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AN EXAMINATION OF THE RISING COSTS OF EMPLOYER-SPONSORED HEALTH INSURANCE IN THE UNITED STATES:

WHAT HAS CAUSED THIS INCREASE AND WHAT CAN BE DONE TO REMEDY THE PROBLEM?

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Employers provide the most common source of health insurance coverage among the nonelderly population in the United States. Health care costs have a direct correlation to the cost of employer-sponsored health insurance. National health expenses jumped from five percent of gross domestic product (GDP) in 1960 to 18 percent in 2011. As costs have risen, so have employer insurance premiums; these increases typically trickle down to employees in the form of lowered wages, decreased hours and increased co-payments and deductibles. Employers and the health insurance companies that work for them are at the forefront of the battle to deal with the problems of the costs and quality of health care in the United States. This paper discusses the history of employer-sponsored health insurance in the United States since its inception in the eighteenth century through today, including the effects of government reform and the Patient Protection and Affordable Care Act (PPACA) on the nation's private insurance system. I investigate universal health care as it affects private, employer-based health care costs. I also propose changes to combat continued increases.

A HISTORY OF EMPLOYER-SPONSORED HEALTH INSURANCE IN THE UNITED STATES: HOW DID WE GET HERE?

The first health services coverage in the United States dates back to 1798, when Congress founded the United States Marine Hospital in Louisville, Kentucky, which provided services for sailors. The hospital deducted fees for services from seamen's salaries. Early insurance policies often gave protection from lost income due to accidents instead of covering health services. During the 1870s and 1880s firms in industries such as mining, lumber and railroads developed plans that covered medical expenses. These plans often covered services at the employers' group industrial clinics where medical care to employees for incidents like industrial accidents and common illnesses were covered (Scofea, 1994).

Industrialization

Many historians link the evolution in health insurance to the growing industrialization in America. In the early twentieth century, proponents for "compulsory" health insurance grew. The goals of this insurance were twofold: to "relieve poverty caused by sickness by distributing individual wage losses and medical costs through insurance" and to "reduce the social costs of illness by providing effective medical care and creating monetary incentives for disease prevention", an early version of the wellness programs popular today (Scofea, 1994: 5). Advocates for this type of insurance were led by I.M. Rubinow, who founded the American Association for Labor Legislation, while opponents included American Federation of Labor president Samuel Gompers, as well as physicians and insurance companies (Scofea, 1994). This type of insurance offered affordable means of health care to those who might otherwise go without due to cost, distance to a physician, or lost wages when taking time away from work. Doctors often made house calls to workers, alleviating these concerns.

The Great Depression

The Great Depression in the 1930s brought noticeable expansions in health insurance. Due to the difficult economic conditions, few Americans could pay for hospital care, which presented many hospitals with serious financial problems. More than 100 hospitals across the country failed in the early years of the Depression, and those that stayed open had only a 50 per cent occupancy rate. In 1929, a group of

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teachers and a hospital in Dallas, Texas made provisions to provide coverage for room and board and for other specific services for 21 days for an annual premium of \$6 per teacher. This advance is considered by historians to be the beginning of Blue Cross (Scofea, 1994).

The concept grew across the country due to its affordability and the improvement in hospital conditions, and some employees entered into arrangements with individual hospitals. The idea stretched to include citywide plans including multiple hospitals. Prepayment plans to cover physicians' services, later known as Blue Shield, developed parallel to the Blue Cross plans. At the same time that Blue Cross and Blue Shield plans were being designed, the development of Health Maintenance Organizations (HMOs) was taking place on the West Coast. An HMO provides an extensive range of health care services to subscribers for a preset rate. The largest and best-known HMO that was designed during the 1930s was Kaiser Permanente. During this period of time, commercial insurance companies Blue Cross and Blue Shield were non-profit and were focusing on writing medical reimbursement benefits along with accident policies. These policies covered medical expenses in cases of accidental bodily injury (Scofea, 1994). This sort of insurance did not entice many subscribers.

By 1940, the U.S. population was 132 million, and only 12 million, or slightly less than 10 percent, were covered by some form of health insurance. Blue Cross and Blue Shield dominated the market with a participation rate of 50 percent. Commercial insurance followed with a market share of 31 percent participation, with HMOs bringing up the rear at 19 percent. By 1950 one half of the United States population had some kind of health care insurance, largely affected by World War II, as I will explain below (Scofea, 1994).

FDR: Picking His Battles

The dependence on employer-sponsored health insurance in the United States is considered by many to be "an accident of history" (Blumenthal, July 6, 2006: 82). Economist Uwe Renhardt was quoted as saying, "If we had to do it over again, no policy analyst would recommend this model" (Blumenthal, July 6, 2006: 82). In 1932, Franklin D. Roosevelt declined to pursue controversial universal health care coverage, although he initially considered it as part of the New Deal. Many FDR contemporaries thought that the president would enact a universal health insurance program as part of Social Security during his first term. Some believe that strong opposition of this plan from the then-powerful American Medical Association would have condemned the Social Security Act in 1935, and that FDR chose to champion social security rather than losing both plans due to objections over health care (Blumenthal, July 6, 2006). FDR was unwilling to risk potential overall political defeat, and withdrew his support of the national health care proposal to protect the rest of his agenda (Altman & Shactman, 2011).

World War II

World War II was greatly responsible for the health care industry's growth. Congress enacted the Stabilization Act in 1942, which restricted the amount of wage increases employers could award, but simultaneously allowed the adoption of employee insurance plans. This motivated the advance of plans through collective bargaining agreements. In 1945, the War Labor Board held that employers could not change or discontinue group insurance plans for the duration of a contract (Scofea, 1994). Since 1943 the cost of health care benefits has been a deductible expense for employers and nontaxable income for workers, except for a short repeal from 1953 to 1954 (Altman & Shactman, 2011).

In 1945, President Harry Truman took up the health care reform cause, supporting single-payer insurance. However, his bill never stood a chance (Altman & Shactman, 2011).

The Role of Unions

Unions played an important part in the spread of employment-based health insurance. In industries dominated by a few large companies, unions used their leverage to make the firms share some of their profits with workers in the form of high wages (once the wartime ban on increases had ended) and substantial health insurance benefits. In industries such as residential construction or women's clothing manufacturing, unions organized industrywide labor-management health insurance plans that gave ample cross-subsidization among organizations and individual employees within firms by charging standard premiums (Enthoven & Fuchs, 2006). The generous health insurance benefits also benefitted non-union workers as their firms worked to attract and retain high-quality workers to remain competitive.

The Hill-Burton Act

In 1946 the Hill-Burton Act was passed, giving the uninsured poor a right to free hospital care. This began the practice of cost shifting, in which privately insured patients were charged more for services to make up for free or reduced care to uninsured patients. This resulted in increased employer health insurance costs. Hospitals that accepted Hill-Burton grant money were required to provide annual charity care equal to three percent of their yearly operating costs or 10 percent of the amount of their grant, whichever was less. Alternately they could agree not to refuse any indigent patients who requested care. By 1975, Hill-Burton had financed 9,200 new medical facilities and 416,000 new inpatient beds (Altman & Shactman, 2011).

In 1949 major medical insurance plans were introduced to supplement standard medical care expenses. Major medical plans are intended to safeguard individuals against extended illnesses and injuries. Major medical insurance involves cost-sharing by the employee through yearly deductibles and coinsurance requirements. Medical expenses above the deductible are shared by the employee and the plan as calculated by a predetermined formula (Scofea, 1994).

Since their inception, major medical plans have grown rapidly. In 1951, two years after the initiation of these plans, 100,000 individuals and their dependents were covered by major medical policies. By the end of 1960, that figure had increased to 32 million, and by the end of 1986 it had grown to 156 million. Vision care benefits were introduced in 1957, with dental care benefits following in 1959 (Scofea, 1994).

Lyndon Johnson and Medicare

President Lyndon Johnson signed the Medicare bill into law in 1965, with prescription drug benefits following much later in 2003. Health care escalated rapidly after the enactment of Medicare and Medicaid, a trend which continued into the 1970s and 1980s. Medicare provides low-cost hospitalization and medical insurance to the nation's elderly. Johnson pointed out that those with private, employer-based health care tended to be wealthier and healthier, while those who needed medical care were the poorest. Commercial insurers began setting premiums by experience ratings in the 1940s, considering the age and health history of the insured. As a result, commercial health insurers became very profitable. By 1963 commercial plans held 63 percent of the market. Most health insurance policies continued to be experience rated until this practice was changed by the PPACA under President Barack Obama in 2010 (Altman & Shactman, 2011).

Ted Kennedy and Richard Nixon

A resurgence of proposed health care reform began in 1971 with Massachusetts Senator Ted Kennedy. Along with United Auto Workers union leader Walter Reuther, Kennedy studied the benefits of a single-payer system in which the federal government would provide health insurance funded by taxes. His bill never made headway. Kennedy continued to champion health care reform, but the 1969 Chappaquiddick scandal precluded his running for president. President Richard Nixon countered

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Kennedy's proposal with one that functioned around an employer-based system that retained private insurance. In 1971 Nixon championed the National Health Insurance Partners Program, a mandate for employers to provide health insurance to their full-time employees. The proposal was a significant step in private health care reform and was again introduced in 1972, but it proved unsuccessful. The American Medical Association (AMA) was afraid that government provided insurance would lead to regulation and price controls, thus opposed the proposed changes. They were proved right when Nixon froze health care costs in 1971, but Congress repealed his authority the following year, and costs rose immediately after the government lifted controls. Kennedy proposed a liberal version of Nixon's bill in 1974 so as not to leave health care reform behind. The bill was defeated (Altman & Shactman, 2011).

Gerald Ford and ERISA

President Gerald Ford signed the Employee Retirement Income Security Act of 1974 (ERISA) into law. ERISA regulates the operation of established pension plans as well as health benefit plans if employers choose to establish one. Some subsequent amendments to ERISA include the Consolidated Omnibus Reconciliation Act of 1985 (COBRA) and the Health Insurance Accountability and Portability Act of 1996 (HIPAA). COBRA provides some employees and their beneficiaries with the right to continue their coverage under an employer-sponsored group health benefit plan for a period of time after the occurrence of events that would otherwise cause termination of coverage, such as the loss of employment. HIPAA prohibits a health benefit plan from refusing to cover an employee's pre-existing medical conditions under certain circumstances. It prevents health benefit plans from certain types of discrimination on the basis of health status, genetic information, or disability. During the 1990s and 2000s, some employers who promised lifetime health coverage to their retirees limited or eliminated those benefits. Employees and retirees who were promised lifetime health coverage have been able to enforce those promises by suing the employer for breach of contract, or by challenging the right of the health benefit plan to change its plan documents in order to eliminate those guaranteed benefits.

Jimmy Carter and Ronald Reagan

President Jimmy Carter made controlling health costs one of his main domestic policies, and his first major initiative was legislation to control hospital costs. However, Congress defeated Carter's bill. In the 1980s under President Ronald Reagan health care spending grew faster than the economy. Major cost differences were seen for services by hospital location, and physician shortages occurred in rural areas due to low physician payments (Altman & Shactman, 2011).

Bill Clinton

The next major proposed reform took place at the beginning of Bill Clinton's presidency in the 1990s. Consumers were feeling rising health care costs in their wallets. National health expenditures rose from \$253 billion in 1980 to \$714 billion in 1990, an annual rate of increase of almost 11 percent. Businesses encountered difficulty in passing on the increased cost of health care insurance to their employees, especially in unionized environments where strikes were threatened. In 1990, 72.2 percent of working-age Americans received their health insurance from employers. However, as people lost their jobs during the difficult economic times of that decade, they lost their employer-based health insurance, and by 1992, 17.8 percent of working-age Americans were uninsured. Clinton considered single-payer, play-or-pay (financed by an employer mandate) or tax credits in his proposed reforms. However, Clinton's bill failed, reaching neither the house nor the senate (Altman & Shactman, 2011).

The Effects of Medicare and Medicaid on Private Insurance: Cost Shifting

Private health care spending increased with the inception of Medicare in 1965. To offset the cost of reduced payments or free care to Medicare and Medicaid patients and the uninsured, hospitals began to charge privately insured patients more than their cost of care. This phenomenon is referred to as cost shifting. In this way, Medicare and Medicaid programs are intertwined with employer-based health insurance, because the costs of one directly affect those of the other. The PPACA has made this matter even more complex, as I will address later in this paper (Altman & Shactman, 2011).

The Last Thirty Years

Per capita health care spending grew in the 1990s. Chief Executive Officers argued that this increase in health care spending would cause United States jobs to be sent abroad in order to cut costs and allow their companies to survive, in spite of the tax breaks they received. Companies also struggled to cover retiree health insurance. Private employers offset these increased costs by lowering wages. Managed care plans grew in the 1990s, and health care premiums declined as a result, partly due to insurance companies' negotiations with providers or imposing price reductions on them. However, a backlash among consumers followed due to large scale denial of services. At the turn of the twentieth century Preferred Provider Organizations, or PPOs, became popular. These plans allow insurers to negotiate discounts with providers in their networks and permit consumers to have more flexibility of choice among their care providers (Altman & Shactman, 2011).

How Employers Manage Insurance Today

Most physicians rely heavily on employer-sponsored health insurance for their pay. More than 159 million Americans, or 62.4 percent of the nonelderly population, had health care coverage through employer-sponsored health insurance in 2004. Employer-sponsored health insurance has been described as a sort of "private social security" and if it disappeared, chaos would ensue. The health of patients in the United States would be at risk, and physicians' incomes would plunge. Employer-sponsored health insurance faces trials that are unlike any seen before in its 70-year history, including unsustainable cost increases (Blumenthal, July 6, 2006).

Health care costs have risen dramatically in recent times. From December 1971 to December 1991, the Consumer Price Index for all items increased 235.5 percent, while the medical care component of the index increased 398.9 percent, or 70 percent higher than for all items (Scofea, 1994). In the early 2000s, the cost of employer-provided health insurance increased 59 percent without any increase in the scope of benefits (Baicker and Chandra, 2005). In an attempt to stanch the upsurge in health care costs, new health care systems and ways of delivering health care services, known as managed care, developed. Two common types of managed care are HMOs and PPOs. According to economist Laura Scofea in her 1994 article, *The development and growth of employer-provided health insurance*, "Managed care integrates the financing and delivery of appropriate health care services to covered individuals and has the following common elements:

- arrangements with selected providers to furnish a comprehensive set of health care services to members;
- explicit standards for the selection of health care providers;
- formal programs for ongoing quality assurance and utilization review; and
- significant financial incentives for members to use providers and procedures covered by the plan" (1994: 7).

As Alain Enthoven and Victor Fuchs point out in their 2006 article, *Employment-Based Health Insurance: Past, Present, And Future*,

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Individual employers, understandably, [have] managed health benefits as a tool in the labor system, not as part of a coordinated strategy to produce an efficient health care system. One employer acting alone to create competition is not rewarded with the competitive health care delivery system that would result if most or all did. The great diversity of interests, circumstances, and views about health insurance among employers has precluded collective action to create a market open to competition from efficient systems (2006: 1543).

Many of the faults of employer-based health insurance existed during the 1950s through the 1970s when the employer-based system was developing. These flaws grew more glaring toward the end of the twentieth century and even more apparent in the twenty-first century due to the quickly increasing costs of insurance relative to incomes (Enthoven & Fuchs, 2006). “. . . [G]reater competitive pressures on United States firms mak[e] it more important than ever that they pass these costs on to employees; and low general inflation, which makes it more difficult for them to do so. As a result, some employers are dropping coverage, others are scaling back in various ways, and the percentage of workers with employer-based coverage is declining” (Enthoven and Fuchs, 2006: 1543).

RESEARCH QUESTIONS

This paper addresses the following research questions: why have private employers’ costs of employer-sponsored health insurance grown so high in the United States? How are these costs affected by health care costs in general? How does this affect their employees? What can be done to remedy this problem?

HYPOTHESES: WHAT HAS CAUSED THESE INCREASES?

When beginning my research, I hypothesized that the main causes of the drastic increase in health insurance costs, thus an increase in employer-sponsored health insurance were:

- 1) the changes in physician qualifications over time,
- 2) advances in technology, and
- 3) high administrative costs of health insurance in the United States.

It was apparent to me that these increases would affect employer behavior as organizations tried to offset the rising costs. Hypothesis 4) was that the end result was borne by workers in the form of reduced wages, reduced hours, reclassification of positions from full-time to part-time and an increase in insurance co-payments and deductibles. In researching these matters I found that while my hypotheses were borne out, there were additional factors at work that I had not considered. The recommendations I make at the end of this paper are somewhat different from my original thoughts based on the results of the variables I discovered.

Better Schooled Doctors

Several changes had occurred in the United States by 1920. Improvements in bacteriology and medical technology contributed to the rise of hospitals as treatment centers. Hospitals became centers not only for surgeries but also for x-rays and laboratories in the 1920s. This growth of medicine as a science helped to encourage sick people to visit physicians and hospitals. Medicine’s image as precise, scientific and effective developed. Some of this development was due to the increased licensure and standards of care among health care practitioners. Following a critical 1910 report on the status of medical education, more rigorous standards for physician education and licensure were implemented. While an improved quality of care ensued, the cost of this additional education was also passed down to patients. As well as reducing the supply of physicians, the report and following reforms in medical

education increased the demand for physician services by growing the quality of physicians' skills, which raised the cost of medical services (Thomasson, 2002).

The Technology Theory

An accepted view among economists is that ongoing innovation is the primary reason that health care costs have risen so rapidly. Fresh inventions from new drugs to microsurgery explain why medical spending has exploded from a mere five percent of the United States economy in 1960 to 16.5 percent in 2006. According to some studies, as much as 65 percent of that growth is due to technology (Gleckman, 2006).

Estimates of the growth of health care spending in the United States are 9.8 percent since 1970, or about 2.5 percent faster than the general economy. Drugs and technologies, which are often introduced into the marketplace after minimal testing to determine their safety and efficacy are significant drivers of these increasing costs. Some investigators have attributed almost half of the increase in spending growth to the introduction of medical innovations (Wallner & Konski, 2008).

In their 2008 article, *The impact of technology on health care cost and policy development*, physicians Paul Wallner and Andre Konski identify some of the ways in which technology pushes increasing health care costs:

- 1) New treatments may be developed for previously untreatable terminal diseases such as AIDS.
- 2) Advances may be made in the management of previously unsuccessfully treated acute conditions, such as coronary artery bypass for coronary artery disease.
- 3) New procedures may be developed for the diagnosis and management of secondary diseases, such as the management of anemia in chronic renal disease.
- 4) Indications for treatment may expand over time.
- 5) Incremental improvements in existing therapies may increase the patient population treated.
- 6) Clinical progress may extend the scope of medical care to conditions once considered as beyond its boundaries, such as substance abuse and mental illness (Wallner & Konski, 2008: 194-195).

It can be difficult to accurately determine whether a new technology increases or decreases health care costs. Therapies that increase spending for individual patients or for a short period of time might reduce the amount of health care dollars spent in the future if they improve outcomes, and an increase in use of one service may decrease the utilization of another. For example, a new vaccine for a common disease may be expensive to develop, distribute, and initially use, but over a period of time it might save large amounts by preventing previously required disease management. Calculation of cost impact becomes complicated when direct and indirect costs are considered. The direct costs to patients and payers are more easily determined and calculated than indirect costs to individuals or society, and payers are largely focused on direct costs to them of delivered care (Wallner & Konski, 2008).

The present system of introducing new technology to the healthcare marketplace lacks cohesion. Billing and payment are problematic based on different hospital-based and freestanding reimbursement systems. Rates may vary widely based on the facility setting (Wallner & Konski, 2008).

The introduction of innovations into the marketplace is influenced by multiple factors, particularly in our free-market, profit-driven system. Consumer demand is a major consideration, driven by expectations, marketing, and vendor/provider self-interest. Payment systems are again a factor, encouraging early post introduction payment for emerging technologies. Developers may be driven by professional and personal goals. Commercial interests play a part and medical technology enterprises

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spend larger amounts on research and development as a percentage of sales than in other industries. The pace of innovation requires rapid introduction of new products to the market (Wallner & Konski, 2008).

On the whole, most experts agree that advances in technology have been a prevalent cause of certain improvements over the past decades but have also added to the drastic growth in health care spending in the United States. Acceptable methods of determination of introduction, use and payment for these technologies in the face of increasing restrictions on health care spending, and new approaches must be considered. Stakeholders must recognize that new approaches may be the only way that research and development can continue to progress (Wallner & Konski, 2008).

A different point of view. While many economists have long believed that technology is the primary factor in the rapid increase in health care costs, Amy Finkelstein, a Massachusetts Institute of Technology professor has challenged the status quo. Finkelstein has resolved that the real reason for the rapidly rising cost of health care is the enormous growth of medical insurance over the past 40 years. Her conclusion is that while technology has played a role, the real reason for this expansion is because doctors, hospitals, and consumers adopt new technology so freely. Finkelstein posits that consumers opt for more care if someone else is footing their bills. Additionally, insurance guarantees a constant stream of income for hospitals and other health care providers. Readily available funds encourage the building of new care centers and stocking up on the latest high-tech equipment with the knowledge that it will be paid for. Paul Ginsberg, president of the Center for the Study of Health System Change in Washington State agrees. He stated, “If you produce expensive new things for medical care, people will buy them” (Gleckman, 2006:1). In other words, insurance itself has caused costs to increase. Ginsberg has completed research in 12 major United States cities that dovetails with Finkelstein’s (Gleckman, 2006).

Some of Finkelstein’s colleagues call her studies “pathbreaking work” and a “change [in] the whole landscape in the way we think about health economics” (Gleckman, 2006: 1). However, not everyone agrees with her conclusions. Some economists think that she has overstated the importance of insurance, and others question whether her results apply to private coverage as well as Medicare. However, Finkelstein’s deductions have prompted many experts to reexamine their long-held views. Finkelstein’s next project is to investigate whether the extra spending has actually paid off with better care (Gleckman, 2006). This differing theory warrants further investigation.

Demanding Consumers

In recent times, consumers have begun to demand the use of new technologies in their care. Patients demand more and more services, increasing costs (Altman & Shactman, 2011). The National Business Group on Health, a non-profit organization representing large employers’ perspectives on national health policy issues, stated, “Unless employees pay for health care services out of their own pockets, they have little incentive to comparison shop for the best price or to consider the most appropriate use of services” (Blumenthal, July 13, 2006: 195). Even when Americans must share costs with their employers, some will demand more and better services (Blumenthal, July 13, 2006).

Timing of costs.

In the United States over 20 percent of the country’s annual medical expenses are consumed in the last year of patients’ lives. Countries other than the United States use cost effective analysis to determine what life-extending treatments are reasonable. For example, if a new drug costs \$100,000 but might extend a life for one month, is the benefit of this drug worth the cost (Altman & Shactman, 2011)? The demand for life-extending health care services in this country is so powerful and our health care industry continues to feed it, thus only an extremely strong force would restrain the rise of health care costs in these scenarios (Blumenthal, July 13, 2006).

End-of-life care in the United States is characterized by aggressive intervention and runaway costs. While this is particularly problematic for Medicare patients, those costs trickle down and effect private,

employer-sponsored health insurance plans, also. The Centers for Medicare and Medicaid Services estimate that more than 25 percent of Medicare spending goes to the five percent of beneficiaries who die each year. The dramatic increase in costs during the last months of a patient's life is largely driven by inpatient hospital stays. Many experts say that the use of multiple, intensive services at the end of life are of little clinical benefit to the patient, rather bringing havoc and pain to a patient's dying experience (MedicareNewsGroup.com, 2014). In 2013, the oldest baby boomers reached the common retirement age of 67. As the baby boomer generation continues to age we can expect to see end-of-life care costs increase due to the size of that generation.

Medical Malpractice Costs

The most recent "medical malpractice crisis" that began at the turn of the twenty-first century refers to the dramatic increase in physicians' premiums for malpractice insurance, and the exodus of some of the larger malpractice carriers from the market. The sizable rise in physicians' malpractice insurance premiums is attributed to the growth in malpractice payments. The insurance industry is influenced by the forces of supply and demand (Loughlin, 2008). The number of medical malpractice carriers has decreased over the past two decades, thus the competition within the industry has somewhat diminished. Consumers of health care are likely to bear the brunt of the cost through increases in the price of health care, and thus health insurance premiums. As malpractice costs rise, the price of purchasing health care through any source will increase. Workers, in turn, may be willing to accept lower wages in exchange for costlier health insurance because they would have to pay more on the open market for it, whether or not the increase in premiums is associated with higher value health care (Baicker and Chandra, 2005).

Administrative malpractice costs (defense and underwriting costs) account for approximately 60 percent of total malpractice costs and only 50 percent of malpractice costs are returned to patients. Nationally there are more than 17 claims for every 100 full-time physicians practicing each year. As compared with other nations, malpractice litigation in the United States is significantly more frequent than in other countries: there are 50 percent more malpractice claims in the United States than in the United Kingdom and Australia combined, and more than 450 percent than in Canada (Loughlin, 2008).

Passing Costs on to Workers

Economists argue that workers pay the ultimate price of health care costs in the form of reduced pay and perhaps the elimination of their coverage altogether. Private insurance decreases as the cost of health insurance increases, and wage increases for middle-class workers are inversely related to the cost of health care as well as other benefits (Blumenthal, Stremikis, and Cutler, 2013). According to a national survey conducted by the Kaiser Family Foundation, the cost of employer-provided health insurance has increased over 59 percent since 2000 with no associated increase in the scale or scope of benefits. Between 2003 and 2004 the price of premiums increased 11.2 percent, a nine percentage point increase in workers' hourly earnings (Baicker and Chandra, 2005). If workers fully value these benefits, then they will shoulder the cost of the increase in reduced wages, with no corresponding change in employment, employment costs, or employee utility. Economists Katherine Baicker and Amitabh Chandra found in researching their 2005 working paper, *The labor market effects of rising health insurance premiums*, that the cost of increases in health insurance premiums is endured by employees through decreased wages and decreased hours for those moved from full-time jobs with benefits to part-time jobs without.

Many employers believe that they also share the burden of rising health care costs. For example, they cannot reduce compensation below the minimum wage, and in these instances must absorb the increased insurance costs for workers at or near that level of pay. To involve employees in cost control, many employers are requiring workers to pay more out of pocket than they have been paying for their insurance and the health care services that they receive. A number of firms have increased cost-sharing by offering plans with high deductibles, often ranging from \$1,000 to \$5,000. Between 2003 and 2005 the proportion of all organizations offering health plans with high deductibles increased from five percent to 20 percent,

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and up to 33 percent among large firms with more than 5,000 employees. The RAND Health Insurance Experiment, conducted from 1971 to 1986 by the Department of Health and Human Services, remains the largest health policy study in United States history. This study confirmed that patients use fewer services when they pay more for them out of pocket, but the study also made it clear that patients reduce the use of necessary services, such as preventative care, as much as they reduce the cost of unnecessary services (Blumenthal, July 13, 2006).

Possible employer responses to increased benefit costs include firms offering benefits exclusively to their full-time employees, and an increase in the cost of a full-time employee compared to a part-time employee induces organizations to substitute part-time for full-time workers. This substitution could result in a decrease in both employer health insurance coverage as well as hours worked, but an increase in employment as measured by the number of employees. Dissimilarly, if health insurance is viewed as a fixed cost per worker, increases in health insurance costs could cause firms to increase the hours of work per employee but reduce the total number of employees. This effect is usually focused on employees who work few hours, as it is this group that would become more costly as a result of an increase in health insurance premiums. Employers have found it financially attractive to move these workers to part-time positions without health insurance (Baiker and Chandra, 2005).

To soften the blow of high deductibles, innovations called consumer-directed health plans use tax-exempt “accounts” to reduce the costs of deductibles to employees. Three types of accounts offer tax benefits to employees enrolled in high-deductible plans. These include health savings accounts (HSAs), the funds in which may be contributed by either employees or employers. A second type of account is the health reimbursement account (HRA), which offers more flexibility for employers. In this scenario, employers reimburse all or part of the employee’s out-of-pocket expenses up to an annual limit but do not actually deposit any funds into an account. The last of the three types of accounts is the older medical savings account (MSA). This account is similar to the HSA, but is combined with a catastrophic health care plan that takes effect when the account is exhausted. (Under the PPACA, only young adults under 30 can purchase catastrophic coverage as well as individuals who have been exempted from the individual mandate because there is no available affordable coverage.) MSAs are available to firms with 50 or fewer employees or to self-employed individuals. In theory, consumer-directed health plans empower employees as health care consumers by providing them with information about the cost and quality of available health care services (Blumenthal, July 13, 2006).

High Administrative Costs

A national survey by PNC Financial Services (PNC) of 200 hospitals and insurance companies addressed soaring costs of health insurance, a major concern of consumers in the United States. The survey showed that the costs of medical services are only one part of the problem. PNC found that administration plays a significant role in total costs, accounting for almost one out of every three dollars that patients spend on health care. PNC pointed out that significant inefficiencies in business offices exist, and survey respondents described medical claims, billing, and payment processes that are prone to errors, redundant, and costly. Some areas of particular concern addressed by hospital executives were that, on average, one in five claims submitted is delayed or denied, and 96 percent of all claims are submitted more than once. Hospitals that do not use electronic billing or claims submission processes reported resubmitting a claim 11 times or more, which is nearly four times that of hospitals using electronic processes (*Life Insurance International*, 2007).

From the insurers’ perspectives, health insurance company executives said that they have to go back to hospitals twice on average to obtain all the information necessary to pay a claim. Consumers also indicated dissatisfaction with the administration of their claims, and almost one-quarter of respondents reported having a legitimate claim denied by their health insurer. As PNC executive Paula Fryland pointed

out, “Health care consumerism is an emerging trend that transfers more decisions regarding health care choices, as well as responsibility for payments back to the patient. Consumers will seek more information about their health care costs” (*Life Insurance International*, 2007: 1). She added that both hospital and insurance executives agreed that a demand for transparency will focus on administrative cost and result of the rooting out of inefficiencies (*Life Insurance International*, 2007).

An interesting requirement relating to administrative costs was included in the PPACA. Insurance companies must issue rebates to enrollees if they fail to spend at least a specified percent of premiums directly on health care, as opposed to administrative or marketing costs (Altman & Shactman, 2011).

Health Insurance Spending in the Twenty First Century: A Possible Slowdown?

The Kaiser Family Foundation, a non-profit, private foundation, has studied health spending in recent years and found that it has been growing at historically low levels. The Office of the Actuary (OACT) in the Centers for Medicare and Medicaid Services reports that national health spending grew by 3.9 percent each year from 2009 to 2011, which is the lowest rate of growth since the federal government began keeping such statistics in 1960. Additional estimates from the Center for Sustainable Health Spending at the Altarum Institute suggest that the slowdown continued into 2012, with health spending growing 4.3 percent (The Kaiser Family Foundation, 2013).

Significant focus has been placed on whether the slowdown in health spending is a result of economic factors, such as the Great Recession of 2007-2009, structural changes in the health system that could also lead to slower growth in the future, or a combination of the two. Experts note that with rare exceptions, trends in health spending have generally tracked with trends in the general economy (Blumenthal, Stremikis, and Cutler, 2013). If this slowdown is a temporary phenomenon driven by economic downturn and low inflation, we can expect health spending growth to bounce back up as the economy recovers in the future. If structural changes are responsible, and health spending is growing more slowly than what would be expected due to the state of the economy, then we may continue to see historically low rates of growth even as the economy returns to full employment (The Kaiser Family Foundation, 2013). An additional cause of this pause in growth could be that new developments are emerging at a slower pace than earlier technologies. Of the 10 best-selling drugs in the United States in 2012, all received Federal Drug Administration approval before 2004. Even if spending progression continues to be slow pressure to reduce health care expenditures will not let up (Blumenthal et al., 2013).

Researchers at the Kaiser Family Foundation and the Altarum Institute’s Center for Sustainable Health Spending developed a statistical model to track how the growth in national health spending varies with macroeconomic indicators. The model allowed researchers assess how much changes in the economy in their entirety are associated with increases in health care spending. They were able to forecast what could happen to the growth in health spending in the future assuming the economy recovers as expected (The Kaiser Family Foundation, 2013).

Two macroeconomic variables were found to be highly predictive of the growth in health spending in any given year: inflation during the current year, measured by the Gross Domestic Product (GDP) deflator, in addition to inflation in the previous two years, and the growth in real GDP during the current year, as well as GDP growth in the prior five years. Research showed that these variables explain over 85 percent of the variation in health spending growth rates from 1965 through 2011. It is unsurprising that inflation and GDP drive health spending growth. Changes in real GDP, reflecting recessions and periods of economic growth, are largely a function of changes in consumer spending, and it follows that consumers would also react by adjusting their spending on health care, also. It could be that consumers use fewer health care services as their incomes decrease and they cut back on spending of other services, or it could be an indirect effect, such as employers cutting back on health benefits or fewer people working and more uninsured individuals during periods of recession (The Kaiser Family Foundation, 2013).

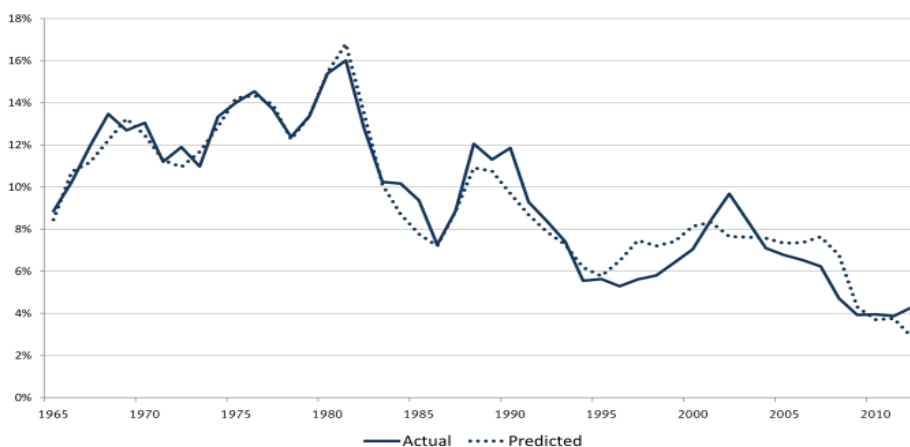
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The Kaiser Family Foundation found that these effects develop slowly, with GDP changes trickling through the health system over a period of six years. “There are a variety of possible explanations for this lagged effect, including:

- Most people are insured, and insurance has an economically protective effect in shielding people from the full cost of health care.
- Consumers may perceive health care as a necessity in a way that is different from other economic goods, and therefore cut back on health spending only after exhausting other ways of trimming household budgets.
- Employers may not make immediate changes to health benefits in response to changes in GDP” (The Kaiser Family Foundation, 2013: 3).

This analysis found that while health spending responds to changes in the economy, the effect is gradual and collective instead of immediate. For example, researchers found that a 1 percent change in real GDP produces a 1.49 percent change in health spending. “The effect is greater than 1.0 because health spending over time grows faster than the economy as a whole, leading to a greater share of GDP devoted to health” (The Kaiser Family Foundation, 2013: 4). The below chart shows the growth in health spending for the period 1965 to 2012, in addition to what The Kaiser Foundation’s model forecasts health spending would have been based only on inflation and changes in real GDP. The chart demonstrates the striking relationship between health spending and the economy, showing health spending growth moving up and down over time closely in sync with macroeconomic measures (The Kaiser Family Foundation, 2013).

Chart 1: Health Spending Growth, Actual vs. Predicted



Source: Analysis by the Kaiser Family Foundation and the Altarum Center for Sustainable Health Spending.

The Patient Protection and Affordable Care Act

The PPACA was signed into law by President Barack Obama in 2010. Like the program put forward by Nixon in the early 1970s, it is built on the current private, employer-based health care system and the private market for health insurance, supplemented by existing public programs such as Medicare and Medicaid. Both Nixon and Obama understood that employer-sponsored insurance is the only practical way to attain universal coverage in the United States, and that a single-payer system is not politically possible at this time. Nixon’s employer mandates avoided tax increase but resulted in lower employee wages. Instead of issuing a mandate, the PPACA charges firms a penalty. The end to underwriting

practices such as exclusions for preexisting conditions and experience ratings are key to this health care reform. A summary of this plan's framework is as follows:

- A near universal system
- An employer "mandate" in the form of a monetary penalty
- Insurance reform ending exclusions for preexisting conditions, refusals to issue, caps on lifetime benefits, and rescissions of coverage
- An individual mandate
- Medicaid expansion to low-income individuals
- Tax credits for low-income individuals and small businesses to buy private coverage
- State-run insurance exchanges for individuals and small businesses
- Financing so that the program will not add to the federal deficit (Altman & Shactman, 2011: 253).

Due to the newness of this law, the long-term effect of the PPACA on health care costs has not been fully realized and will require ongoing future research. Because of the nature of the insurance pool, young, healthy individuals who do not qualify for tax credits have seen an increase in their premiums as they pick up slack for the older and infirm in the system. Critics argue that near-immediate results of the program are the expense (\$1 trillion dollars over 10 years, half of which will be raised through increased taxes and fees), likely rises in insurance premiums, that government will play a greater role in health care, that individuals would be required to buy insurance coverage, and some of those that already had coverage would be forced to pay more money on behalf of the uninsured (Altman & Shactman, 2011).

The PPACA is only more affordable for some. The largest source of revenue for the cost of the bill came from raising and broadening the Medicare withholding tax. This withholding tax had previously been confined to earned income, but the bill broadened the tax to include unearned income such as interest and dividends. Individual taxpayers earning over \$200,000 or families earning over \$250,000 are subject to the tax, and it affects about 2.6 percent of households. The impact of the health reform bill is largely redistributive. Most of it is financed by the wealthy and much of the benefit is realized by the poor and previously uninsured (Altman & Shactman, 2011).

The Future of Employer-Based Health Insurance

While the passage of the PPACA is a major step in reforming the United States health care system, cost and affordability remain major challenges. It is likely that government, private employers and individuals will dissent against the increasing costs of health care if further reform is not forthcoming. Health care premiums for employer-based insurance currently cost over 18 percent of family income, and if current trends continue, they will consume 24 percent by 2020 (Altman & Shactman, 2011).

The PPACA builds on the employer-based health insurance system by developing exchanges by which small employers can offer coverage, as well as penalizing large employers that do not offer coverage. These exchanges, which are open to both employers and individuals, have the potential to alleviate some of the issues faced by small firms that wish to offer insurance to their workers. In the marketplace prior to the PPACA, small firms' capacity to offer coverage was reduced by high administrative costs, low bargaining power to negotiate benefit design and premiums, and a small number of enrollees for risk pooling. By combining employees of small firms into a single risk pool, the exchanges should reduce year-to-year variance in premiums and may increase bargaining power and reduce the amount of administrative spending per employee. However, as the PPACA also expands Medicaid eligibility and provides subsidies for low-income individuals without employer coverage, there are concerns that the new law may cause employers to stop offering health insurance altogether. Workers' preferences regarding insurance coverage have also changed with the introduction of new

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options for subsidized coverage through the exchanges and financial penalties for being uninsured (Eibner, Hussey and Girosi, 2010).

The PPACA includes multiple provisions that experiment with more integrated and coordinated systems of care, which are predicted to reduce costs. A main focus of the plan is to organize care around primary care doctors who coordinate their patients' range of health services, reducing costs by reducing specialist care obtained without referrals. Current health care is not based around primary care, and sufficient incentives for primary care physicians do not exist. Primary care is among the lowest paid specialties, which has led to a shortage of primary care physicians. Obama's plan includes funding to train new primary care physicians. It also includes a bonus after practicing five years of primary care medicine. An increase in payments for Medicare and Medicaid providers will make providing care to these patients more attractive to primary care providers and result in lesser cost sharing. While these provisions are steps in the right direction, even supporters of the PPACA agree that they are not enough in themselves to sufficiently alter the long-term growth trend in health care spending (Altman & Shactman, 2011).

As more people enroll in individual plans through HealthCare.gov and state-operated health insurance exchanges, incrementally, health coverage will become further separated from employment, slowly disentangling the employer-based insurance system that has developed over the last century. Workers who keep their coverage may be forced to shop for it on local business exchanges, aided with a stipend from their employer (Toland, 2014).

RECOMMENDATIONS

Controlling Health Care Costs

In 2009, the United States spent \$2.5 trillion on health care, or \$8,000 per person. Countries such as Canada, Germany and France spend less than half that amount. In 2010, the United States spent over 17 percent of GDP on health care, more than any other country in the world. The average American worker's wages grew by 20 percent between 2000 and 2008, but health insurance premiums grew by almost 100 percent. These figures are five times higher than wage growth and represent one fifth of an individual's annual income. Economists point out that this current rate of cost growth is not sustainable over time (Altman & Shactman, 2011).

Limiting service availability. Consumers today demand the most up-to-date techniques be used in their care. In some instances, these innovations are unproven. As physicians in the private insurance realm are paid a fee per service, there is no incentive for them to keep spending down. One way to limit this costly phenomenon is to regulate health care spending and use, a technique used by many other Western industrialized countries. Other countries restrict the availability of expensive services and regulate the amounts paid to providers, technology manufacturers, and pharmaceutical companies. However, these techniques have a downside. They restrict use and smack of rationing. To date, Americans seem to prefer spending more for their health care rather than accept these restrictions (Altman & Shactman, 2011).

Do Americans use too many health services? The Organisation for Economic Co-operation and Development (OECD) publishes frequent data for its 32 member nations. This provides health data and statistics with which one can compare the United States to similar OECD countries. The results are surprisingly mixed. While residents of OECD countries had 6.8 physician visits per year compared to 3.8 in the United States the United States used more expensive medical procedures like cardiac catheterization, kidney dialysis and transplantations. Those who defend United States medicine argue that these procedures are used to reduce the amount of time patients stay in the hospital, which is shorter than in other countries (Altman & Shactman, 2011).

One reason the United States has higher health care costs than other countries is because its prices are significantly higher. Routine doctor visits are two to 10 times more expensive in the United States than in Canada and some European countries. Procedures, diagnostic tests and pharmaceuticals are also significantly more expensive in the United States. On average, a one night hospital stay in the United States was 25 percent higher than in the most expensive European countries. Some reasons for these comparatively high prices include higher salaries for physicians and health care workers in the United States as compared to other countries, even when adjusted for our higher GDP. Hospitals and consumers in the United States pay markedly more for pharmaceuticals and devices. Higher malpractice insurance costs and significant regulatory requirements also cause additional costs. The United States payment system is also extremely complex. Health providers employ numerous workers to process the bills it sends to private and public payers alike. Single-payer systems have significantly reduced costs (Altman & Shactman, 2011).

Managed care. Managed care was used in the 1990s when the plans implemented utilization restrictions that limited patient choice of doctors and required physicians to get second opinions prior to using expensive services. Health insurers took these actions because they believed expensive procedures and medications were being overused, some of which had limited medical value. For example, studies indicated that Americans received too many magnetic resonance imaging (MRI) and computerized tomography (CT) scans. While the Food and Drug Administration determines whether a drug or device is safe or effective prior to use, limited studies are undertaken to show if a drug or service is medically superior to those already in use. The Obama administration recently funded a program to complete comparative effectiveness research (CER). The purpose of this research is to compare different treatments to determine their clinical effectiveness. Again, Americans have a fear of anything that might lead to the rationing of their health care (Altman & Shactman, 2011).

Cost effective analysis. Another controversial approach is cost effectiveness analysis, which monetizes the benefit of a given drug or treatment and compares it to the cost. It answers questions such as: if a new drug costs 10 times more than an existing drug but only has a marginal benefit, should this more expensive drug be used? This type of analysis is used in countries such as the United Kingdom. In order for a procedure, device or drug to be approved for use in the United Kingdom's National Health Service (NHS), it must be shown to have an acceptable cost effectiveness ratio. A subset of the NHS analyzes the medical effectiveness of a procedure and compares it to existing standards of care or to no treatment at all. The benefit is then calculated in terms of patients' additional quality adjusted life years. This measure includes how much longer the patient will live in addition to the quality of this extended time. If the measure exceeds the NHS's guideline, it will be recommended that the intervention not be covered by the NHS (Altman & Shactman, 2011).

Unsurprisingly, this strategy has been heavily criticized. From a patient perspective, denying treatment due to costs can come across as unconscionable or mercenary, and moreover wealthy patients can pay for these treatments with their own funds. However, the use of cost effectiveness is supported by the United Kingdom population as a suitable way of balancing the needs of its sick population with the amount that the country is willing to spend on medical care. The NHS points out, "With the rapid advances in modern medicine, most people accept that no publicly funded health care system, including the NHS, can possibly pay for every new medical treatment which becomes available. The enormous costs involved mean that choices have to be made" (Altman & Shactman, 2011: 239).

It is questionable that such a scheme would work in the United States because of its unpopularity among consumers. Current United States policy prohibits rationing based on price. However, many policy analysts believe that the United States will never be able to control its health care costs if all possible treatments are available regardless of their cost or efficacy. The United States spends almost double what other countries spend per person for health care, and much of that is spent in an individual's last year of

life. However, if the cost of health care continues to grow at an unsustainable rate, cost effectiveness analysis is likely to emerge as an important policy issue and should receive serious consideration (Altman & Shactman, 2011).

Paying for performance. One health care system reform strategy sometimes used in employer-sponsored health insurance is paying for performance. In this scenario, employers, working with insurers, agree to reward providers who offer a better quality of care, care at a lower cost, or both. Some of these arrangements focus on hospitals, while others concentrate on groups of physicians, and yet others compensate individual physicians on the basis of their performance. This idea has a compelling logic, correcting a major problem in the current fee-for-service system which compensates providers without regard to the quality or efficiency of their services and does not offer any financial incentive to improve their services or to control costs. However, performance can be a difficult thing to measure, and this system could motivate physicians to avoid poor, sick patients whose care is likely to be more difficult to manage than that of healthy, wealthier patients, which would improve the providers' cost of quality statistics. Studies testing the effects of pay-for-performance programs are not yet available (Blumenthal, July 13, 2006).

Reducing administrative costs. The amount of time and money spent on administrative tasks is one of the most exasperating facets of medicine in the United States today. Administrative duties are costly: according to the Institute of Medicine, the United States spends \$361 billion annually in health care administration. The need for more than 850 health insurance companies nationwide selling and contracting with millions of employers and underwriting each one leads to high administrative overhead costs. Reducing administrative costs could involve revising the system of payment to providers, reforming the delivery system and making health care data more available. Costs of marketing health insurance and expenses related to billing and payment are large sources of inefficiency. While the PPACA has initiated the revising of administration of expenses, standardization of forms and processes for billing and claims are considered vital to reengineering our nation's health care system for efficiency. Systemic reform would avoid the pain resulting from health care rationing (Blumenthal et al., 2013).

DISCUSSION

This paper examined the rising cost of employer-sponsored health insurance in the United States. The historical development of the American health care system reflects our country's political culture. Some have referred to the United States's healthcare framework as an accident of history. Unlike many industrial countries in Europe and other parts of the world, Americans place a high value on the private marketplace, making it unlikely that our largely employer-based health insurance system will change or that a single-payer scenario will be adopted. Our piecemeal system makes cost control difficult. Health spending in recent years has been more than 20 percent of the federal budget, which is higher than defense spending. National health expenses jumped from five percent of GDP in 1960 to 18 percent in 2011. Unless changes are made, health spending will continue to grow faster than GDP. As I hypothesized, I found that the largest driving factors in cost increases are technological advances, new treatments, high administration costs, and that these elements pass through employers and eventually on to workers. Additionally, my research showed that consumer demand and medical malpractice costs have played roles in the increases. Ways to solve these issues include managed care, limiting availability of services, paying physicians for performance and standardizing billing practices. These solutions will ultimately involve controlling both use and price, but American consumers have demonstrated an unwillingness to accept changes that could negatively affect them, and it is doubtful that the system will be effectively adjusted without government intervention. From this perspective, the changes made to our health care system by

the PPACA are timely. Americans enjoy their freedom to choose and will not relinquish it without a fight, even as it affects their wallets.

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