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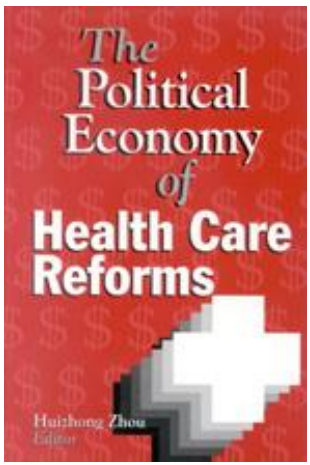

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Health Insurance and the Labor Market

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The system of health insurance and health care delivery in the United States is very much like a patchwork quilt, one pieced together from scraps of cloth of different shapes, sizes, patterns, and textures, and colors. Like the quilt, we have a patchworked array of insurance-providing institutions in the United States, each covering a different segment of the population, and each with its own idiosyncratic rules—its differences in shape, size, pattern, texture, and color, if you will.

There are

- the Medicare part A and B pieces that cover those over age 65 and the disabled under age 65;
- the Medigap pieces that provide additional coverage to the elderly, beyond that available through Medicare;
- the various state Medicaid pieces covering those who are or who have recently been on welfare, or those whose incomes are sufficiently low;
- the myriad of employment-related health insurance pieces, covering many but not all employees, along with their spouses and dependents;
- the employment-based retiree health insurance pieces, covering the former employees of companies, those who have since retired; and
- the pieces that cover students attending various universities throughout the country and elsewhere.

And then there is the backdrop, the part of the quilt that generally goes unnoticed: the uninsured individuals who are not covered by any of the

other insurance pieces and who must pay for their medical expenditures out of pocket or receive uncompensated care.

The analogy can only be taken so far, however. The patchwork quilt evokes images of warmth, love, home and hearth, hot cocoa, a crackling fire at a cabin in the woods. In contrast, the patchwork U.S. health insurance system is more likely to evoke images of frustration, hassle, red tape, paperwork, and annoying voice-automated telephone response systems. The patchwork quilt is not a perfect metaphor, but it is a good one.

There are many important economic implications associated with the fragmented, patchwork system of health insurance coverage that we have in the United States. This chapter focuses on one of these economic implications, namely, the relationship between the various institutions that provide health insurance in the United States, and the labor market decisions made by individuals and employers. More than two-thirds of the gross domestic product in the United States is derived from the labor market—the labor services of individuals employed in producing goods and services in the economy. Distortions in the efficient operation of the labor market can thus have a tremendous effect not only on the welfare of specific individuals, but on the economy as a whole.

But what is the link between health insurance and the labor market? Why is this even a concern? The link derives from the characteristics of the pieces in the patchwork quilt. Many of the insurance-providing institutions in the United States, the pieces of the patchwork quilt, have some connection, either directly or indirectly, to the employment status of individuals. The idiosyncratic relationships between the labor market and the types of health insurance coverage that are available to individuals affects the labor market behavior of both individuals and firms in some very interesting and economically important ways.

Before analyzing the labor market effects of health insurance in the United States, it is important to more closely examine the pieces of the quilt—the various health insurance institutions—and how they are tied to the labor market.

HEALTH INSURANCE INSTITUTIONS IN THE UNITED STATES

By far the most significant piece of the quilt, at least in terms of magnitude, is employer-provided health insurance coverage. This employee benefit provides health insurance to 64 percent of the non-elderly U.S. population. Some of these individuals, about half, receive this coverage by virtue of their own employment, while the rest receive it as dependents of a spouse or parent who works. In addition, some employers provide so-called "retiree" health insurance to former employees who have retired. About 45 percent of the elderly have this type of health insurance from a previous employer.

It is interesting to consider why the United States, in contrast to most other developed countries, has a health insurance system in which employers are the primary providers of insurance rather than the government, at least for the non-elderly, and also why employers are the primary providers of health insurance but not other types of insurance. The United States has repeatedly rejected broad attempts to "socialize" either medical care or health insurance provision. The first such initiative, during the 1930s, failed despite the concurrent genesis of so many other New Deal government social programs. The most recent initiative was the failed Clinton administration attempt at national health reform. And there have been other similarly doomed attempts in the interim. In the absence of universal government-provided health insurance coverage, market forces have pushed employers into their role as primary providers of insurance. These market forces include

- a substantial price advantage given to employers through the tax code because firm health insurance expenditures on behalf of their employees are not counted as taxable income to either the firm or the employees,
- economies of scale that derive from providing health insurance to a large group of individuals, and
- the effectiveness of the workplace as a pooling mechanism to overcome the problems of adverse selection that plague some individual insurance markets, especially the individual market for health insurance.

As an institution, employer-provided health was really established during the two decades following World War II, although there are some limited examples of employers providing such coverage before the war.

The second, third, and fourth pieces of the quilt are various types of government-sponsored health insurance: Medicare, Medicaid, and CHAMPUS. It is interesting that even at the governmental level, there is no single unified health insurance program. By far the largest government health insurance program is Medicare. Medicare was implemented in 1965 to provide health insurance coverage to the elderly, individuals aged 65 and over, many of whom were left uninsured or underinsured upon their retirement when coverage through their former employers ceased. Medicare also covers some individuals under age 65, specifically those who are disabled and eligible for Social Security Disability Insurance. Currently, Medicare covers over 96 percent of those over age 65, and 5 percent of those under age 65.

The third piece of the quilt, Medicaid, is a state-run program funded jointly by the state and federal governments. This program was traditionally a health insurance program for welfare recipients, primarily single mothers and their children, and also for the low-income elderly. In recent years it has been expanded to provide coverage to non-welfare-eligible families with modest incomes, particularly children. There is great heterogeneity among states in the eligibility requirements for Medicaid, and in the benefits that are actually provided—yet another example of the fragmented, patchwork nature of U.S. health insurance. Overall, 9 percent of the elderly are covered by Medicaid, as are 11 percent of the non-elderly.

The fourth governmentally provided piece of the quilt is CHAMPUS/VA, the program that provides health insurance to members of the uniformed services and their families, and to veterans. About 3 percent of the population is covered by this type of health insurance, a fraction that has been falling steadily for years as the number of those in active military service declines because of military cutbacks, and as the number of veterans declines.

The final piece of the patchwork quilt is a bit of a catchall—other private insurance. This category encompasses a broad array of institutions ranging from supplemental Medigap coverage for the elderly, to university-provided health insurance for students, to individually purchased policies from traditional insurers such as Blue Cross/Blue

Shield, to health insurance provided through membership organizations such as a credit union or a trade or professional association. Together, these various types of other private insurance cover about 7 percent of the non-elderly population, and perhaps as much as one-third of the elderly population.

Then, of course, there are the uninsured, those who do not have health insurance through their own or a family member's employment, who are not old enough or disabled enough to qualify for Medicare, who are not eligible or decline to participate in Medicaid or CHAMPUS/VA, and who either cannot afford or choose not to purchase health insurance in the private market. These 43 million individuals represent about 18 percent of the non-elderly population. Due in large part to Medicare, only a small fraction of the elderly, about 1 percent, are uninsured.

With this brief introduction to the various "pieces" of the insurance quilt, let us now turn to how this patchwork array of insurance institutions affects the labor market decisions made by individuals and firms.

HEALTH INSURANCE AND RETIREMENT

Perhaps the most important labor market outcome to consider is employment itself—how does health insurance affect individual participation in the labor market? It affects participation because certain types of health insurance are provided as a condition of employment (for example, employer-provided health insurance), while other types of health insurance are more readily available when individuals are not employed, or not fully employed (for example, Medicaid or university-sponsored student health insurance), while still others are available regardless of employment status (for example, Medicare for those over age 65).

With respect to the effects of health insurance, the most widely studied facet of labor force participation that has been examined is retirement. To what extent does health insurance determine when and how individuals choose to withdraw from the labor force? The answer lies in the interaction between three different pieces of the patchwork quilt: employer-provided health insurance for active employees,

employer-provided retiree health insurance, and Medicare. As already noted, many but not all employers provide health insurance to their employees and to their spouses and dependents. This insurance, however, is usually conditional on employment; employees who cease to work usually find that their health insurance coverage ceases as well. Some companies, however, offer retiree health insurance. About one-third of employers continue to provide health insurance to some or all of their former employees who have retired. For individuals who work at these companies and who are eligible for retiree health insurance, retirement does not imply a loss of health insurance coverage. And once individuals reach age 65, even the absence of retiree health insurance does not imply a loss of health insurance coverage upon retirement, because virtually everyone aged 65 and older is eligible for Medicare.

The interactions between these three different types of health insurance provide several venues through which health insurance can affect the retirement behavior of older individuals. For example, some individuals work in firms that provide retiree health insurance while others do not. For individuals who are younger than 65 and not yet eligible for Medicare, a lack of retiree health insurance should serve as a deterrent to retirement, at least until individuals reach the age of 65. Several studies have found consistent evidence that individuals whose employers provide retiree health insurance leave the labor force earlier than individuals whose employers do not (Madrian 1994a; Karoly and Rogowski 1994; Gustman and Steinmeier 1994; Rust and Phelan 1997; Blau and Gilleskie 1997; and Rogowski and Karoly 2000). My own research suggests that individuals with access to retiree health insurance leave the labor market between 6 and 18 months earlier than individuals who do not have access to retiree health insurance (Madrian 1994a). These individuals are also much more likely to retire before the age of 65. Evidence along these lines but of a more anecdotal nature also comes from a recent Gallup poll in which "61 percent of workers reported that they would not retire before becoming eligible for Medicare if their employer did not provide retiree health benefits." (Employee Benefit Research Institute 1993).

The key thing that generates the relationship between health insurance and retirement just described is that retiree health insurance essentially makes employer-provided health insurance portable across

the transition from work to retirement. Individuals with other types of portable or quasi-portable health insurance should also be more likely to retire, at least before the age of 65, than individuals without portable health insurance. Another institution that makes employer-provided health insurance at least somewhat portable is COBRA, a federal law that took effect in 1986 that requires employers to allow former employees to buy into their former employers' health insurance plan for up to 18 months. In terms of motivating retirement, COBRA is not as generous as retiree health insurance for two reasons: it is of only limited duration while retiree health insurance is not, and it requires much greater out-of-pocket payments than does retiree health insurance. Nevertheless, there is also evidence that the limited health insurance portability instituted through COBRA increased retirement rates for those under age 65 by almost 30 percent (Gruber and Madrian 1995).

Individuals who are covered by non-employment-based health insurance (for example, through Medicaid or policies purchased individually in the private market) also have a type of health insurance coverage that is portable across the transition from work to retirement. Once again, empirical evidence suggests that these individuals are also more likely to retire than are individuals with employer-provided health insurance that would be lost upon retirement, at least before the age of 65 (Rust and Phelan 1997).

An interesting thing happens at age 65 when individuals become eligible for Medicare: even for those individuals with employer-provided health insurance that does not continue into retirement, leaving the labor force no longer implies a loss of health insurance because individuals are covered by Medicare. Thus, Medicare eligibility should provide a strong retirement incentive for those individuals not eligible for retiree health insurance. And indeed, a substantial fraction of 64-year-olds do retire at age 65 when they become eligible for Medicare. Empirical research has to date been unable to precisely quantify the magnitude of this Medicare-induced retirement effect because age 65 also happens to be the normal age to qualify for Social Security and the age at which many pension plans provide full retirement benefits. With so many other factors motivating retirement that are coincident with Medicare eligibility, it is difficult to quantify exactly how big each of the respective effects are. But the evidence on

how other types of health insurance affect retirement suggests that Medicare eligibility should be very important as well.

One idiosyncratic feature of Medicare, which, like other types of health insurance, also generates interesting variations in retirement behavior, is that Medicare only covers individuals and not spouses or dependent children. As a result, the retirement decisions of two individuals without retiree health insurance who are both about to turn 65, one with a spouse who is younger and the other with a spouse who is older, could be quite different. For the individual with the older spouse, retirement at the age of Medicare eligibility will result in a loss of health insurance coverage for neither spouse—both will be covered by Medicare. Indeed, the older spouse already is. In contrast, retirement at the age of Medicare eligibility for the individual with a younger spouse will result in a loss of health insurance coverage for the spouse if the spouse was covered as a dependent on the employee's plan and not through his or her own independent coverage. Interestingly, men with younger wives are less likely to retire than are men with older wives until their spouses also become eligible for Medicare (Madrian and Beaulieu 1998). Thus, retirement is affected not only by one's own Medicare eligibility, but also by the Medicare eligibility of one's spouse.

Health insurance also affects the nature of the transition from work to retirement. Some individuals move from full-time work to full-time retirement, while others pursue a more gradual transition from work to retirement, moving from full-time work to part-time work, and then eventually to full-time retirement. Because employer-provided health insurance is typically contingent upon full-time employment, it is usually difficult to maintain employer-provided health insurance while working part-time. Individuals with retiree health insurance, however, can retire from their full-time jobs and move to a different part-time or self-employment job while maintaining health insurance through their former employers. Research has shown that individuals with retiree health insurance are indeed much more likely to make a gradual transition from work to retirement than are individuals without retiree health insurance. Interestingly, many older workers, when asked, express a desire to make a gradual transition from work to retirement. Thus, health insurance that is portable across the transition from work to

retirement appears to be an institution that enables individuals to retire both when and how they desire (Rust and Phelan 1997).

Understanding how health insurance affects retirement incentives is a particularly important policy issue because the retirement decisions of older individuals could be affected quite substantially in the upcoming years by changes in the institutions that provide health insurance to retirees—a resizing of the pieces in the patchwork quilt, if you will. The first important change is a dramatic decline in the number of employers that offer retiree health insurance. The fraction of employers offering retiree health insurance has fallen by almost half over the past 15 years, in large part because the escalation in medical care costs has made retiree health insurance an incredibly expensive benefit to provide. This erosion in the availability of retiree health insurance coverage will make retirement before the age of 65 much more difficult for many workers. Based on the evidence in the research that I have summarized so far, there will likely be an eventual increase in the average retirement age if the availability of retiree health insurance were the only factor affecting retirement that continued to change. While there has been no research to date explicitly focused on the decline in the availability of retiree health insurance and its effect on retirement, it is interesting to note that the decades-long trend in the declining average retirement age of men ended in 1985, at about the same time that employers began to drop their retiree health insurance plans.

A second potential major change in the health insurance landscape for older workers is the prospect of Medicare reform. There is almost universal consensus in both academic and policy circles that, for any number of reasons, Medicare needs to be reformed. Unfortunately, disagreement on exactly how it should be reformed has resulted in legislative paralysis. There have, however, been numerous proposals to reform Medicare, each of which would affect the labor force participation decisions of older workers in different ways. For example, the Breaux-Thomas proposal that came out of the recently disbanded Medicare reform commission would have raised the Medicare eligibility age to conform with the scheduled increase in the Social Security normal retirement age from 65 to 67. This change would delay retirement for those individuals without access to retiree health insurance, a group which, as just noted, is increasing in size as employers opt out of the retiree health insurance business. In addition, increasing the age of

Medicare eligibility would increase the cost to employers of providing retiree health insurance, and would likely provide even greater incentives for employers to relinquish their retiree health insurance plans. Thus, increasing the age of Medicare eligibility is likely to lead to increases in the average retirement age, both directly through the effect on retirement incentives of individuals without retiree health insurance, and indirectly through the incentive it creates for employers to abandon their retiree health insurance plans.

President Clinton presented a different Medicare reform proposal that would allow all individuals between the ages of 62 and 64 to buy into the Medicare program. By making Medicare available earlier, even though at a nonsubsidized price, this type of reform would actually motivate retirement at younger ages, reinforcing the decades-long trend toward earlier retirement.

Whether the current average retirement age is too high, too low, or just right is a normative question that perhaps warrants an entire chapter of its own. The point is that the health insurance landscape for older workers is currently changing in a very important way as employers give up their retiree health insurance plans, and it is likely to change even further as Congress will eventually make reforms to the Medicare program. These changes will certainly affect not only the retirement decisions of older workers, but also the savings and consumption decisions of younger workers as they make future plans for retirement. The overall economic implications of these changes could be tremendous.

HEALTH INSURANCE AND LABOR FORCE PARTICIPATION

While much of the research on how health insurance affects labor force participation has been directed at the issue of retirement, older individuals are not the only ones whose employment decisions are affected by health insurance. Because the vast majority of prime-aged men work regardless of whether they receive employer-provided health insurance, it is women whose labor force participation decisions are most likely to be influenced by the availability of health insurance. One specific group of women for whom health insurance is likely to be

particularly important are unskilled, less-educated, single mothers. As parents, they are apt to have a higher demand for health insurance coverage than single women without children. But, as single parents, they do not have access to health insurance coverage through their spouses. And, as unskilled single parents, they are qualified primarily for low-wage jobs—jobs that are much less likely to come with health insurance. One source of health insurance coverage that is potentially available to these women is Medicaid. However, until recently, welfare participation was a virtual precondition for the receipt of Medicaid benefits: employment that generated income sufficient to disqualify an individual from receiving further welfare benefits also disqualified an individual from further receipt of Medicaid. Thus, many less-skilled female workers have faced a choice between not working or working part time and receiving Medicaid, or working full time and losing both welfare benefits and Medicaid coverage.

An interesting change in the Medicaid eligibility rules in the late 1980s and early 1990s has made it possible to disentangle the impact of Medicaid eligibility on labor force participation from that of general welfare eligibility. A series of federal and state legislative initiatives have allowed women to maintain their Medicaid coverage for a prespecified period of time after leaving welfare and extended indefinitely Medicaid coverage to many groups of low-income children. These changes effectively make Medicaid portable across the transition from welfare to work for a finite period for welfare recipients themselves, and for a much longer period for their children. Empirical research suggests that this type of Medicaid portability increases both the labor force participation and the hours worked of low-income single mothers (Yelowitz 1995). The former link between Medicaid and welfare participation was, in fact, a deterrent in motivating welfare recipients to find full-time work.

Married women are another group whose labor force participation is likely to be influenced by the availability of health insurance coverage. As already noted, prime-aged men are likely to work regardless of the availability of health insurance. In contrast, married women's labor supply has historically tended to be much more sensitive to the financial incentives associated with work, one of which is health insurance. Because most companies that offer health insurance make it available to both employees and their spouses, many married women receive

health insurance coverage through their husbands. Whether or not a married woman has health insurance through her spouse turns out to be a very important factor in whether and how much she works. Married women with health insurance through their husbands are substantially less likely to work than are women without health insurance from their spouses. And those who do work are much more likely to be employed in part-time rather than full-time jobs—jobs that typically do not provide health insurance (Buchmueller and Valetta 1999; Olson 1998). Thus, for married women, the lack of health insurance from a spouse's employment seems to have a strong influence in motivating married women to find jobs with health insurance themselves.

A recent study of married women's labor supply in Spain uncovered another interesting link between health insurance finance and female labor supply. In Spain, health care is provided by the government and financed out of a mandatory payroll tax paid partially by the firm and partially by the employee. Payment of the payroll tax entitles workers, their spouses, and dependent children to health care, as well as to a pension and sick leave. Among men, compliance with the payroll tax is universal. Among married women, however, over one-quarter of those who are employed work in the "underground" economy where "required" taxes are not paid (de la Rica and Lemieux 1994).

There are many other less-studied avenues through which health insurance is likely to affect labor supply. There is some evidence that the availability of health insurance during times of unemployment affects both the likelihood of and the duration of an unemployment spell (Gruber and Madrian 1997). The link between Medicare coverage and the receipt of Social Security Disability Insurance for disabled individuals under the age of 65 could act as a deterrent for work among the disabled, or at least work that would be sufficient to disqualify them from further disability benefits and the Medicare coverage that accompanies these benefits. University-provided health insurance to students operates in a similar way; individuals can participate in student health plans if they maintain their student status, which typically involves registering for a certain number of credit hours and maintaining satisfactory grades. Employment, or at least full-time employment, may jeopardize an individual's ability to maintain status as a student. Thus, some students who value their health insurance may be deterred from entering the labor market.

HEALTH INSURANCE AND JOB TURNOVER

Health insurance also affects the types of jobs in which individuals are employed. I have already noted that health insurance affects not only labor force participation, but also the choice of full- or part-time work for older individuals contemplating retirement, for married women, and for single women on welfare. Beyond the full- or part-time dimension of job choice, health insurance also influences the choice between various full-time jobs for those who want to work full-time—not only the initial choice of where to work, but also subsequent decisions about whether or not to change jobs. Economists are interested in the issue of job turnover because it is the process by which workers are reallocated away from jobs where they are less productive and into jobs where they are more productive. Impediments to productivity-enhancing job turnover are thus a barrier to economic growth. To make this point in a rather extreme way, imagine how different your life and the whole economy would be if your first employer were also your only employer; that is, if you could never change jobs.

Why does health insurance influence job turnover? One obvious reason is that not all employers offer health insurance. Individuals who have employer-provided health insurance and place a high value on it will be reluctant to switch to a company that doesn't provide health insurance. On the flip side, individuals who don't have employer-provided health insurance and who place a high value on it will be trying to switch to companies that do provide health insurance. An interesting piece of evidence on this front comes from the behavior of married men who are working in jobs without health insurance. Married men without health insurance but who have pregnant wives are twice as likely to change jobs as married men without health insurance whose wives are not pregnant (Madrian 1994b). The impending birth of a child clearly increases the value of health insurance, and these men respond by changing jobs, presumably in an attempt to find work with health insurance.

A second reason that health insurance affects the job turnover decisions of individuals is that not all employer-provided health insurance plans are equal, at least not for an employee who contemplates changing jobs. In addition to variation among employers in the generosity of

the health insurance package in terms of co-payments, deductibles, and what is covered, there are two more subtle issues to consider. The first is that many employers exclude preexisting conditions for a certain period of time. So, even though a new employer and one's current employer may appear to provide identical coverage, the coverage of the new employer may in fact be vastly inferior for families with medical problems if these problems are not covered under the terms of a preexisting conditions exclusion restriction. The second issue is that in the era of managed care, employees do not generally have free choice among medical providers. Thus, an employment change that is accompanied by a health insurance change is also likely to necessitate a medical provider change. Individuals who value relationships with their current doctors may thus be averse to changing health insurance plans even if preexisting conditions are not an issue.

My own research on the relationship between health insurance and job turnover and that of others confirms that health insurance is an important factor in the decision to change jobs. One interesting finding is that among individuals who have employer-provided health insurance, those who also have coverage through the employment of a spouse are much more likely to change jobs than those who do not (Madrian 1994b; Buchmueller and Valetta 1996). In essence, health insurance coverage through a spouse's employment is portable across the transition from one job to another and is one way to skirt the preexisting conditions exclusions that may be in place at a new employer. Another interesting finding is that COBRA, in addition to motivating retirement among older workers, also motivates job turnover among younger workers (Gruber and Madrian 1994). COBRA makes the health insurance from one's former employer portable across jobs, at least for a limited time, but apparently long enough for many to skirt preexisting conditions exclusions.

One particular type of job transition, the movement to self-employment, is also likely to be influenced by the availability of health insurance. The self-employed owners of firms do not generally get the same tax advantages from purchasing health insurance as do employees. Moreover, because most of the self-employed tend to be sole proprietors or have very small firms, they are not able to take advantage of the economies of scale in health insurance provision available to large firms, or the benefits that large firms have in reducing the negative

impact of adverse selection on the costs of insuring their employees. Thus, the health insurance costs of becoming self-employed may be nontrivial. Some research suggests that health insurance is indeed a factor in the decision about whether or not to become self-employed, and that individuals for whom the loss of health insurance is less costly (for example, those with health insurance through a spouse) are more likely to switch from employment to self-employment (Madrian and Lefgren 1998).

The likelihood of a future layoff—involuntary job turnover—may also affect the job choice decisions of individuals who place a high value on health insurance. Several years ago I had an MBA student who had been recently diagnosed with multiple sclerosis, a condition that would almost surely be classified as a preexisting condition. Upon hearing about my research interests, he told me that although he really wanted to work for a consulting firm and had indeed received offers to do so, he had decided to accept a job with a large manufacturing company with essentially a policy of lifetime employment. He reasoned that consulting companies have a reputation for promoting only a very small fraction of their hires to partner; the rest either leave or are dismissed within the first few years. Given his medical situation, he felt that it would be imprudent to accept a job in which there would be uncertainty regarding his future health insurance coverage as a result of the inherent uncertainty in the long-term job prospects at a consulting firm.

HEALTH INSURANCE AND THE EMPLOYMENT DECISIONS OF FIRMS

It is also interesting to consider the relationship between health insurance and job turnover from the employer's perspective. For an employer who offers health insurance coverage, sick employees (or healthy employees with sick dependents) are costly in two ways: they may be less productive and they are likely to generate higher insurance claims. Because of their medical expenditures, these employees may be relatively more attractive targets for layoffs. The link between health insurance and employment may thus have an adverse effect on

families with medical problems if these problems lead to claims-based layoffs. Although I have seen no formal analysis of the prevalence of this type of layoff behavior, there is certainly anecdotal evidence that it does occur.

In addition to its effect on the employment and job choice decisions of individuals, health insurance may also influence the labor demand decisions of employers. There are two features of health insurance provision that are particularly salient in this regard. The first is that health insurance is a fixed cost of employment. Expected employer expenditures on health insurance do not increase when the weekly hours worked by their employees increase, and they do not increase when compensation increases; they only increase when more employees are hired. This feature of health insurance, its fixed-cost nature, gives firms an incentive to economize on the costs of providing health insurance in two ways: by hiring fewer employees but at longer weekly hours, which is one way to maintain production while reducing the overall costs of providing health insurance, and by hiring fewer but more productive employees—employees who can produce more than the average employee would. Some of my own research done in conjunction with David Cutler provides partial evidence that firms have substituted longer weekly hours for fewer workers as health insurance costs have increased over recent years. Moreover, the effects are nontrivial. The increase in weekly hours associated with the increase in health insurance costs between 1980 and 1993 resulted in a change in average weekly hours among those with health insurance equivalent to roughly half the change in labor input that is observed in a typical recession (Cutler and Madrian 1999).

Anecdotally, there have been several strikes in recent years against companies such as General Motors over the issue of perceived excess overtime. Companies have scheduled their workers for overtime on a regular basis, sometimes as many as 20 hours per week, in order to avoid the health insurance and other fixed costs of employment associated with hiring new workers. The workers, preferring shorter hours to an overtime premium, have gone on strike in an effort to pressure the companies into hiring more workers.

The second feature of health insurance that is salient to the labor demand decision is the distinction between full- and part-time workers in the tax treatment of employer expenditures on health insurance. As

already noted briefly, employer expenditures on health insurance are usually not subject to taxation; however, there is one caveat: employers must satisfy a set of IRS nondiscrimination rules which stipulate that if a firm is to provide health insurance, it must make it widely available to nearly all employees. In essence, employers cannot selectively decide that they will provide health insurance to some employees and not to others, either because of favoritism or as a cost-saving measure. However, certain groups of employees, namely part-time, temporary, and seasonal workers, are exempt from the requirements of the nondiscrimination rules. Thus, employers can deny health insurance coverage to part-time, temporary, and seasonal workers while still obtaining favorable tax treatment for their health insurance expenditures on full-time permanent employees. As health insurance becomes more expensive to provide, the nondiscrimination rules give employers an incentive to hire part-time and temporary workers in lieu of full-time workers as a way to economize on insurance expenditures. While there are many reasons behind the phenomenal growth in the temporary help industry over the past two decades, the increasing cost of providing health insurance is surely one of them.

More concrete evidence that employers substitute part-timers for full-timers in the face of higher health insurance costs comes from the state of Hawaii. In 1974, Hawaii mandated employer provision of health insurance to full-time but not part-time workers. Those industries most affected by the mandate, namely industries in which relatively few full-time workers were covered by health insurance initially, saw a large increase in the fraction of workers employed in part-time jobs following the mandate. Essentially, employers who were suddenly faced with large health insurance bills as a result of the mandate decided to substitute part-time workers for full-time workers as a way to skirt requirement of the new law. In contrast, industries in which almost all full-time employees were already receiving health insurance saw little shift in the fraction of full- versus part-time workers (Thurston 1997).

For firms, then, health insurance affects both the size and composition of the workforce that is employed. As health insurance becomes more costly to provide, employers have an incentive to reduce their health insurance costs by substituting overtime for employment, skilled

labor for unskilled labor, and part-time and temporary workers for regular full-time employees.

CONCLUSION

There is an important relationship between labor market outcomes and the institutions and rules governing health insurance provision in the United States. Health insurance is an important factor in almost every labor market decision made by individuals: whether to work, where to work, how many hours to work, and so on. It is also an important factor in the human resource decisions made by employers: how many workers to hire, whom to hire, how to structure the terms and conditions of employment.

But, given that there are many factors that affect the labor market decisions of individuals and firms, why the special concern with health insurance? Because our health care system continues to evolve in ways that influence important labor market outcomes. Significant changes in the health insurance institutions of the United States have taken place over the past 15 years. These include

- the implementation of COBRA, which provides limited health insurance portability to workers covered by employer-provided health insurance,
- passage of HIPAA, which attempts to further increase the amount of health insurance portability in the economy,
- the extension of Medicaid benefits to pregnant women and low-income children regardless of parental participation in either state welfare programs or the labor market,
- the shift away from fee-for-service medicine and toward managed care,
- the tax deductibility of health insurance expenditures of the self-employed,
- small business health insurance pools,
- a dramatic decline in employer provision of retiree health insurance, and

- a proliferation in state-mandated health insurance benefits.

And even more substantive changes continue to be proposed, such as

- changes in the Medicare eligibility age,
- changes in or elimination of the tax-deductibility of health insurance and other employee benefits,
- mandatory community rating of health premiums insurance in the nongroup market,
- further expansions in the availability of publicly provided health insurance, and, of course,
- broad-based national health care reform, an issue that is not widely discussed at the moment but, if history is our guide, will surely resurface at some point in the future.

The merits of these various proposals depend on a variety of things. While most discussion tends to focus on access to health care services and the government budget, it is also important to consider the impact of these proposals on the labor market. Do they promote or impede labor market efficiency? Do they distort the labor supply choices that individuals otherwise would have made? Do they change the hiring decisions of firms?

These issues are perhaps most important not in the United States, but in the developing countries of the world that are currently struggling to design and implement their own health care and health insurance institutions. An important lesson to be learned from the experience of the United States is that while employer provision of health insurance is a convenient way to finance insurance benefits without involving the government budget directly, not everyone is tied to the labor market. Reliance on and encouragement of employer provision of health insurance will invariably result in government programs to fill in the gaps and cover the otherwise uninsured. But it is the interplay between these various institutions, some tied directly to the labor market and others not, that results in distortions of the labor market decisions of individuals and firms.

Is there a way to eliminate the labor market distortions associated with health insurance provision in the United States? Yes and no; one way would be to have nationalized health insurance that covered every-

one regardless of employment status. Such an institution would provide no incentives to be employed or not employed, at least not on the basis of health insurance. However, such an institution would invariably involve distortions along other margins. For example, the tax revenue needed to finance nationalized health insurance would invariably create distortions in the markets that are taxed, quite possibly the labor market if financed through an income or payroll tax. This would, in essence, involve trading one set of labor market distortions for another. It's a gloomy picture, isn't it?

The bottom line, then, is that any system of health insurance provision is likely to involve labor market distortions, either directly through the institutions themselves, or indirectly through the way they are financed. This is not necessarily bad—after all, many of the good things that are provided by the government involve trading one kind of market distortion for another: public education, roads and other forms of infrastructure, and national defense. By understanding the distortions, i.e., where they come from and how big they are, we can begin to make informed decisions about which types of reform will have the greatest beneficial impact on both health and economic efficiency.

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