VIEWPOINT

HEALTH POLICY

Does Employment-Based Insurance Make the US Medical Care System Unfair and Inefficient?

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In the United States, the interests of high-income individuals dominate decisions about what medical care is offered and how it is financed. The result is a less efficient and less equitable medical care system than in other high-income countries. Employment-based insurance plays a key role in determining the production and financing of US medical care.

Employment-based insurance started during World War II as a way for employers to attract needed employees without violating wartime wage controls. After World War II, employment-based insurance spread quickly because group insurance is less costly to administer than individual insurance, and it is less vulnerable to adverse selection of unhealthy patients. Employment-based insurance is particularly popular with high-income employees because the contribution made by employers to the premium is exempt from the employees' taxable income. This exemption cost the US Treasury an estimated $300 billion in 2018.[1]

For many decades, employment-based insurance has set the standard for US medical care, although several features are now being questioned by health policy experts, including but not limited to giving patients a wider choice of clinicians and hospitals, generally relying on fee-for-service payment, and allowing self-referral to specialists. These cost-increasing features are especially valued by higher-income patients. Employment-based insurance covers approximately 60% (180 million of the 310 million) of insured individuals, but enrollment is highly correlated with income. In high-income households (family income >400% of the federal poverty level), 84% are enrolled in employment-based insurance. In low- and middle-income households (family income from 100% to 250% of the federal poverty level), only 35% are enrolled in employment-based insurance.[2] The result is a product mix of care that caters to the preferences of higher-income patients.

Emphasis is on specialty and subspecialty care, expensive technology, extra capacity to facilitate access (US hospitals have an average occupancy rate of 65% compared with an average of 76% according to the Organisation for Economic Co-operation and Development), and more and better-quality amenities, including space and privacy in the hospital.[3] Architects who build in many countries suggest that design for US hospitals must also include better space for visitors and professional staff. This more costly product mix (specialty care and hospital amenities) is appreciated by patients at all income levels, but higher-income patients would and sometimes do pay extra for them. Many low- and middle-income households would be better off if medical care was less costly, and they had more money for other public and private goods and services.

An imperfect but useful analogy to the differences in product mix between the US medical care system and those of other high-income countries is the difference between Whole Foods (a chain of upscale grocery stores) and Walmart (the largest grocery retailer in the United States). Shoppers who buy their food at Whole Foods spend much more than Walmart shoppers for a more expensive mix of products (ie, by analogy, high-cost drugs, access to specialists), not more food. By analogy, if the US government subsidized the Whole Foods shopper as it does for individuals with the tax advantages of employment-based insurance, and imposed on Walmart requirements for products, personnel, and equipment, Walmart's costs and prices would increase. Given enough subsidy for Whole Foods and cost-increasing regulations on Walmart, the low-cost alternative might disappear. Such a low-cost alternative does not exist for most of medical care. Its absence is not a problem for high-income patients, but it is for many low- and middle-income households that would rather spend less on medical care. Of note, there are more than 10 Walmart stores for every Whole Foods store. The opposite is true for medical care as most physicians and hospitals strive for high standards and very few concentrate on lowering costs.

The preference of high-income patients for a costly product mix also adversely affects the efficiency of research and development in the choice of projects because market size influences the direction of investment in innovation. Almost all private medical research and development is directed toward extending the product mix with few attempts to discover new lower-cost interventions with truly disruptive innovations. The interests of high-income patients not only result in inefficiency in medical care production and innovation, but also adversely affect the way the United States finances health care. The present system, which is a mix of employment-based insurance, other private insurance, numerous government programs, including Medicaid and Medicare, each with its own eligibility rules and payment schemes, and out-of-pocket payments, is extremely costly to administer.[4,5] The large role played by private insurance in the United States helps high-income households because the price of the insurance is the same regardless of income, whereas government plans typically require higher-income individuals to pay a larger share of the nation's medical care bill.

In the current US system, no one knows how much the cost of care is borne by different income groups.

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Payment is nominally made by insurance companies and the government, but it is essential to distinguish between who nominally pays the insurance premium and who bears the true cost burden. As another example, suppose a government decides to finance medical care by implementing a tax on retail sales, as the province of Ontario, Canada, does. The law might require that stores pay the tax, or that the customer pays the tax, but the cost burden of the tax would be borne by the customer either way. If the store pays, it will raise prices by the amount of the tax. Similarly, most of the premium for employment-based insurance and half of the federal payroll tax (a portion of which goes to Medicare) are paid by employers, but economists agree that the cost burden is borne by employees in the form of lower wages.[6] For some sources of revenue such as the corporate profits tax, the corporation pays, but economists disagree about how the cost burden is distributed among households who are shareholders, customers, or employees. The answer may vary depending on circumstances such as the competitiveness of the industry, the state of the market for capital, the supply of labor, and other factors. It is important to realize that the majority of costs are borne by households regardless of who is the payer.

How should the cost of medical care be borne by different income groups? The answer depends in large part on how medical care expenditures are viewed. If viewed as similar to other objects of consumption, such as food, clothing, or automobiles, no special financing may be required. Because many households have no medical care expenditures during a year, and 5% have 50% of the expenditures, a different financing system seems necessary. One way to think of the cost is as being similar to reparations imposed on US households by a foreign power that has defeated the United States in a war.[7] Assume the foreign power assigns reparations of $3.5 trillion, which is the approximate total for health care expenditures in 2017, to the 126 million US households in a random and capricious manner so that many pay nothing and others pay more than $100 000. The average would be $28 000 per household. Suppose the United States wanted to offset reparations paid by each household so that the inequality of income in the United States would be the same after as before payment. A tax on income at the same percentage regardless of the level of income (a flat tax) could raise revenue for the federal government needed to compensate each household for its payment of reparations. Countries that have national health insurance come close to this solution by having a flat tax on retail sales or on value-added sales that is initially paid by business firms, but is eventually passed on to consumers.[8]

Suppose the United States had such a system in place with a tax rate set at a level that would raise the $3.5 trillion for reparations. The highest income quintile with 51.5% of US household income and 25 million households would have to pay an average of more than $72 000 per household. The lowest quintile with 3.1% of US household income would pay an average of $4300 per household. The remainder would come from the 3 middle-income quintiles that have a combined income of 45.4% of US household income. Their average equal share would be approximately $21 000 per household.[9] The average (mean) GDP per all household in 2017 was $155 000.

The United States could save a large amount on administrative costs of care if it adopted a simpler financing system, perhaps a single-payer system. Changing the product mix (as illustrated in the comparison with product availability at Whole Foods vs Walmart) would be an even more complex proposition, and would require removal of government regulation and professional strictures that prevent emergence of a lower-cost alternative. A change in the financing system would probably distribute the burden of cost more to high-income households; this is probable but not certain because the present distribution of the cost burden is not known. A change in the method of finance and in the product mix would make US medical care more efficient and probably more fair for the majority of households. According to the media and some academic interpretations of Donald Trump's election as President in 2016, many low- and middle-income individuals perceive that the US economy does not benefit them. Explorations of this question as applied to the US medical care system suggest that there is some basis for those perceptions.

ARTICLE INFORMATION

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