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The Development of an Unequal Social Safety Net: A Case Study of the Employer-based Health Insurance (Non) System

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The U.S. social safety net exacerbates labor market inequalities rather than ameliorating them. This paper traces this theme within an important historical case study: the emergence of the employer-based health insurance system. Employers became the dominant and tax-preferred provider of health insurance in the United States without any federal legislative action. Understanding how this happened may inform current reform efforts. This case study highlights two important factors. The first is path dependency, discussed by Skocpol (1992) and Pierson (2000). They argue that the ambiguous divisions of power and a pluralistic governance framework favor incremental processes of social policy formation in the United States. The second factor is the divisions within the American workforce (Esping-Andersen, 1990). Divisions by race and sex have often led to disadvantaged workers being left out or underserved by U.S. social welfare policy.

Key words: *Social welfare history, health insurance, low-wage work, U.S. Welfare State*

Compared with those of other Western industrialized nations, the U.S. social safety net is exceptional in numerous ways. Federal, state, and local governments in the United States spend far less on social welfare per capita than do peer nations (Gilens, 1999; Rank, 2004). Social benefits are divided

into a visible welfare state and a "hidden" welfare state, which provides support primarily to the middle class through the tax code (Howard, 1997), and social welfare programs are divided into public and private benefits, relying heavily on firms to provide for their workers (Hacker, 2002). All of these factors result in the same exceptional outcome: the U.S. social safety net exacerbates labor market inequalities rather than ameliorating them. Low-wage workers are far less likely to access unemployment insurance than their high-wage counterparts (General Accounting Office, 2000); they are less likely to have health insurance (Collins, Schoen, Colasanto, & Downey, 2003); and they are far less likely to have pension coverage (Mishel, Bernstein, & Allegretto, 2005). Thus, inequalities in the labor market are matched by inequities in the social safety net.

This article traces these themes within an important historical case study—the emergence of the employer-based health insurance system in the United States during the 1940s. In one decade, without any formal legislation, employers became the dominant and tax-preferred provider of health insurance in the United States. Understanding how this system took root offers important insights for those who wish to reform it. The analyses presented here find that two important factors were critical in determining this social policy result. The first is path dependency, discussed by Skocpol (1992) and Pierson (2000). They argue that the ambiguous divisions of power between levels of government within a pluralistic governance framework have led to an incremental process of social policy formation in the U.S. The second factor is the divisions within the American workforce (Esping-Andersen, 1990). Divisions by race, class, and sex have meant that those at the bottom of the economic ladder have often been left out or underserved by the resulting safety net. The following case study draws on existing literature and offers primary historical evidence to show the role of these factors in the development of the employer-based health insurance (non) system in the United States.

Background

Rank writes, "compared to other Western industrialized counties, the United States devotes far fewer resources to

programs aimed at assisting the economically vulnerable" (Rank, 2004, p. 60). Some have referred to this as *American exceptionalism* (Ikenberry & Skocpol, 1987). A variety of theories attempt to understand American exceptionalism. Some trace ideological themes prevalent throughout U.S. social welfare history, such as a historical distaste for government and a strong belief in personal responsibility, which have jointly resulted in moral differentiations by society between the deserving and the undeserving poor (Handler & Hasenfeld, 1991; Katz, 1989, 1996). Others highlight the unique role businesses have played in the development of the safety net (Jacoby, 1997). Some contend that the structure of modern capitalism leads to recurring crises, and that the liberalization of welfare is one way that elites pacify poor workers and stabilize the capitalist system (Piven & Cloward, 1979, 1993). Still others examine differences in class and labor organization in the United States relative to other industrialized nations, suggesting that the divided character of the U.S. labor movement has kept the working class in the United States from securing universal entitlements seen in more generous welfare states (Esping-Andersen, 1990).

Hacker (2002) and Gottschalk (2000) contend that the true cause of American exceptionalism is its long-term reliance on private welfare benefits. Over the years, public and private social welfare programs have become inextricably interwoven so that any reform of one will seriously affect outcomes of the other (Hacker, 2002). Pierson (2000), Skocpol (1992), and others have developed an institutional theoretical perspective for understanding the development of the U.S. social safety net. Such a perspective contends that current public policy debates are limited by past policy decisions. The ambiguous divisions of power between federal, state, and local authorities, along with other characteristics of its governing structure, make systemic change in the United States particularly unlikely. Institutional theory does not preclude change, but rather boxes in the possibilities.

In line with this institutional perspective, the U.S. social safety net has developed slowly and incrementally over time. Most social welfare histories stress the importance of the New Deal, and without question this was a critical juncture. Less appreciated, however, is the importance of the post-World War

II era. In 1945, total government spending on social insurance programs was only $735 million. It doubled in 1946, and by 1955 grew to eight times that size (Historical Statistics on the United States, 2006, nominal dollars).

During the post-war era, many of the divisions within the safety net took shape. Perhaps most important has been the development of social insurance, which many scholars consider to be reserved for "labor force members with a reasonable history of job attachment" (Blaustein, O'Leary, & Wandner, 1997, p. 21). Throughout the history of the U.S. safety net, however, there have always been certain classes of workers with substantial labor force attachment who have been excluded from social insurance benefits based on characteristics of their employment. Agricultural and domestic workers, for example, were categorically excluded from Social Security and Unemployment Insurance for many years (Quadagno, 1988; Norton & Linder, 1996).

In this way, employment characteristics have acted as mechanisms of exclusion: criteria by which certain groups of workers have been ruled ineligible for some of the major social insurance programs in the United States. Job characteristics as mechanisms of exclusion play a particularly important role in the case study offered below. As employer-based health insurance incrementally came to dominate in U.S. health care, many workers and their families were covered quite well. Others, however, were left out, and the key mechanism of this was labor market discrimination that marginalized women and people of color.

The Emergence of Employer-Based Health Insurance

At the turn of the 20th century, only an eclectic group of fraternal organizations, employers, and private insurers offered some form of "sickness" benefits, and most Americans had no health coverage (Hacker, 2002). Employer-based health insurance only became common during the post-World War II era. It has been called an "accidental system" (Gabel, 1999, p. 62), and during the 1940s, few anticipated that it would become the dominant mode of health care coverage (Gottschalk, 2000).

President Roosevelt decided not to include a health care

program as part of the 1935 Social Security Act because of threats from the American Medical Association (AMA). The AMA had proven to be a virulent critic of such proposals in the past, and Roosevelt felt that including a health care program might jeopardize the entire bill, threatening his unemployment insurance and social security programs (Quadagno, 2005). Thus, he postponed action on health care, planning to return to it later. The refocusing of the country on World War II, however, meant that health care did not return to the top of the administration's agenda again during Roosevelt's presidency. In 1939, Senator Robert Wagner of New York proposed adding health care provisions to the existing Social Security Act. Roosevelt, however, did not back the Wagner bill, and it was never reported out of committee (Poen, 1979).

Instead of a national health program, a number of factors spurred the growth of employer-based health benefits during the 1940s. Many argue that the wage freeze imposed during World War II—which set wages at pre-war levels—led firms to offer health benefits in an effort to compete for workers. Hacker (2002), however, writes that the freeze "did not, as is often claimed, single-handedly drive up coverage during the war" (p. 218). In fact, by the end of the war (1945), still fewer than one in four Americans were covered by private insurance. The period of most dramatic growth started a few years after the war, when employer coverage exploded. By 1960, two-thirds of the population was covered by some form of private insurance, with employer-based insurance making up the greatest fraction of this.

A number of other important public policy decisions during the postwar era created clear economic incentives for employers to provide health benefits to their workers. Quadagno (2005) credits the Revenue Act of 1942, which levied an immense tax on corporate profits that rose above pre-war levels. Importantly, the act excluded from profits employer contributions toward health insurance programs and group pension plans, creating an incentive for companies to shift excess profits into benefit trust funds (Gottschalk, 2000). Once the funds were created, there existed institutional momentum to continue them. Also important was a 1943 National War Labor Board ruling that employers' contributions toward

health insurance for their workers would not count as wages and were therefore tax-deductible for employers and exempt from income and payroll taxes for workers. This provided a long-term incentive to compensate and retain employees by offering fringe benefits. These tax benefits were not extended to individually purchased insurance policies. The ruling further meant that labor unions could bargain for increased health and other fringe benefits in lieu of wage increases.

While each of these policy decisions was undoubtedly important in the growth of employer-based coverage, most recent historical accounts point to the power of influential interest groups in U.S. health policy debates over the years (Hacker, 2002; Gottschalk, 2000). Quadagno (2005) stresses the vehement and long-term opposition to nationalized health plans by doctors, headed by the American Medical Association (AMA), which feared that such a system would usurp their autonomy and power. Employers have also historically strongly opposed nationalized health care, lobbying against such reforms each time they were under serious consideration (Jacoby, 1997).

Interest group opposition stood in the face of postwar public support for a more active role by government. In the late 1940s, more than 80 percent of Americans were supportive of health care reform that would reduce the costs of care (Blendon & Benson, 2001). Thus, national health insurance reform remained regularly on the public agenda following 1943, when Senators Robert Wagner, John Dingell and Phillip Murray introduced the Wagner-Murray-Dingell bill to Congress (American Historical Association, n.d.). This legislation would have added a national health program to the Social Security Act by establishing a national medical care and hospitalization fund, to which employers and employees would each contribute 1.5 percent of the first $3,000 of their yearly wages. The self-employed could participate if they contributed the full 3 percent themselves. The fund would have paid for all doctors' care, including specialists, hospitalization up to 30 days, x-rays, and lab tests, but would not have covered dental care or prescription drugs (American Historical Association, n.d.).

The Wagner-Murray-Dingell bill was vigorously supported by organized labor, including the American Federation

of Labor (AFL) and the Congress of Industrial Organizations (CIO), but opposed by the National Physician's Committee, the AMA, and other groups of organized physicians, who denounced it as "socialized medicine" (Poen, 1979, p. 47). It was also criticized for being too centrally administered by the federal government, for not including funds for hospital construction, and for not covering citizens who were not working (American Historical Association, n.d.). Like its predecessors, the bill died in committee.

On April 12, 1945, Harry Truman was sworn into office as president after Roosevelt's sudden death. He wanted to move quickly on a national health insurance program, which he considered the missing piece of the New Deal. Responding just one month later, Wagner, Murray, and Dingell introduced the second version of their bill (American Historical Association, n.d.). It was very similar to the previous version, but the new bill also included coverage for dental and nursing care, as well as offering alternative administrative procedures to protect private medical cooperatives (Poen, 1979). Despite Truman's support, the revised bill still remained stuck in committee.

On November 19, 1945, Truman sent a special message to Congress asking for national health care legislation. He made five specific requests: (1) funds for hospital construction; (2) state grants for public health services and maternal/child health; (3) funds for medical research; (4) expansion of compulsory insurance under Social Security; and (5) cash benefits for sick and disability leave (Truman, 1945). That same month Wagner, Murray, and Dingell re-introduced the health care provisions of their previous plan as yet another bill (American Historical Association, n.d.). This bill, their third attempt, included medical insurance, home nursing, and dental care, as well as grants to states for public health work and infant and maternal health.

Organized labor was essential to advocacy efforts for a national health insurance bill during this period, as they grew in size and influence. In 1940, they represented only about 17 percent of the non-farm U.S. labor force. By 1950, they represented 29 percent of all workers and 40 percent of private sector employees. In contrast, today only 7.5 percent of private industry workers belong to a union (Bureau of Labor Statistics,

2008).

In February of 1944, labor leaders, a group of liberal doctors, and Wagner, Murray, and Dingell, among others, formed a group that would later become known as the Committee for the Nation's Health. This advocacy entity served as a crucial meeting place for organized labor and other allies to coordinate lobbying in support of national health insurance (Poen, 1979). Many labor leaders testified in support of the Wagner-Murray-Dingell bill that spring in hearings before the Senate Committee on Education and Labor. In fact, analyses of the committee transcripts find that 16 individuals representing unions testified in front of the committee in 1946, and these representatives were overwhelmingly in favor of the bill. In comparison, that same year 15 individuals testified representing medical societies (although more than 50 individuals related to the medical profession testified).

William Green, president of the AFL, argued that "though in our opinion the need is for the immediate adoption of an inclusive and comprehensive program, we support this proposal to provide for a national health program because it represents to us a worthy step in the right direction" (National Health Program Part 1, 1946). Solomon Barkind, research director for the Textile Workers of America, made clear that he viewed private insurance only as a stop-gap measure and that his union "favored the introduction of these systems pending establishment of an adequate health insurance program" (National Health Program Part V, 1946). James Carey, secretary treasurer of the CIO, echoed this sentiment saying, "We believe in a Federal System because under it our members and all working people can obtain for themselves and their families complete medical and hospital care." He further argued that "coverage under the voluntary plans is today quite inadequate" (National Health Program Part 2, 1946).

Despite active support by unions and other advocates, like its predecessors, the bill continued to be held up in committee and remained there until the Republicans seized the Congressional majority in November of 1946. This was the first time the GOP had controlled both Houses since 1928. The election was widely considered a referendum on an unpopular president, and it seriously dampened the prospects of serious

movement of his policy agenda, including health coverage reform.

Despite showing strong support for a government health coverage program in 1946, other factors pushed most unions to become bureaucratic entities focused on worker benefits (Root, 1982; Zinn, 1999; Gottschalk, 2000). In June of 1947, the Taft-Hartley Act (formally the Labor-Management Relations Act) passed. This act greatly restricted the powers of organized labor. Among other provisions, it prohibited secondary boycotts and wildcat strikes, allowed states to prohibit closed union shops, and raised doubts about whether fringe benefits were subject to collective bargaining. A 1948 National Labor Relations Board ruling affirmed that fringe benefits were subject to collective bargaining, and this judgment was codified in a Supreme Court ruling that same year. Thus, Quadagno writes, "fringe benefits became organized labor's key strategy for recruiting and retaining workers" (2005, p. 52). As a result, instead of advocating for universal government social insurance, the energies of most labor unions were redirected toward aggressive advocacy of fringe benefits for members. Between 1946 and 1957 the number of workers covered by health insurance plans dramatically increased from 1 million to 12 million (Quadagno, 2005).

This change in emphasis remained a source of division within organized labor. Reuther of the United Auto Workers (UAW) hoped to eventually push employers to support universal government policies by substantially raising fringe benefit costs (Gottschalk, 2000). Whatever the reason for this strategic change, a result was that national health insurance legislation did not receive the same kind of support from organized labor later in the decade that it enjoyed in 1946.

In May of 1947, Truman once again sent a special message to Congress requesting that a national health insurance program be enacted (Social Security Online, n.d.). Later that month, Wagner, Murray, and Dingell introduced a fourth version of their bill, with some concessions based on earlier criticisms. That summer, hearings were held on the latest Wagner-Murray-Dingell bill, but once again it did not come up for a vote (Social Security Online, n.d.). Truman further appointed Oscar Ewing to head the Federal Security Agency (FSA) as

a way to demonstrate continued commitment to health care reform (Quadagno, 2005). In early 1948, Ewing established the National Health Assembly, a group of civic, business, and labor leaders. This body agreed that equal access to health insurance should be guaranteed regardless of race but did not collectively advocate for a national health insurance program to meet this goal (Quadagno, 2005). Simultaneously, the AMA launched a "National Education Campaign against National Health Insurance Proposals" (Social Security Online, n.d.).

In September of 1948, Ewing released *The Nation's Health: A Report to the President*, which shed light on the vast numbers of U.S. citizens who were uninsured and in poor health. The report called for national health insurance. House Republicans immediately moved to discredit the report and Ewing (Quadagno, 2005). They publically investigated AFL- and CIO-run lobbying workshops facilitated under the auspices of the FSA in an attempt to bolster charges that the FSA was using federal funds to spread false information about national health insurance (Quadagno, 2005).

Through all this, most Americans remained supportive of government-led health care reform that would reduce medical costs, even as they became less supportive of a national health insurance plan (Poen, 1979). Truman unexpectedly won reelection in November of 1948, and the Democrats regained control of Congress. Truman, who had campaigned on national health insurance, quickly encouraged Congress to take action on the issue in his third special health message in April 1949. Three days later, Murray introduced an administration-sponsored health bill similar to his previous bills. It is commonly referred to as the Truman Plan. The new bill banned racial discrimination in health care but, in a concession to the South, allowed separate but equal facilities for non-white patients (Quadagno, 2005).

This time around, crucial groups that had previously been supportive lined up to oppose the bill, including the Roman Catholic Church. In 1949, only four individuals representing labor unions testified in front of the Senate Subcommittee on Labor and Public Welfare. James Carey of the CIO testified in favor, saying, "Unions are often accused wrongly of being selfish and seeking their own welfare... We advocate

a national compulsory program in part because we want everyone covered and sharing in the benefits" (National Health Program Part 1, 1949). Nelson Cruikshank of the AFL testified that "Senate bill 1679 presents a complete and comprehensive program to meet the health needs of the nation, resting on the firm foundation of the proven principle of contributory social insurance" (National Health Program Part 1, 1949). Despite these few examples, labor was far less active in support of the bill in 1949, compared to earlier in the decade. With little support and virulent opposition, the Truman Plan, like its predecessors, failed to be reported out of committee.

That same year, a number of alternative health care measures were also forwarded. The first was the Hill-Aiken bill. Partially written by the AMA, it included a government-supported plan to help pay for private insurance for those who could not afford it. Additionally, the Taft-Smith-Donnell bill (S.1581) was a means-tested program to provide federal funds for medical care for the poor. Labor unions opposed these measures because they were aimed only at the poor. Harvey Brown, president of the International Association of Machinists was "unalterably opposed to S.1581 because it rests on the un-American principle of charity medicine" (National Health Program Part 1, 1949). Carey of the CIO furthered the case, saying "any adequate health legislation must meet the needs of the middle-income group of Americans" (National Health Program Part 1, 1949). Poen (1979) contends that Hill-Aiken might have been the best chance for serious legislative action during this period, had Truman been willing to back it. However, Truman never endorsed it for fear of alienating organized labor (Poen, 1979). With the failure of the Truman Plan, the failure of these means-tested proposals, and continued growth of employer-based health insurance, the course of health care in the United States was set for years to come.

The Context: Race and Sex Employment Discrimination During the Postwar Era

As discussed above, private health insurance coverage expanded rapidly during the postwar years. These benefits, however, did not spread to all Americans—or even all

workers—evenly. Marginalized groups were particularly unlikely to be offered employer-based health insurance, mainly because they were excluded from many employment opportunities. U.S. postwar labor relations were marked by race and sex discrimination on the part of employers, unions, and consumers. Blacks and other disadvantaged people of color were excluded from many skilled jobs and relegated to menial ones. Women were excluded from whole industries and occupations, and married women were only able to enter the labor market in larger numbers after institutionalized barriers such as marriage bars (laws that required women to leave their jobs when they married) were repealed. Women were also unlikely to be union members. Thus, in a variety of ways, characteristics of employment such as industry, occupation, unionization, and job status acted as mechanisms of exclusion from economic opportunity. As the country continued down the path of employer-based health benefits as described above, this further stratified labor market and social benefit outcomes.

Blacks and Health Insurance during the Postwar Era

Because of limitations presented by available historical data, this discussion is restricted to understanding health insurance access among blacks during the postwar era. Blacks were the largest minority group in the United States during the period, and available historical research has documented the considerable employment discrimination they faced during the postwar era. During the war demobilization, blacks were typically the first to be fired from wartime industries (Rosenberg, 2003). Black men consistently had a higher unemployment rate than white men throughout the period, and those with jobs were "concentrated in lower status, lower paying jobs" that were less likely to offer benefits (Rosenberg, 2003, p. 142). Some econometric studies of postwar labor market trends have found that racial discrimination in employment receded during the period (Alexis, 1998; Smith & Welch, 1989). Reich, however, found that, after accounting for migration patterns and resulting changes in the occupational distributions, the data "suggest continuity rather than change in racial economic inequality in the period 1950-1970" (Reich, 1980, p. 131).

Unions were complicit in employment discrimination

during the postwar era. A 1946 survey by the American Civil Liberties Union (ACLU) found that roughly 30 unions at that time had official policies discriminating against blacks (Discrimination, 1947). The ACLU further found that few states had laws that adequately protected blacks and other racial minorities from discrimination by unions. Clyde Summers (1946) looked systematically at admission policies among labor unions. At least in terms of official policy, he found that industrial unions fared better, as exclusionary policies were more common in the skilled craft and railroad unions. Summers found that among the marginalized groups he examined, "Negroes are unquestionably discriminated against most severely" (p. 91).

Discrimination in the labor movement persisted throughout the postwar era. As of 1960, the Brotherhood of Railway and Steamship Clerks still maintained segregated lodges and unequal seniority rankings, and the United Brotherhood of Carpenters and Joiners continued to enforce segregated locals. Herbert Hill, labor secretary for the National Association for the Advancement of Colored People (NAACP), gave a report to the NAACP's membership in 1961 detailing racist practices within organized labor. He reported that "the national labor organization has failed to eliminate the broad pattern of racial discrimination and segregation in many important affiliated unions," and that most existing efforts were "piecemeal and inadequate" (p. 109). Hill concluded that discriminatory practices took four major forms: (1) outright exclusion; (2) segregated locals; (3) separate seniority lines; and (4) exclusion from apprenticeships. He warned that the "concentration of unskilled, low-paying jobs with a lack of employment stability together with other income limitations...all contribute to an explanation of why Negroes constitute a permanently depressed economic group" (Hill, 1961, pp. 117-118).

Period data on health insurance coverage by race are limited. Thomasson (2006) has analyzed a 1957 nationwide survey administered by the National Opinion Research Center (NORC). This survey was one of the first to collect nationally representative data on race and insurance coverage. Survey estimates suggest that 75 percent of whites had private health coverage in 1957, compared to 52 percent of blacks (Thomasson,

2006). Among the employed, the current author's analyses find that white workers were more than 20 percentage points more likely to have insurance than black workers, and differences in take-up rates do not explain this gap. Nearly all the black families who were offered group coverage chose to enroll. Thomasson concludes that much of the gap "appears to be in access to group insurance" (2006, p. 534).

As employer-based health insurance became the primary mechanism for health coverage, many blacks found themselves excluded from coverage. The decisions by major unions to focus on employer-based health benefits for members compounded the effects of discrimination. Health outcomes were similarly bifurcated. Thomasson (2006) reports that the "reduction of white infant mortality from 1947 to 1960 was twice that of black infant mortality and was concentrated in causes of death that tend to respond to antibiotics" (pp. 532-533). Certainly access to employer-based health insurance was not the only factor driving this and other differences. Medical facilities continued to be segregated. Nevertheless, health insurance access undoubtedly played a role in the postwar health disparities separating whites and blacks.

Women and Health Insurance Access during the Postwar Era

Only about 14 percent of married women worked for pay in 1940. During the postwar era, this grew rapidly so that by 1970, that proportion was 40 percent. Many factors led to this increased participation in the paid labor force. Some women demanded a wider range of employment opportunities to match rising rates of education. Macroeconomic changes further meant the jobs available to women changed compositionally. By 1970, clerical work had become the largest occupation among women (Costa, 2000). Clerical jobs were less dangerous than manufacturing jobs previously available. Part-time work went from being virtually nonexistent to fairly prominent during the 1940s and 1950s, driven by firms seeking to attract married women. During the postwar era, firms faced a declining supply of unmarried women because of increasing college enrollment, the baby boom, and other factors. In response, firms began to offer part-time jobs, hoping to appeal to married women (Costa, 2000).

Reskin writes that "sex segregation was remarkably resilient over the first 60 years of the twentieth century, despite broad economic and social transformations" (1993, p. 245). Before 1940, sex discrimination was institutionalized in the form of marriage bars. For reasons similar to those spurring the growth of part-time work, marriage bars were eliminated during the 1930s and 1940s. Even as women entered into new occupations and industries, though, they were denied opportunities for promotion (Reskin, 1993). Most female workers continued to be in jobs that were stereotypical for women (Rosenberg, 2003). Sex segregation by industry also meant that women were unlikely to be union members, making up only 17 percent of union members in 1950.

Differences in paid labor market participation between the sexes interacted with the rise of an employer-based health insurance system to create a paradigm in which women were often dependent on their husbands or other family members for coverage. As health insurance came to be treated as compensation, providing it became an extension of the role of men as breadwinners. Drawing again from the 1957 NORC survey (Anderson, Collette, & Feldman, 1958), analyses by the author suggest that about three-quarters of male-headed households reported some form of health insurance in 1957 while the same was true of just under 60 percent of female-headed families. Race appears to have been a compounding factor among female-headed families: only one in four black female-headed households reported any health insurance coverage.

Discussion

The institutional theory of Pierson (2000), Skocpol (1992), and others contends that during any time period, current public policy debates are limited and structured by past policy decisions. The ambiguous divisions of power between federal, state, and local authorities, and other characteristics of its governing structure, make systemic change in the United States particularly unlikely. Policymakers tend to modify existing policy structures incrementally instead of pursuing major reforms. Institutional theory helps in understanding the development of employer-based health insurance in the U.S.

As employer-based coverage grew rapidly during the 1940s, it became less and less probable that a government program would replace it.

This institutional legacy is evident in current health coverage policy debates. The plans currently under serious consideration would attempt to expand health coverage and limit burgeoning medical costs through a mixed private-public approach (Baucus, 2008; Whitehouse.gov, 2009). The Obama Administration's proposal works mainly through existing private insurers. It includes some critical changes, such as mandating that insurers cover pre-existing conditions. It also would open up the current public program that covers Congress to citizens as one option along with private options in a new "National Health Insurance Exchange," while leaving the current health coverage infrastructure largely intact. While many analysts agree that a public-private approach is not the most efficient way to reform the system, the lessons from this article make clear why this system is more politically viable than anything approaching a single payer plan.

Despite the current groundswell of support, the history offered above suggests that there remains some chance no reform will be successful. As they have in the past, many of the country's most powerful interest groups will participate vigorously in the current health coverage debate to defend their interests. Still, it is possible that Reuther's strategy of overloading employers with the costs of fringe benefits has finally proven successful, half a century later. Major employers in the U.S. finally appear willing and perhaps eager to consider and even support serious health reform, and this may be the factor that tips the balance.

If current efforts prove unsuccessful, this or future administrations might consider attempting to harness this new widespread support among employers through a different option: a federal employer health insurance fund. In such a plan, all U.S. firms and the self-employed would be given the opportunity to join a federal program and cover all their workers for a fraction (perhaps one-half or two-thirds) of the average current cost of health insurance for a company of their size. By creating an incentive for firms to buy into a federal program instead of requiring or mandating a change through legislation, a federal

employer health insurance fund might prove more viable than plans that either require participation from all, or plans that allow individuals to buy in. Importantly, it requires no comprehensive legislation. Congressional and executive approval to create a plan in which employers can choose to participate may prove easier to pass than current proposals. Second, it makes the current mandate debate unnecessary. By working through employers, this program takes care of the social insurance pool issue, minimizing concerns about adverse selection with a heterogeneous pool of workers. Importantly, this proposal secures employer funding for much of the program cost. Such a program could simultaneously lower most employers' costs while securing much needed revenue for the program.

Whatever plan ultimately proves successful, the most important role for social welfare advocates is to maximize coverage and quality of care for vulnerable populations. Perhaps the greatest legacy of the employer-based health insurance (non) system—and the U.S. social safety net as a whole—is the extent to which it was and remains based on exclusion rather than inclusion of workers. Many workers with reasonable job attachment have been excluded from health care coverage because they were excluded from employment or relegated to secondary jobs. Industry, work hours, occupation, unemployment and tenure have all kept workers from receiving social benefits in the United States. Further, the major existing public program ostensibly meant to serve the poor—Medicaid—is not well targeted: Less than half of all Medicaid expenditures are spent on the very poor (Grogan, 2008).

In other Western industrialized countries, those facing discrimination in the labor market have been guaranteed health insurance. In the United States, labor market discrimination has been compounded by exclusions from health care coverage and public social insurance programs. A key factor in this has been the divisions among U.S. workers. Organized labor in the United States has secured countless benefits for its members and, often by extension, for all workers in the United States. But during the post-war era, organized labor made a strategic decision to focus on employee benefits and, at the same time, joined employers and government in discriminating against people of color and women. Were the working class not divided

by race and sex, perhaps a more comprehensive result would have been possible. Certainly the 45 million uninsured and many more underinsured Americans is the greatest failure of the employer-based health insurance (non) system. Rectifying this failure through whatever policy changes are possible—be they incremental or, less likely, comprehensive—should be the top health policy priority of social welfare advocates.

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