From Loophole to Mandate

BY KARL RHODES

Federal policies have fostered employment-based health insurance

Employment-based health insurance was born at Baylor Hospital in 1929. At the time, most births still happened at home, but on the eve of the Great Depression, health care delivery and health care financing were on the brink of dramatic transformations.

In 1929, many medical services were beginning to move from homes to hospitals as people became aware of significant advances in medical science. These breakthroughs made institutional health care more attractive, but just as the demand for hospital services was increasing, people's ability to pay for those services was decreasing.

When Justin Ford Kimball was put in charge of Baylor Hospital in Dallas, he quickly discovered that many of its patients were not paying their bills. He also noticed that many of those nonpayers were teachers in the public school system, where he had served previously as superintendent. So Kimball devised a prepaid group hospitalization plan for teachers in the Dallas area. For 50 cents a month, they could purchase insurance that would pay for up to three weeks in Baylor Hospital.

The idea caught on with other hospitals, and by 1940, several of these prepaid plans were operating under the Blue Cross banner following guidelines from the American Hospital Association (AHA). The success of the Blue Cross plans demonstrated that focusing on large groups of employed people could make health insurance work by mitigating the problem of adverse selection — the concern that only sick people would sign up for such plans.

Less than 10 percent of Americans were covered by health insurance in 1940. That percentage was growing as more Blue Cross plans took shape and as commercial insurers began to enter the market, but it was federal government policies that made employment-sponsored health insurance the dominant financing mechanism for American health care. During World War II, the United States instituted strict wage controls administered by the National War Labor Board, but the board did not define employer-paid health care premiums as wages. Faced with surging demand for goods and services and a shortage of traditional workers, corporations started offering group health insurance. By 1957, more than 75 percent of Americans were covered by health insurance, and the vast majority of that coverage was obtained through employer-sponsored plans.

The employment-based system was much better than the charity-based system of hospital financing that it gradually replaced. It kept many hospitals in business, mitigated the problem of adverse selection, introduced economies of scale, and increased access to health care for many people. The system also helped finance the development of new technologies and new drugs that were highly effective. But economists have argued that linking health insurance to employment distorted a variety of labor market decisions and contributed to excessive levels of health care coverage and health care spending.

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A plaque at Baylor University Hospital marks the birthplace of Blue Cross.

Despite these flaws, the employer-sponsored system is not likely to go away anytime soon. In fact, mandating employer-sponsored health insurance for employers with 50 or more full-time-equivalent workers is a key provision of the Patient Protection and Affordable Care Act, also known as "Obamacare." The Act's employer mandate, which takes effect next year, may alleviate some existing labor market distortions while potentially creating some new ones.

Early History

In 1847, the Massachusetts Health Insurance Co. started issuing "sickness" insurance to cover lost wages. At the time, replacing wages was a far bigger issue for sick people than paying health care expenses because most medical treatments were inexpensive and ineffective. Many people resorted to institutional health care only in desperation.

Some employers and labor unions maintained sickness funds, primarily to offset lost wages, and in the late 1800s, a few larger corporations — mostly railroads, lumber companies, and mining operations — started deducting fees from employees' wages to pay company doctors. These arrangements helped inspire the Blue Cross and Blue Shield plans that emerged in the 20th century.

By 1920, there were 16 European countries with some form of compulsory national health insurance, according to Melissa Thomasson, an economics professor at Miami University's Farmer School of Business. In sharp contrast, American movements to create compulsory health insurance programs failed in 16 states during the 1910s.

"We didn't really have the labor movement until the Progressive Era, and when World War I hit, a lot of anti-European sentiment took over," she explains. "We didn't have the strong centralized government that could make things happen, and on the state level, there wasn't the organization and the impetus to make it happen."

But the biggest reason why the United States did not follow Europe's lead was a simple lack of demand. "The public had little confidence in the efficacy of medical care," Thomasson wrote in a 2002 article in *Explorations in Economic History*. "Patients were typically treated at home, and hospitals were charity institutions where the danger of cross-infection gave them well-earned reputations as places of death."

There was a huge difference between good physicians and bad physicians, she notes, but even the best doctors provided few effective treatments. "Good physicians who were educated before 1920 could diagnose you accurately, they could set bones, they could give you diphtheria antitoxin, and they could talk about hygiene, but that's about it."

The development of antibacterial sulfonamides (sulfa drugs) did the most to boost public confidence in doctors and hospitals, Thomasson says. "In 1924, Calvin Coolidge's son gets a blister on his big toe. It goes septic and he dies. In 1936, Franklin Roosevelt's son contracts strep throat. It goes septic and they think he's going to die, but researchers at Johns Hopkins were testing sulfa drugs at the time. They give them to Roosevelt and he makes a miraculous recovery."

This 1920s X-ray machine likely was in service at Baylor when the hospital's leader, Justin Ford Kimball, established the Blue Cross prototype plan in 1929.

The Blue Period

In the early 20th century, hospital care was financed largely by charitable contributions and patient payments, and both of these funding sources were running dry during the Great Depression.

Many hospitals started offering prepaid plans patterned after the Baylor model. As they began to spin off these insurance plans under the Blue Cross banner, the AHA endorsed the ones that followed its guidelines. "The AHA wanted to think about how these plans should be structured, but also they wanted to reduce inter-hospital competition," Thomasson notes. "They didn't want two plans in the same area competing against each other and driving down prices."

Blue Cross programs became nonprofit organizations that received exemptions from taxes and state insurance regulations in exchange for offering community-rated plans. In other words, everyone in a group — sick and healthy alike — paid the same premium. Typically, the Blue Cross plans offered insurance to large groups of employees, which mitigated the problem of adverse selection by providing safety in numbers and by excluding people who were too sick to hold jobs. In an era when work was more physical and employers could avoid hiring people with chronic ailments, a job was a reasonable proxy for good health.

Until the advent of Blue Cross, most physicians had opposed health care insurance because they believed that third-party payers would diminish the quality of medical care by reducing doctors' income and autonomy. The American Medical Association (AMA) successfully lobbied against a provision in the Social Security Act that would have established compulsory national health insurance. But by the late 1930s, the threat of national health insurance and the success of Blue Cross plans prodded physicians to come up with health care plans of their own under the Blue Shield banner. "They were loath to start Blue Shield," Thomasson says, "but they thought perhaps they should forestall any

future efforts for national health insurance by coming up with their own plan."

Taking their cues from the Blues, commercial insurers also started offering health insurance plans. But they were under no obligation to offer community-rated insurance, so they began providing experience-rated plans with lower premiums for healthy people. This practice skimmed some of the cream off the pools of Blue Cross and Blue Shield. According to Thomasson, there is evidence that the Blues were in an "adverse selection death spiral" as early as the mid-1950s. To escape the problems that stemmed from their obligations to community-rate their plans, most of the Blues became traditional insurance companies in the 1980s and 1990s.

Are Benefits Wages?

During World War II, the Stabilization Act of 1942 imposed price and wage controls, but because of the war, demand for goods and services was going up, and the traditional supply of workers (able-bodied men) was going down. So the National War Labor Board allowed corporations to use "fringe benefits" — including company-sponsored health insurance — to recruit and retain workers.

"I don't think it was intended as a loophole," Thomasson says. "I don't think they realized what they were about to set in motion. I think they thought, 'well, it's small potatoes, we're not going to worry about it.' They had no way of foreseeing the amazing medical advances that would increase demand and the subsequent tax treatment that would increase demand again."

For purposes of wage control, the War Labor Board ruled that employer-paid health insurance premiums were *not* "wages," but for purposes of collective bargaining, the National Labor Relations Board (NLRB) ruled in 1948 that fringe benefits essentially *were* wages.

"The labor unions liked it as a benefit that they could bargain for, so when the NLRB said, 'yes, this is something that can be subject to collective bargaining,' the unions became invested," says Thomas Buchmueller, a health economist at the University of Michigan's Ross School of Business.

Another key federal policy emerged in 1954, when the Internal Revenue Service ruled that employer-paid health insurance premiums were *not* wages for tax purposes. The law also clarified that employer-paid premiums were fully tax-deductible for employers.

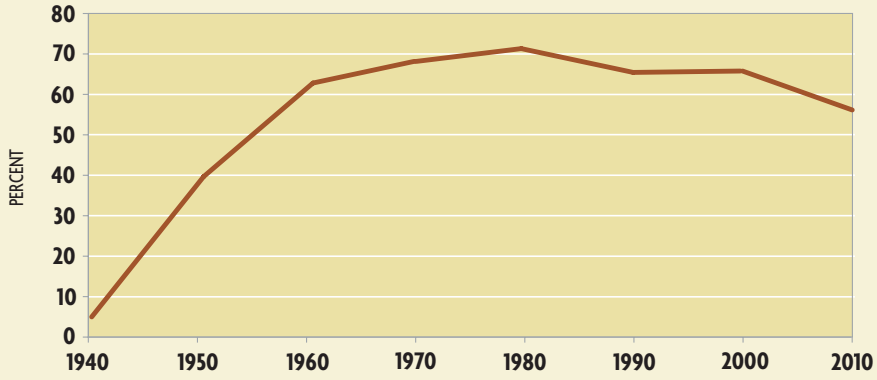
"The thing that really cements it is the tax treatment," Buchmueller says. "The war is over. You have a number of large firms that still have these benefit plans, so the question arises, 'Is this compensation?' And when the IRS says it is not going to consider this taxable income, it created essentially a subsidy where the employer could provide a dollar's worth of benefits for less than a dollar's worth of after-tax cost. The tax angle continues to be part of the business case to this day."

Conflicting federal definitions of "wages" were important catalysts for the growth of employer-sponsored health insurance, but the inadequacy and awkwardness of the charity-based system also was a big factor. During the Great Depression, hospitals quickly discovered that charity and individual payers could no longer fund their growing operations. Some employers maintained charitable funds to assist sick workers, but the collecting and distributing of those funds was burdensome.

Even the corporate number crunchers viewed this burden as a primary problem. In the 1960s — long after the dissolution of the National War Labor Board — actuarial pioneer Wendell Milliman listed four reasons why employers were adopting group health and life insurance plans. His *first* reason was to "eliminate 'passing the hat' among a worker's fellow employees in case of illness or death." His *fourth* reason was to "help in attracting and holding capable employees."

The Rise and Decline of Employer-Sponsored Health Insurance

Percentage of U.S. Population Covered



NOTE: Numbers for 1940, 1950, and 1960 are Health Insurance Council estimates based on the number of people covered by group hospitalization policies issued by traditional insurance companies, Blue Cross, Blue Shield, and medical societies. Most, but not all, of these policies were employer-sponsored. Numbers for 1970 through 2010 are National Health Interview Survey estimates of the percentage of people under age 65 with employer-sponsored health insurance coverage.

Advantages and Disadvantages

By 1980, the employer-based system was providing health insurance to 71 percent of Americans under the age of 65, while Medicare and Medicaid were covering many retirees and other jobless people (see chart). More than 10 percent of the population still lacked coverage, but the system created enough payers to subsidize significant amounts of charity care for nonpayers.

After 1980, however, the share of Americans covered by employer-sponsored health insurance started to decline as the system became increasingly costly.

Employer-sponsored insurance is a good system for the people who can afford it, Thomasson says. "But it limits labor market mobility. It distorts labor market decisions, and the tax treatment

encourages an overprovision of benefits relative to wages."

Labor economists generally agree that employers cover nearly all of their health insurance costs by paying lower wages, but employees who might want to opt out of employer-sponsored health insurance plans typically have no way of capturing their employers' contributions in the form of higher wages. So a young, healthy employee who might be better off with a catastrophic-coverage plan — or no plan at all — might still sign up for his employer's highly comprehensive plan because the employer contribution and the tax subsidy make the deal somewhat beneficial to him.

"Once I am in such a plan, if I get sick, I am going to use more care." Buchmueller asserts. "That's the moral hazard problem. There is really no benefit to me individually to be a hero because the premiums are shared across the whole pool. So more generous coverage leads to greater use of care, which leads to higher premiums."

Tax subsidies, in particular, encourage firms to offer and employees to accept more insurance, as Thomasson noted in a 2003 article in *American Economic Review*. She examined data from the 1953 and 1958 Nationwide Family Expenditures Surveys and estimated the short-term effect of the 1954 IRS ruling. Thomasson found that the tax subsidy increased the amount of coverage purchased by 9.5 percent during that initial five-year period.

Tax-subsidy distortions can be an issue with any insurance system, Buchmueller notes, "but job-lock issues are unique to employer-sponsored health insurance." He cites the example of a worker who wants to retire early. "Prior to the Affordable Care Act, you could have a really hard time going out in the market and buying health insurance, so you might stay in your job until you turn 65. Maybe you want to retire fully, maybe you want to cut back your hours, maybe you want to move to consultant status, but all of those options, which may be preferable to you, are going to be constrained by the availability of health insurance."

Most labor economists acknowledge that job lock is a problem because it makes labor markets less flexible, but they disagree about the magnitude of the problem. Harvard economist Brigitte Madrian analyzed data from the 1987 National Medical Expenditure Survey and estimated that job lock reduced voluntary turnover by 25 percent. Kanika Kapur, an economist at University College Dublin and RAND Corp., later crunched the same numbers and found "insignificant estimates of job lock."

Whatever the extent of the problem, the Affordable Care Act could mitigate some of the effects, according to Thomasson. "We often hear that the Affordable Care Act will destroy jobs because firms won't want more than 50 employees," she says. "But on the other hand, I know people who work for big corporations who would love to start their own businesses, but they don't because of the lack of benefits. So in some ways, having a place for people to be able to purchase affordable insurance outside of the workplace could be a good thing for job creation."

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After the Affordable Care Act's employer mandate takes effect, Buchmueller expects most large employers to continue offering health insurance because tax subsidies and economies of scale remain substantial and because risk-pooling remains effective. "The individual health insurance market is still plagued by adverse selection," he notes. "But with employer-sponsored coverage, you have a group of people who have been brought together for reasons other than purchasing insurance. You have a range of ages, and generally it's a relatively healthy pool."

Thomasson agrees, but she hedges her prediction with an alternative scenario: What if one high-profile firm dropped its coverage, paid the penalty, and raised wages by more than enough to cover the average cost of obtaining health insurance in an exchange? "That firm might lure the people who are less attracted by benefits — the healthier, younger, smarter people," she says. Then other firms might start competing on the basis of higher wages instead of better health insurance.

Just as government loopholes for employer-sponsored health insurance have distorted the labor market, government mandates for employer-sponsored health insurance are likely to distort the labor market, too. "My guess is we will see changes on the margin in the short run," Thomasson says. "For example, firms that are close to that 50 limit may act differently, but I think it's going to take a few years for people to see how it all will work."

Large companies that employ many low-wage workers will face the biggest challenge, Buchmueller predicts. "Those firms are toying with ideas of shifting workers to part-time schedules or just sucking it up and offering them benefits or paying the penalty. But for the bulk of large firms that are currently offering insurance, the calculation has not changed that much." **EF**

Readings

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