Health Insurance in the United States

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This article describes the development of the U.S. health insurance system and its growth in the twentieth century. It examines the roles of important factors including medical technology, hospitals and physicians, and government policy culminating in the development of Medicare and Medicaid.

1900-1920: Sickness Insurance versus Health Insurance

Prior to 1920, the state of medical technology generally meant that very little could be done for many patients, and that most patients were treated in their homes. Table 1 provides a list of pioneering early advances in medicine. Hospitals did not assume their modern form until after the turn of the century when antisepsic methods were well established. Even then, surgery was often performed in private homes until the 1920s.

Table 1: Milestones in Medical Technology

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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<tbody>
<tr>
<td>1850-1870</td>
<td>Louis Pasteur, Joseph Lister and others develop understanding of bacteriology, antisepsis, and immunology.</td>
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<tr>
<td>1870-1910</td>
<td>Identification of various infectious agents including spirochaeta pallida (syphilis), typhus, pneumococcus, and malaria. Diphtheria antitoxin developed. Surgery fatality rates fall.</td>
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<td>1887</td>
<td>S.S.K. von Basch invents instrument to measure blood pressure.</td>
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<td>1895</td>
<td>Wilhelm Roentgen develops X-rays.</td>
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<td>1910</td>
<td>Salvarsan (for syphilis) proves to be first drug treatment that destroys disease without injuring patient.</td>
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<tr>
<td>1920-1946</td>
<td>Insulin isolated (1922), sulfa developed (1935), large-scale production of synthetic penicillin begins (1946).</td>
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<tr>
<td>1955</td>
<td>Jonas Salk announces development of vaccine for polio.</td>
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Medical Expenditures Initially Low

Given the rudimentary state of medical technology before 1920, most people had very low medical expenditures. A 1918 Bureau of Labor Statistics survey of 211 families living in Columbus, Ohio found that only 7.6 of their average annual medical expenditures paid for hospital care (Ohio Report, p. 116). In fact, the chief cost associated with illness was not the cost of medical care, but rather the fact that sick people couldn't work and didn't get paid. A 1919 State of Illinois study reported that lost wages due to sickness were four times larger than the medical expenditures associated with treating the illness (State of Illinois, pp. 15-17). As a result, most people felt they didn't need health insurance. Instead, households purchased 'sickness' insurance -- similar to today's 'disability' insurance -- to provide income replacement in the event of illness.¹

Insurance Companies Initially Unwilling to Offer Health Insurance Policies

The low demand for health insurance at the time was matched by the unwillingness of commercial insurance companies to offer private health insurance policies. Commercial insurance companies did not believe that health was an insurable commodity because of the high potential for adverse selection and moral hazard. They felt that they lacked the information to accurately calculate risks and write premiums accordingly. For example, people in poor health may claim they be healthy and then sign up for health insurance. A problem with moral hazard may arise if people change their behavior -- perhaps engaging in more risky activities -- after they purchase health insurance. According to The Insurance Monitor, “the opportunities for fraud [in health insurance] upset all statistical calculations…. Health and sickness are vague terms open to endless construction. Death is clearly defined, but to say what shall constitute such loss of health as will justify insurance compensation is no easy task” (July 1919, vol. 67 (7), p. 38).

Failure of Compulsory, Nationalized Health Insurance

The fact that people generally felt actual health insurance (as opposed to sickness insurance) was unnecessary prior to 1920 also helped to defeat proposals for compulsory, nationalized health insurance in the same period. Although many European nations had adopted some form of compulsory, nationalized health insurance by 1920, proposals sponsored by the American Association for Labor Legislation (AALL) to enact compulsory health insurance in several states were never enacted (see Numbers 1978). Compulsory health insurance failed in this period for several reasons. First, popular support for the legislation was low because of the low demand for health insurance in general. Second, physicians, pharmacists and commercial insurance companies were strong opponents of the legislation. Physicians opposed the legislation because they feared that government intervention would limit their fees. Pharmacists opposed the legislation because it provided prescription drugs they feared would undermine their business. While commercial insurance firms did not offer health insurance during this period, a large part of their business was offering burial insurance to pay funeral costs. Under the proposed legislation, commercial firms would be excluded from offering burial insurance. As a result, they opposed the legislation, which they feared would also open the door towards greater government intervention in the insurance business.

1920-1930: The Rising Price of Medical Care

As the twentieth century progressed, several changes occurred that tended to increase the role that medicine played in people's lives and to shift the focus of treatment of acute illness from homes to hospitals. These changes caused the price of medical care to rise as demand for medical care increased and the cost of supplying medical care rose with increased standards of quality for physicians and hospitals.

Increases in the Demand for Medical Care

¹ Other factors that contributed to the low demand for health insurance included the fact that insurance was available only through employers and that costs were low outside the workplace.
As the population shifted from rural areas to urban centers, families lived in smaller homes with less room to care for sick family members (Faulkner 1960, p. 509). Given that health insurance is a normal good, rising incomes also helped to increase demand. Advances in medical technology along with the growing acceptance of medicine as a science led to the development of hospitals as treatment centers and helped to encourage sick people to visit physicians and hospitals. Rosenberg (1987) notes that “by the 1920s... prospective patients were influenced not only by the hope of healing, but by the image of a new kind of medicine -- precise, scientific and effective” (p. 150). This scientific aura began to develop in part as licensure and standards of care among practitioners increased, which led to an increase in the cost of providing medical care.

Rising Medical Costs

Physician quality began to improve after several changes brought about by the American Medical Association (AMA) in the 1910s. In 1904, the AMA formed the Council on Medical Education (CME) to standardize the requirements for medical licensure. The CME invited Abraham Flexner of the Carnegie Foundation for the Advancement of Teaching to evaluate the status of medical education. Flexner's highly critical report on medical education was published in 1910. According to Flexner, the current methods of medical education had “…resulted in enormous over-production at a low level, and that, whatever the justification in the past, the present situation... can be more effectively met by a reduced output of well trained men than by further inflation with an inferior product” (Flexner, p. 16). Flexner argued for stricter entrance requirements, better facilities, higher fees, and tougher standards. Following the publication of the Flexner Report, the number of medical schools in the United States dropped from 131 in 1910 to 95 in 1915. By 1922, the number of medical schools in the U.S. had fallen even further to 81 (Journal of the American Medical Association, August 12, 1922, p. 633). These increased requirements for physician licensure, education and the accreditation of medical schools restricted physician supply, putting upward pressure on the costs of physicians’ services.2

After Flexner's report, a further movement towards standardization and accreditation came in 1913, when the American College of Surgeons (ACS) was founded. Would-be members of the ACS had to meet strict standards. For a hospital to gain the accreditation of the ACS, it had to meet a set of standards relating to the staff, records, and diagnostic and therapeutic facilities available. Of 692 large hospitals examined in 1918, only 13 percent were approved. By 1932, 93 percent of the 1,600 hospitals examined met ACS requirements (Shyrock 1979, p. 348).

Increasing requirements for licensure and accreditation, in addition to a rising demand for medical care, eventually led to rising costs. In 1927, the Committee on the Costs of Medical Care (CCMC) was formed to investigate the medical expenses of American families. Comprised of physicians, economists, and public health specialists, the CCMC published 27 research reports, offering reliable estimates of national health care expenditures. According to one CCMC study, the average American family had medical expenses totaling $108 in 1929, with hospital expenditures comprising 14 percent of the total bill (Falk, Rorem, and Ring 1933, p. 89). In 1929, medical charges for urban families with incomes between $2,000 and $3,000 per year averaged $67 if there were no hospitalizations, but averaged $261 if there were any illnesses that required hospitalization (see Falk, Rorem, and Ring). By 1934, Michael M. Davis, a leading advocate of reform, noted that hospital costs had risen to nearly 40 percent of a family's medical bill (Davis 1934, p. 211). By the end of the 1920s, families began to demand greater amounts of medical care, and the costs of medical care began to increase.

1930-1940: The Birth of Blue Cross and Blue Shield

Blue Cross: Hospital Insurance

As the demand for hospital care increased in the 1920s, a new payment innovation developed at the end of the decade that would revolutionize the market for health insurance. The precursor to Blue Cross was founded in 1929 by a group of Dallas teachers who contracted with Baylor University Hospital to provide 21 days of hospitalization for a fixed $6.00 payment. The Baylor plan developed as a way to ensure that people paid their bills. One official connected with the plan compared hospital bills to cosmetics, noting that the nation's cosmetic bill was actually more than the nation's hospital bill, but that “We spend a dollar or so at a time for cosmetics and do not notice the high cost. The ribbon counter clerk can pay 50s., 75s, or $1 a month, yet... it would take about twenty years to set aside a large hospital bill” (The American Foundation 1937, p. 1023).

Pre-paid hospital service plans grew over the course of the Great Depression. Pre-paid hospital care was mutually advantageous to both subscribers and hospitals during the early 1930s, when consumers and hospitals suffered from falling incomes. While the pre-paid plans allowed consumers to affordably pay for hospital care, they also benefitted hospitals by providing them with a way to earn income during a time of falling hospital revenue. Only 62 percent of beds in private hospitals were occupied on average, compared to 89 percent of beds in public hospitals that accepted charity care (Davis and Rorem 1932, p. 5). As one pediatrician in the Midwest noted, “Things went swimmingly as long as endowed funds allowed the hospitals to carry on. When the funds from endowments disappeared the hospitals got into trouble and thus the various plans to help the hospitals financially developed” (American Foundation 1937, p. 756).

The American Hospital Association (AHA) encouraged hospitals in such endeavors ostensibly as a means of relieving “… from financial embarrassment and even from disaster in the emergency of sickness those who are in receipt of limited incomes” (Reed 1947, p. 14). However, the prepayment plans also clearly benefitted hospitals by giving them a constant stream of income. Since single-hospital plans generated greater competition among hospitals, community hospitals began to organize with each other to offer hospital coverage and to reduce inter-hospital competition. These plans eventually combined under the auspices of the AHA under the name Blue Cross.

Blue Cross Designed to Reduce Price Competition among Hospitals

The AHA designed the Blue Cross guidelines so as to reduce price competition among hospitals. Prepayment plans seeking the Blue Cross designation had to provide subscribers with free choice of physician and hospital, a requirement that eliminated single-hospital plans from consideration. Blue Cross plans also benefited from special state-level enabling legislation allowing them to act as non-profit corporations, to enjoy tax-exempt status, and to be free from the usual insurance regulations. Originally, the reason for this exemption was that Blue Cross plans were considered to be in society's best interest since they often provided benefits to low-income individuals (Eilers 1963, p. 82). Without the enabling legislation, Blue Cross plans would have had to organize under the laws

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for insurance companies. If they organized as stock companies, the plans would have had to meet reserve requirements to ensure their solvency. Organizing as mutual companies meant that they would either have to meet reserve requirements or be subject to assessment liability. Given that most plans had little financial resources available to them, they would not have been able to meet the requirements.

The enabling legislation freed the plans from the traditional insurance reserve requirements because the Blue Cross plans were underwritten by hospitals. Hospitals contracted with the plans to provide subscriber services, and agreed to provide service benefits even during periods when the plans lacked funds to provide reimbursement. Under the enabling legislation, the plans "enjoy the advantages of exemption from the regular insurance laws of the state, are freed from the obligation of maintaining the high reserves required of commercial insurance companies and are relieved of paying taxes" (Anderson 1944, p. 11).

Enabling laws served to increase the amount of health insurance sold in states in which they were implemented, causing growth in the market (Thomasson 2002).

Blue Shield: Insurance for Physician Services

Despite the success of Blue Cross and pre-paid hospitalization policies, physicians were much slower in providing pre-paid care. Blue Cross and Blue Shield developed separately, with little coordination between them (McDavitt 1946). Physicians worried that a third-party system of payment would lower their incomes by interfering with the physician-patient relationship and restricting the ability of physicians to price discriminate. However, in the 1930s, physicians were faced with two situations that spurred them to develop their own pre-paid plans. First, Blue Cross plans were becoming popular, and some physicians feared that hospitals would move into the realm of providing insurance for physician services, thus limiting physician autonomy. In addition, advocates of compulsory health insurance looked to the emerging social security legislation as a logical means of providing national health care. Compulsory health insurance was even more anathema to physicians than voluntary health insurance. It became clear to physicians that in order to protect their interests, they would be better off pre-empting both hospitals and compulsory insurance proponents by sculpting their own plan.

Thus, to protect themselves from competition with Blue Cross, as well as to provide an alternative to compulsory insurance, physicians began to organize a framework for pre-paid plans that covered physician services. In this regard, the American Medical Association (AMA) adopted a set of ten principles in 1934 “...which were apparently promulgated for the primary purposes of preventing hospital service plans from underwriting physician services and providing an answer to the proponents of compulsory medical insurance” (Hedinger 1966, p. 82). Within these rules were provisions that ensured that voluntary health insurance would remain under physician supervision and not be subject to the control of non-physicians. In addition, physicians wanted to retain their ability to price discriminate (to charge different rates to different customers, based on their ability to pay).

These principles were reflected in the actions of physicians as they established enabling legislation similar to that which allowed Blue Cross plans to operate as non-profits. Like the Blue Cross enabling legislation, these laws allowed Blue Shield plans to be tax-exempt and free from the provisions of insurance statutes. Physicians lobbied to ensure that they would be represented on the boards of all such plans, and acted to ensure that all plans required free choice of physician. In 1939, the California Physicians’ Service (CPS) began to operate as the first prepayment plan designed to cover physicians’ services. Open to employees earning less than $3,000 annually, the CPS provided physicians’ services to employee groups for the fee of $1.70 per month for employees (Scovea, p. 5). To further these efforts, the AMA encouraged state and local medical societies to form their own prepayment plans. These physician-sponsored plans ultimately affiliated and became known as Blue Shield in 1946.

Blue Shield plans offered medical and surgical benefits for hospitalized members, although certain plans also covered visits to doctors’ offices. While some plans were like the Blue Cross plans in that they offered service benefits to low-income subscribers (meaning that the plans directly reimbursed physicians for services), most Blue Shield plans operated on a mixed service-indemnity basis. Doctors charged patients who were subscribers to Blue Shield the difference between their actual charges and the amount for which they were reimbursed by Blue Shield. In this manner, doctors could retain their power to price discriminate by charging different prices to different patients.

1940-1960: Growth in the Health Insurance Market

After the success of Blue Cross and Blue Shield in the 1930s, continued growth in the market occurred for several reasons. The supply of health insurance increased once commercial insurance companies decided to enter the market for health coverage. Demand for health insurance increased as medical technology further advanced, and as government policies encouraged the popularity of health insurance as a form of employee compensation.

Growth in Supply: Commercial Insurance Companies Enter the Market

Blue Cross and Blue Shield were first to enter the health insurance market because commercial insurance companies were reluctant to even offer health insurance early in the century. As previously mentioned, they feared that they would not be able to overcome problems relating to adverse selection, so that offering health insurance would not be profitable. The success of Blue Cross and Blue Shield showed just how easily adverse selection problems could be overcome: by focusing on providing health insurance only to groups of employed workers. This would allow commercial insurance companies to avoid adverse selection because they would insure relatively young, healthy people who did not individually seek health insurance. After viewing the success of Blue Cross and Blue Shield, commercial health insurance companies began to move rapidly into the health insurance market. As shown in Figure 1, the market for health insurance exploded in size in the 1940s, growing from a total enrollment of 20,662,000 in 1940 to nearly 142,334,000 in 1950 (Health Insurance Institute 1961, Source Book, p. 10). As the Superintendent of Insurance in New York, Louis H. Pink, noted in 1939

... There are twenty stock insurance companies which are today issuing in this state Individual Medical Reimbursement, Hospitalization, and Sickness Expense Policies. About half of these have only recently gone into this field. It is no doubt the interest aroused by the non-profit associations which has induced the regular insurance companies to extend their activities in this way (Pink 1939).

Figure 1: Number of Persons with Health Insurance (thousands), 1940-1960
Community Rating versus Experience Rating

The success of commercial companies was aided by two factors. First, the competitiveness of Blue Cross and Blue Shield was limited by the fact that their non-profit status required that they community rate their policies. Under a system of community rating, insurance companies charge the same premium to sicker people as they do to healthy people. Since they were not considered to be nonprofit organizations, commercial insurance companies were not required to community rate their policies. Instead, commercial insurance companies could engage in experience rating, whereby they charged sicker people higher premiums and healthier people lower premiums. As a result, commercial companies could often offer relatively healthy groups lower premiums than the Blue Cross and Blue Shield plans, and gain their business. Thus, the commercial health insurance business boomed, as shown in Figure 2.

Figure 2: Enrollment in Commercial Insurance Plans v. Blue Cross and Blue Shield


Growth In Demand: Government Policies that Encouraged Health Insurance

Offering insurance policies to employee groups not only benefited insurers, but also benefited employers. During World War II, wage and price controls prevented employers from using wages to compete for scarce labor. Under the 1942 Stabilization Act, Congress limited the wage increases that could be offered by firms, but permitted the adoption of employee insurance plans. In this way, health benefit packages offered one means of securing workers. In the 1940s, two major rulings also reinforced the foundation of the employer-provided health insurance system. First, in 1945 the War Labor Board ruled that employers could not modify or cancel group insurance plans during the contract period. Then, in 1949, the National Labor Relations Board ruled in a dispute between the Inland Steel Co. and the United Steelworkers Union that the term “wages” included pension and insurance benefits. Therefore, when negotiating
for wages, the union was allowed to negotiate benefit packages on behalf of workers as well. This ruling, affirmed later by the U.S. Supreme Court, further reinforced the employment-based system.

Perhaps the most influential aspect of government intervention that shaped the employer-based system of health insurance was the tax treatment of employer-provided contributions to employee health insurance plans. First, employers did not have to pay payroll tax on their contributions to employee health plans. Further, under certain circumstances, employees did not have to pay income tax on their employer’s contributions to their health insurance plans. The first such exclusion occurred under an administrative ruling handed down in 1943 which stated that payments made by the employer directly to commercial insurance companies for group medical and hospitalization premiums of employees were not taxable as employee income (Yale Law Journal, 1954, pp. 222-247). While this particular ruling was highly restrictive and limited in its applicability, it was codified and extended in 1954. Under the 1954 Internal Revenue Code (IRC), employer contributions to employee health plans were exempt from employee taxable income. As a result of this tax-advantaged form of compensation, the demand for health insurance further increased throughout the 1950s (Thomasson 2003).

The 1960s: Medicare and Medicaid

The AMA and the Defeat of Government Insurance before 1960

By the 1960s, the system of private health insurance in the United States was well established. In 1958, nearly 75 percent of Americans had some form of private health insurance coverage. By helping to implement a successful system of voluntary health insurance plans, the medical profession had staved off the government intervention and nationalized insurance that it had feared since the 1910s. In addition to ensuring that private citizens had access to voluntary coverage, the AMA also was a vocal opponent of any nationalized health insurance programs, suggesting that such proposals were socialistic and would interfere with physician income and the doctor-patient relationship. The AMA had played a significant role in defeating proposals for nationalized health insurance in 1935 (under the Social Security Act) and later in defeating the proposed Murray-Wagner-Dingell (MWD) bill in 1949. The MWD bill would have provided comprehensive nationalized health insurance to all Americans. To ensure the defeat of the proposal, the AMA charged every physician who was a member $25 for their lobbying efforts (Marmor 2000).

While serious proposals for government-sponsored health insurance were not put forth during the Eisenhower Administrations of 1952-1960, proponents of such legislation worked to ensure that their ideas would have a chance at passing in the future under more responsive administrations. They realized that the only way to enact government-sponsored health insurance would be to do so incrementally -- and they began by focusing on the elderly (Marmor 2000).

Offering insurance to aged persons age 65 and over provided a means to successfully counter several criticisms that opponents to government-sponsored health insurance had aimed at previous bills. Focusing on the elderly allowed proponents to counter charges that nationalized health insurance would provide health care to individuals who were generally able to pay for it themselves. It was difficult for opponents to argue that the elderly were not among the most medically needy in society, given their fixed incomes and the fact that they were generally in poorer health and in greater need of medical care. Supporters also tried to limit the opposition of the AMA by putting forth proposals that only covered hospital services, which also stemmed criticism that said nationalized health insurance would encourage extensive -- and unnecessary -- utilization of medical services.

Medicare Provisions

The political atmosphere become much more favorable towards nationalized health insurance proposals after John F. Kennedy was elected to office in 1960, and especially when the Democrats won a majority in Congress in 1964. Passed in 1965, Medicare was a federal program with uniform standards that consisted of two parts. Part A represented the compulsory hospital insurance program the aged were automatically enrolled in upon reaching age 65. Part B provided supplemental medical insurance, or subsidized insurance for physicians' services. Ironically, physicians stood to benefit tremendously from Medicare. Fearing that physicians would refuse to treat Medicare patients, legislators agreed to reimburse physicians according to their “usual, customary, and reasonable rate.” In addition, doctors could bill patients directly, so that patients had to be reimbursed by Medicare. Thus, doctors were still permitted to price discriminate by charging patients more than what the program would pay, and forcing patients to pay the difference. Funding for Medicare comes from payroll taxes, income taxes, trust fund interest, and enrollee premiums for Part B. Medicare has grown from serving 19.1 million recipients in 1966 to 39.5 million in 1999 (Henderson 2002, p. 425).

Medicaid

In contrast to Medicare, Medicaid was enacted as a means-tested, federal-state program to provide medical resources for the indigent. The federal portion of a state's Medicaid payments is based on each state's per capita income relative to national per capita income. Unlike Medicare, which has uniform national benefits and eligibility standards, the federal government only specifies minimum standards for Medicaid; each of the states is responsible for determining eligibility and benefits within these broad guidelines. Thus, benefits and eligibility vary widely across states. While the original legislation provided coverage for recipients of public assistance, legislative changes have expanded the scope of benefits and beneficiaries (Gruber 2000). In 1966, Medicaid provided benefits for 10 million recipients. By 1999, 37.5 million people received care under Medicaid (Henderson 2002, p. 433).

Growth of Medicare and Medicaid Expenditures

Figure 3 shows how Medicare and Medicaid expenditures have grown as a percentage of total national health care expenditures since their inception in 1966. The figure points to some interesting trends. Expenditures in both programs rose dramatically in the late 1960s as the programs began to gear up. Then, Medicare expenditures in particular rose sharply during the 1970. This growth in Medicare expenditures resulted in a major change in Medicare reimbursement policies in 1983. Instead of reimbursing according to the "usual and customary" rates, the government enacted a prospective payment system where providers were reimbursed according to set fee schedules based on diagnosis. Medicaid expenditures were fairly constant over the 1970s and 1980s, and did not begin to rise until more generous eligibility requirements were implemented in the 1990s. By 2001, Medicare and Medicaid together accounted for 32 percent of all
health care expenditures in the U.S.

Figure 3:

Medicare and Medicaid as a Share of National Health Expenditures, 1966-2001

Source: Calculations by author based on data from the Centers for Medicare and Medicaid Services (http://cms.gov).

Notes: Percentages are calculated from price-adjusted data for all consumer expenditures, 1996=100.

Endnotes

1 In Canada, fraternal societies were the primary source of sickness benefits and access to a physician in the event of illness. The role of fraternal lodges in insurance declined significantly after 1929. See Emery 1996 and Emery and Emery 1999.

2 These changes may also have increased physician quality, thus leading to an increase in demand for physicians' services that put additional pressure on prices.

3 Stock companies are companies that are owned by stockholders and who are entitled to the earnings of the company. Stock companies are required to hold reserves to guard against insolvency (see Faulkner 1960, pp. 406-29 for a detailed discussion on reserves). Mutual companies are cooperative organizations in which the control of the company and its ownership rest with the insureds. Mutual companies may be required to have reserves, or to engage in assessment liability (in which insureds must pay additional amounts if premiums fall short of claims). Both stock and mutual companies pay taxes.

4 However, the enabling legislation did not give the Blue Cross plans free rein. They required the plans to be non-profit, and to allow free choice of physician by subscribers, and some specified additional requirements. New York was the first state to enact such enabling legislation in 1934, and 32 states had adopted special enabling legislation for hospital service plans by 1943. Other states exempted Blue Cross plans by categorizing them strictly as nonprofit organizations (Ellers 1963, pp. 100-07).

5 Scofea, p. 6. See also Inland Steel Co. v. NLRB (170 F. 2d 247 (7th Cir. 1948) and Ellers, p. 19.

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