Employer-Sponsored Health Insurance and the Growth of Inequality

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Summary of FMZZ

- Employer-Sponsored Health Insurance (ESHI) is currently a head tax. This causes employers to reduce wages equally for all individuals. If ESHI were instead a payroll tax:
  - Wages for non-college grads would rise relative college grads
  - Employment for non-college grads would rise relative to college grads
  - The magnitude of these effects is comparable to other economic changes that have affected non-college grads (outsourcing, robots, etc.)

Implication

- Wage inequality is not the object of interest. We should instead be thinking about “compensation inequality” – total payments by firms to employees.
- This has been about the same but reflects two offsetting factors: (1) more equality for HI; (2) inequality for pensions.

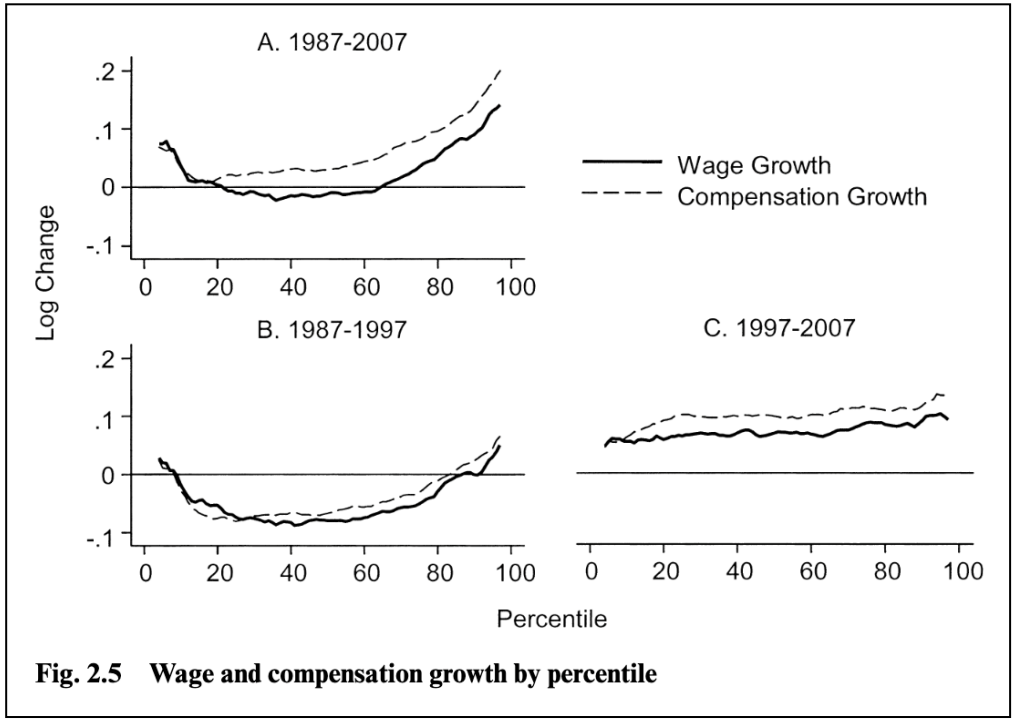


Fig. 2.5 Wage and compensation growth by percentile

Pierce, 2010

Incidence

- This type of analysis requires a theory of incidence.
  - Theory here: labor markets are fully efficient:

$$\text{Total compensation} = MP_L \qquad \forall \text{ worker}$$

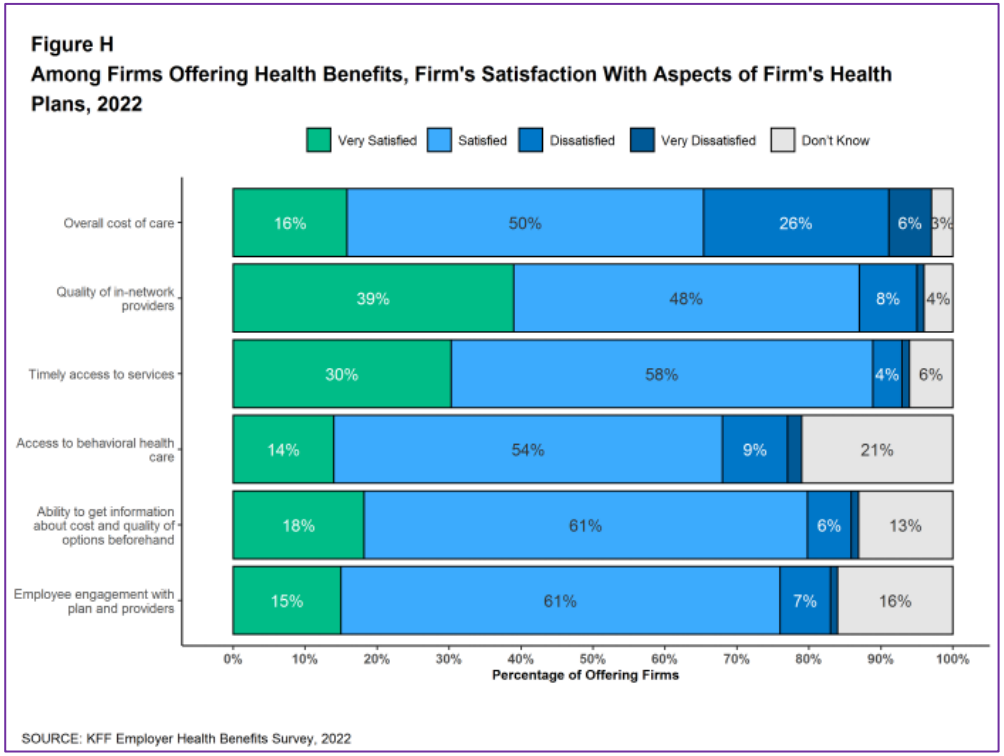
  - We don't have a lot of evidence on this in the case of a head tax.
    - Some data suggest yes [Gruber, AER, 1994], but there are not many studies, they are older, etc.

Facts suggesting an alternative model

- There are large firm effects in wages
  [Card et al., *JPE*, firm effects are 20% of wage variation].

- Firms seem to care a lot about medical spending, even aggregate medial costs.

- Big changes in structure of plans over time, eg shift to high cost sharing.



Possible alternate theories

- Nominal wage stickiness
  - Stagnant productivity cannot be offset by lower wages as HI costs rise. → less wage change but more employment change.
- Separation of benefits from wages
  - Firms pay benefits bill, then pay wage/salary employees at opportunity cost, then pay owners the residual
- Variation in α across groups
  - Difference in valuation of insurance translates into differences in outcomes.

Design a theory around what we know about HI and about changes in the wage structure

- Three ≈ components to increased inequality [Song et al., QJE, 2019]
  - More sorting of higher-paid workers into higher-paying firms
  - More segregation of higher-paid workers to the same firms
  - Declining wages for low wage workers in "mega firms" [10,000+ employees; roughly 750 firms]

- Second and third of these seem most related to HI costs.

Pay structure in mega firms

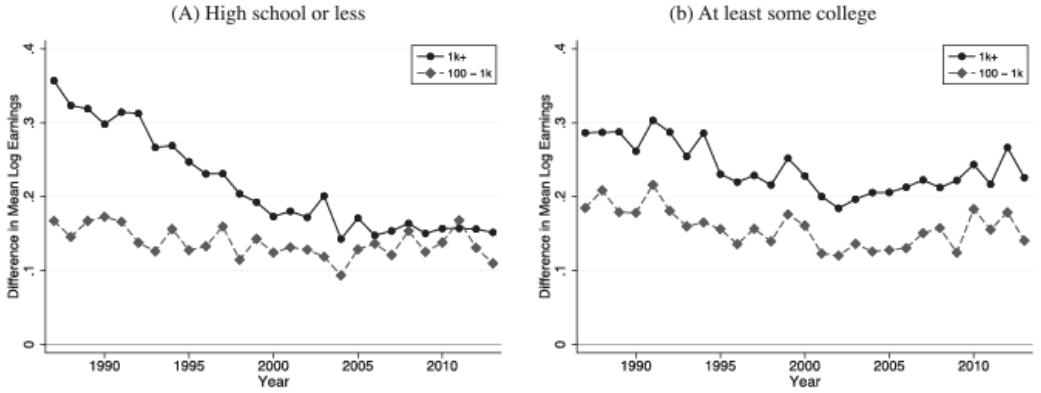


FIGURE VII

The Earnings Premium between Larger Firms (100+ Employees) and Smaller Firms (Less than 100 Employees), by Education

Data are from the CPS Annual Social and Economic Supplement. Only individuals aged 20–60; who earn a positive wage income in the given year; who work at least 35 hours per week for 40 weeks; and who are not in education, public administration, or military industries are included. High school or less refers to those who have no more education than a high school diploma or equivalent. At least some college refers to the remainder of the population: those with at least one year of college education. Values shown are the differences in mean log earnings among those in the given firm size bracket, compared with those in firms with fewer than 100 workers.

Tentative theory

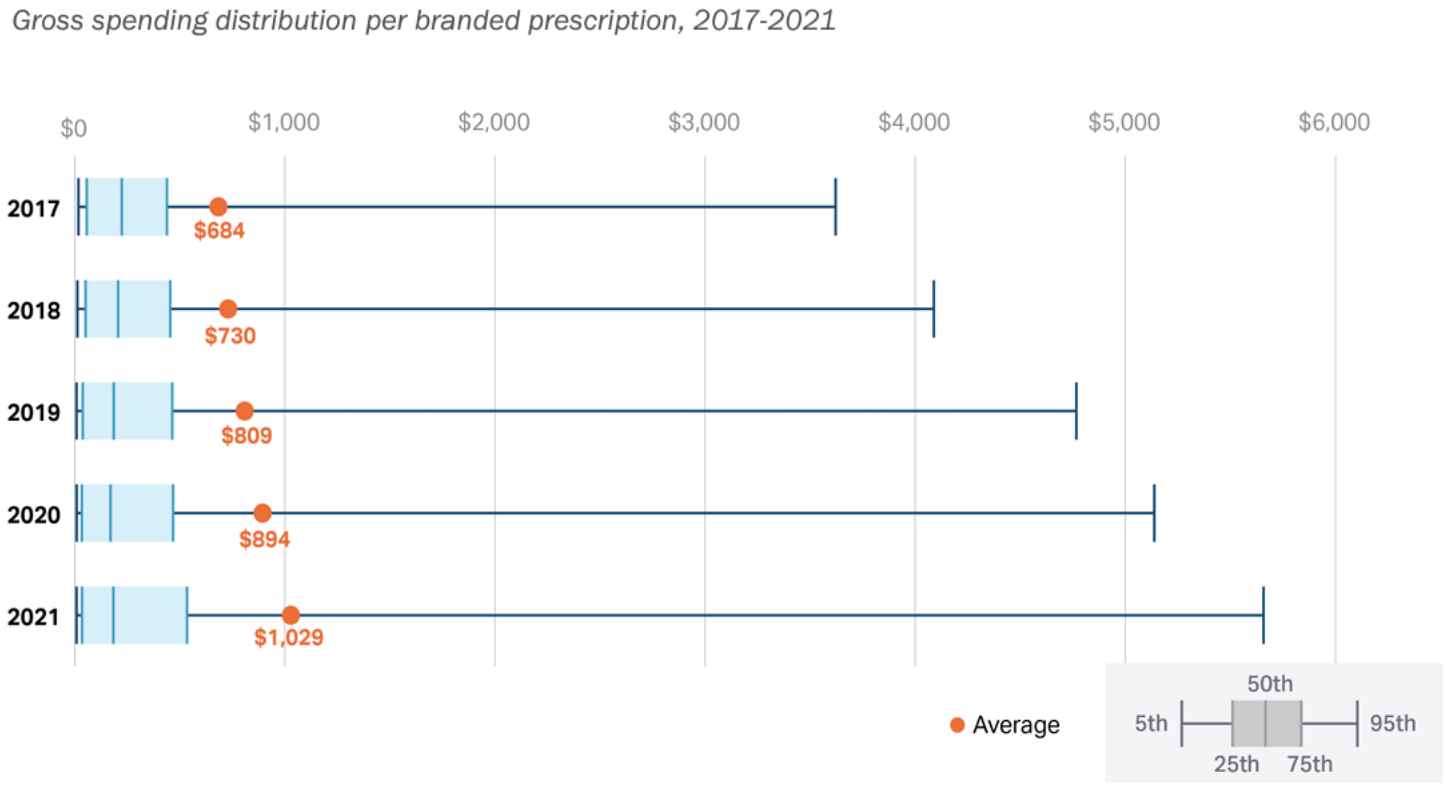
1. Recent cost increases are not as valuable, esp. for low income workers
   - Medical spending increases from targeted and expensive treatments for rare conditions (eg rheumatoid arthritis)

     For those without the condition, value ≈ 0

   - Some of the increase in spending is admin costs and provider rents

   - Another part of the increase is high wage people going to high priced providers. Worth it to them but not others.

Cost increases for medications are extremely skewed.



Notes: Claims with implausible spending and cost-sharing values were excluded. COVID-19 vaccines were excluded from analysis in 2021.
Sources: HPC analysis of the Center for Health Information and Analysis (CHIA) All-Payer Claims database, 2017-2021. Data for 4 large payers were included in the analysis.

Implication

2. Firms push for higher cost sharing
   - Shift costs to people with the condition
   - Discourage people from taking up coverage
   - One-third of privately insured people has a high deductible plan (Deductible ≥ $2,500)

3. High cost sharing + little savings → Value of insurance (α) even lower for people with few assets
   - Esp. if there are alternative to private insurance (Medicaid + exchanges)

4. Implications: Outsourcing, gig work, robots, etc.

Overall conclusions

- Would like a richer model, part of which would allow various threads to be related (outsourcing, robots, HI costs)
  - Employers are not so passive

- Health care inefficiency is a huge issue.