“Tipping Points” of Employer-Sponsored Health Insurance

Will American Businesses Ever Leave the Health Care World?

Henry C. Eickelberg
American Health Policy Institute (AHPI) is a non-partisan 501(c)(3) think tank, established to examine the impact of health policy on large employers, and to explore and propose policies that will help bolster the ability of large employers to provide quality, affordable health care to employees and their dependents. The Affordable Care Act has catalyzed a national debate about the future of health care in the United States, and the Institute serves to provide thought leadership grounded in the practical experience of America’s largest employers. To learn more, visit americanhealthpolicy.org.

Henry C. Eickelberg is a Senior Fellow at the American Health Policy Institute, where his research focuses on public policy changes and emerging innovations impacting the employer-sponsored insurance landscape. Previously, Eickelberg served as corporate Vice President of Human Resources and Shared Services for a Fortune 100 company with international operations. Prior to that, he was a law partner at Jenner & Block where he specialized in executive compensation, ERISA and M&A, and was a consultant with William M. Mercer, Inc. Eickelberg is an adjunct professor of law and faculty advisor at the Georgetown University Law Center, and is the lead instructor for the American Bar Association’s Joint Committee on Employee Benefits M&A workshop for practicing attorneys. Henry is a Fellow of the American College of Employee Benefits Counsel and serves on the College’s Executive Committee. He is a member of the American Benefits Council (ABC), serves on the Board of Directors of the ERISA Industry Committee (ERIC), and is a member of the Bloomberg BNA ERISA Advisory Board.

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"How did you go bankrupt?" Bill asked.
"Two ways," Mike said. "Gradually and then suddenly."

_The Sun Also Rises_, Ernest Hemingway

**The Tipping Point**

For some time, people have wondered aloud for how much longer employers will sponsor health care coverage for their employees given the cost. They’ve speculated whether the erosion of employer-sponsored health care would be gradual (perhaps beginning with small and midsize employers) or sudden (including large employers). Will employers leave the health system voluntarily or be forced out? In short, is there a “tipping point” that, once crossed, will spell the end of broad-based employer-provided health coverage? This paper examines some of the factors that would influence the “tipping point.”

**Looking Back to Look Forward**

In looking at what factors might form a “tipping point” causing employers to end their commitment to broad-based health coverage, it is instructive look back at past fundamental shifts in employment-based benefits and see what factors drove those changes. Over the past several decades, two other major shifts have occurred: (1) elimination of retiree medical benefits; and (2) the shift from defined benefit to defined contribution retirement plans. Both shifts were driven, in large part, by changes that negatively impacted employers’ financials.

**SFAS 106 – Retiree Medical Benefits**

In 1990, the Financial Accounting Standards Board released Statement of Financial Accounting Standard 106 (FAS 106), which changed how corporations were required to report retiree medical liabilities on their financial statements. Before FAS 106 (as it came to be referred), corporations were not required to show an estimate of the future cost of retiree medical benefits they had promised employees on their balance sheet. FAS 106 changed this practice requiring corporations to post the net present value of retiree medical benefits granted on their balance sheets. During the period between FAS 106’s initial publication in 1990 and its adoption in 1993, many corporations curtailed and/or eliminated retiree medical benefits for both existing retirees and actively employed individuals.

**The Shift from Defined Benefit to Defined Contribution Retirement**

Another major change in employer-provided benefits occurred with the shift to defined benefit retirement programs. Beginning in the mid-1980s, defined benefit retirement plans have been largely phased out of corporate-provided benefit programs. It is difficult to identify a single moving event that served as the catalyst. One of the first major changes occurred in the mid-1980s when federal tax rules were changed to limit the deductibility of pension contributions. Additionally, the Financial Accounting Standards Board issued Statement of Financial Accounting Standard 87 (FAS 87), which required additional financial disclosure for corporate defined benefit pension plans. Then, in the early 1990s, Congress passed tax laws that imposed a significant tax of 50 percent on any reversion of pension assets to a plan sponsor, essentially strongly penalizing a plan sponsor who overfunds
their pension obligations. This law was in response to corporate takeovers that “raided” excess pension benefits to the detriment of participants. Over the years, Congress has continued to place greater burdens on defined benefit pension plans, while easing defined contribution retirement plan sponsorship. In 2006 (ahead of the Global Financial Crisis (GFC)), Congress passed a major restructuring of defined benefit plan funding rules making the rules much more sensitive to interest rate changes, but the Federal Reserve, in response to the GFC, embarked on massive asset purchases, along with a “zero rate interest policy” (ZRIP) that, when combined with sharp increases in Pension Benefit Guaranty Corporation premiums, drove up the cost of unfunded pension liabilities. Facing difficult financial conditions and greater uncertainty with their defined benefit pension plans, corporate sponsors have continued to curtail and/or freeze their pension plans.

**Lessons Learned from the Retiree Medical and Defined Benefit Program Changes**

While no two situations are ever the same, there were several common drivers that led plan sponsors to revisit their commitment to retiree medical and defined benefit pension programs. A major force was the change individuals and companies had in the employment relationship. The business world rapidly globalized and became much more competitive. As a result, businesses faced relentless cost pressures. Additionally, tax/regulatory and financial accounting policy changes highlighted retiree medical and defined benefit programs liabilities and costs. Facing greater cost pressures and the need to recognize future retiree medical and defined benefit plan costs and liabilities, corporations took the opportunity to re-examine their commitment to these programs with the clear majority opting to reduce the inherent value.

Looking at the impact on employees, for the most part, retiree medical and defined pension benefit changes had largely a prospective impact, as the changes manifested themselves well in the future. Second, the impact of changes generally fell on individuals who were no longer in the workplace. Third, impacted individuals typically had some alternatives for dealing with the changes created by the loss of retiree medical benefits and/or defined benefit pension. For individuals who lost post-employment medical benefits, they could access temporary health coverage provided under The Consolidated Omnibus Budget Reconciliation Act (COBRA) and Medicare when they reached eligibility. For those who lost future defined benefit pension benefits, they still had social security benefits to draw on in retirement. Additionally, companies generally made available enhanced defined contribution benefits (i.e., 401(k) plans), which allowed these individuals time to save money for retirement. But the fact that changes in retiree medical and defined benefits programs (even though they were significant)—generally only manifested themselves in the future cannot be overstated, especially when comparing such changes to the impact that the loss of employer-sponsored medical coverage would have on active employees and their dependents. Looking back, the primary driver of change for retiree medical benefits was the change in financial treatment. The primary driver for change in defined benefit pensions was a combination tax policy and the Federal Reserve’s zero interest-rate policy changes that acted to drove up the magnitude of existing liabilities and introduced significant volatility in annual pension costs.
In looking at whether there is a “tipping point” at which employers would exit employer-sponsored health care, it’s important to consider the benefits (and challenges) employers face offering health coverage to their employees.

**Value (Actual or Perceived) versus Cost (and Availability)**

A major incentive for employers to offer health benefits to employees is the fact that employees generally perceive that they get a better deal with employer-sponsored health care (versus purchasing coverage on their own). Employer-sponsored health coverage is generally less expensive and more comprehensive than coverage available on the individual market – and most employers subsidize some portion of the total cost of health coverage and do so on a tax-efficient basis. Additionally, employees rely on and trust their employers to navigate the extremely complex health care landscape on their behalf and provide tools to help them make the right decisions regarding coverage. These factors cause employees to see employer-sponsored health care as having a greater value to them than the benefit’s actual cost.

**Health Care: A Benefit for Today**

Unlike retiree medical and defined benefit pensions where the changes manifest themselves in the future and largely affect former employees, eliminating active employee health care would impact the employer’s current workforce. The idea of an employer ending health care coverage and pushing its employees out into an uncertain individual market or a public exchange to secure health care coverage on their own represents a huge impediment to change. Such a change would impact the employer’s entire workforce, including the organization’s executives, who even with their greater financial wherewithal, would not want to relish the prospect of trying to secure comparable individual coverage at a much higher cost.

**Organizational Challenges in Offering Health Care Benefits**

For years, employers have experienced significant health care cost growth. So far, employers have generally continued to offer broad health care coverage because they have been able to absorb the cost increases, as well as and pass them on to employees and customers. But, dealing with escalating health care coverage costs has become exceedingly complex and shows no sign of changing. To manage their health care benefits, employers find themselves having to make significant overhead investments in internal staff with appropriate expertise and external consultants. The job of these professionals is to positively impact the health care “cost curve.” And, while the cost to manage a corporation’s health care program is relatively small as compared to the program’s overall cost, the associated challenges are never-ending. Efficiently buying health care requires coordinating multiple parties each trying to leverage their own interests within a highly-regulated environment. To affect the health care cost curve, employers must navigate a constantly changing supply chain that too often lacks any reasonable transparency as to forward-looking cost drivers.

In assessing a potential “tipping point,” several factors are instructive. To date, employers have been able to absorb the costs of administering, and more importantly, maintaining health care programs. A factor that would potentially signal a “tipping point” would be if employers no longer could find a way to pass along these costs. This could occur if the cost of providing health care suddenly accelerated to a level that made health care costs too large to absorb using the tools
typically available to employers. For their part, employees have seen smaller wage increases as employers have struggled absorbing health care cost increases. Employees have demonstrated an implicit preference for comprehensive health care verses demanding larger pay increases given the cost of coverage on the individual market and the inability to duplicate the comprehensive level of coverage employer-sponsored health care generally provides.

The Health Care Supply Chain: A Study in Change

Over the years, change has been a constant with respect to the health care supply chain. In the 1970s, traditional, fully-insured indemnity plans were prevalent. Many did not cover cancer treatment (due to its high cost and experimental nature). Employers paid a premium to an insurance company which maintained a schedule of reasonable and customary charges. Patients (employees and their dependents, if covered) were responsible for deductibles, out-of-pocket maximums and charges above the insurer’s reasonable and customary schedule. Prescription drugs (to the extent covered) were bundled with the underlying insurance coverage. Preventive care was generally not covered as insurance plans only covered expenses related to an accident or illness.

The comprehensive nature of health care coverage expanded through the 1980s and 1990s, along with the prevalence of Health Maintenance Organizations (HMOs) that put in place the idea that access to medical care (while more comprehensive and generally with the enticement of lower out-of-pocket costs) was restricted to a pre-approved panel of medical providers (doctors and hospitals) whose job it was to efficiently manage patient care. The growth of HMOs helped moderate health care cost growth in the 1990s. During this same time frame, pharmacy benefit manager businesses (PBMs) came into existence as separate, standalone organizations. In addition, medical break-throughs produced innovative blockbuster drugs that were met with strong consumer demand. Employers, interested in obtaining greater market leverage over the cost of these new blockbuster “name-brand” drugs gravitated towards PBMs that could provide better pricing deals (by aggregating their customer purchases) than employers could secure on their own. As a result, many employers looked to “carving out” their drug coverage from their health care programs. This disaggregation allowed employers to leverage one component of their health care spend much more effectively (and with greater tailored programs) than if the employer continued to bundle prescription drug costs inside their health care program. Additionally, many large employers self-funded their health care programs. This caused insurance companies to change their business model away from taking the total financial risk for a company’s health care spending to an organization that managed hospital and physician contracting, adjudicated medical claims and offered employers add-on point solutions, such as a tailored diabetes program. With the shift in financial risk to employers, health insurance companies looked at running their businesses very differently. Their financial incentives moved from controlling health care costs to winning new business based on low-cost administrative processing and efficient contracting with the health care community.

In the 2010s, the passage of the Patient Responsibility and Affordable Health Care Act (ACA) ushered in several new paradigms. The ACA placed several significant constraints on employer sponsors (i.e., removal of lifetime spending limits, expansive of dependent coverage to age 26, imposition of the Cadillac Tax, as well as employer coverage mandates and requirement to provide comprehensive and affordable coverage) and on the insurance industry (i.e., limits on loss-ratios and executive compensation). The passage of the ACA resulted in further industry consolidation as market participants looked to maintain (or grow) their market leverage within the health care supply chain. At the same time, advances in pharmacy, particularly specialty drugs and other innovative treatment plans, resulted in significant cost growth. In the 1970s, it would have been virtually
impossible to actually spend a $1,000,000 in medical treatments on someone during their lifetime. Contrast that reality with today’s where a single course of treatment for a rare, but debilitating condition can run $1,000,000 or more. And, science is promising further medical break-throughs with similar significant price tags.

Employer-Sponsored Health Coverage: On the Outside Looking In

So, where does this leave employers? Fundamental to employers sponsoring health coverage is the ability, in some fashion, to pass along the cost of employer-sponsored health care to consumers (or their employees). With the significant marketplace consolidation among insurance companies, PBMs and, most importantly, medical providers, employers now have fewer organizations to work with in their efforts to mitigate medical cost inflation. Adding together the significant vendor consolidation with legal prohibition on lifetime medical caps and a growing list of innovative drugs costing hundreds of thousands of dollars (and in some cases, millions), employers could well find themselves facing staggering medical cost increases but with significantly diminished market leverage to help abate these costs. The question is: will employers continue to be able to absorb these increases? The only real impediment to moving away for offering health care is the perceived disruption that would occur if all employees were required to obtain health coverage in the individual market.

Government Regulation of Employer-Sponsored Health Care

Federal, State and even Local governments are significantly involved in regulating the delivery of health care. For the most part, the current regulatory environment generally encourages employers to offer health care benefits to their employees. Federal and State income tax laws exempt the value of employer-provided health care from employee income. Employees can save in certain vehicles (on a tax-advantaged basis) to meet future medical expenses. ERISA pre-emption allows employers to side-step State and local insurance regulations that otherwise drive up the complexity and cost of offering health care to their employees. While the passage of the ACA introduced additional complexities for employer-sponsored health care, generally the regulatory environment has remained employer-friendly (or at least is not employer-unfriendly). But the current employer-friendly regulatory climate continues to move in the direction of a greater role for government (Federal, State and Local) in health care delivery. Several States continue to look at ways to introduce universal health care coverage and these initiatives show no sign of abating.

Federal Single-Payer Health Care

The ACA was signed into law in 2010 because the Democratic party had 60 votes in the United States Senate. During the lead-up to the passage of the ACA, there was considerable discussion (and a push by elements with the Democratic party) to include a “public option” as part of the ACA. In large measure, the ACA was patterned off the Massachusetts Health Care Law, which required all individuals to maintain health insurance either through their employer or by purchasing insurance on a State-run exchange. The proponents of the public option wanted at least one of the options available on the insurance exchange to be a government-run medical plan (like Medicare). The public option was not intended to be the only option available, but simply there to give individuals greater choice and to act as a counter-balance to the insured programs that would be offered on the ACA exchange. Others within the Democratic leadership were concerned that existence of a public option would lead to the erosion and eventual exiting of employer-sponsored health care. The concern was that if the public option plan was perceived as materially better (more comprehensive)
and cheaper (more heavily subsidized), it would disrupt the insurance market that the ACA was intended to create. Some supported the ACA, not because they believed it would work, but because they saw it as a first step to single-payer health care. Others were against the ACA, not because they were against government-mandated health care, but because they believed the country should simply move directly to a single-payer system. The bottom line is that the passage of the ACA did not end the discussion on moving to a single-payer system, but only intensified it.

Recently, the idea of moving to a single-payer system has become a central theme for many advocating universal health coverage. Senator Bernie Sanders (I-VT) made it a central issue in his run for the Presidency. A single-payer system (as commonly understood) would prohibit employers from offering health care coverage to their employees. The idea is that all citizens should be treated equally and have access to the same care, and the government has an obligation (in such a rich country as the United States) to make affordable and comprehensive health care available to everyone.

Some employers that are exasperated by raising health care costs have quietly questioned whether it isn’t time for the government to take over the responsibility of providing health care through a single-payer system. Prohibiting employers from offering comprehensive health care to their employees would spell the end of the employer-based health care system. Unquestionably, additional tax revenue would be needed to pay for a universal health care system. It’s hard to say whether the amount of tax revenue needed to support a single-payer system would be more or less than the cost of employer-sponsored health care, at least initially, but in the long-term, it is uncertain whether a government-run program would be more efficient than the private-public system that currently exists.

**State-Run Single-Payer Health Care**

Politicians in some States have voiced support for State-run single-payer health care. Vermont, for example, looked at the idea, but decided against it when it faced the reality of the enormous associated cost. Many within the Republican Party strongly believe in the idea of “States Rights,” which grants States comprehensive authority to experiment among solutions to find the one that works best for their citizens. In February of 2018, HR Policy Association surveyed its nearly 400 members on issues including health care. The members of HR Policy Association are Chief Human Resource Officers (CHROs) of large employers that provide health benefits to more than 9 percent of the private sector workforce in the United States and to over 20 million Americans. In the survey, members were asked: “If assuming employers are no longer required to offer health benefits, how many states would have to implement single-payer systems for your company to consider dropping health care benefits for all employees nationwide?” The majority (59% percent) of respondents said that they would not drop coverage nationwide, but only in those states that implement single-payer systems. Another 20% said that more than 20 states would have to implement their own single-payer systems for them to consider dropping health benefits nationally.

Employers that operate across multiple States have stressed the importance of pre-emption under the Employee Retirement Income Security Act (ERISA). According to HR Policy Association’s February 2018 survey, when asked to select the top three factors out of seven that would serve as “tipping points” for their company, 37 percent selected, “Erosion of ERISA such that self-insured plans become subject to substantially differing state taxes and fees.”
Under ERISA, State laws (other than laws related to insurance and securities) are generally preempted. This stops State and local governments from enacting laws or regulations designed to separately regulate ERISA-covered benefit programs, such as employer-sponsored health coverage. To the extent that States do pass laws (potentially such as a single-payer health care system), one would think that such laws would be pre-empted by ERISA, but if the Federal government somehow relaxed or eliminated ERISA pre-emption in order to allow States to “experiment,” employers might find themselves needing to design State-specific health coverage, thus trading the efficiencies of a uniform national system for the promise of uncertain benefits from innovation and experimentation with new models.

Federal and/or State Health Care Subsidies or Options

Generally, larger employers can provide employees with health care coverage that is more economical and comprehensive than they can secure in the individual market. To the extent that either the Federal and/or State governments began to subsidize the costs – or offer a public option - in the individual marketplace so that health care coverage the individual marketplace was equally as comprehensive and at the same relative cost to employer-provided coverage (assuming the current employer financial subsidy could be paid to employees in a tax-efficient manner, which is currently not possible under today’s tax laws), employees may prefer to secure individual health care coverage outside of the typical employment relationship. In that case, employers may turn to providing health care supplemental coverage (like Medicare coverage) that fills in any financial gaps in coverage (assuming it is legally permissible to do so). This type of a program would be different from a pure single-payer system, in that it would be voluntary and that individuals would purchase coverage on some type of exchange where the cost was subsidized by the government. For example, the progressive Center for American Progress recently proposed a program called “Medicare Extra” where all individuals would be covered by Medicare. Under Medicare Extra, employers would have the option of continuing to provide coverage or allowing employees to enroll in Medicare with the employer paying 70% of the Medicare Extra premiums. Depending on the cost differences, such a program might have a dramatic effect on employer-sponsored coverage.

High-Risk Pools

Like programs that subsidize the purchase of health care coverage, high-risk pools (which are generally run at the State level) could be made available to offer subsidized health care coverage to individuals who have certain qualifying high-cost conditions. The cost of coverage would be subsidized by funds from the high-risk pool. The idea behind high-risk pool is that it allows States to spread the costs associated with the high-risk claimants across a theoretically broader revenue base. The purpose of carving off high-risk claimants into a separate (but independently subsidized pool) is to keep the cost of “ordinary” health coverage as low as possible for as many people as possible.

Employers that offer health care coverage for their employees are generally not eligible to participate in the high-risk pools. Depending on how the high-risk pool (and related insurance subsidizes) are structured, employers in States that offer high-risk pools could find themselves at a financial disadvantage. In such cases, this would serve as a factor that causes certain employers to decrease or eliminate health care coverage they currently sponsor.
Expensive Government Mandates

Health care coverage provided through insured policies generally comes with a number of state insurance mandates. These insurance mandates are medical procedures or conditions that health insurance policies issued in that State are required to cover. Examples of common State insurance mandates, such as infertility treatment, mental health and substance abuse coverage, treatment of autism, coverage of participation in clinical trials, medical procedures received from an acupuncturist or chiropractor. Most large employers self-fund their health coverage and, therefore, are not subject to State-imposed mandates.

Given the ERISA pre-emption that employers enjoy, it is not unforeseeable that the Federal government would impose more and more mandates as part of the ACA’s Essential Health Benefits package. As more and more drugs and procedures enter the marketplace with extraordinarily high price tags, one would expect to see tremendous political pressure applied to make sure that these high cost drugs/devices are available to the limited number of patients who can benefit from them. More mandates will leave employers will less control over their medical trends as legislative mandates attempt to short-circuit potentially lower cost courses of treatment.

Inching (or Running) Towards the Tipping Point

Major Constraints on Eliminating Employer-Sponsored Health Care Coverage

As stated earlier, one factor more than any other acts as a brake on employers jettisoning health care coverage: the inefficient and dysfunctional individual marketplace. It’s one thing for an employer to reconfigure its employment proposition with the effects felt years into the future versus notifying employees that they will now be responsible for securing their own health care coverage. Even for high-paid executives, the prospects of having to purchase comprehensive (let alone) affordable health care coverage in the individual market is daunting – employer-sponsored health coverage is a lot cheaper, more robust and doesn’t involve having to spend the time shopping for coverage.

Trying to ascertain the “tipping point” at which employers would feel it either necessary or desirable to end health care coverage for active employees is very much a process of weighing the alternatives. Every employer faces its own unique challenges and will need to weigh each factor outlined above differently. The purpose of this paper is to aggregate in one place all the reasonable factors that might go into such analysis. But in the end, every employer will need to consider these factors in relationship to its business to decide where the “tipping point” is for them.

Size Matters (and so does Labor Content)

Smaller organizations are likely to “throw-in-the-towel” sooner than larger organizations. There is an overhead component to managing a corporation’s health care costs that (while relatively small to the overall health care spend) is still an overhead cost. Organizations with fewer employees generally compete in markets with other employers that tend not to offer comprehensive health care coverage. It is likely that the prevalence of health care coverage will erode starting with smaller corporations and expanding to medium and larger employers over time. The “gig” economy (where individuals work for multiple employers as independent contractors) is remaking, at least culturally, the prototypical employment contract – and creating additional pressure for new alternatives to the traditional employer-sponsored insurance model.
Employers that need a lot of employees (verses independent contractors) to generate sales revenue will distinctly feel pressure to curtail their financial commitment to employer-sponsored health care. Organizations that are in lower profit margin businesses will search for creative ways to offer health care coverage to their employees using plan designs that allow them to more effectively control their share of the total cost.

**Rapid Cost Growth**

Over the years, medical trend has outpaced general inflation by at least 2 to 1. The question is: what would happen if the cost of medical coverage doubled in say, one or two years’ time? Would employers offering health care coverage be able to either price in this explosive cost either accepting a lower profit margin and/or passing on a greater share of the cost to employees? It’s safe to assume that for many employers, annual cost growth in the 40 percent to 60 percent range would be so significant that they would be left with only very hard choices, including ending health care coverage as it currently exists.

**Government Policy Changes: Single-Payer**

The quickest way for employers to reach the “Tipping Point” would be if government policy (either Federal or State law) prohibited employers from offering employer-sponsored health care. If that happened, it would be “game, set, match”. But, as much as the idea of “single-payer” health care is bandied about, once the cost of running the health care system (without the enormous benefit of employer cross-subsidization and the need for explicit tax increases) sinks in with even the most ardent single-payer supporters, the idea of a single-payer system tends to give people pause.

A more corrosive approach that would likely accelerate the “tipping point” would be undermining the current ERISA pre-emption protection for employer-sponsored health care. Corporations currently don’t mind running a health care program for their employees, but they would mind a situation where the health care program was running them. As soon as corporations felt that they had lost control of their health care costs, the “tipping point” to jettisoning health care coverage could well move rapidly toward reality.

**Miraculous Improvement in the Individual Marketplace**

Employees understand that subsidized employer-sponsored health care is a very good deal. One doesn’t find the same clamoring for employer-sponsored auto insurance coverage. There are clearly efficiencies to group auto insurance (particularly from an administrative and sales/distribution standpoint) that allow for group purchases of auto insurance at a lower price point than the individual market, but nothing equates to the difference in cost (and comprehensive nature) of a well-run group health care program verses health insurance available on the individual market. If regulatory changes created an environment where health care purchased on the individual market was as robust and cost-effective as employer-sponsored health care, this would remove a major impediment for employers to move away from sponsoring health care benefits. According to HR Policy Association’s February 2018 survey, when asked to select the top three factors out of seven that would serve as “tipping points” for their company, 49 percent of respondents selected, “Stabilized individual ACA exchanges that offer the same quality of health care coverage at a reasonable cost.”
Changes in Tax Law and/or Financial Accounting

The major impetus for corporations to revisit the commitment to retiree medical benefits (and defined benefit pensions) was accounting and tax changes that made offering these benefits less palatable. As long as sponsoring active employee health care (or the liabilities associated with those costs) does not pose tax or financial accounting concerns for employers, this should not be an issue. But, if somehow, the financial accounting and/or tax treatment turned negative for employers sponsoring health care, one would expect that corporations would quickly revisit their commitment to employer-sponsored health coverage. HR Policy Association’s February 2018 survey revealed that when asked to select the top three factors out of seven that would serve as “tipping points” for their company, 58 percent of respondents selected “A significant reduction or elimination of the favorable tax treatment of employer-sponsored health care.” This choice had the highest percentage out of all seven options.

Conclusion

For those fully vested in the current system, the operating assumption is that health care is too important a benefit for employees and executives alike for employers to stop offering coverage. In that case, there essentially isn’t a “tipping point” (or the tipping point is so far away and it would take such a monumental shift) that thoughts about a “tipping point” don’t matter.

But, not all employers are the same and all employers do not view their commitment to sponsoring health care the same. Many employers will continue to exit the system as the health care costs approach levels that for their organization are unsustainable. Thus, we are likely to see that the “tipping point” is industry- (and perhaps geographically) specific verses an en masse movement of employers (large and small) moving in unison as they exit the system.

The key question remains: at what point will employers decide that costs and effort in offering broad-based health care programs is outweighed by the cost (and burden) of doing so? For each employer, the calculus to answer this question will be different depending on their economic model, prevalence of offering health care in the marketplace in which they recruit talent, the corporation’s unique culture and a host of other factors we’ve tried to outline in this paper. But, suffice it to say that there is a “tipping point” out there. It may be different for each employer, but the fact remains that there is “tipping point.” For most employers, it will likely be a gradual slide towards not offering coverage; while for others a sudden turn of events could spell the end of the ability and/or willingness to provide health care coverage. How long it will take each employer to reach that point remains an open question, but it’s safe to say that that point closer today than it was yesterday.