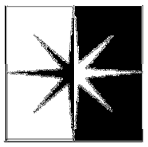

NEW AMERICA
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EMPLOYER HEALTH COSTS IN A GLOBAL ECONOMY: A COMPETITIVE DISADVANTAGE FOR U.S. FIRMS

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HEALTH POLICY PROGRAM

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EXECUTIVE SUMMARY

Most Americans get health insurance through their employers. Business leaders are increasingly united in their belief that rising health care costs threaten America's competitiveness in the global economy, and business support for comprehensive health reform has been growing as a result. However, economists generally believe that it is workers—rather than employers—who pay for health care through lower wages. Although this proposition may hold true in the long run, employers face a variety of constraints that may make it difficult for them to fully shift health costs in the short run.

Health care costs would not burden firms if they could be shifted to consumers through higher prices. But with globalization and increased competition in international markets, this is not feasible. If employers cannot fully shift health costs onto workers or into prices, then how much they pay matters.

As a percentage of payroll, the employer cost of health benefits has exploded over the past few decades. In addition, employer health costs in the manufacturing industry in the United States of $2.38 per worker per hour were much higher than the foreign trade-weighted average of $0.96 per worker per hour in 2005. Employer health costs make the United States less competitive than it could otherwise be.

A new model for health care that includes appropriate subsidies for those who need them and is individual, rather than employer-based, would enable us to finance our 21st-century health system in a more sustainable and competitive way.

INTRODUCTION

Under our patchwork health care system, most of us get our health insurance through our employers. In 2005, 177 million Americans—60 percent of the population—were covered by employer-based health insurance.[1] According to national health expenditure data, employer contributions for coverage in 2005 amounted to nearly $440 billion, or 24 percent of total spending on health services and supplies.[2]

Business leaders are increasingly united in their belief that rising health care costs threaten America's competitiveness in the global economy, and business support for comprehensive health reform has been growing as a result. Businesses have formed coalitions with labor unions and other groups in support of this aim, among them: Better Health Care Together, uniting Wal-Mart, AT&T, the Service Employees International Union (SEIU), and the Communications Workers of America (CWA); Divided We Fail, a coalition of the Business Roundtable, AARP, and SEIU; the Coalition to Advance Healthcare Reform, a grouping of businesses led by Safeway CEO Steve Burd; and the Health Coverage Coalition for the Uninsured, which includes the U.S. Chamber of Commerce.

According to the Ford Motor Company, health care costs add $1,500 to the price of each vehicle it manufactures, which is $600 more per vehicle than its foreign competitors pay.[3] This is only one example of a problem that is also recognized by U.S. labor leaders. "American businesses that provide adequate health benefits," says the AFL-CIO, "are at a significant disadvantage, competing in the global marketplace with foreign companies that do not carry health care costs on their balance sheets."[4] Yet many economists, adhering to traditional economic theory, remain unconvinced that health care costs are a problem for business, arguing that it is workers, not businesses, who ultimately pay for health costs through lower wages.

This paper challenges that traditional theory. After quantifying health costs of employers in the United States and comparing them with the health costs of selected U.S. trading partners, we conclude that, all else being equal, employer health costs put U.S. firms at a competitive disadvantage. This finding has significant policy implications for health care reform. It means that we must reduce reliance on employer financing of health care or risk even more "good jobs" being lost overseas.

Labor Costs and Competitiveness

According to international trade theory, one measure of competitiveness is the relative price of a product—in this instance, the price that U.S. firms charge for a product compared with the price that competing foreign firms charge.[5] The price that a firm can charge, and still make a profit, depends on the cost of production, a major component of which is the cost of labor. However, since higher labor costs may simply reflect higher productivity (high-skilled, more productive workers demand higher wages), it is necessary to take this factor into account in determining the cost of labor to produce each unit of output. It is by comparing the resulting "unit labor costs," which account for differential productivity, that competitiveness in international markets is measured.[6]

Labor costs are mostly made up of employee compensation, which includes wages and salaries, paid leave, supplemental pay, fringe benefits (such as health and pension benefits), and mandatory social insurance contributions (such as the 1.45 percent payroll tax on employers for Medicare hospital insurance). Employer contributions (whether voluntary or mandatory) to health insurance do not hurt competitiveness unless they increase labor costs—that is, unless they are not fully offset by a reduction in wages. Therefore, the issue becomes whether employers can shift health costs in their entirety to workers through lower wages.

Can Employers *Fully* Shift Health Costs to Workers?

Economists generally believe that it is workers—rather than employers—who pay for health care through lower wages.[7] (The corollary of this theory is that if health costs do not increase labor costs, they cannot hurt the competitiveness of U.S. firms.) Economic theory also implies that health costs act as an indirect tax on workers, who ultimately bear their full weight.

Although this proposition may hold true in the long run, employers face a variety of constraints that may make it difficult for them to fully shift health costs in the short run:[8]

- Institutional constraints may prevent employers from reducing wages in the short run. Union contracts, labor market norms, and minimum wages prevent downward wage adjustments.[9]
- In the long run, employers can shift health costs by reducing wage increases. This is how most economists think that employers manage increases in health premiums. However, since 2000, premium growth has exceeded general inflation plus productivity growth by an average of 3.5 percentage points.[10] The actual percentage varies unpredictably from year to year. Thus, health care cost growth produces a series of "shocks" of varying magnitude that cannot be fully shifted into wages in the short run. And because the shocks persist, employers cannot get to the long-run equilibrium where health costs are fully shifted.
- The actual burden or "incidence" of health costs is ultimately decided by the degree to which workers value health benefits over cash wages.[11] At some point, workers will prefer cash wages on the margin to health benefits that are increasing in cost, but not necessarily in perceived value.[12] At the logical extreme, employers cannot reduce wages to zero; obviously workers need and demand a minimum level of cash. The more that total compensation is consumed by health benefits, the less workers will value those benefits on the margin. At this point, it becomes impossible to shift the costs entirely to workers.
- If workers resist wage cuts, employers can respond by replacing them with contingent workers or labor-saving equipment, or by relocating production to a lower-cost region (or country). But this can only be done slowly in the long run.[13]
- Economic theory only considers health costs for active workers. However, retirees account for six percent of employer contributions to health insurance.[14] It is highly unlikely that active workers would accept lower wages to pay for the rising health costs of retirees. This reluctance is illustrated by the fact that only 35 percent of large firms offered retiree health benefits in 2006, which is roughly half the fraction that offered such benefits 20 years ago, when health costs were much lower.[15]

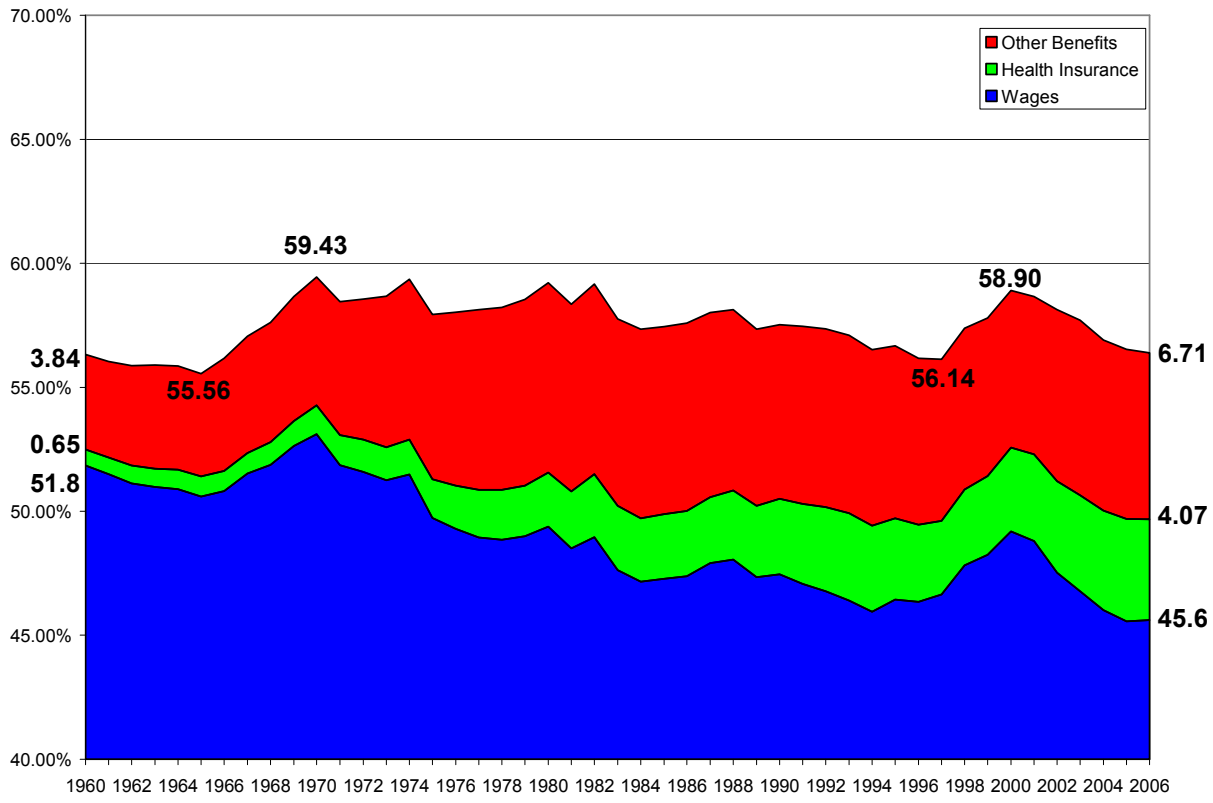
When Premium Inflation Outpaces Overall Inflation

Consider a worker whose total compensation is $35,000, composed of an employer premium contribution of $10,000 for family health care coverage and cash wages of $25,000 (for the sake of simplicity, assume that the worker receives no other benefits). Suppose that the overall inflation rate is 2.5 percent, and that premium inflation is 10 percent. In order to preserve real wages, the worker's total compensation would have to be increased by 2.5 percent, to $35,875. But if the employer continued to pay for the same share of the premium as before, the employer's contribution would rise by 10 percent, to $11,000. If the employer were to subtract the cost of the premium from $35,875, that would leave $24,875 in cash wages for the worker, resulting in an actual pay cut. Given workers' extreme resistance to nominal wage cuts, it is unlikely that the employer would be able to reduce wages to cover the additional health costs. Instead, the employer would either have to scale back health benefits or accept lower profits.

It is important to emphasize that workers bear some of the cost of employer-paid health insurance through lower wages. Our fundamental point, however, is that full cost-shifting to workers is a "long run" phenomenon and the long run can take a very long time indeed. Figure 1 shows the compensation share of GDP, from 1960 to 2006, separated into wages, employer-paid health insurance benefits, and non-health fringe benefits (including pensions and social security payroll taxes).

A cursory glance confirms the basic direction of long-run economic theory: the wage share of GDP declines over time as health and non-health benefits increase. In fact, if you simply compare 2006 to 1960, the theory seems perfectly supported, since the wage share declines by 6.2 percentage points as benefits rise by 6.3 percentage points. But 46 years is a long time to wait for theory to be confirmed, especially if you are running a corporation and competing for labor and customers in the here

Fig. 1. Compensation Share of GDP, 1960–2006.



Source: U.S. Department of Commerce, Bureau of Economic Analysis, National Income and Product Accounts, Tables 1.1.5, 2.2, and 6.6.

Table 1. Change in Compensation Share of GDP by Decade, 1960–2006

	1960s	1970s	1980s	1990s	2000s
Total Compensation	2.36%	-0.88%	-1.87%	0.28%	-2.51%
Wages and Salary	0.80%	-4.12%	-2.05%	0.79%	-3.58%
Other Benefits	1.18%	2.34%	-0.53%	-0.64%	0.38%
Health Insurance	0.36%	0.89%	0.71%	0.13%	0.69%

Source: U.S. Department of Commerce, Bureau of Economic Analysis, National Income and Product Accounts, Tables 1.1.5, 2.2, and 6.6.

and now.

Table 1, which illustrates changes in the compensation share of GDP by decade, reveals two important phenomena. First, the total labor compensation share rises and falls with the relative bargaining power of labor, independent of what is happening to health care costs. Second, while employer-paid health insurance inexorably rises as a share of GDP in each decade, aggregate wages rise in some decades (as a share of GDP) and fall in others. More important, wages never move over an entire decade by the same percentage as health insurance (or even health insurance plus other benefits). The decades that are most troublesome for the long-run theory in which labor gained were the 1960s and the 1990s, in which both wages and health benefits rose. The decades that are most troublesome for the long-run theory in which labor lost ground were the 1970s, 1980s, and 2000s, in which wages fell far more than total benefits (health insurance plus other benefits) rose. The argument that wage growth reflects a mirror image of employer-paid health benefit growth, or even total benefits, is hard to support except over a very long time frame.[16]

Additionally, there is a fair amount of circumstantial evidence to suggest that employers cannot fully shift health costs to workers by lowering wages. If they could do so, they would likely continue to offer the same health benefits as in the past, even in the face of rising health costs. However, employers have been dropping plans, reducing their share of the premium, reducing benefits, or increasing cost sharing (deductibles, co-payments, and co-insurance).

Since 2000, the proportion of employers offering health benefits has declined from 69 percent to 61 percent, the average worker contribution for family coverage has increased by 84 percent (from $1,620 to $2,976), and the proportion of workers in a worker-only plan[17] with a general deductible of $500 or more increased from 14 percent to 34 percent. From 1987 to 2005, the private employer share of premium contributions declined from 77 percent to 73 percent.[18]

There is a fair amount of circumstantial evidence to suggest that employers cannot fully shift health costs to workers by lowering wages.

Clearly, employers are shifting rising health costs to workers by reducing benefit generosity and their share of the premium. This is particularly surprising since under current tax law non-wage compensation is tax free and thus more valuable to workers than wages on the margin. Recent trends of increasing access to section 125 cafeteria plans—which extend the tax advantage to wages deducted from paychecks for the employee's premium payment—not only reduce the preference for employer over employee premium payments, but also actually increase the relative attractiveness of health benefits as a whole since they are now *completely* tax free, and wages are not. Therefore, reducing health benefits cannot be the option most preferred by workers to offset rising health costs, yet that is exactly what more and more employers are doing.

These strategies have resulted in declining health insurance coverage. From 2001 to 2005, the coverage rate of employer-sponsored insurance declined by almost 4 percentage points; of this decline, 48 percent was due to declining sponsorship, 27 percent was due to declining take up (as plans become less affordable), and 14 percent was due to declining

eligibility.[19] Workers are losing coverage mostly because employers are dropping plans, and employers are dropping plans because they cannot shift rising health costs to workers fast enough.

At some point, reducing or eliminating health benefits will make employers less competitive in the labor market. In fact, a major reason why employers offer health insurance in the first place is to attract and retain qualified workers. Eventually, employers may have to accept lower profits to attract and retain qualified workers.[20] This will hurt their competitiveness because less money will be available for investment in productivity-enhancing equipment, technology, and research and development, and less tax revenue will be available for government investment in infrastructure and education. A reluctance to accept lower profits is why so many business coalitions are forming to support comprehensive health reform.

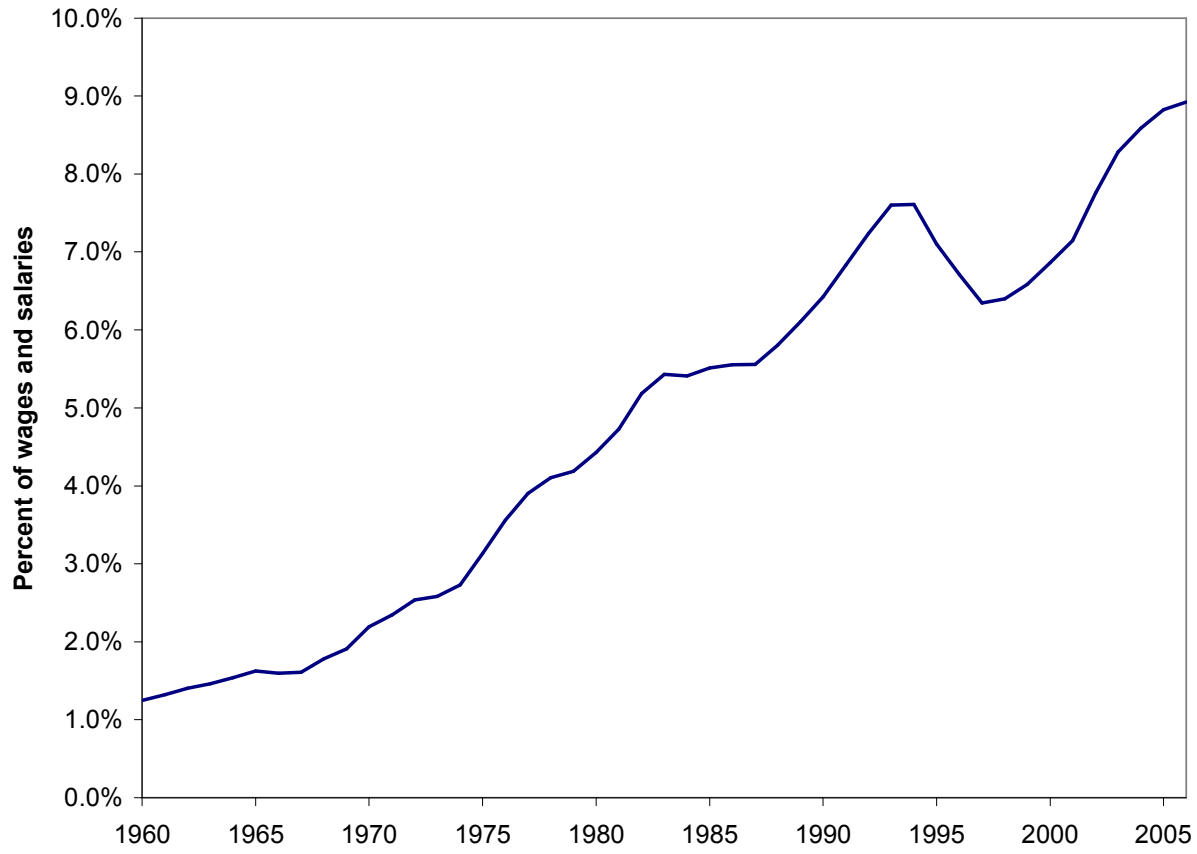
In sum, employers behave as if they cannot fully shift health costs to workers through lower wages in the short run. As Peter Orszag, director of the Congressional Budget Office, pointed out in testifying before the Senate Budget Committee, "A significant issue involved in any reform of the employer-provided system is the short- and medium-term impact on employers' contributions to health insurance. Over time, any changes in those contributions…should be reflected in workers' wages…but the speed of that adjustment could vary."[21]

In the interim, before a full wage adjustment can take effect, employers are in a vise: they must lay off workers, reduce or eliminate health benefits, or accept lower profits. Increasingly intense international competition means that they cannot escape this vise by shifting health costs forward into higher prices.

The Burden of Health Costs on U.S. Industries

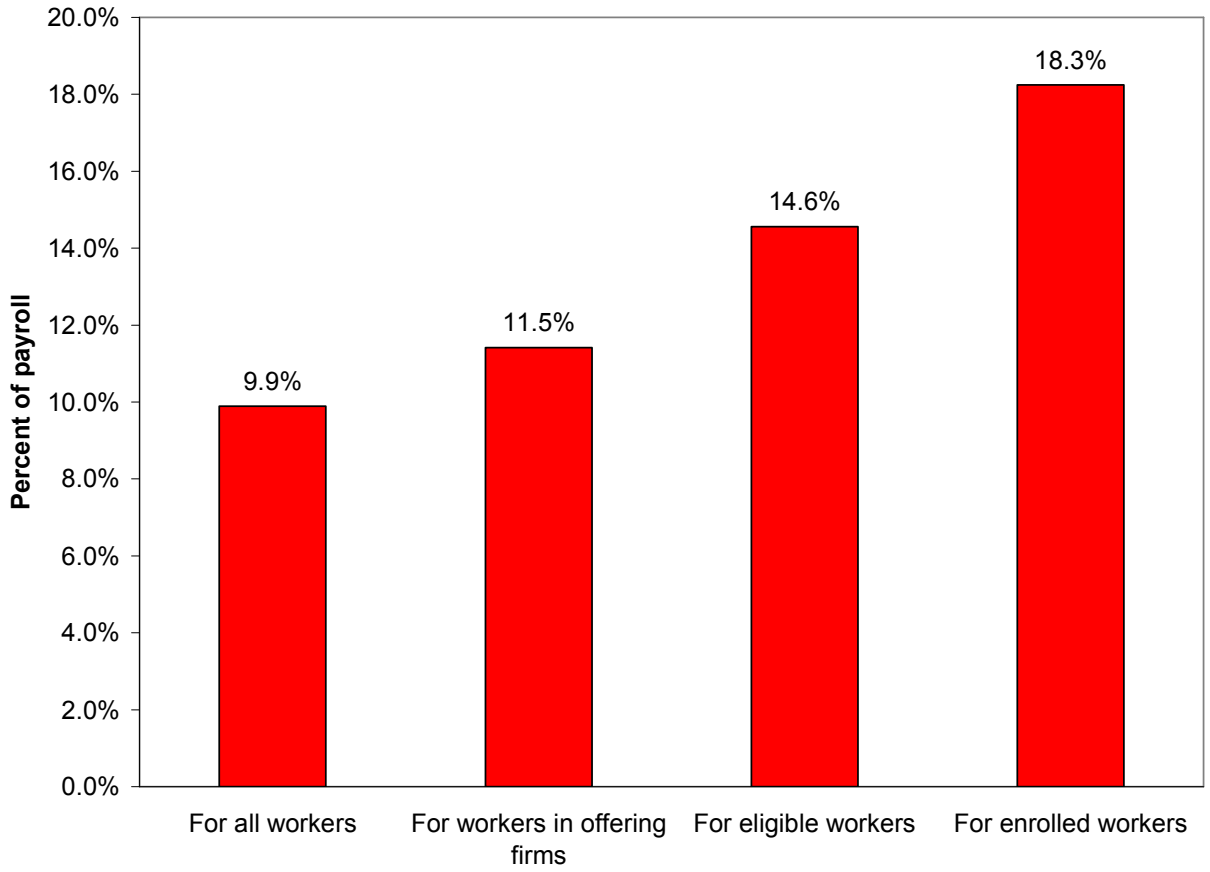
If employers cannot fully shift health costs onto workers, then how much they pay matters. As a percentage of payroll, the employer cost of health benefits has exploded over the past few decades. In 1960,

Fig. 2. Employer Contributions to Private Health Insurance, 1960–2006



Source: U.S. Department of Commerce, Bureau of Economic Analysis, National Income and Product Accounts, Tables 7.8 and 2.2A-B.

Fig. 3. Employer Health Costs, 2007



Sources: Authors' calculation based on payroll data from the U.S. Department of Labor, Bureau of Labor Statistics, *Employer Costs for Employee Compensation—September 2007*, released December 11, 2007. The offer and enrollment rates are from the Agency for Healthcare Research and Quality, *Medical Expenditure Panel Survey,* 2004.

Note: Health benefits are employer contributions to private health insurance; payroll includes wages and salaries, paid leave, and supplemental pay.

health benefits were only 1.2 percent of payroll.[22] Today, according to data from the U.S. Bureau of Labor Statistics, the employer cost of health benefits is 9.9 percent of payroll.[23]

The BLS estimate is the average cost for all private workers, including those who cost nothing because their employers do not offer health insurance. Excluding these workers, the cost per worker in firms that offer health insurance is 11.5 percent of payroll. But many workers in firms that offer health insurance cost nothing because they are not eligible,[24] or do not enroll. Excluding these workers as well, the cost per enrolled worker is 18.3 percent of payroll.[25]

Another measure of employer health costs is the cost per unit of output. As discussed above, this "unit labor cost" accounts for productivity, and is a widely accepted measure of competitiveness. Table 2 illustrates the unit labor cost of health benefits—which we refer to as the "unit health cost"—across selected industries.[26] Setting the average unit health cost for all industries for active workers at 100, each industry's unit health cost is expressed relative to 100, which we refer to as its "relative unit health cost."

The table shows the relative unit health costs for active workers. Not surprisingly, the manufacturing industry's relative cost is among the highest, at 123.5. Other industries with high relative costs are the transportation and warehousing, information (which includes publishing, broadcasting, and telecommunications), and accommodation and food services industries. The retail trade industry, which has lower profit margins than the manufacturing industry, also has higher than average relative costs, at 104.1.

Table 2. Relative Unit Health Costs of Selected Industries, 2004

	Active workers only Average = 100	Active workers and retirees
All industries	100.0	106.8
Manufacturing	123.5	138.8
Retail trade	104.1	105.8
Wholesale trade	96.3	100.0
Transportation and warehousing	140.6	152.1
Information	103.1	122.9
Accommodation and food services	111.0	114.8

Note: The unit health cost is calculated as employer premium contributions (data from the Agency for Healthcare Research) divided by value added (net output), (data from the U.S. Department of Commerce, Bureau of Economic Analysis).

The relative costs change somewhat when adding in the cost of retiree health benefits. Relative costs for the manufacturing and information industries rise substantially, while those for other industries either remain relatively stable or increase only slightly.

Health costs would not burden firms if they could be shifted to consumers through higher prices. But with globalization and increased competition in international markets, this is not feasible. Export prices have declined substantially compared to import prices,[27] making health costs more burdensome for industries that are exposed to international trade.

An industry's trade exposure can be measured by its import share (the share of its domestic output that is imported) and export share (the share of its domestic output that is exported). Table 3 shows import and export shares for selected industries. The manufacturing industry is among the most exposed to trade, while the retail trade industry has no exposure to trade at all. In fact, service industries as a whole are not very exposed to trade. However, recent research suggests that many service industries are increasingly subject to global competition, and their health costs could become more burdensome in the future.[28]

Table 3. Trade Exposure of Selected Industries, 2005

	Import share (%)	Export share (%)
All industries	7.8	8.8
Manufacturing	29.5	13.5
Retail trade	0.0	0.0
Transportation and warehousing	2.0	10.7
Information	0.5	2.8
All service industries	0.3	2.6

Source: U.S. Department of Commerce, Bureau of Economic Analysis, *Survey of Current Business*, December 2006, Table 15: Components of Domestic Supply by Commodity Group, 2002-2005.

Health costs would not burden firms if they could be shifted to consumers through higher prices. But with globalization and increased competition in international markets, this is not feasible.

THE BURDEN OF HEALTH COSTS ON FOREIGN FIRMS

As noted above, in the United States the employer cost of health benefits (with firms that do not offer health insurance included in the calculation) averages 9.9 percent of payroll for all private workers. Adding in the cost of contributions to Medicare hospital insurance, employers spend 11.3 percent of payroll on health care.[29]

Table 4 shows employer health costs in the United States and in selected trading partners. These trading partners—Canada, Japan, Germany, the United Kingdom, and France—are comparable to the United States in that they are developed countries with mature, comprehensive national health systems. In all of these countries, government health programs are financed in part by mandatory em-

Table 4. Employer Contribution Rates and Hourly Cost of Health Benefits, Selected Top Trading Partners

Country (rank in total trade with the U.S.)	Employer contribution rate* (%)	Hourly pay, manufacturing, 2005** ($ U.S.)	Hourly cost of health benefits, manufacturing, 2005 ($ U.S.)
United States	**11.3 overall**		
	13.0 for manufacturing	**18.32**	**2.38**
Canada (1)	4.5[a]	19.21	0.86
Japan (4)	3.74	18.06	0.68
Germany (5)	6.65[b]	25.53	1.70
United Kingdom (6)	1.92[c]	20.91	0.40
France (9)	12.8[d]	16.93	2.17
Foreign trade-weighted average	**4.9**	**19.79**	**0.96**

Sources: U.S. Census Bureau, Foreign Trade Division; International Social Security Association, *Social Security Programs Throughout the World*, 2005 and 2006; U.S. Bureau of Labor Statistics, *International Comparisons of Hourly Compensation Costs for Production Workers in Manufacturing*, November 2006.

*Employer contribution rates are for 2005 for Canada and for 2006 for all other countries. Many of these countries have minimum and/or maximum earnings thresholds above and/or below which the contribution rate is levied. The overall U.S. employer contribution rate is as of March 2007; the rate for manufacturing is for 2005.
**Hourly pay includes pay for time worked, paid leave, and bonuses.

[a]Maximum; varies by province.
[b]Also finances cash sickness and maternity benefits.
[c]Of the 12.8 percent that employers are required to contribute to social insurance, 15 percent is allocated to the National Health Service.
[d]Also finances cash sickness, cash maternity, disability, and survivor benefits.

ployer contributions. Any additional employer financing above the mandatory contribution is limited. Total spending on premiums for private plans—including the employee share and premiums for non-employer plans—is at most 13 percent of total health spending (in Canada), compared to 37 percent in the United States.[30]

With the exception of France, the employer contribution rate for health benefits is highest in the United States. However, the U.S. rate is an average that includes workers in firms that do not offer health insurance and is higher than France's for the manufacturing industry. In addition, the French rate is not strictly comparable to the U.S. rate because it also includes disability and survivor benefits, in addition to medical benefits. The U.S. rate of 11.3 percent is much higher than the foreign average of our sample (weighted by trade value), which is only 4.9 percent.

Table 4 also shows the hourly cost of health benefits for the manufacturing industry—which is of special concern because of the industry's trade exposure. In the United States, the employer contribution rate for the manufacturing industry in 2005 was 13 percent.[31] With average U.S. hourly pay for manufacturing at $18.32, the average hourly cost of health benefits in 2005 amounted to $2.38. Employer health costs in the United States were much higher than the foreign trade-weighted average of $0.96. This does not mean that, taking into account all labor costs, all other production costs, and productivity, the United States is not competitive overall. In fact, Germany and France have very high total labor costs due to mandatory employer contributions for other forms of social insurance. But it does mean that, all else being equal, employer health costs make the United States less competitive than it could otherwise be.

Reform Efforts in Germany and France

While employer health costs are highest in the United States, employer financing has also been a recent issue in Germany and France—the only other countries in our sample with higher-than-average employer health costs.

In Germany, "solidarity" financing—joint financing by employers and employees—has been the subject of "constant grumbling from employers" and is "at the heart of any debate about German health care reform."[1] At a time of increasing international competition, "rises in contribution rates…[have become] a question of international competitiveness."[2]

In 2002, the government established the Rurup Commission, which developed two reform options to partially decouple health care financing from employment.[3] Subsequently, the Social Democrats proposed an All Citizens' Health Insurance plan, which would have added income other than earnings to the taxable base to pay for a reduction in the contribution rate (of about 0.5 percentage points).[4] The Christian Democrats in turn proposed a Flat-Rate Premium Scheme, which would have completely decoupled financing from employment. Under this proposal, all citizens would have paid a flat-rate premium, regardless of income. Employers would have made payments equal to their current contributions to workers, which would have been taxed as wages.[5]

After the election in 2005, the two parties formed a grand coalition, led by Christian Democrat Angela Merkel. In a speech in January 2006, the German federal minister of health said that reform must "reduce labor costs and thus help to boost the competitiveness of our national economy."[6] But neither of the parties' ideas to decouple financing from employment gained traction.

However, in 2005, the 50/50 split between employer and employee contributions was shifted to a mix of 46 percent for employers and 54 percent for employees, reducing the employer contribution rate by 0.45 percent.[7] In addition, Germany recently began to address its high labor costs by increasing its value-added tax (VAT) to pay for a reduction in employer contributions to unemployment insurance.

France may be poised to follow Germany's lead.[8] Before the May 2007 presidential election, Nicolas Sarkozy proposed "le TVA social"—a social value-added tax—that would increase the VAT to pay for a reduction in employer contributions to social insurance. The British newspaper *The Independent* reported that Sarkozy "wants part of the cost of the welfare state—especially health care and unemployment pay—shifted on to France's already high rates of VAT."[9] After the election, Morgan Stanley speculated that one of Sarkozy's main economic reforms in the next five years will be implementation of this "social VAT."[10]

1. Christa Altenstetter, "Insights from Health Care in Germany," *American Journal of Public Health* 93 (January 2003): 38–44.
2. Reinhard Busse and Annette Riesberg, *Health Care Systems in Transition: Germany* (Copenhagen: European Observatory on Health Systems and Policies, 2004), 186.
3. Stephanie Stock, Marcus Redaelli, and Karl Wilhelm Lauterbach, "The Influence of the Labor Market on German Health Care Reforms," *Health Affairs* 25 (July/August 2006): 1143.
4. Ibid., 1149.
5. Ibid.; Busse and Riesberg, *Health Care Systems in Transition*, 204.
6. Ulla Schmidt, "Health Policy and Health Economics in Germany" (speech at the conference, "The American Model and Europe: Past – Present – Future," Friedrich Ebert Foundation, Washington, DC, January 27, 2006).
7. Busse and Riesberg, *Health Care Systems in Transition*, 59.
8. Bill Jamieson, "Germany Leads by Example as France Considers Esocial VAT," *Sunday Business* (London), April 21, 2007.
9. John Lichfield, "Presidential Candidates Battle Over How to Get French Economy Working Again," *The Independent*, May 13, 2007.
10. Eric Chaney, "Sarkozy's Victory—A Vote for Reforms," Morgan Stanley Global Economic Forum, May 7, 2007.

POLICY IMPLICATIONS FOR HEALTH REFORM

America's competitive disadvantage due to employer health costs has significant policy implications for health care reform. If the United States is to maintain its competitiveness in the global economy, health coverage should not rely primarily on employer financing. Thus, government and individuals will have to share more of the burden.

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The Problem with Employer Mandates

Requirements that employers either provide coverage or contribute to health insurance (i.e., employer mandates) are politically attractive because they are a means of financing comprehensive health coverage for all Americans without directly increasing taxes on individuals. However, according to economic theory, workers will ultimately pay the price of employer contributions through lower wages and job losses—a form of indirect taxation. Thus, employer mandates could end up hurting the very individuals that health care reform is meant to benefit. This is why liberal organizations such as the Center for American Progress do not advocate employer mandates in their health reform proposals.[32]

In the short run, as we have argued, employers would partially bear the burden of an employer mandate. Depending on its magnitude, an employer mandate would not do much to alleviate the burden on employers who already offer health insurance, while imposing a new burden on employers who do not. And by failing to spread the financing burden more broadly, an employer mandate could engender strong opposition from small businesses—risking a repeat of the failure of the Clinton reform effort in the early 1990s. Whether the burden of an employer mandate fell on workers or on employers—in truth, it would probably fall partially on both—it could have an adverse impact on workers through either lower wages or reduced employment.

A sound policy rationale for an employer mandate is that it would keep current employer contributions in the system, minimizing the cost to the government. Under a plan for achieving near-universal coverage, other forms of compensation or subsidies for workers could allow employers to drop or scale back their coverage. Under such a scenario, government funding would displace or "crowd out" employer funding, raising the cost to the government. A "play or pay" employer mandate—in which employers would have to offer health insurance or be subject to a payroll tax—would lessen the incentive for employers to drop or scale back their plans. But there is another way to prevent crowd out while avoiding the economic and political problems of an employer mandate.

A New Approach: "Cashing Out" Employers

If the political goal is to minimize increases in tax revenue, we can achieve this by redirecting existing tax subsidies for health care. Currently, employer premium contributions are excluded from workers' taxable income. In 2004, this tax expenditure cost $101 billion in forgone income taxes and $66 billion in forgone payroll taxes, for a total cost of $167 billion.[33] Yet tax expenditures on health care are heavily skewed toward high-income families: the average benefit is $2,780 for a family with income of $100,000 or more, compared to $102 for a family with income of less than $10,000.[34] Targeting this benefit toward lower-income families instead—by replacing the tax exclusion with a refundable, advanceable, sliding-scale tax credit—could provide subsidies to those who cannot afford health insurance while minimizing the cost to the government.[35]

Alternatively, it might also be possible to institute a more gradual transition from an employer-based system to a citizen-based system.

Without the current tax exclusion for employer contributions, employers would almost certainly reduce or eliminate health benefits. In the long run, wages would probably rise gradually to replace the value of health benefits, and total compensation would eventually rise to previous levels. But in the short run, a full wage adjustment might not be possible. As the director of the Congressional Budget Office told Congress, while changes in employer contributions should ultimately be reflected in workers' wages, "*the speed of that adjustment could vary*."[36] If a full wage adjustment did not occur, reform

would simply benefit employers at the expense of workers, and the government would not capture revenue from eliminating the tax exclusion for employer contributions.[37]

For these reasons, the transition from an employer-based health care system would require certain rules. For example, employers could be required to "cash out" their health plans. In a cash-out, employers would be required to convert their premium contributions into higher wages, which workers could then use toward the purchase of health insurance—requiring less government funding for subsidies.[38] In effect, employer funding would be converted transparently into individual funding; it would thereby be preserved, and not displaced by government funding. While total compensation would remain the same, employers would be relieved of future health cost increases, which they are powerless to control. This is one reason why Senators Ron Wyden (D-OR), Robert Bennett (R-UT), Bill Nelson (D-FL), Judd Gregg (R-NH), Lamar Alexander (R-TN), Thomas Carper (D-DE), Norm Coleman (R-MN), Bob Corker (R-TN), Mike Crapo (R-ID), Chuck Grassley (R-IA), Daniel Inouye (D-HI), Mary Landrieu (D-LA), Joseph Lieberman (I-CT), Debbie Stabenow (D-MI), and former Senator Trent Lott (R-MS), along with Representatives Brian Baird (D-WA), Jo Ann Emerson (R-MO), Jim Cooper (D-TN), and Earl Blumenauer (D-OR), have co-sponsored legislation in support of a cash-out plan.[39]

Alternatively, it might also be possible to institute a more gradual transition from an employer-based system to a citizen-based system by capping, rather than eliminating, the tax exclusion for employer contributions (either at a moderate income level, or at a moderate plan value, or both). This would maintain, though reduce, the incentive for employers to continue to offer health benefits, but their decision to do so would be voluntary. Employers who decided to stop offering health benefits could be required to increase their workers' wages by the value of the health benefits they previously received.[40] While this option would not generate as much revenue as eliminating the tax exclusion and requiring an employer cash-out, it might be more politically acceptable to employers and workers reluctant to move quickly away from the familiar employer-based system.

* * *

A new model for health care that is individual-based, rather than employer-based, would reflect the realities of the 21st-century global economy. There are many reasons why health care should be decoupled from employment, not least to improve the competitiveness of American firms by alleviating the burden of health costs on American business. Reforms that build on the employer-based system often involve an employer mandate, which creates more political cost than financing and policy gain. America desperately needs a more efficient health care system, which only comprehensive reform can deliver. If we wish to protect our economic well-being, we must consider the economic implications of our health reform choices.

NOTES

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1. U.S. Census Bureau, *Current Population Survey, 1988 to 2006 Annual Social and Economic Supplements.*
2. This included $366.9 billion in contributions to private health insurance, and $72.7 billion in contributions to Medicare hospital insurance. Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, *Sponsors of Health Care Costs: Businesses, Households, and Governments, 1987–2005*.
3. Nick Carey, "US Companies Seen Warming to Idea of Health Reform," Reuters, June 4, 2007. See also Lee Hudson Teslik, *Healthcare Costs and U.S. Competitiveness*, Council on Foreign Relations Backgrounder, May 14, 2007; and Jonathan Cohn, "What's the One Thing Big Business and the Left Have in Common?" *New York Times Magazine*, April 1, 2007.
4. AFL-CIO Executive Council statement, March 6, 2007.
5. See, for example, Catherine L. Mann, *Is the U.S. Trade Deficit Sustainable?* (Washington, DC: Institute for International Economics, September 1999), ch. 7.
6. See, for example, Edwin R. Dean and Mark K. Sherwood, "Manufacturing Costs, Productivity, and Competitiveness, 1979–93, *Monthly Labor Review*, October 1994, 3–16. The theory that relative unit labor costs are a good indicator of competitiveness has been validated by empirical research. A study of 14 OECD countries over 20 years concludes that relative unit labor costs have an important effect on export market share (with an elasticity of about -0.27). See Wendy Carlin, Andrew Glyn, and John Van Reenen, "Export Market Performance of OECD Countries: An Empirical Examination of the Role of Cost Competitiveness," *The Economic Journal* 111 (January 2001): 128–62. A report by the National Association of Manufacturers quantifies the relative cost of employee benefits for the manu-

facturing industry, but does not isolate the cost of health benefits. See *The Escalating Cost Crisis: An Update on Structural Cost Pressures Facing U.S. Manufacturers* (Washington, DC: NAM, September 2006).

7. See, for example, Uwe E. Reinhardt, "Health Care Spending and American Competitiveness," *Health Affairs* 8 (Winter 1989): 5–21; Jonathan Gruber, "The Incidence of Mandated Maternity Benefits," *American Economic Review* 84 (June 1994): 622–41; and Mark V. Pauly, *Health Benefits at Work: An Economic and Political Analysis of Employment-Based Health Insurance* (Ann Arbor: University of Michigan Press, 1997).
8. Uwe Reinhardt, a prominent health economist who has concluded that health spending does not affect competitiveness, recognizes this: "To be sure, in the very short run, sudden increases in the cost of fringe benefits may act as mere add-ons to a prevailing level of compensation and be at the expense of shareholders." (Reinhardt, "Health Care Spending and American Competitiveness," 8). Therefore, the debate is over how long the short run is.
9. For an empirical analysis of the effect of "sticky" wages, see Benjamin D. Sommers, "Who Really Pays for Health Insurance? The Incidence of Employer-Provided Health Insurance with Sticky Nominal Wages," *International Journal of Health Care Finance and Economics* 5 (March 2005): 89–118.
10. Authors' calculations based on Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2007 Annual Survey*, 2007; U.S. Bureau of Labor Statistics, *Consumer Price Index 1913-2007*; U.S. Department of Commerce, Bureau of Economic Analysis, *National Income and Product Accounts*, "Table 7.1. Selected Per Capita Product and Income Series in Current and Chained Dollars, 2000–2007."
11. Lawrence H. Summers, "Some Simple Economics of Mandated Benefits," *American Economic Review* 79 (May 1989): 177–83.
12. Reinhardt hints at this constraint: "Even if every increase in the cost of employer-paid health care benefits could immediately be financed by the firm with commensurate reductions in the cash compensation of its employees…it would leave employees worse off unless the added health spending bestowed upon employees is valued at least as highly as the cash wages they would forgo to finance these benefits." (Reinhardt, "Health Care Spending and American Competitiveness," 20).
13. Carl J. Schramm, "Living on the Short Side of the Long Run," *Health Affairs* 9 (Spring 1990): 162–65.
14. Authors' calculations based on data of selected industries from Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (2004).
15. Kaiser Family Foundation, *Employer Health Benefits*.
16. The most careful review of the econometric literature concluded that the best evidence suggests that health insurance costs are born by workers as a group, on average, in the long run. Jonathan Gruber, "Health insurance and the labor market," in *Handbook of Health Economics*, *vol. 1A*, ed. A.J. Culyer and J.P. Newhouse (New York, NY: Elsevier Science, 2000), Part 3. Economic theory is agnostic about how long the long run requires to appear. Our basic point is that CEOs competing in global markets do not have time to wait for theory to play out. Their bottom lines are being affected today, as are jobs and prospects for higher-wage economic growth in the future.
17. Ibid. A "worker-only" plan is an individual worker PPO plan rather than a plan that provides family or dependent coverage.
18. Centers for Medicare and Medicaid Services, *Sponsors of Health Care Costs*.
19. Lisa Clemens-Cope and Bowen Garrett, "Changes in Employer-Sponsored Health Insurance Sponsorship, Eligibility, and Participation: 2001 to 2005," Kaiser Commission on Medicaid and the Uninsured Issue Paper, December 2006.
20. Heidi Whitmore, Sara R. Collins, Jon Gabel, and Jeremy Pickreign, "Employers' Views on Incremental Measures to Expand Health Coverage," *Health Affairs* 25 (November/December 2006): 1668–78; Rachel Christensen and Paul Fronstin, "Employer Attitudes and Practices Affecting Health Benefits and the Uninsured," EBRI Issue Brief No. 250, October 2002.
21. Peter R. Orszag, "Health Care and the Budget: Issues and Challenges for Reform," statement before the Committee on the Budget, United States Senate, June 21, 2007.
22. Authors' calculation based on data from the U.S. Department of Commerce, Bureau of Economic Analysis, National Income and Product Accounts Tables 7.8 and 2.2A; see also Employee Benefit Research Institute, *Finances of Employee Benefits, 1960–2003*, January 2005.
23. Authors' calculation based on data from the U.S. Department of Labor, Bureau of Labor Statistics, *Employer Costs for Employee Compensation—September 2007*, released December 11, 2007. Health benefits are employer contributions to private health insurance; payroll includes wages and salaries, paid leave, and supplemental pay.
24. An eligible worker is one who meets the qualification requirements for enrollment in the applicable health plan.
25. The calculations are as follows: 11.5% = 9.9% divided by 86.7% (the percentage of workers in offering firms); 18.3% = 9.9% divided by 54.3% (the percentage of workers enrolled). The offer and enrollment rates are from the Agency for Healthcare Research and Quality, *Medical Expenditure Panel Survey* (2004).
26. The unit health cost is calculated as employer premium contributions divided by value added (gross output minus intermediate inputs like raw materials). Because value added by industry includes value added by firms in that industry that do not offer health insurance, firms that do offer health insurance in an industry that has a lower sponsorship rate would have a unit health cost that is much higher than that industry's average.
27. U.S. Department of Labor, Bureau of Labor Statistics, International Price Program, Import/Export Price Indexes.
28. Alan S. Blinder, "Free Trade's Great, But Offshoring Rattles Me," *Washington Post*, May 6, 2007; Alan S. Blinder, "Offshoring: The Next Industrial Revolution?" *Foreign Affairs* 85 (March/April 2006): 113–28; J. Bradford Jensen and Lori G. Kletzer, "Tradable Services: Understanding the Scope and Impact of Services Outsourcing," Institute for International Economics, Working Paper No. WP 05-9, September 2005.
29. Bureau of Labor Statistics, *Employer Costs for Employee Compensation*.

30. World Health Organization, National Health Accounts (2005).
31. Authors' calculation based on data from the U.S. Department of Labor, Bureau of Labor Statistics, *Employer Costs for Employee Compensation Historical Listing (Quarterly), 2004–2006*, March 29, 2007, table 11.
32. Jeanne M. Lambrew, John D. Podesta, and Teresa L. Shaw, "Change In Challenging Times: A Plan For Extending And Improving Health Coverage," *Health Affairs*, web exclusive (March 23, 2005).
33. John Sheils and Randall Haught, "The Cost of Tax-Exempt Health Benefits in 2004," *Health Affairs*, February 25, 2004, W4-106–12.
34. Ibid.
35. The focus of this paper is financing. But in isolation, reforming the tax code—as President Bush proposes—is likely to create more problems than it solves. Large purchasing pools would be necessary to replicate the role that employers currently serve: reducing administrative costs through economies of scale, and pooling the healthy with the sick. Reform of health insurance markets would be necessary to ensure that everyone has fair access to affordable health insurance. Finally, an aggressive strategy to deliver higher quality care at lower cost would be necessary to ensure affordability and improve health outcomes. For a complete reform proposal along these lines, see Len M. Nichols, *A Sustainable Health System for All Americans*, New America Foundation, July 2007.
36. Orszag, "Health Care and the Budget."
37. If employers did not increase wages, they might have more taxable income. But because the average corporate income tax rate is much lower than the average individual income tax rate, revenue from eliminating the tax exclusion would be much lower.
38. The amount of the raise could be equal to employer premium contributions in the previous year, adjusted for inflation.
39. S.334 and H.R. 3163.
40. The amount of the raise could be equal to prorated employer premium contributions in the previous year, adjusted for inflation.

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