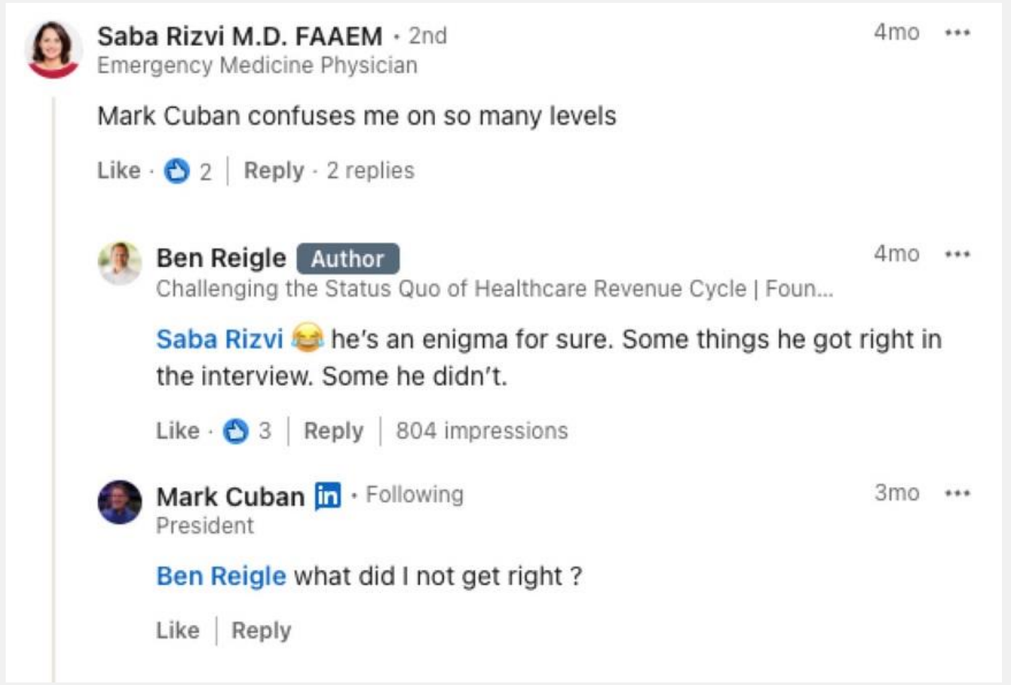
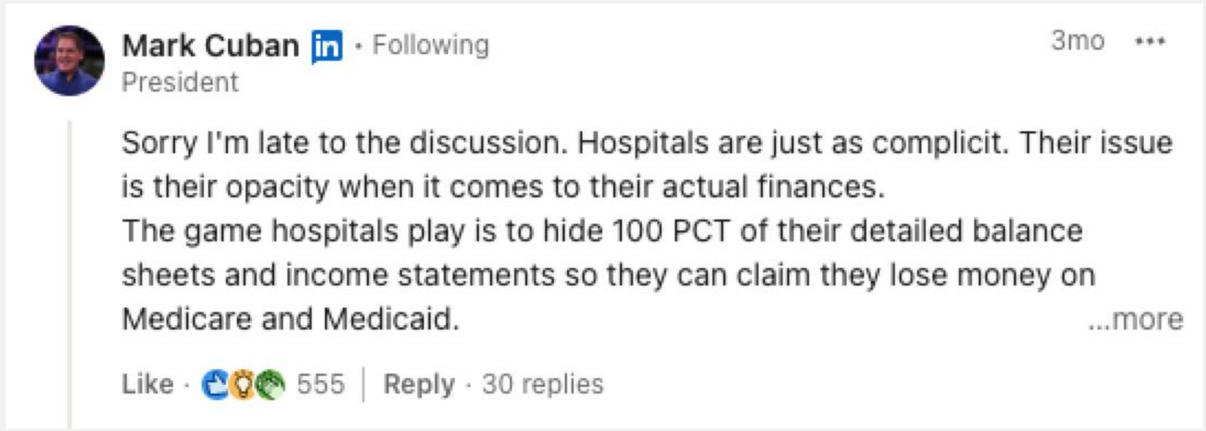
The History of Insurance: Why it Matters

...and where do we go?

The Start

Hospitals are sub-prime lenders





Hit a bigger nerve then I expected...

Overwhelming Response:

- *661,900 Views*
- *2,455 Likes*
- *366 Comments*
- *196 Reshares*

People do not understand how Insurance or patient balances work

Rand Health Insurance Experiment

The 1981 Rand Corporation study was a groundbreaking research project designed to understand the impact of different health insurance designs—particularly varying levels of cost-sharing—on healthcare utilization and outcomes.

The study randomly assigned over 7,000 participants to different insurance plans with varying cost-sharing levels.

HHS commisioned the study by Rand in 1974 for $425M in 2025 dollars

01.

Reduced Utilization

As copayments and deductibles increased, healthcare utilization generally decreased.

02.

Health Effects

The study found that higher cost-sharing did not lead to significant negative health outcomes for the average participant.

03.

High Impact on High Need

Price elasticity was less significant among chronically ill patients, who continued to seek necessary care even with higher cost-sharing.

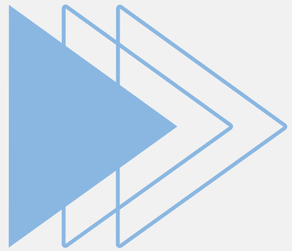
Price Elasticity vs Medical Needs

RAND estimated a price elasticity of approximately –0.2 for overall medical spending.

➤ This means a 10% increase in price (out-of-pocket costs) led to about a 2% decrease in demand for medical care.

Implications:

- People are somewhat price-sensitive—they will reduce their use of care when it costs more.
- The reduction was mainly in non-urgent, discretionary care (e.g., outpatient visits), not in essential inpatient services.



Price Sensitivity is not linear!

Elasticity varied by income and health status: Vulnerable populations (e.g., low-income or chronically ill) faced greater risks from reduced care.

Long Term Issues

Long-Term Tracking was Limited

01

Higher cost-sharing generally did not cause significant long-term health issues, however the study was limited In time

⬆️ Impact on Low-Income and Minority Populations

02

Cost-sharing exacerbated health disparities, leading to worse outcomes among low-income individuals and racial/ethnic minorities.

⬇️ Utilization of Necessary and Preventive Care

03

Higher out-of-pocket costs discouraged both non-essential and essential healthcare, including chronic disease management and preventive services.

Psychological and Behavioral Effects

04

Financial stress and cognitive overload from cost-sharing negatively influenced healthcare decisions and long-term well-being.

How did Insurance start?

Can history teach us anything?

In The Beginning... Workers Comp

*Physicians were cut out of the care

Evolution of Workers Comp

1910's - Labor Reform Movement

State-level initiatives:

- Shortened workweeks
- Limits on child labor
- Workplace injury protections

Workplace Injury Law

Three employer defenses:

- Assumption of risk (employment contract)
- Coworker negligence (not employer's fault)
- Worker's partial fault

*Unions were pushing costs to employers

Workers Comp Laws

- 32 states enacted laws between 1910–1915
- Employers accepting full liability could buy state-provided insurance

Incentive Structure

- Buy insurance → Retain defenses against negligence claims
- No insurance → Lose defenses

Early Stages of Health Insurance

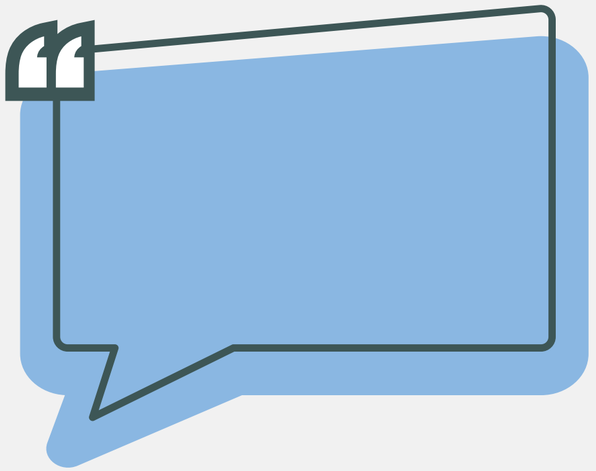
- **Early Push for Compulsory Health Insurance (1916–1919):** Inspired by workers' compensation, proposed plans aimed to insure low-income manual laborers through mandatory contributions from workers, employers, and the state.

- **Widespread Legislative Interest but No Adoption:** Sixteen states considered such laws, but none passed them, largely due to strong political and institutional resistance.

- **Employer and Labor Union Resistance:** Employers opposed added costs without clear financial benefits, while labor unions were divided; AFL leader Samuel Gompers notably objected, favoring wage increases over mandated insurance.

- **Medical Community Opposition:** Although the AMA initially supported the idea in 1915, it reversed its stance by 1920, citing threats to the doctor–patient relationship and drawing from concerns seen with workers' compensation.

How did Physicians respond?



Compulsory health insurance is . . . “Un-American, unsafe, uneconomic, unscientific, unfair, unscrupulous legislation supported by paid professional philanthropists, busybody social workers, misguided clergymen, and hysterical women.”

—Brooklyn physician in 1919 symposium on compulsory health insurance

The Great Depression 1929–1939

Impact on Hospitals:
Hospitals were severely affected by the Great Depression, seeing dramatic drops in revenue, occupancy, and charitable contributions, while charity care needs rose sharply.

Creation of the Baylor Plan:
To address the decline, Justin Kimble at Baylor University Hospital (Dallas) introduced a prepaid hospital plan for Dallas public school teachers—50 cents a month for 21 days of hospital care, excluding physician services due to opposition from the American Medical Association (AMA).

Spread of Hospital Service Plans:
The Baylor model spread, evolving into broader community hospital service plans that covered multiple hospitals rather than just one. By 1933, 26 hospital service plans existed.

Prepaid Medical Groups Circa 1929

Emergence of Prepaid Medical Groups:
During the Great Depression, prepaid group practices like the Ross-Loos Clinic (Los Angeles) and Kaiser Foundation Health Plan were created to offer comprehensive, prepaid care to workers and their families. These plans provided full medical services in exchange for a set fee, pioneering what would later evolve into managed care and HMOs.

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As late as 1959, Kaiser physicians were still excluded from the San Francisco Medical Society

Physician Opposition

- Organized medicine, particularly local and state medical societies, strongly resisted these prepaid plans.
- Physicians running or working for prepaid groups were expelled from medical societies, denying them hospital privileges
- The AMA and state societies engaged in antitrust behavior, leading to a supreme court ruling in 1943

Reason for Resistance

Economic motives were a major driver: prepaid group practices threatened physicians' income by eliminating their ability to price discriminate—charging higher prices to wealthier patients to subsidize lower-income ones—thus challenging a core source of physician profits.

Commercial Plans

Circa 1934

"Commercial life, casualty, and maritime insurance had long existed. However, health was regarded as uninsurable because hazards had to be both definite and measurable. Health was neither."

Morrisey 2011. *History of Health Insurance Chapter 1*

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Core Factors

1. **Defined Event:**
   An admission to a hospital was a definitive event, determined by a physician.

2. **Indemnity Coverage:**
   This made the loss in a covered event measurable, based on the schedule of agreed payments per event.

3. **Physician Pushback:**
   Physicians fought hard to stop plans going any further than hospital coverage.

Formation of Blue Cross

Formation of Blue Cross:
The American Hospital Association (AHA) formed a committee in 1933 to guide and approve these hospital service plans, which eventually became the AHA Blue Cross Commission in 1946. Approved plans had to be nonprofit and offered no competition among themselves (exclusive territories).

Competition and Consumer Choice:
Single-hospital plans encouraged competition among hospitals but limited patient and physician choice. All-hospital plans avoided competition but offered less financial incentive for patients to choose lower-cost hospitals

Insurance Regulations:
Early hospital service plans were initially seen as service prepayment, not insurance. However, states like New York reclassified them as insurance, leading to new enabling legislation exempting Blue Cross plans from certain insurance regulations, like **reserve requirements and state premium taxes**.

"The insurance commissioner would review their rates, and because the reserves were the hospitals themselves, the majority of the board would be composed of the directors of the participating hospitals."
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The assumption of risk implies that hospitals ARE the insurance

1942

World War II

01.

Set wages to level out Inflation. Used Medical coverage as an attraction for workers

02.

Defined Insurance as a condition of employment. Unions could negotiate It just like wages

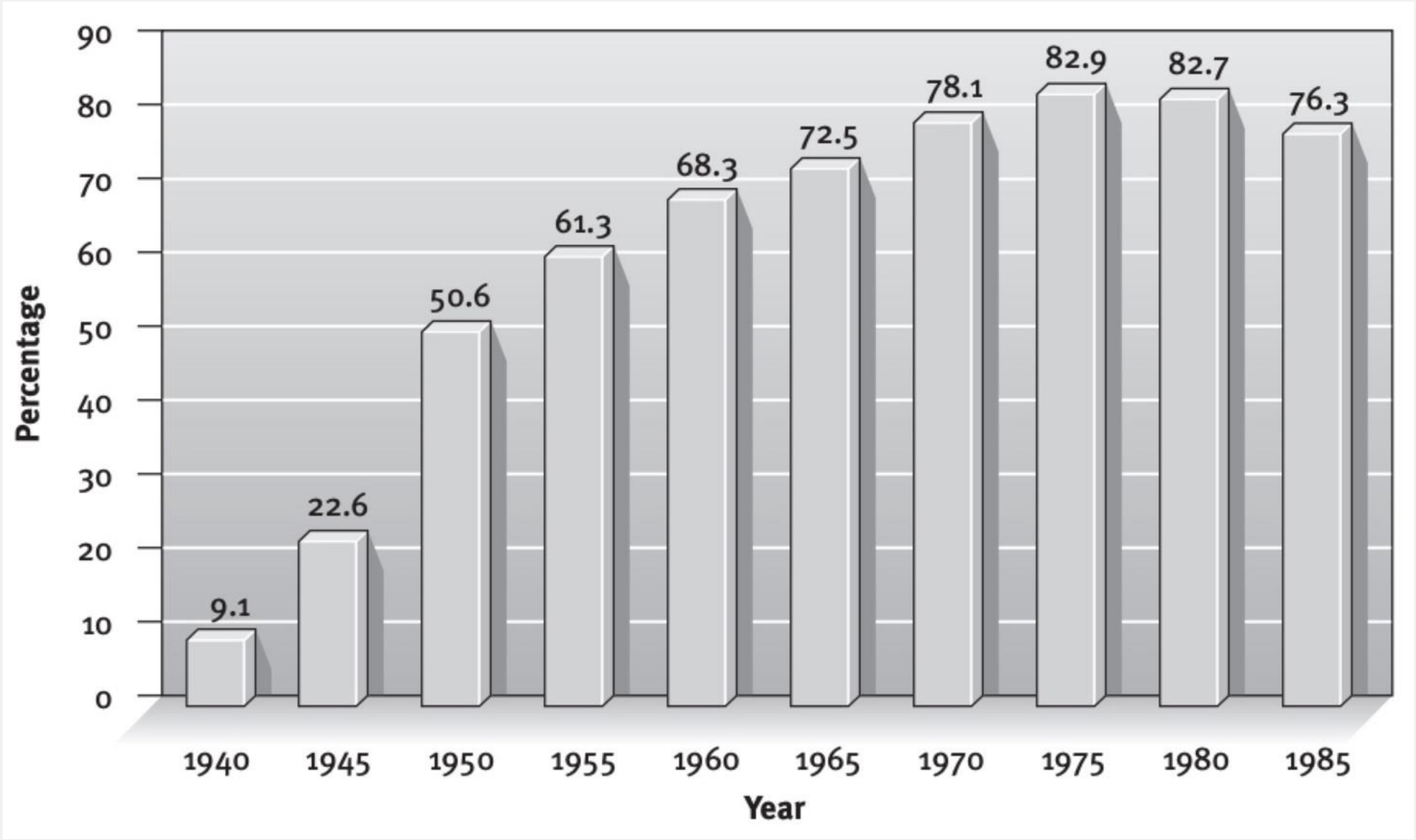
03.

IRS ruled that employer provided health Insurance was tax exempt

Growth of Employer Sponsored plans follows

Widely regarded that the tax code change Is why our system Is shaped the way It Is today

Percentage of US Population with Some Form of Private Health Insurance, 1940–1985



Timeline

Workers Comp begins

Union Power

1910

1915

World War I

Coverage debated

Baylor Hospital Coverage

Great Depression

1929

1936

AHA creates BC

Hospital Admission Coverage

Rise in Commercial Coverage

World War II

1942

1965

Medicare coverage Is created

How does this all connect together?

Let’s Talk About Todays Problem

The Problem

Insurance Models Don’t Work

“...health was regarded as uninsurable because hazards had to be both definite and measurable. Health was neither.”

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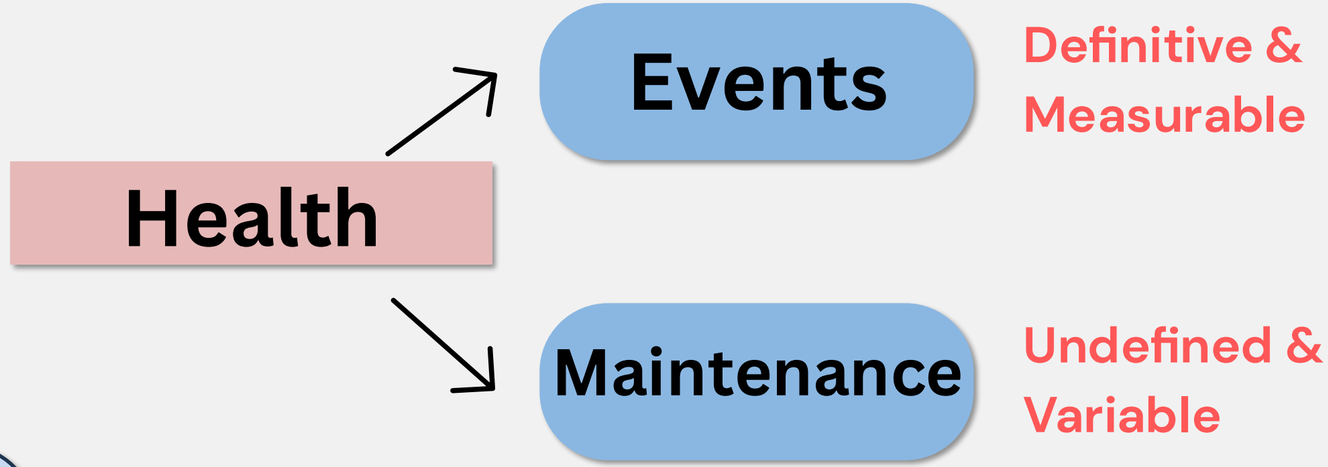

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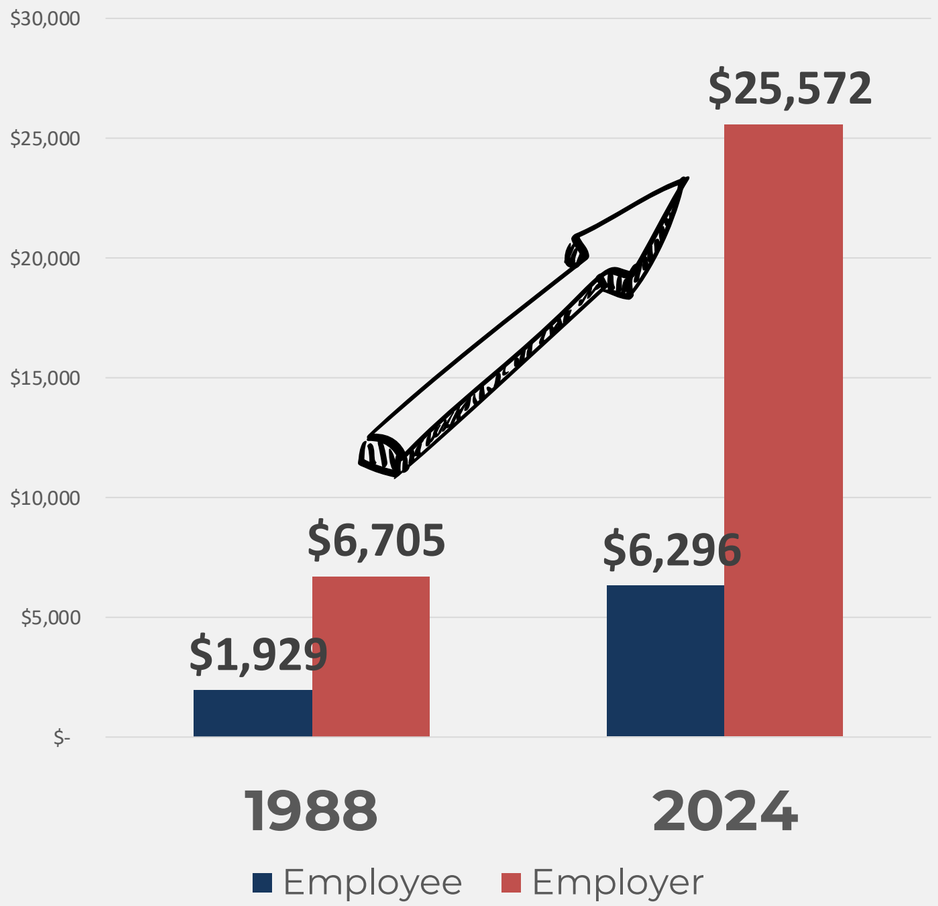
The Progression of Employer Costs



**Adjusted for inflation*

281% Growth in Employer Cost

3.96% Compound Annual Growth Rate

Starbucks now spends more on healthcare for its employees than they do on coffee beans…

Employers as Fiduciaries

***Fiduciary Duty*: The legal and ethical expectation that someone managing another's money or interests must act solely in that person's best interest**

ERISA – 1974 Federal Law designed to ensure employers act as responsible stewards of the health benefits they provide.

What if you thought about these the same?

401k

Health Benefits

Example: Tiara Yachts vs BCBSM

Flip Logic – Blue Card Processing Logic

Flip logic was a rule embedded in NASCO, the claims processing platform used by BCBSM for hundreds of self-funded employer clients. When a claim included a referral from a participating provider, flip logic automatically reclassified the rendering provider—even if they were out-of-network—as in-network.

This triggered claims to be paid at full billed charges rather than the host plan's negotiated rate.

And yet, rather than disable the logic, BCBSM used the overpayment opportunity to fuel its Shared Savings Program, recovering the money and keeping a 30% cut.

Auditing and recouping the very money they overpaid

Internal BCBSM emails, attached to the complaint, provide powerful corroboration. Among the revelations:

They knew the system was broken:

"Flipping logic is in direct contradiction with the group-elected benefit."

They saw the abuse happening in real time:

"Providers bill and get fully reimbursed for highly inflated cost of services."

They knew employers didn't understand the risk:

"Demonstrating effects of the 'flip' logic may cause groups to question their original consent."

And most damningly, they admitted fiduciary responsibility:

"We have fiduciary responsibility to our ASC customers. Our lack of control over the issue was viewed as failure to fulfill this responsibility."

The Unintended Consequence

ACA – 2010 Medical Loss Ratio's were instituted into law. Requiring that 80% be spent on medical care.

The Intention

Consumer Protection: ensure that premium dollars were primarily spent on Medical Care

The Consequence

Created the incentive to inflate costs. Higher premiums is a more effective strategy for increasing profits than cost-cutting.

An absolute dollar total increase.

The Players

What didn’t exist 75 years ago?

Service Provider that assumes Risk

Hospitals

Employers

79% Large Employers Self Insured

Government

Going to do what It does.

Insurers

Big Banks that use Reserves

Est. 30%+ of total cost In the system

The Direct Model

Employers

Ho

Insurance

"The service benefit plans argued that their 'reserves' were their ability to provide care, that the bricks and mortar and staff, not money in the bank, were the assurance that care would be available when needed."

Morrissey - Chapter 1 History of Insurance

The Direct Model

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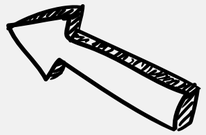
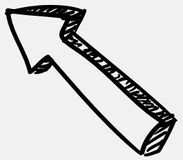
Hospitals

Employers



Government



Insurance

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Defined Risk Holder

Saves 30%+ directly contracting

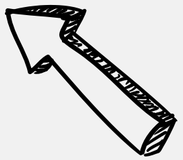
Hospitals

Saves 20-30%+ In efficiency

Government

Still...going to do what It does.

Employers



Reinsurance

Becomes Stop Gap Coverage

The Direct Model

Requirements:

- Hospitals needs to be able to define true cost and determine margin required
- Defined event payment schedule with employers
- Separate maintenance services contracting
- 3rd Party audit function (utilizing AI)
- Insurance type coverage for travel/out of area

The Patient Experience

01. **Maintenance services are combination of OOP and employer paid**

02. **Defined and clear pricing for maintenance services**

03. **Defined benefits and OOP for Events that are dictated by Employer**

04. **Hospital does not collect payments**

Thoughts and Questions

Let’s Talk About it