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The role of business and organized labor in the maintenance of private health insurance in the United States

O papel das empresas e do trabalho organizado na manutenção do seguro de saúde privado nos Estados Unidos

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Resumo

As empresas e o trabalho organizado nos EUA têm estado historicamente envolvidos no seguro de saúde através do emprego, na ausência de um sistema de saúde universal. Este sistema de saúde baseado no emprego continua a ser a forma dominante de cobertura para os americanos hoje, embora a sua importância tenha vindo a diminuir a longo prazo. Ao longo da última década e após a aprovação da Lei de Cuidados Acessíveis, os empregadores e os sindicatos têm por vezes desafiado o sistema. Mas a convergência para um sistema universal será provavelmente um processo longo.

Palavras-chave: Cobertura de seguro saúde. Planos de seguro saúde ocupacional. Trabalho organizado. Negócios. Affordable Care Act. Medicare for All. Benefícios de saúde. Employment Retirement Income Security Act.

Abstract

Business and organized labor in the US have been historically involved in health insurance through employment, in absence of a universal health care system. This employment-based healthcare system remains the dominant form of coverage for Americans today although its importance has been declining over the long-term. Over the last decade and after the passage of the Affordable Care Act, employers and unions have sometimes been challenging the system. But the convergence toward a universal system is likely to be a long process.

Keywords: Health insurance coverage, Occupational health insurance plans. Organized labor. Business, Affordable Care Act. Medicare for All. Health benefits, Employment Retirement Income Security Act.

JEL: I10

Introduction

Unlike unions in Europe, US unions have not played any role in running federal health insurance programs even though they played a key role in their adoption in 1965. At that time, two major programs were created: Medicare, for people aged 65 and over, as well as younger people with certain disabilities or fatal illnesses; Medicaid, for the most disadvantaged. On the other hand, unions have been involved in occupational health coverage, set up and financed voluntarily by employers and negotiated exclusively for their members in establishments where they have managed to gain a foothold. In this way, after World War II, organized labor contributed to the creation of private health insurance, of which they have become one of the main defenders (Gottschalk, 2000), alongside employers and insurance companies (Chapin, 2015).

In the absence of national health insurance, private insurance through employment expanded massively from the 1950s onwards, encouraged by federal tax subsidies. It remains the dominant form of coverage for Americans today although its importance has been declining over the long-term. The US is the only advanced country that relies heavily on employers for health insurance coverage. This system, which is fragile by nature as it is firm-based, has become increasingly expensive over the years. It has helped to involve and anchor unions in collective bargaining. At the same time, employers support the system, at least for their core long-term, full-time workforce, because they have no alternatives on which they could agree. However, in the wake of the Affordable Care Act (ACA) of 2010 (also known as "Obamacare"), over the last decade, employers and unions have sometimes challenged the occupational health insurance system. The transition away from employer-provided insurance is already underway. But the road toward a universal system will be long.

1. Origins and main features of occupational health insurance

The majority of Americans still depend on their employer for health insurance. Employment-based health insurance is rooted in the "welfare capitalism" movement, which was promoted by some large companies up to the Great Depression (ApRoberts, 2000). It was subsequently strengthened by the collective bargaining system which developed in the post-war period, as well as by the introduction of federal tax incentives. It was finally consolidated in the 1970s by federal legislation that allowed companies to self-insure and, in so doing, to evade state legislation on insurance.

1.1 The peculiar occupational health insurance system, a distinctive feature of US healthcare

In 2022, the Census Bureau estimated that publicly financed health insurance, that is Medicare for the elderly and Medicaid for individuals with low income and assets, accounted for the coverage of 36.1% of the US population. Two thirds of Americans (65.6%) relied on private health insurance. Of those, a large majority relied on occupational health insurance coverage (54.5%), that is, health insurance tied to employment. The remaining covered population was insured through a patchwork of

other public and private arrangements, while nearly 8% of the population was uninsured (Figure 1).

Occupational insurance is voluntary for employers: despite the absence of universal coverage in the US, they have no legal obligation to offer health insurance to employees[1]. Indeed, many firms do not offer health insurance to their part-time or temporary workers as well as to low-wage workers because the costs of health benefits represent a huge share of these workers' wages (Case and Deaton, 2020).

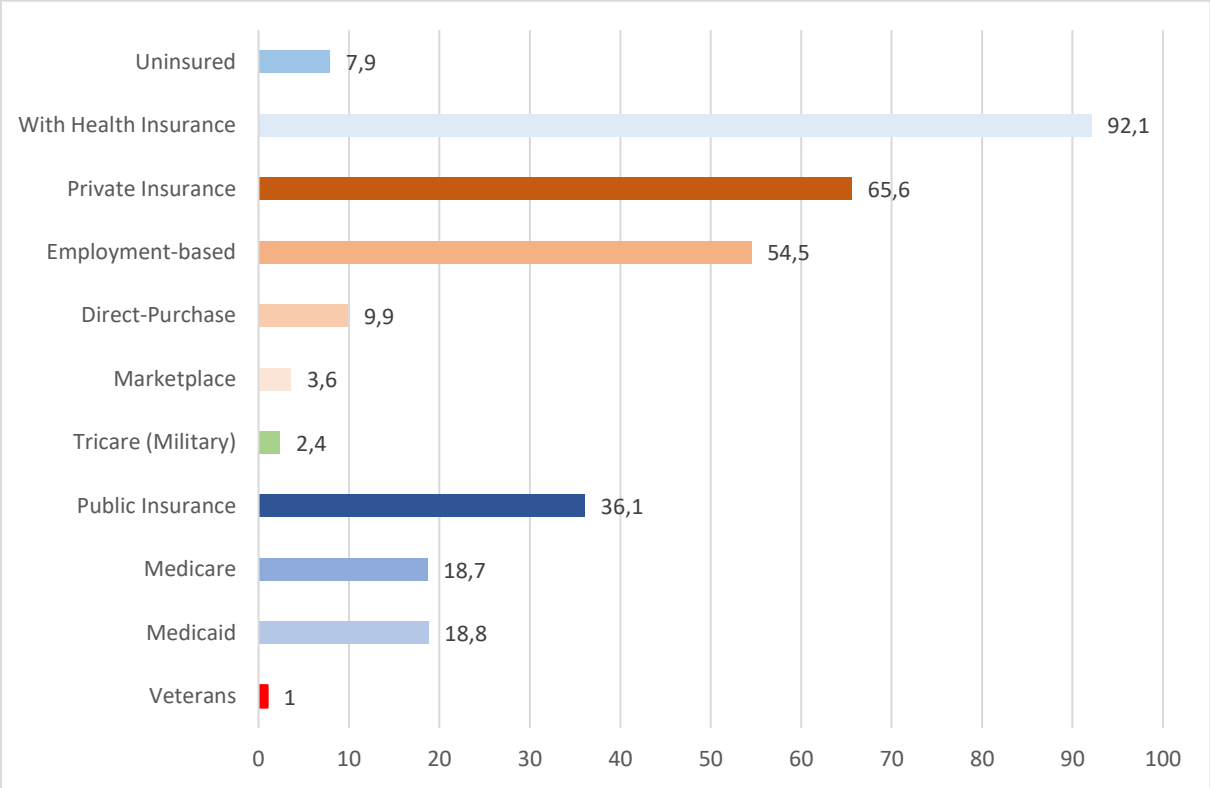
In 2015 however, the Patient Protection and Affordable Car Act of 2010 or ACA introduced a kind of obligation or we might say "incentive". Employers with less than 50 employees are exempt from the "employer mandate"; those with 50 or more employees are required to provide "affordable" coverage, that is coverage which costs no more than 8.39% of an employee's annual salary. Employers must offer such "affordable coverage" to at least 95% of their full-time employees. Full time is defined as at least 30 hours of service a week or 130 hours of service a month. Otherwise, they face a fine ($247.50 per month per eligible employee).

In 2023, more than half of firms (53%) offered health benefits to at least some of their employees, down from 66% in 1999. Nearly all large firms (98% of firms with 200 or more employees) were doing so. Meanwhile, small firms (3 to 199 employees) were less likely to do so (KFF, 2023). Some industries are much less generous in offering health benefits, notably retail (37% of firms) and services (51% of firms) compared to manufacturing (71% of firms). Generally, companies use health coverage as a means of attracting and retaining their workforce, particularly those with specific skills for which they are competing. In service industries, where workforce turnover is high, companies have little incentive to offer such benefits. From the employee's point of view, health insurance is undoubtedly a decisive factor in choosing one employer over another, or in staying in jobs, given the high cost of premiums. According to several surveys, health insurance is the benefit that employees value the most.

Under this type of arrangement, employers entrust specialized departments (benefits departments), sometimes of considerable size, with the task of managing employee benefits, including health insurance. They traditionally choose a private insurance company, which negotiates prices with care providers, often in the greatest secrecy. The insurance company also process claims for reimbursement. Occupational health insurance reached its peak in the 1980s and has been in decline ever since. However, the percentage of the population covered by occupational insurance has been stable since 2014 (Figure 2). It remains the preferred form of health insurance coverage for Americans today.

[1] Furthermore, employees can decline the employer's proposal either because the amount they are required to contribute to the health premium is too expensive or because they may obtain coverage through their spouse.

Figure 1: Percentage of Population by Type of Health Insurance Coverage in 2022



Source: Health Insurance Coverage in the United States: 2022, by K. Keisler-Starkey, L. Bunch & R. Lindstrom, September 2023. The estimates by type of coverage are not mutually exclusive; people can be covered by more than one type of health insurance during the year. The 2022 Current Population Survey Annual Social and Economic Supplement (CPS ASEC) showed that about 43 million people in the US had more than one health plan in 2021.

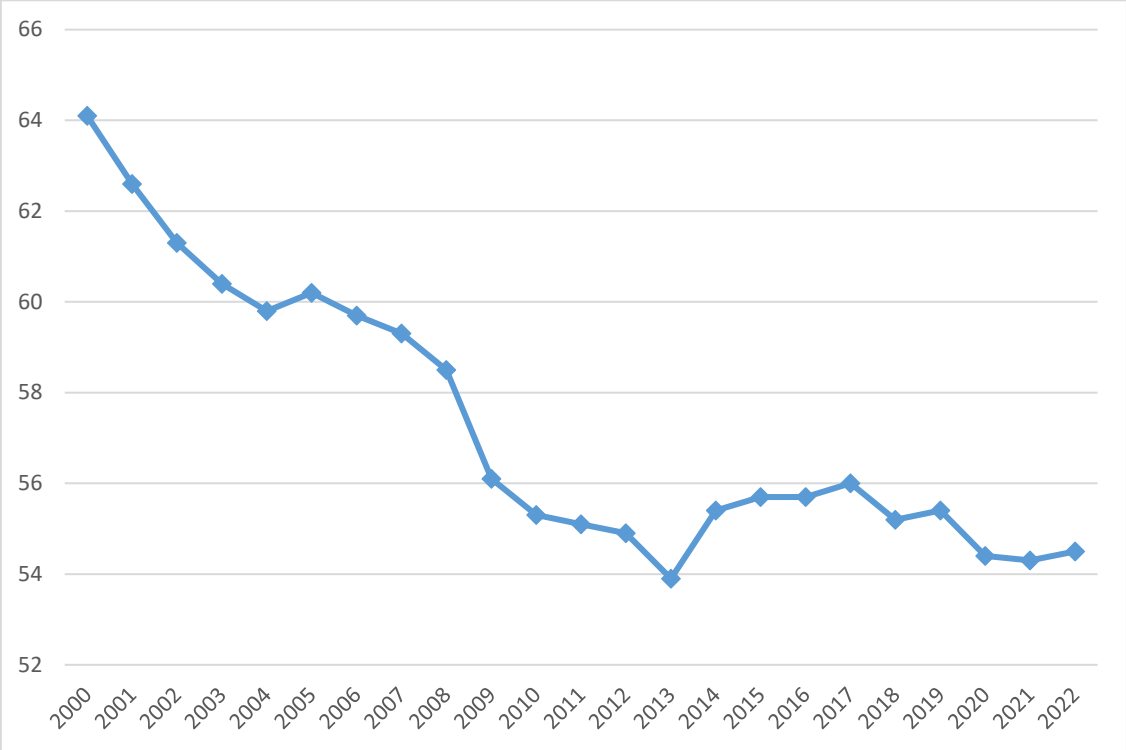
1.2 A legacy of 'Welfare capitalism', World War II and the post-war context

The employment-based insurance system is a legacy of Welfare capitalism, which developed up until the 1930s on the initiative of large companies. It was similar to the paternalism that emerged in some European countries at the end of the 19th century. For American employers, the aim was to grant employee benefits in order to attract and retain workers. Sometimes, it was even intended to cover all their needs in order to better control them, thus avoiding intervention by organized labor and/or the state. At the time, the American Federation of Labor (AFL), which brought together most of the national unions, and its president, Samuel Gompers, along with other union leaders, denounced the principle of compulsory insurance. They were fiercely opposed to any form of public insurance, which they saw as a direct threat to organized labor power.

On the contrary, they believed that members should have their own health insurance financed exclusively by their own contributions, along the lines of workers' mutual aid societies in some European countries. Several schemes of this type were set up at the end of the 19th century by workers themselves (mutual aid societies, fraternal societies for immigrants) and/or by craft unions representing like barbers or granite cutters. At that time, they were managed either partly unilaterally for the benefit of their members or partly jointly with employers. At the beginning of the 20th century however, these

schemes became very inadequate in number (around twenty in all) and in quality (little or no coverage for hospital expenses). For their part, industrial unions, united under the banner of the Congress of Industrial Organization (CIO) created in 1935, were more inclined to call for universal public insurance.

Figure 2: Percentage of the population covered by employment-based insurance



Source : data from US Census Bureau

The Great Depression of the 1930s, with its trail of bankruptcies and unemployment, reshuffled the cards within organized labor. It made it unsustainable for workers to finance such coverage and led the AFL to support public insurance at the federal and/or state level, when the public pension system (Social Security) was adopted in 1935 (Derrickson, 1994). The idea of national insurance gained ground with the emergence of several bills in the late 1930s and mid-1940s. They were supported by the AFL and the CIO, but industrial unions were more concerned about consolidating their power through collective bargaining.

As private health insurance emerged as the essential source of health coverage, they supported the development of private health insurance through employment, which they managed to negotiate for most of their members in large manufacturing companies. The Miners' Union (UMW) set the tone in 1946, followed by the Steel Workers' Union (USW) in 1949, and then the Automobile Workers' Union (UAW) in 1950. The agreement then reached with management (referred to the Treaty of Detroit) became the benchmark for company collective agreements for some thirty years. However, unlike the agreements reached in the mining and steel industries, health coverage for

autoworkers remained the prerogative of management. At the turn of the 1950s, around 95% of the workers represented by the CIO benefited from health coverage obtained through collective bargaining, compared with just 20% of those represented by the AFL.

If this system took off and eventually prevailed, it was also due to a decision by the federal tax authorities in 1943, which favored fringe benefits as a form of compensation in a context of labor shortages and wage freeze during the war. This decision was confirmed in 1954 by the Tax Code. Employers benefited insofar as the employer's contribution to the health insurance premium was considered an ordinary expense and, as such, was deductible from the company's taxable base. Nor it was included in the employees' taxable income who benefited from it. This tax exemption, considered by most economists as largely inefficient and inequitable (Buchmueller & Monheit, 2009) costs the federal government a total of more than $300 billion per year in lost taxes (CBO, 2022).

This system was endorsed by organized labor, who saw it as a way of attracting new members through collective bargaining. In 1948, the National Labor Relations Board, the federal agency that governs US industrial relations, required employers to negotiate employee benefits (supplementary pension and health coverage) with the unions, a decision that was confirmed by the Supreme Court in 1949. In this context, industrial unions became major players and fervent supporters of this "welfare enterprise" system through collective bargaining. However, the Taft-Hartley Act of 1947, drafted by a team of company lawyers, reduced unions' prerogatives. This law imposed strict parity with the employer in the management of multiemployer pension and health funds (supplementary pension and health insurance), which were prevalent in certain sectors characterized by the presence of many part-time, seasonal workers (with high mobility) and small businesses.

1.3 A system consolidated by the Employment Retirement Income Security Act (ERISA) of 1974 and by the Affordable Care Act (ACA) of 2010

This system was consolidated in 1974 with the adoption of ERISA (Employee Retirement and Income Security Act), a law which forms the backbone of the private health insurance system through employment. While most of this legislation was designed to regulate the supplementary pension system for private-sector workers (federal guarantee of supplementary company pensions and pension fund funding obligations), a marginal section of the text (section 514) concerned occupational health coverage, whether the funds were managed unilaterally by the employer (single employer funds) or jointly by employer and union representatives (multiemployer funds also known as Taft-Hartley funds) under the Taft-Hartley Act. While insurance regulation has traditionally been the responsibility of state governments, ERISA allows private sector employers to circumvent this responsibility by self-insuring, i.e., taking on the insurance risk for their covered employees and purchasing reinsurance from private companies if healthcare costs exceed a certain amount.

In practical terms, private sector employers who choose this status no longer have to meet the various state government requirements in this area (setting up a minimum reserve level, paying tax on insurance premiums, offering certain types of coverage, and so forth). This was mainly the case for large companies, which from 1974 onwards operated in a world with very little regulation at federal level, apart from a few minimum accounting and financial transparency requirements on coverage, which were imposed in the mid-1980s.

This section 514 was added in the final phase of negotiations, under pressure from organized labor and large heavy industry. Both sides intended not only to prevent governments from taxing and regulating supplementary pensions negotiated under the 1947 Taft-Hartley Act and more generally, any state interference in collective bargaining (Fox and Schaffer, 1989), but also to oblige employers to offer health insurance. Unions used to negotiate collective agreements at national level in the construction, mining, road and sea transport and clothing industries feared that heterogeneous regulations would undermine their collective agreements, or even that state legislation will interfere with it. This is why ERISA promoted the objective alliance of employers and organized labor in the defense of private insurance through employment and the shaping of a "shadow welfare state" (Gottschalk, 2000).

Later, the reform initiated by Barack Obama in 2010 chose to build around the occupational health insurance system rather than to abolish it. The healthcare industry, notably the health insurance industry which is central to American healthcare (Chapin, 2015) has proven very effective at protecting this model. Even the proposal of a public option, a government-managed insurance, was opposed by most of healthcare industry key groups (not only the insurance industry but also hospitals, physicians, business organizations) and split organized labor. Eventually the amendment to add a public-plan option to the ACA was voted down by the Senate Finance committee (McDonnough, 2012) and the final version of the law did not include it.

2. An inefficient system, based on the vested interests of its stakeholders

This private employment-based system of health benefits grew over the three decades following World War II, involving an increasing number of participants. From the 1980s onwards, this growth stabilized at its peak. It then reversed to start declining, with rebounds in the second half of the 1990s and from 2014 onwards, thanks to the implementation of ACA main measures. Despite its many flaws, occupational health insurance has shown remarkable resilience, supported actually by its key stakeholders. Each of them has its own self-interest in maintaining it, particularly unions on the one hand and employers on the other.

2.1 A fragile, costly system with little protection for some insured people

First, this system is vulnerable to labor market shocks, as shown by the indirect economic consequences of the health crisis linked to the Covid-19 pandemic when unemployment skyrocketed, resulting in loss of occupational health coverage as the economy went into lockdown. Bivens and Zipperer (2020) estimate that 6,2 million workers lost their health coverage between February and July 2020 as a result of

redundancies, even though some of the unemployed were able to enroll in Medicaid because of their income loss, or in the ACA regulated individual markets. In addition, some unemployed people chose to extend their employer coverage, but they had to pay for the full of it. By fragmenting insurance risks rather than pooling them, firms are definitely not appropriate institutions to provide long-term social protection, which requires a stable long-term employment relationship, no longer relevant in the new economy (Lazonick, 2009).

Secondly, this system is very costly for both employers and employees, but in the long run and above all for employees through reduced wages and other benefits (Buchmueller & Monheit, 2009). The annual insurance premium for family coverage stood at $23,968 in 2023, and its annual growth (+7%) was higher than that of wages (+5.2%) and inflation (+5.8%). Of this total, the employer contributes an average of 72.6% of the insurance premium, while the employee pays the remainder (27.4%). What's more, almost a third of workers covered (31%) and near half of those working in SMEs (47%) have an annual deductible of $2,000 or more (KFF, 2023). It means that they have to pay for their healthcare bill until they reach this threshold. Therefore, many people with insurance continue to struggle to afford their health care costs. Medical debt in the US remains an ongoing problem. A government survey suggests that 8% of adults and 15% of US households owed medical debt in 2021[2]. This employment-based system is also costly for the federal government: the premium tax credit for insurance purchased through ACA marketplaces and the exclusion of employer contributions for medical insurance premiums are worth respectively an estimated $76 billion and $299 billion in 2022[3].

Finally, it offers less protection for low-wage workers than do ACA's regulated markets, which provide subsidies for participants earning between 100% and 400% of the federal poverty line. Companies employing large numbers of low-wage workers are unable to provide good coverage for their employees because of its cost, which is in effect subtracted from their wage's level. That is one of the reasons why large companies have outsourced those workers to business-service firms (Case and Deaton, 2020). The result is that a significant number of people are underinsured or inadequately covered in the US, 43% of working-age adults in 2022 and 29% of people with employer coverage according to the Commonwealth Biennial Health Insurance Survey[4].

2.2 Unions entrenched in collective bargaining

In the US, there is no collective bargaining at cross-industry level and employers are not organized for. The various existing employers' organizations (US Chamber of Commerce, National Association of Manufacturers, Business Roundtable, National Federation of Independent Businesses) are playing more of a lobbying role by influencing

2 https://www.healthsystemtracker.org/brief/the-burden-of-medical-debt-in-the-united-states/

3 See "Key Elements of the US Tax System", The Tax Policy Center's Briefing Book, https://www.taxpolicycenter.org/briefing-book/which-tax-provisions-subsidize-cost-health-care

4 The State of US Health Insurance in 2022, September 29, 2022. https://www.commonwealthfund.org/publications/issue-briefs/2022/sep/state-us-health-insurance-2022-biennial-survey

legislation at federal or state level. Sectoral bargaining, that is negotiating for all workers in an entire industry, remains marginal, unlike in European countries (Germany, France) where it has been the norm since World War II. The National Labor Relations Act which governs US industrial relations only provided a legal framework to workplace-based bargaining. However, it did not prevent sectoral bargaining to extend but only in places where unions were sufficiently strong and/or employers had an interest in it. Therefore, sectoral bargaining is limited to a few sectors with strong competition and/or high inter-company mobility (construction, transport, retail, health, entertainment industry). In such cases, the representative union (often a craft union) negotiates private social protection for its members (supplementary pensions and health insurance) with the multiple participating employers in the sector[5]. The advantage for workers is that social benefits are portable from one company to another in the event of professional mobility. So, workers don't lose their benefits when they switch jobs and change employers inside the sector.

Multiemployer health and welfare funds (Taft-Hartley plans), which receive employer (and sometimes employee) contributions, are major purchasers of health coverage. They represent a major source of health coverage for American workers and their families: according to the Department of Labor, 4,7 million workers were members of 1 261 multiemployer health and welfare funds in 2020, but this coverage covers around 20 million people if their dependents and pensioners are taken into account. Their interests have been effectively defended before Congress since 1974 by the National Coordinating Committee for Multiemployer Plans (NCCMP). This organization sealed the objective alliance between business and organized labor after the adoption of ERISA and enabled unions involved in the management of multiemployer funds (notably the building trades) to have their own voice on issues of private social protection.

The Taft-Hartley Act of 1947 requires that contributions received and invested in these funds be managed by an assembly of trustees, made up of equal numbers of union and employer representatives, who determine the conditions of eligibility (a minimum number of hours worked per month). Depending on the sector, it is either employers or unions that have the most influence over the management of such funds; sometimes there is a fine line between the two parties, particularly in certain industries where small size companies dominate the market (construction, transport).

And the working relationship that develops between the administrators, whether they represent employers or unions, tends to be less conflictual once the amount allocated to health coverage has been negotiated. Industry-wide bargaining and day-to-day management of health coverage through a trust have thus contributed to the development of a culture of familiarity and cooperation between unions and insurance world. It has also made day-to-day management of employee benefits a central function of the unions. They perceive it as a means of attracting new members. It also helps to create cohesion and identity within union locals, whose members are scattered over different sites. This is particularly true for the construction (building trades) and retail

[5] The employer's contribution is calculated on an hourly basis by the collective agreement. For example, employers in the California hotel industry pay $10 per hour worked for employee health coverage.

(UFCW) unions, for which the management of multiemployer funds is so important, sometimes employing more staff than the unions themselves.

The development of bargaining at the enterprise (or establishment) level, which is the legal and overwhelmingly dominant form of collective bargaining in the US, has also made a major contribution to the acculturation of organized labor to the world of insurance. But unlike sectoral bargaining, union representatives who negotiate thousands of separate agreements on working conditions, pay and fringe benefits (retirement, health, unemployment, sick leave) in thousands of companies or sites, have no influence on the management of health insurance coverage, which remains prerogative of employers. They do, however, partly negotiate the design of it (sharing of the premium between employers and employees, deductibles, co-payments). Some of them have at best managed to resist the growing tendency of non-union employers, which are not subject to bargain collectively, to shift health care costs towards workers (either through higher premium contributions, co-payments and deductibles, or narrower coverage)[6].

This resistance has not been easy for organized labor. Over the last two decades, many of the disputes arising when collective agreements need to be renewed have focused on defending health benefits, sometimes much more than wages. Health benefits remain a central component of most contract negotiations and a major cause of strike. For example, one of the issues that led to the 40-day strike called by the UAW at General Motors (GM) in autumn 2019 and again to the 6-week strike in 2023 concerned health benefits for its 46,000 unionized workers. Management wanted to shift part of the cost onto its employees but was unable to achieve this goal[7]. This is not stopping the Big three Detroit carmakers (GM, Ford, and Stellantis, ex. Fiat-Chrysler Automobiles), which are among the largest purchasers of health insurance as employers, from trying with the UAW to lower the cost of medical care[8] and, in the case of Ford, from including UAW representatives in a joint committee pursuing the same objectives.

Collectively bargained health coverage, whether administered exclusively by employers or jointly with union representatives (multiemployer plans), generally has lower family premiums than coverage offered by employers who are not subject to collective bargaining. Unionized workers contribute on average 4% and 6% of the premium depending on whether the coverage is individual or family, compared with 18% and 29% respectively for non-unionized workers. Similarly, cost-sharing for medical care is clearly in their favor, if we take into account the amount of out-of-pocket expenses, and so forth (Gabel *et alii*, 2015). While organized labor has historically been able to negotiate generous health coverage, mobilizing full-time union staff in its large local unions to do so, it has often been at the expense of its members' direct wages.

[6] UAW was able to negotiate health care coverage for their members entirely financed by the employer. Co-payments and deductibles at Ford were only introduced with the collective agreement of 1976.
[7] GM union workers only pay 4% of their healthcare costs. GM executives were willing to increase this share to 15% but they failed. By comparison, US workers pay in average 30% of their health insurance premium.
[8] Together with UAW, they created the National Institute for Health Care Reform.

2.3 Employers inclined to the status quo

In the US, employers are among the biggest purchasers on the private health insurance market. Providing health coverage remains one of their main tools for attracting and retaining staff in highly competitive labor markets, given the absence of universal insurance. So, they devote considerable resources to gaining expertise in this area, not only through specialized departments but also by using consultants to help them to design appropriate health care coverage. What's more, such coverage is pretty costly: private health insurance expenditure accounts for the largest share of fringe benefits[9]. It is also the fastest-growing cost among salary supplements. Actually, self-insured employers have little control over their contracts with healthcare providers, for which they generally relied on third-party administrators. Besides, health care purchasing is not a part of most employers' core competencies (Enthoven & Fuchs, 2006). As a result, it is extremely difficult for them to assess whether or not they have obtained the best contract.

Despite this adverse situation, Brown (1993) pointed out that they have been surprisingly silent or reserved in their demands for health policy reform for several reasons. On the one hand, they can pass the cost of healthcare along to employees as mentioned above. Secondly, they may limit wage increases in exchange. Finally, their interests differ across industries (in particular whether they belong to healthcare and health insurance industries or to other industries)[10], depending also on the size of the companies (large self-insured companies versus SMEs), and on the presence or absence of a trade union. They generally delegate those issues to specialized managers, and they are not ideologically inclined to call for greater public intervention or more control in this area.

Barely two decades later, employers' preference for the status quo is once again confirmed. Yet they continue more than ever to be confronted with an ever-increasing health insurance cost, an issue they would be in their objective interest to tackle. Their ambivalent attitude is illustrated by the Obamacare reform in 2010. They did little to exert influence in one way or the other. They did not publicly back the ACA. Nor did they take the risk of criticizing the reform and of bearing blame for its failure, showing themselves unable to take a coherent and unified stand at the time (Smyrl, 2014).

However, it has not prevented large companies from relaunching strategies over the last decade aimed at reducing (and regaining control of) health insurance costs after the failure of Health Maintenance Organizations (HMO) in the 1990s (known as managed care). HMOs are a type of prepaid group health insurance plan implemented in the mid-70s and designed to contain healthcare costs by integrating both healthcare financing and delivery of care (Coombs, 2005)[11]. More recently, some employers (Boeing, Intel, Walmart, Disney and, most recently, GM) have opted to negotiate directly with healthcare providers (hospitals, doctors) without insurance companies, and/or to adopt

[9] In 2023, the hourly labor cost for an employer in the private sector averages $ 43,11 of which $ 30,33 (70,4%) for wages and $ 12,77 for benefits (29,6%). Health insurance accounts for $ 2,94, that is 23% of fringe benefits (Employer costs for employee compensation, December 2023, Bureau of Labor Statistics).
[10] Executives of large firms often seat at hospital boards and have links with local doctors. They are not willing to
[11] HMOs assume full responsibility for financing and providing preventive care in exchange for a predetermined monthly or annual premium. This type of health insurance plan usually limits coverage to care from doctors, hospitals and other health care providers who work for or contract with the HMO.

limited, high-quality healthcare networks[12]. Others form coalitions and focus on solutions aimed at reducing drug bills, such as the Health Transformation Alliance created in 2016, which has around forty members (mainly large companies), or the one created in 2018 between JP Morgan Chase, Berkshire Hathaway and Amazon in the form of a joint subsidiary, but which ceased operations after two years.

3 Signs that the system is being challenged

Employers and unions are entrenched, as we have pointed out, in the employment-based health insurance system, of which they are key stakeholders. The ACA is based on preserving the occupational insurance system. It could however potentially weaken the system because it did not solve the major problem of escalating costs. Nonetheless, the law has created a new dynamic which is paving the way for contesting the system, through a form of low-key contestation on the part of employers, but through a more assertive way on the part of some labor organizations.

3.1 The ambivalence of employers, between loyalty and defection

For reasons outlined above, and as shown by the Employee Benefit Research Institute (EBRI) surveys, employers are unwilling to break the link between employment and health insurance[13]. Many continue to see this benefit as an essential tool for attracting and retaining high potential, highly skilled workers (loyalty). Nevertheless, their actions contribute to weakening the employment-based system, either by deserting it or by offering health coverage that is far less protective (defection).

Just over half of private sector establishments (55%) were offering health coverage to their employees in 2020, compared with 62% in 2010, according to the Bureau of Labor Statistics. As in the case of supplementary pensions, employers' cost-avoidance strategies for health coverage consist of offering less and less so-called "defined benefit" coverage, which guarantees a set basket of care in return for a premium, in favor of so-called "defined contribution" coverage, in which the employer contributes a fixed sum towards health costs, leaving it up to the employee to choose how to allocate it. This amounts to shifting the insurance risk from employers to employees.

These latter types of insurance contracts have existed since the 1980s under the name of "cafeteria plans", but they really took off when the Health Saving Accounts (HSA) came into force at the beginning of 2004. As their name suggests, these are individual savings accounts to which employees and employers contribute tax-free up to a certain limit. The proportion of private-sector employees with access to an HSA rose from 22% to 36% between 2014 and 2023, and in the case of large companies (500 workers or more), from 33% to 56% over the same period[14]. HSAs are generally associated with High Deductible Plans (low premium but high out-of-pocket expenses up to the

[12] Such as the Accountable Care Organizations created under the ACA, which are clinically and financially responsible for the care of a specific group of patients.
[13] With the exception of Warren Buffet who is running Berkshire Hathaway investment fund, who publicly declared in 2017 that a single payer system in the US would probably be the best way to contain health care costs.
[14] From US Bureau of Labor Statistics, National Compensation Survey, https://www.bls.gov/ebs/factsheets/high-deductible-health-plans-and-health-savings-accounts.htm

deductible). This type of combined contract (high-deductible contract + HSA) is popular. 28% of employers offered it in 2019, compared to 4% in 2005 (Maciejewski *et alii*, 2020).

Despite this trend, EBRI surveys also indicate that employers would be prepared to give up offering occupational health coverage to their employees if their competitors start to do so. In particular, they were curious about the potential impact of lowering the Medicare buy-in age from 65 to 60, a proposal put forward by candidate Joe Biden when Bernie Sanders dropped out of the race in the 2020 Democratic primaries. But employers remain deeply suspicious of the federal government's ability to bring down health insurance costs without deteriorating the quality of health coverage. They also might have been tempted to use ACA individual insurance marketplaces to insure their employees when this option is less expensive and offers better quality coverage than occupational coverage. A majority of employers have shown some interest in this alternative. But so far, the ACA has not led to a significant shift from occupational to individual coverage offered by insurance companies on ACA marketplaces.

3.2 Organized labor demands, from universal insurance to "Medicare for All"

Organized labor is far from speaking with one voice when it comes to future health insurance reforms, and in particular the introduction of a universal health system in its various possible forms, including the single payer option. Some unions may have supported this project in the past, like the United Auto Workers (UAW) automotive union, which led the fight within the AFL-CIO until the end of the 1980s, despite its commitment to collective bargaining on health benefits for its members. The UAW leadership role within the federation was however snatched away in the 1990s by the Services Union (SEIU), a rising union force representing many workers in the health and low-wage industries while the UAW was experiencing a decline in membership. The SEIU leader at the time, John Sweeney, who became president of the AFL-CIO in 1995, showed much less interest in a single-payer system, likely to offend his union base, which was attached to its multiemployer coverage but also convinced that employers would never take up this cause. As a result, the AFL-CIO, through its health committee, abandoned its support in favor of the single-payer option in 1993 and backed the Clinton reform bill, which was eventually rejected by the Senate in 1994 (Gottschalk, 2000).

The debates on health insurance reform and the adoption of the ACA in 2010 created a new dynamic within organized labor, but also produced frustrations and concerns. The desirability of universal health insurance and a single-payer system available to all residents (like the France's public health insurance system known as "l'Assurance Maladie", the National Health System in the United Kingdom or the Canada's universal publicly funded healthcare system) has re-entered the public debate in the 2000s. This is embodied in bills introduced by Democratic members of the House of Representatives and the Senate in virtually every federal congressional session since 2009, even if their content differs. The last bill has been reintroduced in 2023 by the Senate HELP chairman, Bernie Sanders. After twenty years of silence, the AFL-CIO passed a resolution at its 2013 convention in Los Angeles in favor of a public option and a single-payer system based on Medicare.

This type of resolution has been regularly renewed at its later conventions, in Saint Louis in 2017 and in Philadelphia in 2022, while specifying that organized labor must retain a role. "Our role is to move toward a single- payer system, like Medicare for All, that provides universal coverage using a social insurance model while retaining the critical role of workers' health plans"[15]. The prudence of these resolutions reflects the ambiguity of unions affiliated with the federation. The issue of a single-payer option is fracturing labor organizations, while most of them remain committed to collective bargaining on health benefits.

The current fragmentation of unions' stance does not exactly reflect the traditional distinction between craft and industrial unions, or between private and public sector unions. It is true that labor organizations, which are involved in the management of multiemployer plans and are more familiar with the legal language of contracts and insurance techniques want to keep playing an active role. This is particularly true for large unions like the building and construction trades or the IBT-Teamsters, known as the union of freight and warehouse workers with its more than 1,2 million members. Both have managed to negotiate not only good health coverage for their members, but also good wages and they clearly prefer the status quo. They were particularly critical of two ACA measures: first, the imposition of a tax on high-cost occupational health coverage (known as "Cadillac"), which is the case for most of the coverage negotiated by unions[16]. Second, the fear that employers would abandon occupational health coverage in favor of individual insurance on the regulated marketplaces. More generally, they also doubted the effectiveness of federal government intervention in this area.

However, some craft unions, which are not among the largest US union federations, are committed to a single-payer system. This is the case for the National Nurses' Union (NNU), the largest union of registered nurses whose 133,000 members are directly confronted with the malfunctioning of the health system. This is also the case for the Hotel and Restaurant Workers' Union (HERE). This union has negotiated health benefits for its 262,000 members which are so expensive that they threaten wage levels and also its ability to organize more establishments in such a low-wage industry. However, the Culinary Workers Union (CWU), an activist union with a strong militant culture, affiliated to HERE and representing casino workers (mostly women and Hispanic immigrants), does not share the vision of the union's international leadership. As it managed to obtain good health coverage for its 139,000 members through its multiemployer fund, it opposed the first proposal for a single-fund system (Medicare For All) introduced in Congress by Bernie Sanders first in 2019. On this occasion, the union demonstrated loudly when the Vermont's senator visited Nevada during the Democratic primaries.

In contrast, industrial unions such as UAW (383,000 members), USW (531,000 members), or public sector unions such as AFSCME (American federation of state, county and municipal employees, 1.2 million members) and AFT (American federation of teachers, 1.6 million members) are more open. They have come out publicly in favor of a single-payer system. Similarly, the service union (SEIU, 1.8 million members) and the

[15] Resolution 10: Winning Guaranteed Healthcare for All, 29th AFL-CIO Convention, June 13, 2022.
[16] The Cadillac tax was never implemented.

IAM machine operator's union (International association of machinists, 529,000 members), although they are administering multiemployer funds and, in the case of the former, played a central role in the adoption of the ACA, are now considering that a government-run health insurance system would free up space and energy for negotiating better wages and working conditions, by reducing the cost of health insurance for employers. This is an important argument. The share of annual compensation paid to Americans in the form of health insurance premiums rather than wages rose from 1.1% in 1960 to 4.2% in 1979 and 8.4% in 2018 (Bivens, 2020). And the ACA was not set up to meet health coverage needs of low-paid workers, who make up the bulk of SEIU and HERE members.

Nor was the ACA intended to meet the needs of workers with occupational health coverage. On the whole, however unions who support a single-payer system are also in favor of maintaining their role in running multiemployer plans and consequently, a role for private insurance companies (supplementary coverage). In addition, they pay little attention to informing their members and the public more generally about a single-payer system.

Conclusion

On the one hand, employers are adopting a wait-and-see attitude which consists of sidestepping the problems posed by employment-based health insurance. On the other hand, organized labor, although some unions have embraced the cause of universal single- payer system, is not taking any initiative in defining the rules of the game and in informing its members. Actually, their membership has been declining since the 1980s: between 1983 and 2023, the proportion of workers who were union members in the employed population has been halved, dropping from 20.1% to 10.8%. This decline is particularly pronounced in the private sector, where the proportion has fallen to just 6.3%, compared with 34.8% in the public sector.

The frequent discrepancy between organized labor's public statements and its actions and also between local and national (or international) unions stems from the fact that they have developed along the lines of business unionism, whose exclusive goal is to enlarge bargaining power of the wage-earners they represent. Therefore, they are inclined to refuse proposals that might displease their rank-and-file members. They also have strong links with the Democratic Party. Most of them have voted against the inclusion of Medicare for All in the party's platform in July 2020 in the midst of the Covid-19 pandemic, even though they had supported legislative proposals along these lines. Their priority is to defend their members' interests, not those of all workers. Negotiated health coverage secures members' loyalty to local unions. Breaking this link is seen as a threat to their survival.

Actually, labor unions are more likely to mobilize locally in favor of a single-payer system. They form alliances occasionally, that do not necessarily reflect the positions of their national federation. Since 2008, they have supported a number of legislative initiatives along these lines at state level (Vermont, California, New York, Illinois, Michigan, Colorado, Oregon), that have never come.

For all these reasons, employer-based insurance has persisted despite recent policy changes and broader trends, such as the Affordable Care Act (ACA) and health care cost inflation. However, new policy initiatives under Joe Biden's presidency (the extension of ACA subsidies[17] and the provision of a public option[18]) might push employers to reconsider offering health benefits to their workers. They might push unions to embrace the solution of a universal system, including a single-payer system. It is clear that today, the boldest initiatives are coming more from the world of politics than from the worlds of business and organized labor, although political obstacles to transforming the system must not be underestimated. So, for such a solution to stand a chance, regardless of institutional barriers pointed out in this article, Democrats would need to control both the White House and the Congress (House of Representatives and the Senate), a situation that prevailed during the landmark healthcare reforms of 1965 (Medicare and Medicaid) and 2010 (ACA), but which is unlikely to recur for the time being.

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[17] The American Rescue Plan (ARP) expanded subsidy eligibility and generosity for people who purchased health insurance plans on the marketplaces established by the ACA (14,5 million Americans in 2022), and the Inflation Reduction Act (IRA) has extended these enhanced subsidies through 2025.

[18] The Biden administration also has explored adding a "public option" to ACA exchanges.

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