

The Organization of Health Insurance Markets

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
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

- **Depression hit hospitals and physicians very hard.**

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.

- **Most coverage is financed by employers.**

During WWII there were wage and price controls which fixed earnings

Employer-paid insurance premiums are excluded from the taxable income of workers (this cost about 50 billion in tax revenues).

Employers will pool risk groups making the insurance company more willing to provide insurance.

Lower threat of adverse selection

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 2005 period.

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 do 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.

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

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.

Strong unions also played a role in the spread of employment-based insurance.

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 the workers 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 unions organized industry-wide labor-management health insurance plans

- **Large-scale entry of commercial health insurance companies into employment-based insurance**

Shift from community rated plans to those with premiums based on actuarial risk.

The actuarial approach quickly evolved into “experience rating”

Larger firms realized that it was cheaper to self-insure

1974 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

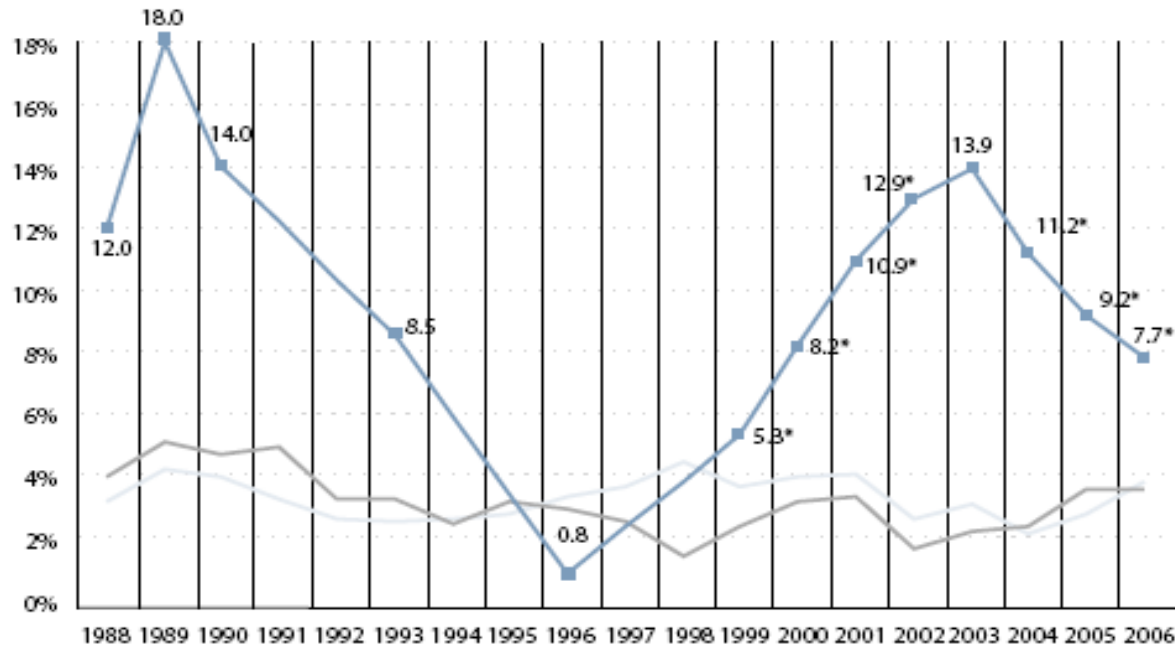
As firm size has decreased and markets have become more competitive, this has made things even tougher.

- **Flaws in the system**

1. administrative costs. 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. 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.
4. labor-management relationships. Employer-based insurance is an important contributor to labor-management strife and bankruptcies. It also affects job mobility.
5. misaligned incentives.
6. The 'Graying' of Group Health Insurance.
declines in employer coverage have not been uniform across all demographic groups.
younger and lower-income groups have disproportionately lost coverage.

EXHIBIT A

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



1988	1989	1990	1993	1996	1999	2000	2001	2002	2003	2004	2005	2006	
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
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
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‡

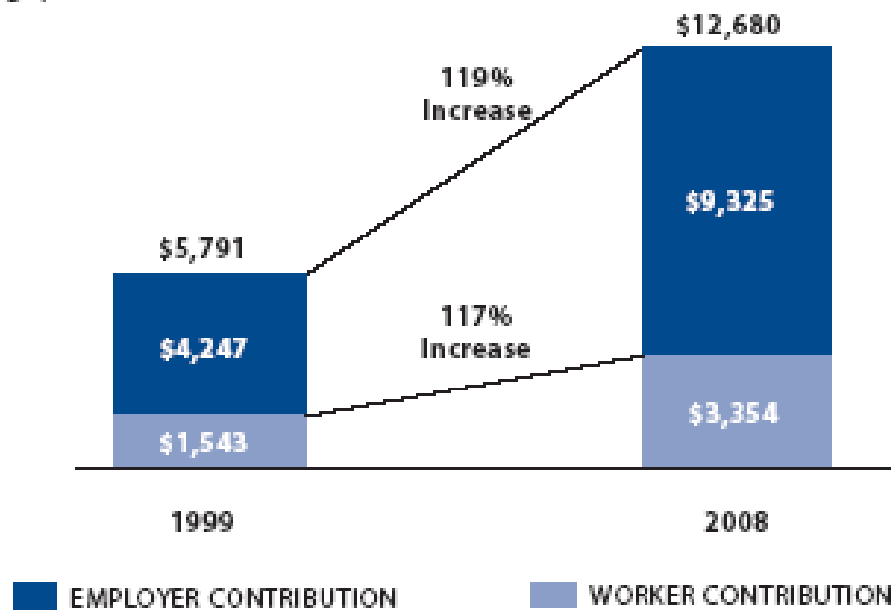
* Estimate is statistically different from the estimate for the previous year shown at $p < .05$. No statistical tests are conducted for years prior to 1999.

‡ 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

EXHIBIT A

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

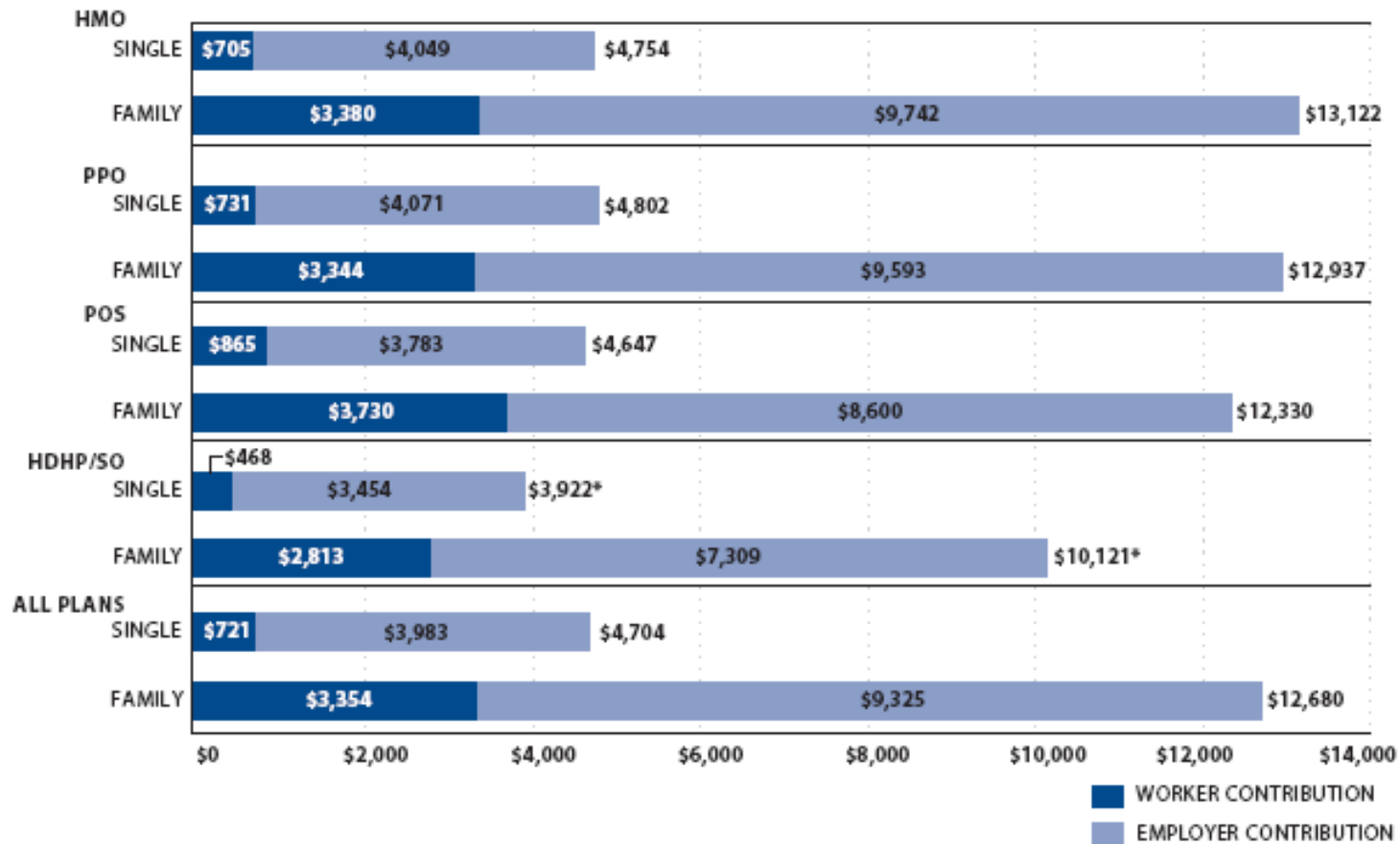


Note: The average worker contribution and the average employer contribution do not add to the average total premium due to rounding.

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

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:

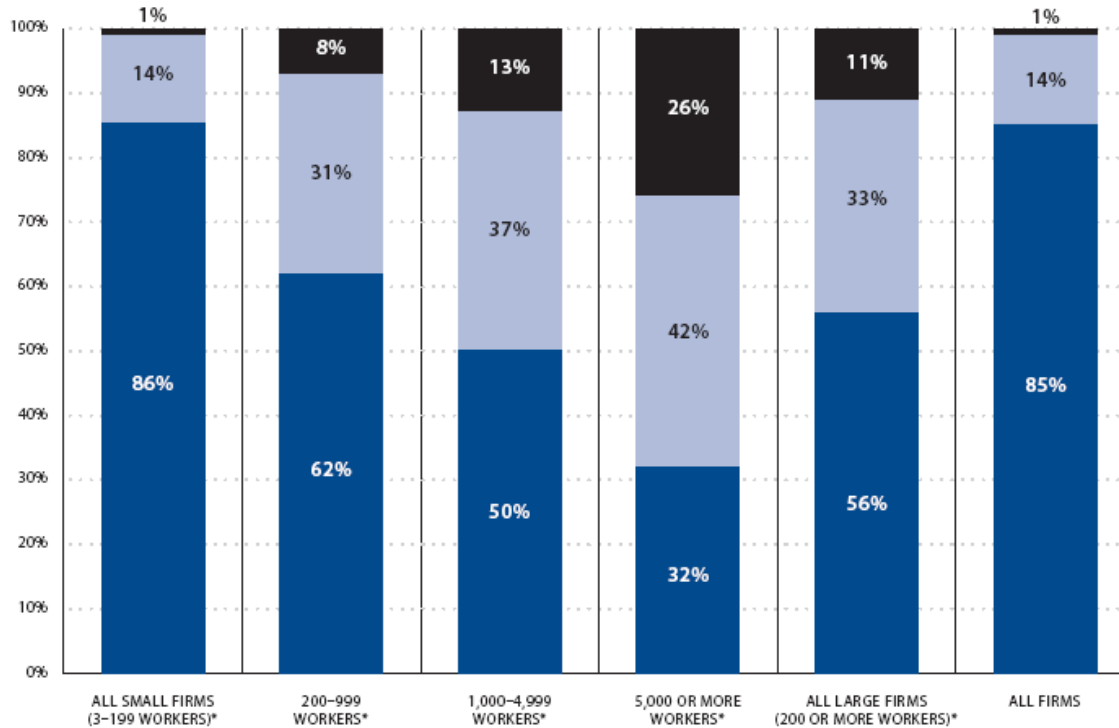
Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2008.

* 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.

- THREE OR MORE PLAN TYPES
- TWO PLAN TYPES
- ONE PLAN TYPE

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 health plan from a private insurer).

The assumption is that competition among insurers will lead to more efficient outcomes – lower prices, more flexible benefits, better technology, quickly 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