social security contributions. Under the assumption that employers pass employment-related taxes and contributions on to their employees, it is the employee who benefits from this tax deduction (Finkelstein, 2002). Additionally, if employees have to pay a separate premium for group insurance, these can be exempted from taxes as well (Monahan and Schwarcz, 2010, pp. 14–15). As this tax advantage only applies to employer group insurance, individual health insurance contracts are getting comparatively more expensive.³ The average tax rate can amount to 34 percent; therefore, tax sponsoring of health insurance alone can already reduce the price of group insurance by 34 percent compared to an individual insurance (Gruber, 2011, p. 516).⁴

In the light of these cost advantages of employer health insurance, employer group insurance could be considered as a preferable alternative over a full individual health insurance.

Cost factors of insurance the remaining health-cost risk

Considering the predominant employer-based system, the remaining health cost risk can be defined by two components: The risk of losing the employer-sponsored insurance and the risk of having developed pre-existing conditions in the meantime. A risk-averse person could therefore be willing to additionally insure the remaining premium risk of employer group insurance on an individual basis. Explaining an insurance gap as the result of foregoing individual protection in a predominantly employer-sponsored health insurance system requires not only analysing the advantage of group insurance over a full individual long-term protection, but also considering obviously existing impediments to insuring only the remaining premium risk.

The dominance of the employer-sponsored insurance system can reduce the benefits of a long-term individual insurance contract, as there is an uncertain planning horizon during the time period under the age of 65. In fact, the individual health insurance market is characterised by a frequent enter and exit at various periods (Brown and Connelly, 2005, p. 28). This can reduce the benefits of a long-term insurance contract (Pauly *et al.*, 1995, p. 150). If the individual insurance should only function as a subordinate, the willingness-to-pay for individual insurance could depend not only on a persons' individual health risk, but also on the individual expected probability of losing (respectively not getting) a job with group insurance. If the individually expected insurance track is not adequately reflected in lower premiums of the individual insurance (because the health care would partially be delivered by the employer), the price of a complementary insurance would be systematically too high.

Additional costs of an insurance contract arise on the side of the insurant; he/she has to consider the remaining risk of health costs, invest time and effort to care and search for such insurance, communicate with the insurer and take a decision. In effect, psychological findings indicate that choice overload may constitute an important barrier to take any action and decision. It could depress insurance take-up (Baicker *et al.*, 2012, p. 115). The problem of choosing and taking the decision to insure a certain risk could be higher for smaller risks if the range of smaller risks is broader, which could make the selection of the health risk less obvious. In this case, the reduction of individual health costs risks via the dominant employer-sponsored system and the institution Medicare could have an effect on insurance take-up, as it might not be worth it to deal with such a comparatively small risks.

To sum up, the institutional setting of the U.S. health insurance system before the implementation of the Affordable Care Act can crowd out the incentive of individual protection against long-term health risk: it reduces

³ Self-employed persons can benefit from limited tax deductions (Monahan and Schwarcz, 2010, pp. 14–15).

⁴ This advantage can be regarded as the state's reaction to employers' increasing payment of fringe benefits: During World War II, wages were fixed to prevent the inflationary dynamics of an increasing demand for labour. To compensate for inadequate wage incentives, employers used the alternative of fringe benefits (Thomasson, 2003). Second, sponsoring employer health benefits was considered as the second-best substitute for a lacking comprehensive social health insurance system (Hacker, 2002). Already at the beginning of the 20th century, implementation of a social health insurance was intended but failed due to the politically fragmented system (Hacker, 2002, p. 194).

the individual health-cost risk, but not proportionally the costs of insuring this risk, therefore raising the relative costs of premium risk insurance. The cost advantage of employer insurance not only results from the linkage of employment and insurance—rather, it is also state-induced, due to the exclusive tax-sponsoring of employer group insurance which creates a large price gap between the two insurance options. Additionally, Medicare insurance after the age of 65 considerably reduces health-cost risks, making it less attractive to complement employer insurance with premium risk insurance; given the fixed costs of considering, searching and purchasing an individual health insurance, the remaining health-cost risk can be too low to be insured separately. As a result, foregoing long-term insurance in favour of employer-insurance can induce non-insurance later on due to a job loss and pre-existing conditions developed in the meantime (Cochrane, 2014, p. 22).

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