Why did the U.S. develop a health care system that relies mostly in the private provision of health insurance?

The business of insurance has long been established. In ancient times, insurance existed for life, fire, and marine. The need for health insurance came after the introduction of machine processes and factory technology in England. Dramatic types of industrial accidents coupled with a better system of communication to spread the knowledge of these events spurred the general public's desire for health insurance. Modern day health insurance institutions have taken on many forms. While other countries have compulsory national heath insurance, the United States relies mostly in the private provision of health insurance. This research paper will describe the economic reasons for the structure of the U.S. health insurance system.

Before 1920, U.S. citizens' main financial concern of medical treatment was the lack of income from missing work, rather than the ability to pay hospital bills. In 1919, the State of Illinois Commission Study estimated that lost wages for individual wage earners were approximately four times as great as the cost of medical care. One reason for the low cost of medical care is that the North American population was widespread and most people had the living space to treat ill family members at home. Instead of health insurance, most purchased "sickness" insurance. It was similar to today's disability insurance, since it was a supplemental income while the insured was unable to work. Proposals for compulsory nationalized health insurance in the U.S. were unpopular because there was a lack of public demand for medical insurance coverage.

As time went on, advances in medical technology and strengthened qualifications for doctors increased the cost of medical service. The medical field became a more precise, scientific field of study and the range of costs for particular diseases and

conditions rose. The U.S. population grew and shifted from rural towns to urban cities. Family living arrangements no longer allotted space for home medical treatment. Since there was a lowered ability to care for the sick at home and the field of medicine was more trustworthy, it became more common to seek professional medical treatment. As the demand for professional medical service increased, so did the price of such treatment and the burden of paying for medical treatment became a public concern. After a five year study that began in 1926, the Summary Volume of the Committee on the Costs of Medical Care estimated the growing financial burden of medical care in absolute terms. During the period from 1928 to 1930, a family with an income of less than $2500 per year lost a maximum annual wage from the inability to work of about one billion dollars, while the amount actually spent on medical care was approximately one and one-half billion. Lower income families spent even more than this on medical treatment. The Committee on the Costs of Medical Care estimated that a family that earned between $1200 and $2500 per year expended a little over half of their expenses for medical care. Families with an income less than $1200 per year spent about five-sixths of their total expenditure on medical treatment.

Despite the growing demand for a way to pay for medical treatment, physicians, pharmacists, and commercial insurance companies were against a compulsory national health insurance system in the early 20th century. Physicians feared that government intervention would lower their fees. Pharmacists were concerned that such a system would provide prescription drugs that would undermine their business. Commercial insurance companies were aware that the proposed nationalized system would not allow them to provide burial insurance, which was a substantial portion of their business.

Proposals for compulsory nationalized health insurance have been, to this date, successfully defeated. Even the most recognized Wagner-Murray-Dingell bills during Truman's presidency, which would have been similar to the Beveridge plan adopted in England, were squashed by vigorous campaign efforts of the American Medical Association.

With a growing demand for a way to pay for increased medical expenses and no compulsory national health insurance system, another group had a need to satisfy the public demand. In 1929, Blue Cross was founded by the American Medical Association (AMA) and offered a hospital bill payment plan. Blue Cross enrollment became particularly popular during the Great Depression, when most people could not afford medical treatment nor could hospitals maintain a steady stream of revenue. This insurance program was mutually beneficial since it offered an affordable method of payment to consumers and was able to generate income during a period of falling hospital revenue. It led to inter-hospital coverage which reduced the competition among hospitals. Since this insurance program was considered in society's best interest, state enabling legislation allowed for Blue Cross to have nonprofit status and thus tax exempt and free of insurance regulations. These state enabling laws increased access to health insurance coverage. Between 1931 through 1955, states with Blue Cross enabling legislation had about 17 percent more insurance coverage per capita than states without such enabling legislation. As displayed in Figure 1 of the Appendix, the number of people with health insurance in the United States increased steadily in general from 1940 to 1960.

Shortly after the foundation of Blue Cross, physicians faced two prospective possibilities. Hospitals could offer coverage for physician services or the emerging social

security legislation in the 1930s threatened the existence of voluntary health insurance. Physicians acted quickly to ensure their best interests with the foundation of Blue Shield in 1934 to cover their services. The established enabling legislation for Blue Cross was also applied to Blue Shield, allowing this institution to be free of tax and insurance statutes. Similar to the increase of Blue Cross coverage, state enabling legislation for Blue Shield increased the amount of coverage purchased within the state. States with Blue Shield enabling legislation sold approximately 11 percent more insurance per capita than states without these laws between 1935 and 1955. Blue Shield allowed physicians the freedom to continue price discrimination. Patients who subscribed to Blue Shield paid the difference between their actual charges and the amount for which they were reimbursed by Blue Shield.

Compensation benefits, other than wages, were not widespread before the Great Depression, a time when there was vast economic distress and an increased consciousness of security. During World War II, wage controls were implemented by the government to manage the economy. These wage controls restricted employers from using wages to compete for scarce labor. The government responded with the Stabilization Act of 1942, which was a tax policy that allowed workers to exempt employer contributions to their health insurance plans from taxable income. It enabled employers to offer “fringe benefits” plans in lieu of wage increases as a means of securing and retaining workers. Since adequate health insurance was high on the list of benefits desired by U.S. workers, the Stabilization Act benefited them by lowering the price of their health insurance coverage and providing income tax benefits. In 1945, the

War Labor Board ruled that employers could not modify or cancel group insurance plans during their contract period.

The new link between employer and health insurance spurred commercial companies to join the health insurance market. Prior to this relationship, it was difficult to determine policies and statistics for "sickness" because it was not well-defined. With the newly established link between employer and insurance, commercial insurance companies found a way to insure relatively young, healthy people who did not individually seek health insurance. It allowed commercial insurance companies to overcome the adverse selection of individual seekers of health insurance by catering specifically to groups of employed workers. While the nonprofit status of Blue Cross and Blue Shield forced them to charge a community rate, that is, to charge the same premium to all subscribers, commercial insurance companies could engage in price discrimination. Since commercial insurance companies were not nonprofit, they could charge subscribers based on experience ratings, allowing them to charge sicker people higher prices than healthy people.

Government interventions, in addition to the Stabilization Act, further solidified the relation between employer and health insurance provider. In 1943, an administrative tax ruling stated that employers' payments to commercial insurance companies for group health coverage on behalf of their employers were not taxable as employee income. Since this ruling only affected direct employer contributions to group insurance plans issued by commercial insurance companies, there was limited applicability. For instance, employer contributions to unions, individual health insurance plans, and other plans with either of the Blues held by employees were not tax exempt under this ruling. Much confusion

surrounded the 1943 tax ruling because "insurance plan" was unclear. In certain instances, the Internal Revenue Service (IRS) reinforced the limitations while other rulings contradicted previous ones by broadening its applicability.

In 1954, the IRS created a standardized set of rules to clarify the 1943 tax ruling. This set of codes is called the Internal Revenue Code (IRC). It was a concise standard to eliminate confusion about the tax exemption rules of employer contributions to their employees' health insurance plans. The IRC broadened the applicability by extending tax exemption of employer contributions to include contributions to individual health plans such as unions. Risk Averse firms were more likely to sponsor insurance plans after the implementation of the IRC because it reduced the uncertainty of the tax treatment of employer contributions. The effect of the 1954 tax subsidy was that the amount of employers and unions that offered group health insurance plans increased. Group insurance was less expensive than individual coverage and it increased access to group coverage. Ultimately, it led to more households having insurance coverage. These tax changes directly made health insurance less expensive for homes with employers who contributed to their health insurance plans. Since employees did not have to pay income tax on these contributions, the "price" of health insurance for employees decreased, and the amount of coverage purchased increased.

The National Labor Relations Board ruling in 1948 enabled unions to negotiate for benefits of workers. This ruling further solidified the relationship between employer and health insurance. In 1949, the National Labor Relations Board also ruled that wages included pension and insurance benefits.

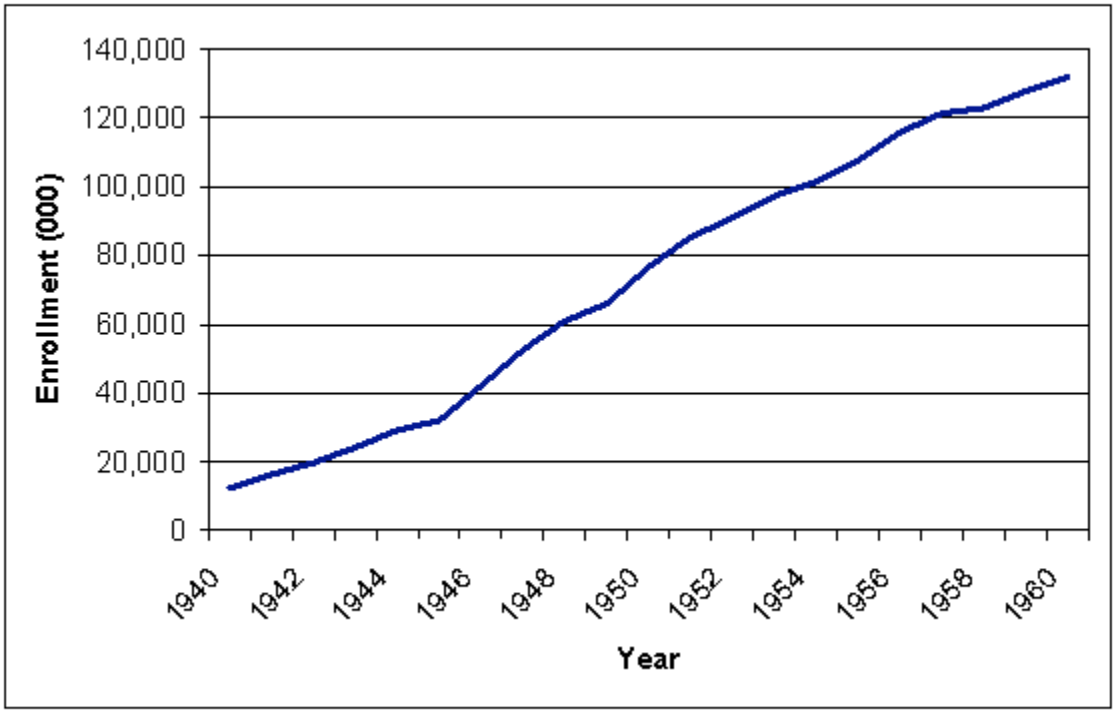
Since health insurance is a normal good, that is, the demand increases with the increase in income, it catalyzed the expansion of the insurance industry in the United States. Despite the increase in the mean value of real accident and health insurance premiums per capita from $2.76 in 1930 to $21.70 in 1955, the overall increase in income per capita in this time period increased the quantity of health insurance demanded by 35 percent. Other influences in the expansion of the health insurance industry from 1930-1955 included the increased amount of manufacturers, lower health insurance prices, and increased hospitals per capita. Each of these increased the quantity of health insurance demanded by 15 percent, 7 percent, and 2.6 percent respectively.

Michael M. Davis noted that "The origin of any institution gives it a direction and trend but does not control its future development" (Davis, 1934). It is imperative to understand the history of the health insurance industry to facilitate our understanding of the industry today. This research paper provided the economic reasoning behind the development of the private provision of health insurance in the United States. Growth in the health insurance sector was spurred by an increased supply after commercial insurance companies entered the market, increased demand as technology increased, and government policies encouraging the popularity of health insurance as a form of employee compensation. The most influential move by the government was in the tax treatment of employer provided contributions to employees that allowed employer contributions to be tax exempt from payroll tax and employees were free from paying income tax on these contributions. Interest in compulsory nationalized health insurance declined after World War II but concerns with medical economics still exist in medicine, business, labor, and government. These factors led the U.S. to rely mostly on the private

provision of health insurance.

Appendix

Figure 1: Number of Persons with Health Insurance (thousands), 1940-1960



Source: *eh.net* Encyclopedia: Health Insurance in the United States, 2003.

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