

The Employer-Based Health Insurance System

MISTAKE OR CORNERSTONE?



SHERRY A. GLIED

For decades, health policy analysts have voiced their disdain for employer-based health insurance. In 1961, Herman and Anne Somers referred to the system as the “‘shotgun’ marriage of medical care and industrial relations” (Somers and Somers 1961, 227). Critics routinely belittle job-based coverage as an unfortunate historical accident, the by-product of short-lived wartime wage and price controls that moved compensation toward such benefits (Hyman and Hall 2001). Analysts today see the dismantling of this illogical, inefficient institution as an essential step toward the development of universal, equitable health insurance in the United States (Fuchs 1994).

Yet employer-based coverage is a remarkably durable institution. For nearly seventy years most Americans who hold insurance have obtained it through their jobs. Nor is employer-based health insurance peculiarly American, the inadvertent consequence of U.S. policies. Internationally, employer participation in the health insurance system is more the rule than the exception. And far from impeding the development of universal, equitable coverage, the workplace is the foundation of several successful universal insurance systems.

Today American health policymakers have proposed a range of alternatives that either intentionally seek to dismantle employer-based coverage or are likely to undermine it. The orthodox view of job-based coverage implies that policies that lead to its disappearance would be desirable, or at worst benign. The historical and international persistence of this institution, however, suggests the need for a second appraisal of this venerable institution.

The Origins of Employer-Based Coverage

In 2002, 92 percent of all privately insured Americans under sixty-five obtained health coverage through their current or past jobs or through the jobs of family members. The percentage of all Americans under sixty-five who have in-

insurance coverage has fallen from 86 percent in 1987 to 83 percent in 2002, primarily because the cost of health care relative to income has risen (Glied and Stabile 2000). Among those under sixty-five who do hold coverage (private or public), however, the share covered through employment has risen. In 1987, 77 percent of the insured held job-based coverage; today the fraction is 79 percent.¹

The conventional history of employer-based coverage in the United States begins during and after World War II, when the federal government imposed price and wage controls. Employers seeking to attract workers offered health insurance and other non-wage benefits as substitutes. The inflation-control policy inadvertently contributed to vast growth in insurance coverage—from 1.3 million people in 1940 to 32 million in 1945 (Health Insurance Institute 1970, 17).

Provisions of the tax code further encouraged employer-based coverage (Thomasson 2002). The tax code does not treat employer payments for health coverage as compensation, and thus exempts them from payroll and income taxes (a practice that the Internal Revenue Service formally codified in 1954). This effective subsidy raises overall coverage but has been widely criticized as highly inequitable (favoring the highest-paid employees who are in the highest tax bracket) and often inefficient (favoring those who purchase more costly plans, including plans that encourage excessive utilization) (Glied 1994). Increases in income and payroll taxes since the 1950s have made this tax subsidy ever more valuable, fostering the expansion of employer-based coverage. Employee payments have also been exempt from tax since 1984, if they are channeled through a flexible spending account.

Although this history portrays job-based coverage as an accident, in fact, private health insurance in the United States has always been job based. In the early twentieth century, when income losses owing to ill health were much more important than coverage for medical costs, several large firms, notably Montgomery Ward, began offering disability insurance (and often medical care) to their employees (Faulkner 1940). Today's paid sick days and job-based short-term disability policies are the legacy of these early ventures. Voluntary fraternal organizations also attempted to provide disability insurance (among other benefits) to their members. Membership in the organizations was fluid, and new members attracted by the availability of these benefits tended to be less healthy than anticipated while young, healthy members often defected, ultimately dooming these plans (Witt 2001).

As the costs (and quality) of medical care rose through the 1920s, paying for medical care became a distinct concern. The Committee on the Costs of Medical Care reported that by 1932 about 670,000 workers participated in some form of industrial fixed-payment medical service (Williams 1932). As the depression deepened and paying for care became more difficult, hospitals developed Blue Cross prepayment plans. Hospitals sold these early Blue Cross plans exclusively to job-based groups, including teachers, bank employees, and newspaper workers—before the mid-1930s these plans excluded even dependents (Reed 1947). Plans typically required employer groups to guarantee a fixed level of participation, usually between 40 percent and 75 percent of their employees (Cunningham and

Cunningham 1997). Efforts to sell Blue Cross products to individuals and very small groups during the 1930s led to significant adverse selection (wherein people who anticipate high health costs dominate a risk pool) and nearly bankrupted some regional Blues (Cunningham and Cunningham 1997).

This early history suggests that while price controls and tax policies have been important to the development and persistence of job-based coverage, they were neither necessary nor sufficient. Empirical studies of the effect of tax subsidies on the institutional structure of health insurance strengthen this claim. Although the effect of these tax provisions, at the margin, is to reallocate coverage from the individual market toward the employer-based market, the magnitude of this effect is quite modest. Studies find that this structural effect operates strongly in small firms with fewer than twenty-five or so employees (Stabile 2002; Finkelstein 2002). In the absence of such a subsidy, about half of very small firm employees with job-based coverage would likely lose access to such coverage (their firms would no longer offer it). This implies that offering coverage is subsidy dependent and not fundamentally economically efficient for these small firms. The subsidy appears to have little effect on the choice of job-based rather than individual coverage among employees in larger firms, however. Even without the subsidy, most workers in large firms would continue to obtain health insurance through their jobs.

The importance of job-based coverage in a wide range of institutional contexts around the world attests to the inherent value of organizing health insurance around employment. Well before voluntary employment-based coverage began in the United States, countries with social insurance systems—most notably Germany (also France, Hungary, Czechoslovakia, and several others)—organized the delivery of many mandatory social insurance benefits, including disability and, eventually, medical insurance, through the workplace (Williams 1932). German employers not only contributed to the cost of public social insurance programs (as in the U.S. Medicare program) but also established and managed private insurance plans (or sickness funds) themselves. The German system has become less reliant on management by individual employers over time, but even today, more than a century after the establishment of universal social insurance, many of the largest German employers continue to operate their own health insurance programs (Amelung, Glied, and Topan 2003).

In countries with other forms of universal insurance, publicly financed and organized plans provide major medical coverage. These plans include the National Health Service model in the United Kingdom, the national health insurance model in Canada, and the social insurance system in France. Yet even in many of these situations, employers continue to provide supplemental insurance coverage. Voluntary job-based coverage exists in Belgium, Canada, Denmark, Finland, France, Hungary, Sweden, and the United Kingdom, among others. While such private insurance is much more limited than in the United States (where private job-based insurance pays for about 27 percent of all health care bills), the predominance of job-based coverage in these private markets is striking (Cowan et al. 2002).

In the United Kingdom, for example, job-based coverage accounts for about

three-quarters of the market for private health insurance, which covers about 11 percent of residents. The high share of job-based coverage in this small private insurance market is particularly striking because employer payments for health insurance are not tax exempt and all private insurance premiums are subject to an additional tax. In France, supplemental job-based coverage accounts for about two-thirds of voluntary private health insurance (which pays for about 10 percent of total health expenditures) (OECD 2001). About two-thirds of Canadians are covered by supplemental job-based coverage, which pays the cost of medical services not covered by the national plan, including prescription drugs (Stabile 2002). The average per-employee cost of private coverage in Canada is about 10–15 percent of the per-employee cost of employer-based coverage in the United States.

Finally, job-based coverage is often the only form of health insurance available to middle-income workers in developing countries. Large firms in Brazil, India, and Indonesia (to name a few) routinely provide health insurance to their employees. In other cases, firms provide direct health services in lieu of coverage (Jack 2000; Marzolf 2002; Naylor et al. 1999).

Employment-based coverage, then, is not just an accident of history. Nor is job-based coverage merely a regrettable and inferior way-station, a stage in the maturation of the U.S. health care system on its road to—take your pick—national health insurance or universal, market-based, individual coverage. Rather, job-based coverage is a unique institution that continues to provide the only available basis for a stable private insurance market.

Why Employment-Based Coverage Works

Medium and large firms appear to provide a natural venue for the sale of health insurance. Bigger firms enjoy substantial administrative cost advantages in most of their activities, from purchasing pens and copy paper to offering paid sick leave and disability insurance (Brown et al. 1990). Obvious economies of scale accrue from the ability to make fewer sales calls and process a single payment rather than many. These administrative savings make it advantageous for firms to offer employees a range of benefits and amenities. These advantages are particularly stark in health insurance markets.

The problem of adverse selection plagues markets for all types of insurance, but it is especially difficult in markets where health risks develop over time. Most people would like protection against both the risk that they will experience a negative health event in the coming year (as in all types of insurance) and the risk that they will develop a chronic health condition that will permanently raise their health care costs. In some markets, such as the life insurance market, innovative long-term contracts encourage people to buy coverage when they are young and retain it even if they discover that they are healthier than expected. Developing sustainable long-term health insurance contracts has proven a more intractable problem. Although several economists have described potential models, no going concern has yet adopted them (Cochrane 1995; Pauly et al. 1995). Instead, nongroup health insurance contracts are annual. Thus an event that permanently raises health care

costs will permanently raise health insurance premiums—precisely the result people would like to avoid.

Job-based coverage through large firms offers the only existing long-term private health insurance. Such firms can solve both the point-in-time and long-term problem of adverse selection better than voluntary organizations because employees constitute a group formed and sustained for reasons other than the need for health insurance. The group may contain a variety of health risks, but there is little reason to expect people with an exceptional demand for health insurance to dominate. Moreover, people decide to remain at or leave firms mainly (though, noted below, not entirely) for reasons other than their health. Indeed, people whose health deteriorates are more likely to leave their jobs (or retire) than are those who remain healthy.

Voluntary organizations could (and in some instances do—witness the Amish, for example) offer stable health insurance just as effectively as firms do, if the hurdles to joining the organization and maintaining membership and the penalties for exit were as great as those for taking on and leaving a job. Employers provide health insurance mainly because employees value the benefit much more highly than the cost employers incur. The lower loading costs and other inherent advantages of group coverage enable employers to “sell” coverage to their employees at a substantial discount. Firms that do not offer this discounted benefit must pay higher wages to attract similar workers away from competitors that do offer such coverage. Thus the total cost of labor compensation is likely to be lower for firms that can offer both wages and coverage to attract workers than for firms that offer only wages (Famulari and Manser 1989).

This administrative advantage makes employers the essential building blocks of a private health insurance system. Moreover, this employer-based system can operate quite effectively without much regulation.² In the nongroup market, regulators aim to moderate rate variation and demand renewable products. By contrast, monitoring the health care costs of potential hires and current employees (and their dependents) at the firm level makes little sense (Bloom and Glied 1991), even without calculating the damage that such a policy would have to the value of the insurance benefit for all employees. Firms have no reason to offer benefits that their employees do not value, so regulation of the content of health insurance can also be minimal. Indeed, under ERISA (the federal law that covers employee benefit plans), medium and large U.S. firms can avoid virtually all substantive regulation of health insurance by self-insuring (Briffault and Glied 2002). While regulation of nongroup markets is full of pitfalls, the employer-based system has operated for about three-quarters of a century as an almost completely unregulated market.

So It Works—So What?

Private health insurance—which, as I have argued, means job-based insurance—operates differently from public insurance. Because it operates in a market, is only lightly regulated, and is highly decentralized, private health insurance can offer much more flexibility than public coverage alone. This flexibility makes

private job-based coverage relatively successful in providing insurance to the large subset of Americans who can afford to buy it at current prices, and makes it a useful alternative or supplement to public systems in other countries.

Private employers purchase health insurance in much the same way that they purchase production inputs. In purchasing inputs, employers seek those that will enable them to make, at the lowest-possible cost, products whose characteristics (including price, color, size, and quality) most appeal to consumers. Likewise, in purchasing health insurance, employers wish to obtain, at the lowest-possible cost, the package of compensation (wages, insurance benefits, and pensions) that their employees most prefer. These goals are relatively straightforward—especially compared with the multiple political and policy objectives of public health insurance programs.

The single-minded pursuit of a low-cost product that keeps employees satisfied makes private employers dismiss pleadings from providers (and, to our dismay, makes them equally dismissive of the suggestions of health policy analysts). In markets, purchasers and their dollars rule. This means that private employers can readily purchase products that reduce payments to one provider group in order to expand benefits in another area. In the 1990s, for example, employers added coverage for prescription drugs to employee benefit packages while restricting provider networks and cutting payments to physicians and hospitals (Centers for Medicare and Medicaid Services 2003; Glied 2003). Providers might justifiably complain that they have lost revenue so drug manufacturers can earn more. Employers simply saw the rise in consumer interest in prescription drugs and decided to buy a product that would satisfy their audience. As the Medicare prescription drug debate and similar struggles in Canada suggest, public health insurance programs have much more trouble redividing the pie in this way, even when such a redivision is justified.

When employers blithely select plans that limit choice of provider or fail to cover chiropractors or limit hospital stays, affected providers seek relief from regulators and legislators. Organized provider groups have clout at the legislative level that dissolves once they enter the marketplace.

Employers' disregard for organized providers allows them (or the private insurers with which they contract) to easily adopt and discard benefit, payment, and organizational innovations. Employers have not necessarily been more innovative than governments in the health care market; government researchers developed many of the most significant payment innovations of the past three decades, such as diagnosis-related groups (DRGs) and resource-based relative value scales. However, benefit, payment, and organizational innovations diffuse much differently in the public and private spheres. Governments commission and then legislate new administrative technologies. Private insurers pick and choose among such innovations.

Some private insurers adopted DRGs while others tried capitated payments, for example, but many discarded these methods in favor of others, such as negotiated per diem payments combined with utilization review (InterStudy Reports HMOs Move to per Diem Rates 2001). Employers tried covering alternative medicine in the mid-1990s, but later eliminated these services when added benefits

led to overuse and high costs (Edlin 2003). Employers also tried managed-care plans that restricted enrollees' choice of providers, but employees weren't satisfied, so employers added point-of-service options. In the early 1970s, when utilization review was new, both private insurers and Medicare began to implement it. In the 1990s, when it no longer seemed to work, private insurers were quick to dismiss it (Prince 1999).

Private plans may make precipitous decisions regarding which innovations to adopt and reject, but this flexibility can be a valuable antidote to the slow pace of public insurance systems. Dropping a previously covered benefit or changing a payment mechanism takes years of hearings and court rulings under Medicare; it takes a phone call under a private insurance plan.

Employers also gain from their ability to shop for the best prices. Health care is local, so shopping opportunities are often limited, but where national markets exist, as in pharmaceuticals, private markets can be adept at seeking out and exploiting opportunities for savings. The success of private plans in restraining drug costs has led many in Congress to favor the use of such plans in arranging prescription drug benefits for Medicare patients. Of course, government purchasers can also reduce prices, simply by exerting their monopsony clout. The advantage of private competition is that cost reduction efforts are less monolithic. Individual purchasers can negotiate lower prices by offering to purchase in bulk, but across the entire market of purchasers, a variety of similar products can remain viable. Such basic differences between government and market approaches were at the heart of the protracted policy debate about how to structure the Medicare prescription drug benefit (Huskamp et al. 2000).

Finally, private markets permit purchasers to make tradeoffs between the value and cost of new technologies. If people want more of something, or want it faster, and they are willing to pay for it, private markets are likely to arise to sell it to them. This responsiveness has costs. By behaving in this way, private markets translate inequities in income into inequities in the consumption of goods and services. Such responsiveness provides an important signal of consumer demand, however, describing not only what people want but how much it is worth to them.

These benefits—flexibility, responsiveness, shopping—are both the advantages of private insurance and the characteristics that have allowed private job-based health insurance to evolve and survive over time. Job-based coverage has accommodated the pharmaceutical revolution, the development of outpatient surgery, and many other technological changes that have altered the health care delivery system. It has endured the decline of labor unions, the rise of the two-earner household, growing international competition, and other upheavals in the American labor market. Private job-based coverage offers a viable, rapid-response mechanism that complements the ever-changing health care delivery system and labor market. These attributes have made job-based coverage the dominant choice for providing health insurance to average-income working Americans and a source of supplementary benefits in a variety of public health insurance systems.

Yet in both the United States and other nations, the role of private job-based coverage is circumscribed. It operates in contexts where its beneficiaries can pay

most of the cost of health care themselves and where the inevitable missteps of private coverage in benefit design, payment mechanisms, and organizational form are bearable. Nowhere does job-based coverage alone provide universal and comprehensive health insurance.

What Job-Based Coverage Cannot Do

Job-based health insurance is a voluntary, market institution. These attributes give the institution its characteristic strengths, but they also limit its use. Despite its strengths, the job-based voluntary private insurance system in the United States leaves over forty million people uninsured.

The most important failing of job-based coverage is in redistribution. Markets and market institutions do not by nature voluntarily redistribute resources.³ Job-based coverage does seem to foster an unusual degree of redistribution across workers of different incomes within firms (working at a firm with higher-wage colleagues raises the probability that a low-wage worker will have coverage). Structural, regulatory, and tax features all contribute to this cross-subsidization. To avoid adverse selection within the employer pool, many insurers require, as a condition of coverage, that most employees take up insurance. Nondiscrimination rules prohibit insurance arrangements that favor only the most highly paid employees. The substantial subsidies that high-wage workers obtain from the favorable tax treatment of job-based coverage may make them willing to cross-subsidize coverage if that is what it takes to maintain their tax benefit. Yet even with these advantages, the degree of income cross-subsidization under private health insurance is limited.

The job-based health insurance system—like any other private system—never provided health insurance to workers with very low earnings, including disabled workers and those with very few skills. The tax exemption for employer-based health insurance provides very little subsidy for the purchase of health insurance for low-wage workers who already face relatively low marginal tax rates. Given these low subsidy levels, many people in this group do not seek out jobs with health insurance coverage, while others turn down coverage when it is offered. In effect, low-wage workers do not trade off cash for benefits. As the cost of health insurance coverage and the employee share of that cost has risen, a growing number of workers are being priced out of the system and no longer accept job-based coverage when it is offered. Increases in the cost of benefits may lead employers to shift low-wage employees out of the pool of workers eligible for benefits, by contracting out jobs or using temporary workers.

Job-based insurance also generates inequities in the availability of coverage across firms: some firms offer better, more generous coverage than do others. These inequities mirror the many inter-firm disparities throughout the labor market. Small firms pay lower wages than large firms, firms with health insurance benefits tend to also offer pensions and disability coverage, and firms in the apparel industry pay lower wages than those in the transport industry, for example (Brown et al.

1990; Krueger and Summers 1987). Prodigious interventions would be required to smooth such deep-seated variations.

Private health insurance markets may also have difficulty redistributing resources from healthy to sick people. An enduring, and reasonable, concern about job-based health insurance is that employers will discriminate against workers whose health care costs are expected to be higher than average. The substantial value to all workers of coverage that does not drop people when they (or their dependents) become ill, however, suggests that employers may find it economically rational not to discriminate against such workers by firing them or reducing their wages.⁴

Employers might rationally avoid hiring people who are clearly likely to have high health care costs (especially if this information can be inexpensively ascertained). Yet while behaving in this way may make sense, there is little evidence that such discrimination occurs often in practice. Identifying such discrimination may be difficult because employers are unlikely to hire workers whom they anticipate will soon become incapacitated, regardless of whether they do or do not offer health insurance. Still, some evidence shows that private employers do hire people with high future health care costs if they are likely to be able to work. For example, longitudinal studies of people with HIV/AIDS find that about 10 percent who were uninsured moved into private coverage (Smith and Kirking 2001).

Problems of redistribution are the most important reason that people cannot obtain coverage through the job-based system. The connection between employment and health insurance also means that even some people who do earn enough to buy private coverage fit poorly into the system. One group of “misfits” consists of those whose employment situation does not readily lend itself to employment-based coverage. These include new-economy workers with contingent employment contracts, multiple jobs, and part-year employment. This group is relatively small and does not appear to be growing (Hipple 2001). Expanding the misfit group to include people who change jobs often (more than once a year) and those who work for very small businesses that would likely not offer coverage if the tax subsidy did not exist yields a substantially larger group.

A very generous estimate of this expanded group would include all workers in firms of twenty-five or fewer workers (although, in fact, many small, stable firms would continue to find it efficient to offer coverage even without the subsidy). This expanded group accounts for just under half of the active U.S. labor force. Some two-fifths of all Americans under sixty-five live in households that either do not include any workers or include only workers of this misfit type. Even in a system with substantial subsidies for the purchase of insurance, this group would probably not find job-based coverage attractive and would prefer to obtain coverage in a regulated individual market. By contrast, about one-half of all Americans under sixty-five have incomes high enough to afford job-based coverage without a subsidy and are attached to a job that could efficiently offer such coverage.⁵

A system of job-based coverage may find it difficult to accommodate households that deviate from the traditional family. The employer-based system dates from an era when families typically included only one wage earner supporting a

spouse and children. Today fewer than 15 percent of households fit this traditional mold. The problems entailed in matching a job-based system to the changing family are apparent in mandatory systems with job-based financing, such as the German health care system (Amelung, Glied, and Topan 2003). The “spousal tax” of job-based coverage can be substantial under these systems because households with two workers subsidize those with only one worker.

The voluntary employer-based health insurance system has, to some extent, adapted to these changes. In particular, by raising the employee share of spousal coverage, private employers have effectively reduced the marriage tax for two-earner households (these households no longer subsidize single-earner households to the same extent). But individually based systems with non-job-based financing (whether private or public) manage such changes in family structure more easily.

Other criticisms of job-based coverage focus on the effects on the labor market of tying health insurance to employment. Many observers have criticized job-based coverage for making U.S. producers less competitive internationally, but this is unlikely in a voluntary system (Reinhardt 1989). Employers have little reason to continue offering coverage unless workers value it enough to pay for it, and if workers pay for coverage through lower wages than they would otherwise receive, health insurance costs cannot affect competitiveness.

More recently, economists have expressed concern that the link between health insurance and the labor market may diminish job mobility—a phenomenon called job lock (Madrian 1994). Job lock can occur if people who anticipate high health care costs are reluctant to leave jobs with health insurance. Job lock implies that current employers treat workers who anticipate high health costs more favorably than nongroup insurers and potential future employers (evidence that job-based coverage offers insurance whose premium does not vary over time). While job lock is very important to individual workers, the best estimates reveal that its impact on the overall U.S. economy is quite small—below 0.1 percent of GDP (gross domestic product) (Gruber and Madrian 2002).⁶

A final set of concerns relates to the effect of job-based coverage on the health care delivery market. Some analysts have argued that employment-based insurance insulates workers from the true cost of health coverage, leading to a more costly health care system than individuals would select on their own. More recently, other critics have argued that in selecting health plans, employers weight cost considerations more heavily than quality measures. In fact, job-based coverage tends to be more generous—in the sense of having greater actuarial value—than coverage that individuals purchase in the nongroup market, but the difference is only on the order of about 10 percent of actuarial value at the median (Gabel et al. 2002).

The greater generosity of employer plans is a predictable result of the open-ended structure of the tax exemption for employer payments, and may not stem from the employment link itself. Studies of plan selection typically find that employers place a lot of weight on price considerations and pay less attention to quality measures (Quality vs. Costs? 2000). In doing so, however, employers mimic the

behavior of most workers, who are also typically very sensitive to price and less sensitive to quality (Scanlon et al. 2002). Some workers would undoubtedly prefer higher-quality coverage than their employers select, but most apparently would prefer lower prices. Employers appear to do a fairly good job of mediating between these two virtues. The poor state of information on health care quality—not the role of employers in processing that information—seems paramount in explaining the lack of sensitivity to quality in both public and private health care.

Employer-Sponsored Insurance in a Reformed Health Care System

The prevailing view of employer-based coverage as a regrettable accident has had important consequences for health policy. By implying that the job-based system is an outgrowth of tax policy rather than a naturally occurring form, this view leads conservative reformers to imagine that a similar, simple tax-based subsidy could trigger development of a large, stable, lightly regulated market offering individual health insurance with stable premiums. This imagined institutional form has never naturally existed anywhere, however. Likewise, by suggesting that employers' role is merely the result of a wartime misstep rather than a flexible vehicle for channeling consumers' demands, this view encourages liberal reformers to believe that a carefully formulated national system can provide a single, equitable level of insurance that covers all the care people desire and will willingly pay for, even as medical care continuously evolves. This structure is also quite uncommon.

A more useful perspective is to see employer-based health insurance as a valuable institution that has unique strengths but is by nature limited in scope. Conservative and liberal reformers are correct that job-based coverage cannot be the sole basis for a universal health insurance system. The most important reason is that the high and rising cost of health care makes it very difficult for lower-income people to purchase insurance coverage, whether in the nongroup market or through employers. The high cost of care implies that expanding the number of people covered by any type of insurance will require substantially raising the level of public redistribution. Even if combined with an appropriate subsidy system, however, employment-based coverage will not be available or appropriate for some people.

What, then, should be the role of job-based coverage in a universal health insurance system? One job-based model considered in the United States is an employer mandate. Hawaii has had such a mandate for nearly twenty years. A mandate, however, would force small, transient firms to provide coverage although it would not be economically efficient for them to do so.

The regulations needed to make a mandate work—including rules about whom employers must cover, how they must treat dual-earner households, and what coverage must include—would erode the flexibility of job-based coverage. The Hawaiian experience also confirms that even with a mandate, a job-based system alone cannot easily produce universal coverage: the state ranked only seventeenth

in the nation in 2001 in the proportion of residents with job-based coverage. Building comprehensive universal coverage on an employment base would diminish the strengths of this institution—its flexibility and responsiveness—and accentuate its weaknesses, particularly its poor compatibility with misfit workers and households.

Instead, reform strategies that maintain job-based coverage as a voluntary marketplace would make better use of this institutional form. Conservative and liberal proposals (as well as many other arrangements) for expanding health insurance can adapt such a voluntary market.

Many conservative proposals include refundable tax credits (which may either offset tax obligations or, for people without tax obligations, make direct payments) for the purchase of nongroup coverage. For most of the target population, these proposals offer more generous public subsidies for coverage purchased in the nongroup market than for coverage in the group market. This subsidy design would encourage some uninsured people to purchase coverage, but it would also lead some insured people to shift from employer-based coverage to nongroup coverage, and may induce some employers to stop offering coverage. Shifts in coverage may be appropriate, because some tax credit beneficiaries will be a better fit in the nongroup market. For most others, however, the desirability of shifting out of group coverage will depend on the quality of the new, subsidized nongroup coverage, and this market has never before played a significant role in providing private health insurance.

A better option would be to ensure that the value of subsidies remains the same regardless of where people purchase coverage. One step toward achieving this would be to convert the existing favorable tax treatment of health insurance into a tax credit system (Pauly et al. 1992). Unfortunately, simply offering income-based tax credits might not preserve the long-term risk-pooling benefits of job-based coverage. Healthy beneficiaries would be tempted to leave the employer's health insurance pool and seek inexpensive coverage in the nongroup market. Such defections would likely lead to greater "experience rating" within employer groups and undermine pooling. To preserve pooling, any system must permit (and perhaps even encourage) employers to require employees to participate in their job-based health plan.

Combined with a mandate that individuals purchase coverage (either through work or in the nongroup market) and a publicly regulated or provided fallback option, such as an expanded state employees' purchasing pool or a Medicaid buy-in program, a tax credit system might achieve near universal coverage. Most employers who now offer coverage would probably continue to do so. Job-based coverage would probably be of higher quality than nongroup coverage because of economies of scale, but such a system would be much more equitable than the current one, and likely more equitable than the distribution of virtually any other good or service in the United States.

An alternative model would permit job-based coverage as an alternative or supplement to a universal health insurance program financed by progressive taxation. The tax-financed program would automatically enroll all Americans, but they could choose to opt out of the program. Those who did so might receive a tax

credit (set at some fraction of the cost of public coverage) toward the purchase of private insurance.

In this arrangement, job-based coverage would offer a private safety valve for the public system, as in the United Kingdom and Germany. The size of the private job-based market would depend on consumer perceptions of the generosity of public insurance and on the size of the tax credit. Changes in private insurance benefits would reflect consumer demand for new benefits or more generous coverage.

The need to incorporate a voluntary, job-based private market into any public system would complicate its design. A hybrid system would be messy at its edges, where public coverage and private coverage overlapped. The availability of a public insurance system might, for example, lead employers to dump unhealthy workers out of their job-based plans. Regulations could forestall some of this dumping, but some risk selection would likely exist even in a tightly regulated system. Some degree of complexity and inefficiency may be a reasonable price to pay for flexibility.

Permitting private insurance to substitute for public insurance would also inevitably reduce equity relative to an ideal universal system. One option would be to add equity protections to the hybrid system, such as by imposing a redistributive health tax (Glied 1997). Recognizing that retaining parallel systems may be the only practical way to extend coverage in an inequitable society may be more realistic, though. Maintaining job-based coverage will reduce government involvement in the health insurance system and limit explicit redistribution—both features that are likely to make a hybrid system more politically acceptable and easier to implement than a unitary system.

The United States could move toward universal health coverage in several ways. Recognizing and incorporating the strengths of voluntary job-based coverage will likely enrich any of these approaches. Treating employer-based coverage as a historical blunder weakens health policy analysis and proposals. A system that recognizes the near-inevitability of job-based coverage is likelier to prove sturdier, more feasible, and ultimately simpler than one that seeks to design it away.

Acknowledgments

The author thanks Douglas Gould and Bisundev Mahato for research assistance and Dahlia Remler for helpful comments on this chapter.

Notes

1. Author's tabulations of the *Current Population Survey*, Bureau of the Census, Washington, DC, 2003. Note that this fraction declined slightly between 2000 and 2002 after growing steadily through the 1990s. The survey questions changed in 1994, leading to increases in estimates of the proportion of people with employer-based coverage. The proportion has also grown if we use 1994 as the base year, however.
2. By contrast, individual-based private health insurance markets, such as that in the Netherlands, are heavily regulated.

3. A small percentage of firms do adjust health insurance premiums so subsidies are greater for lower-income workers.
4. The situation may be different if fellow employees believe that workers are responsible for their own poor health, as when employers penalize workers who are overweight or smoke, or when employers provide financial incentives for weight reduction and smoking cessation (Aeppl 2003).
5. Author's tabulations of the *Current Population Survey*, Bureau of the Census, Washington, DC, 2002.
6. In part, this is because of federal legislation passed in 1986 (COBRA) and in 1996 (HIPAA). Together these laws mandate that workers who leave their jobs may continue their job-based coverage (by paying 125 percent of its full cost) for up to eighteen months, and that workers who move from one insured job to another are not affected by clauses excluding preexisting conditions.

References

- Aeppl, T. 2003. Ill Will: Skyrocketing Health Costs Start to Pit Worker vs. Worker; Employees Gripe That Those with Bad Habits Drive up Insurance Charges for All; Is the Forklift Driver Too Fat? *Wall Street Journal*, June 17.
- Amelung, V., S. Glied, and A. Topan. 2003. Health Care and the Labor Market: Learning from the German Experience. *Journal of Health Politics, Policy, and Law* 29, no. 4: 693–714.
- Bloom, D., and S. Glied. 1991. Benefits and Costs of HIV Testing. *Science* 252 (June 28): 1798–1804.
- Briffault, R., and S. Glied. 2002. Federalism and the Future of Health Care Reform. In *The Privatization of Health Care Reform*, ed. G. Bloche, 49–81. New York: Oxford University Press.
- Brown, C., J. Hamilton, et al. 1990. *Employers Large and Small*. Cambridge: Harvard University Press.
- Centers for Medicare and Medicaid Services. 2003. *National Health Accounts*. Washington, DC: Department of Health and Human Services. Available at www.cms.hhs.gov/statistics/nhe/historical/.
- Cochrane, J. H. 1995. Time Consistent Health Insurance. *Journal of Political Economy* 103, no. 3: 445–473.
- Cowan, C. A., P. A. McDonnell, K. R. Levitt, and M. A. Zezza. 2002. Burden of Health Care Costs: Businesses, Households, and Governments, 1987–2000. *Health Care Financing Review* 23, no. 3: 131–159.
- Cunningham, R., III, and R. M. Cunningham Jr. 1997. *The Blues: A History of the Blue Cross and Blue Shield System*. DeKalb: Northern Illinois University Press.
- Edlin, M. 2003. Demand for CAM Grows, but Belongs in a Separate Benefit Category. *Managed Healthcare Executive* 13, no. 6: 38.
- Famulari, M., and M. E. Manser. 1989. Employer-Provided Benefits: Employer Cost versus Employee Value. *Monthly Labor Review* 112, no. 12: 24–32.
- Faulkner, E. J. 1940. *Accident-and-Health Insurance*. New York: McGraw-Hill.
- Finkelstein, A. 2002. The Effect of Tax Subsidies to Employer-Provided Supplementary Health Insurance: Evidence from Canada. *Journal of Public Economics* 84, no. 3: 305–339.
- Fuchs, V. R. 1994. The Clinton Plan: A Researcher Examines Reform. *Health Affairs* 13, no. 1: 102–114.

- Gabel, J., K. Dhont, et al. 2002. Individual Insurance: How Much Financial Protection Does It Provide? *Health Affairs* (suppl. web exclusives): W172–181. Available at <http://content.healthaffairs.org/webexclusives/index.dtl?year=2002>.
- Glied, S. 1994. *Revising the Tax Treatment of Employer-Provided Health Insurance*. Washington, DC: American Enterprise Institute Press.
- . 1997. *Chronic Condition: Why Health Reform Fails*. Cambridge: Harvard University Press.
- . 2003. Health Care Costs: On the Rise Again. *Journal of Economic Perspectives* 17, no. 2: 125–148.
- Glied, S., and M. Stabile. 2000. Explaining the Decline in Health Insurance Coverage among Young Men. *Inquiry* 37, no. 3: 295–303.
- Gruber, J., and B. C. Madrian. 2002. Health Insurance, Labor Supply, and Job Mobility: A Critical Review of the Literature. Working paper no. w8817. Cambridge, MA: National Bureau of Economic Research.
- Health Insurance Institute. 1970. *Source Book of Health Insurance Data*. Washington, DC: Health Insurance Association of America.
- Hipple, S. 2001. Contingent Work in the Late 1990s. *Monthly Labor Review* 124, no. 3: 3–27.
- Huskamp, H., M. B. Rosenthal, R. G. Frank, and J. P. Newhouse. 2000. The Medicare Prescription Drug Benefit: How Will the Game Be Played? *Health Affairs* 19, no. 2: 8–23.
- Hyman, D. A., and M. Hall. 2001. Two Cheers for Employment-Based Health Insurance. *Yale Journal of Health Policy, Law, and Ethics* 2, no. 1: 23–57.
- InterStudy Reports HMOs Move to per Diem Rates for Hospitals from Capitation Deals. 2001. *Health Care Strategic Management* 19, no. 6: 9.
- Jack, W. 2000. Health Insurance Reform in Four Latin American Countries: Theory and Practice. Working paper. Washington, DC: World Bank.
- Krueger, A. B., and L. H. Summers. 1987. Reflections on the Inter-Industry Wage Structure. In *Unemployment and the Structure of Labor Markets*, ed. K. Lang and J. Leonard, 17–47. New York: Basil Blackwell.
- Madrian, B. 1994. Employment-Based Health Insurance and Job Mobility: Is There Evidence of Job Lock? *Quarterly Journal of Economics* 109: 27–54.
- Marzolf, J. R. 2002. The Indonesia Private Health Sector: Opportunities for Reform: An Analysis of Obstacles and Constraints to Growth. Discussion paper. Washington, DC: World Bank.
- Naylor, C. D., P. Jha, et al. 1999. *A Fine Balance: Some Opinions for Private and Public Health Care in Urban India*. Washington, DC: World Bank, Human Network Development.
- OECD. 2001. *Private Health Insurance in OECD Countries: Compilation of National Reports*. Paris: Insurance Committee Secretariat.
- Pauly, M., P. Danzon, et al. 1992. *Responsible National Health Insurance*. Washington, DC: American Enterprise Institute Press.
- Pauly, M., H. Kunreuther, et al. 1995. Guaranteed Renewability in Insurance. *Journal of Risk and Uncertainty* 10, no. 2: 143–156.
- Prince, M. 1999. HMO Stirs Debate on Reviews. *Business Insurance* 33, no. 46: 1, 66.
- Quality vs. Costs? A Survey of Healthcare Purchasing Habits and Concerns. 2000. *Healthcare Financial Management* 54, no. 7: 68–72.
- Reed, L. S. 1947. *Blue Cross and Medical Service Plans*. Washington, DC: U.S. Public Health Service, Federal Security Agency.
- Reinhardt, U. 1989. Health Care Spending and American Competitiveness. *Health Affairs* 8, no. 4: 5–21.

- Scanlon, D. P., M. Chernew, et al. 2002. The Impact of Health Plan Report Cards on Managed Care Enrollment. *Journal of Health Economics* 21, no. 1: 19–41.
- Smith, S. R., and D. M. Kirking. 2001. The Effect of Insurance Coverage Changes on Drug Utilization in HIV Disease. *Journal of Acquired Immune Deficiency Syndromes* 28, no. 2: 40–49.
- Somers, H. M., and A. R. Somers. 1961. *Doctors, Patients, and Health Insurance*. Washington, DC: Brookings Institution.
- Stabile, M. 2002. The Role of Tax Subsidies in the Market for Health Insurance. *International Tax and Public Finance* 9, no. 1: 33–50.
- Thomasson, M. A. 2002. From Sickness to Health: The Twentieth-Century Development of U.S. Health Insurance. *Explorations in Economic History* 39, no. 3: 233–253.
- Williams, P. 1932. *The Purchase of Medical Care through Fixed Periodic Payment*. Cambridge, MA: National Bureau of Economic Research.
- Witt, J. F. 2001. Toward a New History of American Accident Law: Classical Tort Law and the Cooperative First-Party Insurance Movement. *Harvard Law Review* 114, no. 3: 690–841.