Employer-Based Health Insurance: A Balance Sheet

A political economist sets up the credits and debits of the U.S. system of employer-based health coverage—and doesn’t like how it all adds up.

BY UWE E. REINHARDT

As the United States faces the dynamic global economy of the next millennium, many policy analysts and even some members of Congress have begun to wonder whether employment-based health insurance can remain a cornerstone of the U.S. health care system.

The employer-based system traces its origins to World War II, when Congress illogically allowed employers to use fringe benefits as a means of evading the wage caps that it had imposed at the time. The system thrived in the postwar years, when the U.S. economy ruled the world and American workers enjoyed virtually tenured jobs. Its growth has been further abetted by a tax preference that allows employers to treat the group-insurance premiums paid on behalf of employees as tax-deductible expenses without requiring employees to pay income taxes on this part of their compensation. In effect, this tax preference allows employed Americans to purchase health insurance out of pretax income, a privilege not extended to self-employed or unemployed Americans.

Although the employer-based insurance system covers about two-thirds of the U.S. population, it accounts for less than one-third of total national health spending. This is because public insurance programs have become the catch basins for relatively high cost Americans—the elderly, the poor, and the disabled. Government’s relative importance as a payer for health care is likely to grow in the next century, as the population ages.

Doubts about the employer-based health insurance system’s future have grown during the 1990s, because the system actually shrank as the economy and total employment expanded apace. About 18 percent of working adults are now offered any health insurance by their employer. The more nonelderly Americans are eclipsed and left uninsured by the employer-based system, the more

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compelling is the search for a robust alternative to that system.

This Commentary explores the social merits of the current system within the framework of an account to which the system’s achievements are credited and its shortcomings debited. Severe limitations of space necessarily keep the discussion somewhat superficial. Readers therefore are referred to two earlier papers, on which the present discussion draws.\(^2\)

The System’s Credits

- **The status quo.** One of the chief advantages often claimed for the employer-based system is that it is there. At a purely practical level, the argument is compelling. So far, it remains the most effective mechanism for pooling of health insurance risks in the private health insurance market.

  It would be particularly difficult to eliminate the dubious tax preference now accorded the employer-based system. If it were proposed to add employer-paid premiums to workers’ taxable income, then the imputed incomes probably would have to be adjusted for each employee’s actuarial risk. After all, if a company paid an average premium of $5,000 per worker for all of its employees, would younger and healthier employees accept the addition of $5,000 to their taxable income? To spare employers the daunting task of making these imputations, the easiest way to eliminate the tax preference might be simply to exclude employer-paid premiums from employers’ tax-deductible business expenses. That policy, however, would be likely to meet stiff political opposition from the very people on whom Congress relies for campaign financing.

- **Risk pooling.** Within a given firm, the group policies customary under the employer-based system tend to force healthier and younger employees to cross-subsidize the health insurance of older or sicker employees within the same company. Persons who favor the socialization of the financial risk of ill health—myself included—therefore will credit employer coverage for risk pooling that typically is much broader than that in the market for individually purchased health insurance. Of course, if one took as a benchmark the even broader risk pooling under genuine social insurance systems, such as Medicare or the European health systems, then the extent of risk pooling achieved by the employer-based system must be judged rather limited and spotty. That is particularly so for small
firms with experience-rated group policies.

**Innovation through decentralization.** It has been argued that relative to highly centralized, government-controlled health insurance systems, the relatively unregulated, decentralized U.S. employer-based system naturally offers greater opportunity for experimentation and innovation in the procurement of health care. There is something to this claim, although it can be exaggerated.

For example, the now world-famous diagnosis-related group (DRG) system for paying hospitals and the resource-based relative value scale (RBRVS) for paying physicians were developed not in the private sector but by Medicare. Similarly, the survey instrument of the increasingly popular Consumer Assessment of Health Plans (CAHPS) was developed by the Agency for Health Care Policy and Research (AHCPR) of the U.S. Department of Health and Human Services. Finally, many of the managed care techniques now taken as inventions of American employer-based health insurance actually have been used for decades in the government-controlled health systems of other nations. One thinks here of physician profiles, multi-tier pricing for pharmaceuticals, hospitalists, home care as a substitute for inpatient care, and the like. Even so, in fairness one probably ought to give credit to the employer-based system for some of its recent innovations in the procurement of health care, and that credit is hereby entered.

**Consumers’ preferences.** It may be argued that the employer-based system deserves credit for reflecting the preferences of the American people. The argument seems to be that Americans like the comfortable paternalism built into the system. Although that may be so, one wonders whether this argument does not confuse a preference for private health insurance with a preference for employer-based health insurance.

If Congress had seen fit to allow employers to procure food and automobiles for employees on similarly tax-favored terms, then today employer-provided food and automobiles probably would seem to be preferred by Americans, too, especially if unemployed Americans did not enjoy the same privilege. Under those circumstances, Americans probably would favor that system even if their choice and use of automobiles and food were paternalistically “managed” by their employers, as is their health care today.

“The worst shortcoming of the employer-based system is that protection of entire families is tied to a particular job.”
The System’s Debits

- **“Uninsurance.”** Unquestionably the worst shortcoming of the employer-based system is that the health insurance protection of entire families, including children, is tied to a particular job and lost with that job. By international standards, privately insured Americans cannot really be considered “insured.” They are “temporarily insured,” or “unsured” for short.

In virtually all other industrialized nations, young people know that, come what may, they will have permanent, fully portable health insurance. The United States has never been able to afford its citizens that luxury. Would any private health insurer today be able to offer a young American a life-cycle health insurance contract, akin to the whole-life insurance policies that are available to young Americans? The job-based system has been a major roadblock to the development of fully portable, life-cycle health insurance contracts.

- **Job lock.** Because the employer-based system ties health insurance to a particular job, it can induce employees to remain indentured in a detested job simply because it is the sole source of affordable health coverage. As Jonathan Gruber and Maria Hanratty have shown empirically, relative to the U.S. health system, the fully portable health insurance provided by the Canadian provinces actually facilitates greater labor mobility. Fully portable health insurance, of course, is not contingent on government provision. Within a proper statutory framework, it should be possible to develop fully portable private health insurance that is detached from the workplace.

- **Inequity.** The tax preference enjoyed by the employer-based system is inequitable for two reasons. First, it has never been fully extended to self-employed and unemployed Americans, which is unfair on its face. Second, even among employed Americans with employer coverage, those with high incomes benefit proportionately more from the tax preference than do low-income employees in lower marginal tax brackets.

This inequity is most glaring in connection with the flexible spending accounts available only through the employer-based system. At the beginning of the year employed Americans may deposit into these accounts, out of pretax income, specified amounts to cover out-of-pocket health spending. With this set-aside, well-to-do families can purchase a dollar’s worth of, say, orthodontic work or plastic surgery at an after-tax cost of only about fifty cents, whereas low-income families would pay eighty-five cents or more after taxes for the same work. Furthermore, the law includes the inflationary provision that unspent year-end balances in the accounts accrue to the employer. One suspects that Congress enacted
this inequitable, inflationary provision at the behest of private employers, which found the arrangement helpful in their quest to make their workers accept more overt cost sharing for their health care.

- **Lack of choice.** Whatever benefits employees derive from the current paternalistic system, one price they pay is limits on their choices in the health insurance market. As Stan Jones, Lynn Etheredge, and Larry Lewin reported in 1996, close to half of American employees are offered only one health plan by their employers. They are in what one may call a private single-payer system. Another quarter or so of employees are offered a choice of only two health plans. A more recent Kaiser/Commonwealth national survey of health insurance corroborates these estimates. This lack of choice makes a mockery of the idea of “managed competition.”

- **Lack of privacy.** In many instances, the employer-based system gives private employers access to their employees’ medical records. It is one thing to know that a private insurance carrier has information on the most intimate details of one’s life. It is quite another to think that the personnel department of one’s employer can get access to that information as well. Whatever one may think about health systems abroad, patients in those countries do not worry about this invasion of privacy.

- **Administrative complexity.** The defenders of employer-based health insurance tend to view it as more “efficient” than alternative arrangements. That proposition is incredible, given the current system’s administrative complexity. Exhibit 1 illustrates this point. The data there are the fruits of a multiyear study by McKinsey and Company of the American and German health systems, the latter of which is based on private, not-for-profit sickness funds that operate within a tight statutory framework. The McKinsey research team concluded that the U.S. system is more productively efficient than Germany’s system is. It based that conclusion on the finding that in

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**EXHIBIT 1**

Decomposition Of Differential Per Capita Health Spending In Germany And The United States, 1990

<table>
<thead>
<tr>
<th>Description</th>
<th>U.S. dollars</th>
<th>Percent of German spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per capita spending in Germany</td>
<td>$1,473</td>
<td>100.0%</td>
</tr>
<tr>
<td>Less use of real medical inputs in the United States</td>
<td>–390</td>
<td>–26.5%</td>
</tr>
<tr>
<td>Plus higher prices in the United States</td>
<td>737</td>
<td>50.0%</td>
</tr>
<tr>
<td>Plus higher administrative costs in the United States</td>
<td>360</td>
<td>24.4%</td>
</tr>
<tr>
<td>Plus “other” higher costs in the United States</td>
<td>259</td>
<td>17.6%</td>
</tr>
<tr>
<td>Total additional costs per capita in the United States</td>
<td>966</td>
<td>65.6%</td>
</tr>
<tr>
<td>Per capita spending in the United States</td>
<td>2,439</td>
<td>165.6%</td>
</tr>
</tbody>
</table>


\(^a\) Purchasing power parity.
1990 Germans actually spent $390 more per capita on strictly medical inputs (hospital days, physician visits, drugs, and the like) than did Americans. As the exhibit shows, however, the U.S. system burned up more than the entire savings from its allegedly superior clinical productivity on higher administrative expenses ($360 per capita) and on higher outlays on the catch-all category “other” ($259). Because Medicare and Medicaid are known to spend relatively little on administration, the higher U.S. figure must reflect mainly private insurance. Given that the U.S. system outranks no other system in the industrialized world in either measured health status indicators or patient satisfaction, it can fairly be asked: In what sense is employer-based health insurance “efficient”?

Lack of transparency. Standard economic theory and empirical research have convinced economists that the premiums paid by employers on behalf of employees are merely part of the total price of labor and, over the longer run, are shifted back to employees collectively through commensurate reductions in take-home pay. Unfortunately, it is not known precisely how employers do this. That may be why employees typically assume that their employer fully absorbs the part of the premium that is not explicitly deducted from their paycheck. Unaware of how much their health insurance actually costs them in terms of forgone take-home pay, employed Americans have never showed nearly enough self-interest in health care cost containment. This may explain why over the long run the employer-based system has so frequently acted as the inflationary locomotive in American health care.

Ambiguous Entries

To my mind, the previous entries were clear-cut debits or credits. There remain a number of items whose proper entry into the employer-based system’s account is more ambiguous.

Health spending. It seems to be widely taken as an axiom that private health insurers are always more successful than the public sector is at cost control in health care. This hypothesis does find support in the period 1992–1997, when the national average of the health insurance premiums paid under the employer-based system did rise less rapidly than per capita health spending in the public sector. Therefore, one might be tempted to credit the employer-based system with superior cost control.
As is well known among analysts familiar with the national health accounts, however, the private insurance sector has not consistently outperformed the public sector in this regard. For example, during most of the 1980s premiums in the private sector rose much more rapidly than did Medicare spending per enrollee. That is true again today and for the foreseeable future.

From a long-run perspective, the fairest statement is that in some periods the private insurance sector seems more able to control the growth of health spending, while in other periods the public sector has been more successful.

Managed competition. At the beginning of the decade Americans looked to employer-based health insurance as the spearhead of “managed competition.” That arrangement requires individual households to choose from a menu of rival health plans the one plan that will subsequently regulate (manage) the health care received by family members in case of illness. Such a daunting choice presupposes an information infrastructure capable of informing households about (1) the manner in which the rival health plans regulate health care in case of illness, and (2) the quality of the services rendered by the providers of health care with which the health plans contract for services.

Only a few employers provide workers with such information. Even the roughly 50 percent of Americans whose employer actually does offer them a choice among health plans are given only sketchy information on the plans and usually none on the quality of the providers of health care associated with them. For example, in the HMO Performance Report of the 1997 Benefits Decision Workbook for its New Jersey employees, the Xerox Corporation, which is generally thought of as one of the most sophisticated buyers of health insurance, noted that neither the Oxford Health Plan nor its competitor, U.S. Healthcare, permitted dissemination of a variety of crucial performance data to Xerox employees, including the board certifications of physicians and enrollee satisfaction. As Etheredge has concluded (and I concur), if properly managed competition is ever to develop in this country, chances are that Medicare will have to lead the way.

The NCQA. The employer-based system can claim credit for having created jointly with the managed care industry the National Committee for Quality Assurance (NCQA), which in turn has developed the Health Plan Employer Data and Information Set (HEDIS). HEDIS certainly represents a major contribution to the science of measuring and monitoring the quality in health care. The NCQA has contributed further to quality control through its accreditation of health plans.
Remarkably, however, a national survey in 1997 revealed that only 9 percent of employers made NCQA accreditation a requirement for including a health plan on their offering to employees. Only 1 percent of employers provides HEDIS data to employees to assist them in plan selection. Although interest in the data may have grown since that survey, this sluggish uptake by employers speaks poorly of the entire enterprise.

Perhaps the intended users of the HEDIS data question their validity, because the *modus operandi* of the NCQA represents a classic application of Nobel-laureate economist George Stigler’s now famous “capture theory.” According to that theory, those who are to be regulated by a public body eventually capture the regulatory apparatus. Because the NCQA started as a joint effort between employers and health plans, a certain degree of capture by the health plans was guaranteed at the outset. Not surprisingly, then, participation in the NCQA has remained voluntary on the part of health plans. Furthermore, plans that do submit data to the NCQA can prohibit their dissemination to the public. Finally, all of the HEDIS data, including those on enrollee satisfaction, are self-reported by plans rather than retrieved by a process not under plans’ control. At the very least, employers should have formed and funded a coalition that surveys enrolled consumers externally.

One could debate whether, on balance, the NCQA has been a catalyst or a hindrance in the evolution of managed competition so far. Sometimes a half-hearted effort is worse than none, because its presence precludes or retards the development of superior approaches. In any event, it is not clear how much if any credit is due the employer-based system for establishing the NCQA’s half-hearted effort at quality control.

Although different evaluators may come up with different debits, credits, and account balances for the employer-based health insurance system, I conclude from the exercise that the debits outweigh the credits. This conclusion does not call for the outright abolition of the current system, but it does suggest the need for a parallel system that would be detached from the workplace and that might, over time, absorb the bulk of the current system. With a proper regulatory framework, such a parallel system need not be public; it could rely on private insurance as well.
NOTES
3. Hospitalists are physicians who are permanently stationed in a hospital, although they are not the hospital's employees but could be part of a group practice.
13. The self-reported data are said to be audited, but little is known about the quality of these audits.