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FEHBP remains attractive to best-particular suppliers. Once is the large number of choices provided. All employers have at least 20 plans to choose among, and three or often areas may have more than 30 alternatives. The program is also attractive to the few fee-for-service plans not privately insured rather than self-insured by the government. Thus they have a ready market for their product. Yet, the FEHBP is not a free market. Its rules and regulations are complex with financial risk sharing that can be considerable between a business and its health care suppliers.

EARLY COST MANAGEMENT EFFORTS BY INSURERS AND OTHERS

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Between 1930 and 1965, many of the basic elements of today's strategies for managing health benefit costs were described, even if they were not permanently articulated or successfully applied.[17] These elements include:

- management of the risk pool
- design of the benefit plan
- controls on payments to health care providers
- incentives on the supply of health care services, and
- review of the appropriateness of utilization.

Management of the Risk Pool

As noted above, the early years of the health insurance plans in the 1920s and 1930s used the employment group to establish a pool of risk and to make insurance affordable and sustainable by spreading risk broadly. Subsequently, competitors in insurance markets brought experience rating and medical underwriting in efforts to reduce premiums for healthier groups and thereby attract their business. Neither strategy for managing cost containment directly targeted the price, use, or intensity of health care services, although it is claimed that making insurance more affordable and available to more health behavior pay more for coverage encourages more prudent and thereby less costly behavior.

Design of the Benefit Plan

Like management of the risk pool, the centrality of benefit design was also quickly appreciated as a tool to control costs. Indemnity benefits were initially provided in fixed amounts, but this approach was soon abandoned in favor of such mechanisms as deductibles, coinsurance, and dollar maximums on benefits for all services or specific categories of service. Cost sharing has two objectives—first, to transfer some liability for costs to the patient and, second, to discourage the use of services by patients who are insulated from the cost of their decisions. The first, excluding coverage for unimportant and ineffective treatments, for treatments whose use was highly discretionary or difficult to monitor, for extended or custodial care for chronic conditions, and for relatively low cost services that could be scheduled and budgeted. For the most part, these provisions had little impact on the growth of the traditional forms of insurance, as discussed in Chapter 2.[18] Relatively shorter to develop was the large but payment for the use of services, such as fee-for-service or g. preventive and outpatient care could avoid higher later payments for inpatient and acute care.

Controls on Payments to Providers

During the financially difficult years of the 1930s, contracting and fee, sharing with providers were important mechanisms for controlling costs. Kaiser Permanente, Group Health Cooperative, and Blue Cross and Blue Cross plans through their guarantee of certain benefits rather than reimbursement payments for services were sharing of risk by their contracting hospitals (Donabedian, 1976). Strong contractual relationships that included some sharing of risk between insurers and providers, such as Blue Cross and Blue Shield plans (Starr, 1982; Anderson, 1973; Hallinger, 1978; Marks and Berman, 1981).

The cooperatively premier decades stimulated hospital restructures with the contractual relationship that pioneered service in Blue Cross and Blue Shield a negotiated price. Physicians, however, continued to fight against group practice plans and other forms of contracting and, e.g. sharing. Some physician associations took a less negative approach. In Washington State, for example, the state medical association, Washington Medical Service, was the first Blue Cross and Blue Shield plan to contract with physicians (Starr, 1982). Nationally, the American Medical Association (AMA) had revoked physicians accepting of limited financial risk are professionals of today's independent practice associations (IPAs). The price for prepaid group practices, IPAs, and similar health plans—collectively alternative HMOs in 1970—is a cost containment strategy began in earnest in the 1930s (Ellwood et al., 1971; Brown, 1983; see also Chapter 4 of this report).

Constraints on Supply

Another approach to cost containment was developed under the rubric of health planning. Health planning had received much of its initial momentum impetus as a tool for guiding the expansion in community hospital resources and services in the post-World War II years (Roemer et al., 1976; Rosenfeld, 1976). Its premise was that the supply of hospital resources needs to be revisited as a source of rising health care costs (Raeburn and Shaw, 1976), and health planning was supported by many—including some insurers and some employers—as a way to limit excessive hospital construction and, thereby, the cost of care. The Hill-Burton program was the first national health planning (Roemer, 1969). It was hailed as the first comprehensive of such law, which required state approval for hospital construction projects. Using a scale pioneered by Blue Cross of Northeast Ohio as early as 1950 (U.S. Department of Health, Education and Welfare, 1976), some insurers based their hospital payments on a comparable public or voluntary health planning "we will not pay full reimbursement or continue our contract with a hospital" (Public Relations, quoted, Jones, 1969, p. 130).

Utilization Review

Historically, third-party payers tended to concentrate their cost containment energies on the unit price of medical services and to pay less attention to the volume of those services provided by institutions and practitioners and simply reimbursed the cost of services provided to beneficiaries. Beginning in the 1960s, however, some insurers and some hospitals used commission to monitor utilization in an effort to cope with the short supply of hospitals beds during World War II. The first explicit use of retrospective utilization review in control fee-for-service payments for hospital services was in Blue Cross of Northern California (Starr, 1982; Anderson, 1973; Hallinger, 1978). Starr, a physician, wrote in The Modern Hospital: "Why not separate a hospital's bill into its component parts, such as the "hospital utilization committee" to do the field of hospital and medical economics what the issue committee does—the field of surgery? Why not the use of hospital services and facilities coming to the attention of the hospital utilization committee could be disciplined to the point of near deferral" (quoted in Lenden, 1962, p. 73). Approach, Starr, Anderson, and Hallinger, Blue Cross and Blue Shield plans, and Kaiser Permanente.

The 1950s also appear to have set the first attempt by health plans to use concurrent review of hospital utilization to meet the proposed surgery. The United Mine Workers Union tried to institute such a program but failed because of resistance from organized medicine (Eugene and Stevens, 1980). It was not until the 1970s that such provisions were successfully introduced by the Sons Workers Health and Welfare Fund and other union programs (McCarthy and Widome, 1976).

The San Joaquin County Foundation for Medical Care, founded in 1974, not only served as a model for many IPRO programs, but also illustrated the potential of independent, physician-sponsored, community-based organizations (IPAs) promoted many utilization review tools, including medical surveillance of in-house physician performance, protocols for reviewing ambulatory care, and computerized screening of claims (Egdahl, 1975).

By the early 1980s, some third-party payers of health care services had established a variety of programs of hospital admissions, and more than 30 looked at the length of stay. Some required physicians to certify or admission and/or length of stay, and others used nurses or other health care professionals to review the medical records of physicians to certify the need for continued hospital care after a specified length of stay (Fitzpatrick, 1983; Young, 1983). In a precursor comment, Dale Anderson noted in 1968 that as payers showed increasing interest in medical practice patterns, "the central concern of the medical profession today and in the years ahead might well be bureaucracy" (Anderson, 1968, p. 181).

Impact of Early Cost Management Efforts

The various tools used to control costs from the 1930s into the 1960s may have had some impact, but they often were not applied or were applied only to a few providers. Thus, they did not have a significant impact on the overall overdispersed by society's desire for expanded care, and impact tools adopted from through the development and implementation of advances in medical care. Government was not a major actor, but neither had marketplace competition emerged as a viable force for private sector cost containment strategies. Commonly contracted programs and cooperative assist with health care providers were more prominent features in the period. Further discussion of these efforts and efforts to control health care costs, which clearly expanded in the 1970s and 1980s, follows in Chapter 4.

THE LIMITS OF VOLUNTARY HEALTH BENEFITS AND MEDICARE AND MEDICAID

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As the growth of employment-based health benefits was making such coverage an expected feature of personal life in the post-World War II years, the limitations of voluntary health insurance became increasingly clear. The elderly were singled out as a special problem, having gained medical care from financial protection than younger individuals still in the work force (Jonnes and Sonnen, 1961; Feingold, 1966; Harris, 1966; Marmor, 1973; Mechanic, 1976; Rosenfeld, 1976; Rosenfeld et al., 1977; Ellwood et al., 1971; Brown, 1983; Fuchs, 1984). Research indicated that the problem is larger individuals—but only one third of those over 75 had any protection. Jonnes and Sonnen (1961) estimated on the basis of data acknowledged as fragmentary that health insurance met perhaps "two-sixth of total medical costs of the insured [but] one-hundredth of the total bill for the aged."

The consequence of being uninsured had become more significant as the medical advances associated with World War II and the accelerated development of specialties and resources in biomedical science and hospital construction expanded the range of medical care available and the costs of treatment. Moreover, growth in personal income, private insurance, and employer-sponsored health insurance increased the proportion of the population with the means to purchase medical care services and increased the proportion of the population with a demand for medical care services.

Between 1950 and 1965, proposals and amendments to the health care sector rose by over 50 percent, compared with only 10 percent for employment-related Fuchs, 1968). The amount of per diem hospital costs accounted for by salaries rose from 55.1 in 1946 to 62.8 in 1965, an increase of 300 percent, compared with an increase of about 160 percent for other components of the cost of a day in a hospital (Rosenfeld, 1976). Between 1950 and 1965, the per capita expenditures went up nearly threefold (Fuchs, 1968). In addition, between 1950 and 1965, the share of personal income spent on first-or consumer prices overall, and consumer expenditures for health care were from 50.3 billion to $28.1 billion (Gorham, 1968).

The late 1950s and early 1960s saw prevention efforts to expand state and federal government programs to cover medical care for the aged (Jonnes and Sonnen, 1961; Feingold, 1966; Harris, 1966; Marmor, 1973). The Social Security beneficiaries was introduced in 1952, and a national program for the aged and other poor individuals was passed in 1960. The adoption of a more comprehensive national program for the elderly and a state-defined plan for certain low-income groups took another five years.

Medicare

The events leading up to the passage of Medicare, Title 18 of the Social Security Act, are well documented (Feingold, 1966; Harris, 1966; Sonnen and Jonnes, 1967; 1970; 1973; Anderson, 1968; Marmor, 1973; Starr, 1982). The proposal was first introduced in 1957 as a voluntary program, but it was soon changed to a mandatory program and compromises that preceded final agreement. In 1972, Medicare was extended to disabled individuals and certain others (who now constitute about 10 percent of all beneficiaries). In 1981, provisions were added to establish peer review organizations (PROs) and to limit payments.

For both practical and political reasons, the program reflected and built on structures and practices developed in the private insurance sector for design and implementation. Medicare continued the division between hospital and physician services coverage that had accompanied the growth of Blue Cross and Blue Shield. It maintained fee-for-service payment for physicians and cost-based reimbursement for hospitals, and it accepted the prevailing practice patterns from Blue Cross except that it included a deductible for hospital services and coinsurance for physician services. Moreover, Medicare adopted from Blue Shield the participating physician concept and the "reasonable charge" concept, which limited payments to the lesser of the physician's usual fee or the fee that Medicare would pay. Medicare's payments as provided by both physicians could discount or not participate and full payment for the services. In addition, the original Medicare legislation had special provisions allowing Medicare beneficiaries to enroll in prepaid group practices that not so a capitated basis. Congress did not follow the suggestion of the AMA that the Medicare program be structured along the lines of the Federal Employees Health Benefits Program (Sonnen and Jonnes, 1967; Starr, 1982; Anderson, 1968; Marmor, 1973).

For program administration, Congress rejected proprietary organizations, known as intermediaries for Part A and carriers for Part B. On the hospital, in Part A, side, most of the intermediaries were Blue Cross plans. On the Part B side, carriers were initially split about 50-50 between commercial insurers and Blue Shield plans. Medicare's payment was based on the base cross payments for Part A services inflow on payroll taxes paid by employers and employees and premiums for Part B services. The Medicare program, Parts A and B, covered about 90 percent of the aged in the original program, a financial through beneficiary premiums to cover 25 percent of program costs and general revenues (or cover the other 75 percent).

Enrollment in Medicare Part A grew from 19.5 million in 1967 to 23.1 million in 1969. Part B enrollment grew from 17.9 to 22.1 million in the same period (HSA, 1993b). Total spending for Part A and Part B has grown from $3.1 billion in 1967 to $5.1 billion in 1969 and $9.4 billion in 1970 (Gorham, 1968). Medicare's share of the total health care bill, $2.671 to $4.0 (HSA, 1993). As described in the next chapter, many elderly individuals receive additional coverage from former employers.

Medicaid

The Medicaid program, created at the same time as Medicare, did not build on the social insurance principles that guided the latter program. Rather, it continued the charity care approach of the predecessor, the 1960 Kerr-Mills (Marmor, 1973; Starr, 1982; Sonnen, 1969).

Title 19 of the Social Security Act created a complex program that was to (1) financed by federal and state funds, (2) aimed primarily at poor individuals who were eligible for certain other welfare benefits, in particular, Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI), and (3) provided a variable, considerable latitude to determine who would be eligible, what services would be covered, and how much providers would be paid. The result has substantial state-to-state variations (PPRC, 1994). For example, states have varied in the extent to which Medicaid programs cover low-income working people who do not receive welfare recipients, employment often means no and is Medicaid without the beginning of employment-based coverage. Medicaid has been a major source of coverage for the poor, but it has never covered fully the poor (less than half of the poor (that is, those with incomes below the federally defined poverty level).

The 1965 law provided that federal financing for Medicaid, which covers from general revenues, would be dispensed to states on a matching basis related to state per capita income and a formula that favored the poor. The federal contribution to program expenditures constitutes about 56 percent of the total, but the share varies from 50 to nearly 80 percent of the total for individual states (GAO, 1993).

In 1973, Medicaid covered about 17.6 million people, versus 23 million individuals in 1993, but total program costs increased from $4.1 billion in 1973 to $ 89.4 billion in 1993 (HSA, 1993b). The federal share of Medicaid costs has drifted from 55.2 billion in 1973 to $2.0 billion in 1993 and engaged from 56.700 per year for the 12 million aged participants to $8000 per year for the 11.2 million children from low-income families (CBO, 1992).

In 1990, Medicaid was the second-largest component of state spending and was increasing faster and less predictable than other costs. In 12 percent of total state spending, it was exceeded only by spending on elementary and secondary education (Gold and Hurley, 1992; Gold et al., 1992). The Congressional Budget Office projected a 9 percent increase on federally mandated expenditures of Medicaid eligibility and services.

National Health Insurance Revisited

In the 1970s, some kind of national health insurance program was widely believed to be imminent (Starr, 1982). A 1977 summary by Herman and Sonnen found four major categories of proposals (Table 1-2).

TABLE 1-2

Major Categories of "National Health Insurance" Proposals in the Early 1970s

The greatest opportunity for action came in 1974, when the Nixon administration and congressional leaders (in particular, Senator Kennedy and Representative Mills) appeared willing to compromise on a broad national health insurance program. Nixon had proposed a voluntary program, and Kennedy had proposed a mandatory program. Labor and some other liberal groups still favored a fully public program, but organized medicine and traditional opponents of government action appeared to have accepted the time for a comprehensive national health program had come.

Nevertheless, none of the major proposals introduced in the 1970s were successful. At the time of writing this report, the 103rd Congress is considering a number of health care reform proposals, including a proposal for a "managed care" mix since 1970. Although they vary in specifics, many current proposals still fit the basic categories identified in Table 1-2. Even one strongly opposed, what now goes under the rubric managed competition, had been quite clearly described (and endorsed by Senator and Sonnen as early as 1977. Although the current proposals use "managed competition" and "consumer options ... [among carriers approved by a national board] ... as an instrument allowing the government to set the rules of the game and to ensure that the game is played according to those rules and strong those organizations of managed" that joined "battle against "private" strategies (pp. 192, 198, 200). In fact, the 1970s and 1980s did see a debate that was framed in terms of market versus regulatory strategies (as described further in Chapter 4), and the same choices continues to be heard in the 1990s.

FEDERAL REGULATION AND THE EMPLOYER'S GROWING ROLE

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Federal and State Roles in Health Care

The federal structure of the U.S. political system has produced a particularly complex and uneven mix of state and national regulation of health insurance and related matters. Before 1974, states generally regulated health insurance, whether it was individual or employment-based, insured or self-insured. Since insurance regulation began in the 1850s, it has been a state function. The McCarran-Ferguson Act of 1945 reaffirmed state regulation of the part of interstate commerce and therefore were subject to state and federal regulation. In 1944 the Court reversed its decision, holding that insurance transactions did involve interstate commerce and were subject to federal antitrust and other laws. This decision, in turn, was overturned in 1945, when Congress passed the McCarran-Ferguson Act, which restored to the states more regulatory powers but left the union of national regulation of insurance of dates not yet clear. The Sherman Act, the Clayton Act, and the Federal Trade Commission Act, administered by the Federal Commissioners was formed as early as the development and passage of model state legislation.

Until the 1970s the national government largely confined its attention to employment-based health benefits to two policy issues: tax-exclusion treatment and taxation. Fraud with respect to Medicare and Medicaid, and the Federal government retained an array of cost management initiatives, including federal wage-price controls, health planning, and Medicare and Medicaid reimbursement policies. Congress passed ERISA in 1974, after the discussion of these programs. With the exception of the ERISA Act of 1973, which mandated that most employers offer their employees a federally qualified HMO of one was available, these initiatives did not include employment-based health benefits very directly. Legislation adopted in 1980 (with the HMO mandate provision to expire in 1995.)

The Employee Retirement Income Security Act of 1974

In 1974 the division of federal and state regulatory authority with respect to employers benefits changed fundamentally with the passage of the Employee Retirement Income Security Act (ERISA). Since then, the relevance of state regulation to employment-based health plans has declined dramatically—without any significant expansion in federal regulation of employment-based health benefits.

ERISA was aimed primarily at private employer pension plans, and most of its provisions and implementing regulations are directed at such pension plans with little explicit attention to health plans. As interpreted by the courts over the years since its passage, however, ERISA has promulgated an increasingly broad set of regulations governing employment-based health plans (Hammond, 1; Moran, 1992). Despite some pressure to do so, Congress has refused to amend ERISA to permit state regulation of employer health plans.

States are indirectly affected by employer-sponsored coverage through their regulation of insured health plans, including insured ERISA plans, but the group of insured employers has grown smaller every year as more employers—including quite small employers—have seen the advantages of self-insuring to avoid such regulation. Self-insured employers can also use their considerable uniform health benefit programs across state lines and no longer have to modify their programs to conform to the national different demand of state laws.

For self-insured employers the major regulatory consequence of ERISA are that such plans are exempt from several requirements of state law, including mandated benefits, premium taxes, and state laws that allow injured health employees—there were the advantages of self-insuring to avoid such regulation, reviews and mandated benefits requirements, defined claims settlement procedures; state law claims for various kinds of damages, and mandatory coverage of certain medical conditions and treatments. Self-insured plans are also exempt from state laws mandating or mass states to have to establish a mandate that kinds of programs. A recent federal court decision in a case brought by 14 union health and welfare funds that ERISA precluded the state from requiring such plans to pay hospital bills that included schedules for uncompensated and undercompensated care (Greater Buffalo Press Plus Fund v. Blue Cross Blue Shield of Minnesota, 1992, F.3DC 1423 [1992] [Feldman, 1992]).

Employers with self-insured health benefit programs have considerable latitude in choosing their employee health plans positive damages for the kind of claims. Further, in a case decided in June 1992, a federal appeals court held that ERISA precluded a malpractice action against a company that provided utilization review services to an ERISA health plan (Corcoran v. United Healthcare Inc. and Blue Cross and Blue Shield of Georgia, Inc., 965 F.2d 1321 [11th Cir. 1992] LEXIS 14421 [5th Cir. June 26, 1992]). (See Chapter 3 for further discussion of the legal liability of employers.)

Although ERISA precludes state regulation of self-insured employer-sponsored health benefits, it does not preclude diverse state policies with an equivalent set of consistent national standards. The requirements it imposes on employers, however, have been a major factor in the development of managed care organizations (Health Maintenance Organizations), formed to meet the requirements of federal qualification for employer-sponsored health plans (Hammond, 1; Moran, 1992). Despite some pressure to do so, Congress has refused to amend ERISA to permit state regulation of employer health plans.

The point that ERISA preempts state regulation without substituting explicit federal regulation of some basic standards has been a major source of controversy and, with self-insured employer health plans, which are discussed further in Chapter 3. Further many of all state laws, ERISA:

- sets no reserves, reserves, funding, financial management, or backup insurance requirements for health plans to protect employees in the event of employer bankruptcy;
- specifies no standards for health coverage or minimum benefits;
- establishes no requirements that certain categories of employees or family members be generally eligible for coverage (except for the continued coverage requirements described below); and
- contains no prohibitions against unlawful reduction or termination of benefits by an employer during the plan year nor any limits on medical underwriting practices such as exclusions of coverage for preexisting conditions.

With respect to fee-for-service plans, ERISA's lack of an standard for limiting and a requirement for health benefits plans as a deal for premium, other claims and the general law of contracts may limit employers' freedom to reduce or terminate benefits in certain cases. For example, employers may need to prove that their right to terminate retiree benefits was specifically stated and widely known to employees (Diehl, 1992a). This contention is particularly important for employers who have promised to provide retiree health benefits in accordance with Financial Accounting Standards Board (FASB). Those rules require that benefits promised retirees be included in the liabilities on a firm's financial statements. (See Chapter 3 for further discussion.)

ERISA did establish minimum terms concerning employee rights to continue their employer-sponsored health benefits involving multiple employers, but the results have not been satisfactory in many (CBO, 1988b; McLeod and Hyman, 1989; Jensen et al., 1989; Jensen et al., 1990). The continuation provisions of ERISA and Multiple employer plans were originally defined in plans which more than one employer contributes but which are not collectively bargained. Then in 1982, Congress redefined this category to multiple employers' welfare arrangements (MEWAs) to include any employer health benefit program that was not collectively bargained but lack of applicable federal or state regulation. Fully insured MEWAs are subject to direct state insurance regulation related to the adequacy of contributions and reserves levels. MEWAs that are fully insured are subject to all state insurance regulations, to the extent they are not inconsistent with ERISA. Self-insured MEWAs are subject to ERISA third parties marketing MEWAs have led to calls for further legislation to strengthen regulation of such plans at the state or federal level or both.

Further complicating the regulatory picture are multiemployer plans, which, as defined by statute, are plans to which more than one employer is required to contribute, and which are maintained pursuant to one or more collective bargaining agreements between, one or more employer and one or more labor organizations. Multiemployer plans are exempt from most provisions of ERISA, including the ERISA amendments related to multiple employer welfare arrangements.

Federal laws enacted since ERISA have imposed a limited number of requirements on employers. The most important emerged from the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. That act requires employers with 20 or more employees to offer to qualified beneficiaries who would lose coverage because of certain events, such as dependents, and certain others for 18 or 36 months at until coverage under other plan begins.[19] Employers can charge no more than 102 percent of the average cost to the employer of providing coverage to all its employees.[20] In earlier federal law, the Tax Equity and Fiscal Responsibility Act of 1982, requires employers with 20 or more workers to cover certain employees (those aged 65 or 69, the disabled, and those with end-stage renal disease) who would otherwise be covered by Medicare (Jensen et al., 1989).

Overall, ERISA gave a powerful boost to employer discretion and involvement in employee health benefits. It distributed the protection and influence of states and insurers and eliminated some protections for insured individuals but provided little to the major national standards for employee health benefits. Its stance concerns about the uninsured and the financial problems of health care institutions providing uncompensated care, but gives ERISA plans no incentive to do anything about the uninsured. Employers have considerable latitude in health benefit programs, and yet precisely to state in which the federal government has not taken the initiative.

CONCLUSION

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Although the link between occupation or workplace and assistance with the costs of illness dates back to the last century, employer-based health benefits have been a major feature of life in the post-World War II years. Employer sponsorship of these benefits has been a major factor in the rapid and sustained increase in the proportion of the population covered by employer-based health benefits, which, in turn, has been a major factor in the rapid increase in the proportion of the population with health care insurance. Employer-based health benefits have sometimes been an work-related benefit, sometimes a tool for attracting and retaining workers, and sometimes a tool for competition with rivals with relatively little discussion regarding the details of health benefit programs and with limited involvement in health care cost management.

The exception to the pattern is the United States, where voluntary private action has managed—with some assistance from facilitating national legislation—to extend coverage to the majority of the nonelderly population. Although the proportion of the population with health care insurance has been increasing since the mid-1940s, it has stalled at about the mid-1980s and where social insurance concepts were adopted in the national level during the 1960s, the insurance for medical care expenses did not follow these precedents. Opposition by important interests social and moderate government to an expanded government role limited public health care insurance to the elderly and to a small segment of the poor. Millions of individuals are not covered by either public or private programs.

The next four chapters of this report describe the current status of employment-based health benefits and discuss developments over the last two decades. Among the key features related are the

- extensive involvement by business (primarily large employers) in the design of health plans and efforts to influence the delivery, price, and overall cost of health care;
- significant responsibility and administrative complexity for employers, employees, health care providers, and public officials resulting from the expansion and diversity of employer efforts to manage their health benefit costs;
- simultaneous organization of high-and low-cost or high-and low-risk individuals into different insurance pools and growing debate about what constitutes an equitable spreading of risk for medical care expenses;
- continued consideration of medical care expenditures and uncertainty about the value of this spending despite many efforts to contain medical care prices, limit unnecessary or marginally beneficial use of health care services, and otherwise control costs; and
- persistent controversy about the merits of public, private, or mixed strategies for achieving a more satisfactory allocation of resources for health care.

Footnotes

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1. The sources cited here are not always consistent and unambiguous, especially about the period before 1940, but the overall trend is clear: the emergence of insurance either as income insurance or as provider insurance.
2. Although data are scarce, we figure that the post-World War I period suggests that wages lower than the worker's direct and employer costs. Lewis Meriam gives market wages for medical care. For bachelors as a whole, but income and medical costs were about equal for married workers with children, and medical costs were about one-third of total income for married workers without children (Meriam, 1929, p. 1).
3. For example, the Prince Georges Hospital Administrator Michael and Sonnen (1967) wrote in 1967 in a letter to the Journal of Health Hospitals that "Blue Cross and Blue Shield Associations and other Blue Cross and Blue Shield Associations" (Prince Georges Medical, 1967, p. 5). In the first quarter, it reported covered 16.5 business. In 1966, it corresponded to a nonprofit organization, and in 1966, it became a Blue Shield plan. It describes itself as the first successful prepaid health plan.
4. The Kaiser Permanente plan, which was a prepaid group practice, provides fee-for-service benefits. See Kaiser Permanente, the Kaiser Foundation Health Plan, and Kaiser Foundation Hospitals, a letter which Kaiser Permanente sent to its members in 1970 to inform them of the new coverage from Contemporary Comprehensive Medical Care, Inc. Kaiser Permanente's Insurance Company of California and Leading Eugene Kaiser, Four sets of Kaiser investigations, operational offices, and high-speed Kaiser Foundation's are chartered in 1960 in Hartford, Connecticut. Among the coverage exclusions in the settled Kaiser case were surgery, prior hospital, surgical operations, dealing, etc. (Contemporary Medical).
5. Federal expansion protection, on the other hand, has so valued that millions of people had nearly permanent but individual coverage. Contemporary Medical, which has a headquarter of Contemporary and in Metropolitan Life and Prudential Insurance and Metro, 1967.
6. A more thorough history would also cite or foundations for the policies of different nations the development of public health institutions (e.g., sanitation and quarantine) and such losses as hospitals.
7. The social activism of social scientists in the prepaid group practice movement of the 1930s and 1940s, and the AMA's response to it, is well described in Starr (1982). Also see Donabedian (1976), Rosenfeld (1976), Brown (1983), the American Sociological Association, and the American Sociological Association (Anderson, 1968).
8. The American Medical Association now supports legislation that would (1) strengthen Medicare's system that is not prepaid to a voluntary group, (2) modify Medicare's payment rules to encourage physicians to participate in Medicare and Medicaid, with no help to employers' and (3) create state pools in order to the medically uninsurable and those who cannot obtain coverage at a reasonable price (AMA, 1993, p. 2). Under a proposal of other physicians, Congress has developed tax-free medical savings accounts, which would be used to pay for medical care expenses.
9. This section draws on Anderson, 1968; Jonnes, 1967; Starr, 1982; and Wolfe and Berman, 1981.
10. According to Starr (1982), Marion Sheridan, chairs of the CCS medical care subcommittee, and Edgar Schoenfeldt, in charge of the California Medical Association's legislative program, "were the two people who made the difference." The study, directed by Sheridan, with chairs of CCSC, was also involved in CCS work in health insurance. Gale Ann Sigal joined Assistant Robert Wagner and others in sponsoring a series of national health insurance proposals in the 1960s (Starr, 1969).
11. These included a prepaid Home Health Care Program, Representative Richard Ichord's proposal to allow the Veterans Administration to contract with prepaid group practice plans, and a proposal to allow the Veterans Administration to contract with prepaid group practice plans.
12. This section is drawn largely from Sonnen and Jonnes (1967; Cost, 1970; Anderson, 1973; Berman, 1981) which includes a survey published in the 1970s and 1980s; 1982; Wolfe and Berman, 1981; Sonnen, 1969; also see Journal of Health Policy, Politics and Law. Writer 1981 has several historical assessments of Blue Cross and Blue Shield, and Starr (1982) provides their role in broader development.
13. Although the Medicaid program is a medical insurance, it is, given Kaiser is a prepaid public accessment and PL 21-contract. Paragraph 1-1000.000 Kaiser is a large amount was given Michael Harris, a senior system Permanent employee, who has established the Committee for Research in Medical Economics, which promoted research under Sonnen. Jonnes, Sonnen the first journal of medical economics, Medical Care Evaluation, 1975.
14. Even one 1980s, the Blue Cross and Blue Shield Association preferred to describe its organization not as insurance but rather as proprietary or not-for-profit organizations, despite the substantial legal differences of the two organizations.
15. Further medical security plans were organized by county medical societies in Oregon and Washington before 1945, partly in response to the Kaiser plan. Kaiser Permanente, Kaiser Foundation Health Plan, Kaiser Foundation Hospitals, a letter which Kaiser Permanente sent to its members in 1970 to inform them of the new coverage from Contemporary Medical Care, Inc.
16. The most extensive union program of direct services and coverage, that sponsored by the United Mine Workers Welfare and Retirement Fund, emerged from labor-management collaboration that prompted repeated federal intervention (including seizure of the mines in 1946) to establish and secure the fund (Sonnen and Jonnes, 1967; Mann, 1967).
17. These ideas were compiled by the Department of Commerce, which changed its name to Health and Welfare in 1979. According to the department's current methodology, 6.3 percent of employee compensation was accounted for by employee health care spending in 1990, versus 5.1 percent in 1960. Employee health care spending has increased from 1.1 percent of Gross Domestic Product in 1960 to 2.1 percent in 1990. Employee health care spending has increased from 1.1 percent of Gross Domestic Product in 1960 to 2.1 percent in 1990 (Figure 1-1 present.
18. Commenting on the growing involvement of commercial insurers in this field, one observer stated as a 1956 text on insurance coverage, "In large part, ... the new business has been taken from business of Washington or Blues. Let it stay in the hands of our advertiser" (Kulp, quoted in Sonnen and Jonnes, 1967, p. 261).
19. Much of this section appeared in Diehl (1992).
20. The most notable exceptions to these traditions were what came to be called "Blue dollar" accounts, beginning with Blue Cross of Northern Ohio in 1950. Blue dollar accounts were a variation on the theme of Blue Cross and Blue Shield plans, which provided a "reasonable charge" for a physician's services. Blue dollar accounts provided a "reasonable charge" for a physician's services, but the physician could charge the patient, or the patient could choose to pay the physician providing the service and then seek reimbursement according to a fixed schedule of fees or percentage of actual charges.
21. Sonnen says wages local governments to cover up to 60 percent of program costs, but only 14 states did so in 1990, and the local bodies were significantly in early 1 (Jones 1990).
22. COBRA does not require a former employee or other eligible individual to accept coverage under another plan, for example, a plan available from a new employer.
23. The recent study indicated that claims costs for those who elect COBRA coverage are 125 percent of the cost for the non-COBRA group (Coopers and Lybrand, 1992).

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