Trends in major medical coverage during a period of rising costs

Major medical benefits improved markedly in a cohort of employee health insurance plans during 1974–81; coinsurance rates remained largely unchanged, but more plans included a ceiling on charges to employees while providing higher levels of coverage

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Since their inception in 1949, major medical insurance plans have grown rapidly in popularity, and now cover more than 150 million individuals. These plans offer protection against the large expenses resulting from a major injury or serious illness, paying a substantial portion of hospital and physicians' charges after a deductible amount has been paid by the insured person. While the coinsurance rate applicable to the insured has remained relatively constant in recent years, major medical protection has been enhanced by liberalization of other policy provisions, such as increases in maximum benefits and incorporation of curbs on expenses borne by insured individuals.

Rapid increases in the cost of medical care probably have provided the main impetus for adjustments in major medical coverage. Between 1974 and 1981, yearly per capita national health expenditures more than doubled from $535 to $1,225.[1] During this period, the medical care component of the Consumer Price Index for Urban Wage Earners and Clerical Workers increased at an average 10.1-percent annual rate.[2] Increases in health care expenditures also resulted from costly new treatments generated by advances in medical technology. Improvements in health insurance provisions also mirrored a general liberalization of supplementary benefits as parts of employee compensation during this period. Finally, more attractive major medical benefits offered by insurance carriers may stem from the keen competition which has occurred among individual insurance companies and between the traditional insurance industry and alternative approaches to health care financing, such as self-funding by employers and Health Maintenance Organizations.[3]

This article focuses on changes in major medical coverage over the 1974–81 period among a group of 166 employee health insurance plans either fully or partially paid for by employers. These plans covered approximately 5 million workers in 1979, the last year for which relatively complete employment counts are available. They comprise all plans included in both of two Bureau of Labor Statistics sample surveys: (1) a 1974 study of employment-related health plans with at least 26 participants, whose administrators reported to the U.S. Department of Labor, as required by the Welfare and Pension Plans Disclosure Act of 1958, as amended; and (2) a 1981 study of the incidence and characteristics of employee benefit plans in medium and large firms.[4]

The health insurance plans available for this analysis are mainly those of large employers; 87 percent of the plans covered 5,000 workers or more in 1979, with 31 percent covering at least 25,000 workers. They obviously are not a

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representative sample of all health insurance plans; however, because they cover a substantial number of workers, both union and nonunion, they do offer insight into trends in major medical coverage during the 1974–81 period. Of the 166 plans studied, 147 included major medical provisions in 1974. Eleven plans added such coverage within the next 7 years, while one dropped it, resulting in the total of 157 plans with major medical benefits in 1981 (table 1).

Major medical insurance

Major medical coverage is a relatively recent concept, introduced in 1949 by the Liberty Mutual Insurance Co.[5] Previously, health insurance plans usually consisted of separate coverages for hospital, surgical, and medical (doctors' charges) expenses. The emphasis in these "basic" plans was on "first-dollar" coverage; that is, an insured individual was not required to make an initial payment for care before insurance benefits were forthcoming. However, benefits generally were geared toward short-term care in a hospital with little, if any, coverage of expenses incurred elsewhere. In addition, basic plans typically contained internal limits on either eligible charges or duration of coverage for each type of expense or procedure. Benefits as a rule were inadequate to meet the costs of a chronic disability.

Major medical coverage has altered the focus of health insurance plans. Major medical plans—geared toward protection against the cost of catastrophic illness or injury—typically have maximum payment limits substantially higher than those of basic benefit plans. To hold down insurance premiums, major medical plans eliminate first-dollar coverage and call for cost-sharing by the employee through deductible and coinsurance provisions. The deductible is a specified amount that the insured individual must pay toward medical expenses before any charges are paid by the plan. Medical expenses in excess of the deductible are shared by the insured individual and the plan through a predetermined coinsurance formula; plans typically pay 80 percent of the covered charges while the insured pays the remaining 20 percent. Major medical plans, therefore, are consistent with traditional insurance goals: protection against infrequent and unpredictable large financial risks.[6]

Exhibit 1. Expenses typically covered by major medical plans

Hospital room and board
Hospital—miscellaneous services
Physicians' services—in hospital, office, or home
Surgery and anesthesia
Private-duty nursing

Mental health care
Laboratory tests
Diagnostic X-rays
Drugs and medicines
Medical equipment—artificial limbs, crutches, braces

Rental of wheelchair or hospital bed
Physiotherapy
Radiation therapy
Treatment in outpatient department of hospital
Local professional ambulance service

As indicated in exhibit 1, major medical plans cover in one policy a wide range of medical expenses, subject to a single overall set of payment limitations. (As described later in this article, separate internal limits on benefits may apply to a few categories of health care, such as outpatient mental health care.)

Non-accident related dental care, vision care, and care in a convalescent facility are more often covered through basic plans (table 2).[7] Other expenses commonly excluded from major medical coverage pertain to eyeglasses, hearing aids, routine physical examinations, cosmetic surgery unless necessitated by an accident, employment-related injuries and injuries caused by war, and expenses due to an injury or illness which occurred immediately prior to joining a plan. (The "pre-existing condition" clause normally expires after a 3-month period during which no expenses are incurred because of the condition, or 1 year after joining the plan, whichever comes first.)

Major medical plans have caught on rapidly in the three decades of their existence. In 1951, 100,000 people in the United States—insured individuals and their covered dependents—were under major medical policies.[8] By the end of 1960, the total topped 32 million, and by the end of 1980 it reached 154 million.[9]

Nevertheless, the growing popularity of major medical insurance has not ended interest in basic benefits. Both types of insurance commonly are found within the same health care package (table 1). Of the 166 plans studied, only nine provided coverage solely through basic benefits in 1981. (Provisions of these nine plans are examined at the end of

Table 1. Types of major medical coverage in a cohort of employee health insurance plans, 1974 and 1981

Type of coverage	1974		1981	
	Number	Percent	Number	Percent
All plans	166	100	166	100
With major medical coverage	147	89	157	95
Supplemental plan[1]	110	66	113	68
Comprehensive plan[2]	37	22	44	27
Pure form	10	6	15	9
Modified form	27	16	29	17
With basic coverage only	19	11	[3]9	5

[1]Supplemental plans, as the name indicates, supplement basic plans. They cover expenses that exceed the limits specified by the basic plans and cover some expenses that are not covered by the basic plans.

[2]Comprehensive plans stand alone, without basic coverage, and cover a wide range of medical expenses in a single package. In a pure comprehensive plan, all benefits are subject to the deductible and coinsurance provisions. In a modified comprehensive plan, some expenses (most commonly hospital charges) are covered without deductible or coinsurance requirements.

[3]Includes one plan which replaced major medical coverage with extensive basic coverage between 1974 and 1981.

NOTE: Because of rounding, sums of individual items may not equal totals.

this article). The remaining 157 plans usually included major medical benefits as a supplement to basic benefits. Table 2 shows the frequency of basic and major medical coverages in the 166 plans by type of health care.

Supplemental and comprehensive plans

Major medical insurance is of two types—supplemental and comprehensive. The first type supplements basic plans that normally provide coverage for hospital, surgical, and in-hospital physicians' care up to specified dollar amounts or days of treatment. Supplemental plans customarily cover expenses that exceed the limits in these basic plans; in addition, they provide protection against types of expenses not covered by the basic benefits, such as for private duty nursing and prescription drugs. After exhaustion of basic benefits, an insured individual is responsible for charges up to the amount of the deductible; additional expenses are then paid by the supplemental major medical plan on a coinsurance basis.

The second type of major medical plan stands alone and covers a wide range of medical expenses in a single package—hence the term "comprehensive." In the "pure" form, all covered expenses are subject to deductible and coinsurance provisions. "Modified" forms, in contrast, cover some initial expenses—especially hospital-related—without deductible or coinsurance requirements. For example, a plan might cover in full the first $5,000 of hospital expenses and 80 percent of additional hospital charges. All other types of expenses, however, would not be covered until after the specified deductible was met, at which time the plan would begin to pay 80 percent.[10]

Table 2. Basic and major medical coverage of selected categories of health care, 166 employee health insurance plans, 1981

Category of health care	Plans with coverage under: Basic benefits only		Major medical benefits only	Basic and major medical benefits	Plans without coverage
	Full coverage	Coverage with limitations			
Hospital room and board	4	20	15	127	—
Hospitalization-miscellaneous services	3	19	17	127	—
Extended care[1]	—	58	26	18	64
Surgical care	[2]57	9	32	68	—
Physician visits—in hospital	12	8	50	96	—
Physician visits—office	4	3	133	19	7
Diagnostic X-ray and laboratory[3]	36	6	19	105	—
Hospital outpatient care	25	10	16	115	—
Prescription drugs—nonhospital	4	20	126	12	4
Private-duty nursing	1	1	156	—	8
Mental health care	—	10	17	137	2
Dental care	1	114	9	—	42
Vision care	2	41	3	—	120

[1]Care provided by a nursing facility or home health care agency.
[2]Plans paying physician's fee up to the "usual and customary" charge for the procedure performed.
[3]Charges incurred in the outpatient department of a hospital and outside of the hospital.

NOTE: Dash indicates no plans in the category.

As shown in table 1, about three-fourths of the major medical plans in 1974 and 1981 were supplemental plans.[11] The 11 plans that initiated major medical protection between 1974 and 1981 all added supplemental coverage to existing basic plans. At the same time, a net increase of seven comprehensive plans occurred within existing major medical packages. The "pure" form constituted a minority of the comprehensive plans in both 1974 and 1981, but did increase its share of the total over the 7-year period.

Although supplemental plans outnumbered comprehensive plans in this study, the trend may be toward the latter. The Health Insurance Institute has reported that, during the first three months of 1981, three-fourths of the new group major medical policies issued by insurance carriers were comprehensive rather than supplemental.[12]

Cost-sharing provisions

As noted earlier, major medical plans are characterized by deductible and coinsurance provisions. The former hold down insurance premiums by eliminating numerous small claims, while both cost-sharing features may indirectly curb insurance costs by discouraging overuse of benefit provisions.

Deductibles. All of the major medical plans in this study specified deductibles. These deductibles are normally a uniform dollar amount for insured individuals or a variable amount based on employees' earnings. Deductibles usually must be met once per calendar year by each covered individual, although some plans require that a separate deductible be met for each illness. In most plans, any expenses applied against the deductible in the last 3 months of a calendar year will also reduce the deductible for the next calendar year by that amount. Uniform flat dollar deductibles were predominant in the plans studied, with the most common deductible being $100 (table 3). Relatively few of the plans had adjusted their flat amounts between 1974 and 1981, despite the rapid increases in medical care costs.

Most plans limit the total number of deductibles that a family must pay in a year. No data are available from the 1974 study on family limits for deductibles, but 120 of the 157 major medical plans in 1981 had such a limit, usually two or three deductibles per family. Also, many plans require that only one deductible be met if two or more persons in a family incur expenses as a result of a single accident.

Coinsurance. With few exceptions, major medical plans paid 80 percent of expenses above the specified deductible in both years studied. Nevertheless, there was a tendency to liberalize these coinsurance provisions during the intervening period. Four plans paid less than 80 percent in 1974, but none did so in 1981; and, the number paying more than 80 percent increased from 5 in 1974 to 15 by 1981, most of which were comprehensive plans.

A single coinsurance provision usually applies to all types

of expenses covered under a major medical plan. One common exception is out-of-hospital mental health care, which often is treated separately and covered at a lower coinsurance ratio, usually 50 percent. This pattern was reflected in the major medical plans studied (table 4). Plans that added this benefit during the 1974–81 period, however, tended to provide 80-percent coverage, the same coinsurance rate as for other covered illness.[13]

Limitations on payments

Although expenses covered by major medical plans are shared by the insurance carrier and the insured individual, limits are often set on the amount either must pay. The insured may be protected against the costs of a catastrophic illness by limits on out-of-pocket expenses for deductibles and coinsurance. The major medical plan, however, generally sets an overriding limit on the amount to be paid to any individual. This plan maximum, usually cumulative for a lifetime, limits the claims against the insurer resulting from chronic illness or repeated surgical procedures. Once the plan maximum is reached, any out-of-pocket limit is suspended, and the insured is liable for all additional expenses.

Table 3. Cost-sharing provisions in a cohort of major medical plans, 1974 and 1981

Provision	1974		1981	
	Number	Percent	Number	Percent
All plans	147	100	157	100
Deductible[1]				
Total	147	100	157	100
Uniform dollar amount	121	82	142	90
$25	4	3	4	3
$50	37	25	40	25
$75	3	2	9	6
$100	66	45	81	52
$150	6	4	4	3
Other	5	3	4	3
Based on earnings	26	18	15	10
Flat percentage	17	12	10	6
Scheduled amount	9	6	5	3
Coinsurance[2]				
Total	147	100	157	100
75 percent	4	3	—	—
80 percent	138	94	142	90
85 percent	3	2	8	5
90 percent	2	1	7	4
Out-of-pocket limit[3]				
Total	10	7	79	50
Under $1,000	7	5	14	9
$1,000–$1,500	2	1	39	25
$1,501–$2,500	—	—	19	12
Over $2,500	1	1	7	4

[1]The amount of medical expenses that an insured person must incur before benefits are payable by the plan.
[2]The ratio in which medical expenses are shared by the plan and the insured person. This table reports the percentage paid by the plan.
[3]A limit on the amount of medical expense employees must pay from their own funds in a 1- or 2-year period due to cost-sharing provisions. The plan pays the balance, up to any specified maximum.

NOTE: Because of rounding, sums of individual items may not equal totals. Dash indicates no plans in the category.

Table 4. Coinsurance provisions for out-of-hospital mental health care in a cohort of major medical plans, 1974 and 1981

Coinsurance provision	1974		1981	
	Number	Percent	Number	Percent
All plans	147	100	157	100
With coverage for out-of-hospital mental health care	125	85	142	90
Covered at same coinsurance level as other illnesses	46	31	57	36
Covered at lesser coinsurance level	79	54	85	54
50 percent	73	50	76	48
Other percent	6	4	9	6
Out-of-hospital mental health care not covered	22	15	15	10

Out-of-pocket limits. When an individual is faced with an illness or injury that requires costly treatment—such as heart disease or cancer—the expenses necessitated by cost-sharing requirements can be substantial. As a result, some plans limit the amount individuals have to pay in any 1- or 2-year period. Once this out-of-pocket limit is reached, the major medical plan is fully liable for all subsequent expenses incurred, up to the plan maximum. The individual is not responsible for additional covered expenses through the end of the year in which the illness occurred, or until the end of the following year, depending on the particular plan.

One of the most significant developments in major medical benefits during the 1974–81 period was the increase in the number of plans limiting employees' out-of-pocket expenses. In 1974, only 10 of the plans studied had this limitation, but by 1981 the number had risen to 79, or one-half of the total (table 3). In 1981, out-of-pocket limits were found in 41 percent of the supplemental major medical plans and in 75 percent of the comprehensive plans studied.

Out-of-pocket limits in 1981 most commonly fell between $1,000 and $1,500 for each covered individual, although seven plans did contain limits exceeding $2,500.[14] These ceilings on payments by plan participants tended to be higher than in 1974, but a reversal of this trend may have begun. The Health Insurance Institute reported that of the new group major medical policies issued by insurance carriers during the first 3 months of 1981, 90 percent limited insured individuals' liability; two-thirds set limits under $1,000.[15]

Plan maximums. Limits on the insurer's liability are usually expressed on a lifetime basis or per disability or per year. Lifetime limits are by far the most common. Over the period studied, there was a slight decrease in the proportion of plans that included specified ceilings on benefits, from 93 percent in 1974 to 89 percent in 1981. As shown below, there was also a pronounced shift toward lifetime maximums and away from per disability or per year limits.

	1974	*1981*
All major medical plans studied	147	157
With specified maximum	136	139
Lifetime maximum only	82	108
Per disability or per year maximum only	27	9
Lifetime and per disability or per year maximum	27	22
Without maximum	11	18

One of the most striking developments between 1974 and 1981 was the increase in the amount of plan maximums. Of the major medical plans that were operative in both years, 85 percent had increased maximum benefits by 1981, while 7 percent had kept their 1974 ceilings. The remaining 8 percent of the plans studied provided unlimited benefits in both years.

Of the plans with lifetime maximums in 1974, 59 percent had ceilings under $50,000 (table 5). By 1981, the average ceiling had increased from just over $50,000 to about $250,000, and only 8 percent of the plans had lifetime maximums under $50,000. The percent of plans with lifetime maximums of at least $250,000 increased from 4 percent to 53 percent over the 7 years.

Comprehensive major medical plans included in this study tended to include higher specified lifetime ceilings on benefits than the supplemental plans. In 1981, only 1 of the 38 comprehensive plans had a lifetime maximum below $100,000, compared with 26 of the 92 supplemental plans. Conversely, 69 percent of the comprehensive plans set maximums at $250,000 or more, compared with 47 percent of the supplemental plans.

Most major medical plans with a lifetime ceiling on benefits also contain a reinstatement clause. This clause raises the dollar limit that potentially could be paid by the plan. An individual who has received major medical benefits often can obtain restoration of the full lifetime maximum by furnishing satisfactory medical evidence of insurability. Regardless of the individual's physical condition, however, a typical plan will automatically restore up to $1,000 of the maximum each year.

Table 5. Maximum coverage in a cohort of major medical plans with lifetime coverage limitations, 1974 and 1981

Maximum coverage	1974		1981	
	Number	Percent	Number	Percent
All plans	109	100	130	100
Under $50,000	64	59	10	8
$50,000	23	21	15	12
$75,000	—	—	2	2
$100,000	18	17	23	18
$150,000	—	—	9	7
$200,000	—	—	2	2
$250,000	4	4	40	31
Over $250,000	—	—	29	22

NOTE: Because of rounding, sums of individual items may not equal totals. Dash indicates no plans in the category.

Table 6. Method of funding in a cohort of major medical plans, 1974 and 1981

Funding medium	1974		1981	
	Number	Percent	Number	Percent
All plans	147	100	157	100
Commercial insurer	128	87	110	70
Blue Cross-Blue Shield	15	10	15	10
Self-funded	4	3	31	20
Other[1]	—	—	1	1

[1]Partially insured through a commercial carrier and partially self-funded.

NOTE: Because of rounding, sums of individual items may not equal totals. Dash indicates no plans in the category.

Internal limits. A key feature of major medical plans is their stress on a single overall limit on benefits, cutting across individual categories of health care. Nevertheless, major medical policies may include specific limits on coverage of such items as outpatient mental health care, extended care in a nursing home or by a home health care agency, private duty nursing, and dental care. These internal limits may be expressed as dollar amounts or days of coverage. For example, the most common limitation in 1981 for outpatient mental health care was $1,000 a year.

Funding

The great majority of the major medical plans in this study were financed through commercial insurance companies, which are responsible for both benefit payments and administrative services. Nearly 90 percent of the major medical plans in 1974 were financed in this manner, with the remainder mainly provided through Blue Cross-Blue Shield contracts (table 6). By 1981, however, a substantial increase in self-funding by employers had dropped the proportion of commercially insured plans in the study to 70 percent. Large firms, with substantial financial and administrative resources, are the most likely to choose self-funding. Among their objectives are economy in providing benefits and flexibility in plan design.

Companies able to assume the financial risk of self-funding are not always willing to devote resources to administering benefit provisions. These firms can purchase "Administrative Services Only" (ASO) contracts issued by insurance companies. Under these contracts, insurance companies handle administrative procedures such as claims processing, while the self-insured employers are responsible for benefit payments. The majority of the self-funded plans in this study had ASO contracts.

Plans without major medical coverage

While the proportion of plans with major medical coverage increased from 89 percent to 95 percent over the 1974–81 period, there were still 9 plans in the study without this coverage in 1981. These plans were, however, more comprehensive than the typical basic benefit plans. All but one offered at least 365 days of hospital coverage per illness. Seven of the nine provided full coverage of surgical expenses,[16] and the other two contained fairly liberal surgical schedules. Only one of the plans specified an overall plan maximum ($50,000). In a few cases, provisions for nonhospital and outpatient expenses were limited, but coverage of the most costly medical expenses seemed to be the norm. All nine of the plans without major medical benefits were collectively bargained, which suggests a reluctance by some unions to accept the cost-sharing concepts inherent in major medical plans.

DESPITE THE WIDESPREAD POPULARITY of major medical plans, there is debate as to their merits. Supporters believe that major medical plans offer valuable protection against the expenses of a major illness, while at the same time discouraging overuse of medical services for trivial conditions through the inclusion of cost-sharing requirements. However, critics claim that deductibles and coinsurance are barriers to effective health care because they deter early diagnosis of illness. This delay in seeking medical care may increase hospital usage, which in turn increases the cost of medical care. It is also contended that cost-sharing provisions are ineffective in controlling the use of health care facilities, for physicians, not patients, determine the demand for medical services.[17] Thus, critics often support comprehensive prepaid group practice plans—Health Maintenance Organizations—which stress coverage of first-dollar costs.

Although some disagree with the cost-sharing concepts of major medical insurance, they cannot deny the marked improvement in benefits offered by these plans. Increases in maximum benefits, addition of limits on out-of-pocket expenses, and broadening of risks covered have all helped to improve insured individuals' ability to cope with the high cost of medical care. Will further improvements be made if medical costs continue to rise as sharply as they have in the past decade, or will a reverse trend emerge in an effort to counter increases in insurance premiums? The answer to this question is still far from evident. □

FOOTNOTES

[1] As a percent of gross national product, national health expenditures advanced from 8.1 to 9.8 percent over the 7-year period. See Robert M. Gibson and Daniel R. Waldo, "National Health Expenditures, 1981," *Health Care Financing Review*, September 1982, p. 19.

[2] The annualized rate of change was calculated from data presented in table 19, p. 66 of this issue.

[3] Regarding HMOs, see Allan Blostin and William Marclay, "HMOs and other health plans; coverage and employee premiums," *Monthly Labor Review*, June 1983, pp. 28–33.

[4] The latter study is part of a series of annual surveys conducted in private sector establishments in the United States, excluding Alaska and Hawaii, employing at least 50, 100, or 250 workers, depending on the industry. Industrial coverage includes: Mining; construction; manufacturing; transportation, communications, electric, gas, and sanitary services; wholesale trade; retail trade; finance, insurance, and real estate; and selected services. Findings for 1981 are reported in *Employee Benefits in Medium and Large Firms, 1981*, Bulletin 2140 (Bureau of Labor Statistics, 1982). For information on the background and conduct of the survey, see Robert Frumkin and William Wiatrowski, "Bureau of Labor Statistics takes a new look at employee benefits," *Monthly Labor Review*, August 1982, pp. 41–45.

[5] Herman M. Somers and Anne R. Somers, *Doctors, Patients, and Health Insurance* (Washington, The Brookings Institution, 1961), p. 281.

[6] High-cost, or "catastrophic," illnesses are analyzed in *Catastrophic Medical Expenses: Patterns in the Non-Elderly, Non-Poor Population* (Congress of the United States, Congressional Budget Office, December 1982).

[7] Dental and vision care coverage at times were provided by separate basic plans even where comprehensive major medical policies were in effect. Oral surgery, however, is generally covered by basic surgical benefits or major medical plans.

[8] Somers and Somers, *Doctors, Patients, and Health Insurance*, p. 387.

[9] *Source Book of Health Insurance Data 1981–82* (Washington, Health Insurance Institute, 1982), p. 16. Early BLS studies of major medical plans are reported in *Analysis of Health and Insurance Plans Under Collective Bargaining, Late 1955*, Bulletin 1221 (Bureau of Labor Statistics, 1957); and *Health and Insurance Plans Under Collective Bargaining: Major Medical Expense Benefits, Fall 1960*, Bulletin 1293 (Bureau of Labor Statistics, 1961).

[10] In preparing table 2, modified comprehensive major medical plans providing initial full coverage of expenses were considered as offering both basic and major medical benefits. One of the early comprehensive plans was that offered by the General Electric Co. in 1955. See E. S. Willis, "GE's Experience with Comprehensive Health Insurance," *Monthly Labor Review*, June 1958, pp. 621–25.

[11] About three-fifths of the participants in major medical plans in medium and large firms were under supplemental plans. See *Employee Benefits in Medium and Large Firms, 1981*, p. 5.

[12] *New Group Health Insurance Policies Issued in 1981—Complete Tables* (Washington, Health Insurance Institute, 1981), tables 13, 18.

[13] Apart from mental health care, two of the plans in the study varied the coinsurance rate for different categories of medical care; the most significant ratio in these plans was used in preparing the distribution included in table 3.

[14] Some of the plans also contained overall limits on out-of-pocket expenses for an entire family.

[15] *New Group Health Insurance Policies Issued in 1981*, tables 13, 18.

[16] All seven covered the surgeon's fee up to the "usual and customary" charge for the procedure performed.

[17] For a more indepth look at some criticisms of cost-sharing provisions, see Bert Seidman, "Bad Medicine for Health Care Cost," *AFL–CIO American Federationist*, April–June 1982, pp. 20–28.