THE HISTORY OF HEALTH INSURANCE

The history of health insurance goes back centuries, possibly to ancient China and the Norman Conquest. Henry I introduced sweeping health care reforms to the newly combined kingdoms of England and Normandy. Soon thereafter, at least one “physician,” “John of Essex,” was receiving an honorarium of one penny per day for his efforts. As historians explained, that sum was roughly equal to that paid to a foot soldier or a blind person. Historically, doctors haven’t always been the high earners that they are today (1).

There's clearer historical evidence to suggest that American doctors were receiving capitation-like payments. Mark Twain is on record as saying that during his boyhood in Hannibal, Missouri, his parents paid the local doctor $25 per year for taking care of the entire family regardless of their state of health (2).

As for the ancient Chinese, it is said that many Chinese physicians were paid only if their patients got well. Stories that the emperors cut off the heads of doctors who failed to cure them are only legends (3).

Before 1920, medical expenses in the USA were very low. The chief expense of any illness was not the actual health care costs but the lost wages. According to a study conducted by the state of Illinois in 1919, lost wages from illness were four times larger than the expenses associated with treating the illness. Most families purchased “sickness” insurance (akin to our disability insurance) (4). There was a low demand for health insurance as well as an unwillingness on the part of insurance companies to provide the product. They lacked the information to calculate the risks and to write premiums. Death insurance was common. But “death” was pretty clearly defined, and “loss of health” was much harder to quantitate.

Attempts to enact health insurance

In the early part of the 20th century, several states proposed to enact compulsory health insurance, but all proposals failed. Popular support was low. Physicians opposed the insurance because they feared that it would limit their fees. Pharmacists opposed it because they felt it would undermine their business. Commercial insurance companies opposed it because in most cases the proposed legislation included exclusions for companies that carried burial insurance—and most did. That was a significant part of their business portfolio at the time.

However, in the 1920s to 1930s, the US population was shifting. Families from rural America, who frequently lived in larger homes that could house two or three generations, were moving to the cities, where they were often forced to live in smaller homes. Many of these homes did not have room to care for the sick, even though that was desirable (5). Moreover, as the scientific era began, hopes and expectations were raised for better health and recovery from illness.

Increases in the demand for medical care

If you accept the premise that health insurance is good, it comes as no surprise that rising incomes in the first part of the 20th century also helped to increase demand for health care and eventually health insurance. Advances in medical technology along with the growing acceptance of medicine as a science led to the development of hospitals as treatment centers and helped to encourage sick people to visit physicians and hospitals. “By the 1920s . . . prospective patients were influenced not only by the hope of healing, but by the image of a new kind of medicine—precise, scientific and effective.” This scientific aura began to develop in part as licensure and standards of care among practitioners increased, which led to an increase in the cost of providing medical care (6).

Rising medical costs for doctors: manpower issues

The American Medical Association (AMA) brought about several changes in the 1910s that led to an increase in the quality of physicians. In 1904, it formed the Council on Medical Education to standardize the requirements for medical licensure. The council invited Abraham Flexner of the Carnegie Foundation for the Advancement of Teaching to evaluate the status of medical education. Flexner’s highly critical report on medical education reimbursement: Clemens to Clinton

Health care reimbursement: Clemens to Clinton

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education was published in 1910. According to Flexner, the current methods of medical education had “resulted in enormous over-production at a low level, and that, whatever the justification in the past, the present situation . . . can be more effectively met by a reduced output of well trained men than by further inflation with an inferior product” (7). Flexner argued for stricter entrance requirements, better facilities, higher fees, and tougher standards. Following the publication of the Flexner Report, the number of US medical schools dropped from 131 in 1910 to 95 in 1915. By 1922, the number of medical schools in the USA had fallen even further to 81 (4). These increased requirements for physician licensure, education, and the accreditation of medical schools restricted physician supply, putting upward pressure on the costs of physicians’ services (7).

The birth of the Blues

In the 1930s and 1940s, a greater push for health insurance began. In 1929, a group of Dallas school teachers contracted with Baylor Hospital to provide 21 days of hospitalization for $6 per year. Such prepaid hospital plans began to grow during the Depression, providing a cash flow that helped keep the hospitals afloat during these lean years. The American Hospital Association helped design guidelines for Blue Cross to help reduce price competition among hospitals. Rather than restricting access to certain hospitals, the plans tended to allow open access to good hospitals. Furthermore, the Blue Cross plans were tax-exempt. Finally, enabling legislation was passed that freed the plans from the traditional reserve requirements. Blue Shield, the plans for physician services, came along in the 1930s.

Early growth in health insurance

In the 1940s to 1960s, there was a slow, steady, but seemingly reluctant growth in health insurance. Companies were reluctant because they feared they could not overcome problems relating to adverse selection. Blue Cross/Blue Shield was actually the first company to realize that insuring only groups of employed workers was good business. Those who were healthy enough to work were going to be a healthier group by nature selection. Other commercial carriers began to appreciate the business sense, and they soon began to outpace Blue Cross/Blue Shield.

Government policies also encouraged health insurance. Employers did not have to pay taxes on money contributed to health insurance plans, and employees did not have to pay income tax on the benefit (an IRS administrative ruling in 1943).

Medicare

The rise of Medicare was not so gracious. In 1958, 75% of Americans had some form of private health insurance coverage. The AMA was a very vocal opponent of any form of nationalized health insurance. Rather than fight the AMA, proponents of nationalized health insurance chose, instead, to offer health insurance only to people 65 years and older who could not afford private health insurance and who generally were not employed to receive the benefit.

The national political environment became more favorable when Kennedy was elected in 1960. Following his assassination and the congressional election of 1964, which led to a majority of Democrats, the Johnson administration was able to muster a popular and congressional mandate. The 1965 Medicare Act established parts A and B. Fearing doctors would refuse Medicare patients, the Health Care Financing Administration established the precedent of paying physicians on a profile of fees considered to be “usual, customary, and reasonable.” It also allowed for direct billing.

Nonetheless, the AMA vehemently objected, calling Medicare “the most deadly challenge ever faced by the medical profession” (8). George Lundberg, later the editor of JAMA, recalled: “AMA lobbyists warned that the entitlement program would lead to out of control spending” (9). On that point they were correct.

THE SAGA OF MANAGED CARE

Managed competition

With the passage of the Health Maintenance Organization (HMO) Act of 1973, many thought that the world of health care would come to an end or that the revolution predicted would provide health care value to all citizens and care and coverage for those previously underserved. Neither happened. Renowned author Maggie Mahar summed it up:

Over the past 25 years, market forces have splintered the U.S. health care system, converting what was, at its best, a network of collaborative relationships among patients, doctors, and hospitals into a vast and competitive marketplace.

There is always a temptation to idealize the health care system of the past. While at its best, it encouraged collaboration, doctors and hospitals often had different agendas. Moreover, within the profession many solo practitioners valued their independence above all else. This meant that the majority did not readily learn from one another. That said, the model was one of collaboration rather than competition. Doctors did not see themselves as opportunistic entrepreneurs, and hospitals did not advertise for patients. The Mayo Clinic—one of the first health care “co-ops”—was viewed as the gold standard for what the practice of medicine should be. Most actors in the system genuinely believed that they always put the patients’ interests ahead of their own interests—and probably most did (9).

Managed care was supposed to create a system that would contain costs while simultaneously increasing the quality of care. Our traditional fee-for-service medicine had led to health care inflation because it encouraged caregivers to maximize the number of procedures they perform, ignoring preventive care. Doctors and hospitals were not paid to keep patients well; they were paid to treat them when they were sick.

Caregivers who would try to improve medical outcomes watched their income drop. Duke created an integrated program to treat heart failure, and its patients were healthier, but because there were fewer complications, there were fewer admissions and the hospital lost money. “At times providers are paid even more when the quality of care is worse, such as when complications occur as the result of error” (10). In congressional hearings, Joanne Lynn, director of the Washington Home Center for
Palliative Care Studies, stated: “There are now six randomized control trials showing better ways of taking care of patients with advanced heart failure. Every single one of those programs has folded at the end of the grant funding because it is not sustainable under Medicare” (9).

HMOs and managed care plans had a short-range focus to save money. They did not provide greater value for the price. They did not improve lives with better preventive care. They remained solvent by what was alleged to be care denied and lives ruined. Those that did have preventive care programs found them ineffective because patients in large numbers did not stay with one plan enough years to show, for example, lower long-term health care costs for better managing the acute complications of diabetes. By the end of the 1990s, the public and the providers had complained and rebelled enough that plans had to start loosening their hold. And inevitably, as insurers eased restrictions, costs levitated, along with premiums. From 2000 to 2005, the cost of family coverage jumped 73%, while wages increased only 15% (11).

Unmanaged competition

Health care economist James C. Robinson popularized the term “managed care competition.” This competition brought on market expansion and contraction, diversification and re-focusing, merging and divestiture. Health plans wrestled with purchasers for higher revenues, with providers for lower costs, and with each other for brand name recognition, market dominance, and profit leadership (12).

Consumers, especially the 10% who are the poorest and sickest, are not in a position to make wise, educated choices about their care. Insurance plans that carry a high deductible have been marketed as another alternative for families who cannot afford the $10,000 to $13,000 annual premiums for a family. The problem is that these are the very same families who can least afford to cover a deductible of $5000. High-deductible plans work well for more affluent families, but they do not increase access for those now being priced out of the system (13).

The health care climate was clearly becoming more hostile. A 2004 Harris poll asked how well 15 industries served consumers. It confirmed the widespread distrust of corporate health care. At the bottom of the scorecard, managed care companies tied with tobacco companies. Insurers and drugmakers placed just a notch above oil companies. Of the health care industry, only hospitals ranked in the middle of the list. Banks, computer companies, and airlines all scored higher (14).

The good news and bad news of competition

To the purchasers, the most important feature of a health insurance plan was price. In far second place came network breadth. There was significant concern that health plans and delivery systems might substitute improving satisfaction with “warm and fuzzy” aspects of services for improving the actual technical quality of care, which is harder to measure and harder for enrollees to understand. In general, there was almost no competition on the basis of measured and reported technical quality process or outcomes measures (15). There are several reasons why the managed competition model has been slow to compete based on quality of care outcomes:

- **Lack of purchaser demand.** Purchasers did not initially insist on sophisticated quality measurement and reporting because the attention was on containing health care costs. As the pressure on premium increases decreased, purchasers began to pay greater attention to quality of care, through measures such as the Healthcare Effectiveness Data and Information Set. But this change has been slow.
- **Lack of useful, standardized quality of care indicators.** As managed care developed, quality of care outcomes indicators did not exist. Few methods adjusted for differences in patients’ health characteristics, and most of those had not been validated. The development was further slowed by conflict between health plans and providers and the lack of risk-adjusted premiums and provider payments. Health plans naturally wanted the loyalty of employers and enrollees to rest with the plan, not with the delivery system and providers. Only quality of care reporting at the provider level would enable employers and consumers to determine actual quality differences, at the place where services are actually delivered.
- **Lack of risk-adjusted premiums and provider payments.** Premium and provider payments did not get adjusted for enrollees’ health characteristics. Premiums were usually adjusted only on the basis of age, sex, and location. Without health risk-adjusted payments, health plans and providers have a strong disincentive to compete on quality because they do not want to be known as having the best quality of care for higher-cost illnesses if that would lead to unfavorable selection of enrollees. Without risk-adjusted payments, successful competition based on quality of care could mean substantial financial losses (15).

The model of managed care and the reality

Competition in the late 1990s differed from what had been hoped for. The reality of managed care was far from the model of managed care (15):

- **Purchasing coalitions.** Few small employers were part of the small business purchasing coalitions envisioned in the managed competition model.
- **Financial incentives for enrollees.** Employers were slow to offer financial incentives for employees to choose lower-cost plans and standardized benefit packages. As the purchasers had success in obtaining premiums at lower rates, or at rates that grew more slowly, they had reduced pressure to create purchasing coalitions to craft incentives for enrollees to choose lower-cost plans.
- **Risk-adjusted payments.** Employers did not pay health risk-adjusted premiums to health plans, and plans did not pay health risk-adjusted capitation rates to providers. This key pillar of managed competition is designed to reduce incentives for health plans and providers to select healthier enrollees and leave enrollees with higher costs in other plans.
- **Access, style of care, and technical quality of care.** As explained above, enrollees were not choosing health plans and providers on the basis of valid, understandable, measured, and
reported indicators of important aspects of care, although efforts are under way to change this situation.

- **Integrated systems.** Accountable health partnerships (integrated health plan/delivery system organizations with exclusive relationships with each other), one component of the original managed competition model, continue to be the exception rather than the rule, although their constituent elements (large insurers and organized delivery systems) are emerging.

- **Transformed practice of medicine and prevention.** The practice of medicine and care of populations is changing only slowly. Many of the activities that require clinical integration and prevention—potential pillars of the future health care system—are only beginning in many areas, as are the sophisticated information systems that those activities require.

- **Self-regulation.** The self-regulatory bodies envisioned in the managed competition model that would oversee market competition are not in place, although some organizations (such as the National Committee for Quality Assurance) fulfill some aspects of the roles foreseen for those bodies.

**Lessons learned**

In short, competition did not progress along the lines of the “pure” managed competition model. Purchasers did not demand valid, understandable, and reported measures of health outcomes that really reflected the important dimensions of quality of care. In an era of less government to be used to demand such things, the social responsibility of employers and purchasing coalitions (public and private) becomes great, and the cooperative action of purchasers will be vital in determining the nature of competition, and the quality of health care, in whatever health care system emerges (15).

**THE CLINTON PLAN**

The extent of the health care crisis in 1993 as perceived by Bill Clinton is summarized in the Executive Summary of the Health Security Act of 1993.

Over the next few years, one out of four of us will be without health coverage at some point. Change jobs, lose your job, or move—and your insurance company is currently allowed to drop you. Today’s system is rigged against families and small businesses. Insurance companies pick and choose whom they cover. Then they drop you when you get sick. If you have a pre-existing condition, you usually can’t get any insurance at all.

Insurance companies charge small businesses as much as 35% more than the big guys.

Only 3 of every 10 employers with fewer than 500 employees offer any choice of health plan. Millions of Americans have almost no choice today.

Twenty-five cents out of every dollar on a hospital bill goes to bureaucracy and paperwork—not patient care. Fraud and abuse are exploding, costing us at least $80 billion a year. That’s a dime of every dollar we spend on health care.

Our nation’s health costs have nearly quadrupled since 1980. Without reform, by the year 2010, one of every five dollars we spend will go to health care.

The Clinton Plan guaranteed comprehensive benefits that could never be taken away. It was based on six principles: security, savings, quality, choice, simplicity, and responsibility. It would have controlled health care costs for consumers, businesses, and the nation; improved the quality of American health care; increased the choices for consumers; reduced the paperwork for health care providers; and simplified the system. The plan proposed to accomplish these goals by employing five mechanisms that would clearly broaden and deepen government control over health care:

- A national health board
- Regional health alliances
- A standard benefits package
- Employer mandates
- Government budgets and spending caps

Though the principles espoused were very popular, the plan was a political failure. In *Boomerang: Health Care Reform and the Turn Against Government*, Theda Skocpol, a professor of government and sociology at Harvard University, using primary sources like internal memos and interviews with Hillary Clinton and Ira Magaziner, tells the compelling story of the plan’s failure. Arnold S. Relman, MD, summarized the plan and its failure in his review of *Boomerang*:

Bill Clinton was elected President on November 3, 1992, after promising to introduce a legislative proposal for comprehensive health care reform within 100 days after his inauguration. It was a popular message, and many observers believed that George Bush’s failure to offer a program of his own was a major factor in the election. Shortly after taking office, Mr. Clinton announced the formation of a task force, headed by his wife, Hillary Rodham Clinton, and managed by his friend and political advisor Ira C. Magaziner, to develop a plan for health care reform. It was an auspicious start, and expectations were high.

The President had already stated his ambitious goals: universal coverage, cost control, accountability for quality, and the maximal possible freedom of choice of doctor and insurance plan. He had also decided that the proposed plan would be based on “managed competition,” which meant regulated price competition among certified managed-care plans. The program was to be funded by mandatory tax-deductible contributions from employers, and the competing plans were to be regulated by regional purchasing alliances. New federal revenues, from unspecified sources, would finance insurance for those not covered through employers or existing government programs.

The task force’s assignment was to draw up the detailed organizational and regulatory structure needed to carry out this grand strategy and, where necessary, to prepare tactical options for the President’s decision. For about five months, from February to June 1993, more than 500 experts toiled feverishly on the plan under Magaziner’s direction, secluded in the Old Executive Office Building adjacent to the White House. The secrecy and intensity...
with which they worked were reminiscent of war time. However, nearly nine months elapsed before the plan received final presidential approval. It was unveiled on September 22, 1993, at a dramatic and highly publicized joint session of Congress.

The plan—1342 pages of dense legislative language—was initially received with widespread bipartisan enthusiasm, but in one of the most stunning reversals in recent political history, its prospects soon began to fade. By early 1994, it was in serious trouble in Congress and in the opinion polls. By summer, the Clinton plan, together with a spate of alternative legislative proposals, was hopelessly bogged down in committees. On September 26, Senate Majority Leader George Mitchell announced the obvious—that comprehensive health care reform was dead for that session of Congress. The subsequent Republican sweep in the November elections ensured that it would not soon be resurrected. . . .

Attempting to avoid new taxes and reduce the deficit, Clinton’s team devised a plan so loaded with elaborate regulations to control costs that it inevitably aroused the ire of the foes of “big government.” Intense lobbying by coalitions of small businesses objecting to mandatory participation of all employers and resistance by private health insurance companies worried about restrictions on their access to the huge and lucrative managed-care market also played a central part, according to Skocpol. She criticizes Clinton himself for not taking a more active role in explaining and selling his plan to the public, before the opposition had geared up its antireform campaign. If the President really believed in the proposal, she says, he should have fought much harder for it in public (16). Quote reprinted with permission from the Massachusetts Medical Society.

The rush to present and implement the plan allowed for no “gestation period” during which all the political and special interest groups could engage in study, review, and learned debate. Small business coalitions, private insurance companies, and organized medicine were all excluded from the deliberations that created the plan and proved its most ardent opponents. The authors and especially the president were evasive in public and in private in articulating how it would be financed. The failure to promote what was promised in the election campaign had a devastating effect on Democrats. The failure of the Clinton Plan is largely responsible for the resulting Republican sweep in the November 1994 elections.

WHAT HAVE WE LEARNED?

This “30,000-foot view” of the history of health care reimbursement may seem to be the history of failure. Insurance companies were reluctant to get into health insurance in the first place. The industry expanded based not on a demand for quality by the public or employers but on their ability to make a profit and sustain a business model. As the medical profession, we have a mandate from the public to provide universal health care and a mandate from most of our colleagues to do so without allowing the government to accomplish this with a single-payer system. Physicians opposed insurance at the beginning, opposed Medicare, opposed managed care, and opposed the Clinton Plan. We opposed Medicare with its episode-of-care reimbursement model, which started out as a reasonable and customary fee profile. Maggie Mahar has pointed out how the medical industrial complex—pharmaceutical and device companies—has caused an explosion of costs and cost increases. The politicians, the Clintons, the Democrats and the Republicans, all failed in 1994 to enact health care legislation and reform that they all agreed at the outset was a national moral imperative.

This review has touched on the history of health insurance to the present time. It has reviewed some of the original principles of managed competition and why it failed or failed to be implemented. It reviewed some of the laudable goals of the Clinton Health Plan, yet the Clinton’s dramatic political failure to implement change. I do not intend to provide the answers to what will happen over the next several years when our health care system will either collapse or be redirected to a sustainable model. But we can at least begin that journey with these lessons learned.