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Stuart M. Butler

# Evolving Beyond Traditional Employer-Sponsored Health Insurance

The Brookings Institution

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# Evolving Beyond Traditional Employer-Sponsored Health Insurance

Stuart M. Butler

The Heritage Foundation

This discussion paper is a proposal from the author. As emphasized in The Hamilton Project's original strategy paper, the Project is designed in part to provide a forum for leading thinkers from across the nation to put forward innovative and potentially important economic policy ideas that share the Project's broad goals of promoting economic growth, broad-based participation in growth, and economic security. The authors are invited to express their own ideas in discussion papers, whether or not the Project's staff or advisory council agree with the specific proposals. This discussion paper is offered in that spirit.

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## Abstract

For most working-age families, health insurance coverage is directly connected to the workplace. But because of structural weaknesses in this traditional form of coverage, it is steadily eroding, especially for workers in the small business sector. The health insurance system needs to evolve along a different path if it is to adapt to the goals and needs of today's workforce. Unfortunately, existing laws and insurance arrangements obstruct that evolution. Three key steps are needed to achieve a gradual transformation without disrupting the successful parts of the system. First, states should establish "insurance exchanges." Exchanges would offer an array of coverage options, and families could retain their chosen plan from workplace to workplace with the same tax benefits as those available for traditional employer-sponsored plans. Second, most employers should become facilitators, rather than sponsors, of coverage. While many large employers would continue to sponsor coverage, most employers would hand over sponsorship to an insurance exchange and focus on providing administrative support for their employees' insurance choices. Third, the federal government should reform the tax treatment of health to focus help on lower-income families.

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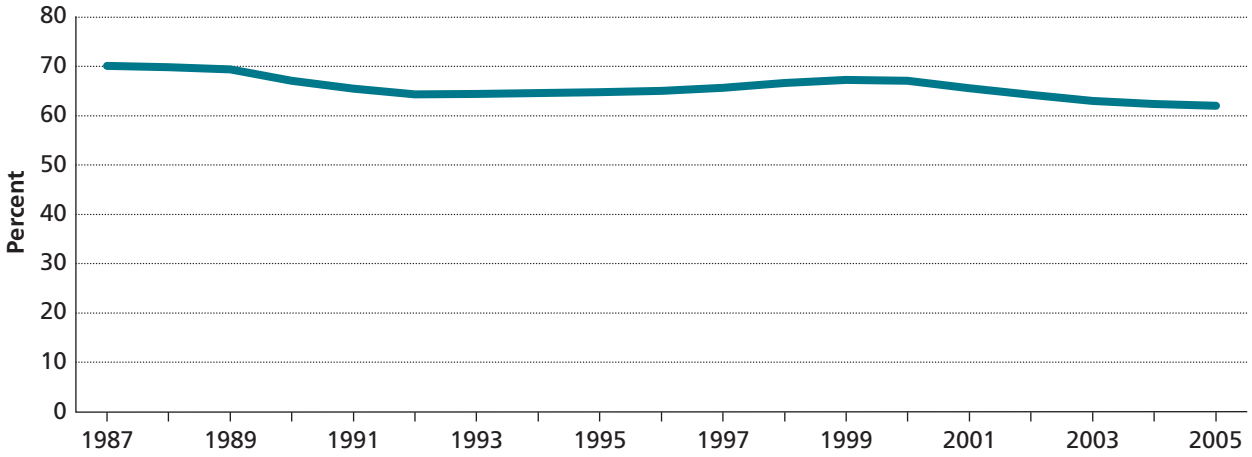
# I. Introduction

Access to adequate and dependable health insurance is one of the keys to economic security. When health coverage is uncertain or unaffordable, workers and their families face broad economic consequences and suffer personal anxiety. For most working-age families in the United States, health coverage is directly connected to the workplace. So the availability or absence of employment-based health insurance, and the structure and cost of benefits when insurance is available, affect basic employment decisions. Coverage, or the lack thereof, influences the choice between full-time or part-time employment and the decision whether to work in one company or another. Workers with medical problems may find themselves locked into a job, unable to switch to a better job or start their own business, because they dare not give up their current benefits. And older, sicker employees may feel forced to put off retirement or have difficulty finding reemployment if they lose a job. The present structure for delivering health coverage thus influences countless employment decisions, weakening the economic security of households and the efficiency of the labor market.

In addition to these effects on families with insurance, the current employment-based system fails to deliver the goal of adequate and secure health coverage for all of the working population. The Census Bureau, using revised data for 2005, reports that 44.8 million people, or 15.3 percent of the population, lacked health insurance in that year. The unrevised data, which provide more specific breakdowns, show that 17.7 percent of all full-time and 23.5 percent of all part-time employees were uninsured (U.S. Census Bureau 2006, p. 22). In fact, although most nonelderly Americans continue to receive health insurance through their place of work, the percentage has been falling over the last two decades, while the proportion who are uninsured has been rising. According to an Employee Benefits Research Institute (EBRI) analysis of Census Bureau data (figure 1), the share of nonelderly Americans with employer-sponsored coverage has been declining steadily in recent decades, from 70.1 percent in 1987 to just 62.0 percent in 2005. Over that same period the proportion of nonelderly Americans without coverage climbed from 13.7 percent to 17.9 percent (Fronstin 2003, 2006).

**FIGURE 1**

**Percent of Nonelderly Americans with Employment-Based Coverage**




Source: Employee Benefit Research Institute estimates of the Current Population Survey, 1988-2005

It is time to recognize the structural weaknesses inherent in the traditional vision of employment-based health insurance and to take steps to allow the employment-based system to evolve into a sounder model that matches more closely the needs of today's workforce. The model proposed in this paper is one based on state-chartered exchanges within which commercial insurers and other entities would offer health insurance to workers and their families. In this model the employer typically would no longer be a *sponsor* or manager of benefits, but instead a *facilitator* of coverage, handling premium payments and arranging tax relief for its insured employees. The availability of coverage, the choice of plan, and the availability of tax subsidies no longer would depend on the employer's decisions about insurance. Instead a separate system of sponsorship and coverage infrastructure would become available in the form of the insurance exchange. For those satisfied with the traditional system of employer-sponsored insurance, that form of coverage would remain: the current role of the employer as both sponsor and facilitator of insurance could continue where it works reasonably well. In either case employers would continue to play a central role in making health insurance available.

Three key steps are needed to achieve this transformation in the employment-based system in a gradual way that avoids disrupting its successful elements:

- **States should establish insurance exchanges.** Exchanges would make available an array of coverage options to working families. Use of a single, statewide insurance exchange would allow families to retain their chosen plan as they move from workplace to workplace, enjoying the same tax benefits as families in traditional employer-sponsored plans.

- **Employers should become facilitators, but not necessarily sponsors, of insurance coverage.** Sponsorship of insurance is a very different function from the management of payments. These should generally be separated. So, while many large employers would continue to sponsor coverage, most employers would hand that task over to the insurance exchange and focus on providing administrative support for their employees' insurance choices.

- **The federal government should reform the tax treatment of health insurance.** While the first two steps would significantly improve the choice and portability of insurance obtained through the workplace, combining these steps with reform of the tax treatment of health benefits would make coverage even more affordable and available to low-paid working families. Specifically, the federal government should gradually phase in greater tax relief for insurance coverage (whether sponsored by an employer or obtained through an exchange) to lower-income families and less to upper-income households than under current law.

These three steps would trigger a natural evolution of the current, employment-based system, enabling it to adjust to the requirements of today's workforce and the widely differing capabilities of employers to organize health insurance. And by rationalizing the system of tax subsidies for health coverage, while creating new options for families to obtain permanent, dependable, and portable coverage of their choice, these steps would speed progress toward the goal of universal coverage.

# II. Why the Time for Traditional Employer-Sponsored Insurance Has Passed

America's employer-sponsored insurance arrangements took root as the result of a series of regulatory accidents rather than as a conscious strategy to design an optimal health system (see box 1). Nevertheless, the system has proved popular over the years, and advocates of this peculiarly American arrangement claim a number of advantages on its behalf.

One is that the workplace is said to be a particularly good location for pooling insurance risks for group coverage. People typically join a firm's workforce for reasons other than the availability of health insurance. Employment-based pools thus have a degree of randomness in the distribution of risk within the group. This makes them in principle less prone to adverse selection, in which less healthy individuals gravitate toward more generous insurance plans, raising the group premium and thus inducing healthier participants to leave, raising premiums further and triggering a "death spiral" of ever-rising premiums. Another claim is that employers provide administrative economies of scale, so that the cost of managing workplace-based health insurance is lower than that of providing group insurance in other ways, and much lower than for individual insurance. A third claim is that employers are effective agents for employees and their families in the health care marketplace. Americans routinely pick a trusted agent, such as a financial adviser or a realtor, to help them make complex decisions or to act as their intermediary in obtaining a service. The purchase of health insurance is likewise a difficult decision, and employers are said to have particular advantages in organizing health coverage for families. Many firms have entire personnel and benefits departments that routinely negotiate benefits with service providers and can tailor coverage to employees' needs, either directly or within collective bargaining.

On the face of it, employment-sponsored insurance does seem to have these attractive characteristics.

**BOX 1**

### Why We Have Employer-Sponsored Health Insurance Today

America's employer-sponsored insurance system is unique among major countries: even Germany's work-based coverage is centered on industries rather than firms. Only in America are coverage and access to health care so dependent upon one's place of work. This system did not come about as the result of a consensus vision or explicit legislation. Although employers here, as in other countries, have always been concerned about maintaining a healthy workforce, an employer-sponsored system would not have begun, much less persisted, without three related developments:

- Wage controls imposed during World War II, which gave employers the incentive to offer, and employees to accept, uncontrolled fringe benefits, including health coverage, because benefits were not subject to controls
- A series of tax rulings, later codified in the landmark 1954 federal tax law, which exempted such benefits from taxation, providing a major tax advantage for employer-sponsored coverage
- A 1948 ruling by the National Labor Relations Board that health benefits were a legitimate subject of collective bargaining, further spurring the growth of employment-based coverage, especially in unionized firms.

For a detailed discussion of these developments, see Glied and Borzi (2004).

But it also has some severe and inherent shortcomings, particularly in the case of smaller employers and in certain sectors of the economy. In addition, the tax treatment of health insurance and certain other policies governing health care have some distorting features that lead to costly inequities and obstruct the development of better coverage arrangements. The rest of this section details some of the flaws in the employment-based insurance system. Although

these flaws do not imply that the system should be dismantled, they should prompt a reexamination, followed by action, to permit this part of the health care system to evolve in a new direction.

## Increasing Worker Mobility

The increasing mobility and changing nature of the workforce have significantly weakened the traditional argument for employer-sponsored insurance as the foundation for coverage for working families. That argument implicitly assumes that these families have a strong and continuous link with a single place of employment. But this is becoming less and less the case in the United States. As the U.S. Department of Labor (2006, especially chapters 3 and 6) notes, not only has there been a steady shift in recent decades of workers from the goods-producing sector to the services sector, where labor turnover is higher, but American workers today generally change employers more frequently. Today as much as a quarter of the workforce changes jobs every year. In addition, whereas in 1983 almost two-thirds of men in their fifties had spent ten or more years with the same employer, by 2004 that fraction had fallen to just over half. Work arrangements are also changing. During the last decade, for instance, the number of workers with alternative employment arrangements (such as independent contractors) increased by over 20 percent, to about 11 percent of the workforce, and today about 17 percent of the workforce is part-time.

This increasing mobility in the workforce and the correspondingly looser employer-employee relationship mean that employer-sponsored insurance is less able to provide working families with continuous, portable coverage. Americans do not have to requalify for their mortgage or their life insurance when changing jobs, but they do face gaps or changes in health coverage. Even if they obtain comparable coverage with another employer, that is not true portability: they may have to give up a preferred physician or switch from one drug to another that may not deal as well with their condition. And although the federal government, in enacting the Consolidated Omnibus Budget Reconciliation Act (COBRA) in the 1980s and Health Insurance Portability and Accountability Act (HIPAA) in the 1990s, has sought to cushion such disruptions in employer-sponsored coverage, these laws do not ensure meaningful portability. HIPAA does not ensure continuity of physician or other benefits for someone who leaves an employer, nor does it ensure that any new coverage will be affordable. Neither HIPAA nor COBRA coverage normally qualifies for tax relief, and so workers who leave a job can find continuous coverage prohibitively expensive.[1]

## Declining Employer Sponsorship of Health Insurance

Employers meanwhile are becoming far less dependable sponsors of insurance for their employees, and many do not sponsor it at all. Worse still, in some parts of the economy employer-sponsored coverage is especially sparse. In particular:

- **Coverage is poor or nonexistent in small firms.** An inherent problem with making the employer the basis of an insurance risk pool is that the smaller the employer, the less the pool represents a good, random mix of the general population with respect to health risk. This actuarial problem, which compounds the administrative hassles and low economies of scale facing small employers considering health coverage, results in low coverage rates in smaller firms. While, for instance, 78.9 percent of workers and dependents in private sector firms of 1,000 or more had employer-sponsored coverage in 2005, the figure was only 48.4 percent in firms with fewer than 10 employees, and only 50 percent among self-employed households. More than 35 percent of workers in firms with fewer than 10 employees were uninsured in 2005, compared with only 13.4 percent in firms employing 1,000 or more (Fronstin 2006, p. 11).

1. For a discussion of portability problems see Goodman (2006).

- **Most very small firms offer no coverage at all.** A large proportion of workers in certain types of firms are not even offered insurance. According to EBRI, data from the Census Bureau's Survey of Income and Program Participation for 2002 indicate that 54.1 percent of uninsured employees were not offered insurance by their employer (Fronstin 2005, p. 15). Firm size is the dominant factor. The annual survey of employers conducted by the Kaiser Family Foundation and the Health Research and Education Trust (2006, section 2, p. 4) found that, in 2005, only 48 percent of firms with 3 to 9 employees, and 73 percent of firms with 10 to 24 employees, offered coverage at all, compared with 98 percent of firms employing 200 or more. Another Kaiser study found that almost half the decline in adults with employer-sponsored insurance during 2001-05 was due to employers (typically small firms) dropping coverage (Clemens-Cope, Garrett, and Hoffman 2006, p. 6).

This gradual erosion of employer-sponsored insurance reveals two very different worlds. In the largest firms, employers generally continue to be stable sources of coverage for workers and their dependents (although some families, largely because of inequities in the tax subsidy system, do not take advantage of it). But in the small business sector, and especially the lower-wage services sector, uncertainty and huge gaps in the coverage available for employees prevail.

## Tax Inequities and Perverse Incentives

The tax treatment of employer-sponsored insurance creates huge inequities and perverse incentives. A major culprit is the excludability of employer-provided health benefits. Employers receive a tax deduction for contributing to insurance coverage for their employees, as they do for most other forms of employee compensation. But the health insurance part of an employee's total compensation is also excludable without limit from the employee's taxable income: workers pay no income or payroll tax on this employment-based health insurance. This is a huge tax break. Thomas Selden and Bradley Gray (2006) estimated the total revenue loss associated with this tax treatment in the personal tax code at $208.6 billion, of which the federal income tax and payroll tax components were $111.9 billion and $73.3 billion, respectively (state income tax subsidies accounted for the remaining $23.4 billion).

But this tax benefit has two inequitable features. First, only those employees whose employer selects and pays for their insurance receive it. The millions of working families whose employer does not sponsor their health coverage are ineligible for this large subsidy,[2] even if they purchase their own insurance, and even if the employer makes a financial contribution to the employee but does not sponsor coverage directly. These workers must pay for coverage with after-tax dollars.

Second, the tax benefit is highly skewed toward employees in higher tax brackets, who typically also have more generous coverage. Selden and Gray (2006) put the average tax subsidy per covered employee at $2,778. But in firms where more the half the employees are low wage (under $10.43 an hour), the average subsidy per enrolled worker was just $2,268, while for firms where more than half were classified as high wage (more than $23.07 an hour), the subsidy was $3,283, almost 45 percent higher. Further, the remaining, unsubsidized portion of an employee's health insurance is a far larger share of income for lower-income employees, leading many to decline the offer of coverage and thus forfeit the subsidy. The actual subsidy per worker for *eligible* (but not necessarily enrolled) workers in low-wage firms averaged just $673. Analyzing the subsidy by family income, John Sheils and Randall Haught (2004) estimated that, in 2004, families with incomes of $100,000 or more received an average health tax subsidy of $2,780, compared with an average of $1,448 for families with incomes between $40,000 and

2. The tax code does offer a limited deduction for self-employed individuals and certain deductions for out-of-pocket employee spending.

$50,000, and just $102 for families earning less than $10,000. Some 26.7 percent of all federal tax expenditure for health insurance went to families earning $100,000 or more, while 28.4 percent went to families with incomes below $50,000—similar proportions, but the latter group is four times as numerous (57.5 percent of families versus 14 percent).

This inequitable subsidy aggravates the general erosion of health benefits among lower-income families, especially within the small business sector. With the price of health insurance rising faster than wages, employers considering insurance as part of the compensation package now face a bill for family coverage amounting to one-third or even one-half of the total compensation they might provide to a low-skilled worker. The economic reality is that firms that do provide health coverage must offset the cost by offering stagnating or even declining cash wages to these workers. If these workers benefited from a generous tax subsidy for their health insurance, that could offset the impact of depressed wages. But without such a subsidy, employer-paid coverage is becoming increasingly unsustainable for lower-income families. Meanwhile economists point out that because the after-tax price of employer-sponsored group insurance to an individual does not closely reflect that individual's usage of services, there is an incentive for covered employees to press for more extensive benefits and to use insured services, but little or no incentive for them to seek cost-effectiveness in their insured medical care. The result is faster-rising health costs, making health care less affordable for both insured and uninsured families.[3]

## Flaws in the Employer-as-Agent Model

Some employers, particularly very large employers with a stable workforce and a sophisticated health benefits department, are effective agents for their employees in the health care marketplace. But the wide spectrum of employer arrangements and the gaps in the system suggest it is time to rethink that role. Among small firms and in the services sector, which, as noted, have relatively high employee turnover, employers may desire to provide good treatment benefits so as to reduce absenteeism but have little incentive to invest in the long-term health of their employees or their dependents, if the employee is likely to leave the firm in a few years. That helps explain why, for example, among firms that do offer insurance, only 49 percent of smaller firms (those with fewer than 200 workers) include dental benefits, while 80 percent of larger firms do (Kaiser Family Foundation 2006, exhibit 2.6).

A corollary is the phenomenon of "job lock." Consider an employee with a high-cost medical condition that is covered by the employer's insurance; such an employee may feel unable to leave the employer for a better job, because the same coverage might be unavailable at the new job. Federal law does give such employees the right to acquire individual coverage, but there are no restrictions on the cost they may face. Furthermore, the employer is in the end primarily the agent of its owners, not its employees. In the case of publicly owned corporations, the rising cost of health care and the financial condition of the firm itself inevitably force management to weigh the health care interests of its employees and their families against the business interests of the firm and its stockholders.

3. For a discussion of the relationship between low cost sharing and rising health spending, see Furman (2007). See also Antos (2006) and Steuerle (2004).

# III. The Health Exchange Plan: Initiating the Evolution of the Employment-Based System

The structural weaknesses of the employer-sponsored insurance system just outlined—increasing mobility of the workforce, rising pressure of health care costs on employers, inequities and perverse incentives in the tax treatment of health coverage, and the inability of many employers to serve as effective agents for their employees—are likely to get worse over time. As they do, they not only will increase the burdens and anxieties of those who remain insured but also will exacerbate the problem of uninsurance—the tens of millions who do without. Recognizing these inherent problems, the reform proposed in this paper seeks to restructure the employer-based insurance system. This reform, called the Health Exchange Plan, would

- **Create large, stable insurance groups for all workers so as to spread insurance risks more widely.** Insurance pools for workers in small or medium-sized firms need to be much larger and more stable over time. Insurance plans could then be made available to working families through these pools to reduce risk and minimize adverse selection.

- **Organize coverage that is continuous and portable between jobs.** For coverage to become truly portable and continuous, it must be controlled and effectively owned by the worker. That requires two things. First, the favorable tax benefits associated with coverage must no longer be conditioned on the employer selecting, controlling, and owning an employee's coverage. And second, coverage should be available through a trusted sponsor or agent other than a person's employer, so that a family can keep its chosen insurance plan as its workers move from employer to employer and when they are between jobs.

- **Transform most employers, especially small and medium-size firms, from sponsors of health insurance into facilitators of health insurance.** It is time for a fundamental change in the role of the employer in health care, separating the choice of insurance plan and organizing functions from the role of facilitating payments and paperwork. All employers should facilitate their employees' coverage decisions by arranging premium payments, adjusting tax withholdings, and perhaps contributing directly to an employee's chosen plan. But only in those cases where a firm and its employees prefer the employer to be the agent should employers continue to sponsor coverage.

- **Make tax subsidies for health care fairer and more efficient.** Reforming the more than $200 billion in federal and state tax breaks available annually could substantially increase the proportion of working families able to afford coverage. That will require targeting the tax benefit far more efficiently to those who really need it. It must also be made more equitable, so that similarly situated people receive similar tax support toward obtaining coverage, irrespective of whom they work for or where they get their coverage.

The Health Exchange Plan is predicated on the conviction that the health insurance system needs a bottom-up evolution, not a top-down revolution. The goals of the transformed system just described could, in principle, be reached through a comprehensive reform of the health insurance system for working families, for example through sweeping changes in the tax treatment of health care and a national restructuring of the insurance market. But there are reasons why such a "revolution" approach would not be wise.

For one thing, as President Bill Clinton discovered in his efforts to transform the system in the mid-1990s, Americans are quite conservative about their

health care. They may tell pollsters that they think the current system needs a complete overhaul, but those with coverage are simultaneously reluctant to see big changes in that coverage, other than to make it cheaper (see, for example, Blendon et al. 2006; Blendon, Benson, and DesRoches 2003). In the health insurance domain, it is important to introduce change gradually, so that people with coverage can adapt.

It would also be unwise to change direction sharply because health care constitutes about one-sixth of the nation's economy, and any major change in the foundations of the employment-based part of the system would have large and complex effects that cannot be predicted with certainty. In addition, a sudden and complete transformation of the tax treatment of health insurance, even if beneficial, would lead to big changes in the tax liability of families and likely would trigger political concern and opposition. So, although it is important to have certain strategic goals as a compass, it makes sense both to proceed gradually and to allow a variety of approaches in different places to be tried and compared. Thus it also makes sense for the states rather than the federal government to take the lead in designing reform, to foster such experimentation and variety. That is how policymakers will best learn to address the complexities of insurance design and health care arrangements.

The first steps of the transformation should focus primarily on those who are served least well by the current system, namely, working families in the small business sector. Creating an architecture that meets the needs of those Americans is most urgent and would provide a working model for others to consider embracing. To be sure, transformation should not be limited to small firms at this early stage. But if it appears successful and attractive for small firms, that would increase the probability that workers and employers in other firms would likewise accept reform, encouraging the rest of the employment-based system to follow.

BOX 2

### Summary of Proposed Policy Changes

**To create insurance exchanges:**

- States would charter the exchanges under state law, much as they now charter such special-purpose nongovernmental entities as state universities. The state would determine such things as the infrastructure for handling premiums and the regulations governing entry requirements and the operation of plans in the exchange, as well as establishing pooling and risk adjustment mechanisms.
- The state would decide whether or not to make the exchange the sole place through which commercial health insurance could be sold to individuals and employer groups.
- The federal government, through regulation or statute, would clarify that employer contributions to an exchange have the same tax-free compensation status for employees as contributions to a traditional employer-sponsored plan.

**To establish a system of employers as facilitators:**

- States would establish procedures whereby premiums collected through payroll deductions would be transmitted to the insurance exchange.
- The federal government would require firms using an exchange to adjust employee tax withholdings to reflect available tax relief, and to establish payroll deduction arrangements compatible with the state insurance exchange's premium aggregator system.

**To reform the tax treatment of health insurance:**

- The federal government would cap the present tax exclusion for employer-sponsored insurance and create a refundable, advanceable, and assignable tax credit for lower-income families.

What would a transformed employment-based system look like ten or twenty years from now? It is impossible to say with certainty, because the exact complexion of employment-related coverage would change over time to reflect household preferences and the manner in which employers adapt to the changes. The proposed reform envisions an employer-as-facilitator arrangement (typically for small and medium-size firms) operating in parallel with the traditional employer-as-sponsor model. But the relative importance of these two types of arrangement in the transformed system is hard to predict. It might turn out that the employer-as-facilitator model is a major improvement for most workers, but that the traditional employer-sponsored system continues to be more attractive for others, such as those who work for very large firms, where the goals of the proposed transformation are already largely in place for long-term employees.

Whatever the pattern turns out to be, the proposed reforms would enable employment-related coverage to adapt in ways that it cannot today. And however the employer-based system changes over time, taking the proposed steps would enable the system to become a pathway to universal coverage rather than an obstacle to that goal.

Three sets of government actions are required to enable the current employer-based system to evolve into a system that incorporates the goals discussed above:

- States should establish "insurance exchanges" to enable families to select their coverage from a wide range of choices, and to retain their chosen plan from job to job. Within this structure, religious, civic, and other organizations should be allowed to function both as plan sponsors and as agents.

- States and the federal government should introduce rule changes and incentives to encourage employers, especially small employers, to become facilitators of health insurance for their employees.

- The federal government should gradually reform the tax treatment of health care spending. Specifically, it should cap the tax exclusion for employer-sponsored health insurance and gradually transform the exclusion into a refundable tax credit for health coverage.

## Establishing Insurance Exchanges

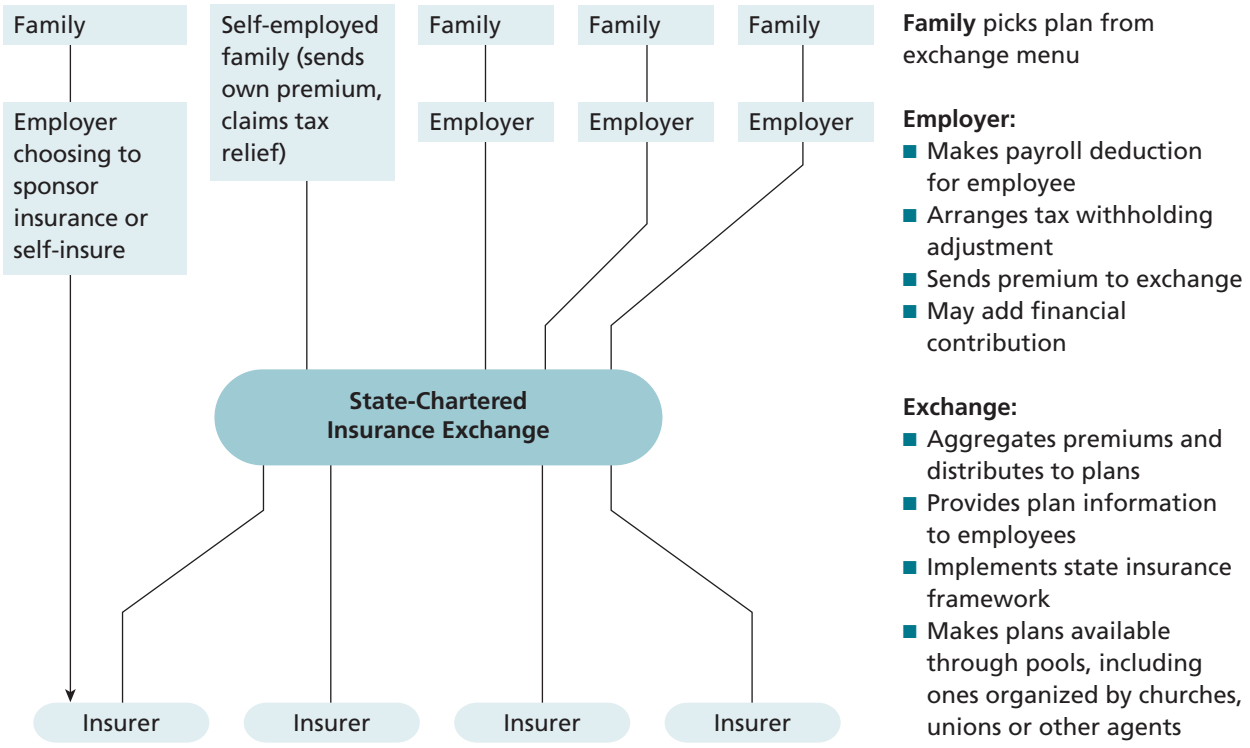
Under the proposed Health Exchange Plan, states would charter insurance exchanges under state law, much as they now charter special-purpose nongovernmental entities such as state universities. These exchanges would in effect be market clearinghouses within which insurance providers would compete to offer workers portable health plans within a framework of standardized administrative procedures and uniform insurance rules. Each insurance exchange would thus function much like a stock exchange, in that the exchange does not itself sell the stock or the health plan but rather provides the venue and regulates the offerings and transactions.

Each state would determine on its own such features as the infrastructure for handling premiums, as well as the regulations and requirements for accepting insurance plans into the exchange. The state also would be responsible for determining pooling, reinsurance, and risk adjustment arrangements and the degree to which firms would, if at all, be required to offer plans available through the exchange to their employees. Some employers would be exempt from such state requirements, notably those sponsoring insurance under federal Employee Retirement Income Security Act (ERISA) regulations, and could continue to sponsor insurance in the same way that they do today if they chose to do so.

Workers eligible for traditional employer-sponsored coverage would not be able to join plans offered through the exchange as individuals. They would have to obtain coverage through their employer and so could obtain an exchange plan only if their employer was using the exchange..

FIGURE 2

**How the Health Exchange Plan Would Work**




The federal government would encourage the use of such exchanges by clarifying that employees obtaining coverage from firms using the exchanges would enjoy the same tax breaks as employees with traditional employer-sponsored insurance.

Employer-sponsored insurance was intended to provide stable group health insurance. But as discussed earlier, for millions of Americans it fails to do so efficiently or, in many cases, at all. To deal with these shortcomings and ensure group coverage that spreads risk and keeps premiums stable, insurance arrangements meeting certain key criteria are needed. One criterion is that the groups created be large enough for the group rate to be stable and predictable, not constantly fluctuating because sometimes a small number of its members incur unusually high medical expenses. Another criterion is that groups be reasonably stable in terms of risk composition over time. If people with medical risks well above the group median migrate into the group, or if healthier people migrate out, it can destabilize the group, leading to a spiraling of rates. Voluntary insurance associations are particularly vulnerable to adverse selection, as sicker people join in order to save money, and healthier people leave because the now-rising group rate makes individual coverage more attractive. A third criterion is true portability: workers should typically be able to retain the coverage that is right for their family even if they change jobs.

States can best ensure these characteristics by establishing insurance exchanges that offer stable, portable coverage through large groups for those workers and their families who currently lack such coverage.

An exchange is important to achieving a transformed system because it does two things. First, it provides what have been described as the "market organizer" and "payment aggregator" functions

needed so that working families without adequate coverage today can obtain coverage that mimics the best features of traditional large-employer coverage (see Haislmaier and Owcharenko 2006). And second, by designing the exchange to dovetail with federal employee benefit law, it makes possible a seamless facilitator role for employers. Various forms of exchanges have been proposed, such as by Alain Enthoven (2003; see also Singer, Garber, and Enthoven 2001).

Although states do not need federal legislation to create exchanges, explicit clarifications of federal rules would encourage states to establish them. Under today's federal law, for instance, employees pay no income or payroll tax on compensation in the form of an employer contribution to an employer-sponsored health plan. A Treasury ruling or a declaratory federal law stating that the same tax exemption would apply to any contributions toward coverage made through a qualified state health insurance exchange would remove any lingering uncertainty for states. Such a ruling or law would relieve the employer and the exchange of having to go through the legal artifice of the employer "sponsoring" a separate "plan" and the exchange contracting to "administer" the plan. There should be additional federal regulatory or statutory clarifications in other areas, such as the application of nondiscrimination rules to employer contributions for coverage in an exchange where plans are sold on an age-rated basis (that is, with different premiums for participants of different ages).

Insurance exchanges would not be costly to implement, because in reality they would merely take over and centralize the existing sponsorship functions of the typical large firm, and the administrative costs could be factored into the price of insurance offered through the exchange.

**Existing models.** Models currently exist of what insurance exchanges would look like and how they would function. The state of Massachusetts made an insurance exchange, which it dubbed the "Commonwealth Connector," a core part of its new health insurance system, and other states are developing similar legislation (Haislmaier and Owcharenko 2006). The Federal Employee Health Benefits Program (FEHBP), an older example of an exchange at the national level, covers about 8 million federal employees as well as retirees. Although technically a traditional employer-sponsored program (the employer being the federal government), the FEHBP in practice works like a giant exchange with complete plan portability across the various federal agencies and congressional offices.

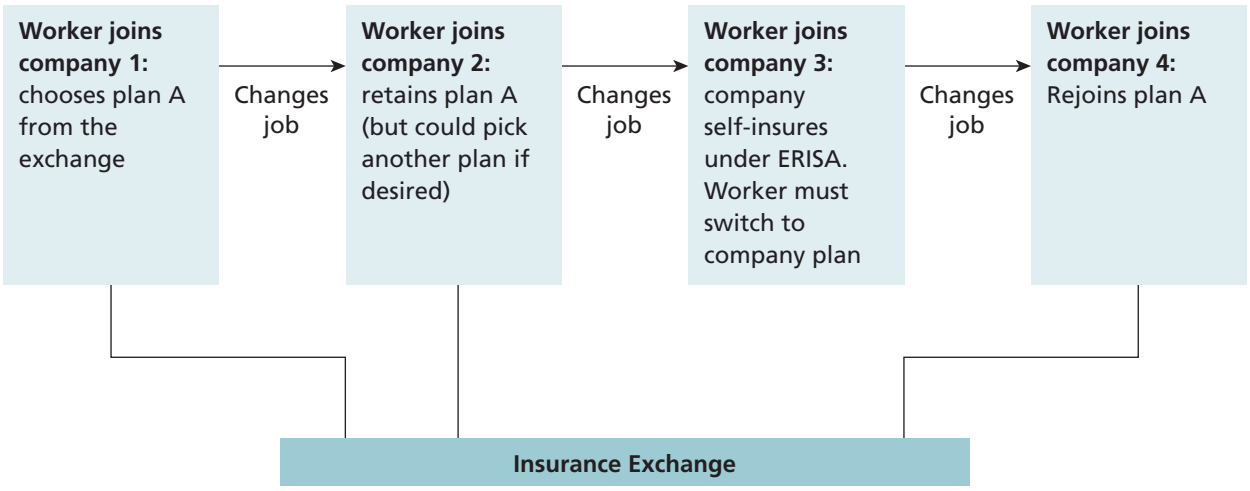
The Office of Personnel Management (OPM) administers the FEHBP. Once OPM has approved a wide range of national and local plans, it is the employee or retiree, not his or her immediate employer (a member of Congress, say, or a federal judge, a federal agency, or even the Postal Service), who chooses the plan. The government makes a significant tax-free contribution to each plan, and OPM handles the administrative details. Plans must meet certain basic conditions and must provide the OPM with standardized information on their benefits and terms. OPM then distributes enrollment information to beneficiaries and manages the premium collections and payments to plans. Although many of the FEHBP plans are available only in certain areas, and some are restricted to certain categories of employees, most federal workers have access to the same wide range of plans, whether they work in a small congressional office or a huge agency, and they can retain the same plan if they switch federal jobs or retire.

As Edmund Haislmaier and Nina Owcharenko (2006) explain in their discussion of the health exchanges developing in Massachusetts and other states, the basic insurance exchange structure has several important features that make it more practical than the traditional employer-sponsored alternatives:

- **It makes coverage more available and portable.** Once an employer makes the exchange its "employee welfare benefit plan" for purposes of

FIGURE 3

**How Portability is Achieved under the Health Exchange Plan**
(for a family with four employers over time)




federal law, the firm's workers and their dependents have access to the plans available through the exchange, which enjoy the same tax and other benefits as employer-sponsored coverage. These benefit plans are made available by but not run by the employer. So, if an employee switches jobs, he or she can retain the previously chosen plan without restriction (see figure 3). The firm does not have to negotiate with plans or create its own self-insured plan, as under traditional employer-sponsored insurance. Firms can also prorate coverage contributions for part-time employees, with the expectation that the worker will be able to get full coverage directly through the exchange, funding the balance of the premium out of other family earnings, most likely from another job held by the employee or his or her spouse. Self-employed individuals can also join directly simply by virtue of being a resident of the state.

- **It acts as a premium aggregator.** In the FEHBP the premiums for each worker's chosen plan are deducted from the worker's paychecks and combined with the government subsidy for federal employees, and the aggregate amounts are transferred by OPM to the insurance providers. This sharply reduces the paperwork and other complexities for federal employees and for individual federal offices and agencies. In addition, OPM provides plan information to employees and organizes an annual "open season," during which employees can switch plans. The exchange system proposed here would include a similar "premium aggregator" and informational role. For employers participating in its exchange, Massachusetts is creating a uniform payroll withholding system that operates much like federal and state tax withholding and like OPM's system for the FEHBP. In this way administrative costs can be reduced, and the exchange's responsibility as a clearinghouse reduces the payment risk that insurers build into their premiums.

- **It provides a framework for insurance rules and pooling.** Plans offered through an exchange, like plans offered through the FEHBP, have to comply with a set of state insurance rules (federal in the case of the FEHBP) intended to make coverage affordable, portable, and consistent. To maximize the effectiveness of an exchange in helping manage risk for plans and for families, states would have to set uniform minimum benefit and rating standards as well as

procedures for handling high-risk individuals. States also would enact laws governing carrier solvency, actuarial sufficiency (are the premiums to be charged for the plan likely to cover the expected benefit payments?), and market conduct (such as the insurance provider's business practices for offering coverage and handling claims).

- **It increases the availability of plans offered by trusted agents.** The exchange provides a framework in which plans can be offered not only by commercial insurers but also by not-for-profit organizations acting as sponsoring agents. Just as union-sponsored plans are available under the FEHBP, so plans sponsored by unions, religious groups, and other organizations could be offered through an exchange. Exchanges would foster such trusted-agent plans for several reasons. For one thing, with plans contracted through exchanges deemed equivalent for tax purposes to employer-sponsored plans, the tax disadvantage faced by such plans when sold in the current individual market would disappear. For another, an exchange with a risk adjuster would minimize the adverse selection bias for or against a plan that appealed to a particular social group, and so organizations with generally sicker or healthier groups would not destabilize the market. The same would be true of plans that tended to attract individuals with certain specific medical conditions based on data showing that they do a superior job of managing the costs and outcomes associated with that condition.

**The critical federal role.** The federal government has a critical role in facilitating state insurance exchanges by making it clear that employees obtaining coverage through the exchanges would enjoy the same tax breaks as employees with traditional employer-sponsored insurance. The federal government has already indicated that state exchanges meet the requirements of an employee welfare benefit plan, with the exchange deemed the plan administrator. And the Treasury has indicated that money collected by an employer and sent to an exchange carries the same tax benefits for an employee as money for an employer-sponsored plan. Thus the federal government appears to treat a plan obtained through an exchange much like one obtained through the FEHBP. But to remove any remaining uncertainty or ambiguity, either the Treasury should issue a clear ruling on the tax treatment of contributions to an exchange, or Congress should enact clarifying language.

**The central role of employers.** The Health Exchange Plan envisions employers being the access point to the insurance exchange. But the proposal is compatible with various ways of accomplishing this, from voluntary contracts with the exchange to a state mandate for certain classes of firm to take part.

Self-employed individuals could join the exchange directly, and in principle, it would be reasonable to allow non-self-employed workers to join directly as well. There are good reasons, however, for a state to make employee access to an exchange contingent on his or her employer contracting with the exchange to provide coverage.

One reason is that employers have become efficient facilitators of payments. If policymakers had decided to construct an exchange system before the advent of employer-sponsored insurance, they might well have chosen to allow all working families to join directly. But decades of employer involvement in benefits have created an infrastructure of payroll deduction procedures, tax withholding, and other roles for the employer that makes the place of employment a practical entry point for health insurance, even in the case of small firms.

In addition, the experience with payroll deductions for pensions and health coverage indicates that even if employees are not required to sign up, making it easy to do so at the workplace does increase the probability that the employee will take the offered benefits. So, in keeping with the vision of the employer as a facilitator, there is good reason on behalf of families to encourage employers,

even small firms, to designate an exchange as their source of coverage and so make that coverage more accessible for their employees.

**Limiting adverse selection.** Gaining employer acceptance of exchanges also requires steps to limit the threat of adverse selection. An employer who willingly provides insurance today will understandably worry that if individual employees have the ability and incentive to pick and choose between the firm's group coverage and another arrangement, adverse selection could undermine the employer's group plan. The fear of adverse selection is a reason why employers who offer coverage often resist tax credit proposals or other proposals they fear would induce healthier employees to pull out of their plan.

The need to limit such adverse selection underscores why the Health Exchange Plan envisions employers as the point of entry to the exchange system, with states determining the details. Firms currently regulated under ERISA would not be required to take part in state-initiated exchanges and could continue their current forms of coverage—but they could join if they wished. That is why the employer decides whether or not all its employees will have access to the exchange, and why employees with employer-sponsored insurance would be allowed to use the proposed tax credit only for that coverage, if it is available. Over time, however, one might expect more and more employers to opt for an exchange as their designated source of coverage as they and their employees come to see the advantages.

## Employers as Facilitators, Not Sponsors

Under the Health Exchange Plan, employers choosing to use the exchange, or required to do so under state law, would have two key functions: handling their employees' tax relief, and organizing the collection and payment of premiums to the exchange. Accordingly, employers using an exchange would be required under federal law to do two things. First, they would have to adjust employee tax withholdings to provide employees with tax relief for payments made to the exchange. Second, they would have to arrange an automatic payroll deduction and payment system, much as many do today for flexible spending accounts or for savings plans such as 401(k) retirement plans and 529 college savings plans. This deduction system would have to be linked to the payment aggregator system administered by the exchange for premium payments.

For those typically larger firms that choose to continue to sponsor insurance under ERISA or within the bounds of state insurance law, there would be no change and no new requirements.

Creating an insurance exchange with the same tax benefits to employees and employers as traditional employer-sponsored insurance would allow employers to delegate most insurance selection and management—the health care human resource functions—to the exchange. They would retain only the basic bookkeeping functions that make the workplace a convenient and efficient location to sign up for health insurance or for savings plans.

This separation of employer sponsorship and facilitating functions would be good for employees, since it would increase their choice of tax-advantaged plans, by providing access to plans available through trusted agents in the exchange rather than only plans selected by the employer. Families with plans obtained through a state insurance exchange would also gain the certainty and true portability of coverage that millions of working families lack today.

The separation would also be good for employers. While the typically larger firms that are comfortable with traditional plan sponsorship could continue to organize and manage employee coverage, other employers could avoid those headaches. Yet they would also have an important new way of providing health benefits via the workplace—benefits that would typically be more attractive than those available through the vast majority of firms today,

with expanded choice and improved portability. By delegating the cumbersome sponsorship functions, these employers could then focus greater attention on their core business activities. In addition, with the exchange itself distributing the insurance risk associated with higher-risk families, employers opting for the exchanges would have few or no concerns about potential medical problems associated with new hires.

Separating the sponsorship and facilitation functions would actually make it more attractive for smaller firms to make coverage available to employees, and even to contribute to it. With the exchange available as a source of coverage, small firms could offer access to a range of coverage that is normally unthinkable for them to offer today. And free of the administrative complexity and selection risk, many such firms likely would decide to contribute to comprehensive benefits (for example, through a defined financial contribution) rather than struggle to offer less adequate benefits themselves as they often do today.

It is important, however, to appreciate that a system based on employers as facilitators rather than as sponsors is not the same as moving in the direction of defined contributions: the facilitator role refers to a separate mode of coverage and is compatible with either a defined-contribution or a defined-benefit model. For firms and employees pursuing a defined-contribution arrangement, the exchange, together with the employer in its facilitator role, would enable workers to steer such contributions toward a plan that is portable and most in line with their needs. But combining an exchange with an enhanced facilitator role for employers also would enable those firms committed to defined benefits—especially smaller firms with limited insurance expertise—to offer portable coverage and greater choice. The reason is that, within this framework, an employer can still commit to financing the actuarial value of a specified benefit package, while allowing the employee to select an exchange-sponsored plan with employer funds based on the cost of a defined benefit. In effect, the FEHBP works in this way, since the government commits to a contribution based on the premium cost of specific benchmark plans, and so the contribution is indexed to specific benefits rather than to a defined cash contribution.

**Delivering tax relief through withholding.** The facilitation role would be nothing new for firms. Employers of all sizes today are required by federal law to carry out such a role in the tax system. They must distribute IRS (and typically state) tax withholding forms to workers, deduct appropriate amounts from paychecks for payroll and income taxes, and remit the money to the government. When the employee claims tax deductions and credits, such as a mortgage deduction, a child credit, or the Earned Income Tax Credit, the employer must adjust the withholding accordingly. But although employers facilitate the operation of the tax system in America, they do not sponsor it. And even smaller firms neither face undue hardship in carrying out the withholding obligation nor serve as tax accountants or advisers for their employees.

Under the Health Exchange Plan, the only change would be that this requirement to adjust tax withholdings would also apply to contributions made to a health insurance plan within an exchange. Employers would have to adjust for whatever federal and state tax relief applied, including any new tax credits (see below). The burden on employers would be minimal. A recent major survey sponsored by the Commonwealth Fund found that 76 percent of large employers and 88 percent of small firms (those with 3 to 199 workers) expressed willingness to administer a tax withholding mechanism to deliver a tax credit (Whitmore et al. 2006, exhibit 3, p. 1673).

**Collecting and remitting premiums through payroll deductions.** Employers of all sizes commonly act as facilitators for their employees who contribute to retirement and other savings plans, such as 401(k) plans and 529 plans. The employer arranges a payroll deduction, adjusts the tax withholding, and in many cases also makes a financial contribution. A critical feature of such employer-facilitated savings plans is that they are portable: the

plan and its tax benefits follow the employee from one employer to the next, and the plan remains with the employee if he or she leaves the workforce.

Under the Health Exchange Plan, employers could and should facilitate portable, tax-preferred health insurance in a similar way. If a state established an insurance exchange and an employer made the exchange available to its employees—either voluntarily or as required by the state—federal law would require that employer to arrange a payroll deduction system for the employees and to make payments to the exchange on their behalf. In turn, the exchange would provide standardized and unbiased information on available health plans, in accordance with its obligations under federal law as the plan administrator. Workers would pick the plan they wished, and the employer would consolidate and remit regular payments to the exchange, making appropriate adjustments to each worker's paycheck after adding whatever financial contribution the employer had agreed to make. The exchange then would aggregate the premium payments and disburse them to the plans according to their enrollments.

Although a requirement to establish a payroll deduction system would be a new obligation for some firms, particularly very small ones, the burden has been sharply reduced in recent years thanks to improved computer technology and the ready availability of contract payroll management companies. Perhaps not surprisingly, then, the Commonwealth Fund survey also found strong employer willingness to set up payroll deduction arrangements to assist employee enrollment in non-employer-sponsored coverage. Some 73 percent of large firms and 88 percent of small firms expressed willingness to organize payroll deductions to pay the premiums for government-administered health programs (Whitmore et al. 2006).

## Reforming the Tax Treatment of Health Insurance

Under the Health Exchange Plan, Congress would enact a cap on the existing unlimited exclusion of employer-sponsored insurance from taxable income, while also phasing in a refundable, advanceable, and assignable tax credit for lower-income families. Amounts above the cap would become taxable for employees above a certain income. The cap would be indexed each year to the consumer price index (CPI). Workers eligible for the credit could use it only for health insurance. They would have to use it for plans offered through a state insurance exchange if their employer made the exchange available to them. If instead their employer sponsored coverage, they would have to use it for that insurance.

The changes proposed so far would be important steps toward the goal of health care security for working American families through a rationalized employment-centered system. De-linking the sponsorship of coverage from the facilitation of coverage at the workplace would lead to significant improvements in the availability of coverage through a gradual evolution of the current system. De-linking the existing tax breaks for health coverage from direct employer sponsorship would also be a significant step toward a fairer and more efficient tax subsidy system. It would achieve greater "horizontal" tax equity: tax benefits would become more similar for comparable families in different employment situations.

But even with these improvements in horizontal equity, the "vertical" inequities would remain. The tax treatment of health care would still provide large subsidies to upper-income families with generous employer-sponsored insurance, and inadequate or no subsidies to lower-income families struggling to afford even modest insurance. Thus reforming the tax treatment of health insurance is the third key piece of the reform equation. Although structural tax reform is not necessary for the evolution of today's employment-based system into a postindustrial model, it would sharply increase the new model's ability to provide health security to lower-paid working Americans.

Economists and health analysts broadly agree on the general outlines of a desirable reform of the tax

treatment of health insurance. On one side of the tax ledger, reformers would taper down, and some would eventually end, the personal income tax exclusion for employer-sponsored health insurance, at least for upper-income households. This would reduce the importance of health insurance as a tax-free fringe benefit or eliminate it altogether. But to make the tax subsidy for health coverage more equitable, reformers would simultaneously phase in a tax credit for health insurance, whether obtained from the employer or from other sources. In this way the tax subsidy would gradually be refocused onto those who most need help and would no longer be confined to employer-sponsored insurance.

Several large-scale versions of this restructuring have been put forward as legislative or policy proposals, including by this author (Butler 2001). Because of the impacts of the current tax breaks on tax revenue and household incomes, however, any large-scale and rapidly implemented reforms would involve significant transfers of tax benefits and significant disruption. Those major financial effects, in tandem with the general reluctance of Americans to countenance rapid change in their health care situation, make a radical redesign of the tax treatment of health care over a short period unwise. More gradual and limited steps are needed.

**Place a cap on the tax exclusion.** Under the Health Exchange Plan, Congress would enact a gradually tightening cap on the value of the tax exclusion for employer-sponsored health insurance, while simultaneously introducing a tax credit for low-income families. The value of sponsored benefits above the cap would be taxed as cash compensation for families above a certain income. Such a reform could be made revenue neutral over time. Or it could involve new net tax benefits. Or it could be designed to achieve a net reduction in the projected growth of the tax subsidy, which could help to dampen the escalation of health costs generally, yielding potential savings in public as well as private health care costs (see Antos and Rivlin 2007).

The cap would be set high enough to initially affect only a relatively small proportion of Americans, thereby limiting the political resistance. However, the cap would be indexed at a rate lower than the current anticipated cost escalation of employer-sponsored coverage, such as the CPI, so that over time a steadily larger number of employees would be affected. The cap in the plan offered in 2007 by President Bush ($15,000 for family coverage and $7,500 for individuals) may be unduly high (the average family plan costs approximately $11,000) but is probably more politically achievable in the short term than a tighter limit.

Under the proposal, the value of plans offered to employees in excess of the cap would become taxable only for households above a certain threshold income, in the same way that a portion of Social Security benefits is taxable above a certain income. Families with more modest incomes could enjoy comprehensive coverage and still not be affected. The income threshold would not, however, be indexed. The combination of a CPI-indexed cap and a nonindexed income threshold means that, over time, an increasing proportion of plans and of households would be subject to the limit on the exclusion.

The impact of the cap would depend on how employers and employees responded to the tax reform, but it is likely that there would be gradual and actually beneficial effects over time. One effect would be a long-overdue rebalancing of compensation. In recent years total compensation has grown quite strongly in the United States, while cash earnings have not. The reason for this, especially since 2000, has been that tax-free fringe benefits have risen as a proportion of total compensation. The present unlimited tax exclusion encourages this trend. A limit on the exclusion would encourage employees to consider accepting more of their compensation in other forms. Some might opt for more tax-advantaged education and retirement savings, while many would opt for more cash income. Another long-term effect would be to encourage employees, not just employers, to press for more economical health services in the future.

**Create a refundable, advanceable, and assignable tax credit for lower-income families.** Several lawmakers have put forward tax reform proposals designed to replace the current federal tax exclusion (in whole or in part) with a federal tax credit to help make health insurance more affordable for lower-income families.[4] A credit is more efficient and more vertically equitable than a deduction or an exclusion. A credit also is more flexible and can be calibrated to concentrate most or all of the tax subsidy on lower-income families. Some proposals use simple credits, while others (for example, Butler 2001) recommend more complex credits designed to address various goals, such as minimizing work disincentives and adapting the credit for families with severe medical needs.

The most practical form of tax credit for a lower-income family would cover most of the cost of a reasonable level of coverage in the family's geographic area while retaining the incentive to seek value for money. Families with incomes below 200 percent of the official family poverty level (the FPL is approximately $20,000 for a family of four), for instance, could be made eligible for a federal tax credit to offset 90 percent of the cost of a health plan, capped at the average cost of major basic plans in the state. If an employee were offered coverage through the workplace, the employee could use the credit for that coverage only, and the credit would apply only to the out-of pocket costs the employee incurs under the plan.

The structure, which is open to many variants, is intended to achieve certain important goals. One is to ensure that the credit covers most of a base insurance plan for lower-income families wherever they live. Analyses indicate that many are unwilling or feel unable to do so unless the net cost (including both out-of-pocket costs and premiums) is close to zero (Sheils and Haught 2003, pp. A6-A8). A second goal is to balance costs and work incentives. A dilemma with credits and other subsidies is whether to phase them out rapidly as income rises, in which case the effective marginal tax rate can be very high and work is discouraged, or gradually, in which case the budget cost is very high as less needy families are subsidized. This proposal envisions ending the credit abruptly once income eligibility is exceeded, to keep the arrangement simple and costs down. Such "cliff" approaches exist today in several major programs, such as Medicaid and SCHIP (the State Children's Health Insurance Program), and the negative impact on work is acceptable. A third goal is to prevent tax "double-dipping." Since workers with employer-sponsored coverage already receive an exclusion, the credit is limited to out-of-pocket insurance costs.

The credits in the Health Exchange Plan would be refundable, advanceable, and assignable. Since millions of lower-income families pay little or no federal income tax, a credit would have to be refundable in order to provide any assistance, such that families whose calculated credit exceeded their tax liability would receive the difference in cash from the government. Advanceability—meaning that the credit would be available through the year rather than only at the end of the tax year—is important because otherwise many lower-income families would likely be unable to pay their premiums when due. Such an advanceable credit could be factored into withholding calculations at the place of work and into the proposed payroll deduction for premium payments. Finally, assignability means that the credit could be transferred from the individual to the chosen health plan in return for a reduced premium—much like in the FEHBP, where the government subsidy for the federal worker is paid directly to the plan and the premium is correspondingly reduced. This is simple and particularly helpful for families who do not earn enough to have to fill out a tax return.

4. An example is the Tax Equity and Affordability Act (S. 3754), introduced in 2006 by Senator Mel Martinez (R-FL). A bill proposing a comprehensive restructuring of the tax treatment of health care, replacing the entire tax exclusion with a refundable tax credit, was introduced in 1993 (S. 1743, H.R. 3689) by Senator Don Nickles (R-OK) and Representative Cliff Stearns (R-FL).

# IV. Possible Variations on the Basic Proposal

The three-part proposal outlined above contains several precisely specified features. But a number of variations in these features would also be compatible with the broad goals.

## Designing Insurance Exchanges: State and Federal Roles

The Health Exchange Plan views insurance exchanges as the most promising vehicle to accomplish the goal of a state-based framework for insurance plans to achieve more effective pooling, better spreading of risk, and real portability. But the details of regulations to reach those goals is left to the states, on the grounds that they are best placed to develop rules for their particular situation and to experiment with new approaches.

To be sure, there are differences of opinion as to what the best state rules would be. While the Massachusetts legislation requires tight community rating (all persons in a given community pay the same premium), exchange proposals in Maryland and the District of Columbia permit rating bands based on age and other criteria (Haislmaier and Owcharenko 2006, pp. 1584-85). States should experiment with alternative strategies for constructing large, stable pools for coverage through the exchanges. One possible way to stabilize a voluntary pool, for instance, is to charge lower premiums to those who remain insured within the pool than to those who move in and out of coverage. The Maryland and D.C. proposals, for example, would allow insurers to impose premium surcharges and some restrictions on preexisting conditions on persons who have gaps in coverage (Haislmaier and Owcharenko 2006, p. 1585). In addition, states could encourage the offering of long-term insurance contracts.

To arrange stable and affordable coverage, states also need to experiment with ways to adjust for selection effects among plans within the pool. Age-related premium bands, for example, would make coverage more affordable for younger, healthier individuals, inducing those who are better risks to participate in the pool. States might also apply reinsurance or insurer "risk-transfer" pool requirements to all coverage sold within a state, whether inside or outside of the exchange. The Maryland and D.C. proposals would establish such a special "back-end" risk adjuster, with all insurers required to contribute to a common pool, from which payments would be made back to the insurers to adjust for disparities in enrollment levels of high-cost individuals.[5]

An insurance exchange would ensure true portability of insurance within a state for the families of workers who move between employers offering access to the exchange (assuming the insurance plan is available in their new neighborhood if they move within a state). To achieve portability across state lines, states might draw up agreements to link their exchanges and to allow transfers between states.

**A national insurance exchange?** Some might argue that a national exchange, or set of national exchanges, would be better and more practical than state-level exchanges. To be sure, states do vary in their capacity to develop and implement innovative proposals such as health exchanges. But establishing a federal system of exchanges would not be a wise variant of the proposal.

For one thing, the regulation of insurance in the private sector is primarily a state function. Thus any attempt to create a national exchange, or to introduce federally designed exchanges at the state

5. Interestingly, the problem of adverse selection in the community-rated FEHBP is less severe than might be expected. A probable explanation, write Curtis Florence and Kenneth Thorpe (2003), is that the premium subsidy level for federal employees is sufficiently large that even though employees seek good value at the margin, many healthier employees still choose very comprehensive benefits.

level, would immediately be sidetracked into a debate over the federal preemption of state insurance laws and the form and structure of the new federal regulations that would be applied to plans sold through a national exchange. Second, those families who would benefit most from an exchange are typically those employed in small or medium-size firms in one geographic location, and a state-based reform design can more easily address local conditions. Third, although certain general characteristics of an exchange are essential if it is to achieve the goals of reform, there are many different ways to design the details to accommodate different local conditions. Finally, it is generally easier to get important changes under way with an evaluation or demonstration project on a smaller scale, which would yield valuable experience and evidence that might shape broader national reforms later. This does not mean that every state must be an innovator. As with most state-based innovations in public policy in other areas, such as welfare and education, certain states would likely take the lead in designing exchanges while others would tend to follow.

**"Outcome-based" state rules to foster coverage through exchanges.** State-based rules for insurance exchanges could still be harmonized with national goals for reducing the number of uninsured without unduly restricting state flexibility and innovation. The proposed state-centered approach, for example, is compatible with proposals that would condition tax relief and federal health funding on plausible state action to make insurance available and affordable. The approach is also compatible with bills now before Congress that would encourage states to propose to the federal government a range of steps to reduce uninsurance within their borders, including congressionally enacted legislative waivers from existing federal laws and programs. These bills would provide waivers and federal grants for an experimental period, depending on how successful the state was in reaching agreed outcome measures.[6]

## Employer and Individual Mandates

The Health Exchange Plan does not include a mandate on employers to participate in the exchange, but states could decide to include one (excluding ERISA-regulated employers choosing to retain their company plan). States could also decide whether or not to require employers to contribute to an employee's plan through an exchange, although such a requirement would surely be offset by reduced wage compensation.

It might be argued that the Health Exchange Plan would be more likely to reach the goal of universal coverage if it contained an individual or employer mandate (or both). To be sure, the proposal is compatible with the idea of individual or employer mandates and could operate smoothly if a state were to introduce such requirements. That would be up to the state, in keeping with the state-centered approach. But the proposal is designed to begin a gradual evolution of employer-based coverage with the active support of employers. An employer mandate risks triggering opposition from the key business constituency, while perpetuating the myth that employers "pay for" coverage when the cost really comes out of total compensation.

A limited form of individual mandate can be justified as a way of enforcing appropriate personal responsibility in a society that underwrites emergency room care for the uninsured. Nevertheless, the proposal omits an individual mandate for two reasons. The first is that such a mandate is unfair unless the individual or family has the means to carry it out. Perhaps when all the tax reforms proposed above are fully implemented, all individuals and families

6. Bipartisan bills now before both houses would significantly change federal law and allow states to make significant changes in their law to reduce uninsurance. Examples are the legislation (H.R. 506) introduced by Representatives Tammy Baldwin (D-WI) and Tom Price (R-GA) and legislation (S. 325) by Senators George Voinovich (R-OH) and Jeff Bingaman (D-NM). For an analysis of this general approach see Aaron and Butler (2004).

could then afford coverage, and a mandate would be reasonable. But it might not work out that way. The second reason is that a controversial individual mandate might not in any case be needed to achieve near-universal coverage, as the combination of tax reform with automatic enrollment and payroll deductions likely would sharply increase the proportion of working families signing up for coverage.

## Employers as Facilitators: Automatic Enrollment

The payroll adjustment system in the Health Exchange Plan might be enhanced by encouraging employers to adopt automatic enrollment. Although a mandate on employers to include automatic enrollment would be unwise and would likely trigger political opposition, states choosing to require firms to make the exchange available to their employees could include a requirement for automatic enrollment. Under this arrangement, employers would automatically withhold a premium from each employee sufficient for individual or family coverage under a "base option" plan designated by the state and available through the exchange. Employees could avoid this default enrollment by designating an alternative plan, much as workers can avoid an automatic tax withholding amount by indicating another amount on their W-4 form. Absent a state individual mandate to purchase basic insurance, under automatic enrollment employees could decline coverage altogether by signing a document indicating that they understood the consequences of lack of coverage.

The idea of automatic enrollment has been gaining interest in recent years as a means of increasing the take-up rate of health and savings plans at the workplace while increasing administrative efficiency (for example, see Etheredge 2001, Davis and Schoen 2003, and Meyer and Silow-Carroll 2003). The automatic enrollment system used for Part B premiums in Medicare achieves sign-up rates of over 90 percent. And evidence from workplace automatic enrollment for 401(k) plans suggests that it can sharply increase sign-up rates for insurance. Studies by Brigitte Madrian and others (Madrian and Shea 2000, Choi et al. 2005), for instance, found that automatic enrollment boosted 401(k) enrollment from 13 percent to 80 percent among workers earning less than $20,000 a year.

## Reforming the Tax Treatment of Health Insurance

**Designing a tax cap.** The Health Exchange Plan includes a cap on the value of an insurance plan that can be excluded from taxable income, but this cap could be designed in a variety of ways, depending on economic, budget, and political considerations. The tax "bite" over time, and hence the revenue generated to finance a tax credit, would in part depend on the index used, if any, to adjust the cap each year, and this would depend on political feasibility. The proposal uses the CPI, whose rate of increase is well below average annual premium increases, so that over time an increasing proportion of plans would exceed the cap. However, the revenue generated by a cap would also depend on the response of consumers and health care providers to the new limit on tax-advantaged insurance. If, as advocates of tax reform argue, the market responded with stronger competition and more cost consciousness on the part of consumers, the future rise in insurance premiums would be slower and new tax revenue would be less.

The proposal envisions the "excess" coverage above the cap being added to a family's taxable income, in the same way that excess contributions to an IRA or other limited tax-advantaged account are taxed, but only if family income exceeds a certain level. Initially an alternative approach might be to tax the excess only for those paying the alternative minimum tax. This income-based approach would avoid significant opposition from (typically unionized) employees with very expensive health plans that constitute an unusually large proportion of their compensation. But making the excess taxable at all income levels would be an alternative and would raise more revenue to fund tax reform.

The revenue that the cap would yield over time could be used to enhance tax subsidies for the neediest working families. In his fiscal 2008 budget request, as noted above, President Bush proposed a cap of $7,500 in excludable health plans for individual workers ($15,000 for family coverage), although the revenue impact was complicated and blunted by offering a "standard deduction" equal to the cap for workers whose plans cost less.[7] In 2005 the Congressional Budget Office (CBO) examined the impact of a proposal to cap the personal tax exclusion for employer contributions to insurance and health accounts (such as flexible spending accounts) at $8,640 per year for family coverage and $3,720 for individuals. A cap at that level would affect most families with coverage, and CBO (2005, p. 284) estimated that it would yield $17.5 billion in revenue in 2006, rising to $59.9 billion in 2010 and $705.9 billion over 2006-15.

Another version of a tax cap was introduced in 2006 by Senator Mel Martinez (R-FL). His bill (S. 3754) would cap the tax exclusion at $5,000 for individual coverage and $11,500 for families. These amounts would not be indexed. According to Congress' Joint Committee on Taxation, a cap at this level would increase federal revenue by almost $24 billion in fiscal 2007, rising to over $68 billion in fiscal 2011. The committee estimated that this would cover more than four times the cost of a refundable tax credit for 100 percent of health insurance up to $2,000 for individuals and $4,000 for families, if the credit were gradually phased down for family incomes above $30,000.[8] Capping the exclusion at the relatively low amounts in these examples would affect millions of Americans and so would be politically unwise, but they indicate how the impact grows over time. Capping at a much higher initial amount would be a wiser, more achievable step.

**Varieties of tax credit.** Although the federal government would be responsible for most of the cost of a health insurance credit program, the states could be seen as partners in creating the credit, just as many other health programs are shared federal-state responsibilities. The proposed reforms would benefit states financially by reducing the costs associated with uninsurance. Hence it would be reasonable to use some of those savings (such as the federal "disproportionate share" money for hospitals with many low-income and uninsured patients) to help cover the cost of the federal credit or to finance a state supplement to the federal subsidy. In addition, states with an income tax code mirroring the federal code would gain revenue from the cap on the tax exclusion, which could be used to supplement the credit.

The Health Exchange Plan envisions a credit that covers a percentage of the premium up to a maximum, with an income eligibility cap and an abrupt ending of eligibility above the cap. But there is legitimate debate about the best design of such a credit, given the multiple goals of maximizing target efficiency, minimizing budgetary cost, and optimally aligning consumer incentives. Reasonable designs include flat dollar amounts (which could be made taxable and so related to income), sliding-scale credits based on income, and credits based on expenditure compared with income. Credits might also be grafted onto other general reforms of the tax treatment, such as that proposed by President Bush.

There are also various ways to address the concern that reconciling tax credit payments at the end of the tax year, as with other tax breaks, could lead to severe financial difficulties for lower-income families who have misestimated their withholding because their income has changed through the year. That could discourage these families from applying for an advance on their credit, and that in turn would make the credit less effective in covering their premiums. A rough-and-ready alternative would be to base the credit amount on the family's income in the previous year. In the case of very low income employees, the assignability of the proposed credit could avoid the need for reconciliation.

7. For an analysis of the Bush proposal see Burman et al. (2007).
8. Letter to Senator Tom Coburn (R-OK) from Thomas Barthold, Joint Committee on Taxation, October 12, 2006.

# V. Questions and Answers about the Health Exchange Plan

## What would be the advantages for the typical family of an insurance plan obtained through an exchange?

Employed families in exchange-sponsored plans would have the advantage of workplace administration, with the employer responsible for the bookkeeping functions of premium payment and tax adjustment, and many would receive an employer contribution to the premium cost. But unlike with typical employer-sponsored coverage today, even coverage through large employers, these families would gain tax-advantaged access to a large range of exchange-sponsored plans. The family could choose a plan that meets its preferences, working perhaps through a trusted agent such as a labor organization or church consortium. Families could also retain their plan when a worker in the family switched jobs among employers in the exchange system.

A positive byproduct of families retaining their coverage between jobs, and thus perhaps for many years or even decades, is that insurance companies would have a stronger incentive to offer policies designed and priced for long-term coverage. Today most health insurance, including employment-based group insurance, is priced and designed more for the short term, because working families typically change coverage often during their lives as they change jobs. But as more and more families retained their coverage through participation in an exchange, renewable long-term contracts would likely become more common, as they are in life insurance, and there would likely be an increased emphasis on preventive services. Indeed, with the prospect of a longer-term relationship between insurer and insured, and especially if a reinsurance or risk adjustment system were created within the state, insurers likely would be more willing to accept long-term contracts with limited premium variation as a requirement of doing business.

## Would there be significant changes for employees in large firms?

No. For large self-insured employers there would be no change in the way employees obtain coverage unless the firm and its employees decided to switch to the exchange-based system. If the firm's plan is regulated under ERISA, the state could not require the employer to offer access to the exchange-sponsored plans. Its employees typically would continue to receive employer-sponsored health benefits. If they switched to another employer with sponsored insurance, they would, as today, come under a new plan, perhaps with different benefits and service providers. If they changed jobs and did not move to another large firm with sponsored insurance, however, they could become eligible for portable, continuous insurance from the exchange by signing up through their new employer (if that employer participates in the exchange), or on their own as individuals.

Other firms could continue to sponsor commercial group insurance, if they wished and if state law allowed it. Again the employees would see no change in their benefit availability today, and if they moved to another employer that sponsored coverage, they would come under that employer's plan. But if they switched jobs to an employer that participated in an exchange, they could sign up for an exchange-sponsored plan and keep that plan from employer to employer going forward.

Still other employers, including many who currently sponsor coverage, could decide instead to participate in the exchange and take on the role of facilitator of their employees' benefits. In this case the employer's role would be to arrange for the collection of premiums and make tax withholding adjustments, much as many of these same employers do today for employee savings plans, and remit the money to the exchange. These employers

could, if they chose, make a financial contribution to their employees' coverage, as a fixed contribution or even as a defined benefit-like percentage of the premium cost of some maximum level of plan. The government's contribution as an employer in the FEHBP takes this hybrid form.

Employees in firms large and small could, however, be affected by the tax reform proposals, depending on their income and the value of their employer-sponsored plan. They would have to review their compensation package in this case and perhaps choose to take any "excess" benefits in some other form of compensation. Lower-paid employees in employer-sponsored plans who are eligible for a tax credit would have to use it for their employer's plan.

## Doesn't the Health Exchange Plan risk weakening the employment-based system or even causing it to unravel?

No. On the contrary, it would actually strengthen the existing system by putting it on a sounder footing that is more compatible with underlying trends in employment, the strengths and weaknesses of employers as organizers of coverage, and the generally accepted goal of portable, affordable, and continuous coverage.

The successful parts of the current employer-sponsored system would be largely untouched, other than by the limits placed on today's open-ended tax exclusion. But the less successful parts would be strengthened and rationalized in a number of ways. For one thing, the exchanges and the facilitator role envisioned for most employers would bolster coverage among employees in smaller firms, by playing to the strengths of these firms while relieving them of the burdensome complexity and financial risk of sponsoring coverage. For another, the new tax credit available to households for out-of-pocket coverage would also induce many families to sign up for offered dependent coverage that they currently decline as too costly.

The proposal also includes features that would appropriately protect employment-based coverage from the adverse selection or "crowding out" pressures that typically accompany efforts to help the uninsured, such as expansions in Medicaid, SCHIP, and other forms of government-sponsored coverage. For example, the tax credit must be used for employment-based coverage if such coverage is offered, avoiding the concern that younger, healthier employees might leave an employer's insurance pool. Moreover, firms currently vulnerable to adverse selection or gyrating insurance premiums because of a changing workforce could gain greater stability by transitioning to coverage offered through an exchange.

## Rather than give credits to individuals, why not give tax incentives to employers to expand traditional coverage?

Subsidizing employers, especially smaller employers, to sponsor coverage would not fix the many limitations of employer-sponsored coverage discussed above. Moreover, targeting such tax subsidies efficiently would be very difficult, leading to very high federal costs for each additional insured family at those firms where a significant proportion of the workforce already signs up for insurance. And trying to target an employer subsidy only to lower-income households would compromise privacy by requiring the employer to know the employee's household income.

## How would the value of an employer-sponsored plan be determined for purposes of calculating the amount in excess of the tax-exempt limit?

Employees do not receive information on the premium value of their group insurance on their year-end W-2s, and in the case of self-insured employer plans there is not even a premium amount to report. So how could the value of coverage be assessed and fairly allocated between healthier and sicker employees?

It is certainly more complicated to assess tax on noncash group insurance products than on cash income, but we do have experience in capping the tax-free status of group insurance in the case of employer-paid life insurance. Only the first $50,000 of such insurance is excludable from the employee's taxable compensation. The group premium amount for additional coverage appears on the W-2 and is taxable. In this case—as would be the case in health insurance—because the imputed premium amount for "excess" life insurance is group rated, younger employees (who could get cheaper individual coverage) would pay comparatively more tax for the same benefit.[9]

Determining a premium value for the self-insured and self-funded coverage common in very large companies is indeed an issue. A simple approach would be to use the existing rules for COBRA coverage, which employers already must make available to departing employees. Another issue concerns the often significant difference (similar to the case of life insurance) between the nominal value of the group coverage and the actuarial value based on the employee's medical risk. Again, this is probably best addressed under existing federal discrimination law, which places limits on the permissible variation of premiums and contributions for different classes of employee. But in those companies with collective bargaining contracts, another option might be for the union and management to assign values to certain classes of employee in the context of an overall compensation agreement. An additional point is that there are typically other tax-advantaged health accounts available at the workplace, such as flexible spending accounts, and so a concern is that limiting the tax-free status of insurance provided directly by employers could lead simply to employers and employees trying to avoid the tax cap by agreeing to shift insurance into other tax-free accounts. This might be addressed by applying an aggregate cap to all tax-free employment-based accounts.

## What types of trusted-agent organizations might offer plans through exchanges?

The creation of insurance exchanges, together with official clarification that exchange-sponsored plans would convey the same tax relief as employer-sponsored plans, likely would encourage certain types of organization to organize insurance.

**Unions.** One likely agent would be unions, not just as advisers for households comfortable with unions but also as sponsors of plans. Unions and labor-based mutual societies have a long history in this country and others of acting as "friendly societies" offering benefits, not just as benefit negotiators. Unions are also active as health sponsors in other ways, for example as organizers of plans under the Taft-Hartley Act. These plans are common in the construction industry, but also are offered in other industries where employment is often interrupted or workers frequently move between employers, such as in the hotel sector. Some unions also are already significant plan sponsors in the FEHBP, where many nonunion workers are able to pick coverage offered through unions. One of the largest plans, the Mail Handlers Benefit Plan, with over 250,000 enrollees, is not restricted to regular union members; indeed, the plan has five times as many enrollees as regular members. Others join because the union has assembled an attractive set of benefits and acts as the agent for its enrollees.

**Religious organizations.** Religious-based health plans would also become more widespread if members could obtain tax or other assistance to purchase coverage through these groups. American churches and other religious associations and lodges have a long history of involvement in providing social services for their congregations and in operating hospital systems. Indeed, religious fraternal organizations, many of them church-affiliated and many of these African-American, were a major source of health insurance—sometimes as capitated health

9. I am grateful to my colleague Edmund Haislmaier for his guidance on the issue of estimating the tax value of employer-sponsored insurance.

plans reminiscent of today's HMOs—in the first part of the twentieth century (Beito 2000, chapters 9 and 10). These later declined, not because the sponsors ceased to be trusted agents, but because the unsubsidized plans were unable to compete with tax-subsidized employer-sponsored insurance and Medicaid. Tax neutrality would level the playing field. For lower-income African-Americans especially, the church today is often a far more stable institution in the community than local small employers—and has a long history of engagement in education, housing, and other social services.

**Other nonemployer agents.** Other affinity groups, such as state farm bureaus and professional associations, exist in part to negotiate health coverage for their members. But again, the current tax code does not encourage employees in most instances to choose these agents, even if they are more trusted than their employers. Reform would likely lead to a resurgence in plans offered by these groups.

An important aspect of all such agent relationships is that the organization does not typically shoulder the insurance risk itself. More typically, the organization assembles the group and negotiates with an insurance carrier to provide the insurance, receiving a fee from the insurer for performing marketing and some management functions. Farm bureau plans typically offer coverage designed for rural families yet underwritten through a separate insurer. The Mail Handlers Benefit Plan, for instance, is backed by the First Health Group. In each case the organization is performing an agency role, much as many employers do, although large employers also typically carry a significant part of the insurance risk.[10]

**Other employers as health agents.** In the future another possible alternative to one's own employer as health agent might be other employers. After all, it is common for large companies to sell to the public certain services initially designed for internal use. For example, after telecommunications deregulation in the 1960s and 1970s allowed other carriers to compete with AT&T's long distance monopoly, some major firms decided to offer their internal communications services outside the firm.[11] The Southern Pacific Railroad, for instance, opened up its internal communications network to outside customers under the brand name Sprint. Other companies have taken advantage of relatively neutral tax laws and regulations in finance to offer services originally designed for their own operations. The General Motors Acceptance Corporation (GMAC), for example, offers a wide range of insurance and mortgage products to a market well beyond GM's initial exclusive focus on its car purchasers.

Unfortunately, the tax laws governing health insurance, unlike those governing the tax treatment of mortgage loans, discourage GM and other firms from taking similar steps to market their health plans to a wider public. Still, some companies have edged into the field. In particular, John Deere created its own HMO in the early 1980s, mainly for its own employees, and then began to offer coverage to other employers and purchased health operations to serve its new market. The company's for-profit health division even offered coverage to individuals as a Medicare HMO and provided managed care Medicaid services in several states and to federal workers under the FEHBP. The health company was sold to UnitedHealthcare in 2006. Marketing to the FEHBP, Medicare, and Medicaid was attractive to Deere because the subsidies in those programs are not restricted to employees of the company. Making the tax system more neutral might encourage other companies to consider opening up their plans through insurance exchanges.

10. Many large interstate employers self-insure, meaning that they themselves hold the insurance risk, although some also purchase catastrophic insurance. Sometimes firms self-insure in order to gain greater freedom from state insurance rules by instead coming under federal ERISA regulation. Other (typically medium-size or smaller) firms purchase insurance for their employees, contributing to coverage and contracting with an insurance company.
11. For a summary of these decisions see Crandall and Ellig (1995, pp. 18-19).

## Could the first two elements of the Health Exchange Plan proceed without the tax reform element?

Yes. States and the federal government could move forward with insurance exchanges and the facilitator role for employers without restructuring the tax treatment of health insurance. If states, within current federal law, created exchanges similar to Massachusetts' Connector, families enrolling in exchange-sponsored plans via their employer would be eligible for today's tax exclusion. An explicit ruling or change in the law would help encourage states to create exchanges by clarifying policy and perhaps making it more flexible, but would not be essential. The proposed structural tax reform would significantly improve the affordability of coverage for lower-income Americans and take advantage of the other elements in the proposal, but it is not a precondition for these other elements.

## Could the tax reform element proceed without the first two elements?

Yes, but its impact would be greatly enhanced by the exchanges and the revised employer role. Certainly, reforming the tax treatment of health insurance alone would result in a more equitable distribution of tax subsidies and greater coverage. But the impact of tax reform would be increased significantly by the other elements of the proposal—which is why they are central to it. The availability of the proposed tax credits within a state could be made conditional on the state taking active steps to make coverage more affordable and available, if not through the steps proposed here to enhance employment-based insurance, then through other state proposals designed to move toward universal coverage.

# VI. Conclusion

America's health insurance system for working families is completely out of step with the needs of today's mobile workforce. Millions of working families have no coverage at all, and those with employer-sponsored insurance face gaps in coverage and the loss of vital services whenever they change jobs or their work situation. Unlike the other intensely personal and important decisions a family makes, such as where to live and where to educate their children, access to the health care system for most working Americans is controlled by their employer, not by the family itself. And while government provides over $200 billion each year in tax relief to subsidize this system, most of that subsidy goes to those who need help the least, while more needy working families get little or no assistance.

There are really two worlds in employer-sponsored insurance. There is the world of large firms, where coverage is broadly available and continuous—provided an employee remains working for that large firm. And there is the world of small firms, where employees face the enormous medical and economic insecurity of gaps in coverage.

It is time to recast this system, created almost accidentally in the context of the industrial era, into a system appropriate for the postindustrial world of a surging services sector, high labor mobility, and changing work arrangements. The key is to de-link the availability, control, and subsidization of health coverage from the place of work. Those families and their employers who are satisfied with the current system could keep things the way they are. But those who are dissatisfied could join an alternative that has been allowed to evolve out of the traditional notion of employer-sponsored insurance. In the proposed new system, families could choose their coverage and keep it from job to job, thanks to state-based insurance exchanges and to employers willing to help manage the insurance transaction rather than sponsor insurance itself. And the tax subsidy would be based on need. By slowly transforming today's health insurance system in this way, we would achieve greater economic as well as health security for America's working families.

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