



Viewpoint

Employer-Based Health Insurance and Employee Compensation

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The costs of private health insurance have continued to soar, consuming an ever-greater share of total compensation for employers and employees. Although the factors associated with the increases in health insurance costs have evolved incrementally during the past 2 decades,¹ the role of health insurance in the stagnation of real incomes has been underappreciated by the public. At the same time, escalating costs and declining financial protection from private health insurance call into question whether employees perceive value from health insurance that is commensurate with the cost.

For employers, health insurance costs for family health insurance have increased from \$10 157 in 2000 to \$22 463 in 2022, a 121% increase (all health insurance and family income values are reported in real dollars).^{2,3} Health insurance costs as a percentage of median family household income have increased from 13% to 25% from 2000 to 2021.^{2,3} Employer contributions to health insurance have increased from \$7603 to \$16 253 in 2021, or from 10% of household income to 18% of household income. For workers, employee contributions toward their coverage increased from \$2554 to \$5968, or from 3% of household income to 7% of household income. Overall, from an employer perspective, total compensation has increased by 20% from 2000 to 2021, including employer contributions to health insurance. At the same time, family household income after health insurance (calculated by subtracting employee contributions to health insurance from median family household income) increased by only 7% between 2000 and 2021.

Given that so much of the increase in worker compensation during the past 2 decades has been consumed by health insurance costs, it is important to ask whether the value of health insurance has increased during this period. Might the average worker benefit from an increasing share of their income going to health insurance? Unfortunately, while the costs of health insurance have increased, the value of health insurance appears to have declined.

One measure of value is derived from the structure of private health plans. Deductibles have increased from \$545 to more than \$3000 (in real dollars), so that even after purchasing a health plan, enrollees must pay an average of 3% of their household income before the plan begins to provide coverage for services. Furthermore, in 2022, 28% of workers with employer-sponsored insurance had a high-deductible health insurance plan with a savings option, increasing worker financial responsibility.³

A second measure of value is the financial protection provided by health insurance. From a theoretical perspective, people who purchase insurance are considered risk averse, and benefit from the financial predictability of having insurance coverage. Given the cost of medical care, people may see more benefit from health insurance coverage as the financial risk has grown, especially if they perceive that they may need advanced medical treatments or services; technically, this value may be diminished if the plan has a catastrophic coverage limit.

Yet health insurance designs may offer limited financial protection for most consumers who need basic health care services. For example, the new financial transparency efforts may reveal the average amount paid by a health plan for a service, but do not provide a binding cost estimate.⁴ In seeking care, even from an in-network clinician, patients may find themselves billed for much more than the estimated amount—differences could come from inclusion or exclusion of services from a price estimate, from the use of different types of clinicians, or from different practice patterns across clinicians. Fortunately, the No Surprises Act⁵ provides some relief from the scourge of surprise

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medical bills from out-of-network physicians. Most health plans offer no protection from these types of cost discrepancies.

At the pharmacy, purchasing medications using health benefits can produce higher out-of-pocket cost than paying cash and using a coupon service (eg, GoodRx). Financial protection for catastrophic care, often the justification for the high cost of health insurance, is also a concern. Researchers found that 12 months after a cancer diagnosis, 76% of patients with private health insurance reported major financial hardship after receiving cancer care through a US National Institutes of Health–sponsored clinical trial.⁶ Another study showed that even after the expansion of insurance coverage through the Affordable Care Act,⁷ 50% of low-income adults with serious psychological distress reported a financial barrier to care. Furthermore, health plans can deny payment for services and place a burden on patients to navigate either practitioner financial services offices or payer appeal processes.

Even standard industry tools, such as assessment of actuarial value of a plan, offer only modest support for individual patients. Actuarial value is a measure of how much of average benefit costs a health plan is expected to cover more than for 1 year at a population level. It is a tool that can be useful in comparing cost-sharing in the health insurance exchanges but is not a guarantee of health care costs for an individual patient (nor an assessment of value given an individual's level of needs).

Beyond financial protection, health insurance may not be sufficient to ensure access to care for individuals. Once an employee purchases a health plan, they may find it difficult to obtain primary care services if there is a lack of availability of in-network primary care clinicians. For example, a study of primary care access reported that only 60% to 69% of patients who requested a new patient physical examination using private health insurance were able to obtain one, and almost 35% had to wait for at least 1 month for that scheduled visit.⁸ There are no standard network adequacy measures for health plans, and little transparency around access limitations associated with narrow network plans. For specific clinical services, it is easy to imagine that the most experienced physician on a regional basis is excluded from a narrow network.

Looking forward, we are already seeing requests for large rate increases by private health plans (7% median increases for 2023⁹). For employees, these cost increases reflect the underlying hospital business model. Although most of the patients using hospital services are publicly insured (63% of patients on average), hospitals have developed a business model where almost all of their profits are driven by prices charged to privately insured patients (29% of patients on average). To implement this strategy, hospitals have aggressively adopted business models to ensure leverage in contract negotiations with private health plans, prompting the massive hospital and practice consolidation we have experienced. This model has been successful, with private health plans paying 224% of Medicare payments in 2020.¹⁰ As hospital costs increase, hospitals will need to negotiate for even higher prices from patients who are privately insured to balance their financial model. Given hospital leverage and strategy, prices for privately insured individuals may increase faster than overall hospital costs in the coming years.

The financial press is reporting on the economic repercussions of health insurance cost trends on employers, but the real burden is on employees. More and more of total compensation is being diverted to health benefits that provide increasingly less financial protection and less access for individuals. It remains an open question whether this economic crisis will be the factor that finally forces the health care market to focus on the concerns of workers for value, access, and quality.

ARTICLE INFORMATION

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