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EMPLOYER-SPONSORED HEALTH INSURANCE AND THE PROMISE OF HEALTH INSURANCE REFORM

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I. Introduction

The central role that employers play in financing health care remains a distinctive feature of the U.S. health care system, and the provision of health insurance through the workplace has important implications well beyond its role as source of health care financing. Currently, as it has for the last half century, employer-sponsored insurance (ESI) dominates the US health insurance landscape. For example, in 2006, over 60 percent of the non-elderly population was covered by ESI, representing 90.1 percent of all private coverage (Fronstin 2007). Most employers provide health insurance to their workers and approximately 90 percent of full-time private sector employees work at establishments that offer coverage.[1]

Apart from its importance in financing health care — private health insurance, dominated by ESI, accounts for two-fifths of personal health care spending — ESI significantly affects a variety of labor market outcomes. Health insurance contributes to individual and household decisions to participate in the labor market, to work full or part time, to obtain particular types of jobs, and to engage in self-employed entrepreneurial activities. ESI obtained by retired employees remains a valued post-employment benefit that influences retirement decisions. For employers, ESI remains an important inducement to attract workers in highly competitive labor markets.

[1] Authors' tabulation using 2005 data from the MEPS-IC.

Despite its prominence in health insurance markets and partly because of its importance in household coverage and employment decisions, long-standing concerns and recent developments have once again made the employment-based health insurance system the subject of intense scrutiny and debate. At issue is whether ESI can retain its primacy in an era of striking changes in labor markets and employment relationships, growing international competition and globalization, stagnant employee earnings, fiscal uncertainty for national and state economies, and above all, the continuing rise in health care costs. Finally, with the apparent presidential nominees of both parties offering very different visions of how to expand coverage, the employment-based system once again faces a challenge by those who would constrain its financing and expand access to the individual insurance market.

In this paper, we consider the "goodness of fit" of ESI in the current economic and health insurance environments and in light of prospects for a vigorous national debate over shape of health care reform. The issue that we explore is whether ESI can have a viable role in health system reform efforts or whether such coverage will need to be significantly modified or even abandoned as reform seeks to address important issues in the equitable distribution of health insurance coverage, to create expanded health plan choices and competition in health insurance markets, and to structure incentives for the more efficient use of health services.

II. Setting the Stage

Key Historical Developments

Although employers in a few industries (notably railroad and mining) in the late 19th century provided direct health services to their employees through payroll deductions, and several other employers and labor unions provided sick benefits to their employees and members, the link between health insurance and the workplace most appropriately dates to the origins of group health insurance in the late 1920s. In 1929, what would become the nation's first "Blue Cross" plan was formed when a group of Dallas school teachers contracted with Baylor University hospital to provide up to 21 days of inpatient care for a fixed annual payment of $6.00. The link between employment and private health insurance was strengthened during World War II when in1943, the War Labor Board ruled that controls over wages and prices imposed by the 1942 Stabilization Act did not apply to fringe benefits such as health insurance. In response to this ruling, many employers used insurance benefits to attract and retain scarce labor. In 1948 and 1949, the National Labor Relations Board provided further impetus to workplace coverage by ruling that health insurance and other employee welfare plans were subject to collective bargaining. Finally, in a landmark 1954 ruling, the Internal Revenue Service clarified an earlier administrative court ruling regarding the income tax status of ESI by exempting such benefits from income taxation and adding this provision to the tax code.[2] Today, 162 million non-elderly Americans have ESI either in their own name or as a dependent, and for 2006, the tax subsidy from federal and state ESI tax exemptions is estimated to be $208.6 billion (Selden and Gray 2006).

Despite these historical precedents and its apparent staying power, the employment-based insurance system has long been subject to criticism regarding the equity and efficiency of its

[2] For more on the history of ESI, see Scofea (1994), Employee Benefit Research Institute (EBRI 2002), and Thomasson (2002, 2004). Our discussion draws from these sources.

financing and provision, its role in contributing to rising health care costs, and most recently, whether such coverage can remain affordable for workers and their families. As a result, ESI may be increasingly vulnerable to changes viewed as necessary to address these concerns and to accommodate broader health care reform.

Recent Trends in Cost and Coverage

Data in Figure 1 illustrate present and ongoing concerns about the cost and affordability of ESI. These data show that for most of the last two decades, year-to-year percentage increases in health insurance premiums have grown faster than comparable measures of inflation and worker earnings, even during periods when premium growth was diminishing. Such increases in ESI premiums have also translated into an increased financial burden for American workers. Although the share of premiums paid directly by employees has remained relatively constant over the past decade at around 15 percent for single coverage and 25 percent for family coverage (based on data from the MEPS-Insurance Component), in dollar terms, average employee contribution for ESI more than doubled between 1996 and 2006—from $342 to $789 for single coverage from $1305 to $2890 for family coverage (Figure 2).

In addition to these cost pressures, the changing nature of employment relationships in the US have given some observers pause regarding the ability of ESI to remain a reliable source of coverage. For example, Swartz (2006) notes that in an effort to economize on labor costs, employers have substantially changed the nature of the employment contract from a stable, long-term relationship to one encompassing shorter-term and more tenuous employment arrangements. As a result, more workers are employed via temporary, short-term contracts, on a contingent basis,

or though free-lance employment arrangements, and these changes have altered the traditional role of the workplace as source of health insurance for many well-educated and professional employees. Price and Burgard (2008) also cite the shift from long-term employment contracts in standard jobs providing full-time workers with regular pay and fringe benefits, to lower-paying non-standard jobs of short or uncertain duration providing little in the way of fringe benefits.

Figures 3 and 4 plot trends in ESI offers and coverage from 1996 to 2006 using data from the MEPS-IC and the March Current Population Survey (CPS), respectively. The employer data in Figure 3 present offer rates for three establishment size categories: less than 25, 25 to 99, and 100 or more employees. Offer rates for smaller firms increased slightly from 1996 to 2000, a period of very robust economic growth in the US.[3] In 2000, 45 percent of establishments with less than 25 employees and roughly 85 percent in the middle size category offered ESI. The later years encompass a mild recession and subsequent period of moderate economic growth whose benefits were largely concentrated among high earning individuals. By 2006, offer rates for establishments with less than 100 employees fell to roughly their 1996 levels. Figure 4 shows that the percentage of workers with coverage in their own name did not grow with employer offers during the boom years of the late 1990s, but rather stayed essentially constant at between 54 and 55 percent between 1996 and 2002, before declining slightly in each of the next four years.

The combination of rising premiums and labor market changes has not only led to a decline in the overall rate of coverage, but has exacerbated pre-existing disparities in ESI coverage.

[3] Previous research using data from the MEPS household component has documented that the percentage of employers offering coverage was essentially the same in 1996 as in 1987 (Cooper and Schone 1997).

In Table 1 we present data from the household component of the Medical Expenditure Panel Survey (MEPS) on the likelihood of being a full-year policyholder for the years 1996, 2000, and 2005. The data are tabulated by age, race/ethnicity, education, income, and health status.

The breakdown by age illustrates what Keenan, Cutler, and Chernew (2006) have described as the "graying" of ESI. Using CPS data for the years 2000 to 2004, they find declining ESI coverage rates for younger workers, but no change for individuals between the ages of 55 and 64. The figures in Table 1 are roughly consistent with this pattern, though the declines in full-year policy holder status are slightly less pronounced than the coverage changes reported by Keenan et al. As they note, the combination of the changing age composition of ESI pool together with rising premiums could further strain the ability of this source of coverage to offer risk protection.

For all race/ethnic groups, the percentage of adults who were ESI policyholders increased between 1996 and 2000. However, for all groups but Asians these gains were eroded by 2005. In each of the years, the coverage rate was lowest for Hispanics. One reason is that the Hispanic population includes a disproportionate share of non-citizens, who have extremely low rates of coverage (Buchmueller et al. 2006). Several recent studies show that the low rate of ESI coverage for Hispanics and non-citizen immigrants is explained largely by the fact that such individuals are less likely to work for firms that offer insurance (due in part to low human capital and language barriers) as opposed to a greater tendency to decline coverage (Dushi and Honig 2005; Buchmueller et al. 2006; Rutledge and McLaughlin 2007; Reschovsky, Hadley, and Nichols, 2007). Thus, the low rate of private health insurance coverage among these vulnerable groups can

be attributed mainly to the restricted job opportunities they face, rather than a weaker preference for insurance.

The MEPS data indicate steep gradients related to education and family income. College-educated workers are roughly three times as likely as high school dropouts to be a full-year policyholder. Similarly, individuals in families with incomes greater than 4 times the federal poverty level (FPL) are roughly twice as likely to be policyholders as those whose incomes fall between 125 and 200 percent of the FPL. For most of the education and income groups the percent that were ESI policyholders increased between 1996 and 2000 but fell between 2000 and 2005.

In the last panel of Table 1 we cut the data by self-reported health status. Standard economic models of the health insurance market suggest that when insurance premiums are not fully risk-rated, either because of private decisions by employers or government regulations, low-risk consumers may drop out of the market rather than paying premiums that are high relative to their actuarial risk. Some argue that this type of behavior result can explain the low rates of coverage among younger workers. The data on health status, however, provide little support for this adverse selection argument. For all three years, ESI policyholder status is significantly higher among people who rate their health as good or excellent compared to higher risk individuals who say they are in fair or poor health.

Because the data in Table 1 refer only to adult policyholders, they do not reflect the large changes that have occurred over time in the pattern of insurance coverage within families. The expansions of public coverage, most notably the State Children's Health Insurance Program

(SCHIP) and the Medicaid expansions of the late 1980s and early 1990s, have altered the sources of coverage within families with access to employment-based coverage. For example, between 1997 and 2005, the percentage of single-parent families in which all members had private insurance declined from 67.1 percent to 53.5 percent, while that for married couples with children declined from 85.1 percent to 80.4 percent, with the decline in private coverage made up by public insurance (Vistnes and Schone 2008). For an earlier period, work Monheit and Vistnes (2005) also revealed that these factors contributed to a decline in ESI coverage for dependent family members. For example, among families with an ESI policyholder, the percent of two-parent families in which all members were insured declined from roughly 96 percent in 1987 to 90 percent in 1996, while that for single-parent families declined from over 90 percent to roughly 85 percent.

As a final area of concern, we note that the provision of ESI by employers as a retirement benefit has significantly eroded over time. Analysis of MEPS-IC data for 1997 to 2003 by Buchmueller, LoSasso, and Johnson (2006) reveal that this decline was especially severe for smaller and medium-sized establishments. For example, among establishments with fewer than 100 employees fell by a third over this period and by 25 percent for those with 101 to 500 employees. Among larger firms, the decline in offers of ESI retiree coverage was less pronounced, declining by 9 percent over the study period. Although less severe, these trends mark a continued erosion of retiree coverage initially observed between 1988 and 1993 in data from the Kaiser Family Foundation. The reduced availability of this source of coverage has important implications for efficient labor force and retirement decisions by near-elderly workers as few affordable insurance alternatives may exist prior obtaining Medicare at age 65.

Overall, the data on costs, coverage, and the changing nature of employment present a mixed picture of the health of the ESI system and its prospects for the future. Contrary to the claims made by some commentators that the employment-based system is "vanishing," "ending," or "dying" (see full quotes and references in Fronstin 2007), the system is not in free-fall. Interviews with ten very large employers conducted by the Employee Benefit Research Institute (EBRI) revealed that ESI is still considered a valuable tool in recruiting and retaining worker. None of the employers interviewed were on the verge of dropping health insurance, nor did that they expect other large employers would do so. These impressions are consistent with the data showing that the percentage of firms offering health insurance as an employee benefit has remained remarkably stable over time. For advantaged workers, policyholder and coverage status have remained fairly stable and while premiums have increased significantly, health insurance benefits as a percentage of total private sector compensation has increased only slightly, to 6.9 percent in 2006 from 5.9 percent a decade earlier.[4]

At the same time, there is real cause for concern. Disparities in access to ESI and rates of coverage related to age, education, race, ethnicity and nativity are large and growing, and the gains in the likelihood of being full-year policyholder obtained during the latter part of the 1990s have deteriorated for a number of groups. The employers surveyed by EBRI expressed concern that coverage availability at small employers could be in jeopardy and recognized that that the

[4] For the public sector, the level and growth in ESI costs are both higher. In 2006, health benefits were 10.7 percent of compensation for government employees, up from 7.7 percent in 1996. These figures are from the National Compensation Survey conducted by the U.S. Bureau of Labor Statistics. (http://www.bls.gov/ncs/).

current ESI system must undergo significant changes to ensure accessible and affordable coverage, and this remains a key challenge for the employment-based system.

III. The Basic Economics of ESI

The Advantages of ESI

Although managers and the business media often speak of the burden of health care costs falling on employers, economists typically assume that in the long run it is workers who pay for health benefits through reductions in wages or other employee benefits. According to this economic viewpoint, the question "why do employers provide health insurance as an employee benefit?" should be rephrased as "why do so many workers choose to purchase insurance through their employers rather than directly in the individual insurance market?" The answer is that there are significant savings associated with ESI.

These savings flow from three main sources. First, because important administrative costs vary with the number of contracts, rather than the number of individuals covered by a contract, there are substantial economies of scale associated with purchasing insurance through a group. Second, because employer-sponsored groups were formed for reasons other than purchasing insurance and because they tend to be stable over time, employer provision greatly reduces the problem of adverse risk selection, which is a significant concern in the individual market.[5] As a result of these two factors, the administrative load for ESI is roughly half that for

[5] Although the notion that employer provision greatly mitigates the problem of adverse selection is widely accepted among economists, the theoretical basis for this belief is informal. Recent

individually purchased policies: 15 to 20 percent compared to 30 to 40 percent (Swartz 2006). The third source of cost advantage comes from the fact that, as noted earlier, employer payments for health insurance are exempt from federal and state income and Social Security payroll taxes. On average, this exemption effectively reduces the price of insurance by between 35 and 40 percent (Gruber 2001; Bernard and Selden 2001).

Cost savings from administrative economies of scale and more efficient risk pooling increase with group size. Although the value of the tax exemption is not explicitly tied to size, because compensation tends to be higher in larger firms (Brown and Medoff 1989), this advantage is likely correlated with firm size as well. These factors explain the strong relationship between firm size and employer offers documented in Figure 3. Among employers offering ESI, there are also large size-related differences in the degree of employer involvement and the nature of benefits offered. Roughly 80 percent of private sector establishments with 500 or more employees choose to self-insure rather than purchase coverage directly. Since self-insured firms are exempt from state benefit mandates and other regulations, self-insuring provides employers a greater ability to shape the benefit package to the demands of their own employees and to actively manage costs. Large firms are also more likely to offer a choice of insurance options and to support employees in choosing among those options.[6] Some very large firms have been quite active in pushing for innovation in both insurance and health care delivery. A notable example is the Leapfrog Group, a

papers by Bhattacharya and Vogt (2006) and Ellis and Ma (2007) attempt to develop models that generate this outcome as an equilibrium result.

[6] Seventy-one percent of establishments with 1000 or more employees offer a choice of plans.

coalition of large employers that has been on the forefront of the movement to improve health care quality and patient safety.

As noted above, administrative economies of scale and a larger enrollee base to spread risks result in lower premiums for a given set of benefits as firm size increases. In the typical large firm providing ESI, premiums for the firm tend to be experience-rated over time but at a given point in time, community-rated within the firm. That is, all employees within the workplace face the same premium and employee contribution for a health plan of given benefits and payment provisions. As with any community rate, distributional consequences emerge that favor older and sicker workers and "penalize" younger healthier workers, leading to intergenerational tension. Specifically, the former face premiums well below their actuarial risk profiles, while younger workers face premiums that exceed their expected health spending. The result is an implicit set of cross subsidies from younger and healthier workers to older and sicker workers. Additionally, premiums do not increase continuously with family size but instead, are set for discrete groupings, such as single individuals, married couples without children, and family coverage for couples with children. The use of discrete categories also creates cross subsidies from smaller to larger families (Gruber 2008).

Such disparities in ESI premiums` could be mediated if a young worker could expect to stay with a firm as s/he aged or as family size increased. In this way, such a worker would willingly pay the higher community rate when young or subsidize larger families, knowing that s/he would be the beneficiary of such cross subsidies when older and/or with a larger family. As we note below, one often overlooked feature of the tax treatment of health insurance is its

moderating effect on the net losses obtained by younger healthier workers facing such community-rated premiums. Finally, it is also important to note that regulatory efforts have been extended to small firms to constrain the range of premiums they face when purchasing coverage and to address questionable insurer practices that yield excessive premiums.[7]

The Disadvantages of ESI

Certain features of the current ESI system are less salutary and represent long-standing criticisms of employment-based coverage. While the preferential tax treatment of ESI premiums increases the number of Americans with private insurance, it has also been criticized for promoting excessive levels of insurance coverage, which in turn result in higher levels of health spending. The tax treatment of ESI also can be criticized on equity grounds as well. Because it comes in the form of an unlimited exemption, rather than a tax credit, the tax subsidy for ESI is regressive, flowing disproportionately to high income families both because they face higher marginal tax rates and because they tend to hold more expensive policies.

While the tax treatment of ESI remains controversial, it is important to recognize that the tax subsidy may play a moderating role in reducing disparities in the monetary returns to enrolling in ESI. As Monheit, Nichols, and Selden (1995/96) and Selden and Bernard (2004) show, differences in the net benefit to having ESI (defined as premiums less health plan payments) across households are significantly reduced once the value of the tax subsidy is included to offset full premium payments by workers (assuming workers bear the full incidence of employer

[7] A number of studies examine the effects of state-level small group regulations. Several chapters in Monheit and Cantor (2004) provide reviews of this literature.

contributions). As a result, the tax subsidy promotes continued participation of certain types of households such as those with young and healthy families who provide much of the benefit flow to older and sicker enrollees. In this way, as Enthoven and Singer (1996) have observed, the tax exclusion for ESI is "an important part of the glue that holds employment groups together as risk pools for purchasing health benefits" (page 199).

The benefits of group purchase are less significant for smaller firms. Although loading factors for small groups are lower than those found in the non-group market, small firms face higher average administrative costs than larger firms, putting them at a competitive disadvantage relative to larger firms. Employees of small firms have fewer and generally less attractive options than their counterparts who work for large organizations. For example, only 12 percent of establishments with 50 or fewer employees offer more than one health insurance plan. Individuals who have a choice of plans tend to report higher levels of satisfaction with their coverage and the health care they receive (Schone and Cooper 2001).

Other criticisms of the ESI system focus on spillovers to the labor market. The link between health insurance and the workplace may create inefficiencies by distorting the behavior of workers and employers. One distortion that has received considerable attention is a negative effect of ESI on voluntary job mobility, or "job-lock." Surveys consistently indicate that a large percentage of workers have stayed in a job that they wanted to leave for fear of giving up their health benefits,[8] though the evidence from academic studies is mixed.[9] Other research suggests

[8] For example, nearly half of the respondents to a 2008 survey conducted by the AFL-CIO say that they or one of their family members have had this experience (AFL-CIO 2008).
[9] For a comprehensive review of the literature in this area, see Gruber and Madrian (2004).

that the fact that employers typically provide health benefits only to full-time employees affects worker decisions about how many hours to work.[10]

Estimates suggest that the economic cost of job-lock is relatively small (Monheit and Cooper 1994; Gruber 2008). Even if job-lock is a real source of inefficiency, an argument can be made that the problem stems from the non-group market. If affordable non-group coverage were widely available, individuals who chose not to work or to work for a small firm that doesn't provide insurance could be assured access to coverage.[11] Similarly, the well-documented relationship between the availability of retiree health benefits and the propensity of workers to retire before they attain Medicare eligibility can be attributed in large part to the unattractiveness of the options available to "near-elderly" adults in the non-group market (Rogowsky and Karoly 2000; also see the review by Gruber and Madrian 2004).

Whether or not ESI has a causal effect on job mobility, it is clear that the system does not work well for people who, for other reasons, have high rates of turnover. This weakness is increasingly significant in light of long run trends in the labor market, such as a declining job security and increases in the number of independent contractors and other types of contingent work. The link between insurance and the workplace has the effect of amplifying the income loss associated with job loss (Kuttner 2006; Simon and Schroeder 2006). Even for workers who transition from one job to another without a spell in unemployment there are efficiency costs. The fact that job changes often lead to changes in insurance also reduces the incentive of workers,

[10] See, for example, Buchmueller and Valletta (1999).

[11] A recent study by DeCicca (2008) suggests that a New Jersey regulation prohibiting insurer discrimination against high risk individuals contributed to an increase in self-employment in that state.

employers and insurers to invest in health and prevention (Herring 2006; Cebul et al 2007; Fang and Gavazza 2007).

IV. ESI and Health Insurance Reform

Overview of different approaches to health care reform

Figure 5 provides a perspective on alternative approaches to health insurance expansions. The boxes to the right of health insurance expansion box acknowledge approaches that encompass implementation of a single-payer health insurance system and expansions of public coverage. Although implementing a single-payer system has for many years received much attention in reform discussions, Gruber (2008) has observed that it is highly unlikely that such a system will receive serious consideration given the vested interests of a private insurance system with annual revenues in excess of $500 billion. Even if it were politically feasible, moving to a single-payer system would likely entail dismantling the current ESI system. Therefore, we do not consider this class of expansion strategies in any detail.

Public sector expansions would not necessarily eliminate ESI as we know it. Rather, such expansions would likely focus on certain vulnerable populations, as in the recent efforts to expand income eligibility and allow parental enrollment in the State Children's Health Insurance Program (SCHIP), and in proposals to allow some population groups to buy into Medicare or into the Federal Employee Health Benefits Program (FEHBP). As with the single payer approach, political factors represent a significant constraint for this class of strategies. We expect that ideological disagreements over expansions of public coverage beyond originally

targeted at low-income populations are likely to limit their consideration as broad strategies. Even if these political barriers could be overcome, the effects of these types of policies on ESI would likely be indirect. Most notably, increased eligibility for public insurance may "crowd out" private coverage. While such effects may reduce private coverage, incremental public insurance expansions by themselves would not materially alter the nature of ESI or group insurance markets. Therefore, we do not offer a detailed consideration of this approach either.

We focus primarily on strategies in which private insurance remains the predominant mechanism for financing health care. The diagram shows that among private-sector expansions, there is a basic dichotomy between voluntary and mandated approaches. Considering mandatory coverage (the right-hand side of the figure), there is a further dichotomy between individual and employer-based mandates. An employer mandate could be a strict requirement of doing business in a state or could have an element of voluntarism, as in the "pay or play" mandates (as in Massachusetts where employers who do not offer coverage voluntarily are required to "pay" an annual contribution per employee). The line joining the individual and employer mandates represents the fact that a combined approach has been proposed in a few states, including California, Maine and New Mexico, and has been implemented as part of Massachusetts' recent reforms (Kaiser Commission on Medicaid and the Uninsured 2008).

An individual mandate does not necessarily imply a decline in employer-based coverage as under such proposals targeted population groups typically have the option of obtaining coverage either through the non-group insurance market or through ESI. Such a choice is not

without equity and efficiency implications, given the present differences in the tax treatment of health insurance between these markets as well as the pooling advantages of ESI noted earlier.[12]

Laws that would mandate coverage would likely include exemptions. These exemptions have important implications for coverage and economic welfare. By compelling individuals to obtain coverage, preferred consumption for some individuals is likely to be diminished and accompanying welfare losses will result. Thus, those whose welfare losses are perceived as especially severe (e.g., individuals and families of fairly low economic status) may be exempt from the mandate and efforts may be made to enroll them in public coverage. For others, subsidies are likely to be required over some income range in order to offset some of the welfare losses from a mandate imposed on those with weak health insurance preferences or other pressing financial obligations. As regards subsidies, policymakers will have to decide between direct cash rebates for premiums paid, tax credits, or tax deductions. While the first two options differ only in the way the subsidies are administered, using tax deductions (as in President Bush's insurance expansion proposal of January 2007) will make the subsidy regressive.

Employer mandate proposals typically include exemptions for small firms or firms employing a large proportion of low-wage workers. Both types of exemptions recognize that unemployment may be an unintended consequence of an employer mandate should employers of such firms be unable to fully absorb the cost of the mandate, or pass the cost onto low-wage workers in the form of reductions in wages or other benefits. However, because uninsured

[12] As a result of such disparities in the tax treatment, some proposals have advocated extending the tax exemption to the non-group market, while others have suggested eliminating or capping the tax subsidy to ESI.

workers are disproportionately low-wage workers employed in small firms, such exemptions can be problematic from the perspective of achieving universal coverage. For example, as Baicker and Levy (2008) note, exempting firms with less than 25 workers could eliminate 45 percent of targeted workers from an employer mandate. As a result, the level of subsidy support will be critical in helping to approach universal coverage and in forestalling any unintended employment effects due to employer responses to the mandate.[13]

Finally, as Summers (1989) has pointed out, if workers fully value an insurance mandate, the adverse employment effects typically associated with a mandate may be eliminated as workers increase their labor supply to offset the employment costs associated with the mandate. In this regard, Summers notes that a mandate will be more efficient than the use of taxes to financing an insurance expansion. However, since a mandate will likely require subsidies, some loss of efficiency due to distortions associated with its financing will likely appear.

Although mandated coverage is a legal requirement imposed by on residents of specific jurisdictions, this alone will not guarantee participation levels consistent with desired enrollment. As Glied, Hartz and Giorgi (2007) have noted the effect of a mandate critically will depend up the level of enforcement and degree of penalties imposed for violation. In this regard, early experience under the Massachusetts state mandate is instructive as relatively low penalties failed

[13] Baicker and Levy's simulation of the employment effects of a generic employer mandate that does not include subsidies suggests that these employment effects may be small (224,000 workers representing 4.5 percent of uninsured workers or 1.4 percent of workers at risk for unemployment) relative to the gain in coverage (15.7 million workers now insured). However, they note that such unemployment is likely to be concentrated among low-skilled and economically vulnerable workers (e.g., high school dropouts, minorities, and women).

to induce individuals with weak preferences for health insurance to enroll in mandated coverage (Belluck 2007).

Voluntary approaches to expanding coverage (the left-hand side of the figure) can also be applied to both the non-group insurance and to ESI. In contrast to mandates, such measures seek to induce individuals to enroll in either type of coverage by reducing out-of-pocket premium costs through subsidies (i.e., tax credits or deductions) in the short term, and over the longer term, through more general efforts to eliminate inefficiencies the health care system and to contain health care costs. Given the voluntary nature of these approaches, subsidy levels become critical and research suggests that substantial subsidies will be required to induce a desired enrollment response (e.g., Marquis and Long 1995). Actual experience with voluntary efforts have not been encouraging as suggested by the experience of displaced workers who were eligible to received tax credits under the Trade Act of 2002 and by the poor response of employers in several states who received premium subsidies (Hadley and Reschovsky 2001).

The potential for adverse risk selection is a fundamental issue for private insurance markets and, by extension, for coverage expansion policies built around private coverage. To the extent that mandates can achieve near-universal coverage, the problem of adverse selection is greatly reduced, though not eliminated. If everyone is required to have insurance regardless of their expected need for health care, insurers have less reason to worry about consumers who seek coverage because they are sick. Still, in the absence of risk-rated or adequately risk-adjusted premiums, incentives for insurers to seek good risks and shun bad ones will likely remain.

Adverse selection is a much greater concern for policies aimed at expanding voluntary coverage, especially those aimed at increasing non-group coverage by voluntary means. The viability of such strategies will depend critically on the rules that are established for insurer behavior and the treatment of high-risk individuals. Roughly half of all states currently have laws that address aspects of market failure in the non-group market, including guaranteed issue and renewal requirements, constraints on pre-existing conditions, and limits on premium variation. Some evidence suggests that these policies have increased non-group coverage among high risks, while reducing coverage slightly among low risks, with varying consequences for overall coverage rates (Monheit et al. 2004;LoSasso and Lurie forthcoming). This result illustrates a basic trade-off between the interests of high and low risk consumers that in the non-group market.

Adverse selection is likely to be less of an issue for voluntary policies that seek to expand ESI coverage. As noted, employer-sponsored groups, especially large ones, represent stable risk pools that mitigate insurer concerns about selection while protecting higher cost employees from a large financial burden. Because risk pooling works less well for smaller firms, regulations governing insurer underwriting practices have developed for the small group market. Nearly every state enacted such policies in the early 1990s. The best evidence suggests that although these laws did not increase coverage as their proponents had hoped, they also did not cause small group markets to unravel, as many critics had predicted, although in some cases, unintended consequences for enrollment and premiums resulted (Buchmeller and DiNardo 2002; Monheit and Schone 2004; Simon 2005). So, while these regulations can be criticized on various

grounds, it is fair to say that neither cream-skimming nor adverse selection is a major problem in the employer-sponsored group market.

As the last box on the left-hand side of our diagram indicates, outreach efforts may also prove critical in achieving success through voluntary expansions, as has been the experience of enrollment in SCHIP.

In sum, given the prominence of ESI, the interests of workers, many employers, and insurers in maintaining this system of coverage, and despite criticism regarding the equity and efficiency of ESI, it is highly unlikely that efforts to expand health insurance coverage will abandon such coverage. However, despite such entrenched support, there are some who believe that it is time to replace ESI for a system of individually-purchased coverage that, in theory, can provide individuals with expanded health plan choice, portability, and the benefits of insurance market competition. Below, we explore these divergent views before concluding with a discussion of the how ESI must change in order to accommodate a meaningful a health insurance expansion that addresses some longstanding objections to this form of coverage.

Building on the Current ESI System

For many years, leading reform proposals have been designed to build on the current system. Many of these involved mandatory participation. For example, employer mandates were proposed early on by the Nixon Administration, figured prominently in the health reform debates of the early 1990s, and a mandate was a critical component of the Clinton Administration's Health Security Act. Employer mandate legislation was enacted in Massachusetts (in 1989) and

Washington (1993), but both laws were repealed before they went into effect. More recently, a 2002 California law that would have required firms with 20 or more employees to provide health insurance or pay a fee to a state-sponsored pool, met a similar fate when it was struck down in a direct referendum.[14]

The one existing example of a long-standing employer mandate is Hawaii's Prepaid Health Care Act (PHCA). The PHCA was passed in 1974, just months before the Federal Employee Retirement Income Security Act (ERISA), which has been interpreted to effectively preclude states from enacting employer mandates. Hawaii's experience suggests that requiring employers to offer insurance can significantly increase coverage, while at the same time showing that employer mandates alone cannot achieve universal coverage. While non-elderly Hawaiians are significantly more likely to be insured than their counterparts in other states, nearly 9 percent remain uninsured.

More recently, mandates targeted at individuals have received more attention in health care reform proposals and debates. Massachusetts' landmark health insurance reform is notable for its use of an individual mandate and in the recent Democratic Presidential Primary, one of the few policy issues on which the major candidates differed concerned individual mandates: Hillary Clinton's health care proposal included a mandate for all individuals, while Barack Obama's proposal included a mandate for children, but not for adults. As we have noted above, this new

[14] More narrowly focused employer mandates have been proposed in other states such as Maryland, which in 2006 passed the "Fair Share Health Care Fund Act" which would have required very large employers to spend at least 8 percent of payroll on health benefits. The law, dubbed the "Wal-Mart Bill" because it was written to target that company, was later struck down for violating Federal law.

emphasis on individual mandates, however, does not represent a move to replace ESI or diminish the role of employers as an individual mandate can be satisfied by obtaining coverage through an employer. Moreover, the Massachusetts law imposes a "pay or play" requirement on employers: those that do not provide health benefits must pay a "fair share" contribution toward the cost of their employees' insurance. The Obama reform proposal, like those of his former Democratic rivals, has a similar requirement.

The Massachusetts plan and national proposals like it can be seen as pragmatic responses to the strengths and weaknesses of the ESI system. These plans implicitly recognize that for a large number of workers and their families, the system works fairly well, and therefore do not attempt to alter the basic incentives leading to the dominance of ESI.[15] Large employers in Massachusetts have no incentive to drop health benefits nor do their employees have an incentive to drop out of the group to purchase insurance as individuals. At the same time, the Massachusetts plans and related proposals recognize that mandates on individuals, rather than employers, are likely to be more effective in increasing coverage and less likely to induce labor market distortions.

A key element of the Massachusetts plan is the Commonwealth Connector, a state agency established to manage the state's small group and non-group insurance markets. In many respects, the Connector replicates the services provided by the human resource departments of very large firms or the Office of Personnel Management in the case of the FEHBP. The Connector determines the menu of health plans available to individuals and small employers that choose to join the pool and regulates the benefits and underwriting policies of these plans. Employees of

[15] As a practical matter, states have limited ability to alter the tax subsidy for ESI.

large private firms or the Federal government are not charged premiums based on their individual risk characteristics and cannot be denied coverage that is offered to their fellow employees. Similar rules apply to coverage obtained through the Connector.

A recent evaluation based on a survey of how individuals fared under the first year of Massachusetts' reform paints an encouraging picture (Long 2008). Uninsured rates among working adults have declined by nearly half (from 13 percent to 7 percent) and survey respondents reported improvements in access to care, reductions in high out-of-pocket medical care costs, and fewer problems paying for medical care. However, the longer run success of the program will depend on whether the state is able to address the growth in costs necessary to support enrollment. More generally, the ability to have a reliable and sustainable source of financing for the subsidies required to ease the financial burden and welfare losses that accompany a mandate is a critical requirement for successful implementation.

Replacing the ESI System

These policies can be contrasted with strategies that seek to weaken the connection between health insurance and employment. For a number of years, Republican health care reform proposals have emphasized increasing coverage by expanding the non-group health insurance market. Similar to earlier proposals made by the Bush Administration, John McCain's health care plan would replace the tax subsidy currently given to ESI with a refundable tax credit that could be used to partially defray the cost of purchasing insurance as an individual or through a voluntary association (Buchmueller et al 2008).

Replacing the open-ended tax exclusion with a refundable tax credit would address some of the inequities of the current system. From the perspective of vertical equity, the tax expenditures would no longer flow disproportionately to higher income families. Horizontal equity would be improved as people who obtain insurance outside the ESI system will now receive the same subsidy as people with ESI. However, as noted, a cost of replacing the tax exclusion with a tax credit paid directly to individuals is a weakening of the "glue" holding the employment-based system together and an unraveling of this market. As a result, such a policy change would increase inequities along other dimensions. A major shortcoming of contemporary non-group markets is that "high risk" consumers can face extremely high premium, restrictions on benefits and in many cases outright denials of coverage (Pollitz et al 2001).[16] Thus, without the introduction of new protections, shifting enrollment from group to non-group insurance would result in a reduction in implicit subsidies flowing from healthy individuals to the unhealthy.

Shifting enrollment from ESI to non-group insurance would not only have distributional consequences, but would likely lead to an increase in certain types of costs. For example, the unraveling of employment-based risk pools could make the individual market or specific plans within this market even more susceptible to problems of adverse risk selection and thus, could yield behavior by insurers that emphasizes competition on the basis of favorable risk selection rather than health plan cost and quality. Because insurers in the non-group market devote more

[16] Individuals with chronic health conditions are most acutely affected by medical underwriting, though the practice is not limited to consumers most people would consider "sick." For example, according to recent media reports some non-group insurers deny coverage or charge substantially higher premiums to women who have previously given birth by C-section (Grady 2008).

resources to medical underwriting, administrative expenses would increase. The loss of economies of scale would also increase administrative costs and reduce the share of premiums going to medical care.

The higher administrative costs for non-group insurance is an important reason that policies sold in that market tend to have less comprehensive benefits than ESI. Therefore, moving from a system dominated by ESI to one where more insurance is obtained in the non-group market would mean that many Americans would face a greater exposure to out-of-pocket medical expenses. Whether or not this is a positive development is a matter of perspective. The Bush and McCain proposals are motivated by a strong belief that the most significant problem with today's health insurance system is that patients are over-insured and therefore consume inefficiently high levels of services. High deductible Health Savings Accounts (HSAs) and other consumer-driven health plans (CDHPs) figure prominently in these Republican proposals. While these plans have been available for several years, they still represent a very small share of the group market.[17] Moreover, as survey data from the Employee Benefit Research Institute has revealed, enrollees' satisfaction with such plans is not especially high, and some individuals have reported deferring or postponing care in response to the high out-of-pocket costs associated with such plans (Fronstin and Collins 2005). Additionally, such health plans have important implications for equitable access to health care and equity in its financing (Rosenthal and Daniels 2006).

[17] According to a 2006 employer survey, 4 percent of workers with ESI are enrolled in a CDHP. This is only one point higher than the market share of conventional indemnity plans (Claxton et al 2006).

V. Back to the Future: Strengthening the Role of ESI in Health Insurance Expansions

If ESI is to serve as the focal point for health insurance expansions or at least, retain its position of prominence, there are three longstanding areas of concern which must be addressed. First, portability must be assured since it is both futile and frustrating to implement an ESI-centered reform only to permit gaps in coverage to occur as some workers lose or change jobs, or otherwise sever employment relationships. Second, greater equity and efficiency of ESI must be achieved through a modification of the regressive tax deduction of such coverage and its implications for health plan choice. Third, improved access by small employers to affordable health insurance must be achieved so that they are no longer disadvantaged in the types of insurance products they can offer and with regard to the accompanying cost of coverage compared to their large-firm counterparts. We briefly comment on how reform can be implemented to accommodate these concerns.

State-based or Regional Insurance Pools – the HIPC Model

One of the key organizing entities in President Clinton's proposed Health Security Act of 1993 was the regional health insurance alliance or health insurance purchasing cooperatives (HIPCs). As conceived, such alliances embodied the principles of managed competition and were to assume responsibility for establishing a menu of plan choices, negotiating with insurers, disseminating health plan information, setting minimum benefit standards, and enrolling eligible individuals. Individuals and smaller employers (5000 or fewer employees) were to obtain

coverage from the HIPC while larger employers (> 5000 employees) could form corporate alliances.

Health insurance pooling mechanisms have clear relevance for ESI in the context of health insurance expansions, and in various forms have been included in expansion proposals by candidates during the Democratic presidential campaign.[18] In particular, insurance alliances explicitly address issues raised by the first and third points noted above. The problems associated with lack of health plan portability – job lock and loss of coverage due to gaps in employment – can be attenuated as plans can be provided by employers or purchased directly through the HIPC with shared financing by individuals and employers. Such alliances also have the advantage of natural economies of scale in managing health coverage and in promoting health plan competition, thus easing the administrative and other cost barriers faced by small firms seeking coverage. Finally, alliances provide a vehicle for those without employment to seek individual coverage, and their large pooling mechanism, together with appropriate subsidies to ensure participation by those in good health, should reduce concerns of adverse selection by those without access to ESI, especially should an individual mandate fail to be implemented.[19]

[18] For example, Senator John Edwards' proposal included regional "health care market" purchasing pools and would permit employers to offer coverage through these pools. Senator Barack Obama has proposed a National Health Insurance Exchange for purchases of private coverage and would allow small businesses and individuals without access to ESI to obtain through a new public plan. Senator Hillary Clinton proposed allowing businesses, employees, and the uninsured to purchase coverage through a new Health Choices Menu. The Menu would be part of the Federal Employees Health Benefits Program and have a broad range of private insurance options (Collins and Kriss 2008).

[19] Ginsburg (2008) has recently advocated the use of insurance exchanges but only with regard to strengthening the role of individual insurance in the context of a universal coverage expansion.

As we have noted above, the Commonwealth Connector in the Massachusetts health plan has emerged as a workable model of such a purchasing alliance for small employers and individuals. At issue is whether larger employers can offer coverage through such an alliance and whether it will be administratively and politically feasible to develop more extensive connector-like pooling mechanisms should policymakers deem it necessary to establish risk pools on a regional basis (as in the original Clinton plan) to address issues of regional cost growth and to achieve greater equity in the quality of health plan coverage. To do so, the issue of how to resolve differences in existing state insurance regulations – state insurance reform laws and health insurance mandates – will need to be addressed. However, for the present, it would appear that state-based alliances could provide an adequate first step in resolving the two problems we have identified.

Limiting but not Eliminating the Tax Subsidy

The final concern that must be addressed is establishing greater equity in the present tax treatment of ESI and addressing the efficiency implications of an open-ended tax subsidy. As we have noted, the present tax exclusion is a regressive subsidy and has been alleged to encourage over-insurance and excessive use of medical care. Completely removing the tax benefits associated with ESI is unlikely to be politically feasible as has been seen with regard to President Bush's 2007 proposal to substitute a regressive flat tax deduction for the current tax treatment of ESI. A frequently proposed alternative to the current tax treatment is a cap on the tax deduction at a specific dollar amount. While, capping the tax subsidy might achieve somewhat greater

equity in tax benefits among employees, it would also be perceived as a tax increase for higher earners, and is unlikely to affect the comprehensiveness of health plan benefits or spur health care cost containment in the short run (Fronstin and Salisbury 2007). However, providing health plans with standard health benefits through in a health plan alliance, capping the tax deduction, and allowing individuals to pay the full marginal costs of more extensive coverage, might achieve some savings in health care spending while still allowing those willing to pay additional costs to obtain more extensive benefits. However, equity issues based on ability to pay for additional benefits will have to be addressed.

Health Care Costs - The Fly In Any Ointment

Finally, the ability to maintain a prominent and sustainable role for ESI in health insurance expansions, and more generally, to ensure access to such coverage through reduced premiums and through sustainable income-related subsidies, will hinge critically on the ability of employers, insurers, and providers to actively work to contain health care costs. Thus, measures to address such cost growth, including value-based purchasing and broad application of evidence-based medicine, more appropriate use and diffusion of medical technologies, chronic disease management, and better exchanges of health-related information among providers, as well as other cost-containment measures, must proceed on a parallel track with insurance reform in order to ensure the viability of the employment-based insurance system.

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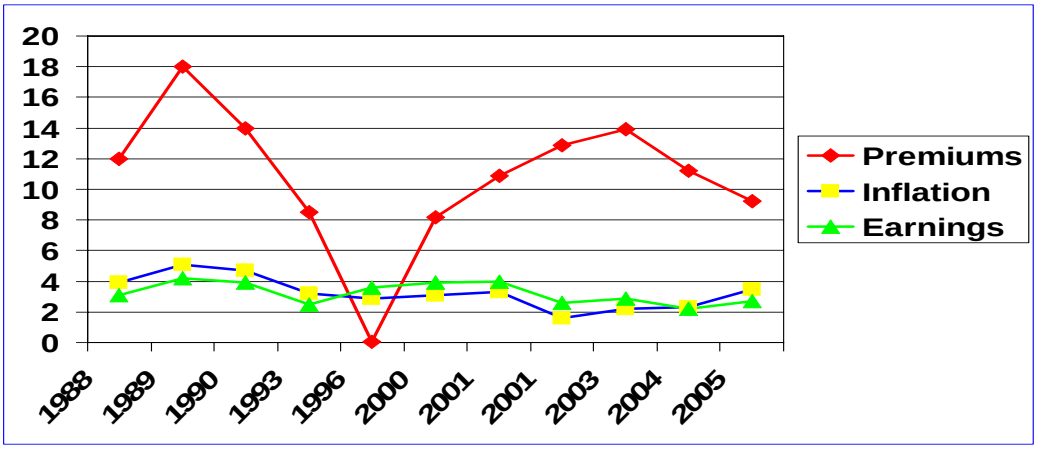
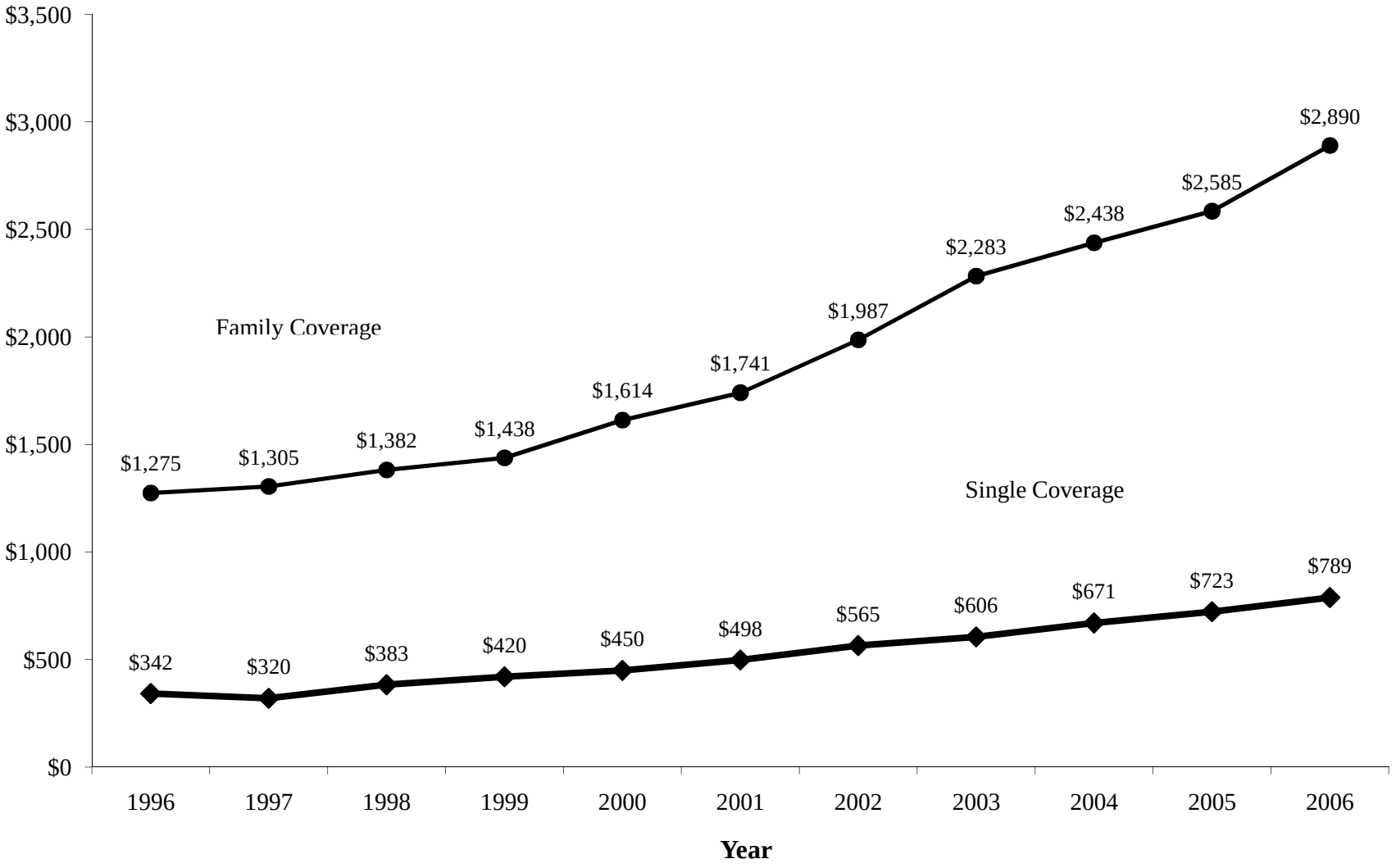
Figure 1
Trends in Premiums compared to Overall Inflation & Earnings: Percent Change over Prior Year



Source: Kaiser Family Foundation, 2006.

Figure 2. Average Employee Premium Contributions, 1996 to 2006



Source: Medical Expenditure Panel Survey--Insurance Component

Figure 3. ESI Offer Rates By Establishment Size, 1996 to 2006

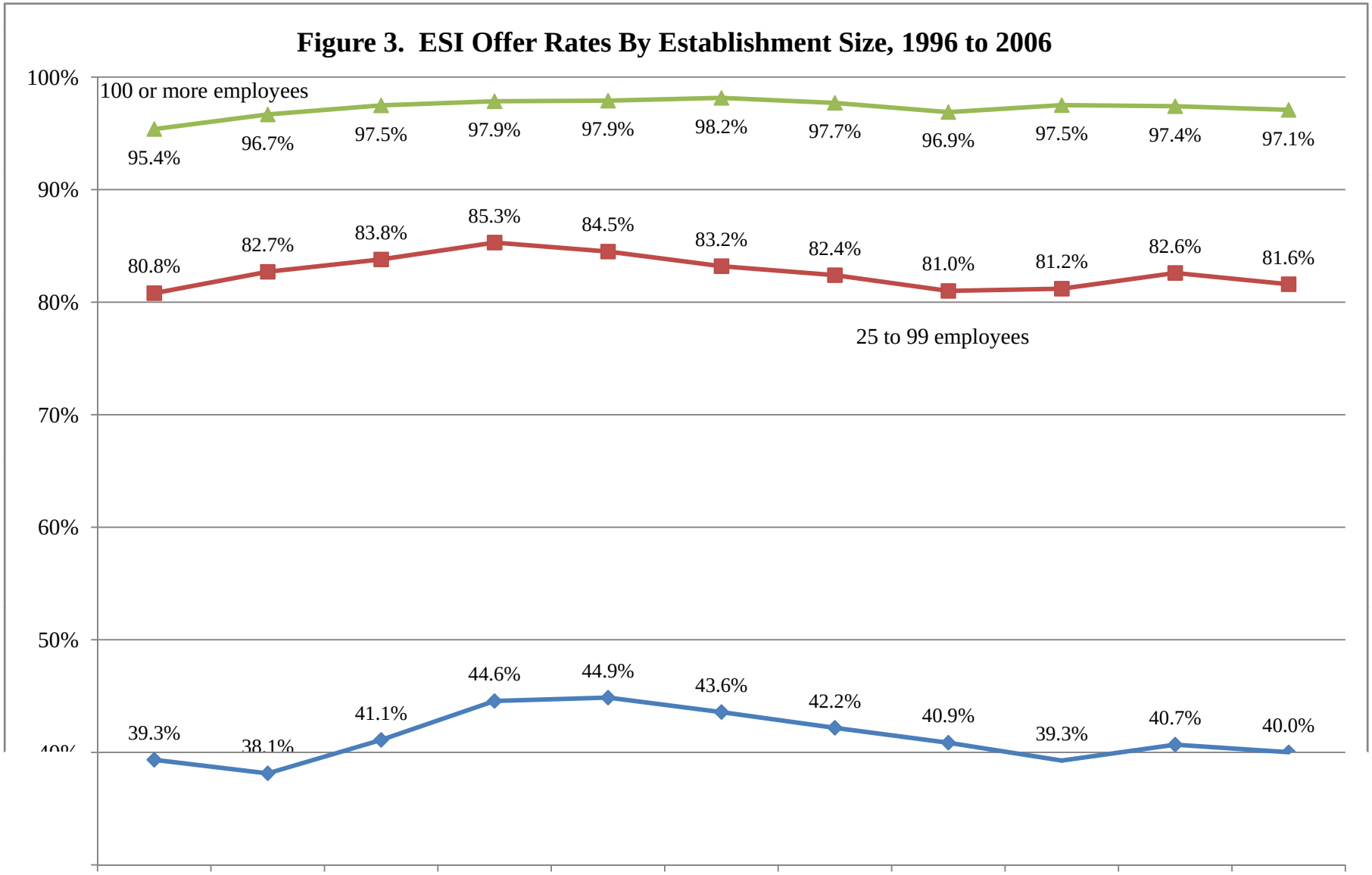
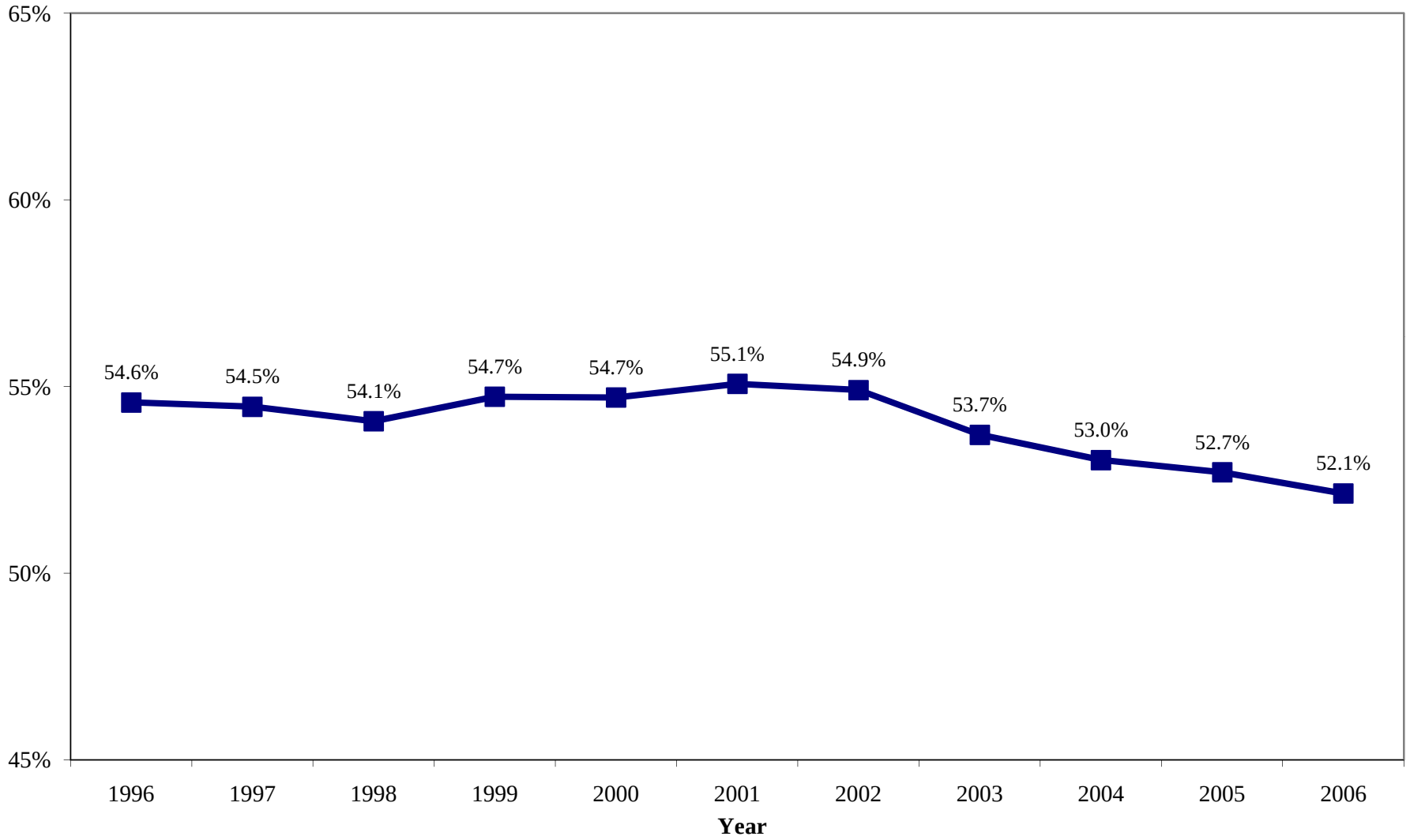


Figure 4. Percent of Workers with ESI in their Own Name, 1996 to 2006



Source: March Current Population Survey

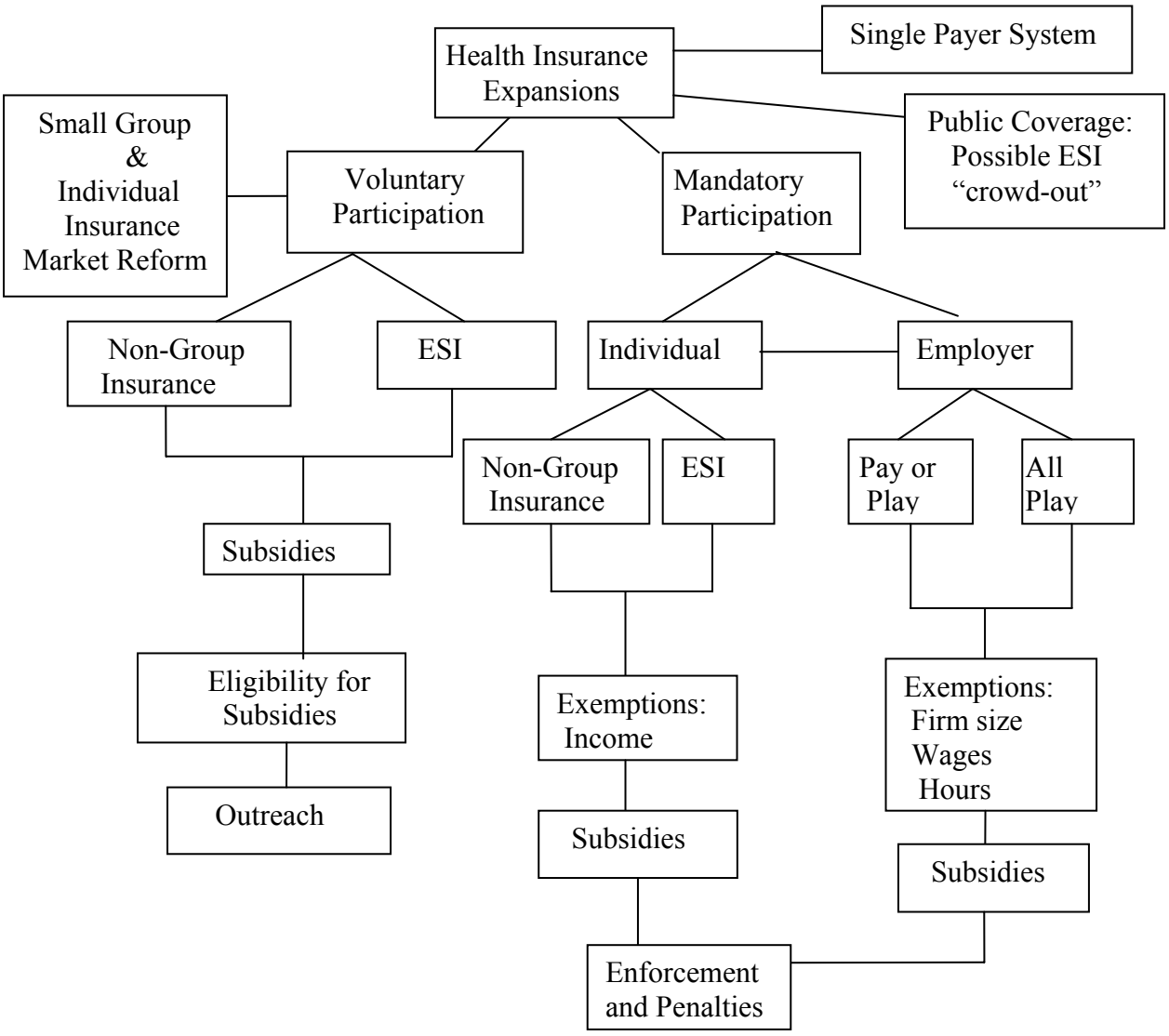


Figure 5: Anatomy of Health Insurance Reform

Table 1. Likelihood of being a Full-Year Policyholder of ESI by Selected Characteristics, 1996, 2000, and 2005: Persons Ages 19-24.

	1996	2000	2005
Characteristic			
All persons	40.3% (0.59)	42.4% (0.67)	39.3% (0.44)
Age			
19-24	13.1% (1.09)	12.3% (0.88)	12.1% (0.84)
25-34	40.3 (1.15)	42.8 (1.19)	38.7 (1.09)
35-44	45.6 (1.03)	48.0 ((1.01)*	42.9 (0.94)*
45-54	49.5 (1.01)	51.1 (1.07)	46.9 (0.86)*
55-64	42.2 (1.38)	45.8 (1.27)*	46.0 (0.93)**
Race/Ethnicity			
White	43.5 (0.71)	45.3 (0.70)*	42.8 (0.55)
Black	35.2 (1.49)	40.5 (1.52)**	37.2 (1.07)
Hispanic	26.3 (1.37)	29.2 (1.08)*	25.7 (0.86)
Asian and other race/ethnicity	34.8 (2.19)	34.6 (2.58)	35.8 (1.56)
Years of education			
<12	19.7 (1.08)	19.5 (0.97)	17.9 (0.84)
12	38.2 ((0.87)	39.7 (0.99)	37.4 (0.76)
13-15	40.2 (1.14)	43.9 (1.07)**	38.7 (0.81)
16 or more	55.3 (1.01)	59.3 (0.85)***	54.7 (0.92)
Income as % of poverty line			
Poor	6.7 (0.64)	7.6 (0.78)	5.6 (0.54)
Near-poor	14.3 (1.32)	12.1 (1.75)	13.6 (1.27)
Low income	26.5 (1.05)	25.9 (1.16)	22.2 (0.85)***
Middle income	45.0(0.88)	43.5 (0.90)	41.1 (0.73)***
High income	53.1 (0.73)	55.4 (0.85)**	53.3 (0.71)
Health status			
Excellent	43.7 (0.86)	45.2 (0.93)	41.0 (0.82)**
Very good	44.5 (0.92)	47.3 (0.81)**	43.5 (0.71)
Good	38.1 (1.06)	39.3 (1.25)	38.6 (0.87)
Fair or poor	23.4 ((1.24)	25.7 (1.15)	25.2 (1.16)

Source: Authors' tabulations of Medical Expenditure Panel Survey – Household Component for years 1996, 2000, and 2005. Income as a percent of the federal poverty level (FPL) defined as

follows: poor (≤ FPL); near-poor (> FPL through 1.25*FPL); low income (>1.25*FPL through 2.00*FPL); middle income (>2.00*FPL through 4.00*FPL0); high income (> 4.00*FPL).

* p <0.10; ** p<0.05; *** p<0.01 for comparisons to 1996 policyholder rates.