Unintended consequences of health insurance through employment

This is something that we can all agree about. I am going to describe some unintended consequences of the recently proposed legislation to achieve universal access to health care, starting with its prehistory. In the 1930s there was much controversy about socialized medicine. A competent attempt at hospital insurance was floated under the name Blue Cross. Only the name survives. The actuaries and accountants who devised the original plan emphasized community rating in order to make the premiums affordable for the entire population, with special concern for those with chronic diseases. Community rating was absolutely needed to raise enough revenue from the healthy to cover the sick. These pioneers thought of many other ideas, like the ideas that lab and X-ray services were covered only in the hospital. I remember in the 1940s and early 1950s, when a patient could be a hospital patient for that purpose only. This was because, at that time, consistent quality control existed only for hospital laboratories and X-ray departments. Blue Cross wanted to pay only for top-quality services because it was more cost-effective.

Along came wage and price controls during World War II. Employers competed for scarce employees with fringe benefits, especially health insurance, because these were not included in the wage controls. Later I heard from a labor executive that some labor leaders regretted pushing for health insurance at work because otherwise the government would have been compelled to provide it for the entire population.

Health insurance as a fringe benefit at work was the beginning of “cherry picking” by insurance companies looking for the healthiest groups to insure, thus enhancing profitability. Blue Cross still exists in name—most, if not all, Blue Cross plans have now gone commercial.

We all applaud the purpose of the Patients’ Bill of Rights, defending the public from arbitrary authority at Health Maintenance Organization (HMO) headquarters. An unintended consequence is increasing numbers of part-time employees and employers opting out of health insurance entirely. The percentage of our population without health insurance is rising steadily. The costs of an effective Patients’ Bill of Rights will accelerate the increasing proportion of our population that is uninsured or inadequately insured because of increasing numbers of employers ceasing to cover health insurance because of increasing costs.

Another unintended consequence of high-cost fringe benefits at work is compulsory overtime, with its health and social consequences. I am referring not only to more stress and less family time, but also to more unemployment. It is cheaper for an employer to pay overtime to existing employees than to hire new help because of the increased expenditure for the new employees’ fringe benefits, like health care.

A rather subtle but important point: insurance through employment, because of employees changing employers every few years, results in inadequate funding of preventive medicine—the insurance companies do not want to pay for a benefit that will ultimately accrue to another insurance company years later.

Unintended consequences creep into the best-laid plans, the main reason for pilot programs for innovations.

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What happened to my State Medical Society?

This is written in response to the House of Delegates action at the Annual Meeting of the Wisconsin Medical Society (Society), during which the House voted to oppose the single-payer system approach to solving the health care crisis, which worsens as costs continue to rise 6% to 10% each year.

When I was active in the Society and the Reagan recession occurred in 1982, we cooperated with the government agencies in trying to provide care to those who became unemployed. Along with the federal government, we established “We Care,” a program that provided free care to those people who were unemployed due to the recession. While individual physicians waived their fees, the government provided funding to cover technologic expenses such as blood counts, urinalysis, electrocardiograms, and X-rays. It was our way of demonstrating that we cared about our patients.

Today, a solution to the health care crisis is mandatory, and I approach, which in my opinion will prevail, is the single-payer system. The recent Society action is viewed by me, the media, and many politicians as meaning that we in the medical profession are more interested in our pocketbooks than in solving the escalating health care crisis for our patients. To me, it will result in the politicians not involving the medical profession as they should when developing a solution, and the outcome will be harmful to all.

If the Society presented an answer to the crisis it would be different; but it appears that they want more of the same, which is no longer acceptable to the majority of American people.

Personally, my experience as Medical Director of an Health Maintenance Organization (HMO) for 16 years, dealing with state and federal government on Medicare and Medicaid contracts left me strongly opposed to government medicine. However, today only the government can ensure coverage for all citizens while controlling costs, something private insurance companies cannot or will not do.

I would urge the Society to rescind their opposition to the single-payer system as soon as possible and try to convince the politicians and John Q. Citizen that our main concern is for the health of all Americans.

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