LOBBY SEVEN

Volume 2 November 29, 2016

HEALTH INSURANCE, PART I

1945 – 2008: Paging Dr. Frankenstein

"You can check out any time you want. But you can never leave!" - Eagles

Nobody would have deliberately set out to design the health insurance system we have. It makes no sense. Incentives are misplaced, negative externalities abound, inefficiencies are layered on inefficiencies. And the politics of health insurance are toxic; any changes that are made will produce some winners and some losers, and people who are currently satisfied reasonably fear change.

We are going to tackle this system in 3 parts. Part I describes how our health insurance system came to be. Part II will describe what the Affordable Care Act, or "ACA", did and why. With a new administration coming in, the Affordable Care Act will be in the crosshairs. Part III will discuss some of the changes being proposed, and I'll opine as to the likelihood of various outcomes.

- Why did employers get into health insurance?
- Who is getting their health insurance from the government?
- What did the health insurance ecosystem look like just before the Affordable Care Act?

Why did employers get into health insurance?

Before World War II, health economics were simple; almost all Americans paid directly for their medical care. It was a time before MRIs, billion-dollar wonder drugs, and soaring levels of joint replacement[1]. We all know how far medicine has advanced in the span of a lifetime, but let's take a minute to imagine a world without:

- Antibiotics (discovered 1928, not widespread until after WW2)
- Chemotherapy (1940s)[2]
- Tylenol (1948)
- Pacemakers (1958)
- Ultrasounds (1953-1965)
- Vaccines for typhus (1937), flu (1945), polio (1955), measles (1964)
- DNA fingerprinting (1985)

I can go on, but you get the point – there just wasn't nearly as much health care you could buy, so the issue of how to pay for it was not so critical.

In the 1930s Blue Cross launched the first product that looks at all like modern health insurance. But the market really took off due to World War II[3]. Wars generally cause inflation, and FDR reasonably worried that the largest war effort ever would do the same to the U.S. In order to fight potential inflation, the National War Labor Board was created with the power to prevent work stoppages and

[1] 2.5 million Americans have an artificial hip and an additional 4.7 million have an artificial knee. Among Americans over 80, it's 6% and 10% of the population respectively. American Academy of Orthopaedic Surgeons.

[2] The Emperor of All Maladies talks about the start of cancer treatment and is a great and tragic thing to read. I can't imagine the world where we literally had no treatment options for cancer other than drastic surgery.

[3] Eventually, I'm sure we'll find something to write about that wasn't started by FDR.

control wages in critical war industries[4]. But they added a loophole which is still having unintended consequences: health benefits were exempted from these wage controls. Companies couldn't compete for workers on salaries, so they started competing on benefits. Because the premiums are tax deductible for the employer - and untaxed for the employee – it is more efficient for an employer to buy the insurance than to pay employees more and let them buy it themselves. In 1960, the Federal Employees Health Benefit Program was created[5]. Around that time most federal, state and local government employees started receiving health benefits from their employer also.

Fast forward a bit, and health insurance became a de rigueur feature of a "good job". Proud Jewish mothers of recent college graduates started bragging that their kid "has a job and it even has health insurance.[6]" In 2008, 58.5% of Americans received health insurance from their employer[7]. But there are a few problems with an employer-based system. First, the employer will choose the health plan, which your doctor may or may not accept. Then, job switchers will almost by definition need to change plans (and thus maybe doctors). The self-employed and owners of small businesses will find it prohibitive to establish a "group plan", so employer-based systems discourage entrepreneurship. Also, as the cost of health care has increased, more companies began cancelling their benefit plans, or at least forcing employees to pay a larger share. Finally, an employer-based system does very little for people who are out of the work force for any reason.

If people can reasonably go and buy health insurance on their own (what is called the "individual market"), these problems are mitigated. But as we will see, the individual market started to become highly dysfunctional towards the end of the 20th century.

Who is getting their health insurance through the government?

As we've seen, by the 1960s, employer-based plans dominated the health insurance market. But large groups of people were left uncovered, and Presidents Kennedy and Johnson began to push Congress to take action on behalf of some of these groups. Raised by President Truman as a moral obligation in 1945, it has been part of the Democratic Party's platform to use government provided solutions to ensure universal health insurance[8]. Alternatively, the Republican Party has consistently supported a market-based approach, opposing any government involvement, especially Federal[9].

Retirees were a large group of citizens who lacked insurance. Some elderly citizens maintained coverage through a retirement plan from a previous employer, but according to a 1960s study, about half of Americans over 65 were uninsured[10]. With large Democratic majorities resulting from the landslide

[4] The NWLB was created by an FDR executive order. Imagine a President today, even in war time, unilaterally creating a board with the power to freeze wages and prevent strikes. A simpler time I suppose.

[5] I don't know much about the FEHB and it is of course complex. You can see here and here if you want to learn more.

[6] Source: my mother, circa September 2001

[7] Census.gov - Income, Poverty, Health Insurance, 2009. The 2008-2009 "status" numbers I quote are from this report.

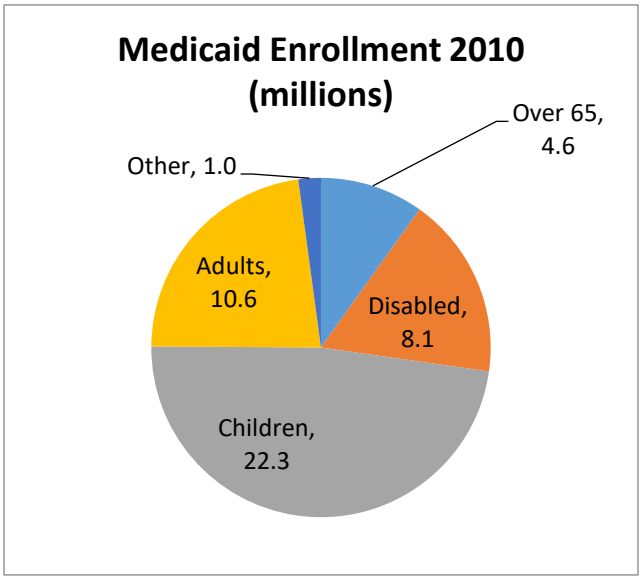
[8] See the 1948 Democratic Party Platform, for example

[9] 2016 Republican Party Platform. One departure from "no federal involvement" is the idea of buying insurance across state lines. This would involve the federal government overriding state regulators to allow buyers to purchase insurance which is permitted in a second state (insurers can already sell a policy in any state where it is approved).

[10] Politifact has a nice summary of the health insurance situation for elderly Americans in the 1960s.

1964 election[11], Medicare was created as an amendment to Social Security.

The basic financial structure of Medicare is therefore similar to Social Security: funded by a direct payroll tax, appropriated through mandatory spending, surplus goes into a Trust Fund (similar to but separate from the OASDI Trust Fund in Vol. 1). Originally, Medicare had two major programs: hospital/hospice insurance (Part A) and outpatient insurance (Part B). In 1997, Medicare was modified to allow seniors to receive the coverage through private plans, which came to be called Medicare Advantage (Part C). Finally, in 2006, a prescription drug program was added (Part D). It was also expanded over time to include some disabled persons under the age of 65. Today, approximately 46 million seniors and 9 million non-seniors receive health insurance through Medicare. The program has been successful at its prime goal; by 2008, only 1.7% of American seniors lacked health insurance.



The next large group without access to health insurance was, speaking broadly, poor people. But it's misconception that Medicaid is a welfare program, with benefits going to people who are not working (either due to their choice or inability to find work). A look at the population on Medicaid shows this is not the case (see figure[12]).

Even among the adults in Medicaid, it is estimated that around 72% are in families with at least one working adult[13]. In other words, Medicaid enrollees are largely either out of the workforce for valid reasons or employed by a company through which they do not receive health benefits. The growth in adults in Medicaid (from 6.9 million to 10.6 million during the period 2000 to 2005) is mostly due to fewer employers offering health coverage[14].

Medicaid operates in a fundamentally different manner than Medicare (or Social Security). Medicaid is a partnership between the federal government and each state; the coverage available through Medicaid varies greatly depending on where you live[15]. For states whose Medicaid systems meet certain requirements, the Federal Government is committed to picking up 50% of the total costs (wealthier states) or more (76% in Mississippi)[16]. The basic Medicaid requirements to gain Federal cost-sharing are fairly low; states following the minimum will still have large populations who earned too much to receive Medicaid, but worked at jobs that did not offer benefits. Many states therefore offer Medicaid benefits to a larger population than the minimum required.

By the 1990s, there was a strong movement to try to close this "coverage gap" among minors. While history has written that Hillary Clinton's health

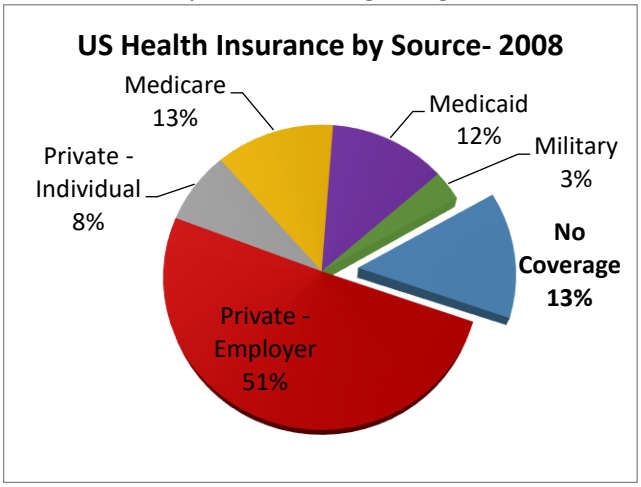
[11] Vote tally here. The GOP had only 32 senators and 140 representatives in 1965.
[12] CMS Statistics 2014
[13] CPBB Employment Requirement for Medicaid
[14] Adults in Medicaid increased further (to 12.1 million) by 2010, but much of this increase was likely due to increased unemployment with the financial crisis.
[15] Arizona didn't create a Medicaid program until 1982, a full decade after every other state. During that period, their taxpayers were paying 50% of all other states' Medicaid programs.
[16] National Women's Law Center, 2006

insurance initiative in 1993 was a failure, this ignores the very significant step of creating the State Children's Health Insurance Program, or "S-CHIP"[17]. S-CHIP works as a federal-state partnership, the same as Medicaid (in some states they are run together). By 2009, 7.7 million children under 18 were covered by S-CHIP[18].

In addition to these programs, the Government also directly provides healthcare in its role as an employer. When considering the system as a whole, these people are more similar to those in employer plans, as opposed to Medicare/Medicaid. But for completeness sake, around 35 million people have health care through their government employer – two-thirds as federal/state/local employees and the remainder through military (TriCare or Veterans Administration)[19].

What did the Health Insurance ecosystem look like before the Affordable Care Act?

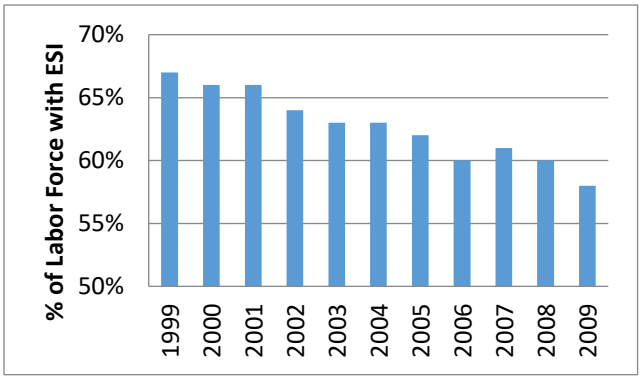
We've now covered in fair detail how the US public and private health insurance systems came to exist. But, as we will see below, starting around 1995 strains in the system were beginning to affect more and more Americans. Let's start with a chart to describe the status of the health insurance system just before the ACA[20].



Then, the changes in total US National Health Expenditures (NHE) **after inflation**[21]:

Period	Description	NHE Growth
1961-65	Pre-Medicare / Medicaid	7.5%
1966-73	Coverage Expansion	7.2%
1973-82	Rapid Price Growth	5.8%
1983-92	Payment Change; Continued Rapid Growth	6.5%
1993-99	Cost Containment (i.e. HMOs)	4.1%
2000-02	Backlash to Cost Containment	6.2%
2003-07	Slowdown in Spending	4.2%

Then, the decline in employer sponsored health insurance (ESI)[22] - note that this doesn't include the fact that employee's out of pocket costs have steadily increased[23].



It seems clear what is happening– the cost of providing health care increased; employers

[17] This is now officially called just "CHIP", but the S-CHIP name is probably better known.
[18] Kaiser Family Foundation
[19] ACA Signups. This data is as of 2016, I couldn't find 2008 data on people receiving insurance through their government employer, but the story wouldn't change significantly. I did randomly find that Federal civilian employment was the same in 2014 as in 1966 – despite the population growing by 120,000,000 Office of Personnel Management
[20] Census.gov. Note that the numbers don't add to 100% because some people have multiple sources of coverage
[21] Center for Medicare and Medicaid Services
[22] Kaiser Family Foundation
[23] If you've been employed with benefits over this period, you don't need a source to know this statement.

sponsored a lower portion and/or cancelled coverage entirely; more people fell into the "Medicaid Gap", forced to either buy their own insurance or go without. Why did so many people go without health insurance? Remember that these are Americans who earn **too much** to be eligible for Medicaid. Which brings us to the allegory of the death spiral[24].

Let's say that you lose your employer sponsored coverage. Maybe your employer stops offering it, maybe you are laid off, maybe you leave to start your own company – the reason why doesn't matter. You research health insurance choices, price check several insurers and choose a plan that is the best for you, your wife, 1.9 children and dog. To protect against the catastrophic risk of a major health issue, your insurance company places you in a "pool" of insured who will be charged similar rates; the pool is closed to new joiners, but anybody can leave at any time by simply not paying their premium.

Over time, people in your pool begin to develop various ongoing health conditions. High blood pressure, lupus, diabetes, heart disease – just the luck of the draw, but people are going to get sick. The cost to the insurer starts to increase, so they increase the premiums for everybody. But your family got lucky, no major ongoing health issues – so when the premiums increase, you leave your health insurer, find a new plan, get placed in a new pool and begin the process again.

But for those left in the pool, healthy families leaving means that the average health of those remaining worsens quickly. The increase in premiums begins to accelerate. Those left in the pool are left with an unenviable choice: they can try to remain in the pool, which is getting harder and harder to afford; or they can go without insurance – the families still in the pool have major medical problems and no new pool will take them. Even for "healthy pools", the costs begin increasing due to insurance company overhead; they had to ensure that unhealthy families are denied access to the new pools[25].

In case this wasn't bad enough, the state governments got involved[26]. Constituents complained about getting rejected for coverage, so several states began to make it illegal to deny coverage for "pre-existing conditions", which is called "guaranteed issue" [27]. Because insurance had to be priced based on the average of the people buying said insurance, healthier members of the pool quickly began to skip insurance (which was overpriced from their perspective). Just like states without this regulation, the pool became sicker and insurance companies raised rates, driving out the healthiest members, so the pool became sicker and insurance companies…well you get the idea. A death spiral. And this isn't theoretical outcome. New York had one of the worst death spirals as the number of residents in the private insurance market decreased from 1.2 million to 31,000[28].

It's easy to find other ways in which health insurance doesn't behave according to supply and demand. Let's say that you start a health insurance company that offers great coverage for adult-onset diabetes and your competition offers great coverage for lung cancer. The obese will become your loyal customers, while no smokers sign up. Because of the difference in the populations, each of your pools will require more treatment than expected. Your costs increase, you increase premiums, healthier people leave the pool. Offering a choice has created a death spiral.

This brings us to 2010. Total national health is continuing to increase faster than inflation, pushing

[24] I borrowed some of my death spiral story from healthinsurance.org

[25] In Tennessee, Blue Cross / Blue Shield eventually turned down one-third of applicants. See 24.

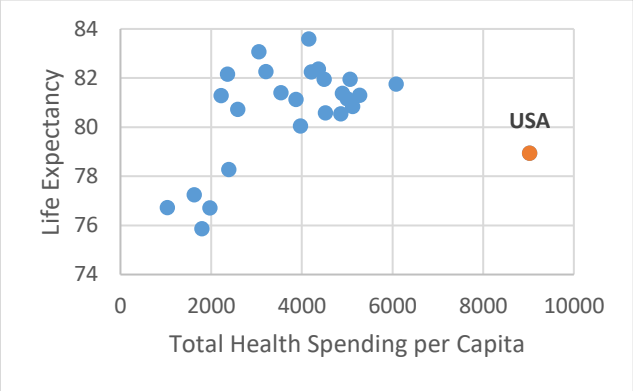
[26] Pre-ACA, almost all insurance regulation was at the state level

[27] Or, similarly, limit the additional amount that applicants could be charged due to health status, which is called "community rating".

[28] Some states passed better designed regulation than New York, but conceptually faced the same problem.

more people into the private insurance market, which is becoming constantly more strained. The rate of uninsured was increasing every quarter – and the factors driving this increase were accelerating. People without insurance were foregoing preventative treatment; skipping these treatments not only worsened their own outcomes, but it increased spending across the system (generally, the earlier something is treated the less expensive the treatment). Even where the health outcome was positive, the financial strain began to show. In a 2-tiered pricing system, individuals had no access to the reduced prices negotiated by large networks. Health bills became by far the largest source of personal bankruptcies in the US[29].

My takeaway: the health insurance market can not operate solely on the market principles of supply and demand. While more government regulation can also be counterproductive, an insurance system without regulation will lead to a death spiral. More competition, price transparency, tax breaks – none of them can avoid this fact. But it can lead to this[30]:



I've chosen life expectancy, but most metrics show the same thing. We are spending far more than any other country on health care – and we don't have much to show for it. In Part II, we'll be looking at the Affordable Care Act, created to try to both reduce the cost of health care as well as improve outcomes.

So in Volume 2, we are going to add a new section, "Meta". I received several good follow-up questions to Volume 1, so I thought it made sense to answer them.

Q1: What is the return on the Social Security Trust Fund certificates in West Virginia?

A1: Several people asked this. The SSA provides very detailed data on their site: SSA. For 2015, it was 3.225%

Q2: Why do people who have significant other income still receive Social Security? In other words – why isn't it means tested?

A2: When it was created, FDR did not want SS to appear to be a "welfare" program; he thought it would be more difficult to cut benefits if everybody was receiving them (and this has in fact been the case). However, SS benefits are also taxed as income. If your marginal tax rate is 50% you will receive a much smaller net benefit than if it is 0%.

Q3: Why are you writing this stuff? Do you expect to eventually have [Insert preferred feature here]?

A3: Volume 3 is going to discuss this. In short, the plan is to produce anything that people are showing they value; there is no end goal right now. But please keep letting me know how to improve it – previous ones are not ignored, just take time to implement.

Q4: What can I expect in the near future?

A4: This is all tentative, but I'm targeting 4 articles in the next 60 days: What is LobbySeven; Healthcare Part II: The ACA; Four months in 1933; Healthcare Part III: Can we "Repeal and Replace". In general, I'm hoping to publish every two weeks, depending on complexity of the topic.

---

[29] The Atlantic.

[30] OECD countries only. Health data as of 2014 from OECD. Life expectancy data from World Bank.