Building On The Job-Based Health Care System: What Would It Take?

A blueprint for preserving the U.S. system's strengths while addressing its weaknesses.

by Jack A. Meyer and Sharon Silow-Carroll

ABSTRACT: Recent surveys indicate widespread public support for reforming health care by building on our mixed public/private system. The authors present a blueprint for such reform, along with design choices and their implications, that would improve access, cost control, and quality. Requiring employers to provide coverage, or at least to help workers obtain group insurance, combined with income-based premium subsidies, expanded public programs, and backup "insurance exchanges," would make affordable coverage available to nearly everyone. Cost control and quality improvement would be achieved mainly through pressures applied on the health care system by multiple, large purchasers that wield much buying power.

The employer-based health care system in the United States, accompanied by Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP), could serve as a foundation upon which to build a better system. As explained in the paper by Robert Blendon and colleagues, which accompanies this paper on the *Health Affairs* Web site, there is widespread public support for working within the framework of our mixed public/private health system to broaden coverage, hold down spending, and improve quality.

The purpose of this paper is to develop a detailed blueprint showing how this construction project could proceed. We present a series of specific design features that address the fundamental weaknesses and stress points in our current system while building on its strengths. A few of these design features are controversial; for these we present advantages and disadvantages.

■ **Pros and cons of the current system.** The U.S. employer-based system is leaving about one out of six nonelderly people uninsured. The system lacks cost discipline, as clearly manifested by both the recent surge in premiums and the long-term trend in inflation-adjusted health care spending. Consumers have pressed for wide-open networks of providers and few if any limits on their use of health ser-

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vices. The health care industry has experienced a wave of consolidations and mergers, some of which yield entities with strong market power that leads to higher prices. Further, workers' ability to exclude from taxable income their employers' contributions toward health insurance amounts to an open-ended government tax subsidy, which underwrites cost escalation and provides benefits that are poorly targeted to financial need. Also, there is mounting evidence of widespread inappropriate care and a disturbing frequency of medical errors.[1] A growing literature documents the tragic underuse of medically effective preventive and primary care; routine referrals to hospitals performing a lower volume of certain medical procedures than the threshold associated with better health outcomes; and unnecessary tests and procedures.[2]

Yet our current system, with all of its flaws, is still the engine for basic medical research and the generator of advanced medical technology that benefits people throughout the world. Also, we are beginning to develop a modern information infrastructure that can reduce medical errors and improve quality of care. The challenge is to develop a realistic reform strategy with broad-based political appeal that reduces the gaps and addresses the deficiencies in our system while shoring up its strongest features.

■ **Elements of a new strategy.** In 2001 an estimated 162.3 million active workers and their dependents obtained health coverage through the employer-based system, 16.4 million people bought health coverage on their own in the nongroup market, some 40.9 million people were uninsured, and the rest of the population was enrolled in public coverage programs such as Medicare and Medicaid.[3] More than three-fourths of the uninsured are in working families. Among uninsured workers, about three out of five are employed by a firm that does not offer health coverage. One out of five workers are ineligible for their company's health benefits. Another one out of five workers turn down their employers' health coverage offer, usually because they cannot afford their share of the cost.[4]

How can we build on such a mixed system to achieve universal coverage, long-term cost control, and provider/health plan accountability for quality? We propose the following key elements of a strategy that would address this challenge. (1) All Americans would have access to affordable health coverage; this would be accomplished through a combination of employer-sponsored insurance, premium subsidies tied to income, "backup" large insurance pools, and expanded public coverage programs. (2) The health care system would remain pluralistic, and a large portion of the population would be enrolled in one of several types of large insurance pools, with sponsors including large companies, cooperatives representing small companies, Medicare and Medicaid, and some form of regional insurance exchanges.

(3) Cost control and quality improvement would be achieved mainly through pressures applied on the health care system by multiple large purchasers that wield much purchasing power; these purchasers would employ a mix of demand-

side and supply-side measures. The market incentives constituting the demand-side strategy would place greatest emphasis on premium sharing at the point of enrollment in health plans or care systems (to steer patients to health plans with lower-cost, high-quality providers), with some but relatively less emphasis on cost sharing at the point of service use. The supply-side strategy would feature efforts to reduce inappropriate care and promote quality through such mechanisms as the medical management of people with chronic illness and disability, the development and sharing of best practices and evidence-based medicine, and the proliferation of technology to support such practices.

Improving Access

Achieving universal coverage would require ensuring that everyone in the United States can participate in either private or public coverage systems. This could be accomplished by requiring employers to provide their workers with job-based coverage or to help workers obtain group insurance; expanding public coverage programs such as Medicaid and SCHIP and providing income-based subsidies for others with low incomes who still do not qualify for these programs; and establishing "insurance exchanges" (described below) for people without access to employer or public coverage and for others who cannot find affordable coverage in the private sector.[5]

There are two basic strategies for expanding employment-based health coverage. First, employers' contributions to health coverage could be made a legally mandated employee benefit and treated the same as employer contributions to Social Security and Unemployment Insurance. Second, employers could be required to help workers join an insurance exchange, using automatic enrollment unless workers specifically decline it. Workers would be enrolled in the employer's health plan if the firm chooses to fund coverage. Either way, the employer would perform some administrative functions related to collecting and forwarding employees' premium contributions.

■ **Mandatory coverage.** If the first approach is selected, several design choices must be made. These include whether to require employers to cover a minimum portion of the premium, what constitutes a minimum benefit requirement, and whether to make special provisions to assist small companies. Even under this mandatory employer contribution, some expansion of public programs would be needed to cover people who would not qualify for Medicaid and are excluded from job-based coverage. Nonworking poor adults without dependent children might be made eligible for Medicaid, and premium assistance programs could assist workers who cannot afford their share of employer-sponsored coverage.

A mandate on employers to offer health coverage and finance part of the premium would likely reduce the number of uninsured people much more than a voluntary approach would achieve. This strategy also would hold down the cost of reform to taxpayers, as the expansion in government programs needed to fill in the

gaps between required employer coverage and public programs would be relatively small.

The disadvantages include the likelihood that some workers (in firms newly providing coverage) would see reductions in wage gains or nonhealth benefits, even actual wage reductions, as employers try to maintain prior levels of total compensation. Other workers could lose their jobs—particularly people working at the minimum wage, whose earnings cannot be adjusted downward. Some workers might prefer more flexibility in the mix of wages, health coverage, and other benefits than would occur under a mandate. Finally, although the actual burden of this "head tax" would fall mainly on workers, for the reason just explained, employers would write the checks initially, and many would oppose government "intrusion." Employer opposition played a major role in thwarting past reform proposals featuring employer mandates, including the 1993 Clinton health care plan.

■ **Helping employees get coverage.** Under an alternative approach, employers would have a choice of either funding coverage or helping workers enter insurance exchanges. Government coverage programs would be greatly expanded, and new premium assistance scaled to income—in the form of tax credits or vouchers—would help lower-income people purchase private insurance. A design choice is how much to rely on government program expansion versus premium assistance. The decision would be reflected in eligibility criteria for each type of aid.

Proponents of public program expansion point out two fundamental advantages. First, it would provide comprehensive coverage with either nominal enrollee contributions (Medicaid) or modest payments (SCHIP). Further, Medicaid provides a number of "wraparound" health and social services that are vital to the well-being of low-income people but seldom are covered in the private market. Second, this approach builds on an existing administrative apparatus to determine eligibility, to facilitate enrollment in managed care plans, to pay providers and health plans, and to collect funds from the federal government to "match" state contributions.

An advantage of tax credits or vouchers is that they can be structured to promote cost-conscious choices by households. For example, linking the subsidy amount to the price of an efficient health plan would discourage the purchase of more costly plans that require higher out-of-pocket contributions. Proponents highlight the importance of using tax credits to boost the private market and hope that this will encourage greater competition among insurers. Tax credits, as envisioned in this option, would be refundable and advanceable, to provide assistance to people with low incomes and no tax liability and to avoid cash-flow problems. They could be either fixed-dollar amounts or proportional to the premium size.

Some combination of public program expansion and premium assistance could be devised. For example, this option could start with making all adults living below the federal poverty level eligible for Medicaid and making parents of children

with SCHIP eligible for that program. Tax credits could be made available for people with incomes above those thresholds.

■ **Additional measures to improve access.** *Automatic enrollment and continuation features.* Mechanisms would be included whereby people are automatically enrolled in a coverage option and continue with it unless they specifically decline it or there is evidence that they are no longer eligible.[6] This is likely to greatly increase take-up and continuation rates and help reduce the number of uninsured people.

Direct service outreach. Insurance coverage strategies could be supplemented by direct service outreach initiatives. This could involve augmenting government support for community health centers; the use of mobile treatment facilities and community health care workers to carry health care into remote or underserved areas; and increased support for public programs that augment the supply of physicians and other medical personnel in underserved areas, assist AIDS patients in obtaining high-cost but effective treatment, and provide nutrition support and other services to infants and pregnant women.

Keeping A Pluralistic System

The proposed strategy would establish insurance exchanges—essentially group-purchasing cooperatives—designed to serve a wide range of people who cannot obtain insurance through either employer-sponsored coverage or the major government programs. An insurance exchange would negotiate and contract with many health plans or "care delivery systems" that would offer standardized coverage products to all people entering the exchange.[7] To ensure access, exchanges would operate with various rules such as open enrollment, guaranteed issue and renewal, and modified community rating.[8] Risk adjustment among the participating health plans would be necessary to ensure that plans with higher-risk enrollees were compensated adequately.

The success of an insurance exchange rests largely on its size; the more people it represents, the greater its clout in negotiating for lower rates and demanding quality standards, the greater the economies of scale in administrative functions, and the more easily it can spread and adjust risk.

Properly structured insurance exchanges could gather people who work for businesses that do not offer coverage, who fail to qualify for or cannot afford employer coverage, and who are not eligible for public coverage programs. This would include people who work in part-time, temporary, and contract jobs, along with full-time permanent workers who work for companies that choose not to fund health coverage (assuming that the employer mandate option is not implemented). Exchanges could also be the source of coverage for small firms (for example, fifty workers or fewer) and their workers. Lower-income people obtaining coverage through exchanges could apply their tax credits/vouchers, and everyone would have a choice of health plans and care delivery systems.

■ **One versus multiple exchanges.** A design choice is whether to establish one

insurance exchange in each region or to permit and encourage multiple, competing exchanges. Under the former approach, there would be one quasi-public exchange in each state, county, multistate region, or other area to be determined. A key advantage of this approach is that having one exchange would ensure that it represents a large number of people, thereby enhancing its negotiating power and ensuring economies of scale. Also, the functioning of the exchange could be more easily monitored and modified to ensure appropriate access, cost control, and risk adjustment among its health plans.

Under the multiple exchange approach, one exchange could be set up as a quasi-governmental organization in each designated area, but the private sector could also continue to develop and operate various forms of purchasing cooperatives. Proponents argue that under this scenario, various approaches to managing costs and improving quality could be tried, with perhaps more innovation emerging from the competition.

Either design would require effective mechanisms for dealing with risk segmentation between the exchange and other coverage options. In particular, with exchanges operating under open enrollment and other rules designed to ensure access, if other sources of coverage (other private insurance or cooperatives) are not required to follow the same rules, then the exchanges would be vulnerable to adverse risk selection (enrolling older and sicker people) as low-risk people go outside the exchange to get lower premiums.

■ **Treatment of small businesses.** Another design choice is whether to require very small businesses that want to purchase coverage to do so through the exchanges. Since exchanges work best if they are large, a case can be made for requiring certain groups to use an exchange as their source of coverage. It could be argued, for example, that very small firms (those with ten workers or fewer) opting to offer health coverage should be required to use an exchange, since such firms have the most trouble finding affordable coverage and have little bargaining clout as individual buyers.[9] The counterargument is that small businesses should be as free as larger businesses to make their own decisions about whether to enter an exchange, use an alternative pool such as an association health plan, or obtain their own separate insurance coverage. The decision of whether to require very small firms that opt to offer health coverage to obtain it through an insurance exchange will obviously have a large impact on the number of people who end up getting their coverage through the exchanges.

Controlling Costs

A strategy that builds on our current system could use a number of cost-control mechanisms that are compatible with mixed public/private, organized group purchasers of health care. Such mechanisms could include the following.

■ **Exercising negotiating power.** Cost control would depend on large firms, coalitions of small and medium-size companies, insurance exchange managers, and

government purchasers exercising their bargaining leverage to reduce health plan premiums and providers' fees.[10] They would also be in a position to set and enforce contractual standards for quality improvement, intended to lower longer-term costs. Special emphasis could be placed on case and disease management to improve health and functional status for people with chronic illness and disability whose unmanaged conditions are an important source of spending increases.

■ **Creating incentives for consumers.** Cost control could be enhanced with incentives for consumers at the point when they select health plans or care systems once a year during open enrollment. That is, consumers would be required to contribute more to enroll in more expensive, less efficient health plans. We contend that applying financial incentives at a juncture when consumers can make dispassionate and rational decisions is preferable to imposing large financial disincentives to use services when they are sick. This does not preclude, however, the use of modest and affordable deductibles, copayments, and coinsurance or tiered networks under which consumers pay more when they use services provided by certain high-cost providers.

■ **Capping or eliminating the tax exclusion.** An important, though controversial, design choice is whether to change employees' ability to exclude their employers' contributions to health coverage from their taxable income. If these open-ended tax subsidies were capped or eliminated, the incentive to overinsure might be reduced. Any change in the tax treatment of employers' contributions to health coverage, however, will be met with strong opposition from many business and labor groups. These opponents argue that the tax treatment of health coverage contributions should not be described as a "subsidy," which connotes some form of welfare-based public assistance. They also believe that a cap on the exclusion would be administratively cumbersome.

■ **Assessing new technology.** Under any reform scenario, the United States needs to develop a better system of assessing the medical effectiveness and cost-effectiveness of advanced medical technology. This involves case-by-case evaluations of the impact of new drugs, medical devices, surgical procedures, and diagnostic tests to determine the conditions under which their use actually improves patients' health. It also entails examining the impact of the new technology on systemwide health costs and such workplace effects as reduced absenteeism. Promising technology should be targeted to uses for which it passes such tests.

■ **Strengthening the best features of managed care.** A number of managed care tools, which have been in use for some time, need to be carefully evaluated to determine their potential to improve health outcomes and lower costs. Those that prove effective should be strengthened. These could include elements that have been weakened if not discarded in response to the consumer backlash against managed care. For example, provider profiling based on both fees and adherence to practice guidelines could be reinforced, with the results used to narrow the very broad networks of providers that now characterize most managed care plans.

Other tools include utilization management to identify high-cost providers (for example, excessive lengths of hospital stay), early intervention and screening, and case management and disease management. While focusing on high-risk or high-cost patients through case and disease management has clear benefits to health and functional status, additional research is needed to determine its impact on short- and long-term health care costs.

None of these measures is capable of making dramatic or immediate reductions in health care spending. But if we evaluate their use and develop both incentives and financing sources for their adoption and broader implementation, these tools could contribute to both quality improvement and cost management.

■ **Enforcing antitrust laws.** A number of the key sectors of the health care industry have consolidated from a large number of competitors to just a few, with negative consequences on cost control. Federal enforcement of antitrust laws should be strengthened.

■ **Fostering medical malpractice reform.** Tort reform might consist of some type of caps on noneconomic damages such as for pain and suffering (that is, awards that go beyond compensation for medical expenses and lost earnings), as well as changes in the way attorneys are compensated in malpractice actions. There is also a need to examine the practices of insurers and protect legitimate patient claims.[11]

■ **Reducing fraud and abuse.** Health care fraud is widespread and costly. The federal government recovered more than $3 billion in fraudulent claims against Medicare filed by health care providers over a recent five-year period, and the states are becoming more active in investigating Medicaid fraud.[12] Efforts to weaken the False Claims Act, which permits whistleblowers to bring claims against corporations committing fraud and calls for stiff penalties, should be resisted. Corporate integrity agreements should be more closely monitored by the federal government to assure compliance with settlement agreements.

Promoting Quality Improvement

The effort to improve quality would rely largely on multiple group purchasers to promote and encourage adoption of best medical practices and to meet quality goals. The science involved in developing practice guidelines, electronic medical records, computer-assisted physician order entry, and other quality-related tools is developing rapidly. But the politics and sources of financing required for the widespread adoption of these tools are more difficult.

■ **Identify quality indicators, measurement tools, and best practices.** A series of initiatives led by the medical community, and supported by government and private-sector purchasers of care, should be geared to the development of quality indicators and measurement tools and the identification and use of effective, efficient medical practices. Clearly, physicians, hospitals, and other health care providers and researchers must take the lead in determining best medical practices and forging practice guidelines. But other stakeholders must play a role in encouraging adher-

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ence to these practices. Quality measurement should compare the performance of health care providers, not just health plans. Assistance must be offered to physicians and hospitals whose performance falls short of standards, and this outreach and technical assistance must be financed by either the purchasers of health care or government at some level. Finally, employers and health plans must have the courage to steer their business away from providers who reject this assistance or who continuously perform poorly.

■ **Develop capacity and willingness to conduct standardized public reporting.** Health plans and care delivery systems would be required to publicly report information on health outcomes and patient safety to payers or various statewide organizations, or both. Data would be fully transparent and timely. Some providers have resisted this transparency but have faced few if any consequences, and some states have eliminated the data commissions they set up to do this reporting.

■ **Use a national clearinghouse.** Some form of centralized repository and clearinghouse of information on quality of care and performance could be maintained. This might build on the work of the Quality Forum, which is developing a set of core quality and performance data on a national basis and is promoting standardized measures and specifications. The Quality Forum is also offering a set of collection, verification, and audit tools to foster adherence to practice guidelines.

■ **Move to computer-based technologies.** This would involve building an electronic medical record system containing clinical information that can be electronically stored and transferred securely and confidentially. Information on patients' conditions and treatment requirements could be shared among physicians and allied medical personnel, communication between doctor and patient could be improved, and patients' chronic conditions could be monitored from their homes by their physicians. Electronic systems also could be used to schedule appointments, enroll patients in government insurance programs for which they are eligible, and issue reminders about preventive care.[13] Further, technology could be used to avert medical errors, as in the case of computer-assisted physician order entry.

Although some physicians and hospitals have adopted these electronic tools to improve quality, many others have not. Some are simply resistant, while others cite legitimate concerns about the implementation cost. Thus, some government funding could be necessary to assist in the adoption of these technologies. Purchasers would then be justified in requiring the use of these tools as a condition of doing business with health care providers.

■ **Install financial incentives for quality.** Providers who follow evidence-based practice standards and adopt proven technology to reduce medical errors should be rewarded with higher payments. The combination of strong technology assessment

and rewards for top quality would replace the long-standing U.S. practice of applying allowable prices to all providers without regard to performance.

How To Finance A New System

A reform plan that builds on the employer-based health care system will require new subsidies for lower-income people. It will also require some financing for a national initiative to install proven technology to improve quality of care in hospitals, clinics, and physicians' offices. A responsible reform plan must fully finance these obligations. This could be done through general revenue—either through direct federal outlays, financed by an increase in income taxes, or other means including eliminating or placing a cap on the open-ended exclusion of employers' premium contributions from workers' taxable income. Other financing sources, such as redeploying disproportionate-share hospital (DSH) payments and other safety-net support, could also be considered, along with such measures as earmarked "sin tax" increases. If a new subsidy program (such as tax credits) covers some people now in Medicaid or SCHIP, some offsets will be realized.

The blueprint outlined in this paper provides a way to address the problems of access, quality, and cost by building on the current health care system. This approach has a number of attractive features. It allows for the steady adoption of new medical technology with the potential to save lives and improve quality of life. It reflects the pluralism that is so characteristic of American life and permits consumers, to some extent, to customize their health coverage instead of experiencing a "one-size-fits-all" approach. It keeps large corporations, which have been a source of innovation, in the system.

There are, however, some trade-offs in adopting this strategy. Although market incentives are designed to create pressure on health care providers to lower prices and practice more efficiently, the intended results could be checked by market power in the health care industry and could take considerable time to play out. In contrast, government-imposed price and technology limits are likely to provide stronger and quicker cost control.

The quality improvement techniques outlined here are neither fully proven nor easy to implement. Also, the most effective means of moving to universal coverage under this model—an employer mandate—is politically challenging and has some adverse side effects. Expanding Medicaid and SCHIP and providing meaningful subsidies to low-income people requires new public expenditures. These new outlays must be financed, which may be politically unpopular, but the alternative of adding further to government deficits is unacceptable.

The various reform components outlined above, however, could be woven into a coherent plan that moves us toward our goals over time. It does this by building incrementally on our current mix of public and private insurance, which appears to be the preferred approach of most Americans.

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NOTES

1. See, for example, L.T. Kohn, J.M. Corrigan, and M.S. Donaldson, eds., *To Err Is Human: Building a Safer Health Care System* (Washington: National Academies Press, 1999); Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the Twenty-first Century* (Washington: National Academies Press, 2001); and IOM, *Fostering Rapid Advances in Health Care: Learning from System Demonstrations* (Washington: National Academies Press, 2002).
2. See, for example, M. Chassin, "Assessing Strategies for Quality Improvement," *Health Affairs* (May/June 1997): 151–161; M.A. Schuster et al., "How Good Is the Quality of Health Care in the United States?" *Milbank Quarterly* 76, no. 4 (1998): 517–563; and R.A. Dudley et al., "Selective Referral to High-Volume Hospitals: Estimating Potentially Avoidable Deaths," *Journal of the American Medical Association* 283, no. 9 (2000): 1159–1166.
3. P. Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2002 Current Population Survey,* Issue Brief no. 252 (Washington: Employee Benefit Research Institute, December 2002).
4. See B. Garrett, L.M. Nichols, and E.K. Greenman, "Workers without Health Insurance: Who Are They and How Can Policy Reach Them?" *Community Voices* (1 August 2001).
5. For a discussion of insurance exchanges, see S.J. Singer, A.M. Garber, and A.C. Enthoven, "Near Universal Coverage through Health Plan Competition," in *Covering America: Real Remedies for the Uninsured,* vol. 1, ed. J.A. Meyer and E.K. Wicks (Washington: Economic and Social Research Institute, 2001).
6. See E. Steuerle, "A Workable Social Insurance Approach to Expanding Health Insurance Coverage," in *Covering America: Real Remedies for the Uninsured,* vol. 3, ed. J.A. Meyer and E.K. Wicks (Washington: ESRI, forthcoming).
7. A care delivery system in this context is a group of providers that agrees to bear some financial risk for providing services to a group of enrollees for a preset contribution from payers.
8. Without these rules, other mechanisms would be necessary to make health coverage affordable to higher-risk people who are rejected from insurance plans or required to pay exorbitant premiums, such as high-risk pools or the inclusion of such people in Medicaid.
9. For a discussion of this issue, see R. Curtis and E. Neuschler, *Tax Credits for Individual Health Insurance: Effects on Employer Coverage and Refinements to Improve Overall Coverage Rates* (Washington: ESRI, August 2002).
10. For a description of how this approach might work, see A.C. Enthoven and S.J. Singer, "Market-Based Reform: What to Regulate and by Whom?" *Health Affairs* (January 1995): 105–119. Enthoven and Singer call this approach the "sponsored-group model."
11. For an in-depth treatment of malpractice reform, see A.H. Nevers, "Medical Malpractice Arbitration in the New Millenium: Much Ado about Nothing?" *Pepperdine Dispute Resolution Law Journal* 1 (2000): 45–90; and U.S. General Accounting Office, *Medical Liability: Impact on Hospital and Physician Costs Extends beyond Insurance* (Letter Report), Pub. no. GAO/AIMD-95-169 (Washington: GAO, 29 September 1995).
12. J.A. Meyer, *Fighting Medicare Fraud: More Bang for the Federal Buck* (Washington: Taxpayers against Fraud, June 2003).
13. IOM, *Fostering Rapid Advances in Health Care,* 58–59.