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THE HISTORY DEVELOPMENT PERIODS OF MEDICAL INSURANCE IN THE USA

Summary. The investigation is devoted to health insurance in the USA. The reasons of health insurance appearance are searched. Periodic classification of medical insurance history in the USA is done.

Keywords: medical insurance, history, USA, periods.

Raising of problem. One of society prosperity signs is the state ability to provide citizens health with medicine care. A state health protection supposes identical, but not always sufficient medical services for all social groups. Opposite to free state medicine are voluntarily, obligatory medical insurance and paying medicine. In spite of the fact that Constitution of Ukraine declares free medicine for the Ukrainian citizens, the tendencies of requiring payment medicine have more and more predominating character. Therefore experience of development of medicine insurance institute abroad has the special actuality for Ukrainian legislators. This way the answers may also be found from looking behind through the history of the U.S. medical insurance system.

Analysis of the last researches and selection of unsolved problems. The problem of medicine insurance was reflected in works of E.Filimonova, M. Golovina, L. Lebedeva, N. Shvedova, V. Sherbakov etc. It also was researched abroad in US: Kala Swartz Ladenheim, Katherine Scofea, Laura A. Reed, Louis S. Thomasson, Melissa Murray and many others. But the selection of historical periods and reasons of medicine insurance foundation in USA are still remain unresearched.

Exposition of basic material. The American life insurance system was established in the mid-1700s. The earliest forms of health insurance, however, did not emerge until 1850, when the Franklin Health Assurance Company of Massachusetts began providing accident insurance, to cover injuries related to railroad and steamboat travel. From this, sickness insurance covering all kinds of illnesses and injuries soon evolved, but the first modern health insurance plans were not formed until 1930 [1].

The first of what could be called individual "health" insurance plans became available in the United States during the Civil War. The plans were accident insurance providing coverage for injury related to travel by railroad or steamboat. Massachusetts Health Insurance of Boston offered early group policies with a relatively comprehensive list of benefits as early as 1847. Individual accident insurance proved a successful venture, so these kinds of early plans began to evolve into more expansive programs that covered a broader range of illness and injury, including early versions of disability coverage by the end of the nineteenth century. In the early years of the twentieth century, groups began developing relationships with health care providers to develop what would become the predecessors to modern health insurance plans, or fee-based contracts [2].

Health insurance is a term that relates to a contract wherein the individual contributes a regular premium with the expectation that should something happen, the insurer will provide for the individual in question. The term dates to the Progressive Era in the United States, where the debate was already well underway regarding the role of the government in health care. Though health insurance in America has its origins in a related system called "sickness insurance," it was really when the British passed their National Insurance Act in 1911 using the term "health insurance" that the term fell into favor. [3].

By the early twentieth century , the American Medical Association (AMA), which has its

roots in the nineteenth century, began creating licensing standards and better standards for medical training in higher education en route to developing medical specializations—advancements that without question have prolonged life spans and increased life expectancy, but at ever-increasing costs. Medical expense insurance, in other words, supplemented what patients previously had to pay up front entirely out of their available income [4].

Sickness insurance tended to provide supplementary income on par with modern disability insurance, and was more favorable through the 1910s since at the time wages lost from missing work were far in excess of the cost of health care, which was still scattered and much less relied upon than today. Instead, the reasonably clear concept of a "sickness fund" – a kind of health insurance that stepped in to dampen the effects of financial shock suffered as a result of missing work – was often "sufficiently competent and fair in their delivery of financial and...medical assistance [5].

In the first quarter of the twentieth century, then, health insurance was little used and, for that matter, remained little needed. To put it bluntly, "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" [6]. As medicine became more advanced with respect to scientific discoveries of the era, treatment gradually moved out of the home and into health centers, particularly with respect to increased understanding of germs and procedural antisepsis. Though surgery continued to be conducted in private homes into the 1920s, the identification of infection-causing bacteria and communicable disease combined with a better understanding of the body's immune system to drive down surgery fatality rates [6].

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 [6].

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 benefited 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 [7, 5].

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" [8, 14].

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". 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) [9, 82].

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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 [10, 5].

Further defeats of nationalized health insurance in the Fifties and Sixties culminated in 1965, when Congress enacted Medicare and Medicaid. Medicare provided compulsory hospital insurance for people over the age of 65, as well as subsidized medical insurance, while Medicaid provided care for low-income people, though the federal-state program varied across state lines according to each state's relative per-capita income. Both programs have grown immensely, though critics of Medicare show that physicians were still able to price discriminate and, since doctors were permitted to bill patients directly, patients were reimbursed only what the program would pay and had to make up the difference. Medicaid expanded eligibility in the 1990s, but still had significant limitations in coverage [6].

By the 1970s, the United States federal government took an interest in learning more about uninsured Americans. They found that the majority of the uninsured lived in poverty or near the poverty line, and many of those were children. The decision to create child-specific health programs and expand Medicaid has enjoyed some success, and yet the number of uninsured Americans still rose, including at a greater rate in the middle class [11].

In 1996, Congress passed two bills that demonstrated the federal government's recommitment to regulate the health insurance industry. The Mental Health Parity Act was a boost to psychiatric benefits, while the Health Insurance Portability and Accountability Act (HIPAA) brought about important medical legislation, including helping employees maintain insurance between jobs, if they became self-employed, or were otherwise separated from the employer-packaged managed health care plan. Though the HIPAA is by no means a major health reform, it has "far-reaching implications...because it creates a statutory framework for the federal government to use in collaborating with state governments to regulate insurance markets, setting the stage for future mandates" [12].

The bill came three years after Congress rejected President Bill Clinton's plan that would have provided health insurance for all Americans, and was modest compared to Congressional proposals in 1994 to reach a compromise in reforming health care. Nevertheless, the HIPAA allowed the federal government to join states in oversight and regulation, a role some lawmakers continue to reject and others are still pursuing.

Today, the Children's Health Insurance Program (CHIP), which dates to 1997, helps provide insurance to low-income children, and new measures to provide greater quality and comprehensiveness in consumer-directed health care have emerged. But the debate challenges further evolution or reform as partisan politics confront the health insurance question, from what should be covered to whom should be covered [6].

Conclusion. So, the analyzed history of USA health insurance gives the right to say that it has five main history periods:

1. The establishment of life insurance system;
2. providin accident insurance;
3. sickness and pre-paid insurance;
4. ten principles of AMA;
5. enaction of Medicare and Medicaid.

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Озернюк Г.В. Історичні періоди розвитку медичного страхування в США.

Анотація. Дослідження присвячено медичному страхуванню в США. Досліджені причини виникнення медичного страхування. Проведена класифікація історичних періодів розвитку медичного страхування в США.

Ключові слова: медичне страхування, історія, США, періоди.

Озернюк А.В. Исторические периоды развития медицинского страхования в США.

Аннотация. Исследование посвящено медицинскому страхованию в США. Исследованы причины появления медицинского страхования. Проведена классификация исторических периодов развития медицинского страхования в США.

Ключевые слова: медицинское страхование, история, США, периоды.