

The Organization of Health Insurance Markets

This section deals with some of the specifics of insurance markets in the US – mainly the importance and effects of employer-provided health insurance.

I. Employer Provision of Health Insurance

Most people with insurance obtain it through their employer through either private insurance, Blue Cross and Blue Shield plans, managed care plans or self insured companies

In 2007 expenditures in health care were almost \$1.9 trillion. Of this about 45 percent was paid with public funds and 55 percent was privately funded. This percentage has not changed much over the last 20 years: in 1980 public funds accounted for about 40 percent of expenditures.

Note that out of pocket payments have dropped dramatically (in %terms) from 1970 to 2005. in 1970 out-of-pocket payments accounted for about 40% of expenditures, by 200 or so, this dropped to 15%. Most of the shift going to private health insurance.

More detail is below in the table from the Centers for Medicare & Medicaid Services.

<http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf>

Table 6 Personal Health Care Expenditures Aggregate, Per Capita Amounts, and Percent Distribution, by Source of Funds: Selected Calendar Years 1970-2007

		Third-Party Payments								
						Public				
Year	Total	Out-of-Pocket Payments	Total	Private Health Insurance	Other Private Funds	Total	Federal ¹	State and Local ¹	Medicare ²	Medicaid ³
Billions of Dollars										
1970	\$62.9	\$24.9	\$38.0	\$14.1	\$1.7	\$22.2	\$14.4	\$7.8	\$7.3	\$5.0
1980	214.8	58.1	156.6	61.2	9.2	86.2	62.3	23.9	36.1	24.7
1990	607.6	136.2	471.4	204.6	30.5	236.3	172.8	63.5	106.6	69.7
2000	1,139.2	192.6	946.6	402.8	57.0	486.9	369.7	117.1	215.9	187.0
2001	1,238.3	199.5	1,038.8	441.0	56.4	541.4	411.7	129.7	238.8	208.9
2002	1,340.3	211.2	1,129.1	482.3	58.3	588.6	448.3	140.3	256.0	230.7
2003	1,447.5	224.6	1,222.9	521.5	63.8	637.6	486.5	151.1	274.1	250.9
2004	1,550.2	234.9	1,315.4	560.6	65.0	689.8	527.6	162.1	300.6	269.9
2005	1,655.1	247.0	1,408.2	598.9	69.0	740.2	563.3	176.9	327.4	288.8
2006	1,765.5	255.0	1,510.5	637.9	73.8	798.7	620.6	178.1	382.8	285.4
2007	1,878.3	268.6	1,609.7	680.3	78.8	850.6	663.0	187.6	409.6	303.9
Per Capita Amount in Dollars										
1970	\$299	\$119	\$181	\$67	\$8	\$106	\$69	\$37	(4)	(4)
1980	932	252	680	266	40	374	270	104	(4)	(4)
1990	2,394	536	1,857	806	120	931	681	250	(4)	(4)

2000	4,032	682	3,350	1,426	202	1,723	1,309	415	(4)	(4)
2001	4,339	699	3,640	1,545	198	1,897	1,443	454	(4)	(4)
2002	4,651	733	3,918	1,674	202	2,042	1,556	487	(4)	(4)
2003	4,979	773	4,206	1,794	219	2,193	1,673	520	(4)	(4)
2004	5,281	800	4,481	1,910	221	2,350	1,798	552	(4)	(4)
2005	5,588	834	4,755	2,022	233	2,499	1,902	597	(4)	(4)
2006	5,902	852	5,049	2,133	247	2,670	2,075	596	(4)	(4)
2007	6,219	889	5,330	2,253	261	2,816	2,195	621	(4)	(4)
Percent Distribution										
1970	100.0	39.6	60.4	22.3	2.8	35.3	22.9	12.4	11.6	8.0
1980	100.0	27.1	72.9	28.5	4.3	40.1	29.0	11.1	16.8	11.5
1990	100.0	22.4	77.6	33.7	5.0	38.9	28.4	10.4	17.5	11.5
2000	100.0	16.9	83.1	35.4	5.0	42.7	32.5	10.3	18.9	16.4
2001	100.0	16.1	83.9	35.6	4.6	43.7	33.2	10.5	19.3	16.9
2002	100.0	15.8	84.2	36.0	4.3	43.9	33.4	10.5	19.1	17.2
2003	100.0	15.5	84.5	36.0	4.4	44.0	33.6	10.4	18.9	17.3
2004	100.0	15.2	84.8	36.2	4.2	44.5	34.0	10.5	19.4	17.4
2005	100.0	14.9	85.1	36.2	4.2	44.7	34.0	10.7	19.8	17.4
2006	100.0	14.4	85.6	36.1	4.2	45.2	35.2	10.1	21.7	16.2
2007	100.0	14.3	85.7	36.2	4.2	45.3	35.3	10.0	21.8	16.2

¹ Includes State Children's Health Insurance Program (Title XXI) and State Children's Health Insurance Program (SCHIP) expansion (Title XIX). ²Subset of Federal funds. ³Subset of Federal and State and local funds. ⁴Calculation of per capita estimates is inappropriate. NOTE: Per capita amounts based on July 1 Census resident-based population estimates for each year. Numbers and percents may not add due to rounding. Dollar amounts shown are in current dollars. SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group; U.S. Bureau of the Census.

Note the large change in the out of pocket proportion. Almost 40% of total expenditures in 1970, declined to 17% in 2000. The percentage for 2007 is 14.3%. So other than those on public programs, the majority of health care is funded through insurance.

The existence of private insurance came largely out of the Great Depression. Prior to this there was no such market, or people were self insured.

Depression hit hospitals and physicians very hard. So in an effort to get back patients Hospitals provided the initial capital to start the Blue Cross plans and controlled the organization. Physicians did the same to start the Blue Shield plans. These were non-profit insurers controlled by their prospective provider and thus served their interest. In the 1970s these organizations were split off from the providers. Most states "Blues" have merged together into one Blue Cross/Blue Shield independent non-profit organizations. These plans were originally given special tax exemptions, which made them more attractive to employers, since they were able to offer cheaper coverage, but these advantages have withered as the tax laws and insurance laws have changed.

Most coverage is financed by employers. During WWII there were wage and price controls which fixed earnings, but the federal govt. exempted health insurance benefits (and others) from

these freezes. Employer-paid insurance premiums are excluded from the taxable income of workers (this cost about 50 billion in tax revenues in 2001). To see how this encourages compensation in the form of benefits consider the following example

An individual earns \$1,000 per week and would like to buy health insurance. Suppose he is in the 28% tax bracket so his take home pay is \$720 per week. If his insurance cost \$50 per week then his take home pay would be \$670 per week. Now suppose that his employer provided his insurance for him at a cost of \$50 and pays him \$950 in cash so that his compensation is the same. His take home pay is now 72% of 950 which is \$684. So he is \$14 better off if his employer provides the insurance. Employers also benefit from this since they do not have to pay Social Security taxes on the \$50 since it is considered an expense and not a factor payment.

Note also that the cost of the same level of coverage will not be the same if the worker buys an individual policy than if he gets it through his employer. Employers will pool risk groups making the insurance company more willing to provide insurance. Thus the worker can get more for his money if he gets the coverage through his employer.

Changes over time

Data from the Employee Benefit Research Institute show that Employer-based coverage reached its peak in the 1980s and has been declining since then. Between 1987 and 1999 coverage of workers ages 18-64 fell 2.8 percentage points, between 1999 and 2004 it fell another 3.5 percentage points. Thus, 6.3 percentage points over the 1987 to 2004 period. Data from the Bureau of Labor Statistics show a decline for full-time workers in the private sector of 15 percentage points between 1989 and 2003.

Another large shift that has occurred in employer-based insurance is its transformation from quasi-social insurance to insurance based on actuarial principles. The latter assumes that insurance is to protect against unpredictable risks for individuals or subgroups; if risks are predictable, premiums are adjusted for the differential. Under social insurance, individuals or subgroups who are expected to use more care to not pay a differential premium; the excess costs are shared collectively – those with lower risk cross-subsidize those with higher risk.

Early in the post WWII period employment-based insurance was mostly quasi-social insurance. The principle underwriters were nonprofit Blues; they typically followed community rating in pricing their policies. Thus, there was considerable cross-subsidization of insurance across industries and firms in the same community and across workers in the same firm. This cross-subsidization was facilitated by the dominance of large firms in many of the most important industries of the time – GM, US Steel, Alcoa, and DuPont – who enjoyed substantial profit and were shielded from both domestic and global competition. In regulated industries, profits were even more secure allowing such firms as AT&T, the largest private employer, to offer generous health insurance benefits to its employees. When premiums rose, AT&T could easily pass on the increase to telephone subscribers. Now AT&T is in a competitive struggle with many other companies, and competition in the auto industry is driving GM close to bankruptcy.

Strong unions also played a role in the spread of employment-based insurance. In industries dominated by a few giant firms, unions used their “countervailing power” to make the firms share some of their potential profits with workers in the form of higher wages and generous health insurance benefits. Unions provide a “collective voice” to the worker’s needs and so allow the compensation (as well as working conditions and other aspects of the job) to be divided into the components that are most valuable to those particular groups of workers. In the absence of unionism there is much less flexibility.

In industries with many small firms, such as residential construction or clothing manufacturing, unions organized industry-wide labor-management health insurance plans that provided considerable cross-subsidization among firms and among individual employees within firms by charging uniform premiums regardless of expected utilization.

Large-scale entry of commercial health insurance companies into employment-based insurance led to a shift from community rated plans to those with premiums based on actuarial risk. The community rating system could not survive when those groups with below-average expected utilization were skimmed off by the offer of lower premiums. The actuarial approach quickly evolved into “experience rating” where the premium for a group in any given year is based on its use of services in the previous year. Larger firms realized that it was cheaper to self-insure, and self-insurance received an additional boost in 1974 when the Employee Retirement Income Security Act (ERISA) prohibited states from applying coverage mandates to self-insured plans. The world of employment-based insurance is now largely one of every firm on its own, and the advent of health savings accounts reduces cross-subsidization even among employees in the same firm. As firm size has decreased and markets have become more competitive, this has made things even tougher.

Flaws in the system

Today the flaws in employment-based insurance are apparent:

1. administrative costs. The need for more than 1000 health insurance companies to sell and contract with millions of employers, underwriting each one, adds greatly to administrative overhead. The website for America’s Health Insurance Plans (AHIP) claims 1300 member companies (<http://www.ahip.org/content/default.aspx?bc=36>). Administrative costs are estimated to be on the order of 11 percent of the premium, and this does not include the cost to employers to purchase and manage health care spending, including consultants, benefits managers, and brokers.
2. allocation of costs. Under job-based insurance, the costs of health care are passed on to workers in a way that many people believe is inequitable. In competitive markets, employers’ contributions to health insurance typically result in lower wages (see below). Average earnings have been pretty flat (after adjustment for inflation), while health care costs have been increasing. Before taxes, the cost of \$10k per year is borne approximately equally by a worker making 30k and by one whose salary is 200k. After taxes, higher-paid workers actually pay less for health insurance than lower-paid workers, because they are in higher tax brackets.
3. coverage of the population. Employer coverage leaves out many people and cannot provide the basis for comprehensive coverage of the whole population that is not aged, disabled, or poor. Only 60% of firms with 1-199 workers offered coverage in 2005, about 20 percent of workers in firms that offer insurance are not eligible. Small firms are least likely to offer coverage. People lose their coverage when they lose their jobs. Job-based coverage leaves out many self-employed, nonpoor, and pre-Medicare widows.
4. labor-management relationships. Employer-based insurance is an important contributor to labor-management strife and bankruptcies. It also affects job mobility. As employers attempt to pass on insurance costs to employees, that are forced to do painful things such as reducing coverage or reducing wages. *Note that when the price of gasoline increases to more than \$3.00 per gallon, we don’t yell at our employer as if it is his/her fault.*
5. misaligned incentives. Employment-based insurance has assigned to employers the responsibility to manage health care purchasing for most Americans, but employers have, at best, weak incentives to act collectively to increase the efficiency of the system. Health care purchasing is not a part of most employers’ “core competencies”. As it has

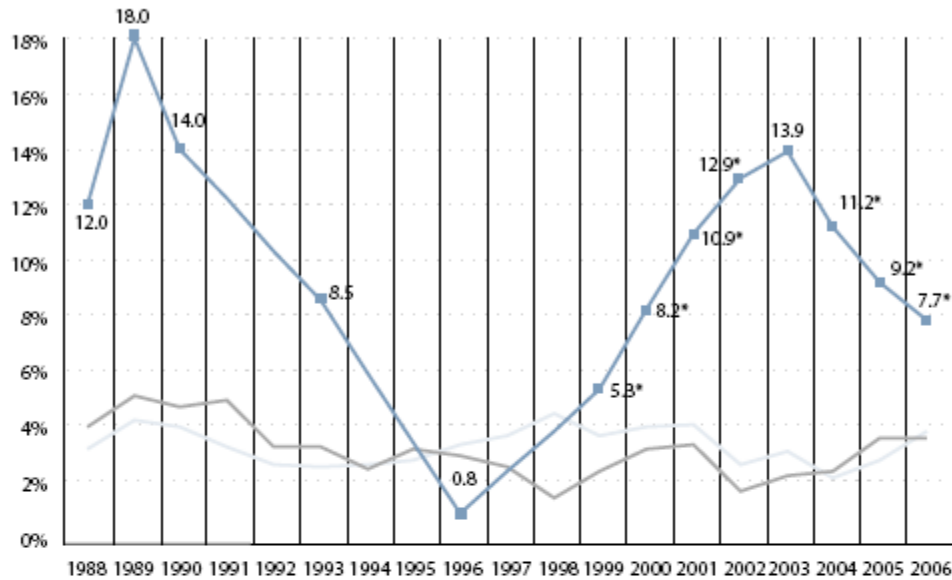
- evolved, employer insurance has helped perpetuate the inefficiencies inherent in the fragmented, uncoordinated fee-for-service small-scale practice model that still accounts for most health care delivery. FFS contains incentives for overuse, underuse, and misuse. There are few incentives for disease management, or any other type of preventative care, etc. Firms are not in the position to negotiate with multiple providers and offer a menu of contracts to their employees. This increases the bargaining position of the insurer, and does not allow the employee to appreciate any savings (or extra expense) inherent in any given plan.
6. The 'Graying' of Group Health Insurance. Note that the declines in employer coverage have not been uniform across all demographic groups. Private coverage has been in a slow decline since the late 1980s, and younger and lower-income groups have disproportionately lost coverage. Between 2000 and 2004, for example, declines in employment-based coverage were steepest for younger and low-income people, while coverage rates for older non-elderly adults (55-64) increased slightly. Note that this could affect the stability of the system over time: if those with systematically lower spending are more likely to lose coverage over time, the effects of increasing costs and declining coverage could become multiplied. This type of an effect suggests that that huge problem looming ahead for Medicare, may actually hit private insurance first!

For these reasons, many economists now feel that it is time to get past employer-based insurance. This is not saying that employers should not contribute to the cost (though some arguments can be made for that as well), but that the risk pool should not be based on the place of employment.

Trends in Employer coverage

EXHIBIT A

Percentage Increase in Health Insurance Premiums Compared to Other Indicators, 1988–2006



Year	1988	1989	1990	1993	1996	1999	2000	2001	2002	2003	2004	2005	2006	Indicator
HEALTH INSURANCE PREMIUMS	12.0	18.0	14.0	8.5	0.8	5.3*	8.2*	10.9*	12.9*	13.9	11.2*	9.2*	7.7*	HEALTH INSURANCE PREMIUMS
OVERALL INFLATION	3.9	5.1	4.7	3.2	2.9	2.3	3.1	3.3	1.6	2.2	2.3	3.5	3.5	OVERALL INFLATION
WORKERS' EARNINGS‡	3.1	4.2	3.9	2.5	3.3	3.6	3.9	4.0	2.6	3.0	2.1	2.7	3.8	WORKERS' EARNINGS‡

* Estimate is statistically different from the estimate for the previous year shown at $p < .05$. No statistical tests are conducted for years prior to 1999.

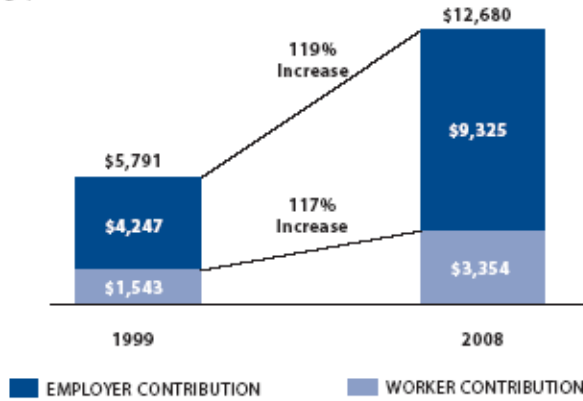
‡ Data on percentage increase in workers' earnings are seasonally adjusted data from the Current Employment Statistics survey (April to April). For additional information about this data, see the Survey Design and Methods section in the full report.

Note: Data on premium increases reflect the cost of health insurance premiums for a family of four. For additional information about the increase in workers' earnings estimate, see the Survey Design and Methods section in the full report.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2006; KPMG Survey of Employer-Sponsored Health Benefits, 1993, 1996; The Health Insurance Association of America (HIAA), 1988, 1989, 1990; Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1988–2006; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey (April to April), 1988–2006.

EXHIBIT A

Average Health Insurance Premiums and Worker Contributions for Family Coverage, 1999–2008



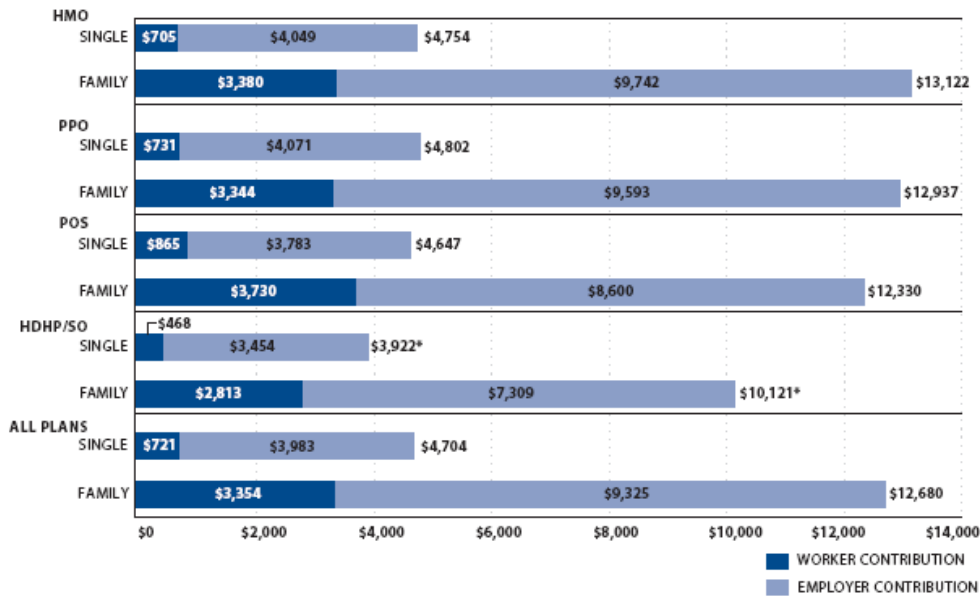
Note: The average worker contribution and the average employer contribution do not add to the average total premium due to rounding.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2008.

Note that the employee’s percentage of the premium has not changed much. In 1999 it was $1543/5791=26.6\%$. In 2008 it was $3354/12680=26.5\%$.

EXHIBIT B

Average Annual Firm and Worker Premium Contributions and Total Premiums for Covered Workers for Single and Family Coverage, by Plan Type, 2008



* Estimate of Total Premium is statistically different from All Plans estimate by coverage type ($p < .05$).

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2008.

Percentage of Firms Offering Health Benefits, by Firm Size, 1999–2008

FIRM SIZE	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
3–9 Workers	56%	57%	58%	58%	55%	52%	47%	48%	45%	49%
All Small Firms (3–199 Workers)	65%	68%	68%	66%	65%	63%	59%	60%	59%	62%
All Large Firms (200 or More Workers)	99%	99%	99%	98%	98%	99%	98%	98%	99%	99%
ALL FIRMS	66%	69%	68%	66%	66%	63%	60%	61%	60%	63%

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2006.

Offer rates have decreased the most for small firms.

Percentage of All Workers Covered by Their Employers' Health Benefits, in Firms Both Offering and Not Offering Health Benefits, by Firm Size, 1999–2008*										
FIRM SIZE	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
3–24 Workers	50%	50%	49%	45%	44%	43%	41%	45%	42%	43%
25–49 Workers	56	63	62	57	59	56	55	55	51	57
50–199 Workers	61	62	67	64	61	56	59	62	59	60
200–999 Workers	69	69	71	69	68	69	65	66	65	67
1,000–4,999 Workers	68	68	69	70	69	68	69	68	69	69
5,000 or More Workers	64	66	69	68	68	67	66	60	63	64
All Small Firms (3–199 Workers)	55%	57%	58%	54%	53%	50%	50%	53%	50%	52%
All Large Firms (200 or More Workers)	66%	67%	69%	69%	68%	68%	66%	63%	65%	66%
ALL FIRMS	62%	63%	65%	63%	62%	61%	60%	59%	59%	60%

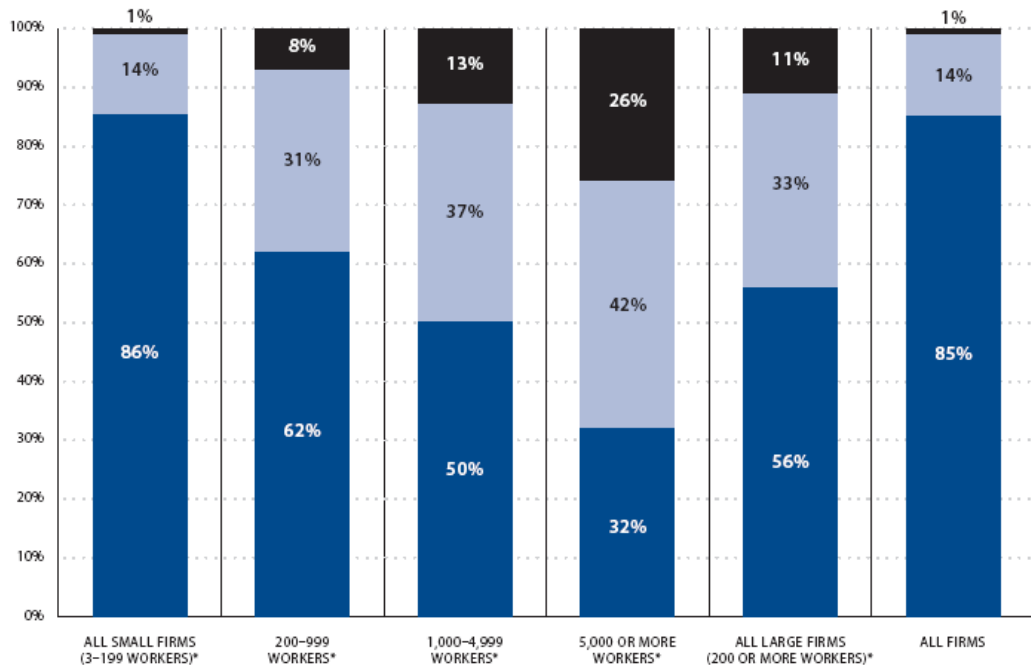
SOURCE:
Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2008.

* Tests found no statistical difference from estimate for the previous year shown (p<.05).

Coverage rates have not declined as much – except for the smallest firms

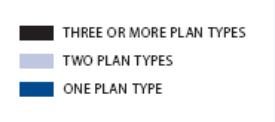
EXHIBIT 4.1

Among Firms Offering Health Benefits, Percentage That Offer One, Two, or Three or More Plan Types, by Firm Size, 2008[†]



SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2008.



* Distribution is statistically different from distribution for all other firms not in the indicated size category ($p < .05$).

† Although firms may offer more than one of each plan type, the survey asks how many are offered among the following types: conventional, HMO, PPO, POS, and HDHP/SO.

Note: The survey asks firms how many plans of each given type they offer. However, we do not know if each plan type is offered to all covered workers at the firm. For example, some workers might be offered one type of plan at one location, while at another location they are offered a different type of plan.

Most firms are only offering one or two types of plans.

EXHIBIT 10.1

Percentage of Covered Workers in Partially or Completely Self-Funded Plans, by Firm Size, 1999–2008*

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
3–199 Workers	13%	15%	17%	13%	10%	10%	13%	13%	12%	12%
200–999 Workers	51	53	52	48	50	50	53	53	53	47
1,000–4,999 Workers	62	69	66	67	71	78	78	77	76	76
5,000 or More Workers	62	72	70	72	79	80	82	89	86	89
ALL FIRMS	44%	49%	49%	49%	52%	54%	54%	55%	55%	55%

SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2008.

* Tests found no statistical difference from estimate for the previous year shown (p<.05).

Note: Due to a change in the survey questionnaire, funding status was not asked of firms with conventional plans in 2006. Therefore, conventional plan funding status is not included in this figure for 2006. For definitions of Self-Funded and Fully Insured plans, see the introduction to Section 10.

Self insurance has become more prominent – among large firms
Benefits include exemption from state regulations and state insurance premium taxes (as per ERISA). Requires large pool of enrollees to spread risk sufficiently.

How competitive is the insurance industry?

The US is unique in its reliance on the private insurance sector to finance healthcare for its residents (in the Netherlands and Switzerland individuals are required to purchase and approved healthplan from a private insurer).

The assumption is that competition among insurers will lead to more efficient outcomes – lower prices, more flexible benefits, better technology, quicky adaptation to changing times, etc.

A 2004 report by the FTC and DOJ finds most “experts” believe the market is highly competitive (with vocal exceptions of groups representing physicians).

This belief has spilled into the public sector as well as there has been a rapid outsourcing of public insurance to the private sector (in both Medicare and Medicaid), as well as lax antitrust enforcement. Over the past 20 years there has been extensive insurer consolidation (with only three challenges by the DOJ and only in select markets).

Note that to measure this empirically is tough to do. One would want a measure of the degree of market power among private insurers – or how much control over the price of their product do insurers have? Given the complicated nature of insurance contracts and the multi-market nature of firms and insurers (and the fact that insurance companies probably don’t want people to know!) makes this tough to do.

A study by Leemore Dafny, a health economist at Northwestern University attempts to measure the extent of market power enjoyed by private insurers. She obtains a database of fully insured health plans offered by a sample of large, multi-site employers between 1998 and 2005.

She finds that firms with positive profit shocks subsequently face larger premium increases (even for the same health plan).

This increase is greatest in markets with the fewest insurance carriers – the effect is particularly large when there are 6 or fewer carriers). Note that if markets were competitive then insurers vying for each contract would bid down the premium until it had no relation to the employer’s willingness to pay.

That is, a multi-site firm with high profits in a given year will subsequently face significantly higher health insurance premiums – but only at sites served by a concentrated insurance market.

Firms are much less likely to switch carriers in “good times”, since this exposes them to more profit extraction.

Appears that the strong bargaining position of insurers in concentrated markets enables them to capture more of the extra surplus generated by profit shocks.

“a 10-percentage-point increase in the after-tax return on assets (about a one standard deviation change) is followed by a 1.2 percent increase in health insurance premiums. Given that operating margins for insurers are generally less than 5 percent, this is a rather large effect.

In 1998 only 7 percent of covered employees were in markets with 6 or fewer carriers, by 2005 this was 23 percent – and continues to grow.

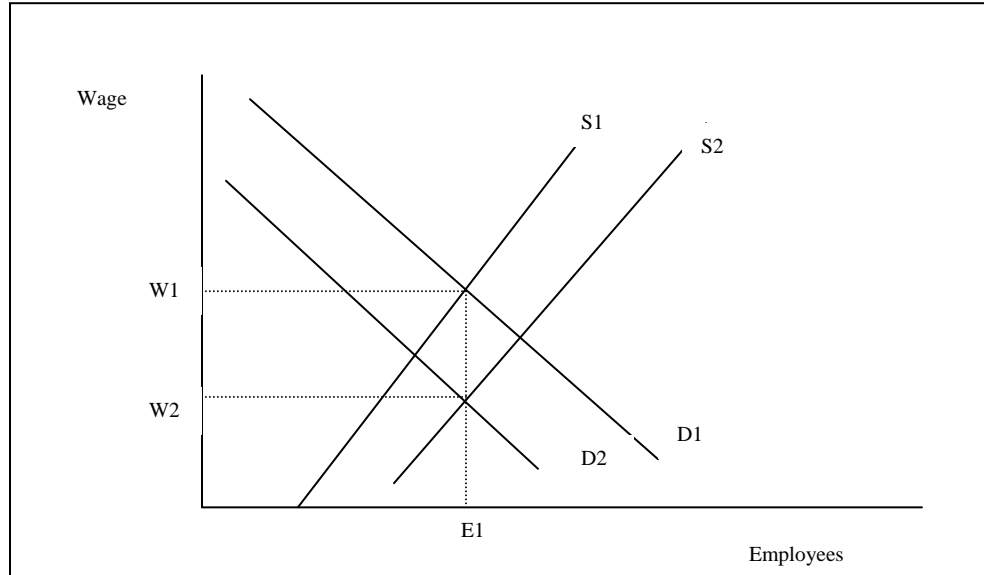
Likewise Katherine Ho finds looks at the “upstream bargaining” between insurers and hospitals. She finds that insurers tend to successfully extract the rents of hospitals in their networks

Who Pays for Insurance?



For many employees the firm provides them with insurance coverage. But who bears the burden of this benefit is a different question.

To see this consider the supply and demand for labor:



Here the supply is a supply of labor – workers' willingness to work at various wages. The demand for labor is firm's willingness to hire workers based on what their contribution to revenue for the firm. Before any benefits are offered the supply is S1 and demand is D1 and so equilibrium is a wage of W1 at an employment level of E1. Note the Y axis measure the monetary wage paid to workers.

Now suppose the firm offers the worker an insurance policy worth $\$z$ per hour (assume for simplicity that this policy also cost the firm $\$z$ per hour as well). Then the demand curve will shift down by an amount $\$z$ – the firms’ willingness to pay wages will decrease by an amount equal to what it has to pay in insurance benefits. At the same time the supply of labor will increase –shift to the right by an amount $\$z$. Thus the new equilibrium will be along the new demand D_2 and Supply S_2 , at a wage of W_2 and employment of E_1 . So notice that the new wage W_2 is exactly equal to $W_1 - z$, and employment stays the same.

In other words, the worker’s wage is lowered by an amount exactly equal to the amount of insurance. Thus the worker “pays” for the insurance by accepting a proportionate lower wage.

Note that this ignores the potential of moral hazard with health insurance. Suppose that once insured, individuals tend to consume health care to the point where marginal benefit is lower than marginal cost. This will tend to drive up the cost of health insurance for everyone, so that while the firm still pays $\$z$ /hour for the insurance it is worth something less than $\$z$ to the worker. In this case the supply curve will shift down by something less than S_2 and so the new equilibrium will tend to entail a higher wage than W_2 , but the employment level will be lower than E_1 .

At the same time the above analysis also ignores the fact that since the firm is able to pool risk, the amount of coverage it is able to provide for $\$z$ is likely to be more generous than what the employee could purchase on his or her own. In this case the supply will shift by something more than S_2 and the equilibrium will be a wage lower than W_2 and employment higher than E_1 .

So the risk pooling effect tends to work against the moral hazard effect.

Family Coverage – Most firms that offer insurance for family members of their employers typically require the worker to pay directly for the additional cost of that coverage. Single workers and workers with families receive the same salary, if the worker with family wants the family coverage the premium is taken directly out of the worker’s wage. Ignoring the differences in tax liability that this creates, both are equally well off.

For firms that do pay for family coverage note that there will be a cross-subsidization. The firm is legally prevented from paying equally qualified workers different wages because one has a family, so it must pay both the same wage. In this case the single workers will tend to subsidize the insurance coverage of their co-workers with families. Note that this will tend to result in these types of firms attracting only workers with families, which may be a good thing! This is an example of how a firm can use benefits to attract a certain type of worker that would be illegal to do with wages (if the firm thinks married workers are more stable and productive by offering spousal coverage they will attract married workers, but if they offer higher wages to those who are married, they will be found guilty of discrimination).

Note that the above analysis is static (there is no change over time). What happens as health care costs increase? This is where it gets sticky!

See the following:

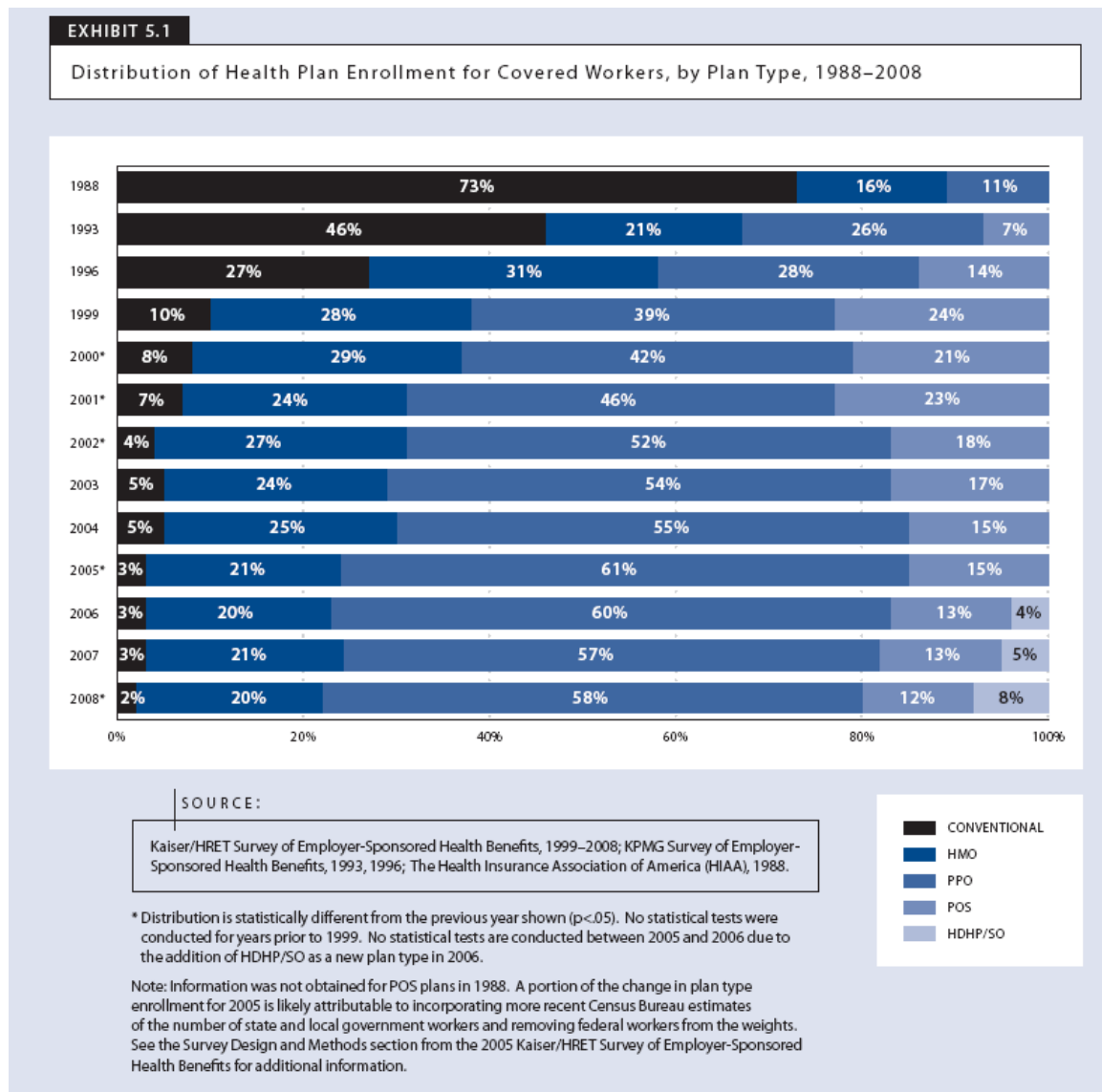
[Boston Globe: On-The-Job Training](#)

[Denver Post: Companies rewarding good health with gifts](#)

Managed Care

The distribution of employee-sponsored insurance

Among employee sponsored plans, managed care is now the dominate mode:



Managed care:

HMO = Health Maintenance Organization. These plans generally provide comprehensive care and the marginal costs are generally very low (no copays or deductibles), but they require that all care be delivered through the plan's network and that the primary care physician (or gatekeeper authorize most services provided. Generally if you receive care out of plan there is no coverage (though there are exceptions for being out of town or not having a particular specialty in the plan, etc.) The Staff Model HMO employs the physicians directly. Plans that set up networks by contracting with physicians in solo or small group practices are called independent practice associations (IPAs).

There are still a few staff model HMOs around (they are popular in California with Kaiser), but are less popular than PPOs.

PPO= Preferred Provider Organization. These are similar to HMOs, but they give the patient the option of going out of network. Usually the marginal costs are very low if care is received in-network, but there is a large penalty for going out of network (large deductible and copays)

POS = Point of Service Plans. Like PPOs, POS plans offer two tiers of insurance benefits with higher cost for out of network providers than with in-network providers. But like HMOs, POS plans assign each member a gatekeeper physician who must authorize care in order for the care to be covered.

HDHP/SO are high deductible health plans with a savings option. – see health savings account.

As managed care became a dominant form of health insurance throughout the 1990s there is pretty convincing evidence that this resulted in a one time reduction in health care expenditures. This is consistent with managed care helping to alleviate the moral hazard problem

But note that this did nothing to affect the *growth rate* in health care expenditures.

While, from society's standpoint the emergence of managed care seems to have improved efficiency. It made lots of people angry.

Managed care is a market based (supply-side) attempt to alleviate the moral hazard/physician induced demand problem. Under its various forms, the common theme is that the insurance company pays the providers some fixed fee to treat the patients under the insurance company's contract. The consumer generally has a small co-payment for care, but the marginal cost to the consumer is still close to zero. The incentive to restrict care is given to the provider.

In addition, managed care will generally use the following to contain costs:
Selective Contracting – payers negotiate prices and contract selectively with local providers
Steering of enrollees to the selected providers
Utilization review of the appropriateness of provider practices. This may be prospective , concurrent, or retrospective.

From another perspective managed care is not a good thing to the extent that it gives providers little incentive to provide adequate care for their patients, restricts the choices of physicians and consumers and lowers the quality of care being provided.

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From the view of the hospital and physician, moral hazard is “good for business”, and so reducing it hurt business. Physician incomes were reduced throughout the 1990s, and they were some of the most outspoken opponents of managed care. Consumers tend to dislike managed care because given the way the system is structured they are not allowed to consume all the care they would like. The marginal cost to them of additional care is quite low (a \$10 co-pay, plus

transportation costs, etc.) so they would like to consume additional care, but their insurance company does not allow them to. Thus, the structure of the insurance contract creates friction between consumers, physicians, the hospital, and the insurance company.

A successful managed care contract must provide providers enough compensation to cover their costs of treatment plus enough to make them willing to sign on, but the premium charged to consumers must be low enough to attract consumers into the contract (typically through employers). This balance has been difficult to achieve.

Thus as managed care insurance companies were pressured to expand the choices available to consumers and physicians, their ability to achieve cost savings has been diminished and they have lost market share to other forms of insurance.

While managed care still has a large share of the private insurance market, the future is somewhat unclear.

Managed care in public insurance

Medicare+Choice programs have been declining since 1999. In 1999 peak enrollment was around 7 million (out of a total enrollment of about 38 million). As of July 1, 2002 enrollment was about 5.5 million. As the government reduced (or did not increase) payments to insurers, many companies withdrew from Medicare+Choice. But the plan is for this to increase. Now renamed Medicare Advantage, it is a large part of the recent reforms.

On the other hand, Managed care's presence in Medicaid has been fairly stable. More than half of Medicaid enrollees are in a managed care type of arrangement. Some have argued that Medicaid is managed care's final bastion. Why would this be?

Many of the arguments against managed care – lower quality, restricted access, incentives to under-provide imply that managed care insurance is inferior to other types of coverage. Do these apply to Medicaid? If so, why has MC managed to maintain such a strong presence?

Note the incentives are different. Medicaid is a welfare program we are providing care for those who otherwise could not afford it (or for reasons of adverse selection, the market would not operate efficiently).

Note that in many ways Medicaid is, by definition, a managed care plan. The government is the managed care provider. In some ways contracting with private managed care insurers is redundant.

Consumer-Driven Health Care

The shopping problem in health care

One of the big problems in health care is that consumers really don't understand the good they are producing. The idea is that we have some stock of health and are "producing" that good through the use of inputs (environment, lifestyle, etc. and health care). But, in many situations, we really don't understand how health care inputs affect our health. In other markets we have the same problem, but can solve it through trial and error. These are so-called "experience goods". Over time you can figure out what you like and don't like by learning from "mistakes". This is

not possible for health care since the mistakes can be pretty expensive. So we have a shopping problem. We've come up with numerous ways of solving this problem:

1. Traditional fee-for-service insurance allowed the physician to be the shopper for the patient
2. managed care – the insurer in many ways became the shopper for the patient.
3. consumer-driven health care. The consumer is the shopper?

Note that managed care was a supply-side attempt at reducing the moral hazard problem of over-consumption. The incentives were given to the physicians and hospitals to limit the amount of healthcare provided. On the other hand, consumer driven health plans are a demand-side attempt at lowering spending. The logic here is to increase the *marginal* cost of care by increasing co-payments and deductibles while lowering monthly premiums. Then giving the consumer a “savings” account that he/she spends as needed for his/her health care needs. This type of plan then forces the consumer to compare the marginal cost of care to the marginal benefits.

Note that the moral hazard issue all assumes that the demand for health care is price-elastic. That is, that consumers are sensitive to changes in the price

So the effectiveness in consumer driven plans in lowering health care costs, to a certain degree, depend on how elastic the demand for health care is. These are pretty tough to estimate, but estimates are as follows:

Hospital Admissions:	-.14
Hospital LOS	-.06 to -.29
Physician Office Visits	-.08 to -.35
Total Spending	-.22 to -.79
Preventative Care	-0.43

These numbers imply demand is pretty inelastic: A 10 percent decrease in price will result in about a 1.4 percent increase in hospital admissions. So these numbers would imply that the moral hazard effect from insurance is not all that large in general (though for certain markets the demand is likely to be much more price sensitive (second opinions, the marginal test, etc. and so consumer driven plans are likely to result in savings here).

Note that the demand elasticities above are for the market in general, firm specific elasticities are much larger.

Physician Services –3 to –5.7
Hospital services (patient days or admissions) -.74 to -.8
These are numbers as they apply to a particular hospital or office.

So if a physician practice increased its price by 10% (relative to other offices in the market) we'd expect visits to decrease by 30 to 60 percent,
Likewise if a hospital increased its prices by 10% (relative to the market) visits would decrease by 7 to 8 percent.
Note this implies that physician services are much more competitive than hospital services.

The medical home¹

A new concept in the organization of care is the medical home. The idea is motivated out of the growing role of and the current system's failure to manage chronic conditions. As the table below shows, a major reason for escalating costs is the growing prevalence of chronic conditions.

Figure. 2⁴ Unhealthy Lifestyles and Aging Demographics Drive Costs Up

EXHIBIT 3
Decomposition of Changes in Nominal Health Care Spending,
Fifteen Most Costly Medical Conditions, 1987-2000

Condition	Total change in spending (millions of dollars)	Percent changes in spending attributes to		
		Increased cost per treated case	Rise in treated prevalence	Increased population
Heart disease	26,228.5	68.6	1.1	30.3
Pulmonary conditions	24,792.0	37.5	41.9	20.6
Mental disorders	24,503.3	21.1	59.2	19.7
Cancer	17,734.3	41.9	27.4	30.7
Hypertension	15,385.8	59.8	18.9	21.3
Trauma	14,596.6	169.1	-108.5	39.5
Cerebrovascular disease	11,078.9	20.8	60.3	18.9
Arthritis	10,282.8	44.3	31.6	24.1
Diabetes	9,626.8	23.6	49.8	26.6
Back problems	9,486.4	21.7	52.6	25.8
Skin disorders	7,286.5	54.8	22.0	23.2
Pneumonia	7,203.8	9.38	-18.4	24.6
Infectious disease	6,191.6	95.2	-17.5	22.3
Endocrine	5,029.1	28.0	43.4	28.6
Kidney	3,231.4	8.8	55.8	35.4

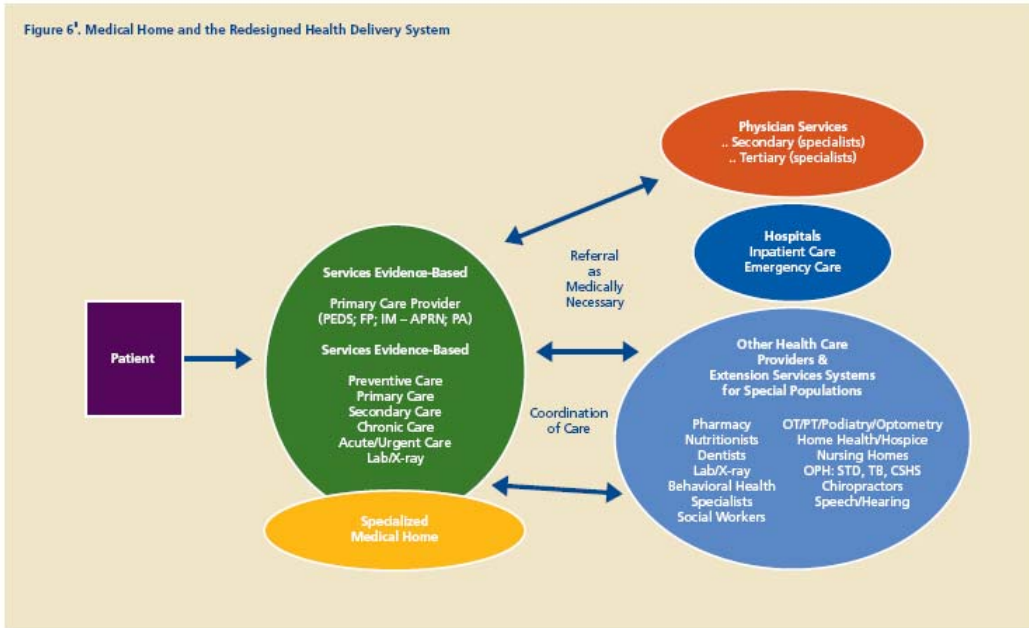
Source: 1967 National Medical Expenditure Survey (NMES) and 2000 Medical Expenditures Panel Survey, Household Components (MEPS-HC)

Note: All changes were statistically significant at the .05 level except for changes in spending, kidney disease (at the .10 level): rise in treated prevalence, heart disease (not significant): and increased cost per treated case, endocrine and kidney disease (not significant). Medical conditions ranked by change in spending between 1987 and 2000.

The Medical Home is a term used to describe a health care model in which individuals use primary care practices as the basis for accessible, continuous, comprehensive and integrated care. The goal is to provide a patient with a broad spectrum of care, both preventative and curative, over a long period of time, and coordinate all of the care the patient receives.

¹ Much of the following is taken from: "The Medical Home: Disruptive Innovation for a New Primary Care Model", Deloitte Center for Health Solutions. 2008

Figure 6¹. Medical Home and the Redesigned Health Delivery System



Critical Features of the Medical Home: A Platform for Guided Self-Care Management

<ul style="list-style-type: none"> • Personal physician – Each patient has an ongoing relationship with a Primary Care Physician (PCP), as well as clinician health coaches, who are trained to provide first-contact, continuous and comprehensive care. These clinicians are competent in the use of active listening, health coaching, evidence-based holistic medicine, clinical information technology, population-based outcome improvement and measurement, care team recruitment and leadership.
<ul style="list-style-type: none"> • Physician-directed primary care professional organization – A physician leads a team of health coaches who collectively take responsibility for the ongoing care of patients. The day-to-day operation of the practice is focused on managing population-based outcomes and maximizing individual patient adherence to a distinct, customized self-care management program that leverages information technology. Note: A health coach is an allied professional (nurse/patient educator) with specialized training in patient behavior modification and motivational interviewing to match patient values, preferences and triggers to specific, measurable, short-term, self-care lifestyle modifications.
<ul style="list-style-type: none"> • “Whole person” orientation toward adherence, not compliance, incorporating holistic methods with conventional allopathic interventions – The primary care team is responsible for providing all of the patient’s health care needs and appropriately arranging care with other qualified professionals. This includes care for all stages of life: acute care, chronic care, preventive services, and end-of-life care, with strong consideration for the individual’s value system, personal preferences and level of engagement in decision making. A key focus is the dispensation of directives (prompts, alerts, reminders) in teachable moments to patients and family members/significant influencers to expedite adherence to self-care suggestions (not just compliance to directives). In these clinical models, holistic therapeutic interventions, such as mindful daily practices, are integrated with traditional therapeutic interventions.
<ul style="list-style-type: none"> • Monitored, coordinated and integrated care using electronic medical records and personal health records – Care is facilitated across all elements of the complex health system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient’s community (e.g., family, public and private community-based services) by registries, health information exchanges, and other electronic means to assure that patients get the indicated care when and where they need and want it, in a culturally and linguistically appropriate manner. The information exchanges among members of the patient’s care team are synchronized and real-time. These technologies are also used to reduce unnecessary visits, tests and referrals. Sharing information among medical homes and other providers in the local and regional care system is indicative of an advanced medical home model.
<ul style="list-style-type: none"> • Measured and managed adherence to evidence-based practices by the care team and the patient – Results measures are hallmarks of the medical home. They range from measures of processes and outcomes to patient satisfaction and success rates in changing behavior: <ul style="list-style-type: none"> • Evidence-based medicine and clinical decision-support tools guide decision making. Non-adherence by the care team and/or the patient is monitored and measured, and root-cause analysis is conducted to assess errors and near-misses. • Physicians in the practice accept accountability for continuous quality improvement by voluntarily engaging in performance measurement and improvement. • Patients actively participate in decision-making, and feedback is sought to ensure patients’ expectations are being met. • Information technology is used to appropriately support optimal patient care, performance measurement, patient education, and enhanced communication. • Patients and families participate in quality improvement activities at the practice level.
<ul style="list-style-type: none"> • Enhanced accessibility: care anywhere, anytime – Care is available via open scheduling, expanded hours and new communications options among patients, their personal physician and practice staff. Innovations such as group visits, cyber-visits, robust customized educational tools and self-monitoring devices are available through the practice.
<ul style="list-style-type: none"> • Emphasis on physician incentives for improvements in self-care management – Physician reimbursements appropriately recognize the added value provided to patients who have a patient-centered medical home. The payment structure should: <ul style="list-style-type: none"> • Reflect the value of patient-centered care management work that falls outside of the face-to-face visit. • Pay for services associated with care coordination within a given practice and among consultants, ancillary providers, and community resources. • Support adoption and use of health information technology for quality improvement. • Support enhanced communication access such as secure e-mail and telephone consultation. • Recognize the value of technology-based physician work associated with remote monitoring of clinical data. • Allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in reduced payments for face-to-face visits.) • Recognize case mix differences in the patient population being treated within the practice. • Allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting. • Allow additional payments for achieving measurable and continuous quality improvements.

See the following:

[NY Times: Disruptive Innovation, Applied to Health Care](#)

[NY Times: UnitedHealth and I.B.M. Test Health Care Plan](#)