2014

Employer-Based Health Care Insurance: Not So Exceptional After All

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I. INTRODUCTION

For some time, it has been common for policy experts to criticize the U.S. health care system's reliance on employer-sponsored insurance.[1] For individuals, access to health care coverage before enactment of the Affordable Care Act (ACA) often depended on employment with companies that provided good benefits.[2] For companies, the connection between employment and health care coverage is thought to impose a competitive disadvantage with overseas counterparts,[3] who do not have to provide health care coverage as an employee benefit—in other developed countries, people receive their health coverage through a national health care system. As health care costs have jumped, they have increased a company's overall costs to the extent that, according to one colorful characterization, GM became "a health insurance provider that also happens to make cars."[4] Hence, during the debate over health care reform, many experts argued that individuals would have a more secure source of coverage, and businesses would sell more of their goods and services,[5] if the United States abandoned employer-based coverage.[6]

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1. *See, e.g.*, Uwe E. Reinhardt, *Employer-Based Health Insurance: A Balance Sheet*, 18 HEALTH AFF. 124, 127–29 (1999) (discussing a number of problems with employer-sponsored coverage, including access, equity, and choice).

2. Kathryn L. Moore, *The Future of Employment-Based Health Insurance After the Patient Protection and Affordable Care Act*, 89 NEB. L. REV. 885, 895–96 (2011). For many low-income persons, that dependence still may be the case until their states choose to participate in ACA's Medicaid expansion.

3. Toni Johnson, *Healthcare Costs and U.S. Competitiveness*, COUNCIL ON FOREIGN REL. (Mar. 26, 2012), http://www.cfr.org/competitiveness/healthcare-costs-us-competitiveness/p13325.

4. Jeff Jacoby, Op-Ed., *GM's Healthcare Dilemma*, BOS. GLOBE, June 16, 2005, at A19.

5. There are other disadvantages to employer-sponsored coverage. For example, employers may not offer many health plan options to their employees, or they may favor plan features that serve the majority of their workforce well but are not desired by a substantial minority of their employees. David A. Hyman & Mark Hall, *Two Cheers for Employment-*

II. THE NOT-SO-EXCEPTIONAL UNITED STATES

But the problems with employer-based coverage have been overstated and misfocused. While the United States may be unusual in its reliance on employer-sponsored insurance, U.S. employers are not exceptional in terms of their role in financing health care spending. Employers in France, Japan, and the Netherlands, for example, also shoulder a high percentage of their countries' health care costs. In France, employer payroll taxes account for more than half of the national health insurance system's financing,[7] and large Japanese employers pay more than half of the premiums for their employees' health care policies.[8] In the Netherlands, employers cover half the costs of coverage under the national health insurance plan.[9] Moreover, American businesses likely would not see a decrease in their share of health care spending even if the United States overcame political obstacles and adopted a government-operated, single-payer system. Instead of contributing to the cost of their employees' private health care coverage, employers would have to contribute to the cost of the payroll or other tax that would fund single-payer care. There is less benefit than meets the eye for employers from an elimination of employer-sponsored coverage.[10]

Based Health Insurance, 2 YALE J. HEALTH POL'Y L. & ETHICS 23, 26–27 (2001). That said, many individuals face limited options when they purchase their health insurance policies directly from insurers, and these concerns are less significant than the concerns about access and costs.

6. Reformers have discussed a number of alternatives to employer-sponsored coverage. For example, the United States could switch to a "Medicare-for-all," single-payer system, in which everyone would enroll in a government-sponsored system patterned after Medicare for people age 65 or older. The Physicians' Working Group for Single-Payer National Health Insurance, *Proposal of the Physicians' Working Group for Single-Payer National Health Insurance*, 290 JAMA 798, 799 (2003). Or the government might provide a voucher to everyone to purchase coverage from private insurers on government-regulated health insurance exchanges. Committee for Economic Development, QUALITY, AFFORDABLE HEALTH CARE FOR ALL: MOVING BEYOND THE EMPLOYER-BASED HEALTH-INSURANCE SYSTEM 5–6, 43–46 (2007), *available at* http://www.ced.org/reports/single/quality-affordable-health-care-for-all-moving-beyond-the-employer-base.

7. Victor G. Rodwin, *The Health Care System Under French National Health Insurance: Lessons for Health Reform in the United States*, 93 AM. J. PUB. HEALTH 31, 34 (2003).

8. T.R. REID, THE HEALING OF AMERICA: A GLOBAL QUEST FOR BETTER, CHEAPER, AND FAIRER HEALTH CARE 86–87 (2009); JOHN CREIGHTON CAMPBELL & NAOKI IKEGAMI, THE ART OF BALANCE IN HEALTH POLICY: MAINTAINING JAPAN'S LOW-COST EGALITARIAN SYSTEM 14–16 (1998). For small companies, the government pays about fourteen percent of the cost of health care insurance premiums, with employers and employees splitting the remainder of premiums equally. REID, *supra*, at 87; CAMPBELL & IKEGAMI, *supra*, at 16.

9. Wynand P.M.M. van de Ven & Frederik T. Schut, *Universal Mandatory Health Insurance in the Netherlands: A Model for the United States?*, 27 HEALTH AFF. 771, 774 (2008).

10. There appears to be a trend toward employers switching from providing health insurance coverage to providing a stipend with which an employee can purchase health care

Indeed, it is not even clear that employers have borne any real responsibility for their employees' health-care costs. In fact, it is the worker who pays for health care benefits through a diminished wage. Businesses offer a package of compensation that includes wages, pension, health care, and other benefits. If the costs of health care coverage increase, then other components of an employee's compensation package will not increase very much.[11] Thus, as health insurance premiums have jumped in the past few decades, employee wages have been largely stagnant. But corporate profits per employee have increased substantially, reaching a post-World War II record as a share of the country's gross domestic product.[12] Health care costs have come out of employee pay rather than employer profit.[13]

International comparisons reflect the trade-off between wages and health care benefits. U.S. manufacturing firms pay a higher percentage of compensation in health care benefits than do manufacturers in Canada, Germany, and the U.K., but wages plus health care benefits in the United States are similar to those in Canada and the U.K. and lower than those in Germany.[14]

The adoption of ACA diminishes even further the incentives to discard employer-sponsored coverage. Experts rightly criticized the effect of em-

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coverage, and some analysts expect this trend to become widespread. S&P Capital IQ Global Markets Intelligence, *The Affordable Care Act Could Shift Health Care Benefit Responsibility away from Employers, Potentially Saving S&P 500 Companies $700 Billion*, 8–10 (Apr. 29 2014), *available at* http://images.politico.com/global/2014/04/30/health_care_4-29_3.html. This trend is similar to the change that already has occurred with pension benefits. Instead of employers promising a pension to their employees upon retirement ("defined benefit" plans), employers make annual contributions to their employees' retirement accounts during the employees' working years ("defined contribution" plans). Stewart E. Sterk & Melanie B. Leslie, *Accidental Inheritance: Retirement Accounts and the Hidden Law of Succession*, 89 N.Y.U. L. REV. 165, 170–75 (2014).

11. Sherry A. Glied & Phyllis C. Borzi, *The Current State of Employment-Based Health Coverage*, 32 J.L. MED. & ETHICS 404, 406 (2004).

12. Michael D. Shear & Steven Greenhouse, *Obama Will Seek Broad Expansion of Overtime Pay*, N.Y. TIMES, March 12, 2014, at A1. For a graph of corporate profits over time, see *Corporate Profits After Tax (without IVA and CCAdj)/Gross Domestic Product*, FRED ECON. DATA, http://research.stlouisfed.org/fred2/graph/?g=cSh (last visited Jun 20, 2014).

13. Ezekiel J. Emanuel & Victor R. Fuchs, *Who Really Pays for Health Care? The Myth of "Shared Responsibility,"* 299 JAMA 1057, 1057–58 (2008).

14. Len M. Nichols & Sarah Axeen, *New America Foundation, Employer Health Costs in a Global Economy: A Competitive Disadvantage for U.S. Firms*, NEW AM. FOUND., at 10 (2008), http://www.newamerica.net/files/nafmigration/EMPLOYER_HEALTH_COSTS_IN_A_GLOBAL_ECONOMY.pdf. Some U.S. employers may be disadvantaged compared to their foreign competitors if they pay health care costs for their retirees and their ratio of working employees to retired employees is not very high. Malcolm Gladwell, *The Risk Pool: What's Behind Ireland's Economic Miracle—and G.M.'s Financial Crisis?*, THE NEW YORKER, August 28, 2006, at 30, *available at* http://www.newyorker.com/archive/2006/08/28/060828fa_fact.

ployer-sponsored coverage on workplace mobility.[15] Employees who wanted to start their own businesses may have been deterred from doing so by the prospect of having to purchase their own health care coverage, especially if they had a preexisting medical condition. This "job lock" put a drag on economic productivity. But the job lock problem largely disappears under ACA. Now, the entrepreneur will be assured of access to federal subsidies for the purchase of affordable, community-rated insurance.[16]

As the job lock problem illustrates for access to coverage, what really mattered about employer-sponsored coverage in the United States was the porous safety net for people who did not have access to good insurance from their employers.[17] With ACA greatly strengthening the safety net with its Medicaid expansion and exchange subsidies, individuals become far less dependent on their employment status for their health care insurance. Indeed, the Congressional Budget Office recently estimated that over the next 10 years, ACA will lead 2.5 million Americans to stop working at their jobs. These individuals had maintained their employment because prior to ACA, they had to, in order to earn health care benefits.[18]

If there is an argument for abandoning employer-based coverage, it lies in concerns about cost containment. U.S. employers may not bear a disproportionate share of health care costs compared to their overseas counterparts, but their total employment costs may be driven up because health care spending is so high in the United States. The higher the costs of health care, the more employees will demand in compensation. If total spending can be reduced, the costs for health care coverage would decline, and employers could reduce their compensation without a detrimental impact on the standard of living of their employees.

Does having a system of employer-sponsored coverage make it more difficult to contain health care costs? The answer depends on why health care costs are higher. As discussed in the next section, observers have cited a number of reasons that might explain why health care spending is so much

15. Reinhardt, *supra* note 1, at 127.

16. Shaila Dewan, *Unfettered Capitalism?*, N.Y. TIMES, Feb. 23, 2014, at MM20.

17. That also was true in France in the 1980s because of low public subsidies. Subsequent financing reforms have addressed the problem there. Simone Sandier et al., *Health Care Systems in Transition: France*, EUR. OBSERVATORY ON HEALTH SYS. & POL'Y, at 8–10 (2004), http://www.euro.who.int/__data/assets/pdf_file/0009/80694/E83126.pdf.

18. Annie Lowrey & Jonathan Weisman, *Health Care Law Projected to Cut the Labor Force*, N.Y. TIMES, Feb. 5, 2014, *available at* http://www.nytimes.com/2014/02/05/us/politics/budget-office-revises-estimates-of-health-care-enrollment.html. The 2.5 million estimate refers to full-time equivalents. Hence, with part-time workers included, the number of people who withdraw from the workforce will come to more than 2.5 million. The Congressional Budget Office (CBO) is available at *Labor Market Effects of the Affordable Care Act: Updated Estimates*, CONG. BUDGET OFF., at 127 (2014), http://www.cbo.gov/sites/default/files/cbofiles/attachments/45010-breakout-AppendixC.pdf.

higher in the United States than in other countries. While some commonly-cited explanations are more persuasive than others,[19] the cost problem is not a consequence simply of having employer-sponsored health coverage. Even if individuals were to purchase their policies directly from insurers or receive their coverage from the government, concerns about costs would exist. What is more important is that governments in other countries play a much bigger role than does the U.S. government in limiting health care spending. In other words, the role the government plays in regulating health care prices—whether paid by private or public insurers—is much more important for cost containment than whether employers play a major role in the health care system.

III. HIGH COSTS OF U.S. HEALTH CARE

A. Do Higher Costs Reflect Poorer Health for Americans?

It is often thought that U.S. health care costs are higher because Americans are not as healthy as their overseas counterparts. Americans smoke too much, drink too much, and eat too much.[20] If people would eschew tobacco and adhere to a Mediterranean diet,[21] they would be much healthier and not need as much health care.

While it is true that many Americans should make healthier choices about their lifestyles, that does not explain the higher level of health care spending in the United States. In fact, Americans smoke less and drink less alcohol than residents of other countries.[22] And while Americans are more likely to suffer from obesity, it is difficult to explain higher U.S. health care

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19. For example, higher labor costs in the United States are important. *See* discussion *infra* Part III(D). On the other hand, we cannot attribute the higher U.S. spending to poorer health metrics, such as smoking or alcohol use. See, *infra* note 23.

20. The quality of calories eaten may be much more important than the quantity of calories consumed. *See* David S. Ludwig & Mark I. Friedman, *Increasing Adiposity: Consequence or Cause of Overeating?*, 311 JAMA 2167 (2014), *available at* http://jama.jamanetwork.com/article.aspx?articleid=1871695. Obesity may result in large part from diets high in processed carbohydrates, such as chips, crackers, cakes, soft drinks, sugary breakfast cereals, and white bread. David S. Ludwig & Mark I. Friedman, *Always Hungry? Here's Why*, N.Y. TIMES, May 18, 2014, at SR1, *available at* http://www.nytimes.com/2014/05/18/opinion/sunday/always-hungry-heres-why.html.

21. Ramón Estruch et al., *Primary Prevention of Cardiovascular Disease with a Mediterranean Diet*, 368 NEW ENG. J. MED. 1279, 1288–89 (2013) (finding that a diet with an emphasis on olive oil, fruit, nuts, vegetables, whole-grain cereals, and fish and poultry and a low consumption of red meat, processed meats, and sweets reduced the risk of heart attacks, strokes, and deaths from cardiovascular disease).

22. Chris L. Peterson & Rachel Burton, *U.S. Health Care Spending: Comparison with Other OECD Countries*, CORNELL U. ILR SCH., at 32 (2007), http://digitalcommons.ilr.cornell.edu/cgi/viewcontent.cgi?article=1316&context=key_workplace.

costs in terms of poorer health. Americans actually suffer less from high-cost medical conditions than people in Western European countries. According to estimates by McKinsey & Company, a global management consulting firm, the lower prevalence of these conditions may save the United States $57-70 billion a year in spending.[23]

If Americans suffer less from high-cost medical conditions, why is life expectancy lower in the United States? An important factor is the more youthful population in the United States.[24] Twenty-year-olds in Europe may be healthier than 20-year-olds in the United States, and 60-year-olds in Europe may be healthier than 60-year-olds in the United States, but 20-year-olds in the United States are healthier than 60-year-olds in Europe. The better health of younger Americans offsets the poorer health of older Americans.

B. Do Higher Costs Reflect Patients Who Are Not Cost-Conscious?

Many observers cite the fact that patients in the United States are not very cost-conscious when they decide whether to seek health care services.[25] Because health care insurance covers most of the costs of medical treatment, people are too quick to go to the doctor. Rather than nursing a cold at home, people might visit their physicians' offices. And this is not surprising. If the costs of medical care are $100, and the care yields a "value" of only $50,[26] it should not be provided. But when patients pay only part of the cost, then much care that is not worth its overall costs will seem worthwhile to the patient. For example, if the patient only pays $25 of the $100 cost for the $50 value, it will be worth it to the patient.[27]

Health care insurance not only leads people to seek health care that should not be sought. It also discourages people from considering price

23. Diana Farrell et al., *Accounting for the Cost of US Health Care: A New Look at Why Americans Spend More*, MCKINSEY GLOBAL INST., at 23–24 (Dec. 2008), *available at* http://www.mckinsey.com/insights/health_systems_and_services/accounting_for_the_cost_of_us_health_care.

24. *Id.* at 24.

25. *See, e.g.*, Richard L. Kaplan, *Who's Afraid of Personal Responsibility? Health Savings Accounts and the Future of American Health Care*, 36 MCGEORGE L. REV. 535, 547–48 (2005) (observing that insurance leaves many individuals with "no incentive to economize on health care expenditures").

26. Of course, it is difficult to put a monetary value on the benefits of health care. However, such valuations are implicitly made for purchases all the time. When I decide whether to spend $500 or $700 for a refrigerator, I need to decide whether the extra $200 will provide me more or less than $200 worth of benefit. (I also need to decide whether the extra $200 will provide more or less benefit if spent on other products or saved for use at a later date.)

27. Russell Korobkin, *Comparative Effectiveness Research as Choice Architecture: The Behavioral Law and Economics Solution to the Health Care Cost Crisis*, 112 MICH. L. REV. 523, 529 (2014).

when choosing among different physicians to provide health care that should be sought. If insurance covers the costs of elective surgery, then patients will have little reason to care whether their surgeons charge more or less than other surgeons.

Undoubtedly, health care insurance dulls the cost sensitivity of Americans, but citizens of other countries also carry health care coverage.[28] Their sensitivity to costs also is reduced. To blame health care insurance for higher U.S. health care costs, it would have to be true that health care coverage picks up a higher percentage of health care costs in the United States than in other countries. To some extent, that is the case. While Americans pay more total dollars out of pocket for their health care through deductible and co-payments,[29] they generally pay a smaller percentage of their health care costs out of pocket.[30] For example, Canadians, Japanese and the Swiss all pay a higher percentage of the costs of their health care.[31]

Nevertheless, for a number of reasons, focusing on the cost-sensitivity of patients is not the answer to high health care spending. First, there are real problems with reforms that would make patients more sensitive to the costs of care. Many observers suggest insurance policies, such as health savings accounts, that give patients more "skin in the game."[32] By requiring patients to pay higher deductibles or co-payments, people will hesitate before seeking care whose benefits do not justify its costs. Making patients more sensitive to costs will reduce their demand for health care. However, laypeople do not always distinguish between necessary and unnecessary care. Hence, imposing higher deductibles and co-payments leads to a reduction in demand across the board, not just with respect to unnecessary care.[33]

Second, making patients sensitive to costs where it really matters would undermine the whole purpose of health care insurance. People buy health care coverage so they will be protected from very high health care costs that would be unaffordable. Even when patients face high deductibles

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28. For a useful comparison of different health care systems, see REID, *supra* note 8.

29. David A. Squires, *The U.S. Health System in Perspective: A Comparison of Twelve Industrialized Nations*, THE COMMONWEALTH FUND, at 2 (July 2011) (reporting higher out-of-pocket expenses in the United States than in other countries, except for Switzerland), http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2011/Jul/1532_Squires_US_hlt_sys_comparison_12_nations_intl_brief_v2.pdf.

30. Peterson & Burton, *supra* note 22, at 34–35.

31. *Cost Sharing for Health Care: France, Germany, and Switzerland*, KAISER FAM. FOUND., at 5 (January 2009), http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7852.pdf.

32. Timothy Stoltzfus Jost, *Access to Health Care: Is Self-Help the Answer*, 29 J. LEGAL MED. 23, 34 (2008) (discussing the growth in advocacy for health savings accounts).

33. Melinda Beeuwkes Buntin et al., *Consumer Directed Health Care: Early Evidence About Effects on Cost and Quality*, HEALTH AFF., Oct. 2006, at w516, w523–25, *available at* http://www.amcp.org/WorkArea/DownloadAsset.aspx?id=10983.

and co-payments, their total out-of-pocket costs are capped to protect them from financial ruin.[34] These cost caps limit patient sensitivity to price disparities among physicians and hospitals for high-cost services. Patients needing heart surgery or cancer chemotherapy will blow past their out-of-pocket caps whether they go to the $50,000 hospital or the $100,000 hospital. As a result, it is difficult for greater cost-sharing to create sufficient patient sensitivity to health care costs.[35]

Finally, even if focusing on patient sensitivity to costs were the answer to the health care cost problem in the United States, patient insensitivity to costs is not a phenomenon of employer-sponsored coverage. Whether people sign up for coverage at the workplace, the marketplace, or with government, health insurers have to make the same decisions about the extent to which they want their customers to share the costs of health care.

C. Do Higher Costs Reflect Physicians and Hospitals that Are Not Cost-Conscious?

In addition to patient insensitivity to costs, observers also cite physician and hospital insensitivity to costs.[36] Under the predominant system of fee-for-service reimbursement, physicians and hospitals are paid primarily on the basis of the quantity of care that they deliver.[37] The more heart or spine operations performed, the greater the earnings of surgeons and hospitals. Hence, doctors and hospitals face powerful incentives to overprescribe, and there is important evidence that they do so. One study examined what happened when a chain of outpatient clinics switched from pure salary to an incentive-based system of compensation.[38] Under the incentive system, phy-

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34. Affordable Care Act, Pub. L. No. 111-148, Title I, § 1302(c) (2010) (codified at 42 U.S.C.A. § 18022(c) (2014)).

35. There are more nuanced ways to make patients cost conscious, including "reference pricing," in which insurers will reimburse in full only for low-cost providers (after the patient meets any deductible or co-payment requirements). If a patient chooses a high-cost provider, then the patient will be responsible for the difference in fees between the low-cost and high-cost providers. But data suggests that the potential impact of reference pricing is limited. Chapin White & Megan Eguchi, *Reference Pricing: A Small Piece of the Health Care Price and Quality Puzzle*, NAT'L INST. FOR HEALTH CARE REFORM RES. BRIEF, NO. 18 (Oct. 2014), *available at* http://www.nihcr.org/Reference-Pricing2. *See also* Harald Schmidt & Ezekiel J. Emanuel, *Lowering Medical Costs Through the Sharing of Savings by Physicians and Patients: Inclusive Shared Savings*, JAMA INTERNAL MEDICINE (Oct. 20, 2014) (proposing a model of shared savings to encourage the selection of lower-cost providers), *available at* http://archinte.jamanetwork.com/article.aspx?articleid=1916913.

36. *See* David Orentlicher, *Cost Containment and the Patient Protection and Affordable Care Act*, 6 FLA. INT'L U. L. REV. 67, 71–72 (2010).

37. *Id.*

38. David Hemenway et al., *Physicians Responses to Financial Incentives: Evidence from a For-Profit Ambulatory Care Center*, 322 NEW ENG. J. MED. 1059 (1990).

sicians would earn either a fixed wage per hour or a commission on fees generated, whichever was higher.[39] After the switch, physicians scheduled more frequent appointments for their patients and ordered more blood tests and x-rays.[40] Other researchers have found similar results. In a review of studies that had compared different methods of compensation, researchers found that fee-for-service physicians tended to schedule more patient visits and perform more elective procedures.[41] Other studies have found that when physicians perform expensive diagnostic procedures themselves (e.g., MRIs or cardiac stress testing) rather than referring their patients elsewhere for the testing, patients are much more likely to undergo the testing.[42]

While fee-for-service reimbursement promotes higher health care costs,[43] its use alone cannot explain differences in spending between the United States and other countries. Fee-for-service compensation is common around the world, including in countries such as Germany and Japan,[44] where health care spending is much lower than in the United States.

Indeed, health care spending in the United States is not higher than in other countries because of how often American doctors see their patients in the office or treat them in the hospital. Data do not suggest that the United States spends more simply because Americans receive more health care services.[45] To be sure, the volume of health care services plays a partial role. While residents of other countries, such as Australia, Belgium, and the UK are more likely than Americans to visit the doctor or be admitted to the hospital,[46] Americans often rank at or near the top in terms of the frequency with which expensive procedures, such as coronary artery bypass surgeries, are performed.[47] Reducing the provision of unnecessary high-cost treatments is an important strategy to contain health care costs. But more important than the amount of services Americans receive are the prices that are charged for those services. Americans spend more on health care than do

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39. *Id.* at 1060.

40. *Id.*

41. Carine Chaix-Couturier et al., *Effects of Financial Incentives on Medical Practice: Results from a Systematic Review of the Literature and Methodological Issues*, 12 INT'L J. FOR QUALITY IN HEALTH CARE 133, 137 (2000).

42. *See* Christopher Robertson et al., *Effect of Financial Relationships on the Behaviors of Health Care Professionals: A Review of the Evidence*, 40 J.L. MED. & ETHICS 452, 454 (2012).

43. *See id.* at 456.

44. *See* Jonathan Oberlander & Joseph White, *Systemwide Cost Control — The Missing Link in Health Care Reform*, 361 NEW ENG. J. MED. 1131, 1132 (2009).

45. Peterson & Burton, *supra* note 22, at 5, 11, 16; Gerard F. Anderson et al., *It's the Prices, Stupid: Why the United States Is So Different from Other Countries*, 22 HEALTH AFF. 89, 100–01 (2003).

46. Peterson & Burton, *supra* note 22, at 6, 7.

47. Peterson & Burton, *supra* note 22, at 12–16.

patients in other countries primarily because prices for health care services are higher in the United States.[48] Coronary artery bypass surgery and hip replacements, for example, are twice as expensive in the United States as in Canada.[49] Patients might spend ten times the amount in the United States for MRI scanning than in Japan.[50] The cost per service is much more important than the volume of services in explaining differences in health care spending between the United States and other countries.[51]

D. The Problem of Higher Prices in the United States

Why do Americans pay higher prices for the same health care services than citizens of other countries? In part, we can explain higher health costs in the United States on account of two factors: Medicine is a labor-intensive good, and health care labor is more expensive in the United States than in other countries.[52] As long as health care workers earn higher salaries in the United States than in other countries, health care costs will be higher in the United States. While costs decline in other industries as machines replace workers, it is much more difficult to substitute machines for physicians, nurses, or other health care providers.

To some extent, patients can take advantage of lower labor costs overseas by obtaining their health care in other countries ("medical tourism"[53]), but it is much easier to turn to foreign manufacturers for cars or electronics than to foreign physicians for health care. Indeed, there are serious limits to the ability to substitute foreign health care for domestic health care.[54] In an emergency, people need to seek their health care close by, and they also need a primary care physician whose office is conveniently located.[55]

There are some ways to address the contribution of high labor costs to high health care costs. For example, the United States could rely more on

48. Anderson et al., *supra* note 45, at 100–02; Peterson & Burton, *supra* note 22, at 16.

49. Peterson & Burton, *supra* note 22, at 22. Price differentials are even greater between the United States and countries like India and Thailand, spurring the growth of "medical tourism." *See* I. Glenn Cohen, *Protecting Patients with Passports: Medical Tourism and the Patient-Protective Argument*, 95 IOWA L. REV. 1467, 1471–73 (2010).

50. REID, *supra* note 8, at 92–93.

51. Anderson et al., *supra* note 45, at 90, 101, 103; Peterson & Burton, *supra* note 22, at 17.

52. Kaz Miyagiwa & Paul Rubin, *Why Is Medical Care Expensive in the U.S.?*, 4 THEORETICAL ECON. LETTERS 68 (2014); Peterson & Burton, *supra* note 22, at 17.

53. Cohen, *supra* note 49, at 1471–75; Nathan Cortez, *Embracing the New Geography of Health Care: A Novel Way to Cover Those Left Out of Health Reform*, 84 S. CAL. L. REV. 859, 862–63 (2011).

54. Cortez, *supra* note 53, at 887–89.

55. *See* Anderson et al., *supra* note 45, at 101–02.

nurse practitioners or physician assistants and less on physicians to deliver health care.

But whatever the role of labor costs in driving up health care costs, the higher cost of labor in the United States is not the result of a system that relies on employer-sponsored health care. Whether insurers sell their policies directly to the public or through employers, they face the same landscape of health care labor costs.

Indeed, as a general matter, the price differentials between the United States and other countries do not reflect the fact that Americans obtain their health insurance through their employers rather than purchasing it directly from insurers. Much of the price differential reflects the fact that the United States relies heavily on a private health care system rather than on a government-operated health care system. In a national health care system, the government can bargain more effectively with doctors, hospitals, and pharmaceutical companies than can the private U.S. insurance companies. A single purchaser has much more leverage than do multiple purchasers that are competing with each other for contracts with doctors and hospitals.[56]

If the greater negotiating leverage of government is a key factor in driving health care costs down in other countries, then it is not so important whether the United States has employer-sponsored coverage or not. Even if families obtained their coverage directly from insurers, the negotiating problem still would exist. In other words, the important question is not whether individuals purchase their coverage directly from private insurers or indirectly through their employers but whether health care prices are set by government or private insurers.

How, then, can the U.S. health care system realize the negotiating leverage that health systems in other countries enjoy? Of course, changing to a single-payer, "Medicare-for-all" system would be one path, but the debates over health care reform in this country, including the debates that yielded the Affordable Care Act, demonstrate the infeasibility of that approach. Alternatively, even if political realities prevent single-payer health care in the United States, single-payer leverage can be accomplished in a private insurance system through "all-payer regulation."[57] In all-payer negotiation, all insurers would collectively negotiate a single reimbursement regime for

56. Anderson et al., *supra* note 45, at 102; Oberlander & White, *supra* note 44, at 1132. There may be an additional contribution to U.S. health care costs. While purchasers of health care in other countries negotiate with a stronger hand, sellers of health care in the United States may enjoy greater negotiating leverage than their foreign counterparts. Hospital mergers in the United States have amplified the bargaining power of health care providers. Peterson & Burton, *supra* note 22, at 42. While the greater bargaining power of health care providers has driven up U.S. health care costs, it is not clear whether this factor explains differences in spending between the United States and other countries. *Id.*

57. *See* Oberlander & White, *supra* note 44, at 1132.

physicians, hospitals, and other health care providers.[58] This happens in other countries with multiple insurers, such as Germany and Japan, sometimes with the government overseeing the negotiations.[59]

It also may be possible to bring costs down by shifting from fee-for-service reimbursement to salaries for physicians, fixed budgets for hospitals, or other methods for financing health care that do not reward providers based on the quantity of care delivered. Indeed, regardless of the choice between employer-sponsored coverage and other approaches, fee-for-service reimbursement is a problem. Even in single-payer systems, fee-for-service health care exerts strong inflationary pressures that present serious challenges for government.[60] Hence, it may be the case that good financing reform would bring costs under control and eliminate the need for other strategies for cost containment. In other words, by replacing fee-for-service with other forms of reimbursement, health care costs might be contained while still maintaining employer-sponsored health care. Indeed, many proponents of the Affordable Care Act believe that the cost-containing provisions of the Act will bring health care spending under control in our system of employer-sponsored health care insurance.

IV. CONCLUSION

While critics of employer-sponsored coverage often have cited its burden on business or its coverage gaps for low-income or unemployed workers, those concerns were never serious or have been mitigated by the Affordable Care Act. The link between employment and health care has been a real problem in the past for workers who did not enjoy good health benefits or for the unemployed, but the Affordable Care Act responds to that problem with its health exchange subsidies and Medicaid expansion.

As to the concern that employer-sponsored coverage puts American businesses at a competitive disadvantage, it turns out that employers in other countries also pay a substantial share of their employees' health care costs. Moreover, the high costs of health care insurance in the United States have been borne by workers through a diminution in wages rather than by employers through a diminution in profits. Indeed, profits have risen even as health care costs have increased.

If there is a remaining concern about employer-sponsored coverage, it would be the possibility that it plays a role in health care cost inflation. But

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58. *Id.*

59. *Id.* at 1132; REID, *supra* note 8, at 90–91.

60. Mark Stabile et al., *Health Care Cost Containment Strategies Used in Four Other High-Income Countries Hold Lessons for the United States*, 32 HEALTH AFF. 643, 643 (2013) (observing that the rate of growth in health care spending was higher in Canada than in the United States between 2000 and 2010).

the reasons for America's higher health care costs lie elsewhere than in the country's reliance on employer-sponsored coverage. While steps should be taken to contain health care spending, those steps can be taken whether or not employer-sponsored coverage is retained.