SIXTH EDITION

UNDERSTANDING HEALTH POLICY

A CLINICAL APPROACH

THOMAS BODENHEIMER • KEVIN GRUMBACH

Mc Graw Hill LANGE™

a LANGE medical book

UNDERSTANDING HEALTH POLICY

A Clinical Approach

SIXTH EDITION

Thomas Bodenheimer, MD
Adjunct Professor
Department of Family & Community Medicine
University of California, San Francisco

Kevin Grumbach, MD
Professor and Chair
Department of Family & Community Medicine
University of California, San Francisco

Mc Graw Hill Medical

New York Chicago San Francisco Lisbon London Madrid Mexico City
Milan New Delhi San Juan Seoul Singapore Sydney Toronto

ISBN: 978-0-07-177053-8
MHID: 0-07-177053-4

The material in this eBook also appears in the print version of this title: ISBN: 978-007-177052-1, MHID: 0-07-177052-6.

Notice

Medicine is an ever-changing science. As new research and clinical experience broaden our knowledge, changes in treatment and drug therapy are required. The authors and the publisher of this work have checked with sources believed to be reliable in their efforts to provide information that is complete and generally in accord with the standards accepted at the time of publication. However, in view of the possibility of human error or changes in medical sciences, neither the authors nor the publisher nor any other party who has been involved in the preparation or publication of this work warrants that the information contained herein is in every respect accurate or complete, and they disclaim all responsibility for any errors or omissions or for the results obtained from use of the information contained in this work. Readers are encouraged to confi rm the information contained herein with other sources. For example, and in particular, readers are advised to check the product information sheet included in the package of each drug they plan to administer to be certain that the information contained in this work is accurate and that changes have not been made in the recommended dose or in the contraindications for administration. This recommendation is of particular importance in connection with new or infrequently used drugs.

Contents

Preface

Understanding Health Policy: A Clinical Approach is a book about health policy as well as about individual patients and caregivers and how they interact with each other and with the overall health system. We, the authors, are practicing primary care physicians—one in a public hospital and clinic and the other, for many years, in a private practice. We are also analysts of our nation's health care system. In one sense, these two sides of our lives seem quite separate. When treating a patient's illness, it seems that health expenditures as a percentage of gross domestic product or variations in surgical rates between one city and another seem remote if not irrelevant—but they are neither remote nor irrelevant. Health policy affects the patients we see on a daily basis. Managed care referral patterns determine to which specialist we can send a patient, the coverage gaps for outpatient medications in the Medicare benefit package affects how we prescribe medications for our elderly patients, and differences in access to care between families on Medicaid and those with private coverage influences which patients ended up seeing one of us (in the private sector) and which the other (in a public setting). In *Understanding Health Policy*, we hope to bridge the gap separating the microworld of individual patient visits and the macrouniverse of health policy.

THE AUDIENCE

The book is primarily written for health science students—medical, nursing, nurse practitioner, physician assistant, pharmacy, social work, public health, and others—who will benefit from understanding the complex environment in which they will work. Physicians feature prominently in the text, but in the actual world of clinical medicine, patients' encounters with other health care givers are an essential part of their health care experience. Physicians would be unable to function without the many other members of the health care team. Patients seldom appreciate the contributions made to their well-being by public health personnel, research scientists, educators, and many other health-related professionals. We hope that the many nonphysician members of the clinical care, public health, and health science education teams as well as students aspiring to join these teams will find the book useful. Nothing can be accomplished without the combined efforts of everyone working in the health care field.

THE GOAL OF THE BOOK

Understanding Health Policy attempts to explain how the health care system works. We focus on basic principles of health policy in hopes that the reader will come away with a clearer, more systematic way of thinking about health care in the United States, its problems, and the alternatives for managing these problems. Most of the principles also apply to understanding health care systems in other nations.

Given the public's concerns about health care in the United States, the book concentrates on the failures of the system. We spend less time on the successful features because they need less attention. Only by recognizing the difficulties of the system can we begin to fix its problems. The goal of this book, then, is to help all of us understand the health care system so that we can better work in the system and change what needs to be changed.

CLINICAL VIGNETTES

In our attempt to unify the overlapping spheres of health policy and health care encounters by individuals, we use clinical vignettes as a central feature of the book. These short descriptions of patients, physicians, and other care-givers interacting with the health care system are based on our own experiences as physicians, the experiences of colleagues, or cases reported in the medical literature or popular press. Most of the people and institutions presented in the vignettes have been given fictitious names to protect privacy. Some names used are emblematic of the occupations, health problems, or attitudes portrayed in the vignettes; most do not have special significance.

OUR OPINIONS

In exploring the many controversial issues of health policy, our own opinions as authors inevitably color and shade the words we use and the conclusions we reach. We present several of our most fundamental values and perspectives here.

THE RIGHT TO HEALTH CARE

We believe that health care should be a right enjoyed equally by everyone. Certain things in life are considered essential. No one gets excited if someone is turned away from a movie or concert because he or she cannot afford a ticket. But sick people who are turned away from a medical practice can make headlines, and rightly so. A simple statement of the right to health care reads something like this: All people should have equal access to a reasonable level of appropriate health services, regardless of ability to pay.

In 2009, the United States entered into a fierce debate over whether health care should be a right. The debate focused on President Barack Obama's campaign to enact universal health insurance. Following a year of public ferment, Congress passed the Affordable Care Act, which goes a long way toward guaranteeing health care as a right. Yet, at the time of writing this edition of *Understanding Health Policy,* the controversy continues with challenges to implementation of the Affordable Care Act.

THE IMPERATIVE TO CONTAIN COSTS

We believe that limits must be placed on the costs of health care. Cost controls can be imposed in a manner that does relatively little harm to the health of the public. The

rapidly rising costs of health care are in part created by scientific advances that spawn new, expensive technologies. Some of these technologies truly improve health care, some are of little value or harmful, and others are of benefit to some patients but are inappropriately used for patients whom they do not benefit. Eliminating medical services that produce no benefit is one path to "painless" cost control (see Chapter 8).

Reduction in the rapidly rising cost of administering the health care system is another route to painless cost containment. Administrative excess wastes money that could be spent for useful purposes, either within or outside the health care sector. While large bureaucracies do have the advantage of creating jobs, the nation and the health care system have a great need for more socially rewarding and productive jobs (eg, home health aides, drug rehabilitation counselors, childcare workers, and many more) that could be financed from funds currently used for needless administrative tasks.

There is a growing consensus that health care cost increases are bad for the economy. Employers complain that the high cost of health insurance for employees reduces international competitiveness. If government health expenditures continue their rapid rise, other publicly financed programs essential to the nation's economy (eg, education and transportation) will be curtailed and the unsustainable government budget deficits will strain the future of the nation's well-being.

Rising costs are harmful to everyone because they make health services and health insurance unaffordable. Many companies are shifting more health care costs onto their employees. As government health budgets balloon, cutbacks are inevitable, generally hurting the elderly and the poor. Individuals with no health insurance or inadequate coverage have a far harder time paying for care as costs go up. As a general rule, when costs go up, access goes down.

For these reasons, we believe that health care costs should be contained, using strategies that do the least harm to the health of the population.

THE NEED FOR POPULATION-BASED MEDICINE

Most physicians, nurses, and other health professionals are trained to provide clinical care to individuals. Yet clinical care is not the only determinant of health status; standard of living and public health measures have an even greater influence on the health of a population (see Chapter 3). Health care, then, should have another dimension: concern for the population as a whole. Individual physicians may be first-rate in caring for their patients' heart attacks, but may not worry enough about the prevalence of hypertension, smoking, elevated cholesterol levels, uncontrolled diabetes, and lack of exercise in their city, in their neighborhood, or among the group of patients enrolled in their practices. For years, clinical medicine has divorced itself from the public health community, which does concern itself with the health of the population. We believe that health caregivers should be trained to add a population orientation to their current role of caring for individuals.

ACKNOWLEDGMENTS

We could not have written this book by ourselves. The circumstances encountered by hundreds of our patients and dozens of our colleagues provided the insights we needed to understand and describe the health care system. Any inaccuracies in the book are entirely our responsibility. Our warmest thanks go to our families, who have provided both encouragement and patience.

Earlier versions of Chapters 2, 4, 5, 8, 9, and 16 were published serially as articles in the *Journal of the American Medical Association* (1994;272:634–639, 1994;272:971–977, 1994;272:1458–1464, 1995;273:160–167, 1995;274:85–90, and 1996;276:1025–1031) and are published here with permission (copyright, 1994, 1995, and 1996, American Medical Association).

CONCLUSION

This is a book about health policy. As such, we will cite technical studies and will make cross-national generalizations. We will take matters of profound personal meaning—sickness, health, providing of care to individuals in need—and discuss them using the detached language of "inputs and outcomes," "providers and consumers," and "cost-effectiveness analysis." As practicing physicians, however, we are daily reminded of the human realities of health policy. *Understanding Health Policy: A Clinical Approach* is fundamentally about the people we care for: the uninsured janitor enduring the pain of a gallbladder attack because surgery might leave him in financial ruin, or the retired university professor who sustains a stroke and whose life savings are disappearing in nursing home bills uncovered by her Medicare or private insurance plans.

Almost every person, whether a mother on public assistance, a working father, a well-to-do physician, or a millionaire insurance executive, will someday become ill, and all of us will die. Everyone stands to benefit from a system in which health care for all people is accessible, affordable, appropriate in its use of resources, and of high quality.

Thomas Bodenheimer
Kevin Grumbach
San Francisco, California
February, 2012

1 Introduction: The Paradox of Excess and Deprivation

Louise Brown was an accountant with a 25-year history of diabetes. Her physician taught her to monitor her glucose at home, and her dietician helped her follow a diabetic diet. Her diabetes was brought under good control. Diabetic retinopathy was discovered at yearly eye examinations, and periodic laser treatments of her retina prevented loss of vision. Ms. Brown lived to the age of 88, a success story of the US health care system.

Angela Martini grew up in an inner-city housing project, never had a chance for a good education, became pregnant as a teenager, and has been on public assistance while caring for her four children. Her Medicaid coverage allows her to see her family physician for yearly physical examinations. A breast examination located a suspicious lesion, which was found to be cancer on biopsy. She was referred to a surgical breast specialist, underwent a mastectomy, was treated with a hormonal medication, and has been healthy for the past 15 years.

For people with private or public insurance who have access to health care services, the melding of high-quality primary and preventive care with appropriate specialty treatment can produce the best medical care in the world. The United States is blessed with thousands of well-trained physicians, nurses, pharmacists, and other health caregivers who compassionately provide up-to-date medical attention to patients who seek their assistance. This is the face of the health care system in which we can take pride. Success stories, however, are only part of the reality of health care in the United States.

EXCESS AND DEPRIVATION

The health care system in the United States has been called “a paradox of excess and deprivation” (Enthoven and Kronick, 1989). Some persons receive too little care because they are uninsured, inadequately insured, or have Medicaid coverage that many physicians will not accept.

James Jackson’s Medicaid benefits were terminated because of state cutbacks. At age 34, he developed abdominal pain but did not seek care for 10 days because he had no insurance and feared the cost of treatment. He began to vomit, became weak, and was finally taken to an emergency room by his cousin. The physician diagnosed a perforated ulcer with peritonitis and septic shock. The illness had gone on too long; Mr. Jackson died on the operating table. Had he received prompt medical attention, his illness would likely have been cured.

Betty Yee was a 68-year-old woman with angina, high blood pressure, and diabetes. Her total bill for medications, which were only partly covered

under her Medicare plan, came to $200 per month. She was unable to afford the medications, her blood pressure went out of control, and she suffered a stroke. Ms. Yee's final lonely years were spent in a nursing home; she was paralyzed on her right side and unable to speak.

Mary McCarthy became pregnant but could not find an obstetrician who would accept her Medicaid card. After 7 months, she began to experience severe headaches, went to the emergency room, and was found to have hypertension and preeclampsia. She delivered a stillborn baby.

While some people cannot access the care they need, others receive too much care that is costly and may be harmful.

At age 66, Daniel Taylor noticed that he was getting up to urinate twice each night. It did not bother him much. His family physician sent him to a urologist, who found that his prostate was enlarged (though with no signs of cancer) and recommended surgery. Mr. Taylor did not want surgery. He had a friend with the same symptoms whose urologist had said that surgery was not needed. Since Mr. Taylor never questioned doctors, he went ahead with the procedure anyway. After the surgery he became incontinent of urine.

Consuelo Gonzalez had a minor pain in her back, which was completely relieved by over-the-counter acetaminophen. She went to the doctor just to make sure the pain was nothing serious, and it was not. The physician gave Ms. Gonzalez a stronger medicine, indomethacin, to take three times a day. The indomethacin caused a bleeding ulcer requiring a 9-day hospital stay at a cost of $27,000 to her health insurer.

Too Little Care

In 2009, over 50 million people in the United States had no health insurance. Many are victims of the changing economy, which has shifted from a manufacturing economy based on highly paid full-time jobs with good fringe benefits, toward a service economy with lower-paying jobs that are often part-time and have poor or no benefits (Renner and Navarro, 1989). Three-fourths of uninsured adults are employed. Lack of insurance is not simply a problem of the poor but has also become a middle-class phenomenon, particularly for families of people who are self-employed or work in small establishments. Many people with health insurance have inadequate coverage. In 2007, 45% of adults could not get needed care because they could not afford to pay the bills (Collins et al, 2008).

Too Much Care

According to health services expert Robert Brook (1989):

…almost every study that has seriously looked for overuse has discovered it, and virtually every time at least double-digit overuse has been found. If one could extrapolate from the available literature, then perhaps one-

fourth of hospital days, one-fourth of procedures, and two-fifths of medications could be done without. (Brook, 1989)

A 1998 report estimated that 20%–30% of patients continue to receive care that is not appropriate (Schuster et al, 1998). A 2003 study found that elderly patients in some areas of the country receive 60% more services—hospital days, specialty consultations, and medical procedures—than similar patients in other areas; the patients receiving fewer services had the same mortality rates, quality of care, access to care, and patient satisfaction as those receiving more services (Fisher et al, 2003a and 2003b). In 2009, health care quality expert Brent James estimated that half of all health care dollars are wasted (James, 2009).

THE PUBLIC'S VIEW OF THE HEALTH CARE SYSTEM

Health care in the United States encompasses a wide spectrum, ranging from the highest-quality, most compassionate treatment of those with complex illnesses, to the turning away of the very ill because of lack of an ability to pay; from well-designed protocols for prevention of illness to inappropriate high-risk surgical procedures performed on uninformed patients. While the past three decades have been witness to major upheavals in health care, one fundamental truth remains: the United States has the least universal, most costly health care system in the industrialized world (Davis et al, 2010).

Many people view the high costs of care and the lack of universal access as indicators of serious failings in the health care system. In 2009, only 15% of people in the United States believed that the system was working well (Blendon et al, 2009). In 2010, 33% of Americans reported not seeing a doctor or not filling a prescription due to costs, a prevalence of access problems considerably higher than that in other developed nations (Schoen et al, 2010).

UNDERSTANDING THE CRISIS

In order to correct the weaknesses of the health care system while maintaining its strengths, it is necessary to understand how the system works. How is health care financed? What are the causes and consequences of incomplete access to care? How are physicians paid, and what is the effect of their mode of reimbursement on health care costs? How are health care services organized and quality of care enhanced? Is sufficient attention paid to the prevention of illness, and what are different strategies for preventing illness?

How can the problems of health care be solved? Does the health reform law enacted by Congress in 2010 provide the answer? Can costs be controlled in a manner that does not reduce access? Can access be expanded in a manner that does not increase costs? How have other nations done it—or attempted to do it? How might the health care system in the United States change in the future?

REFERENCES

Blendon RJ et al. The American public and the next phase of the health care debate. *N Engl J Med*. 2009;361:e48.

Brook RH. Practice guidelines and practicing medicine. *JAMA*. 1989;262:3027.

Collins SR et al. *Losing Ground: How the Loss of Adequate Health Insurance Is Burdening Working Families*. New York: Commonwealth Fund; 2008.

Davis K et al. *Mirror, Mirror on the Wall*. New York: Commonwealth Fund; 2010.

Enthoven A, Kronick R. A consumer-choice health plan for the 1990s. *N Engl J Med.* 1989;320:29.

James BC. A conversation with Brent C James, MD. Health reform debate overlooks physician–patient dynamic. *Managed Care*. December 2009:18(12):31.

Fisher ES et al. The implications of regional variations in Medicare spending. Part 1: The content, quality, and accessibility of care. *Ann Intern Med*. 2003a;138:273.

Fisher ES et al. The implications of regional variations in Medicare spending. Part 2: Health outcomes and satisfaction with care. *Ann Intern Med.* 2003b;138:288.

Renner C, Navarro V. Why is our population of uninsured and underinsured persons growing? The consequences of the “deindustrialization” of the United States. *Int J Health Serv*. 1989;19:433.

Schoen C et al. How health insurance design affects access to care and costs, by income, in eleven countries. *Health Aff (Millwood)*. 2010;29:2323.

Schuster M et al. How good is the quality of health care in the United States? *Milbank Q*. 1998;76:517.

2 Paying for Health Care

Health care is not free. Someone must pay. But how? Does each person pay when receiving care? Do people contribute regular amounts in advance so that their care will be paid for when they need it? When a person contributes in advance, might the contribution be used for care given to someone else? If so, who should pay how much?

Health care financing in the United States evolved to its current state through a series of social interventions. Each intervention solved a problem but in turn created its own problems requiring further intervention. This chapter will discuss the historical process of the evolution of health care financing.

MODES OF PAYING FOR HEALTH CARE

The four basic modes of paying for health care are out-of-pocket payment, individual private insurance, employment-based group private insurance, and government financing (Table 2–1). These four modes can be viewed both as a historical progression and as a categorization of current health care financing.

Type of Payment	Percentage of National Health Expenditures, 2009
Out-of-pocket payment	12%
Individual private insurance	3%
Employment-based private insurance	31%[b]
Government financing	47%
Other	7%
Total	100%
Principal Source of Coverage	**Percentage of Population, 2009**

Uninsured	17%
Individual private insurance	5%
Employment-based private insurance	48%
Government financing	30%
Total	100%

Source: Data extracted from Martin A et al. Recession contributes to slowest annual rate of increase in health spending in five decades. *Health Affairs*. 2011;30:11–22; US Census Bureau: *Income, Poverty, and Health Insurance Coverage in the United States, 2009*. p. 60–238, September, 2010.

[a]Because private insurance tends to cover healthier people, the percentage of expenditures is far less than the percentage of population covered. Public expenditures are far higher per population because the elderly and disabled are concentrated in the public Medicare and Medicaid programs.

[b]This includes private insurance obtained by federal, state, and local employees, which is in part purchased by tax funds.

Table 2–1. Health care financing in 2009[a]

Out-of-Pocket Payments

> *Fred Farmer broke his leg in 1911. His son ran 4 miles to get the doctor, who came to the farm to splint the leg. Fred gave the doctor a couple of chickens to pay for the visit. His great-grandson, Ted, who is uninsured, broke his leg in 2011. He was driven to the emergency room, where the physician ordered an x-ray and called in an orthopedist who placed a cast on the leg. The cost was $1800.*

One hundred years ago, people like Fred Farmer paid physicians and other health care practitioners in cash or through barter. In the first half of the twentieth century, out-of-pocket cash payment was the most common method of reimbursement. This is the simplest mode of financing—direct purchase by the consumer of goods and services (Figure 2–1).

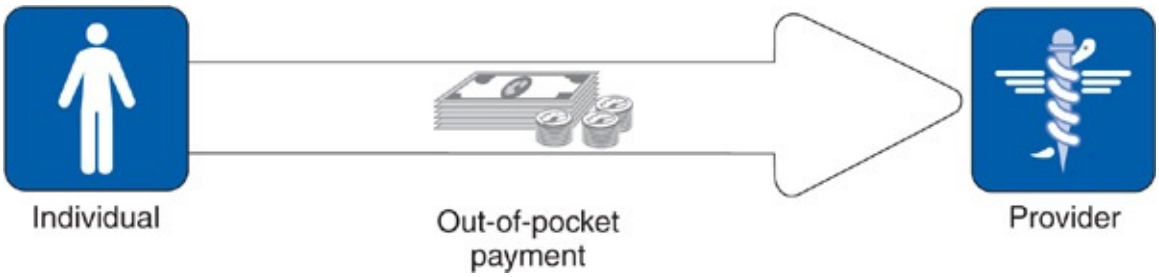

Figure 2–1. Out-of-pocket payment is made directly from patient to provider.

People in the United States purchase most consumer items, from DVD players to haircuts, through direct out-of-pocket payments. This is not the case with health care (Arrow, 1991; Evans, 1984), and one may ask why health care is not considered a

typical consumer item.

Need versus Luxury

Whereas a DVD player is considered a luxury, health care is regarded as a basic human need by most people.

> *For 2 weeks, Marina Perez has had vaginal bleeding and has felt dizzy. She has no insurance and is terrified that medical care might eat up her $500 in savings. She scrapes together $100 to see her doctor, who finds that her blood pressure falls to 90/50 mm Hg upon standing and that her hematocrit is 26%. The doctor calls Marina's sister Juanita to drive her to the hospital. Marina gets into the car and tells Juanita to take her home.*

If health care is a basic human right, then people who are unable to afford health care must have a payment mechanism available that is not reliant on out-of-pocket payments.

Unpredictability of Need and Cost

Whereas the purchase of a DVD player is a matter of choice and the price is known to the buyer, the need for and cost of health care services are unpredictable. Most people do not know if or when they may become severely ill or injured or what the cost of care will be.

> *Jake has a headache and visits the doctor, but he does not know whether the headache will cost $100 for a physician visit plus the price of a bottle of ibuprofen, $1000 for an MRI, or $100,000 for surgery and irradiation for brain cancer.*

The unpredictability of many health care needs makes it difficult to plan for these expenses. The medical costs associated with serious illness or injury usually exceed a middle-class family's savings.

Patients Need to Rely on Physician Recommendations

Unlike the purchaser of a DVD player, a person in need of health care may have little knowledge of what he or she is buying at the time when care is needed.

> *Jenny develops acute abdominal pain and goes to the hospital to purchase a remedy for her pain. The physician tells her that she has acute cholecystitis or a perforated ulcer and recommends hospitalization, an abdominal CT scan, and upper endoscopic studies. Will Jenny, lying on a gurney in the emergency room and clutching her abdomen with one hand, use her other hand to leaf through a textbook of internal medicine to determine whether she really needs these services, and should she have brought along a copy of Consumer Reports to learn where to purchase them at the cheapest price?*

Health care is the foremost example of asymmetry of information between

providers and consumers (Evans, 1984). A patient with abdominal pain is in a poor position to question a physician who is ordering laboratory tests, x-rays, or surgery. When health care is elective, patients can weigh the pros and cons of different treatment options, but even so, recommendations may be filtered through the biases of the physician providing the information. Compared with the voluntary demand for DVD players (the influence of advertising notwithstanding) the demand for health services is partially involuntary and is often physician-rather than consumer-driven.

For these reasons among others, out-of-pocket payments are flawed as a dominant method of paying for health care services. Because the direct purchase of health services became increasingly difficult for consumers and was not meeting the needs of hospitals and physicians to be reliably paid, health insurance came into being.

Individual Private Insurance

> *Bud Carpenter is self-employed. He recently purchased a health insurance policy from his insurance broker for his family. To pay the $500 monthly premium, he had to work some extra jobs on weekends, and the $2500 deductible meant he would still have to pay quite a bit of his family's medical costs out of pocket. Mr. Carpenter preferred to pay these costs rather than take the risk of spending the money saved for his children's college education on a major illness. When his son became ill with leukemia and the hospital bill reached $80,000, Mr. Carpenter appreciated the value of health insurance. Nonetheless he had to feel disgruntled when he read a newspaper story listing his insurance company among those that paid out on average less than 60 cents for health services for every dollar collected in premiums.*

With private health insurance, a third party, the insurer, is added to the patient and the health care provider, who are the two basic parties of the health care transaction. While the out-of-pocket mode of payment is limited to a single financial transaction, private insurance requires two transactions—a premium payment from the individual to an insurance plan (also called a health plan), and a reimbursement payment from the insurance plan to the provider (Figure 2–2). In nineteenth-century Europe, voluntary benefit funds were set up by guilds, industries, and mutual societies. In return for paying a monthly sum, people received assistance in case of illness. This early form of private health insurance was slow to develop in the United States. In the early twentieth century, European immigrants set up some small benevolent societies in US cities to provide sickness benefits for their members. During the same period, two commercial insurance companies, Metropolitan Life and Prudential, collected 10–25 cents per week from workers for life insurance policies that also paid for funerals and the expenses of a final illness. The policies were paid for by individuals on a weekly basis, so large numbers of insurance agents had to visit their clients to collect the premiums as soon after payday as possible. Because of the huge administrative costs, individual health insurance never became a dominant method of paying for health care (Starr, 1982). In 2009, individual policies provided health insurance for only 5% of the US population (see Table 2–1).

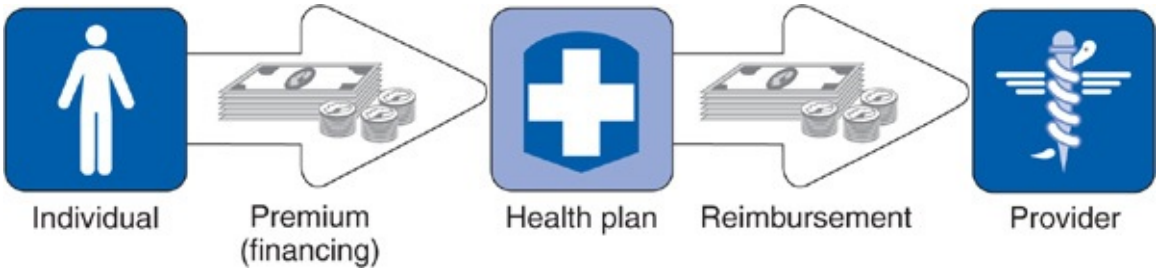

Figure 2—2. Individual private insurance. A third party, the insurance plan (health plan), is added, dividing payment into a financing component and a reimbursement component.

Employment-Based Private Insurance

> *Betty Lerner and her schoolteacher colleagues each paid $6 per year to Prepaid Hospital in 1929. Ms. Lerner suffered a heart attack and was hospitalized at no cost. The following year Prepaid Hospital built a new wing and raised the teachers' prepayment to $12.*
>
> *Rose Riveter retired in 1961. Her health insurance premium for hospital and physician care, formerly paid by her employer, had been $25 per month. When she called the insurance company to obtain individual coverage, she was told that premiums at age 65 cost $70 per month. She could not afford the insurance and wondered what would happen if she became ill.*

The development of private health insurance in the United States was impelled by the increasing effectiveness and rising costs of hospital care. Hospitals became places not only in which to die, but also in which to get well. However, many patients were unable to pay for hospital care, and this meant that hospitals were unable to attract "customers."

In 1929, Baylor University Hospital agreed to provide up to 21 days of hospital care to 1500 Dallas school-teachers such as Betty Lerner if they paid the hospital $6 per person per year. As the Great Depression deepened and private hospital occupancy in 1931 fell to 62%, similar hospital-centered private insurance plans spread. These plans (anticipating health maintenance organizations [HMOs]) restricted care to a particular hospital. The American Hospital Association built on this prepayment movement and established statewide Blue Cross hospital insurance plans allowing free choice of hospital. By 1940, 39 Blue Cross plans controlled by the private hospital industry had enrolled over 6 million people. The Great Depression reduced the amount patients could pay physicians out of pocket, and in 1939, the California Medical Association set up the first Blue Shield plan to cover physician services. These plans, controlled by state medical societies, followed Blue Cross in spreading across the nation (Starr, 1982; Fein, 1986).

In contrast to the consumer-driven development of health insurance in European nations, coverage in the United States was initiated by health care providers seeking a steady source of income. Hospital and physician control over the "Blues," a major

sector of the health insurance industry, guaranteed that reimbursement would be generous and that cost control would remain on the back burner (Law, 1974; Starr, 1982).

The rapid growth of employment-based private insurance was spurred by an accident of history. During World War II, wage and price controls prevented companies from granting wage increases, but allowed the growth of fringe benefits. With a labor shortage, companies competing for workers began to offer health insurance to employees such as Rose Riveter as a fringe benefit. After the war, unions picked up on this trend and negotiated for health benefits. The results were dramatic: Enrollment in group hospital insurance plans grew from 12 million in 1940 to 142 million in 1988.

With employment-based health insurance, employers usually pay most of the premium that purchases health insurance for their employees (Figure 2–3). However, this flow of money is not as simple as it looks. The federal government views employer premium payments as a tax-deductible business expense. The government does not treat the health insurance fringe benefit as taxable income to the employee, even though the payment of premiums could be interpreted as a form of employee income. Because each premium dollar of employer-sponsored health insurance results in a reduction in taxes collected, the government is in essence subsidizing employer-sponsored health insurance. This subsidy is enormous, estimated at $260 billion per year (Gruber, 2010).

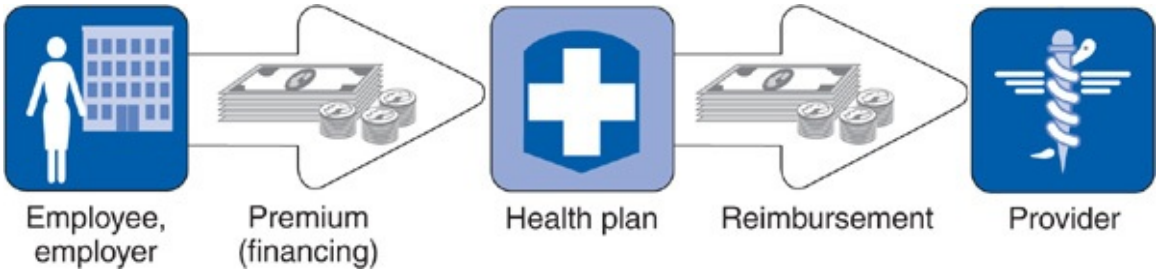

Figure 2–3. Employment-based private insurance. In addition to the direct employer subsidy, indirect government subsidies occur through the tax-free status of employer contributions for health insurance benefits.

The growth of employment-based health insurance attracted commercial insurance companies to the health care field to compete with the Blues for customers. The commercial insurers changed the entire dynamic of health insurance. The new dynamic was called **experience rating.** (The following discussion of experience rating can be applied to individual as well as employment-based private insurance.)

> *Healthy Insurance Company insures three groups of people—a young healthy group of bank managers, an older healthy group of truck drivers, and an older group of coal miners with a high rate of chronic illness. Under experience rating, Healthy sets its premiums according to the experience of each group in using health services. Because the bank managers rarely use health care, each pays a premium of $200 per month.*

Because the truck drivers are older, their risk of illness is higher, and their premium is $400 per month. The miners, who have high rates of black lung disease, are charged a premium of $600 per month. The average premium income to Healthy is $400 per member per month.

Blue Cross insures the same three groups and needs the same $400 per member per month to cover health care plus administrative costs for these groups. Blue Cross sets its premiums by the principle of community rating. For a given health insurance policy, all subscribers in a community pay the same premium. The bank managers, truck drivers, and mine workers all pay $400 per month.

Health insurance provides a mechanism to distribute health care more in accordance with human need rather than exclusively on the basis of ability to pay. To achieve this goal, funds are redistributed from the healthy to the sick, a subsidy that helps pay the costs of those unable to purchase services on their own.

Community rating achieves this redistribution in two ways:

1. Within each group (bank managers, truck drivers, and mine workers), people who become ill receive benefits in excess of the premiums they pay, while people who remain healthy pay premiums while receiving few or no health benefits.
2. Among the three groups, the bank managers, who use less health care than their premiums are worth, help pay for the miners, who use more health care than their premiums could buy.

Experience rating is far less redistributive than community rating. Within each group, those who become ill are subsidized by those who remain well, but among the different groups, healthier groups (bank managers) do not subsidize high-risk groups (mine workers). Thus the principle of health insurance, which is to distribute health care more in accordance with human need rather than exclusively on the ability to pay, is weakened by experience rating (Light, 1992).

In the early years, Blue Cross plans set insurance premiums by the principle of community rating, whereas commercial insurers used experience rating as a "weapon" to compete with the Blues (Fein, 1986). Commercial insurers such as Healthy Insurance Company could offer cheaper premiums to low-risk groups such as bank managers, who would naturally choose a Healthy commercial plan at $200 over a Blue Cross plan at $400. Experience rating helped commercial insurers overtake the Blues in the private health insurance market. While in 1945 commercial insurers had only 10 million enrollees, compared with 19 million for the Blues, by 1955 the score was commercials 54 million and the Blues 51 million.

Many commercial insurers would not market policies to such high-risk groups as mine workers, leaving Blue Cross with high-risk patients who were paying relatively low premiums. To survive the competition from the commercial insurers, Blue Cross had no choice but to seek younger, healthier groups by abandoning community rating and reducing the premiums for those groups. In this way, many Blue Cross and Blue Shield plans switched to experience rating. Without community rating, older and