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LIBERTY, JUSTICE, AND INSURANCE FOR ALL: RE-IMAGINING THE EMPLOYMENT-BASED HEALTH INSURANCE SYSTEM

Carolyn V. Juárez*

This Note examines the history of employment-based health insurance and the inherent historical limitations that have led to an erosion of health insurance coverage. Based on a review of several studies, this Note argues that the number of uninsured Americans has reached crisis proportions. State reform efforts, legislative proposals, and other proposed solutions have failed to repair the system. Nonetheless, this Note argues that employment-based health care is integral to the structure of national health care. Furthermore, health insurance coverage can be increased by combining employment-based health care with three reforms: large-employer mandates, refundable tax credits, and purchasing pools. This Note concludes that, despite its flaws, the employment-based health care system can serve as a foundation on which to make effective changes and increase levels of health insurance coverage.

> "Every day, we worry . . . [f]or now, I live with a knot in my stomach each day[.]"[1]

> "When I was uninsured, my wife and I had to weigh our health decisions, questioning whether our child was sick enough to justify a visit to the doctor[.]"[2]

> "[W]e are playing Russian roulette with our own health care."[3]

In their own words, uninsured Americans tell a heartbreaking story of worry, guilt, and, above all, awareness of what a risky proposition it is to be uninsured in the United States.

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1. CoverTheUninsuredWeek.org, Personal Stories: Melissa Adams (2004), *available at* http://covertheuninsuredweek.org/stories/index.php?StoryID=33 (on file with the University of Michigan Journal of Law Reform).

2. CoverTheUninsuredWeek.org, Personal Stories: Joseph Cabrera (2004), *available at* http://covertheuninsuredweek.org/stories/index.php?StoryID=13 (on file with the University of Michigan Journal of Law Reform).

3. CoverTheUninsuredWeek.org, Personal Stories: Deb Pettid (2004), *available at* http://covertheuninsuredweek.org/stories/index.php?StoryID=6 (on file with the University of Michigan Journal of Law Reform).

Although the United States spends an estimated $1.4 trillion on health care and is projected to spend as much as $1.8 trillion in 2005, which is twice as much per person than any other industrialized country, the number of uninsured Americans has increased for the second consecutive year.[4] The most recent annual report released by the U.S. Census Bureau in its Current Population Survey shows that in 2002, about 15.2% of Americans, or 43.6 million people, did not have health care coverage for the year, a 2.4 million increase from the previous year.[5] The uninsured are not clustered geographically; the states with the largest number of uninsured people range across the country and include California, Texas, New York, Florida, and Illinois.[6] Contrary to popular perception, the uninsured are working. Of the people who were uninsured during 2001–2002, 70.7% were employed and 7.2% were actively looking for employment.[7] Lack of health care coverage cuts across income levels: although more than half of individuals in families with incomes at or below the federal poverty level were uninsured, 16.5% of people with incomes four or more times the poverty level were also uninsured.[8]

These statistics have real, life-and-death effects. The uninsured often forego preventive care, such as routine checkups and cancer screening, and delay or forego needed medical care for chronic conditions or recommended treatments.[9] As a result, the uninsured have a fifteen to eighteen percent mortality rate increase compared to those who are insured, and as many as 18,000 unin-

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4. OFFICE OF DISABILITY, AGING AND LONG-TERM CARE POLICY, U.S. DEP'T OF HEALTH AND HUMAN SERVICES, ADDRESSING THE NEW HEALTH CARE CRISIS: REFORMING THE MEDICAL LITIGATION SYSTEM TO IMPROVE THE QUALITY OF HEALTH CARE 11 (March 3, 2003), *available at* http://aspe.hhs.gov/daltcp/reports/medliab.htm (on file with the University of Michigan Journal of Law Reform). *See also* Robert F. Rich, *Health Policy, Health Insurance and the Social Contract*, 21 COMP. LAB. L. & POL'Y J. 397, 414 (2000) ("The paradox of the U.S. health care system is that we spend more on health care than any other country in the world, but we do not observe a similar increase in the quality of care that is being provided."); Gina Keating, *Strike Shows Health Care Boots Pay as No. 1 Issue*, REUTERS NEWS SERV., Oct. 13, 2003, *at* http://www.insurance-portal.com/101503.htm#3 (on file with the University of Michigan Journal of Law Reform) ("In 2000, the United States spent $1.3 trillion on health care, more than any other developed nation and more than it spent on national defense[.]").

5. Lisa Richwine, *Those Without Health Insurance Increasing*, REUTERS NEWS SERV., Sept. 30, 2003, *at* http://lists.insurance-letter.com/archives/insurance-letter/200310/msg00000.html#2 (on file with the University of Michigan Journal of Law Reform).

6. FAMILIES USA, GOING WITHOUT HEATH INSURANCE: NEARLY ONE IN THREE NON-ELDERLY AMERICANS 3 (Mar. 2003), *available at* http://www.familiesusa.org/site/DocServer/Going_without_report.pdf?docID=273 (on file with the University of Michigan Journal of Law Reform).

7. *Id.* at 5.

8. *Id.* at 6.

9. *Id.* at 14–15.

sured people die each year because of a lack of health insurance.[10] The uninsured also affect emergency care for all patients. Currently, many uninsured people forego traditional doctor's office visits; uninsured adults are four times more likely, and uninsured children are five times more likely, to visit emergency rooms as a regular place of care.[11]

Any hospital that receives Medicare funds—virtually all any hospitals in the United States—is required "to provide treatment to all patients seeking care for emergency medical conditions regardless of the ability to pay and regardless of their eligibility for Medicare."[12] As a result, emergency rooms are crowded with people who have non-emergency illnesses, such as diabetes, heart disease, and flu. When emergency rooms are crowded with those who a primary care physician could treat, there are longer waits for true emergencies. In addition, society subsidizes these visits. When the uninsured go to private hospitals, the cost of care is added to the bills of insured patients, ultimately passing through the system to insured patients and their employers in the form of higher premiums and deductibles.[13] When the hospital is public, the costs are borne by taxpayers through state and county spending on indigent health care services.[14]

Many commentators and politicians describe these alarming effects as a genuine health care crisis. They attribute the number of uninsured to decreased employment-based coverage resulting from lost jobs as the economy struggles through a recession, as well as to sharply rising health care costs.[15] Many employers—mainly small employers, low-wage employers, and employers with older workers—do not offer health insurance because the cost of providing health insurance to their employees is simply unaffordable.[16]

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10. *Critical Condition: Peter Jennings Interviews ABC NEWS' Medical Editor on the Health-Care Crisis*, ABCNEWS.COM, Oct. 21, 2003, *at* http://abcnews.go.com/sections/WNT/DrJohnson/healthcare031021.html (on file with the University of Michigan Journal of Law Reform).

11. FAMILIES USA, *supra* note 6 at 14. In Denver, "[t]he crush of nonpaying patients has forced both of Denver's public hospitals to post nurses at the door to screen out people who don't have a life-or-death problem." Allison Sherry & Marsha Austin, *The Uninsured: Less Money for System, Fewer Options for Patients*, DENVER POST, Mar. 9, 2003, at 2.

12. Rich, *supra* note 4, at 406 (describing the Emergency Medical Treatment and Active Labor Act of 1986).

13. James B. Roche, *Health Care in America: Why We Need Universal Health Care and Why We Need It Now*, 13 ST. THOMAS L. REV. 1013, 1023 (2001).

14. *Id.*

15. FAMILIES USA, *supra* note 6, at 11.

16. *Id.*

Even where employers do offer health insurance coverage, some employees cannot afford to pay their share of the premium cost.[17]

Predictably, there is sharp division among lawmakers, insurance companies, and employers over the proposed solutions to this crisis. Proposals include transitioning from the United States' traditionally employment-based system to a single-payor system run by the federal government; mandating employment-based coverage; structuring small- and medium-sized insurance purchasing pools; and providing voucher-like tax credits to the uninsured.

Because a problem of this magnitude did not pop up overnight, Part I of this paper will present a brief history of employment-based health care and failed legislative attempts to repair the system, and will summarize some of the more innovative state solutions to the problem. Next, Part II will use California's Measure SB2, requiring businesses to offer health care coverage, to provide context for a more detailed examination of the strengths and weaknesses of the employer-based system and employer-mandated coverage. Finally, Part III will survey the battleground over who should pay for health care coverage, and will advocate reform that blends employer mandates, tax credits, and purchasing pools.

I. Understanding the Health-Care Debate

The current American health care system is largely employment-based. While there are government programs that cover the poor and elderly, such as Medicaid and Medicare, employment-based health insurance covers 61.3% of the population.[18] Employment-based health benefits have become such a hot-button issue in labor negotiations that in 2003, more than 80,000 supermarket workers in California and four other states went on strike and transit workers in Los Angeles and garbage workers in Chicago walked off the job, all disputing proposed changes in their health benefits.[19] Some employees are even agreeing to accept smaller pay raises in exchange for retention of health plans that require them to pay little or nothing for comprehensive health insurance.[20]

17. *Id.*

18. The percent of the population covered by employment-based health insurance actually decreased 1.3% from 2001. *See* Richwine, *supra* note 5.

19. David E. Rosenbaum, *Co-Paying the Piper: Do Some Pay Too Little for Health Care?*, N.Y. Times, Oct. 26, 2003, at 1.

20. Workers at Verizon and the Big Three automakers have agreed to these concessions. *Id.*

Employment-based health care was not always the norm. In fact, it is a relatively new innovation that has gradually gained ground over the past few decades, assisted in part by legislation and the rise of the managed care system. Part I addresses the historical circumstances contributing to the current popularity of employment-based health care, and examines the failure of national legislation to address many of the problems with the system. Finally, Part I ends with a discussion of the various ways that states have attempted, with mixed success, to close the gaps created by piecemeal regulation of employment-based health care.

A. How Did We Get Here? The History of Employment-Based Health Insurance

Before World War II, employers provided few Americans with health insurance: one estimate suggests that only four million Americans, or approximately 3% of the population, had employment-based coverage in 1930.[21] However, during World War II the Office of Price Administration implemented wage and price controls over employee wages in an attempt to stem inflation.[22] Many benefits, such as employer-provided insurance and pensions, were not included in wage calculations and, therefore, were excluded from the controls.[23] Freezing wages combated inflation, but, as a secondary effect, forced employers to compete in the labor market by enhancing fringe benefits such as health insurance.[24] Labor unions promoted the provision of such benefits and, during the late 1940s and 1950s, insisted on increasingly richer benefit packages as compensation.[25]

In addition to providing a means by which employers could compete for labor, there were, and still are, tax incentives that encourage employers to contribute to health insurance and employees to seek employer-based plans. The Internal Revenue Service (IRS) and Congress, in turn, expressly allowed employers to deduct insurance payments as ordinary and necessary business

21. David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH POL'Y, L. & ETHICS 23, 25 (2001). Some employers were an exception and offered forms of managed care to workers and their families, but the medical profession "vehemently opposed such 'contract' or 'corporate' practice, and sought to limit the spread of such arrangements." *Id.*

22. *Id.*

23. *Id.*

24. *Id.*

25. *Id.* at 26.

expenses without requiring them to include the amounts as income paid to employees.[26] The tax treatment effectively provides a subsidy for employment-based health care (currently worth a total of more than $100 billion in foregone tax revenue per year), allowing employers to purchase health insurance by using employees' before-tax income instead of forcing employees to purchase it with after-tax income.[27] The subsidy created a significant incentive for employees to continue receiving health insurance through their employers, and provided a means for employers to avoid the full impact of tax rates that, during World War II, were as high as 85%.[28] Currently, this subsidy creates a major barrier to reworking the employment-based health care system: the government is effectively paying half of each employee's premium, which encourages employees to prefer employer-provided health insurance to taxable income.[29]

By 1954, because of the wage controls, union endorsement of employer-provided benefits, and the federal tax structure, employment-based health insurance covered 70% of all workers.[30] Commentators have noted that the popularity of such plans has led to a uniquely American view of health care as a privilege, expressed as a benefit of employment.[31] However, this view is changing as the percentage of the population covered under employment-based plans has steadily decreased and more Americans join the ranks of the uninsured.[32]

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26. *Id.* at 25. The IRS issued a ruling to this effect in 1943, and withdrew it ten years later. *Id.* In 1954, Congress effectively resurrected the ruling by amending the Internal Revenue Code to "expressly exclude employment-based coverage from taxable income." *Id.*

27. *Id.* As Hyman and Hall explain it, the subsidy "is a function of the marginal tax rate for any given taxpayer, but its size is larger for higher-income taxpayers because of the progressivity of federal taxation." *Id.*

28. Dayna Bowen Matthew, *Controlling the Reverse Agency Costs of Employment-Based Health Insurance: Of Markets, Courts, and a Regulatory Quagmire*, 31 WAKE FOREST L. REV. 1037, 1042 (1996). The tax structure allowed employers to spend fifteen cents on each after-tax dollar to offer health benefits and permitted the employer to deduct the payments as a business expense and exclude the benefit from employees' taxable income. *Id.*

29. NAT'L CTR. FOR POLICY ANALYSIS, CONSENSUS ON HEALTH REFORM BRIEF ANALYSIS No. 199 (1996), *available at* http://www.ncpa.org/ba/ba199.html (on file with the University of Michigan Journal of Law Reform) [hereinafter CONSENSUS ON HEALTH REFORM]. Every dollar of health insurance premiums paid by employers escapes an income tax, "a 15.3 percent Social Security (FICA) tax, and a 4, 5, or 6 percent state and local income tax, depending on where the employee lives.... For an employee in the 50 percent tax bracket, for example, $2 of nontaxed health insurance need be worth only slightly more than $1 to be preferable to $2 of taxable wages." *Id.* This subsidy costs the federal government about $84 billion a year in tax subsidies for employer-provided health insurance, and state and local governments pay another $10 billion. *Id.*

30. *Id.*

31. Rich, *supra* note 4, at 399.

32. Matthew, *supra* note 28.

Recent polls show that a majority of Americans are concerned about the future of the health insurance system.[33] Mobilization efforts such as Cover the Uninsured Week, supported by former Presidents Gerald Ford and Jimmy Carter, have attempted to focus the nation's attention on the plight of the uninsured.[34] Such efforts have renewed the debate over solutions to the employment-based system—a system that, though historically entrenched, is increasingly seen as flawed.

B. Federal Failures: Regulatory Gaps and Failed Attempts to Expand Coverage

Federal legislation is one of the most frequently advocated methods of expanding the scope of health-care coverage to include those outside the employment system. The checkerboard of regulations, including Medicare and Medicaid, the Employee Retirement Income Security Act ("ERISA"), the State Children's Health Insurance Program ("SCHIP"), and the Consolidated Omnibus Budget Reconciliation Act ("COBRA"), have helped cover people left out by the now-traditional employment-based system; however, haphazard coverage and preemption of traditional forms of regulation actually worsen the problem by leaving employment-based health insurance effectively unregulated.[35] Compounding the problem, more far-reaching legislative efforts such as the Clinton-sponsored Health Security Act of 1993 have failed to substantially reform the health care system.

Medicare[36] and Medicaid[37] provide an entitlement to health insurance coverage for the elderly and for low-income people who meet eligibility standards and work to cushion the effects of the decrease in employment-based health care coverage. Medicare covers nearly all of the elderly,[38] while Medicaid covered about

33. An ABC News poll shows that, although 64% of people with health insurance are satisfied with their health care, 59% are worried about being able to afford it in the future. *See Critical Condition*, *supra* note 10.

34. Press Release, CoverTheUninsuredWeek.org, Former Presidents, Surgeons General and Health Secretaries Head Effort on Uninsured (Sept. 30, 2003), *available at* http://www.covertheuninsuredweek.org/media/docs/release093003.php3 (on file with the University of Michigan Journal of Law Reform).

35. Hyman & Hall, *supra* note 21, at 29.

36. 42 U.S.C. § 1370 (2000).

37. 42 U.S.C. § 1396a (2001).

38. KAISER COMM'N ON MEDICAID AND THE UNINSURED, KEY FACTS: THE UNINSURED AND THEIR ACCESS TO HEALTH CARE 1 (Jan. 2003), *available at* http://www.publiceducation.

25.7% of the population in 2002, up from 25.3% in 2001.[39] However, Medicaid coverage for adults is limited by stringent income eligibility standards[40] and, faced with budget deficits and rising Medicaid enrollment, many states are looking toward cutting Medicaid benefits to low-income people to help balance state budgets.[41]

SCHIP[42] has reduced the number of uninsured poor and near-poor children and "represents the greatest investment the United States has made in children since the enactment of Medicaid."[43] SCHIP was enacted in 1997 and provided $48 billion over ten years to states, which were required to choose between expanding Medicaid to cover more children or creating new programs to cover children under the age of 19 whose families are ineligible for Medicaid and meet specified income guidelines.[44] Despite the limited success of SCHIP, 9.2 million children remain uninsured.[45]

Although ERISA's stated purpose is to protect employees participating in employee benefit plans,[46] the statute is limited to "welfare benefit plans," also known as employment-based health insurance plans.[47] ERISA creates a large loophole in the regulatory scheme: insured plans are subject to state regulation, while self-insured plans are only subject to ERISA's "relatively lax regulatory scheme."[48] As a result, employment-based health insurance is effectively unregulated, since ERISA fails to seal the gaps in regulatory oversight.

COBRA[49] was heralded as a program in which the federal government had finally acted to stem the growing tide of uninsured

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org/pdf/CHIP/Uninsured_and_Their_Access.pdf (on file with the University of Michigan Journal of Law Reform).

39. Richwine, *supra* note 5.

40. KAISER COMM'N ON MEDICAID AND THE UNINSURED, *supra* note 38, at 2 ("[E]ven the poorest are generally ineligible if they do not have children.").

41. Charles Ornstein & Sue Fox, *The State; Blazing a Trail for Health Care*, L.A. TIMES, Sept. 15, 2003, at A1.

42. 42 U.S.C. § 1397ii (2001).

43. Rich, *supra* note 4, at 411.

44. *Id.*

45. KAISER COMM'N ON MEDICAID AND THE UNINSURED, *supra* note 38, at 1.

46. Employee Retirement Income Security Act (ERISA) of 1974, 29 U.S.C. §§ 1001–1461 (1994). *See also* Matthew, *supra* note 28, at n. 165.

47. Matthew, *supra* note 28, at 1065, 1067 ("Health insurance provided by employers through commercial insurance companies is a welfare benefit plan.").

48. *Id.* at 1065.

49. The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, 29 U.S.C. §§ 1161–1168 (1994). COBRA is a part of ERISA and "provides that health plans must allow a qualified employee to continue coverage for a minimum of 18 months and imposes a duty on the plan administrator to notify participants or their beneficiaries of such a right." Matthew, *supra* note 28, at n. 166 (citations omitted).

and provide an answer to what is described as "job-lock." "Job-lock" is the predicament that results from the linkage of employment and health coverage: many health insurance policies include waiting periods or exclusions for pre-existing conditions, or the worker may particularly value the terms of her current coverage, which can chill job mobility.[50] Congress also saw COBRA as a solution to a related problem: when workers lose their job, they also lose their health care coverage. Congress designed COBRA to enhance continuity and portability of health care coverage,[51] but its effects have been limited. While it does allow employees to continue the coverage received under the employment-based system, it requires employees to pay a 2% fee in addition to paying the full cost of their premiums.[52] As a result, the costs of such coverage are often prohibitive: an estimated four out of five unemployed workers who were eligible for COBRA coverage declined to purchase it.[53]

Although more comprehensive federal legislation is needed to close the regulatory gaps, when legislators have proposed such reforms, critics have vociferously opposed them. Perhaps the most notorious example of the failure of national legislation is the Health Security Act of 1993 ("HSA").[54] The premise of the proposed legislation was a re-envisioning of health care as a legal right for all citizens, not a privilege conferred by employment.[55] The Act proposed universal access to health care by "providing incentives to private insurance companies, enabling the formation of small groups and 'purchasing cooperatives,' and by increasing the role of government in providing access and services, as required."[56]

Large insurance companies, businesses and provider groups waged a public relations and lobbying war to convince Americans that the Clinton proposals would increase the cost of health care, extend the scope of government regulation over individual choice to an unacceptable level, and decrease the quality of health care

50. Hyman & Hall, *supra* note 21, at 28.

51. *Id.* at 29.

52. FAMILIES USA, *supra* note 6, at 11 ("[A]n unemployed worker must usually pay the employer's full costs . . . plus a 2% administrative fee. The national average cost of employer-provided family coverage plus a 2% fee is $8,113 a year.").

53. *Id.*

54. The HSA was, by no means, the only proposal introduced. In the same period, at least ten alternative proposals for health care reform were introduced, all of which were defeated in Congress. Rich, *supra* note 4, at 408. *See also* Theda Skocpol, *The Rise and Resounding Demise of the Clinton Plan*, HEALTH AFFAIRS, Spring 1995, at 66.

55. Rich, *supra* note 4, at 408. The Supreme Court has held that there is no fundamental right to health care nor is the United States obligated to provide health care to its citizens. Scott D. Litman, Note, *Health Care Reform for the Twenty-First Century: The Need for a Federal and State Partnership*, 7 CORNELL J.L. & PUB. POL'Y 871, 877 (1998).

56. *Id.*

that citizens receive.[57] Americans and other established participants in the health care system, accustomed to the workings of the employer-based system, became worried that the Clinton plan would drastically change or restructure the way the system had operated.[58] The critiques from employers and the health care industry, as well as the partisan attacks, focused these worries and ultimately persuaded Americans to reject the plan.[59]

C. State Efforts

Due to the failure of federal legislation to satisfactorily regulate employment-based health insurance, and to the collapse of proposed legislation that would dramatically expand coverage by reforming the employment-based system, there is increasing sentiment that states should step up to the regulatory plate.[60]

State and local governments are getting increasingly creative in their search for solutions to the health-care crisis. Approaches include creating purchasing pools to make health insurance more affordable for small businesses (California and New York City), implementing programs that subsidize the employee share of health insurance premiums for low-wage workers (Massachusetts, San Diego, Oregon, and Rhode Island),[61] and enacting mandates requiring businesses to provide health insurance (Hawaii).[62] Despite the variety of approaches, state and local governments have failed to make significant inroads on the crisis.

The biggest problem with the most obvious solution, subsidies for employees, is money. With the current state of the economy, many state and local governments are struggling to fund even basic services, let alone provide subsidies for health care. As a result, states have managed to scrounge money from less traditional places: at various times, Massachusetts' Insurance Partnership program has funded the program from federal matching Medicaid

57. *Id.*

58. Skocpol, *supra* note 54, at 78.

59. *Id.*

60. According to E. Richard Brown, director of the UCLA Center for Health Policy Research, "[w]e see little evidence from Washington that the current administration and the current Congress are going to do anything about the huge number of uninsured people in the country . . . I think there's growing sentiment that states need to do something." Ornstein & Fox, *supra* note 41.

61. Kimberly Weisul, *Throwing a Line to Uninsured Workers*, BUS. WK., Oct. 13, 2003, at 1.

62. Ornstein & Fox, *supra* note 41.

funds, the state budget, and tobacco settlement money.[63] There are also strict guidelines on who can benefit from the program: to qualify, small companies must pay at least half their workers' premiums and individual employees must make less than twice the federal poverty guidelines.[64]

Some programs, such as New York City's HealthPass program and Michigan's Muskegon County Community Health Project, are even more innovative. The HealthPass program does not offer subsidies, but eases administrative burdens on small companies by offering the employers a choice of 26 plans although the employer only writes one check.[65] HealthPass covers 80% of its costs through fees and is expected to break even by the end of 2004.[66] Muskegon County subsidizes health-care costs through a combination of Medicaid money and direct contracts with doctors, through which the organization has convinced many doctors to lower their rates.[67]

Hawaii is the only state that has enacted and implemented employer-mandated health care insurance.[68] Hawaii's Prepaid Health Care Act[69] requires most businesses to provide health insurance to employees who work at least 20 hours per week for four consecutive weeks.[70] Employers may cover the full cost of coverage or may choose to share the costs with their employees based on a fixed formula that requires the employer to contribute 50% of the cost and limits the employee's share to 1.5% of wages.[71] The mandate had dramatic effects at first, reducing Hawaii's uninsured population from 30% in the early 1970s to as low as 5% in the 1980s.[72] However, the percentage of uninsured has recently increased to 10% of Hawaii's population, and it is estimated that 58% of the uninsured are employed.[73] The increase is often attributed to a combination of several factors: sharply rising insurance rates, a

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63. Weisul, *supra* note 61.

64. *Id.*

65. *Id.*

66. *Id.* at 2.

67. *Id.*

68. Ornstein & Fox, *supra* note 41. Massachusetts and Oregon passed similar mandates, but, in the face of strong business opposition, repealed them before they took effect. *Id.*

69. HAW. REV. STAT. § 393 (1974).

70. THE HAWAI'I UNINSURED PROJECT, HAWAII'S PREPAID HEALTH CARE ACT ENSURES HEALTH COVERAGE FOR SOME WORKERS 1, *at* http://www.healthcoveragehawaii.org/pdf/PrepaidHealthCareAct.pdf (on file with the University of Michigan Journal of Law Reform).

71. THE HAWAI'I UNINSURED PROJECT, PREPAID HEALTH CARE ACT 1, *at* http://www.healthcoveragehawaii.org/target/prepaid.html (on file with the University of Michigan Journal of Law Reform).

72. THE HAWAI'I UNINSURED PROJECT, *supra* note 70.

73. *Id.*

number of blows to Hawaii's tourism-based economy that caused many employers to cut costs by hiring part-time workers, and an increase in the number of self-employed workers.[74]

Hawaii's program had a drastic effect on employment patterns and practices in the state. The employer mandate caused about 55% of Hawaii's employers to restrict wage increases and caused about 33% to reduce other employee benefits.[75] Employment statistics worsened as a result of the mandate: about 40% of employers reduced the number of employees and 10% hired part-time instead of full-time workers.[76] The mandate also affected the economy: 60% of the employers raised prices to offset the burden created by employer mandates.[77]

Hawai'i's predicament demonstrates that, although employer mandates can be successful when regulating larger businesses, employees of small- to medium-size companies and self-employed workers still slip through the cracks. Employer mandates are only part of an effective reform.

II. THE GOOD, THE BAD, AND THE UGLY: EMPLOYER MANDATES AND CALIFORNIA'S LANDMARK LEGISLATION

Although the effectiveness of employer-mandated coverage is in dispute, as seen in Hawaii's struggle with such mandates, California recently enacted a proposal to require that many California employers offer health insurance to their employees. To provide some context for examining the overall structure of employer mandates, Part II of this paper first examines California's legislation. The next section of Part II identifies the benefits and beneficiaries of employer-mandated coverage, and then suggests a better, more workable solution.

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74. Matt Sedensky, *Hawaii's Uninsured Population Grows*, ASSOC. PRESS, Oct. 21, 2003, *at* http://www.sunherald.com/mld/sunherald/living/health/7065117.htm (on file with the University of Michigan Journal of Law Reform).

75. NAT'L CTR. FOR POLICY ANALYSIS, IS HAWAII A MODEL FOR HEALTH CARE REFORM? BRIEF ANALYSIS NO. 126 (Aug. 19, 1994), *available at* http://www.ncpa.org/ba/ba126.html (on file with the University of Michigan Journal of Law Reform).

76. *Id.*

77. *Id.*

A. *California's Plan: Hanging Hopes on SB2*

The recently passed California measure, SB2,[78] is a ray of hope for many: it finally addresses the growing number of uninsured in California, and experts hope the bill will jump-start sputtering efforts in other states. According to legislative findings, the bill will help provide coverage to the more than 80% of California's working uninsured and their families.[79]

In short, the bill establishes the State Health Purchasing Program, and provides health care to employees that work at least one hundred hours per month and have worked for the same employer for three months.[80] It begins regulating large employers first, then moves down the ladder to smaller employers: employers with more than two hundred employees must begin offering benefits by January 2006, but the legislation gives employers with between twenty and two hundred employees until 2007 to offer coverage.[81] Employers may choose between providing health coverage and paying a fee to the state, which would be used to pay for coverage. If the employer chooses to provide health coverage, it will be required to pay at least 80% of the cost of the policy, with the remaining cost paid by the employee.[82] The legislature attempted to mitigate the effects on medium-size businesses by providing that employers with at least twenty workers, but fewer than fifty, are only required to provide health insurance if the California legislature also passed a 20% tax credit for those businesses.[83] The legislature did not forget family members: businesses with at least two hundred employees must also cover their employees' dependants.[84]

California's bill should decrease the number of uninsured patients in emergency rooms, saving millions in charity costs, as well as other added costs that emergency room backlogs add to the economy.[85] When California reaches its 2006 and 2007 deadlines,

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78. Health Insurance Act of 2003, CAL. LABOR CODE § 2120 (West 2003).

79. *Id.* § 1(d).

80. CAL. LABOR CODE § 2122.2 (West 2003).

81. *Health Insurance Legislation At-A-Glance*, ASSOC. PRESS, Sept. 13, 2003, 1, *at* http://www.sfgate.com/cgi-bin/article.cgi?f=/news/archive/2003/09/13/state0640EDT0042.TL&type=health (on file with the University of Michigan Journal of Law Reform).

82. *Id.*

83. *Id.*

84. *Id.*

85. *All Things Considered Profile: California Bill that Would Require Businesses to Provide Health Insurance for Employees and their Dependents* (National Public Radio broadcast, Sept. 22, 2003). To illustrate the magnitude of the problem, in 2002, more than 40% of the billed medical service charges at Denver Health Medical Center were not paid. Sherry & Austin, *supra* note 11, at 3.

only those employees who meet the minimum time and duration requirements and work for businesses with at least fifty employees will benefit from the legislation. However, the mandate still fails to cover many Californians; in particular, those employees who work part-time, have recently changed jobs, work for small businesses, or are unemployed.

B. A Crash Course in Employer-Mandated Coverage

Ironically, while California's efforts and employer-mandated health care in general do provide benefits to the some uninsured people, the scheme may harm the very people legislatures aim to protect and may ultimately generate a detrimental ripple effect in the business economy.

1. The Right Stuff: The Benefits of Employer-Based Coverage—When employers offer health insurance to employees, they satisfy the needs of workers, increase the quality of care and reinforce Americans' views on government involvement. In addition, employment-based health insurance improves market conditions by solving market imperfections, and, generally, helps maintain a functioning market for insurance.

Surveys show that employees are generally satisfied with their employment-based coverage.[86] The pervasiveness of employment-based health insurance allows employers use their market power to pressure providers to improve the quality of care. Groups of employers have successfully initiated economic incentives to improve the quality of care provided; instead of paying providers based on service targets (e.g., the number of patients treated and the amount of time spent with a patient), employers have tied compensation to performance.[87] Some employers have also decided to purchase health care services only from providers who have made specified investments in error reduction safeguards.[88]

Employment-based coverage also agrees with traditional American attitudes regarding government involvement in personal information. When employers handle coverage, "the government's

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86. Hyman & Hall, *supra* note 21, at 30.

87. *Id.* at 35.

88. *Id.* One employer group estimates that investments including computerized systems for prescribing medicines, twenty-four hour staffing of intensive care units by critical care physicians, and referral of complex procedures to hospitals with the highest survival rates, if implemented by all non-rural hospitals, could save up to 58,300 lives per year and prevent 522,000 medication errors. *Id.*

access to sensitive information on its citizens is sharply constrained."[89] Although employees are still wary of employers possessing this information, they are far less concerned than they would be if the government had access. Administration costs of employment-based coverage are relatively lean compared to the massive bureaucracy that would likely arise if coverage were handled by the government, gratifying Americans who doubt the competence and compassion of government bureaucracy.[90]

Low administrative and marketing costs mean that employers improve market conditions and create efficiencies of scale, increasing the portion of the insurance premium that goes to pay medical costs rather than to administrative overhead.[91] Employment-based insurance also mitigates the market effects of "adverse selection," which occurs when potential insureds know more about their particular risks than the insurer knows.[92] When an insurer prices its product, it calculates the risk for the market segment it is evaluating. However, within market segments, people are not homogenous—they have different risks of illness. If only some people purchase insurance and if the insurer does not learn this information, disproportionate numbers of sicker people will subscribe "because those with greater than average risk will find the average price more attractive than those of lesser risk."[93] Ferreting out risk information can be costly and often prices higher-risk people out of the market.[94] Employment-based risk pools reduce the market cost of insurance by alleviating cost increases associated with adverse risk selection and risk rating. The pools exist for reasons independent of the demand for coverage, so insurers can "safely assume that the group's future medical expenses will approximate the group's recent experience, [allowing] the insurer to assess the overall group's average risk simply by observing its claims experience . . . rather than assessing each individual member's risk."[95] This disconnect between the group and the demand for coverage means that group members will not select in or select out just because of risk or cost; the group's risk remains stable, so insurance coverage can be written at lower cost than individual

89. *Id.* at 33.

90. *Id.*

91. The largest employer groups incur overhead costs of less than 5%, compared to 20% for smaller groups and more than 30% for individual purchasers. *Id.* at 31.

92. *Id.* Adverse selection exists to some degree in all insurance markets and, at an extreme, may destroy the market. *Id.* at 32.

93. *Id.* at 31.

94. *Id.* at 32.

95. *Id.*

plans.[96] Finally, workers are, on average, healthier than non-workers,[97] lowering the cost of coverage even further.

2. Here's the Catch: Downsides to Employer-Based Coverage and Government Mandates—While there are a great many positive aspects of employer-based health care coverage, there are a number of identified drawbacks as well. When it comes to health care coverage, employers and employees have conflicting interests that are not always resolved in favor of the employee. Further, when employers are required to pay for the majority of the premium cost, those expenses are set-off by decreases in employee compensation. Requiring employers to pay for health coverage may harm small- and medium-size business, and limit business' ability to respond to market changes.

Employers choose health insurance plans with an eye toward maximizing their labor supply while incurring the lowest possible expense. Therefore, employers generally offer the wage-benefit package that will be optimal for the average employee.[97] Employer information as to employee preferences for coverage and quality of health care is imperfect,[98] so an employer-selected optimal benefit package will only satisfy the needs of a homogeneous group of workers. However, employees are a heterogeneous group; they are people of different genders, backgrounds, and ages, with and without dependants, and, therefore have different incidences of illness and medical needs.[99] The result is a predictable disjunction between the coverage preferences of the employee and the optimal plan selected by the employer.[100]

Employees likely will not notice the divergence until well after employment begins. Employers list health insurance as an available benefit to employees, but job applicants often note the benefit as a positive without really investigating or having the opportunity to investigate the policy's terms.[101] Even if employees did investigate and review an employer's coverage, the average worker is not likely to be familiar enough with the terms of competing health insur-

96. *Id.*

97. Matthew, *supra* note 28, at 1056.

98. Hyman & Hall, *supra* note 21, at 27.

99. Matthew, *supra* note 28, at 1056.

100. Hyman & Hall, *supra* note 21, at 27.

101. Matthew, *supra* note 28, at 1062. Professor Matthew explains that it is almost impossible for employees to monitor an employer's insurance purchase *ex ante*: the employment contract is usually signed well after the employer has negotiated the insurance coverage, insurance contracts are complex and usually inaccessible for comparison until after the employee has commenced her employment, and the market for most positions does not permit side-by-side comparisons of similar jobs with different health care plans. *Id.*

ance plans to be able to compare the employer's program with others in the market.[102]

The employment-based health care system has become so ingrained in the collective labor psyche of Americans that many workers fail to realize that they do actually pay for benefits in the form of decreased compensation. Employer contributions to health insurance plans are actually a form of compensation to the employee, despite tax treatment to the contrary, and as coverage costs increase, the result is lower wages for the employee.[103] Most employees believe that the employer is footing the entire bill for employees' health care coverage, and are thus relatively indifferent to the cost of their coverage.[104] Because of this indifference, experts speculate that Americans over consume with respect to health care: they see doctors more often, elect more procedures, and take more medicine than needed simply because most of the cost is covered by insurance.[105] Studies show that the drastic increase in health care spending over the past thirty years parallels the decline in the patient's share of the health care bill from 48% in 1960 to 21% today.[106] Many economists have concluded that Americans' over consumption of health care will cause health care costs to spiral out of control unless patients are required to pay more out-of-pocket for their care.[107] This perpetuates the dilemma: as health care costs rise, employees are forced to pay more of their wages to support their coverage.

These faults in the employer-based system can slow business growth when the government implements mandates. The major objection that most employers make to mandated coverage is not necessarily the increasing cost of coverage per se, but the effects that increased costs have on business competition. Employer-mandated coverage can slow growth as employers spend more of their revenue on employee benefits instead of developing their businesses. In California, many employers already view the state's

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102. *Id.* Even when a prospective employee is able to compare the coverage, the employee is unlikely to object to the terms of the policy and is "even less likely to find objectionable features of the policy a dispositive factor" in the choice of whether or not to accept the position. *Id.* at 1063.

103. Hyman & Hall, *supra* note 21, at 28.

104. *Id.*

105. Rosenbaum, *supra* note 19, at 1.

106. NAT'L CTR. FOR POLICY ANALYSIS, *supra* note 29.

107. Rosenbaum, *supra* note 19, at 3. But health economist Uwe Reinhardt disagrees with the effects that requiring higher out-of-pocket payments will have on low-income workers: if people pay more for health care, it results in "rationing health care according to income. People like you and me would continue to get all we want, and those without means would have to do without." *Id.*

high tax rates as unfriendly to business.[108] New financial burdens on employers could drive businesses away from California or slow expansion to a halt.[109] Employers are also concerned about the patchwork of state regulations; with such wide variations in state regulations, it is impossible to have consistent policies when operating across the country.[110] Consequently, to avoid employing people who work enough hours to qualify for employer-mandated coverage, employers may simply hire greater numbers of inexpensive, part-time workers.

III. EMPLOYER MANDATES + INNOVATION = A SOLUTION TO THE HEALTH INSURANCE CRISIS

There are few simple solutions to complex problems. While employer-based health insurance may be such an entrenched system with enough benefits and effectiveness to make it impracticable to completely overhaul, there are still gaping coverage gaps that result in significant numbers of uninsured persons. Employer-mandates may reduce the number of uninsured, but they have unacceptable effects on the labor market and small- to medium-size businesses, and fail to cover many low-income workers and non-workers. Existing legislation fails to fill coverage gaps or mitigate effects on small- and mid-sized businesses; as a result, the system needs more innovative solutions. Part III of this paper first examines several proposed solutions to the crisis, then advocates a solution: a blend of legislation to mandate coverage for employees of large employers, tax credits to unemployed individuals or individuals employed by small- and mid-sized businesses, and purchasing pools to mimic the market benefits that employer groups achieve.

A. Modest Proposals

Commentators have suggested several solutions, including creating voluntary purchasing pools by which uninsured persons can

108. *All Things Considered Profile*, *supra* note 85.

109. *Id.* The California Chamber of Commerce considers the California bill to be a threat to midsize business and plans to challenge the law. *Id.*

110. Peter Cappelli, *What Will the Future of Employment Policy Look Like?*, 55 INDUS. & LAB. REL. REV. 724, 726 (2002).

replicate the risk-spreading benefits of an employment group, instituting a single-payor government sponsored system, and providing refundable tax credits to put money directly into the hands of the uninsured. All of these proposals are plagued by fundamental flaws such that if implemented as a stand-alone solution, they would fail even more people than the current system does.

1. Purchasing Pools—Many advocates of reform point to private insurance purchasing associations as the solution. In such associations, individuals are grouped together and acquire health insurance coverage much the same way that employers do now. In theory, these associations negotiate lower rates and achieve economies of scale through inter-association competition.

Although several states have implemented forms of purchasing pools in which small businesses join together make health insurance affordable,[111] voluntary individual purchasing pools would be much less effective. If voluntary pools are protected from regulation, as large employers are now, and are allowed to set rates according to the pool's claims experience, which provides an incentive to lower costs and to bargain for better rates, the system could have a detrimental effect on other markets for insurance.[112] Pools with better claims experiences will likely "draw off the better risks from the individual and small group markets, causing them to collapse into high-risk pools."[113] Setting rates according to the claims experience could also result in a shop-around effect: when different associations offer similar coverage based on the risk profile of people belonging to the pool, it creates a "turbulent market dynamic" in which people continually shop for pools with healthier members.[114] Finally, purchasing pools would not actually improve economies of scale because transaction costs remain high: each insured would require individual service instead of a single purchaser (such as an employer) acting for an entire group.[115]

In summary, the benefits of voluntary purchasing pools are limited: they are a poor imitation of the efficiencies that employment-based insurance pools create, and lack the cohesion, risk-spreading, and economies of scale that inhere in employment-based pools.[116]

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111. Weisul, *supra* note 61, at 1.
112. *See* Hyman & Hall, *supra* note 21, at 37.
113. *Id.*
114. *Id.*
115. *Id.* at 37–38.
116. *Id.* at 38.

2. *Single-Payor Systems*—Reformers repeatedly tout single-payor systems, especially government-implemented and administered plans, as constituting the best fix for the health-insurance crisis, and have pointed to other industrialized countries as examples of successfully implemented programs.[117] Single-payor systems do solve some of the problems of other proposed systems, in particular, the risk-adjustment problem that arises when insurance purchase is not mandated. In such a situation, healthy people will drop their coverage, while subsidies are required for people who are unable to afford coverage.[118] To prevent insurer "red-lining" of subscribers who become expensive (meaning that their health costs exceed the premium) the subsidies must be risk-adjusted, and risk adjustment is imperfect at best.[119] Single-payor systems also solve the "adverse selection" phenomenon.[120] Both the risk-adjustment and the adverse selection problems are eliminated simply because all people are covered, regardless of their particular risk.

However, single-payor systems do have drawbacks. Perhaps the largest hurdle to implementing a single-payor system is supplanting current private expenditures with public tax dollars. When implementing a single-payor system, the government would have to increase tax receipts to fully replace the entire amount of private health care payments, which outrages employers and insurers, not to mention employees.[121] Single-payor systems are uniquely susceptible to problems such as budgetary pressures, since available health care funding amounts "are determined every year based on

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117. The country most often used as an example of a successful single-payor system is Canada, which has a publicly financed, privately delivered health care system, known to Canadians as "Medicare." The system has evolved over fifty years to its present form in which each province or territory is responsible for managing and delivering health services in adherence to national principles, and provides public access to medically necessary hospital, inpatient, and outpatient health services. Canada finances the system through taxation, primarily in the form of provincial and federal personal and corporate income taxes, as well as through some provincial sales taxes, payroll levies, and lottery proceeds. *See generally* HEALTH CANADA, CARE NETWORK website, *available at* http://www.hc-sc.gc.ca/hppb/healthcare; Roche, *supra* note 13 (surveying various countries' universal health care systems, including Germany, Japan, Canada, and the Netherlands).

118. Hyman & Hall, *supra* note 21, at 38.

119. *Id.*

120. *See supra* Part II.B.1.

121. In 1999, private health spending was estimated at $654 billion. To raise this amount to replace all private spending would require an 89% rise in federal income tax receipts, or a 39% rise in all federal revenues, including not only personal and corporate taxes, but also Social Security, Medicare, and inheritance. ALAN SAGER & DEBORAH SOCOLAR, RAISING THE MONEY FOR HEALTH CARE FOR ALL: TRADITIONAL SINGLE PAYOR FINANCING VERSUS POOLED FINANCING, *available at* http://dcc2.bumc.bu.edu/hs/Upload061002/Raising%20the%20money%20for%20HEALTH%20CARE%20FOR%20ALL.pdf (on file with the University of Michigan Journal of Law Reform).

how effectively health care can compete with other budgetary priorities."[122] In single-payor government-run systems, the government must also "navigate the complexities of setting prices, picking qualified providers, and making long-term capital investment decisions." Each of these efforts increases the amount of bureaucracy required to perform these tasks, creating coordination problems which have the potential to increase cost, diminish options for access and compromise quality of care.[123]

Opponents vociferously denounce such complex single-payor systems as requiring too much oversight, and claim that the "socialization" of medicine would result in decreased quality of services.[124] When the government begins allocating health care benefits and services, critics argue, it eliminates individual freedom to contract for medical services.[125] Americans tend to view bureaucracy and government programs that limit market choices with suspicion, further clouding the outlook for single-payor systems.[126]

3. Tax Credits—Recently, legislators announced several proposals for health insurance tax credits.[127] Many, if not most, of the plans have the advantage of bipartisan support, but still fail to solve, and often exacerbate, many of the adverse selection and risk spreading problems endemic in the market. The main feature of most plans is a refundable tax credit: an individual or family can benefit from the credit even if they pay no income taxes. The plans differ chiefly in the proposals for implementation and delivery of the tax credits, with most of the debate centering on whether the tax credit should be given to employers or directly to individuals.[128]

122. Hyman & Hall, *supra* note 21, at 38.

123. *Id.* Canada is in the process of reforming its health care system to address some of these same criticisms. *See generally* Allan S. Detsky & C. David Naylor, *Canada's Health Care System—Reform Delayed,* 349 NEW ENG. J. MED. 804 (Aug. 21, 2003).

124. *See* Litman, *supra* note 55, at 876.

125. *Id.*

126. A mere "two out of every ten citizens believe that the government 'will do the right thing most of the time.'" Litman, *supra* note 55, at 876 (citation omitted).

127. The House of Representatives passed H.R. 3529, which provided health insurance tax credits as part of the economic stimulus bill, on December 20, 2001. LYNN ETHEREDGE, THE HERITAGE FOUND., HOW TO ADMINISTER HEALTH INSURANCE; BACKGROUNDER #1516 (Jan. 31, 2002), *available at* http://www.heritage.org/Research/Healthcare/BG1516.cfm (on file with the University of Michigan Journal of Law Reform).

128. There is, of course, extensive debate over the amount of the proposed tax credits. Proposals vary widely; most establish flat-dollar credits for individuals and families, some index the credits to the Consumer Price Index, while one provides a credit equal to 30% of the cost of health insurance premiums. IRIS J. LAV & JOEL FRIEDMAN, CTR. ON BUDGET AND POLICY PRIORITIES, TAX CREDITS FOR INDIVIDUALS TO BUY HEALTH INSURANCE WON'T HELP MANY UNINSURED FAMILIES 17 (Feb. 15, 2001), *available at* http://www.cbpp.org/2-15-01tax2.pdf (on file with the University of Michigan Journal of Law Reform).

Many commentators denounce the trend toward implementing social policy through tax credits. Although tax credits often receive bipartisan support,[129] in actuality many tax credits never reach the low-income families who are the intended recipients. Tax credits only reach those who file income taxes; the tax system exempts those with low- or no-income from filing tax returns, precluding receipt of tax credits. The ostensible solution is a refundable tax credit, such as the Earned Income Tax Credit (EITC), which allows the government to write a check.[130] However, the refundable tax credit has several downsides. To work with the current system, refundable tax credits are limited to those with positive earnings necessitating tax return filing.[131] Further, refundable tax credits are typically paid in a lump sum at the end of the year, requiring recipients to wait until then to receive money to pay expenses.[132] Many proposals calling for health care tax credits would exacerbate this effect by requiring recipients to pay for their health insurance throughout the year without receiving any immediate credit to offset expenditures.

A system that gives tax credits directly to small- and mid-sized businesses that currently do not provide health insurance would eliminate neither the difficulties employers face when attempting to choose a plan that fits the needs of all employees, nor the high costs that small business owners incur because of their inability to form large risk-spreading pools. In addition, if the government provides tax credits only to small businesses, "it ends up subsidizing the insurance of highly paid workers such as doctors, lawyers and computer engineers who work for small firms," undermining the purpose of the tax credit, which is to assist people who are unable

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129. Republicans like credits because they look like tax cuts, while Democrats like them because they achieve social policy goals without officially raising spending. William G. Gale, Editorial, *Tax Credits: Social Policy in Bad Disguise*, CHRISTIAN SCIENCE MONITOR, Feb. 16, 1999, at 11.

130. FRANK SAMMARTINO & ERIC TODER, URBAN INST., SOCIAL POLICY AND THE TAX SYSTEM 5 (Jan. 1, 2002), *available at* http://www.urban.org/UploadedPDF/310418_TaxSystem.pdf (on file with the University of Michigan Journal of Law Reform).

131. *Id.* The EITC is less cumbersome than many other social programs, such as the Food Stamp program, which requires personal trips to government offices and completion of applications and documentation. *Id.* at 13. In contrast, the EITC only requires filing an additional schedule with a recipient's tax return. *Id.* at 13–14. However, many recipients find income tax forms complex and pay a professional tax preparer to complete their return, further depleting the amount received from the credit. *Id.* at 14.

132. SAMMARTINO & TODER, *supra* note 130, at 14. To get their returns faster, many EITC recipients pay fees to arrange refund anticipation loans. *Id.* If annualized, the average interest rate for a refund anticipation loan is 222.5%. Press Release, Consumers Union, Consumers Union Advises Taxpayers to Avoid Refund Loans (Feb. 20, 2003), *available at* http://www.consumersunion.org/finance/RAL-03.htm (on file with the University of Michigan Journal of Law Reform).

to afford insurance.[133] Income restrictions on the credit could raise well-founded privacy concerns: employers would have to obtain income information on employees and others in their households.[134] Finally, tax credits to small businesses would fail to cover groups of uninsured people who either not working or are working for large companies but cannot afford their share of the premiums.

Instead of paying credits to employers, tax credits could be paid directly to employees. However, aside from the practical cash-flow effects that delayed receipt of tax credits has on low-income recipients, there are more general class and market effects to a system that delivers tax credits directly to employees instead of providing the credits to employers. If employees have to go it alone in the insurance market, it will be difficult for older people and less-healthy people to obtain insurance at reasonable costs.[135] Employer-based health plans might fall by the wayside as employers elect not to provide coverage because employees would be able to secure an individual tax credit. Although tax credit advocates claim that the credit will help create a market for cheap health insurance plans,[136] others disagree. Proposals that allow individuals to choose to use their credit either for employer-based coverage or for privately purchased insurance would exacerbate the adverse selection phenomenon; younger and healthier employees would look for lower-cost coverage outside of employer plans, resulting in increased premiums in employer-based plans for the older or less-healthy employees who remain in those plans.[137]

Regardless of which method of delivery is selected or whether the credit is refundable, tax credits complicate the tax code. Each additional credit makes tax policy more complex and makes it less likely that broad tax reforms will succeed.[138] However, the practice

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133. Press Release, The Heritage Found., Give Health Insurance Tax Credits Directly to Employees, Study Says (Mar. 19, 2001), *available at* http://www.heritage.org/Press/NewsReleases/NR031901.cfm (on file with the University of Michigan Journal of Law Reform).

134. *Id.*

135. LAV & FRIEDMAN, *supra* note 128, at 2.

136. SAMMARTINO & TODER, *supra* note 130, at 18.

137. Instead of decreasing the number of uninsured, adverse selection in this scenario could actually increase that number. Because of adverse selection, some employers would drop coverage for their employees, preferring that employees use the tax credit instead of providing benefits, creating 4.1 million newly uninsured employees that would be forced to buy insurance outside the marketplace. LAV & FRIEDMAN, *supra* note 128, at 8.

138. In recent years, many reformers have called for extensive reforms of the existing progressive tax structure. Proposals include supplanting the income tax for the first $100,000 in income, instituting a flat tax, and eliminating income tax entirely in favor of the value-added tax. *See* Julie Roin, *The Consequences of Undoing the Federal Income Tax*, 70 U. CHI.

of implementing social policy via the tax code is not likely to change anytime soon. The tax system provides a structure through which social reforms can be accomplished more efficiently and with less bureaucratic expansion than would result from the creation of an entirely new government program. Put simply, we have gotten used to using the tax system to implement social policies ranging from the EITC to credits for college education. Even if some tax credits are bad policy, the tax system achieves other socially useful policies more efficiently than other approaches would.[139]

B. Putting it All Together—Crafting the Best Solution

Even the most frequently advocated solutions discussed in the previous section have significant shortcomings. While one proposal may remedy a particular aspect, the basic problem is so complex and of such magnitude that no single proposal will be able to solve one issue without simultaneously creating or exacerbating another. With that in mind, using government mandates to retain the current employment-based system, but supplementing the system by adding advance, refundable tax credits and creating purchasing pools will provide the most comprehensive and workable answer to the health care crisis. Although "tweaking" the employment-based system is a much less sweeping solution than many reformers would advocate, it may be the most politically viable, practically workable, and socially acceptable way in which to proceed.[140]

The employment-based system should be maintained as it is and should be free from government mandates that disproportionately affect small- and mid-sized business growth. Although a significant portion of the population is uninsured,[141] employer-based plans insure a considerable majority of Americans.[142] Mandates that affect

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L. REV. 319 (2003); Michael J. Graetz, *Erwin N. Griswold Lecture Before the American College of Tax Counsel: Erwin Griswold's Tax Law—And Ours*, 56 TAX LAW. 173 (2002).

139. *See* SAMMARTINO & TODER, *supra* note 130, at 7.

140. According to Professors Hyman and Hall, the repeated failure of attempts to create a national health care system testify to the difficulties that confront aspiring reformers. In health care, there are too many competing vested interests, and too few people who are fundamentally dissatisfied with their coverage, for comprehensive reform to be politically viable under ordinary circumstances. We believe that incremental reforms are all that is likely to emerge from the political process during the foreseeable future. Hyman & Hall, *supra* note 21, at 39.

141. 15.2% of the population is uninsured. Richwine, *supra* note 5.

142. 64.1% of Americans are covered by health insurance plans related to employment. ROBERT J. MILLS, U.S. CENSUS BUREAU, CURRENT POPULATION REPORTS—HEALTH INSUR-

only large employers, most of which already offer health insurance benefits, reinforce the status quo while avoiding the effects on business growth that result from broader mandates. Large employer mandates do not disrupt the competitive job market: mandated coverage would act as a floor, allowing large employers to continue to use health benefits above that floor to compete for employees. In addition, large employer mandates reduce the risk that employers will drop coverage when the credit is implemented, choosing to let their employees take the credit and fend for themselves.

With coverage by large employers mandated, the holes in the employment-based system—the dearth of coverage for part-time employees, for employees of small- and mid-sized businesses, and for the unemployed and other displaced workers—could be patched by introducing tax credits given directly to employees. Use of the tax credit could be limited to those persons who pre-qualify by electing to purchase insurance through a large purchasing pool, perhaps through a state coalition,[143] which would help spread risk among large groups and keep insurance costs down.

Potential recipients would apply for the tax credit during an enrollment period.[144] The credit would only be available to those who are not insured by their employer because their employer does not offer insurance, because the person is unemployed and not covered by a family member, or because the premiums exceed a certain percentage of household income. Those eligible for the tax credit would choose a purchasing pool with which to be affiliated, select a qualified plan, and determine a desired amount of payroll deductions (if any premium cost remains after deducting the tax credit) to be withheld from paychecks by employers or from unemployment compensation.[145] Persons who prefer to sign up for, or continue receiving, coverage with public programs such as

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ANCE COVERAGE: 2000 2 (Sept. 2001), *available at* http://www.census.gov/prod/2001pubs/p60-215.pdf (on file with the University of Michigan Journal of Law Reform).

143. This is a watered down version of Representative Pete Stark's proposal, which would allow tax credits to be claimed only for the purchase of qualified plans sold through a new federal Office of Health Insurance. LAV & FRIEDMAN, *supra* note 128, at 17. However, many supporters of tax credits strongly oppose such regulation and it is highly unlikely that Congress would pass a tax credit with that type of federal regulation. *Id.* State purchasing pools may be more palatable to legislators.

144. Modeled after annual open enrollment periods currently employed by public and private entities. Most open enrollment periods designate a specific window of time in which employees can change their benefit coverage; elections are in effect until the next annual enrollment period, unless the employee experiences a qualifying change in family or employment status (e.g. birth of a child, marriage, or a spouse/partner secures employment).

145. Those without surplus income, for example, students, should choose a default "zero premium" plan. Etheredge, *supra* note 127, at n.10.

Medicare or SCHIP could also choose to do so during the enrollment period. Once employers withhold premiums, they would send them to a central clearinghouse for remittance to insurers.

Existing payroll systems and unemployment processing systems could process the credits and premiums. The IRS acts as a financial intermediary for achieving many policy goals.[146] The existing infrastructure—Social Security numbers, wage and payroll tax withholding, and information reporting—can all be utilized to issue tax credits.[147] By using the IRS and existing systems, the reform would avoid expanding the income tax filing system or creating a "lag time" while individuals wait for vouchers and mail them to insurance companies. The insurers would notify the Treasury Department of their selection by an employee; the Treasury Department would then pay insurers the portion of the tax credit due for the payroll period.[148]

This solution has numerous advantages. The eligibility requirements ensure that tax credits do not go to persons covered through an employment-based system, avoiding the spiral of adverse selection that would occur if healthy employees chose to take the tax credit and opt out of their employer-provided coverage.[149] Requiring affiliation with a heterogeneous purchasing pool before receiving the tax credit spreads the insurer's risk throughout the pool, improving economies of scale and making it possible for older people and people with health problems to obtain insurance. Deducting premiums above the credit amount from payroll checks and unemployment compensation does not create an administrative morass: payroll and unemployment compensation systems already process a minimum of eight standard deductions from checks.[150] Set enrollment periods provide a level of certainty for insurers' risk calculations. Finally, with the advent of widespread electronic banking, remittance of premiums and tax credits to insurers could be paperless and would only marginally increase administrative responsibilities.

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146. For example, the IRS administers the Earned Income Tax Credit, a progressive, refundable tax credit. Fred T. Goldberg, Jr., *From FDR to W: The IRS as Financial Intermediary*, 29 OHIO N.U. L. REV. 1, 11 (2001).

147. *Id.* at 12.

148. Etheredge, *supra* note 127, at 3.

149. *See* Hyman & Hall, *supra* note 21, at 40 ("[T]he more extensive the tax credits, the greater the potential for adverse selection, as younger and healthier employees can suddenly exit existing pools . . . we suggest that tax credit proposals should initially focus on those who do not currently have access to employment-based coverage.").

150. Employer payroll processes handle deductions and reports, including Social Security payments, Medicare and income tax payments, and unemployment and disability insurance. Etheredge, *supra* note 127, at 3.

However, this proposal is not perfect. Although tax credits paid through the existing payroll, unemployment, and Social Security disbursement systems will make the tax credits available to all persons that receive such income, those who do not work or receive any government assistance will fall through the cracks. These people will continue to rely on direct spending programs for health coverage.[151] Risk spreading by forming state purchasing pools may be considerably more difficult than many proponents suggest.[152]

The biggest obstacle to implementing a refundable tax credit through advance disbursements is the possibility that a tax credit recipient might owe the government money at the end of the year. Advance credits are based upon predictions of a recipient's yearly income.[153] Because individual and family incomes can fluctuate throughout the year, a taxpayer could receive an advance tax credit, but during reconciliation at tax time, could find out that such fluctuation precludes eligibility.[154] The IRS could be responsible for determining eligibility, but such responsibility would add another level of bureaucracy to the process and, for many Americans, would evoke the specter of increased government intrusion into everyday life. Further, the IRS has a discouraging record for correctly determining eligibility: a recent IRS study discovered that 25.6% of EITC claims were erroneous.[155] Currently, the IRS does not collect information on health coverage.[156] Perhaps employers could bear some of the burden in assisting with eligibility determinations, but that would not necessarily eliminate the possibility of error and abuse.

CONCLUSION

The number of uninsured Americans has reached crisis proportions. This crisis has alarming life-and-death effects on real people and families. Although the American health insurance system is largely employer-based and has been since World War II, it still fails to insure a significant number of people. Legislative solutions and

151. SAMMARTINO & TODER, *supra* note 130, at 5.

152. LAV & FRIEDMAN, *supra* note 128, at 7.

153. SAMMARTINO & TODER, *supra* note 130, at 15.

154. Experiences with the EITC, another advance, refundable tax credit, have shown that families are deterred from using this option for fear of owing money to the IRS at tax time. LAV & FRIEDMAN, *supra* note 128, at 11.

155. SAMMARTINO & TODER, *supra* note 130, at 14.

156. LAV & FRIEDMAN, *supra* note 128, at 12.

programs such as ERISA, SCHIP, and Medicare and Medicaid have neglected to remedy the predicament in which many people find themselves. State reform efforts have had moderate success in creating alternative programs, with California's employer-mandated coverage being the most recent attempt.

Employer mandates may seem to benefit employees and make a dent in the number of uninsured, but if they are too far reaching, they ultimately impair the ability of small- and medium-sized business to function, much less grow. Employer mandates may be necessary to maintain the current level of employer-based coverage, but effective solutions need to combine mandates with other programs to mitigate their detrimental effects.

Reform advocates variously tout single-payor systems, private purchasing pools, and tax credits as solutions that will miraculously overhaul our employer-based system and solve our health insurance crisis. However, the employer-based system is largely effective at insuring our population and is so fundamental to Americans' perception and valuation of employment that it would be virtually impossible to abandon wholesale. This Note advocates a combination of large-employer mandates to maintain the current employer based system, refundable tax credits to help employees of small- and medium-size business, low-income workers and unemployed persons to afford coverage, and purchasing pools to reduce the effect of adverse selection and maximize risk-spreading.

Although this combination falls short of perfection, perfection is not the goal. Valid reform ideas should act in accordance with ethical and societal norms and should be politically achievable and legally workable. With these standards in mind, the proposed reform is valid: it would effectively reduce the number of uninsured Americans while placing virtually no burdens on the insurance and labor markets, employers, or existing administrative systems and it is politically and legally achievable, especially in light of the extensive bipartisan support for reforms incorporating tax credits. On balance, the benefits of this reform should outweigh the costs. It is time America prioritized health insurance for all.