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THE EMPLOYER HEALTH CARE BURDEN

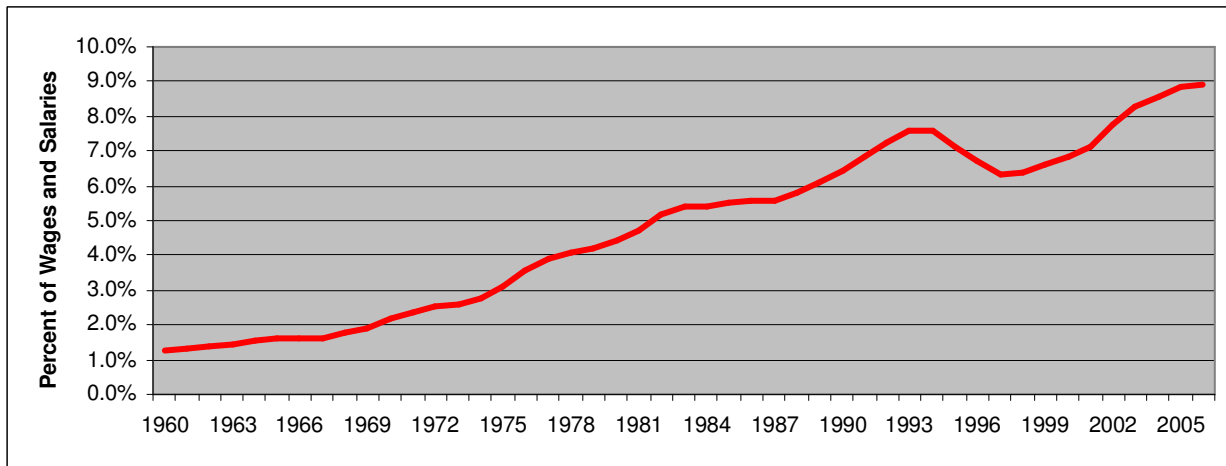
Sarah Axeen and Elizabeth Carpenter*

Sixty percent of Americans currently receive health insurance through their employers.¹ Rising health care costs threaten the competitiveness of employers and the stability of middle-class jobs. A 21st-century health care model must include financing innovations to make the health system more sustainable for both employees and employers.

DEFINING THE EMPLOYER BURDEN

In 2006, private employers spent nearly \$459 billion on health insurance.² Employer health care costs have increased steadily as a percentage of hourly wages and salaries since 1960.³

Figure 1. Employer Share of Wages and Salaries Spent on Health Insurance, 1960–2006



Source: Bureau of Economic Analysis, "National Income and Product Accounts Table," 1960–2006. Data from tables 2.2A and 7.8.

Another measure of the employer burden is the share of payroll spent on health insurance contributions. Payroll includes hourly wages, salaries, supplemental pay (overtime and bonuses), and paid leave.⁴ In 2006, U.S. employers spent 9.9 percent of payroll on health insurance contributions.⁵ This exceeds the amount they contributed to employee Social Security taxes in that year.⁶

However, roughly two-fifths of U.S. firms do not offer health care coverage.⁷ When these non-offering firms are excluded from consideration, average employer costs for health insurance coverage rise to 11.5 percent of payroll. Further, many employees who are offered health insurance by their employers do not enroll. When accounting for workers who opt to enroll in employer-sponsored coverage, the amount firms spend on health insurance rises to an average of 18.4 percent of payroll.

Table 1. Percent of Payroll Spent on Health Benefits, September 2007

Percent of Payroll	All Firms	Firms that offer health insurance	For employees enrolled in health insurance
Health Benefits	9.9%	11.5%	18.4%

Source: Bureau of Labor Statistics, "Employer Costs for Employee Compensation," September 2007.

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EFFECTS OF THE EMPLOYER BURDEN

- The employer health care burden:
- Puts U.S. firms at a competitive disadvantage compared to foreign firms
 - Forces firms to cut back on health care benefits
 - Results in “good jobs” being lost overseas

High health care costs are often reflected in the price of goods. For example, American automobile manufacturers estimate that employee health insurance costs add \$1,500 to the price of a car.⁸

American employers bear a higher health care burden than their major trading partners. This undermines U.S. competitiveness in the global marketplace.

Table 2. International Comparison of the Hourly Cost of Health Benefits U.S. and Major Trading Partners, Manufacturing Industry, 2005

	Percent of payroll spent on health benefits	Hourly pay, manufacturing industry	Hourly cost of health benefits, manufacturing industry
United States	13.0	\$18.32	\$2.38
Canada	4.5 ^a	\$19.21	\$0.86
Japan	3.7	\$18.06	\$0.68
Germany	6.7 ^a	\$25.53	\$1.70
United Kingdom	1.9 ^b	\$20.91	\$0.40
France	12.8 ^c	\$16.93	\$2.17
Foreign, weighted average	4.9	\$19.79	\$0.96

Sources: Employer contribution rates are from the International Social Security Association, “Social Security Programs Throughout the World,” 2005 (Canada) and 2006 (all other countries). Hourly pay includes pay for time worked, paid leave, and bonuses: Bureau of Labor Statistics, “International Comparisons of Hourly Compensation Costs for Production Workers in Manufacturing,” November 2006.

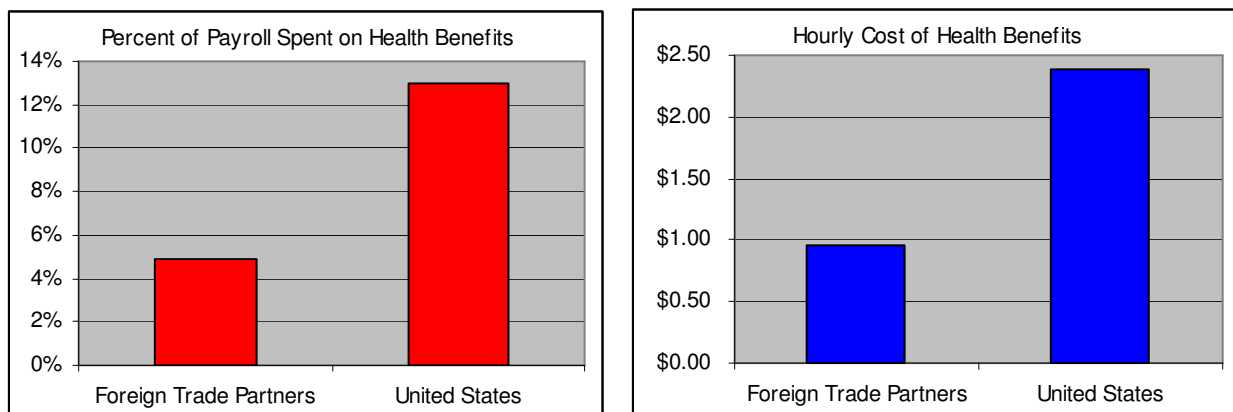
^aMaximum; varies by province.

^bFifteen percent of the 12.8 percent employer contribution is allocated to the National Health Service.

^cAlso finances cash sickness, cash maternity, disability, and survivor benefits.

The manufacturing industry faces particularly high levels of pressure to compete internationally. U.S. manufacturers pay \$2.38 an hour for health benefits, while manufacturers among America’s major trading partners pay only \$0.96 an hour on average.

Figure 2. United States versus Foreign Trade Partners, Manufacturing Industry, 2005



Sources: Employer contribution rates are from the International Social Security Association, “Social Security Programs Throughout the World,” 2005 (Canada) and 2006 (all other countries). Hourly costs from Bureau of Labor Statistics, “International Comparisons of Hourly Compensation Costs for Production Workers in Manufacturing,” November 2006.

ECONOMIC THEORY

Economic theory says that rising health care costs do not affect a firm's profits because workers bear the burden of health insurance expenses through lower wages.⁹ While this may be true in the long run, employers cannot fully shift the increasing costs of health insurance to employees in the short run.

Why Can't Health Care Costs Be Shifted to Employees in the Short Run?

- Institutional constraints like union contracts and minimum wages prevent employers from reducing wages.¹⁰
- In the long run, employers can shift health costs by reducing wage *increases*. Health care premium growth has exceeded the sum of inflation and productivity growth by an average of 3.5 percentage points in recent years.¹¹ However, the actual growth of health costs has changed by different, unpredictable amounts each year (see table 3). Thus, health care cost growth cannot be fully shifted into wages in the short run because employers cannot accurately predict how much premiums will grow from year to year. Therefore some fraction of health care costs is coming out of profits.

Table 3. Premium Increases, 1999-2007

	1999	2000	2001	2002	2003	2004	2005	2006	2007
Premium Increases	5.3%	8.2%	10.9%	12.9%	13.9%	11.2%	9.2%	7.7%	6.1%

Source: Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits: 2007 Annual Survey," 2007. Bureau of Labor Statistics, "Consumer Price Index: Annual Percent Changes," January 2008.

- If workers resist wage cuts, employers can replace them or relocate their jobs. However, since this cannot be done quickly employers are still burdened with rising health costs in the short run.¹²
- Economic theory applies only to health costs for active workers—not to health costs for retirees, who account for 6 percent of employer contributions to health insurance.¹³ It is highly unlikely that active workers would accept lower wages to help pay for the rising health costs of retirees.

Decreasing numbers of firms are offering health insurance to employees. Other employers are drastically reducing the benefits they provide and asking employees to bear an increasing share of costs. Since 2000, the percentage of employers offering health benefits declined from 69 percent to 60 percent.¹⁴ Over the same period, the average worker contribution for family coverage increased by 102 percent.¹⁵ This evidence suggests employers cannot fully shift changes in health insurance costs to workers and that rising health care costs have a tangible effect on employers' bottom line.

Table 4. Average Worker Monthly Premium Contributions for Family Health Insurance and Employer Health Insurance Offer Rates, 1999-2007

	2000	2001	2002	2003	2004	2005	2006	2007
Premium Contribution	\$135	\$149	\$178	\$201	\$222	\$226	\$248	\$273
Proportion of Firms Offering Health Benefits	69%	68%	66%	66%	63%	60%	61%	60%

Source: Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits: 2007 Annual Survey," 2007.

For these reasons, reducing the health care burden for employers and workers must be central to any health reform proposal. For a policy proposal that incorporates this vision, see Len Nichols, [A Sustainable Health System for All Americans](#) (New America Foundation, July 2007).

This issue brief contains data and analysis from *Employer Health Costs in a Global Economy: A Competitive Disadvantage for U.S. Firms* by Len Nichols and Sarah Axeen, New America Foundation, May 2008.

NOTES

- ¹ Kaiser Family Foundation and Health Research and Educational Trust, “Employer Health Benefits: 2007 Annual Survey,” 2007.
- ² Office of the Actuary, “National Health Expenditures: Table 5,” Centers for Medicare & Medicaid Services, 2006. This number represents “Private Business Expenditures” minus “other private” and “other public.”
- ³ U.S. Bureau of Economic Analysis, “National Income and Product Accounts Table, 1960–2006.” The data on wages and salaries are from table 2.2A, and the data on health insurance contributions are from table 7.8.
- ⁴ Wages and salaries include: hourly straight-time wage rate or, for workers not paid on an hourly basis, straight-time earnings divided by the corresponding hours. Straight-time wage and salary rates are total earnings before payroll deductions. Supplemental pay includes: overtime and premium pay for work in addition to the regular work schedule (such as weekends and holidays), shift differentials, and nonproduction bonuses (such as referral bonuses and lump-sum payments provided in lieu of wage increases). Paid leave includes: vacations, holidays, sick leave, and other leave with pay. Bureau of Labor Statistics, “Glossary,” U.S. Department of Labor, 2008, <http://www.bls.gov/bls/glossary.htm>.
- ⁵ U.S. Bureau of Labor Statistics, “Employer Costs for Employee Compensation: All Civilian Workers,” September 2007.
- ⁶ Ibid.
- ⁷ Kaiser Family Foundation and Health Research and Educational Trust, “Employer Health Benefits: 2007.”
- ⁸ Jonathan Cohn, “What’s the One Thing Big Business and the Left Have in Common?” *New York Times Magazine*, April 1, 2007.
- ⁹ See, for example, Uwe E. Reinhardt, “Health Care Spending and American Competitiveness,” *Health Affairs* 8, no. 4, (Winter 1989): 5–21; Jonathan Gruber, “The Incidence of Mandated Maternity Benefits,” *American Economic Review* 84 (June 1994): 622–41; and Mark V. Pauly, *Health Benefits at Work: An Economic and Political Analysis of Employment-Based Health Insurance* (Ann Arbor: University of Michigan Press, 1997).
- ¹⁰ For an empirical analysis of the effect of “sticky” wages, see Benjamin D. Sommers, “Who Really Pays for Health Insurance? The Incidence of Employer-Provided Health Insurance with Sticky Nominal Wages,” *International Journal of Health Care Finance and Economics* 5, no. 1, (March 2005): 89–118.
- ¹¹ Authors’ calculations based on Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2007 Annual Survey*, 2007; U.S. Bureau of Labor Statistics, *Consumer Price Index 1913-2007*; U.S. Department of Commerce, Bureau of Economic Analysis, *National Income and Product Accounts*, “Table 7.1. Selected Per Capita Product and Income Series in Current and Chained Dollars, 2000–2007.”
- ¹² Carl J. Schramm, “Living on the Short Side of the Long Run,” *Health Affairs* 9, no. 1, (Summer 1990): 162–65.
- ¹³ Authors’ calculations based on data of selected industries from Agency for Healthcare Research and Quality, *Medical Expenditure Panel Survey*, 2004.
- ¹⁴ Kaiser Family Foundation and Health Research and Educational Trust, “Employer Health Benefits: 2007.”
- ¹⁵ Ibid.

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