Transformations of the State
CRC 597

TranState Working Papers

The Changing Public/Private Mix in the American Healthcare System

Mirella Cacace

No. 58

Universität Bremen • University of Bremen
Jacobs Universität Bremen • Jacobs University Bremen

Staatlichkeit im Wandel • Transformations of the State
Sonderforschungsbereich 597 • Collaborative Research Center 597

Mirella Cacace

The Changing Public/Private Mix in the American Healthcare System

TranState Working Papers

No. 58

Sfb597 „Staatlichkeit im Wandel“ – „Transformations of the State“
Bremen, 2007
[ISSN 1861-1176]

Mirella Cacace
The Changing Public/Private Mix in the American Healthcare System
(TranState Working Papers, 58)
Bremen: Sfb 597 „Staatlichkeit im Wandel“, 2007
ISSN 1861-1176

Universität Bremen
Sonderforschungsbereich 597 / Collaborative Research Center 597
Staatlichkeit im Wandel / Transformations of the State
Postfach 33 04 40
D - 28334 Bremen
Tel.:+ 49 421 218-8720
Fax:+ 49 421 218-8721
Homepage: http://www.staatlichkeit.uni-bremen.de

Diese Arbeit ist im Sonderforschungsbereich 597 „Staatlichkeit im Wandel“, Bremen, entstanden und wurde auf dessen Veranlassung unter Verwendung der ihm von der Deutschen Forschungsgemeinschaft zur Verfügung gestellten Mittel veröffentlicht.

Deutsche Forschungsgemeinschaft
DFG

The Changing Public/Private Mix in the American Healthcare System

ABSTRACT

This paper discusses the fundamental changes in the American health care system during the past four decades. By applying a multidimensional framework, the changing role of the state in financing, service provision, and in the regulation of the health care system are scrutinized. The results suggest a considerable “blurring” of the private, market based health care system of the United States. While the state constantly retreats from service provision, it substantially intensifies its engagement in financing and also in the regulation of the system. The most path-breaking changes in regulation, however, are observed through the introduction of managed care, which, from a private market side, brought new elements of hierarchical coordination into the system.

CONTENTS

The Changing Public/Private Mix in the American Healthcare System

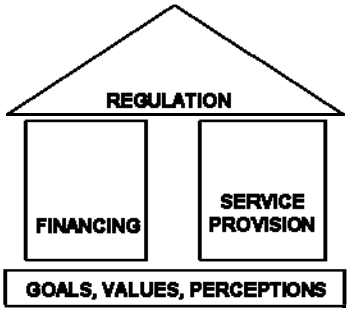
1. INTRODUCTION

1.1 Research context and analytical approach

This paper addresses the changing role of the state[1] in the American health care system during the past four decades. It starts from the point in time, when the state became an important actor through the introduction of the public health insurance programs Medicare and Medicaid[2] in 1965. The economic crisis following the oil price shocks in the 1970s, however, forced the government to put cost containment strategies at the top of its agenda. The pertinent question here is therefore, how the role of the state has changed under the condition of “permanent austerity” (Pierson 2001). As the state is not the only actor in the American health care system, a complex interplay between public and private interventions (Hacker 2002: 23, Oberlander 2002) will come under scrutiny.

In order to approach this research question in a systematic way, a multidimensional analytical framework is suggested distinguishing between the role of the state in *financing*, s*ervice provision,* and the *regulation dimension* of health care systems (Rothgang/Cacace/Grimmeisen et al. 2005). Using the analogy of a house (*figure 1*) that represents the health care system in total, financing and service provision are the pillars. The regulation dimension represents the roof and therefore relates to the pillars by describing which aspect of the health care system, financing or service provision, is regulated. The fundament symbolizes the values, goals, and perceptions in health care.[3]

Figure 1: Financing, service provision and regulation of health care systems



Source: Rothgang/Cacace/Grimmeisen et al. (2005)

---

1 In the US-context the notion of “the state” might be somewhat misleading. In this contribution, “the state” is the summary category for the federal, the states’, and the local governments. I will refer to “the stat**es**” in the following, whenever addressing the single member states.

2 Medicare and Medicaid provide health care coverage for the aged, the disabled, and for the indigent.

3 This part of the house will not be explored here. See Albrecht/Frisina (2006) for a comparative examination of values in the health care systems of Britain, Germany, and the US.

Historically, market competition has been the dominant coordination mechanism in the health care system of the United State emphasizing the relevance of *private actors* in all aforementioned dimensions: in financing, in service provision, and in the regulation of health care. During the observation period, the growing role of the state primarily becomes manifest in funding of health care and in the regulation of these government-funded programs. This is most surprising as conventional wisdom about the deregulatory American state in general, and the “private nature” (Docteur/Suppanz/Woo 2003: 5) of the health care system in particular, teaches us the contrary. But in 2003, the level of public health expenditure measured as a percentage of the GDP was exactly as high in the US (6.8%) as, for example, in the United Kingdom; a country in which the role of the government in health care financing is very strong (OECD Health Data 2006). Not even included in these figures are considerable amounts of tax exemptions (about 1% of GDP) through which the federal government subsidises private employment-based health insurance. Thus in terms of total health care expenditures, today more than half of spending comes from public sources.

A second major trajectory of change to be explored here was initiated by the emergence of a phenomenon which is often viewed as particularly American (Glied 2000: 709), namely through managed care[4]. Managed care deeply affects the relationship among the three main actors in health care systems: insurers, providers and beneficiaries (Hacker/Marmor 1999). A highly diverse array of managed care arrangements has almost completely supplanted conventional indemnity insurance[5] today. In short, managed care arrangements brought about their own, particular instruments of steering providers’ and patients’ behaviour. From a regulatory perspective, a hierarchical form of governance has been established. Interestingly, although the US-government supported the spread of HMOs in the 1970s and contracts with private managed care organizations

[4] Managed care is often contrasted with conventional indemnity insurance highlighting that there is “some kind of interference” in the transactions between insurers, doctors, and patients in the former. It is, however, not easy to define managed care in general, as it encompasses a highly diverse array of institutional arrangements. Thus although a catch-all-definition of managed care would be very helpful at this point of reading, it is impossible to provide one. Hacker and Marmor (1999) take this point and propose to make no general statement about managed care at all but to differentiate carefully between different forms that emerged, i.e. between Health Maintenance Organizations (HMOs), Point of Service (POS), or Preferred Provider Organizations (PPOs) for example. I follow this proposition in my examination of managed care in section 2.

[5] Indemnity insurance was the dominant private health insurance arrangement until in the late 1980s (Kaiser/HRET 2006). In the US, indemnity insurers reimburse for covered health care services only according to a percentage of what they consider the “usual and customary” charge. The provider is allowed to balance bill, i.e. to charge the patient for the difference. In addition, indemnity insurers require cost sharing from the insured persons.

today, it is *not* the state but private market participants that created this hierarchical mode of coordination (Cacace 2008, cf. Hsiao 2002).

In order to explore these changes in detail, this contribution continues with a health care system overview (1.2). A short legislative history in section 1.3 provides with information on the most important reforms between 1965 and today. Due to its crucial importance, the next section (section 2) is dedicated to managed care, its growth and the instruments applied. What follows is a detailed assessment of the changing role of the state. By applying the analytical framework put forward above, changes are examined in the financing dimension (section 3), in service provision (section 4), and in the regulation dimension (section 5). Finally, section 6 concludes by bringing together the evidence about the changing public/private mix in the American health care system.

1.2 Health care system overview

Today, about 68% of the US population has private insurance; either employment based (60%) or as directly purchased individual plans (9%). The most vulnerable low-income groups (13%) as well as the aged over 65 and the disabled (14%) are covered by the main public insurance programs Medicare and Medicaid (US Census Bureau 2006). Although it had repeatedly been on the political agenda, no mandatory universal health insurance scheme has yet been legislated in the US. Thus in 2005, 16% of the US population was without health insurance.[6] Furthermore, due to inadequate benefit packages, millions must be considered as *under*insured (Schön/Davis/How 2006, Stone 2000).[7]

In private insurance, premiums are calculated based on the expected health risk. Depending on the specific health plan, cost sharing[8] is required from the insured person. The major part of the privately insured receives coverage through group health plans provided by the employer on a voluntary basis (employer-sponsored health insurance). The state influences employer’s decision to offer coverage by making their contribution tax deductible. These tax subsidies are quite substantial as they account for 113 billion US$ (US OMB 2006), i.e. about 1% of the GDP or 7% of total health care expenditure.

---

6 Due to double coverage, these figures do not add up to 100%.

7 According to the US Census Bureau (2006: 20) people were considered “*un*insured” if they were not covered by any type of health insurance at any time in the previous calendar year. Under the category of “coverage” head counts are reported (see section 5.1). The term “*under*insured”, however, relates to the content of the benefit package, i.e. the number and kinds of services included in an insurance contract (see section 5.6) and means that some insured persons, although they are covered by insurance, receive only a minimum of health care benefits.

8 Cost sharing may have the form of deductibles, coinsurance rates, and co-payments, or any combination of these elements. A deductible means that a certain amount (like first US$ 500 per year) is to be paid out of the patient’s pocket before the insurance makes any pay-outs. Coinsurance is usually paid as a percentage rate (e.g. 10%) of the health care bill. Co-payments are defined as fixed amounts required per doctor visit, for example.

Employers either self-insure[9] their employees or they contract with private health insurers in order to provide coverage. As they pay the major part of the insurance premium, i.e. between 73% of the cost for family insurance and 84% for individual coverage on an average (Kaiser/HRET 2006: 61), they pre-select the health insurance plans offered to their employees. Employers' choice therefore plays a major role in the competition between plans (Cacace/Rothgang/Thompson 2007, Keen/Light/Mays 2001). In employer-sponsored insurance, the number and the risk structure of employees within the firm is relevant for premium calculation. Small employers with a few severely ill employees may face prohibitively high premium costs (Reinhardt 1993, Kaiser/HRET 2006). Thus, while most large employers offer health insurance, a great deal fewer small businesses actually provide coverage.[10] By the same rationale, private health insurance can be unaffordable for single individuals who are not covered by group insurance. All these factors contribute to the fact that insurance coverage is closely linked to the specific working place.

The public Medicare program is established as a social insurance scheme that provides health benefits to all individuals aged over 65. The program is divided into Part A for hospital insurance and Part B covering outpatient doctor visits. In both cases relatively high co-payments are required from the beneficiaries and some services like e.g. long-term care, are not covered by Medicare at all (Green Book 2004). As a consequence, many beneficiaries in addition hold a private insurance policy called Medigap[11] in order to insure them against cost sharing and for uncovered services.

Medicaid, by contrast, is a means-tested program financed through federal and state tax revenues. Medicaid offers quite comprehensive coverage for the health care needs of the most vulnerable parts of the poor population (Reinhardt 2005). At present, all government funded health care programs[12] taken together account for nearly half of total health care spending.

---

9 Self-insurance is a health care financing technique by which employers pay claims out of an internally funded pool bearing the full financial risk for the health care cost of their employees. Occasionally, the administration of plans is left to private insurance carriers.

10 In 2006, only 60% of firms with 3-199 workers offered coverage compared to almost 100% of large firms (200 or more workers). This number declined from 68% in 2000 (Kaiser/ HRET 2006: 34).

11 Medigap is a supplementary health insurance policy sold by private insurance companies to cover the services not included in the Medicare program. Medigap policies are regulated by federal and state law and are standardized in order to secure comparability.

12 In addition to Medicare and Medicaid, the government finances some minor programs like e.g. the public health programs and some programs provided for special population groups, like the active members of the military services and their families and the veterans (e.g. TRICARE, Veteran Affairs).

The delivery of services, with the medical profession and hospitals as the chief actors, is largely the domain of the private sector. Hospitals, represented by the American Hospital Association (AHA), are mainly private non-profit providers. Although some physicians[13] are directly employed in hospitals or in Health Maintenance Organizations (HMOs), most are self-employed private professionals either working independently or as part of a medical group (Walshe 2003: 52, Jacobson 2001). The medical groups incorporate a number of physicians, either in a single specialty area but often across a number of specialties (multispecialty groups). The majority of specialists conduct their practices within a hospital setting.

Since the concern for the quality of health care provision has increased in recent years, service providers are increasingly monitored and evaluated. Managed care organizations, too, are held responsible when the quality of care is not met. For this purpose almost all US-member states have passed patients' right laws providing the legal basis for litigation against health insurance plans in the cases when needed services are denied (Docteur/Suppanz/Woo 2003, Flood/Stabile/Tuohy 2001). This also gave rise to some regulatory power being given to the courts.

Due to the simultaneous decentralization and fragmentation of the American health care system, administrative costs[14] are high and considerable sources of inefficiencies exist (Woolhandler/Himmelstein 2002, Reinhardt 1993). Thus while the advocates of the system speak in favor of the freedom of choice and consumers' sovereignty, critical observers condemn its "undesirability, unaffordability, and ungovernability" (Marmor/Mashaw/Harvey 1992: 175). Indeed, health care in the US is the most expensive within the OECD world consuming more than 15% of the GDP, while the nation as a whole ranks relatively low on customary health-status indicators (Schoen/Osborn/ Huynh et al. 2005, Reinhardt 2005). On the other hand, the American health care system has brought about some innovations, the most path-breaking examples being managed care and Diagnosis Related Groups (DRGs[15]), which were the forerunners for similar arrangements all over the OECD world.

---

[13] The term "physician" in this case study is used as a summary category for the whole profession, i.e. for primary and specialist care doctors, surgeons etc.

[14] It is estimated that about 25% of total health care spending today is absorbed by administration (Woolhandler/Himmelstein 2002).

[15] DRGs were introduced in 1983 by the Medicare program as a reimbursement method for hospital stays. In contrast to the cost reimbursement method that was supplanted, the DRGs are calculated in advance, i.e. prospectively. For DRG calculation, all illnesses are split into currently about 540 groups and costs per case are estimated within each group. Adjustments are made for certain factors such as local wage levels, teaching hospitals, duration of stay, and hospitals with a large proportion of indigent patients. DRG payments cover the hospital stay in-

1.3 The major reforms

In 1965 the Johnson administration enacted Medicare and Medicaid as publicly funded programs under the Titles XVIII and XIX of the Social Security Act. Medicare falls within the authority of the Department of Health and Human Services (DHHS) and is now administered by the Centers of Medicare and Medicaid Services[16] (CMS). In the Medicaid program, the federal government sets the broad guidelines under which the states administer the single programs.

After the state increased the access to health care through Medicare and Medicaid, the oil price shock and “tax payer’s revolt” forced the government to put cost containment strategies at the top on the agenda (Marmor 2000, Patel/Rushefsky 1999). Once that this need was of paramount importance, the debate about *how* to cope with soaring health costs centered on two broad approaches; namely whether the state or the market is more promising in achieving this objective (Marmor/Mashaw/Harvey 1992). Therefore, as a regulatory measure, the federal government and the states began to control the number and the rates of hospitals beginning in the early 1970s. In addition, peer review organizations were established to evaluate and monitor care provided in the publicly funded programs. At about the same time, the federal government promoted the cost saving effects of HMOs. In 1973 it established the HMO Act targeted at the spread of managed care in private and in public settings. Although both approaches to contain health care cost – the regulatory and the market based – were applied, their success was limited. Continuingly rising medical costs combined with a recession during 1973–1975 contributed to the withdrawal of proposals to establish a national health insurance program in the mid-1970s (Patel/Rushefsky 1999).

Although Medicare and Medicaid were under severe fiscal pressure almost from the moment the programs began, major inclusion processes into the public schemes halted. In 1981 President Reagan’s proposal to abolish the entitlement character of the Medicaid program failed to pass the Congress, but the program nevertheless experienced some major changes. In line with Reagan’s “new federalism” the states got more discretion in defining eligibility rules and also obtained waivers[17] to force Medicaid beneficiaries into private managed care plans. In the Medicare program, a prospective payment system (PPS) based on Diagnosis Related Groups (DRGs) was introduced in 1983. Thus, in contrast to his rhetoric of *de*regulation, the Reagan administration in fact more

cluding all ancillary services *without* surgery and other physician fees. Investment costs are included to a certain degree (Getzen 2004).

16 The CMS until 2001 was known as the Health Care Financing Administration (HCFA).

17 Waivers allow the member states to deviate from federal regulation in the Medicaid program.

heavily regulated the public health care programs, especially as the medical profession is concerned.

In private insurance, the McCarran-Ferguson Act of 1945 assigns general regulatory and tax collecting competency to the single member states (Jost 2001, Pollitz/Tapay/Hadley et al. 2000). Thus a decentralized approach is taken with the consequence of considerable variation between the member states. What is more, in 1974, through the Employee Retirement Income Security Act (ERISA), the federal government exempted all self-insured health plans from the states' taxation, regulation, and control (Hacker 2004, Gabel/Jensen/Hawkins 2003).[18] Unregulated private insurance, however, produces adverse effects. Thus the de-regulations of ERISA worsened the situation of the uninsured (Cacace/Rothgang/Thompson 2007). To partially overcome these limitations, the federal government mandated the COBRA-plans[19] in 1985 as a minimal protection of workers in the transition between jobs.

In order to solve the problem of the high number of uninsured, President Clinton proposed to establish mandatory insurance on the basis of "managed competition" (cf. Enthoven/Kronick 1989a,b) in 1993. According to the proposal, coverage should be provided through employers in a government-regulated, but highly competitive insurance market. The reform proposal, however, failed against the strong resistance of several actors (Quadagno 2005, Giaimo/Manow 1999). After the defeat of the Clinton plan several incremental steps were taken to increase access to existing public and private programs (Hackey 2001, Walshe 2003, Pollitz/Tapay/Hadley et al. 2000). In 1996 the Health Insurance Portability and Accountability Act (HIPAA), for example, was established to secure portability and the continuation of private group insurance. HIPAA is a federal law, thus all states and all health plans, even those exempted under ERISA, have to comply with HIPAA. Another step in this direction was the Balanced Budget Act (BBA) of 1997. With the BBA President Clinton signed the most noteworthy extension

---

[18] For example, most US-states mandate private insurers to finance an internal risk-pool in order to cover those parts of the population who are otherwise hard to insure (Acs/Long/Marquis et al. 1996). Under ERISA, self-insured health plans do not contribute to the financing of these pools. The effects of ERISA have been quite substantial as self-insurance grew considerably. While in 1984 only about 8% of all insured workers were covered by self-insurance, currently 55% are in some sort of self-insured health plan (Erdmann 1995: 102, Kaiser/ HRET 2006: 127).

[19] In the case of job loss or in the transition between jobs, COBRA-plans enable the individual to continue group health plans on a premium, which is calculated on the basis of risk pooling. However, the duration of COBRA plans is restricted from 18 to a maximum of 36 months, and the insured has to pay the full costs (102%) out of his/her own pocket. COBRA-plans received their name as they are created under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985.

of Medicaid, the State Children's Health Insurance Program (SCHIP), into law. In addition, the Medicare+Choice (Part C) program was created, which gave Medicare beneficiaries a wider choice of managed care health plans. HIPAA and the BBA legislation also laid the fundamentals for Medical Saving Accounts (MSA)[20] in private insurance and in the Medicare program thereby underlining the increasing reliance on private market arrangements in the public programs (Fuchs/James 2005).

The growing importance of the private sector arrangements also becomes most evident when considering the most recent Medicare legislation, the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. The MMA was enacted to offer a voluntary drug benefit[21] to subscribers to be phased in by 2006. The benefit can be offered as a stand-alone benefit (Part D) or as a part of managed care plans, which from 2003 on was called Medicare Advantage thereby replacing Medicare+Choice. In both cases, private insurers offer the drug benefit and are allowed to negotiate with pharmaceutical companies for drug prices; thus the boundaries between the public and the private become increasingly blurred (Gold 2005).

2. THE EVOLUTION OF PRIVATE HIERARCHY IN THE MANAGED CARE MARKET

The fundaments for managed care were laid as early as in the 1930s, but it took a considerable time span for managed care to break through. With managed care a new and exceptional mode of governing the health care system emerged, as hierarchical control over market participants is exerted by private actors, namely by private health insurers (Cacace 2008, cf. Hsiao 2002). Due to the impact of these events for the following argumentation, this section is inserted here to provide an overview of the instruments applied in managed care (section 2.1) and the most relevant stages of its evolution (section 2.2). From the highly diverse array of managed care arrangements, it focuses on the Health Maintenance Organizations (HMOs), the Preferred Provider Organizations

[20] MSA are part of a broader range of insurance products called consumer-driven health plans, which rely on high deductibles in order to make consumers price-conscious about their choices. MSA must be combined with very high-deductible health plans providing only a minimum benefit to the insured. The money saved in the accounts may be spent on the benefits at the time services are needed.

[21] The MMA is criticised because the statutes prevent the CMS from bargaining with drug companies for lower drug prices leaving this task explicitly to the private health plans that offer the benefit, instead. Another critical issue is that the program heavily relies on consumer out-of-pocket payments. The standard drug benefit in 2007, for example, requires a deductible of US$ 265. Once this deductible is reached, the enrolee pays a coinsurance rate of 25%. If total spending for drugs reaches 2,400 US$, the enrolee has to bear all cost until total spending reaches about 5,450 US$ *(doughnut hole)* (Kaiser Foundation 2007). From that amount on, the consumer receives catastrophic coverage, but still has to contribute a 5% coinsurance rate.

(PPOs), and Point of Service Plans (POS). These organizational forms are the most common arrangements in a highly diversified managed care market and most appropriate for an illustration of the ongoing changes.

2.1 The mechanisms of governance in managed care

Although there is no single broadly accepted definition, there seems to be some agreement that managed care differs with respect to the specifications of the contractual relationship between insurer, patients and service providers from conventional insurance (Glied 2000: 709, cf. Cacace 2008). More specifically, managed care organizations may interfere in the relationship between doctor and patient and limit the services provided, or they may contract with selected providers only (selective contracting), thereby limiting the choice of provider. What complicates the analysis, is the fact that the instruments applied to control providers' and patients' behaviour once differed largely between the organizational forms but become increasingly mixed today (cf. Hacker/Marmor 1999).

In the first Health Maintenance Organizations (HMOs) that emerged in the American health care market, insurers and service providers became integrated into *one* organization (see e.g. Wagner 2003, Patel/Rushefsky 1999). For this purpose, HMOs employed primary and specialist care providers on a salary and built up or acquired their own clinics. Thereby HMOs not only merged the functions of insurance and service provision under unified ownership, but also tightly integrated inpatient and outpatient care provision (Newbrander/Eichler 2001). This vertically and horizontally integrated organizational form stands in deep contrast to traditional indemnity insurance where insurers, inpatient and outpatient care providers were used to operate independently from each other. While in indemnity insurance the provider is reimbursed according to the fee he or she demands (fee-for-service principle), the services in an HMO are provided at a fixed price agreed upon in advance (prospective payments). Over time, the HMO market became highly diversified with the staff-model, the group-model, the network-model, and the independent practice association (IPA)[22] as the core managed care organizations. In addition, so called "mixed models" emerged which combine at least two

[22] The staff-model characterizes an HMO where the physicians are employed on a salary. In the group-model, the HMO contracts with a provider *group*, which in turn employs the single physicians. The group-model HMOs (like the staff-models) are *closed-panel* HMOs, because the physicians must be members of the contracted group practice to participate in the HMO. In the network-model and in Independent Practice Associations (IPAs) the HMO contracts with more than one provider group and also with individual practices in the latter. IPAs are an *open-panel* arrangement, which means that they contract with all physicians who meet the selection criteria of the IPA and the HMO. Network-HMOs in contrast can be either closed or *open-panel* HMOs (cf. Wagner 2003).

aforementioned HMO-models. Since about one decade, the portion of the IPAs and of mixed models grew markedly amongst HMOs.

In the staff-model HMO, physicians are employed on a salary, which is optionally combined with a financial incentive (bonus/malus option) (Wagner 2003, Amelung/Schumacher 2004). In all other cases, i.e. the group-model, the network-model, and the IPAs, the HMO selectively contracts with one or several multispecialty provider groups. Providers are selected according to their economic and quality-related performance (credentialing), and contract renewal depends on the providers' actual performance characteristics (Kongstvedt 2003, Erdmann 1995). Selective contracting implies some scope for negotiation between insurers and providers. Thus, depending on the competitive market environment, the HMO can use its market clout in order to bargain for lower prices (Amelung/Schumacher 2004). Payment is usually performed on a prospective all-inclusive capitation rate, which means that providers receive a fixed sum per HMO-subscriber (Wagner 2003). Although the capitation rates are risk-adjusted, usually by taking age and gender as indicators, the risk of treatment is shifted from the insurer towards the provider. Therefore the service provider is forced to match economic considerations with medical treatment decisions if he contracts with an HMO on a capitation basis. But also mixed remuneration methods are applied, including discounts on a fee-for-service rate where a portion of payment is withheld and paid out depending upon the performance of provider. In addition, providers have to accept review procedures and further inference in clinical decision-making.

Not only the provider's, but also the patients' behavior is controlled in an HMO. There are several restrictions put on patients' utilization of care. For example, the patient's free choice of doctors, a principle that was traditionally upheld in indemnity insurance, is constrained to pre-selected providers. In most HMOs a gatekeeper, which in general is the primary care physician, restricts patients' access to specialists and optionally also to inpatient hospital care. Depending on the seriousness of their ailment, patients in HMOs might not even see a physician at all during their episode of illness, as new professional careers like the nurse practitioner or the physician assistant were established to provide appropriate care at lower cost (Scott/Ruef/Mendel et al. 2000). Cost sharing, as an alternative method of steering the excessive consumption of services *(moral hazard)*, in general is not applied by HMOs. With this respect HMOs differs crucially from indemnity insurance and from the Preferred Provider Organizations, which are illustrated next.

In a Preferred Provider Organization (PPO), a network of self-employed providers is related to the managed care organization through contracts. In this respect PPOs do not differ substantially from most HMOs. Instead of using a capitation, remuneration is usually performed on discounted fee-for-service rates (Kruse 1997). The discounts pro-

vide some scope for bargaining and each party's relative negotiation strength determines how the risk shared between the providers and the managed care organization (Amelung/Schumacher 2004, Joffe 2003). Although discounted fee-for-service payments typically do not concentrate as much risk on physicians as when capitation payments are applied, physicians' behavior is monitored by utilization reviews[23] and standardization requirements. Selective contracting is also a powerful instrument to influence physicians' behaviour and as the PPO network constitutes an important source of revenue, physicians are concerned not to be de-listed from the provider panels (Rich/Erb 2005). Because there is usually no gatekeeper, patients in a PPO have direct access to specialists (Newbrander/Eichler 2001). Additionally, they may choose a provider from outside of the contracted network, yet at the cost of higher co-payments.

The Point of Service Plans (POS) combine the features of HMOs and PPOs. In POS the consumer chooses a provider at the time the service is needed and makes co-payments if he does not accept gatekeeping or the pre-selected network. Therefore the POS and PPO alike provide more choice but at the same time use cost sharing as an instrument to influence consumer's behaviour.

2.2 The proliferation of managed care

Managed care health plans compete with traditional indemnity insurance on lower prices for services and lower cost sharing while at the same time providing more comprehensive benefit packages (Erdmann 1995). As a result of this highly competitive process indemnity plans, which had prevailed in employer-sponsored health insurance at 73% in 1988, were almost completely driven out of the market by 2006 (3%) (Kaiser/HRET 2006: 57). At the same time, many fundamental changes *within* the managed care landscape took place, like e.g. the increasing "profitization" of managed care organizations, the rapid growth of the Preferred Provider Organizations (PPOs), and the increasing demand for regulation as one consequence of the managed care *backlash*[24].

---

[23] According to the point in time they set in, utilization reviews are categorized as prospective, concurrent or retrospective instruments. Pre-certification or second opinion requirements, for example, mean that approval must be obtained from the insurance company, before elective surgery is performed (prospectively). As a form of retrospective review, managed care organizations will sometimes refuse to pay for services that do not meet their standards (Getzen 2004: 205).

[24] The backlash describes an increasing reservation of the public against managed care as a consequence of quality concerns, rising especially in conjunction with the HMOs from the mid-1990s on (Blendon/Brodie/Benson et al. 1998).

In the 1970s, when managed care was still rare, relatively small non-profit[25] Health Maintenance Organizations (HMOs) were the only arrangements that were offered. From the mid-1980s on, HMOs experienced enormous growth, increasing consolidation, and the conversion into commercial for-profit enterprises (“profitization”). While in 1981 only 12% of all HMO enrolees subscribed to a for-profit plan, this number increased to 63% by 1997 and remains at that level until today (CMS 2003a). HMOs proliferated quickly; within less than 10 years they doubled their market share from 16% (1988) of all covered workers to 31% in 1996 (Kaiser/ HRET 2006). From 1996 on, the number of HMO enrolees declined and the more loosely structured PPOs, gained ground in the managed care market, a development referred to as the managed care backlash. In response to the backlash, most HMOs started Point of Service Plans (POS) in order to regain market share. POS peaked around 1998/99 with 24% of all covered workers but declined thereafter. By 2005 only 21% of all covered workers subscribed to a HMO, and 13% to a POS with declining tendency, while PPOs account for 61% (Kaiser/ HRET 2006). As the for-profit ownership is even more prominent in PPOs, more than 70% of managed care organizations are for-profit today (Town/Feldman/ Wholey 2004).

Now turning to the role which the state played in these changes, the federal government clearly supported the spread of HMOs in public and in private settings. Convinced by the efficiency gains to be attained, the federal government passed the HMO Act in 1973. The HMO Act advised employers with more than 25 employees (who offer health insurance to their workers at all) to include at least one managed care plan in their set of choices. In addition, federal funds were provided to HMOs, which qualified[26] to serve Medicare beneficiaries. The HMO Act had some effects on the growth of HMOs, but only further deregulation, including the federal requirement to relax states’ restrictions on selective contracting in the 1980s, supported the breakthrough of managed care (Glied 2000). In the 1980s the state assumed a more active role in promoting managed care amongst the beneficiaries of the public programs. Initiated through the Omnibus Budget Reconciliation Act (OBRA) of 1981, the US-member states received the option

[25] Non-profit HMOs receive subsidies but are also subject to premium regulation. Most importantly, they are not allowed to adjust their premium rates to the individual health risk but have to apply *community rating*, which is the same mode of premium calculation like e.g. social insurance schemes. Non-profit HMOs therefore have competitive disadvantages as compared to for-profit organizations. I will come back to this important difference in detail when discussing the regulation of the financing system in section 5.2.

[26] These qualification requirements were highly restrictive and therefore somewhat released in the late 1970s and early 1980s.

to waive[27] from federal Medicaid regulation in order to move beneficiaries into private managed care plans. Through the Balanced Budget Act (BBA) waivers were no longer required to make participation in managed care mandatory from 1997 on (Glied 2000). The percentage of Medicaid beneficiaries choosing (or having to choose) managed care grew from 9.5% in 1991 to 58% in 2002 (Hackey 2001, CMS 2003a). For Medicare beneficiaries, yet the incentives to join managed care plans were modest by comparison. As most Medicare beneficiaries hold Medigap policies, which insure them against the risk of cost sharing and incomplete benefit packages, participation in managed care is less attractive. Moreover, Medicare beneficiaries are used to having a free choice of provider and therapy (Reinhardt 2005), a principle that is not supported by managed care. Thus market penetration of Medicare+Choice was low; peaking at 16% in 1999, and declining thereafter to 14% in 2002 (CMS 2003a). However, with the most recent Medicare reform, the MMA of 2003, participation rate in managed care plans is expected to increase (Gold 2005).

While the federal and the states' government embraced an active role in moving Medicare and Medicaid beneficiaries in managed care plans, the states' governments have also been active in passing laws that restrict managed care practices from the mid-1990s on (Rich/Erb 2005: 244). In response to lobbying by consumers and health care providers, many states legislators enacted Patient's Bill of Rights for consumer protection and so called "anti-managed care laws"[28] (Quadagno 2005, Aspen Health Law Center 1998). While the consumer protection laws enabled the litigation of managed care organization in the case of the denial of service regarded as necessary, the anti-managed care laws allowed some providers, especially pharmacies, the access to managed care markets (Flood/Stabile/Tuohy 2001, Jensen/Morrisey 1999). The states thereby limited the degree of control managed care organizations were able to exert on patients and providers.

3. THE FINANCING DIMENSION

In order to explore the changing role of the state in the American health care system, we now turn to the three analytical dimensions, i.e. to financing, service provision, and regulation. To start with the financing dimension, the role of the state is measured quan-

[27] The waiver applied in this case is the section 1915(b) (freedom-of-choice waiver), which allowed the states to experiment with new modes of provider reimbursement.

[28] Anti-managed care laws denote any-willing-provider (AWP), freedom-of-choice and direct-access regulation, designed to delineate the nature of provider-panels created by managed care firms. AWP regulation requires a managed care organization to include or contract with any provider who is willing to accept the terms of the network. Freedom-of-choice and direct-access laws allow subscribers to obtain services from any licensed provider outside the network (at higher co-payments) or to bypass their gatekeeper (Jensen/ Morrisey 1999).

titatively as the portion of public spending on total health care expenditures. Under public expenditures, tax funded programs as well as social insurance schemes are subsumed.[29] The private sources of health care financing comprise private health insurance, out-of-pocket payments, and other private funds such as charities – a source with some relevance in hospital funding in the US. Thus after a short presentation of the total level of health care spending in the American health care system (section 3.1), this section turns to the public/private mix, i.e. the structure of financing health care (section 3.2). Furthermore, a detailed picture of the role of the state in terms of financing is provided by an inter-sectoral comparison (section 3.3). The sectoral approach differentiates between inpatient (hospital) care, outpatient (ambulatory) health care, the dental health care sector and the pharmaceutical sector. Section 3.4 summarizes the results of the financing dimension.

3.1 The changing level of financing

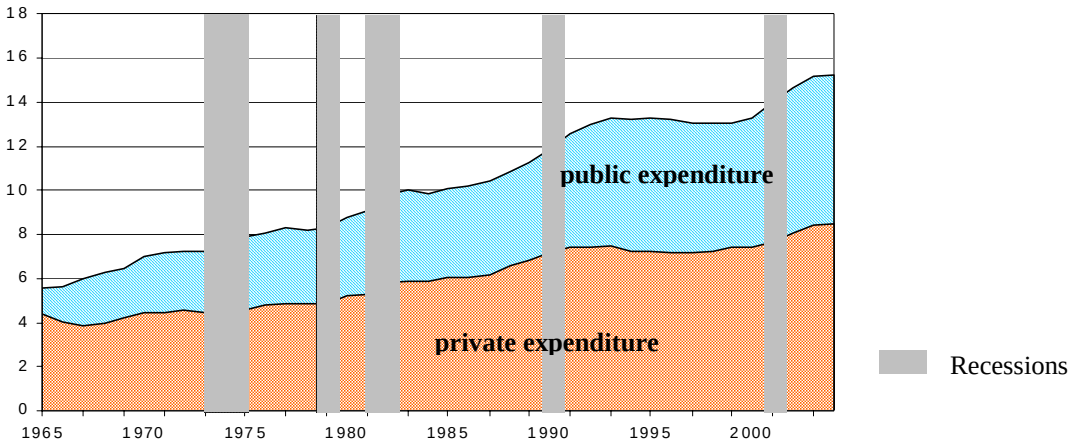
Total health care expenditure in the US increased from US$ 205 per capita in 1965 to US$ 6.100 in 2004 (OECD Health Data 2006). Over the same period, total expenditure in percentages of the GDP rose from 5.6% to 15.3%, which is the highest rate of all OECD countries[30]. The expenditure growth rate shows no linear progression; phases of accelerated growth and intermission can be observed instead. In addition, as we see from *figure 2*, some periods of expenditure growth like, for example, in 1981/82 and in 2001 correspond with phases of economic recession[31]. Though in the other periods, health care cost measured as a share of GDP rose without changes in the denominator.

[29] In other countries, like Germany or Austria, for example, social insurance contributions are associated with self-governing autonomous collective actors (Rothgang/Cacace/Schmid 2006). This is not the case in the US, however. Therefore both tax funding and social insurance financing are considered jointly and attributed to the role of the state.

[30] The OECD average in 2004 was 8.8%.

[31] The phases of economic recession date to the years 1973–1975, 1980, 1981/82, 1990/91 and 2001 (NBER 2007).

Figure 2: Total health expenditures as a share of GDP



Source: OECD Health Data 2006

Until in the early 1980s, the growth of total health care expenditures was mainly fed by an increase in public expenditure caused by the introduction and the expansion of the public Medicare and Medicaid programs. Starting from 1983, when Diagnosis Related Groups (DRGs) were introduced in the Medicare program, public expenditure growth stagnated. But there were no long-run effects of DRGs on health care costs (Getzen 2004: 391). Medicare and Medicaid expenditures steeply increased thereby consuming an ever-increasing share of the GDP. Thus the public programs have been the main driving force for an increase of total health expenditures in the beginning of the 1990s. Private expenditures, on the other hand, accelerated in the 1980s and remained almost constant from 1992 on, fluctuating around 7–7.5% of GDP and even shrinking occasionally in absolute terms. The decade of the 1990s is marked by a rapid expansion of managed care in private health insurance followed by the inclusion of Medicaid beneficiaries into private managed care plans. The observations therefore support the view that managed care had considerable effects on the containment of health care cost.[32] Starting with the economic shock in the aftermath of 9/11, total health expenditure again has risen rapidly in absolute terms and, due to a slow-down in economic growth, even more dramatically in relation to the GDP (CMS 2006). Cumulated over five years, between 2000 and 2005, premiums for family coverage have increased by 73% (!), compared with inflation growth of 14% and wage growth of 15% (Kaiser/HRET 2005:

[32] Managed care has been evaluated many times for its cost-containing and quality-related performance (see e.g. Miller/Luft 1997, Miller/Luft 2002). Most surveys concluded that they significantly reduced health care cost although some of these savings may have been achieved by selecting subscriber groups with favourable risk-structure *(cream-skimming).* The evidence about the quality of service provision is more mixed, however. For an overview of the cost and the quality issues in HMOs see e.g. Rich/Erb (2005) or Glied (2000).

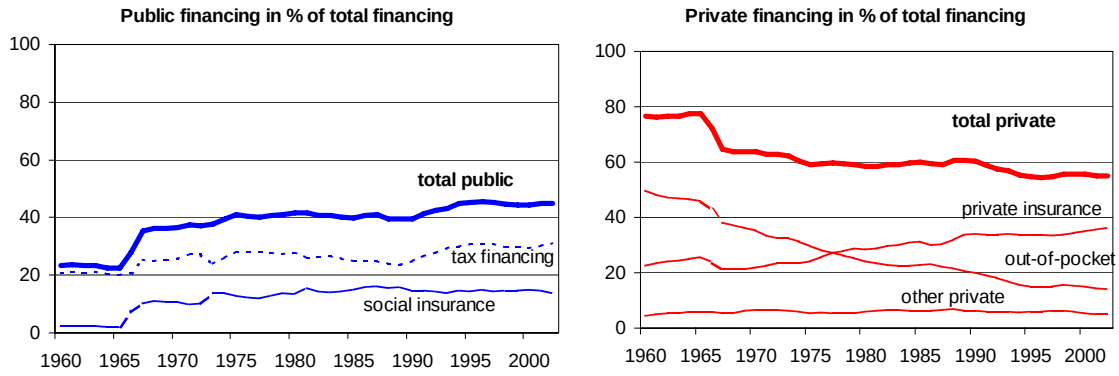
1, cf. Kaiser/HRET 2006: 18). Hence, since the beginning of the new millennium the longest period of slow growth in health care expenditure has come to an end.

3.2 Changes in the financing structure

Before Medicare and Medicaid were introduced, only about 23% of total health expenditure came from public funds, mainly from taxes, while the overwhelming share in health care expenditure derived from private sources, especially out of pocket (45% in 1965). At that point in time, only some minor programs, i.e. workers' compensation and temporary disability insurance were financed by some sort of social insurance contribution (CMS 2006).

Figure 3 illustrates that with the implementation and expansion of Medicare and Medicaid, the public/private mix of financing health care in the US underwent a fundamental change. Public tax financing and social insurance financing increased considerably while private expenditures decreased correspondingly. The Medicare program gave considerable rise in social insurance funding thereby enforcing a principle that was hardly established in the American health care system.

Figure 3: Public and private financing as a percentage of total health care financing



Source: OECD Health Data 2006

The effects of the implementation of the public programs and an initial expansion phase resulting from the inclusion of disabled persons in the Medicare program lasted until around 1975. By 1975 public funding covered 41% of all health care expenditure, after which it levelled off, remaining relatively stable until it started increasing again in the early 1990s. The new flow of public funds mainly accrues to the tax-financed Medicaid program, and reflects several changes in the program features. The peaking poverty rate around 1993, the payments made to disproportionate share hospitals (DSH)[33], and the

[33] In the DSH program service providers are remunerated more generously for their services Medicaid payments since they serve a higher number of uninsured or underinsured patients than the average hospital, which serve a disproportionate share of Medicaid or low-income patients.

set-up of the State Children's Health Insurance Program (SCHIP) in 1997 contributed to this increase (Kaiser Commission 2002). In 2004, almost 45% of health care expenditure came from public sources. About 32% of total health care expenditure was tax-financed; 12.5 % derived from social insurance contribution.

This picture changes, when tax exemptions are considered through which the federal government subsidises private employer-sponsored insurance. The practice of providing tax subsidies is not unusual within the OECD world, though it is quantitatively much more important in the US than in other countries (Adema/Ladaique 2005, Hacker 2002). It is estimated that in 2006 the federal government has spent about US$ 133 billion (US OMB 2006), which is about 1% of the projected GDP of that year, in federal tax deductibles as subsidies to employer-sponsored health insurance programs.[34] The OECD health data categorize the tax exemptions under private health care spending. As Woolhandler and Himmelstein (2002) emphasize, this assignment is incorrect as the subsidies are forgone tax revenues and therefore levied from public sources. Their *re*-calculation *(see second line in figure 4)* shows that this amount is quite substantial.

Figure 4: Diverging estimates of public health expenditures (in % of total exp.)

Year	**1965**	**1970**	**1975**	**1980**	**1985**	**1990**	**1995**	**1999**
OECD 2006	22.7	36.5	41.1	41.3	39.8	39.7	45.3	43.8
W&H 2002	30.7	44.4	51.0	55.4	54.6	55.1	61.2	59.8

Source: OECD Health Data (2006), Woolhandler/Himmelstein (2002)

According to these results, the public share started to surpass its private counterpart as early as 1975. The disparity between the estimates and the official figures widens over time. In 1999, almost 60% of total health expenditures came from public funds as compared to 44% reported by the OECD on the basis of national statistics. Hence, the role of the state in financing health care is considerably higher than is commonly assumed (Docteur/Suppanz/Woo 2003, Hacker 2002, Stone 2000). If this funding structure is then divided "tri-chotomously" into tax financing (45%), social insurance contribution (15%) and private financing (40%), US health care will be predominately tax-funded. Therefore it is not appropriate to call the US a private system with respect to financing today.

When recalling *figure 3* we see a second remarkable trend in US health care financing; this time as an interesting shift *within* private financing. Although private insurance funding reacted to the introduction of Medicare and Medicaid with a temporary drop, it

[34] By comparison, federal governments' spending on Medicare was about US$ 309 billion in 2004 and US$ 173 billion on Medicaid. The co-financing of the states in the Medicaid program accounted for US$ 120 billion in 2004 (CMS 2006). Therefore, as Iglehart (1999) has already stated in 1999, tax expenditures make up the third largest federal health program after Medicare and Medicaid.

soon recovered, assuming a constantly growing share in health care financing. Thus at the same time when public funds have accounted for an ever increasing portion of the health care bill, private insurance financing also expanded and out-of-pocket payments declined (Levit/Freeland/Waldo 1990). Beginning in the 1970s and accelerated through the spread of managed care from the mid-1980s on, private insurance started to widen the scope of benefits and tighten requirements for out-of-pocket payments. While private insurance made up 25% of total health care financing in 1965, this figure had risen to 37% by 2004. Out-of-pocket payments for health care decreased from a high 45% in 1965 to about 30% in 1975 and down to 13.2% in 2004. This out-pocket-rate is remarkable as it is lower than Canada for example (14.9%) and even slightly below Denmark (13.9) (OECD Health Data 2006).

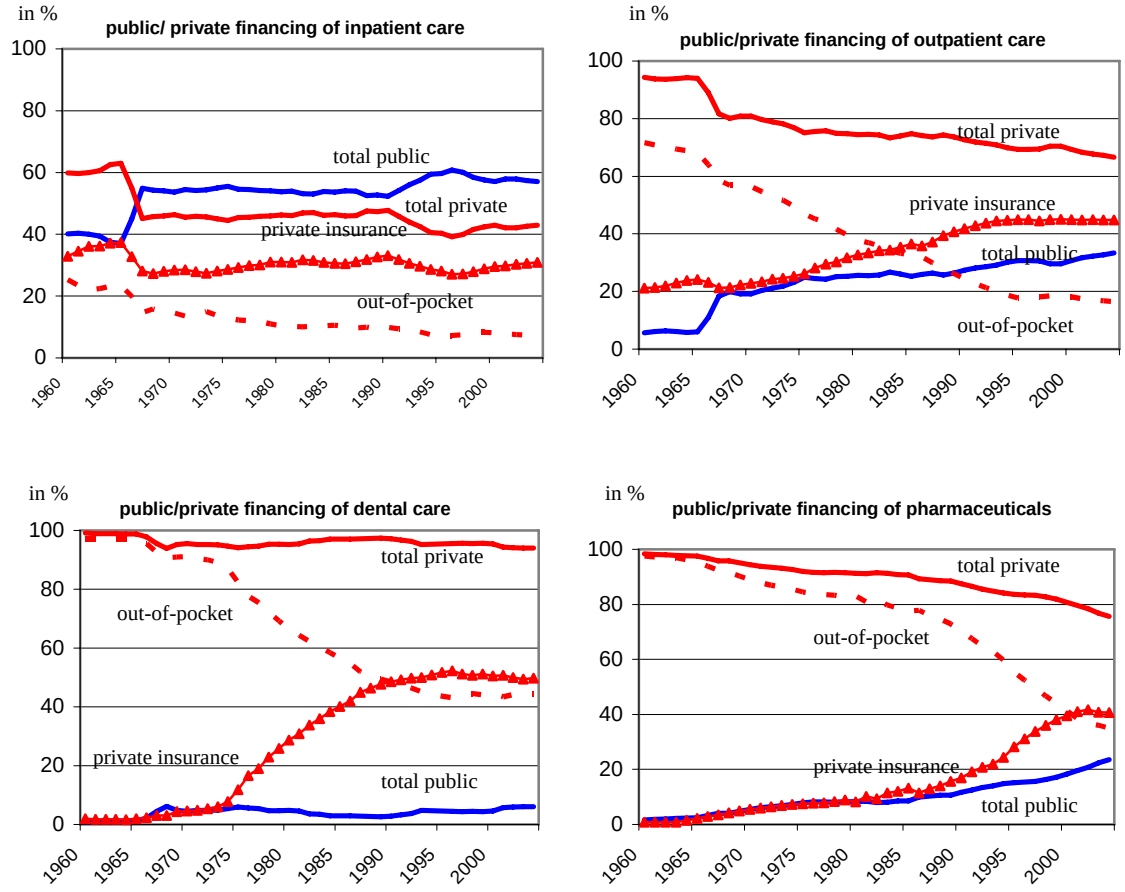
In sum, this means a considerable rise in collective financing through both, the public programs and private insurance financing as well. These quantitative data, however, have to be read with caution as they do not reflect the degree of solidarity achieved by collective financing in the US health care system. More precisely, solidarity in private health insurance financing is restricted as premium calculation, within some limits set by the federal and states' governments, follows the principle of risk-equivalence *(experience-rating)* and therefore implies only minimal re-distributional effects.

3.3 Intersectoral comparison

In order to investigate the trends described above in greater depth, public spending in the inpatient and the outpatient as well as the dental and the pharmaceutical sector will be examined separately here. At the beginning of our observation period, the role of the government in financing is rather modest in all sectors, but it is most prominent in the sector which consumes most resources, i.e. in inpatient care. In 1965, the public expenditure constituted about 37% of total expenditure in the inpatient sector, as compared to 6% in outpatient care (CMS 2006). Public financing at this time was of almost no quantitative relevance in either the pharmaceutical (2.4%) or in the dental health care sector (1.2%).

In the inpatient health care sector the public/private mix altered fundamentally when Medicaid and Medicare were introduced. Public expenditure rose from 37% (1965) to about 55% of total inpatient care expenditure in 1975. In the 1990s a second leap is observable, augmenting the public share by another 5% to over 60% of total inpatient care expenditure. From the mid-1990s onwards this trend halted, and public financing of inpatient care fluctuated henceforward at around the 60% margin until 1997 but fell from then on to 57% in 2004. Out-of-pocket payments fell from 24% in 1965 to 7.4% in 2004.

Figure 5: Public and private financing in the health care sectors



Source: Centers for Medicare & Medicaid Services (CMS 2006): Health Accounts[35]

Inpatient care is the costliest of all health care sectors, consuming a large part of the financial resources. Bearing in mind that the public share in *total* health expenditure was 45% in 2004 (OECD Health Data 2006), we can clearly identify a disproportionate share of public financing allocated to the inpatient sector. In addition, the inpatient sector is the only one in which public expenditure exceeds private financing today. Thus the state assumed (and has always had), the strongest role in that sector.

The growth rate of public financing was even more dramatic in the outpatient sector. From 1965 to 1975 public expenditure had expanded from 6% to 25% of outpatient spending, followed by a more or less constant increase throughout the 1980s and 1990s, amounting to 31% in 2004. Out-of-pocket payments fell from 68% to about 18% in 1995 within a span of thirty years and have continued to decline slightly until today.

Compared to all other sectors, public expenditure is lowest in dental health care. This is most plausible as routine dental care procedures are not covered under Medicare, nor are dental care services in general included in the basic Medicaid package. The public

[35] Please note that tax exemptions, which effectively are public expenditures, also are included in private financing in the CMS data sets.

share nevertheless rose from 1.2% in 1965 to 6 % in 2004. At the same time there was a considerable increase in private insurance financing, particularly between the mid-1970s and the mid-1990s. Again, we find a remarkable decline in out-of-pocket payments, which can largely be explained by the penetration of managed care plans into the market. In contrast to traditional private indemnity insurance, managed care health plans regularly include dental care procedures in their benefit packages. Out-of-pocket expenditure dropped steeply from 97% in 1965 to 44% in 2004.

The pharmaceutical sector was least affected by the introduction of Medicare and Medicaid, as no outpatient drug coverage was included in Medicare, for example, when the program was established. In the Medicaid program, prescription drugs are an optional benefit. Nevertheless, public drug expenditures rose steadily over the period under investigation. They grew from a low 2.4% in 1965 to 15% in 1995 and reached almost 24% in 2004. We see, therefore, that the pharmaceutical sector was influenced less by the introduction of the public programs than by their expansion over time, especially over the last decade. Private insurance financing steeply increased, especially beginning from the 1990s, and amounted to about 41% in 2004, while out-of-pocket financing fell from over 95% in 1965 to 35% in 2004. Depending on the further development of the new Medicare drug benefit (*see MMA in section 1.2*), Medicare funding is expected to increase and individuals' out-of-pocket and Medicaid spending to decline in the coming years (Kaiser Foundation 2006, Heffler/Smith/Keehan et al. 2005).

3.4 The changing role of the state in financing

To sum up this analysis for the financing dimension, there is a strong increase in public involvement in the US health care system from the beginning of the observation period in 1965 onwards. This flow of public funds into the system is largely due to the public Medicare and Medicare programs, but also a result of constantly rising tax exemptions to the benefit of private, employer-sponsored health insurance. Therefore, it is no longer appropriate to label the American health care system a private system with respect to financing but rather a "mixed system" (Marmor 2006, Oberlander 2002). This finding implies a considerable blurring of the financing system, especially as with the social insurance contributions an almost completely new element of health care financing entered the American health care system.

Private insurance financing also increased which means that collective financing through both public and private insurance led to a considerable decline in out-of-pocket payments in all health care sectors. This development was supported by the diffusion of managed care arrangements seeking competitive advantages (Gabel/Ginsburg/Pickereign et al. 2001). With HMOs and their followers penetrating the private market, benefit packages became more comprehensive and cost sharing declined. Thus, taking developments from the mid-1960s on into consideration, a "privatization of risks" (Hacker

2004) in *purely quantitative* terms is not observed for the financing of the American health care system.

But these quantitative data do not reflect the fact that insurance protection leaves severe gaps in coverage. In addition, as mentioned before, the solidarity-aspect of private health insurance financing needs to be questioned. What is more, due to high total health care spending in the US, even low out-of-pocket payment rates equal relatively high absolute amounts. All these aspects, however, are dealt with in the regulation dimension, especially in the regulation of coverage and the financing system in sections 5.1 and 5.2. This brings us back to the necessity to explore all three dimensions simultaneously, i.e. the financing, the service provision and the regulation of the health care system.

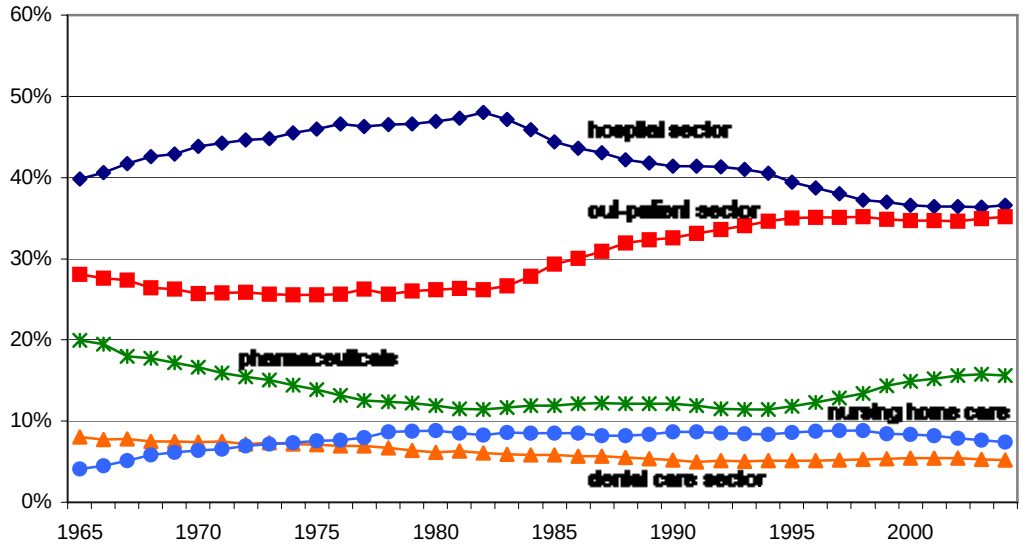
4. THE SERVICE PROVISION DIMENSION

Service provision is the second dimension which is measured quantitatively. Yet there is no straight way to quantify the role of the state in the delivery of services over *all* sectors (Rothgang/Cacace/Schmid 2006). Therefore we first measure the size and the public/private mix *in each sector*, i.e. in the hospital sector, the nursing home sector, the outpatient sector, the dental health care sector, and the pharmaceutical sector (section 4.1). The most appropriate measurement approach, which allows for comparison among the sectors at the same time, is to use monetary terms. Monetary data indicate the flow of funds into the health care sectors thereby explaining the changing size of the respective sector over time. In a second step, data on the public and private responsibility in each sector are used to describe the changing the public/private mix (section 4.2). In order to combine data on the size of the sectors with the information on its public/private mix, an indicator (Public Service Provision Index = PPI) is provided in the concluding section (section 4.3).

4.1 The size of the health care sectors

During the whole study period, most monetary resources are absorbed by the hospital sector (CMS 2006). From 1965 up to a turning point the percentage of total health expenditures allocated to the hospital sector rapidly increased from about 40% in 1965 to 48% in 1982. This turning point is clearly marked by the introduction of the DRG-based payment system for hospital care. The share subsequently decreased as quickly as it rose, eventually arriving at 37% of monetary resources in 2004 (see *figure 6*). Correspondingly, the monetary resources allocated to the outpatient sector remained constant at a few percentage points below the 30% margin and increased from the early 1980s on.

Figure 6: Percentages of monetary resource flows in all sectors[36]



Source: CMS 2006, own calculation

The nursing home sectors' relevance increased during the study period, fostered by demographic changes. Between 1965 and 1980 the percentage of monetary resources devoted to that sector doubled from 4% to 9%. From 1998 on, the point in time when DRGs were introduced also for the nursing home sector (cf. CMS 2003c) the share decreased to 7% in 2004. Monetary resources allocated to the dental care sector remained stable at 7%–8% of total until the late-1970s and then started to decline, eventually reaching 5% in 2004. The percentage of resources allocated to the pharmaceutical sector sharply declined from 21% in 1965 to about 12% in the mid-1990s. From 1995 to 2004, however, the percentage of monetary resources spent on pharmaceuticals rose again rapidly to 16%. Due to price increases and higher consumption levels, prescription drugs have represented a rapidly growing cost component in service delivery (Docteur/Suppanz/Woo 2003).

The introduction of the DRG-based prospective payment system (PPS) in Medicare had a major impact on the two largest sectors in terms of resource flows, i.e. the hospital and the outpatient sector. In the hospital sector, rates were forced down and procedures that have been performed on an inpatient basis have been moved to outpatient settings. At the time of their introduction DRGs uniquely applied to Medicare patients but as Medicare is almost a "monopsony buyer" (Ruggie 1992: 932) of inpatient care, the bulk of the hospital care procedures fell under the PPS. Medicaid and private insurers followed the Medicare example and introduced DRGs in the 1990s (Raffel/Raffel 1997, Getzen 2004). The spread of managed care, too, gave rise to a shift from inpatient

[36] This calculation follows an institutional classification of monetary resources.

treatment to the less costly outpatient sector (Kronenfeld 2002, Levit/Lazenby/Braden et al. 1997). Prior authorization requirements for hospital stays, most common in managed care, provoked efforts to provide care in the most appropriate setting. Hence, over time relatively less monetary resources were directed into the inpatient and more to the outpatient sector.

Correspondingly, the total number of inpatient beds[37] decreased from 8.8 beds per 1,000 of population in 1965 to 3.6 beds in the year 2000, which is one of the lowest inpatient bed ratios in the OECD world (Docteur/Oxley 2003). The average length of stay for patients fell sharply and procedures that have been performed on an inpatient basis were moved to outpatient settings (AHA/Lewin 2006). At the same time, there was an almost linear increase in employment in the hospital sector, growing between 1965 and 2000 from 10.1 to 16.2 employed persons per 1,000 of population. The decrease in the number of inpatient beds should therefore not conceal the fact that the hospital sector is still expanding in terms of employment. With the spread of managed care and the resulting competitive pressure, hospitals were forced to deploy their personal resources more efficiently. Thus efficiency, measured as the ratio of full time equivalent per admission[38], has improved from the early 1990s on, a period marked by rapid increases in managed care (Kaiser Foundation 2004). But this measure has to be read with caution as the DRG-based payment system provides an incentive to discharge patients early and to re-admit them in case of complications thereby rising the number of admissions.

In the outpatient medical sector, the number of practicing physicians increased from 1.3 per 1,000 of population in 1975 to 2.4 in 2004 which is below the OECD average (2.9) (DHHS 2006, OECD Health Data 2006). The increase in the number of dentists and pharmacists was less substantial. In 1980 there were 0.5 practising dentists per 1,000 of population as compared to 0.6 in 2000. Over the same period the number of pharmacists rose from 0.6 per 1,000 of the population to 0.7 (OECD Health Data 2006).

4.2 The public/private mix in the health care sectors

Having gathered the information on the size of the respective sectors and its changes over time, the next step is to describe the changing public/private mix in each health care sector. Coming first to the hospital sector, we distinguish according to the ownership of facilities between public, private non-profit and private for-profit hospitals.

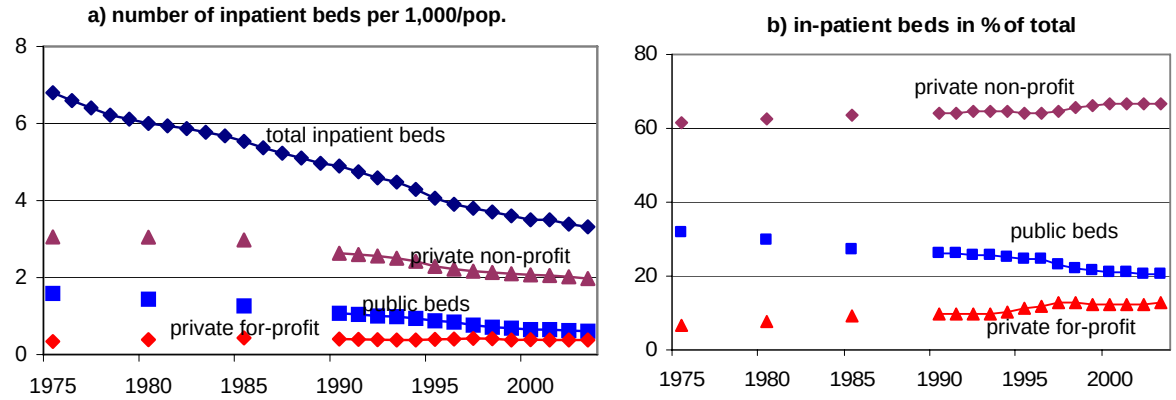
---

[37] American Hospital Association (AHA): Hospital Statistics, several years. Data include acute care and long-term care beds in hospitals and exclude nursing homes and a small number of non-federal hospitals which are not registered within the AHA.

[38] See AHA (2000: Appendices) for this concept of measuring efficiency.

In 2004 the AHA counted 5,759 acute care hospitals with about 956,000 inpatient beds in the US (AHA/Lewin 2006). Over all ownership status, most hospital beds, i.e. about 85%, are owned by hospitals operating at the community level.[39] The following figure provides with information on the changing number of inpatient beds *(figure 7a)* and also on the corresponding market share according to ownership *(figure 7b).*

Figure 7: Beds according to ownership (1975-2003)



Source: DHHS (2006), American Hospital Association (AHA 2000, AHA 2006a, AHA/Lewin 2006), own calculation.[40]

Turning now to the role of the state in hospital care provision, the share of inpatient beds in public ownership in relation to total hospital beds serves as an indicator. Included in the number of public hospital beds are all federal, state and local inpatient beds.[41]

The public share declined from 32% of all hospital beds in 1975 to about 20% in 2004 *(see figure 7b)*. An accelerated decrease is observable over the past ten years. Throughout the observation period, most inpatient beds are owned by private non-profit hospitals. In 1975, private non-profit beds accounted for about 60% of all inpatient beds. Although the absolute number of beds in non-profit ownership decreased, this

[39] Community hospitals as defined by the AHA are all non-federal, short-term general and special hospitals whose facilities and services are available to the public.

[40] The percentages *(figure 7b)* are adjusted by omitting missing values. The DHHS/AHA data do not explain the ownership status of all registered inpatient beds; nevertheless, quality of data improves over time. While for the year 1975 ownership data are available for only about 75% of all inpatient beds, in 2003, the ownership of almost 90% of all inpatient beds is explained.

[41] As they traditionally respond to local needs, most public hospitals are located at the state and local community level. There are, however, also some hospitals owned by federal government institutions like e.g. the military hospitals operated by the Department of the Army or by the Department of Veterans Affairs. The number of federal hospitals also includes a few prison hospitals and inpatient beds operated by the US Public Health Service.

type of hospital was able to expand its market share to 66% in 2004. During the same period the number of beds in private for-profit ownership expanded from 7% to 13% while their absolute number remained almost constant (*see figure 7a*).

These numbers reflect a fundamental and ongoing change in the American hospital industry as a response both: market requirements and government policies. In the light of increasing market competition following the growth of managed care, government sold out its municipal hospitals (Getzen 2004). Remarkably, however, not only the market, but also the government played a role in creating this environment by shifting the beneficiaries of the public programs into managed care and through the introduction of DRGs in the Medicare program. Thus in the 1980s there was an increasing concern that a few, very large commercial suppliers will dominate the hospital industry (Döhler 1990). But this expectation did not come true because in order to secure a minimum treatment of the uninsured and those unable to pay, government supports the non-profit hospitals by providing tax subsidies (Andrews 2005; see also *section 5.4*). Therefore, it happened not only that non-profit provider converted into for-profit companies, but also the other way round (Scott/Ruef/Mendel et al. 2000). Hence, non-profit service provision still prevails in the US hospital market today, although the market share of private for-profit hospitals is on the increase.

Unfortunately, for the nursing home sector no comparable data on inpatient beds exists. From the CMS data we know that the portion of private for-profit providers is considerably higher than in the hospital sector and public provision is only about 5% today (CMS 2003 b).

Turning now to the outpatient sector, the public/private mix is determined by the employment status of providers. By definition, self-employed outpatient physicians are considered as private providers.[42] But, strictly speaking, not all physicians in the US can be categorized as outpatient providers, and not all physicians are self-employed. A small percentage (less than 3%) of physicians are inpatient care providers, as e.g. those employed full time in hospitals by the federal government or in university hospitals (AHA 2006b, Graig 1999). Nevertheless, most physicians are outpatient care providers. In these settings, physicians can be self-employed or employed under salary, like e.g. in a HMO. The number of physicians working on a salary is considerable: in physician-owned practices and in HMOs, the share of employed US physicians increased from 24% in 1984 to more than 35% today.[43] But since both, HMOs and group practices are private organizations it is justified to consider the employed physicians as private enti-

[42] Compare Rothgang/Cacace/Schmid (2006) to this concept.

[43] See Graig (1999) and AMA (2006) (own calculations).

ties, too. The fact that all (outpatient) dentists and pharmacists are also private providers allows the conclusion that outpatient service provision as a whole is private.

4.3 The changing role of the state in service provision

In order to fully assess the changing role of the state it is necessary to combine the sector-specific data by generating a formula for an assessment of the role of the state over *all* sectors. For this purpose, we suggest a Public Service Provision Index (PPI)[44], which results when multiplying the share of monetary resources allocated to each sector with its respective public and private shares of service provision in percentages. By doing this over a period of several years, we obtain one condensed indicator for the role of the state over all sectors and its change over time.

In 1975 the PPI was 15%, which means that 15% of overall service delivery were public and 85% private at that point in time. This indicates an already low level of public involvement in service delivery at the time our data series starts. Public service provision was highest in inpatient hospital care, a sector that entered the computed indicator with the strongest weight since most monetary resources were allocated to it.

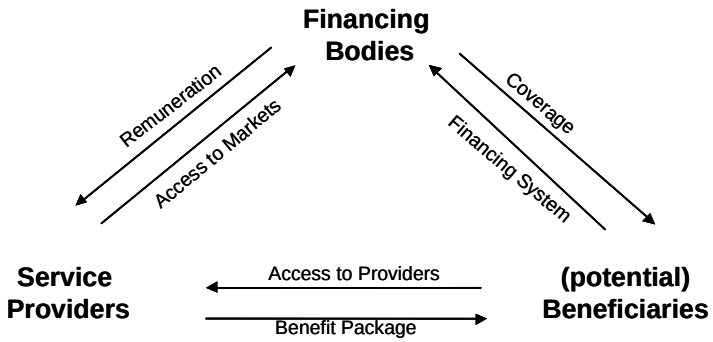
In the first decade from 1975 to the mid-1980s, the monetary resources directed to the hospital sector increased. But this increase was not sufficient to over-compensate the *direct retreat* of the state from service provision, which resulted in the first instance from decreasing numbers of inpatient beds in public ownership. Thus the computed indicator shifted to 12% in 1985 indicating a slow but constant retreat of the state. From the mid-1980s on, caused by the introduction of the Diagnosis Related Groups (DRGs) and the spread of managed care, the size of the hospital sector declined and relatively fewer resources were devoted to it. These developments had major effects on the public/private mix as resource flows were re-directed from the inpatient sector, where the state played at least a certain role, to the outpatient sector, which is entirely private. Thus while the direct retreat of the state from service provision continued; it was enforced by an *implicit retreat* due to the withdrawal of resources. In sum, both effects in combination led to an acceleration of the observed phenomenon ending up with a PPI of only 8% in 2004, thereby clearly indicating a retreat of the state in service provision.

5. THE REGULATION DIMENSION

In the first two dimensions the role of the state was measured directly as the public share in financing and service provision respectively. We now come to the third aspect of the role of the state, namely the *regulation dimension.* Here the relationships between the three main actors in health care systems are relevant: the service providers, the financing bodies, and the (potential) beneficiaries *(see figure 8)*.

[44] Compare Rothgang/Cacace/Schmid (2006) to this concept.

Figure 8: The regulation dimension



Source: Rothgang/Cacace/Grimmeisen et al. (2005: 3), own adaptation

Six relationships between the main actors of health care systems are to be examined. First, we need to ask *who* regulates the relationship between the financing bodies and the (potential) beneficiaries. Within this relationship, the regulation of health care coverage (4.1) and the financing system (4.2) are discussed. In the relation between service providers and financing bodies, the question is *who* regulates the remuneration system (4.3) and the access of service providers to the health care market (4.4). In the last relationship, i.e. between service providers and beneficiaries (or patients), we assess *who* regulates the access of patients to providers (4.5) and the content of the benefit package (4.6).

5.1 Coverage

Starting with the relation between (potential) beneficiaries and financing agencies, we first examine who is responsible for coverage decisions and the inclusion of further sections of the population. It is important to note that in our concept coverage refers to the percentage of the population covered (head counts), and not to the question of comprehensiveness of the benefit package (*see section 5.6*). For an investigation of the role of the state it is not only relevant to ascertain whether it assumes the task of providing coverage directly through public programs, but also to what extent the state regulates coverage in private insurance. *Figure 8* provides an overview of the most relevant forms of coverage in the US health care system.[45]

[45] Due to double coverage, the figures based on US Census data do not add up to 100%. Double coverage occurs for example when persons eligible for Medicare are poor and therefore also receive Medicaid benefits. Some individuals covered by employer-sponsored insurance are eligible for Medicare at the same time.

Figure 9: Health insurance coverage in % of total population

		1965	1970	1975	1980	1985	1990	1995	2000	2005
public insurance	Medicare	0[a]	10[a]	12[a]	13[a]	13[a]	13	13	14	14
	Medicaid						10	12	11	13
	total government						25	26	25	27
private insurance	total private	72[b]	78[b]	83[b]	82[b]	76[b]	73	70	72	68
	empl.-based						60	61	64	60
total covered							86	85	86	84
uninsured[46]							14	15	14	16

Sources: a) CMS (2006), own calculation b) HIAA (2002). All data from 1990 on collected by the US Census Bureau (2006: 21)

Medicare and Medicaid have undergone a series of major inclusion processes since their inception (Holahan/Weil/Wiener 2003, Weissert/Weissert 2003, Patel/Rushefsky 1999). After Medicare was set up for the aged in 1965, the federal government in 1973 incorporated disabled people and most people with end-stage renal disease into the program. As the percentage of people aged 65 or older increased from 9.5% of total population in 1966 to 12.3% in 2002, the proportion of the population covered by Medicare rose correspondingly.

In the Medicaid program, the federal government sets the general guidelines for decisions on coverage, as e.g. the federal poverty line (FPL) as a reference parameter for eligibility, and leaves a certain degree of discretion to the states. The federal state furthermore determines which groups of the population *have* to be included in the Medicaid program and which groups *may* optionally be included.[47] Individual states may decide to expand Medicaid coverage and receive federal matching funds on an open-end basis as far as federal criteria are met. Additionally, individual states may set up their own general assistance programs, which is one explanation for the considerable disparities in health care coverage between the states[48]. Starting in the early 1990s, the federal government mandated to cover certain groups of children. But President Clintons' welfare reform of 1996 also caused some reductions in eligibility (Weissert/Weissert 2002). The most noteworthy expansion of Medicaid occurred in 1997 with the BBA, when the federal government mandated states to extend public coverage systematically to low-

[46] According to the US Census Bureau people are considered "uninsured" if they were not covered by any type of health insurance at any time in the previous calendar year. Therefore health insurance coverage is likely to be underreported as compared with other national surveys (US Census Bureau 2006: 20, 59).

[47] For this purpose the federal government defines the "categorically needy" groups of the population. These are further split into a "mandatory needy" group consisting mainly of parents and children, pregnant women and some Medicare beneficiaries who *must be* covered, and an "optionally needy" eligibility group. The optionally needy group includes individuals to whom states *may* extend Medicaid eligibility.

[48] A comparison across states shows that Texas (25.1%) and New Mexico (21.4%) had the highest proportions of uninsured, while Minnesota (8.5) had the lowest (3-year average 2002-2004) (US Census Bureau 2006).

income children through the State Children's Health Insurance Program (SCHIP) (Quadagno 2005). Some expansion in Medicaid coverage though, has been offset ("crowded out") by reductions in employer-sponsored coverage for families and by a contraction of other state programs (Stone 2000). Moreover, not all Medicaid/SCHIP eligible persons *de facto* draw on the programs, due to administrative hurdles (Reinhardt 2005: 109).

Major inclusion processes into the private insurance scheme date back to the time during and after World War II. In this era, employers started to offer health insurance as a "fringe benefit" when mandated wage stops restricted their means of attracting and rewarding employees (Döhler 1990). Today, employers' decision to offer coverage is highly dependent on the premium costs[49] and on economic performance in general (Cutler 2002). Therefore this inclusion process is stagnating and employer-based coverage is declining.[50] If no employer-sponsored coverage is available, individuals may decide to buy insurance based on individual contracts. Within this system, good risks have an incentive not to seek coverage and bad risks may face difficulties to receive coverage because insurers are allowed to deny contracts for severely ill persons (Cacace/Rothgang/Thompson 2007). Thus only a small percentage of less than 9% of the population has private coverage based on individual contracts.

The number of uninsured increased in recent years. In order to mitigate this adverse effect, most states have established high-risk pools for covering those who are otherwise hard to insure (Docteur/Suppanz/Woo 2003). Those without insurance have access to emergency care through hospitals, which are legally bound to provide at least minimal treatment (see EMTALA of 1985 in *section 5.5*). In addition, non-profit hospitals have to provide charity care in exchange for their tax-exempt status. If the patient is not able to pay the hospital bill, the costs for the treatment provided are either borne by the hospital or shifted to other patients with more generous insurance (Getzen 2004, Giaimo/Manow 1999).

In 1985, through COBRA, the federal government forced private insurers to provide coverage for employees who lost or quit their job under the condition of group health benefits during a transition period. Yet, the law only applies to plans that are sponsored by employers with more than 20 employees. Moreover, the duration of COBRA plans is restricted[51], and the insured has to pay the full costs (102%) out of his/her own pocket.

---

[49] Since 2000, premiums for family insurance coverage have increased by 73%, compared with an inflation growth of 14% and wage growth of 15% (Kaiser/ HRET 2005: 1).

[50] Within the past six years, the percentage of firms offering health benefits declined from 69% to 61% in 2006 (Kaiser/HRET 2006: 34).

[51] From 18 months in case of loss of employment to a maximum of 36 months if there is a change in family status.

From 1996 on, HIPAA further enabled portability and the continuation of group insurance. Essentially, HIPAA precludes insurers from imposing pre-existing condition[52] clauses on new employees, prohibits discrimination against individual group members based on health status, and requires insurers to make insurance available to certain individuals who lost group coverage and exhausted their COBRA (Quadagno 2005, Pollitz/Tapay/Hadley et al. 2000). Another, less obvious but most influential, public policy to govern private insurance coverage is the tax-exempted status assigned to employer-sponsored health plans (Hacker 2004: 245).

Summing up the regulation of coverage most briefly, the role of the state definitely increased during the past four decades. The state offers coverage to the aged and the indigent, and it regulates and subsidizes private insurance. Nevertheless, it is far away from the notion of a “strong state”. The provision of tax exemptions is a rather weak, incentive based and market conform instrument as compared to other means of regulating coverage e.g. through mandating universal insurance. Thus, although the state has been an important actor in providing coverage for the most expensive health risks, private employers are the main actors when it comes to coverage decisions.

5.2 Financing system

In order to assess the role of the state in the regulation of the financing system, we need to establish who regulates premiums, premium increases and co-payments in health insurance. Again, the role of the state cannot be fully comprehended by merely analyzing government programs; it is also necessary to examine how federal and/or state government regulation affects private insurance.

The regulation of premiums and co-payments[53] in the Medicare program falls within the authority of the federal government, more precisely the Department of Health and Human Services (DHHS) (Marmor 2000). Part A of the Medicare program (hospital insurance) is an obligatory program funded by payroll tax contributions paid half by employees and half by employers. The premium rate is fixed by law; since 1986 the contributions count 2.9% of the taxable wage base. When Part A was introduced, a ceil-

---

[52] Pre-existing conditions are physical or mental conditions already existing before an insurer agrees to insure an individual. Some insurers also refuse to cover pre-existing conditions, require waiting times for their treatment or completely deny coverage for an applicant.

[53] Under the Medicare program, co-payments are increasingly required to cover costs. In 2003 hospitalized patients were charged US$ 840 per episode of up to 60 days, and between US$ 210 and US$ 420 for the next 30-60 or more days respectively (Green Book 2004). Physicians, within boundaries, are allowed to charge Medicare patients for medical services not covered by or in excess of the Medicare program (Reinhardt 2005: 90). For a comparison of cost-sharing requirements under Medicaid, Medicare and a private Blue Cross/ Blue Shield Plan, see Kaiser Commission (2002a: 68ff).

ing was imposed on premium rate. In 1991 the federal government lifted this ceiling and in 1994 abandoned it altogether thereby allowing for a considerable inflow of funds into the program (Hoffman/Klees/Curtis 2000). Medicare Part B (supplementary medical insurance) is an optional program that covers outpatient care. Part B is partly financed through monthly premiums[54] (2006: 78.20 US$ p.m.) with subsidies from general tax revenues. The federal government has regulated the level of subsidization since the program began. Today, premiums cover 25% of the cost of the program, with general government revenues covering the remaining 75% (Green Book 2004). In addition, since the OBRA of 1990, the federal government also regulates the private Medigap insurance market by imposing requirements on the standardization of plans and restrictions on the exclusion of risks (Keen/Light/Mays 2001, Kruse 1997).

In Medicaid and SCHIP, the federal government gives states the option to receive funds, the so-called federal medical assistance percentages (FMAP), if they structure their programs along federal guidelines. The federal government matches state spending on an open-end basis, i.e. the more a state spends on Medicaid or SCHIP, the more it can receive. The FMAP in the Medicaid program varies between a minimum of 50% and 77% and is adjusted annually in line with the average state citizens' per capita income. In general, higher matching rates up to 83% are achieved within the SCHIP program. The federal government leaves decisions on cost sharing under Medicaid to the discretion of the states, but it puts restrictions on co-payments and even prohibits states from imposing any form of cost sharing on specific population groups (Kaiser Commission 2002: 64).

In private insurance, the insurers set premiums and also decide on cost sharing elements. As no risk-equalization scheme is established in the US health care system, the private insurance industry faces enormous adverse selection problems (Cacace/Rothgang/Thompson 2007).[55] Insurers, therefore, deploy a great deal of resources

---

[54] Additionally, an annual deductible of 110 US$ applies. The most recent changes in the Part B program entail a means-test, which requires a small percentage of high-income beneficiaries to pay higher premiums.

[55] A risk-equalization scheme shifts premium incomes from health insurers with good structures to those with bad structures. This, for example, is established in the German statutory insurance for levelling off the different risk structures of the sickness funds in order to restore competition and to prevent adverse selection. Adverse selection occurs when an insurer is not able to rate the health risk of the applicants. In this case the insurer will calculate the insurance premium based on an average risk expectation. This average premium will attract relatively poor risks and deter the good health risks. If poor risks join the pool, however, the insurer will be forced to increase the premium and good risks will be further deterred. This process can repeat itself with the consequence of a breakdown of the insurance market.

in order to adjust premium rates to accommodate pre-existing conditions. As a consequence, premiums for single individuals may be prohibitively high.

In employer-sponsored health insurance, premiums in general are calculated based on *experience rating*[56], where premiums reflect the average risk structure of one specific employee group. This was not the case in times when non-profit insurers dominated the market place as they were forced to apply *community rating* in the calculation of premiums. As the method of community rating resembled more a social than a private insurance scheme, the element of solidarity was enforced (Enthoven/Fuchs 2006). This principle, however, had to be abandoned due to competitive pressures from the fast-growing for profit insurance industry. Consequently, the risk-pools became increasingly fragmented and the re-distributional effects declined (cf. Hacker 2004).

Small employers are not able to spread risk over many employees and therefore may face prohibitively high premiums if their staffs comprise severely ill employees. Those employers who offer insurance, have considerable influence on insurance premiums and substantial scope for bargaining especially when they are large or if they are represented by one of the powerful employer-associations (Keen/Light/Mays 2001). One of the most influential factors on private insurance premium rates was the competitive market forces triggered by the introduction of managed care. Managed care arrangements competed with traditional indemnity insurers on lower premium cost and less cost sharing requirement. But the beneficial effect of competition as to be seen in decreasing prices also brought some major disadvantages, especially for firms with unfavorable risk structure and for individuals with high health risks.

The regulation of the private insurance business is delegated from the federal to the states' governments. The states' activity was low at the beginning of our observation period, but from the mid-1980s onwards, the premium increase and risk-adjustment practices in employer-sponsored health insurance have increasingly been regulated[57]

---

[56] *Experience-rated* premiums in employer-sponsored insurance are based on the average actual or expected use of health care services of that *specific employee group*. The alternative method of premium calculation is *community rating* based on the experienced health care needs of the population of a given *geographic area* (see also section 2.2). As a consequence of competitive pressure from experience rated plans, community rating today is the exception.

[57] States require private insurers to hold a financial reserve to minimize the risk of insolvency, to contribute to state guarantee funds to cover the payments of insolvent insurers, and to establish high-risk pools to cover the otherwise hard to insure (Docteur/Suppanz/Woo 2003, Acs/Long/Marquis et al. 1996). In addition, some states also influence the content of the benefit package of single health plans and the types of providers to be mandatorily included (GAO 1996). Nearly every state has passed legislation to improve portability, access, and rating practices

(Jensen/Morrisey 1999, Jost 2001). In addition, at the federal level, government restricted insurers' ability to exclude pre-existing conditions through HIPAA in 1996 (Jost 2001). Nevertheless, individual states regulate insurance business to varying degrees. It should also be borne in mind that the federal government prevents states from effectively regulating employer-sponsored health insurance due to ERISA. Thus in general "neither federal nor the states governments have exerted much influence on the private insurance market" (Stone 2000: 956).

In conclusion, the federal and the state governments regulate the financing system in all publicly funded programs and they also prevent the exclusion of risks in the private Medigap market. In private insurance, however, with the countervailing effects of increased state-based regulation and federal *de*regulation, government fell well short of its potential. Thus private insurers are given a relatively free rein in setting their premiums according to market requirements and powerful employers are able to bargain on premium prices. Important changes in premium amounts and in cost-sharing requirements can be attributed to the spread of managed care, which triggered a fierce price competition in the insurance market.

5.3 Remuneration

Remuneration is the first aspect to be considered with respect to the relation between financing agencies and service providers. The question to deal with in this section is *who* regulates the payment of providers. Regulation can affect the remuneration method applied and/or the payment rates.

From the implementation of the public programs, the federal government paid hospitals on a retrospective cost-reimbursement basis. The rates were set at "reasonable cost" thereby covering all expenses and allowing the hospitals to break even. This negative incentive for cost containment has led to a considerable price increase for hospital stays. Due to the recession in the early 1970s, this became an increasing concern for policy makers. As a consequence, all hospital prices were frozen for the duration of three years in the Economic Stabilization Program (ESP). The late 1970s even witnessed an economy-wide "voluntary effort" of hospitals to reduce the rate of cost increases (Getzen 2004, Levit/Lazenby/Braden et al. 1997). But neither the ESP, nor the voluntary efforts were regarded as sustainable (Brown 1992). The most path-breaking reform in hospital remuneration was the introduction of the DRG-based prospective payment system (PPS). Unlike the rate setting programs that were supplanted, DRGs are administered prices that reimburse service providers prospectively. In 1983 DRGs were mandatorily introduced in the Medicare program. In Medicaid, the federal law regulated to pay hos-

for policies sold to small employers or to individuals. Individual health insurance plans are also regulated. This however, to a lesser extent (Jost 2001).

pitals at the same reasonable-cost rates until the states were allowed to pay much lower “reasonable and adequate” cost in 1981 (Boren Amendment). These rates were very low, thus in a move to prevent risk-selection, the federal government required states to make payment adjustments to hospitals, which serve a disproportionate share of Medicaid and low-income patients (DSH program) and provided matching funds for these purposes (Kaiser Commission 2002: 106). With the BBA of 1997, the government repealed all federal payment regulation in the Medicaid program. Since that point in time the states decide on reimbursement policies and are only obliged to publish final rates, methodologies, and justifications. Thereby the states are given much more discretion with the consequence of large regional disparities in provider remuneration (Weissert/Weissert 2002: 222). A highly relevant aspect is that the states increasingly forced their Medicaid beneficiaries to receive their care through managed care arrangements. In managed care, provider remuneration is subjected to the management-techniques of the private health plans therefore the power to regulate service providers was transferred from the government to private actors (Reinhardt 2005).

Physicians in outpatient practices too, were traditionally free to charge the service fees that they deemed appropriate and were reimbursed their full costs, especially while out-of-pocket payments was the dominant form of financing outpatient health care services. Soon after its’ implementation, Medicare Part B adopted a method called “usual, customary, and reasonable” from private non-profit Blue Shield plans in order to limit fee-for-service reimbursements (Getzen 2004). Under both, Medicare and Medicaid, physicians must accept the assigned payments, which means that they are not allowed to balance bills[58], or only to a limited extent (Kaiser Commission 2002). From 1992 on, the resource-based relative value scale (RBRVS)[59] was introduced under the Medicare program. RBRVS represents a fee schedule and is coupled with a strict budget for the total annual outlay on physician services, the volume performance standard. Like the DRGs, private insurers also adopted the RBRVS on a voluntary basis.

In private insurance managed, care was most relevant for the regulation of service providers’ remuneration (see section 2.2 for details). With managed care, a switch from a retrospective towards a prospective payment system was implied. Especially in the first decades of managed care, when vertically integrated HMOs dominated the man-

---

[58] In general, physicians under UCR may still continue to charge the amount they consider as adequate. However, they are reimbursed by the insurer according to the scheduled prices and charge the remainder and, where applicable, co-payments to the patient (balance billing). Under the Medicare program, balance billing is allowed, but only up to 15% of the scheduled fees (Reinhardt 2005)

[59] The RBRVS gives each physician service a point value. After the physician and insurance company agree on the value per point, payment for each service is determined.

aged care market, considerable control was exerted on service providers (Jacobson 2001). Completely new incentive schemes were set up with prepaid capitation payments and risk was shifted from the health plans to the providers to a considerable degree. As a consequence, the growth of managed care had a considerable impact on the incomes of physicians (Kronenfeld 2002). With the managed care backlash and the growth of the Preferred Provider Organizations (PPOs), less strict remuneration methods are applied in managed care, reversing this trend to a certain degree. Thereby vertical integration of insurers and service providers gave way to a bargaining process in which insurers and providers have to agree on capitation payments or on discounts on fee-for-service rates.

The results derived from the analysis indicate that the remuneration system was increasingly regulated during the past four decades. In the public programs, this was exerted through government regulation, culminating in the introduction of DRGs and RBRVS. But although the government regulated the payment of providers in the public programs, it gave the medical profession a relatively free hand in transactions with private insurance (Stone 2000: 957). In private insurance, managed care organizations have created their own instruments to gain control over service providers, thereby bringing considerable hierarchy into the system. Therefore private market actors worked as a substitute for, or as a “functional equivalent” of government regulation. As a growing number of Medicare and Medicaid beneficiaries have meanwhile joined managed care plans, the exertion of hierarchical control on provider remuneration has spilled over to the public programs. Today the market share of more loosely structured forms of managed care is growing indicating a tendency to relax control over service providers again.

5.4 Access of health care providers to markets

The following section describes the regulation of the access of health care providers to public or private financing sources. By access regulation, the quantity, the quality and/or the price of services in the health care market can be controlled. The pertinent question here is therefore to what degree the state assumes this task, and which actors take over if it does not.

As a consequence of the Hill Burton Act, which provided federal funds for hospital expansion from 1946 on, there was a sizable surplus of inpatient beds in the 1960/70s (Döhler 1990). The regulation of construction set in under the federal National Health Planning Act of 1974. This law required all states to adopt certificate-of-need (CON) laws by 1980, subjecting expansion as well as new entrants to the hospital market to a certification process. The Health System Agency (HSA)-network, a system of state and local health planning agencies, was created to oversee the program. Until in the 1980s the CON laws were quite successful, but the Supreme Court had to come to the conclusion that they constituted an illegal restraint of trade and repealed the process (Getzen 2004, Marmor/Mashaw/Harvey 1992). From 1983 on, when DRGs were introduced in

the Medicare program, the Congress retreated from the regulation of hospital construction, convinced that the new payment system would be efficient in regulating the number of hospital beds (Brown 1992).

As an additional instrument to gain control over access to the public programs as a source of financing, federal and state governments mandated review processes to monitor the quality performance of hospitals from the 1970s onwards (Walshe 2003, Tuohy 1999). In 1972 the federal government established the Professional Standards Review Organizations (PSROs) as a peer review mechanism. The PSROs were able to deny approval of payment if the treatment provided was not medically necessary, not of adequate quality, or delivered in an inappropriate facility. Nevertheless, PSROs remained ineffective and therefore in 1983 were substituted by the Peer Review Organizations (PROs), which have the status of private organizations and may be organized as for-profit enterprises. The federal grants formerly directed to the PSROs, were supplanted by competitive contracts (Brown 1992, Döhler 1990). In 1987 the scope of the PROs was extended to the review of outpatient care (Patel/Rushefsky 1999). In addition, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), a private non-profit organization composed of members of medical associations[60], provides voluntary accreditation to hospitals. The JCAHO however, is under the control of professional bodies and thus in effect a self-regulatory structure (Walshe 2003: 58, Jacobson 2001).

An additional aspect in access regulation of inpatient care providers is the tax-exempt status devoted to non-profit providers. Throughout the observation period, the government plays a crucial role in the support of non-profit hospitals through tax subsidies.[61] In exchange, these have to provide community benefits, i.e. free or low cost health care services to the poor or indigent in exchange thereby mitigating the adverse effects the health care system has on the uninsured to a certain degree. Through these tax exemptions, the federal government exerts considerable influence on the public/private mix in the hospital sector (Gray 1991).

Now turning to the outpatient sector, the quantity of physicians also increased during the boom of the early 1960s owing to federal support given through the Health Pro-

---

60 The American College of Physicians (ACP), the AHA, the AMA, and the Canadian Medical Association (CMA) joined the founders of the JCAHO, the American College of Surgeons (ACS).

61 Hospitals may be exempt from taxation under section 501(c) (3) of the Internal Revenue Code. In 1996 the amount of aggregate annual tax subsidies is estimated at US$ 8.5 billion. Since the relative importance of non-profit institutions in providing charity care is declining, however, the current debate is about whether the non-profits still deserve their tax-free status today. For a very recent discussion of this subject see e.g. the contributions in Health Affairs, web exclusive No. 25 (2006) at www.healthaffairs.org.

fessional Educational Assistance Act (Getzen 2004). Although there was increasing concern about the considerable surplus of physicians from 1970 on, federal outlays for the training of medical school students remained substantial, leading to a 104% increase in the supply of active physicians from 1970 to 1995 (Patel/ Rushefsky 1999, Kronenfeld 2002). Today the number of medical schools is regulated by several professional bodies such as the AMA and the American Association of Medical Colleges (AAMC), which have an interest in regulating the number of graduates, and thus checking and constraining the supply of physicians.

As a private sector approach to the regulation of health plans, the National Committee for Quality Assurance (NCQA), a private, non-profit organization was established in 1991. The NCQA makes information on private health plans and physicians available to employers and to the general public and is also responsible for the management of HEDIS[62] (Health Plan Employer Data and Information Set). The NCQA certification became increasingly important also for government programs, as most public payers require an NCQA-accreditation of the health plans if they are to serve the beneficiaries of Medicare or Medicaid.

Again, it is managed care that had a major impact on physicians' access to the health care market through its policies of selective contracting and credentialing. Both affected physicians' bargaining power, allowing competition and control to enter a formerly autonomous professional field. However, beginning in the mid-1990s, service providers also sought to restore their autonomy and to regain market power. Supported by the backlash from the general public and the media against managed care, they were able to exert pressure on states' legislators, which weakened the ability of managed care organizations to exert control over service providers' access to financial resources (Rich/Erb 2005, Blendon/Brodie/Benson et al. 1998).

Subsuming these observations briefly, the government increasingly restricted access for providers to the public sources of financing from 1965 onwards. The quality control requirements gave rise to new forms of cooperation between public and private entities (Jacobson 2001, Döhler 1990). But these structures are largely self-regulatory mechanisms, dominated by the medical profession. In the realm of private insurance, the role of the state in regulating access was weak at the beginning of our observation period and still remains defensive today. From the private market side managed care came into play, initiating fierce competition amongst service providers about access to financial resources. Paradoxically, while the federal and the states' government were promoting

[62] HEDIS is a set of standardized performance measures for comparing the performance of managed health care plans. HEDIS also includes a standardized survey of consumers' experiences that evaluates plan performance. HEDIS is sponsored, supported and maintained by the NCQA (see http://www.ncqa.org/ Programs/HEDIS).

managed care for the beneficiaries of the public programs, the states forced managed care organizations to relax their regulatory instruments at the same time (Rich/Erb 2005). Thus, over the past decade, the medical profession has been able to regain some elements of autonomy and the scope for self-regulation.

5.5 Access of patients to health care providers

When exploring the access of patients to health care providers, the underlying value of freedom of choice comes into play, as it may be explicitly or implicitly restricted when it comes to regulation. In order to assess the role of the state, we examine which actor(s) regulate the patients' access to service providers.

In the public programs, access of patients to health care providers was restricted to physicians, hospitals, and other service providers who take assignment, i.e. they have to acknowledge an approved rate as payment in full before treating Medicaid and Medicare patients. Medicare payments are an important source of revenue, so service providers regularly agreed to take assignment. This incentive does not necessarily work with Medicaid patients, however. Although benefits must be provided by law, and medical professional ethic also demands this, physician treatment is often actually denied to Medicaid patients (Getzen 2004). This means effectively that risk-selection takes place, discriminating against those with low ability to pay. In addition, the federal government gave the states wide discretion to limit Medicaid recipients' freedom to choose doctors or hospitals through the Boren Amendment in 1981 (Patel/Rushefsky 1999). In order to guarantee a minimum access to health care for the most severe risk groups, the federal government enacted the Emergency Medical Treatment and Active Labor Act (EMTALA)[63] in 1985, which required that hospital access be granted to emergency patients even when they are not able to pay.

In private insurance, the unrestricted freedom of choice of medical care providers has prevailed in times of indemnity insurance, a principle that for a long time was upheld by organized physicians. This changed fundamentally when HMOs gained a foothold, restricting the access of patients to health care providers to pre-selected groups or networks and through gatekeeping. In addition, new professional carriers like the nurse practitioner or the physician assistant were created, to supplant the treatment by physicians in the case of less severe ailments (Scott/Ruef/Mendel et al. 2000). Furthermore, the access of patients to specialist services was restricted through utilization reviews, a widely used instrument in managed care arrangements. As the participation of Medicare

[63] The Emergency Medical Treatment and Active Labor Act (EMTALA), which was passed in 1985 as part of the COBRA, requires hospitals to provide an appropriate medical screening exam and to treat patients until they are stable, or are transferred to another facility.

and Medicaid beneficiaries in managed care increased over time, the restrictions put on patients’ access to providers spilled over to the public programs.

When the market share of HMOs started to fall from the mid-1990s on and PPOs gradually became the most dominant type of managed care arrangement, the gatekeeping requirement was dropped and also the option to choose the provider was restored (Newbrander/Eichler 2001). Most states supported this development with legislation enabling direct access to specialists, thereby weakening the gatekeepers’ function (Aspen Health Law Center 1998). PPOs restrict patients’ access to a pre-selected network of providers, which are selected according to their performance characteristics, but they allow a free choice of provider at the cost of higher cost-sharing.

When summarizing these changes, it is necessary to start from the fact that traditionally a free choice of provider was promoted as a “patient’s right” which was heavily protected by the medical profession. Again, private managed care has brought about the most crucial changes in the regulation of the system. The introduction of privately organized managed care into the US health care system brought in the strong and effective elements of gatekeeping and selectively contracted provider networks. The emergence of more loosely structured managed care arrangements weakened the restrictions with the effect that the patients regained choice and service providers were able to restore their autonomy. The government has restricted the access of patients to health care providers under the public programs by setting a limit on provider payments. The beneficiaries who (were forced to) join managed care, though experienced considerably stronger elements of control of access to providers.

5.6 Benefit package

The benefit package comprises the number and kind of services that are (regularly) covered by an insurance contract. As an indicative of the role of the state in regulation, the content of the benefit package can be defined by law. If insurers and/or other actors determine the scope of benefits, however, it may become an instrument of competition.

Right from its inception, it was the function of the Health Care Financing Administration (HCFA) to supervise whether new procedures and technologies are to be rated as “reasonable and necessary” for Medicare services. In 1978 the National Center for Health Care Technology (NCHCT) was established as a government measure to manage developments in medical technology. NCHCT was required to disseminate, publish, and make available all standards, norms, and criteria developed concerning the use of particular health care technologies, but it had no regulatory competencies. After federal funding for NCHCT ceased in 1982, the private non-profit Institutes of Medicine (IOM) took over. Until today, the IOM provide evidence-based information and advice to policy-makers and the public. Evidence-based medicine and Health Technology Assess-

ment (HTA)[64] were also established through the public Agency for Health Care Research and Quality (AHRQ), which was founded in 1996 and offers services to public and private bodies. In its inception, the AHRQ was commissioned with the development of clinical guidelines but meanwhile has retreated from this task and focuses on quality measurement and general improvements in health care. The AHRQ makes clinical practice guidelines available to the public; but the development of these guidelines is in the hand of professional bodies.

Nowadays, the Centers for Medicare and Medicaid Services (CMS) evaluate services on the basis of HTA reports. In general, the CMS determines a uniform benefit package for all Medicare beneficiaries by law. Even if Medicare beneficiaries are enrolled in managed care, a minimum benefit package must be provided. In the case of the recently introduced drug benefit, for example, the Medicare statutes regulate that private insurers must offer either a defined standard benefit or an alternative that is equal in value (“actuarially equivalent”) (Kaiser Foundation 2006). Apart from that minimum requirement, the government delegates the management of benefits to private insurers. As a consequence, beneficiaries in managed care are more restricted in the benefits they receive than under the traditional Medicare program (Reinhardt 2005). Reinhardt (2005: 100) therefore detects a shift from defined benefits to defined contributions[65], which constitutes a major change in the fundamentals of social insurance.

Under the Medicaid program, the federal government determines a minimum benefit package by requiring that in order to receive federal matching funds certain basic services must be offered to the categorically needy population in any state program. Any amendments made to the benefits package must be submitted to the state Medicaid plan for approval by the CMS. Under a special category of waivers, in this case the section 1115 waiver, the single US-member states may vary the benefit package. The most renowned experiment with the 1115 waiver is the Oregon Health Plan, which in the 1990s allowed the state of Oregon to include a larger part of the population into the Medicare program at the cost of the denial of services to all Medicaid recipients (cf. Rothgang/Greß/Niebuhr et al. 2004).

In the private scheme, the insurer has a relatively free reign in the determination of the content of the benefit package. Thus, beneath the premium rate, the benefit package

---

64 Health Technology Assessment (HTA) is a technical means to support decision-making regarding the content of the benefit package. Evidence-based medicine and clinical practice guidelines, in contrast, focus on the management of specific clinical problems or disease conditions.

65 A defined benefit plan promises a specific health benefit. Defined contribution plans in contrast, do not specify which benefits will be obtained but the amount to be contributed, instead. Therefore the benefits of defined contribution plans are less calculable.

constitutes an important element of competition. Packages vary considerably, ranging not only from indemnity insurance to managed care arrangements, but also from one contract to another. In general, managed care competed by offering more comprehensive benefit packages including preventive services.

Most states regulate the content of the benefit package to a certain degree, for example by mandating coverage for special treatments (e.g. prevention) or by requiring private insurers to include some types of services, as e.g. optometrists and chiropractors services (GAO 1996). But regulation varies considerably from state to state. In addition, as emphasized before, ERISA exempts all self-funded employer-sponsored health plans from states' regulation of the benefit package. It should also be borne in mind that in employer-sponsored insurance decisions concerning the benefit package are influenced by employers' pre-selection of health plans. In Medical Saving Accounts (MSA), a defined benefit catalogue only applies as far as it is defined by the high-deductible health plan MSA have to be combined with, which again implicates a shift from defined benefits to defined contributions. MSA are not yet wide spread, but they are heavily promoted by the current Bush Administration (Fuchs/James 2005).

Over all public and private schemes, the benefit package in some cases is highly incomplete and therefore much of the health risk has to be borne by the insured person. This phenomenon still lacks an analytical definition, but is described on an empirical basis by the term "under"insurance. Schoen/Davis/How et al. (2006) estimate, that about 35 % of all US adults were either *un*insured or *under*insured in 2003.

In sum, while under the public programs the benefit package is determined by government regulation; it constitutes an element of competition in private insurance. With the government regulation of benefit packages in private insurance being weak, their content is in the first instance left to the insurers and is influenced by employers' preselection of health plans. Most importantly, the decision on the scope of the benefit package partially devolves from government to private insurers when government shifts its Medicaid and Medicare beneficiaries into managed care arrangements.

6. SUMMARY AND CONCLUSION

Starting from the two major trajectories elaborated in this contribution, the results subsumed in this concluding section will be broken down into the main categories of analyses i.e. the financing, the service provision and the regulation dimension. The first aspect elaborated in this paper is that the role of the state has increased considerably in the American health care system, especially in financing and thereby also in the regulation of the government financed programs. But in the realm of private insurance, hierarchical state regulation especially vis-à-vis private service providers remained weak. Therefore the second point to be made is that as a consequence of this regulatory "vacuum", private insurance arrangements commonly subsumed under the term managed care, par-

tially filled in this gap by developing their own modes of governing providers' and patients' behaviour. Interestingly, although supportive in many respects, it is *not* the state but private market actors that brought these mechanisms of hierarchical coordination into the health care system.

Coming now to the results in detail, we see a strong increase of public involvement in the *financing dimension.* Through Medicare and Medicaid, the public sector took over responsibility in financing health care for the most expensive health risks. Social insurance financing, a source with almost no relevance until 1965, became an important element of the financing mix from the introduction of Medicare on. Most funding, however, comes from taxes today. Especially in the first decades of our observation period, collective financing through private insurance also increased stimulated by governments' tax policy. As a consequence, out-of-pocket payments declined considerably in relation to other sources of funding. At about the same time, though, the redistributional aspects of private insurance financing decreased. Hereby the major part of the population is affected, as private insurance is the dominant mode of coverage in the American health care system.

In the *service provision* dimension, direct state involvement in the delivery of services was traditionally low and diminished over time. More precisely, we do not only observe that the role of the state decreases *directly* as a consequence of diminishing beds capacities in public ownership, but we also witness an *implicit* retreat of the state as less resources were devoted to the inpatient care sector. The corollary is that service delivery in the US is predominately private. At the same time, the government influences the provider structure by providing tax subsidies to the benefit of private *non-profit* inpatient care providers. As a consequence, non-profit providers by far dominate the hospital market until today. Hence, the hypothesis of a change from the "positive to the regulatory state" (Majone 1997) is supported in hospital care, which means that the retreat of the state is partially compensated by a corrective through government regulation.

Beginning in the early1970s, the state also interfered more heavily in the professional autonomy, as we observed in the *regulation dimension*. But these hierarchical provider regulations remained restricted to the public programs. In transactions with private insurance, in contrast, the state gave the medical profession a relatively free hand. Hierarchically structured, private managed care arrangements filled this regulatory vacuum and acted as a substitute, or as a "functional equivalent", to government regulation. Especially Health Maintenance Organizations (HMOs) allowed for control over providers and patients as they introduced strong instruments like gatekeeping and selective contracting. Thus private actors brought in a considerable degree of hierarchical regulation into the American health care system. But service providers were also able to restore

their autonomy. With the backlash against HMOs, which was supported by states legislation, more loosely structured managed care arrangements gained ground. Thus the managed care market tends to be less regulative today than in the mid-1990s. At the same time, bargaining emerged as a coordination mechanism in the relationship between insurers and providers as new remuneration methods were established.

Also on the financing side, government regulation mainly affected Medicare and Medicaid while the state has not exerted much hierarchical control on the private insurance market. Here managed care also played a role as it reduced premium rates while at the same time offering more comprehensive services. Yet today, private insurance premiums grow rapidly and the number of the uninsured increases as government failed to mandate universal health insurance.

While the demarcation line between the public and private programs was quite sharp until the mid-1980s, these boundaries became increasingly blurred during the past decades. New remuneration methods and fee schedules established in Medicare constitute a “public good” which was adopted by private insurers. On the other hand, more Medicare and especially Medicaid beneficiaries join managed care, thus we observe a spill over effect from private hierarchical arrangements to the public programs.

In sum, an increasing role of the state is observable in financing and in the regulation of the US health care system. Thus we find a considerable blurring of the formerly private system of health care financing through the incorporation and strengthening of public modes of financing, namely tax-funding and social insurance financing. But at the same time we observe a loss of solidarity in private insurance funding. In the service provision dimension, the state is on the retreat. While state regulation in the first instance increased in the realm of the public programs, private managed care arrangements partially filled in this regulatory gap by developing their own instruments of hierarchical coordination. Today, as the boundaries between public and private programs blur, the hierarchical governance mechanisms of private managed care arrangements increasingly complement (and even substitute) government regulation. As a result, within the past forty years, the regulation of the American health care system changed from a private competition-based structure into a most complex public/private mix. One of its basic characteristics, i.e. the significance of private market actors, has been preserved over time.

REFERENCES

Acs, G., Long, S.H., Marquis, M.S. and Fairly Short, P. (1996) Self-insured Employer Health Plans: Prevalence, Profile, Provisions, and Premiums. *Health Affairs*, 15, 266-278.

Adema, W. and Ladaique, M. (2005) Net Social Expenditure, 2005 Edition: More comprehensive measures of social support. *OECD Social, Employment and Migration Working Papers* No 29. OECD, Paris.

AHA (2000) - American Hospital Association: Hospital Statistics, 2000 Edition, Chicago, IL.

AHA (2006a) - American Hospital Association: *Fast facts on US hospitals.* Online source: http://www.aha.org/aha/resource-center/Statistics-and-Studies/fast-facts.html (last visit: 10/16/2006).

AMA (2006b) - American Medical Association: Physician Statistics. Online source: http://www.ama-assn.org/ama/pub/category/2676.html (last visit: 10/16/2006).

AHA/Lewin (2006) - American Hospital Association and The Lewin Group: *Trendwatch Chartbook 2006.* Online source: *http://www.ahapolicyforum.org/ahapolicyforum/trend-watch/chartbook 2006.html* (last visit: 11/09/2006).

Albrecht, K. and Frisina, L. (2007): Identifying value change in health care systems in Great Britain, Germany and the U.S. *(preliminary title and authors' order*). In Rothgang, H., Cacace, M.; Grimmeisen, S., Helmert, U., Wendt, C., *The Changing Role of the State in OECD Health Care Systems. From Heterogeneity to Homogeneity? Palgrave Macmillan (forthcoming 2007)*

Amelung, V.E. and Schumacher, H. (2004) *Managed Care*. Gabler, Wiesbaden.

Andrews, C. (2005) Concentration of U.S. Hospitals, 1991-1999, and its Implications for a National Health Program. *International Journal of Health Services*, 35, 39-61.

Aspen Health Law Center (1998) *Managed Care State Regulation*. Gaithersburg, Maryland.

Blendon, R.J., Brodie, M., Benson, J.M., Altman, D.E., Levitt, L., Hoff, T. and Hugick, L. (1998) Understanding the Managed Care Backlash. *Health Affairs*, 17, 80-94.

Brown, L.D. (1992) Political Evolution of Federal Health Care Regulation. *Health Affairs,* 17-37.

Cacace, M. (2008): *Der Beitrag der Neuen Institutionenökonomie zur Erklärung des public-private mix im Gesundheitssystem der USA* (Arbeitstitel). Campus *(forthcoming 2008)*

Cacace, M., Rothgang, H. and Thompson, T. (2007): Harnessing Competition, Protecting Solidarity: A Comparison of Health Care Markets in Germany, Great Britain, and the United States. *TranState Working Papers*. Bremen: Collaborative Research Center 597 Transformation of the State. URL: www.state.uni-bremen.de, *forthcoming.*

CMS (2003a) - Centers for Medicare and Medicaid: *Health Care Industry Market Update - Managed Care.* Online source: http://www.cms.hhs.gov/CapMarketUpdates/ (last visit: 11/09/2006).

CMS (2003b) - Centers for Medicare and Medicaid: *Health Care Industry Market Update - Nursing Facilities.* Online source: http://www.cms.hhs.gov/CapMarketUpdates/ (last visit: 11/09/2006).

CMS (2003c) - Centers for Medicare and Medicaid: *Health Care Industry Market Update - Acute Care Hospitals.* Online source: http://www.cms.hhs.gov/CapMarketUpdates/ (last visit: 11/09/2006).

CMS (2006) - Centers for Medicare and Medicaid: *Medicare & Medicaid Statistical Supplement.* Online source: http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp (last visit: 11/09/2006).

Cutler, D.M. (2002) Equality, Efficiency, and Market Fundamentals: The Dynamics of International Medical-Care Reform. *Journal of Economic Literature*, 40, 881-906.

DHHS (2005) - National Center for Health Statistics: *Health, United States, 2005. With chartbook on Trends in the Health of Americans*. Hyattsville, Maryland, 2005. Online source: http://www.cdc.gov/nchs/data/hus/hus05.pdf (last visit: 04/05/2006)

DHHS (2005) - National Center for Health Statistics: *Health, United States, 2006. With chartbook on Trends in the Health of Americans*. Hyattsville, Maryland, 2006. Online source: http://www.cdc.gov/nchs/data/hus/hus06.pdf (last visit: 25/01/2007)

Docteur, E. and Oxley, H. (2003) Health-Care Systems: Lessons from the Reform Experience. *Economic Department Working Papers* No 374. OECD, Paris.

Docteur, E., Suppanz, H. and Woo, J. (2003) The US Health Care System: An Assessment and Prospective Directions for Reform. *Economic Department Working Papers* No 350. OECD, Paris.

Döhler, M. (1990) *Gesundheitspolitik nach der ‚Wende'. Policy-Netzwerke und ordnungspolitischer Strategiewechsel in Großbritannien, den USA und der Bundesrepublik Deutschland*. Sigma, Berlin.

Enthoven, A.C. and Fuchs, V.R (2006) Employment-based Health Insurance: Past, Present, and Future. *Health Affairs*, 25, 1538-1547.

Enthoven, A.C. and Kronick, R. (1989a) A Consumer-Choice Health Plan for the 1990s - Universal Health Insurance in a System Designed to Promote Quality and Economy (First of Two Parts). *The New England Journal of Medicine*, 320, 29-37.

Enthoven, A.C. and Kronick, R. (1989b) A Consumer-Choice Health Plan for the 1990s - Universal Health Insurance in a System Designed to Promote Quality and Economy (Second of Two Parts). *The New England Journal of Medicine*, 320, 94-101.

Erdmann, Y. (1995) *Managed Care*. Nomos, Baden-Baden.

Flood, C.M., Stabile, M., Tuohy, H. C. (2001) The Borders of Solidarity: How Countries Determine the Public/Private Mix in Spending and the Impact on Health Care. *Health Matrix, forthcoming,*12 (2).

Fuchs, Beth and James, Julia A. (2005) *Health Saving Accounts: The Fundamentals.* National Health Policy Forum (NHPF) Background Paper, Washington DC.

Gabel, J.R., Ginsburg, P.B., Pickereign, J.D. and Reschovsky, J.D. (2001) Trends in Out-of-Pocket Spending by Insured American Workers, 1990 - 1997. *Health Affairs*, 20, 47 - 57.

Gabel, J.R., Jensen, G.A. and Hawkins, S. (2003) Self-insurance in times of growing and retreating managed care. *Health Affairs*, 22, 202-210.

GAO (1996) - United States General Accounting Office: *Health Insurance Regulation - Varying State Requirements Affect Cost of Insurance.* Health, Education and Human Services Division, GA/HEHS-96-161, B-271084, Washington, DC.

Getzen, T.E. (2004) *Health Economics. Fundamentals and Flow of Funds*. Wiley, New York, NY.

Giaimo, S. and Manow, P. (1999) Adapting the Welfare State - The Case of Health Care Reform in Britain, Germany, and the United States. *Comparative Political Studies*, 32, 967-1000.

Glied, Sherry (2000) Managed Care. In Culyer, A.J. and Newhouse, J.P. (eds.), *Handbook of Health Economics*. Elsevier, Amsterdam, Vol. 1A.

Gold, M. (2005) Private Plans in Medicare: Another Look. *Health Affairs*, 24, 1302-1316.

Graig, L.A. (1999) *Health of Nations: An International Perspective on U.S. Health Care Reform.* Congressional Quarterly, Washington, D.C.

Gray, Bradford H. (1991) *The Profit Motive and Patient Care: The Changing Accountability of Doctors and Hospitals.* Harvard University Press, Cambridge, MA.

Green Book (2004) *Committee of Ways and Means: Green Book 2004*. House Ways and Means Committee Prints: 108-6, 2004.

Hacker, J.S. (2002) *The Divided Welfare State: The Battle over Public and Private Social Benefits in the United States*. Cambridge University Press, Cambridge.

Hacker, J.S. (2004) Privatizing Risk without Privatizing the Welfare State: The Hidden Politics of Social Policy Retrenchment in the United States. *American Political Science Review*, 98, 243-260.

Hacker, J.S. and Marmor, T. (1999) How Not to Think About Managed Care. *University of Michigan Journal of Law Reform*, 32.

Hackey, R.B. (2001) State Health Policy in Transition. In Hackey, R.B. and Rochefort, D.A. (eds.), *The New Politics of State Health Policy*. The University Press of Kansas.

Heffler, S., Smith, S., Keehan, S., Brorger, C., Clemens, M.K. and Truffer, C. (2005) U.S. Health Spending Prjections for 2004-2014. *Health Affairs (Web Exclusive February)*, W5-74 - W75-85.

HIAA - Health Insurance Association of America. (2002) *The Source Book of Health Insurance Data,* 2002, Washington D.C.

Hoffman, E.D.J., Klees, B.S. and Curtis, C.A. (2000) Overview of the Medicare and Medicaid Programs. *Health Care Financing Review*, 21, 1-19.

Hsiao, W.C. (2002) Erfahrungen mit staatlicher und privater Regulierung im US-amerikanischen Gesundheitssystem. *Managed Care, Nr. 8/ 2002,* 13-15.

Iglehart, J.K. (1999) The American Health Care System. Expenditures. *The New England Journal of Medicine*, 340, 70-76.

Jacobson, P.D. (2001) Regulating Health Care: From Self-Regulation to Self-Regulation. *Journal of Health Politics, Policy and Law*, 26, 1165-1177.

Jensen, G.A. and Morrisey, M.A. (1999) Employer-Sponsored Health Insurance and Mandated Benefit Laws. *The Milbank Quarterly*, 77, 425-459.

Joffe, Mark S. (2003): Chapter 32: Legal Issues in Provider Contracting. In Kongstvedt, Peter R. (ed) *Essentials of Managed Health Care.* Jones and Bartlett Publishers, Boston.

Jost, T.S. (2001) Private or Public Approaches to Insuring the Uninsured: Lessons from International Experience with Private Insurance. *New York University Law Review*, 76, 419-492.

Kaiser Commission (2002) - The Kaiser Commission on Medicaid and the Uninsured: The Medicaid Resource Book. Online source: http://www.kff.org/medicaid/2236-index.cfm (last visit: 06/20/2005).

Kaiser Foundation (2004) - The Kaiser Family Foundation: Trends and Indicators in the Changing Health Care Marketplace. Online source:http://www.kff.org/insurance/7031/index.cfm (last visit: 04/20/2006).

Kaiser Foundation (2006) - The Kaiser Family Foundation: *Fact Sheet Medicare: The Medicare Prescription Drug Benefit. Update July 2006*. Online source: http://www.kff.org/medicare/upload/7044-04.pdf (last visit: 07/15/2006).

Kaiser/ HRET (2005) - The Kaiser Family Foundation & Health Research and Educational Trust: Employer Health Benefits 2005, Annual Survey. Online source: http://www.kff.org/insurance/7315/index.cfm (last visit: 23.03.2006).

Kaiser/ HRET (2006) - The Kaiser Family Foundation & Health Research and Educational Trust: Employer Health Benefits 2006, Annual Survey. Online source: http://www.kff.org/insurance/7527/index.cfm (last visit: 21.01.2007).

Keen, J., Light, D.W. and Mays, N. (2001) *Public-Private Relations in Health Care.* King's Fund, London.

Kongstvedt, Peter R. (2003) Chapter 6: Primary Care in Managed Health Care Plans. In Kongstvedt, Peter R. (ed) *Essentials of Managed Health Care.* Jones and Bartlett Publishers, Boston.

Kronenfeld, J.J. (2002) *Health Care Policy: Issues and Trends*. Praeger, Westport, CT.

Kruse, J. (1997) *Das Krankenversicherungssystem der USA. Ursachen seiner Krisen und Reformversuche*. Nomos, Baden-Baden.

Levit, K., Freeland, M.S. and Waldo, D.R. (1990) National Health Care Spending Trends: 1988. *Health Affairs*, 171 - 184.

Levit, K.R., Lazenby, H.C., Braden, B.R., Cowan, C.A., Sensenig, A.L., A., M.P., Stiller, J.M., Won, D.K., Martin, A.B., Sivarajan, L., Donham, C.S., Long, A.M. and Steward, M.W. (1997) National Health Expenditures, 1996. *Health Care Financing Review*, 19, 161-201.

Majone, G. (1997) From the Positive to the Regulatory State: Causes and Consequences of Changes in the Mode of Governance. Journal of Public Policy, 17, 139-167.

Marmor, Theodore R. (2006): Personal interview with Ted Marmor during his visiting professorship at the New York University (NYU), Mai, 8th 2006.

Marmor, Theodore R. (2000) *The Politics of Medicare,* 2 nd Ed. De Gruyter, New York.

Marmor, T.R., Mashaw, J.L. and Harvey, P.L. (1992) *America's Misunderstood Welfare State. Persistent Myths, Enduring Realities*. BasicBooks, New York.

Miller, R.H. and Luft, H.S. (1997) Does managed care lead to better or worse quality of care? *Health Affairs*, 16, 7-25.

Miller, R.H. and Luft, H.S. (2002) HMO plan performance update: An analysis of the literature, 1997-2001. *Health Affairs*, 21, 63-85.

NBER - National Bureau of Economic Research (2007) Business Cycle Expansions and Contractions. Online source: http://www.nber.org/cycles/cyclesmain.html#announcements (last visit 20.04.2007).

Newbrander, W. and Eichler, R. (2001) Managed Care in the United States: Its History, Forms, and Future. In Ron, A. and Scheil-Adlung, X. (eds.), *Recent Health Policy Innovations in Social Security*. Transaction Publishers, New Brunswick, pp. 83-106.

Oberlander, J. (2002) The US Health Care System: On the Road to nowhere? *Canadian Medical Association Journal,* 167 (2), 163-168.

OECD Health Data (2006) - OECD Health Data 2006, 1st version: *Comparative Analysis of 30 Countries.* OECD, Paris.

Patel, K. and Rushefsky, M.E. (1999) *Health Care Politics and Policy in America* (2. Ed). M.E. Sharpe, New York, London.

Pierson, Paul (2001) Coping with Permanent Austerity: Welfare State Restructuring in Affluent Democracies. In Pierson (ed.) *The New Politics of Welfare State*, Oxford University Press, 410-456.

Pollitz, K., Tapay, N., Hadley, E. and Specht, J. (2000) Early Experience with 'New Federalism' in Health Insurance Regulation. *Health Affairs*, 7-22.

Quadagno, J. (2005) *One Nation - Uninsured*. Oxford University Press.

Raffel, M.W. and Raffel, N.K. (1997) United States. In Raffel, M.W. (ed.), *Health Care and Reform in Industrialized Countries*. The Pennsylvania State University Press, University Park, Pennsylvania, pp. 263-289.

Reinhardt, Uwe E. (1993) Markt und Gesundheit: Das amerikanische Krankenversicherungssystem. In Jahrbuch für Kritische Medizin. Band 20, *Die Regulierung der Gesundheit*, Hamburg 1993, S. 7-20.

Reinhardt, Uwe E. (2005) The mix of public and private payers in the US health system. In Maynard, A. (ed.), *The Public-Private Mix for Health*. The Nuffield Trust, Oxford, pp. 83-117.

Rich, Robert F. and Erb, Christopher (2005) The two Faces of Managed Care: Regulation and Policymaking. *Stanford Law & Policy Review*, 16, 233-275.

Robinson, James C. and Casalino, Lawrence P. (1996) Vertical Integration and Organizational Networks in Healthcare. *Health Affairs*, Vol. 15 No 8, 7-22.

Rosenthal, M.B. (2004) Doughnut-hole Economics. Insurance often serves purposes other than risk protection. *Health Affairs,* 23, 129 - 135.

Rothgang, H. (2006) Die Regulierung von Gesundheitssystemen in vergleichender Perspektive: Auf dem Weg zu Konvergenz? In Claus Wendt und Christof Wolf (eds) *Soziologie der Gesundheit,* Sonderheft 46/2006 der Kölner Zeitschrift für Soziologie und Sozialpsychologie S. 298- 319. Verlag für Sozialwissenschaften, Opladen/Wiesbaden.

Rothgang, H., Cacace, M., Grimmeisen, S. and Wendt, C. (2005) The Changing Role of the State in Health Care Systems. In Leibfried, S. and Zürn, M. (eds.), *Transformations of the State?* Cambridge University Press.

Rothgang, H., Cacace, M. and Schmid, A. (2006) *“Blurring Regimes” in Healthcare: Convergence in Financing, Service Provision and Regulation of Health Care?* Paper presented at the 4th ESPAnet

Conference at the University of Bremen on 21st-23rd September 2006. Stream No. 10: Health Market and Social Policy.

Rothgang, H., Greß, S., Niebuhr, D. and Wasem, J. (2004) Der Oregon Health Plan - Ein Beispiel für "rationale Rationierung"? *Sozialer Fortschritt,* 53, 206-219.

Ruggie, M. (1992) The Paradox of Liberal Intervention: Health Policy and the American Welfare State. *The American Journal of Sociology*, 97, 919-944.

Schoen, C., Davis, K., How, S. and Schoenbaum, S. (2006): U.S. Health System Performance: A National Scorecard. *Health Affairs (Web Exclusive Nov/Dec)* 25: w457-w475

Schoen, C., Osborn, R., Huynh, P.T., Doty, M., Zapert, K., Peugh, J and Davis, K. (2005) Taking the Pulse of Health Care Systems: Experiences Of Patients with Health Problems in Six Countries, *Health Affairs (Web Exclusive),* w5509-w5525.

Scott, W.R., Ruef, M., Mendel, P.J. and Caronna, C.A. (2000) *Institutional Change and Healthcare Organizations - From Professional Dominance to Managed Care.* The University of Chicago Press, Chicago and London.

Stone, D. (2000) United States. *Journal of Health Politics, Policy and Law*, 25, 953-958.

Town, Robert, Feldman, Roger and Wholey, Douglas (2004) The Impact of Ownership Conversions on HMO Performance. *International Journal of Health Care Finance and Economics*, 4, 327-342.

Tuohy, C. (1999) *Accidental Logics*. Oxford University Press, New York.

US Census Bureau (2006) US Census Bureau: De Navas-Walt, C., Proctor, B.D. and Hill Lee, C. *Income, Poverty, and Health Insurance Coverage in the United States: 2005*. Current Population Reports, P60-231, U.S. Government Printing Office, Washington D.C., 2006.

US OMB (2006) - US Government, Office of Management and Business: *Analytical Perspectives, Budget of the United States Government, Fiscal Year 2007.* U.S. Government Printing Office, Washington, DC 20402–0001, 2005.

Wagner, Eric R. (2003) Chapter 2: Types of Managed Care Organizations. In Kongstvedt, Peter R. (ed) *Essentials of Managed Health Care.* Jones and Bartlett Publishers, Boston.

Walshe, K. (2003) *Regulating Healthcare*. Open University Press, Maidenhead.

Weissert, C.S. and Weissert, W.G. (2002) *Governing Health - The Politics of Health Policy.* The Johns Hopkins University Press, Baltimore.

Woolhandler, S. and Himmelstein, D. U. (2002) Paying for National Health Insurance - and not getting it. *Health Affairs*, 21, 88-98.

LIST OF ABBREVIATIONS

AAMC	American Association of Medical Colleges
ACP	American College of Physicians
ACS	American College of Surgeons
AHA	American Hospital Association
AHRQ	Agency for Health Care Research and Quality
AMA	American Medical Association
AWP	any-willing-provider
BBA	Balanced Budget Act
CMA	Canadian Medical Association
CMS	Centers of Medicare and Medicaid Services
COBRA	Consolidated Omnibus Budget Reconciliation Act
CON	certificate-of-need
DHHS	Department of Health and Human Services
DRG	Diagnosis Related Group
DSH	disproportionate share hospitals
EMTALA	Emergency Medical Treatment and Active Labor Act
ERISA	Employee Retirement Income Security Act
ESP	Economic Stabilization Program
FMAP	federal medical assistance percentages
FPL	federal poverty line
GAO	United States General Accounting Office
GDP	Gross Domestic Product
HCFA	Health Care Financing Administration
HEDIS	Health Plan Employer Data and Information Set
HIAA	Health Insurance Association of America
HIFA	Health Insurance and Flexibility and Accountability
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
HSA	Health System Agency
HTA	health technology assessment
IPA	independent practice association
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
MMA	Medicare Prescription Drug, Improvement, and Modernization Act
MSA	Medical Saving Accounts
NCHCT	National Center for Health Care Technology
NCQA	National Committee for Quality Assurance
OBRA	Omnibus Budget Reconciliation Act
POS	Point of Service
PPO	Preferred Provider Organization
PPS	prospective payment system
PRO	Peer Review Organization
PSRO	Professional Standards Review Organization
RBRVS	resource-based relative value scale
SCHIP	State Children’s Health Insurance Program

BIOGRAPHICAL NOTE

Mirella Cacace is research fellow at the Collaborative Research Center “Transformations of the State”, University of Bremen.

Telephone:	+49 421 218 8731
Fax:	+49 421 218-8721
E-Mail:	mirella.cacace@sfb597.uni-bremen.de
Address:	University of Bremen, Collaborative Research Center „Transformations of the State“, Linzer Strasse 9a, D 28359 Bremen