

Cambridge University Press

978-1-107-04488-3 - Ensuring America's Health: The Public Creation of the Corporate Health Care System

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Excerpt

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Introduction

The U.S. health care system boasts outstanding care. From all across the globe, the wealthy travel to the United States to receive innovative treatments from accomplished physicians practicing in renowned medical centers. Yet the American medical system has glaring imperfections that have long puzzled observers.

Why is health care so expensive? Accounting for almost 18 percent of the nation's gross domestic product (GDP), the cost of American medical care is exorbitant. A yawning gap separates the United States from the second most expensive systems of Germany, France, and the Netherlands, which spend between 11 and 12 percent of GDP on medical services.¹ In the United States, high-priced health insurance has traditionally placed coverage out of the reach of many consumers who lack either employer subsidies or some form of government provision.

Furthermore, why is U.S. health care delivery fragmented? Rather than providing patients with integrated medical care in one location, physicians generally practice either individually or in single-specialty groups. This structure forces elderly, chronically ill, and difficult-to-diagnose patients to navigate arduous and lengthy care routes in an attempt to obtain services from various specialists. Because no single physician or group of physicians is responsible for the patient's complete care, doctors lack incentive to scrutinize the extensive prescription lists of elderly patients or ensure that difficult cases obtain proper diagnoses. In theory, general practitioners fill these roles. However, once a general practitioner has referred a patient to a specialist, only rarely do both physicians find space in their busy schedules to consult with each other, whether via phone or computer, about that patient. Moreover, general practitioners

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are not rewarded financially for taking time to sort through complex cases; they are usually paid flat annual per-patient fees or fixed reimbursements for office visits and certain services and procedures. They can consequently spend only so much time on activities that are not, to use a favorite term of lawyers, “billable.”

This problem leads us to a related series of conundrums. What has happened to the “art” of medicine? Why do many physicians practice with one eye directed at the patient while the other eye is fixated on insurance company reimbursements and standardized treatment parameters?

The answer to these questions can be found in the distinctive economic arrangements that order health care financing and delivery – what I will refer to throughout this study as the “insurance company model.” Insurance companies occupy a central position in medical care. Insurers decide which services and procedures qualify for policy coverage, influence physician pay and hospital revenues by setting reimbursement fees, and shape medical practices by requiring that health care providers follow treatment blueprints to obtain compensation. Many scholars have taken this authority for granted, assuming that insurance companies are filling an intrinsic role in private medical care. Yet the insurance company model was only one option among an array of organizational possibilities that might have structured the private market.² And in comparison with alternative arrangements, the insurance company model has delivered medical services less efficiently and more expensively.

So how did insurance companies acquire such a dominant role in health care? Politics – not the logic of the market – positioned insurance companies at the heart of American health care.

During the late 1930s, American Medical Association (AMA) leaders decided that, among all the ways of organizing medical services, insurance-company-funded policies offered physicians the most professional security. The AMA derived authority to shape the market not only from the doctoring profession’s cultural standing, but also from state licensing and medical practice laws that endowed the association with regulatory power. For AMA officials, safeguarding physician sovereignty trumped economic efficiency. They therefore created a particular insurance company model: their design required insurers to reimburse the services of individual physicians rather than medical groups; compensate practitioners for each service or procedure provided; and allow doctors to practice medicine as they saw fit, free from supervision or interference. Both physicians and insurers hoped to severely limit health insurance.

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Doctors feared losing autonomy to third-party financiers. Insurers were troubled by the cost implications of funding physicians who could arbitrarily increase the price and supply of medical services. Meanwhile, the AMA opposed and suppressed all other health care prepayment plans, whether sponsored by businesses, mutual aid societies, consumer organizations, unions, or even physician groups.

Professional calculations soon merged with national politics to cement into place the centrality of insurance companies. Most policymakers and health care experts – indeed, insurers themselves – recognized that insurance company financing that complied with AMA demands would cause problems. Of particular concern was the likelihood that the payment mechanism would rapidly drive up service costs and insurance premiums, thereby limiting coverage rates among the populace. To prevent such a scenario, both Democrats and Republicans offered numerous health care reform proposals throughout the 1940s and 1950s. Paradoxically, reform initiatives further entrenched the AMA-crafted insurance company model. This development occurred when insurers and physicians decided that the best way to defeat health care reform was by rapidly and dramatically expanding insurance in order to prove that the “voluntary”^{*} market could supply generous, comprehensive coverage for all population groups.³

Predictably, as the insurance company model spread, medical costs skyrocketed. So ground-level organizations – insurance companies, physician offices, medical societies, and hospitals – began evolving to regulate the relationship between financiers and service providers. As insurers attempted to contain costs, they gradually expanded their function from simply financing services to also supervising medical care and coordinating the health care system.

Once a durable institutional framework was established in the private sector, policymakers began accommodating that pattern. In 1965, they built Medicare around the insurance company model: the program incorporated the financing and cost control structures that physicians and insurers had already created. Policymakers also appointed insurance companies to act as administrators on behalf of the federal government. Thus, over the course of approximately three decades, insurers developed from system outsiders into the primary financiers of voluntary health care as well as the overseers of both private and public medical services.

^{*} Throughout this work, the terms “voluntary” and “private” will be used interchangeably. This reflects contemporary usage – how many interest group leaders, health care analysts, and policymakers used these terms during the period under study.

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Meanwhile, policymakers and citizens came to see their role as a “natural” feature of the health care system.⁴

EXPLAINING DISTINCTIVE FEATURES OF U.S. HEALTH CARE

Understanding the insurance company model and how it came to govern health care sheds light on three system characteristics: high costs, fragmented care, and corporate arrangements. Most narratives assert that medical costs became a significant issue after the passage of Medicare.⁵ Yet recognition of the cost problems associated with third-party financing that complied with AMA specifications discouraged commercial insurance companies from entering the health care market until the late 1930s – and even then they did so reluctantly, on the most restricted basis possible. By the end of the 1940s, most insurance company policies still limited coverage to a portion of hospital costs. Nevertheless, as medical insurance gained traction among consumers during this period, health care costs rose so quickly that they began outstripping price increases in every other category of goods and services.⁶

The fundamental principle of moral hazard warned underwriters not to issue insurance products that would decrease policyholders' incentive to avoid the risks for which they were insured. Home and automobile insurance have been stable underwriting fields because, barring outright fraud, subscribers attempt to avoid house fires and car accidents. Illness, however, is difficult to define, and many patients seek out excessive services and procedures when they are paid for by a third party. Most significantly, under the insurance company model, physicians – the individuals with the requisite expertise and skills to determine when a patient truly required medical care – were financially rewarded for providing as many services as possible. To comply with AMA guidelines, insurance companies had to reimburse physicians, not with set salaries or per-patient capitation fees, but on a fee-for-service basis. Moreover, for many years after the insurance company model was introduced, insurers lacked the authority to even question, much less regulate, physician practices. These broadly understood cost problems fueled health care reform initiatives throughout the 1940s and 1950s.

Other factors – including overprovision of care driven by physician fear of malpractice suits and increased demand from government programs such as Medicare – have certainly contributed to rising costs. Nevertheless, the insurance company model and the way it has structured patient and service provider incentives remains the primary culprit.⁷ This legacy constitutes one of the greatest economic challenges facing Americans today.

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Fragmented care emerged as a second key feature of the insurance company model. Fearing that corporate, hierarchical organization would overtake health care, AMA leaders insisted, from the time that they endorsed insurance in the 1930s, that insurers finance only individual physicians or, at most, doctors who practiced with one or two peers from the same specialty. Insurers were prohibited from contracting with multi-specialty organizations. This directive proved critical as, during the first half of the twentieth century, doctors demonstrated a desire to provide integrated patient care by forming groups that incorporated physicians from various specialties, ranging from general practitioners to surgeons and ophthalmologists. There were sound medical reasons to establish such groups as they facilitated discussion of complex cases. Moreover, because these groups were responsible for the entire patient – for the patient's overall wellness – doctors were impelled to find proper diagnoses, even in cases that required considerable amounts of diagnostic testing and consultation. Today, if a physician encounters difficulty with a chronically ill patient or tricky-to-diagnosis individual, the simplest course of action is to refer the patient to another doctor or specialist. If the patient never receives adequate care or a proper diagnosis, no one practitioner is responsible for or would likely even know the patient's final health outcome.

The third aspect of U.S. health care that this narrative explains is its corporate or pseudo-corporate structure. As health care coverage expanded and costs rose, insurance companies forged overlapping institutions with doctors and hospitals, creating payment systems, channels of communication, and cost containment procedures that established and tightened the financier-provider relationship. Through these structures, insurance companies gradually assumed the role of managers attempting to supervise the work of employees, in this case, physicians and hospital administrators.⁸ Although the process occurred incrementally and only through numerous battles with service providers, insurance companies expanded their mandate from simply underwriting the risks associated with medical services consumption to, ultimately, regulating health care. This process began during the 1950s and continues to this day. In this way, insurance companies have become intricately involved in the delivery of care, issuing, in the name of cost control, blueprints and parameters that guide physicians on how to practice medicine.

ORGANIZATION OF THE NARRATIVE

To fully explore the organizations, ideas, and people that helped create the insurance company model, this narrative employs a multilevel

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institutional approach. Trade and professional associations acted as institutional bridges that connected events in the federal political realm with developments at the ground level, in the organizations – such as doctors' offices and insurance companies – that interacted directly with patients and policyholders. Thus, the primary characters in this story are the AMA, which represented physicians; the Health Insurance Association of America (HIAA, known today as America's Health Insurance Plans or AHIP), which promoted commercial or for-profit insurance companies; and the National Association of Blue Shield Plans (NABSP), which led nonprofit medical plans that insured physician services.⁹ The leaders of these associations lobbied policymakers, not only to prevent the adoption of universal, government-managed health care but also to obstruct even modest reform policies that would have altered the insurance company model. The Blue Cross Association (BCA), which represented nonprofit hospital plans, played a crucial supporting role, peeling away from other private interests to favor limited government intervention in health care while also contesting the AMA for the loyalty of NABSP leaders. In addition to conducting political operations, each of these associations translated lessons learned during federal reform debates into marching orders that directed the economic behavior of members: physicians, insurance companies, and nonprofit insurance plans. This chain of command allowed interest groups to shape the health care market in response to the criticisms that political reformers lodged against the insurance company model.

Chapter 1 surveys early forms of health care organization, evaluating how, through the first half of the twentieth century, the AMA stifled an evolving and innovative market rife with numerous financing experiments. During the 1930s and 1940s, mounting calls for federal health care reform finally forced AMA officials to compromise and allow the market to progress beyond its nineteenth-century template. They approved health insurance *but only* policies funded by insurance companies that complied with stringent criteria, including fee-for-service compensation for individually practicing doctors. AMA leaders chose the insurance company model hoping to maintain physician independence by keeping third-party financiers far removed from the delivery of medical care.

Chapter 2 considers political developments under Presidents Harry S. Truman and Dwight D. Eisenhower. In response to the innate problems of the insurance company model, both Democrats and Republicans persistently attempted to reform the health care sector in order to

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provide broader and more generous insurance coverage. Private interests battled these measures by attempting to develop health insurance in a manner that would allow them to declare the voluntary market superior to any scenario that entailed federal intervention. Within this setting, physicians, for-profit insurance companies, and nonprofit plans jockeyed to obtain political power and market standing. Chapters 3 through 5 assess these activities by presenting detailed examinations of the AMA, HIAA, and NABSP. Evaluating the effectiveness of their divergent political, economic, and organizational strategies elucidates the contested nature of professional and occupational standing.¹⁰

Chapter 6 completes the process of tracing federal political influence through trade associations, down to ground-level organizations. It explores how insurance companies, nonprofit plans, AMA medical societies, physician offices, and hospitals developed to support the rapid growth of insurance products that were designed to mitigate political critiques. The problem of rising costs profoundly shaped their activities. Although insurers initially operated in the health care field entirely dependent on the goodwill and support of doctors and hospital leaders, as they pursued cost containment, they gradually inverted that relationship to obtain authority over service providers.

Chapter 7 reviews the Medicare debates between 1957 and 1965, examining them in the light of voluntary sector developments. Although health interests had sufficiently expanded insurance to thwart previous legislative reforms, the inherent inefficiency of private arrangements combined with the higher costs of caring for aged patients hindered their success in the field of elderly coverage. However, by this point, the policy-makers seeking government-funded aged health care believed it necessary to harness the institutional scaffolding that insurers and physicians had already constructed. After years of maturation, the voluntary sector had far more organizational capacity than the public sector; moreover, employing existing financing and delivery structures allowed policy-makers to brand Medicare as an ideologically moderate response to the problem of elderly care. By adopting the insurance company model that had previously been so controversial, Medicare validated that very paradigm and obscured numerous alternatives.

STATE–SOCIETY RELATIONS

Ensuring America's Health displays four closely related, indeed, overlapping themes that illuminate state–society relations. Each of these themes

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emphasizes the symbiotic relationship between public policy and private market development. In presenting this narrative about health care, I am advancing a larger project that attempts to dismantle the imaginary wall that scholars and opinion makers often erect between government and civil society.¹¹

The first key point this history demonstrates is that the U.S. health care economy was assembled through intertwining public and private authority.¹² Scholars have increasingly brought private sector development into the narrative of health care policy. I build upon this theme to emphasize how a specific economic model, generally categorized as a creation of the private sector, is in fact rooted in complex state–society relations.¹³ Even as attempts to reform health care failed, calls for government intercession reverberated through the medical services market, shifting the economic strategies and actions of private interests. Through public policy debates, government officials and reformers articulated their aims for health insurance growth and the insurance product's design, including liberal coverage benefits. Trade associations hurried to accomplish these goals to forestall federal programming. Indeed, the consistent pattern of interaction between policymakers and large interest groups created a variety of corporatism, a “soft corporatism,” in which the government played an informal and indirect – although pivotal – role in fashioning the “private” market's final form. Though policymakers did not wish to expand the insurance company model, they nevertheless accomplished their objectives of making medical insurance policies widely available and more generous.¹⁴

Second, just as one cannot understand market configuration without looking to the political sphere, one cannot fully appreciate the nature of political debates or the choices that legislators made in assembling public programs without delineating the voluntary market's architecture. The insurance company model's deficiencies animated reform debates throughout the tenures of both Truman and Eisenhower. At the same time, as the institutions supporting private health insurance matured, their very presence narrowed the range of options available to politicians seeking reform. Thus, the voluntary sector demarcated the boundaries of political debates and informed the distinctive attributes of government programming. By the mid-1960s, federal officials were ready to legitimize the insurance company model by designing Medicare to adopt its structural arrangements and by appointing insurance companies and nonprofit plans as program administrators. Since the passage of Medicare, it has been almost impossible to dislodge the insurance company model from the health care system.

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The third major theme – path dependency – explains why these public–private linkages endured. Institution building creates path dependency. During the 1930s, neither the public nor private sectors were organized to meet mass consumer demand for health insurance. A critical juncture occurred when AMA leaders designated the insurance company model the only acceptable form of health care prepayment, thereby determining the particular avenue through which the public–private compact would be negotiated. The insurance company framework subsequently filtered the range of acceptable responses to political pressure, and health interests swiftly advanced the market through AMA-blessed provisions. The decision of policymakers to design Medicare around insurance company arrangements represented the zenith of this feedback process. Moreover, unlike organizations, which have defined boundaries, institutions drive broader transformations, embodying the “rules of the game in a society” or “the humanly devised constraints that shape human interaction.”¹⁵ As the insurance company model and its products expanded, the tacit assumptions and ideas supporting them became entrenched. Thus, evolving institutional norms endowed a particular economic model with cultural power and, eventually, political authority, bestowing upon it an air of naturalness and inevitability.¹⁶

The final theme examined in this narrative is the interrelated nature of political and economic power among private actors. Analyzing trade associations’ planning and behavior reveals the extent to which professional and occupational authority is contingent upon policy developments. Not only did the AMA’s battle to prevent federal intervention in health care fall short, but doctors also failed to escape corporate organization with its attendant third-party controls and regulations. Furthermore, after Medicare’s passage, the reputation of the AMA as a collection of compassionate experts laboring for the public good lay in tatters.¹⁷

Meanwhile, insurers elevated their station in the marketplace and in the federal political arena: after Medicare’s passage, they joined with public policymakers to restrict service provider sovereignty as the primary means toward reducing costs. Insurance company dictates, constructed to depress health care prices, increasingly constrained the earning potential of doctors, or at least how they earned their income, and regimented the practice of medicine. Yet for all the problems associated with the insurance company model, it has proven resilient. Indeed, the recent passage of comprehensive health care reform has only further embedded insurance companies in their position at the center of the American medical system.

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Background: Physicians Choose the Insurance Company Model, Late Nineteenth Century–1940s

Throughout the twentieth century, American physicians exercised an enormous degree of cultural authority. Occupational groups possess cultural authority to the extent that they can shape the institutions, collective ideas, scripts, and patterns of behavior that order human interactions within their sphere of activity.¹

Associations are key to securing this power. Whether medical, legal, or academic, professional associations secure cultural authority by establishing and validating member expertise to the public. Educational and credentialing requirements, even ethical codes, verify that members of a profession belong to an “exclusive, elite group” meriting broad grants of societal influence.² Founded in 1847, the American Medical Association (AMA) helped doctors renovate their somewhat humble occupation into an esteemed, powerful profession. However, the task of securing command over health care and then elevating the profession was filled with conflict and uncertainty – the process required AMA leaders to negotiate with, haggle among, and even bully other societal groups, ranging from competing medical practitioners to political challengers.

At the end of the nineteenth century, revolutionary scientific advances endowed physicians with valuable knowledge and skills in the most critical of subjects – human life. AMA leaders seized upon and leveraged this expertise to acquire governing power over the medical sector. They secured licensing laws that permitted them to determine who could become a physician and also deployed substantial control over the organizations most crucial to the production of health services: medical schools and hospitals.³ Through these mechanisms, American physicians became the chief arbiters of what constitutes a legitimate disease or illness and the