

MAKING UNIVERSAL HEALTH CARE WORK*

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OVERVIEW OF THE HEALTH CARE SYSTEM

In 2003, national health expenditures totaled \$1,678.9 billion, about 15.3% of the gross domestic product.¹ The per capita health care expenditure was \$5,671.² The United States currently spends about twice as much, per capita, on health care as other industrialized nations.³

The principal coverage mechanisms are employment-based health insurance, Medicare, and Medicaid.⁴ In 2004, for example, 174 million Americans (59.8%) were covered by employment-based private health insurance, 26.9 million (9.3%) bought their own private insurance, 79.1 million (27.2%) had government health insurance (i.e., Medicare, Medicaid, or military health care), and 45.8 million (15.7%) had no coverage.⁵

Most nonelderly Americans receive their health care coverage through employment-based coverage provided to workers and their families. For example, Table 1 shows that 159.1 million nonelderly Americans (62.4%) received their health care coverage through an

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1. NAT'L CENTER FOR HEALTH STATISTICS, HEALTH, UNITED STATES, 360 (2005). See also NAT'L CENTER FOR HEALTH STATISTICS, "FAST STATS" WEB PAGE (2006), available at <http://www.cdc.gov/nchs/fastats/hexpense.htm> (last visited Oct. 18, 2006).

2. *Id.*; see also COMMITTEE ON WAYS AND MEANS, 108TH CONG., 2004 GREEN BOOK: BACKGROUND MATERIAL AND DATA ON PROGRAMS WITHIN THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS, Appendix C-1 (Comm. Print 2004) (stating 2001 stats), available at <http://waysandmeans.house.gov/Documents.asp?section=813> (last visited Oct. 18, 2006).

3. OECD FACTBOOK: ECONOMIC, ENVIRONMENTAL, AND SOCIAL STATISTICS 199 (Organisation for Econ. Co-operation and Dev. ed., 2005).

4. U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2004, at 60 (2005).

5. *Id.*

employment-based plan in 2004.⁶ Another 34.2 million (13.4%) were covered by Medicaid, and 6.2 million (2.5%) were covered by Medicare that year. All in all, some 210.4 million nonelderly Americans (82.2%) had health coverage in 2004, while 45.5 million (17.8%) had no coverage.

Table 1 *Health Care Coverage of the Nonelderly, 2004*⁷

<i>Source of Coverage</i>	<i>Millions</i>	<i>Percentage</i>
Total population	255.9	100.0
Employment-based coverage	159.1	62.4
Individually Purchased	17.0	6.6
Public	45.5	17.8
Medicare	6.2	2.5
Medicaid	34.2	13.4
Military health care	8.1	3.2
No health insurance	45.5	17.8

The Medicare program provides nearly universal coverage for elderly Americans. For example, Table 2 shows that 95 percent of the elderly were covered by Medicare in 2004, and only 0.8 percent of the elderly were without health care coverage that year. Also, in addition to Medicare, many elderly Americans are covered by employment-based retiree health insurance and/or individually-purchased Medigap policies.

6. See John E. Buckley & Robert W. Van Glezen, *Federal Statistics on Health Care Benefits and Cost Trends: An Overview*, 127 MONTHLY LAB. REV. 1, 2-11 (2004); Paul Fronstin, *Uninsured Unchanged in 2004, But Employment-Based Health Care Coverage Declined*, 26 EMPL. BENEFIT RESEARCH INST. NOTES NO. 10, Oct. 2005, at 2-10.

7. See *supra* note 4, Table HI-2 (Author's computations for Health Insurance coverage status and type of coverage of all people by age and sex from 1987 through 2004 – Eds.)

Table 2 *Health Care Coverage of the Elderly, 2004*⁸

<i>Source of Coverage</i>	<i>Millions</i>	<i>Percentage</i>
Total population	35.2	100.0
Employment-based coverage	12.5	35.5
Individually Purchased	10.0	28.3
Public	33.6	95.4
Medicare	33.5	95.0
Medicaid	3.3	9.4
Military health care	2.5	7.1
No health insurance	0.3	0.8

All in all, the federal government is heavily involved in providing health care assistance through Medicare, Medicaid, the State Children's Health Insurance Program ("SCHIP"), veterans' benefits, the exclusion for employer-provided health insurance premiums, the deduction of health care costs, federal employee benefits, and other mechanisms. In 2001, for example, the federal government accounted for 32.9% (\$406.6 billion) of all personal health spending, and state and local governments picked up another 10.6% (\$130.4 billion).⁹

MILLIONS OF AMERICANS LACK HEALTH CARE COVERAGE

Far and away the biggest problem with the American health care system has to do with coverage. In 2004, for example, while 245.3 million Americans (84.2%) had some type of health care coverage, 45.8 million (15.7%) were without coverage.¹⁰ Clusters of individuals that tend to lack coverage include employees of small business, workers who lose their jobs, workers who decline employer coverage, low-income parents, low-income childless adults, the near elderly, young adults, children, and immigrants.¹¹

8. See *supra* note 4, Table HI-2. (Author's computations for Health Insurance coverage status and type of coverage of all people by age and sex from 1987 through 2004 – *Eds.*)

9. COMMITTEE ON WAYS AND MEANS, 108TH CONG., *supra* note 4, at Table C-9.

10. Author's computations from U.S. CENSUS BUREAU, HISTORICAL HEALTH INSURANCE TABLES, at Table HI-2 (2005), available at <http://www.census.gov/hhes/www/hlthins/historic/hihist2.html> (last visited Oct. 18, 2006). The estimated number of uninsured in the text is a cross-sectional estimate and so understates the number of people who experienced a spell without insurance that year. Longitudinal estimates that ask whether people had spells without insurance over a one or two-year period produce higher counts. See generally, PAMELA FARLEY SHORT, COUNTING AND CHARACTERIZING THE UNINSURED (2001).

11. STAN DORN, TOWARDS INCREMENTAL PROGRESS: KEY FACTS ABOUT GROUPS OF UNINSURED (2004); see generally HAROLD POLLACK & KARL KRONEBUSCH, HEALTH INSURANCE AND VULNERABLE POPULATIONS, 1-52 (2004).

Of particular concern, many of those without insurance are workers. Indeed, of the 37.3 million uninsured Americans between 18 and 64 years old in 2004, 27.3 million worked during the year, 21.1 million of these working full-time.¹² Moreover, contingent and part-time workers are especially at risk. For example, in February of 2005 only 18% of contingent workers were covered by health insurance from their employer, although 59% did have insurance from some source.¹³

Pertinent here, a recent study by the Employee Benefit Research Institute explored the reasons why wage and salary workers ages 18 to 64 lacked coverage in 2002.¹⁴ That study found that 41.9% of those workers reported they worked for an employer that did not offer health insurance, another 17% worked for an employer that offered benefits but were not eligible for those benefits, and another 27 were offered benefits but chose not to participate. Of those who were not eligible for their employer's benefits, 57% worked part time, 30 percent had not completed the required waiting period, and almost 9% were temporary or contract workers. Of those who chose not to participate, 75.4% reported that they were covered by someone else's plan, and 22% said the employer's plan was too costly.

Part and parcel of the growing coverage problem is the fact that health care costs are spiraling out of control. Spending on health care has grown from under 6 percent of gross domestic product in 1965 to 16% in 2004 and is expected to reach 19% by 2014 and 22% by 2025.¹⁵ These ever-increasing costs have put pressure on employers, employees, and governments. For example, health insurance premiums rose by 73% from 2000 through 2005, compared to inflation growth of just 14% and wage growth of just 15%.¹⁶ The average annual premiums for employment-

12. U.S. CENSUS BUREAU, *supra* note 4, at 18. See also U.S. General Accounting Office, *Medicaid: Transitional Coverage Can Help Families Move from Welfare to Work*, GAO-02-679T (Washington, D.C., Apr. 22, 2002).

13. BUREAU OF LABOR STATISTICS, CONTINGENT AND ALTERNATIVE EMPLOYMENT ARRANGEMENTS, FEBRUARY 2005, at Table 9, available at <http://www.bls.gov/news.release/conemp.nr0.htm> (last visited Oct. 18, 2006).

14. Paul Fronstin, *Employment-Based Health Benefits: Trends in Access and Coverage*, EBRI ISSUE BRIEF NO. 284, Aug. 2005, at 1, available at http://www.ebri.org/publications/ib/index.cfm?fa=ibDisp&content_id-3574 (last visited Oct. 18, 2006). See also LINDA J. BLUMBERG & LEN M. NICHOLS, WHY ARE SO MANY AMERICANS UNINSURED? 35-95 (discussing how worker and employer choices combine to determine coverage levels).

15. COUNCIL OF ECONOMIC ADVISORS, ECONOMIC REPORT OF THE PRESIDENT 2006, at 85-86 (Washington, DC: U.S. Government Printing Office, 2006).

16. THE HENRY J. KAISER FAMILY HEALTH FOUNDATION AND HEALTH RESEARCH AND EDUCATION TRUST, EMPLOYER HEALTH BENEFITS: 2005 ANNUAL SURVEY 17 (Menlo Park, CA and Chicago, IL: Henry J. Kaiser Family Health Foundation, 2005). See also BUREAU OF LABOR STATISTICS, NATIONAL COMPENSATION SURVEY: EMPLOYEE BENEFITS IN PRIVATE INDUSTRY

based coverage rose to \$4,024 for single coverage in 2005 and \$10,880 for family coverage.¹⁷ Moreover, both Medicare and Medicaid spending are on “unsustainable” growth paths.¹⁸

Of particular concern, the administrative costs associated with the American health care system are “enormous,” with estimates ranging anywhere from \$90 billion a year to \$294 billion a year.¹⁹ Every health care plan has a different set of rules, and it seems as if every insurance company, employer, hospital, and doctor has a different set of claim forms.

Another significant problem has to do with risk segmentation in the small-group and individual insurance market.²⁰ In a free market, insurance companies will offer their best premium rates to healthy individuals and make older and sicker individuals pay much more for identical coverage. In doing so, the premiums will cover the anticipated health care costs (leaving a little extra for profits). Large employers can spread the anticipated health care costs of a few higher-risk employees over a much larger number of low-risk employees; consequently, large employers can secure relatively low group-term health insurance rates. On the other hand, insurance companies will charge individuals and small employers much higher rates for the same coverage, and those higher rates will effectively price many individuals and small businesses out of the market.

IN THE UNITED STATES, MARCH 2005, at 15-16 (showing employer and employee monthly premiums in 2005).

17. BUREAU OF LABOR STATISTICS, *supra* note 16.

18. COMMITTEE ON WAYS & MEANS, 109TH CONG., HEARING ON THE FUTURE OF SOCIAL SECURITY (testimony of U.S. Government Accountability Office Comptroller General David M. Walker) (March 9, 2005), *available at* <http://waysandmeans.house.gov/hearings.asp?formmode=detail&hearing=388> (last visited Oct. 18, 2006). *See generally* U.S. General Accounting Office, *Highlights of a GAO Forum: The Long-Term Fiscal Challenge*, GAO-05-282SP (Washington D.C., Feb. 2005); SOCIAL SECURITY AND MEDICARE BOARDS OF TRUSTEES, STATUS OF THE SOCIAL SECURITY AND MEDICARE PROGRAMS: A SUMMARY OF THE 2005 ANNUAL REPORTS (2005), *available at* <http://www.socialsecutiry.gov/OACT/TR/> (last visited Oct. 18, 2006); DANIEL SHAVIRO, WHO SHOULD PAY FOR MEDICARE? (Chicago and London: University of Chicago Press, 2004); CONGRESSIONAL BUDGET OFFICE, THE LONG-TERM BUDGET OUTLOOK (Washington, DC: Congressional Budget Office, 2005).

19. LEIF WELLINGTON HAASE, A NEW DEAL FOR HEALTH: HOW TO COVER EVERYONE AND GET MEDICAL COSTS UNDER CONTROL 25 (2005).

20. Elliot K. Wicks, *Issues in Coverage Expansion Design: Coping with Risk Segmentation: Challenges and Policy Options*, 2 ECO. AND SOCIAL RESEARCH INST. 1-9 (2003), *available at* http://www.esresearch.org/covering_America.php (last visited Oct. 18, 2006).

MODEST CHANGES THAT COULD IMPROVE THE HEALTH CARE SYSTEM

While universal coverage should almost certainly be our ultimate goal, we might want to start with a more incremental approach that focuses on designing and expanding health care programs for particular groups of the uninsured.²¹ For example, the government might want to expand the Medicaid and SCHIP programs to cover virtually all low-income children. Of the 8.9 million children who were uninsured in 1999, some 4.6 million were actually eligible for Medicaid, and another 2.3 million were eligible for SCHIP.²² The government needs to develop policies to get those uninsured children covered. In addition, the federal government could expand its Medicaid and SCHIP programs so that the systems cover all children in families with incomes up to say, 300% of the poverty income guidelines.²³

The government might also expand Medicaid or develop other programs to ensure seamless coverage for individuals making the transition from welfare to work.²⁴ For example, it could make sense to simplify transitional medical assistance by allowing former welfare recipients to continue their Medicaid coverage for months or even years after they start working, regardless of income level. Another approach would be to create a new form of earnings subsidy that would provide health care vouchers for low-income workers.²⁵ Together, these kinds of programs could help ensure that virtually all low-income working families have adequate health care coverage.

Similarly, the government could extend health care coverage to more unemployed workers by expanding the recently created health care coverage tax credits. Created by the Trade Reform Act of 2002, these credits pay up to 65% of the health care premiums of qualifying workers

21. See generally DORN, *supra* note 11.

22. Lisa Dubay et al, *Five Things Everyone Should Know about SCHIP*, A-55 THE URBAN INST. 1 (Oct. 2002), available at <http://www.urban.org> (last visited Oct. 18, 2006) (finding that about 27 percent of poor children were uninsured in 2002).

23. See HEATHER BOUSHEY et al., *HARDSHIP IN AMERICA: THE REAL STORY OF WORKING FAMILIES* 49 (Washington, DC: Economic Policy Institute, 2001); HEIDI HARTMANN, ET AL., *SURVIVAL AT THE BOTTOM: THE INCOME PACKAGES OF LOW-INCOME FAMILIES WITH CHILDREN* 77 (Institute for Women's Policy Research, 2004).

24. See JOEL F. HANDLER & YEHESEKEL HASENFELD, *WE THE POOR PEOPLE: WORK, POVERTY, AND WELFARE* 131-36 (1997).

25. See Robert H. Haveman, *The Clinton Alternative to "Welfare as We Know It": Is It Feasible?*, in *THE WORK ALTERNATIVE: WELFARE REFORM AND THE REALITIES OF THE JOB MARKET* 185, 200 (Demetra Smith Nightingale et al. eds., 1995).

who lost their jobs because of foreign trade.²⁶ Another approach would be to extend COBRA health care continuation coverage to 36 or more months or until eligibility for Medicare at age 65.²⁷ The government might also be able to expand coverage for employees of small businesses by giving tax credits to employers that provide health insurance to their employees.²⁸

We might also want to encourage community groups and nonprofit organizations to offer health care plans and give them the same types of tax and regulatory advantages that are now available only to employment-based plans. For example, President Bush recently called for the creation of so-called “association health plans” for small businesses that would allow insurance to be more portable and purchased more easily across state lines.²⁹

We might also think about modifying the Employee Retirement Income Security Act (ERISA) so federal preemption no longer prevents state efforts to expand coverage. In that regard, Maryland recently flexed its muscles and enacted legislation that would require companies with at least 10,000 employees (i.e., Wal-Mart) to spend at least 8% of payroll on health care or give the difference to the state.³⁰ In July of 2006, however, a federal district court struck that legislation down, ruling that it was preempted by ERISA.³¹ Perhaps now there will be more interest in relaxing ERISA’s overly-broad preemption rule so the states can have the ability to experiment with a broader range of approaches for expanding coverage.

Finally, we might also think about adopting rules to counter insurance industry policies that drive up premium costs in the individual and small-group market. In general, the government can reduce such insurance industry risk segmentation practices by preventing it from occurring in the first place or by allowing it but offsetting its effects.³² Community rating is an example of the first approach. Under a community rating system,

26. Trade Act of 2002, Public Law No. 107-210, 19 U.S.C. § 3801 (2002).

27. Len M. Nichols, *Policy Options for Filling Gaps in the Health Insurance Coverage of Older Workers and Retirees* in ENSURING HEALTH AND INCOME SECURITY FOR AN AGING WORKFORCE 451, 456-57 (Peter P. Budetti et al. eds., 2001).

28. See Bowen GARRET ET AL., WORKERS WITHOUT HEALTH INSURANCE: WHO ARE THEY AND HOW CAN POLICY REACH THEM? 25 (Urban Institute ed., 2001); see also Jonathan Gruber, *Tax Policy for Health Insurance*, in TAX POL’Y AND THE ECON. 19, 39-63 (James M. Poterba, ed., 2005).

29. See COUNCIL OF ECONOMIC ADVISORS, *supra* note 15, at 100.

30. See Editorial, *Beating Up on Wal-Mart*, WASH. POST, January 12, 2006, at A20.

31. Matthew Mosk & Ylan Q. Mui, “Wal-Mart Law” in *Md. Rejected by Court*, WASH. POST, July 20, 2006, at A1.

32. Wicks, *supra* note 20, at 4.

insurance companies are required to take all comers and charge them all the same rate.³³ Alternatively, under the second approach, the government could allow wide variation in premiums based on risk but provide subsidies to help older and higher-risk individuals pay their higher premiums, offsetting the risk.

MORE COMPREHENSIVE SOLUTIONS

Ultimately, however, the government will need to develop programs that provide a way to achieve nearly universal health care coverage. With universal coverage, we should finally be able to reduce our health care system's burdensome administrative costs, as well as get medical treatment costs under control.

Universal coverage would also solve much of the distortion in labor markets that results from the current structure of the health care system. In particular, universal coverage would solve the problem of job lock, as workers would no longer lose their health insurance benefits solely because they changed jobs. Universal coverage would also solve the problems relating to the transition from welfare to work and the transition from disability to work. Today, recipients of welfare or disability benefits can lose Medicaid or Medicare coverage if they enter or reenter the work force.³⁴ With universal coverage, however, they would not lose their coverage.

Over the years, there have been countless suggestions about how to achieve universal coverage. Some have argued for a single-payer national health insurance system.³⁵ That could be as simple as expanding Medicare to cover everyone,³⁶ or as complicated as President Bill Clinton's 1993 health care reform proposal.³⁷

Many proposals call for employer mandates, requiring employers to either provide health care coverage for their workers or pay a payroll tax so the government can provide coverage.³⁸ This is sometimes referred to as

33. *Id.*

34. *See generally* HANDLER, *supra* note 24.

35. *See* David U. Himmelstein & Steffie Woolhandler, *National Health Insurance or Incremental Reform: Aim High, or at Our Feet?*, 93 AM. J. OF PUB. HEALTH 102 (2003).

36. *See generally* James A. Morone, *Medicare for All*, in 2 COVERING AMERICA: REAL REMEDIES FOR THE UNINSURED, 63, 63-74 (Economic and Social Research Institute ed., 2003).

37. The Health Security Act of 1993, S.1757, 103rd Cong. § 1 (1993); *see generally* WHITE HOUSE DOMESTIC POLICY COUNCIL, HEALTH SECURITY: THE PRESIDENT'S REPORT TO THE AMERICAN PEOPLE (1993).

38. Michael Calabrese & Lauri Rubiner, *Universal Coverage, Universal Responsibility: A Roadmap to Make Coverage Affordable for All Americans* 2004 NEW AM. FOUND. 4, 6.

the “play or pay” approach.³⁹ Alternatively, there are a number of proposals that call for individual mandates, requiring individuals to secure coverage from their employers or some other source, but the burden to secure coverage is on the individual, not the employer.⁴⁰ Numerous proposals would also create tax credits or other financial incentives to help employers or individuals secure coverage.⁴¹ Still other proposals call for the establishment of purchasing pools in every state, and others call for various insurance market reforms.⁴²

A UNIVERSAL COVERAGE/UNIVERSAL RESPONSIBILITY APPROACH

THE NEW AMERICA FOUNDATION PROPOSAL

One of the more promising approaches for universal health care coverage is typified by a recent proposal by the New America Foundation.⁴³ Under this approach, the government would guarantee access to adequate and affordable health insurance for everyone.⁴⁴ In exchange, each person would be required to maintain health insurance and to pay for that insurance with a combination of employer and employee contributions and government assistance based on ability to pay.⁴⁵ An adequate but basic level of health care coverage would be required, and community insurance pools would be established in each state to offer individuals a choice among alternative health care plans.⁴⁶ Government assistance would be provided in the form of refundable tax credits calculated on a sliding scale based on need.⁴⁷

39. HAASE, *supra* note 19, at 8.

40. These mandates could be enforced, for example, by denying certain tax benefits unless the individual provides proof of coverage. JOINT COMMITTEE ON TAXATION, PRESENT LAW AND ANALYSIS RELATING TO THE TAX TREATMENT OF HEALTH CARE EXPENSES 21 (2006).

41. *Id.* at 19-20.

42. Calabrese, *supra* note 38, at 1, 5 (proposing the establishment of purchasing pools to offer an individual several different alternative insurance plans); *see also* HEALTH CARE ACCESS AND AFFORDABILITY CONF. COMM. REP., Apr. 3, 2006, available at <http://www.mass.gov/legis/summary.pdf> (proposing certain insurance market reforms to reduce premium costs).

43. *See generally* Calabrese, *supra* note 38; HAASE, *supra* note 19.

44. Calabrese, *supra* note 38, at 1, 3.

45. *Id.* at 1-2.

46. *Id.* at 1, 5.

47. *Id.* at 5.

THE NEW MASSACHUSETTS HEALTH PLAN

Similarly, Massachusetts recently enacted major legislation designed to achieve nearly universal coverage.⁴⁸ The new law requires individuals to have health insurance and redeploys state funds to help pay for it.⁴⁹ Within three years, the law is expected to provide health insurance coverage to 95% of the 550,000 uninsured Massachusetts residents. Everyone “plays their part:” individuals, government, health care providers, and employers.⁵⁰

The law creates a new agency—the Massachusetts Health Insurance Connector—to connect individuals and small businesses with health insurance products and to ensure that individuals continue to have insurance when they change jobs.⁵¹ There are also insurance market reforms.⁵² For example, the law will merge the individual and small-group markets in July 2007, a provision that will produce an estimated drop of 24 % in non-group premium costs.⁵³

The Massachusetts law also provides health care subsidies for low-income residents through a new Commonwealth Care Health Insurance Program.⁵⁴ Under this program, sliding-scale subsidies will be available to individuals with incomes below 300% of the federal poverty level (\$48,000 for a family of 3 in 2006), and there will be no premiums for people with incomes below 100% of the Poverty Level (\$9,600 for an individual in 2006).⁵⁵ Additionally, there are no deductibles.⁵⁶ Medicaid will also be expanded, for example, to cover children in families with incomes up to 300% of the poverty level.⁵⁷

Under the individual mandate, individuals must have health insurance by July 1, 2007.⁵⁸ The penalty for not having insurance in 2007 is the loss of the personal exemption.⁵⁹ In subsequent years, the penalty will be a fine equal to 50% of the monthly cost of health insurance for each month

48. See HEALTH CARE ACCESS AND AFFORDABILITY CONF. COMM. REP. *supra* note 42.

49. *Id.* at 1.

50. *Id.*

51. HEALTH CARE ACCESS AND AFFORDABILITY CONF. COMM. REP. *supra* note 42, at 1.

52. *Id.*

53. *Id.*

54. *Id.* at 2.

55. *Id.* at 2-3.

56. HEALTH CARE ACCESS AND AFFORDABILITY CONF. COMM. REP. *supra* note 42, at 3.

57. *Id.* at 2.

58. *Id.* at 3.

59. *Id.* at 4.

without insurance.⁶⁰ Those who cannot afford insurance, however, will not be penalized.⁶¹

Employers who do not make “fair and reasonable” contributions will be required to make per-worker “fair share” contributions.⁶² These contributions will be capped at \$295 per full-time-equivalent worker, per year; however, businesses with 10 or fewer employees will not have to make these contributions.⁶³

A UNIVERSAL COVERAGE/EARNINGS SUBSIDY APPROACH

Another promising approach is to combine an *employer* mandate with targeted health-care subsidies.⁶⁴ Under this approach, all employers would be required to either provide health care coverage for their workers or pay a payroll tax so the government can provide coverage (“play or pay”).⁶⁵ In addition, the government would provide targeted subsidies to help pay the health-care costs of low-income workers and their families.⁶⁶

To be sure, an employer mandate—without more—could decrease employment opportunities for low-skilled workers.⁶⁷ On the other hand, an employer mandate combined with government subsidies could be designed to increase employment opportunities.

According to standard economic theory, employee compensation is tied to productivity, and employers only care about total compensation, not about the mix between wages and health benefits. Consequently, employers would respond to an employer mandate by providing health care coverage and offsetting those costs by decreasing cash wages. But there are two problems with making that kind of dollar-for-dollar offset.

First, the minimum wage would prevent some employers from reducing cash wages by enough to cover their costs. Consider a firm that pays its workers \$7.00 per hour but does not provide any health insurance. Under an employer mandate, that firm would have to provide health care

60. HEALTH CARE ACCESS AND AFFORDABILITY CONF. COMM. REP. *supra* note 42, at 4.

61. *Id.* at 3.

62. *Id.*

63. *Id.* at 3-4.

64. See CHARLES R. MORRIS, *APART AT THE SEAMS: THE COLLAPSE OF PRIVATE PENSION AND HEALTH CARE PROTECTIONS* 58 (New York: Century Foundation Press, 2006).

65. *Id.*

66. *Id.* at 57-58.

67. See generally Amy Wolaver et al., *Mandating Insurance Offers for Low-Wage Workers: An Evaluation of Labor Market Effects*, 28 J. OF HEALTH POL. POL'Y & L. 883 (2003) (suggesting that policies that increase health care coverage among low-wage workers tend to decrease full-time employment for that group).

coverage for its workers. If that health coverage costs the equivalent of \$3.00 per hour, the firm would want to cut wages to \$4.00 per hour, but the \$5.15 minimum wage would make that impossible. To the extent that the employer mandate raises the labor costs of workers above the market value of their labor, some workers would lose their jobs.⁶⁸

Second, an employer mandate would also result in changes in the supply of labor, depending on the value that workers put on receiving health insurance. If workers value health insurance over its cost, they would increase their labor supply. If workers would rather have cash, however, then they would decrease their labor supply.⁶⁹

The net effect of an employer mandate on employment is ambiguous, but the empirical evidence suggests that a decline in the employment levels of low-waged workers is likely.⁷⁰

Still, a well-designed system of government subsidies could more than offset the adverse impacts of an employer mandate. Those subsidies could be provided either to employers or to workers, perhaps in the form of an earnings subsidy. For example, the federal government could provide a tax credit to the employers of low-wage workers to help offset the increased costs of providing health insurance.⁷¹ Alternatively, the federal government could provide health care vouchers to workers that could be used to purchase health care from authorized providers.⁷²

TRANSITION TO UNIVERSAL HEALTH CARE

We can and we should make the transition from the current system to a system of nearly universal coverage. For example, the elements of such a transition could include tax changes, an employer mandate, and an individual mandate.⁷³

68. Also, if some types of workers are exempt from the mandate – such as part-time and contingent workers – then employers are likely to convert full-time jobs with coverage to part-time or contingent positions without coverage. See KATHERINE BAICKER & AMITABH CHANDRA, *THE LABOR MARKET EFFECTS OF RISING HEALTH INSURANCE PREMIUMS* 21 (2005).

69. Alternatively, those workers who value the coverage the least would have an incentive to move on to jobs that do not offer coverage; see also BAICKER AND CHANDRA, *supra* note 68, at 21.

70. Wolaver et al., *supra* note 67, at 911.

71. See Haveman, *supra* note 25, at 197-98.

72. *Id.*

73. See C. Eugene Steuerle, *A Workable Social Insurance Approach to Expanding Health Insurance Coverage in 3 COVERING AMERICA: REAL REMEDIES FOR THE UNINSURED* 97, 97-112 (Washington, DC: Economic & Social Research Institute, 2003) (proposing larger private and public spending on health care through tax credits, individual choices and employer contributions).

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TAX CHANGES

The exclusion for employer-paid health insurance premiums should be capped at a fixed-dollar amount and gradually replaced with a refundable tax credit.

AN EMPLOYER MANDATE

Employers should be required to offer, but not necessarily pay for, at least one state-approved health insurance plan for employees. Employers should be encouraged to adopt the practice of automatically enrolling employees in the employer's health plan unless the employees specifically choose to opt out.

AN INDIVIDUAL MANDATE

Individuals would be required to get health insurance or lose tax benefits such as personal exemption and standard deduction.

CONCLUSION

All in all, it is both necessary and possible to redesign the health care system so it provides universal coverage, and we should be able to do it in a way that minimizes work disincentives. In short, we can make universal health care work.