Ensuring America's Health: Publicly Constructing the Private Health Insurance Industry, 1945–1970

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"Ensuring America's Health" demonstrates how public and private power intermingled to embed a specific organizational model—the insurance company model—into the health care system. The dissertation draws on government documents, trade association papers, company archives, and interviews with policymakers, insurance industry leaders, and physicians. In addition to exploring health care politics, it presents a detailed study of major trade associations and ground-level organizations, such as individual insurance companies and physician offices. This history reveals the degree to which policy debates and private sector organization have informed one another; exposes the factors driving US health care costs; and details the origins of the system's pseudo-corporate structure, which places insurance companies in a supervisory role over physicians and hospitals.

After Maria Carr, a 43-year-old California resident and school administrator, had arthroscopic surgery to treat a hip bone spur in 2009, her insurance provider, UnitedHealth, refused to cover the treatment. The claim denial left Carr with a $21,225 bill. Jacquelyn Haynes, a Florida mother of two, battled Aetna for over a year to obtain coverage for an innovative surgery to save her eyesight. In another case, Cigna refused to pay for the liver transplant of a dying 17-year-old California girl. Nataline Sarkisyan's liver began to fail after she had a bone marrow transplant to treat leukemia. Bad publicity forced the company to

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relent and cover the operation, but Sarkisyan passed away on the day that Cigna modified its decision.[1]

Insurance companies occupy a central position in the US health care system—insurers make decisions about which procedures are covered, influence the way medicine is practiced through treatment blueprints, and determine physician pay by setting service fees. Many scholars take this influential position for granted, assuming that insurance companies occupy a natural role in the delivery of private medical care. Yet the insurance company model was only one option among an assortment of organizational arrangements that could have structured the private market. Moreover, insurance companies did not gain their dominant role because of their ability to minimize transaction costs, offer efficient organization, or compete with other forms of financing. The way federal politics interacted with the private sector positioned insurance companies not only as the financiers of medical services but also as the principal managers and coordinators of the US health care system.

American health care has long been viewed through a dichotomous framework that categorizes systems as either government-run or based on private markets. Most health care studies attempt to explain why the United States embarked on a different path than western and northern European countries, which possess centrally managed, universal systems. As seen through this lens, the health care narrative consists of a series of political reform battles. Peeling back this first layer of analysis reveals how distinctive features of American politics impeded comprehensive reform. For example, the nation's decentralized system of governance, divided among federal, state, and local authorities, created numerous policy hurdles for reformers. Some authors point to the tenacity of classical liberal concerns as a means of explicating the failure of nationalized health care. Other scholars demonstrate how, during the first half of the twentieth century, federal agencies had less governing capacity than the well-funded and sophisticated bureaucracies housed in corporations, trade associations, and professional organizations. Indeed, the strength of private health interests, particularly the American Medical Association (AMA), is a central premise in these studies.[2] This body of scholarship

1. Konrad, "Claim Denied? Time for Some Perseverance"; Cox, "Patient Overcomes Aetna's Rejections to Her Eye-Saving Surgery"; Burling, "When a Health Insurer Won't Pay."

2. These works include Hirshfield, *The Lost Reform*; Numbers, *Almost Persuaded*; Hoffman, *The Wages of Sickness*; Poen, *Harry Truman versus the Medical Lobby*; Harris, *A Sacred Trust*; Mayes, *Universal Coverage*. For analysis that focuses on public opinion, see Jacobs, *The Health of Nations*. For arguments grounded in the state's institutional structure, see Skocpol, *Protecting Soldiers and Mothers*; Steinmo and Watts, "It's the Institutions Stupid!" For historical treatments

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has been crucial to understanding the most visible political conflicts over health care. However, such analyses tend to neglect significant developmental features—in seeking to explain what the system lacks, this vein of examination often overlooks how US health care assumed its distinctive public-private form.

A second category of scholarship blurs the line between public and private health care. Jacob Hacker demonstrates how conservative politicians fought comprehensive reform by directing federal subsidies toward employer-provided medical insurance. Federal policy granted valuable tax write-offs to businesses that purchased fringe benefits, including health insurance, for workers. Hacker highlights the timing and rapid buildup of voluntary insurance to explain the absence of government-managed health care. The growth of voluntary insurance constructed a wall too high for reform-oriented policymakers to scale: the spread of private coverage helped defeat President Harry Truman's bid for universal insurance at the end of the 1940s. Subsequent attempts to enact comprehensive reform pitted politicians against middle-class and union workers accustomed to receiving employer-supplied benefits.[3]

My dissertation demonstrates how public and private authority mingled, not only to foster voluntary insurance but also to construct the health care system around a specific organizational model—one based upon insurance company funding and management. It explores the institutions forged at the intersection of public and private authority through a multi-tiered study of federal politics, trade associations, and ground-level organizations such as individual insurance companies and physician offices. By recasting the health care narrative from one that lurches from one failed reform effort to the next into an account of gradual evolution, it illuminates how public policy reshaped the private sector, and in turn, how voluntary institutions influenced the choices of policymakers. Tracing the development of the insurance company model explains many distinctive features of US health care, including the system's high costs and pseudo-corporate structure, within which insurers attempt to supervise physician work and the way medicine is practiced.

that examine the power of private interests in shaping the health care system, see Gordon, *Dead on Arrival*; Alford, *Health Care Politics*; Navarro, *Medicine under Capitalism*; Quadagno, *One Nation Uninsured*. Admittedly, my attempt to categorize these works is somewhat crude. Many of these excellent monographs go far beyond single variable explanations of why the United States lacks nationalized health care. For example, although Gordon emphasizes the importance of private interests in blocking health care reform, he also explores race, gender, and the rapid development of private insurance.

3. Hacker, *The Divided Welfare State*. Also see Klein, *For All These Rights*; Gottschalk, *The Shadow Welfare State*.

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Chapter Summaries

Chapter one examines how, out of numerous possible ways of organizing health care, private health groups settled upon the insurance company model. The chapter begins by exploring how doctors practiced medicine during the late nineteenth and early twentieth centuries. It surveys the doctor's individual proprietorship model, physician struggles to gain professional status, and practitioner attempts to remain autonomous in a society increasingly organized through large bureaucratic structures.

The chapter reviews the early history of health insurance and demonstrates that commercial insurance companies hesitated to underwrite medical services for several reasons. First, they cited moral hazard, which occurred when subscribers lost incentive to protect themselves against the risks for which they were insured. Moreover, because illness is often difficult to define, patients could demand unnecessary care. Second, doctors had financial incentive to provide patients with as many services and procedures as possible when a distant corporation was paying the bill. Third, insurance companies lacked the authority to supervise physician practices. Although insurance companies experimented with several types of medical coverage during the late nineteenth and early twentieth centuries, the financial losses associated with these offerings convinced executives to avoid further entanglement in the health care sector.

However, businesses, consumer organizations, unions, and doctors began to experiment with various ways of funding and delivering medical services. In the most popular of these market experiments—prepaid doctor groups—physicians worked together to provide services to patients in return for a set monthly fee. Prepaid physician groups controlled costs while offering patients integrated, multi-specialty care.

Although a variety of groups sought to structure health care for efficiency (or to promote their own power, as with many business and labor groups), the AMA assumed an obstructionist mantle. AMA leaders attempted to thwart market modernization by opposing both group practice and health insurance. AMA officials feared that physician groups and third-party financing would give birth to medical corporations, which would inevitably limit the salary and autonomy of doctors. Furthermore, AMA leaders associated corporate organization with government-managed health care: they believed that once the private sector was organized efficiently, then the government would assume control. Thus, the association punished doctors who deviated from the nineteenth-century, individual practice model by having the licenses and hospital privileges of errant physicians revoked.

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During the 1930s, proposals for federal health care reform finally forced organized doctors to capitulate. The AMA continued to oppose doctor groups but reluctantly approved insurance—*but only* policies financed by insurance companies. AMA leaders hoped to prevent insurers from becoming deeply involved in health care by keeping insurance companies at a distance: organized physicians demanded fee-for-service reimbursements (rather than salaries or per-patient fees) and indemnity payments, which went directly to policyholders and thereby allowed doctors to individually negotiate patient bills.

Because of the inherent costs and risks involved in this model, insurance industry leaders continued to resist writing medical insurance policies. Nevertheless, mounting requests from businesses seeking medical coverage for employee groups and a desire to impede federal reforms persuaded them to reconsider and begin selling health care coverage during the 1930s and 1940s. Hesitant, even fearful to take this step, insurance executives reassured themselves by pledging to issue only severely restricted policies. They pinned their hopes on major medical or catastrophic coverage, which only reimbursed subscribers for a portion of hospital costs in the event of an accident or severe illness. Illnesses that qualified for insurance were catalogued on a small, pre-stipulated list.

Blue Cross and Blue Shield plans also assumed a place under the umbrella of AMA-approved insurance. In 1929, nonprofit leaders began establishing Blue Cross plans to provide hospital insurance. During the late 1930s and 1940s, constituent AMA medical societies founded Blue Shield plans to underwrite physician services. Although national AMA leaders balked, local doctors launched the nonprofit programs to oppose government reform efforts, prevent Blue Cross from financing physician services, and retain control over health insurance.

These developments erected the underpinnings of the US health care system's contemporary structure. Although neither physicians nor commercial insurers were happy with the arrangements, the insurance company model would soon come to dominate and organize almost every aspect of the health care market.

Chapters two and three review political reform battles under Presidents Truman and Eisenhower. President Harry Truman's attempt to create a government-managed health care system is well known. What is less appreciated is how reformers—though unsuccessful in achieving universal care—nevertheless set the terms that would guide subsequent political debates. The arguments of liberal reformers revolved around two primary issues: efficiency and equity. They asserted that insurance company policies were simply

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too costly to satisfy mass consumer demand.[4] Indeed, in 1948, less than half of Americans owned medical coverage.[5] Reformers also highlighted meager policy benefits to contend that insurance company coverage could never mollify consumers seeking ready access to modern medical advances. Because policymakers on both sides of the aisle embraced Keynesian policies and displayed a concomitant concern for facilitating consumption, such criticism resonated loudly throughout the political class.

Thus, well after Truman's plan was defeated, moderate Democrats and Republicans, including President Dwight Eisenhower, continued proposing legislation to reform or dislodge the costly and inefficient insurance company model. These proposals included subsidies for prepaid doctor groups, efforts to strengthen nonprofit plans, and the president's Reinsurance legislation to federally underwrite losses that insurers sustained when they liberalized coverage or extended policies to high-risk applicants such as the elderly. Although these reform programs appeared minor in the wake of Truman's comprehensive proposal, they nevertheless promised to rearrange the market in ways that threatened private interests, particularly organized physicians and commercial insurance firms.

The continual threat of federal intervention in health care created a neo-corporatist environment in which the health insurance market was shaped by a combination of public and private power. Political debates transformed the economic goals of private health interests. Federal policymakers, through the informal power of unsuccessful reform proposals, outlined a politically influenced consumer ideal that called for mass production of generous insurance policies. The message to private health interests was clear: in order to defeat reform measures and prove the voluntary market's strength, they would

4. Throughout the dissertation, I counter a conventional narrative that claims health care costs became a problem only after Medicare's passage. For example, Fein, *Medical Care, Medical Costs*; Davis, et al., *Health Care Cost Containment*; Quadagno, *One Nation Uninsured*, chapter four. Recently, scholars have recently begun revising the traditional argument to demonstrate that health care costs began creating difficulties well before the 1965 Medicare Bill. See Klein, *For All These Rights*, 217–18, 242–43; Rothman, "The Public Presentation of Blue Cross, 1935–1965."

Although some scholars blame technological advances for persistent increases in health costs, such analysis makes technology a determining force, separate from the decisions and financial incentives of businesses, service providers, and customers. See Mechanic, *The Growth of Bureaucratic Medicine*, 9–22; Fuchs, "Economics, Values, and Health Care Reform"; Newhouse, "Medical Care Cost"; Glied, *Chronic Condition*; Cutler and McClellan, "Is Technological Change in Medicine Worth It?"; Glied, "Health Care Costs." For a discussion of the importance of health care markets in relation to the efficient use of technology, see Fuchs, *The Health Economy*, 29–31, 107.

5. *Source Book of Health Insurance Data*, 10.

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have to dramatically increase population coverage and transform the insurance product from a limited mechanism into a means for paying almost all expenses associated with medical care. To accomplish this task, organized physicians and insurers had to overcome their mutual suspicions and work together. Thus, reform measures, paradoxically, helped to entrench the very insurance company model that they were intended to displace.

Federal policy also aided private interests as they attempted to radically expand insurance company financing. Under the Eisenhower administration, politicians institutionalized tax breaks to businesses that purchased employee insurance and created a massive health insurance program for federal workers. These programs assisted physicians and insurers as they raced to organize the private market and thereby obstruct government reform.

Chapter four presents a revisionist portrait of the AMA. It argues that focus on the association's victory over universal health insurance has led scholars to overstate AMA power. Certainly, the AMA derived strength from physician professional standing, large membership numbers, enormous financial resources, and a federated structure—based upon national, state, and local associations—that facilitated doctors' ability to lobby politicians at every level of government.[6] Nevertheless, AMA leaders deployed political, organizational, and economic strategies that, while initially successful, gradually sapped the influence of organized physicians.

The AMA famously defeated Truman's reform proposal with a massive publicity campaign against "socialized medicine." However, the victory convinced AMA officials that such tactics would perpetually sustain their political objectives. Furthermore, although the AMA's leadership included ideologically moderate physicians, an ultra-conservative faction, led by Texas doctor F.J.L. Blasingame, gained control of the association's policymaking process. These officials led the AMA to oppose any government reform, no matter how minor. Thus, throughout Eisenhower's two terms, organized physicians stridently campaigned against myriad "compromise" reforms as well as international treaties, public health measures, Social Security expansion, federal disability benefits, and public programs for the poor. This approach alienated one-time political allies, the

6. For traditional histories of the AMA, see Harris, *A Sacred Trust*; Hirshfield, *The Lost Reform*; Burrow, *AMA*; Starr, *The Social Transformation of American Medicine*, 275–89; Quadagno, *One Nation Uninsured*; Hacker, *The Divided Welfare State*, 197–99, 238–40; Marmor, *The Politics of Medicare*, 38–41. Interestingly, the work that goes furthest down the road of revisionist history is an AMA-authorized book. Campion, *The AMA and U.S. Health Policy*. Campion examines the AMA's dysfunctional leadership and organizational disarray.

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public, and physician-members. The association's political authority, which had once been derived largely from grassroots mobilization, now began to crumble as members became increasingly apathetic and discontent.

The AMA's organizational structure also undermined the power of physicians. An elite leadership with divided decision-making power failed to develop long-term strategies around which they could unite members. Once objectives were formulated, the AMA's sprawling and fragmented bureaucracy had difficulty accomplishing them.

Furthermore, AMA leaders failed to develop the health care market in a manner that would mitigate reform initiatives and public criticism. Rather than proactively seeking ways to both protect physician sovereignty and make health services readily accessible for consumers, AMA leaders retreated to a reactionary position and left insurance companies to organize the market.

Chapter five examines the Health Insurance Association of America (HIAA), a trade association about which historians have written very little.[7] Health insurers created the HIAA in 1956 in response to persistent federal reform efforts. Moreover, HIAA founders wished to break away from life insurance executives, many of whom viewed health insurance as a bargaining chip that could be surrendered in political negotiations to limit Social Security.

The split from life insurance associations allowed the HIAA to adopt a more conservative political approach, inspired by the HIAA's first president and most influential leader during this period, Edwin J. Faulkner. Although the HIAA adopted the same positions as the AMA, insurance leaders, fearing a public reaction against "big business" power, deliberately shunned political publicity and lobbied policymakers behind the scenes.

Also in contrast to the AMA, insurance executives created a streamlined, efficient organization. HIAA leaders exercised robust governing authority over member companies: the leadership effected inter-firm cooperation, blunted political criticism by implementing industry regulation, standardized insurance products, and fostered expertise in medical underwriting.

Most importantly, HIAA leaders rapidly organized the health care market around insurance company products. They persuaded

7. Today, the HIAA is known as America's Health Insurance Plans (AHIP). AHIP gained notoriety during the Clinton health care debates for launching the "Harry and Louise" commercials, which scholars have credited with helping influence public opinion against the reform package. However, no systematic attention has been given to the HIAA's formation and development during the post–World War II period. On the Clinton Health Care Plan, see Skocpol, *Boomerang*; Hacker, *The Road to Nowhere*.

member companies to defeat federal reform initiatives by spreading and liberalizing health insurance—despite the well-recognized financial risks inherent in such efforts. For profit insurers, along with their nonprofit competitors, increased insurance coverage from a little more than one quarter of the population in 1945 to almost 80 percent of the population by 1965.[8] Commercial companies expanded benefits to cover medical services both in and out of the hospital, experimented with guaranteed renewable policies that provided coverage regardless of the policyholder's health and sold approximately 30 percent of their policies to individual subscribers (rather than employee groups) despite the increased risk of adverse selection.[9] Additionally, as the Medicare debates began to heat up at the end of the 1950s, HIAA leaders obtained state enabling laws that allowed firms to pool financial and administrative resources to sell health insurance to the elderly. Notwithstanding these organizational efforts, companies lost money to cover aged subscribers. Nevertheless, by swiftly capturing a dominant position for their products, HIAA leaders would shape the future economic and political trajectory of the health care system.

Chapter six provides the first comprehensive examination of the establishment and evolution of Blue Shield.[10] Founded by constituent AMA medical societies, Blue Shield plans owed their existence and continuation to organized physicians. Medical society leaders formally supervised the nonprofit plans and stacked their governing boards with AMA members. Blue Cross also plied influence over Blue Shield. At the local level, Blue Cross administrators, who underwrote hospital services, helped their sibling nonprofits administer complementary policies that covered physician services.

To complicate Blue Shield's dependency on two separate organizations, AMA and Blue Cross leaders frequently disagreed about political and economic matters. AMA leaders insisted that Blue Shield follow their political marching orders, and the nonprofit often complied. In contrast, Blue Cross leaders were receptive to moderate

8. *Source Book of Health Insurance Data*, 10.

9. The high proportion of guaranteed renewable and individual policies revises narratives asserting that commercial firms "cherry picked" the healthiest subscribers by only underwriting employee groups, thus leaving Blue Cross and Blue Shield with the sickest policyholders. Still, the nonprofit plans probably applied less stringent underwriting practices than did their commercial competitors; such practices would have increased their risk profile. See Thomasson, "Did Blue Cross and Blue Shield Suffer from Adverse Selection?," 1–27.

10. Most scholars have focused on the hospital plans under Blue Cross. Law, *Blue Cross: What Went Wrong?*; Anderson, *Blue Cross since 1929*; Miller, *American Health Care Blues*; Cunningham, *The Blues*. The Cunningham book has a much thinner history of Blue Shield than Blue Cross. Similarly, the 1991 special edition of the *Journal of Health Policy, Politics, and Law*, which surveys the nonprofit movement in health care, focuses on hospital prepayment plans.

reform proposals and lobbied policymakers to subsidize their goal of providing generous nonprofit insurance to the entire population. AMA leaders distrusted Blue Cross officials' attempt to introduce federal funding into medical care, their close connection to hospitals, and their alliance (though sometimes testy) with labor unions.

In order to minimize Blue Cross authority over medical nonprofits and preserve local physician control, AMA leaders attempted to keep the National Association of Blue Shield Plans (NABSP) weak and decentralized. However, without robust NABSP leadership, disparate Blue Shield plans had difficulty selling coverage to large employee groups that spanned geographical areas. This organizational weakness hindered nonprofits' ability to compete with commercial insurance firms.

Over time, the AMA's strategy drove Blue Shield leaders away from physicians and into Blue Cross' sphere of influence. Moreover, as medical nonprofits expanded, they became too financially and administratively complex for physicians to effectively supervise. The NABSP gradually centralized power over member-plans, and medical nonprofits created an integrated federation that was increasingly independent of AMA power. The child of organized physicians would grow up and reverse power relations—during the 1960s and 1970s, Blue Shield partnered with Blue Cross to begin constricting physician autonomy and monitoring doctor work. This development paved the way for the NABSP to merge with the Blue Cross Association during the 1970s.

Following the review of national trade association development, **chapter seven** takes the reader into ground-level organizations: individual insurance companies, nonprofit plans, doctors' offices, and medical societies. The chapter examines how these organizations, under instructions from the trade associations to which they belonged, evolved to support the insurance company model.

The primary problem accompanying the insurance company model was costs. Insurers' initial forecast proved correct: moral hazard combined with AMA dictates, such as fee-for service reimbursement, drove up medical service prices.

Cost problems combined with the rapid expansion of health care coverage induced insurers and physicians to forge overlapping institutions to negotiate their increasingly intimate financing relationship. This process created a pseudo-corporate framework—one that placed insurers in a supervisory position over doctors and the delivery of medical care. To support this development, commercial insurance companies decentralized operations so their representatives could interact with medical society representatives and individual doctors in various regions. Insurers harnessed newly acquired medical

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expertise to implement a variety of cost containment measures, ranging from requiring doctors to obtain permission for hospital admissions to compelling physicians to follow standardized treatment practices. In response to insurers' concerns about rising costs, constituent AMA medical societies established utilization review committees to evaluate physician charges and procedures. Insurers used data from these committees to further develop their knowledge of health care and monitor physician behavior. As doctors began accepting payments directly from insurance companies, rather than from patients, they became ever more dependent on insurers' rules and regulations. Doctors hired office administrators to handle insurer relations and began to modify patient treatments according to insurance billing practices.

In this way, insurance companies expanded their role from merely underwriting the risks associated with medical services consumption to also managing and coordinating the health care system. The web of institutions that insurance companies developed to support their policies helped establish a position of cultural and political legitimacy for their products. Once the institutions necessary to support insurance company financing took hold at the ground level, they appeared to be the result of "natural" market forces rather than the product of top-down decision making.

Chapter eight revises traditional Medicare accounts by demonstrating that legislative battles over the program were not simply dualistic struggles that set liberal reformers against conservative politicians and private health interests. Because of the high costs of insurance company coverage, almost all policymakers agreed on the necessity of providing federally funded health benefits to elderly citizens.[11] Most significantly, all Medicare proposals, whether offered by Democrats or Republicans, attempted to build upon rather than displace the insurance company model.

Medicare debates stretched on for almost eight years because liberal policymakers hoped to construct a platform upon which they could develop a universal system, whereas conservative policymakers wanted to create a limited, inelastic program. Politicians were divided into ideological camps over issues of means testing, Social Security versus general revenue financing, and the preferred degree of insurance company participation. Although liberal policymakers favored supplanting the insurance company structure with federal

11. For traditional narratives, see Starr, *The Social Transformation of American Medicine*, 286–88, 367–70; Marmor, *The Politics of Medicare*. In contrast, Rashi Fein discusses an "emerging consensus" among policymakers. Fein, *Medical Care, Medical Costs*, 56.

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administration, they quickly realized that employing private sector institutions would not only permit them to harness existing organizational capacity but also would allow them to promote their proposal as ideologically moderate. Policymakers aligned with the Kennedy and Johnson administrations reassured voters that under their Medicare proposal, senior citizens would have the same type of medical coverage to which consumers had grown accustomed.

AMA leaders, hoping to replicate the success they had in defeating Truman's proposal, launched an all-out publicity war against Medicare. However, because of the broad consensus in favor of aged health benefits and because the Kennedy and Johnson administrations' proposal was perceived by the public as politically moderate, reformers successfully portrayed organized physicians as heartless villains with little concern for the vulnerable elderly population. The AMA not only suffered a political loss with the passage of Medicare but also emerged from the episode with a disgruntled membership base and dwindling public approval numbers.

Due to the high costs of insuring the elderly and a mounting political consensus in favor of aged benefits, HIAA leaders vacillated over whether to endorse a conservative version of Medicare. They ultimately refused to do so, believing that any such program would eventually develop into universal health care. Insurers also worried about the consequences of involving their companies in programs that entailed complicated mixtures of public and private power. Instead, they timidly opposed Medicare. HIAA leaders' decision to stay out of the public eye proved astute: commercial insurers weathered the debates without attracting the harsh criticism directed at organized physicians.

Still under the thumb of organized physicians, Blue Shield leaders followed the AMA's political line; however, they failed to mount a vigorous campaign against Medicare. Like their commercial competitors, Blue Shield administrators recognized the benefit of offloading financial losses associated with aged coverage to the government. Meanwhile, Blue Cross leaders endorsed Medicare and negotiated with policymakers to carve out a lucrative administrative role for nonprofit plans.

In the end, the 1965 Medicare program legitimized the previously contested insurance company model. Policymakers appointed insurance companies to administer the program by acting as financial intermediaries between the government and service providers. Thus, Medicare adopted the institutions that insurers and physicians had already created to govern their financing relationship. Now, in addition to managing and coordinating the private health care sector, insurance companies were overseeing the public health care sector as well.

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The epilogue briefly reviews health care legislation and reform proposals since Medicare. It demonstrates how politicians have continued to tailor policy proposals and legislative initiatives, including cost containment measures, to accommodate the insurance company model.

Additionally, the epilogue contrasts the AMA's deteriorating political authority with the increasing political and economic power of insurers, who have often allied with federal officials to constrain health care costs by decreasing physician and hospital autonomy. Indeed, insurers and service providers have frequently used political battles as proxies to negotiate their principal-agent relationship. For example, leaders of the AMA, America's Health Insurance Plans (AHIP, the renamed HIAA), and Blue Cross agreed to back President Barack Obama's Patient Protection and Affordable Care Act. In return for their support, however, organized physicians demanded that the legislation decrease insurance company authority over medical practices; in contrast, insurance leaders requested additional power to supervise and regulate physician work.

The dissertation concludes by reviewing three primary characteristics associated with insurance-company-financed and -managed health care: high costs, fragmented care, and poor doctor distribution. The analysis reveals that because the Obama administration and liberal Democrats failed to institute a public option, the recent reform legislation—unsurprisingly, given the history presented here—preserves the broken insurance company model.

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