1995

A Historical Perspective of Medical Care Coverage in the United States

Rhonda Noyes
University of North Dakota

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A HISTORICAL PERSPECTIVE OF MEDICAL CARE COVERAGE IN THE UNITED STATES

by

Rhonda Noyes
Bachelor of Science in Physical Therapy
University of North Dakota, 1994

An Independent Study
Submitted to the Graduate Faculty of the Department of Physical Therapy
School of Medicine
University of North Dakota
in partial fulfillment of the requirements for the degree of Master of Physical Therapy

Grand Forks, North Dakota
May
1995
This Independent Study, submitted by Rhonda Noyes in partial fulfillment of the requirements for the Degree of Master of Physical Therapy from the University of North Dakota, has been read by the Faculty Preceptor, Advisor, and Chairperson of Physical Therapy under whom the work has been done and is hereby approved.

[Signatures]

Beverly Johnson
(Faculty Preceptor)

Beverly Johnson
(Graduate School Advisor)

[Signature]

(Chairperson, Physical Therapy)
### PERMISSION

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**Signature**  
Rhonda Susan Noyes

**Date**  
April 19, 1995
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ACKNOWLEDGEMENTS

This project would not be complete without recognizing those who guided and inspired me throughout its formulation. First, thanks to Beverly Johnson for taking an active interest in my ideas for this project and for providing excellent suggestions and recommendations that helped to make all of those ideas come together. Last, but definitely not least, I thank my parents for all of the support, encouragement, and "words of wisdom" throughout the past seven years.
ABSTRACT

Reimbursement of medical services by third-party payers is becoming more contingent upon the effectiveness of services at an affordable cost. The push for cost containment brings about the need for the health care professional to have a sound understanding of medical care coverage to provide quality services at an affordable price.

The present coverage of medical care in the United States is largely dependent upon medical benefits offered by employers. In order to understand current trends in medical care coverage and the reliance on employer based coverage, this independent study explores the origins and development of the current medical care reimbursement system. A review of the origins and development of health insurance helps the health care professional to understand the foundation of the current reimbursement system, as well as provides him/her with a basis on which to recommend cost effective changes for the future.
CHAPTER 1

INTRODUCTION

The state of America's health care system has been a topic of recent discussion throughout the media, state and local governments, the medical community, as well as corporate America. At issue is the growing number of people in the United States who are uninsured for medical services and the increase in overall health care spending.

The 1990 Population Survey reported by the Bureau of Labor Statistics identified about 35.7 million Americans below the age of 65 without health insurance.¹ Current estimates of the uninsured are 37 million people without health insurance (Time Magazine. November 25, 1991:35). Two-thirds of the uninsured population are within families of steadily employed full-time workers. Many of these working Americans can not afford the high price of private health insurance, yet their income exceeds qualification for Medicaid.²

The rising cost of covering medical services has led some states to stiffen the eligibility criteria for Medicaid. Many states can not afford the rising cost of Medicaid for the poor. Only 40% of the population living under the poverty level was covered by Medicaid in 1991.²
Numerous sources report the increasing portion of the United States' gross national product (GNP) devoted to health care services. *Time Magazine* reported in 1991 that 12.3% of GNP was spent on health care, increased from 9.4% in 1980 (*Time Magazine*. November 25, 1991). The Health Care Financing Administration reported that health care consumed 13.2% of GNP in 1991.³

An aging population, new technology, defensive medicine, and the lack of accountability in traditional health coverage plans all contribute to the rise in health care cost (*Time Magazine*. November 25, 1991:35).

Older Americans alone consume more expensive health care. In 1987 persons 65 and older comprised 12% of the population, however, they consumed 36% of total personal health care expenditures. In 1992 persons 65 and older represented 12.6% of the population. This percentage is predicted to climb to 21.8% by the year 2030.⁴

The expansion of new technology and services also drives up the cost of health care along with the practice of defensive medicine. The practice of defensive medicine is estimated to add $21 million to the total health care bill as doctors order extra tests and procedures in an attempt to protect themselves from malpractice suits (*Time Magazine*. November 25, 1991:35).

Third party reimbursement of medical services provided little incentive to control cost. Overall lack of cost
consciousness within traditional coverage systems has created lack of responsibility for controlling cost on the part of health care providers and consumers. Traditional health insurance plans initially provided "first dollar" coverage for health care services. Providers and health care consumers were basically given a "blank check" for medical services.\(^3\)

The nation's increased spending on health care reduces funds available for federal expenditures such as education, public safety, national defense, and infrastructure (Congressional Quarterly. September 26, 1992). Daniel Callahan, director of the Hastings Center, reported that in 1960 the United States spent 6% of its GNP on education and health care. By 1990 the percentage of GNP the United States spent on health care doubled while the percent spent on education remained at 6% (Fortune. March 26, 1990).

Not only does the nation's increased spending on health care drain funds from other federal programs, it impacts the overall economy. Large corporations that provide medical coverage to their employees are finding the expense tougher to bear. Many employers have cut their work force, reduced health benefits, or both due to the high price of medical coverage (Time. November 25, 1991). Corporations also are influenced to raise the price of their products to balance the increase in production expenditures. The Chrysler Corporation reported in 1992 that employee health costs add
The United States’ rapidly increasing expenditure on health care and its large number of uninsured are current issues of national debate. For the last two years Congress has been exploring ways to change the current health care system. Congress has focused on bills that improve access to, reduce the cost of, and modify the tax treatment of health care benefits.⁷ Proposals for health care reform have included market based reform, implementation of a Canadian style single payer system, and employer mandates for medical care coverage. With the overturn in party affiliation of congressional members in the November 1994 elections to a predominantly Republican House and Senate, the matter of health care reform as a federal issue has essentially been buried.

Although Congress’ recent debate over health care cost and coverage may not bring about any major change in the current health care system, professional organizations in the medical industry have critically addressed these issues. Organizations like the American Physical Therapy Association (APTA) have analyzed reimbursement for services by third-party payers. Reimbursement has become more contingent upon the quality and cost effectiveness of the service.⁶,⁷,⁸ Under such conditions it is important for the physical therapist to have a working knowledge of the current system of medical
care coverage.

Currently the national health care system relies heavily on insurance provided by employers. The forms of coverage provided by employers ranges from traditional fee-for-service plans to managed care systems such as Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). Some employers are even self-insuring employees.

In order to get a full understanding of the current system and the predominance of employer provided insurance, it is necessary to start with the history of medical care coverage in the United States. A review of the history of medical coverage in the United States will aid the health care professional in two ways. First, health care professionals will gain a better understanding of the current system. Second, by having knowledge of historical medical coverage and its evolution over the years, health care professionals will be better prepared to foresee future trends and changes in medical care coverage.

The purpose of this independent study is to review the history of medical care coverage in the United States. The coverage of allied health services, specifically physical therapy, will be analyzed with respect to the historical development of medical coverage.
Table. Glossary of Reimbursement Terms

<table>
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<tr>
<th>Reimbursement Methods</th>
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<tr>
<td><strong>Fee-for-service</strong>-- The traditional method of payment of health care services. Health care providers charge a certain amount for each service rendered to a patient. The provider usually seeks reimbursement for services from a private insurer or the government. The most common forms of fee-for-service reimbursement are:</td>
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<td><strong>Usual, customary, and reasonable</strong>--Reimbursement is based upon: (1) the usual or median fee charged by a provider, (2) the common fees charged by providers of the same service in the same geographic area, and (3) the reasonable fee that is usual and customary or is permissible due to special circumstances.</td>
</tr>
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<td><strong>Relative value scale</strong>--The cost of the service is based upon the &quot;value&quot; of the service. Each service is assigned value points based upon such factors as time necessary to administer the service, etc. The points are then converted to dollar amounts and a fee schedule is created. Workers' Compensation is based on this form of fee payment in many states.</td>
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<td><strong>Capitation</strong>--The provider is prepaid a fixed sum per capita for each person treated, regardless of the number of services rendered to each person or how often the person is treated. This form of reimbursement is most often seen in</td>
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Diagnosis Related Groups (DRGs)--A system that reimburses health care providers fixed amounts for all care given in connection with standard diagnostic categories. Medicare was the first insurer to develop this method of payment, but now it is used by other third-party payers.\textsuperscript{2,11}

Insurance Plans

Privately Financed Insurance--The following forms of medical insurance are funded primarily by the private sector which includes employers, individuals, consumer groups, and other non-government parties. Keep in mind that the government may contract the services of private insurers to administer publicly funded medical coverage.\textsuperscript{2}

**Blue Cross**--An independent, non-profit corporation insuring on a service basis against the cost of hospital care in a certain geographic area.\textsuperscript{2}

**Blue Shield**--An independent, non-profit corporation insuring on a service basis against the cost of surgical and medical care in a specific geographic area.\textsuperscript{2}

**Commercial insurance plans**--For profit insurance companies underwriting health care benefits to individual policy holders or to groups of individuals
such as a group of employees working for one employer. Aetna and Liberty Mutual Insurance Co. are examples of commercial insurance companies.\(^2\)

**Self-insurance**—A benefit plan underwritten by an employer in which that employer will bear the risk of funding the medical benefits for its employees as opposed to purchasing benefits from a conventional insurer who would then bear the risk. Claims under the self-insurance plan can be administered by a third-party such as an insurance company or an independent administrator. Self-insurance is usually the option of a large company or corporation.\(^10\)

**Workers' Compensation**—A no-fault insurance plan that is designed to compensate workers for lost income and medical expenses due to work related injuries, disease, or death. Workers's Compensation laws are state mandated, so plans may differ from state to state. Usually these plans are funded through premiums paid by employers. Workers' Compensation insures the employer against liability for accidents occurring on the job in return for compensation paid to the worker or the worker's family.\(^11\)
Table. Glossary of Reimbursement Terms (cont)

Health Maintenance Organization (HMO)--An organization that provides a wide range of comprehensive health care services for subscribers at a fixed payment rate (capitation). In some situations there is no additional copayment or fee. Subscribers must receive services within the HMO network. Services received outside of the network are not reimbursed by the HMO. An HMO can be sponsored by labor unions, employers, insurance companies, government, medical schools, hospitals, and consumer groups.¹,²

Group/staff arrangement--An HMO arrangement that delivers health care services at HMO owned facilities with groups of salaried providers.¹

Independent Practice Associations (IPAs)--An HMO arrangement that contracts with providers who maintain their own offices and usually are paid by the HMO according to an agreed upon fee-for-service basis.¹

Preferred Provider Organization (PPO)--Health care providers contract with an organization to treat subscribers at a discounted fee-for-service rate. The subscriber receives lower out-of-pocket expenses if services are received from the contracted providers or hospitals.¹
Publicly Financed Health Insurance--The following forms of medical coverage are financed by the federal and state governments through tax dollars. Keep in mind that the government may contract locally with private insurers to administer Medicare or Medicaid.²

Medicare--Federal medical insurance for persons over the age of 65 and selected groups under that age provided for under the social security system. Medicare was created from the 1965 amendments to the Social Security Act. Reimbursement through Medicare is now based upon DRGs. Medicare comes in the two following forms²:¹¹:

Part A--Mandated hospital insurance that is funded from social security taxes (FICA) with some cost sharing by participants.

Part B--Supplemental voluntary insurance that covers physicians' services and selected medical services not covered under Part A, such as outpatient physical therapy.

Medicaid--Federal and state medical insurance that covers health care for low-income and disabled persons. States receive federal funds through the Health Care Financing Administration (HCFA) to assist in providing services to persons who meet eligibility criteria.
Table. Glossary of Reimbursement Terms (cont)

Eligibility criteria vary among states, but must meet specific federal guidelines. About 60% to 70% of Medicaid funding comes from the federal government, the rest coming from state and local funds. Medicaid services are commonly administered at the county level. 11

Insurance Policy Terms

Coinsurance—Policy provision often found in major medical insurance which defines a specified percentage of medical costs the insurer is responsible for. A common percentage is 80%. The insured pays the balance of 20%. 2, 10, 11

Comprehensive insurance—Major medical plans which cover a wide range of medical services in one package. All covered expenses are subject to a deductible and a coinsurance requirement before benefits are provided. 2, 10, 11

Copayment—A specified dollar amount charged to the insured for a covered service. A copayment is usually paid at the time of receiving the service and is a predetermined rate. For example, an HMO may require a $5 copayment per physician office visit. 2, 10, 11

First dollar coverage—The insured is not required to make an initial payment before benefits under the insurance policy are available. 1, 11
Table. Glossary of Reimbursement Terms (cont)

==----------------------------------------------------------------------------------------------==
Indemnity--The benefits paid in a predetermined amount in the event of a covered loss. Reimbursement for medical expenses can be paid directly to the insured or to the provider of the service. In some cases it is up to the provider to bill either the insured or the insurer for reimbursement. A true or traditional indemnity payment is paid directly to the policy holder to compensate for lost income due to disability or medical expenses incurred from accident or illness.\textsuperscript{1,2,5}

Open enrollment--A provision that allows an individual to change health insurance plans during a set period of time before being subject to preexisting condition clauses.\textsuperscript{11}

Out-of-pocket--Payments for health care above the amount paid on the premium. Examples are copayments and deductibles.\textsuperscript{5,11}

Premium--The periodic payment that is necessary to keep a policy active. The premium covers projected claims and administrative expenses.\textsuperscript{2,10}

Supplemental insurance--A plan that offers additional coverage to benefits provided in a basic plan by covering expenses that exceed the limits of the basic plan and expenses not covered by the basic plan.\textsuperscript{1}
Table. Glossary of Reimbursement Terms (cont)

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<th>Health Care Reform and Miscellaneous Terms</th>
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<td>Community rating--Health insurance premiums are set based on the average costs of providing medical services to all people in a geographic area. No adjustment is made for each individual's medical history or likelihood of using these services.</td>
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| Cost Shifting--"Some consumers and third party payers end up paying more for their health insurance or health care because large employers, insurance companies, and government receive discounts on the price of health care provided to people covered under their health plans. The amount paid is often below the actual cost to provide that care."
| Employer mandates--The employer is required to pay fully or partially the cost of insuring employees for health care services. Employers not covering employees face penalties in the form of taxation to cover the medical expense of individuals not insured by an employer. The public sector assumes the primary responsibility for coverage of those individuals not within the work force. |
| Experience rating--The process of determining the premium rate of a group of insured based fully or partially on prior medical expenses incurred under the insurance plan. |
| Gross National Product (GNP)--Total value of goods and services produced each year in a nation. |

2, 5, 11
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<th>Glossary of Reimbursement Terms (cont)</th>
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<tr>
<td><strong>Managed Care</strong> -- &quot;A general term for organizing networks of health-care providers, such as doctors and hospitals, to enhance the cost-effectiveness of their work.&quot;</td>
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<td><strong>Portability</strong> -- A provision that allows continuous health care benefits when changing jobs or health plans without being subject to a waiting period or preexisting condition clause.</td>
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<tr>
<td><strong>Professional Review Organization</strong> -- A commission of practicing physicians who monitor the utilization and quality of health care services provided under Medicare and Medicaid. The commission was created by federal law.</td>
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<tr>
<td><strong>Single payer system</strong> -- A system under which one party pays for all medical services rendered. The single payer is usually the government as in the Canadian single payer system.</td>
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<tr>
<td><strong>Underwriting</strong> -- The process by which an insurer determines whether or not and on what basis an application for insurance will be accepted.</td>
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CHAPTER 2
HISTORY

The participation of employees in employer provided health insurance stood at 83% in 1991. This percentage has been declining since 1979 when 97% of employees were covered by employer based benefits. The decline concurs with the increase in full-time workers required to contribute toward their health care premium. The decline in coverage of full-time employees is also a direct reflection of the decline in the number of medically insured people on the national level. During the 1980s the percentage of the population under the age of 65 that was medically insured dropped for the first time in the history of health insurance. During the same period, health expenditures continued to escalate. Of the estimated 35.7 million uninsured people in the United States, two-thirds are workers and their families. To understand the current trends in our nation's health care system it is necessary to review the very beginning and the development of the medical coverage system.

The First Forms of Medical Coverage.—The earliest forms of health insurance were established for workers as coverage against wages lost due to accidents. Prior to 1900
health insurance was available to certain workers through individual accident policies written by insurance companies or by plans established voluntarily by employers. The first individual accident policy was offered by the Franklin Health Assurance Co. in 1850. The policy would pay the bearer $200 indemnity in the event of injury and $400 for total disability from a steamboat or railway accident. By 1899 there were 47 companies insuring workers against job related injuries. During this time period new plans were introduced with expanded coverage for loss of income due to temporary disability from almost all common illnesses and for disability from industrial accidents.

Towards the turn of the 19th century plans that covered medical services for employee groups were established by the mining, lumber, and railroad industries. These employers were the first to offer prepaid medical programs. The most well known of the first prepaid group practices was the Western Clinic in Tacoma, WA. The Western Clinic prepaid physicians a fixed monthly fee to treat its employees for industrial accidents and common illnesses. Prepaid group practices were the earliest form of what we call Health Maintenance Organizations (HMOs) today.

As the United States made the transition to an industrialized nation more people were employed by a second party and large numbers of people were working together in the workplace. Employers saw a need to provide health
care coverage to employees. Several theories behind employer provided benefits have been cited in the literature. The first theory suggests that the employer provides employee benefits as a "paternalistic" gesture. The employer may have a general concern for the economic welfare of the workers expressed by offering protection against economic disaster. "Employers may also provide worker benefits to meet the demands of labor unions, to attract and keep good employees, or to remain competitive with other employers in the labor market."\textsuperscript{15}

Although the concept of employer sponsored health insurance was present during this time period, most workers remained unprotected from economic loss due to a job related injury. Industrial injuries among employees happened at a high rate as conditions in the work place were often dismal. There were few government regulations for the work environment in the early stages of industrialization.\textsuperscript{16,17}

Workers disabled due to an injury on the job were compensated for lost income only if they could prove the employer responsible through litigation. A worker had little chance of winning a compensation case around the turn of the century. Courts tended to side with the influential monopolies of the era. In the event a worker won a law suit, he still rarely received compensation. A majority of the compensation sum went for the payment of litigation fees.\textsuperscript{16,17} For this reason the first Workers' Compensation
Acts were passed by individual states in 1911. The first Workers' Compensation laws made the employer liable for injuries occurring on the job. The employer was then responsible for compensating the worker for lost wages. 18

Average Americans paid for the medical attention they did seek through their own resources. 5 It is important to remember that the delivery of health services at this period in history was quite primitive compared to the health care we receive today. Theories and practices in communicability of disease and aseptic techniques had yet to become widespread. Hospitals for the most part were funded through charity and were places for indigent sick people. Most people were taken care of at home. Physicians practiced in a realm that was largely unregulated. Physicians could often do nothing for their patients as the scientific aspect of medicine was in its infancy. 5,12

During the 1920s standards for accreditation and licensure for hospitals, medical schools, and medical practice began to develop. A person seeking medical attention through a medical professional or facility now had a better chance of getting favorable help for his or her condition. The public began to view hospitals in a more favorable light. 5,12

Improved health care standards expanded the types of medical services available to the patients. Physical therapy was first practiced as an area of medical specialty
in the United States in the early 1900s. Robert W. Lovett, M.D. organized nonphysician personnel into teams to provide programs of physical treatment for the many who suffered during the epidemic of infantile paralysis. These early "physical therapists" went on to establish physical therapy as a medical service in the United States.¹⁹

The earliest formally trained practitioners of physical therapy were the Reconstruction Aides. Reconstruction Aides were trained during World War I to restore function to military forces as well as the civilian work force. The work of the Reconstruction Aide was described as a supplement to medicine and surgery at the time.¹⁹

1929-1939: Conventional Forms of Insurance.—In the early 1930s hospitals were drastically affected by the depression.¹,⁵,²⁰ Occupancy rates dropped as much as 50% as the majority of the population could not afford medical services. Hospitals began to try new strategies for the reimbursement of medical services in order to survive the harsh economic conditions of the depression. This experimentation with reimbursement of medical services led to the establishment of the conventional forms of health insurance presently in use.¹,²⁰

The 'Blues'.—In 1929 University Hospital in Dallas, Texas introduced a style of reimbursement for medical services that quickly became popular during the depression era.¹,²,⁵,¹² A group of school teachers at Baylor University
contracted with the hospital to provide basic medical services for a $6 annual premium per member. This contract is considered to be the first model for Blue Cross.1,2,5,12

The first city wide Blue Cross plan was introduced in 1932 in Sacramento, California. Individuals paid a small monthly premium to a central fund which was redistributed to participating hospitals. The direct contracting with groups guaranteed hospitals payment for their services.1

Physicians followed the hospitals' example of contracting directly with city and employee groups for payment of services. In 1939 the California Physicians Service provided physician services to members of employee groups for a fixed low monthly payment. This is considered to be the first Blue Shield plan.1 The Blue Cross and Blue Shield plans were thus closely tied to the medical community from the beginning. They did not compete with each other as Blue Cross covered basic hospital services and Blue Shield covered basic physician services.5

The Blues plans were open enrollment, meaning anyone could subscribe regardless of health status. This created broad community pooling of insured groups. High risk persons were able to receive low premiums because the risk was spread out over the community.5

The Blues plans are credited as being the birth of our traditional health insurance system. The Blue Cross/Blue Shield model established the basic principles of our current
health care coverage system. The basic principles of our current health care coverage system include:

* Medical services are paid for on a fee-for-service basis.
* Medical care consumers have a choice of provider.
* Consumers have a low out-of-pocket payment at the time of the service (first-dollar coverage).
* Financing for medical services is through a third party.

Commercial Insurance Policies.--Commercial insurance companies began to write policies for basic medical care following the development of the Blue Cross and Blue Shield health insurance plans. Until then commercial insurers had been writing accident policies. Commercial insurance companies realized the low risk and profit possibilities of underwriting basic medical services following the success of the Blues' health insurance plans. Usually commercial insurance policies were tailored to each customer, especially work groups.

The commercial insurance companies adopted the same basic principles as the Blues plans. Commercial insurers reimbursed medical services on a fee-for-service basis similar to the Blues plans, but unlike the Blues, they used the indemnity approach as opposed to the cost/charge method which directly covered all reasonable provider expenses (see Table on page 6).
Overall, the commercial plans reinforced the basic principles of reimbursement first set forth by the Blue Cross and Blue Shield plans. Bovbjerg et al make the observation that there seemed to be no appreciation for how expensive this plan of health care coverage ultimately could be. Some factors they report as contributing to this are the low coverage rate, low payment levels, and lack of sophisticated medical technology during this period of time.

Prepaid Group Practices.--The Great Depression also increased experimentation with prepaid group practices. Prepaid group practices were later called Health Maintenance Organizations (HMOs). The earliest reported community based prepaid group health service was started in Elk City, Oklahoma in 1927. Consumers in the small farming community purchased $50 shares in the construction of the Community Hospital in return for medical services provided by the hospital.

In 1929 a prepaid group practice was also started for employees of the Los Angeles Department of Water and Power. Donald Ross and H. Clifford Loos, two Los Angeles physicians, provided prepaid medical services to these city employees. Their clinic was known as the Ross-Loos clinic. The prepaid health service was a success, membership was extended to additional city employees in the following years.

The largest HMO in the United States, Kaiser-Permente,
originated at a remote aqueduct construction site in Southern California. Workers of the Kaiser Co. who suffered serious injuries on the job were required by their insurance company to travel to a medical facility 200 miles away to receive medical services. Sidney Garfield, a physician working at the construction site, built a 10 bed hospital on skids that could be dragged along as construction progressed. He later convinced the insurance company to pay him directly in advance for each of the Kaiser employees in return for the provision of all necessary on the job medical care. Garfield also worked out an arrangement by which voluntary deductions could be made from workers' salaries in exchange for off the job medical services for them and their families.¹⁴

Garfield's ingenuity received favorable attention from Henry Kaiser who had connections with the company building the aqueduct and who was the owner of the insurance company. In 1937 Kaiser asked Garfield to set up a similar program for workers and their families in Washington state at the construction site of the Grand Coulee Dam. Kaiser approached Garfield again in 1942 with another proposal to set up services for shipyard plants in the San Francisco Bay area which employed 90,000 workers during the war effort. Following the war, enrollment in the Kaiser-Perment Health Care Program was opened to the public in order to preserve the patient population. Kaiser-Perment Health Care Plan
now serves nine geographic areas with a membership of 4.6 million members.\textsuperscript{14}

Although the prepaid group practice health plans were successful in the local areas in which they were introduced, organized medicine strongly opposed the development of such prepaid medical services at every turn, often through litigation. Legal support of and consumer satisfaction with prepaid group practices did little to expand the use of such practices prior to 1970. Limited access to and knowledge of the prepaid system, economic threats, and organized medicines outright opposition to such plans curtailed the use of prepaid medical services among the general population.\textsuperscript{14}

In 1940 the percentage of the population covered by some form of health insurance stood at 9\%. Fifty percent of the insured population was covered under a Blue Cross/Blue Shield plan. Commercial insurance covered 31\% of the insured population, and 19\% of the insured population was covered by other types of health plans including prepaid group practices.\textsuperscript{1}

By the end of the 1930s the American Physiotherapy Association (APA) had been organized by former Reconstruction Aides. The name of the APA would later be changed to the American Physical Therapy Association (APTA).\textsuperscript{21} Following World War I and the infantile paralysis epidemic, the scope of physical therapy turned toward
serving the work force and solving some of the industrial problems of civil life through the use of physical therapeutics. Physical therapists were most likely reimbursed for their services through hospitals and physicians.¹⁹

**1940-1960: Medical Coverage and Benefits Expand.**

Between 1940 and 1960 more people gained coverage for medical services especially through conventional health insurance. The work place provided a major growth in the number of insured people. Through collective bargaining on the part of unions in the 1940s workers were able to gain medical benefits.¹ ⁵ This was largely a result of the Stabilization Act of 1942 in which Congress froze wage increases to that of the cost of living.¹ Benefits were not affected by the wage freezes. Unions used their bargaining power to gain more for workers through expanded benefit plans.

The tax treatment of worker benefits also encouraged work group purchase of health insurance. In 1954 tax coding exempted benefits from federal taxation for both the employer and the employee. Paying for medical services with pre-tax dollars increased the value of wages and benefits for workers and reduced taxes due for employers. Employer provided medical benefits were then more attractive to both employer and employee.⁵

Throughout the 1950s unions continued to gain more
bonuses for workers by effectively bargaining for first
dollar coverage paid by the employer. Such arrangements
further reduced patients' knowledge of the cost of medical
services.1,5

Another trend in the 1950s was increased selection of
commercial insurance as opposed to plans offered by the Blue
Cross/Blue Shield plans.5 The commercial companies were
able to provide greater variety in coverage as opposed to
the standard plans offered by the Blues.1,5 This especially
became true with the introduction of major medical insurance
to supplement basic medical care coverage plans. Liberty
Mutual Insurance Co. first introduced this type of major
medical insurance in 1949. Major medical insurance is now
available in two forms, supplemental and comprehensive (see
Table on page 6). Major medical plans in both forms have
grown greatly over the past four decades with 100,000
policies written in 1951 increasing to 156 million by 1986.1

Not only did the variety of insurance packages increase
throughout the 1950s, but medical services covered by
insurance expanded. In 1957 insurance for vision care was
introduced followed by the introduction of dental insurance
in 1959. Coverage for these services was usually offered as
an additional bonus under an employer's benefit plan.1

Commercial insurance companies were able to set the
price of a group's coverage based on prior utilization of
medical services as group policies became the standard mode
of coverage. This "experience rating" of medical coverage created lower prices for low risk groups and higher prices for high risk groups.\(^5\)

By 1960 the characteristics of our current health insurance system were strongly entrenched. Health insurance was tied to the work place or a work group making coverage non-portable. Insurance companies practiced risk pooling and they provided first dollar coverage which decreased cost consciousness. Over two thirds of the population had private health insurance in 1960, yet 55% of personal health care was the individual patient's responsibility. Public (government) funding of health care took up merely 10% of total health care spending. This was primarily in the form of tax subsidy, federal grants for hospital construction through the Hill-Burton Act, and for education of health care professionals. The Federal Employees Health Benefits Plan was also established in 1959, providing government funded health benefits to federal employees.\(^5\)

During the 1940s and 1950s World War II created an increased demand for physical therapists. The war required a physically capable military and work force. A polio epidemic during this period of the century placed even further demands on the practice of physical therapy. The education of qualified personnel to meet the increased manpower demands imposed by the war was a top issue with the APA in the early 1940s. Education continued to be an issue
as the profession sought to establish and maintain specific standards of education. ¹⁹

1960s: Medicare and Medicaid.--The Social Security Amendment of 1965 created publicly funded health care through Medicare and Medicaid. These plans were largely modeled after the already existing Blue Cross and Blue Shield plans. Hospitals and physicians were further assured reimbursement for services provided and increased utilization of services from the poor and older Americans. ⁵

Medicare, created under Title 19 of the Social Security Amendment of 1965, created health insurance for persons over 65 and others covered under the Social Security Act of 1935. ² Medicare is funded through federal payroll taxes (FICA). Part A of Medicare is like Blue Cross, it offers automatic entitlement for basic hospital coverage. Part B offers voluntary enrollment for coverage of physicians fees and other medical expenses (outpatient physical therapy for example). Part B is intended to model Blue Shield plans. ⁵

Federal and state funded health insurance was created for people of low income under Title 19 of the Social Security Amendment of 1965. States were to receive federal funds to assist in providing services to persons who met eligibility criteria. Eligibility criteria and administration of funds was left to the individual states’ discretion as long as it met federal guidelines. ² Today about 60–70% of Medicaid funding comes from the federal
government, the rest comes from state and local funds. Medicaid funds are commonly administered at the county level."

With the greater assurance of reimbursement for medical services brought on by Medicare and Medicaid, the types of services offered by the medical field expanded. Specialty services such as occupational therapy, respiratory therapy, physical therapy, social work, dietetics, and pharmacy became the standards in hospital care.

By 1970 only 35% of health care spending came from direct out-of-pocket payments by patients. Federal payments for health care doubled from 1960 to equal 20% of total health care spending by 1970. The remainder of the health care bill was met by private insurers, state and local governments, and tax subsidies. During the 1960s the portion of the population obtaining insurance through the work place continued to grow while the portion obtaining insurance individually dwindled. By the end of the 1960s the majority of medical coverage was defined in relation to the work place."

1970s: Cost Containment.--Federal and state governments began to show more concern about the cost of health care following the adoption of Medicare and Medicaid. Bovbjerg et al highlight the manifestations of this cost consciousness as being federal requirements for utilization/quality review of Medicare hospitalizations.
The National Health Planning Act required states to regulate hospital growth through certificate of need. State governments also began to experiment with hospital price control through prospective payment programs.

In 1973 Congress passed the Health Maintenance Organization (HMO) Act in an effort to solve the nation's health care cost problems. The passage of the HMO Act was largely the result of a diligent campaign by Dr. Paul Ellwood, the director of the American Rehabilitation Institute. Ellwood felt that the United States' health care system would be more functional if it incorporated incentives to promote health. Ellwood found that such a system for health promotion already existed in the prepaid group practices like Kaiser-Permenter. Ellwood was responsible for coining the term "Health Maintenance Organization" for such prepaid group practices.

The federal HMO Act provided financial support for the development of HMOs as well as required employers to include HMO membership as an option in their standard benefit package. By 1979 there were 224 HMO plans, a substantial increase from the 33 prepaid group practices operating in 1970.

In addition to the growth in operating Health Maintenance Organizations during the 1970s, there was a growth in the number of large employers who self-insured their employees. The federal ERISA legislation exempted
employers from state regulations for mandated benefits and for taxation of insurance premiums.  

Overall, in the 1970s there was expansion of private coverage in the form of HMOs and employees who self-insured. Cost containment strategies attempted by the federal and state governments did little to control the rising cost of health care. In 1970 the percent of GNP spent on health care stood at 7.4% and by 1980 that statistic stood at 9.2%.  

1980-Present: The Era of Managed Care.--The 1980s was a decade of continued strategies for containment of health care expenditures, not only by the federal and state governments, but also by private insurers. In the 1980s the federal government adopted a prospective payment system for Medicare. Private insurers began to experiment more with managed care programs such as HMOs and PPOs.  

The Prospective Payment System (PPS) for inpatient hospital services was adopted in 1983. As opposed to the former Medicare system of retrospective reimbursement per case, the Prospective Payment System fixed hospital reimbursement rates in advance for specific Diagnosis Related Groups (DRGs). Under the PPS provisions the hospital earns no more than the DRG allows, even if it ends up spending more for a Medicare case. If the hospital spends less for a case, the hospital still earns the full payment for that DRG.
In addition to adoption of a Prospective Payment System for Medicare, federal legislation made Medicare reimbursement secondary to private employment group coverage. With the rising cost of health care spending and responsibility for enrollees, employers began to experiment more with HMOs and PPOs in their benefits packages. In 1980, 3% of health care enrollees employed in large and medium establishments were in managed care programs, all of which were HMOs. In 1991 33% of enrollees were in managed care plans, including 16% in PPOs.

During the 1980s, traditional fee-for-service plans, in an effort to control rising cost, began to adopt managed care features previously seen in HMOs and PPOs. The Employee Benefits Survey has monitored the growth of such features which include "requiring hospital preadmission certification, utilization review, and penalizing enrollees for not seeking second opinions for nonemergency surgical procedures." In 1989, 59% of individuals with employer based health insurance were enrolled in plans which had managed care features, including HMOs and PPOs.

Despite the cost containment efforts of the 1980s, health care expenditures continued to rise while the percentage of the insured population dropped for the first time in history. Bovbjerg et al claim the overall drop in the percentage of persons insured is due to the decrease in private coverage. The drop in private coverage reflects the
decrease in worker participation in employee offered health care benefits. The Employee Benefits Survey found that since 1979 the participation rate of full-time employees in employer provided health insurance plans dropped from 97% to 83% in 1991.¹

The decrease in worker enrollment in employer provided health insurance plans parallels an increase in the percentage of workers required to contribute toward their own premiums. Between 1979 and 1991 the percent of employees making contribution toward their own health care increased from 27% to 51%. Not only were more workers required to pay a portion of their premiums, the monthly premiums that workers were required to pay were 2.5 times higher in 1991 than in 1983. In addition to shared payment of premiums, workers paid increased copayments for health care services.¹

With the increasing prevalence of managed health care beginning in the 1980s, health care providers including physical therapists have experienced increasing pressure to control cost.⁵,⁶,⁷,⁸ Utilization review boards limited the number of reimbursable treatments per diagnosis. Other managed health care features have forced more accountability for the cost and quality of services upon the physical therapist.⁶,⁷,⁸

**Summary.**—Historically health insurance in the United States was born from the need of an industrialized nation.
As the needs and demands of society changed, health care coverage evolved into its traditional form. Traditionally, coverage of health care in the United States has been on a fee-for-service and choice of provider basis with a third party responsible for reimbursing the health care provider. Current events imply that ultimately this system of coverage was expensive due to the poor incentive to control cost.

The overall historical trends that have been described include an increase in access and coverage of health care services through the work place, growth of public funding of health care coverage, and an increase in the nation’s productive capacity spent on health care. In recent years increased expenditures on the high cost of medical care has prompted insurers and employers to turn to managed health care as a means to contain cost.
A historical review of health care coverage in the United States reveals its close relationship to the economic structure of our society. Traditional health insurance was initially developed to protect workers from economic hardship in the event of work related injury. Towards the turn of the 19th century a few employers saw the need to begin offering coverage to their workers as industrialization demanded a large and capable work force. By offering medical coverage within employee benefit plans, employers were able to attract and maintain the manpower necessary to run their industries. During the 20th century the percentage of medically insured individuals within the general population increased via employer provided health care benefits. As a result, most private health insurance plans today are tailored to meet the needs and demands of the working population.

Private insurers attracted employers of large work groups to purchase coverage by offering plans that covered a wide variety of medical services beyond basic financial protection against loss due to catastrophic illness or injury. Availability of major medical insurance, in
addition to the growth of medical technology, increased demand for broader coverage of the medical services following World War II and continuing into the 1960s. Workers and unions increasingly viewed the provision of such medical coverage within employee benefit plans as a right, comparable to fair wages.

The introduction of government funded medical care in the 1960s increased the general public’s perception of medical coverage as a basic right. People from all age and socioeconomic categories of the population could potentially be covered by insurance funded by an outside source. The working population under the age of 65 was covered by private insurance plans, usually provided through an employer. Government financed Medicare and Medicaid covered those over the age of 65 and the poor respectively. Once all portions of the population could receive coverage for medical care, people expected that coverage would be provided for them in one way or another, either through the government or through an employer.

Medicare’s use of the traditional fee-for-service reimbursement method further blinded consumers and providers of medical care from the ultimate cost of health care. Third-party payment of medical care, funded by both government and employers, created a barrier between the medical care provider and the patient that obscured the customary rules of supply and demand. Providers were
assured payment of services they deemed medically necessary and patients continued to demand these services at little to no cost. Employers and government were left to bear responsibility for payment of the increased utilization and growing cost of medical care.

The ultimate costliness of our traditional reimbursement system has resulted in a growth in the percentage of uninsured persons within the population and an increase in public responsibility for medical care funding. Employers, who historically volunteered medical care coverage, have been forced to reduce or drop funding of employee medical benefits. Requirements for increased employee contributions towards medical care, either through shared premium costs or higher deductibles and copayments, have placed more responsibility on the worker for medical care funding. Many workers who cannot afford to pay for employer offered medical coverage do not qualify for coverage under Medicaid. Consequently, steadily employed, full-time workers and their families make up the largest portion of the population that is uninsured.

The general public has experienced an increase in responsibility for medical care funding not only through increased contributions towards its own coverage, but also through the escalating cost of Medicare and Medicaid. The expense of funding Medicare alone has become a large public responsibility. Older persons in general consume more
expensive health care than the remainder of the population. The portion of the population over the age of 65 is predicted to nearly double by the year 2030. The aging of the population has the potential to create added crisis for publicly funded medical coverage if health care costs are not controlled.

Increased government and personal responsibility for medical care funding has promoted consciousness for the cost of health care coverage and services. The consumers of health care coverage, which includes both employers and employees, have demanded affordable coverage of health care. As a result, private insurers have placed greater responsibility on health care providers to control the cost of medical services. Providers of health care services are no longer given a "blank check" to provide any service they deem medically necessary. Third-party payers are now requiring justification for the cost effectiveness and necessity of medical services.

The demand for cost containment of medical coverage has been evident in the growing trend of employee and employer selection of managed health care organizations, namely Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). Traditional insurance plans sponsored by or offered through employers are also marked by the appearance of cost containment and managed care features. Under these systems of coverage, medical services
are scrutinized by utilization review, capitations are imposed on reimbursement of services, and limitations are being placed on the types of procedures or treatments that are covered.

Services such as physical therapy have not been immune to the cost containment approaches used by third-party payers. Limits on physical therapy visits, frequency, and payments have been set by insurers who have little knowledge of physical therapy, despite the fact that physical therapy services comprise less than 1% of total health care costs. Inadequate or inappropriate coverage and reimbursement of services by third-party payers could be detrimental to the physical therapy profession, as an estimated 50% of the costs for physical therapy services are reimbursed through private insurers.

Physical therapists need to take a proactive approach to obtain adequate reimbursement for the services they provide. Physical therapists who provide cost effective services and develop a working relationship with third-party payers will help promote the establishment of appropriate reimbursement guidelines. The provision of cost effective services will not only require continued research with emphasis on outcome studies, but also adequate knowledge and understanding of the current reimbursement system.

This review of the history of medical insurance in the United States was written with the intention of providing
the health care professional with a working knowledge of the current reimbursement system. The author attempted to present and interpret historical events in health care coverage with objectivity so that the health care professional is presented with a solid basis on which to recommend cost effective changes for the future.

The recent failure of national health care reform has left the current health care system to pick up the pieces and deal with the issues of high health care costs and a growing number of middle class working Americans who are uninsured or inadequately covered for medical care. The future of the current health care system is dependent upon its ability to contain costs so that medical care coverage and services are affordable to employers and the working class. The health care professional has a responsibility, to the health care system and consumers, to recommend cost effective changes in utilization and coverage of medical services.
REFERENCES


