An Introduction to the Health Care Crisis in America: How Did We Get Here?

by

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INTRODUCTION

This paper provides an overview of the crisis in the U.S. health care system and lays the groundwork for a deeper investigation into the nature of the current crisis. It addresses three important issues. First, it provides a snapshot of the health care system and the institutional arrangements through which health insurance is currently obtained and administered. The second part of the paper examines the institutional development of the U.S. health care system and examines the events that led to the emergence of a system in which the majority of the population relies on an employer for health insurance coverage. It is argued that the current system of employer-sponsored health insurance has its origins in: 1) the failure of early twentieth century proposals for compulsory national health insurance; 2) the impact of World War II wage and price controls; 3) the role of unions and collective bargaining in the early postwar period; and 4) the impact of preferential tax treatment for "fringe" benefits beginning in the mid-1950s. The last part of the paper identifies a series of disturbing trends and suggests that the limits to employer-based health insurance have been reached. The beginning of the contemporary crisis is traced back to the end of the post-WWII prosperity in the 1970s, and it is argued that employer-based coverage is unlikely to remain the dominant source of insurance in the coming decades.

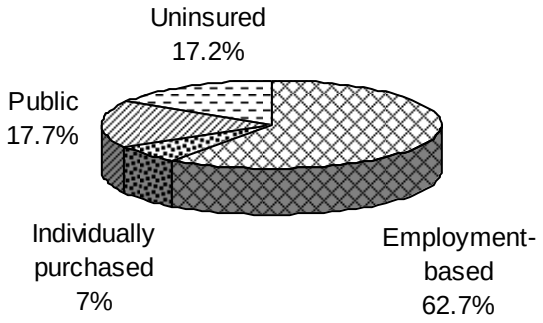
HEALTH CARE IN AMERICA: A SNAPSHOT OF THE CURRENT ENVIROMENT

The United States does not provide health care to its citizens the way the rest of the industrialized world does. Instead of guaranteeing coverage for all, it relies on a patchwork system of market-based institutions in which those who are insured sometimes

receive coverage as a condition of employment, sometimes purchase individual policies and sometimes obtain coverage through public programs such as Medicaid[1] and the State Children's Health Insurance Program (SCHIP). Figure 1.1 shows where the non-elderly population (i.e. those under 65 years of age) obtains its health insurance coverage. As the data reveal, the vast majority of this population group – over 60 percent – relies on an employer for health insurance.[2]

Figure 1.1

Sources of Health Insurance, Nonelderly Population, by Own Work Status 2005



Source: Paul Fronstin, Employee Benefit Research Institute, May 2007

A relatively small number of those under age 65 – about 7 percent – purchase coverage in the individual market, and about two-and-a-half times that many – today roughly 45

[1] Adopted in 1965, Medicaid is a joint federal and state program that provides health insurance for the poor and disabled. The federal government offsets its share of the funding (roughly 50-80 percent, depending on a state's income) from general revenue. The majority of those covered are women and children, but the vast majority of the spending supports the 30 percent or so who are disabled.

[2] About half of those who receive coverage through an employer work directly for the firm, while the rest receive it as a spouse or dependent of someone who is employed by the firm.

million people – lack any kind of health insurance whatsoever.[3] The number of Americans without insurance would be even more staggering in the absence of government programs, such as Medicaid and SCHIP, which have provided insurance for millions of low-income families (particularly children) when their employment-based coverage was lost (Gould, 2005).[4] In total, the government picks up the tab for almost 18 percent of the non-elderly population.[5]

Figure 1.2 shows the four most important players in the health care arena. Employers, governments and individuals comprise the group of Purchasers who supply

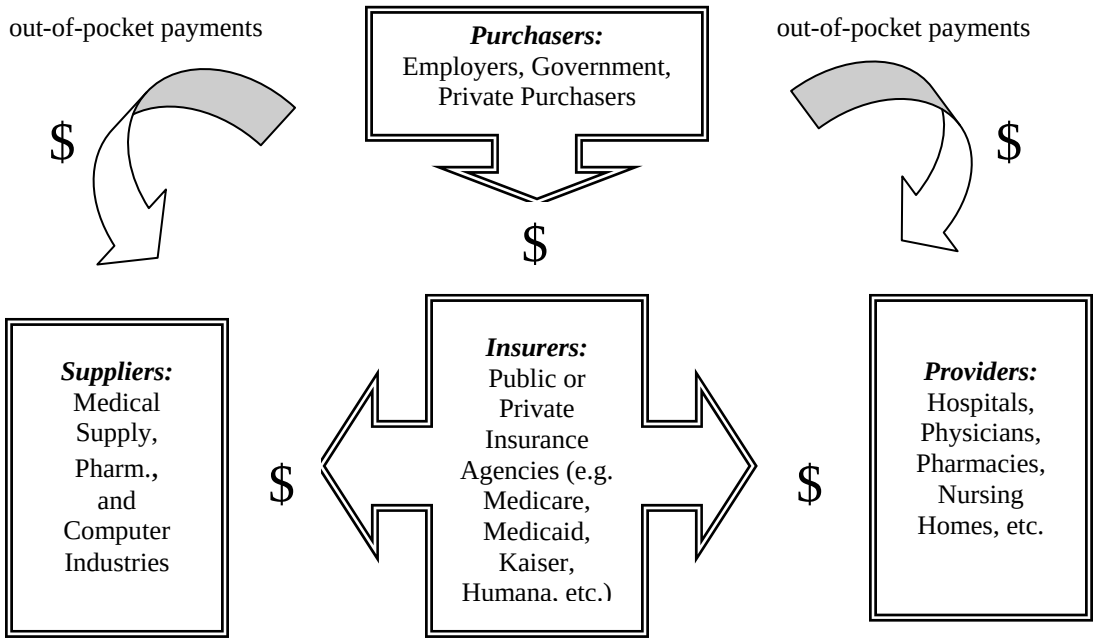
[3] Employer-provided coverage is available to some of the uninsured, though they often refuse it because they cannot afford the premiums. Indeed, studies confirm that employees are less likely to enroll in an employer's plan when the employee contribution is relatively high and that the primary reason people are uninsured is the high cost of health insurance coverage (Kaiser Family Foundation, 2004). This appears to be especially true for low-wage workers (Blumberg et. al, 2004). Many other people – e.g. temp or part-time workers – lack even the option to enroll in a company health plan, and still others are effectively shut out of the health insurance market due to pre-existing conditions.

[4] There was a 2.3 percentage point increase in Medicaid (including SCHIP) coverage from 2000 to 2004, which partially offset the 3.8 percentage point drop in employer-provided health coverage during the same period.

[5] When the elderly population is included, government coverage is extended to about 78 million people – Medicare covers roughly 40 million elderly (over age 65) and disabled Americans, and Medicaid covers about 38 million of the nation's poor.

Figure 1.2

The U.S. Health Care System at a Glance



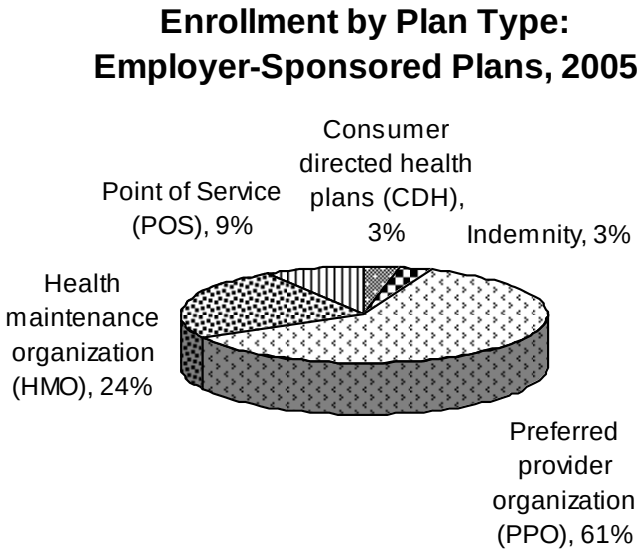
funds to public or private Insurers. The Insurers then reimburse Providers and Suppliers by disbursing a portion of the funds they collect from Purchasers. Under this system, both Purchasers and Insurers are considered "payers", and there is a fundamental conflict between them and the Providers and Suppliers who receive the payments they make. The former would generally prefer to reduce health care payments, while the latter are keen to maximize their receipts. Thus, health care costs "represent a battleground among competing interests" (Bodenheimer, 2005, 848). As the largest purchasers of health insurance coverage, employers are typically interested in reducing the premiums that must be paid, while Insurers have an incentive to protect their profits by maintaining higher premiums. At the same time, however, Insurers must compete for business by offering competitively-priced plans.

Those covered by employer-based health insurance typically have access to one or more of the following plans. The first kind of plan is the Health Maintenance

Organization (HMO). An HMO can be any organized plan other than a traditional health insurance company that sponsors health care coverage. Some HMO plans are very restrictive, requiring that the HMO's own employees provide care in the HMO's own hospitals or clinics, while other plans are cooperative agreements among independent hospitals, doctors and other health care providers. The second type of plan is offered through a Preferred Provider Organization (PPO). These plans also offer network-based managed care, but they are generally less restrictive than their rival HMOs because patients can see a specialist without a physician's referral, and they can see any doctor they choose for a higher out-of-pocket cost. Third, there is the traditional indemnity, or fee-for-service, plan. Under this type of plan, patients see a doctor of their choice and receive reimbursement for "covered" medical expenses (i.e., those listed in their benefits summary). Fourth, is the Point-of-Service (POS) plan, which combines elements of the HMO and PPO plan types. Point-of-Service plans require enrollees to designate an in-network physician, but they allow patients to seek out-of-network care if they are willing to pay higher out-of-pocket costs. Finally, there is the Consumer Directed Health (CDH) plan. These plans are formed from Health Reimbursement Accounts (HRAs) or Health Savings Accounts (HSAs), which provide traditional insurance for non-routine care but require individuals to incur higher out-of-pocket expenses to cover routine care. As Figure 1.3 shows, plans offered through PPOs are currently the most popular plan type.[6]

[6] Consumer-Directed Health Plans are expected to be the fastest growing type of plan in the coming years, as employers look to shift more of the cost burden to employees in their on-going attempt to cope with rising health care costs. We will examine these plans more closely in Part VI of this *Series on Health Care*.

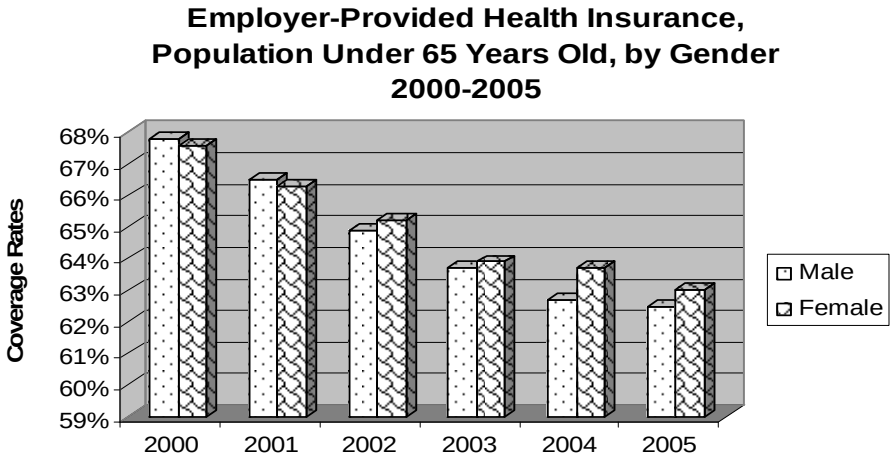
Figure 1.3



Source: 2006 Mercer National Survey of Employer-Sponsored Health Plans

Now that we know where most Americans get their health insurance and what kind of coverage most of them have, it is time to look more closely at the characteristics of the insured population. We focus on the segment of the population that receives coverage through an employer since this is the most common source of health insurance. Our goal is to learn more about the characteristics of those with employer-based coverage. Figure 1.4 offers a gender-based look at this group. A number of points should be immediately clear. First, well over half of all men and women rely on employer-based insurance, making it the most common source of coverage for both population groups. Second, both men and women have experienced a sharp decline in employer-based coverage during recent years. Finally, females are now more likely than their male counterparts to have employer-provided health insurance.

Figure 1.4



Source: Fronstin, 2007, EBRI Issue Brief No. 305

But gender is not the only area in which coverage is distributed unequally. In fact, as Blumenthal notes, there is a "raft of arbitrary inequities in the availability of health insurance" across population groups (2006, p. 86). Figure 1.5 details some of these inequities.

Figure 1.5 Workers Aged 18-64 with Employment-Based Coverage, by Race, Income, Occupation, Firm Size, Industry and Education, 2005

	Percentage covered within category
Race	
White	70.4
Black	50.4
Hispanic	41.3
Other	61.8
Family Income	
Under $10,000	12.2
$10,000 - $19,999	22.8
$20,000 - $29,999	41.1
$30,000 - $39,999	55.9
$40,000 - $49,999	66.1
$50,000 - $74,000	76.2
$75,000 and over	85.8
Occupation	
Managerial and professional specialty	84.0
Service occupations	55.5
Sales and office occupations	73.0
Farming, fishing and forestry	39.2
Construction, extraction, and maintenance	57.8
Production, transportation, material moving	68.1
Firm Size	
Private Sector	70.8
fewer than 10	49.5
10-24	59.9
25-99	70.0
100-499	77.1
500-999	79.9
1,000 or more	79.6
Industry	
Agriculture, forestry, fishing, mining and construction	51.7
Manufacturing	79.5
Wholesale and retail trade	70.6
Personal services	64.8
Public sector	88.1
Education	
Less than high school	32.7
High school	57.7
Some college	66.7
College	79.4
Post-college	85.7

Source: Fronstin, EBRI, Issue Brief No. 305

As Figure 1.5 shows, whites are more likely to have coverage than blacks, Hispanics and other minority groups; wealthier families are more likely to have coverage than poorer ones; and college educated people are more likely to have coverage than those without degrees.[7] In addition to the inequities across race, gender, income and education, there are inequities across industries and occupations. For example, those who work in professional or managerial occupations are much more likely to have employer-sponsored insurance than those working in construction, sales or farming. Similarly, those working in the manufacturing industry are more likely to have coverage than those employed in wholesale and retail trade. Finally, those working for large companies are more likely to have coverage than those who are employed by smaller firms.

There are a number of reasons why small employers are less likely to offer health insurance than larger employers.[8] First, the relatively high cost of underwriting and administering policies for a small number of employees makes it too costly for many of them to provide coverage. Second, small employers frequently state that their employees have access to other forms of coverage (e.g. through a working spouse), making it unnecessary to offer health insurance in order to attract workers. Third, small business owners often argue that many of their employees would never acquire coverage anyway, since turnover rates are relatively high and there is usually a waiting period before benefits kick in for new employees. Finally, since small businesses have a higher failure

[7] According to the Commonwealth Fund, workers earning more than $15 per hour are more than twice as likely to have employer-provided health insurance as those earning less than $10 per hour (Collins, 2004).

[8] Although large firms remain more likely to offer health insurance than smaller ones, the proportion of uninsured workers employed by firms with 500 or more employees has been increasing. This is in part due to the loss of manufacturing jobs and a decrease in unionization rates (Stanton, 2004).

rate than larger firms, small employers tend to limit "fringe" benefits in order to keep costs under control.

THE INSTITUTIONAL DEVELOPMENT OF EMPLOYMENT-BASED HEALTH INSURANCE

The previous section provided an overview of the current state of the U.S. health care system. As noted above, the central financing mechanism is employer-sponsored private health insurance, supplemented by an array of public insurance and subsidy programs designed to help cover those most likely to lack coverage through an employer (in particular the poor and the elderly). This section of the paper explores the historical development of the employment-based system of health insurance. In particular, it explains why the U.S. market for health insurance developed primarily as a private, employment-based system when most European nations adopted some form of nationalized, compulsory health insurance.[9] Below, we examine the origins and evolution of employment-based insurance and show that it emerged largely as an "accident of history that evolved in an unplanned way" (Blumenthal, 2006, p. 82).

The institutional evolution of the American health care system is, perhaps, most fruitfully examined in relation to the institutional evolution of American capitalism. For the history of health care provisioning reveals the myriad of ways in which the system has been shaped by developments within the broader political economy of American

[9] The original function of health insurance was income stabilization. Health insurance compensated sick workers for lost wages and was seen as a way to maintain the "productive effort and political allegiance of the working class" (Starr, 1982, p. 238). Germany adopted the first nationalized system in 1883. Following suit were Austria (1888), Hungary (1891), Norway (1909), Serbia (1910), Britain (1911), Russia (1912) and the Netherlands (1913). For more on this, see Mills (1937).

society. We therefore begin with an examination of the social, economic and political forces that laid the foundation for the emergence of the modern health care system.

The Failure of National Health Insurance Proposals 1915-1948

Throughout the nineteenth century, there was scarcely a market for health insurance in the United States. Family members cared for one another within the home, and there was little reliance on the services of doctors or hospitals. By the end of the nineteenth century, this was beginning to change. The increasing industrialization of the American economy initiated a breakdown of the 'household economy' as:

> [F]amilies came to depend on the labor of their chief wage earner for income and on the services of doctors and hospitals for medical treatment. In individual households, sickness now interrupted the flow of income as well as the normal routine of domestic life, and it imposed unforeseen expenses for medical care . . . In the economy as a whole, illness had an indirect cost in diminished production as well as a direct cost in medical expenditure (Starr, 1982, p. 236).

By the late 1920s, medicine began to play an even larger role in people's lives. Acute illnesses were increasingly treated at medical facilities (as opposed to homes) and hospitals became the centers for surgeries, X-rays and laboratories (Thomasson, 2002). Along with these advances came an increase in the costs of treating illness and a desire for some form of social protection to replace the traditional relations embedded in the household economy of pre-industrial America. In response to these and other developments, groups of social reformers arose in the early part of the twentieth century to champion the cause of compulsory national health insurance.

Inspired by the advances in social legislation achieved in the area of worker's compensation, the American Association for Labor Legislation (AALL)[10] produced the first such proposal in 1915. The legislation was designed to provide compulsory "sickness" insurance to industrial workers and their dependents. Specifically, the plan would cover "sick pay" for income lost due to illness and a lump-sum payment to assist with funeral expenses in the event of death. The plan was to be financed by contributions from workers and their employers with additional support from general tax revenues. The program was defended on the grounds of social justice and economic efficiency – the former because it spread the risks of financial ruin and the latter because it mitigated the social costs of illness. The AALL's campaign for health insurance might have succeeded if Theodore Roosevelt , who was nominated by the Progressives in the election of 1912, had defeated Woodrow Wilson. However, the campaign got underway just as support for Progressivism, as a political force, was beginning to wane.

It was two decades before there would be another political campaign to increase the involvement of the national government in the management of social welfare. This time it was President Franklin D. Roosevelt who believed that Americans needed some form of protection against the growing costs of illness and economic insecurity. During the Progressive Era, advocates for social insurance placed health insurance near the top of the agenda. But the nation's priorities were reordered in the ensuing years, as massive job loss during the Great Depression elevated unemployment insurance to the top of the

[10] Founded in 1906, the AALL is best described as a group of social progressives. It consisted primarily of academics who were concerned with the extremes of capitalist industrialization – e.g. child labor, unemployment and workplace disability. The association's membership included John R. Commons and Richard Ely, and Irving Fisher gave the presidential address to the AALL in 1916 (Starr, 1982, p. 246).

reform agenda. Although health insurance was no longer considered a top priority, Roosevelt came close to introducing legislation for universal health care coverage after his election in 1932. At the time, a proposal for universal health insurance was linked to the Social Security Act, which Roosevelt strongly supported. But the American Medical Association (AMA) had a great deal of political clout, and it strongly opposed a universal entitlement to health care. Roosevelt is said to have pulled his support for national health insurance in order to prevent the AMA from dooming his Social Security legislation (Blumenthal, 2006). So Roosevelt succeeded in providing Americans with Social Security, unemployment insurance and workmen's compensation, but he decided that health insurance would have to wait.[11]

In 1945, while the war was winding down, Harry S. Truman became the first American president to wholeheartedly advocate for national health insurance. He proposed a single health insurance system to protect all classes of society, but his program met with considerable resistance on both professional and political fronts. As soon as the details of the plan were released, the National Physicians Committee issued an emergency bulletin encouraging doctors to oppose the program. More opposition from the medical profession came from the AMA, which stoked the fears of communist influence by claiming that doctors would become "slaves" under Truman's health insurance plan. Thus, the debates played out against the backdrop of cold war politics as the Republicans "charged that national health insurance was part of a larger socialist

[11] There is speculation that Roosevelt was talked out of pushing for universal coverage by a small group of physicians, including his son's father-in-law, with whom he reportedly had lunch the day before indicating that he was dropping the health insurance component of his Social Security legislation (Blumenthal, 2006). Toward the end of his life, Roosevelt revealed that he was planning to return to the health care agenda after the war was over (Starr, 1982).

scheme" (Starr, 1982, p. 284). Meanwhile, private insurance strengthened its grip and support for Truman's plan dropped sharply in public opinion polls. By the late 1940s anticommunist sentiments and powerful lobbying efforts made the prospects for national health insurance "vanishingly improbable" (Starr, 1982, p. 285).

The Emergence of an Employment-Based System: 1929-1955

The demand for health insurance increased throughout the 1930s and 1940s, as the development of antibiotics and improvements in anti-infection techniques gave rise to an increased demand for medical care. The increasing supply and demand for health care – with its attendant rise in prices – required a means of financing which did not rely on family income and savings. However, a non-market based solution to rising costs and expenditures was precluded by the failure of reform proposals in the first part of the twentieth century. To fill this void, an alternative system of private health insurance emerged.

Although they were initially reluctant to do so, hospitals and insurance companies helped to accommodate the growing demand for medical care and health insurance by organizing prepayment plans and marketing them directly to worker groups. Offering health insurance coverage to groups of employees yielded two major benefits to the underwriter.[12] First, it enabled them to overcome the problem of adverse selection (i.e. it was unlikely that a disproportionate share of those seeking coverage would be in poor health). Second, the plans allowed employers to deduct premiums from employee

[12] Interestingly, the first health insurance plans were offered by hospitals and not by commercial insurance companies. The first "Blue Cross" plan was offered by Baylor University Hospital in 1929 "as a means to ensure that patients paid their hospital bills" (Thomasson, 2002, p. 237).

paychecks, thereby lowering the administrative costs associated with selling insurance (Thomasson, 2002).

The popularity of these prepaid health insurance plans increased during the Great Depression, when hospitals relied on them in order to smooth receipts in the face of declining revenues.[13] The American Hospital Association (AHA) encouraged the proliferation of prepaid health plans, organizing them under the name Blue Cross, and state laws gave the plans tax-exempt status and allowed them to operate as nonprofit organizations. These "enabling laws facilitated the availability and growth of prepaid health insurance" (Thomasson, 2002, p. 238).

But while many hospitals saw the benefits of offering prepaid policies, the physicians themselves tended to oppose health insurance because they "feared that interference from a third party would restrict their income and limit their ability to price discriminate" (ibid., p. 239). In time, they decided that it was in their interests to offer their own prepaid plans, so they introduced Blue Shield plans, which covered the reimbursement of physicians' services.[14] Like the Blue Cross plans, Blue Shield plans were given tax-exempt status and permitted to operate as nonprofits. In exchange for these special provisions, Blue Cross and Blue Shield were initially required to community-rate their policies, which required them to charge different employee groups the same premium, regardless of their health status.

[13] Mahar (2006) notes that average receipts per patient fell from $236.12 to $59.26 in the aftermath of the Crash of 1929.

[14] Groups of physicians were so interested in protecting their ability to price discriminate that they ensured that laws were passed to prevent the Blue Cross plans from covering physician services (Thomasson, 2002).

The success of the Blues soon invited competition from commercial, for-profit insurance companies that were not required to community-rate their policies. When it came to marketing policies to healthy employee groups, the for-profit insurance companies could often undercut the Blues because they were allowed to experience-rate their policies, offering lower-priced policies to healthier employee groups and charging higher premiums to sicker groups. Competition intensified, and by the 1940s the market for private health insurance began to grow rapidly. Between 1940 and 1950, the number of Americans with private health insurance increased from 20.6 million to 142.3 million (Blumenthal, 2006). But this explosion in coverage was not simply due to increased competition and a growing demand for health insurance. Rather, a series of government policies, passed in the 1940s and 1950s, provided private insurers with a new outlet for their services – U.S. employers – and paved the way for explosive growth in the health insurance industry.

Responding to the inflationary pressures of a wartime economy, the federal government imposed wage and price controls to prevent employers from raising wages in order to compete for scarce labor. While stripping them of their power to increase wages, the 1942 Stabilization Act allowed employers to expand their benefit offerings. By permitting employers to offer health insurance to their employees, the government provided private insurers with a new market for their products.[15] In the years that followed, the government passed several additional rulings that reinforced the efforts of insurance companies to link health insurance with employment and institutionalized the employment-based system of health insurance that exists today.

[15] A small number of U.S. companies offered health insurance coverage to their employees before WWII.

The first piece of legislation, passed by the War Labor Board in 1945, ruled that employers could not change or cancel an employee's insurance plan during the contract period. The second ruling, which became law in 1949, mandated that benefits should be considered part of the compensation package so that unions could haggle over both wages and health insurance in their contract negotiations. Finally, in 1954, the IRS decided that workers would not be taxed on the contributions that their employers made to their health insurance plans.[16] This preferential tax treatment for "fringe" benefits gave businesses an incentive to offer health insurance to their employees.

In sum, employer-provided health insurance, as an institution, emerged during the two decades following WWII. The system is a legacy of Roosevelt's decision not to pursue universal health insurance in the 1930s. The decision has been called "an early triumph of a vision championed by modern conservatives, in which the private sector in the United States fulfills essential social responsibilities assumed by governments in most other industrialized nations" (Blumenthal, 2006, p. 83). As one would imagine, the private sector's ability to fulfill these responsibilities depends crucially on the economic fortunes of its business sector.

The Postwar "Golden Age" and the Health Care Crisis of the 1970s

With the employment-based system firmly in place by the mid-1950s, the incidence of employer-provided coverage expanded rapidly over the course of the next few decades.

[16] Under the current tax code, health insurance premiums paid by employers on behalf of their employees are tax-deductible. President George W. Bush's tax advisory commission is considering sweeping cuts in the tax benefits of employer-provided health insurance. By reducing the tax break, many employers would be discouraged from providing health insurance coverage, pushing many employees into private insurance markets – the goal of the policy – and many more into the ranks of the uninsured.

The supply of health care was stimulated by various government initiatives in support of scientific research and hospital construction. The most important piece of social legislation during this period was the 1946 Hospital Survey and Construction Act (also known as the Hill-Burton Act), which provided states with grants to support the construction of new hospitals. However, despite the expansion of both the supply and demand sides of the health care industry, the fundamental organizational structure for the financing and delivery of health care remained intact.

Most importantly, the financing of care remained largely retrospective, fee-for-service payment, with providers continuing to exert considerable control over pricing and regulatory decisions. This contributed to an explosion in costs and aggregate expenditures, but there was, at the time, no great sense of concern over health care inflation. Price increases were made tolerable by the economic expansion of the so-called "Golden Age" of capitalism, which generated rapid increases in output, employment and real wages. Thus, while the share of total expenditures going to health care had begun to increase sharply, much of the increased spending was considered justified in the face of scientific advances and increasing economic prosperity.

As the expansion continued, those with ties to the labor market enjoyed an increase in the richness of their benefits. But enhancements also reached those without such ties. The economy was booming, and many Americans had come to believe that a great nation must ensure a minimum level of health care for its citizens. To provide for those without employer-based coverage, Congress enacted Medicaid and Medicare as part of the Great Society program in 1965.

The passage of these bills had two immediate effects. First, they substantially enlarged the U.S. health care market. Millions of Americans who previously lacked health insurance now enjoyed coverage under one of these publicly funded plans. Second, they altered the composition of health care spending. As the government covered a larger portion of the health care bill, the share of out-of-pocket spending decreased. The combined effects of the increase in federal funding and the decrease in out-of-pocket spending generated sharp increases in the price of health care:

> From 1960 to 1975 the share of health care expenditures paid by third parties increased from 45 to 67 percent. Like most private plans, Medicare and Medicaid reimburse providers on a fee-for-service basis. Since under fee-for-service, doctors and hospitals make more money the more services they provide, they have an incentive to maximize the volume of services. Third-party fee-for-service payment was the central mechanism of medical inflation (Starr, 1982, p. 385).[17]

Throughout the 1970s, sharp increases in medical costs spawned various forms of legislation aimed at slowing the pace of health care inflation.

For example, in August 1971, President Nixon imposed wage and price controls in an effort to contain inflationary pressures.[18] These efforts continued in 1972, with the creation of Professional Standards Review Organizations, which were designed to limit the expansion of Medicare costs by increasing the oversight of physician practices. In 1973, the government sought a managed care solution to the problem of rising health care costs by passing the Federal HMO Act.[19] With health costs still mounting, the

[17] The reimbursement practice for hospitals and doctors has since changed. Today, Medicare and Medicaid reimburse health providers on a fixed fee schedule.
[18] In most sectors of the economy, these controls were lifted in January 1973, but they were maintained for health care until April 30, 1974.
[19] The Federal HMO Act did a number of things to promote the creation and expansion of HMOs. First, it provided seed money for nonprofit HMOs. Second, it offered eligible

government attempted to limit the growth of hospitals and other health care facilities under the National Health Planning and Resources Development Act of 1974.[20] The Employment Retiree Income Security Act (ERISA) was passed the same year.[21] The ERISA legislation allowed employers to design their own coverage packages and refuse to cover things like in vitro fertilization or to satisfy state requirements for minimal mental health coverage (Blumenthal, 2006).

Despite the various measures to contain them, health care costs continued to increase throughout the 1970s. When President Carter took office in 1977, he entered with a perceived mandate to implement a national health insurance program. He viewed cost containment as a necessary first step and quickly proposed legislation to restrain health care inflation. But his proposals got bogged down in Congress, where the focus became a debate over the relative merits of "competition" versus "regulation" as the best way to control health care costs (Moran, 2005).

By 1982, the nation had endured double-digit increases in health care spending for seventeen consecutive years. Health care inflation outpaced GDP growth, and wages no longer kept pace with rising health care costs. Whereas the nation had been able to

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HMOs an exemption from state regulation. Finally, the Act included a "dual choice" provision, which required mid-sized and larger firms (i.e. those with more than 25 employees) to offer HMOs as a coverage option.

[20] Readers might wonder why the government would seek to curb the expansion of supply facilities in order to mitigate price increases, since economic theory tells us that greater supply leads to more competition and falling prices. But, as Mahar (2006) explains, "when it comes to health care . . . greater supply only excites greater demand", as hospitals and physicians compete for patients, brand name image, and loyalty (p. 16).

[21] The passage of ERISA had a destabilizing effect on the health care delivery system. As firms self-insured their employees, relatively healthy and higher-paid employees were withdrawn from the risk pools covered by private insurance companies. This left behind a smaller population of less healthy individuals and resulted in an increase in premiums, which made it more difficult for smaller employers to offer health insurance coverage to their employees.

absorb rising costs during the boom times of the 1950s and 60s, lackluster growth and an erosion of middle-class incomes left Americans looking for new solutions to the problem of health care inflation. Widespread dissatisfaction with the state of the medical care system inspired a backlash against liberalism and government that culminated in the election of President Reagan in 1980.

Neoliberalism and the "Managed Care Revolution" of the 1980s and 1990s

Shortly after Ronald Reagan was elected president in 1980 he declared that the nation's health care system had become too reliant on federal funding. Consistent with the neoliberal philosophy that characterized his presidency, Reagan sought to shift responsibility away from the federal government and onto the market. Deregulation and an unwavering faith in the efficacy of unfettered markets epitomized the ideological tenor of his administration The nation's health care system soon underwent a major reconstruction.

In the early 1980s, Washington eliminated the federal aid that helped to support the nonprofit operations of nearly all of the nation's HMOs.[22] In response, many of these organizations converted themselves into for-profit enterprises.[23] At the same time, HMOs grew in popularity as employers began switching to managed care in massive numbers. The managed care model reorganized fee-for-service methods by limiting a patient's choice of provider and reimbursing providers according to prospective fee

[22] The original intent of the HMO Act of 1973 was to encourage the creation and proliferation of nonprofit operations through federal grants and loans. In 1981, nearly 90 percent of all HMOs were nonprofits (Mahar, 2006).

[23] By 1986, 59 percent of all HMOs operated on a for-profit basis.

schedules rather than costs incurred. In 1993, 67% of those with employer-provided coverage were enrolled in managed care plans (Gruber, 2000).

But market-based care governed by the restrictive features of the HMOs was not the panacea that many hoped for. While managed care did succeed in reigning in costs for a period of time – 1982 to 1986[24] – medical costs later escalated and health care inflation stood at 15 percent by 1990. This is because the HMO, which serves as a middleman between the doctor and the patient, carries an additional level of management and profit. As Keyser explained, the middleman takes a cut, and that cut "consumed much of the economic advantage that might have been expected in comparison to traditional fee-for-service" (1993, p. 90). Mahar agrees, noting that "the very entrepreneurs who promised to reign in health care costs were in fact attracted by the sea of green – the seemingly unlimited flow of health care dollars" (2006, p. 25).

In 1992, Bill Clinton made health care reform a cornerstone of his presidential campaign. His effort to fundamentally reorganize the health care delivery system began soon after his election, with an announcement that First Lady Hillary Rodham-Clinton would head a Task Force on National Health Care Reform. A comprehensive plan to provide universal health care for all Americans was introduced as the Health Security Act on November 20, 1993. Despite the fact that the legislation was introduced in a Democratic-controlled Congress, it failed to garner sufficient support.[25] By the mid-1990s, health care inflation once again outpaced generalized price inflation. Then, in the

[24] During this period, the rate of increase in total health care spending declined (Mahar, 2006).

[25] In partnership with the insurance industry, Conservatives launched a successful campaign against the Clinton plan, and even many Democrats withheld support for the President's plan.

late 1990s, when the economy experienced its strongest expansion in decades, employers became concerned with recruitment and retention and relaxed their grip on cost containment.[26] When the economy turned down again in 2001, health care costs had already begun to increase rapidly. And, once again, employers looked for ways to defray rising premiums. This time around, they opted for benefit restructuring – relying heavily on greater employee cost sharing – as opposed to restrictive managed care models.

The lesson in all of this is that the American health care delivery system is constantly evolving in response to a changing economic and political landscape. During the boom times of the 1950s and 1960s, liberal advocates of health rights tended to argue for greater access to care and increased protection against the costs of illness. And they succeeded in expanding access to care because tax revenues were rising, profits were strong and productivity was increasing. But when the economy weakens, it sets up a conflict between the liberal critic's demand for equality and access to care and the concern of government and business to control costs (Starr, 1982). This occurred with jobs crisis of the 1980s and 1990s, and it "translated into a severe instability of health insurance coverage" (Nayeri, 1995, p. 58). Since 2001, soaring health care costs and a jobless economic recovery have intensified the internal contradictions of the employer-based system of health care provisioning. Indeed, the system itself appears unsustainable in the face of mounting contradictions driven by a series of disturbing trends.

[26] Surveys show that workers had become increasingly dissatisfied with managed care plans by the late 1990s. Employers faced mounting pressure to offer plans with fewer restrictions on provider choice and greater access to care. Preferred Provider Organizations (PPOs) emerged as the dominant alternative to HMOs.

TRENDING TOWARD A COLLAPSE OF THE EMPLOYER-BASED HEALTH CARE SYSTEM

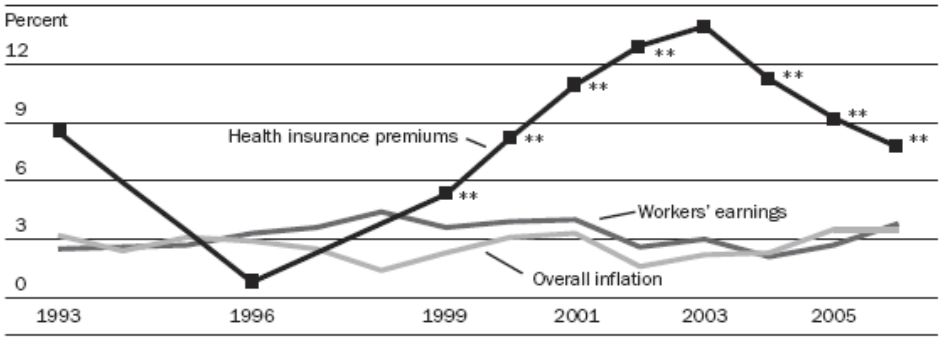
Although the employment-based system remains the bedrock of the modern health care system in the United States, it "faces challenges that are unparalleled in its roughly 70-year history" (Blumenthal, 2006, p. 82). Indeed, the limits to employer-provided health insurance appear to have been reached, peaking in 2000, when 66.8% of the population had employer-based coverage. The story is a complex one, and it reveals no single villain. Below, we examine a multitude of forces that are currently working to destabilize the American health care delivery system.

The Thinning Out of Employer-Sponsored Coverage

The labor market has been the primary means of obtaining health insurance coverage in the United States, partly due to the risk-sharing nature of the private health insurance market. While employers benefit from these economies of scale, they also incur substantial costs when health benefits are offered. Indeed, nearly 20 percent of the more than $7 trillion that U.S. employers spend annually on worker compensation is devoted to benefits (retirement, health and other benefits). As a result of escalating health care costs, health benefits have taken an ever-increasing share of employers' benefit spending. In 2005, employers spent $596.5 billion on health benefits, up from $399.6 billion in 2000 (MacDonald, 2007). Until recently, the cost of health insurance was kept at an affordable level for the majority of employers and working Americans. But this is no longer the case. As Figure 1.6 shows, health insurance premiums have been rising considerably faster than wages and prices, and this is "placing significant strains on the employer-sponsored health insurance system" (The Kaiser Family Foundation, 2005).

Figure 1.6

EXHIBIT 1
Increases In Health Insurance Premiums Compared With Other Economic Indicators, 1993–2006



SOURCES: Premiums: Henry J. Kaiser Family Foundation/Health Research and Educational Trust Survey of Employer-sponsored Health Benefits, 1999–2006, and KPMG Survey of Employer-sponsored Health Benefits, 1993 and 1996. Inflation: Bureau of Labor Statistics, Consumer Price Index (U.S. City Average of Annual Inflation, April to April), 1993–2006. Earnings: Bureau of Labor Statistics, seasonally adjusted data from the Current Employment Statistics Survey (April to April), 1993–2006.
NOTES: Data on premium increases reflect the cost of health insurance premiums for a family of four. Data are weighted by covered workers. Statistical significance indicators denote that premium estimates are statistically different from the estimate for the previous year shown.
** $p < .05$

With medical inflation far outpacing inflation in general, employers have taken various steps to defray rising benefit costs.[27] One strategy has been to require employees to participate in greater cost-sharing by mandating higher premiums and larger deductibles and co-pays. But not all firms have been willing to share in the burden of rising health care premiums. Some have engaged in cost-shifting (i.e. they have cut wages in order to offset rising health care expenditures), and others have simply decided to eliminate health care from the benefit package.[28] As a consequence of these actions, the percentage of all employers offering health insurance to their employees during the last six years has dropped from 69 percent to fewer than 60 percent.[29]

[27] Part III of this *Series on Health Care* will examine the laundry list of strategies employers have adopted in their effort to defray rising health care costs.
[28] Indeed, according to a survey by the National Federation of Independent Businesses (NFIB), sixty-five percent of small-business owners say that high costs are the reason they do not offer health insurance to their employees (Baird, 2005).
[29] The rate of employer-sponsored coverage continued to decline, even as the economy added 1.5 million jobs between 2003 and 2004 (Gould, 2006).

But this "thinning out" of coverage has extended beyond the working population. Among those hardest hit are the dependents of covered workers who continue to lose employer-based insurance as firms increasingly choose to cover only their own employees. Indeed, children accounted for the largest share of the roughly 3.7 million people who lost employer-provided health insurance between 2000 and 2004. And while public programs have taken up some of the slack,[30] medical inflation and state budget constraints are making it difficult for programs like Medicaid and the State Children's Health Insurance Program (SCHIP) to continue to absorb the growing number of uninsured Americans.

Another group that has suffered a sharp decline in employer-based coverage rates is America's retirees. Retirees began losing access to employer-based coverage in the early 1990s, following a 1990 ruling by the Financial Accounting Standards Board (FASB). The ruling mandated that, beginning in 1992, businesses that offered health benefits to their retirees would have to include their *future* retiree health care expenses in their *current* financial reports. The implementation of this rule had the immediate effect of reducing the valuation of these firms on Wall Street. As a result, the proportion of mid-sized and large firms that offered health care to their retirees fell by almost 50 percent between 1980 and 2000. Retirees are now one of the least likely groups to have employer-sponsored insurance.[31]

[30] Between 2000 and 2004, the number of people receiving Medicaid (including SCHIP) increased by nearly 8 million.

[31] Other groups include employees of small establishments, minorities (especially Hispanic males), young adults (19-24) and near-elderly working women with health problems (Stanton, 2004).

But the most alarming statistic, in a system that ties access to health insurance to participation in the labor market, is the drop in employer-based coverage for prime-age working adults. In fact, members of this group were 26.7% more likely to be uninsured in 2004 than in 2000. And while there are still government programs to help prevent children[32], elderly and disabled people from becoming uninsured, there is little support for prime-age working adults when they lose coverage through an employer.

More Alarming Data on the State of the U.S. Health System

The rising health insurance premiums and declining coverage ratios examined above are not the only forces working to destabilize the U.S. health care system. Below, we chronicle just some of the other trends which, if they remain unchecked, will affect not only the stability of the U.S. health care delivery system but also the broader macro economy and the security of millions of American families.

- Eighty percent of Americans reported that they were dissatisfied with high national health care costs (ABC News/Kaiser Family Foundation/USA Today, 2006).
- Over 45 million Americans are uninsured – more than 8 million of them are children.
- Approximately 15.6 million adults are underinsured (Hellander, 2006).

[32] The Bush administration has recently tightened the standards that are used to determine when coverage can be provided to uninsured children. The goal of the new policy is to prevent states from expanding coverage under the State Children's Health Insurance Program (SCHIP) to middle-income families. Many state officials oppose the stricter limits, arguing that they "could jeopardize coverage for thousands of children" (Pear, 2007, NYT Article).

- Since 2000, premiums for employer-sponsored health insurance have been rising four times faster than workers' earnings (Kaiser Family Foundation, 2004).
- The average employee contribution to an employer-sponsored plan has increased more than 143 percent since 2000.
- Average out-of-pocket costs for deductibles, co-payments for medications and co-insurance for physicians and hospital visits have risen 115 percent since 2000.
- As a share of GDP, U.S. personal health care spending has more than doubled over the past three decades (Ginsbburg and Nichols, 2002-03).
- Total national health expenditures are expected to increase to $4 trillion by 2015, when they are projected to account for 20 percent of GDP (Borger, 2006).
- Americans pay more, both as a share of GDP and on a per-capita basis, than citizens of other major industrialized nations.
- The U.S. ranks far behind its international competitors in terms of health outcomes (e.g. longevity and infant mortality), despite spending significantly more on health care.
- Almost half of all Americans report that they are very worried about having to pay more for their health care or health insurance (National Coalition on Health Care, 2007).
- Fifty percent of all bankruptcy filings were partly the result of medical expenses (Himmelstein, et. al, 2005).
- Every 30 seconds someone in the U.S. files for bankruptcy in the aftermath of a serious health problem (National Coalition on Health Care, 2007).

- One-half of workers in low- and mid-range compensation jobs and one-quarter of workers in higher-compensation positions reported problems with medical bills or were paying off accrued medical debt (Collins, et. al, 2004).
- More than 25 percent of those surveyed in a study by The Access Project reported that they were unable to make rent or mortgage payments or that they suffered bad credit ratings because of medical debt (Seifert, 2005).

The system for delivering health care in the United States is under great stress, and the pressures are mounting. If cost increases continue unabated and employers persist in their attempt to shift more and more of the burden onto the working population, the ranks of the uninsured will continue to expand, health outcomes will worsen, more people will be forced into bankruptcy, families will dissolve, and all of this will dampen economic activity in the rest of the economy.

CONCLUSION

In the absence of national health insurance, Americans have long depended on employer-sponsored insurance as the primary means of protection against the cost of illness. Under this system, access to coverage is linked to the fortunes (and misfortunes) of America's business sector. During the so-called "Golden Age" of American capitalism, the health care system survived rising costs and increasing out-of-pocket medical expenditures as the economy experienced historically low-levels of unemployment, rising real wages based on productivity gains, and strengthened collective-bargaining rights. Costs increased, but firms and their employees were able to absorb these expenses because revenues and wages kept pace.

However, the economy faltered in the early 1970s, and America's businesses struggled to accommodate the rising costs of providing health insurance. Various efforts at cost-containment were attempted through public sector legislation and private sector innovation, though nothing succeeded in bringing about a permanent abatement in health care costs. Since then, the employer-based system has weathered many challenges. Innovations, such as HMOs, helped to mitigate spiraling cost increases, and an eventual shifting away from these restrictive managed care plans helped to temper growing dissatisfaction among the insured.

Today, the system faces many new challenges. As before, the number of uninsured Americans continues to rise, but this time around bankruptcy and foreclosure threaten the stability of the macro economy as well as the financial system. Employers have shifted too much of the burden onto the working population, whose incomes are not growing rapidly enough for them to endure it. And the social safety net, which has been whittled at away for decades, remains under attack. Unless there is a substantial abatement in health care cost increases, the fallout will likely bring about a radical restructuring of the health care system. As Moran notes, employer-based insurance "will continue to thin out and could amount to a 'catastrophic only' insured benefit before we are too far into the next decade" (2005, p. 1420).

It is impossible to predict what the system will look like a decade from now. But one thing is for certain – powerful lobbies will push to retain the for-profit system (with subtle modifications that protect their interests), while the majority of Americans and a growing number of physicians will push for a fundamental reorganization of the health care system.

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