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Revising Employers' Role in Sponsoring and Financing Health Insurance and Medical Care

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Globalization of markets is the straw that is breaking the camel's back of employer-financed health insurance in the United States. General Motors' (GM) CEO Rick Wagoner is perhaps the most visible chief executive to declare that the cost of health care must be reallocated away from employers and toward workers and the government. In 2006, Wagoner and his counterparts at Ford and DaimlerChrysler proposed that the federal government assume responsibility for the medical costs of the people in the top 1 percent of the health care expenditure distribution. Since people with medical expenses in the top 1 percent of the population account for about 30 percent of all health care spending each year, Wagoner and his colleagues argue for a significant shift in how we finance health insurance in the United States.¹

GM's concerns about employee health care expenses are widely shared among employers. Between 2000 and 2006, the proportion of the nonelderly population (younger than 65) with employer-sponsored health insurance (ESI) went from 66.8 percent to 62 percent (Fronstin 2006). Employment-based health insurance coverage has contracted and expanded over the past two decades with changes in the economy, but the current decline is larger and faster than in previous periods. Moreover, the percentage of firms offering health benefits fell from 69 percent in 2000 to 61 percent in 2006 (Claxton, Gil et al. 2006). These trends reflect the rapid rise in health insurance premiums: between 2000 and 2005 they increased 73 percent (Gabel et al. 2005). The annual rates at which premiums grew are much higher than the annual increases in the Consumer Price Index and workers' wages, and they exceed productivity growth rates (Bureau of Labor Statistics 2007; Gabel et

al. 2005). Perhaps not surprisingly, companies reacted by attempting to hold down increases in their health insurance costs.

Even before 2000, employers were engaged in efforts to hold down health insurance costs—some stopped sponsoring coverage, and others (generally new companies) opted not to begin sponsoring coverage; some shifted to hiring workers on a contractual basis or as temporary workers so they would not be eligible for the companies' health benefits; and others increased the employee share of premiums and/or other out-of-pocket costs (e.g., the annual deductible or co-payments when obtaining care). Although the Census Bureau's February Employee Benefit and Contingent Worker Supplement to the Current Population Survey (CPS) shows little increase in the use of contingent workers between 2000 and 2005, there is increasing anecdotal evidence of people being hired to work as contract or temporary workers or having to become self-employed workers (Swartz 2006).² Small service firms that in earlier decades might have been composed of a president and employees now frequently are organized as "virtual companies" in which there is a founder-president and all the other workers are technically self-employed associates or consultants. Such contingent work arrangements enable firms to avoid providing fringe benefits altogether. These moves shifted more health care costs onto employees and no doubt prevented premiums from rising faster than they did. Yet the concerns raised by the chief executives of the "Big Three" automotive makers visibly show that the future financing of ESI is far from certain. With growing competition from companies abroad, American workers can no longer assume that "good jobs" will provide ESI as part of the compensation package.

This chapter explores the question of what will happen to employer-sponsored health insurance in the next few decades with increased global competition. In particular, this chapter focuses on the question of how we might share the costs of health care between employers, employees, and government (that is, taxpayers). In the next section we review why and for whom health insurance has been a component of total compensation. In the third section we briefly describe the enormous growth in health care spending and health insurance costs over the last 50 years. It is the rapid rate of growth in these costs, particularly during the last decade, that has been causing employers to argue that they cannot continue to pay as much as they have for ESI.

We then examine in the fourth section the effects of both rising health insurance costs and global competition on employers and their efforts to reduce their ESI costs. The effects are widespread. In the fifth section we turn to the future and consider how the country might reorganize the financing of health insurance. We begin by examining different schemes that are being used in three European countries—the Netherlands, Germany, and Switzerland—to compare how other countries have chosen to share the costs between employers, workers, and individuals and companies as taxpayers to the government to help subsidize lower-income people. Three principles are then suggested for framing how we might share the costs of health insurance among individuals and employers. In the sixth section we develop back-of-the-envelope estimates of the amount of money spent by private health insurance and other sources for the medical care of the nonelderly in 2005. We use this as a starting point to estimate how that sum could be financed through premiums and different taxes on individuals and companies rather than the current system of employer and employee payments.

In the concluding section, we discuss the benefits of increased equity and efficiency in the economy that would result from restructuring the financing of health insurance, along with the fact that private insurance plans can still exist. Finally, we note that there is an urgency to creating a new financing structure—before the global competition and rising health insurance costs cause companies to cross a threshold where less than half of the nonelderly population have ESI.

HEALTH INSURANCE AS PART OF COMPENSATION FOR WORK: WHO PAYS?

Economic theory suggests that workers will accept fringe benefits in lieu of part of their wages if the value of the fringe benefits is at least equal to the value of the forgone wages. This implies that workers are paying for health insurance by giving up some of what they otherwise would have received as higher wages and salary. The tax code treatment of the share of health insurance premiums paid by employers slightly complicates the simple trade-off between wages and health insurance provided by an employer. Since 1954, premiums paid by employers (or

in the case of self-insured firms, the premium equivalents) have been treated as nontaxable income by the U.S. tax code (Burman 1994).³ This means that a dollar of premium paid by the employer, unlike a dollar of wages, is not subject to the employer and employee payroll taxes for Social Security and Medicare hospital insurance (currently a total tax of 15.3 percent) or the employee's federal and state income tax. Avoiding payroll taxes on health insurance premiums provides a strong incentive for employers to offer ESI rather than additional wages and for workers to want ESI rather than additional wages.⁴

Yet health insurance is a product that cannot be purchased in small incremental amounts, and employers cannot set up different combinations of wages and health benefits among different employees. Current laws require that employers who offer a fringe benefit must offer the same benefit to all employees; they cannot distinguish among classes of employees by offering different versions of a benefit to different sets of workers. Insurers in turn are unwilling to create many tiers of premium classes (the tiers that have come into use are: single person, married couple, parent and child[ren], and family headed by two adults) because as the number of tiers increases, there is less opportunity for spreading risks across all workers in a company. The result is that workers who earn quite different wages or salaries pay the same premium for health insurance.⁵ Under these circumstances, it is almost impossible for either companies or workers to trade income at the margin for the price of health benefits for individual workers. Moreover, most employees are aware that what they pay out-of-pocket for their share of the premium for ESI is significantly less than what they would have to pay for insurance in the individual insurance market, particularly if they would be paying with after-tax income. Further, ESI policies generally cover more health care services and require lower out-of-pocket cost-sharing than policies in the individual market. As a result, almost all employees of large companies either take up ESI if it is offered or have ESI through a spouse's employer (Haas and Swartz 2007).

Despite the fact that economic theory suggests that employees pay for health insurance by forgoing wage and salary income, the common public perception is that it is employers that pay. The belief that employers pay for health insurance has roots in the decade after World War II, when unions were agitating for large companies to give them a percentage of payroll for union-run social welfare programs, includ-

ing health insurance. As Klein (2003) has documented in detail, neither large insurance companies nor large manufacturing companies wanted the unions to run the health plans. The Taft-Hartley Act of 1947 made official what was already the standard of the day—unions could not run social welfare plans independently of employers, and employers could avoid collective bargaining over health insurance by simply announcing that they were paying for health insurance for the employees. The 1950 contract settlements between the United Auto Workers and the Big Three automakers—known as the Treaty of Detroit because the unions agreed to a five-year contract, reducing the threat of labor disruptions—and the subsequent 1955 bargaining agreements further solidified the public impression that it was employers that were paying for health benefits.

The perception that employers pay for ESI also was bolstered by the way in which firms use fringe benefits, including health insurance, to woo or retain workers with desirable skills, especially in a tight labor market. Although the large unions in manufacturing and mining obtained health insurance in the 1950s, the growth in ESI coverage in the 1950s and 1960s occurred especially among white-collar professionals. The large manufacturing companies that chose to provide health benefits to the unions naturally gave the same or better benefits to their white-collar workers. This set a pattern for nonmanufacturing businesses—to attract and keep college-educated and other highly skilled workers, fringe benefits, including health insurance, had to be part of the compensation package. White-collar workers who were not self-employed took it for granted that they would have ESI and treated it as an expected perk that the employers provided.

But this part of the history of health insurance as a fringe benefit should be seen not as evidence per se that employers pay for health insurance. Instead, it contributes to the argument that how the premiums are shared between companies, workers, and others—principally purchasers of a company's product and a company's stockholders—depends on the labor market and the market for the product. For example, workers who have skills that are in short supply are able to obtain greater compensation because of their bargaining position with employers. When the supply of workers exceeds the demand for them (as is often the case with people with general skills), the workers are in a weak position for obtaining compensation on a par with workers who have skills in short

supply. Firms with a predominantly low-wage workforce are much less likely to offer ESI because they do not need to increase compensation to be able to recruit or retain workers. When “low-wage” companies do offer ESI, it is usually because they occupy a niche in which they provide highly desired customer services and that allows them to shift at least some of the benefit costs to the customers. Starbucks, for example, faces strong demand for its lattes and frappuccinos, so it can charge relatively high prices for coffee and offer ESI to its low-wage workers. In this case, it is the coffee drinkers who are paying a large share of the costs for Starbucks’ employees’ health benefits. Thus, it is too simplistic to argue that ESI is paid only by either workers or employers. Depending on the circumstances, workers, companies, consumers, and company stockholders all pay varying shares of the costs.

Several empirical studies have shown that the costs of fringe benefits are largely paid by workers (see, for example, Eberts and Stone [1985]; Gruber and Krueger [1991]; and Woodbury [1983]). Using differences in the timing when 23 states required health insurance policies to cover maternity benefits before the federal government followed suit in 1978 (with the Pregnancy Discrimination Act), Gruber estimated the states’ mandates’ effects on wages (Gruber 1994). He found that between 59 and 90 percent of the cost of the mandates was shifted back to workers via reduced wages in the states with the mandates, and that the wages of married women were particularly reduced relative to the wages of single women and married men. But, as Blumberg (1999) has pointed out, there has been little research on the wage effects of job-based general health insurance, and there is little evidence as to how workers’ wages are adjusted to compensate for the costs of the health benefits. Thus, we do not have a clear picture of the extent or configuration of how the burden of paying for employer-sponsored health insurance is shared between workers, companies, consumers, and companies’ stockholders.

Perhaps because it is not clear how much workers pay for ESI, employer claims that they pay for health benefits have been relatively unchallenged in public discussions of who pays. The tax code treatment of the share of health insurance premiums paid by employers reinforces the idea that employers pay for health insurance rather than the workers. The fact that what companies pay for health benefits is referred to as a cost in the same way that other inputs to the company’s produc-

tion process are costs of production also implies that employers pay for health benefits.

Thus, for more than 50 years, employer-sponsored group health insurance has been viewed as something that employers pay for, not employees. Given the history of how ESI started, it is somewhat ironic that we now find employers wanting to not pay for health benefits.

GROWTH IN HEALTH CARE SPENDING AND HEALTH INSURANCE COSTS

To see why employers are trying to limit what they pay for health benefits, it is important to understand how much health care has changed in the last half-century—how much more medicine can do and how much more it costs. In 1960, per capita health care spending in the United States was \$944 (in 2005 dollars); by 2005 (the last year for which we have data) it was \$6,697—a 600 percent increase (Levit et al. 1994). During those same 45 years, median family income increased from \$31,390 to \$56,194 (both in 2005 dollars)—a 79 percent increase—and productivity in the nonfarm business sector of the country increased by 160 percent (Council of Economic Advisers 2007, Table B-49, p. 288; U.S. Census Bureau n.d.a., Table F-7). A small portion of the increase in health care spending per capita is attributable to the aging of the population, but the vast majority is due to changes in how we are able to treat diseases and conditions (Newhouse 1992, 1993). At the end of World War II, it would have been next to impossible for large companies (or indeed anyone) to predict that medical care would change so dramatically between the midcentury point and 2000 as to increase health care spending per capita by so much more than incomes or productivity.

In the 1950s, the three biggest causes of death were heart disease, cancer, and stroke. People who had these conditions generally did not live long. But in the intervening five decades we have made enormous progress in combating these diseases. The sharp decline in smoking and tobacco use and the recognition that cholesterol increases the risks of heart disease and stroke have reduced the incidence of all three, even though they remained the leading causes of death in 2006. Yet it is the advances in medicine that have contributed the most to the increased

survival rates for people diagnosed with these diseases. New drugs, new surgical techniques, and new diagnostic testing devices have increased life expectancy for people diagnosed with a wide variety of previously untreatable illnesses and conditions that are now considered chronic illnesses, including renal disease, Parkinson's disease, multiple sclerosis, and COPD (chronic obstructive pulmonary disease). Advances in medicine also have enabled millions of people to have higher quality of life when they have conditions ranging from torn ligaments to cataracts to HIV to knees or hips that need replacing. But these advances have come at a price—Americans now have per capita health care expenditures that are the highest in the world and 50 percent larger than the two countries with the next highest per capita spending, Norway and Switzerland (Anderson et al. 2006).

Thus, the shift in employer attitudes regarding sponsoring group health insurance for workers has to be seen in the context of how different medical care is today compared to what it was 50 or 60 years ago. Private industry employers did not anticipate that a fringe benefit that equaled about 1–2 percent of compensation in 1960 would equal 7 percent in 2006; for state and local governments the growth in the costs of health benefits was even higher—in 2006, health benefits equaled 10.7 percent of total compensation for their workers (Bureau of Labor Statistics 2007).

Employers' Efforts to Slow Health Care Spending

From the 1950s through the 1970s, the set of medical services covered by most health insurance policies expanded from simply a per diem payment for a limited number of hospital days to covering a high percentage of the costs for a high number (often unlimited) of hospital days, physician services, and more diagnostic tests. By the early 1980s, prescription drug coverage also began to be added to the package of covered services. The expansion of services covered by health insurance was encouraged by the tax treatment of employer payments for health insurance, especially as incomes were rising from the 1950s through the early 1970s as productivity increased.

But in the second half of the 1970s, productivity growth stalled, and when the country experienced the recession of 1981–1983, employers began to actively look for ways to slow the growth in their health care

spending. Managed care plans were viewed by employers as a particularly promising mechanism. The hope was that managed care plans would restrict spending by reducing choice of health care providers and thereby obtaining discounts in fees from providers. In part because of the HMO Act of 1973, which required employers that offered ESI to offer an HMO alternative if one were located nearby, the fraction of employees at large employers (200 or more employees) who were in managed care plans increased from 5 percent in 1984 to 50 percent by 1993; by 1998, that fraction increased further to 86 percent (Marquis and Long 1999). Small firms that offered ESI also shifted their workers to managed care plans during this time: by 1995, only 31 percent of workers in small firms with ESI were enrolled in indemnity plans. The growth in health care spending did, in fact, slow during the early to mid-1990s, although it is now widely believed that the slowdown was not a direct result of managed care per se.

Workers, however, were not happy with managed care plans' restrictions on which medical care providers they could see. By the late 1990s, with a very tight labor market and a booming economy, employers worked with managed care plans to develop alternative plan structures that permitted greater choice of providers. Perhaps in part because of fewer restrictions on providers, but more likely because of the large number of new prescription drugs that came on the market in the late 1990s, as well as advances in arthroscopic surgical techniques and radiological scanning, health care spending resumed its higher growth rates after 2000.

An unintended consequence of the shift to managed care plans was that a very large share of the population became used to "first-dollar" coverage—that is, they paid only a nominal co-payment when they sought medical care and faced no other co-payment or deductible. Before managed care became so widespread, the vast majority of insured Americans had indemnity insurance coverage. Indemnity policies required the insured individual to pay out-of-pocket for the first \$100 or more of medical care each year (the deductible) and then usually 20–30 percent of all allowed (insured) medical expenses above the deductible. A generation of the working age population has lost the idea of insurance as protection against catastrophic medical expenses. The result is that if they do not expect to use much medical care in the coming year, they view the current levels of premiums as being excessive. This is

especially true among young and healthy individuals who have to pay most or all of the premium themselves because they are employees of small firms or are self-employed. It helps explain why people who used to be employed within companies but now are self-employed and working on contracts are not buying individual insurance.

More Reliance on Cost-Sharing of Medical and Insurance Costs

Since the pullback from relying on managed care to slow the growth in health care spending, employers have shifted their efforts toward imposing more costs of medical care on individuals and creating health plans that also involve more management of diseases and conditions. Almost all employers with more than 500 employees now are self-insured, and they have been especially active in developing plans that contain deductibles of \$500 (or more) per person and payment incentives to the insurers if they meet benchmarks for preventive care and disease management. In addition, co-payments for office visits and emergency room visits have doubled since 2001 for most people with preferred provider organization (PPO) types of health plans (Claxton, Gabel et al. 2006). By increasing the use of deductibles (as well as the dollar amount of deductibles) and adopting higher co-payments for physician office visits and diagnostic tests, employers have likely prevented premiums from rising more than they did.⁶

Some employers also increased the fraction of the premium for which employees are responsible, particularly for family policies. While on average the employee shares of premiums for individual and family policies have not changed much since 2000, there is substantial variation in the fraction paid by employees. In 2006, the average employee share of premiums was 16 percent for individual coverage and 27 percent for family coverage. But, depending on the size of the firm someone works for and the fraction of workers who are low-wage within the firm, a worker can pay very different shares of the premium (Claxton, Gabel et al. 2006). Yet for all the efforts by employers to increase the cost-sharing by employees for health care costs, ESI premiums rose an average of 73 percent between 2000 and 2005 and an average of 68 percent between 2001 and 2006 (Claxton, Gabel et al. 2006; Gabel et al. 2005).

It is in this context that companies facing competition from abroad are especially concerned about their ability to continue to pay for health care costs. Although the European Union countries finance their health insurance systems with a combination of worker-individual premiums (or taxes) and employer contributions largely based on payroll taxes, a key point is that EU countries have significantly lower per capita health costs than the United States. Thus, employer payments for health insurance in the EU are lower than they are in the United States. With the exception of Japan, Asian and Latin American countries generally do not require employers to contribute much if anything to the health care costs of their workers. For many U.S. firms, the choice is therefore to move their operations to lower-wage countries—with far lower employer payments to health care costs—or to radically restructure their role with ESI here.

RIPPLE EFFECTS OF RISING HEALTH INSURANCE COSTS

While it is clear that companies facing direct competition from abroad are most sensitive to the increasing health insurance costs, the twin effects of rising health insurance costs and globalization are more nuanced and widespread among employers of all sorts in the United States.

Manufacturing Was the Beginning

Although manufacturing was the first industrial sector to be seen as losing to the lower wage workforces in Asia and Latin America, it slowly became apparent that what enabled goods to be made abroad was the expansion of relatively inexpensive and fast transportation. Containers that could be loaded up at the factory and then quickly loaded onto trucks, ships, or airplanes dramatically reduced shipping time between countries (Levinson 2006). Then, with the advent of the Internet and global computer communications by the early 1990s, suddenly shipping time for services that rely on electronic transmission was the same within the United States as across the world—and it wasn't just manufacturing that could be done more cheaply overseas. Many types

of services can now be provided by people in other countries who are paid less than Americans. These services range from call centers taking reservations to software engineers who may be located 6–12 time zones from other workers but can take advantage of the time difference and the Internet to jointly work on new software programs.

Companies that have been most obviously affected by foreign competition are in manufacturing; many of these companies and industries had both aging production equipment and aging workforces (so-called legacy workforces)—automobiles, steel, durable appliances, and textiles/clothing are the prime examples. Those industries have been through several episodes of wrenching downsizing of their companies, and will experience more such downsizing in the coming decade.

Services Sector Industries and Small Firms

The growth in employment in the United States since the mid-1980s has been in construction and the services sector, especially financial services, professional and business services, education and health-related services, and entertainment and leisure services (Bureau of Labor Statistics n.d.; Council of Economic Advisers 2005; Swartz 2006, Figure 2.2, p. 22). Although some of these industries may seem insulated from foreign competition because they cater to individuals and sell their services to American companies, they are not insulated from the pressures to keep labor costs low. Rising health insurance costs are therefore a target in the efforts to keep labor costs competitive. Electronic transmission of information has enabled many service industries to ship or threaten to ship some of their jobs offshore, essentially reducing employee bargaining power in wage negotiations.

At the same time, while manufacturing was dominated by large companies until very recently, the dominant type of firm in construction and the services sector is small (fewer than 50 employees). Growth in employment in these industries explains why, since 1979, a rising share of the private sector workforce has been employed by firms with fewer than 50 workers.⁷ In 2005, 43 percent of the private sector workforce was employed by small firms; in 1979 it was 37 percent.

For many years, small firms have been far less likely to offer ESI than large firms: 36 percent of firms with less than 10 employees offer ESI and 66 percent of firms with 10 to 24 employees offer ESI, com-

pared with 95 percent of firms with more than 100 employees (Agency for Healthcare Research and Quality 2003, Table 1.A.2). Small firms face much higher premiums per person than do large firms because they have to buy policies underwritten by insurers; they do not have the financial resources to self-insure their employees' health care costs. Insurers have to account for the risk of adverse selection in the small group market when they price small group policies, and the risk increases as the size of the firm shrinks. Insurers' concern with adverse selection is that small firms that apply for coverage without buying other types of insurance (for example, life insurance) are more likely to be owned by someone who either has a health problem within his or her family or knows something about the health needs of a favorite employee. Until the 1990s, when a substantial fraction of large employers became self-insured, insurers could use their large-group insurance policies to cross-subsidize the higher risks in the small group insurance part of their business. Today, most insurers do not underwrite the health care costs of large employers; instead they are paid to be administrators of self-insured large companies. This change has helped drive up insurance costs for small firms even faster than the increase in premium equivalents among self-insured large firms. Thus, the last two decades' shift in private sector employment to the service sector and smaller firms coincided with a change in the insurance business that increased the costs of small firms' health insurance policies—at the very time that worries about foreign low-wage labor started rising.

Small businesses also typically have short lifetimes; many are small retail shops, restaurants, and service businesses that have an average tenure of two years. When any business starts up, it is short on cash—revenues lag behind start-up costs. Although many small businesses may want to offer health benefits, the more than doubling of premium costs since 2000 contributes to small firms' decisions not to offer insurance. They are reluctant to offer a benefit that they suspect they will not be able to afford within three years.

Finally, many service sector firms may not face direct competition from overseas but they supply services to companies that are facing foreign competition, which keeps up the pressure to reduce costs. Firms in the professional and business services, for example, work with companies that compete with international firms, and these service firms are constantly looking for ways to reduce their labor costs so they will not

lose business. Among small professional services firms, it is not uncommon now to find “virtual” firms, where a person who has a reputation for client service obtains a contract for a service that actually requires several people to do the job, and then the person goes to other self-employed people he or she has worked with in the past and gives them contracts to work on the job at hand. A decade or more ago, these people would all have been in-house employees of large companies with ESI. But because the services they provide are not “core competency” functions, they now have to sell their services as independent contractors. Increasing numbers of people in software development, information technology in general, marketing consulting, advertising and writing, and a host of professional business support activities are such contract workers, and they do not have employer-group health insurance.

Service Companies with Large Numbers of Low-Wage Workers

A different type of ripple effect caused by fears of foreign competition exists in service industries with high numbers of low-wage and low-skilled workers—for example, the entertainment industry, protective services, food processing, and long-term care health services. Globalization has meant the movement of low-wage labor from other countries to these industries in the United States, in contrast with the movement of manufacturing to countries with lower-wage workers. Many service sector firms do not need to offer ESI to attract workers since there has been a steady supply of workers with the general skills needed for such firms. In the past, low-skilled workers might have organized to demand higher wages and fringe benefits such as ESI, but with a steady influx of immigrant workers willing to work for low wages, they have been reluctant to organize to demand higher wages and fringe benefits. Such workers know that other recent immigrants will be willing to take their place for the same low wages and lack of health insurance. Similarly, service-sector firms with low-wage workers know that if they were to provide ESI, they would be underbid in competition for contracts by firms with lower labor costs because they do not offer ESI.

Effects of Demographic Changes on Employers' Health Insurance Costs

The decline in ESI coverage, especially among workers in the 25–34-year-old and 35–44-year-old age cohorts, is coming at the same time that the demographics of the U.S. population are marked by the baby boomers in the older half of the workforce. The baby boomer cohort is currently 44–61 years old and consists of about 73.5 million people. The cohorts just behind them are 25–34 and 35–44 years old, and they include almost the same number of people: 70.3 million (U.S. Census Bureau n.d.b.). Roughly 10.5 million of the baby boomers are uninsured, but 18.3 million of the 25–44-year-olds are uninsured. With sharply smaller numbers of younger adults covered by ESI, the employers that do offer health benefits are facing higher premiums (or premium equivalents if they are self-insured) in part because so many younger workers are not part of the risk pool. When the baby boomers were younger, they had low levels of health care spending (as is typical of younger adults) and cross-subsidized the relatively smaller numbers of older workers in their firms. Today, that degree of cross-subsidization within firms no longer exists.

The demographic shift among workers also has reinforced companies' decisions to limit their financial obligations for retiree health benefits. (Abraham and Houseman [2008] have a more detailed discussion in Chapter 5 of how retiree health benefits are likely to change in the next decade.) Since 1988, the fraction of companies with 200 or more employees that are offering retiree health insurance has declined sharply, from 66 percent to 33–35 percent in 2005 and 2006 (Claxton, Gabel et al. 2006). The catalyst for this decline, most of which occurred by 1993, is widely believed to be a change in how the future costs of retiree benefits are to be accounted for in companies' financial statements. The non-governmental Financial Accounting Standards Board (FASB) required that companies show the expected future retiree health benefit costs as liabilities on their financial statements for fiscal years beginning after December 15, 1992. (As of 2007, larger state and local governments also are required to show liabilities for future benefits on statements; smaller government units have an additional two years to meet the new rules. These employers, too, are under financial strain because of inadequately funded future obligations and concerns

about funding for current employees.⁸) Since 2000, the percentage of medium and large firms offering retiree health benefits has been vacillating between 33 and 38 percent, with most of those companies that do offer retiree benefits being large or older firms in particular industries. But because newer firms are particularly likely to have large shares of younger workers and have not offered retiree health benefits, their lower labor cost structure is putting pressure on those companies that do provide retiree health benefits. They are cutting back on retiree health benefit provisions for people who were hired within the last 10 years and/or limiting the company's financial obligations for such benefits in the future.⁹ Recent surveys of employers and retirees also show that a rising number of companies are shifting the rising costs of retiree health benefits onto the retirees. Thus, over the last decade especially, companies became quite conscious of retiree health benefits costs and the adverse effects of having an aging workforce. The FASB accounting rules changes for retiree health benefits reinforced companies' unease about the rising costs of offering health benefits to active workers as well as retirees.

Large and long-standing companies are particularly likely to have high fractions of their workforces who are baby boomers. Much has been made of the Big Three automakers' legacy workforce (and retiree health benefits costs) and how foreign-owned car manufacturers that produce cars in the United States—with their younger American workers—have much lower health benefits costs per car made in the United States.¹⁰ It is not surprising that many production workers at large companies are now hired on a contingent basis (Dey, Houseman, and Polivka 2007). They are paid on a lower pay-scale and are not permanent employees, so the companies do not pay benefits. For the large self-insured firms, this strategy allows output per worker to be obtained at a lower labor cost. But when these firms report the costs of health benefits per employee, they are focusing just on their aging workforce and do not include the contingent workers who would cost much less if they also had health benefits.

For smaller companies that are not large enough to self-insure, the decline in younger workers covered by true health insurance policies means that small group health insurance premiums are rising faster in part because the pool of people with such policies are aging. This fur-

ther increases the pressures on small businesses to stop offering health benefits.

Thus, it would be incorrect to conclude that it is the large companies in the United States that have been most affected by the rising costs of health insurance and intensified competition due to globalization. Instead, the effects are widespread, with ripples expanding throughout the economy and with the greatest effects on younger adult cohorts. It is increasingly clear that our system of private health insurance built on employer-sponsored coverage is under pressure from rising health care costs and global competition and is unraveling in many directions.

RECONFIGURING HOW WE PAY FOR HEALTH INSURANCE: WHAT MIGHT EMPLOYERS PAY?

With employers moving to reduce their exposure to the costs of health care, it is increasingly likely that a large fraction of the U.S. workforce soon will not have ESI as we have known it in the second half of the twentieth century. People with highly sought-after skills may still obtain health insurance as a fringe benefit. But a rapidly increasing number of jobs that are currently considered good jobs will not have ESI as part of the compensation or will include only a defined contribution to help pay for health benefits.

This is a sea change in the American employment relationship.¹¹ The change provides an opportunity for reconfiguring the financing of health insurance so there can be more equity in how much people with the same income pay for health coverage. But the opportunity comes with an urgent need to devise a new financing structure quickly, ahead of the market changes being driven by companies' responses to increased globalization and rising health insurance costs.

As a starting place for restructuring the financing of health insurance, it is useful to see what several European countries have done recently to reconfigure their financing of health insurance. Many people in the United States regard other countries' health insurance systems, especially those in Europe, as being nationalized systems with a single payer and all health care providers as employees. This is not the case, however. A number of countries have private health insurance plans (or,

as many Europeans call them, sickness funds) that compete with one another for enrollees. The countries collect funding for the insurance from a variety of sources and generally funnel the revenues to a central government fund that then disperses the funds to the health plans. The central government fund also is used to subsidize lower-income people's payments and in some cases to adjust the payments to reflect the expected higher costs of older or sicker individuals.

How Three Other Countries Finance Health Insurance

The Netherlands, Germany, and Switzerland are the three European Union countries with the highest percent of GDP spent on health care in 2003: Switzerland had 11.5 percent, Germany 11.1 percent, and the Netherlands 9.8 percent (Anderson et al. 2006). While they spend less per person than the United States (which spent 15 percent of GDP on health care in 2003 and 16 percent in 2005), all three countries changed their health insurance systems and financing structures within the past decade. They also all rely on private health insurance plans, providing useful examples of how we might consider alternative structures for financing U.S. health insurance.

The Netherlands implemented its changes on January 1, 2006 (De-Jong and Mosca 2006; Prinsze and van Vliet 2008). Everyone in the country is covered for basic services; people can purchase additional coverage if they want. There are 33 health insurers (some of which are for-profit) that compete for enrollment. They cannot turn away any applicant for basic services although they can deny coverage for supplemental policies. People can choose between plans that do and do not have deductibles; those with deductibles have lower premiums.¹² Everyone pays a nominal premium that depends on which plan they choose (in 2006, the average was 1,050 euros, or about \$1,500). In addition to the premium, employers pay a payroll tax of 6.5 percent on their employees' income up to 30,105 euros (about \$43,050), or a maximum tax of about 2,000 euros (\$2,860) per year.¹³ Self-employed people and retirees pay 4.4 percent of their income. Low-income people can apply for a subsidy, which is dependent on a person's income. About 30 percent (5 million people) of the population receive such subsidies. The health insurance costs of children under age 18 are viewed as the responsibility of the country, so parents do not explicitly pay for their

children's health plans, although the children enroll in whichever plan the parents choose. The Dutch also reward people who have no medical expenses in a year with up to 255 euros in rebates.¹⁴ The Dutch have long had a tradition of community-rated premiums, which continues under the revised health insurance system. To compensate insurers that might experience high numbers of enrollees with high medical costs, the Dutch are continuing their use of a risk adjustment mechanism that they have been expanding since 1992 and that provides risk-adjustments to the premiums. As a result, insurers receive a risk-adjustment from a central (federal) fund according to the risk characteristics of the people who enrolled in the plan. (The risk characteristics are a mix of simple demographic characteristics and recent medical care use factors.)

Germany requires that all people with annual incomes below about 47,250 euros (\$67,570) participate; about 10 percent of the population is exempt from the social system. Employees pay 7.5 percent of their salaries (up to 47,250 euros) and employers pay 6.6 percent of their workers' salaries (up to 47,250 euros) for insurance. For the compulsory insurance, children and nonworking spouses are covered "free of charge"; there are no distinctions between individual and family policies. However, in the private insurance system, family members are charged separately. Private insurance premiums are set to reflect the expected risk of individuals, and the insurance companies can turn people down for coverage. (The insurance companies have full access to a person's medical records.) Germany is very concerned about stabilizing the financing of its health care system and reducing the costs of labor in order to increase German companies' competitiveness.

Switzerland implemented changes to its health insurance system in 1996. It now requires that everyone enroll in a health insurance plan. (Like the United States, there were fierce debates about mandating coverage, but since the law was passed, there has been widespread acceptance of the requirement [Noble 2007].) Insurance plans compete on premiums—like the Dutch system—but not on services provided. Like the Dutch, everyone has basic coverage and can purchase supplemental coverage if they want; they do not have to buy the supplemental and basic policies from the same insurance plan. (There were 93 insurance plans in 2004.) Premiums are community rated by canton for the mandatory basic package of benefits, and there is considerable variation in the premiums by canton. This has created disparities by income since

people are restricted to buying their coverage within the cantons where they live. Insurers cannot reject someone who applies for the basic coverage but they can reject applicants for the supplemental policies. Most people have the same insurer for both plans, leading some to speculate that people are afraid to change basic plan insurers for fear that their premium for the supplemental policy might then increase significantly. To reduce the income consequences of per capita premiums, the federal government and the canton government subsidize the premiums for basic coverage through tax-financed, means-tested subsidies. Other than paying taxes to the federal and canton governments, companies do not pay for the financing of health insurance. In 1996, the expectation was that people would pay no more than 6 percent of their tax-adjusted income for health insurance, but it appears that a majority of people are now paying 8–10 percent of income.

Principles for Financing Health Insurance

The recent experiences of these three countries offer suggestions for how we might think about financing the costs of health insurance in the United States. Most importantly, they provide a set of principles that ought to govern how we share the costs among various interested parties. Three principles stand out. First, everyone is required to enroll in a health insurance plan that covers a basic set of services, and everyone pays at least a nominal premium. Second, the countries all subsidize lower-income people via taxes that flow to a central, federal fund. The Dutch further adjust the premium payments that go to the private insurance plans with risk adjustments based on a person's age, gender, and prior medical history. These risk adjustments also come from the taxes collected by the federal government. Third, companies help pay for the health insurance. Of the three countries, only Switzerland does not tax companies specifically for health insurance; however, the companies do pay taxes that are part of the general revenues used to subsidize lower-income people's premiums.

We could apply these same principles to a new financing system for health insurance in the United States. Requiring everyone to enroll in a health insurance plan and setting a nominal premium for every person implies that individuals have an obligation to participate in a social compact such as health insurance. Moreover, requiring everyone to

contribute at least a small amount toward the costs of their health care reinforces the social compact of sharing risk for high health costs while simultaneously signaling that everyone is entitled to access to health care. Collecting additional revenues from individuals in proportion to their family income ensures that no person or family pays more than what is deemed an affordable percent of income, and that higher-income people contribute to the subsidization of lower-income people. Such a system also creates equity in that people with the same levels of income pay the same amount toward health insurance. Our current system does not have this equity. Premiums for health insurance depend primarily on the number and age distribution of a person's fellow workers.

Requiring companies also to contribute to the financing of health insurance is part of the social compact. Companies benefit tremendously from having a healthy workforce, and it seems reasonable therefore that they also should contribute to the financing of health care. Since (as we discussed earlier) not all companies actually hire people as their own employees, it is important that companies be the organizational entities that are required to contribute to the financing of health insurance and not just "employers." Companies might share in the financing of health care in a myriad of ways. For example, payments could be based on payroll, the number of employees (both those who are on the company's payroll and those who are there as temporary or contract workers), profits, or the value added by the company. Given our concern with the future of jobs in America, it is important that the financing mechanism for companies' contributions not contain incentives for companies to reduce the number of people working for them.

As we discussed earlier, the common perception is that employers pay most of the costs of health insurance. But as we also discussed, the costs are shared among workers, companies, consumers, and company stockholders, and the actual shares are determined by the markets for the labor used by the company and the product produced by the company. Embedded in the three principles are a notion of a social compact and a desire for equity in how the financing will be shared among individuals and companies. The social compact involves a responsibility to participate in the health insurance system—we all benefit from a system that ensures access to health care and we all have to contribute to that system. Further, subsidies to make sure people in weaker economic circumstances have a basic level of insurance are part of the

social compact. Equity requires both that people in the same economic position pay the same amount and that companies contribute equally on whatever metric is chosen for determining company payments.

Note that these principles would permit basic health insurance coverage to be disconnected from where one works—basic insurance would be portable across jobs. This would increase the efficiency of the labor market in terms of sorting people to jobs where their talents might best be used. Although the Health Insurance Portability and Accountability Act of 1996 (HIPAA) was intended to minimize “job lock” caused by workers’ concerns about losing health insurance if they changed jobs, people still have such concerns. Reconfiguring health insurance financing so that a person’s benefits did not depend on a particular company would eliminate the inefficiencies in labor market sorting and increase overall labor productivity.

FUNDS NEEDED FOR U.S. HEALTH INSURANCE: HOW MIGHT THEY BE REAPPORTIONED?

We can do a back-of-the-envelope estimate of how health insurance financing would need to be distributed across all sources by examining recent health care expenditures by private health insurance and other private funds that financed care for the uninsured. Such expenditures would be covered by health insurance if we structure the financing such that everyone has health insurance. Note that almost all of this spending already is financed by employers and individuals, so in restructuring how we would pay for health insurance, we do not need to raise new monies other than what would be needed to cover the uninsured who need subsidies. Also, since we are interested in how we might restructure the financing for private health insurance, we will exclude health care spending paid for by Medicare and Medicare supplemental insurance, Medicaid, and the military health care system.

In 2005, the last year for which we have national health spending data, the United States spent a total of almost \$2 trillion on health care (Catlin et al. 2007). We will use the financing sources in 2005 for our estimates, which are shown in Table 3.1. Of the \$2 trillion, a little more than half (55 percent) was purchased with private funds (out-of-pock-

Table 3.1 Estimate of Health Care Spending That Would Have Been Paid by Private Insurance in 2005 for the Nonelderly Who Are Not Covered by Medicare, Medicaid, or the Military Health Care System, Using 2005 Health Care Expenditures (for illustrative purposes only)

Type of spending and assumption	\$ (billions)
(1) Total U.S. health care spending	2,000
(2) Paid by private health insurance	700
Less 20% paid by Medicare supplemental	<u>-140</u>
(3) Paid by private health insurance for nonelderly	560
Plus administrative costs: 10–15% of revenues	<u>+ 62 – 100</u>
(4) Total private insurance costs for nonelderly	622 – 660
(5) Out-of-pocket spending	250
Retain as out-of-pocket spending	<u>-150 – 200</u>
(6) Would be covered by private insurance	50 – 100
(7) Other private funds	140
(8) Would be covered by private insurance	140
(9) Total (2005) spending that would have been covered by private insurance	815 – 900

et spending by consumers, private health insurance, and other private funds). Private health insurance accounted for almost \$700 billion. This includes spending paid by Medicare supplemental health insurance policies, however. If we assume that 20 percent of the spending financed by private health insurance came from Medicare supplemental policies, then approximately \$560 billion was paid by private health insurance for the nonelderly (line 3 of Table 3.1).¹⁵ This does not include administrative costs associated with health insurance—it simply tells us how much private health insurance policies paid out for health care services. Since the costs of billing and insurance-related administrative activities need to be included in our estimate of insurance costs, we could estimate those costs as 10–15 percent of what is collected in premium revenues (Kahn et al. 2005). That is, the \$560 billion of health care spending for the nonelderly paid by private insurance would equal 85–90 percent of premium revenues. This suggests that premium revenues for private insurance for the nonelderly were almost \$622–\$660 billion in 2005 (line 4 of Table 3.1).

Out-of-pocket spending on health care in 2005 was about \$250 billion (line 5 of Table 3.1). Out-of-pocket expenditures are generated by people with and without health insurance. Uninsured people often pay for medical care when they use it (and sometimes they pay more than an insured person) (Anderson 2007). Insured people are responsible for out-of-pocket expenditures for co-payments (including for prescription drugs) and deductibles as well as expenditures for over-the-counter medications and medical equipment that are not covered by insurance. In addition, some medical services such as mental health or substance abuse care often are not covered by health insurance policies, so expenditures for such health care are paid out-of-pocket even by people with health benefits. We can assume that health insurance is likely to retain cost-sharing at the time of seeking medical care, and that a number of medical services such as mental health and substance abuse services would be covered with limits. Then perhaps between \$50 and \$100 billion of what were out-of-pocket expenditures in 2005 would be covered by health insurance if all the uninsured were covered (line 6 of Table 3.1). The \$140 billion of health spending in 2005 paid by other private funds largely involves charity care, and we could assume that all of that spending would be covered by insurance under the new financing structure (line 8 of Table 3.1).

Taking all these spending estimates and assumptions together, the total amount of spending that we might have covered by private insurance and that we would have needed to pay for under a new financing structure in 2005 is between \$815 and \$900 billion (line 9 of Table 1). These expenditures would have been for people who were covered by private health insurance or were not insured; that is, they were for people who were not covered by Medicare, Medicaid, or military health coverage. In 2005, there were 203 million such people (out of a total population of 294 million) who generated these expenditures.¹⁶ On a per capita basis then, the spending financed by insurance would have been approximately \$4,000–\$4,435.

Note that in thinking about how we might reconfigure the financing for health insurance, the new system of premiums and taxes would replace payments currently made by individuals and companies for health insurance. We would raise a modest amount more from premiums and taxes than we now obtain from premiums paid by workers and employers, but everyone not currently insured would be covered.¹⁷

Distributing the Financing for Health Insurance

How would we restructure the way we finance the \$815–\$900 billion (in 2005 dollars) for private health insurance? First, recall that these funds are not “new” or additional funds that have to be raised from individuals and companies. These funds were, in fact, spent on health care for the nonelderly in 2005. What we want to create is a new arrangement for how these same funds would be raised from a combination of premiums paid by individuals and taxes paid by individuals and companies. The new arrangement would substitute for the premiums individuals and companies are paying now for private insurance as well as other private funds that pay for medical care. In the aggregate, the amount could be split between workers, companies, people who are not employed for pay, and company stockholders, as well as other payers of collective taxes raised by the federal government. We can assume that anyone with an income below the poverty level would be enrolled in Medicaid (or be fully subsidized), and anyone eligible for Medicare would be enrolled in Medicare, so we are focused on restructuring how we finance the \$815–\$900 billion for private insurance. We might reallocate these costs along the following lines for individuals and companies.

Individuals

First, we could set a nominal annual premium of \$1,000 per person; this would account for approximately \$200 billion. Of course, not everyone would be able to pay such a premium—subsidies would have to be provided to people with family incomes between the poverty level and some threshold.¹⁸ But \$1,000 per year is less than \$100 per month, and many people who are not eligible for Medicaid should be able to pay a sizeable portion of the \$1,000. Moreover, the \$1,000 per person per year is about what most people with employer-sponsored health insurance now pay out-of-pocket for their share of the premium, so it would not be a new burden for most people.

The remaining \$615–\$700 billion (plus whatever funds will be needed for the subsidies to the nominal premiums) would be paid by higher-income people (who include stockholders) and companies. Calculating how the members of these two groups might share the responsibility for the costs requires estimating sophisticated models of the distribution

of income, profits and productivity, and taxes paid by individuals and companies. More to the point, the distributional consequences of new taxes for health insurance must be considered in conjunction with the effects of other taxes. It is unlikely that reconfiguring how we might finance health insurance would be considered without a general review of the current tax code.¹⁹

Nonetheless, we can use estimates of changes in tax rates to obtain rough estimates of how much money might be raised by changes in the tax rates. In thinking about these estimates, we need to recall that what people and companies are paying now for health insurance would be replaced by any new taxes and premiums. Thus, people's out-of-pocket contributions to the total premium for their employer-sponsored coverage would become their tax payments for health insurance. For our purposes here, we will make a simplifying assumption that premium payments (or premium equivalent payments) by companies for health insurance would not be paid as increased income to workers. By assuming this, we can ignore the increased tax payments that workers and companies would have to pay if such payments became taxable income. Moreover, as we discuss below, these payments will shift to payroll taxes (or some other tax) that the employers will pay.

Currently, for individuals, the lowest tax rate for ordinary taxable income is 10 percent and the highest rate is 35 percent (for income above \$349,700 in 2007).²⁰ The Congressional Budget Office (2007) has estimated the change in revenues that would occur if small changes were made in a number of taxes. If all tax rates on ordinary income were increased by 1 percentage point, tax revenues would increase by \$30.3 billion in 2010. If just the top ordinary tax rate were increased by 1 percentage point, revenues would go up by only \$5.5 billion in 2010. Thus, it is clear that very small changes in the individual tax rates would not yield the magnitude of funds needed. A tax code change that would yield somewhat larger revenue increases is to limit the total of itemized deductions (for example, state and local income and property taxes, home mortgage interest payments, and contributions to charitable institutions) to 15 percent of a household's income. This would cause tax revenues to increase by \$54.7 billion in 2010 and \$90.3 billion in 2011. In contrast to these changes, if the tax cuts enacted since 2001 are made permanent, tax revenues will decline by \$97.8 billion in 2011 and \$174.7 billion in 2012. In the face of growing needs for federal dollars,

these tax revenue losses could not easily be made up by small changes in the tax rates.

Clearly, for taxes on individuals to fund a substantial share of the \$615–\$700 billion for health insurance, the personal income tax cuts of 2001 will have to be rolled back and additional taxes imposed. But we are not expecting that individuals will pay all of the \$615–\$700 billion—the principles noted earlier include the principle that companies should pay substantial amounts of the health insurance costs, too. Moreover, since companies now are paying the majority of health insurance costs and we are simply working to restructure how the total costs are allocated, we would expect those same dollars to be coming into the financing system. The dollars will likely be distributed differently across all companies, however, because many companies do not now offer ESI as we discussed earlier. The question is, how should those dollars be apportioned?

Companies

Corporate income does not appear to be a good basis for taxing companies to finance health insurance—only about 8 percent of businesses currently pay corporate income taxes. In July 2006, corporate tax receipts for the nine months between September 2005 and June 2006 were \$250 billion (Andrews 2006).²¹ The corporate income tax has been a declining source of federal revenues since 1950. In 1952, corporate income tax receipts accounted for almost a third of federal tax receipts, but since the 1980s they have accounted for less than 10 percent (Friedman 2003).

Payroll taxes have replaced corporate income taxes as a substantial source of federal tax revenues. In 1952, they accounted for 10 percent of all federal tax receipts, but in 2003, the fraction was 40 percent (Friedman 2003). The second largest payroll tax paid by companies is that for the Medicare Part A Trust Fund, also known as the Medicare Hospital Insurance (HI) Trust Fund. The Medicare payroll tax is 1.45 percent and it applies to all employee earnings paid by an employer (there is no maximum on what is taxable income); individual workers also pay a tax of 1.45 percent on their wages and salary, so the combined Medicare HI tax rate is 2.9 percent of earnings.²² In 2006, the Medicare HI payroll tax revenues were \$211.5 billion—half paid by companies and half paid by workers (Social Security and Medicare Boards of Trustees 2007).

This provides an estimate of the amount of financing we could raise from employers if we were to use a payroll tax: a tax paid by employers of almost 3 percent of payroll in 2006 would have raised about \$215 billion and a tax of 6 percent would have raised about \$430 billion. To put this in perspective, a payroll tax of 6 percent would have raised at least 60 percent of the \$615–\$700 billion needed in 2005.

There are benefits and costs to using a payroll tax for obtaining company financing for health insurance. The costs are that a payroll tax raises the costs of labor, providing an incentive for companies to look for cheaper ways of producing their products, most likely involving less labor. However, the payroll tax needs to be seen in the context of how much many companies are now paying for ESI; a 6 percent payroll tax is on average what companies that provide employer-sponsored health insurance are paying now. Equally important, it is likely to be less expensive than what companies expect health insurance premiums will cost them later this decade. The other cost associated with using a payroll tax to collect health insurance financing from companies is that an increasing number of workers are not technically employees of a company—they are hired through temporary agencies or contract houses or are self-employed and have a contract to do a specific task. They are not part of the payroll for which companies pay taxes. If a payroll tax is used to obtain financing from companies, then it needs to apply to companies that hire people as contingent workers as well.

The primary benefit from using a payroll tax is that it redistributes the costs of employer financing of health insurance so that all employers are paying for health insurance. Large companies with legacy workforces will no longer be paying significantly more for ESI than their competitors with younger workforces. Further, the payroll tax creates a progressive tax across companies relative to company payrolls—companies with low-wage workers would pay less than companies with high-income workers, so companies with high margins would subsidize companies with low margins.

Summary of Distributing the Financing across Individuals and Companies

In sum, if we had been financing private health insurance for the nonelderly in 2005, we would have needed between \$815 and \$900 bil-

lion. An annual per person premium of \$1,000 paid by everyone who was not enrolled in Medicaid or Medicare would have raised about \$200 billion. The remaining \$615–\$700 billion would then have been shared by individual taxpayers and companies. If companies exchange what they are paying now for ESI for a payroll tax of 6 percent, revenues of about \$430 billion would have been collected. The remaining \$185–\$270 billion would have to come either from increased taxes paid by individuals or a combination of individuals and a slightly higher payroll tax.

A SEA CHANGE AND THE NEED TO ACT QUICKLY

We are in the midst of a sea change in how private health insurance is financed for most Americans. The last half of the twentieth century was a period when employer-sponsored health insurance grew rapidly and became the source of private health insurance for as many as 70 percent of the nonelderly population. But in the last decade, the proportion of nonelderly with ESI has declined to about 60 percent, and employers are pulling back from paying for health insurance to the extent that they did even just five years ago. The twin forces behind this sea change are the global economy and the continuing high rates of increase in health care spending and insurance premiums. Looking to the near future, it is clear that we need to restructure how we pay for health insurance before the economic changes already under way cause a large fraction of the nonelderly to become uninsured.

Greater Equity and Efficiency

The need to restructure how we finance health insurance provides an opportunity for creating a financing system that is more equitable and more efficient than the current system of ESI and individually purchased coverage. Restructuring the system so everyone would have coverage and everyone would pay in proportion to their income is far more equitable than what we have now. Currently, whether a person has insurance at all and the premium that a person pays depend on where a person works, who else works for the company, and a person's own de-

mographic characteristics and health history. Restructuring the financing so a company would pay only a tax rather than being involved in negotiating premiums and terms of a policy also is more efficient for employers. Companies would not have to pay for administrative costs associated with sponsoring health insurance. They also would not have to worry about possible adverse consequences to their premiums of hiring someone who has a medical condition (for example, diabetes or asthma). As a result, the labor market would operate more efficiently.

Restructuring the financing of health insurance also would create a safety net for everyone—something that is going to be increasingly important as the country goes through other significant changes affecting our economy and society in the next two decades. The global economy is forcing changes on how we manufacture and produce an increasing array of products, putting pressure on pensions and retiree health coverage as well as health insurance. The demographic changes and longer life expectancies are pushing people to rethink how long they need to work to have enough income in retirement. It is increasingly obvious that many Americans do not have sufficient savings to carry them through their old age. This is coming at a time when Medicare is in need of a financing restructuring, too. Finally, the age cohorts that are currently most affected by the lack of health insurance are also cohorts that are being squeezed by debts for higher education and the consequences of deficit spending over the past six years. Having a basic level of health insurance for everyone would provide a level of security that is going to be greatly needed if we are to avoid a general malaise.

Basic Insurance and the Need to Restrain Growth in Spending

The United States is not alone in struggling to slow the rate of increase in health care spending. All of the OECD countries and Japan are experiencing similar rates of increases in health care spending. This is good for American companies that are competing with companies in these countries since their health care costs are increasing at about the same rate as those in the United States. But at the same time, the similar rates of growth in spending mean that if we are to be successful competitors in a global economy, we need to restrain the rate of growth in the United States to keep our labor costs competitive. Particularly given the difficult transitions we are likely facing in the next decade or

two, we simply cannot afford to have per capita spending on health care continue to rise at rates that far exceed productivity growth.

One way to restrain growth in medical spending is to finance only a basic package of health care services. This is the conclusion that the European Union countries have reached, although some allow people to purchase supplemental coverage if they wish. A basic package of health care services could include most if not all of the health care services that are now covered by most large companies. But in the future, new services would have to be shown to be cost-effective to be included in the basic package. This would provide an incentive for innovators to look for less costly ways of producing the same service.

Private Insurance Can Be Retained

Restructuring how we pay for health insurance does not have to be synonymous with a single-payer, national health insurance system. We can still have a system where people choose among private health insurance companies just as they do in the Netherlands and Switzerland. Financing funds are collected in these countries through a central agency, and then premium equivalent funds are sent to the insurers selected by individuals. However, in order to compensate insurers for enrolling individuals who may be likely to incur higher than average medical expenses, we also would want to adjust the premium payments for factors known to increase health care spending. As noted earlier, the Netherlands has a risk adjustment system that does this, and the risk adjustment models are very similar to those developed by Medicare and Medicaid for adjusting payments for enrollees who are in managed care plans. We also would need to understand more about why there are large regional differences in how much medical care people receive—specifically, how many different types of services are provided. To the extent that those differences are meaningful and justified, we also would need to adjust premiums on the basis of where one lives.

Finance Restructuring Must Be Done Quickly

The United States is experiencing a sea change in businesses' attitudes toward their role in financing and organizing health insurance for workers. Particularly because of the pressures from the global economy,

companies feel they cannot compete if they cannot control spending for employee health benefits. Given the rapid rate of increase in premiums for ESI over the past six years especially, employers have reached a level of frustration where they no longer believe they can continue to pay for future costs of health coverage. Many also have decided that they do not need to offer ESI to attract or retain workers. This slippage in business support for ESI is likely to accelerate over the next decade, creating a crisis for millions of Americans as well as medical care providers.

This looming crisis could be mitigated or even avoided altogether if the country's public and private policy leaders move now to establish a new structure for financing health insurance for the nonelderly who are not enrolled in Medicaid or Medicare. There is an urgent need to start restructuring the financing—it will take time to agree on the different shares that workers, companies, people who are not employed for pay, and company stockholders will pay. And in the meantime, the market forces that are driving companies to decide they cannot afford to pay more for health insurance will continue to pressure businesses. As the percentage of companies that offer ESI gets closer to 50 percent, which it will within this next decade, we will arrive at a tipping point where large numbers of firms may choose to stop sponsoring health benefits. We need to structure a new way of paying for health insurance—with the help of business leaders, labor leaders, academics, and public policymakers—before we reach that tipping point.

America's challenge in the new global economy is to provide a safety net of social services—particularly health insurance—so that companies and workers will be able to use their imagination and skills to create new products that the world economy will purchase. Sharing the financing of these social services more equitably among companies and individuals will help ensure growth in the American economy—on which a future of good jobs and a strong nation depends.

Notes

I want to thank particularly Susan Houseman, Timothy Bartik, and Frank Levy for providing helpful comments on earlier drafts of the chapter; they are not responsible for any errors that remain.

1. Given the role that the country's largest companies—including General Motors—played in the decade right after World War II in establishing employer-sponsored group health insurance rather than supporting national health insurance, there is some irony in the leaders of the automotive industry now suggesting that the government should have a large responsibility for health care expenditures.
2. People who have studied the contingent workforce, including Susan Houseman, have raised concerns about the way respondents to the CPS may be answering questions about where they work and therefore whether the survey is picking up the full extent to which people are working as contract workers or as self-employed people.
3. Congress enacted section 106 of the Internal Revenue Code of 1954, which eliminated confusion arising from a 1953 IRS ruling that seemed to contradict its 1943 ruling that employer contributions to health insurance policies were tax-exempt.
4. In addition, an employer can pay more for ESI and thereby provide something more for all employees—but if the employer increases the wages of everyone in a certain position or rank, the employer then has to increase the wages of all the workers in more senior positions. This can be a far more costly proposition for companies.
5. Companies may choose to create different premium shares paid by employees based on income tiers—so higher-income employees pay more than lower-income workers—but the premium charged per employee by the insurer is the same within policy tier choice. Self-insured employers could set employee shares of premiums individually—perhaps on the basis of income, for example—but they have been reluctant to do this. One reason may be that companies have long stressed that ESI is a group benefit, and even self-insured firms are loathe to break the grouping bonds by setting employee shares of premiums that are highly tailored to individual workers' characteristics.
6. Note, however, that by shifting more of the lower level of medical expenses onto workers, people are bearing more of their medical expenses when they are sick or if they have chronic conditions.
7. Author's tabulations from the U.S. Department of Labor, Bureau of Labor Statistics, Office of Employment and Unemployment Statistics, Covered Employment and Wages (ES-202) data. See also Swartz (2006, Chapter 2, pp. 22–23).
8. State and local governments' accounting standards are set by the Governmental Accounting Standards Board (GASB), which in 2005 adopted rules similar to those of FASB. See also Freudenheim and Walsh (2005) and Carroll (2007).
9. Moreover, as employment growth has been occurring in firms that are new companies, a rising fraction of current workers do not have retiree health benefits as part of their benefits. This puts yet more pressure on those companies with aging workforces to reduce their labor costs by restricting their own obligations for retiree benefits for current workers.
10. The competition between the Big Three automakers and Toyota America offers a stark illustration of these differences. The Big Three contend that when wage, health care, retiree health care, and pensions are included, they pay UAW work-

- ers \$70–\$75 per hour, whereas Toyota and the other Japanese automakers pay \$40–\$45 per hour for cars made at plants in the United States.
11. Momentum for this shift appears to be growing as rapidly as the shift from defined benefit pensions to 401(K) plans a decade ago and the move by employers to change their ESI benefits from indemnity health insurance plans to managed care plans at the end of the 1980s and early 1990s.
 12. The highest deductible in 2006 was 500 euros (or about \$715) per person. See the Royal Netherlands Government (2006). All dollar amounts in this chapter are based on the exchange rate as of October 18, 2007, which was \$1.43.
 13. Technically, the individuals pay the 6.5 percent tax on their income up to 30,150 euros, but employers are required to reimburse this amount to their employees.
 14. In 2005, almost 4 million people received this rebate.
 15. Author's assumption based on approximations from Keehan et al. (2004).
 16. Author's calculations from census data contained in DeNavas-Walt, Proctor, and Lee (2006).
 17. Of course, perhaps as many as 40 percent of the people currently uninsured would be covered by Medicaid or be fully subsidized for their health insurance premium because they are poor or near-poor.
 18. We could assume that 22.8 million uninsured with incomes between one and three times the poverty level in 2006 would be subsidized on a sliding scale related to their incomes. If the average subsidy were \$700 per person, such a subsidy would cost about \$16 billion.
 19. Three issues are particularly likely to cause the tax code to be revised. One is the fact that the country now has a large deficit. The second is that the alternative minimum tax (AMT) is not doing what it was intended to do and is instead affecting the taxes of increasing numbers of Americans. Third, there is increasing evidence that the very highest income earners in the country have benefited tremendously over the past two decades from the growth in productivity, but that the great bulk of people with incomes below the top 5 percent have not gained at all (see Levy and Temin 2007). Moreover, the changes in the tax code since 2001 have been highly regressive; if made permanent, they will become even more regressive. (If the tax cuts become permanent in 2011—as opposed to sunseting at the end of 2010—the burden of federal taxes will shift onto middle-income taxpayers.) As the Urban Institute-Brooking Institution's Tax Policy Center (2006) estimates, taxpayers in the top 1 percent of the income distribution would see their share of the federal tax burden fall by 0.5 percentage points, while the share paid by households in the middle of the income distribution would increase by 0.1 percentage points. All of this suggests that before 2010, the country will at a minimum repeal the tax cuts for the highest income households, and then begin a serious overhaul of the tax code.
 20. Income from long-term capital gains is taxed at lower rates, as is income from dividends (until 2010). The alternative minimum tax (AMT) will become the tax system for almost all people with incomes between \$200,000 and \$500,000 by 2010 if it is not changed; and the Urban Institute–Brookings Institution's Tax Policy Center (2006) estimates that almost half of all households with incomes

between \$75,000 and \$100,000 will pay the AMT by 2010 unless Congress acts to change current law. The AMT is extremely complicated, so comparing ordinary income tax rates with the AMT is not meaningful.

21. The \$250 billion for the nine months was 26 percent larger than the amount raised a year earlier for the same nine months.
22. The primary payroll tax collected from companies is the tax for Social Security for Old-Age and Survivors Insurance (OASI)—what most people call Social Security. Employers pay a tax rate of 5.3 percent on earnings up to an annual maximum per person (\$97,500 in 2007) for the OASI Trust Fund. Workers also pay 5.3 percent of their earnings up to the annual maximum so the combined payroll tax paid by employers and workers for OASI is 10.6 percent. There is a second Social Security payroll tax for the Disability Insurance (DI) Trust Fund; the DI payroll tax is 0.9 percent, which employers and workers each pay for a combined rate of 1.8 percent on earnings up to the annual maximum.

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