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## Comments

### **EMPLOYER HEALTH-CARE MANDATES: THE WRONG ANSWER TO THE WRONG QUESTION**

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#### I. INTRODUCTION

A great paradox lies beneath the health-care debate in this country, one that reflects both the greatness and the shortcomings of our capitalist democracy. The United States has long been a leader in developing ever-better surgical, medical, and diagnostic procedures. Yet critics are quick to point out that, despite the seemingly wide range of available treatments, millions of Americans remain uninsured.<sup>1</sup> In widely-quoted studies, the United States falls far behind other developed countries in measures of the overall quality of the health care system.<sup>2</sup> How can these seemingly contradictory situations be reconciled?

As is often the case, the explanation for one paradox may lie buried within another. For most U.S. citizens, health care is either an employment

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1. For an illustration, consider the platforms of the various 2008 presidential candidates. *See, e.g.*, Jane Gross, *A Complicated Balance of Policy and Personal*, N.Y. TIMES, Apr. 1, 2007, at A19 (noting John Edwards' focus on universal health care in his primary run). The debate has penetrated popular culture as well. *See, e.g.*, SICKO (Dog Eat Dog Films 2007) (chronicling the deficiencies in the American health care system).

2. *See, e.g.*, News Release, The Commonwealth Fund, New National Scorecard: U.S. Health Care System Gets Poor Scores on Quality, Access, Efficiency, and Equity (Sept. 20, 2006), [http://www.commonwealthfund.org/usr\\_doc/Scorecard\\_Release\\_FINAL\\_9-19-06.pdf?section=4059](http://www.commonwealthfund.org/usr_doc/Scorecard_Release_FINAL_9-19-06.pdf?section=4059) (noting that the United States lags behind other nations on key healthcare indicators).

benefit that their employers provide in the form of a tax-free health plan,<sup>3</sup> or a subsidy in the form of Medicare or Medicaid. Many Americans take for granted that they will never have to spend more than a fixed amount of money for coverage, regardless of the amount of care they receive.<sup>4</sup> What we refer to as “health insurance” is in many ways a pre-paid health plan, as most beneficiaries are certain to use the services of the insurance at some point.<sup>5</sup>

Employers provide the majority of these plans.<sup>6</sup> Although the nation has become comfortable with this arrangement, this setup significantly contributes to the perceived problem of inadequate access to health care in the United States. Still, while the problem is significant, it is not quite as drastic as the quoted statistics indicate. Consequently, proposals for laws that mandate employers to provide health insurance to their employees are misguided and based on mistaken premises.

Part II of this Comment explores the origins of the system in which employers pay for employees’ health care, and covers the more recent phenomenon of state mandates. It concludes with an analysis of some of the economics literature on employer-based health care. Part III discusses in greater depth some of the problems with, and critiques of, the employer-based system’s ability to provide broad coverage. Part III also considers the relatively recent efforts in Massachusetts to ensure that all of its citizens have insurance, and specifically focuses on the provisions that function as weak mandates on employers to provide insurance. Part IV presents an alternative to employer-based health care and is followed by concluding remarks in Part V.

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3. *See generally* The Kaiser Family Foundation & Health Research and Educational Trust, *Employer Health Benefits, 2006 Summary of Findings* [hereinafter 2006 Kaiser Findings] (summarizing findings on employer-sponsored health insurance based on a national survey of private and public employers of three or more workers).

4. After paying yearly premiums, if the employer does not cover an employee’s medical service or product, the employee must pay annual deductibles and per-visit co-pays.

5. This characteristic of health insurance does not extend to all forms of insurance. With car insurance, for example, a careful and lucky driver who regularly pays insurance premiums may never receive a dime back from the insurance company. The only benefit for that driver was the assurance that insurance would cover the driver in an accident. In fact, what we refer to as “health insurance” often is used interchangeably with the term “health care.”

6. *See* 2006 Kaiser Findings, *supra* note 3, at 1 (noting that, in 2006, employers provided coverage for over 155 million non-elderly in the United States).

## II. THE HISTORICAL ORIGINS AND DEVELOPMENT OF EMPLOYER-BASED HEALTH CARE AND STATE EMPLOYER MANDATES

### A. *Employer-Based Health Care*

Employers have not always been the nation's primary providers of health insurance. The current system traces its origins to the price controls instituted during World War II.<sup>7</sup> Because contributions to health insurance did not count as wages, employers had to compete for workers by offering health benefits that were exempt from the wartime price controls. But, what began as a short-term loophole to compete for quality labor during the war era became an entrenched apparatus, due to an IRS ruling that employees did not have to pay income tax on the health benefits that employers provide.<sup>8</sup> Coupled with the fact that employers could deduct the benefits they provided as a business expense, health insurance became a tax-free gift from Uncle Sam to employers.<sup>9</sup> By amending the Internal Revenue Code (IRC), Congress made permanent the IRS ruling to exempt health benefits from income tax.<sup>10</sup> Large firms realized that it would be cheaper to self-insure than to pay a third-party insurer to do anything more than administer the program. Furthermore, the Employee Retirement Income Security Act (ERISA) of 1974<sup>11</sup> made self-insurance even more attractive to employers because the new law prohibited states from enacting laws that would overburden these self-insured plans. As such, most large firms now self-insure.<sup>12</sup> Health coverage by employers reached a peak in the late 1980's,<sup>13</sup> and employers now cover 63% of non-elderly individuals in the country with health insurance.<sup>14</sup>

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7. David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH POL'Y L. & ETHICS 23, 25.

8. *Id.*

9. *Id.* It could be argued that employers are the real beneficiaries of this system. With wage controls now a long-forgotten relic, employers can offer this benefit to employees at what is effectively a discount price. Because the value to employees is greater than an equivalent in taxed cash compensation, employers can substitute a greater amount of wages than they would if health insurance were taxed.

10. See I.R.C. § 106 (1986) (excluding health and accident plans from employee gross income calculations); see also I.R.C. § 125(a) (1986) ("Except as provided in subsection (b), no amount shall be included in the gross income of a participant in a cafeteria plan solely because, under the plan, the participant may choose among the benefits of the plan.").

11. Employee Retirement Income Security Act, Pub. L. No. 93-406, 88 Stat. 829 (1974) (codified as amended in scattered sections of 26 & 29 U.S.C.).

12. Alain C. Enthoven & Victor R. Fuchs, *Employment-Based Health Insurance: Past, Present, And Future*, 25 HEALTH AFFAIRS 1538, 1540 (Nov./Dec. 2006).

13. *Id.* at 1539.

14. Brigitte C. Madrian, *The U.S. Health Care System and Labor Markets* 1-34, 2 (Nat'l Bureau of Econ. Research, Working Paper No. 11,980, 2006).

### B. State Mandates

In recent years, in an effort to broaden the insured population, a majority of states have considered legislation that creates either a mandate or negative incentive (i.e., a penalty) to induce employers to provide health insurance.<sup>15</sup> Proponents of these mandates<sup>16</sup> advance the theory that employers are in the best position to reach the widest swath of people with coverage. This type of plan is referred to as a “pay or play” law.<sup>17</sup> The justification for a mandate or penalty is that uninsured employees ultimately drain common resources when they either receive Medicaid or utilize emergency care that other state taxpayers subsidize. Thus, the argument goes, employers that do not provide insurance should pay back the state and the taxpayers for the inevitable drain on public resources.<sup>18</sup>

At last count, twenty-eight states have considered enacting mandates in the last three years.<sup>19</sup> Of those states that considered “pay or play” laws, twenty states were unable to pass bills through committee,<sup>20</sup> six states have bills remaining before committees,<sup>21</sup> and two states passed the mandates. With respect to the two states that passed the mandates, Maryland and Massachusetts, the Fourth Circuit Court of Appeals invalidated Maryland’s

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15. See National Conference of State Legislatures, Health Insurance 2006 Pay or Play Bills, <http://www.ncsl.org/programs/health/payorplay2006.htm> (last visited Oct. 23, 2008) [hereinafter NCSL] (listing bills in state congresses that propose various forms of employer mandates).

16. Governor Ed Rendell of Pennsylvania advocated a statewide health insurance reform law that included an employer mandate, suggesting a 3% payroll tax on businesses with more than fifty employees that do not provide health insurance to workers. The Governor later bowed to pressure from employer groups and dropped the payroll tax from his plan. See Tom Barnes, *Health Plan Progress Disappoints Rendell*, PITTSBURGH POST-GAZETTE, Dec. 16, 2007, <http://www.post-gazette.com/pg/07350/841773-85.stm> (last visited Nov. 26, 2008).

17. NCSL, *supra* note 15.

18. *Id.*

19. *Id.*

20. These states and their respective bills are: Alaska HB 449 (2006), Arizona SB 1232 (2006), Colorado HB 1316 (2006), Connecticut SB 462 (2006), Florida HB 813 (2006), Georgia SB 579 (2006), Iowa SB 2246 (2006) and HF 2430 (2006), Kansas HB 2579 (2006) and SB 557 (2006), Kentucky HB 98 (2006) and HB 493 (2006), Louisiana SB 69 (2006), Mississippi SB 2684 (2006), Missouri HB 1463 (2006) and related bill SB 944 (2006), New Hampshire HB 1703 (2006), HB 1704 (2006), and HB 633 (2006), Oklahoma HB 2678 (2006), Rhode Island HB 6917 (2006) and HB 6984 (2006), Tennessee SB 3392 and related bill HB 3962 (2006), HB 3354 and related bill SB 3729 (2006), Virginia HB 258 (2006), Washington HB 2517 (2006) and SB 6356 (2006), West Virginia HB 4024 and identical bill SB 147, and Wisconsin AB 860 (2006). *Id.*

21. These states and their respective bills are: Michigan SB 87 (2007), Minnesota HB 39 (2007), California SB 1414 (2006) and SB 593 (2006), New Jersey AB 2513 (2006) and SB 47 (2006), New York SB 7090 (2006), AB 9534 (2006), AB 4129 (2006), SB 6989 (2006), AB 9776 (2006), and SB 6644 (2006), and Ohio HB 471 (2006). *Id.*

mandate after the state legislature overturned a veto from the governor<sup>22</sup> and Massachusetts toned down its proposal significantly. As of this Comment's printing, Massachusetts remains the only state other than Hawaii<sup>23</sup> with a pay or play mandate officially on the books and unchallenged by a court decision.<sup>24</sup> Nevertheless, Massachusetts's mandate may also be invalidated if the Second Circuit Court of Appeals follows the Fourth Circuit Court of Appeals' decision and holds that ERISA preempts pay or play mandates.<sup>25</sup>

C. *The Massachusetts Plan—An Experiment in Progress*

The Massachusetts plan offers insight into the workings of a successfully implemented health care mandate. On April 12, 2006, the Massachusetts state legislature passed Chapter 58 of the Acts of 2006, which provided a comprehensive plan to push the state towards the elusive goal of universal health coverage.<sup>26</sup> When signing the bill into law, then-Governor Mitt Romney vetoed the mandate provisions that imposed fines and other negative incentives on employers that did not provide their workers with health insurance. In his veto signing statement, Governor Romney stated simply that the mandates were "not necessary to implement or finance health care reform."<sup>27</sup> The legislature, however, overrode the Governor's veto and enacted the original bill into law in its entirety.<sup>28</sup>

The Massachusetts plan attacks the problem of an uninsured

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22. See *Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d 180 (4th Cir. 2007) (holding that ERISA preempted Maryland's law that required super-large employers to either provide health benefits to their workers or face stiff penalties).

23. Hawaii passed its Prepaid Health Care Act in 1974, shortly before Congress passed ERISA in that same year. Though initially challenged, Congress granted the Hawaii act an exemption from ERISA. See Fernando R. Laguarda, Note, *Federalism Myth: States as Laboratories of Health Care Reform*, 82 GEO. L.J. 159, 181 (1993) (discussing the Hawaii Prepaid Health Care Act); National Conference of State Legislatures, Hawaii-Prepaid Health Care Act, <http://www.ncsl.org/programs/health/dhmaine.htm> (last visited Oct. 23, 2008) (noting Hawaii's exemption from Congress). Hawaii remains the only state with such an exemption, but there is a low compliance rate in the state and the Prepaid Health Care Act lacks adequate enforcement mechanisms. Peter D. Jacobson & Rebecca L. Braun, *Let 1000 Flowers Wilt: The Futility of State-Level Health Care Reform*, 55 U. KAN. L. REV. 1173, 1175-77 (2007).

24. See NCSL, *supra* note 15 (listing pay or play mandate proposals by various states).

25. See Part III(D) (discussing potential preemption challenges that ERISA may pose to pay or play mandates).

26. The Massachusetts Plan, 2006 Mass. Acts 58, available at <http://www.mass.gov/legis/laws/seslaw06/sl060058.htm>.

27. Signing Statement of Governor Mitt Romney, Attachment A (Apr. 12, 2006) (on file with author), <http://www.ncsl.org/print/health/vetoletter.pdf>.

28. H.R. 4850, 2006 Leg., 184th Sess. (Mass. 2006) was enacted into law as 2006 Mass. Acts 58.

population from several angles. First, on the individual front, it creates an “insurance connector” that gives individuals and small businesses access to group insurance products that are portable from one employer to another, which individuals can maintain outside of a formal job.<sup>29</sup> Second, the plan creates an individual mandate that requires all non-exempt individuals<sup>30</sup> to obtain and maintain health insurance by July 2007.<sup>31</sup> Third, the plan subsidizes insurance for individuals who earn less than 300%<sup>32</sup> of the federal poverty line (currently \$10,400 for an individual with no other household members).<sup>33</sup>

The plan also has three provisions that create obligations for employers.<sup>34</sup> First, it requires each employer to offer a “cafeteria style plan” to employees,<sup>35</sup> also known as a “Section 125” plan.<sup>36</sup> Second, it forces companies with more than eleven full-time equivalent workers to make a “fair and reasonable premium contribution”<sup>37</sup> to a group health plan. The plan leaves the meaning of a “fair and reasonable” contribution open to further regulatory interpretation. Currently, state regulation defines the phrase as either (1) an enrollment of 25% of full-time employees in the employer’s plan,<sup>38</sup> or (2) an employer’s payment of 33% of the premium costs for all of its fulltime employees.<sup>39</sup> Finally, the plan provides for a “fair share contribution” in the form of payment from employers that do

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29. MASS. GEN. LAWS ch. 176Q (2007).

30. The state board of Massachusetts enacted an exemption for individuals who can demonstrate that they are unable to afford even the lowest-cost insurance, based on a sliding scale calculation. See 830 MASS. CODE REGS. 111M.00(3)(c)(2007) (making the Massachusetts Commonwealth Health Insurance Connector responsible for setting annual affordability schedules for the individual mandate).

31. MASS. GEN. LAWS ch. 111M, § 2 (2007).

32. *Id.*

33. Annual Update of the HHS Poverty Guidelines, 73 Fed. Reg. 3971-72 (Jan. 23, 2008).

34. Known collectively as “employer mandates” or the “pay or play” provisions.

35. MASS. GEN. LAWS ch. 151F, § 2 (2007) (“Each employer with more than 10 employees in the commonwealth shall adopt and maintain a cafeteria plan that satisfies 26 U.S.C. 125 and the rules and regulations promulgated by the connector . . .”).

36. Referring to 26 U.S.C. § 125 (2006) (defining cafeteria-style plans as those that allow employees to choose among different plans).

37. MASS. GEN. LAWS ch. 149, § 188(b) (2007) (“[E]ach employer that (i) employs 11 or more full-time equivalent employees in the commonwealth and (ii) is not a contributing employer shall pay a per-employee contribution at a time and in a manner prescribed by the director of workforce development, in consultation with the director of unemployment assistance, in this section called the fair share employer contribution.”).

38. Some state legislators suggest that this percentage should be increased to as high as 50%. See Jeffrey Krasner, *Business Leader Suggests Health Law Too Easy on Firms*, BOSTON GLOBE, Feb. 2, 2007, at C1 (stating that 50% should be the standard to keep “good people working for [the company]”).

39. 114.5 MASS. CODE REGS. 16.03(3)(c)-(d) (2007).

not pay a “fair and reasonable premium contribution.”<sup>40</sup> This provision is known as “pay or play.”<sup>41</sup> Due to a series of compromises, however, the “pay” factor “shall not exceed \$295 per employee which may be made in a single payment, or in equal amounts semi-annually or quarterly, at the employer’s discretion.”<sup>42</sup> As a testament to the motivation behind this provision, the contribution is “calculated to reflect a portion of the cost paid by the state for free care used by workers whose employers do not provide insurance.”<sup>43</sup>

#### D. Health Insurance and Incentives

A review of scholarly literature on the economics of health insurance, particularly employer-based health insurance, may inform the discussion about how people tend to respond to incentives. Specifically, how do individual incentives relate to the current system of employer-based health insurance? Several studies<sup>44</sup> illuminate the trend that people’s behavior, whether consciously or not, is shaped by their incentives to work or retire, to stay in a job or to move, and to insure or not to insure.

The first question relevant to a discussion about providing broader health coverage should ask why people lack coverage in the first place. An easy answer is that people cannot afford such coverage. Although sometimes true, this is not necessarily the correct answer in all cases. Affordability is a relative concept; unless an individual literally is destitute, his or her decision not to buy health insurance is exactly that—a decision. As things stand, a truly destitute individual would likely qualify for Medicaid.<sup>45</sup> Depending on the importance of having at least some degree of health coverage, a person could spend all of his or her money on health care, and subsequently qualify for Medicaid. Judge Richard Posner, of the U.S. Court of Appeals for the Seventh Circuit, posited as much when he stated:

[It is not] a scandal, or even a serious inefficiency, that many millions of workers do not have health insurance. Their health

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40. *Id.*

41. See, e.g., David A. Hyman, *The Massachusetts Health Plan: The Good, the Bad, and the Ugly*, POL’Y ANALYSIS (Cato Inst., Wash. D.C.), June 28, 2007, at 4 (discussing potential preemption of pay or play provisions).

42. MASS. GEN. LAWS ch. 149, § 188(c)(10) (2007).

43. Massachusetts Health Care Access and Affordability Conference Committee Report (Apr. 3, 2006), at 4, <http://www.mass.gov/legis/summary.pdf>.

44. See, e.g., Brigitte C. Madrian, *Employment-Based Health Insurance and Job Mobility: Is There Evidence of Job Lock?*, 109 Q. J. OF ECON. 27, 52 (1994).

45. See The Henry J. Kaiser Family Foundation, *Medicaid—Kaiser State Health Facts*, <http://www.statehealthfacts.org/medicaid.jsp> (last visited Oct. 23, 2008) (describing state-by-state eligibility for Medicaid).

care is paid for my [sic] Medicaid if they cannot afford to buy health insurance whether directly or as part of an employee group health insurance plan. Those that can afford health insurance but forgo it either are young and healthy or are risk preferrers, gambling that they will avoid illnesses requiring expensive treatment. If their gamble fails, they will have to pay out of their pockets, and when their pockets are empty (their assets depleted) go onto Medicaid, where their care will be subsidized.<sup>46</sup>

While this account may sound somewhat cold, it reflects the reality that, excluding some very serious exceptions, many of the uninsured choose to remain uninsured, even if it is a bad choice. Even the characterization of a “bad choice” reflects a moral judgment that health, or more accurately, insurance against the possibility of future bad health, is more valuable than whatever else a person trades for health. This argument would seem less drastic if health insurance functioned as true protection against future disaster, rather than as essentially a pre-paid health care plan. The category of catastrophic health insurance, which insures against less likely, but potentially expensive medical events and conditions, is more affordable than the comprehensive coverage that many insurers offer.

One study about health care affordability found results that challenge some basic assumptions in the health care debate. M. Kate Bundorf and Mark V. Pauly analyzed the definition of “affordability” as it relates to health care.<sup>47</sup> Somewhat surprisingly, they found that many who can “afford” health insurance do not have coverage, while many who cannot “afford” health insurance do have coverage.<sup>48</sup> This study illustrates that, notwithstanding the many individuals who gravely need assistance,<sup>49</sup> commentators must not take even basic definitions for granted in this sometimes emotionally charged debate.

One criticism of the employer-based system is that it makes health insurance less portable. The theory behind this criticism is that, because work plans make most insurance available at cheaper costs, an employee with an uninsurable ailment will be strongly disinclined to leave his or her job, as it likely will be difficult or impossible to acquire insurance from a different source. This phenomenon is known as “job-lock.”<sup>50</sup> Based on job-lock theory, one economist posits the following:

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46. Posting of Richard Posner, [http://www.becker-posner-blog.com/archives/2007/04/the\\_reform\\_of\\_h.html](http://www.becker-posner-blog.com/archives/2007/04/the_reform_of_h.html) (Apr. 15, 2007, 19:29 EST).

47. M. Kate Bundorf & Mark V. Pauly, *Is Health Insurance Affordable for the Uninsured?*, 25 J. OF HEALTH ECON. 650, 650 (2006).

48. *Id.* at 667.

49. This Comment stresses this point to make clear that for many people, health care is truly unaffordable, such that they must take drastic and tragic measures to secure some form of coverage.

50. Madrian, *supra* note 44, at 27.



[W]e would expect retirement rates to be higher among those with portable health insurance. Once individuals reach age 65 and are eligible for Medicare, losing health insurance coverage completely is no longer a concern for those workers previously covered by employer-provided health insurance. Thus, after age 65, retirement rates among those with non-portable insurance will no longer be lower, and indeed, may increase if individuals have postponed retirement until becoming eligible for Medicare.<sup>51</sup>

Indeed, “[s]everal studies have found evidence that individuals whose employers provide retiree health insurance leave the labor force earlier than individuals whose employers do not.”<sup>52</sup>

In two particular findings, Professor Bridgette Madrian found strong evidence of job-lock.<sup>53</sup> First, married men without health insurance who have pregnant wives are twice as likely to change jobs as married men without health insurance whose wives are not pregnant.<sup>54</sup> This suggests that the search for adequate health insurance is bound tightly to the search for employment.<sup>55</sup> Second, Madrian found that individuals covered through their spouse’s insurance are more likely to change jobs.<sup>56</sup> While this conclusion may reflect mixed survey results, it could also reflect two different types of job mobility: intended and forced. An individual who needs better insurance might change jobs, even if he or she otherwise is quite content and productive, which in turn causes an unnecessary loss in efficiency. Likewise, if a person is not bound to an employer for health insurance, he or she probably would move to a better job in line with market forces.<sup>57</sup>

Yet another study found that firms in Hawaii would rather require their existing employees to work longer hours than hire new employees, to avoid health care costs that rise with each additional worker but not with increased hours.<sup>58</sup> This effect has been observed across states.<sup>59</sup>

Although not studied widely, another interesting side-effect of

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51. Madrian, *supra* note 14, at 8.

52. *Id.*

53. Madrian, *supra* note 44, at 52.

54. *Id.* at 49.

55. *Id.* at 47-50.

56. Madrian, *supra* note 14, at 18.

57. *Id.* at 17.

58. See Norman K. Thurston, *Labor Market Effects of Hawaii’s Mandatory Employer-Provided Health Insurance*, 51 INDUS. & LAB. REL. REV. 117 (1997) (finding that, after Hawaii mandated employers to provide health insurance in 1974, companies with few covered full-time workers saw dramatic rises in the number of part-time workers).

59. David M. Cutler & Brigitte C. Madrian, *Labor Market Responses to Rising Health Insurance Costs: Evidence on Hours Worked*, 29(3) RAND J. ECON. 509, 530 (1998); see Madrian, *supra* note 14, at 20-21 (finding that firms have increased significantly the weekly hours worked by fewer workers in response to rising health care costs).

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increasing access to health insurance is that the new demand for health care may not match the supply of available treating physicians. A recent article in the *New York Times* highlighted the long waits for primary care visits that have emerged in the wake of Massachusetts' comprehensive scheme to universalize health insurance.<sup>60</sup>

In sum, regulated health insurance markets create a host of complicated incentives that affect individuals' decisions about whether to purchase health coverage. Relevant studies, however, have not been able to define a clear link between these incentives and individuals' coverage decisions.

### III. THE PROS AND CONS OF AN EMPLOYER-BASED SYSTEM

#### A. *Strategic Advantages of the Employer-Based System*

Despite its flaws, the employer-based health care system has some apparent advantages that have kept it around for over sixty years. Perhaps the strongest argument in favor of the employer-based system is that it avoids adverse-selection problems.<sup>61</sup> Some even argue that employer-based coverage is "a key factor in the survival of the private insurance market,"<sup>62</sup> explaining:

Insurance markets of all types can become unstable because people choose to purchase coverage (or choose which type of coverage to purchase) based on their own information about their likely need for services, a process called adverse selection. This selective purchasing behavior can make it difficult for insurers to accurately price their policies and may ultimately drive them out of business. Because employment groups are generally formed for reasons other than health insurance purchasing, insurers can avoid this selection problem by covering groups.<sup>63</sup>

One somewhat banal, though not insignificant justification is simply that the system has worked thus far. Employers have been the bedrock of our private health care system for the majority of the twentieth century<sup>64</sup> and the country has produced many of the greatest innovations in health

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60. Kevin Sack, *Universal Coverage Strains Massachusetts Care*, N.Y. TIMES, Apr. 5, 2008, at A1.

61. In this context, adverse selection is the process whereby the persons who pose the least risk to insurers will self-select cheaper coverage, and leave the most risky persons to pool together. This process essentially would repeat until the least insurable are effectively uninsurable.

62. Sherry A. Glied & Phyllis C. Borzi, *The Current State of Employment-Based Health Coverage*, 32 J.L. MED. & ETHICS 404, 407 (2004).

63. *Id.*

64. *Id.* at 404.

care. In reality, however, “[v]irtually no one defends the health care status quo in the United States . . . .”<sup>65</sup> Though the quality of care available to many in the United States is virtually unmatched, access is not as widely available or affordable as one would expect in a competitive market environment.

Some other oft-cited justifications for the employer-based system are that it improves worker loyalty, decreases turnover, and reduces truancy due to illness.<sup>66</sup> Nevertheless, a decrease in turnover is not necessarily a desirable economic outcome. In fact, some cite decreased turnover due to job-lock for fear of losing valuable health insurance as a downside of the employer-based system.<sup>67</sup> Although the other two arguments of reducing absenteeism and improving loyalty both are positive outcomes, the *employer* does not necessarily have to provide health care to achieve these ends. Employers could create the same, if not better, outcomes if they give workers the cash equivalent of health care, and allow them to buy their own coverage or use the money as they see best.

A final argument in favor of the current system is that it protects against risk over time. In the risk-over-time hypothesis, individuals who are not in a group plan are subject to termination from their individual plans as soon as a chronic and expensive condition materializes.<sup>68</sup> While some regulations, including amendments to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to extend applicability to individual insurance policies,<sup>69</sup> can prevent this type of problem, some argue that regulations to prevent insurers from dropping clients outright remain insufficient; “selection often drives up prices for those who choose to remain in the market.”<sup>70</sup> One response to these arguments is that individuals, even outside the workplace, would be able to pool together in affinity groups to purchase health insurance in group plans and spread the cost of risk amongst themselves. Such groups might include unions, religious organizations, and industry associations, which government initiatives could support. An example familiar to New Yorkers in particular is the Freelancers Union, with its well-known marketing campaign to attract new members in part through the union’s health

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65. Edward A. Zelinsky, *The New Massachusetts Health Law: Preemption and Experimentation*, 49 WM. & MARY L. REV. 229, 276 (2007).

66. Glied & Borzi, *supra* note 62, at 405.

67. See Madrian, *supra* note 44, at 47 (noting that health insurance may distort job mobility); Jonathan Gruber, *Health Insurance and the Labor Market* 1-86, at 1 (Nat’l Bureau of Econ. Research, Working Paper No. 6762, 1998) (noting that workers may be “locked” into their jobs for fear of losing health insurance).

68. *Id.*

69. The Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 (1996).

70. Glied & Borzi, *supra* note 62, at 407.

insurance offerings.<sup>71</sup>

*B. Problems Associated with Employer-Provided Healthcare*

Despite the arguments to maintain a system in which employers primarily carry the burden to provide health care for the nation's workforce, more convincing claims militate against the status quo. Employer-based health care creates unfair tax advantages, misaligns incentives and preferences, results in excessive reliance on federal support, and generates numerous market inefficiencies.

1. Unfair Tax Advantage

The tax advantage discussed in Part II, *supra*, is the engine that drives the employer-based system. Any tax incentive, however, is really just a redistribution of sorts.<sup>72</sup> As it stands, the employed get a tax break to procure health insurance, whereas the unemployed do not get the same advantage.<sup>73</sup> This simply adds to an uneven playing field, as individuals outside of group plans face adverse selection problems that result in already-higher costs.<sup>74</sup>

2. Misaligned Incentives

Employers act as third-party intermediaries between the insured and the product. Because employers by definition must provide insurance to groups of people, they must choose to offer insurance products that meet the basic needs of all their employees, such that employers are not able to customize their choice of insurance products the same way an individual who purchases his or her own insurance might.<sup>75</sup> The most striking example of this is that employers generally favor managed care, whereas employees prefer the greater flexibility of plans that allow choices of providers.<sup>76</sup> If the system aligned incentives completely, employers and

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71. See Judith Messina, *Independent Workers Come of Age*, CRAIN'S N.Y. BUS., Jan. 1, 2007, at 13 (discussing the Freelancers Union's efforts at providing services and advocacy for independent contractors).

72. See Posting of Richard Posner, *supra* note 46 (noting that taxpayers and employees really pay for employer-based health care through tax subsidies and lower wages brought on by the higher labor costs of job-based health insurance).

73. For an illustration of this phenomenon, see Messina, *supra* note 71 (explaining that independent contractors trade certain benefits for their employment autonomy).

74. *Id.*; Posting of Gary Becker, *supra* note 80.

75. David A. Hyman, *Regulating Managed Care: What's Wrong with a Patient Bill of Rights*, 73 S. CAL. L. REV. 221, 233-34 (2000).

76. *Id.* at 227.

employees would prefer the same insurance products. Some even argue that “[m]ost of the difficulties with employment-based insurance stem from the fact that someone other than the ultimate consumer of health care is making most of the decisions about what coverage to purchase and how much to pay.”<sup>77</sup>

### 3. Inefficiencies and Over-Spending on Health Care

In the health insurance context, several studies indicate that more coverage does not necessarily mean better coverage. In the famous fifteen-year RAND Health Insurance Experiment (RHIE) that began in 1971,<sup>78</sup> investigators determined that, among test groups who had access to different levels of insurance coverage, higher co-insurance rates had no adverse consequences on the average person.<sup>79</sup> Because health care benefits are not part of taxable income and there are no limits on the deductible amount, employers have incentive to load up on health benefits and offer the “best” possible plan to woo the best job seekers.<sup>80</sup> However, as the RHIE makes clear,<sup>81</sup> providing more coverage will not necessarily ensure healthier workers.<sup>82</sup> Even absenteeism may increase with better insurance, perhaps because doctor visits become more affordable.<sup>83</sup> In fact, the RHIE suggests that employees are often over-insured and consume more health products without realizing a gain that would be expected in normal consumption behavior.<sup>84</sup>

Furthermore, some maintain that better access to health care through more comprehensive insurance can lead to riskier behavior and worse health. In one study, Jonathan Klick and Thomas Stratmann found that alcohol use increased at a statistically significant rate after the government

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77. Hyman & Hall, *supra* note 7, at 26-27.

78. Robert H. Brook et al., *The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate* (RAND Health, Santa Monica, Cal.), 2006, [http://rand.org/pubs/research\\_briefs/2006/RAND\\_RB9174.pdf](http://rand.org/pubs/research_briefs/2006/RAND_RB9174.pdf).

79. See Jonathan Gruber, *The Role of Consumer Copayments for Health Care: Lessons from the RAND Health Insurance Experiment and Beyond* (The Henry J. Kaiser Family Foundation, Menlo Park, Cal.), Oct. 2006 (highlighting lessons from the Rand Health Insurance Experiment).

80. Posting of Gary Becker, [http://www.becker-posner-blog.com/archives/2007/01/reforming\\_the\\_a.html](http://www.becker-posner-blog.com/archives/2007/01/reforming_the_a.html) (Jan. 29, 2007, 20:54 EST).

81. Brook et al., *supra* note 78, at 3.

82. See, e.g., Jonathan Klick & Thomas Stratmann, *Subsidizing Addiction: Do State Health Insurance Mandates Increase Alcohol Consumption?*, 35 J. LEG. STUD. 175 (2006) (finding increased availability of addiction treatment led to higher alcohol consumption rates).

83. JOSEPH P. NEWHOUSE, *FREE FOR ALL? LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT* (Harvard Univ. Press 1993).

84. Brook et al., *supra* note 78, at 3.

introduced laws that required insurers to provide drug treatment coverage.<sup>85</sup> Likewise, it has been suggested, if not proven, that wide access to health care of an unprecedented quality has caused the obesity epidemic in the United States, as consumers feel freer to engage in risky eating behavior when sated with the knowledge that science will cure all ills.<sup>86</sup> Once recognized, this inefficiency became a main impetus for President George W. Bush's push<sup>87</sup> for Health Savings Accounts (HSA).<sup>88</sup> The theory behind HSAs is that, if consumers are given money in the form of tax free contributions instead of directly-subsidized health services, they will be more cost-conscious and will consume insurance products more efficiently.<sup>89</sup>

#### 4. Reliance on Federal Programs

Employer-based health care is not a panacea—it does not cover everyone. In 2000, the percentage of firms that offered health benefits was 69%,<sup>90</sup> while in 2006, only 61% of firms offered health benefits to at least some of their employees (a similar percentage to the previous year).<sup>91</sup> Inevitably, a system that relies so heavily on employers to provide insurance creates massive gaps of coverage with, namely, the unemployed, underemployed, self-employed, and the retired. To fill those gaps, the government had no better option than to bolster the bloated spending programs of Medicaid and Medicare.<sup>92</sup>

#### 5. Overall Market Inefficiencies

A tangible result can be observed in the automobile industry,<sup>93</sup> where the burden of lifetime health care costs and pension obligations to workers

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85. Klick & Stratmann, *supra* note 82, at 7.

86. MICHAEL POLLAN, *IN DEFENSE OF FOOD: AN EATER'S MANIFESTO* 9 (Penguin Press, N.Y. 2008).

87. *See, e.g.*, Tami Luhby, *Bush Proposal to Push Health Savings Accounts*, *NEWSDAY*, Jan. 24, 2007 (discussing President George W. Bush's plans in previous years to promote HSA's).

88. *Cf.* Jennifer Spiegel, Comment, *Employee Driven Health Care: Health Savings Accounts, More Harm Than Good*, 8 U. PA. J. LAB. & EMP. L. 219 (arguing that HSA's are not a good vehicle for making health care spending more efficient).

89. *Id.* at 223-24.

90. 2006 Kaiser Findings, *supra* note 3, at 4.

91. *Id.*

92. *See* Madrian, *supra* note 14, at 4-5 (providing an overview of the U.S. health care system and discussing the impact of a fragmented system of health insurance delivery).

93. *See* Joseph B. White et al., *GM Labor Deal Ushers In New Era for Auto Industry*, *WALL ST. J.*, Sept. 27, 2007, at A1 (documenting GM's contractual restructuring of health care benefits to its employees).

who sometimes live over 40 years after retirement has crippled domestic manufacturers.<sup>94</sup> Japanese car makers have capitalized on this situation and advanced to lead the race by becoming the largest car-makers in the world.<sup>95</sup>

### C. *Why Mandates are Particularly Problematic*

As with the tax incentives in the classic system of employer-based health care, mandates encourage employers to assume the burden of covering their workers. Nevertheless, mandates use sticks instead of (or in addition to) carrots.<sup>96</sup> The only deficiency that a mandate aims to cure is when employer health care does not reach a wide enough swath of the population. Even if the problems enumerated in Part II (B) did not exist, mandates would fail to accomplish their goal, and in fact can make the situation worse.

According to one study, about 60% of uninsured workers will remain uninsured if New York enacts its pay or play plan.<sup>97</sup> The study used the New York plan to estimate what effect similar plans would have in other states if enacted. One of the major reasons the large number of uninsured would remain untouched is that small companies, which the plan exempts out of economic and political necessity, employ over 40% of uninsured workers.<sup>98</sup> Another complicating factor is that the plans would not benefit the majority of workers who earn less than twice the poverty line.<sup>99</sup> Most troubling, the report finds that, as with a minimum wage law, a pay or play mandate would drive up the effective cost of hiring low skilled workers in a region by adding an additional layer of cost, which consequently takes away jobs from the very population that the solution intends to help.<sup>100</sup>

On the other hand, mandates also do what they are meant to do, i.e., to ensure that more employers provide health insurance to their employees. By creating such an incentive, however, the problems with employer-based health care become more widespread. An example of the ensuing irony comes from then-presidential candidate Barack Obama's platform on

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94. See Chad Terhune & Laura Meckler, *A Turning Point for Health Care*, WALL ST. J., Sept. 27, 2007, at F1 (discussing economic problems of employer-based health care).

95. Amy Chozick & Norihiko Shirouzu, *GM Slips Into Toyota's Rearview Mirror—Japanese Firm Passes U.S. Rival for First Time in Quarterly Global Sales*, WALL ST. J., Apr. 25, 2007, at A7.

96. See generally Hyman, *supra* note 41 (reviewing the strengths and weaknesses of the Massachusetts plan).

97. Richard V. Burkhauser & Kosali I. Simon, *Who Gets What From Employer Pay or Play Mandates?* 9 (Nat'l Bureau of Econ. Research, Working Paper No. 13,578, 2007).

98. *Id.*

99. *Id.* at 15.

100. *Id.* at 24.

health care reform.<sup>101</sup> While the campaign promised portability and choice through a National Health Insurance Exchange to make health coverage affordable for individuals and small businesses, it simultaneously proposed that “[e]mployers that do not offer coverage or make a meaningful contribution to the cost of quality health coverage for their employees [must] contribute a percentage of payroll toward the costs of their employees['] health care.”<sup>102</sup> Such a negative incentive will encourage more employers to offer insurance, which, in turn, *limits* portability and choice.

#### D. ERISA Preemption

Whether or not mandates are beneficial, their successful enacting faces an uphill legal battle. In *Retail Industry Leaders Ass'n v. Fielder*,<sup>103</sup> the Fourth Circuit upheld a lower court's ruling that ERISA preempted Maryland's pay or play plan and therefore nullified the state's plan.<sup>104</sup> The court found that, “[b]ecause the Act directly regulates employers' provision of healthcare benefits, it has a ‘connection with’ covered employers’ ERISA plans and accordingly is preempted by ERISA.”<sup>105</sup> The Maryland mandate effectively targeted one company, Wal-Mart,<sup>106</sup> through various provisions that restricted the mandate to super-large employers, and thus singled out the Arkansas-based company.<sup>107</sup> But, the decision did not rest on equal protection<sup>108</sup> grounds—it was based entirely on the laws of federal preemption.<sup>109</sup> Similarly, in a suit against a New York county that passed a comparable provision, the same plaintiff-organization successfully challenged the county's law in the Eastern District of New York.<sup>110</sup>

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101. Barack Obama & Joe Biden: Plan for a Healthy America, <http://www.barackobama.com/issues/healthcare/> (last visited Oct. 22, 2008); see Shan Carter et al., *On the Issues: Health Care*, N.Y. TIMES, <http://elections.nytimes.com/2008/president/issues/health.html> (last visited Oct. 23, 2008) (comparing the positions of presidential candidates Barack Obama and John McCain on health care issues).

102. *Id.*

103. 475 F.3d 180 (4th Cir. 2007).

104. *Id.* at 198.

105. *Id.* at 197.

106. *Id.* at 183.

107. *Id.* at 184-85.

108. See U.S. CONST. amend. XIV, § 1 (stating the Equal Protection Clause's mandate that no state shall “deny to any person within its jurisdiction the equal protection of the laws”).

109. U.S. CONST. art. VI (declaring federal law as the “supreme Law of the Land” that may preempt states in certain subject areas).

110. *Retail Indus. Leaders Ass'n v. Suffolk County*, 497 F. Supp. 2d 403, 418 (E.D.N.Y. 2007).



These two cases demonstrate a probable basis upon which courts may invalidate the law in Massachusetts or in any other state that passes a pay or play mandate; ERISA likely will preempt a state law if the law unconstitutionally infringes upon the congressional mandate for ERISA to regulate certain employers' benefits programs.<sup>111</sup> Nevertheless, this issue is unlikely to fade away soon, as significant pressure mounts on both sides of the issue, and some argue that ERISA should not preempt plans that offer employers a choice to either pay or play.<sup>112</sup> In either case, advocates of pay or play mandates seek to amend ERISA to allow state experimentation with employer mandates and other health care provisions that ERISA possibly may preempt.<sup>113</sup>

#### IV. AN ALTERNATIVE TO THE EMPLOYER-BASED SYSTEM

This Comment has identified several aspects of the employer-based health care system that foster misaligned incentives, inefficient distribution of health services, and inefficiencies in overall health care markets. This section proposes that alternative market-based systems may avoid some of these problems.

Health Savings Accounts<sup>114</sup> encourage individuals to pay for medical expenses out-of-pocket by allowing individuals to apply pre-tax dollars toward eligible medical costs.<sup>115</sup> For an HSA to qualify, it must be accompanied by a high deductible health plan<sup>116</sup> (otherwise known as catastrophic health insurance). Individuals must pay for routine expenditures out of the tax-deductible HSA, but the insurance plans kicks in if an individual needs a major service that exceeds his or her deductible.<sup>117</sup> Requiring individuals to pay for the most routine medical

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111. See, e.g., Zelinsky, *supra* note 65 (finding that the Massachusetts fair share contribution provision is likely to be overturned under the same analysis as the Fourth Circuit used in *Retail Industry*).

112. See, e.g., Rebecca A.D. O'Reilly, *Is ERISA Ready for a New Generation of State Health Care Reform? Preemption, Innovation, and Expanding Access to Health Care Coverage*, 8 U. PA. J. LAB. & EMP. L. 387, 407 (arguing, before the Fourth Circuit's decision in *Retail Industry*, that the Maryland plan is distinguishable from the previous health plans that ERISA preempted, because the Maryland plan provided a choice to employers to either dedicate 8% to health care costs or pay the difference to the state).

113. See, e.g., Zelinsky, *supra* note 65 (arguing that Congress should amend ERISA to allow states greater freedom to regulate healthcare).

114. See 26 U.S.C. § 223(e) (2006) (codifying the tax rules that govern Health Savings Accounts).

115. See Spiegel, *supra* note 88, at 224-29 (summarizing the requirements and guidelines of HSA's).

116. See 26 U.S.C. § 223(c)(1)(A)(i)(2006) (defining an eligible individual as one covered under a high deductible healthcare plan).

117. 26 U.S.C. § 223(d)(1)(2004) (defining allowable HAS contributions and spending).

procedures, albeit with pre-tax dollars, creates a disincentive for excess treatment.

By shifting the purchasing decisions from third parties back to the individual, HSAs address the problem that employer-sponsored plans cause, i.e., that pre-paid insurance plans effectively encourage an “all-you-can-treat” mentality among the insured.<sup>118</sup> In a normal consumption environment, a consumer would evaluate the cost against the benefit. In the current health care environment, because costs are generally fixed and the large premiums that employers pay are tax-free, health consumers are encouraged to use more services without due regard for the true costs. When the cost of each incremental procedure approaches zero, the benefit of conducting one more test or undergoing one more procedure may seem to outweigh the risk of not doing so, even as the potential reward of that test or procedure itself approaches zero. As such, the consumer does not recognize true costs and uses services in a way that creates inefficiency. In turn, market inefficiencies drive up the costs of premiums and overall medical care, which further bars entry to low-income individuals.

One common criticism of HSAs is that they disproportionately benefit the affluent because they are structured as a tax benefit.<sup>119</sup> But, that concern ignores the broader impact that the efficient use of medical resources can have on decreasing costs of medical care, which frees health care providers from bloated cost structures associated with the “all-you-can-treat” health plans. Additionally, HSAs and catastrophic insurance can be coupled with directly refundable tax credits rather than simple refunds, which would provide cash for health coverage to anyone who files a tax return.<sup>120</sup>

Of course, a person might forego critical treatment to save his or her own money, as opposed to that of the insurance program or employer. Several factors, however, allay that concern. First, some measure of control before spending on health services is efficient<sup>121</sup> and may even have beneficial effects, such as limiting the moral hazard problems associated with insurance.<sup>122</sup> Second, there is no indication that, when faced with the

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118. See Brook et al., *supra* note 78 (documenting the impact of cost-sharing in healthcare programs).

119. Spiegel, *supra* note 88, at 228.

120. The McCain presidential campaign had proposed such a rebate. See McCain-Palin 2008, <http://www.johnmccain.com/Informing/Issues/> (follow “Health Care” hyperlink) (last visited Oct. 23, 2008) (containing the McCain campaign’s proposal to offer such rebates); see also Carter et al., *supra* note 101 (comparing the presidential candidates’ proposals on healthcare).

121. See, e.g., Brook et al., *supra* note 78 (documenting the positive impact of cost sharing in health care); Gruber, *supra* note 79 (evaluating the tradeoffs of patient co-insurance charges).

122. See Klick & Stratmann, *supra* note 82, at 181-82 (discussing how limiting the costs

option, people will choose to spend funds from an HSA to achieve better health now at the cost of having less money available in the account for future potential needs. Even if people do make this choice, there is no reason to suspect that it is a bad choice, or that individual consumers of health care are any less capable to make these risk/benefit decisions than an outside organization.<sup>123</sup> In the true meaning of the word “insurance,” health insurance would resemble closely an HSA plan. Insurance would provide coverage (at a much lower cost) for rare, potentially bank-breaking occurrences, but not for routine expenditures.

By analogy, HSAs more closely resemble the auto-insurance market, where regular coverage typically applies only in the event of major accidents. For example, if auto insurance covered routine maintenances such as oil changes, tune-ups, new tires, etc., the cost for the insurance would rise dramatically even if typical expenditures did not go up. If the RAND study<sup>124</sup> is any indication of the behavior of insurance utilization as a consequence of availability, it is easy to imagine that drivers would change their oil far more frequently when they do not have to pay out of pocket, even to a point beyond what is necessary.

## V. CONCLUSION

Despite the American public’s familiarity, and perhaps comfort, with the notion that employers provide health insurance, the employer-based health care system is the wrong answer. In fact, the very question of how best to provide health insurance to every American should be rephrased as how best to ensure that every American has access to affordable, quality health care. Health care costs are soaring, physicians are leaving primary care for specialties with higher reimbursements, and significant portions of the population remain not only uninsured, but also without access to quality care. The solution is to explore other market-based mechanisms for providing health care, rather than requiring that more employers provide more insurance. More efficient alternatives, such as Health Savings Accounts, can make access to health care more widely available. This option avoids some of the pitfalls of typical employment-provided health care, and has some unique benefits that promote individual responsibility for planning for health coverage in advance. Although this Comment does not discuss them, other suggestions exist as well, including a proposal for

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of addictive behavior can result in an increase in that type of behavior, or “rational addiction”).

123. See, e.g., Posting of Richard Posner, *supra* note 46 (discussing regulatory and market-based approaches to reducing the cost of healthcare).

124. Brook et al., *supra* note 78.

individual rather than employer mandates.<sup>125</sup>

The employer-based health care system maintains the broken status quo because it creates misaligned incentives, eliminates otherwise viable market forces, and to an extent, removes the individual from the decision-making process in his or her own health and well-being. Politicians and lawmakers who look to fix the system often turn to employers and ask how best to ensure that they provide *more* health insurance. But they are asking the wrong question; the challenge of increasing efficient access to health care requires shifting employers out of the business of providing health care, and instead finding creative ways to enable individuals to purchase the care they want and need in a market-based system.

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125. See, e.g., The Massachusetts Plan, *supra* note 26 (legislating individual mandates as part of a comprehensive plan to achieve universal health coverage); see also Obama & Biden, *supra* note 101 (suggesting a plan that does not institute individual mandates across the board, but calls for mandatory coverage of children). *But see*, Sack, *supra* note 60 (reporting that the Massachusetts individual mandate may be one factor causing a shortage of primary care physicians in the state).