

Why We Should Keep The Employment-Based Health Insurance System

Despite its flaws, the current system offers the best foundation on which to build for the future.

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TODAY 168 MILLION NONELDERLY AMERICANS—old and young, wealthy and poor, healthy and sick—enjoy the security of private health insurance; the vast majority are covered through employer-sponsored health plans. Yet despite the many advantages of this system, it has come under increasing criticism.

While some see the employment-based system as limiting consumer choice, others argue that inequities within it are contributing to the growing number of uninsured Americans, estimated to rise from forty-three million to fifty-three million in the coming decade, even under favorable economic conditions.¹ But although some wish to address this problem through a health care program run by the federal government, others maintain that a health care financing structure based on individual choice would both expand private coverage and improve accountability, efficiency, and quality through a system that functions more like a “pure” free market.

This Commentary explores the benefits of the employment-based system and explains why it provides the best foundation for expanding coverage to more Americans. We note that given Americans’ preference for private, voluntary health coverage, neither a government-run system nor a government-mandated individual system is a desirable option.²

Americans generally prefer to allocate resources using private markets, in large part because decision making is decentralized. This is especially beneficial in health care, where decisions often involve personal trade-offs. Moreover, when competition in the private market works well, it rewards innovation and punishes both

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low-quality and high-cost providers. Under perfect conditions, market-based systems allocate scarce resources across competing demands for those resources, thereby balancing the cost of production with consumers' preferences.

Real-world markets, however, are not always perfect, and some characteristics of our health care system limit the market's ability to allocate resources efficiently or equitably. Nevertheless, employer-sponsored health plans' ability to pool risks and influence both the quality and the cost of care offers significant administrative efficiencies and results in coverage that costs less than the equivalent individual coverage does. This, combined with the fact that the public benefits when each individual consumes health care services, makes the employment-based system important to national health care policy.

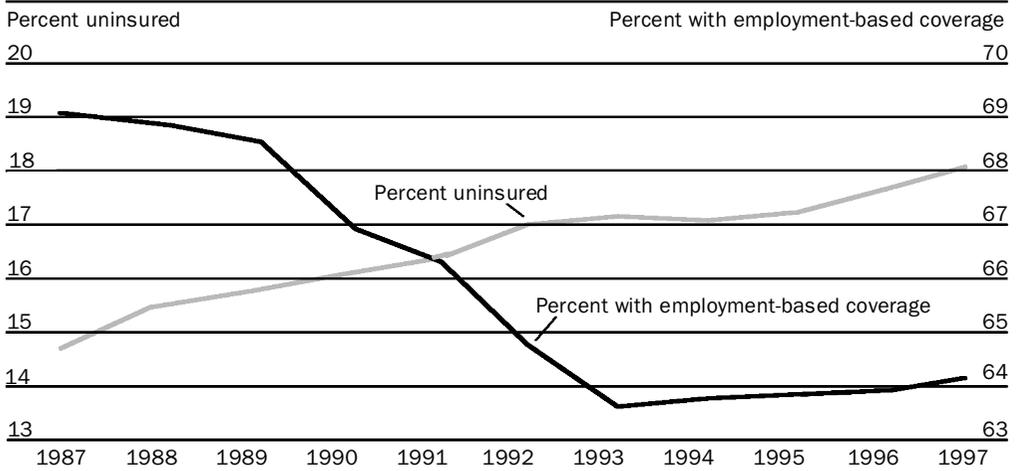
Tax Preference For The Employer-Based System

In 1997, 61 percent of Americans (64 percent of those under age sixty-five) were covered through an employment-based plan, as either employees or dependents (Exhibit 1). Among the nonelderly, more than 90 percent of those who have private insurance received it from an employment-based plan.³

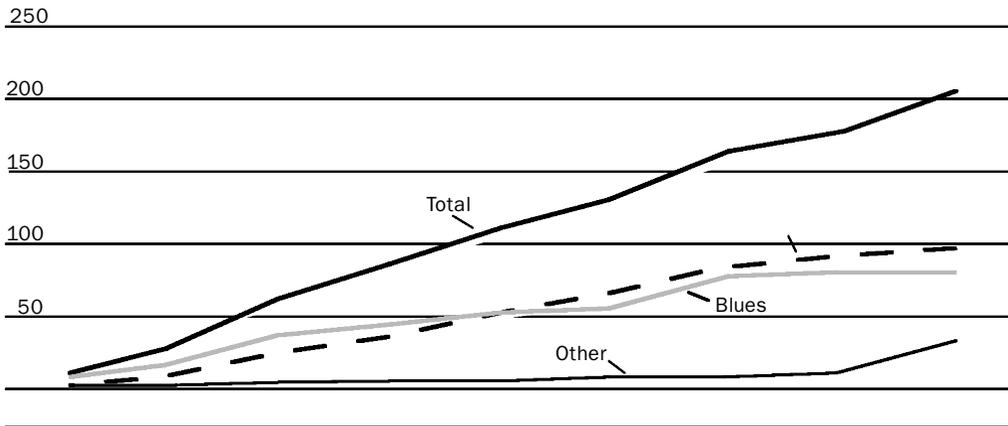
The favorable tax treatment of health insurance as an employee benefit has encouraged the proliferation of employer-sponsored health plans (Exhibit 2). Since 1954 employers' contributions for employee health insurance have been excluded from income for the

116 **CURRENT SYSTEM**

EXHIBIT 1
Trends In Health Insurance Coverage For Persons Under Age Sixty-Five, 1987-1997



SOURCE: W. Custer, *Health Insurance Coverage and the Uninsured* (Washington: Health Insurance Association of America, January 1999).

EXHIBIT 2**Growth In Group Health Insurance Coverage, By Type Of Coverage, 1940-1980**

purpose of determining payroll taxes and federal and state income taxes. This exclusion is essentially a subsidy for the purchase of health insurance for those who receive coverage through the workplace.

Most employers that offer health coverage contribute to its cost; in larger firms this contribution typically represents about 75 percent of the cost of individual coverage and about 65 percent of the cost of family coverage.⁴ This means that there is little benefit from not participating in a health plan, even for those who perceive their health risk as low. Participation rates are consequently very high, and persons generally considered to be good health risks remain in the employer's risk pool, which effectively reduces the premium and makes employment-based health insurance more cost-effective than the alternatives.⁵

Critics of the employer-based system say that the tax preference is inequitable because persons who lack access to the coverage cannot benefit from the exclusion. However, the tax preference further increases the ability of employment-based coverage to pool risk—the main advantage that employment-based health insurance has over individual health insurance.

Employment-based insurance spreads risk more broadly and therefore more efficiently than individual health insurance and, consequently, is less affected by adverse selection. The problems created for the individual health insurance market by consumers' particular health care needs, which shape the purchasing decision, are well documented.⁶ In contrast, employer-sponsored health plans are of-

“The group purchase of health insurance through the workplace makes that coverage affordable to poorer risks.”

ferred to employees and their dependents as part of a compensation package—and a person’s self-assessment of risk is only one of many factors leading to acceptance or rejection of a job offer.⁷

The tax subsidy promotes participation in health plans by those who otherwise would experience large net losses from participation. Some evidence exists that without tax subsidies, low-risk persons might leave pools at a higher rate than high-risk persons do because the cost of coverage would exceed its value.⁸ If enough employees chose not to participate, employers might simply terminate their health plans, especially if those who dropped out tended to be better risks.⁹

If the tax subsidy were removed with no other changes in the tax code, twenty million adults would no longer have employment-based health insurance.¹⁰ About 3.5 million more adults would purchase individual health insurance policies. But those in poor health—according to self-reported measures of health status—would be hit hard: The number of employer-insured adults with at least one family member in poor health would fall from 47 percent to 31 percent, a drop of sixteen percentage points.

Even more telling, the percentage of good risks with private coverage outside the employment-based system would increase by three percentage points, while the percentage of poor risks with other private coverage would fall slightly. Even the percentage of employer-insured adults with healthy families would fall twelve percentage points if the exclusion were repealed. These results further support the notion that the tax subsidy reinforces the risk pooling inherent in employment-based health insurance, thereby increasing the number of Americans with coverage.

In short, an inherent economic dynamic favors employment-based group coverage over individual coverage. Employers’ decisions to offer health insurance depend on the demand for coverage by the workforce they wish to attract and retain. Although good risks have a lower demand for health insurance than poorer risks have, the tax preference for employer-sponsored coverage in effect lowers its price. This induces more good risks to demand insurance; as the demand rises, more employers offer coverage. And when coverage is offered as a part of compensation, the vast majority of employees participate, thereby reducing the effects of adverse selection. Thus, the group purchase of health insurance through the

workplace makes that coverage affordable to poorer risks—the more vulnerable members of society. Individual purchase of insurance would not achieve this societal good.

Finally, some economists have argued that the tax preference provides an incentive for the purchase of too much insurance, resulting in a distorted market for health services, inefficient allocation of scarce resources, and increased health care cost inflation.¹¹ This argument ignores the social benefit provided by a person's access to health care services. Clearly, the current public policy debate centers on increasing health insurance coverage, not limiting it.

Employers As Purchasers

An important feature of the employment-based health insurance system is that many employers are sophisticated purchasers of health care. As such, they played a large role in stemming the rapid rise in health care costs of the late 1980s.¹² Employers were important catalysts in the development of managed care. In addition to slowing health care cost inflation, managed care emphasized prevention and screening and brought new approaches to managing chronic diseases. Without employers' support, and the relatively generous benefit levels common with employer-sponsored health plans, the continued development of managed care—and of network-based managed care in particular—might be hindered.¹³ This is a critical concern; without the cost savings created by managed care, it is likely that the number of uninsured Americans would be much higher.¹⁴

The value of employers' efforts to control health insurance costs must not be underestimated. Overall, the cost of coverage is the primary reason why many Americans lack health insurance.¹⁵ In fact, almost two-thirds of the uninsured report that they do not have health insurance because it is too expensive.¹⁶ The rapid growth of health care spending relative to personal income can account for almost all of the increase in the number of uninsured workers between 1979 and 1995. This suggests that employers' efforts to control health care costs by fostering price competition and managed care directly benefit workers, especially those low-wage earners who otherwise would be unable to purchase coverage.¹⁷

Employers also are working to improve the quality of health care. Roger Evans, manager of the health services evaluation section at the Mayo Clinic, has said:

Reform is being driven by progressive employers, by those concerned about quality. . . . They are the ones driving positive changes and those changes benefit not only the employers involved, they also help improve the entire care/delivery system for everyone.¹⁸

Limitations Of The Individual Insurance Market

Individual health insurance is often proposed as an alternative to employer-sponsored group coverage. However, even though roughly ten and a half million nonelderly Americans who do not have access to employment-based coverage rely on the individual health insurance market, it has a number of limitations, not all of which are related to its small size.¹⁹

The decision to purchase coverage in the individual market is different from the decision in the employer-sponsored market. Individuals tend to make economic decisions that are in their own financial best interest. In a voluntary individual health insurance market, each purchaser must compare the cost of coverage with the likely value of the benefits that will be received, and thus a consumer's expectations for future health care needs become the primary factor driving the purchase of coverage. This results in a market that operates in a fundamentally different fashion than do the employer-sponsored group market and most social insurance programs.²⁰ The residual nature and the individual-purchase dynamic of the individual market make market turnover rates very high; as many as 40 percent of individual policies are held for one year or less.²¹

Can this market's limitations be addressed? Not easily, because those limitations arise from the voluntary purchase of coverage by individuals. Current state reform efforts are attempting to add guaranteed issue and rating restrictions—requirements that actually would raise costs and reduce access.²² Benefit mandates, which also are likely, would further raise the cost of coverage.²³ More-complex solutions, such as risk-adjustment mechanisms, have yet to be proved effective and are accompanied by additional complications, not the least of which is an increased role for government.

Even if the current tax preferences were replaced by refundable tax credits for individuals, the net number of Americans with health insurance coverage still would decline. So far, no tax-credit scenario modeled by researchers has markedly reduced the number of uninsured Americans. In fact, most have resulted in increases.²⁴

The Employer-Based System: Basis For Reform

The employment-based health insurance system is not a historical accident. Its characteristics flow directly from our society's desire to maximize access to health care, our commitment to voluntary private markets, and the market advantages of employer-sponsored health insurance.

The inherent structural advantages of the employment-based private health insurance market, coupled with complementary tax and

public policies, have allowed employers to help control health care costs, improve quality, and maximize health benefits for a wide range of Americans from diverse economic and social backgrounds. The success of these efforts, during the past decade in particular, shows that the employer-based system harnesses the unique risk factors and other attributes of the health insurance market, for the benefit of the public. These advantages simply are impossible to replicate in any alternative based on a voluntary system.

Voluntary markets will continue for the foreseeable future, markets in which each purchaser must compare the value of the coverage received with the cost of the premiums and decide whether or not coverage makes sense. With a voluntary market, any implicit subsidy that requires some people to pay more for health insurance so that others can pay less is, in effect, a "tax" that can be avoided simply by not buying health insurance.

Continued reliance on the employment-based health insurance system, with its ability to attract a broad range of individuals, in conjunction with targeted subsidies for specific population segments who are not eligible for, or cannot afford, employer coverage, would seem to be the best strategy for increasing access in a voluntary market. Access to affordable coverage needs to be extended to far more Americans, but such efforts should supplement and strengthen the current employment-based system, not replace it.

OUR SOCIETY CONTINUES TO FACE important challenges in moving toward a more efficient, cost-effective, and universal health care system. Perhaps the most difficult challenge is to maintain the balance between private and public coverage to maximize access to health care services, control costs, and reward innovation. As long as we continue to rely on the voluntary purchase of health insurance, the natural tendency of consumers to make financial decisions that are in their own economic best interest will limit the size of the implicit subsidies that can be generated, particularly in the individual market, without greatly reducing the number of persons who choose to purchase coverage. The employment-based health care system offers a solid, proven foundation upon which to build any reform, and it should be preserved. On the other hand, reforms based on attempts to break the link between employment and health insurance coverage are unlikely to be successful and have the potential to greatly increase the number of Americans who lack health insurance.

NOTES

1. W. Custer, *Health Insurance Coverage and the Uninsured* (Washington: Health Insurance Association of America, January 1999).
2. An exhaustive literature exists on the disadvantages of a government system and the antipathy of Americans to such a system. See, for example, R. Blendon et al., "Voters and Health Care in the 1998 Election," *Journal of the American Medical Association* (14 July 1999): 189–194; M. Walker and M. Zelder, *Waiting Your Turn: Hospital Waiting Lists in Canada (9th Edition)*, Critical Issues Bulletin (Vancouver, B.C.: Fraser Institute, September 1999); S. Hall, "For British Health System, Bleak Prognosis," *New York Times*, 30 January 1997, A1; K. Donelan et al., "The Cost of Health System Change: Public Discontent in Five Nations," *Health Affairs* (May/June 1999): 206–216; T. Jost, "German Health Care Reform: The Next Steps," *Journal of Health Politics, Policy and Law* (August 1998): 697–711; and C. Dargie, S. Dawson, and P. Garside, *Policy Futures for UK Health: Pathfinder* (Draft) (London: Nuffield Trust for Research and Policy Studies in Health Services, September 1999).
3. Custer, *Health Insurance Coverage and the Uninsured*.
4. *National Survey of Employer-Sponsored Health Plans, 1997* (New York: William M. Mercer, 1998).
5. A. Monheit et al., "How Are Net Health Insurance Benefits Distributed in the Employment-Related Insurance Market?" *Inquiry* (Winter 1995/96): 372–391.
6. A consumer's choice of health insurance coverage in an individual market is determined by a self-assessment of his or her own risk and income. Those with the greatest demand for health insurance are thus most likely to use health care services. Premiums in the individual market therefore are higher, to cover the costs of the greater risks. *Providing Universal Access in a Voluntary Private-Sector Market*, Public Policy Monograph (Washington: American Academy of Actuaries, February 1996); L. Nichols, "Regulating Non-Group Health Insurance Markets: What Have We Learned So Far?" (Paper presented at the Robert Wood Johnson Foundation/Alpha Center meeting, The Evolution of the Individual Insurance Market: Now and in the Future, Washington, D.C., 20 January 1999); S. Zuckerman and S. Rajan, "An Alternative Approach to Measuring the Effects of Insurance Market Reforms," *Inquiry* (Spring 1999): 44–56; L.J. Blumberg and L.M. Nichols, "First, Do No Harm: Developing Health Insurance Market Reform Packages," *Health Affairs* (Fall 1996): 35–53; and L. Blumberg and L. Nichols, *Health Insurance Market Reforms: What They Can and Cannot Do* (Washington: Urban Institute, 1995).
7. Although employment itself may act as a health screen, given employment-based coverage's favorable selection, just under half of Americans with employment-based coverage are dependents of workers. P. Fronstin, *Features of Employment-Based Health Insurance*, EBRI Issue Brief no. 201 (Washington: Employee Benefit Research Institute, 1998).
8. Monheit et al., "How Are Net Health Insurance Benefits Distributed?"
9. *Tax Reform and the Impact on Employee Benefits*, Public Policy Monograph (Washington: American Academy of Actuaries, Spring 1997).
10. This estimate is based on variations in state marginal income tax rates. See W. Custer and P. Ketsche, "The Tax Preference for Employment-Based Health Insurance Coverage," Working Paper (Center for Risk Management and Insurance Research, Georgia State University, April 1999).
11. M. Feldstein, "The Welfare Loss of Excess Health Insurance," *Journal of Political Economy* (March/April 1973): 251–280; M. Feldstein and B. Freidman, "Tax Subsidies, the Rational Demand for Insurance, and the Health Care Crisis," *Journal of Public Economics* (April 1977): 155–178; and M. Pauly, "Taxation, Health Insurance, and Market Failure in the Medical Economy," *Journal of Economic*

- Literature* 24, no. 2 (1986): 629–675.
12. Fronstin, *Features of Employment-Based Health Insurance*; and U.S. General Accounting Office, *Health Insurance: Management Strategies Used by Large Employers to Control Costs*, Pub. no. GAO/HEHS-97-71 (Washington: GAO, 1997).
 13. *Tax Reform and the Impact on Employee Benefits*.
 14. J. Sheils and R. Haught, *Managed Care Savings for Employers and Households: Impact on the Uninsured* (Falls Church, Va.: Lewin Group, 18 June 1997).
 15. GAO, *Private Health Insurance: Continued Erosion of Coverage Linked to Cost Pressures*, Pub. no. GAO/HEHS-97-122 (Washington: GAO, 1997).
 16. K. Donelan et al., “Whatever Happened to the Health Insurance Crisis in the United States?” *Journal of the American Medical Association* 276, no. 16 (1996): 1346–1350.
 17. R. Kronick and T. Gilmer, “Explaining the Decline in Health Insurance Coverage, 1979–1995,” *Health Affairs* (March/April 1999): 30–47.
 18. Business Roundtable Health Insurance and Retirement Task Force, *The Spillover Effect: How Quality Improvement Efforts by Large Employers Benefit Health Care in the Community* (Washington: Business Roundtable, June 1998).
 19. GAO, *Private Health Insurance: Millions Relying on Individual Market Face Cost and Coverage Trade-Offs*, Pub. no. GAO/HEHS-97-8 (Washington: GAO, 1996). For a personal yet technically astute view of the limitations of the individual health insurance market, see R. Lake, “Seeking Answers: A Health Actuary Views the Dilemmas of Individual Policies,” *Actuary* (April 1998): 1, 4–5.
 20. “Risk Classification in Individually Purchased Voluntary Medical Expense Insurance” (Washington: American Academy of Actuaries, February 1999); and *Providing Universal Access in a Voluntary Private-Sector Market*. Key factors are that the purchase decision is made by individual consumers and that there is no external subsidy to ensure that coverage is a good economic deal for the healthy as well as the sick. Arrangements that have the form of group purchasing but do not alter these fundamental characteristics will have the same limitations as the current individual market. Conversely, while perhaps not politically feasible, a legal requirement that individuals purchase coverage, or a significant external subsidy, could alter the operation of the market even if all other aspects were left unchanged. For a detailed model of the effect of individual purchase decisions on blocks of individual health insurance policies, see W. Bluhm, “Cumulative Anti-Selection Theory,” *Transactions of the Society of Actuaries* 34 (1982): 215–246.
 21. D. Chollet and A. Kirk, *Understanding Individual Health Insurance Markets: Structure, Practices, and Products in Ten States* (Washington: Alpha Center, March 1998); and Lake, “Seeking Answers.”
 22. Custer, *Health Insurance Coverage and the Uninsured*; J. Marsteller et al., *Variations in the Uninsured: State and County-Level Analyses* (Washington: Urban Institute, June 1998); Zuckerman and Rajan, “An Alternative to Measuring the Effects of Insurance Market Reforms,” and M.L. Schriver and G.M. Arnett, “Uninsured Rates Rise Dramatically in States with Strictest Health Insurance Regulations,” *Backgrounder* (Washington: Heritage Foundation, 14 August 1998).
 23. G. Jensen and M. Morrissey, “Mandated Benefit Laws and Employer-Sponsored Coverage” (Washington: Health Insurance Association of America, January 1999).
 24. D. Cox and C. Topoleski, “Individual Choice Initiatives: Analysis of a Hypothetical Model Act” (Paper presented at the EBRI-ERF Policy Forum, Severing the Link between Health Insurance and Employment: What Happens If Employers Stop Offering Health Benefits?, Washington, D.C., 5 May 1999).