COMMITTEE CERTIFICATION OF APPROVED VERSION

The committee for Rebecca B. Lunstroth certifies that this is the approved version of the following thesis:

EMPLOYER-BASED HEALTH INSURANCE IN THE UNITED STATES FROM 1920-PRESENT: THE FALL OF AN EMPIRE

Committee:

William Winslade, Ph.D., J.D.,
Supervisor

Kyriakos Markides, Ph.D.

Ronald A. Carson, Ph.D.

Dean, Graduate School

EMPLOYER-BASED HEALTH INSURANCE IN THE UNITED STATES FROM 1920-PRESENT: THE FALL OF AN EMPIRE

By

Rebecca B. Lunstroth, J.D.

Thesis
Presented to the Faculty of The University of Texas Graduate School of
Biomedical Sciences at Galveston
in Partial Fulfillment of the Requirements
for the Degree of

Master of Arts

Approved by the Supervisory Committee

William Winslade, Ph.D., J.D.
Kyriakos Markides, Ph.D.
Ronald A. Carson, Ph.D.

December 2006
Galveston, Texas

Key words: Health policy, Health Insurance

Acknowledgments

I would like to thank the numerous historians and policy analysts who have written on this topic. I would also like to acknowledge the faculty and staff of the Institute for the Medical Humanities. Their endless desire to push my intellect to its fullest limits and their utmost patience are forever appreciated. Lastly, I want to thank my family-my husband Jost, daughter Emily, and son Jack-for allowing me to turn our lives upside down and inside out so that I could follow this dream.

EMPLOYER-BASED HEALTH INSURANCE IN THE UNITED STATES FROM 1920-PRESENT: THE FALL OF AN EMPIRE

Publication No._____

Rebecca B. Lunstroth, J.D., M.A.
The University of Texas Graduate School of Biomedical Sciences at Galveston, 2006

Supervisor: William Winslade

The United States is the only industrialized nation that relies almost exclusively on private employers to fund health care. As this thesis will set out to demonstrate, the ability of private employers to fund this burden has been slowly eroding to the point that the system is on the brink of collapse. Without viable alternatives in place our health-care system will begin to fail the people who most rely on it: wage earners who work for private companies. How did we get to this point? Historically, the establishment of employer-based health insurance evolved largely outside the political arena, and the federal government's involvement was initially relegated to sustaining the system - not fixing it. Thus, presidential administrations that attempted to change how health care was funded have been unsuccessful in their campaigns. The reasons for these failures will be explored in the context of recommending solutions that acknowledge the malfunctions in the current system, as well as the foundation of that very system which has kept employer-based health insurance the backbone of the health-care industry of America.

TABLE OF CONTENTS

Page

List of Tables

CHAPTER 1: Introduction

In the late 1920s, commercial marketers of insurance considered health insurance (or rather sickness insurance as it was referred to then) as an oxymoron, incapable of being marketed. There were a number of reasons cited. First, sickness was considered a significant insurance risk because medical utilization was not a predicable event. Second, unlike life insurance that is paid only once over a person's life, the expense and duration of an illness could not be measured in advance. Lastly, medical care in the 1920s was considered a discretionary item and therefore spending would be hard to predict and/or control. Ironically, what was once considered a risky business proposition early in the twentieth century became a multimillion industry by the middle of century. Moreover, providing health insurance through one's employment happened quite accidentally. The concept of private health insurance was created outside the political arena by a group of unassociated men from various walks of life. The downturn in the economy, growth of medical technology, demands of the patient and physician, and the philosophy of medical societies all converged in the 1940s to create a ripe climate for this experiment to succeed. What began in Dallas, Texas, in 1929, when 1,356 school teachers paid fifty a

month for up to twenty one days of hospitalization now extends to approximately two-thirds of all Americans.

There are numerous indicators that the voluntary, employer-based system is in jeopardy of imploding: Since the mid-1970s, the numbers of employers who offer insurance to their employees has been declining, especially among small businesses where the majority of workers are employed. The number of people who are enrolling in or "taking-up" the benefit is also declining. While the offer rate and enrollment continue to decline, the cost of health insurance continues to rise beyond both inflation and wage growth.

Moreover, nonstandard employees, those who work less than thirty-five hours a week or on a contract or temporary basis, are seldom offered health insurance For example, in the Dallas area, Albertons, the grocery chain recently converted about ten thousand of its employees to part-time so that the company could avoid paying benefits and remain competitive with other area stores (notably Wal-Mart) that don't offer benefits.

The first section of this thesis will trace the history of employer-based health insurance between 1912 and 2004. In doing so it will reveal how health insurance was a private initiative and how federal legislation unintentionally accelerated its growth and structure. Moreover, it will help explain why more recent attempts at restructuring the system have proved to be almost impossible. Chapter 2 will analyze a large sum of data to illustrate how, where, and why the system is failing. Chapter 3 will review the available options for correcting this failure, and Chapter 4 will recommend a course of action to reverse this trend.

CHAPTER 2: The Evolution of Employer-Based Health Insurance

Of the 255.1 million nonelderly (under sixty-five years of age) people living in the United States in 2004, over 209 million had some type of health insurance: the vast majority or 61 percent were covered by employer-based health insurance.[1] This figure alone is not distinguishable in any way. Put into context, however, it reveals a rather disturbing trend in what is considered the foundation of health insurance in America. Employer-based health insurance leveled off in the 1970s and 1980s and has decreased from 66 percent in 1988 to 64 percent in 1990 to what it is now.[2] However, the number of people receiving insurance through the workplace continues to drop. In addition to the dwindling number of people receiving health-care insurance through their employer, a closer examination reveals that the level of benefits being provided is continuing to decline while the premiums, copays and deductibles all rise. The government during various periods throughout the twentieth century has to differing degrees attempted to change how health care is provided, but since it was virtually absent from its creation, the government's role has been limited to setting tax policy and labor laws. To better understand how the U.S. arrived at a private system of funding, the first section of this paper traces the rise and decline of employer-based health insurance in America between 1918 and 2004 and additionally explores the role of the government in enabling this private movement.

Before elaborating on the history of employer-based health insurance the below example examines what is meant by employer-based health insurance and illustrates the vast number of options that employers offer to employees. In essence, employer-based health insurance is not a standard product that looks the same from employer to employer, but varies in many respects. A person is considered to have employer-based health insurance when his or her workplace offers health insurance coverage as a benefit to its employees. What varies considerably is the type and cost of coverage. For

---

[1] Kaiser Family Foundation, "Health Insurance in America: 2004 Data Update," http://www.kff.org/uninsured/upload/Health-Coverage-in-America-2004-Data-Update-Report.pdf (accessed May 20, 2006).

[2] Marilyn J. Field and Harold T. Shapiro, eds., *Employment and Health Benefits: A Connection at Risk* (Washington, D.C.: National Academy Press, 1993), 87.

example, Employer A may offer five different types of plans ranging in coverage. For a small monthly premium the employee may enroll in a defined contribution plan which is a hybrid of an indemnity plan/savings account that covers health expenses but only after a significant deductible, typically five thousand or ten thousand dollars, is met (but by which a tax exempt health savings account is established to help offset costs). Thus, the first five thousand to ten thousand dollars of expenses is absorbed solely by the employee before any benefit takes affect. For a much larger monthly premium Employer A also offers a Preferred Provider Plan (PPO) which provides a richer benefit (i.e., less expensive) to subscribers who use a network of providers and a more expensive option but more flexibility if they chose to go outside the network. If the subscriber uses the network they have a lower deductible to meet and typically a copayment of ten to thirty dollars every time they see a physician. If the employee goes outside of this network of providers, his or her deductible will be higher and the cost of seeing this outside provider is typically shared on a percentage basis with the employee bearing 50 percent of the expense and the insurance picking up the other 50 percent. Employer A may also offer a couple of different Health Maintenance Organizations (HMOs) that traditionally do not afford subscribers any flexibility outside of the assigned network; however, the out-of-pocket costs for this plan are minimal. Likewise, the amount that an employer contributes to the overall premium varies from company to company with larger companies typically assuming a larger portion of the premium than small companies.[3] Regardless of what type of insurance is being offered and how much the employee is being told to contribute, it is still considered employer-based health insurance because it is being offered through the workplace. Likewise, this arrangement typically ends (with the exception of coverage under the Consolidated Omnibus Budget Reconciliation Act or COBRA, which is funded entirely by the ex-employee) when employment ends. Equally important in understanding the nuances of employer-based health insurance is recognizing the voluntary nature of it. There are no laws or statutes that mandate employers to give this benefit to their employees. How did the United States arrive at this system of health care?

[3] Kaiser Family Foundation, "Health Insurance in America: 2004 Update."

The Movement through the 1930s

By the middle of the seventeenth century, insurance companies began offering individual policies that covered the loss of wages due to illness or industrial accident. The first such policy was written in 1850 by the Franklin Health Assurance Company of Massachusetts in 1850. Other insurance companies followed suit offering variations of these plans that included options such as death benefits and weekly loss of wages.[4] By 1864, coverage was available for virtually every type of accident and at the turn of the century forty-seven companies were issuing some form of accident insurance. Both accident and life insurance companies entered the health insurance field at the turn of the century covering policyholders' loss of income due to a number of diseases such as typhus, scarlet fever, small pox, etc.[5] The insurance policies however, covered loss of wages, not medical expenses.

At the beginning of the eighteenth century a few commercial health insurance companies were established for the purpose of offering health insurance, but they went bankrupt because there was no way to predict instances of illness or injury. All insurance (then and now) is predicated on a risk/benefit structure that takes into account incident rates, the cost of paying for the incident while at the same time providing for some level of profit. In the life insurance market for instance, a person only died once so underwriters could predict with a certain amount of accuracy how many deaths would occur during a period and set rates according. Insurance companies could not predict, however, when and how often a person would get sick or injured or how much it would cost to treat the illness or the accident. By example, modern insurance companies know the likelihood of a forty-five-year-old smoker getting lung cancer and set rates accordingly. Without this type of data, however, companies could not determine a rate structure. There was also the problem (and still is) with managing who signed up for health insurance since a plan could not afford to insure only sick people.[6] Further, commercial insurers at the time thought that health insurance (or rather sickness

---

[4] Ibid., 3.

[5] Marshall W. Raffel and Norma K. Raffel, *The U.S. Health System: Origins and Functions*, 4th ed. (New York: Wiley & Sons, 1994), 211.

[6] Ibid., 9.

insurance as it was originally called), was an oxymoron incapable of being marketed. Underwriting sickness was considered an insurance risk because medical utilization was not a predictable event that occurred at certain times. Additionally, unlike say life insurance that is payable once in a person's life, illness is of an unknown duration and expense.

During the 1870s and 1880s companies engaged in mining, lumber, and railroads began to develop plans to cover the medical needs of their employees. The first plan of this type was offered by the Western Clinic in Tacoma, Washington. The clinic prepaid doctors a fixed monthly fee to provide their members with needed service including care for industrial accidents and common illnesses. Since the majority of these clinics were conceived because these companies operated in remote locations not served by the medical profession, organized medicine did not challenge these early arrangements that they would later contest when they were established in urban areas. The first plans to pay for hospital care were organized in 1912 in Rockford, Illinois and Grinwell, Iowa in 1927. Each of these offered payment for limited hospital services.[7] During this same period HMOs were formed on the West Coast. The concept was to provide a wide range of comprehensive health-care services to subscribers at a predetermined rate. The Ross-Loos clinic was the first HMO. It was formed in 1929 by two physicians in Los Angeles for Department of Water and Power employees.[8] The California Medical Association unsuccessfully attempted to deprive physicians their license if they practiced at this clinic. The American Medical Association (AMA) was also unsuccessful in attacking another cooperative group practice in Washington, D.C., where the clinic enlisted the support of the U.S. Attorney General.[9] In 1930, Kaiser Permanente, the most successful and widely known HMO, was formed in California. At the time workers who were building a dam in a remote part of California had to be sent two hundred miles away to obtain medical care. Sidney Garfield, a physician at the construction site, convinced Henry Kaiser, the owner of the company, to pay him directly and in advance for each employee in exchange for providing medical care to employees, both on and off the job.

---

[7] Ibid., 212.

[8] Laura A. Scofea, "The Development and Growth of Employer-Provided Health Insurance," *Monthly Labor Review* 5 (March 1994): 5.

[9] Raffel and Raffel, 129.

Kaiser, who also owned insurance companies, was so impressed with the results that he asked Garfield to establish similar practices in other sites.[10] Kaiser, however, escaped direct confrontation with the medical societies primarily because it established its own hospitals thus avoiding the problem with giving hospital privileges to its employees. After World War II (WWII) Kaiser started its rapid growth along the West Coast.[11] However, since HMOs can serve only a specific geographic market, their concept can be copied but not easily replicated across markets.

The employer-based health insurance that spread in other locations had its roots in Texas. The Baylor Plan of Texas was the model that was used by others across the country. As noted above, insurance companies began offering cash benefits to offset the loss of wages due to accidents or sickness in the late 1800s, and various experiments with providing people with hospital and medical coverage were being studied throughout the United States. Although prepayment health insurance plans had already been implemented in Rockford, Illinois and Grinwell, Iowa, it was the Baylor plan that launched Blue Cross and private health insurance as we know it today. The Baylor Plan was developed by Robert Kimball specifically for teachers in Dallas, Texas. In 1918, Robert Kimball was the superintendent of the Dallas schools. In that same year an influenza epidemic made its deadly rounds throughout the United States, including Dallas. The epidemic hit teachers especially hard for two reasons. First, a teacher's pay was very low to begin with, so unless the teacher had some other source of income she could not afford medical care. Second, school districts had created extremely harsh policies on extended illness. If a teacher became sick, she was entitled to two weeks of half-pay and then she was terminated from the payroll. These meager benefits harmed not only the teachers, who would lose their jobs, but also their students who had to continually acclimate to new teachers. Kimball set out to create the "Sick Benefit Fund," a wage-replacement plan that sought to give teachers more generous benefits when they were out sick. In order to determine the appropriate level of funding, Kimball studied the absentee records of the district and determined the average number of days lost per teacher per month. From this he determined the amount of funding that would be

[10] Scofea, 5-6.
[11] Raffel and Raffel, 130.

needed and concluded that teachers and principals would have to contribute one dollar a month into a common fund to receive a benefit of five dollars a week.[12]

Kimball left the school district shortly thereafter to pursue other opportunities, and in 1929, he was appointed Executive Vice President in charge of the Baylor Hospital and its affiliated schools. His primary task was to restore the fiscal health to the hospital.13 There were two primary factors that were creating financial hardship for the hospital: first, patients were not always able to pay their hospital bills; and, second, new technologies that both enabled doctors to make more accurate diagnosis and proscribe better treatments required a larger capital investment then was previously needed. These two factors led Baylor (in addition to most hospitals) to financial instability. The Dallas teachers whom Kimball once oversaw were one such group that was unable to fully afford hospital care.

Kimball reflected on the work he had done to create the Sick Benefit Fund to ascertain whether a similar solution could be employed to help teachers pay their hospital bills. Kimball questioned whether you could even insure a person's health. Not only did Kimball lack the necessary statistics in which to base premiums, in the 1920s medical care was considered a discretionary item.[14] Thus, people did not regularly seek care when they needed it therefore, there was little statistical data available on the incidence rate. These obstacles notwithstanding, Kimball, not discouraged by the lack of success to date continued to pursue the concept of developing and creating a private insurance scheme.[15]

Although there was very little useful historical data on the incident rates and cost of illnesses on which to base rates, Kimball recognized that the data he used to create the Sickness Benefits Fund could also be used to develop health insurance. These accounts recorded each time the [sickness] fund was used, the hospital where the services were rendered, the length of the stay, the diagnosis and the cost of the service. The data revealed that on average, teachers spent fifteen cents a month on hospital expenditures.

---

[12] Samuel Schaal, *Lone Star Legacy: The Birth of Group Hospitalization and the Story of Blue Cross and Blue Shield of Texas* (Dallas: Taylor Publishing 1999), 5-6.

[13] Ibid., 7.

[14] Randall Bovbjerg, Charles Griffin, and Caitlin Carroll, "US Health Coverage and Cost: Historical Developments and Choices for the 1990s," *Journal of Law, Medicine & Ethics*" 21 (Summer 1993): 141.

[15] Schaal, 9.

Kimball recognized that if teachers had insurance that covered hospital bills, utilization was likely to double. As such, he estimated that a forty-five cents per month premium would be required to fund such as scheme and rounded it up to fifty cents a month. Hence, the first published health insurance formula was created and on December 20, 1929, the Group Hospitalization Plan at Baylor became operational. One thousand, three hundred and fifty-six teachers or 75 percent of the eligible pool signed up for the insurance. The scheme was simple: For fifty cents per month, members were entitled to twenty-one days' hospitalization in any one calendar year which included the operating room and laboratory services at Baylor Hospital. In the event that the plan paid out less than it took in, the money would be put into a fund for future use.[16] The teachers were guaranteed services as opposed to a cash settlement. Likewise, the hospital was also guaranteed payment from the fund and they did not have to concern themselves with collecting payment from their patients.

In addition to being able to determine an appropriate rate schedule there were other factors that contributed to the birth and success of employer-based health insurance. In 1927, a group of forty-two prominent Americans in the field of healthcare (including representative from the AMA), set out to research and report on a number of areas including the medical needs of the American people. One very controversial report split the committee itself with the majority (thirty-nine out of fifty) recommending the adoption of group practice and voluntary insurance as the best means of solving the current problems associated with getting health care while the minority attacked the group practice model and cautiously accepting insurance in principle but suggested that the government needed to pay for indigent care. According to Anderson, this report set the stage for adoption of private health insurance as the principle method of financially protecting people from the costs of ill-health.[17]

It wasn't until the late 1930s however, that the idea of private health insurance became widely accepted. By 1935 there were only fifteen insurance hospital insurance plans in eleven states.[18] There were a number of reasons why the concept did not grow

[16] Ibid., 10-11.
[17] Ibid., 94-101.
[18] Raffell and Raffel, 212.

faster, reaching more people. One of the biggest obstacles to selling the plan was the general public's overall suspicion of the health-care industry. During this time hospitals were having significant financial problems and people were skeptical as to what would happen to their "prepaid" dollars. They wanted assurances that their money would be protected and that services would be provided if and when they were needed.[19] In addition to a skeptical public, the vast majority of people had yet to realize the costs associated with health care in the 1930s. During this period of time hospital utilization was still at its infancy and the number of procedures and the costs associated with those procedures were limited. Another reason that health insurance didn't spread quicker was the ambivalence shown by middle class.[20] Even though some suggest that the middle class was the impetus behind health insurance they did not advocate for it in any structured or unified way. Yet another reason for the slow spread is that the financial hardships associated with hospitalization were only realized by a minority of the population. For example, an average day in a hospital in 1929 cost only a few dollars which was not large relative to the typical income of the day.[21] Moreover, the people who were impacted by huge hospital bills were a silent minority: unorganized without a voice in either Washington, the state legislatures, the medical associations or in academia. A forth reason the early health insurance plans did not spread quicker throughout the country is that the AMA having fought against compulsory health insurance was still advocating a market place that was free from any government or third party intervention. In fact, some in the AMA did not understand why insurance was even needed. For instance, W. C. Rappleye, the Director of Study Commission on Medical Education of the AMA gave an address in 1930 where he made two key points on this issue: He noted first that current expenditures on health care ($2,250,000,000) were not excessive in proportion to our nation's wealth especially for the protection afforded and the services rendered. Next, he went on compare our nation's health expenditures with other luxury items and non-essentials and figured that we spent three times more on tobacco and two times more on candy than on our health. As such, he argued that as a

[19] Ibid.,. 15.
[20] Field and Shapiro, 56-59.
[21] Bovbjerg, Griffin, and Carroll, 142.

nation we should have no problem paying for medical services.[22] Most importantly however is that during the early 1930s the American Hospital Association was slow to endorse any type of prepayment scheme mainly because they did not, (despite some early successes) think it would solve their financial difficulties.[23] Hence, it was individual leaders and not the American Hospital Association or any government agency that pioneered similar plans across the United States.[24]

In Dallas, Kimball had no desire to market his concept beyond the teachers but recognized that in order to maintain the financial soundness of the hospital he needed to enroll more people. Thus, in October of 1929, Kimball hired Bryce Twitty to market his Baylor Plan.[25] In the summer of 1930, Twitty presented the plan to the Dallas Morning News but the employees thought the plan sounded too good to be true and only one person enrolled. As chance would have it, the new enrollee became hospitalized that same day and when her fellow workers saw that she was not responsible for paying the hospital bill the majority of Dallas Morning News employees immediately signed up for the plan. Twitty and Kimball's target participation was twenty-three thousand enrollees because that was the number of enrollees that the Baylor Hospital could absorb. In their first year of operation the plan lost only a little bit of money, in fact, far less than they would have otherwise lost in bad debt.[26] The early success of the Baylor plan led others to follow suit with modification.

Dr. J. H. Groseclose, founder and administrator of Methodist Hospital in Dallas, was initially skeptical of Kimball's scheme and threatened to file an injunction against Baylor for selling prepaid hospital services. In response, Kimball invited Groseclose to view first hand how the Baylor plan worked and, shortly thereafter, Groseclose created and implemented a very similar plan contracting with an outside company. The

---

[22] Annual Conference of Secretaries of Constituent State Medical Association, November 14-15, 1930, *American Medical Association Bulletin* 26 (1931): 35.

[23] Olin W. Anderson, *Blue Cross since 1929: Accountability and the Public Trust* (Cambridge, Mass.: Ballinger Publishing, 1975), 43.

[24] Raffel and Raffel, 212.

[25] Anderson, *Blue Cross since 1929*, 19.

[26] Schaal, 14.

company, National Hospitalization System, Incorporated, took Kimball's idea and commercialized it by taking a profit out of each subscription that they sold.[27]

S. E. McCreless an insurance salesman in San Antonio, Texas, decided to implement the Baylor plan in San Antonio but his scheme was met with some resistance. The medical community protested that the Baylor plan limited enrollees' free choice of physicians by requiring that all services be provided by one hospital, regardless of where the physician practiced. Hence, both the patient and the physician were limited to one hospital. The medical society welcomed and supported the pre-payment system but wanted to see it extended to other area hospitals, giving more flexibility to both contract holders and physicians. McCreless was successful in signing up other hospitals and in 1931 the first multi-hospital plan was implemented. Five hospitals in Houston followed suit two years later with some minor changes.[28]

In 1930, concurrent with the events taking place, Kimball attended the American Hospital Association (AHA) convention in New Orleans and during a meeting someone raised the topic of prepaid health insurance. Kimball was asked to share his experiences and word of the Baylor Plan spread throughout the convention.[29] Thus, the Baylor plan provided a platform for others whose efforts played a significant role in pioneering health insurance as we know it today. They came from various backgrounds, but they all shared a common goal of creating a health insurance scheme for their communities. Since no national society had been formed yet to help manage the growth of private health insurance each of these initiatives was community based. Frank Van Dyk, a salesman and fund raiser with an eighth-grade education was the executive secretary of the Essex County Hospital Council in New Jersey, when he heard about the plans in Dallas.[30] In his capacity with the hospital council Van Dyk was responsible for collecting the hospital's unpaid bills. He initially met with the National Hospitalization System people who oversaw the Methodist plan but was put off by its profit making structure. Van Dyk then

---

[27] Ibid., 15

[28] Robert Jolly, "Five Houston Hospitals Join in Hospital Insurance Plan," *Modern Hosptial* 34 (October 1932): 20.

[29] Schaal, 19.

[30] Robert M. Cunningham Jr., "Notes on The Birth of Blue" *Hospitals* 53 (April 1979): 93.

met with the people at Baylor. Van Dyk liked the concept but like McCreless in San Antonio, thought that clients ought to have the choice of more than one hospital. On January 1, 1933, Van Dyk implemented a multi-hospital plan in Essex County, New Jersey.[31] Van Dyk also figured out the actuarial base for the first community-wide plans in New Jersey and New York.[32]

Another early plan that provided early guidance was the one established in Charleston, West Virginia, in 1933. Originally designed as a for-profit plan, the public became suspicious and the concept was quickly turned over to a non-profit entity made up of participating hospitals and a representative from the local county medical society. Charleston expanded on what the others had done and extended coverage to family members; eliminated pre-insurance physicals; and extended coverage to provide for ambulatory services.[33]

Other community pioneers included E. A. can Steenwyk a school teacher and writer from St Paul; J. Douglas Coleman a colleague of Van Dyk's who organized the first plan in Maryland; John Mannix, a hospital administrator who helped organize plans in Cleveland and Detroit and who negotiated one of the first labor contracts with the autoworkers; and C. Rufus Rorem, a University of Chicago economist. While these men worked to implement plans in their communities it was Rorem who became the defacto leader over the movement. Rorem had been a member of the national Committee on the Cost of Medical Care and worked for the Rosenwald Fund, a Chicago foundation that studied hospital accounting and financing. That led to his appointment as chairman of the AHA's Committee on Uniform Hospital Accounting and his involvement in the new group hospitalization prepayment movement. He later became secretary of the AHA's Committee on Hospital Service which eventually evolved into the independent Blue Cross Association. Rorem insisted on the principles that guided the early plans: not-for profit organizations, community service, public representation and supervision and service benefits rather than cash indemnities.[34] According to Anderson, the fusion of these

---

[31] Schaal, 20.

[32] Jolly, 93.

[33] John Hart, "Group Hospitalization Plan Succeeds Despite Unusual Difficulties," *Modern Hospital* 38 (May 1934): 69.

[34] Cunningham Jr., 93.

men from varied backgrounds but with similar aims resulted in the creation of the private health insurance movement.[35] Of particular note is the obvious absence of government involvement. These early initiatives were the brainchild of independent men who created a solution to the financial needs of both consumers and hospitals. In fact, when Rorem was asked about his views on compulsory insurance, he stated that the federal government should help make the voluntary system work and should not attempt to replace it.[36]

How would you summarize the early private health insurance movement? The earliest plans were created by business people in an attempt to provide health-care services to employees who were living in remote areas of the country where health care was not available. Although these arrangements were divergent from how the AMA sought to promote health-care services, they were largely ignored because there was little to no competition for services in these parts of the country. What ultimately became Blue Cross was similarly conceived in an attempt to provide a financial vehicle that would afford teachers some protection against the cost of illness, while providing hospitals with a steady and reliable source of income. Absent in all of these early initiatives was any type of government involvement, either formal or informal. Plan design including financing, coverage and risk were all determined without government involvement. Moreover, their non profit status helped them overcome public skepticism[37] and they were publicly perceived to have a more social role than ordinary insurance.[38] The employer as the primary vehicle for offering this service would not evolve until WWII, but the mechanism had been put into motion.

---

[35] Olin W. Anderson, *Health Services in the United States: A Growth Enterprise since 1875* (Ann Arbor, Mich.: Health Administration Press, 1985), 123.

[36] Anderson, *Blue Cross since 1929*, 64.

[37] Although some of the early plans (Methodist in Dallas) were developed to make a profit, a consistent feature of the Blue Cross plans was their nonprofit status.

[38] Bovbjerg, Griffin and Carroll, 143.

The Early Compulsory Movement

In an address to the Annual Conference of Secretaries of Constituent State Medical Associations in 1931, W. C. Rapplelye, M.D. noted that 23 of the leading countries of the world had adopted compulsory sickness insurance.[39] Most of these plans had two goals in mind: First, to relieve poverty caused by sickness by distributing wage loss and medical bill; and second, to lower the social cost of illness by providing medical care and preventing monetary incentives for disease prevention.[40]

By the early 1900s the United States had begun to explore compulsory health insurance. In the late 1910s, as a precursor to the compulsory insurance debate, the majority of states had enacted some type of workers' compensation legislation that provided for wage continuation and comprehensive medical care in the event of an industrial accident or illness.[41] This new legislation altered the employer-employee relationship by placing financial liability for industrial accidents on the backs of employers. Prior to this legislation employees were held completely responsible for any injuries they incurred on the job. As a result of this legislation, the cost of injuries and illnesses sustained on the job were for the first time absorbed as the cost of doing business.[42] What's notable is the speed in which workers' compensation legislation expanded from state to state. How and why did this type of legislation spread so quickly? A coalition of interested parties consisting of labor, employers and insurers were able to agree that a workers' compensation insurance scheme was in the best interest of all parties: it protected the employer from lawsuits brought by injured employees; the

---

[39] Annual Conference of Secretaries of Constituent State Medical Association, 35.

[40] Ronald L. Numbers, "The Third Party: Health Insurance in America," in *Sickness & Health in America*, ed. Judith Walzer and Ronald Numbers (Madison: University of Wisconsin Press, 1997), 269-84.

[41] Initially, only a few states offered comprehensive medical care, but by the end of the war most states added a similar benefit.

[42] Nathan Sinia, Olin W. Anderson, and Melvin L. Dollar, *Health Insurance in the United States* (New York: Commonwealth Fund, 1946), 8.

injured employee received compensation for lost wage as well as medical treatment and; it created a new industry for insurers.[43]

As a result of workers' compensation legislation, many physicians got to experience compulsory medical care and the majority did not like what they saw. For instance, local practitioners were paid according to an arbitrary fee that was not necessarily aligned with their regular cost structure.[44] The primary issue, therefore, was their autonomy and income. That notwithstanding, workers' compensation legislation was passed in all states but organized medicine now how something to rally around.

The American Association for Labor Legislation (AALL), the group who led the successful drive for workers' compensation legislation spearheaded the drive for compulsory health insurance. Although the name may suggest otherwise, the AALL was founded in 1906 by a group of reform-minded citizens who had close ties with academia.[45] Although this group had experience lobbying state and federal legislatures, the group was comprised entirely of private individuals. They were not formed by any state or federal mandate and as such, did not have any authorization or directive. In 1912, the AALL appointed a committee, the Committee on Social Insurance, to prepare a model bill for introduction in state legislatures and by 1915 a tentative draft was complete. The AALL proposal had three primary components: Compulsory participation of all employed persons; voluntary participation from those who were self-employed and; an emphasis on illness prevention. The plan was financed jointly through employer and employee taxes as well as public funds and the bulk of the plan would be administered through employers.[46]

During this same period, the AMA formed a committee on social insurance to work with the AALL. The AMA's initial response to the AALL's plan both nationally and locally was quite positive and a couple of states approved compulsory health

---

[43] Price V. Fishback and Shawn Everett Kantor, *A Prelude to the Welfare State: The Origins of Workers' Compensation* (Chicago: University of Chicago Press, 2000), 136.

[44] Numbers, "The Third Party," 271.

[45] Ronald L. Numbers, *Almost Persuaded: American Physicians and Compulsory Health Insurance, 1912-1920* (Baltimore: Johns Hopkins University Press, 1978), 15.

[46] Field and Shapiro, 60.

insurance in principle. However, that welcoming response was short-lived.[47] First, the AMA committee that was formed to work on compulsory insurance was never sanctioned by the board of trustees or the House of Delegates. Once word spread that there was a committee promoting a national health insurance plan within the AMA, opponents from within and outside the organization publicly denounced their opposed to any type of compulsory health insurance. Second, once the opposition became formable, it became obvious that the AALL did not have a strategy or the money to wage a campaign to overcome this opposition.[48] As such, the AALL was not in a position to further this cause in either a private or public forum.

Why did the AMA so vehemently oppose compulsory healthcare? First, they felt that any type of compulsory insurance would hinder a patient's free choice of a physician.[49] This freedom of choice was the foundation of a free market enterprise for the private physician and wholeheartedly supported by the AMA. Second, the AMA was concerned about receiving payment, or some alternative form of payment from someone other than the patient. The fact that the payer could quite possibly be the government made matters even worst. Third, the AMA was concerned that the administration of such a compulsory health scheme would be made up of non-physicians and the AMA wanted to ensure that they would have majority representation. According to Numbers however, the chief objection to compulsory health insurance was the negative impact it would have on physician's incomes.[50] World War I (WWI) began in 1917 and the Committee on Social Insurance was suspended until the end of the war. Although the state medical societies continued to debate national healthcare, it was finally taken off the table at the 1920 annual AMA conference and a formal policy in opposition to compulsory insurance was entered into the record.[51]

Aside from lacking support from organized medicine, there are other reasons why the earliest compulsory health insurance movement failed. The first compulsory health insurance legislation was created by the Germans in 1883 and spread rapidly to other

---

[47] Anderson, *Health Services in the United States*, 71.
[48] Ibid., 72-73.
[49] Ibid., 73.
[50] Numbers, "The Third Party," 270.
[51] Anderson, *Health Services in the United States*, 75-76.

countries including Austria, Russia and The Netherlands.[52] As the United States entered into WWI there was significant anti-German sentiment.[53] Additionally, physicians who initially championed the compulsory debate were the same doctors who rejected it four years later and when the AMA formally abandoned compulsory health insurance physicians in general were advised that this approach was in their best interest.[54]

Opposition to compulsory healthcare also came from parties other than the AMA. Private insurance companies were the first to attack compulsory insurance on the grounds that it would take business away, even though they were not writing policies that covered health costs at the time. The insurance industry feared that any type of compulsory scheme would ultimately cover lost wages and burials, policies they did write. Opposition also came from the pharmaceutical companies who feared that the government would become a monopoly buyer of drugs. Retail druggists worried that they would have to compete with hospitals.[55] The most unexpected opposition came from Samuel Gompers, President of the American Federation of Labor (AFL). Gompers maintained that compulsory insurance would weaken the labor movement and unions by denying them the ability to bargain for and provide social welfare benefits for their members.[56] As a hard-line trade unionist, Gompers was suspicious of government involvement in health and welfare issues for the workers and urged a study of voluntary schemes.[57]

Although the first formal debate over compulsory health insurance came to an abrupt end when the United States entered WWI, it is worth noting that the AHA, unlike the AMA, did not oppose compulsory health insurance. In fact, the AHA regarded compulsory health insurance as inevitable and likened it to workers' compensation regulations. They did not however formally endorse the movement and remained

---

[52] Numbers, *Almost Pursuaded*, 10.

[53] Anderson, *Health Services in the United States*, 79. The AMA maintained their position against any type of government-sponsored health insurance until they acquiesced to Medicare.

[54] Numbers, "The Third Party," 271.

[55] Anderson, *Health Services in the United States*, 85-88.

[56] Sofea, 5.

[57] Anderson, *Health Services in the United States*, 74.

someone ambivalent on the issue. [58] In summary, the AALL's campaign never attracted a broad base of support outside of academics, reformers and a few state senators and representatives.[59]

Another remarkable observation of this first attempt to create a compulsory health insurance scheme is the absence of the federal government in the documented debate. Unlike current deliberations on the health-care crisis where politicians take center stage, private citizens spearheaded the effort and the AMA quashed theses first deliberations on compulsory healthcare.

The second organization to form in an attempt to legislate compulsory health insurance was the Committee on the Cost of Medical Care (CCMC). Similar to the AALL, the CCMC was comprised of a group of non-governmental men that felt that the unpredictable nature of sickness made it difficult for most families to afford the necessary care.[60] Between 1928 and 1932 the CCMC published over twenty-five reports concluding with a final piece that included both a majority and minority opinion.[61] In summary, the majority report recommended creating community health centers to meet the needs of families and to recognize that most people could not afford the cost of health care they recommended prepaid sickness insurance. The report was short on details, but, it noted that any insurance scheme should not be a commercial enterprise and that the government and the rich should subsidize the poor. The minority opinion opposed insurance in any form fearing that it would involve into a compulsory, government-directed program.[62] Continued opposition from organized medicine and a largely disinterested public rendered the report moot.[63] Playing a prominent role once again was organized medicine. Absent again from the debate were federal and state governments.

In the aftermath of the depression the government created the Committee on Economic Security (CES). Acknowledging the devastating effects of the depression and

---

[58] Ibid., 89.

[59] Jonathan Engel, *Doctors and Reformers: Discussion and Debate over Health Policy, 1925-1950* (Columbia: University of South Carolina Press, 2002), 13.

[60] Ibid., 20.

[61] Colin Gordon, *Dead on Arrival: The Politics of Health Care in Twentieth -Century America*, (Princeton, N.J.: Princeton University Press, 2004), 15.

[62] Engel, 40.

[63] Ibid., 52.

the inability of most to afford health care, the most contentious issue before it was sickness insurance.[64] The CES' preliminary recommendations called for a compulsory system of health care acknowledging and following in the steps of most European countries. The medical advisory board rejected the proposal in full and said the best policy would be to postpone any action on health insurance stating that the conditions that had produced programs abroad were vastly different than what was being experienced in the United States and that further study was needed. The board went on to say that the inability of poor people to gain access to health care was really one of ignorance.[65] Thus, the Social Security Act of 1935, one of the hallmarks of the New Deal was passed without mention of any type of health insurance, save some grants to states for public health efforts.[66]

The government's first few attempt at wrangling with how to get health care to those who did not have access failed on many levels. First, like the private initiatives that preceded the CES, organized medicine was better prepared than the committees that were organized to development recommendations, and they successfully launched attacks against the government's recommendations. There is also documentation to suggest that the CES never felt adequately prepared to really tackle the issue and instead spent the majority of its time and energy moderating the fears of organize medicine.[67] Furthermore, the CES did not have the support from any one constituency: neither the general public nor labor leaders rallied to the call and the hospitals, despite statistics to the contrary, were content with the status quo.[68]

The Great Depression and World War II

In the 1920s and 1930s, as medical care improved it also became more expensive and thus, the cost of obtaining such care became a concern for most Americans except the very wealthy.[69] Some writers on the topic of third party health insurance attribute its

[64] Ibid., 70.
[65] Ibid., 89.
[66] Ibid., 93.
[67] Gordon, 17.
[68] Engel, 94-95.
[69] Ibid., 4

origins to the Great Depression which began in 1929, and lasted throughout most of the 1930s. During the depression hospital income from endowments and contributions decreased by nearly two-thirds while charity cases increased four-fold.[70] While the depression alone significantly reduced the income of hospitals, other factors were important in setting the stage for private health insurance. At the same time occupancy rates were declining, major advances were being made in health care such as antibiotics, modern surgery and anesthesia. These advances required more money than hospitals were able to earn or raise through donations and expenditures rose accordingly.[71] The need for additional capital to pay for new technologies coupled with the economic downturn and eventual depression put hospitals in a precarious situation. In the late 1920s hospital care became more expensive, but fewer people were able to pay their entire bill because of the downturn in the economy. Anderson maintains however, that health insurance was inevitable because hospitals operated better with a steady source of income and families could better meet the rising costs of medical care if their risks were spread.[72] As such, the Great Depression merely accelerated the third party payer system because the hospitals that were impacted financially were receptive to alternative means of accepting payment. If hospitals (and ostensibly, the doctors who worked there) were willing to entertain insurance payments how then did insurance penetrate the workplace? After all, in the 1940s, the loss of wages due to sickness was of more concern than the cost of care.[73]

The growth in employer-based health insurance in the 1940s can partly be attributed to World War II and the associated legislative actions that were taken to control prices and labor markets. Prior to WWII labor unions did not present a unified voice on health insurance–whether private or compulsory. For example, William Green, president of the American Federation of Labor (AFL) articulated that compulsory health insurance was in the best interest of the worker. Others, such as the International Ladies Garment Workers' Union (ILGWU) recognized that their members could not afford to purchase

---

[70] Numbers, "The Third Party," 272.

[71] Sephen Cha, "The Development of Health Insurance," *Medicine and Health/Rhode Island* 83 (September 2000): 269.

[72] Anderson, *Blue Cross since 1929*, 16.

[73] Engel, 71.

health care in the open market and they created their own health-care plans. By 1938, one hundred and twenty-two thousand garment workers were afforded care for anywhere between fifty cents and one dollar. The United Auto Workers Union (UAW) only offered their members acute hospital care.[74] Thus, the representatives of organized labor could not further an agenda because they could not agree upon one.

In the late 1930s and early 1940s, most employers did not view health care as compatible with either welfare capitalism or payroll-based social security that was recently legislated through the National Labor Relations Act or the Social Security Act.[75] As such, in the minds of most employers at this time there was no compelling reason to offer health insurance benefits to employees. As WWII proceeded and the United States experienced labor shortages, the federal government imposed federal wage restrictions that significantly changed the employer-employee relationship. To minimize disruptions caused by employee turnover, the National War Labor Board suspended conventional bargaining and implemented wage freezes. In 1942, the National War Labor Board approved wage increases in the form of non-wage benefits.[76] Therefore, health benefits became a way of working around wage freezes and by the end of the war health care for employees had tripled.[77] To further persuade employers to offer health benefits, the National Labor Relations Board and the Supreme Court ruled that employer contributions to benefit plans were considered wages and were therefore a negotiable item in collective bargaining agreements.[78] Through a combination of government regulations, the inability or inaction of the government to articulate a cohesive compulsory plan, and the success of employer-based and union-operated plans, union enthusiasm for a mandated plan waned. The war driven economy had the unexpected result of generating a market for employer-based health insurance. Most employees were extremely satisfied with this arrangement that provided them protection from both illness and bankruptcy.[79]

---

[74] Ibid., 126-28.
[75] Gordon, 55.
[76] Anderson, *Blue Cross since 1929*, 45.
[77] Field and Shapiro, 70.
[78] Anderson, *Blue Cross since 1929*, 45.
[79] Engel, 203.

Although the early employer-based plan lacked any real actuarial basis and terms and conditions varied widely from one employment group to another, by the end of the 1940s nearly half of the population claimed to have some type of coverage although it was primarily limited to hospitalization. Only 3 percent of the population had comprehensive coverage and that was primarily in the form of prepaid services clinics that were limited to a specific geographical location. Employers recognized early on that premium sharing by employees ensured that the plan would not be overused, but since insurers required a minimal participation level in order to insure the group, 75-80 percent of the employers paid the entire premium to avoid not getting coverage. Paying the entire premium also gave companies some security that they had some control over the plan.[80]

To a large extent the United States accidentally stumbled upon employer-based health insurance. What if we never entered into a depression? If the hospitals were not experiencing cash flow problems would they have been as receptive to enter into insurance arrangements? After all, Kimball designed the first plan primarily to stabilize the operating income of Baylor Hospital and secondarily to help teachers with their hospital bills. Similarly there is no evidence to suggest that the War Board sought to include benefits as non-taxable wages in an effort to afford more employees coverage. On the contrary, the spread of employer-based health insurance was market driven in an effort to retain employees during a labor shortage. These unexpected events created the enterprise as we now know it. In 1948, the Brookings Institute, a moderately liberal think tank endorsed this voluntary system giving it a new level of legitimacy. And what about those who were not afforded employer-based insurance? The Institute said that problems of the poor should be handled by the government and charity but that the current system was working for the employed.[81]

The Nature and Growth of Employer-Based Health Insurance: 1950s to Present

By 1950, Blue Cross has forty million subscribers[82] and by 1958 approximately three-quarters of the one hundred and twenty-three million Americans with private health

[80] Gordon, 70.
[81] Engel, 279.
[82] Ibid., 45

insurance were covered through their employers. Of this one hundred and twenty-three million, about thirty-six million were covered through collective bargaining agreements. In 1954, the federal government clarified that employer contributions were generally tax deductible as a business expense and were to be excluded them from the taxable income of employees.[83] Thus, the government provided employers with an additional tax impetus to offer health insurance in the form of tax relief. In 1959, Congress passed a bill giving civil servants and the nation's largest group of employee's access to Blue Cross and Blue Shield coverage.[84] By 1960 there were seventy-nine Blue Cross plans, sixty-five Blue Shield plans, two hundred and fifty to three hundred prepaid group practices and over two hundred commercial insurance companies who were selling various policies.[85] Hence, by the end of the 1950s, having health insurance through one's work place was the norm. The proliferation of commercial products however, drastically changed the face of employer-based insurance.

In the 1950s and early 1960s, most cost concerns were overshadowed by society's desire to expand health care and improve outcomes by engaging in research. Two tools were utilized to contain costs during this period. The first was to transfer some of the liability to consumers in the form of premium sharing and deductions, and the other was to discourage patient demand for care by also shifting the cost of the first dollars used to the consumer.[86] By in large, neither the cost of providing insurance nor the expense of utilizing insurance was a great concern of either employers or employees.

Blue Cross plans, partly because of their non-profit status which brought them a degree of integrity and party because they were the first health insurance programs to be marketed nation-wide, covered the vast majority of employees through the 1950s. The early plans were fairly simple straight forward in that they provided subscribers with a benefit in the form of services that were guaranteed by the hospital rather than a cash payment. Furthermore, all hospitals were assured adequate payments so that quality would not be jeopardized.[87] Therefore, if a policy holder was hospitalized, Blue Cross

[83] Field and Shapiro, 70.
[84] Anderson, *Blue Cross since 1929*, 74.
[85] Field and Shapiro, 71.
[86] Ibid., 74.
[87] Ibid., 68.

made the payment directly to the hospital. Blue Shield plans that reimbursed physicians operated in a similar manner and were marketed along side Blue Cross plans. The other unique feature of the Blue Cross plans were how they spread risk among subscribers. The centrality of any insurance plan is to manage risk across a pool so that those who use the insurance in a group are supplemented by those who do not utilize the medical care. At its inception, the Blue Cross plans elected to charge all members of a group the same amount. This became known as community rating.[88] Thus, all workers in any given community were charged the same premium regardless of their occupation, their average age or their past utilization of health care. As commercial insurers recognized that there was a demand for health insurance they entered the market, but used tools from their other services such as life insurance and took a different approach to how it marketed its product to employers. First, the commercial insurers sought to base premiums on an employer's utilization or past claims experience, the specific demographics of the employer group, as well as the occupation that they were engaged in, and largely ignored the larger community. This is known as experience rating and medical underwriting and is a means of reducing premiums for healthy groups while increasing premiums for older and unhealthy group.[89] Second, commercial insurance places a greater emphasis on consumer or employee cost sharing in the form of deductibles.[90] By imposing up front costs, the insurance company is spared the burden of processing every claim and consumers are subtlety dissuaded from using the insurance. Third, commercial insurance is indemnity based meaning that subscribers are reimbursed for their outlays. By doing this the insurance companies avoid having to negotiate rate schedules with providers. Into the early 1950s, commercial insurance typically covered hospitalization, surgical reimbursements based on a fee schedule and a range of flat allowances for maternal care and out-of-pocket services. The insurers were reluctant to insure anything but hospitalization and increasingly used experience rating as a means to guard against adverse selection and cherry pick good risks.[91] Thus, a mechanism was put into position that placed older employee groups and those engaged in hazardous occupations at a

[88] Anderson, *Blue Cross since 1929*, 44.
[89] Field and Shapiro, 72-74.
[90] Ibid., 72.
[91] Gordon, 73.

disadvantage for purchasing insurance. However, since commercial insurance offered more flexibility in plan design and the opportunity for lower premiums, they surpassed the Blues in the early 1950s and by the 1960s most Blues dropped the practice of community rating.[92]

By 1960, nearly 70 percent of all full-time workers received benefits from their employers. Personal wealth was no longer a factor in the consumption of health care and the cost of health care was no longer a concern or burden for the millions of Americans who had coverage.[93] Despite the successes of employer-based there was one group in particular did not benefit from this system. Unless an employer offered retiree health benefits, workers who left employment in their sixties did not have any type of health coverage. The passage of Medicare in 1965 alleviated this situation but also created a huge market for health-care providers. Up until this time the federal government was only nominally involved in employer-based health insurance through laws they passed on collective bargaining and taxation. With the enactment of Medicare, the government now how to concern itself with the intricacies of plan design, risk management and spending levels.[94]

As one group of Americans became entitled to health care another group was adversely impacted by the shift in the United States economy. The deindustrialization of the late 1960s slowed the growth of employer-based health insurance. As the economy shifted from high-wage, high benefit, industrial employment to a low-wage, no-benefit service economy, the wisdom of voluntary employment-based health insurance market was seriously questioned. At the same time there was remarkable inflation which provided employers with a rare opportunity to rethink what their role should be in the health insurance marketplace.[95]

The cost of insurance rose through the late 1950s and early 1960s and settled into a pattern of double digit inflation by 1964. This phenomenon was aided by how payment to doctors and hospitals were then structured. In order to appease the medical community which always had a tenuous relationship with the insurance community, underwriters

[92] Ibid., 75.
[93] Engel, 313.
[94] Field and Shapiro, 79-82.
[95] Gordon, 83.

used the "usual, customary and reasonable" system of billing. This ensured that doctors could remain autonomous agents and was a compromise between a rigid rate schedule and a blank check.[96] However, as fees continued to rise, so did the liability of the insurance companies who then passed the cost on to employers.

Private health spending ran steadily over inflation growing an average of 10 percent a year between 1968 and 1998. Between 1965 and 1990, health-care spending ballooned from 6 percent of the gross domestic product (GDP) to 15 percent of the GDP and the amount being spent by businesses continued to grow in the same manner. After 1965, and the enactment of Medicare and Medicaid, health politics revolved less about expanding employer-based health insurance and more about the ability to slow medical spending.[97] Through the 1980s and early 1990s, the rate of coverage for civilian workers went from 61 percent to 54 percent and for low-wage workers that rate fell from 30 percent to 14 percent. By one estimate, every one-hundred jobs lost in manufacturing resulted in a net loss of two hundred and twenty-four covered persons. Conversely, for every one hundred service jobs created, forty persons received health insurance coverage.[98] Thus, the transformation from an industrial economy to a service economy had a significant impact on the number of people who were afforded health insurance coverage. These statistics will be reviewed in more detail in Chapter 3 of this paper.

As the cost of health insurance rose employers found themselves in the position of having to take a greater role in the management and design of this benefit. The most significant move to control costs was the introduction and subsequent popularity of Health Maintenance Organizations (HMOs) and other managed care options.[99] HMOs gave employers and insurers alike greater control over health costs and patterns of utilization by designing in measures that promoted primary and preventative care and discouraged and in some cases penalized the utilization of specialists. By the late 1990s enrollment in HMOs swelled to over 85 percent of all covered employees and growth in spending slowed from 12 percent in the 1980s to 5 percent in the 1990s.[100] However, the

[96] Ibid., 84.
[97] Ibid., 243.
[98] Ibid., 85-91.
[99] Ibid., 87.
[100] Ibid., 88.

slowing in health spending could not be sustained in the long run. First, consumers rebelled against the strict constraints that were imposed upon them and as a result, these limitations slowly eroded. Second, the majority of HMOs provided consumers with very low copayments and as a result utilization increased, rising costs.

Summary

As we enter the twenty-first century, employment-based health insurance provides coverage for one hundred and sixty million Americans, reaching nearly three out of five non-elderly. The number of organizations, both public and private offering health insurance has dropped from 69 percent in 2000 to 60 percent in 2005, driven primarily by a significant decline in the number of small firms (less than two hundred workers) offering coverage. At the same time premiums, deductibles and copayments continue to rise and the take-up rate (the number of employees who sign up for the benefits) continues to decline all pointing to a system that is failing.[101]

What has the history of employment-based insurance taught us? First, up until the enactment of Medicare and Medicaid in 1965, the government played a very minor role in personal health services. This enabled health plans to develop without the input or cooperation of the local, state and/or federal government. Had the government played a larger role in healthcare financing, the need for insurance may have never existed.

Group hospital insurance as we know it today developed and thrived as a result of a number of factors converging at the right time. It developed as a response to the growing cost concerns of the hospital in the late 1920s: costs were increasing as a result of new medical technologies and revenues were declining as a result of a downturn in the economy. It was created for a class of people who worked, but who could not afford this type of care. Insurance developed the way it did because of our democratic process and our libertarian nature: there was minimal governmental involvement. It was a natural and incremental response to the family financial problems caused by rising medical costs without government intervention. In Anderson's words, it was both a conservative and

[101] Kaiser Family Foundation, "Employer Health Benefits 2005 Annual Survey," http://www.kff.org/insurance/7315/index.cfm (accessed May 24, 2006).

innovative movement.[102] Conservative in that it was a fully private effort. Innovative in that it was a private effort stemmed at solving a social issue. It was truly American because it encompassed the values of self-determination and self-help with only minimal government intervention.

And how did this enterprise become a benefit that is now expected by most employees? Was it the fact that Robert Kimball had access to information from the teachers he once supervised and his social experiment worked or was it the nature of the insurance that required risk to be bourn by a group rather than individuals? Both the actions of the War Board as well as subsequent taxation legislation enabled the industry to prosper and grow. Without such legislature, especially that allowing employers to deduct the cost of wages from taxable income, it is doubtful that the industry would have thrived. However, as the following section will reveal, this privately based system is covering fewer and fewer people at a greater and greater cost ultimately leading to its demise. In one author's view,

> Employment-based health insurance, floated as an alternative to public insurance in the middle years of the [twentieth] century, is now more like a leaky life raft for politicians clinging to budget-neutral solutions and workers with nowhere else to swim.[103]

[102] Anderson, *Blue Cross since 1929*, 20.
[103] Gordon, 299.

CHAPTER 3: How and Why Employer-Based Health Insurance is Failing

As outlined in Chapter 2 of this paper, employer-based health insurance became the backbone of the United States health-care system in the 1940s. In many respects the history of its development is a portrayal of the American way whereby an economic tool was developed to aid a fledging hospital industry. Neither federal nor state governments were involved in the creation of employer-based health insurance yet subsequent federal legislation enabled its rabid expansion. Employer-based health insurance has never reached every American, let alone every American worker. The inability or unwillingness to pass comprehensive health-care legislation aside, this was never seen as overly problematic until our economy shifted from a manufacturing to a service industry. Once the transition in the economy began, fewer and fewer employers offered health insurance benefits and for those companies who continued to offer it, the price of coverage was frequently too expensive for employees. The following section will examine the weaknesses in the present system and present available statistics to illustrate how this benefit and hence, the system is failing. It will evaluate the number and types of employers who offer health insurance benefits, the types of benefits that are being offered, the cost to employees of enrolling in these benefits and the number and types of employees who are routinely excluded from the system. Moreover, it will illustrate the limited options that are available outside the employer-based system and demonstrate the inadequacies of this system.

The following statistics were reported in the most recent Kaiser Family Foundation survey, "Health Insurance Coverage in America": The number of non-elderly who are uninsured increased for the forth consecutive year by eight hundred thousand to forty-five and one-half million in 2004. That equates to one out of every five adults under sixty-five or, 21 percent of the adult population. This number grew from 17.9 percent in 2000. Next, as it relates to employer-based health insurance, over 80 percent of the uninsured come from working families: 70 percent of these households have at least one full-time worker and 13 percent have at least one part-time worker. Over twenty-seven million workers are uninsured. Out of this group of working

uninsured, 77 percent (almost twenty-one million) work full-time and 49 percent are either self-employed or work for a small business that employs less than twenty-five employees. 56 percent of this group earns less than twenty thousand dollars a year. Kaiser concluded this study by stating that the growth in the uninsured has been driven by declines in employer-based insurance.[104] These statistics begin to illustrate the inadequacies of the current employment-based system. Moreover, when we talk about the uninsured, we typically think about the unemployed and downtrodden, and because of our system of insurance, we don't think about the group who is working.

Voluntary Nature

The voluntary nature of employer-based health insurance automatically imposes barrier to obtaining it. Since the system is based on a combination of employer good-will, union bargaining and economic labor conditions, employees are not guaranteed that their employer will offer the benefit nor is there any guarantee that the benefit will remain at the same level for the same price. As mentioned above, employer-based health insurance has never reached every employee and few efforts (with varying levels of success) have been made to mandate that employers offer the benefit. As a result, people are naturally excluded from the system. However, there have been some trends over the years that make the voluntary system more problematic than in the past. First, high wage earners are more likely to be afforded health insurance than low wage earners. One study cites that only 20 percent of American families earning in 20 percent of the income spectrum have employer-based coverage versus 84 percent in the top.[105] A 2004 Kaiser survey revealed that 86 percent of employees earning at or above 400 percent of the federal poverty level (FPL)[106] had employer-based health insurance and as income dropped so did the percentage of employees who had coverage.[107] Thus, people working in lower wage jobs are over four times less likely to be offered health benefits than those

[104] Kaiser Family Foundation, "Health Insurance in America: 2004 Data Update."

[105] Elise Gould, "The Chronic Problem of Declining Health Coverage: Employer-Provided Health Insurance Falls for Third Consecutive Year" (New York: Economic Policy Institute 2004). http://www.epinet.org/content.cfm/issuebrief202 (accessed March 30, 2006).

[106] In 2004 the FPL was $19,307 for a family of four. To illustrate, 400 percent of the FPL equals $77,228; 300 percent equals $51,921 and; 200 percent equals $38,614.

[107] Kaiser Family Foundation, "Health Insurance in America: 2004 Data Update."

working in higher wage jobs. Likewise, statistically speaking, those working in blue collar occupations are less likely to have health insurance and almost two-thirds of working adults under the age of sixty-five hold blue collar jobs. Of the one and forty-three million people who work, 37 percent (52.9 million) of the population holds white collar jobs yet only 19 percent of this population is uninsured whereas 63 percent (90 million) of the population works in a blue collar capacity yet 81 percent are uninsured. The definition of blue collar has expanded to include people who work in clerical positions and in retail.[108] Accordingly, people working in the vast majority of jobs in the United States are not afforded health insurance because it is not required of U.S. employers. Moreover, this statistic is in itself misleading because it fails to give all the details. For example Wal-Mart, the nations largest company based on Fortune magazine's annual list of the Fortune 500 in 2005, advertises that it provides its associates or blue-collar workers with health benefits. Upon closer examination however, Wal-Mart has a six month wait period for new blue collar employees and the coverage they offer does not cover flu shots, childhood vaccinations or preventative health-care.[109] Although Mal-Mart claims to offer benefits, the statistics reported do not evaluate the adequacy of the benefit. At Wal-Mart, with a few exceptions employees are subject to a one thousand dollar deductible before benefits are paid and for family coverage that deductible increases to three thousand dollars.[110] Consequently, even though you may have health insurance as a Wal-Mart employee, if you have family coverage you must pay the first three thousand dollars in health-care costs before your benefits take affect. In fact, Wal-Mart's coverage is so marginal that researchers at the University of California-Berkeley's Center for Labor Research and Education found that 27 percent of children of employees there are enrolled in Medicaid CHIPs compared to the average of 22 percent for the retail industry.[111]

---

[108] Ibid.

[109] MSNBC, "Wal-Mart Changes Some Healthcare Benefits," April 17, 2006, http://msnbc.msn.com/id/12357363/ (accessed May 14, 2006).

[110] Employees can see a doctor up to three times and can get three prescription drug fills with a twenty dollar copayment before the deductible must be met.

[111] Walmart Watch, "The Mighty Pen," http://walmartwatch.com/blog/archives/the_mighty_penn/ (accessed June 5, 2006).

Similarly, just as lower wage earners are negatively impacted by our current system so too are non-standard employees. There has been an increase in the number of workers in non-standard jobs over the years. A non-standard employee is defined as someone who works part-time or less than thirty-five hours a week or in a temporary or contract capacity. Non-standard workers make-up about 25 percent of the U.S. work force or 34.4 million people. The largest group of non-standard workers are those who work part-time. This group of 18.3 million people comprised 13.3 percent of the total work force in 2001 and the number is forecast to increase. However, only 21 percent of non-standard employees have insurance through their jobs. Whereas about 87 percent of the regular full-time work force is offered health insurance, only 40 percent of non-standard workers are offered the benefit.[112] Furthermore, the take-up rate for non-standard employees is 54 percent vs. 85 percent for regular workers. The take-up rate for this group is low because they either have other health insurance coverage or the coverage they are being offered is too expensive. The rate of uninsurance for this group may be even higher because one investigation revealed that many in this group report that they have insurance when in fact their employer has merely given them a discount card affording them care at a lower rate, but not insurance. In a 2003 survey of employers, about 54 percent of the companies reported that only full-time workers were eligible for health benefits. Wal-Mart for example recently revised its policy for part-time associates by reducing the waiting time for enrollment from two years to one year. Thus, if you are a part-time employee at Wal-Mart, you are afforded health benefits,

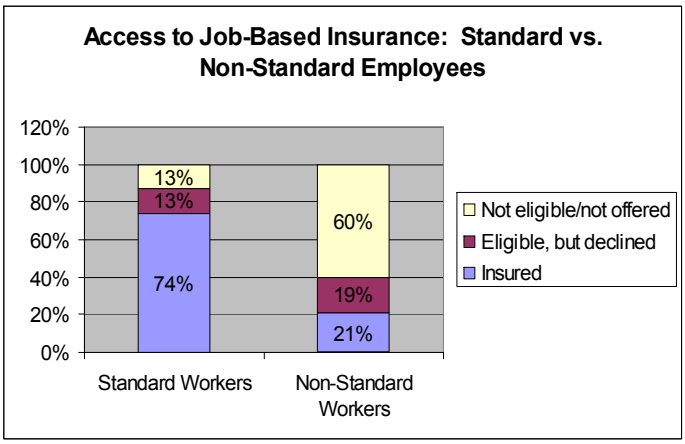

Table 3. Access to Job Based Insurance: Standard versus Non-Standard Employees

[112] Elaine Ditsler, Peter Fisher, and Colin Gordon, "On the Fringe: The Substandard Benefits of Workers in Part-Time, Temporary, and Contract Jobs," (New York: Commonwealth Fund, 2005), http://www.cmwf.org/usr_doc/879_Ditsler_on_the_fringe_substandard_benefits.pdf (accessed May 1, 2006).

but only after working there for one year. Once you have been on the payroll for a year, you can enroll in the benefit program outlined above with a one thousand dollar or three thousand dollar deductible. The U.S. Census confirmed the adverse impact the system has on non-standard employees reporting that over 37 percent of employees not having insurance were not eligible to participate in the employer's plan primarily because they were temporary, part-time or hadn't completed the probationary period. 46 percent of these chose not to enroll because they have coverage else where or coverage was too expensive.[113]

The second predicament with the current system is similar to the first. Even if an employer offers health insurance, the employee does not have to participate or "take up" the employer's offer. Thus while fewer employers are offering health insurance, a declining number of employees are taking up the benefit. For example, in 1988, eighty-eight percent of all employees who were eligible for coverage took it up compared to 85 percent in 2001. One out of every seven workers declined health benefits.[114] Another study shows take-up rates declining even more substantially falling from 81 percent in 1977 to 80 percent in 1996.[115] Although many who turn it down do so because they receive coverage elsewhere, usually from a spouse, the predominant reason given for turning down the benefit is cost.[116] Thus, it is reasonable to assume that as costs continue to increase, take-up rates will continue to decline resulting in greater numbers of non-standard employees with out health insurance.

The cost of providing employee health insurance has risen significantly and employers are continuing to pass these increases on to employees in the form of higher premiums, higher deductibles, higher copayment, fewer benefits and other barriers such as waiting periods. A 2002 Commonwealth Fund Issue Brief reported the following: Two out of five adults with employer-based coverage paid more for their premiums or

---

[113] Carmen DeNavas-Walt, Bernadette D. Proctor, and Cheryl Hill Lee, "Income Poverty, and Health Insuance Coverage in the United States: 2004," (Washington,: D.C.: U.S. Census Bureau, 2005). http://www.census.gov/prod/2005pubs/p60-229.pdf (accessed May 2, 2006).

[114] David M. Cutler, *Employee Costs and the Decline in Health Insurance Coverage* (Cambridge, Mass.: National Bureau of Economic Research, 2002), 8-9.

[115] Gould, 2.

[116] Cutler,11.

received reduced benefits; one-quarter reported a large increase in premiums and one out of six experienced both an increase in cost-sharing and an increase in premiums.[117] Consider the following chart that details the rise in premiums in comparison to the rise in both inflation and wage:

Growth in Premiums versus Wages and Earnings									
Health Insurance Premiums	18.0%	14.0%	8.5%	5.3%	8.2%	10.9%	12.9%	13.9%	11.2%
Overall Inflation	5.1%	4.7%	3.2%	2.3%	3.1%	3.3%	1.6%	3.5%	2.3%t
Workers' Earnings	4.2 %	3.9 %	2.5%	3.6%	3.9%	4.0%	2.6%t	2.7%t	2.2%

Table 4 . Growth in Premiums versus Wages and Earnings

In 2004, the average premium paid by employees for single coverage was six hundred and ten dollars for single coverage and two thousand seven hundred and thirteen dollars for family coverage. Since 1988, the premium for single coverage has increased 537 percent. Family coverage has increased 335 percent for the same period of time.[118] Accordingly, employees must determine whether they can afford to have this premium deducted from their paycheck. Consider the following example: Employee A works as laborer earning seven-fifty an hour or one thousand two hundred and nine-eight dollars per month. His company gives its employees one option for health insurance at a cost of sixty dollars per month for single coverage and two hundred and seventy-five dollars per month for family coverage. This employee must determine whether he can afford insurance after first covering his current bills such as rent, utilities and food. For many low wage earners, health insurance is luxury that is not affordable. Thus, it is not surprising that low-wage earners have reduced take-up rates as compared to higher wage earners. However, even if the employee is able to afford the insurance they must be able to pay the higher deductible and copayments.

[117] Jennifer W. Edwards, Michelle M. Doty, and Cathy Schoen, "The Erosion of Employer-based Health Coverage and the Threat to Workers' Health Care: Finding from the Commonwealth Fund 2002 Workplace Health Insurance Survey" (New York: Commonwealth Fund, 2002), http://www.cmwf.org/usr_doc/edwards_erosion.pdf p2 (accessed March 8, 2006).

[118] Kaiser Family Foundation, "Employer Health Benefits 2005 Annual Survey."

Average annual deductibles and copayments have continued to increase as employers continue to find ways to pass additional costs on to employees. Deductibles, the amount that must be paid before some or all benefits go into effect have increased on average, 269 percent between 1988 and 2005 for single coverage in conventional plans; by 71 percent for HMOs and by 328 percent for PPOs. For family coverage the increase for this same time period has been 217 percent, 141 percent, and 679 percent respectively. The average PPO or HMO plan for example did not have a deductible in 1988. However, as costs continued to increase, employees now have to pay up to six hundred dollars before they are reimbursed for any health-care costs.[119] Thus, employees are now responsible for paying greater monthly premiums and deductibles.

In addition to premium increases and a growth in deductibles, copayment for physician visits and prescription drugs continues to escalate. In 1996, 83 percent of all employees enrolled in an HMO paid between five dollars and ten dollars to see a primary care physician. By 2005, 61 percent of enrollees were paying a copayment of between fifteen dollars and twenty dollars. Similarly, as the cost of prescription drugs continue to escalate, employers are using tiered cost-sharing arrangements to encourage the use of generic drugs and discourage the use of higher cost prescriptions. Tiered cost-sharing has grown from 27 percent of all employees in 2000, to 70 percent in 2005. Between 2000 and 2005, the average copayment for preferred drugs increased 69 percent from thirteen dollars per prescription to twenty-two dollars and the copayment for nonpreferred drugs has increased 106 percent from seventeen dollars to thirty-five dollars. Some plans ever have four tiers that require up to a seventy-five dollar copayment for certain prescriptions.[120] What do these figures illustrate? As the price of health insurance increases, employees are being asked to absorb these costs in the form of higher premiums, higher deductibles and higher copayment. Although studies have revealed that higher costs in general result in lower take-up rates, there is no data detailing if the higher rates pertain to only the premiums or the entire package. Surveys have revealed however, that almost half of all employees are cognizant of the higher premiums and/or

[119] Kaiser Family Foundation, "Employer Health Benefits 2004 Annual Survey," http://www.kff.org/insurance/7148/upload/2004-Employer-Health-Benefits-Survey-Full-Report.pdf (accessed March 8, 2006).

[120] Kaiser Family Foundation, "Employer Health Benefits 2005 Annual Survey."

cutback in benefits and in general, are concerned about whether they will continue to have similar coverage in the future.[121]

In addition to deciding whether to offer benefits, determining what type of benefits to offer and how much employees should share in the cost, and choosing what types of employees are eligible for coverage; employers also have the opportunity to place other restrictions on access to benefits. For example, only one in three employees has coverage that starts immediately upon employment. 11 percent of employees at companies offering plans face waiting times of four month or more. In general to avoid administrative costs associated with offering health care, smaller firms have greater waiting periods than larger firms.[122] However, as we saw above, Wal-Mart, the nation's largest employer requires a waiting time of six months for full-time associates and one-year for part-time workers. Thus, even though a firm advertises that they offer health insurance, a certain number of employees will never qualify because of waiting times.

The voluntary nature of nature of our current system adversely impacts low wage earners, non-standard employees, those working for smaller employers and those employed in blue collar occupations. Regrettably, the majority of the U.S. work force falls into one of these categories. Legislative mandates requiring employers to offer health insurance have largely failed. To date, Hawaii is the only state to successfully enact employee mandates. Employer mandates were important components of the last two efforts to establish national health insurance under the Nixon and Clinton administrations and mandates in Massachusetts and Washington were repealed due to declining support for the measure. Proponents view it as the most efficient way (without government intervention) to get more people covered. Opponents suggest that it will burden the system by raising the cost of premiums and could adversely impact wages and employment levels.[123] Thus while the voluntary nature of our health-care system affords employers a level of flexibility in what is offered, how much burden is to be shouldered

---

[121] Edwards, Doty, and Schoen, 5.

[122] Jon Gabel, Jeremy D. Pickreign, Heidi H. Whitmore, and Cathy Schoen. "Study Highlights Employer Policies that Deter Health Plan Enrollment" *Health Affairs* 20 (July/August 2001): 196-201.

[123] Claudia L. Schur, Marc L. Berk, and Jill M. Yegian, "Workers' Perspectives on Mandated Employer Health Insurance" *Health Affairs Web Exclusive* 12 (March 17, 2004): W4-130.

by each of the parties and which employees are included and excluded from the plan, by its vary nature it excludes a large portion of the work force and those who do not work.

Lack of Portability

Since health insurance is directly tied to employment, periods of high unemployment significantly impact the rate of insurance coverage. With very few exceptions, (i.e. retiree benefits), when an employee leaves a job he or she forfeits the benefits that came with that job. Thus, when employment ends so does one's health insurance. In an attempt to minimize the disruption caused by leaving a job and the benefits that went with it, in 1985, Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA). COBRA requires employers with twenty or more employees who offer health benefits to continue coverage to their former employees (and dependents) for up to eighteen months or until they can obtain alternative coverage.[124] The price of said coverage is to be borne completely by the former employee plus up to 2 percent for administrative fees. The concept is sound in that Congress legislated a mechanism where by an unemployed person can continue to receive health insurance benefits from his former employer. However, in a 2002 survey, the Commonwealth Fund found that only one in four people would be very likely to continue their health insurance coverage through COBRA if they became unemployed, and cost was cited as the main reason.[125] Thus, even though Congress sought to minimize the impact that unemployment has on health benefits it has been largely ill-conceived and cost prohibitive. Moreover, this same survey confirmed that higher wage employees were more likely to continue their benefits through COBRA than lower wage earners. However, 47 percent of all wage earners stated that they were not too likely or not likely at all to enroll in COBRA. When asked if they would continue coverage if COBRA was subsidized only 16 percent of all respondents reported that they would not likely enroll in the benefit.[126] Additionally, employers with fewer than 20 employees escape the requirements of

[124] Field and Shapiro, 85.
[125] Edwards, Doty, and Schoen, 4.
[126] Ibid.

COBRA so cost notwithstanding, many people who leave small companies are not even afford the opportunity to continue their group coverage.

In an attempt to address some of these deficiencies in 1996, Congress passed The Health Insurance Portability and Accountability Act (HIPAA). HIPAA in part, requires insurers to proved individual coverage to workers who leave their jobs and places limits on pre-existing conditions, but it does not limit the premiums that are charged, which for many are too expensive. Moreover, thirty-seven states allow individual insurers to deny coverage to certain applicants.[127] Thus, this continued lack of portability induces many employees to remain in their positions solely to retain their insurance benefits. The impact of "job lock" is not a subject of this paper, but it can cause stress, lost productivity and lost creativity. Although the federal government has acknowledged the problems that are associated with tying benefits to employment by passing legislation, the fact remains that continuing group coverage through COBRA or purchasing an individual policy in the market remains cost prohibitive for many people. Thus, an employee assumes a certain level of risk if and when they find themselves without a job and without health insurance.

Limited Options Outside of System

What are the options for obtaining coverage if your employer does not offer health insurance benefits? What do you do if you are laid off from your position at the age of sixty-two and your employer does not provide retiree health benefits? Or, what if your employer offers benefits, but the cost to cover your family is cost prohibitive? In all of these scenarios, your choices are limited in part because of the way insurance markets operate. As outlined in section 1 of this paper, employer-based health insurance was created and is sustained through the pooling of risk. The more people you can include in a pool the greater the ability for them to share in the cost illness. Insurance companies are commercial enterprises seeking to make a profit. As such, they look to create pools of people whose health is on average, better than the total population and discourage or

[127] Sharon Silow-Carroll, Todd Kutyla, and Jack A. Meyer, "The State of Employment-based Health-care and Business Attitudes about Its Future" (Washington, D.C.: Economic and Social Research Institute, 2001) http://www.esresearch.org/Documents/Busattitudes2001.pdf p.31 (accessed March 8, 2006).

charge higher rates to those who are in worse health than the average person. The most effective and efficient way for insurance companies to pool risk is to provide coverage to already formed groups of people such as employers. The larger the pool, the more the risk is spread. Conversely, smaller pools are not as able to absorb serious illnesses experience by one of their members. Thus, smaller employers frequently pay higher premiums for similar coverage because there are fewer employees in the pool. With few exceptions, if someone's employer does not offer health insurance their only option is to seek an individual policy in the open market. However, since the policy is based solely on one's own medical history and age, (or the age and medical history of the family), the price and package that is available varies significantly and in many instances is not adequate or is cost prohibitive. For a young, health person, individual coverage is somewhat affordable and available. For example, in 2001, individual coverage for a single person was one thousand six hundred and forty-four dollars a year. That same policy cost three thousand four hundred and eighty dollars for a healthy fifty-year old and five thousand six hundred and eighty-eight dollars for a sixty-year old.[128] If the person seeking insurance in the open market has a pre-existing condition, the insurance company can deny coverage altogether, provide it but limit coverage (known as an exclusionary rider), or charge more to off-set the risk. To address the issue of affordability, the person could enroll in a major medical plan that provides only catastrophic coverage. These plans typically exclude the first five thousand or ten thousand dollars of expenses (the deductible) then cover a percentage of the expenses thereafter. High deductible plans with a health savings account are typically have a similar design, but there are concerns about whether enrollers will seek preventative care since they have to pay the first thousand dollars and do not receive any coverage until something serious occurs. So while there are options outside of the group market they can be very limiting, especially for someone who has a pre-existing medical condition. What if you are unable to get an individual policy?

[128] Elisabeth Simantou, Cathy Schoen, and Stephanie Brugegman, "Market Failure? Individual Insurance Markets for Older Americans," *Health Affairs* 20 (July/August, 2001): 144-46.

To date, thirty states have created high risk pools for individuals who are unable to purchase health insurance on the open market because of a pre-existing condition. They are safety nets for those who can afford them. More than two hundred and fifty thousand people nation-wide are enrolled in high risk pools. They are typically state-created non-profit associations that are self-funded through premium payments.[129] The rates are significantly more than what a healthy person would pay in the market. In Texas for example, a policy for a forty-six-year-old nonsmoker with a one thousand dollar deductible costs seven hundred and ninety-three dollars per month or nine thousand five hundred and sixteen dollars a year, significantly more than the three thousand four hundred and eighty dollars referenced above.[130]

The lack of options in the outside market also poses a significant threat to retirees who leave the work force prior to becoming Medicare eligible at age sixty-five. This weakness has been further exacerbated by the erosion of retiree benefits. In 1988, 66 percent of large companies (those employing over two hundred employees) offered retiree health benefits. In 2005, only 33 percent of large firms are providing retiree benefits and this trend is expected to continue. Additionally, retirees who still have benefits have seen the cost of their insurance increase considerably: an average of 27 percent from 2003 to 2004 for those under sixty-five and an increase of 24 percent for those over sixty-five.[131] And as noted above, the market for coverage becomes tighter as one gets older, so the options are more limited.

Employer-based health insurance has never covered the entire work force. At its height it covered 75 percent of all employees. To date, it covers 61 percent of all workers. The available options outside of employer-based coverage however are extremely limited. Because there is no pool, the person seeking an individual policy is individually rated. Thus, if the person is healthy, there are a number of affordable options. However, if the person seeking coverage has a pre-existing condition, policies

---

[129]HealthInsurance.org, "Risk Pools: Affordable Health Insurance for Medically Uninsurable Individuals," http://www.healthinsurance.org (accessed June 2, 2006).

[130]TxHealthPool.com, "Health Pool Benefits," http://www.txhealthpool.org (accessed June 2, 2006).

[131] Kaiser Family Foundation, "Trends and Indicators in the Changing Health-care Marketplace," http://www.kff.org/insurance/7031/index.cfm (accessed March 8, 2006).

become more expensive and harder to obtain. Thus, as fewer and fewer employers offer health insurance and/or a smaller percentage of employees actually enroll, additional options must be made available.

Nature of Insurance Has Adverse Impact on Small Business Owners and Other Groups

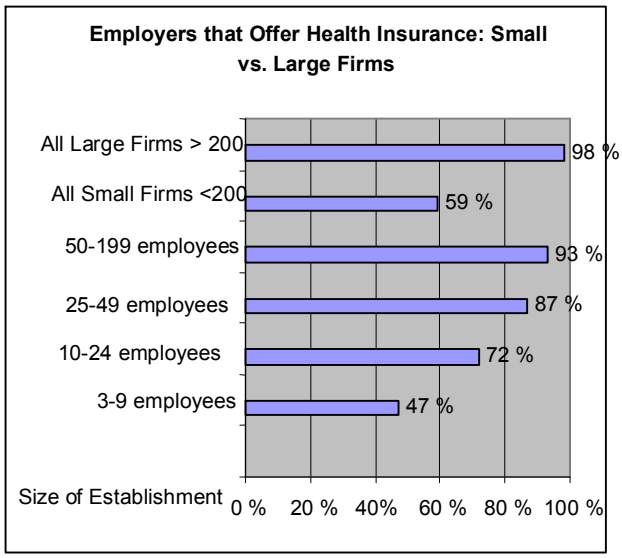

Table 5. Employers that Offer Health Insurance: Small versus Large Firms

Since 1990, the number of employees working for companies with fewer than 20 employees has increased by 16 percent: those working in companies with between one and four employees has grown 11 percent and those in organization with five to nine employees has grown 6 percent during the same time period. In fact, 25 percent of all employees work for organizations employing fewer than twenty people and 86 percent of all establishments have fewer than twenty employees.[132] The vast majority of employers are considered small and a quarter of the work force is employed by one of these small companies. However, small companies are less likely to offer health insurance than large companies. In fact, as depicted in this chart, small employers are almost half as likely to offer health insurance to their employees as large employers. Moreover, the number of very small firms (less than ten employees) offering benefits has dropped from 53 percent in 1996 to the current rate of 47 percent and the rate for small firms has decreased from 78 percent in 1996, to 72 percent in 2005. The percentage of large firms offering health insurance has remained somewhat steady since 1996.[133] More and more people are working for smaller firms and

[132] U.S. Census Bureau, *Statistical Abstracts of the United States: 2006* (Washington, D.C.: U.S. Government Printing Office, 2006), 512-15.

[133] Kaiser Family Foundation, "Kaiser/HRET Survey of Employer-sponsored Health Benefits, 1999-2005," http://www.kff.org/insurance/7315/sections/ehbs05-2-2.cfm (accessed March 8, 2006).

almost 40 percent of these companies are electing not to offer health insurance. Moreover, small companies who do offer health insurance are at a disadvantage because they lack the purchasing and hence, pooling power of large companies, experience higher administrative cost and are typically unable to self-insure. Additionally, since their employee pools are smaller, they face greater financial risk should one of their employees experience a serious illness.[134]

When the Kaiser Family Foundation surveyed small businesses that did not provide insurance to ascertain how they arrived at this decision, 72 percent reported that the premiums were too high and 34 percent said that the administrative hassle of providing insurance was too great. Moreover, small firms who do offer health insurance usually offer fewer choices, experience higher premiums and tend to pass more of the cost on to employees.[135]

Similarly, work groups that have older and sicker employees are also disadvantaged because of experience rating and the impact demographics have on underwriting. So while younger work groups can take full advantage of the marketplace, older groups experience higher premiums.

Attempts to organize small business owners in order to create larger employer-pools have been largely unsuccessful.[136] If history is any indication, the plight of the small business owner and the employees who work for them will continue on the path of fewer options, higher costs and less over-all participation in health insurance further exacerbating the present system.

Summary

The above section has sought to illustrate the erosion of employer-based insurance. Over time, fewer and fewer employers are offering health insurance benefits and due to health-care inflation, smaller numbers of employees are enrolling in the

---

[134] Jon Gabel and Jeremy D. Pickreign, "Risky Business: When Mon and Pop Buy Health Insurance for Their Employees," (New York: Commonwealth Fund, 2004), http://www.cmwf.org/usr_doc/gabel_riskybusiness_ib_722.pdf (accessed March 8, 2006).

[135] Kaiser Family Foundation, "National Survey of Small Business, April 2002," http://www.kff.org/insurance/upload/National-Survey-of-Small-Businesses-Survey-Highlights-and-Chartpack.pdf (accessed March 8, 2006).

[136] Gabel and Pickreign, 5.

benefit when it is offered. Small businesses and companies that employ an older work force are more disadvantaged because they have fewer options, higher administrative costs and a lack of purchasing power in the market place. Non-standard employees and low wages earners are similarly disadvantaged. The former group is largely excluded from receiving benefits and low wage earners must pay a larger share of their income on premiums, thus fewer enroll in benefits. In order to receive health insurance benefits an employer must first offer them. As we have seen the amount of employers offering health insurance, especially those employing fewer than two hundred employees, has steadily declined over the years and only 59 percent of all small employers offer benefits: as the number of employees drops, so too does the likelihood that the employer will offer benefits. At the same however, the number of small businesses continues to grow as does the number of employees working for them. Thus, the likelihood of receiving benefits declines proportionately. Next, the employee must qualify for the benefit. As the above analysis has disclosed more and more employees are working in either a part-time, contract or temporary capacity and as such, are largely excluded from receiving health insurance benefits. Moreover, employers impose wait periods of up to one year before benefits become active. Considering that 20 percent of all employees have less than twelve months of tenure with their current company, these wait periods further erode the reliable base of health insurance.[137] And last, the employees must be able to afford the premium and subsequent deductibles and copayments. Since 1982, the cost of employer-based insurance has increased (in real dollars) by 260 percent; the employee's burden has increased by 350 percent. Between 1988 and 2003, a worker's monthly premium for family coverage has increased almost four times from fifty-two dollar a month to two hundred and ten dollars a month.[138] Premiums, deductibles and copayment all continue to rise as employers remain committed to shifting the burden to employees. Lower wage earners are disproportionately impacted by medical inflation and are frequently unable to afford the cost of the premium. Finally, the system of employer-based health insurance is so entrenched that few affordable options are available in the outside market. The lack of

[137] U.S. Census Bureau, 398.

[138] Kaiser Family Foundation, "Employer Health Benefits, 2003 Annual Survey," http://www.kff.org/insurance/ehbs2003-1-set.cfm (accessed March 8, 2006).

options adversely impacts retirees under the age of 65, those who are in between jobs and those who are not afforded coverage through their jobs.

CHAPTER 4: Are There Alternatives? How to Stop the Bleeding

Despite the bleak picture painted above, in a 2001 study conducted by the Economic and Social Research Institute, a majority of employers reported that they wanted to continue their role in both financing and managing health benefits. Even among firms that don't currently offer coverage, employers felt obligated to provide this benefit. That notwithstanding, they did not favor any type of employer mandates and although they were largely distrustful of the government, they felt that expansion of existing programs (SCHIPs, Medicaid, Medicare) was the best way to cover the uninsured.[139] Before exploring options to address the short comings of employee-based health insurance, some mention should be made of the strengths in our current system so that we can build upon these in the recommendations. Although the present system is covers fewer and fewer people, employer-based health insurance still insures a majority of the population and as discussed above, employee populations are an excellent vehicle for risk sharing. Further, while employees may stay on a job that is ill-suited, employer-based insurance most likely reduces turnover for firms that provide it and the insurance and the administrative offices that coordinate it afford employees a level of expertise that they would not otherwise have if they had to obtain coverage in the open market. In spite of its many limitations and continued price escalations, the vast majority of those that have employer-based health insurance are content with the present system.[140] Lastly, employer-based health insurance is compatible with our notion that less government is better than more government.

[139] Silow-Carroll, Kutyla, and Meyer, 45.
[140] Edwards, Doty and Schoen, 5.

The Players and Questions

Numerous authors and studies have proposed how to get health insurance into the hands of the unemployed or the employed that are not offered it and/or can not afford it. Before exploring these studies it is important to acknowledge the current breakdown between private and private payers. As the below statistics reveal, the government spends a sizable amount of its budget on health care. While this paper has focused almost exclusively on the private market, a good percentage of the non-elderly have public health insurance. In 2004, 13 percent of the U.S. population was receiving Medicaid, the federal/state health insurance program created in 1965 that affords coverage to America's sickest and poorest citizens. An additional 2 percent of the U.S. population receives health care through other government agencies such as the Veterans Administration or the Indian Health Service.[141] Not included in these statistics are the millions of Americans over the age of 65 who are entitled to receive health care through Medicare. In 2005, the federal government spent 12 percent of its total budget on Medicare.[142] Equally revealing are the total health-care expenditure figures: in 2002, between Medicare, Medicaid and other government financed programs, the government paid for

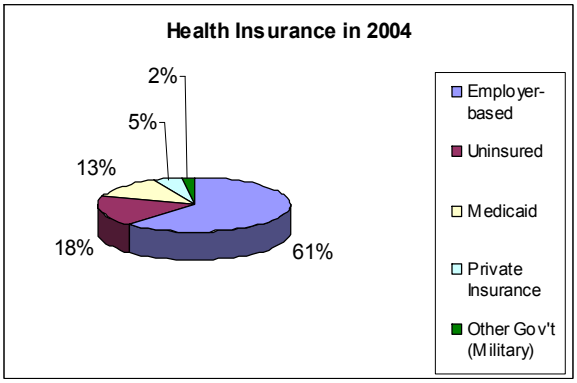

Table 4. Health Insurance in 2004

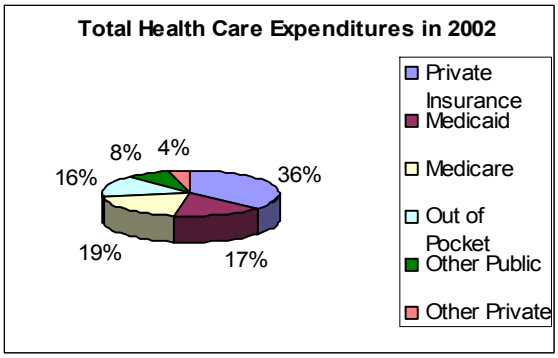

Table 5. Total Health Care Expenditures in 2002

[141] Kaiser Family Foundation, "Health Insurance in America: 2004 Data Update."

[142] Kaiser Family Foundation, "Medicare Chartbook," 3rd ed., Summer 2005, http://www.kff.org/medicare/upload/Medicare-Chart-Book-3rd-Edition-Summer-2005-Report.pdf (accessed June 6, 2006).

approximately 44 percent of all health-care bills with consumers paying 15 percent and private insurance paying for 36 percent of all bills.[143] In addition to paying for almost half of all health-care expenses, the U.S. government heavily finances employer-based health insurance by excluding what employers pay in premiums as a business deduction, excluding the cost of health benefits as taxable wages and allowing employees to exclude premium payments from their taxable income. In 2000, the government financed health insurance to the tune of $141 billion, one of the most expensive tax subsidies on record.[144] These figures are presented to give the reader an understanding of the magnitude in which the government is already financing our privately-based enterprise.

Despite the government's involvement in providing health insurance, health care and billions of dollars in tax subsidies, employer-based health insurance is still largely a private enterprise. Employers can freely chose whether-or-not to provide the benefit and if they provide it, they are free, to a large extent, to design the benefit package and set the amount that employees will be responsible for contributing, both to premiums, deductibles and copayments. Employers can chose which insurance companies they want to purchase insurance from and they can change carriers yearly to obtain better pricing and/or services. Employers can set eligibility policies deciding who is eligible to receive insurance and who isn't eligible. Moreover, employers can elect to impose waiting periods before benefits become activated and they can choose to extend or not extend benefits to dependents. Similarly, while businesses can choose which insurance carriers to use, insurance companies can refuse to do business with any given employer if they think the risk in that group outweighs the likelihood of making a profit on the coverage. Alternatively, insurance companies can elect to charge excessive premiums as they deem appropriate. Employers and insurance companies can do all of this without any government intervention.

The government's involvement in employer-based health insurance has been largely relegated to setting tax policy, labor law and more recently, attempting to make employer-based health insurance more portable. As illustrate by the above data, the government has been largely ineffective at getting private insurance into the hands of

[143] Kaiser Family Foundation, "Trends and Indicators."
[144] Silow-Carroll, Kutyla, and Meyer, 19.

more people because they are attempting to regulate a private enterprise that consists of more than one industry or group. Who are these groups and what stake do they have in employer-based health insurance?

First there is the insurance industry that is providing insurance and/or administrative services to the companies that provide insurance. They are largely interested in maintaining the status quo and preserving the favorable tax treatment afforded health insurance. Insurance companies are companies that have been created to generate a profit for their owners and/or shareholders and they want to ensure that they are not required to assume the risk of groups and/or individuals that would not further this mission. There are the health-care providers who want to ensure a steady stream of patients and payment and who want as little regulation and managed care as possible. In addition to health-care providers, organized medicine also has a stake in how health care is provided and they continue to want as much autonomy as they did in the early twentieth century. Next there are the companies who provide health insurance whose main concern is controlling the cost of both the insurance and health care in general. While the above-mentioned survey stated that they wanted to continue in the role of providing health insurance, it is doubtful that they would take this stance if the favorable tax treatment was repealed. Moreover, as the United States continues to operate in the global economy, U.S. companies are feeling the financial disincentive of providing health (and other welfare) benefits; the governments of a vast majority of their international competitors provide health insurance and or universal coverage creating an uneven playing field. Labor unions also have a stake in health insurance and under many collective bargaining agreements have a legal duty to negotiate benefits for their members. Big labor was once able to negotiate extremely attractive benefit packages for its members. In recent years however, it has had to make concessions or risk losing jobs as companies downsize in order to remain competitive. Unlike the 1940s, labor has more recently united around a single-payer plan. Then there is the federal and state government who currently shoulders a great deal of the financial burden for providing insurance and health care. The government would like to shift this burden and see more people with private health insurance. However, they also recognize that they play a role in getting and financing care for society's most vulnerable. Politically, the government

also feels the pressure of having to deal with greater and greater numbers of uninsured, the majority who are employed. Finally, there are the people: those with employer-based insurance, those that have either Medicare and/or Medicaid and those without any insurance. People in general want access to health care at an affordable price. In summary, the health insurance debate impacts every person living in this country. Some like the AMA have a powerful voice in Washington whereas the uninsured have virtually no voice. Some, like the insurance companies, want to maintain the status quo and grow employer-based health insurance whereas labor unions have almost unanimously lobbied for a single-payer system that would provide health care to everyone. Therefore, before any meaningful and workable solutions can be identified and implemented, the appropriate stakeholders must be willing to work together. Moreover, the stakeholders need to agree upon what it is we are trying to fix or achieve. Although the purpose of this paper is not to analyze these issues in detail, a brief discussion of them is order to better understand workable solutions.

The first and most basic question to be answered is, what is it that we are trying to achieve? Is the goal to get everyone[145] health insurance or is the goal to get everyone health care? These are two very different goals: insurance doesn't ensure that a person will have access to care and as illustrated above, benefits come in many different sizes, packages and price ranges. Therefore, any discussion on insurance should define what a minimal package of benefits would or should include. If it's health care that we want to give everyone, then the debate must center on what level of care is acceptable since unlimited health care is cost prohibitive. If the stakeholders and/or politicians can not identify what the end should looks like, then they can't very well work on identifying how to solve the problem The next fundamental issue is who should shoulder the financial burden of providing health insurance? Most employers don't offer health insurance because of the expense and the majority of employees who don't enroll in it even if it's offered do so because they can't afford it. How then can it be made more affordable to both parties and who, if anyone should help make it more affordable? And who should pay for coverage and/or care for those outside of the work force? At what

[145] The term *everyone* is being used since who deserves coverage is outside the scope of this paper.

income level should coverage be subsidized? Isn't the tax treatment currently afforded employer-based insurance a form of a subsidy? If so, is this appropriate or should it be reallocated to those in greater need? Or alternatively, should employer-based insurance continue to be market-driven with government programs providing benefits only to the most vulnerable? Connected to who should pay for what, the next issue is agreeing upon the most appropriate role of government be it in financing, legislating and/or providing insurance and/or health care. To date the government has been a bit schizophrenic: it has played a huge role in both legislating and providing coverage to certain sectors of the population but has been largely absent in legislating changes to enable expanding employer-based insurance. What then do we want the government to do? Can the private sector accomplish what we want and if so, what does it need from government? Until the stakeholders can come to some agreement on these issues proposed initiatives will likely fail. Last, but not insignificant, how much change are we willing to withstand? While incremental changes to our system have less of an overall impact, they are easier to implement and politically more viable. Alternatively, comprehensive change is harder to agree upon and implement, but the changes accompanied by it are more sweeping. The best example of comprehensive reform is Medicare that entitled all Americans over age sixty-five to health care. Having said that, what follows are proposals that have been made and their benefits and weaknesses in increasing the numbers of people who have insurance. In looking at these proposals it is necessary to remember what has already been stated: employer-based health insurance has never afforded coverage to everyone, even workers. As such, any solution must address the issues raised above and the stakeholders must agree upon the goals that are to be achieved.

Solutions to getting health care and insurance to more people can be broken down into two categories, comprehensive and incremental. Comprehensive solutions seek to give coverage to everyone and involve huge changes to the current system whereas incremental changes seek to expand coverage within the current system. Politically, incremental changes are easier to sell, legislate and implement although they are not as far reaching. Comprehensive solutions take a rare political climate and perfect timing.

What follows is a review of both comprehensive and incremental solutions to increasing the number of people who have health care or insurance.

Comprehensive Solutions

One solution for ensuring that everyone has coverage is to abolish our current employer-based system and replace it in full with a single-payer system. This has been the topic of many books and articles and establishes health care as a right in that everyone would be eligible to receive health care.[146] Single-payer coverage would eliminate insurance companies and tax subsidies and would be largely financed through a combination of payroll taxes and premium contributions. Proponents of a single-payer scheme maintain that significant cost saving would be realized by eliminating the third party payer–the insurance company. Presently, the administrative cost of our third party system total about eighteen dollars out of every dollar spent.[147] A single-payer system eliminates the administrative overhead and profit requirements that currently burden our health-care system and replaces it with a single-payer, the federal government. It also endorses the notion that health care is a right; something that everyone is entitled to receive such as police protection. The largest advantage of a single-payer system is that it does not depend on employers to supply insurance and since it is not tied to employment people would be free to change jobs without fear of losing their insurance. It also covers those that are not employed or covered under the current system. Moreover, everyone would be entitled, more or less, to a standard set of benefits, similar to Medicare. Finally, while a single payer plan has proponents their voices are often silenced or ignored.

In a small study conducted in Massachusetts, researchers asked 1787 physicians (who were members of the AMA) their views on a single-payer health-care system. Of the 50 percent who responded to the questions about which structure would provide the

---

[146] See Jill Quanagno, *One Nation Uninsured*: *Why the U.S. Has No National Health Insurance* (Oxford: Oxford University Press, 2005), and Daniel S. Hirshfield, *The Lost Reform: The Campaign for Compulsory Health Insurance in the United States from 1932 to 1943*, (Cambridge, Mass: Harvard University Press, 1970).

[147] The Physicians' Working Group for Single-Payer National Health Insurance, "Proposal of the Physicians' Working Group for Single-Payer National Health Insurance" *JAMA* 290 (August 13, 2003): 798-805.

best care for the most people for a fixed amount of money, 63.5 percent of physicians chose a single-payer system; 10.7 percent said managed care and; 25.8 percent, supported a fee-for-service system. While a majority supported a single-payer system, only 51.9 percent thought their colleagues would support such as system. Additionally, the majority said that they would take a reduction in pay or income for reduced paperwork. Furthermore they agree that it is government's responsibility to ensure the provision of medical care and believe that insurance firms should not play a major role in health-care delivery.[148]

The most glaring obstacle with a single-payer system is that we have not agreed that health care is a right nor is there any indication that we are moving in that direction. Second, there are many stakeholders, such as the insurance industry, organized medicine and a good deal of the population who are opposed to this concept and without their buy-in it is doubtful that the country will adopt such a scheme. Moreover, in the Economic and Social Research Institute study, employers largely opposed a single-payer system.[149] Additionally, the vast majority of politicians are opposed to a single-payer system which leaves labor unions and citizens as the only real advocates.[150] There are also two huge issues which are not easily resolvable: first is the issue of financing. Since health care would be afforded to everyone utilization would increase as would total health-care spending. Who would pay for this? Assuming that we are unable to control health-care spending, who will assume the burden for the increases in cost from year to year? Are we willing to spend that much of the federal budget and our taxes so that everyone can be afforded as standard package of care? Additionally, what would the package of benefits look like? Would we be required to ration care and if so, how are we going to decide who will be denied care and for what? The second issue has to do with whether or not people and or physicians can opt out of this. Americans value free choice. Can the system build in enough choice? And if it can't will people be able to opt out of it? In a

---

[148] Danny McCormick, David Himmelstein, Steffie Woolhandler, and David H. Bor, "Single-Payer National Health Insurance: Physicians' Views," *Archives of Internal Medicine* 164 (February, 9, 2004): 300-4.

[149] Silow-Carroll, Kutyla, and Meyer, 68

[150] Robin Toner and Anne Kornblut, "Wounds Salved, Clinton Returns to Health Care," *New York Times*, June 10, 2006, national edition, section 1.

single-payer system presumably everyone that needs a hip replacement will be able to get the operation. This however, will result in waiting lines. Who gets to the front of the line and how do we determine who gets priority? Are we even willing to wait in line for the greater good?

The vast majority of powerful stakeholders do not support universal coverage. It would mean an end to commercial health insurance as we know it and would give government even greater control over health care and health-care financing. If however, the stated goal of any health-care reform is to get health care into the hands of as many people as possible, universal coverage is the simplest way to achieve this goal. Moreover, if big business continues to lose market share in the global economy, the status quo may no longer be in their interest and business leaders may look to Washington for a single-payer solution to relieve them of this obligation. However, for universal health care to ever take become a reality, a crisis of unknown proportions will have to take place.

Another comprehensive way to achieve universal coverage is to institute personal mandates. The government would legislate that all people are required to carry a requisite amount of health insurance. Unlike a single-payer system, personal mandates would keep the current system largely intact and would be minimally disruptive. A significant amount of people would continue to receive employer-based insurance and those that don't have it could possibly buy into the federal health-care system (thereby minimizing the need for risk segmentation) or other insurance pools. For those who can not afford health insurance the government would provide some sort of subsidy to make it affordable. The simplest way to view this proposal is to liken it to automobile insurance: states require proof of automobile insurance before they will issue a person a driver's license. As mentioned above, this proposal keeps the current system intact and therefore, minimally disrupts the stakeholders. There are however a number of challenges with legislating personal mandates. First, like automobile insurance, many people may initially sign up for a policy, but then drop it after they obtain their license. Moreover, many peopled drive without a license. In order for a mandate to work there must be some system in place to ensure that people abide by it. Second, the stakeholders and/or legislators would have to define a minimally acceptable level of insurance that

everyone must purchase. What they settle upon has important cost and health implications. Suppose that everyone is required to carry catastrophic coverage, the most reasonably priced product on the market. Catastrophic coverage typically covers major accidents and illnesses after a deductible is paid. If this is the minimally required coverage, what about preventative care? Is it ever subsidized for low wage earners or the unemployed or must they forgo it? Alternatively, should the government mandate a richer plan that covers physician visits and preventative care? Who then would pay the added cost? What is the health-care system's obligation if someone doesn't have insurance? Although personal mandates leave the current system relatively in tact, it generates a whole host of questions that would need to be seriously debated.

Ezekiel J. Emanuel and Victor R. Fuch have proposed a third type of comprehensive reform based on vouchers. In short, every Americans under the age of sixty-five would receive a voucher which is good for basic health services provided by a qualified health insurance company. These companies would have to offer guaranteed enrollment and renewal for the risk-adjusted value of the voucher regardless of a person's experience rating. Individuals and families would presumably have a choice of plans from which to choose and people could purchase additional services beyond this basic package with after-tax dollars. The plan would be entirely financed through a value-added tax which is based on personal consumption. Employer-based health insurance and means tested program such as Medicaid and CHIPs would be folded into the voucher system as would Medicare in the future. The authors claim that a voucher system is administratively efficient and not easily evaded. Indeed, this proposal addresses a number of deficiencies that exist in our current system: first, everyone is guaranteed basic health-care coverage without means testing or exclusions. The way it is financed directly links any expansion in the basic package with the public's willingness to increase taxes. Since the benefits package is not tied to employment there is complete continuity of coverage and all users support the system based on their personal consumption. The authors also suggest that there are a myriad of questions to be answered before such a plan could ever be implemented.[151] Similar to a single-payer system, what does the basic

[151] Ezekiel J. Emanuel and Victor R. Fuchs, "Health-care Vouchers–A Proposal for Universal Coverage," *New England Journal of Medicine* 352 (March 24, 2005):1255-57.

package of benefits include and exclude? How would you arrange for care beyond the states package of benefits and how would you subsidize low wage earners and the unemployed? Moreover, how would health plans qualify to participate and what kind of reimbursement system would you implement?[152] Since this proposal is fairly new, organized medicine has not addressed it. However, given its vastness and America's lack of appetite for big changes, it too may be end up as merely rallying point for uninsured advocates.

Incremental Changes

Incremental reforms and experiments are taking place all the time. For instance, the State Children's Health Insurance Program (SCHIPs) was legislated in 1997, to afford children living below 200 percent of the federal poverty level (who do not qualify for Medicaid) health insurance coverage. More recently, the state of Massachusetts legislated sweeping changes and enacted both employer and individual mandates. These changes notwithstanding, the uninsured rate continues to climb. Why then do we continue to tweak the system with incremental reform if isn't effective at addressing the problem? In summary, incremental reform is politically safer, easier to implement and less costly then the ideas presented above. To date they have been largely unsuccessful in getting health insurance and/or care to more people. What follows is a brief discussion of various incremental reforms.

One type of incremental reform is to legislate employer mandates that require all employers over a certain size to offer benefits to employees. As mentioned above these have largely failed and are politically sensitive because it shifts the majority of the burden to small businesses, many who are unable to afford insurance premiums. Aside from the political burden, employer mandates do nothing for the unemployed and fail to address the numerous issues already addressed such as levels of coverage, exclusions and wait periods. On the other hand, the employer-mandate builds off of our current system and leaves the insurance industry fully intact.

---

[152] Ezekiel J. Emanuel, and Victor R. Fuchs, "Health-care Reform: Why? What? When? What it Might Take to Effect Comprehensive Change," *Health Affairs* 24 (November/December 2005): 1407-8.

A second incremental reform is to extend Medicaid and/or Medicare so that more people are eligible. This proposal also keeps the current system intact but puts additional financial burdens on state and federal governments. For instance, Medicare eligibility could be lowered to age 60 or SCHIPs could be expanded to include the parents and/or guardians of those enrolled. However, the administrative burdens associated with the means-tested programs make them problematic and adding more people to their rolls would only compound these problems. They require costly determination of eligibility, impose high marginal tax rates on recipients and encourage people to remain unemployed. Furthermore, many people who are eligible fail to apply because of the administrative hassle and many people who initially qualify are bounced in and out of the program causing discontinuation of coverage.[153] So while each state already has programs in place, the administrative and financial burdens of extending them make a less than desirable option. Moreover, since the states have a certain amount of freedom to set the eligibility requirements over a certain legislated minimum, when state budgets become lean, states tend to tighten up these requirements forcing people off the program thus leaving them without health coverage.

A third type of incremental reform falls under the tax reform or subsidy umbrella. The government can directly subsidize the cost of private insurance for those who are unemployed and can not afford the entire premium. Alternatively, the government can give tax credits to employers, employees and/or the unemployed who purchase insurance. Moreover, the government could abolish the special tax treatment afford to employers who purchase insurance and redirect those tax savings into subsidies or credits. In summary, any manipulation of taxes or subsidies does not impact the current system and merely attempts to influence behavior. If the goal is to get health insurance into the hands of the working poor, then tax credits would have a minimal impact because the tax rates for this group are already low. Thus, this group would benefit more from a subsidy. If on the other hand, the goal was to get more employers to offer benefits, then a change in taxation may be more advantageous. In either instance, the government is using tax

[153] Gerry Fairbrother et. al "Costs of Enrolling Children in Medicaid and SCHIP," *Health Affairs* 23 (January/February 2004): 242.

dollars to stimulate the market without mandating any type of behavior. Therefore, the outcomes of this incremental reform are more subtle, but less predictable.

A fourth type of incremental reform is to establish purchasing cooperatives that would enable both small business owners and/or individuals to buy competitive health insurance. As outlined above, small businesses and individuals are disadvantaged buyer because they are unable to spread risk; therefore they are charged higher premiums for fewer benefits. For the last fifteen years states have sought to expand coverage to small businesses by creating purchasing cooperatives, but they have largely failed because they limited the type of plans available for purchase. The Massachusetts reform bill addresses these past failures by creating the Connector which will operate as a clearing house where businesses and individuals can purchase an array of policies from a variety of insurance companies.[154] Since the legislation establishing this new purchasing cooperative was just enacted there is no data on whether their experiment will succeed, but the theory is well grounded in that a chief component of the plan is choice.

Other incremental reforms include quality incentives which seek to reward physicians and health-care systems for reducing expenses; government reinsurance whereby the insurance companies are protected against substantial losses and; managed competition which seeks to improve efficiencies in the market. Any type of incremental reform is limiting in that it only addresses a fraction of the overall problem. However, its limiting nature is what also makes it politically more viable, easier to implement and easier to sell to the American people. The following proposal assumes the following: first, health care is right that all citizens are entitled to receive. Next, traditional insurance is not the best means for ensuring that everyone gets the care they are entitled to receive. Along these same lines, comprehensive reform must be administratively efficient or the system will be cost prohibitive. Any administrative savings should be applied to supplying health care and should not be absorbed as the cost of doing business. Next, in order for a comprehensive system to work we must acknowledge that care will be rationed. Last, this proposal acknowledges the value that Americans place on choice.

---

[154] Edmund F. Haislmaier, "The Significance of Massachusetts Health Reform," (Washington, D.C.: Heritage Foundation, 2006), http://www.heritage.org/Research/HealthCare/wm1035.cfm (accessed April 3, 2006).

Therefore, this proposal provides for a private system of third party insurance and supplemental insurance for those who can afford to purchase it on the open market.

In short, a comprehensive health reform package would entitle all citizens to a minimum package of services that would include preventative care, physician fees, laboratory and testing fees, hospitalization and prescription drugs. To discourage over-use of the system, each initial physician's visit would cost a standard, nominal amount to be collected and used by the physician and/or practice. Since services beyond a physician's visit are typically directed by the doctor, there would not be a copayment involved in securing these services. The federal government would be the single-payer and fees would be established on a region basis by yet-to-be created boards. Employer-based health insurance, Medicaid and SCHIPs would be disband and merged into this single-payer system. Moreover, individuals would be allowed to purchase third party supplemental insurance to cover those items that are rationed, to upgrade the single-payer package, or to replace it in total. If an individual chooses to purchase a full third party package, the insurance would be required to include the treatment of any complications, rehabilitation and home support so that a person who opts out of the public system in whole can not re-enter it because there was an error in the private sector. However, to dissuade people from opting out altogether, all citizens will be required to pay into the system accordingly even if they never use it, thereby making it financially unattractive – analogous to private schooling. For their part, physicians would need to chose whether to participate in the private or the public system, but they could not do both.

A Hybrid Solution

This proposal begins with the premise that health care is a right. First, unlike other goods and services such as a house, a car or clothes, health care is not something that people look to purchase. You need food and clothing to exist from day to day, but you may seldom need health care. Conversely, people don't want to get sick and therefore, don't anticipate needing health care on any regular basis until they become ill. Moreover, when people do fall ill they rarely have a choice but to seek treatment. Therefore, most health care is not purchased routinely but rather out of necessity when the body isn't performing up to par. Our current web of privately-based and government-

sponsored health insurance is really quite schizophrenic: on the one hand the majority of the non-elderly are left to their own devise to secure health care either through their employment or in the open market. On the other hand, as a matter of law, the elderly, some percentage of veterans and the indigent (if they remain indigent), are entitled to health care. As a society we are saying to one segment of the population that you have a right to health care yet to another we are saying that it's really in your best interest to obtain insurance in the event you fall ill. What is being suggested here is that we extend the right of some to all.

What is the best way to further this agenda? Is it to keep our current web of private insurance providers and public payers? As referenced in the first section of this paper, insurance companies were reluctant to establish health insurance because illness and disease were such unpredictable events. Traditionally, insurance financially protects us from infrequent or atypical events: when our house catches on fire or when we get into an automobile accident. The insurance protects us against our losses. Moreover, payment is based typically on replace costs; the amount needed to rebuild the home or the value of the care that was destroyed. Illness, accidents and disease (regardless of our current state of health) on the other hand will eventually impact everyone and therefore, we will all need the care of a doctor or an operation at some point in time. Knowing that utilization of heath care is a foreseeable event that will occur many times over in any given life makes it a very different beast than other types of insurance. Moreover, while our auto insurance will help replace our car and our life insurance will help pay outstanding bills, our health insurance may never restore our health; may never make us whole again. Additionally, once we fall ill, we may need more care, not less. Or, we may get cured, but we will experience illness again and again. Traditional insurance was never established for this ongoing relationship and purpose. Moreover, we seek preventative care when we aren't even sick to guard against future illness and disease. Clearly, preventative services don't fall under a traditional insurable event either. Additionally, third party insurance is expensive. As cited above, the administrative expenses absorb 18 percent of all health-care expenditures. Couldn't this money be better spent on health care? Lastly, in order for insurance companies to make a profit in this market they must avoid risk or spread it over as large a group as possible. Therefore,

the people who are most in need of protection are the ones least likely to get it, whether through employment (chronic illness usually results in unemployment) or the open market. Thus, this proposal maintains that health insurance is the least effective, least efficient and least moral way to protect us against the financial burdens of disease and illness. This proposal argues that insurance is not the best vehicle for insuring our nation's health. First, the administrative costs and inefficiencies make it cost prohibitive. Second, the philosophy behind insurance is to help make people whole after an unexpected event. While we don't expect or ever want to get sick, in most instances, illness and diseases are unavoidable. Moreover, regardless of how much insurance you purchase, you may never recover from your illness. Therefore, insurance is not the best means of providing protection. Finally, the nature of the insurance business is contrary to the objective of assuring that everyone has health care.

Although third party insurance is not the best vehicle for ensuring that all citizens have health care, there is a role for it in this proposal. First, this proposal recognizes that choice is a premium commodity and that people in general do not like to be told what to do. Therefore, a third-party market will exist to supplement the single-payer system and for those who can afford it, to replace the single-payer system in total. Thus, unlike most single-payer proposals, this plan suggests that we maintain a tiered system. The majority of the population will receive a basic package of care and the wealthier or those that want additional options can pay for enhanced coverage. This coverage could include rationed services, private rooms and in some cases, completely private care. This is not vastly different from what we have today yet it guarantees everyone a basic minimum package. Many European nations are experimenting with ways to integrate private insurance into their public systems which include expanding patient choice, market incentives, and the role of private insurance. Two lessons are clear when reading about these attempts: first, it is easier to design a role for private markets at the beginning of a reform movement and second, there is a place for private markets in comprehensive, publicly funded health care.[155]

---

[155] Richard B. Saltman and Josep Figueras. "Analyzing the Evidence on European Health Reform," *Health Affairs* 85 (March/April 1998): 87-91.

For this proposal to receive serious considerations a number of outstanding issues would need to receive additional attention. First is the issue of financing. Even though the government funds the majority of health care today their budget is not large enough to fund a basic health-care package for all Americans for the indefinite future. Should there be an earmarked tax or some type of social insurance to fund health care? On an organizational basis, how will physicians, testing facilities, hospitals and rehabilitation centers be reimbursed and who will make those decisions initially and on an ongoing basis? Additionally, knowing that the government does not have the funds to finance everything for everyone, there must be serious debate about what an acceptable level of benefits includes and equally important, excludes. Medicaid rations care, so we have gone down this road before. Likewise, the citizens of Oregon engaged in this debate. The next issue that would need additional study is exactly how a private system would work along side a public system. Included in this debate is whether facilities would need to be wholly pubic or private. Finally, there are all the transition issues of how we get from where we are to where we want to go? In summary, this proposal would need to begin to address all of these issues to ascertain its viability both financially and organizationally.

CHAPTER 5: Conclusion

Health insurance was the brain child of a few men who sought to financially stabilize hospitals in the 1930s. The first plan in Dallas was created primarily to boost hospital revenues and secondarily, to help the teachers pay their hospital bills. Thus, the initial purpose of health insurance was vastly different than other types of insurance. Most insurance is bought to protect the policy holder against financial loss – whether of life, property or income. In the case of health insurance you can never really seek protection against getting sick; you can only seek protection against the money you spend trying to regain health. In fact, early insurers were reluctant to enter the health insurance market because its very nature was contrary to insurance principles: disease and illness were unpredictable events. Moreover, the cost of providing wholeness was impossible to achieve. However, a few historical events generated a new insurance instrument that sought to protect against the financial burdens of illness and these same events tied this instrument to employment. The Great Depression of the late 1930s put hospitals in a financial predicament and prepaid insurance helped administrators see their way out of this financial crisis. Shortly thereafter, health insurance (and welfare plans) provided large companies with a way to reward employees during the wage freezes imposed during World War II. Moreover, these benefits received favorable tax credit assisting both employers and employees. Thus, within the scope of less than twenty years, the United States had established an elaborate system of private, voluntary, employer-based health insurance. As the price of health care began to skyrocket in the late 1960s, the federal government responded by requiring employers to offer employees HMOs if one existed. Absent this 1973 legislation (and subsequent efforts to make insurance more portable), the government has been largely ineffective at making any changes to this employer-based system.

Statistically, employer-based health insurance is failing: fewer and fewer employers are offering it as a benefit; smaller and smaller numbers of employees are qualifying for the insurance and; smaller and smaller percentages of employees are able to afford the premium. The cost of insurance continues to increase by double digits

outpacing both inflation and the growth in wages. As the price of insurance increases employers continue to pass these costs on to employees in the form of higher premiums, deductibles and copayments. Furthermore, U.S. businesses are beginning to feel the burden of providing an expensive benefit that many of their international competitors have provided for them by their governments. Retiree health benefits have been on a steep decline recently. Are employee health benefits soon to follow?

If the system is failing what can be done to rectify the situation? There have been limited experiments with both incremental and comprehensive reform at the state and local level but to date there has been limited federal initiatives. To complicate the debate there are a number of stakeholders with competing interests. The insurance industry, our current administration and the AMA would like to grow private insurance. Labor Unions and the majority of the population would like to see comprehensive reform. Moreover, there are some fundamental questions that must be asked and answered before any meaningful reform, incremental or comprehensive can be initiated. The largest of these questions is deciding whether health care is a right, a need or a privilege.

The proposal presented in this paper presumes that health care is right. Our government has said that it is a right for some segments of our population so why not extent that right to all citizens? Moreover, unlike other goods and services, no one want wants illness and disease. Therefore, the very nature of health care differs drastically as a commodity. Second, insurance is not the best vehicle for delivering health care to a large population. It should supplement a single-payer system but it should not be the primary or dominant vehicle by which we are provided care: it's administratively expensive and the business principles behind insurance are contrary to providing both preventative health care and ensuring the health of a nation.

Our current system of voluntary insurance was founded and continues to operate under private market conditions. Therefore, any government involvement in extending it is politically problematic. As fewer and fewer people have the opportunity to enroll in employer-based health insurance our public systems will also stretch and break. Moreover, if business leaders decide they want out of the insurance business altogether the government should be prepared with an alternative plan. Our country will never adopt a fully mandated public program. Therefore, create a hybrid system where

everyone is afforded a basic package of health care and everyone is equally afford the opportunity to purchased supplemental insurance or opt out all together. Is it a tiered system? Yes, it's a system whereby those with more resources will be afforded more benefits, but that is the nature of choice and the foundation of this country.

Bibliography

Anderson, Olin W. *Blue Cross since 1929: Accountability and the Public Trust*. Cambridge, Mass.: Ballinger Publishing 1975.

———. *Health Services in the United States: A Growth Enterprise since 1875*. Ann Arbor, Mich.: Health Administration Press, 1985.

Annual Conference of Secretaries of Constituent State Medical Association, November 14-15, 1930. *American Medical Association Bulletin* 26 (1931): 35-48.

Bovbjerg, Randall, Charles Griffin, and Caitlin Carroll. "US Health Coverage and Cost: Historical Developments and Choices for the 1990s." *Journal of Law, Medicine & Ethics* 21 (Summer 1993): 141-62.

Cha, Stephen. "The Development of Health Insurance." *Medicine and Health/Rhode Island* 83 (September 2000): 271-79.

Cunningham, Robert M. Jr. "Notes on the Birth of Blue." *Hospitals* 53 (April 1979): 93-96.

Cutler, David M. *Employee Costs and the Decline in Health Insurance Coverage*. Cambridge, Mass.: National Bureau of Economic Research, 2002.

DeNavas-Walt, Carmen, Bernadette D. Proctor, and Cheryl Hill Lee. "Income, Poverty, and Health Insurance Coverage in the United States: 2004." Washington, D.C.: U.S. Census Bureau, 2005. http://www.census.gov/prod/2005pubs/p60-229.pdf . Accessed May 2, 2006.

Ditsler, Elaine, Peter Fisher, and Colin Gordon. "On the Fringe: The Substandard Benefits of Workers in Part-Time, Temporary, and Contract Jobs." New York: Commonwealth Fund, 2005. http://www.cmwf.org/usr_doc/879_Ditsler_on_the_fringe_substandard_benefits.pdf. Accessed May 1, 2006.

Edwards, Jennifer W., Michelle M. Doty, and Cathy Schoen. "The Erosion of Employer-based Health Coverage and the Threat to Workers' Health Care: Findings from the Commonwealth Fund 2002 Workplace Health Insurance Survey." New York: Commonwealth Fund, 2002. http://www.cmwf.org/usr_doc/edwards_erosion.pdf p2. Accessed March 8, 2006.

Emanuel, Ezekiel J., and Victor R. Fuchs. "Health-care Reform: Why? What? When? What it Might Take to Effect Comprehensive Change." *Health Affairs* 24 (November/December 2005): 1399-1414.

———. "Health-care Vouchers–A Proposal for Universal Coverage." *New England Journal of Medicine* 352 (March 24, 2005): 1255-60.

Engel, Jonathan. *Doctors and Reformers: Discussion and Debate over Health Policy, 1925-1950*. Columbia: South Carolina University Press, 2002.

Fairbrother, Gerry, Melinda I. Dutton, Deborah Bachrach, Kerry-Ann Newell, Patricia Boozang, and Rachel Cooper. "Costs of Enrolling Children in Medicaid and SCHIP." *Health Affairs* 23 (January/February 2004): 237-43.

Field, Marilyn J., and Harold T. Shapiro., eds. *Employment and Health Benefits: A Connection at Risk*. Washington, D.C.: National Academy Press, 1993.

Fishback, Price V., and Shawn Everett Kantor. *A Prelude to the Welfare State: The Origins of Workers' Compensation*. Chicago: University of Chicago Press, 2000.

Gabel, Jon, and Jeremy D. Pickreign. "Risky Business: When Mon and Pop Buy Health Insurance for Their Employees." New York: Commonwealth Fund, 2004. http://www.cmwf.org/usr_doc/gabel_riskybusiness_ib_722.pdf. Accessed March 8, 2006.

Gabel, Jon, Jeremy D. Pickreign, Heidi H. Whitmore, and Cathy Schoen. "Study Highlights Employer Policies that Deter Health Plan Enrollment." *Health Affairs* 20 (July/August 2001): 196-206. Accessed March 8, 2006.

Gordon, Colin. *Dead on Arrival: The Politics of Health Care in Twentieth-Century America*. Princeton, N.J.: Princeton University Press, 2003.

Gould, Elise. "The Chronic Problem of Declining Health Coverage Employer-Provided Health Insurance Falls for Third Consecutive Year." New York: Economic Policy Institute, 2004. http://www.epinet.org/content.cfm/issuebrief202. Accessed March 30, 2006.

Haislmaier, Edward F. "The Significance of Massachusetts Health Reform." Washington, D. C.: Heritage Foundation, 2006. http://www.heritage.org/Research/HealthCare/wm1035.cfm. Accessed April 3, 2006.

Hart, John. "Group Hospitalization Plan Succeeds Despite Unusual Difficulties." *Modern Hospital* 38 (May 1934): 67-69.

"Health Pool Benefits." http://txhealthpool.org. Accessed June 2, 2006.

Hirshfield, Daniel S. *The Lost Reform: The Campaign for Compulsory Health Insurance in the United States from 1932 to 1943*. Cambridge, Mass.: Harvard University Press, 1970.

Jolly, Robert. "Five Houston Hospitals Join in Hospital Insurance Plan." *Modern Hospital* 34 (October 1932): 19-22.

Kaiser Family Foundation. "Employer Health Benefits, 2003 Annual Survey." Menlo Park, Calif.: Kaiser Family Foundation, 2003. http://www.kff.org/insurance/ehbs2003-1-set.cfm. Accessed March 8, 2006.

———. “Employer Health Benefits 2004 Annual Survey.”. Menlo Park, Calif.: Kaiser Family Foundation, 2004. Kaiser Family Foundation Benefits-Survey-Full-Report.pdf. Accessed March 8, 2006.

——— “Employer Health Benefits 2005 Annual Survey.” Menlo Park, Calif.: Kaiser Family Foundation September, 2005. http://www.kff.org/insurance/7315/index.cfm . Accessed May 24, 2006.

——— “Health Insurance in America: 2004 Data Update.” Menlo Park, Calif.: Kaiser Family Foundation, 2005. http://www.kff.org/uninsured/upload/Health-Coverage-in-America-2004-Data-Update-Report.pdf Accessed May 20, 2006.

———. “Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2005.” Menlo Park, Calif.: Kaiser Family Foundation, 2005. http://www.kff.org/insurance/7315/sections/ehbs05-2-2.cfm. Accessed March 8, 2006.

———. “Medicare Chartbook, ” 3rd ed., Menlo Park, Calif.: Kaiser Family Foundation, 2005. http://www.kff.org/medicare/upload/Medicare-Chart-Book-3rd-Edition-Summer-2005-Report.pdf. Accessed June 6, 2006.

———. “National Survey of Small Business, April 2002.” Menlo Park, Calif.: Kaiser Family Foundation, 2003. http://www.kff.org/insurance/upload/National-Survey-of-Small-Businesses-Survey-Highlights-and-Chartpack.pdf. Accessed March 8, 2006.

———. “Trends and Indicators in the Changing Health-care Marketplace.” Menlo Park, Calif.: Kaiser Family Foundation, 2004. http://www.kff.org/insurance/7031/index.cfm. Accessed March 8, 2006.

McCormick, Danny, David Himmelstein, Steffie Woolhandler, and David H. Bor. “Single-Payer National Health Insurance. Physicians' Views.” *Archives of Internal Medicine* 164 (February 2004): 300-4.

MSNBC. “Wal-Mart Changes Some Healthcare Benefits.” http://msnbc.msn.com/id/12357363/. Accessed May 14, 2006.

Numbers, Ronald L. *Almost Persuaded: American Physicians and Compulsory Health Insurance, 1912-1920*. Baltimore: John Hopkins University Press, 1978.

———. “The Third Party: Health Insurance in America.” In *Sickness & Health in America*, edited by Judith Walzer and Ronald L. Numbers, 269-84. Madison: University of Wisconsin Press, 1997.

The Physicians’ Working Group for Single-Payer National Health Insurance. “Proposal of the Physicians’ Working Group for Single-Payer National Health Insurance.” *JAMA* 290 (August 13, 2003): 798-805.

Quanagno, Jill. *One Nation Uninsured: Why the U.S. Has No National Health Insurance*. Oxford: Oxford University Press, 2005.

Raffel, Marshall W., and Norma K. Raffel. *The U.S. Health System: Origins and Functions*. 4th ed. New York: Wiley & Sons, 1994.

"Risk Pools: Affordable Health Insurance for Medically Uninsurable Individuals." http://www.healthinsurance.org. Accessed June 2, 2006.

Saltman, Richard B., and Josep Figueras. "Analyzing the Evidence on European Health Reform," 85 *Health Affairs* (March/April 1998): 85-108.

Schaal, Samuel. *Lone Star Legacy: The Birth of Group Hospitalization and the Story of Blue Cross and Blue Shield of Texas*. Dallas: Taylor Publishing, 1999.

Schur, Claudia L., Marc L. Berk, and Jill M. Yegian. "Workers' Perspectives on Mandated Employer Health Insurance." *Health Affairs Web Exclusive* 12 (March 17, 2004): W4-130.

Scofea, Laura A. "The Development and Growth of Employer-Provided Health Insurance." *Monthly Labor Review* 5 (March 1994): 3-10.

Silow-Carroll, Sharon, Todd Kutyla, and Jack A Meyer. "The State of Employment-Based Health-Care and Business Attitudes about Its Future." Washington, D.C.: Economic and Social Research Institute, 2001. http://www.esresearch.org/Documents/Busattitudes2001.pdf Accessed March 8, 2006.

Simantou, Elisabeth, Cathy Schoen, and Stephanie Brugegman. "Market Failure? Individual Insurance Markets for Older Americans." *Health Affairs* 20 (July/August, 2001): 139-49.

Sinia, Nathan, Olin W. Anderson, and Melvin L. Dollar. *Health Insurance in the United States*. New York: Commonwealth Fund, 1946.

Toner, Robin, and Anne Kornblut. "Wounds Salved, Clinton Returns to Health Care." *New York Times*, June 10, 2006, national edition, sec. 1.

U.S. Census Bureau. *Statistical Abstracts of the United States: 2006*. Washington, D.C.: U.S. Government Printing Office, 2006.

Walmart Watch. "The Mighty Pen." http://walmartwatch.com/blog/archives/the_mighty_penn/. Accessed June 5, 2006.

VITA

Rebecca B. Lunstroth is originally from Pittsburgh, Pennsylvania After graduating from college she worked for the Texas Department of Labor and the U.S. Department of Labor as a compliance officer. During this time Rebecca attended law school in the evenings and upon graduation she went to work for Shell Oil Company in Norco, Louisiana in Labor Relations. She remained with Shell and its subsidiaries for the next fourteen years accepting positions in operations management, health and safety, information systems as well as human resources. Rebecca left Shell to pursue her master's degree in 2002.

In 2004, Rebecca accepted a position with the John P. McGovern, M.D. Center for Health, Humanities and the Human Spirit at the University of Texas Health Science Center at Houston. She acts in both an administrative and academic capacity splitting her time between teaching medical ethics to second year medical students and developing and measuring a humanities-based curriculum and running the day to operations of the McGovern Center.

Education

B.A., May 1981, Indiana University, Bloomington, IN
J.D., May 1988, South Texas College of Law, Houston, TX