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National Trends in the Cost of Employer Health Insurance Coverage, 2003–2013

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Abstract Looking at trends in private employer-based health insurance from 2003 to 2013, this issue brief finds that premiums for family coverage increased 73 percent over the past decade—faster than median family income. Employees' contributions to their premiums climbed by 93 percent over that time frame. At the same time, deductibles more than doubled in both large and small firms. Workers are thus paying more but getting less protective benefits. However, the study also finds that while premiums continued to rise through 2013, the rate of growth slowed between 2010 and 2013, following implementation of the Affordable Care Act. While families experienced slower growth in premium contributions and deductibles over this period, sluggish growth in median family income means families are paying more in premiums and deductibles as a share of their income than ever before.

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OVERVIEW

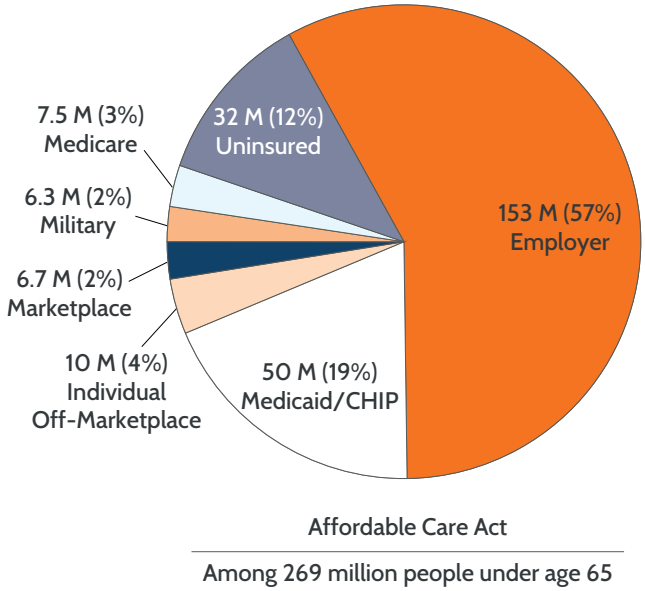
Recent news has focused on the cost of health insurance plans in the Affordable Care Act's marketplaces, but only 6.7 million people—or 2 percent of the population—are currently covered by marketplace plans. While the number of people enrolled in marketplace plans will climb to an estimated 9 million to 9.9 million in 2015 and eventually to 25 million over the next four years, people with marketplace coverage will still comprise only about 9 percent of the nonelderly population.[1] When we look at changes in the cost of health insurance and the implications for U.S. families, it is therefore important to examine trends in employer plans. About 57 percent of the under-65 population—or more than 150 million people—have insurance through employers (either their own or that of a family member) in 2014 (Exhibit 1).

This issue brief looks at national trends in employer-sponsored insurance from 2003 to 2013, the latest federal data available. Total insurance premiums paid by employers and employees rose much faster than median household income over that time. In addition, the amount that workers contributed to their premiums also climbed. At the same time, people with job-based insurance paid more out of pocket when they got health care: more plans have deductibles and the size of those deductibles has more than doubled over the decade.

There is, however, cause for optimism. While premiums continued to rise through 2013, the rate of growth slowed between 2010 and 2013, the years following implementation of the Affordable Care Act. This slowdown occurred both nationally

and, as we will describe in a forthcoming report on state trends, in 31 states and the District of Columbia. During this period, provisions of the law that apply to employer health insurance went into effect.

Exhibit 1. Estimated Source of Insurance Coverage, 2014



Note: The number of uninsured in 2014 was calculated using CPS estimates for 2013 minus an estimated 9.5 million fewer uninsured in 2014. The number of people enrolled in Medicaid/CHIP in 2014 includes the approximately 9.1 million new Medicaid enrollees in 2014. Estimate of individual o -marketplace is midrange of ASPE 2014 estimate.
Sources: Analysis of 2014 Current Population Survey by Sherry Glied and Claudia Solis-Roman of New York University for The Commonwealth Fund; ASPE, How Many Individuals Might Have Marketplace Coverage After the 2015 Open Enrollment Period? Nov. 2014; Centers for Medicare and Medicaid Services, Medicaid and CHIP: September 2014 Monthly Application, Eligibility Determinations, and Enrollment Report, Nov. 2014; The Commonwealth Fund A ordable Care Act Tracking Survey, April–June 2014.

FINDINGS

Employer Health Insurance Premiums at a 10-Year High, with Slower Growth After 2010

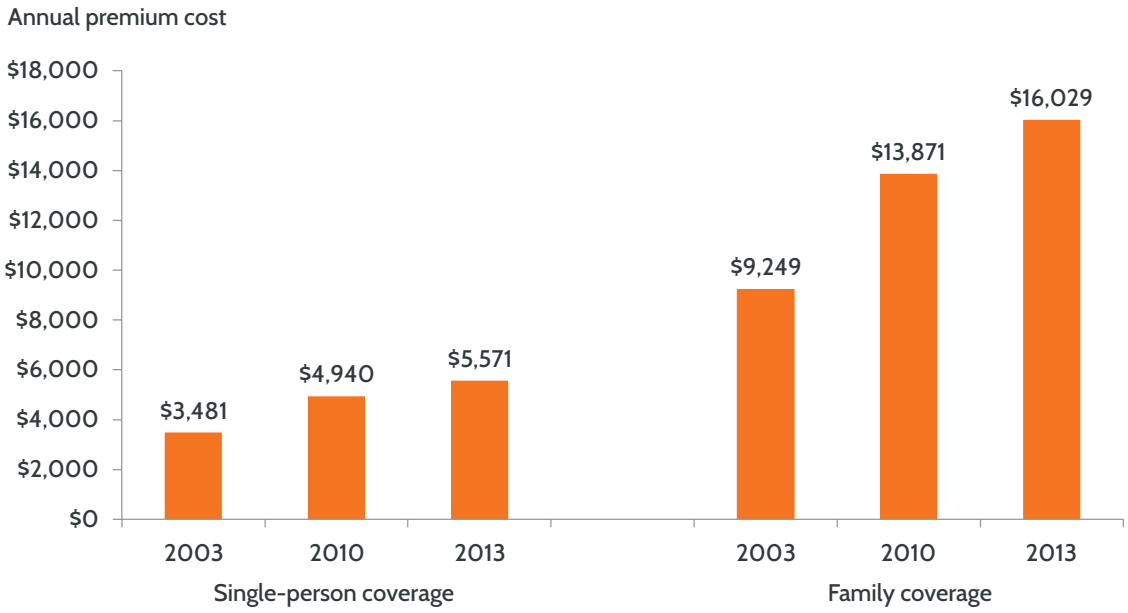
Average annual health insurance premiums for employer-sponsored family coverage reached $16,029 in 2013, up from $9,249 in 2003, an increase of 73 percent (Exhibit 2). Premiums for single coverage also rose markedly over the period, climbing from $3,481 to $ 5,571, or 60 percent.

Because the Affordable Care Act, which went into effect in 2010, included provisions that applied to employer plans beginning that year, we looked at trends in premiums before and after 2010. All nongrandfathered plans (i.e., health plans that were not in existence when the ACA was signed into law on March 23, 2010) are required to allow young adults to remain on or enroll in a parent's plan to age 26 and include recommended preventive services without cost-sharing. Both these provisions were expected to modestly increase premiums.[2] In addition, health insurers were required to spend at least 80 percent or 85 percent of premiums on medical costs for small and large employer health plans, or pay rebates to employers and covered employees. This provision has been found to have a mild decreasing effect on premiums.[3]

The analysis shows that the rate of growth in premiums after the passage of health reform slowed, compared with the average annual growth rate in the seven years prior to the law. From 2003 to 2010, premiums for employee-only plans grew at an average annual rate of 5.1 percent (Exhibit 3). In the three years since the ACA was enacted (2010–2013), growth in premiums slowed to 4.1 percent per year.

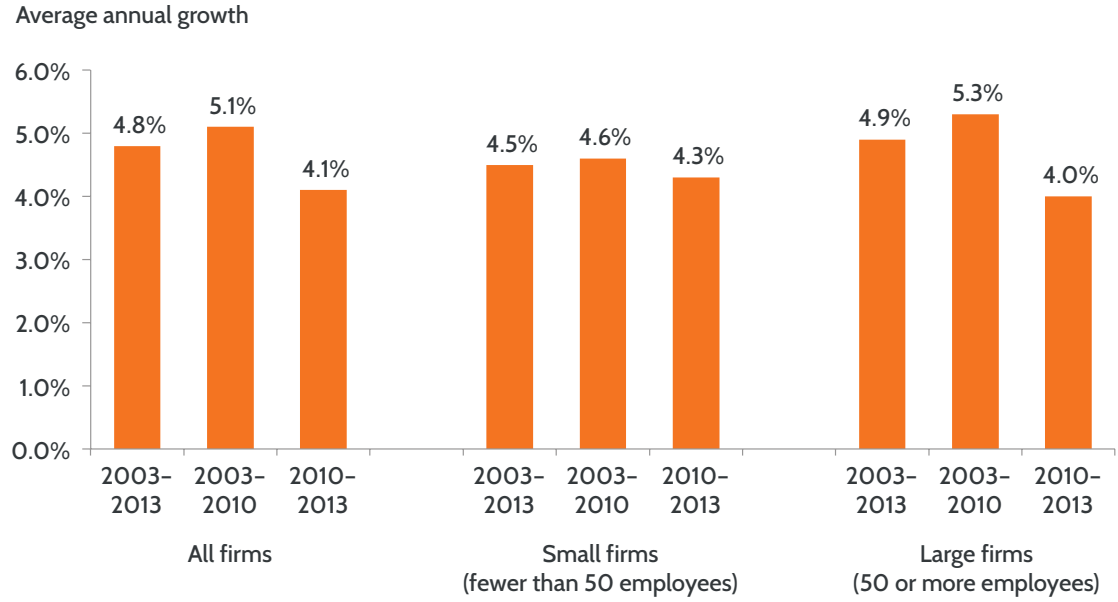
The reduced rate of premium growth was more pronounced in large employer plans than in small employer plans, primarily because premiums in large employer plans grew at a faster rate in 2003–2010 than did those in small employer plans. Premium growth after the passage of the Affordable Care Act was about the same for both large and small employers.

Exhibit 2. Average Premiums for Employer-Sponsored Single-Person and Family Health Insurance Plans, 2003, 2010, and 2013



Source: Medical Expenditure Panel Survey–Insurance Component, 2003–2013.

Exhibit 3. Average Annual Rate of Growth for Employer-Sponsored Single-Person Health Insurance Plans in All, Small, and Large Firms

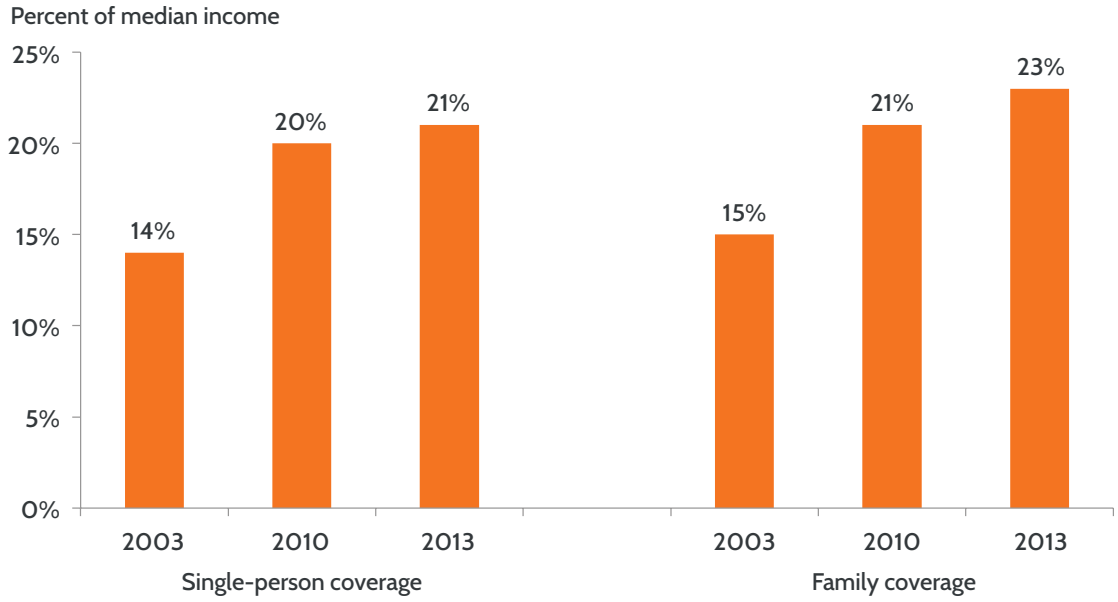


Source: Medical Expenditure Panel Survey–Insurance Component, 2003–2013.

Premium Increases Outpace Growth in Family Income

Despite the recent slowdown in growth, insurance premiums have risen faster than median incomes for the under-65 population. While average family premiums have climbed by 73 percent since 2003, median family income has risen by 16 percent over the same time period (data not shown). As a result, total premiums (including the employer and employee shares) relative to income have continued to climb for middle-income working-age families. In 2013, average annual family premiums were 23 percent of median family income, up from 15 percent in 2003 and 21 percent in 2010 (Exhibit 4). There are similar trends in premiums for single coverage: average premiums have climbed 60 percent over the decade, while median income for single-person households has grown by only 11 percent.

Exhibit 4. Average Health Insurance Premiums as Percent of Median Income, 2003, 2010, and 2013



Analysis of 2003–2014 Current Population Surveys by Sherry Glied and Claudia Solis-Roman of New York University for The Commonwealth Fund.
Source: Medical Expenditure Panel Survey–Insurance Component, 2003–2013.

Annual Employee Premium Contributions Have Grown, But Rate of Growth Has Slowed in Recent Years

In an effort to reduce their costs of providing health insurance, employers over the past decade have increased the amount that workers contribute to their premiums and to their health care, through higher deductibles and copayments. As a result, employees are paying more for plans that provide less financial protection.

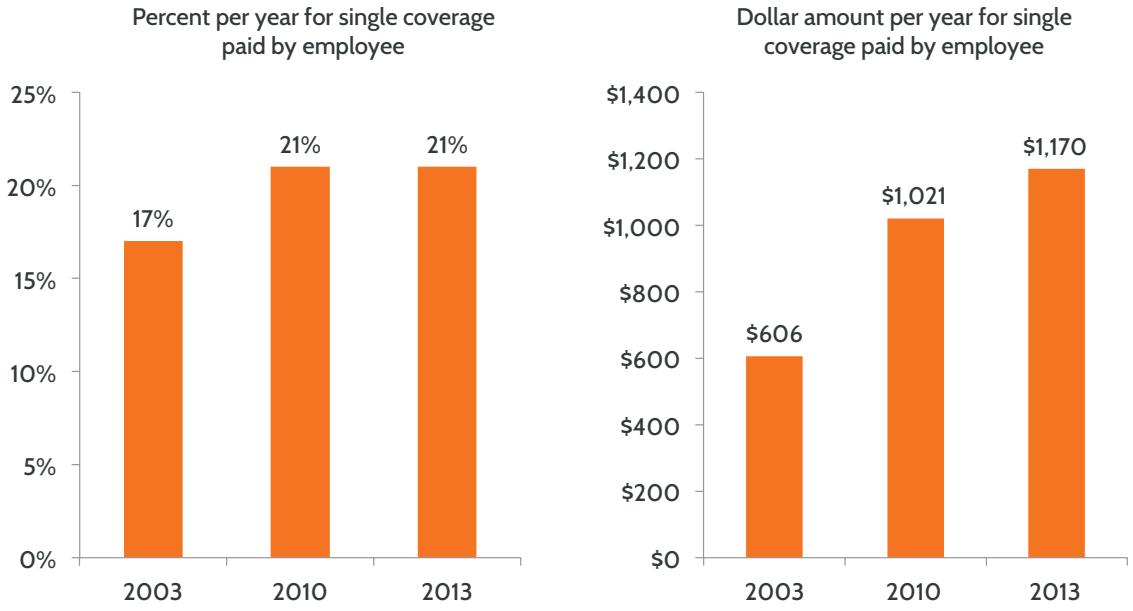
In 2013, U.S. employees contributed 21 percent of the total premium for employee-only coverage. This is unchanged from 2010, but an increase from 17 percent in 2003 (Exhibit 5). However, because premiums have grown, the actual amount that workers contribute toward premiums has climbed from $606 in 2003 to $1,021 in 2010 to $1,170 in 2013, or an increase of 93 percent over the decade.

And, because income growth has been slow throughout the decade, employees are paying more for their share of premiums. In 2013 and 2010, average premium contributions for single coverage in employer plans were 4 percent of median income, compared with 2 percent in 2003 (data not shown).

Deductibles More Than Doubled from 2003 to 2013, But Rate of Growth Moderated in Recent Years

Although workers are paying more for their health insurance, their premiums are buying less financial protection, partly because more plans include deductibles and the size of those deductibles has spiked dramatically.[4] In 2013, 81 percent of workers were enrolled in a health plan with a deductible, up from 78 percent in 2010 and just over half (52%) in 2003 (Exhibit 6).

Exhibit 5. Total Employee Contribution to Single-Person Employer-Sponsored Health Insurance Premiums, 2003, 2010, and 2013



Source: Medical Expenditure Panel Survey–Insurance Component, 2003–2013.

Exhibit 6. Private Health Insurance Deductibles: State Averages by Firm Size and Household Type, 2003, 2010, and 2013

	2003	2010	2013	Average annual growth 2003–10	2010–13
Share of enrollees who have a deductible on their employer-sponsored plan	52%	78%	81%		
Average, all firms					
Single-person plan	$518	$1,025	$1,273	10.2%	7.5%
Family plan	$1,079	$1,975	$2,491	9.0%	8.0%
Average, small firms					
Single-person plan	$703	$1,447	$1,695	10.9%	5.4%
Family plan	$1,575	$2,857	$3,761	8.9%	9.6%
Average, large firms					
Single-person plan	$452	$917	$1,169	10.6%	8.4%
Family plan	$969	$1,827	$2,307	9.5%	8.1%

Note: Small firms = firms with fewer than 50 employees; large firms = firms with 50 or more employees.
Source: Medical Expenditure Panel Survey–Insurance Component, 2003–2013.

Over the same time period, average deductibles for a single person in employer health plans more than doubled, climbing from $518 in 2003 to $1,025 in 2010 and $1,273 by 2013. The average annual rate of growth in deductibles exceeded 10 percent from 2003 to 2010, but has slowed to 7.5 percent since 2010. However, as with employee contributions to premiums, incomes have lagged growth in deductibles such that deductibles are consuming an ever-growing share of worker income. In 2013, average deductibles for a single-person plan were 5 percent of median income, up from 4 percent in 2010 and 2 percent in 2003 (data not shown). This means that by 2013, the combination of

employee premium contributions and deductibles for single coverage amounted to 9 percent of median income, up from 5 percent in 2003.

In 2013, workers in small firms (i.e., those with fewer than 50 employees) faced higher deductibles on average than their peers in larger firms (i.e., those with 50 or more employees): $1,695 vs. $1,169. This difference has narrowed over time as larger employers have increased deductibles more rapidly than have small firms.

DISCUSSION

This analysis confirms recent employer survey data from the Kaiser Family Foundation: a slowdown in the growth of premiums and deductibles in the past few years, notably since the passage of the Affordable Care Act in 2010.[5] This is consistent with prior estimates by Jon Gabel that the early provisions in the law that applied to employer plans, such as the young adult coverage requirement, would have only minor effects on premiums.[6] In addition, recent research suggests that the law's medical loss ratio requirement may have dampened premium growth over the period.[7] The 2017 implementation of the tax on higher-cost employer plans, the so-called "Cadillac tax," is expected to slow premium growth.[8]

The recent moderation in employer premiums is consistent with trends in premiums for plans offered through the Affordable Care Act's marketplaces in 2014 and 2015. In 2014, the first year that plans were available through the marketplaces, premiums on average were significantly below levels projected by the Congressional Budget Office. For 2015, changes in premiums from the prior year were modest for benchmark silver plans, and declined in many states.[9] A number of factors have contributed to this: the law's temporary reinsurance and risk corridor programs that protect insurers from above-average claims cost, insurer competition and an increase in the number of plans offered through the marketplaces in 2015, and robust enrollment with reasonably well-balanced risk pools.[10]

It is not yet clear whether moderate premium growth will continue. The slowdown in employer premium growth reflects a combination of reduced use of services by employees and their families and somewhat slower increases in prices for hospital and other services (Exhibit 7). However, this may change as the economy recovers and returns to more robust

Exhibit 7. Private Insurance 2008–2012: Change in Average Use and Prices

Percent change in use and average price paid per service, by category			
	2009/2010	2010/2011	2011/2012
Hospital (inpatient)			
Use[a]	–2.4%	–1.5%	–2.9%
Average price paid	5.2%	5.6%	5.4%
Outpatient			
Use[a]	–0.7%	1.2%	0.9%
Average price paid	5.9%	4.9%	5.6%
Professional procedures			
Use[a]	–1.4%	0.9%	1.9%
Average price paid	3.0%	2.9%	1.1%
Prescriptions (filled days)[b]			
Use[a]	0.5%	0.1%	0.6%
Average price paid	2.1%	1.6%	3.2%

[a] Per 1,000 insured people younger than age 65 and covered by employer-sponsored insurance.
[b] Includes brand-name drugs and generics. Prescriptions uncategorized as brand-name or generic not included in the data because of low dollar amounts and low utilization.
Source: 2012 Health Care Cost and Utilization Report, Health Care Cost Institute, Sept. 2013.

growth. The Centers for Medicare and Medicaid Services recently projected that the costs of private insurance will return to more rapid growth after five years of historically slow increases.[11]

The Affordable Care Act includes provisions aimed at improving the way health care is delivered and lowering the costs of doing so. These provisions, which apply only to Medicare, include testing alternative ways of paying for health services, as well as new ways of organizing health care providers to enable more coordinated care for patients. The law also helps Medicare to partner with private payers and states to spread these innovations across the country, but it is unclear how widely they will be adopted.

It is also uncertain whether families across the income spectrum will share in savings that may accrue from slower growth in health care costs and premiums. Research has shown that the slower growth in wages during the past decade has been part of a trade-off to preserve health benefits.[12] But while growth in premiums and deductibles has slowed over 2010–2013, median family income, when adjusted for inflation, remains below 2010 levels. Indeed, U.S. families are still trying to recapture lost income from the financial crisis and recession of 2008: real median income is 8 percent lower than it was in 2007. It is unlikely that most families at the middle and lower end of the income distribution are able to detect or feel the premium slowdown in their pocketbooks since they are paying more in premiums and deductibles as a share of their income than ever before.

The challenge to policymakers, researchers, and stakeholders will be to continue to pursue efforts to contain health care cost growth, while ensuring that savings are shared with patients and their families.

METHODOLOGY

The issue brief analyzes national trends in private-sector health insurance premiums, employee premium shares, and deductibles for the under-65 population from 2003 to 2013, based on the Medical Expenditure Panel Survey (MEPS) of private employers in all states. The data on premiums and deductibles come from the annual federal surveys of employers, with representative state samples. We also compare total premiums with median household incomes for the under-65 population. Income data come from the U.S. Census Bureau's Current Population Survey of households. Calculation of premiums as a share of median incomes uses the average total annual cost of private group health insurance premiums for employer-sponsored coverage, including both the employer and employee shares. This analysis updates previous Commonwealth Fund analyses of state health insurance premium and deductible trends.[13] A future issue brief will focus on the state-specific findings.

NOTES

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