TRANSCENDING EMPLOYER-BASED HEALTH INSURANCE

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INTRODUCTION

High levels of innovation and rapid change characterize the American economy. This process not only leads to exciting new products and services, but also to sometimes quite dramatic organizational changes in the way we obtain products and services. Typically this process is the result of technical and/or entrepreneurial breakthroughs. Think of the remarkable changes wrought by the idea of routing a national system of air-delivered overnight packages through just one airport sorting-station (Federal Express), or of creating a huge "virtual" bookstore on the Internet (amazon.com). Even more dramatic, perhaps, consider the revolutionary thinking that replaced huge mainframe computer systems for most uses with the democratizing innovation of PCs and the Internet.

Such innovation often can be bottled up or distorted by regulatory and legislative restrictions, and it can be uncorked by removing those barriers. Consider the explosion in telecommunications that accompanied the regulatory and legal decisions beginning in the 1960s that gradually eliminated AT&T's long distance monopoly.[1] Certain of these decisions permitted large companies to sell access to their internal communications systems first to other businesses and then to household customers. One company that took advantage of this regulatory liberalization was the Southern Pacific Railroad, which opened up its internal network in 1970 under the name "Sprint." After subsequent sales and mergers Sprint is now the nation's third largest long distance company, and has branches all over the world.

When we look at health care in America we also see rapid innovation: from remarkable new pharmaceuticals to breakthrough surgical procedures. There is, too, a high degree of organizational and managerial innovation. But this latter innovation takes place within a set of constraints and perverse incentives, resulting mainly from the tax system, which has greatly distorted the pattern of organizational innovation that would otherwise occur. Indeed, the most important feature of today's system – employment-based insurance – owes its continued dominant status almost entirely to a $125 billion federal and state tax subsidy available only to that form of coverage.[2] There is a political

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[1] For a summary of these decisions see Robert Crandall and Jerry Ellig, *Economic Deregulation and Customer Choice: Lessons for the Electric Industry,* (Fairfax, VA: Center for Market Processes, George Mason University, 1995), pp. 18-19.
[2] John Sheils and Paul Hogan, "Cost of Tax-Exempt Health Benefits in 1998," *Health Affairs*, vol. 18, no.2 (March/April 1999), pp. 176-181.

disinclination to change a tax break that large. But the system also continues in part because of a strong tendency to assume that employment-based system is the only plausible way to provide good health access to health care for working families, despite the gaps and frustrations associated with the system.

The thesis of this paper is that this view of health care is much like the earlier presumption that long-distance telephone service was a "natural monopoly," or that IBM mainframe computers had an inherent advantage over all alternatives. If we were to take the step of dismantling the tax-driven obstacles to rapid organizational innovation outside the framework of employer-based coverage, we could see a very different, and better, health system in the future. This new system would be based on a more normal and advantageous relationship between consumer and instead of the interests of the third-party (insurer) and fourth-party (employer) payers who dominate the economic relationship today. And while the employer-based system would undergo substantial change, this paper will argue that the place of employment would continue to play a key role in health care, albeit a different one. Moreover large, employer-sponsored plans could have a huge role in the health care market – but again a different one from their typical role today.

This paper will review the problems with the employer-based system and speculate on how the health system for working families would evolve if there were to be major changes in the tax treatment of health care. It will then consider some of the issues that have to be explored for such an alternative system to operate. Complex issues and difficulties would certainly have to be addressed, as with every major innovation in every market. But there is good reason to believe that they can be overcome once there is the economic incentive to do so – just as they have when economic incentives have changed in other industries – while the flawed economic relationships in the current system guarantee continued frustration and uninsurance.

WHY TODAY'S SYSTEM NECESSARILY FAILS

Besides the elementary objective of having access to a level of health care considered reasonable in an affluent and civilized society, general economic principles suggest that four key elements are among those needed for consumer satisfaction and long term efficiency:

- Wide choices among competing plans and services. Competition and consumer choice spurs efficiency. But it also increases the probability that the consumer will be able to obtain a plan or service that is most attuned to their needs and desires, thereby realizing maximum value.

- Ownership and control of plans and resources. As the old adage goes, "He who pays the piper calls the tune." The person who controls the resources, and chooses the

plans that will be made available to families, is the client who will be served and whose values and goals the insurer will address.

- Affordability. With good health care considered to be a necessity and not a luxury, the cost of care for families must be reasonable. But spreading risk to avoid prohibitive costs for high-risk individuals means devising methods of pooling risk and creating subsidies for low-income individuals.

- The importance of intermediaries Health care does differ in degree from many other services in that its complexity and potentially prohibitive cost requires considerable knowledge to make good purchases. In such a market agents or intermediaries become very important. But for a consumer to be satisfied, those intermediaries must share the interests and goals of the consumer, not merely be knowledgeable and convenient.

For millions of Americans, the employment-based system fails to achieve these essential elements, yet the enormous tax bias in favor of employer-sponsored insurance poses a huge obstacle to other arrangements.

The way in which the tax system heavily favors employer-sponsored insurance has been discussed at length elsewhere.[3] The large cash value of the tax benefits for upper-income employees, and small value for lower-income families, draws particular criticism. But an even bigger problem is that as a condition of the tax benefit, workers must hand over control of most health coverage decisions to their employer. The employer then uses part of the employee's compensation to purchase a health plan. That means the employer becomes both the intermediary in the economic relationship and the entity that "calls the tune" for insurers. This peculiar arrangement may be quite acceptable to those employees who feel that their employer's values and decisions coincide with their own (possibly as a result of collective bargaining.) In a growing number of cases, however, the arrangement conflicts with the four core elements above, leading directly to many of the frustrations and coverage problems experienced today. For example:

- Employment mobility. In an economy with increased job mobility, for an ever-larger proportion of the population an employment-based group is no longer a stable, long-term foundation for health insurance. A high level of job mobility for a family or in an industry mean a high degree of change and uncertainty associated with employment-based health insurance.

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[3] See Shiels and Hogan, "Cost of Tax-Exempts Health Benefits"; Robert B. Helms, "The Tax Treatment of Health Insurance – Early History and Evidence, 1940-1970," in Grace-Marie Arnett (editor) *Empowering Health Care Consumers* (Ann Arbor: University of Michigan, 1999); Congressional Budget Office, *The Tax Treatment of Employment-Based Health Insurance* (Washington, D.C.: US Government Printing Office, March 1994).

- Small employers and risk pools. Proponents of employment-based coverage argue that the tax-supported system is needed to pool risk.[4] But with a different set of tax benefits and regulations alternative pools could be formed (examples will be discussed later). Moreover, employment-based pools are very inadequate in many instances. Employees who switch jobs, for instance, usually must switch pools and hence plans. And while major employers with a large insurance pool and a sophisticated human resource department can negotiate good and economical coverage, this is not the case with most smaller employers who lack expertise and economies of scale. Surveys indicate that administrative costs for small firms can be several times those of larger firms, measured as a proportion of premiums.[5] Attempts by states and the federal government to create special pools for small employers merely underscores this deficiency.

- Uninsurance among working families. With tax subsidies linked so closely to employer-sponsored insurance, it is hardly surprising that uninsurance is heavily concentrated among workers in those sectors where firms tend to be small and employee turnover is high, especially in services and retail. Roughly half of uninsured workers are found in these sectors of the economy. In 1996, less than half of firms with less than 50 employees offered insurance, compared with 99 percent of those with more than 200. For those firms below 50 employees where most workers earned less than $10,000, only 19 percent were offered health benefits.[6]

- Frustration among the insured. Just as predictable is the growing feeling among insured families that they have been losing control over their health care, due to the simple fact that the insurer's client is the employer. This is now leading to demands for a Patients Bill of Rights to institute legal and regulatory remedies where normal consumer economic power is lacking.

AN ALTERNATIVE VISION

The problems associated with the employment-based system are unlikely to be solved because they are mainly due to the absence of normal economic relationships, not the result of technical or practical problems that might be solved with hard work and application. A better approach to these problems would be to imagine how health care for working people might rearrange itself if steps were taken to remove the huge tax

[4] See William S. Custer, Charles N. Kahn III, and Thomas F. Wildsmith IV, "Why We Should Keep The Employment-Based Health Insurance System," *Health Affairs*, vol. 18, no. 6, November/December 1999, pp. 117-118.
[5] *Tax Treatment of Employer-Based Health Insurance*, p.5.
[6] General Accounting Office, "Employment-Based Health Insurance: Medium and Large Employers Can Purchase Coverage, But Some Workers Are Not Eligible," GAO/HEHS-98-184, July 1998. This and other characteristics of employer-sponsored insurance noted in this paragraph are included in Karl Polzer, "Retooling Tax Subsidies for Health Coverage," Issue Brief No. 728, National Health Policy Forum, George Washington University, 1998.

barrier against organizing health coverage outside the place of work. Specifically, let us imagine how the system might change if tax (or other) subsidies were available to families *wherever* they obtained a health plan. This step would create a more normal bilateral relationship between consumer and health plan. It would "uncork" a process of organizational creativity in response to that changed relationship – much as other waves of change have followed sweeping regulatory or legal decisions in the past. And of course it would also raise new issues and challenges that might have to be addressed by public policy.

Let us first consider first what such a system might look like, and then the policy issues the system would raise.

Element 1: Equitable Tax Treatment of Health Care. A reform of the tax system to end the current bias in favor of non-employer sponsored insurance would have three core features.

First, it would make the tax system neutral with regard to the *method* in which a family paid for health care. There would cease to be any tax advantage for otherwise uneconomic over-insurance, because families paying directly for all or part of their medical care henceforth would enjoy the same tax benefits as those paying via insurance.

Second, it would make the tax system neutral with regard to the *source* of a plan. Say a worker decided to devote part of his compensation to purchasing its health plan, either in the individual market or though a non-employment group, such as a union, church or other affinity group. This worker would receive the same tax relief as a worker choosing to allow his employer to use part of the compensation to purchase the plan for him.

Third, it would concentrate most assistance on those families with the highest level of health expenditures compared with family income.

As many analysts and lawmakers have argued, the best method for doing this would be through some form of refundable tax credit with a corresponding reduction or elimination of the tax exclusion for employer-sponsored insurance.[7] Under a proposal developed by this author and colleagues at The Heritage Foundation, the tax exclusion and all other deductions for health-related expenses would be repealed. It would be replaced with a new refundable tax credit for unreimbursed medical expenses, including insurance, out-of-pocket medical costs qualifying for the current federal deduction, and contributions to a medical savings account. [8] A version of the proposal formed the basis

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[7] For example, see Mark V. Pauly, "An Efficient and Equitable Approach to Health Care Reform," and C. Eugene Steuerle and Gordon B. T. Mermin, "A Better Subsidy for Health Insurance?" in Arnett, *Empowering Health Care Consumers*;

[8] Several versions of the Heritage proposal have been developed over the last decade. For example, see Stuart M. Butler, "A Tax Reform Strategy to Deal With The Uninsured," *Journal of the American Medical Association*, vol. 265, no. 19, May 15, 1991; Stuart M Butler, "Expanding Health Insurance Through Tax

of legislation (S 1743) introduced in 1993 by Senator Don Nickles (R-OK) and Representative Cliff Stearns (R-FL).

Under the basic Heritage proposal, households not enrolled in Medicaid, Medicare or other government-sponsored programs would be eligible for a credit. All families would be required to enroll in a federally-qualified insurance plan, which would have to include at least minimum catastrophic overage. Such plans also would have to incorporate limited underwriting, with premiums varying only on the basis of age, sex and geography, with the same rates applying to new enrollees as existing enrollees. Employees could leave an employer-sponsored plan only if a majority of the workforce voted to close down the plan or the employer decided to do so. In either case the employer would have to demonstrate maintenance of effort by adjusting worker cash compensation by the value of the plan.[9]

The credit would be in the form of an above-the-line refundable tax credit. It would be a sliding scale credit, based on total costs compared with income. Thus lower-income and/or generally sicker individuals would qualify for a higher percentage credit. A budget-neutral version of the credit has been estimated to provide the following credit structure.[10]

Health expenses	**Credit (per cent of expenses)**
Amount below 10% of gross income (including value of employer contribution)	22%
Amount 10-20% of gross income	44%
Amount above 20% of gross income	66%

Element 2: Affinity Groups as Intermediaries. It has often assumed that only the alternative to traditional employer-based health coverage is the individual market with its

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Reform," *The Kaiser Project On Incremental Health Reform* (Menlo Park, CA: Kaiser Foundation, 1999). See also John Sheils, Paul Hogan and Randall Haught*, Health Insurance and Taxes: The Impact of Proposed Changes in Federal Policy* (Washington D.C.: National Coalition on Health Care, 1999), pp. 41-52.

[9] The amount of cash for each worker could be calculated in one of two ways: either by collective bargaining or according to a schedule reflecting the same categories as the underwriting limits imposed on plans. The latter schedule means the cashed-out compensation would be in proportion to the cost of plans available to the worker.

[10] Under this version, achieving universal coverage, there would be an explicit net transfer of after-tax income from (generally) upper-income households to (generally) lower-income households. In another version of the proposal, costing $55 billion annually in extra tax relief and grants to the states, no income group would experience an explicit increase in tax and health costs. See Sheils, *Impact of Proposed Changes in Federal Policy* pp.41-52.

high administrative costs, complexity for consumers, segmentation of risk, and limited opportunities for individuals to bargain for good deals. But where the tax system no longer distorts choices, a far more natural type of market relationship would be for families to seek health coverage through intermediary institutions they are affiliated with and trust. These intermediary organizations would act as informed and powerful "agents" on behalf of individuals and bargain with providers – a rational element in the economic equation when the consumer himself is not a sophisticated buyer. To be sure, this agent function is held up as a key advantage of today's employment-based market. But it is not a feature that should be thought of as somehow restricted in principle only to employer-based plans. With a more neutral tax/subsidy system, other institutions would have a comparative advantage over employers in many cases – particularly in employment sectors with high levels of uninsurance and dissatisfaction.

Many of these intermediaries could be the normal community-based mediating structures of society, such as churches, unions, school associations, elderly organizations, tribal groups and similar bodies. In a more consumer driven market with tax neutrality, unions would be very likely to emerge as intermediaries, both because of the strong long-term attachment of many Americans to unions and their experience in negotiating health benefits.

The "friendly society" role of unions has a long history in this and other countries. In those markets where there are fewer tax and regulatory obstacles to union-sponsored plans they do exist, and indeed flourish. The Federal Employees Health Benefits Program, with nine millions covered individuals, is perhaps the closest employment-based analog to the consumer-controlled market being discussed, given its size, stable workforce, and wide selection of competing plans. It is interesting that several of the leading FEHBP plans are organized by unions, such as the Mail Handlers, which offer even offer associate membership to non-members of the union wishing to gain access to the health plan. Indeed, the Mail Handlers Benefit Plan, backed by CNA Insurance, has roughly 10 times as many enrollees as the union has regular union members. These unions do not carry the insurance risk themselves, but organize a group and negotiate an insurance package from an insurer for a fee. Consider, too, the many union plans operating under the Taft-Hartley Act, where union-sponsored plans are a very rational way of providing coverage when there is only a weak relationship between employer and worker. The Taft-Hartley health plan organized by the International Brotherhood of Electrical Workers, for example, was a response to the loose structure of rural electrical co-operatives.

Church-based health plans would also be a likely development if church members could obtain tax or other assistance to purchase coverage through these groups. The black churches, for example, have a long history of involvement in social services for their congregations. For lower-income African-Americans especially, the church is a far more stable institution in the community than local, small employers – and one that clearly has the long-term social welfare of families firmly in mind. In addition, the Catholic Church and other denominations sponsor networks of hospitals. Since churches,

like unions and many other groups, also routinely communicate by mail with their members, these intermediaries also present a lower-cost "piggyback" way of marketing health plans and reducing administrative costs.

Element 3: New Markets for Large Employer-sponsored Plans. Proposals to offer comparable tax breaks or other subsidies to non-employment group coverage typically is seen as a threat to large employer-sponsored plans, and especially to the job security of corporate employee benefit managers. But with certain safeguards for large employer pools, these proposals actually offer huge new potential markets for such plans.

It is common for large companies to sell to a general market certain services initially designed for internal use. Telecommunications is an example already mentioned, as is financial services. The General Motors Acceptance Corporation (GMAC), for example, offers a wide range or insurance and mortgage products. Yet although health insurance plans are a major "internal business" for large corporations, few so far have seen their plans as a product to offer in other markets. But the main reason for this, in addition to the complex state and federal regulation that would affect companies offering such coverage to a general market, is the large tax barrier to that innovation. The value of the tax exclusion means that even the most cost-efficient corporate plan could rarely entice workers with coverage through their employer to request a cash-out of benefits so that they could join the corporate plan. Since few uninsured families receive tax or other subsidies to purchase insurance, even that potential market is quite thin.

Nevertheless, some companies have chosen to market their health plan expertise within the constraints of current law. One whose activities hint at what could happen in a more liberalized environment is the John Deere Company. Intent on improving the health care of its own employees while reducing costs, the company created its own HMO. It then began to offer coverage to other employers and purchased health operations to serve its new market. But it has not confined itself to offering its expertise and facilities to employer groups. The company's for-profit health division, John Deere Health Care, also offers coverage to individuals as a Medicare HMO, and provides managed care Medicaid services in six states. The Deere Plan is also available to some federal workers under the FEHBP. Out of more than 400,000 enrolled in Deere plans in the Midwest and Southeast, less than 20 percent are John Deere employees. The tax code, however, makes it very uneconomic for Deere to offer coverage to groups of working families (except federal workers) other than through their employer.

With a tax and regulatory system more conducive to entrepreneurship by corporate health plans, one could imagine a surge of new ventures by existing corporate plans, reminiscent of similar patters when restrictions were removed for spin-off ventures in other industries. This would be especially true if they could operate with the freedom available under ERISA. Very likely some these would take the form of partnerships between corporate plans and other groups, including churches. Perhaps such partnerships could include even unions. It may not even be too fanciful to imagine labor and management health benefits negotiators deciding to team up to market their plan to non-

employees – a GM-UAW health plan would be a very marketable plan in Michigan, for instance, bringing in revenue for the union as well as the automaker.

AN INFRASTRUCTURE FOR NON-EMPLOYER HEALTH PLANS

The employment-based system does have a relatively simple infrastructure to it. The subsidy through the tax system (the tax exclusion) is essentially administered by the employer, who simply does not include the value of group health benefits in a worker's pay stub or W2 form. The value of the exclusion reaches workers in effect because their federal taxes are based on only the cash portion of their compensation. Payments to the insurer (or to the agent administering a self-insured plan) for each worker choosing that plan are grouped together, requiring few checks to be cut. Premiums are group rated for broad categories of workers (such as single and family coverage) and based usually on the claims history of the group.

This relatively simple system, however, has features that are far from ideal. For example, large tax inequities are hidden from the employees. Two similar employees doing exactly the same job often receive very different total compensation. And prospective employees with high-cost medical conditions often fear that too many questions about the company health plan will jeopardize employment prospects. Still, it is claimed that it would be too costly or even unworkable for employees to enroll in group plans other than those sponsored by employers. But if the barriers to non-employment based groups and coverage were removed, a system could be established that would have many of the positive returns of successful employer-based plans while dealing with its deficiencies and extending coverage to those outside the current system. One can speculate on the structure of such a system – and the policy steps that might be necessary – by considering existing models and relevant arrangements.

The Federal Employees Health Benefits Program (FEHBP) is a useful starting point to tease out the basic features that would be needed and the type of infrastructure that could work. To be sure, there is one employer for the nine million covered individuals – the federal government – but the FEHBP actually functions like a very open, individual-based system. An employee of a House member's district office in Wichita may ultimately work for the same employer as an auditor in the Treasury, or a Senator, but in a day-to-day sense the FEHBP allows these employees to act as individuals in the choices they can make and in the intermediary groups they can join.

In a nutshell, the infrastructure of the FEHBP operates as follows. The federal worker receives information each year on a wide range of plans in his area (i.e. not just a selection limited by his office or agency employer). These plans are approved centrally by the Office of Personnel Management (OPM). The premium price of the plan is community rated (single or family), and the price is stated after taking into account a percentage tax-free premium subsidy (with a maximum) provided to all federal workers

and retirees by the government. When he selects a particular plan, his immediate employer submits payroll withholding information to OPM and the cost of the plan is deducted from his government paycheck. OPM acts as a paperwork clearinghouse for the cash flow of the system, authorizing payments to be made to each plan based on their total enrollees.

A similar infrastructure could be developed for non-federal workers, in which the place of employment would typically be the "point-of -entry" to the system, and yet that system would not be employment-based in today's sense of employer-groups and sponsorship. To be efficient and comprehensive, such an infrastructure would have to contain three basic elements: a method by which tax subsidies can reach families easily and at the time premiums are due; a relatively simple method for collecting premiums and paying a wide range of plans available to any family; and a method of forming stable groups outside the place of work.

1) Delivering Tax Subsidies to Families

The simplest way to deliver the subsidy to workers would be through an adjustment in tax withholdings, much as deductions (e.g. for mortgage interest) or credits (e.g. the child care credit) are typically handled today with the employer remitting tax payments to the government that are net of the credits. If a system of payroll deductions for health premiums were in place (see below), the credit/premium transaction would be relatively simple for both employer and employee. In particular, a worker would receive the credit in increments during the year, coinciding with premium payments, rather than in a lump sum or otherwise out-of-phase with insurance costs.

Needless to say, the more complicated the credit (such as a sliding scale credit, or a credit also for out-of-pocket costs) the more difficult it would be to calculate the credit and withholding amount accurately. Still, it would not be difficult to do so to a tolerable degree of accuracy. It should be remembered that withholding today is not an exact science for employer or employee, especially if income or a family situation changes. It should not be beyond the capabilities of the Treasury to adjust the withholding instructions for firms and employees to enable a reasonably accurate credit to be calculated for a given income and premium. Moreover, for workers in restricted network managed care plans, the premium would in any case constitute almost all the costs eligible for a credit, making, making tax reconciliation simple.

An alternative option for some families, particularly for lower income families who may not even file tax returns today, would be to permit eligible credits to be transferred to the insurance plan in return for reduced premiums. This would mirror the FEHBP premium system in which federal employees are quoted premiums net of the government contribution. Thus rather than deal with the withholding system, a family would have only to establish its eligibility for a fixed or simple percentage credit. The plan would adjust the premium and obtain the equivalent amount from the government (as a payment or adjustment in corporate taxes). Senator Tom Daschle (D-SD) proposed

such a transferable tax benefit several years ago. This alternative could also be made into an attractive option for workers concerned about owing money because of withholding errors when taxes are reconciled each year. In effect, the transferable credit would be a simpler option, much like the standard deduction is a simpler option for those who do not wish to itemize their taxes.

If the worker suffered a spell of unemployment, the credit transference mechanism would not be affected. But in cases where the credit had been delivered through withholding, insurers could be required to accept part payment of premiums until the eligible credit could be delivered through the unemployment and the insurer made whole by a direct government payment for the "missed" credit.

2) Collecting and remitting premium payments.

A system could operate with individual families writing monthly or quarterly checks to a health insurer, much as they write checks for tax-advantaged mortgages. But the uncertainty (for the insurer) and high administrative costs of such a system does make some form of employment-based payroll deduction attractive. Yet it would be onerous for an employer with, say, 10 employees to make arrangements to withhold and transmit funds to potentially 10 different insurers – just as it would be if a lawmaker's district office had to organize payments to 10 plans for 10 employees. So the emergence or creation of the functional equivalent of OPM (or better still a choice between several competing "OPMs") would be a logical development.

Under such an arrangement, an employer might contract with a firm carrying out the clearinghouse function.. The clearinghouse firm would make available, though the employer, standardized and unbiased information on the health plans available in the area. Workers would pick the plan they wished, and the employer would remit just one check each accounting period to the clearinghouse firm, making appropriate adjustments to each worker's paycheck after adding whatever financial contribution the employer had agreed to make to his employees' health insurance. The clearinghouse firm would pool the funds and send payments to each plan based on the number of the plan's enrollees it handled.

Firms and organizations similar to this already exist to handle related functions and these or similar institutions could be expected to enter the market if the tax barrier were ended. Payroll firms already process paycheck withholding for many small employers. Third Party Administrator (TPA) firms handle many functions already for self-insured companies, including detailed financial transactions, and could be expected to offer clearinghouse services. Private enrollment brokers, under contract to states, provide information and assistance to Medicaid and SCHIP eligible individuals and process the enrollment when a plan has been selected. And in the pension area, the non-profit TIAA-CREF pools and manages almost $300 billion in pension funds for over two million people working in 9,000 academic institutions.

A legal requirement that an employer must deduct the appropriate premium and send it to any plan chosen by an employee likely would trigger the rapid development of a system of clearinghouse firms. Other possibilities, perhaps more attractive to those who are more skeptical of the creatively of markets, would be competing bodies chartered by state government and modeled on TIAA-CREF.[11] One proposal to set up a version of such bodies was introduced in 1995 (S. 1062) by Senator James Jeffords (R-VT). Still another possibility, perhaps in tandem with other methods, would be for OPM itself to establish a national clearinghouse system using the infrastructure of the FEHBP.

3) Forming stable groups.

As noted earlier, one of the central claims for employment-based coverage is that it is a practical way of forming stable groups for insurance purposes. But as also noted earlier, this comes at a high price in terms of equity and consumer control. For millions of working Americans and their families, there *is* no employment group, either because their employer does not offer insurance or it is too expensive for families to enroll. Even where employer-sponsored coverage is available, such groups are "captive" collections of enrollees since the employer controlling the group determines the choices, medical services and costs available to families. Moreover, these groups offer continuity and a measure of stability only as long as the worker remains with the firm.

On the other hand, non-employer sponsored groups would provide freedom of plan choice and the opportunity of a long-term association separate from a family's employment pattern. But that very freedom is said to undermine the stability of voluntary private health insurance pools outside employment, and hence the feasibility of a non-employment based system. At issue, then, is whether these concerns could be addressed. In a simple sense, the problem boils down to money: can we construct a pooling system such that revenues to an insurance plan are reasonably in line with the costs of treating the individuals who choose the plan, yet the out-of-pocket cost of care for the enrollee (premiums and non-insured costs) does not differ widely for people of differing health care risk?

These risk selection and payment issues have been discussed extensively by analysts in the context of Medicare and the small-group employment-based market, so they are not unique to the non-employment pools described here. This is not the place to review the debate on these complex issues at any length, but rather to sketch out the possible features of a structure that with more research and experimentation likely would enable the insurance risk issues in the proposed system to be handled tolerably well.

Under this structure, very large plans (such as the large employer spin-offs or major union plans described earlier) might operate like today's multistate employer plans as associations under a modified version of ERISA, spreading risk through a large pool.

[11] A bill (S. 1922) to establish a government-chartered corporation to operate a pension system similar to TIAA-CREFF was introduced in 1996 by Senators Jeff Bingaman (D-NM) and James Jeffords (R-VT). A similar structure is one option for health care, albeit not one favored by the author.

A legislative proposal (HR 1687) to create such associations under ERISA was offered in 1999 by Representative John Shadegg (R-AZ). Smaller individual plans, on the other hand, would have to operate within a system of competing insurance co-operatives chartered by states or the federal government. These cooperatives would incorporate modified community rating together with a reinsurance/risk adjustment mechanism.

The most promising arrangement for plans with smaller pools is a blend of "prospective" and "retrospective" risk adjustment. The prospective feature allows plans to vary premiums according to broad categories of risks (such as age and geography). Meanwhile "retrospective" re-insurance adjusts revenues based on the actual paid claims of their enrollees.[12] The latter adjustment would be financed from a re-insurance pool to which all plans contributed. An additional federally chartered national pool or set of regional reinsurance pools could act as a final reinsurer between the cooperatives.

This arrangement for smaller plans (offered, perhaps, though groups of churches, smaller unions etc acting as intermediary agents but not risk holders) has the advantage of reducing the incentive for plans to avoid higher-cost individuals and seek only low-risk enrollees. It would also reduce the incentive inherent in strict community rating for low-risk individuals to eschew insurance. With the *ex ante* feature limited in scope, the prospective element in the risk adjuster also retains an incentive for plans to find better ways of managing costs for sicker enrollees. And while premiums would vary for families with certain broad categories of risk, these variations would be limited and predictable. Moreover, in the case of the Heritage proposal, the design of the tax credit (larger, refundable credits for high costs compared with income) would partially offset the burden of premium costs for higher-risk and/or lower-income families.

To be sure, techniques for pooling risks and adjusting payments to smaller plans are still not well developed, especially within a setting of wide choice. But this challenge also applies to smaller groups in the employment-sponsored sector – or to Medicare – just as they would do in the proposed non-employment structure. Policymakers would need to refine pooling techniques with or without the proposed reform. Yet resolving these issues for employment-based insurance still would not deal with the fundamental problems of control and ownership inherent in employer-sponsored insurance outlined at the beginning of this paper.

"BIG BANG" OR "CONTINUOUS CREATION": GETTING FROM HERE TO THERE

Change in an industry often takes place rapidly, especially if it is the result of a major innovation in product design or a legal decision. Product innovations in computer hardware and software have been rapidly and continuously changing that industry in recent years. So have legal and regulatory decisions in the telecommunications industry.

[12] For a review of the issues involved in blended approaches to risk adjustment see Linda J. Blumberg and Len M Nichols, "Health Insurance Market Reforms: What they Can and Cannot Do," Urban Institute 1998. See also Joseph Newhouse, "Risk Adjustment: Where Are We Now," *Inquiry*, Summer 1998.

For that matter, legislative and employer decisions to foster managed care already have wrought major changes in health care delivery in recent years.

Concern about further rapid change in health care potentially triggered by tax reforms ironically lead many people to resist major steps that would begin to deal with the chronic problems of uninsurance and frustration with employer-sponsored plans. Their fear is that although encouraging alternatives to employer-based plans might solve some problems, large and successful employer-based plans would begin to unravel and the situation for many insured families would deteriorate.

Predictions of dire consequences are common whenever a policy change is proposed that would allow consumers the power to choose services from new competitors. They are usually best ignored. Nevertheless, health care is such a sensitive and politically charged issue that it could be prudent to pursue a gradual route to change. It should be recognized, however, that this carries its own dangers. The prospect of introducing competition gradually does give existing players an enormous incentive to try to mold legislation to limit competition, meaning the advantages of new choices and services reach the consumer only slowly, if at all.

This author, together with David Kendall, has laid out an incremental approach that would use a tax credit approach to begin the process of change by creating a parallel, non-employment based system for the uninsured.[13] This "parallel universe" proposal would create offer a refundable credit for families lacking access to employer-based coverage. It would also establish a "wall of separation" designed to protect existing large employer-sponsored plans by limiting eligibility and retaining or only slightly modifying the current tax exclusion. Several bills, as well as a presidential campaign proposal by Senator Bill Bradley, also would establish a restricted parallel system for the uninsured.[14] The Butler-Kendall proposal envisions a limited federal credit while giving states greater flexibility to use existing health programs, such as SCHIP, to supplement the credit.

A goal of such an incremental strategy is to begin to establish the infrastructure described above, albeit to serve only a limited part of the working population. Over time the success or otherwise of this infrastructure could be compared with the performance of the employment-based system, and future legislation could open up eligibility for the parallel system where it appeared more effective. It is impossible to predict how the health care system might evolve under this approach, or for that matter under a more radical approach. It might well turn out, for example, that employment-based coverage would continue to be the more successful vehicle in some parts of the economy, such as for workers in large corporations with low worker turnover. Meanwhile non-employment

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[13] Stuart Butler and David B. Kendall, "Expanding Access And Choice for Health Care Consumers Through Tax Reform, *Health Affairs*, vol. 18, no. 6 (November/December 1999), pp. 45- 57.

[14] Such bills have been introduced in this Congress by, among others, Representatives James McDermott(D-WA) and James Rogan(R-CA)(HR 1819), Representative Richard Armey(R-TX) (HR 2362), Representative John Shadegg (R-AZ)(HR 1687) and Representative "Pete" Stark (D-CA)(HR 2185).

based coverage might dominate in other sectors, such as seasonal work or the service sector.

Whether through a sweeping reform of the tax system or a more limited reform, the critical point is to begin to dismantle the $125 billion-a-year tax obstacle standing in the way of organizational creativity in health care. This obstacle distorts the most basic economic relationships in the system, locking millions of Americans out of insurance coverage and leading to intense frustration among millions who do have a plan. Until it is addressed, this huge and inequitable tax bias in favor of employer-sponsored insurance will make it impossible to achieve the objective of affordable basic health care for all Americans. To be sure, a large system of non-employment based group insurance presents many challenges. But the experience of other industries is that when restrictions to entrepreneurship are removed, and there are powerful incentives to succeed, creative solutions are rapidly, and continuously, discovered.