Becoming an outstanding physician requires more than just empathy, education, good communication skills and sound clinical judgment. It also demands insight into how health care is financed so you can understand and adapt to the challenges patients face in accessing care and ensure you get compensated fairly for your work.

Content related to health systems science—an understanding of how care is delivered, how health professionals work together to deliver that care, and how the health system can improve patient care and health care delivery—has become more frequent on the United States Medical Licensing Examination (USMLE). The National Board of Medical Examiners includes the topics in its USMLE Content Outline and offers a dedicated health systems science subject examination.

To help medical students, the AMA Accelerating Change in Medical Education Consortium has collaborated with the “InsideTheBoards” podcast to create a health systems science (HSS) podcast series. Each episode of the HSS series offers on-the-go learning by breaking down practice exam questions with expert guests.

A recent episode features a conversation with a physician and a medical student about health care economics, focusing on the history of health insurance in the U.S. and its implications for patients and physicians.

How we got here

More Americans get their health insurance through employer-based plans than any other source, yet most probably have no idea why this is.

“Prior to World War II, only a fraction of health insurance was provided through employers,” said Richard Lu, a third-year medical student at Harvard Medical School.
But with the war came inflation, and after Congress passed the Stabilization Act of 1942, the president froze wages and salaries for all workers. In lieu of higher salaries, employers began offering health insurance as a fringe benefit to attract and retain employees.

“After the wage freezes, that number skyrocketed and it became entrenched in a path-dependent kind of way, where insurance became something that people worked for,” Lu said. “And this idea—this notion of insurance as being earned through employment and provided by your employer—kind of stuck from then on.”

Other hidden features of insurance

Tying insurance to employment presents obvious obstacles to ensuring everybody can see a doctor when they need to see one. But employer-based coverage—as well as some public health insurance programs, such as Medicaid, a joint federal and state program for people with limited income and resources—even has downsides for those who get it.

“My insurance is state-based,” said Ned Palmer, MD, MPH, an attending physician at Boston Children’s Hospital and Harvard Medical School. “And so as soon as I leave Massachusetts, I struggle to find health care that my insurance would cover,” meaning patients can then be on the hook for huge out-of-pocket costs if they need to access care.

But one doesn’t need to travel out of state to get hit with unaffordable out-of-pocket costs with employer-based plans. Take copays, for example.

“Twenty dollars doesn’t mean the same thing to everybody,” added Dr. Palmer, also chief strategy officer of Panacea Financial, which is a sponsor of the “InsideTheBoards” podcast. “Twenty dollars is a fixed amount, and $20 to somebody who is making a $200 a week, for instance, is very different than somebody who’s making $2,000 a week. And so … the same pricing structure ends up differentially affecting those who are lower wage and lower income. It creates a much higher barrier to entry.”

The podcast’s guests also discussed how insurers in the U.S. are shifting from fee-for-service to value-based payment and broke down the key components of physician compensation packages.

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