Two Cheers For Employment-Based Health Insurance

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> *Reform, sir, reform? Don't talk to me of reform. Things are bad enough as they are.*
>
> —Sir Henry Maudsley[1]

Employment-based health insurance is the Rodney Dangerfield of health policy: it gets no respect from anyone. Liberal enthusiasts of a one-payor system view the existence of employment-based health insurance as a major impediment to the achievement of universal comprehensive coverage.[2] From the opposite end of the political spectrum, free market enthusiasts attack employment-based health insurance on the grounds that individual preferences are systematically ignored, and cost-quality trade-offs are inappropriately constrained when employers select coverage for employees.[3] Advocates for a patient bill of rights complain that managed care is favored by employers (not employees), and argue that employers are motivated by profits, instead of the best interests of their employees.[4] Prominent health policy scholars and the media routinely condemn the linkage between employment and health insurance.[5] Even employers, who offer coverage as a way of attracting and retaining employees, are at best lukewarm about their role in the coverage market.[6]

Given these unfavorable attitudes, it is not particularly surprising that reforming these arrangements has been a perennial topic on the policy agenda—even though most employed individuals with health insurance obtain their coverage through their employers, and the employment-based market provides coverage for approximately 177 million Americans.[7] During the past six decades, thousands of pieces of legislation have been

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introduced at the state and federal levels, seeking reforms ranging from the incremental to the radical. Legislation has sought to change the tax treatment of health insurance premiums, encourage more people to purchase health insurance on their own, partially or completely eliminate employers from the coverage market, mandate all employers to provide coverage, require employers to include specified benefits or providers in their coverage, and the like. Articles supporting and criticizing each of these competing proposals and offering additional reforms fill the pages of medical, legal, economic, and health policy journals.

This Article steps back from this morass of competing proposals and considers the employment-based coverage market from a comparative institutional perspective.[8] This approach allows us to assess the costs and benefits of the existing system against the likely alternatives, and provide a more balanced foundation for assessing proposed reforms. As the title of this Article suggests, we conclude that the employment-based coverage market deserves "two cheers," and relatively modest incremental changes are all that are required (or for that matter, politically likely, during the foreseeable future) to ensure the continued smooth functioning of the employment-based coverage market.[9]

Our assessment that the employment-based coverage market deserves "two cheers" is unlikely to satisfy most commentators, irrespective of whether they favor a one-payor system, universal adoption of medical savings accounts, or something in between. The score we assign to employment-based health insurance obviously falls well short of perfection. Yet, it is important to keep in mind that perfection is never an appropriate standard for judging real world policies and institutions.[10] Any "reform" of the employment-based coverage market will replace the existing institutional arrangements and problems with new (and not necessarily improved) institutional arrangements and problems.[11] Prudent policy-making requires that one has a full appreciation of the advantages and disadvantages of existing arrangements, and a framework for determining whether proposed reforms, on balance, make things better or worse.[12] In this Article, we seek to provide the information and analysis necessary to accomplish both of these goals.

Part I explains how employers ended up occupying such a central role in modern health policy and provides a snapshot of the current coverage marketplace. Part II outlines a number of problems with the current system. Part III provides a comparative institutional perspective on the problems outlined in Part II. Part IV considers the politics of incremental reform, offers a few modest "fixes" to the problems outlined in Part II, and addresses the problem of the uninsured.

I. WHERE WE ARE, AND HOW WE GOT HERE

A. The Rise of Employment-Based Coverage

Employers were initially marginal players in the coverage market, but they quickly assumed a dominant position. In large part, this outcome was simply a historical accident, fueled by federal labor and tax policy. Before World War II, some employers offered early forms of managed care to their workers and families, but these employers were very much the exception.[13] The medical profession vehemently opposed such "contract" or "corporate" practice, and sought to limit the spread of such arrangements.[14] By one estimate, no more than four million Americans, or approximately 3% of the population, had employment-based coverage in 1930.[15]

The first dramatic increase in employment-based coverage came during World War II. Wage and price controls were instituted by the Office of Price Administration in an attempt to deal with inflation.[16] Employer contributions to insurance and pension funds were not counted as wages, and were accordingly excluded from the wage controls. The freezing of cash wages forced employers to compete for scarce labor by enhancing their fringe benefit packages. Health insurance offered a straightforward way for employers to sweeten their compensation package in a manner that would be quite appealing to potential employees.

The second impetus for employment-based coverage was the federal tax code. In 1943, the Internal Revenue Service issued a ruling indicating that the amounts paid by employers for insurance for employees did not constitute income to employees, even though employers could deduct these amounts as ordinary and necessary business expenses.[17] Ten years later, the IRS withdrew this ruling, but Congress amended the Internal Revenue Code in 1954 to expressly exclude employment-based coverage from taxable income.[18] In effect, this asymmetric tax treatment allows employers to purchase health insurance for their employees using employees' before-tax income, rather than forcing employees to purchase it themselves with after-tax income. The amount of 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.[19] In the aggregate, this subsidy is worth more than $100 billion in foregone tax revenue per year, and is the second largest tax expenditure, after home mortgage interest.[20] The result is a substantial financial incentive for employees to obtain coverage through their employer if at all possible.[21]

Labor unions were another factor in the rise of employment-based

coverage. During the late 1940s and 1950s, unions aggressively bargained for richer benefit packages, with health insurance at the top of their list.[22] In industries in which unions were strong (e.g., manufacturing and public-sector employment), the result was that many subscribers obtained first-dollar insurance coverage and medical care at no out-of-pocket cost to themselves whatsoever.[23] Employers with non-unionized workforces also offered rich benefits to discourage their employees from unionizing.[24]

B. A Snapshot of the Employment-Based Coverage Market

Although the figures have fluctuated somewhat in the past decade, employment-based coverage seems to have stabilized at approximately 65% of the under-65 population, or roughly 177 million Americans.[25] Most employees of large and medium-sized corporations now have access to employment-based coverage, although not all of them choose to take advantage of it.[26] Employment-based coverage is much less available to those who work in certain industries (e.g., agriculture, retail, and food service), temporary and part-time employees, and those who work for small businesses.[27] Dependents of employees can usually obtain coverage through the working member of the family, but increased cost sharing has caused some erosion of such coverage in recent years. The result of these patterns is that approximately thirty-nine million Americans are uninsured in any given year—even though about 85% of the uninsured live in families headed by an individual who works at some time during the year. More than 50% of the uninsured are full-time, full-year workers, or their family members. The remaining sixty-five million Americans are covered by Medicare, Medicaid, or another governmental program, and thus do not require employment-based coverage.[28]

Commentators wax poetic about the social role of health insurance, and treat the decision to offer and purchase such coverage in morally weighted terms.[29] However, the evidence is fairly clear that potential subscribers approach coverage decisions in traditional economic terms. When faced with a choice of health care coverage, price is the key driver of the decision-making process, and a significant number of individuals who have access to coverage through their employer decline it on the grounds it is too expensive.[30]

II. PROBLEMS WITH AN EMPLOYMENT-BASED SYSTEM

Most 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.[31] By selecting particular insurance products to offer their employees, and excluding others, employers necessarily influence what services are covered, and the circumstances under which those services can be delivered. In like fashion, by selecting particular insurance products, employers effectively dictate the scope and nature of the cost-quality-access trade-offs their employees can make.[32] Although some employers offer their employees multiple health insurance arrangements, approximately half of employed workers are not offered such a choice.[33] Even when multiple plans are offered, there is little ability to tailor coverage to particular needs and tastes.[34] The net result is a series of informational, preference, and incentive mismatches—between employers and employees, and between employee groups and individual employees—that play out in the cost and breadth of the coverage that is offered.

A. Heterogeneous Preferences

Because employee preferences with regard to cost, quality, and access are heterogeneous, and employer information as to employee preferences and health care quality is imperfect, the result is that there are predictable disjunctions between the coverage preferences of any given employee and the terms selected by the employer on behalf of the employment-based risk pool as a whole.[35] For example, some employees might prefer that their insurance cover more extensive postpartum hospitalization, while others might prefer better coverage of AIDS, and some employees might simply prefer less generous coverage in exchange for a higher take-home salary. The distribution of these preferences will also vary from employer to employer; the employees of a start-up software company in Silicon Valley are likely to want a quite different package of benefits than the employees at an automobile assembly plant in Detroit.[36] Whatever the choice, the specification of coverage necessarily implies a series of trade-offs within the risk pool, with significant distributional implications within and across identifiable groups.

B. Incentive Mismatches

Even when there is uniformity of preferences within employee ranks, there are incentive mismatches between employers and employees. An employer may care greatly about conditions that affect its most highly valued employees, but show less consideration for conditions that disproportionately affect employees who are fungible, or work in a division slated for sale or closure. Incentive mismatches also affect issues of quality. Because employers internalize only a portion of the benefits of better

quality care, they have less incentive to favor any particular quality enhancement than do employees as a group.[37]

Stated more concretely, because plans are a "bundled" product aimed at a diverse workforce, the alternatives that any given employer offers frequently do not include desired and desirable features from the perspective of any given employee, while also including features an individual employee may regard as a waste of money.[38] Changes in coverage also induce disruption and dislocation costs, whose magnitude is greatest for those with chronic conditions requiring highly specialized care.[39] It is commonplace (and completely accurate) to describe these mismatches as a source of market failure in the coverage and delivery markets.

C. Information Imperfections

Additional difficulties are created by the lack of transparency of the employment-based coverage system. Employer contributions are just another form of compensation to employees—and increased costs of coverage result in smaller wages for employees.[40] However most employees (and some employers) believe that employers are footing the bill for the coverage that employees receive. The result is that employees are relatively indifferent to the cost of their health care coverage (at least to the extent their employer is the one writing the check), while employers are extremely concerned about the cost of providing coverage for their employees. This lack of transparency creates a set-up for conflict between employers and employees about the nature and cost of coverage. Indeed, the lack of transparency probably accounted for much of the backlash against managed care, as employees did not perceive that they had received any benefit from the change, even though they received most of the estimated "savings" of $300 billion in the form of higher wages.[41]

D. Labor Market Dislocations

The linkage of employment and health coverage also creates sequencing difficulties when one changes jobs, or loses a job. Many health insurance policies contain waiting periods or exclusions on pre-existing conditions, which chill job mobility ("job-lock").[42] A worker might also choose to stay in his current job if the substantive terms of insurance coverage are particularly valuable to the worker or his family, even though another job might offer greater opportunities or a higher salary.[43] Similarly, because coverage is linked to employment, individuals who lose their jobs simultaneously lose their health insurance coverage.[44] Congress

was sufficiently concerned about these problems that it sought to enhance continuity and portability legislatively.[45]

When employers do not offer coverage at all, employees are unable to purchase such coverage on tax-advantaged terms, no matter how much they might desire it. Temporary and part-time workers also have difficulty obtaining coverage because of their transitory connection to any given employer. When these factors are combined with the substantial geographic variation in the distribution and type of employers, the result is that some states have substantially higher rates of uninsurance, simply because of employment demographics in that state.[46]

E. Regulatory Dislocations

Finally, all of these problems are worsened by the haphazard manner in which federal law preempts the traditional forms of regulatory oversight that would apply were the coverage not employment-based. In brief, state insurance commissioners have traditionally regulated the terms of insurance contracts quite aggressively, and state courts routinely employed common law causes of action to encourage insurers to deliver what they promise.[47] However, the Employee Retirement Income Security Act of 1974 (ERISA) creates a large loophole in this structure by preempting most state-level regulation of health insurance if it is provided in connection with employment,[48] and by providing only an exceedingly limited set of remedies (lawsuits are, to a first approximation, limited to the value of the denied services). This approach makes sense for protecting pension funds, which was ERISA's primary focus. Health benefits were included in ERISA as an afterthought, with little consideration given to whether the same regulatory framework would work—a problem that became increasingly obvious as managed care came to dominate the coverage market.

The result of this statutory framework is to leave employment-based health insurance effectively unregulated, since ERISA contains no substantive regulation of health benefits. ERISA does provide that the state can indirectly regulate an employee benefit plan if the plan purchases insurance from a state-regulated insurer (an "insured" employee benefit plan). However, only limited forms of regulation are allowed, and many potential tort claims are still preempted. Moreover, if the employer provides its own insurance (a "self-funded" employee benefit plan), the plan is effectively not subject to any state regulation. Thus, so long as coverage is employment-based, ERISA makes it extremely difficult to employ the traditional mechanisms for ensuring accountability—a fact that has helped fuel the drive for a patient bill of rights.[49]

This litany of problems makes it clear why reform of these

arrangements is a popular topic. Yet, initiating such reforms solely on the basis of complaints about the status quo is akin to convicting a defendant after hearing only from the prosecution.[50] It is one thing to identify shortcomings in employment-based coverage, and quite another to draw the conclusion that any given reform is necessary and appropriate—irrespective of whether the reform is aggressive state and federal regulation, elimination of ERISA preemption, replacing employment-based coverage with a one-payor system, medical savings accounts, or an individual mandate. Instead, a comparative institutional perspective requires that we consider whether employment-based coverage, for all its imperfections, outperforms alternative institutional arrangements. As Professor Neil Komesar concisely noted, "bad is often best, because it is better than the existing alternatives."[51]

III. COMPARATIVE INSTITUTIONAL ANALYSIS

A. Advantages of an Employment-Based System

Viewed from a comparative institutional perspective, employers perform several important and under-appreciated functions for employees in the coverage and delivery markets. First, the agency problems noted above often are more theoretical than real. Although the involvement of employers in the coverage market was effectively accidental, they are actually fairly well suited for the position they find themselves in. Surveys and focus groups indicate that employers do a reasonably good job reflecting their workers' values and preferences, just as one would expect in a reasonably competitive labor market.[52]

Employment-based coverage also helps to solve other types of market imperfections. In particular, employers provide useful search and aggregation functions for their employees in connection with the specification of coverage terms. This process of "informational intermediation" helps compensate for the bounded rationality of individual employees, and ensures that coverage will not be limited to conditions that are salient to employees at the time of purchase.[53] Medium and large employers also have personnel departments, which can cost-effectively handle coverage design, enrollment, premium collection, and dispute resolution. Many employers have developed as much sophistication and expertise in health insurance as that of most insurers. The result is that employers can bargain aggressively for discounts, serve as an effective advocate for employees who are involved in coverage disputes, and obtain more value for their employees' money than employees could do on their own.[54]

Employers also improve market conditions without even trying. Since employers are offering group coverage, they create significant efficiencies of scale with regard to administrative and marketing costs. This advantage is reflected in the portion of the insurance premium devoted to paying medical costs, rather than going to administrative overhead. Overhead costs for the largest employer groups are typically 5% or less, whereas these costs reach around 20% for smaller groups, and go above 30% for individual purchasers.[55] Savings of this magnitude allow the purchase of more extensive coverage than otherwise would occur.

Employment-based insurance also promotes more comprehensive coverage by virtue of the substantial tax subsidy associated with such insurance.[56] Insurance pools naturally tend to suffer from lack of cohesion and stability. It is not a simple matter to form a group that is willing to pool their health insurance expenses and arrange for (and selectively subsidize) insurance, such that almost everyone in the group will opt into coverage. If members of the group have widely varying risk profiles and can obtain comparable coverage outside the group setting, the healthier ones will opt out and purchase individually at a rate cheaper than the average cost for the entire group. In other words, the savings to healthier members from disaggregating the group could well exceed the savings from group economies. In these circumstances, only the tax subsidy makes it significantly more attractive to purchase coverage through one's employer. Therefore, the tax subsidy plays the important role of keeping intact the heterogeneous risk pools that are needed to achieve the administrative efficiencies found in employment-based health insurance.

Healthier members opting out of a group is one form of a more general phenomenon known as "adverse selection." This phenomenon is pervasive in insurance and can cause insurance to become partially or entirely unmarketable. Adverse selection occurs when potential subscribers know more about their individual risks than the insurer knows.[57] Suppose, for instance, that a health insurer approaches a market assuming that all people of the same age and sex have the same risk of disease or injury and so the insurer prices its product accordingly—say, at $3,000 for males aged 40 to 45. Naturally, not all men this age have the same risk of illness. Some are in excellent shape, some have average health, and some are already sick. If the insurer is not able to act on this information (or is prohibited from learning it), and if only some people purchase insurance, a disproportionate number of sicker people will subscribe, because those with greater than average risk will find the average price more attractive than those of lesser risk. A pool of sicker-than-average subscribers will obviously end up costing more than $3,000 per person, so an insurer that

wants to remain solvent will raise its price—say to $3,500. This does not solve the adverse selection problem, since at any price the insurance is by definition more attractive to higher-risk than to lower-risk subscribers.

Adverse selection exists as an imperfection to some degree in all insurance markets, and it is increased by laws (such as community rating) that require insurers to disregard certain risk factors. Adverse selection discourages the purchase of insurance by some people who would otherwise have chosen to purchase coverage. At the extreme, adverse selection may destroy the market altogether, since the tendency is for prices to migrate towards those that are appropriately charged for the highest risks. Obviously, this price point is unaffordable for many—and a bad deal for most—potential subscribers. One remedy for adverse selection is for insurers to engage in risk underwriting, by learning as much as possible about the risks of individual subscribers and to group and price subscribers according to their actual risks. This process is referred to as risk selection (or risk assessment) and risk rating. The effect is to create multiple, separately priced risk pools that are each stable. In individual health insurance, risk selection is done through questionnaires and medical exams. Ferreting out more refined risk information can be costly. Moreover, this process results in higher-risk people being priced out of the market, and in types of coverage that are more attractive to higher-risk people not being offered at all.

Employment-based coverage offers a partial solution to these problems. Because an employment-based risk pool exists for reasons independent of the demand for coverage, the significance of adverse selection in the coverage market is greatly attenuated. Employers, except for the very smallest "mom-and-pop shops," are not motivated to purchase insurance by specific anticipated health care needs (such as an anticipated pregnancy). Therefore, the insurer can safely assume that the group's future medical expenses will approximate the group's recent experience. This allows the insurer to assess the overall group's average risk simply by observing its claims experience (experience rating), rather than assessing each individual member's risk. More importantly, because the group exists for non-insurance reasons, new members of the group will not be higher-than-average risk and group-leavers will not be lower-than-average risk. In other words, group members will not select in or select out of the group just because of the insurance, so the group's risk will remain stable. In combination, this means that coverage can be written in the employment-based market at a considerably lower cost than would be the case if each member of the pool presented individually and requested coverage.

Employment-based groups are also cost-effective vehicles for

insurance, because workers (and, to a lesser extent, their beneficiaries) are healthier on average than non-workers. This demographic reality lowers the cost of coverage still further. As a consequence of these economic advantages, insurance purchased by employees through large employers costs about one-third less than equivalent coverage would cost in the individual insurance market, if it were available—and equivalent coverage is often not available at all.[58]

Employment-based coverage is also the nexus for cross-subsidization within pre-existing risk groups. Because employment-based coverage is not risk-adjusted or underwritten within the risk pool, there are, by definition, systematic cross-subsidies flowing within the pool.[59] Although these arrangements fall well below the degree of social solidarity desired by advocates of one-payor systems, they are real, and long-standing.[60] The success of employment-based coverage in maintaining these internal cross-subsidies should be contrasted with the difficulty that states and the federal government have encountered in mandating or maintaining such cross-subsidization.[61]

As private actors, employers also have greater flexibility in the design and implementation of cost-cutting and quality-enhancing initiatives than public payors. Public payor initiatives typically trigger opposition and lobbying; private payor initiatives are (relatively) insulated from such processes.[62] In like fashion, public payors are subject to constitutional and statutory norms of uniformity and openness, while private payors have greater freedom to provide different benefits to different customers and to define their obligations and methods of dispute resolution by contract.[63]

Employment-based coverage also neatly maps onto traditional American attitudes regarding government.[64] The large public programs (Medicare and Medicaid) are reserved for those who are too poor or high-risk to have market options.[65] When responsibility for coverage is handled by private parties, the government's access to sensitive information on its citizens is sharply constrained. Employees are less than thrilled that their employers have access to this information, but they are even less enthusiastic about the government having the information. Similarly, when employers are responsible for making coverage arrangements, the government has considerably more limited involvement than would otherwise be the case—a feature that is particularly desirable if one doubts the competence and compassion of a governmental bureaucracy.[66]

Finally, employment-based coverage may allow for more innovation with regard to coverage arrangements. Although Medicare was responsible for a number of significant innovations in payment patterns (e.g., prospective payment via diagnosis-related groups (DRGs) and the

resource-based relative value scale (RBRVS)), such arrangements tend to be all-or-nothing developments. Because of the large number of employers, coverage innovations can develop in a bottom-up fashion. For example, a number of employers are flirting with moving from "defined benefit" coverage (in which the employer picks one or more coverage options for all of its employees) to a "defined contribution" arrangement (in which employees receive a specified amount to be used for the purchase of whatever coverage they desire).[67] These proposals coincide with the emergence of web-based systems that individuals can use to shop for such coverage.[68] Although such arrangements create problems of risk adjustment, they hold out the potential of eliminating many of the previously outlined agency problems associated with the involvement of employers in the coverage market.

An even more intriguing development is the interest of some employers in using their market power to force providers to improve the quality of care they are providing. Historically, individual patients have paid little attention to the problem of low quality care, since they tend to rate the quality of care they personally receive quite highly.[69] Such confidence is unwarranted; the quality of American medicine varies widely. Some services are over-utilized, others are under-utilized, and utilization rates vary from place to place in unexplained ways.[70] Patients are also frequently injured as a result of medical treatment. The Institute of Medicine estimated that between 44,000 and 98,000 deaths per year result from medical mistakes—making medical error the eighth leading cause of death in the United States.[71] Every year, medical errors kill more people than motor vehicle accidents, breast cancer, and AIDS.[72]

Although these problems are generally not salient to individual recipients of health care, employers have started to address them.[73] Predictably enough, they are using economic incentives to encourage providers to ensure the quality of care they provide, instead of paying providers based on variables that bear little or no relationship to the quality of care that is rendered (e.g., the amount of time a provider spends with a patient, the number of patients a provider treats, the number and type of procedures a provider performs, the number of weeks a provider is employed, or the number of patients in a provider's practice).[74] The acknowledged leader in this campaign to develop "value-based purchasing" is the Pacific Business Group on Health (PBGH), a consortium of employers who collectively spend more than $3 billion annually on health care for nearly three million employees. In 1995, PBGH began negotiating performance contracts with the HMOs with whom they dealt. HMOs that failed to meet targets on a variety of performance measures were required

to forfeit a small portion of their fees.[75] Once performance was tied to compensation, the quality of care that was rendered started to improve.[76] PBGH's success has led other groups to copy its strategy.[77]

Employers are also taking steps to address the problem of medical errors. The Leapfrog Group, a consortium of employers, has pledged that its members will purchase health care services only from providers who have made certain specified investments in error reduction. Hospitals must adopt computerized systems for prescribing medicines, patients requiring particularly complex procedures must be referred to hospitals with the highest survival rates, and hospitals with intensive care units must provide twenty-four hour staffing by critical care physicians.[78] Each of these initiatives has been demonstrated to improve patient outcomes, and there appear to be substantial financial savings associated with implementing them. Indeed, Leapfrog Group estimates indicate that these three improvements could save up to 58,300 lives per year and prevent 522,000 medication errors, if implemented by all non-rural hospitals in the United States.[79]

To be sure, these initiatives are small steps by only a few employers.[80] However, even these baby steps are more than any federal or state health program has been able to do—or is likely to do, given the political dynamics under which these programs operate.[81] When the New York Department of Public Health suggested the use of performance-based compensation for cardiac surgery, physicians and hospitals pressured legislators to prohibit such arrangements.[82] Medicare has had limited success with its attempts to designate "centers of excellence" for cardiac and orthopedic surgery, as providers have claimed that the centers are being selected primarily on grounds of cost, rather than quality.[83]

B. Problems with Reforms

Although the employment-based coverage market has all of the weaknesses outlined previously, a fair comparison requires one to consider the analogous weaknesses of any proffered "reform." It is easier to identify agency conflicts and bounded rationality than it is to solve such problems. Any system of preference aggregation invariably creates a problem with preference mismatch—and the larger the group being aggregated the worse the problem. Any given "reform" will not solve all of the problems found in the employment-based market, and it may well make some of them worse—particularly when one factors in the likelihood of legislation by anecdote, symbolic blackmail, and agency capture.

Enthusiasm is not a sufficient precondition to ensure that "reforms" improve on the status quo. The critical institutional competence question

is whether those who will be designing and running the system after the "reform" has been implemented have the necessary information, preferences, and incentives to outperform the employment-based market. In economic terms, the issue is which agency relationship is less imperfect across the relevant dimensions of cost, quality, and access. In reality, most of the "reforms" suffer from the same weaknesses as the employment-based coverage system—and when a "reform" performs better on one aspect of the incentives/information/preferences mismatch triad, it usually does worse on another aspect of the triad. Alternatively, the "reforms" may trigger adaptive responses that are socially inefficient, and make everyone worse off. Thus, it is far from clear that any of the reforms will actually improve the status quo—particularly if the reforms are not subject to the market test of allowing affected individuals to determine whether they prefer the status quo ante.

For example, if employment-based health insurance is abandoned, adverse selection will become a much more serious problem. Risk selection (both favorable and unfavorable) is likely to require regulatory attention.[84] If each person is allowed to contract for the precise coverage he or she anticipates needing, those seeking to purchase any given policy will disproportionately be those expecting to make claims under the policy. As costs for that particular policy rise to reflect claims experience, those who do not value the specified coverage will make alternative arrangements—triggering still-greater increases in premiums and more defections from the risk pool. In short order, many forms of coverage will be unavailable at any price.

The problems presented by risk selection are illustrated by the difficulties potential subscribers currently encounter purchasing health insurance in the individual market. A recent study approached nineteen insurers in eight different states with a variety of hypothetical purchasers who had common, but not terribly serious, health problems—for example, a person with hay fever, a person with a bad knee from an old sports injury, a child with asthma and ear infections, and an overweight smoker with high blood pressure. The study found that 90% of the time, full coverage was not available at standard rates. Either coverage was refused, premium surcharges averaging 38% were imposed, or the condition in question was excluded.[85]

Employers represent an effective solution to the risk selection collective action problem. If large numbers of people leave the employer coverage market, legislators and regulators will need to address the issue—most likely by reforming how insurance is sold in the individual market and mandating a menu of benefits. Unfortunately, when legislatures

mandate benefits, they simply replace one set of preference aggregation problems (at the employer level) with a worse set of preference aggregation problems (because the process is conducted at the state or federal levels), coupled with the distorting consequences of symbolic blackmail and private self-interest on the substantive content of the mandates.[86] Other market reforms, such as guaranteed issue, open enrollment, and versions of community rating essentially attempt to replicate for the individual market the risk pooling and efficiencies that currently exist in the employer market. However, the technical problems in accomplishing this goal are much greater than the current models that exist in the small group market.[87] In the small-group market, employers' role in forming insurance pools and selecting coverage helps to solve the adverse selection problems created by restricting insurers' ability to underwrite according to health risk. In the individual market, however, adverse selection problems become insurmountable. States that have required versions of open enrollment and community rating for non-employer sponsored health insurance have seen insurance prices rise steeply and rates of coverage drop significantly.[88]

Many advocates of non-employer based insurance point to private purchasing associations as the solution to the problems in the individual market. They contend that a variety of different pools, resembling current discounting arrangements for trade association and professional groups, could, in competition with each other, replicate the role that employers play in negotiating lower rates and achieving economies of scale.[89] Although there is force to these arguments, considerable technical difficulties exist in determining how these hybrid entities would operate at the border of the individual and group markets without disrupting either market. Advocates argue that these association pools should be protected from regulatory mandates that do not apply to large employers, and these pools should be allowed to set their rates according to the group's overall claims experience, as is done for large employers, in order to have an incentive to lower costs and bargain for better rates. If this is done, however, these private associations are likely to draw off the better risks from the individual and small-group markets, possibly causing them to collapse into high-risk pools. Also, different associations offering similar coverage based on the risk profile of people who happen to belong to each pool creates a turbulent market dynamic in which people continually shop to join an association in which most people are healthier than they are. Finally, initial experience with existing insurance cooperatives indicates that they only marginally improve economies of scale. Transaction costs remain high because each subscriber has to be dealt with individually,

rather than a single purchaser acting on behalf of an entire group.[90] In short, voluntary pools contain only a shadow of the efficiencies created by employment-based pools. At bottom, they lack both the cohesion and the economies of scale in employment-based pools.

Even if the individual market can be successfully reformed, non-employment-based coverage would create significant risk adjustment problems. If insurance purchase is not mandated, healthier people will drop coverage. Subsidies are required for those who cannot afford coverage, but the subsidies must be risk adjusted to prevent insurer "red-lining" of subscribers whose anticipated health costs exceed the allowable premium. The science of risk adjustment is far from being perfect, despite two decades of development—and its complexity is likely to rival that of other administered pricing systems such as DRGs.[91]

A single-payor system addresses some of these problems (particularly adverse selection), but it worsens others. In particular, the problem of preference aggregation is substantially worsened when everyone in a state (or in the nation) is included in a single risk pool covered by a single benefits package—with the substantive content of that benefits package greatly influenced by political lobbying, symbolic blackmail, and self-interest.[92] Single-payor systems are also uniquely vulnerable to larger budgetary pressures, as the amounts available to pay for health care are determined every year based on how effectively health care can compete with other budgetary priorities.[93] Many Americans are also suspicious of the public bureaucracy, which will be required to administer such programs. Finally, once the government is a monopsony purchaser, it must navigate the complexities of setting prices, picking qualified providers, and making long-term capital investment decisions. Each of these decisions creates major coordination problems that separately, and in combination, have the potential to increase cost and undermine quality and access. More generally, there are substantial hazards from both under-payment and over-payment, and little probability of convergence toward the "right rate" over time.[94]

IV. WHERE DO WE GO FROM HERE?

A. The Logic of Incremental Reform

There are serious collective action problems associated with building the necessary support for enacting sweeping reforms. Machiavelli framed the problem quite neatly:

> There is nothing more difficult to take in hand, more perilous to

> conduct, or more uncertain in its success, than to take the lead in the introduction of a new order of things. Because the innovator has for enemies all those who have done well under the old conditions, and lukewarm defenders in those who may do well under the new. This coolness arises partly from fear of the opponents, who have the laws on their side, and partly from the incredulity of men, who do not readily believe in new things until they have had a long experience of them.[95]

Given this dynamic, it is not at all surprising that periods of sweeping reform (e.g., the New Deal and the Great Society) are relatively rare. Institutional and political considerations also make it hard for anything but incremental changes to emerge from the legislative process—and implementation raises additional barriers.[96] 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.[97] Not surprisingly, reform enthusiasts have turned their attention to incremental reforms.[98] Given this dynamic, we believe that incremental reforms are all that is likely to emerge from the political process during the foreseeable future.[99]

B. Some Incremental Reforms of Employment-Based Insurance

It is fair to ask what changes, if any, we would make in the employment-based coverage market. We believe that several important changes will help ensure the continued smooth functioning of the employment-based market, while simultaneously addressing some of the problems identified previously. However, we do not fully agree on all of the details regarding the specific changes that we believe are appropriate, and on the degree of enthusiasm we each have for particular proposals. Also, we hasten to add that our modest "fixes" will not completely solve the problems identified previously, and they will create new problems of their own—but, as noted previously, the right question is whether, on balance, these "fixes" make things better when assessed across all the relevant parameters. We suggest three specific reforms: (1) changing the tax subsidy so that those without access to employment-based insurance can enter the coverage marketplace on more equal footing than is currently the case; (2) amending ERISA to create more sensible state and federal regulatory and liability regimes; and (3) encouraging the use of purchasing pools.

1. Tax Subsidy Reform. There are a wide variety of ways in which the

tax subsidy can be fixed, depending on what one wants to accomplish, and how much one wants to spend.[100] Most proposals start with providing tax credits to workers who currently do not have employment-based coverage. Other proposals include the self-employed or everyone who might want to purchase private insurance. Depending on the specifics, such arrangements can effectively create a partial voucher system for the purchase of health care coverage, and eliminate the horizontal and vertical inequities associated with the current system.[101] However, the more extensive the tax credits, the greater the potential for adverse selection, as younger and healthier employees can suddenly exit existing risk pools. Therefore, we suggest that tax credit proposals should initially focus on those who do not currently have access to employment-based coverage. Beyond that group, we believe that such reforms should be implemented gradually, in order to evaluate the effect on existing risk pools. The advantage of this approach is that it provides a market test of the comparative advantage (if any) of employers in structuring and administering the coverage market, while simultaneously addressing the problem of the uninsured.

2. *ERISA Reform.* Our second, not-so-minor, repair is to amend ERISA, with due care for the competing considerations of federalism, the varying need for regulatory oversight of different parts of the employment-based coverage market, and the issue of managed care liability. This subject is far too complicated for us to address in this limited space, and we do not fully agree on the specifics of this "repair." However, we do agree on several basic principles:

a. Existing law treats coverage quite differently, depending on whether it is individual, employer-purchased, employer-self-funded, or sponsored by a religious or governmental employer. Such divisions are wholly artificial, and create distorting incentives in the coverage market. The choice between state and federal regulation should not turn on such fortuities and quirks. Accordingly, the regulatory framework should be revised to treat "like" coverage alike, irrespective of the context through which it is secured.

b. States should have greater leeway to regulate employment-based health insurance, with a continuing role for federal oversight. State authority makes sense where the issues and solutions are likely to vary regionally, along with social and economic conditions. Experimentation and competition among state regulatory regimes is also beneficial in its own right, for the familiar reasons captured in the slogan "laboratory of the states."[102] On the other hand, many important innovations in coverage and delivery arrangements likely would not have occurred without the "breathing room" created by ERISA preemption.[103] Also, national uniformity is sometimes highly

desirable, and some forms of state regulation will undoubtedly be unwise and unduly burdensome. In keeping with these considerations, federal preemption should occur on a more targeted basis, instead of being sweeping and presumptive.

c. Health insurers should not be virtually immune from certain forms of liability because of the accident of ERISA preemption. A liability scheme should be devised that sets sensible default rules for allocating responsibility for medical error throughout the various components of managed health care systems, but that leaves the parties (e.g., providers, payors, and subscribers) free to reallocate this responsibility by contract. One of these default rules is that employers should not be subject to managed care liability solely by virtue of their role in selecting, designing, or paying for health insurance.

3. Purchasing Cooperatives. Finally, we suggest that purchasing cooperatives or associations be made more widely available to individuals and employers. In order for this to occur, the complex and obscure regulatory treatment of these association pools should be clarified and streamlined, especially when they cross product and geographic market boundaries. More specifically, federal or uniform state law should more clearly define whether insurance sold through pooled arrangements is treated as individual or group insurance. If it is treated as group insurance, then the law should define whether it is small or large group insurance, and, if the latter, the law should delineate the appropriate type for oversight of self-insured arrangements. To avoid disrupting existing employment-based markets, care must be taken to prevent purchasing pools from being used as vehicles for risk selection. Options for addressing this problem include requiring that subscribers make longer-term commitments to association pools, or limiting the circumstances under which subscribers can join or change these pools (e.g., only every three years, or upon changing jobs or moving to a new area).

C. Whither the Uninsured?

What then of those who are left out of the employment-based system? Critics of employment-based coverage typically treat the existence of the uninsured as a moral trump card, justifying immediate and comprehensive reform regardless of the social and economic costs. We agree that addressing the problem of the uninsured is an appropriate reform objective, and we have proposed the use of tax credits to address the problem. However, we believe that the relationship between the employment-based coverage market and the uninsured cannot be resolved on the basis of moralizing. Employers provide coverage (or fail to do so) out of self-interest, and employees accept or decline coverage after making

a similar assessment. Employers operate in a competitive labor market—and they are no more morally blameworthy for failing to offer insurance to their employees than they are blameworthy for not paying their minimum wage employees more than minimum wage. Similarly, employees who decline to accept coverage either assess their risks differently, or simply have a better use for their money than buying coverage.[104] There is no compelling theoretical or practical reason to treat all of these decisions, which occur in the shadow of a competitive labor market, as a failure of employers or of the employment-based coverage market.

The availability of employment-based pooling mechanisms may (or may not) offer the best opportunity to address various social problems, but this possibility should not be viewed as creating a moral obligation on the part of employers to meet the social needs that our society has proven unwilling to address, despite repeated opportunities to do so. As Professor Mark Pauly observed:

> [T]he worsening of the lot of the uninsured under market competition, if it occurs and is not offset by government, would not be an example of market failure. Rather, it would be an example of serious 'government failure' (at least in the sense of citizens collectively making a bad decision), an example of political failure, and perhaps of moral failure. Markets would be doing what they do best. It would be government that would be failing to do what it should do. Market competition will have abolished a type of charity that citizens, when faced with the challenge to pay for it explicitly and consciously, determined to be not worth its cost.[105]

CONCLUSION

It is not all that hard to envision reforms that, had they been adopted much earlier, might well have turned out to be superior to the status quo. Unfortunately, the transition costs and social dislocations in discarding the existing system are likely to be enormous.[106] It may appear intellectually unsatisfying to settle for an imperfect institutional arrangement simply because it happens to be the one in place—particularly when the current system arose largely by accident. However, the history of attempts at national health insurance reform is an unhappy one, and human beings appear to be psychologically hard wired to prefer the status quo.[107]

More importantly, any significant change in the existing framework is likely to prompt massive adjustments. Employers are already exceedingly skittish about their role in the coverage market, and they can only be pushed so far. Consider the impact of Financial Accounting Standard 106, an accounting ruling effective in 1993 that required employers to carry as a

current liability on their balance sheets their promises of future health benefits for retirees. This relatively minor change prompted some employers to drop retiree health benefits altogether and many more to scale back the extent of those benefits.[108]

The debate about the competing patient bills of rights reflects similar concerns. A major concern in the debate is whether increasing employers' risk of managed care liability will prompt them to drop coverage altogether.[109] Most of the competing bills have strong language intended to allay this concern, reflecting that the risk is taken seriously on both sides of the political spectrum. We should expect widespread disruptions—both intended and unintended—when wholesale reform of the employment-based system is undertaken.

On balance, the existing system, as imperfect as it is, may be the best we can do under the circumstances. One good indicator of this is that, when asked, most employees would prefer that their employers continue their role in selecting health insurance.[110] This does not mean that the employment-based market cannot be improved through judicious market-enhancing initiatives. Yet, the truth of the matter is that an employment-based coverage market does have real strengths, even in its current form, and the proposed "reforms" have their own weaknesses, which any rigorous assessment of the alternatives must weigh in the balance. The fact that the existing system delivers a range of coverage and delivery options to 177 million Americans is itself a strong point in its favor, even without factoring in the transition costs to the brave new world offered by reform advocates.

References

1. Norval Morris, Judicial Conference—Second Circuit—82 FRD 221, 297 (1978) (quoting Sir Henry Maudsley, the noted British historian).

2. *See* SHARON SILOW-CARROLL ET AL., IN SICKNESS AND IN HEALTH? THE MARRIAGE BETWEEN EMPLOYERS AND HEALTH CARE (Econ. and Soc. Research Inst. 1995); Uwe E. Reinhardt, *Employer-Based Health Insurance: A Balance Sheet,* 18 HEALTH AFF., Nov.-Dec. 1999, at 124, 127.

3. *See* EMPOWERING HEALTH CARE CONSUMERS THROUGH TAX REFORM (Grace-Marie Arnett ed., 1999); Stuart Butler & David B. Kendall, *Expanding Access and Choice for Health Care Consumers Through Tax Reform,* 18 HEALTH AFF., Nov.-Dec. 1999, at 45, 46.

4. David A. Hyman, *Regulating Managed Care: What's Wrong with a Patient Bill of Rights,* 73 S. CAL. L. REV. 221, 246 (2000).

5. *See, e.g.,* Alain C. Enthoven, *Consumer-Centered vs. Job-Centered Health Insurance,* 57 HARV. BUS. REV. 141, 151 (1979) ("There is little to lose and much to gain by cutting today's link between jobs and health insurance."); Victor R. Fuchs, *The Clinton Plan: A Researcher Examines Reform,* 13 HEALTH AFF., Spring 1994, at 102, 110 ("We must disengage health insurance from employment. This tie never had a rational basis.... Sooner or later, the inequities and inefficiencies associated with employment-based health insurance will become so apparent as to dictate disengagement."); Uwe E. Reinhardt, *Employer-Based Health Insurance: R.I.P., in* THE FUTURE U.S. HEALTHCARE SYSTEM: WHO WILL CARE FOR THE POOR AND UNINSURED? 325, 348 (Stuart H. Altman et al. eds., 1998) ("On balance, it can be asked whether a system with so many inherent flaws merits shoring up through public policy—its numerous virtues notwithstanding—or whether it had not best be left to its own slow demise."); Jennifer Steinhauer, *Hidden Barriers to Health Coverage,* N.Y. TIMES, Oct. 19, 2001, § 3, at 11 (presenting trade-offs associated with employer involvement).

6. *See* S. SILOW-CARROLL ET AL., THE STATE OF EMPLOYMENT-BASED HEALTH COVERAGE AND BUSINESS ATTITUDES ABOUT ITS FUTURE (2001) (depicting lukewarm support of employers for continued involvement in coverage market); James Robinson, *The End of Managed Care,* 285 JAMA 2622, 2623 (2001) ("Employers now purchase ever less employee satisfaction at an ever-growing price.... While many employers remain committed to funding health insurance...the trend is to offer information, options, and partial financial support, but to otherwise get out of the decision-making position in health care."); Interview by Patrick Mullen with Regina Herzlinger, Professor, Harvard Business School (May 1998) *available at* http://www.managedcaremag.com/archives/9805/9805.qna_herzlinger.shtml ("Employers are saying, 'Look, I've got a business to run here, I can't run the health care business and my own business.'").

7. Jon R. Gabel, *Job-Based Health Insurance, 1977-1998: The Accidental System Under Scrutiny,* 18 HEALTH AFF., Nov.-Dec. 1999, at 62; *see generally* Robert Kuttner, *The American Health Care System: Employer-Sponsored Health Coverage,* 340 NEW ENG. J. MED. 248 (1999).

8. *See generally* NEIL K. KOMESAR, IMPERFECT ALTERNATIVES: CHOOSING

INSTITUTIONS IN LAW, ECONOMICS, AND PUBLIC POLICY (1994) (outlining comparative institutional analysis).

9. *See infra* Part IV.

10. *See* RICHARD EPSTEIN, SIMPLE RULES FOR A COMPLEX WORLD 32 (1995) ("First best solutions are rarely if ever, possible; thus the beginning of wisdom is to seek rules that minimize the level of imperfections, not to pretend that these do not exist. No contract, no association is ever bullet proof: no matter what rights, duties, institutions and remedies are chosen, in some circumstances they will be found wanting. Bad outcomes are therefore consistent with good institutions and we cannot discredit these institutions with carefully selected illustrations of their failures. Counterexamples may be brought to bear against any set of human institutions. The social question, however, is concerned with the extent of the fall from grace. The fact of the fall should be taken as a necessary truth, not a shocking revelation. Perfection is obtainable in the world of mathematics, not in the world of human institutions."); Harold Demsetz, *Information and Efficiency: Another Viewpoint*, 12 J.L. & ECON. 1, 1 (1969) ("The view that now pervades much public policy economics implicitly presents the relevant choice as between an ideal norm and an existing 'imperfect' institutional arrangement. This *nirvana* approach differs considerably from a *comparative institution* approach in which the relevant choice is between alternative real institutional arrangements.").

11. *See supra* note 1.

12. Indeed, one of the shortcomings of the managed care backlash has been the failure of most commentators to appreciate the benefits of existing arrangements and the trade-offs associated with the proffered alternatives. Instead, the general tactic (exemplified by the debates over gag clauses and drive-through deliveries) has been to offer a highly unrepresentative anecdote, and bemoan the defects in the system that it purportedly reflects. *See generally* David A. Hyman, *Managed Care at the Millennium: Scenes From A Maul*, 24 J. HEALTH POL., POL'Y & L. 1061 (1999) (presenting evidence that legislative initiatives regarding gag clauses, drive-through deliveries, and access to emergency care are misconceived); Hyman, *supra* note 4, at 237-44 (outlining the atypical nature of the anecdotal evidence relied upon by Congress in framing patient protections against managed care); David A. Hyman, *Drive-Through Deliveries: Is "Consumer Protection" Just What the Doctor Ordered?*, 78 N.C. L. REV. 5 (1999) (providing an in-depth examination of the merits of consumer protection legislation against "drive-through deliveries."); David Mechanic, *The Managed Care Backlash: Perceptions and Rhetoric in Health Care Policy and the Potential for Health Care Reform*, 79 MILBANK Q. 35, 53 (2001) ("The ongoing public debate often does not accurately convey the key issues or the relevant evidence. Important perceptions of reduced encounter time with physicians, limitations on physicians' ability to communicate options to patients, and blocked access to inpatient care, among others, are either incorrect or exaggerated.").

13. PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 200-06 (1982).

14. *Id.* at 203-09.

15. *See* Robert B. Helms, *The Tax Treatment of Health Insurance: Early History and Evidence, 1940-1970*, at 8 *in* EMPOWERING HEALTH CARE CONSUMERS

THROUGH TAX REFORM, *supra* note 3. The population of the United States in 1930 was 122,288,177. *See* Inter-university Consortium for Political and Social Research, Census Data for the Year 1930, *at* http://fisher.lib.virginia.edu/cgi-local/ensusbin/census/cen.pl?year=930.

16. *See* INST. OF MED., EMPLOYMENT AND HEALTH BENEFITS: A CONNECTION AT RISK 70 (1992).

17. *See* Helms, *supra* note 15, at 11.

18. *See* SHERRY GLIED, REVISING THE TAX TREATMENT OF EMPLOYER-PROVIDED HEALTH INSURANCE 4 (1994); *see also* I.R.C. § 106 (1986) ("Gross income [of an employee] does not include contributions by the employer to accident or health plans."); I.R.C. § 3121 (1986) (similarly excludes the employer's contribution from payroll taxes).

19. *See* Helms, *supra* note 15, at 10; John Sheils & Paul Hogan, *Cost of Tax-Exempt Health Benefits in 1998*, 18 HEALTH AFF., Mar.-Apr. 1999, at 176, 179, 181 (modeling tax subsidy and concluding that it is "heavily skewed toward high-income groups," with 68.7% of the total subsidy going to the 36% of the population with incomes greater than $50,000.).

20. *See* Jay Soled, *Taxation of Employer-Provided Health Coverage: Inclusion, Timing and Policy Issues*, 15 VA. TAX. REV. 447 (1996) (estimating $74 billion in foregone taxes); Sheils & Hogan, *supra* note 19, at 178 (presenting estimate that tax subsidy totals $124.8 billion); NAT'L HEALTH POL'Y FORUM, ISSUE BRIEF NO. 728, *Retooling Tax Subsidies for Health Coverage: Old Ideas, New Politics*, http://www.nhpf.org/cfm/register.cfm (estimating $96 billion in federal and $12 billion in state foregone taxes).

21. Congress has partially leveled the playing field, by allowing self-employed taxpayers to deduct a percentage of their payments for health insurance policies. I.R.C. § 162(l)(B) (1986). Currently, the applicable percentage is 60%, but it is scheduled to increase to 100% in 2003. However, this approach necessarily excludes individuals who are not self-employed, even if their employer does not offer coverage.

22. *See* JOSEPH CALIFANO, AMERICA'S HEALTH CARE REVOLUTION: WHO LIVES? WHO DIES? WHO PAYS? 44-45 (1986); STARR, *supra* note 13, at 310-15.

23. CALIFANO, *supra* note 22, at 13. ("Like most large companies with employees represented by the United Automobile Workers and such other big unions as the United Steelworkers, Chrysler had allowed the collective-bargaining process to produce a health care benefit package for everything from coronary bypass surgery to fixing ingrown toenails, with no incentive for its employees to buy prudently.").

24. *Id.* at 45 ("First-dollar coverage plans spread like an infectious flu through a crowded elementary school—not only among union employees, but among non-organized white-collar workers as well.").

25. *See* Stephen H. Long & M. Susan Marquis, *Stability and Variation in Employment-Based Health Insurance Coverage, 1993-1997*, 18 HEALTH AFF., Nov.-Dec., 1999, at 133; ROBERT J. MILLS, U.S. CENSUS BUREAU HEALTH INSURANCE COVERAGE: 2000 (Sept. 2001), *available at* http://www.census.gov/prod/2001pubs/p60-215.pdf.

26. *See* EMPLOYEE BENEFIT RES. INST., ISSUE BRIEF NO. 213, EMPLOYMENT-BASED HEALTH BENEFITS: WHO IS OFFERED COVERAGE VS. WHO TAKES IT (1999), *available at* http://www.ebri.org/ibex/ib213.htm ("The 13.7 million workers

who were offered coverage but declined it gave a number of reasons for doing so. In the majority of cases (61 percent), the worker was covered by another health plan. Of the remainder, 20 percent reported that health insurance was just too costly."); Philip F. Cooper & Barbara Steinberg Schone, *More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996*, 16 HEALTH AFF., Nov.-Dec. 1997, at 142, 144 (noting rapid increase in the number of Americans (currently five million) who had access to employment-based health insurance but declined coverage and are uninsured); Jon R. Gabel et al., *Embraceable You: How Employers Influence Health Plan Enrollment*, 20 HEALTH AFF., July-Aug. 2001, at 196.

27. CATHY SCHOEN & KAREN DAVIS, THE COMMONWEALTH FUND, ISSUE BRIEF: EROSION OF EMPLOYER-SPONSORED HEALTH INSURANCE COVERAGE (1998), http://www.cmwf.org/programs/insurance/schoen_erosion_ib_297.asp.

28. This is a slight oversimplification because there is some cycling between Medicaid and employer-based coverage, and some Medicare beneficiaries also have coverage through their former employers.

29. *See, e.g.*, John D. Banja, *The Improbable Future of Employment-Based Health Insurance*, 30 HASTINGS CTR. REP., May-June, 2000, at 17 ("Virtually all ethicists have condemned America's private, voluntary purchase approach to health insurance as a national disgrace."); Nancy Jecker, *Can an Employer-based Health Insurance System Be Just?* 18 J. HEALTH POL., POL'Y & L. 657 (1993); Deborah A. Stone, *Beyond Moral Hazard: Insurance as Moral Opportunity*, 6 CONN. INS. L.J. 11 (2000).

30. *See* Lynn Etheredge et al., *What Is Driving Health System Change?*, 15 HEALTH AFF., Winter 1996, at 93, 98 ("The evidence shows that individuals tend to select lower-price plans from employers' multiple-choice offerings and that even small premium differences can drive enrollment shifts among health plans."); M. Susan Marquis & Stephen H. Long, *To Offer or Not to Offer: The Role of Price in Employers' Health Insurance Decisions*, 36 HEALTH SERVICES RES. 935 (2001); Catherine G. McLaughlin, *Employers as Agents for Their Employees*, 36 HEALTH SERVICES RES. 827 (2001); Roger S. Taylor, *Commentary*, 56 MED. CARE RES. & REV. 60, 62 (1999) ("[T]he majority of consumers were willing to trade the ability to choose providers for a reduction in out-of-pocket costs.... This helps explain why, when offered both a fee-for-service plan and a more managed care plan...the majority chose managed care."); Kenneth E. Thorpe & Curtis S. Florence, *Why Are Workers Uninsured? Employer-Sponsored Health Insurance in 1997*, 18 HEALTH AFF., Mar.-Apr. 1999, at 213, 217 (finding that workers who were eligible for health insurance and rejected it mostly did so because of its high cost); *see also supra* note 26. As with all preferences, employees differ in their enthusiasm for trading choice for lower prices. *See* Ha T. Tu & Peter Cunningham, *Strong Opinions Held About the Tradeoff Between Choice of Providers and Cost of Care*, 4 CENTER FOR STUDYING HEALTH SYSTEM CHANGE: DATA BULLETIN, 1 (1997) *available at* http://www.hschange.org/CONTENT/93.

31. In economic terms, these difficulties are typically described and analyzed as involving agency costs. *See* Gail Agrawal, *Resuscitating Professionalism: Self-Regulation in the Medical Marketplace*, 66 MO. L. REV. 341, 370-71 (2001) (discussing agency problems caused by employment-based purchasing of health insurance); Dayna B. Matthew, *Controlling the Reverse Agency Costs of Employment-Based Health*

Insurance: Of Markets, Courts, and a Regulatory Quagmire, 31 WAKE FOREST L. REV. 1037 (1996).

32. Mark Pauly et al., *Individual Versus Job-Based Health Insurance: Weighing The Pros and Cons,* 18 HEALTH AFF., Nov.-Dec. 1999, at 28, 31.

33. KAREN DAVIS, THE COMMONWEALTH FUND, ASSURING QUALITY, INFORMATION, AND CHOICE IN MANAGED CARE: PERCENTAGE OF ADULTS AGES 18-64 IN WORKING FAMILIES WHO HAVE A CHOICE OF HEALTH PLANS (1997), *available at* http://www.cmwf.org/programs/health_care/hccahtml/dt10970 1.asp; M. Susan Marquis & Stephen H. Long, *Trends In Managed Care And Managed Competition, 1993-1997,* 18 HEALTH AFF., Nov.-Dec. 1999, at 75; Sally Trude, *Who Has a Choice of Health Plans?,* HSRISSUE BRIEF (Center for Studying Health System Change, Washington, DC), Feb. 2000, at 1, *available at* http://www.hschange.org/CONTENT/ 55.

34. MARK A. HALL, MAKING MEDICAL SPENDING DECISIONS § 7 (1997).

35. *See* Hyman, *supra* note 4, at 226-27; Russell Korobkin, *The Efficiency of Managed Care "Patient Protection" Laws: Incomplete Contracts, Bounded Rationality, and Market Failure,* 85 CORNELL L. REV. 1 (1999).

36. Catherine G. McLaughlin, *Health Care Consumers: Choices and Constraints,* 56 MED. CARE RES. & REV. 24, 25 (1999) ("While health insurance is but one factor in firm choice, it is not difficult to believe that young, single males may deliberately choose to supply their labor to a small, high-tech firm that offers no health insurance in exchange for higher wages, and that a young male with similar skills but two small children and a wife who does not want to enter the labor market may instead supply his labor to IBM, earning a lower salary, but receiving a rich family health insurance package at a large group rate."). Once one is actually employed, it is not clear how many people will be willing to change their jobs because the coverage is not to their liking. *See* George Annas, *Patients' Rights in Managed Care—Exit, Voice, and Choice,* 337 NEW. ENG. J. MED. 210 (1997). However, to the extent employee satisfaction was a factor in offering coverage in the first place, it is unclear why employers would suddenly start selecting coverage options that alienate their employees.

37. *See* Thomas Bodenheimer & Kip Sullivan, *How Large Employers are Shaping the Health Care Marketplace—Part II,* 338 NEW ENG. J. MED. 1084, 1087 (1998) ("[E]mployers do not necessarily represent the best interests of their employees."); Hyman, *supra* note 4, at 233 ("Quality is difficult to assess, let alone value—and employers and employees are likely to differ on the appropriate mix of cost, quality, and access, even before illness strikes."). *But see* Fernando Montenegro-Torres et al., *Are Fortune 100 Companies Responsive to Chronically Ill Workers?,* 20 HEALTH AFF., July-Aug. 2001, at 209 (presenting evidence indicating that large employers are doing a good job, in many instances better than Medicare, in dealing with chronically ill employees and dependents).

38. *See* Judith R. Lave et al., *Changing the Employer-Sponsored Health Plan System: The Views of Employees in Large Firms,* 18 HEALTH AFF., July-Aug. 1999, at 112, ("[B]ecause employers sponsor only a limited number of health plans, some employees may be forced to 'buy' more or less health insurance than they want.").

39. A change in the coverage offered by an employer can result in employees suddenly discovering that their health care

providers are no longer "in the network," and they must either pay more to stay with their existing provider, or find a new provider. *See* Thomas Bodenheimer & Kip Sullivan, *How Large Employers are Shaping the Health Care Marketplace—Part I,* 338 NEW ENG. J. MED. 1003, 1007 (1998) (describing such switching as "disruptive" and "intolerable").

40. *See* MARK PAULY, HEALTH BENEFITS AT WORK: AN ECONOMIC AND POLITICAL ANALYSIS OF EMPLOYMENT-BASED HEALTH INSURANCE (1997); Linda J. Blumberg, *Who Pays For Employer-Sponsored Health Insurance?,* 18 HEALTH AFF., Nov.-Dec. 1999, at 58.

41. Given this perspective, it is not surprising that employees pressured legislators to address these problems—often on the basis of highly unrepresentative anecdotes. *See* Hyman, *supra* note 4, at 237-41. There is also an important public choice aspect to the story as well, because most of the patient protections turn out, on closer examination, to constitute provider protection. *Id.* at 223 n.5.

42. In one survey, "job lock" was understood by respondents to include such things as whether a potential employer offered coverage, whether that coverage was comparable to that offered by the current employer, and whether the insurance was affordable. *See* EMPLOYEE BENEFIT RES. INST., HEALTH INSURANCE PORTABILITY AND JOB LOCK: FINDINGS FROM THE 1998 HEALTH CONFIDENCE SURVEY, 19 EBRI NOTES NO. 8 (1998). To be sure, the absolute magnitude of such "job lock" is considerably less than is commonly believed. *See* Mark Pauly, *Regulations Against Bad Things That Almost Never Happen, But Could: HIPPA and the Individual Insurance Market,* 22 CATO J. (forthcoming 2002).

43. For example, if one's current employer covered fertility treatments and a prospective employer did not (or imposed substantial waiting periods) and one were in the middle of a series of expensive fertility treatments, it is unlikely that one would be willing to change jobs. However, viewed from another perspective, this is simply a consequence of the fact that coverage terms vary among employers, and such variation can cause adverse selection, as employees on the margin select employers whose coverage best matches their preferences. Stated differently, in a competitive labor market, employers compete for employees by offering different mixes of wages and coverage. It is hard to come up with a coherent argument why competition for employees should be limited only to variations in wages, and coverage should converge on some Platonic ideal, unless one is prepared to imbed that preferred outcome in the beginning assumptions. *See* David F. Levi, *In Memoriam Philip B. Kurland,* 64 U. CHI. L. REV. 1, 4 (1997) ("The key to establishment of an infallible argument has been most fully developed by the Supreme Court of the United States: it is to embed the conclusion in the premise. It is always easier to get from here to here than to get from here to there.").

44. *See* Interview by PBS with Uwe Reinhardt, Professor, Princeton University *at* http://www.pbs.org/healthcarecrisis/Exprts_intrvw/u_reinhardt.htm (suggesting that "the devil systematically built our health insurance system [which] has the feature that when you're down on your luck, you're unemployed, you lose your insurance.... Only the devil could ever have invented such a system. Humans of goodwill would never do this.").

45. Health Insurance Portability and Accountability Act, Pub. L. 104-191, 110

Stat. 1936 (1996); 29 U.S.C. § 1161 (1994); David L. Gregory, *COBRA: Congress Provides Partial Protection Against Employer Termination of Retiree Health Insurance*, 24 SAN DIEGO L. REV. 77 (1987); Thomas Somers, *COBRA: An Incremental Approach to National Health Insurance*, 5 J. CONTEMP. HEALTH L. & POL'Y. 141 (1989).

46. *See* Peter J. Cunningham & Paul B. Ginsburg, *What Accounts for Differences in Uninsurance Rates Across Communities?*, 38 INQUIRY 6 (2001). In particular, the southern and western United States have substantially higher rates of uninsurance.

47. Because the points in this paragraph have been covered extensively elsewhere and are already well understood by those familiar with health care law and policy, we provide only a short summary. For additional background discussion of insurance regulation and ERISA pre-emption, see generally Mary Anne Bobinski, *Unhealthy Federalism: Barriers to Increasing Health Care Access for the Uninsured*, 24 U.C. DAVIS L. REV. 255 (1990); Jesselyn Alicia Brown, *ERISA and State Health Care Reform: Roadblock or Scapegoat?*, 13 YALE L. & POL'Y REV. 339 (1995); Catherine Fisk, *The Last Article about the Language of ERISA Preemption? A Case Study of the Failure of Textualism*, 33 HARV. J. ON LEGIS. 35 (1996); and Jana K. Strain & Eleanor D. Kinney, *The Road Paved with Good Intentions: Problems and Potential for Employer-Sponsored Health Insurance Under ERISA*, 31 LOY. U. CHI. L.J. 29 (1999).

48. 29 U.S.C. § 1144 (1994); *see also* Daniel Fox & Daniel Schaffer, *Health Policy and ERISA: Interest Groups and Semiprotection*, 14 J. HEALTH POL., POL'Y & L. 239 (1989); Leon Irish & Harrison Cohen, *ERISA Preemption: Judicial Flexibility and Statutory Rigidity*, 19 U. MICH. J.L. REFORM 109, 111 (1985).

49. *See* David A. Hyman, *Accountable Managed Care: Should We Be Careful What We Wish For?* 32 U. MICH. J.L. REFORM 785 (1999) (providing a similar analysis for liability rights against MCOs). Whether traditional forms of accountability have actually ensured the delivery of high quality care is, of course, another matter entirely. *See* David A. Hyman & Charles Silver, *Just What the Patient Ordered: Result Based Compensation for Health Care*, WASH. & LEE L. REV. (forthcoming 2001) (detailing highly variable quality of American medical care, and proposing the use of explicit financial incentives to deliver high quality care).

50. *See* CHRISTOPHER B. MUELLER & LAIRD C. KIRKPATRICK, EVIDENCE § 655 (1999) ("If the calling party's opponents cannot subject the witness to cross-examination for reasons that are not his fault, some remedy is necessary.... If cross-examination is permanently blocked, the direct testimony usually should be stricken in both civil and criminal cases, or a mistrial declared if the direct testimony is critical and striking it would not be effective.").

51. *See* KOMESAR, *supra* note 8, at 204. Our comparative institutional analysis considers the benefits of existing arrangements against the major competing alternatives. Not all of our critiques apply to all of the alternatives, so it is important for the reader to be clear about the frame of reference associated with any given critique.

52. *See* EMPLOYEE BENEFIT RES. INST., EMPLOYMENT-BASED HEALTH INSURANCE: A LOOK AT TAX ISSUES AND PUBLIC OPINION, ISSUE BRIEF NO. 211 (July, 1999), *available at* http://www.ebri.org/ ibex/ib211.htm ("A recent public opinion survey conducted by the Employee Benefit Research Institute found that 68 percent of Americans with

employment-based health insurance were satisfied with the current mix of benefits and wages."); Lave et al., *supra* note 38, at 112; John R. Moran et al., *Preference Diversity and the Breadth of Employee Health Insurance Options,* 36 HEALTH SERVICES RES. 911 (2001); Pamela B. Peele et al., *Employer-Sponsored Health Insurance: Are Employers Good Agents for their Employees?,* 78 MILBANK Q. 5 (2000).

53. Hyman, *supra* note 4, at 235.

54. *See* James Maxwell et al., *Corporate Health Care Purchasing Among Fortune 500 Firms,* 20 HEALTH AFF., May-June 2001, at 181.

55. Mark A. Hall, *The Geography of Health Insurance Regulation: A Guide to Identifying, Exploiting, and Policing Market Boundaries,* 19 HEALTH AFF., Mar.-Apr. 2000, at 173.

56. To be sure, more comprehensive coverage is a double-edged sword, because it worsens the problem of moral hazard. Moral hazard is the tendency of insurance to increase the risk that is insured against, and the damages that result from the materialization of that risk. For a classic example, recounted in the form of a joke, see Marc Galanter, *The Conniving Claimant: Changing Images of Misuse of Legal Remedies,* 50 DEPAUL L. REV. 647, 657 (2000) ("A lawyer and an engineer were fishing in the Caribbean. The lawyer said, 'I am here because my house burned down and everything I owned was destroyed. The insurance company paid for everything.' 'That is quite a coincidence,' said the engineer, 'I'm here because my house and all my belongings were destroyed by a flood, and my insurance company also paid for everything.' The lawyer looked somewhat confused and asked, 'How do you start a flood?'"). In the health care context, a person with insurance is more likely to consume more health care services when illness strikes. *See* Mark Pauly, *The Economics of Moral Hazard,* 58 AM. ECON. REV. 531, 535 (1968) ("[T]he response of seeking more medical care with insurance than in its absence is a result not of moral perfidy, but of rational economic behavior."). This fact explains why, from an economic perspective, comprehensive coverage is not socially optimal. Much of the fundamental structure of insurance policies can be explained by the need to control moral hazard. With traditional (indemnity) health insurance, co-payments and deductibles were employed to limit voluntary increases in the size of the covered loss. Many forms of managed care relied on non-financial barriers to treatment to accomplish the same result. When a policy must be renewed annually, moral hazard is also deterred by setting the premium on the basis of past loss experience. Finally, loss prevention strategies (e.g., wellness programs) can play a role as well. *See* EMPLOYEE BENEFIT RES. INST., EMPLOYMENT-BASED HEALTH PROMOTION AND WELLNESS PROGRAMS, 22 EBRI NOTES NO. 7 (2001).

57. The following discussion is based on MARK A. HALL, REFORMING PRIVATE HEALTH INSURANCE (1994). An additional source of adverse selection arises when the insurer is prohibited from using such information pursuant to state or federal law. Thus, anti-discrimination laws aimed at insurance coverage markets can actually create a potent source of discrimination, when compared to a risk-based market baseline.

58. This cost savings is independent of the tax advantages that accrue from employment-based coverage.

59. There is some evidence to suggest that employee wages are adjusted to reflect

the costs of coverage. *See* Blumberg, *supra* note 40, at 58-59. Obviously, the size of the cross-subsidies will be smaller to the extent that wages are adjusted for their existence. However, it appears that wages are adjusted on a demographic class basis, rather than on an individual basis, so there will still be some degree of cross-subsidization. *See id.*

60. William S. Custer et al., *Why We Should Keep the Employment-Based Health Insurance System*, 18 HEALTH AFF., Nov.-Dec. 1999, at 115.

61. *See, e.g.*, THEDA SKOCPOL, BOOMERANG: HEALTH CARE REFORM AND THE TURN AGAINST GOVERNMENT (1999). Similar difficulties have beset efforts to adopt parity for mental health coverage, and community rating. *See* Daniel P. Gitterman et al., *Toward Full Mental Health Parity and Beyond*, 20 HEALTH AFF., July-Aug. 2001, at 68; HALL, *supra* note 57, at 38-43.

62. *See* HALL, *supra* note 34, at ch. 3; James F. Blumstein & Michael Zubkoff, *Public Choice in Health: Problems, Politics and Perspectives on Formulating National Health Policy*, 4 J. HEALTH POL., POL'Y & L. 382, 389-90 (1979) ("Decentralized choices by nongovernmental decisionmakers...has greater potential for precluding symbolic concerns from becoming inextricably involved in policy formulation and will likely point more attention to necessary economic tradeoffs. The design of institutions and policies should therefore take into account the 'susceptibility to symbolic blackmail' of governmental institutions when health issues are directly implicated."); Richard Epstein, *Living Dangerously: A Defense of Mortal Peril*, 1998 U. ILL. L. REV. 909, 927 ("[B]efore embarking down the road to [regulation], one has to make some estimate of the relative chances of success or failure, given the danger of regulatory capture and excess that can subvert a legislative program from any direction.... Private markets are more resistant to these pressures because exit and entry possibilities keep established players in line. State monopolies, on the other hand, can easily misbehave...."); Uwe E. Reinhardt, *Demagoguery and Debate over Medicare Reform*, 14 HEALTH AFF., Winter 1995, at 101, 103 ("One great advantage of cost and quality control through private regulators is that the latter are swift and usually not open to appeal.").

63. *See* Steven L. Schooner, *Fear of Oversight: The Fundamental Failure of Businesslike Government*, 50 AM. U. L. REV. 627 (2001); Joshua I. Schwartz, *Liability For Sovereign Acts: Congruence and Exceptionalism in Government Contracts Law*, 64 GEO. WASH. L. REV. 633 (1996).

64. *See* JACOB HACKER, THE ROAD TO NOWHERE 86 (1997) (noting "generic public distrust of government"); James A. Morone, *The Bias of American Politics: Rationing Health Care in a Weak State*, 140 U. PA. L. REV. 1923, 1924 (1992) ("Americans do not like government."). Indeed, for more than two decades, a clear majority of Americans have not believed the federal government is likely to "do what is right." *See* Robert J. Blendon & John M. Benson, *American's Views on Health Policy: A Fifty-Year Historical Perspective*, 20 HEALTH AFF., Mar.-Apr. 2001, at 33, 42. It remains to be seen whether these figures will remain as high in light of the events of September 11, 2001. *See* Richard Morin, *Poll: National Confidence, Pride Soar*, WASH. POST, Oct. 25, 2001, at A7 (noting survey indicating that 64% of Americans trusted the government to do the right thing most of the time or just about all the time, the highest figure since the poll began in 1966).

65. These programs came about because of a relatively unique combination

of circumstances, and did not represent a blanket repudiation of traditional American attitudes regarding governmental programs. *See* THEODORE E. MARMOR, THE POLITICS OF MEDICARE 126-27 (2d ed. 2000) ("A consensus on the seriousness of American medical care problems did not signify agreement on the shape, magnitude, or priority of those problems.... In fact, the more complex the problem, like making medical care accessible to and affordable for all Americans, the less likely that such an agreement can be forged, despite widespread agreement that the situation needs fixing.").

66. Even proponents of a single-payor system recognize that this is a "real issue and not just a rhetorical challenge." GORDON SCHIFF & DAVID HIMMELSTEIN, PHYSICIANS FOR A NATIONAL HEALTH PROGRAM, QUESTIONS AND ANSWERS ABOUT SINGLE PAYER NATIONAL HEALTH INSURANCE, (May 19, 1996), *at* http://www.pnhp.org/basicinfo/qa2.html ("Would you really turn 15% of our economy over to government with the efficiency of the post office, the compassion of the IRS, and the cost effectiveness of the defense department?").

67. *See* CENTER FOR STUDYING HEALTH SYSTEM CHANGE, DEFINED CONTRIBUTIONS: THE SEARCH FOR A NEW VISION, ISSUE BRIEF NO. 37 (Apr. 2001), *available at* http://www.hschange.org/CONTENT/310; EMPLOYEE BENEFIT RES. INST., DEFINED CONTRIBUTION HEALTH BENEFITS, ISSUE BRIEF NO. 231 (Mar. 2001), *available at* http://www.ebri.org/ibex/ib231.htm; Julie Appleby, *Benefits Firms Await Health Care Shift,* USA TODAY, July 27, 2000, at B3; Greg Scandlen, *Defined Contribution Health Insurance* (National Center for Policy Analysis, Oct. 2000), *available at* http://www.ncpa.org/bg/bg154/bg154.html.

68. *See* Ron Winslow & Carl Gentry, *Health-Benefits Trend: Give Workers Money, Let Them Buy a Plan,* WALL ST. J., Feb. 8, 2000, at A1; http://www.ehealth insurance.com; *see also* Arti K. Rai,, *Reflective Choice in Health Care: Using Information Technology to Present Allocation Options,* 25 AM. J. L. & MED. 387 (1999) (noting the advantages of such technology in allowing employees to make their own cost/quality/benefit trade-offs).

69. *See* DAVID DRANOVE, THE EVOLUTION OF MEDICAL CARE: FROM MARCUS WELBY TO MANAGED CARE 143 (2000) ("Yet even when evidence emerges to indicate that some providers have below-average quality, most patients pretend they are some kind of 'Lake Wobegone' of medical care, where 'all of the providers are above average.'"); Blendon & Benson, *supra* note 64, at 41 ("[M]ore than 80 percent of Americans have reported that they are satisfied with their last visit to a physician.").

70. *See* Thomas Bodenheimer, *The American Health Care System—The Movement for Improved Quality in Health Care,* 340 NEW ENG. J. MED. 488 (1999); Mark R. Chassin, *Is Health Care Ready for Six Sigma Quality?,* 76 MILBANK Q. 565, 566 (1998); Mark A. Schuster et al., *How Good Is the Quality of Health Care in the United States?,* 76 MILBANK Q. 517 (1998).

71. *See* INSTITUTE OF MEDICINE, TO ERR IS HUMAN 22 (1999). These figures have been controversial; researchers have argued that many of the patients would have died anyway, or that reviewer assessments are unreliable. Rodney A. Hayward & Timothy P. Hofer, *Estimating Hospital Deaths Due to Medical Errors: Preventability is in the Eye of the Reviewer,* 286 JAMA 415 (2001); Christopher M. Hughes et al., *Deaths Due to Medical Errors are Exaggerated in Institute of Medicine Report,* 284

JAMA 93 (2000). Those involved in the preparation of the Institute of Medicine report have defended these figures. Lucian Leape, *Institute of Medicine Medical Error Figures are not Exaggerated,* 284 JAMA 95 (2000).

72. *See* INSTITUTE OF MEDICINE, *supra* note 71, at 1.

73. *See* ALPHA CENTER, PURCHASING PATHFINDERS (2001) (describing efforts of employers to "buy-right"); JACK MEYER ET AL., AGENCY FOR HEALTH CARE POL'Y RES. PUB. NO. 98-0004, THEORY AND REALITY OF VALUE-BASED PURCHASING, (Nov. 1997), *at* http://www.ahrq.gov/qual/meyerrpt.htm (describing the few employers who are using financial incentives and other techniques to improve health care for employees as "pioneers"); Helen Halpin Schauffler et al., *Raising The Bar: The Use of Performance Guarantees by the Pacific Business Group on Health,* 18 HEALTH AFF., Mar.-Apr. 1999, at 134.

74. *See* R. Adams Dudley et al., *The Impact of Financial Incentives on Quality of Health Care,* 76 MILBANK Q. 649, 654 (1998); Fred J. Hellinger, *The Impact of Financial Incentives on Physician Behavior in Managed Care Plans: A Review of the Evidence,* 53 MED. CARE. RES. & REV. 294 (1996); Alan L. Hillman et al., *How Do Financial Incentives Affect Physicians Clinical Decisions and The Financial Performance of Health Maintenance Organizations?* 321 NEW ENG. J. MED. 86 (1989); James C. Robinson, *Theory and Practice in the Design of Physician Payment Incentives,* 79 MILBANK Q. 149 (2001).

75. The measures included the number of pregnant women who received prenatal care during the first trimester, mammography, Pap smears, childhood immunizations, diabetic retinal exam, and cesarean sections. *See* Schauffler et al., *supra* note 73, at 135.

76. *Id.* at 137-38.

77. *See, e.g.,* Bodenheimer & Sullivan, *supra* note 39, at 1005-07 (Minnesota Buyers Health Care Action Group); Linda O. Prager, *Coalition Proposes Pay Based on Quality,* 43 AM. MED. NEWS, June 19, 2000, at 8; Massachusetts Health Care Purchasers Group, *available at* http://www.mhpg.org/ (last visited Oct. 31, 2001).

78. *See* THE LEAPFROG GROUP, PATIENT SAFETY, *at* http://www.leapfroggroup.org/safety1.htm (last visited Oct. 31, 2001).

79. *See* THE LEAPFROG GROUP, ECONOMIC IMPLICATIONS OF THE LEAPFROG PATIENT SAFETY STANDARDS (John D. Birkmeyer ed., June 2001), *available at* http://www.leapfroggroup.org/toolkit/LF.Costs.Final.pdf.

80. *But see* M. Susan Marquis & Stephen H. Long, *Prevalence Of Selected Employer Health Insurance Purchasing Strategies in 1997,* 20 HEALTH AFF., July–Aug. 2001, at 220 (presenting data indicating many employers are using quality information in choosing which health plans to offer).

81. *See supra* note 62.

82. *See* MICHAEL L. MILLENSON, DEMANDING MEDICAL EXCELLENCE 196 (1997). The proposal is described in greater detail in Sarah Lyall, *Proposal Ties Hospital Reimbursement to the Quality of Care,* N.Y. TIMES, Dec. 25, 1992, at B1.

83. *See* AMERICAN ASSOCIATION OF ORTHOPAEDIC SURGEONS, HCFA ANNOUNCES DEMONSTRATION PROJECT FOR JOINT REPLACEMENT SURGERY, (May 1996) *at* http://www.aaos.org/wordhtml/wash_rep/hcfa0596.htm (criticizing Centers of Excellence Initiative for focusing on cost instead of quality); HEALTH CARE FINANCING ADMINISTRATION, FREQUENTLY ASKED QUESTIONS, *at* http://www.hcfa.gov/research/qpappfaq.htm (last visited Dec. 9, 2001) (outlining Centers of

Excellence demonstration project).

84. LESLIE A. JACKSON & SALLY TRUDE, CENTER FOR STUDYING HEALTH SYSTEM CHANGE, STAND-ALONE HEALTH INSURANCE TAX CREDITS AREN'T ENOUGH, ISSUE BRIEF NO. 41 (July 2001), *available at* http://www.hschange.org/CONTENT/347; Katherine Swartz, *Markets for Individual Health Insurance: Can we Make them Work with Incentives to Purchase Insurance?*, 38 INQUIRY 133 (2001).

85. Karen Pollitz, *How Accessible is Individual Health Insurance for Consumers in Less-than-Perfect Health?* (Henry J. Kaiser Family Foundation, June 2001); *see also* Elisabeth Simantov et al., *Market Failure? Individual Insurance Markets For Older Americans*, 19 HEALTH AFF., July-Aug. 2001, at 139.

86. *See* Hyman, *supra* note 4, at 246-53, 259-63.

87. Hall, *supra* note 55, at 178-79.

88. Mark A. Hall, *An Evaluation of New York's Health Insurance Reform Law*, 25 J. HEALTH POL., POL'Y & L. 71 (2000).

89. *See* Mark A. Hall et al., *HealthMarts, HIPCs, MEWAs, and Association Health Plans (AHPs): A Guide for the Perplexed*, 20 HEALTH AFF., Jan.-Feb. 2001, at 142.

90. Elliot Wicks & Mark A. Hall, *Purchasing Cooperatives for Small Employers: Performance and Prospects*, 78 MILBANK Q. 511 (2000).

91. Robert Kuttner, *The Risk-Adjustment Debate*, 339 NEW ENG. J. MED. 1952 (1998).

92. *See* Hyman, *supra* note 4, at 246-53, 259-63.

93. The range of possible outcomes is neatly demonstrated by the differing financial status of the Medicare and Medicaid programs—with the latter varying tremendously from state to state.

94. One recent example of this phenomena is that low Medicare reimbursement for mammography has resulted in a shortage of providers and lengthy waiting periods for those who wish to obtain such screening. *See* M. William Salganik, *Breast-Test Centers Decline as Need for Them Increases*, BALT. SUN, Oct. 28, 2001, at 1C; Judy Muller, *Fatal Wait: Women Have Trouble Finding Doctors To Provide Mammograms*, abcNEWS.com, Aug. 23, 2001, *at* http://abcnews.go.com/sections/wnt/WorldNewsTonight/mammogram010823.html. This problem will become even more acute if Medicare succeeds in raising the number of beneficiaries who receive recommended mammography screening from its current low level. *See* CENTER FOR MEDICARE & MEDICAID SERVICES, QUALITY OF CARE–PRO PRIORITIES, *at* http://www.hcfa.gov/quality/11a2-c.htm (describing breast cancer initiative, to address the fact that only "30 to 60 percent of women over age 50 undergo routine mammography," and a substantial proportion have never had a mammogram). Similar risks are associated with monopsony purchasing in the pharmaceutical market, as the desire to obtain low prices for today's beneficiaries is at war with the importance of ensuring adequate funds are available for research to develop next year's treatments.

95. NICCOLO MACHIAVELLI, THE PRINCE 17 (Robert M. Adams ed. & trans., Norton Press 1977) (1513).

96. *See* Morone, *supra* note 64, at 1928.

97. HACKER, *supra* note 64; Lawrence D. Brown, *Who Shall Pay? Politics, Money, And Health Care Reform*, 13 HEALTH AFF., Spring 1994, at 175.

98. *See* ECONOMIC AND SOC. RES. INST., COVERING AMERICA: REAL REMEDIES FOR THE UNINSURED (Elliot K. Wicks ed., June 2001), *available at* http://www.esresearch.org/RWJ11PDF/summary.pdf; Judith Feder et al., *Covering the Low-Income*

Uninsured: The Case for Expanding Public Programs, 20 HEALTH AFF., Jan.–Feb. 2001, at 27 ("Any initiative to extend health insurance to the forty-three million Americans without it is likely to take an incremental strategy rather than a universal or comprehensive approach."); Symposium, *Strategies to Expand Health Insurance for Working Americans,* 38 INQUIRY 90 (2001).

99. A more Machiavellian interpretation is that incremental reforms are focused on appeasing the interests of the middle and upper classes, and thus fragment the coalition that would otherwise bring about more sweeping reforms. This argument is not consistent with the fact that incremental reforms have been proposed by both Democrats and Republicans. More to the point, it is hardly a dispositive indictment of a policy reform that it does not solve everything simultaneously. Indeed, the economic and social upheaval that would appear necessary to produce truly comprehensive reform of the entire health care delivery system is sufficiently sweeping that comprehensive reform has found virtually no takers since the demise of the Clinton plan. Regardless, the reforms we propose include both the "haves" (i.e., people with insurance) and the "have nots." Unless one is inclined toward a Marxist view that such reforms should be shunned precisely because they undermine the necessary widespread misery to bring about global reform, it is hard to justify opposition to incremental reform as such.

100. *See, e.g.,* Arnett, *supra* note 3 (collecting various papers on the subject); Butler & Kendall, *supra* note 3; Lynn Etheredge, *A Flexible Benefits Tax Credit for Health Insurance and More,* 20 HEALTH AFF., May-June 2001, at 8; Mark V. Pauly & John Goodman, *Tax Credits for Health Insurance and Medical Savings Accounts,* 14 HEALTH AFF., Spring 1995, at 125. Strictly speaking, it would be preferable from an economic perspective to "fix" the tax subsidy by eliminating it but the political dynamics make that an extremely unlikely outcome. *See* Hyman, *supra* note 4, at 274 (listing market-enhancing regulatory strategies, including "the leveling (preferably down, but more likely up) of the tax consequences of purchasing health insurance through employer and non-employer-based markets.") Tax credits are preferable to tax deductions because their value is not affected by one's tax bracket; they can be made refundable; and they are not contingent on whether one itemizes.

101. Government programs, such as Medicare, can also be converted into voucher programs so that individual beneficiaries can purchase private coverage. However, given the complexity of this issue, we limit our analysis to the use of tax credits for those not covered by governmental programs.

102. *See* New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting) ("It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country."). One intriguing possibility is to move insurance regulation toward a corporate law model. Employers and insurers could be required to subject themselves to the laws and regulations of a single state, but allowed to select the state. As with corporate charters, this system would create a market for regulatory oversight, and would allow employers and insurers to select the regulatory regime that functioned most efficiently and cost-

effectively matched the needs and preferences of their risk pool(s). The ability of employers and insurers to exit from the state's regulatory oversight (taking their premium taxes with them) would temper opportunistic behavior by legislators and regulators. A race to the bottom would be unlikely because the state's residents would be the first to be affected. *See* Christopher C. DeMuth, *Why The Era of Big Government Isn't Over,* 109 COMMENTARY, Apr. 2000, at 23, 29; Tom Miller, *A Regulatory Bypass Operation,* 22 CATO J. (forthcoming 2002).

103. *See* Hyman, *supra* note 49, at 810.

104. To be sure, employee calculations of risk are subject to an array of biases, and are likely to be influenced by the perceived availability of "safety-net" providers, who will take care of them without regard to ability to pay. *See* Korobkin, *supra* note 35, at 48-60; Bradley J. Herring, *Does Access to Charity Care For the Uninsured Crowd Out Private Health Insurance Coverage?* (unpublished manuscript on file with authors).

105. Mark Pauly, *Trading Cost, Quality, and Coverage of the Uninsured: What Will We Demand and What Will We Supply?, in* THE FUTURE U.S. HEALTHCARE SYSTEM: WHO WILL CARE FOR THE POOR AND UNINSURED? 364 (Stuart Altman et al. eds., 1998). One influential commentator has suggested that this failure has come about "not because Americans are unusually callous toward the poor, but in part because the American health system has priced kindness out of the nation's soul." Reinhardt, *supra* note 5, at 327. However, it is unclear the extent to which these revealed preferences are price-sensitive.

106. In this regard, employment-based insurance may be a true example of a path-dependent institutional arrangement. *See generally* Oona A. Hathaway, *The Path Dependence of the Law: The Course and Pattern of Legal Change in a Common Law System,* 86 IOWA L. REV. 601 (2001). *But see* Hyman, *supra* note 4, at 270 n.157 ("First, it is easier to articulate a theory of path dependence than it is to find empirical evidence of the phenomenon in the health care marketplace, let alone evidence that it can be fixed without inducing worse distortions. Second, the tumultuous restructuring of the health care economy in the past decade away from fee-for-service and toward managed care suggests that there are no real impediments to further restructuring—except those created by well-meaning legislators, that is. Finally, if medicine were really beset by path dependence, we would still be bleeding people for fevers.").

107. Russell Korobkin, *The Status Quo Bias And Contract Default Rules,* 83 CORNELL L. REV. 608 (1998).

108. EMPLOYEE BENEFIT RES. INST., RETIREE HEALTH BENEFITS: WHAT THE CHANGES MAY MEAN FOR FUTURE BENEFITS, ISSUE BRIEF NO. 175 (July 1996), *available at* http://www.ebri.org/ ibex/ib175.htm.

109. David M. Studdert et al., *Expanded Managed Care Liability: What Impact on Employer Coverage?,* 18 HEALTH AFF., Nov-Dec. 1999, at 7, 20-22 (modeling impact of liability on employer participation in coverage market); Marsha Austin, *Patients' Bill May Spur Firms to End Benefits,* DENVER POST, Aug. 8, 2001, at C-01.

110. *See supra* note 52.