

Evolution Of The Health Care System In The United States

By Rhondda Tewes

Despite having 47 million uninsured Americans, the United States spends twice as much per capita on health care as other industrialized nations that provide health insurance to all their citizens. And yet we lag behind those nations on all three indicators of healthy lives: high life expectancy, low preventable mortality and low infant mortality. The U.S. infant mortality rate in 2004 was 7.0 deaths per 1000 live births, compared with 2.7 deaths per 1000 live births in the top three of 13 countries evaluated.¹

In 2007, we spent \$2.4 trillion, or \$7,900 per capita, on health care and we are now projected to reach \$3.1 trillion in 2012 and \$4.3 trillion in 2017 which will represent 20 percent of our GDP (gross domestic product).²

What does all that money provide? Not nearly enough. In addition to the 46 million uninsured during 2006-07, as many as 89.5 million people under the age of 65 were uninsured for at least one month or more, while 16 million people were considered under-insured.¹

Our health care system is not only too expensive, it fails to provide us with the comprehensive, universal coverage that is taken for granted by the citizens of other industrialized nations – nations with whom we compete in a global market. How did this happen?

A Brief History

Medical care was relatively inexpensive in the early part of the 20th century although there were attempts by progressive reformers to protect workers against both wage loss and medical costs beginning around 1915. At that time, people were more concerned about loss of pay when they were ill; so “sickness funds” were established to provide insurance against lost wages.³

Despite a general mood of complacency during the 1920s, reformers began to emphasize the cost of illness instead of lost wages and advocate for “sickness” insurance, particularly for the middle class. The inadequacy of rural health facilities, however, had not yet been addressed.⁴

The Great Depression that ended the 20s brought multiple changes. An historic change was the Social Security Act, which was passed in 1935. However, a push within the Roosevelt administration to include health insurance was defeated by internal government conflicts over priorities.

The Depression created serious cash flow problems for everyone – including hospitals and surgeons and, to a lesser degree, general practitioners. As a result, against the advice of insurance professionals, hospitals created the first structured, pooled financing mechanism for health insurance: Blue Cross. What Blue Cross offered was private coverage for hospital care in dozens of states. Reluctantly, physicians soon followed with Blue Shield, which was originally limited to surgical procedures performed in the hospital. Coverage was later expanded to office visits and eventually evolved into major medical coverage.⁴

In exchange for tax and regulatory advantages (tax exemption as well as exemption from the provisions of insurance statutes), Blue Cross/Blue Shield (the “Blues”) provided open enrollment periods and community rating (charging the same premium to the sick as well as the healthy).⁴

Concurrently, progressive employers began to provide health benefits to their workers through group insurance. Pioneered by the Blues, group insurance was a new and cost-efficient way to provide coverage

to large numbers of people while minimizing anti-selection (workers were assumed to be younger and healthier than the general population). At about the same time, a few employers began to rely on, and even created, group practices (e.g., Kaiser), which were the first health maintenance organizations (HMOs).⁴

During this period, commercial insurance companies had chosen not to enter the health insurance market because they were concerned about adverse selection making business unprofitable (more sick than healthy people would want insurance). However, after the Blues had shown the way by insuring large groups of individuals, thereby reducing the risk, the picture changed (enough healthy people compensated for those who were ill).⁴

Commercial insurers, however, were profit-making organizations and did not have to use community rating. They could rate by experience, charging more for sick individuals than for healthy. This enabled them to offer relatively healthy groups lower premiums than the Blues. As a result, business boomed in the commercial market from 1940-60.^{3,4}

Two major rulings in the 1940s reinforced the employer-provided health insurance system. The first ruling was issued in 1945 by the War Labor Board and stated that employers could not modify or cancel group insurance plans during a contract period. In 1949, a ruling by the National Labor Relations Board, in a labor dispute, stated that the term “wages” included pension and insurance benefits – a decision that enabled unions to negotiate benefit packages, as they already did wages, on behalf of workers.^{3,4}

This ruling, later affirmed by the U.S. Supreme Court, further solidified the employment-based system. However, the most influential government intervention to shape the employer-based system of health insurance was a ruling in 1943. It stated that employer payments made directly to commercial insurance companies for group medical/hospital employee premiums were not taxable as employee income.^{3,4}

That ruling was codified and extended in 1954, and the result was increased demand for employer-provided health insurance throughout the 1950s. By focusing on providing health insurance only to groups of employed workers, private insurance companies were able to overcome the adverse selection problems they had feared would make the health insurance market unprofitable.³

Earlier, in November 1945, President Harry Truman, noting that 40 percent of the population still lacked access to adequate health facilities, addressed Congress and proposed a new national health care program, known as the Murray-Wagner-Dingell bill. It met opposition from labor as well as the American Medical Association, and, following the outbreak of the Korean War, Truman was forced to abandon it.^{3,4}

By 1958, almost 75 percent of U.S. citizens were covered by some form of private insurance, and the medical profession had been able to avoid the government intervention and nationalized insurance they had feared since early in the century. Doctors’ concerns from the beginning had been the preservation of their independence and ability to charge different fees to different patients for the same procedures – less to the poor, more to the wealthy.³

No serious proposals for government-sponsored health insurance were proposed during the eight years of Dwight Eisenhower’s presidency. Proponents of such plans believed that they would have to be enacted incrementally and they began to concentrate on the elderly. Their work ultimately led to the passage in 1965 of Medicare and Medicaid under President Lyndon Johnson.³

Medicare and Medicaid Evolve

Physicians actually benefited from Medicare, which insures citizens aged 65 and over. Part A funded hospital bills and Part B funded major medical expenses. Initially, Part B reimbursed physicians according to their “usual, customary, and reasonable rate” and allowed them to bill patients directly so that patients had to be reimbursed by Medicare. Physicians were also permitted to price discriminate by charging more than what Medicare would pay, which meant that patients had to pay the difference out of pocket. Then, as now, funding for Medicare came from payroll taxes, income taxes, trust fund interest and enrollee premiums for Part B (supplemental medical insurance for physicians’ services).⁴

By 1980, Medicare claims expenditures had risen dramatically and resulted in a major change in reimbursement policy. Reimbursement of Medicare claims through the use of “usual, customary, and reasonable rates” was replaced by a set of fee schedules based on diagnosis (diagnosis related groups or DRGs) and is the system in use today.⁴

It should be noted that when discussing the current cost of Medicare, it is important to separate the cost of medical claims from the cost of administering the plan. The administrative cost of Medicare remains very low today at 3 percent, particularly when it is compared to the 15 to 20 percent overhead of private plans.⁵ However, the cost of the plan's medical claims is very high because Medicare insures only our most vulnerable citizens - those over 65 and the disabled, the worst possible risk pool.

Over the years Medicare has been amended. In 1977, the Health Care Financing Administration (HCFA) was established to administer the Medicare and Medicaid programs. In 1982, TEFRA (the Tax Equity and Fiscal Responsibility Act) made it easier and more attractive for HMOs to contract with the Medicare program. In 2003, the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) made significant changes. It created a prescription drug discount card good until 2006, allowed for competition among health plans to foster innovation and flexibility in coverage, and covered new preventive benefits.⁶

By 2006, the changes begun by Medicare in 2003 had been completed. Medicare was amended by adding Parts C and D to the original A and B. Part A continues to cover inpatient hospital expenses and helps cover skilled nursing facilities, hospice and home health care if certain conditions are met. Part B helps cover doctors’ services and outpatient care. Part D partially covers prescription drugs and Part C supports Medicare Advantage Plans. These latter plans are private, for profit, managed care insurance plans that compete with traditional Medicare by providing Parts A, B and sometimes D in one plan. However, the government must subsidize private insurers to enable them to compete with traditional Medicare. As a result, in 2008, the government spent 13 percent more than the cost of traditional Medicare to provide this privatized coverage.⁷

Medicaid, also enacted in 1965, is the nation’s principal safety-net health insurance program. It covers health and long-term care services for 59 million low-income Americans (as of November 2008). Most recipients are in working families. Without Medicaid, the majority of enrollees would be uninsured. Financed jointly by the federal government and the states, the program is administered by the individual states within broad federal guidelines. Therefore, benefits vary from state to state. The program accounts for almost one-sixth of total personal health care spending in the United States, and the federal government currently finances 57 percent of Medicaid spending.

Recipients must meet financial criteria and also belong to a “categorically eligible” group, i.e., children, parents with dependent children, pregnant women, people with severe disabilities and the elderly. Although the sick and frail make up a relatively small share of the Medicaid population, their share of total spending is significant – 1 percent of enrollees with the highest medical expenses and long-term care costs accounted for 25 percent of Medicaid spending in 2004.⁸

Medicaid also pays for 60 percent of nursing home residents. Because so many elderly citizens are inadequately insured for long-term care, they spend down their assets in order to qualify for coverage by Medicaid. The result is that Medicaid pays for one in five health care dollars and one out of two nursing home dollars owed for long-term care.⁹

SCHIP, the State Children's Health Insurance Program, is a more recent federal program that was enacted just over ten years ago. In February 2009, President Barack Obama signed into law its successor, the Children's Health Insurance Reauthorization Act (CHIPRA). The program is now known as CHIP and provides health insurance to our youngest citizens.¹⁰

Other Health Care Attempts

Since the passage of Medicare and Medicaid, there have been sporadic efforts to legislate government-sponsored health care reform that would ensure comprehensive health care for all U.S. residents. Senior citizens and labor groups both worked in support of a plan co-sponsored by Sen. Edward Kennedy in the 1970s. Led by the Committee for National Health Insurance (CNHI), supporters reached out to many civil rights and anti-poverty groups but relied on professional staff, conferences and Washington-based lobbying, rather than grassroots lobbying. Weakened by interest-group squabbles, the CNHI bill competed with 13 other health insurance proposals sponsored by the AMA and commercial insurance companies. Finally, reform lost momentum when the massive health care inflation of the 1970s led to an emphasis on cost control rather than on expanding coverage.¹¹

The number of uninsured continued to rise throughout the 1980s causing increasing public discontent. President Bill Clinton began his presidency with enormous popular support for health insurance reform. Introduced with great fanfare and anticipation, his Administration's efforts floundered. A common criticism then and now is that the plan was overly complicated, difficult to explain and depended on the same elite-based planning and decision making that had isolated previous reform efforts from grassroots influence and support. The result was that the plan generated enormous opposition, was poorly understood by many citizens and met the same fate as Kennedy's effort. As Harvard Professor Theda Skocpol, PhD, stated in her 1996 book, *Boomerang: Health Care Reform and the Turn against Government*, "Democrats and supporters of the proposal were in disarray and were disinclined to explain the proposal's provisions." Both the Kennedy and Clinton attempts relied on professional staff, conferences and Washington-based lobbying to achieve their goal, rather than on grassroots lobbying. Both failed. This contrasted with the unity, resources and grassroots effectiveness of the plan's opponents.¹²

In 1994, after the defeat of President Clinton's health care reform effort, major changes in the private health care insurance system began to be implemented by health insurance companies. These changes and their effect on beneficiaries are described in "A Short History of Major Changes in the U.S. Health Care System Since 1994: Costs, Coverage and Quality."¹³ For basic facts and figures on the cost of health care in the United States, see "What is Driving the Rapid Rise in U.S. Health Care Costs?"¹⁴

The idea of a public plan competing with private plans is one of the reform options currently being considered in Congress. To learn how a public plan might be structured to compete with private plans, see "Understanding Healthy Competition: How to Structure Public Health Insurance Plan Choice to Ensure Risk-Sharing, Cost Control, and Quality Improvement."¹⁵

The result of this systemic failure is that the U.S. Congress is once again struggling to legislate meaningful and cost-effective reform that will provide universal coverage that is both comprehensive and affordable. As citizens, it is important that we understand the problem so that we can be a part of the solution.

Endnotes:

- ¹ <http://www.annals.org/cgi/reprint/148/1/55.pdf>
- ² <http://nchc.org/facts/cost.shtml>
- ³ <http://eh.net/encyclopedia/article/thomasson.insurance.health.us>
- ⁴ http://faculty.smu.edu/tmayo/health_percent20care_percent20timeline.htm
- ⁵ <http://dollarsandsense.org/archives/2008/0508harrison.html>
- ⁶ <http://www.cms.hhs.gov/History/Downloads/CMSProgramKeyMilestones.pdf>
- ⁷ <http://www.therubins.com/medicare/advantage.htm>
- ⁸ http://www.kff.org/medicaid/upload/7235_03-2.pdf
- ⁹ http://www.kff.org/medicaid/upload/key_percent20Medicare_percent20and_percent20Medicaid_percent20Statistics.pdf
- ¹⁰ http://www.lwv.org/AM/Template.cfm?Section=Health_Care_Education&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=13472
- ¹¹ <http://www.ajph.org/cgi/reprint/93/1/75?maxtoshow=&HITS=10&HITS=108RESULTFORMAT=&author1=Beatrix+Hoffman>
- ¹² <http://www.rwjf.org/reports/grr/023490.htm>
- ¹³ http://www.lwv.org/AM/Template.cfm?Section=Health_Care_Education&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=13491
- ¹⁴ http://www.lwv.org/AM/Template.cfm?Section=Health_Care_Education&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=13499
- ¹⁵ http://www.lwv.org/AM/Template.cfm?Section=Health_Care_Education&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=13518

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