I’m going to talk with you today about a topic that is subject to a lot of attention in politics and the media today: Health care. Specifically, I want to talk to you about how our system of health care is primarily based on employer-sponsored insurance, and how the Affordable Care Act may reinforce this as the primary method of obtaining health insurance, yet this is not the best policy. To do so, I’ll give you a general picture of our health care system in terms of costs and insurance structure, talk to you about how and why our health care system started to develop as a mostly employer-based system, and how since then the costs in our system have spiraled out of control. Though employer-sponsored insurance is not the reason why our costs are so high, I believe it is one of the fundamental contributors and because of political factors, it has not been one of the main culprits experts have focused on reforming.

I became interested in this specific issue over the summer when I interned at a consumer advocacy organization called Health Care For All in Boston, MA. A large part of my job was to keep up with political issues, especially those pertaining to Massachusetts and national health care reform, and explain these issues in layman’s language through the organization’s blog. A few weeks into my internship, McKinsey and Co. released a study about employers’ anticipations of the Affordable Care Act. The study’s main finding was that, according to surveys, over 1/3 of businesses planned to “definitely or probably” stop offering employer-sponsored coverage to their employees and instead, would refer employees to the health exchanges that each state will set up come 2014.
Liberals in the health policy world went nuts because they believed this report provided more ammunition for Republicans to criticize Obamacare, as the health care law is strongly built upon employer responsibility and posits financial penalties on employers who do not provide insurance to their employees. The main problem is that if these predictions are true, then the CBO’s estimates of federal subsidies needed in the exchange would be way underestimated, and the law may be unsustainable.

Instead of following the tune at the rest of the office, I questioned whether the erosion of employer-based insurance would be such a detrimental shift. Sure, our system is based on employers providing health insurance to employees as part of a benefits package. But employer-sponsored insurance has been on the decline for many years. In 1999, 69% of Americans got their health insurance through their jobs. Ten years later, just 57% of Americans get their health insurance through their employers (Robert Wood Johnson Foundation, 2011). In addition, the US is one of the only developed countries in the world where employees depend on their employers to provide health insurance. Most other countries are able to offer universal coverage to their citizens regardless of employment situation, and are able to provide comprehensive benefits at a fraction of the cost. Princeton economist and highly regarded health policy expert Uwe Reinhardt once said about employer-sponsored insurance: “If we had to do it over again, no policy analyst would recommend this model” (Eibner, Hussey, & Girosi, 2010).

So how and why did this system evolve? To start, health insurance in the United States had its origins in the Great Depression. Hospitals became inundated with patients unable to pay for their medical bills. In response, Blue Cross, a non-profit organization,
formed to provide hospital insurance that was approved by the American Hospital Association in 1932. Once this form of insurance became popular, commercial companies entered the picture offering different types of medical insurance including surgical and physician insurance. Employer-sponsored insurance became popular in the years during and after WWII. At the home front, employers were forced to comply with wage and price controls in order to prevent excessive inflation. However, fringe benefits up to five percent of wages were not considered inflationary so employers were able to increase compensation through health insurance benefit rather than higher wages. In addition, in 1954, the IRS decided that fringe benefits provided to employees would not be subject to federal income and payroll taxes. As a result, employers began to attract better workers through providing health insurance to their employees in lieu of higher wages. Total enrollment in group-sponsored insurance rose from less than 7 million to about 25 million subscribers; over 60% of the population had some type of health insurance by the end of 1954 (Money-Driven Medicine).

Maggie Mahar, a health journalist and author of Money-Driven Medicine argues that the spread of employer-sponsored insurance in the post-WWII period is what really set the stage for health care as a potentially lucrative business. And at first, everyone was happy. Employers realized that every dollar devoted to insurance benefits earned a greater return in attracting and motivating conscientious employees because benefits were not taxed, whereas an added dollar of income would be. Employees were happy because they didn’t notice that the additional dollars contributed to benefits packages could instead be devoted to wages. In other words, employees felt, and continue to feel at times, that health insurance is a benefit above and beyond wages. However, economists assume that if
benefits were not provided through the employer, we would instead realize the cost of benefits in the form higher wages.

In 2009, 61% of non-elderly Americans received health insurance through their employer, while 20% received insurance through Medicare and just 5% purchased non-group private health insurance (Robert Wood Johnson Foundation; KFF). The remaining 19% of non-elderly Americans were uninsured. In recent years, more and more small businesses have dropped coverage because of increasingly costly health insurance premiums. This problem is especially concentrated among smaller purchasing groups, who do not have as much leverage to negotiate with insurance companies, and who do not have as many people to spread the risk. With larger pools of people, the risk is spread across a greater group, which drives down the premium for a particular purchasing group. Because premiums are determined by this “experience rating,” individuals or small groups are faced with higher premiums and often forgo health insurance altogether, which is demonstrated by the mere 5% of nonelderly Americans who do purchase non-group insurance.

United States health expenditures have been increasing faster than the economy overall since the 1960s, and health care now comprises about 18% of United States GDP. In 2009, this was about $8,086 per person (Kaiser Family Foundation Slideshow, Health Expenditures and share of GDP). It’s not that we’re not spending enough on health care to deliver quality care to everyone, it’s that we unequally divide our resources, and a main contributor to this is how much of our health insurance comes through employer-employee ties. In 2011, the average employer-sponsored health insurance premium for a family rose to $15,000, up 9% from 2010 (Kaiser Family Foundation, 2011).
To combat the steep increases in health insurance premiums, employers have been requiring employees to contribute more to their health insurance premiums in recent years. From 2001-2011, there has been a 113% increase in premiums, and a 131% worker contribution increase (Kaiser Family Foundation Employer Benefits Survey, 2011). That means that the average employee now pays $4,129 per year for his or her family’s premium. On top of the premium, however, are costs incurred before the deductible, coinsurance, co-payments, etc. so the costs don’t end with the extremely high premium. Some employees realize the high cost of insurance and even when employers offer coverage options, if cost-sharing is too high, employees are more likely to decline the offer of employer-sponsored insurance, adding to the number of uninsured. However, the $10,000+ that employees miss out on through these benefits are usually not cashed out into higher wages that will allow employees to buy essential items like food, housing, and saving for their children’s college.

Despite the high cost of coverage, 80% of Americans are happy with their health insurance (Gallup Poll, 2009). Employees are detached from the entire price of their health benefit plans. Though the employee share of the premium may be rising, employers and employees are still able to use pre-tax dollars to finance insurance. The average $10,944 employers contribute to insurance premiums is often masked from their employees and thought of as a gift above salary. In addition, employees have little choice in plans offered by their employers, further removing consumers from the purchase of health insurance. We’re attached to this system and most Americans want to keep it. The discussion of removing employer-based insurance is often politically unpopular; as this might bring us
closer to the dreaded “socialized” medicine that many folks associate with universal coverage.

One of the main reasons President Obama and other political figures are so keen on keeping employer-based insurance is that we’re comfortable with it, and for the most part, it has done its job to insure large numbers of Americans and provide relatively high quality benefits packages for lower prices than could be attained in the individual non-group marketplace. In many respects, it has allowed insurance to function as it should, where healthy, low risk members subsidize the health costs of the sick, high-risk patients. But this only works when employers offer coverage, and the relative health of one individual will not greatly affect the risk of the larger group. On the flip side, smaller companies that provide insurance to their employees may be reluctant to hire a new employee that will incur serious medical costs and raise the premiums of the small pool of employees.

Lastly, businesses for the most part, still like employer-sponsored health insurance, especially if they have the resources and quantity in numbers to reach economies of scale and negotiate relatively low premiums for high quality products to offer employees. This attracts better employees, and again, employee health insurance is not taxed, so each additional dollar added to benefits has a greater return than an additional dollar added to salary.

Now that I’ve outlined some of the relatively positive outcomes of an employer-based health insurance system, I’d like to focus on the adverse consequences of such a system. The tax code that allows businesses to use non-taxed dollars to purchase health insurance for employees is equivalent to a huge subsidy from the federal government, estimated at about $108.5 billion dollars in 2004. According to Mahar, this subsidy is
skewed in favor of families earning more than $100,000 a year because they are more likely to have employer coverage and because they are in a higher tax bracket, so they benefit more from tax-free perks. For lower to middle income folks, whose employers are less likely to provide health insurance to them, health insurance options are expensive in the non-group market, often provide less comprehensive benefits packages and employees are forced to use their after-tax dollars to purchase coverage. As you can see, the tax code disproportionately favors richer Americans with higher paying jobs, mostly at larger companies. This contributes to the growing social and economic inequality in the United States. Without health, we have nothing. Middle-income folks without Medicaid or employer sponsored insurance as an option often forgo insurance and hope for the best, risking the lives of themselves and their family members. With the high cost of medical bills, not surprisingly, over 61% of bankruptcies in the United States is related to outstanding medical bills (Money-Driven Medicine).

Health care spending has outpaced GDP growth by 2.4% each year since 1970, and no one knows exactly why. Some attribute this increase in spending to the high cost of our technology, the greediness of doctors, medical malpractice, overuse of imaging and diagnostic services, the overabundance of specialty physicians, and the increasing epidemics such as obesity and heart disease. All of these factors contribute to the growing price tag of health care, but underlying our health care system is the American desire for more services, higher technology, the best doctors, the cleanest facilities, etc. While I will not argue that better technology and cutting-edge research should be blamed for the rising costs, I will argue that employer-sponsored health insurance has allowed prices to skyrocket and the demand for services to grow beyond that of other countries. According
to Johnathon Cohn, author of *Sick*, as benefits in employer-sponsored health insurance packages kept getting more and more comprehensive, the availability of services at little or no cost encouraged people to use more medical services, which tends to lead to more spending overall. During the 1970s, when the overall economy was growing so fast, businesses were able to absorb the rising costs of health care on behalf of their workers, and workers barely noticed that higher premiums were eating into their paychecks.

However, in the late 80s, large manufacturing companies were desperate to cut costs and could no longer absorb the harsh premium hikes, thus forced to discontinue health insurance coverage. In the 90s, the same trend followed, with big corporations like Wal-Mart becoming more sparing with its employee benefits offerings, limiting health insurance to full-time workers who had been at the company more than two years. In 1993, General Motors said that health insurance alone added more than $700 to the price of each car or truck. This number doubled in 2004, making it difficult for GM to compete with foreign car manufacturing companies that are not compelled to provide health insurance to employees (*Sick*).

One glaring reason employer-sponsored health insurance is not the panacea for a health care system is simply that health insurance is tied to employment. This means that once an individual loses his job, he loses the health coverage he and his family depend on. Though health insurance benefits can still be provided a short time after an individual leaves his job, once it’s gone, it’s gone. Without gaining another job that offers health insurance, individuals are forced to either remain uninsured or purchase unreasonably expensive insurance in the non-group market. The average employer insurance contract has an annual turnover of 20-25%, so this isn’t a rare event, either. The process of
switching health insurance plans is both expensive and confusing, contributing to even higher premiums as the front-end of these transitions cause even the most efficient insurers to spend 5% of their premiums just to do it right. These administrative costs are unnecessary and wasteful, helping to contribute to the ever-increasing price of premiums.

There is simply an unnatural link between employers and health insurance. We do not depend on our employers to provide us with auto insurance, home insurance, or life insurance, so what makes health insurance different? If individuals had more skin in the game, and were compelled to make wise decisions about where their health care dollars went, they would likely make smarter decisions when purchasing health insurance. When we think someone else is paying for our health care i.e. our employers, we don’t feel much pressure to learn the true cost of our medical care. For example, I’m fairly confident that not many of you in this room know how much Lancaster General Hospital charges for an MRI scan, or how much an appendectomy would cost. The truth is, the cost you may incur pales in comparison to the high cost insurance companies are liable for. Though transparency in health care is another huge problem, in that reliable health data is hard to come by, consumers would show a greater interest in what care they are receiving and at what price if they are directly choosing their insurance plans and paying their family’s premium. When consumers are not concerned about the real cost of their health care, they will usually opt for the state-of-the-art MRI scan or surgical procedure, and providers feel little pressure to compete on price. Again, the result is rising health care costs reflected through ever-increasing premiums. As health insurance becomes more and more expensive, and these increasing costs are broadcast daily in the media, Americans feel apprehensive
about changing jobs they are unsatisfied with, and become more dependent on the benefits provided by their employer.

One benefit of not getting health insurance through an employer is avoiding out of network problems and having the ability to switch insurance plans if unsatisfied. Most employers only offer a small array of health insurance options to their employees, often picked over by the Human Resources departments. These plans may or may not represent the best value or the most comprehensive benefits to consumers. To employers, the greatest concern is cost, but to families, preference for certain doctors or hospitals in the plan’s network may outweigh costs, but when insurance is offered through the employer, it is difficult for employees to switch plans if they are unsatisfied.

Economically, employer-sponsored health insurance makes no sense. Because most Americans depend on their employers for health insurance, the ability of private businesses to manage and absorb health care expenses directly impacts our protection against the costs of illness. When the United States economy and global markets are doing well, US businesses are more willing and able to contribute to employee benefit plans. However, these ripple effects are profound, and when the market is not doing well, failing businesses are unable to continue to offer health benefits, and Americans are left unemployed and uninsured, vulnerable to all sorts of costly diseases with no way to pay for the treatment costs they may incur.

The argument against employer-sponsored insurance is not an ideological one; it’s a practical one. No other successful health care system in the world includes employment as the main basis of gaining health insurance, and for good reason. Milton Friedman astutely put it: “There is no more reason for an employer to provide his employees with medical
care than there is for him to provide them with food or clothing or housing. The reason why employer provided medical care is so prevalent today is a result of a tax provision introduced following WWII which exempted employer-provided medical insurance from being subject to taxes” (The Cure). According to Friedman, we should not let one bad government policy (excluding health benefits from employer taxes) lead to another one. His solution: eliminate the tax deduction on any medical care expenses, which would greatly increase tax revenue to the federal government. In addition, employees should instead get health insurance through the free-market. This should sound familiar, because besides the individual mandate to purchase insurance, the health exchanges are one of the fundamental components of the Affordable Care Act.

The Affordable Care Act promulgates employer-sponsored insurance and goes so far as to fine employers for failing to provide reasonable benefits to employees. Though the ACA sets forth numerous provisions that will make health care more equitable and available, the employer mandate to provide health coverage is a move in the wrong direction. While health policy experts work to reinvent the way doctors are paid and hospitals deliver health care, a greater problem still persists, which is that of employer-sponsored health care and the tax code. Though it would be a problem if over 1/3 of all employers dropped employee health coverage because federal subsidies may not be enough to cover the influx of uninsured entitled to use subsidies to purchase coverage in the exchange, if instead the United States adopted a shift away from employer-sponsored insurance, we would generate substantial revenue from additional tax receipts. This is because economists argue that over the long term, market forces determine total compensation, including wages and benefits that employers pay to employees. When health
insurance costs go up faster than the ability to increase overall compensation, then employers will reduce cash increases or other benefits, or go out of business. However, if employers instead pass on the cost of health care to employees in the form of wages, employees can use this additional, taxed, income to purchase health insurance in the new exchanges. Though individuals would have less money to purchase health insurance, the additional revenue collected through higher wages would be able to subsidize coverage in the exchanges. In addition, the whole purpose of the exchanges is for private health plans to compete on the basis of benefits and price, which aims to eventually bring down the cost of health insurance premiums. As Uwe Reinhardt suggests: “the aim should be to develop a robust, parallel system of fully portable insurance that individuals or families can purchase on their own, in a properly regulated and organized market, with public subsidies where deemed necessary” (Reinhardt, 2009).

While this dramatic shift may be politically infeasible in the short-term, a similar situation in Switzerland should provide confidence that such a change can happen, and the new system of health care in Switzerland can inform health policy makers in the United States. Washington Post correspondent T. R. Reid traveled the world to find cost-effective ways to cover every American by borrowing ideas from foreign models of health care. Switzerland, which has the second highest medical spending per capita, models its healthcare system very similarly to the method I have just described to you. In addition, Switzerland started off very much like the United States, with an employer-sponsored health care system. Traditionally, Switzerland had a network of nonprofit health insurance plans, and workers bought health insurance through their employers. However, in the 80s, for-profit health insurance providers began to compete with these nonprofits and began to
cherry-pick members and deny expensive claims, much like many of the health insurance companies do in the United States (though these practices will be limited with the implementation of the ACA). In the 90s, Switzerland’s health system was similar to the United States: unsustainable costs and a growing population of uninsured adults. Unlike the United States (so far), Switzerland displayed its commitment to solidarity as its people became outraged when about 5% of the population was uninsured. A special task force created a new law that separated health insurance from employment, and required every family to go to the market to buy insurance. Insurance companies were required to offer a basic package of benefits to all applicants, the package determined by the government, and insurers could not make a profit on this basic health coverage. If anyone didn’t sign up, they were automatically assigned to one of the identical companies and the premium was deducted from their paycheck. However, like the US, the Swiss are also fond of capitalism and free-market approaches, and in order to allow private insurers to make a profit on health care, they were allowed to sell supplemental coverage, as well. Insurers were happy, because they were still able to make a profit and gained enough consumers to keep them solvent. Consumers were happy, because they were covered by health insurance with no ties to employment, and the country was again committed to the principle of solidarity, as Reid described. The new system that went into effect in 1996 has provided universal coverage to Switzerland. A conservative businessman who reported to Reid claimed: “Nobody would want to go back to the system before, when some people were locked out of the insurance. We have a system now that means everybody, rich or poor, can have the best health care we can provide. It is accepted; it is working” (The Healing of America, pg. 181).
The basics of the Swiss system I believe appeal to most Americans: Universal coverage, free-market provided insurance, and the preservation of healthcare as a profit making industry. Though health insurance is still expensive in Switzerland, health spending as a percentage of GDP has remained about the same since before the legislation passed. In addition, insurance profits are even higher overall than before the legislation, and companies are able to successfully compete for business without skimping on essential benefits or denying claims.

This brings me back to the McKinsey & Co. study published in the middle of the summer. If the future trend of insurance will be a decline in employer-sponsored insurance, would this be such an awful outcome? The answer is no. Without an employer-sponsored system, the free market could actually provide multiple private players competing to sell products that deliver high quality benefits packages at lower costs. Employees would no longer be masked to the true costs of health care, and would more intelligently purchase health insurance that fits their needs. In addition, if all Americans purchased individual and family insurance in these exchanges, the risk pool would be huge, as all Americans would be paying into the system. Of course, we would need to be careful of high-risk pools and plans that include extremely high deductibles and skimpy benefits, but other countries systems can demonstrate the logical shift we must make to create a system of health care that is more equitable and affordable.
References


