

HISTORY OF HEALTH INSURANCE IN THE UNITED STATES

Health insurance, as we generally think of it in the United States, began with the Great Depression in the 1930s. In this chapter, we review the history of health insurance and demonstrate how that history is linked to current health insurance developments. Predating private health insurance were efforts at government-sponsored coverage for workplace injury and a tradition of industrial sickness funds. The Great Depression led hospitals and then physicians to implement forms of insurance as means to ensure payment for services. Interestingly, conventional insurance and managed care were developed at this same time. The advent of World War II, the growth of the labor movement, and the federal tax code all fostered the growth of employer-sponsored coverage. Medicare was introduced in 1965 to provide coverage to older citizens; it mimicked the private coverage common at the time. Commercial insurers aggressively competed with others by offering lower premiums to larger employers, based on their lower claims experience. Federal preemption of state insurance laws led to dramatic growth in self-insured employer plans. The 1980s saw the development of managed care, prompted by rapidly increasing healthcare costs and the emergence of self-insured employer plans. Managed care's ability to selectively contract revolutionized healthcare markets by introducing price competition and led to a backlash against managed care. In the 2000s, healthcare costs are again rising rapidly, and efforts are under way to encourage insured individuals to pay more out-of-pocket through the use of high-deductible health plans with tax-sheltered health savings accounts. In 2010, the Patient Protection and Affordable Care Act (ACA) was enacted, which promises to substantially change the US health insurance markets.

Prehistory: Workers' Compensation and Sickness Funds

At the turn of the century in 1900, Teddy Roosevelt was president, and the United States was entering what came to be known as the Progressive Era. Roosevelt championed a series of antitrust enforcement efforts designed to reduce the influence of manufacturing, transportation, and oil firms that had

grown large during the Industrial Revolution. Women's suffrage was seriously debated. At the state level, there were efforts to shorten the workweek, limit child labor, and deal with workplace injury.

Under common law, employers were liable for injuries that occurred at their facilities if the employer was negligent. Employers had three defenses against negligence claims. First, they could argue that the worker had assumed the risk as part of the employment contract. Second, they could argue that the injury was caused by the negligent acts of a coworker rather than those of the employer. Third, they could argue that the worker was at least partially at fault. Injuries were common, and court cases seeking to determine negligence and obtain awards for damages were common. Fishback and Kantor (2000) argue that state workers' compensation laws arose because workers' rights advocates saw such reforms as a means of shifting the costs of workplace injury to the employer. Employers saw the reforms as a way to reduce the legal costs associated with negligence claims and to increase the payments to injured workers while reducing overall costs.

Between 1910 and 1915, 32 states enacted workers' compensation insurance. Under these programs, employers accepted full liability for workplace injuries and could buy insurance coverage through their state. If employers purchased workers' compensation insurance, they retained all three legal defenses against negligence. However, if they did not buy coverage, they were denied these defenses.

Organized medicine supported the workers' compensation legislation apparently under the view that injured workers would go to their family doctor for care, and the doctor would be paid by the workers' compensation fund. Instead, however, employers began to directly retain and sometimes employ physicians to provide care. This followed the model of some firm-specific clinics in the mining and lumber industries, notably in the states of Minnesota and Washington, respectively (Starr 1982). As a result, the majority of local physicians saw a reduction in the demand for their services. Those who had employer contracts did better, of course.

All of this background is relevant because it affected the design of subsequent health insurance plans. Numbers (1979) and Starr (1982) describe the political dynamics. In the period leading up to and following World War I, a number of state initiatives proposed compulsory health insurance based on the workers' compensation model. One plan, promoted by the American Association of Labor Legislation, called for coverage of all manual laborers with income of less than \$100 per month for medical bills and lost income. Compulsory contributions from the employee, the employer, and the state government would be included. Those who were not in a covered group could join voluntarily.

Between 1916 and 1919, 16 states considered such legislation; none adopted it. Employers tended to oppose this legislation because, unlike workers' compensation, it did not have any offsetting reduction in costs. Labor unions had mixed views. Samuel Gompers, the founder of the American Federation of Labor (AFL), was opposed. He believed that workers knew how to spend their money and the role of the union was to get them more money to spend. The American Medical Association (AMA) officially favored this legislation in 1915 but opposed it by 1920, arguing that the insurance interfered with the doctor–patient relationship. Indeed, the experience with workers' compensation suggested as much. Physician opposition could be intense.

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 (Numbers 1979, p. 181)

However, to assume that no private health insurance existed during this period would be a mistake. In fascinating historical research, John Murray (2007) argues that “sickness funds” had existed at least from the time of the Civil War. These funds were established by employers, unions, and fraternal organizations. Workers made weekly contributions of about one percent of their wages to the fund. When one of the fund members became too ill or injured to work, the fund would provide him with cash, often 60 percent of his wages. One might think of this coverage as similar to the Aflac indemnity coverage (with the duck) that one often sees advertised at sporting events today. The first survey by the federal government estimated that nearly 1,300 such nonfraternal funds existed in 1890. By the progressive period, Murray (2007) estimates that 20 percent of industrial workers were members of a sickness fund. Even though the sickness funds did not provide health insurance per se, Murray argues that satisfaction with these plans is an underappreciated reason why the early compulsory health insurance initiatives failed so completely.

Blue Cross

The Great Depression began in October 1929 and, as fans of the classic movie *Ferris Bueller's Day Off* well know, it was caused by escalating international

Dealing with Fundamental Insurance Challenges

As we will see in subsequent chapters, two fundamental challenges facing insurers are “adverse selection” and “moral hazard.” The former implies that sicker people will try to join insurance plans designed for healthier people. The latter, that once obtaining coverage, people will have incentives to “be sick” and use the benefits. The early sickness funds faced these same problems. They dealt with the adverse selection problem by establishing age limits, requiring medical examinations, and applying waiting periods before members could join the plan or collect benefits. They dealt with the moral hazard problem by having a committee of fellow fund members visit the sick or injured member to determine if he was sick enough to collect. One typically also had to be sick for a few days before the benefits would begin. The fundamental challenges are enduring.

rounds of tariff increases that reduced worldwide demand for goods and services. In the United States, the Hawley-Smoot Tariff raised import taxes on agricultural commodities to 49 percent. Students of Friedman and Schwartz (1963) will also know that an extraordinarily tight money supply leading to the collapse of the banking sector was the other major cause.

Local hospitals were affected by the Depression like other firms. Ronald Numbers (1979) reported that between 1929 and 1930 Baylor University Hospital, then in Dallas, Texas, saw its receipts drop from \$236 to \$59 per patient. Occupancy rates dropped from 71.3 to 64.1 percent, and contributions were down by two-thirds. Charity care, in contrast, was up 400 percent.

Justin Kimble, the administrator of Baylor University Hospital, devised a means for people to pay for hospital care. He enrolled 1,250 Dallas public school teachers into the Baylor Plan. For 50 cents a month, he promised to provide 21 days of care in his hospital. Because of AMA opposition to insurance plans, the plan only covered the hospital, not physicians' services.

The model spread to other hospitals. In 1932 a plan was established in Sacramento, California. However, unlike the Baylor plan, which covered services at only a single hospital, the Sacramento plan covered services at any hospital in the community. By 1933, 26 such “hospital service plans” were in operation.

Local hospitals turned to their trade association to provide guidance in establishing hospital service plans, so called because the participating hospitals agreed to provide the services regardless of reimbursement from the

plan. The American Hospital Association (AHA) established its Committee on Hospital Service in 1933 and began approving plans. This committee became the AHA Hospital Service Plan Commission in 1936 and the AHA Blue Cross Commission in 1946. The criteria for approval included that the plans were nonprofit, were designed to improve public welfare, had dignified promotion, covered hospital charges only, and allowed for a free choice of physicians (MacIntyre 1962). In 1937 the AHA added an additional criterion—no competition among plans. This meant that the Blue Cross Commission granted exclusive geographic market areas to each approved plan. Even today, each nonprofit Blue Cross plan has an exclusive market area.

In today's terms, we might think of the original Baylor single-hospital plan as a preferred provider organization. Subscribers had hospital coverage but only if they used the single hospital in the network. This gave consumers a financial incentive to choose one hospital over another. In fact, other hospitals in the Dallas area soon developed their own hospital service benefit plans (Starr 1982). In contrast, the all-hospital plans did not pit one local hospital against another, which meant that patients benefited little financially from shopping for inpatient services among hospitals.

Single-hospital plans resulted in: "... competition among hospitals and interference with the subscriber's freedom of choice and physician's prerogatives in the care of patients."

—Rufus Rorem, director of the
AHA Blue Cross Commission (Starr 1982, p. 297)

Most states viewed the new hospital service plans as the prepayment of hospital services, rather than as insurance. In 1933, however, the New York state insurance commissioner determined that the plans should be viewed as insurance. The logic was clear. The plans collected payments in advance and promised to provide care at some future date, not unlike life or casualty insurance. The upshot of this ruling was that the new health plans were required to comply with existing insurance laws; particularly, they had to have reserves to meet future claims. 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. The state legislature was called on to resolve the dispute, and it created special enabling legislation that specified that these service benefit plans—that is, these Blue Cross plans—would be nonprofit and exempt from 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. By 1939, 25 states had such enabling legislation.

Today Blue Cross (and Blue Shield) plans exist in most states under enabling legislation. This is why they sometimes must go to the state legislature to add a line of business, such as life insurance, or to convert from nonprofit to for-profit status.

Blue Shield

The development of Blue Shield plans mirrors that of Blue Cross. The first medical service plan, analogous to the hospital services plans, was the California Physicians' Service, established in 1939. The plans had two key features. First, they required free choice of physician, and second, they were indemnity rather than service benefit plans. This meant that the plans paid the patient a dollar amount for each covered event; the patient, in turn, was responsible for paying the physician. This is much like the Aflac plans of today. The AMA began approving plans in 1939 and followed the model established by the hospitals with Blue Cross.

As the Depression continued, physicians became more tolerant of hospital insurance: "Hospital services plans reduce for the patient any financial worry which so frequently retards recovery. Nor is it too crass to take cognizance of the fact that the patient without a hospital bill to pay can more readily meet the expense of medical fees."

—Carl Vohs, physician at AMA convention
in 1937 (Cunningham and Cunningham 1997, p. 34)

Commercial Insurance

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. The problem with offering a policy that paid when one was sick was that everyone had an incentive to declare herself sick once she had coverage. When the hospital service plans became popular, the commercial insurers found a way to resolve the problem. They didn't offer health insurance; they offered hospitalization coverage. An admission to a hospital was a definite event, determined by a physician. In 1934 commercial carriers began offering hospital coverage. Initially, they did not provide physician coverage, but they did offer *surgical* coverage, beginning in 1938, because surgeries were definite events. Both types of plans provided

indemnity coverage. This made the loss in a covered event measurable, based on the schedule of agreed payments per event. The indemnity coverage also avoided provider concerns that the insurer would contract directly with selected hospitals and physicians.

Prepaid Group Practice

Prepaid group practice was the forerunner of managed care. Similar to Blue Cross, these plans began in 1929 in response to the Great Depression. Kessel (1959) provides a vivid discussion of the early history. The Ross-Loos Clinic in Los Angeles was among the first prepaid group practices, although some earlier plans existed in Minnesota and Washington, and as early as 1905 and 1909, respectively (MacIntyre 1962). The clinic provided prepaid care to the 2,000 workers and their families of the Los Angeles Department of Water and Power. The department contracted with the clinic to provide employees with comprehensive care. In response to this action, the founders of the Ross-Loos Clinic were expelled from the county medical society. This penalty was serious because hospital bylaws required medical staff members to be members in good standing of the local medical society. Lack of medical society membership meant that hospital access was denied.

Such physician opposition to prepaid group practice was common. Dr. Michael Shadid and the Elk Grove, Oklahoma, Farmers Union created a prepaid health plan enrolling 6,000 residents of Elk Grove for \$50 per year. The state medical society opposed the plan, attempted to deprive Shadid of his license to practice, expelled him from the medical society, and kept other physicians who were willing to practice with him out of Oklahoma through licensure denials.

In 1933, Dr. Sidney Garfield established the Kaiser Foundation Health Plan in California. He was charged with unprofessional conduct, and the state board of medical examiners suspended his license to practice. This ruling was overturned by the courts. Similar actions were directed against group practice plans in Milwaukee, Chicago, and Seattle. Plan physicians were denied membership in their local medical societies and denied access to hospitals.

As a result of being denied access to hospitals, the early prepaid plans were forced to build and use their own hospitals. Today's health maintenance organizations (HMOs) that own their own hospitals, plans such as Kaiser-Permanente and Group Health Cooperative of Puget Sound, may continue to operate their own facilities for reasons of control and efficiency, but originally they did so because it was the only means of obtaining ongoing access to hospitals.

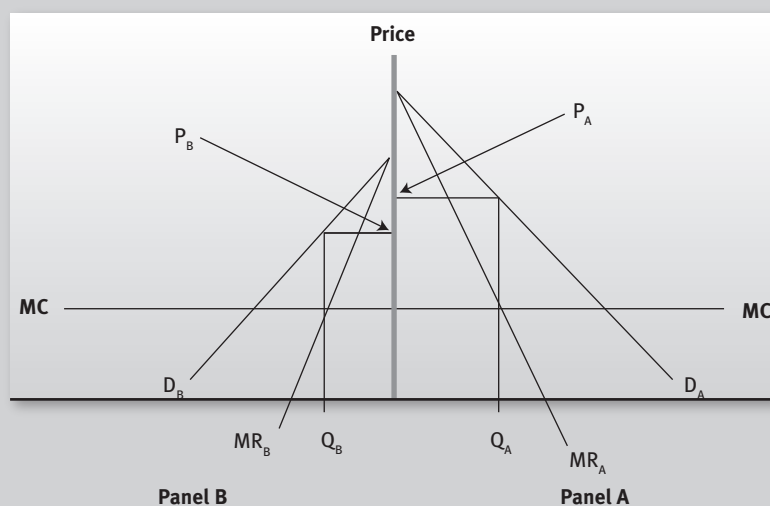
In 1937, Group Health Cooperative in Washington, DC, was a non-profit cooperative of Federal Home Loan Bank employees. It had salaried physicians. The AMA and the local medical society engaged in reprisals against

participating physicians, prevented consultations and referrals, and persuaded all hospitals to refuse privileges. In 1938, the Justice Department charged the AMA under the Sherman Antitrust Act. The Supreme Court held against the AMA in 1943. Opposition continued, however. Group Health Cooperative filed an antitrust suit against the King County (Washington) medical society and won a state supreme court decision in 1951 (McCaffree and McCaffree 2001). As late as 1959, Kaiser physicians were still excluded from the San Francisco Medical Society (Kessel 1959).

Why Was Medicine So Opposed to Prepaid Group Practice?

Reuben Kessel (1959) argues that the opposition to prepaid group practice stemmed from the threat such plans posed to physicians' incomes. At that time, physicians used a sliding fee schedule to charge patients. Patients with a greater ability to pay were charged a higher price, and those with fewer resources paid less. Physicians argued that this mechanism provided care to those who could not afford to pay. While this may have been true, Kessel argues that it was simple price discrimination designed to maximize profits. Prepaid practice posed a threat because it could undercut the price paid by higher-income patients, thereby taking away substantial profits.

EXHIBIT 1.1
Economics
of Price
Discrimination



(continued)

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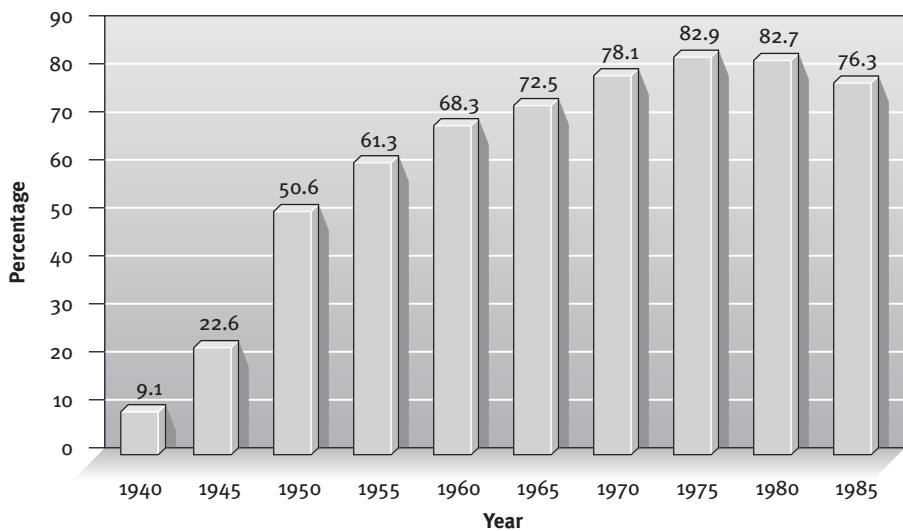
More formally, see Exhibit 1.1, a Janus diagram with two back-to-back physician service market diagrams. To keep the graphics simple, assume the marginal cost (MC) of physician services is constant and identical in each market—thus, the horizontal MC curve. Panel A is the more affluent market, characterized by a greater willingness to pay and a more inelastic demand curve D_A . The marginal revenue associated with these patients is MR_A . The profit-maximizing price charged to them is P_A . Panel B reflects a less-affluent market. Here, too, profit maximization requires setting marginal revenue (MR_B in this case) equal to MC and selling that quantity in the less-affluent market at price P_B . The advent of a prepaid group practice would disproportionately attract people from Panel A, who have more to save financially by leaving their current doctor and joining the new group practice plan. Physicians might argue (and did) that they had patients who couldn't even afford to pay a price equal to MC and that the physicians, nonetheless, provided the patients with care, incurring a loss on each. Regardless of the veracity of these claims, the people in Panel A (as well as those in Panel B, as drawn here) were paying more than the cost of care, and these are the people who were most likely to abandon their physicians for the prepaid plan. Thus, regardless of whether the physicians spent their profits on themselves or on the poor, prepaid group practice posed a serious threat.

Early Growth of Health Insurance: The 1940s and 1950s

Private health insurance grew rapidly during the 1940s and 1950s, but obtaining accurate measures of the extent of coverage is difficult. Exhibit 1.2 shows the percentage of the US population with some sort of health insurance coverage from 1940 through 1985. Only 9 percent of the population had insurance on the eve of World War II. That percentage had more than doubled to nearly 23 percent by the end of the war. It more than doubled again by 1950 and was close to 70 percent by 1960.

Three reasons are usually given for this rapid growth. The first is the imposition of wage and price controls during World War II. The United States entered the war in December 1941. As men volunteered and were drafted into the armed forces, the domestic economy was stressed by increased demand for war material. Through its National War Labor Board, the Franklin Roosevelt administration set wages in each industry, beginning in 1942. Firms, competing for labor, attracted many women into the labor

EXHIBIT 1.2
Percentage
of US Popu-
lation with
Some Form of
Private Health
Insurance,
1940–1985



market for the first time. In addition, the Labor Board determined that health insurance was not to be considered a wage. This meant that one way firms could compete for scarce labor was to offer health insurance to their employees.

A second reason for the rapid growth in health insurance was the expansion of organized labor over this period. Union influence on health insurance stemmed in part from the 1947 Taft-Hartley Act, which defined health insurance as a condition of employment and, therefore, a subject for collective bargaining.

The third reason for the rapid growth in health insurance was the treatment of health insurance in the federal tax code. The tax code was actually silent on whether employer-sponsored health insurance was to be considered income subject to federal income taxation. As Thomasson (2003) notes, in 1943 the Internal Revenue Service issued a private ruling holding that employer-provided health insurance benefits were not subject to federal income taxation. Contradictory and inconsistent private rulings emerged over the 1940s and early 1950s, prompting Congress to enact legislation in 1954 that exempted employer-sponsored health insurance from federal income taxation. As we discuss in later chapters, this tax exclusion is a key reason why the US health insurance market looks the way it does. The tax code effectively encourages employees and their employers to shift compensation toward untaxed health insurance and away from taxed money income. This tax subsidy is a big deal. The Congressional Budget Office (2013a) estimates that the federal tax subsidy alone amounted to \$248 billion in 2013. To put this in context, Medicare spending for inpatient and outpatient hospital services in 2012 was only slightly less. In the insurance industry, the

1940s and 1950s saw the AHA's Blue Cross Commission spun off from the AHA and the creation of the Blue Cross Association in 1960; it merged with the Blue Shield Association in 1977 to form the Blue Cross and Blue Shield Association (Cunningham and Cunningham 1997). Heretofore, Blue Cross and Blue Shield plans had dominated the health insurance markets; however, in the 1950s, commercial insurers became much more formidable players and consistently had more total subscribers than did the Blue Cross and Blue Shield plans after 1954 (Health Insurance Association of America 1990).

The 1960s and 1970s

The insurance functions of Blue Cross and Blue Shield plans were pretty simple in their early years. The plans engaged in community rating, which meant that all of the subscribers of a plan were in one large risk pool. Premiums were determined essentially by projecting the growth of claims and dividing by the number of subscribers. Commercial insurers began to challenge this in the 1950s through experience rating, and by the 1960s, experience rating had driven out community rating.

Suppose an insurer is able to identify a group of people who are reasonably healthy and, therefore, low utilizers of care, relative to others. Teachers or bank employees may be good examples. The insurer could approach these groups and promise them an insurance premium that reflected their likely lower claims experience. This is experience rating. While community-rated plans, such as Blue Cross, include low-, medium-, and high-cost subscribers, the experience-rated plan disproportionately includes low-cost subscribers. As a result, it can provide the same coverage at a lower premium and still make money. Moreover, the community-rated plan will experience cost increases simply because it loses its low-cost subscribers.

We fought tooth and nail. To the last gasp. But then you get to the point where unions are pulling out because they know damn well their experience is better. We would have lost the telephone company. We would have lost the gas company. We would have lost—we did lose—the state employees, 30,000 of them, because we were not experience rating.

—William McNary, CEO, Blue Cross of Michigan (Cunningham and Cunningham 1997, p. 100)

This was the commercial insurers' approach. They offered lower premiums to groups with low claims experience. Blue Cross and Blue Shield

were forced to switch from community rating or face a future in which they were the insurer of only the highest-cost subscribers. In the 1960s, the last Blue Cross plan gave up community rating.

Development of Medicare and Medicaid

When the Franklin Roosevelt administration and the 74th Congress enacted Social Security in 1935, the program did not include any health insurance provisions. This was in part because of the strong physician opposition to government-sponsored health insurance that had emerged during the progressive era and which still remained strong.

As World War II wound down, the Truman administration turned to domestic issues and in September 1945 began working on a national health insurance plan that would provide insurance coverage to all Americans. This proposal was similar to bills submitted during the war that never emerged from committees in Congress. The coverage was to be paid for by a tax of 4 percent on the first \$3,600 of wages and salaries. Truman argued that this plan was not socialized medicine because people could choose their own doctors and hospitals, and providers did not work for the government. This stance did not dissuade physician opposition. Instead, the AMA and the AHA supported the legislation proposed by Senators Lister Hill (D-AL) and Harold Burton (R-OH). The Hill-Burton Act, when passed in 1946, resulted in substantial subsidized hospital and nursing home construction over the next 25 years (Hamilton 1987).

Advocates of a national insurance plan continued their efforts, but much of their attention was redirected to obtaining medical care for the elderly. During the mid-1950s, proposals were advanced for hospital and nursing home insurance coverage for the elderly. However, these bills never got out of committee, largely because of opposition by Wilbur Mills (D-AR), the powerful chair of the House Ways and Means Committee, and Senator Robert Kerr (D-OK), who were concerned that rapidly rising medical costs, if tied to Social Security, would lead to substantially higher payroll taxes and undermine the Social Security program. Instead, they proposed and the Congress passed the Kerr-Mills Act in 1960, which provided federal funding to states to assist in the provision of medical care for seniors receiving welfare benefits (Rettenmaier and Saving 2000).

The Lyndon Johnson presidential landslide victory over Barry Goldwater in 1964 brought in large Democratic majorities in both houses of Congress, with Democratic candidates calling for enactment of health insurance for the elderly. Paul Feldstein (1988) argues that the prime movers in the push for Medicare, as we have come to know it, were the unions. He contends that the large industrial unions wanted a program based on Social Security eligibility and funded by payroll taxes rather than income taxes.

Eligibility based on Social Security participation, rather than a low-income standard of eligibility, meant that high-income union members would be eligible. The payroll tax meant that the costs would be disproportionately borne by lower income, nonunion, workers. The fact that many healthcare costs would be paid by the government program rather than employer insurance plans meant that wages for workers could be negotiated upward. (See Chapter 14 on compensating differentials.) The AHA supported this view because the elderly had higher healthcare costs than others. The community-rated hospital insurance plans that Blue Cross still embraced in the face of growing experience rating by commercial insurers meant that these high-cost patients were disproportionately in the Blue Cross plans. The younger, lower-cost enrollees were disproportionately in the commercial insurer plans. Thus, Medicare would become responsible for the high-cost Blue Cross enrollees.

Republican opponents of this approach, led by John Byrnes (R-WI), instead argued for a voluntary program that was need-based, with financing coming from general tax revenues and a premium paid by seniors. This plan included physician and drug coverage as well as hospital and nursing home care. The AMA, in contrast, pushed its Eldercare model, which was an expansion of Kerr-Mills for seniors. This proposal expanded federal support for state medical assistance to low-income seniors (Cunningham and Cunningham 1997).

Cunningham and Cunningham (1997) describe the final bill as the “three-layer cake” crafted by Representative Mills in the Ways and Means Committee. It had elements of all three main proposals. The union–AHA-supported bill became Medicare Part A, with hospital and limited nursing home coverage tied to Social Security eligibility and funded by increases in payroll taxes. The Republican Byrnes proposal focusing exclusively on physician and ambulatory services became the voluntary Medicare Part B program, funded by general tax revenues and premiums on seniors. The AMA’s Eldercare proposal was expanded beyond the elderly to provide coverage for a number of low-income populations and funded as the federal–state matching Medicaid program. The House passed the full bill 315 to 115, and after further debate and amendments, the Senate passed it by a 68 to 21 vote margin. President Johnson signed the legislation in former President Truman’s hometown of Independence, Missouri, in July 1965.

ERISA and the Growth of Regulation

The key health insurance event of the 1970s was triggered in December 1963, when the Studebaker Corporation closed its US automobile plant in South Bend, Indiana, and left an underfunded pension plan. Congress responded to this and other pension concerns in 1974 with the Employee Retirement Income Security Act (ERISA). This large piece of legislation was

designed to protect defined-benefit pension plans. It did this largely by providing tax incentives to encourage employers to prefund their pension plans and by requiring participating pension plans to contribute to a government-affiliated reinsurance fund (the Pension Benefit Guarantee Corporation) to bail out future pension plan defaults. The legislation also included a relative handful of provisions dealing with “welfare plans”—that is, health insurance plans.

Employer health insurance plans that were self-insured under the terms of ERISA were subject to the federal ERISA statute and not subject to state insurance regulation. Large employers had argued that they often had plants in several states and that trying to provide consistent and uniform coverage was made difficult by the differing insurance regulations that the states imposed. Moreover, efforts to self-insure their workers were hampered by state insurance regulations that were not designed for such efforts. Under ERISA, self-insured plans were not subject to state insurance regulations dealing with reserves or coverage requirements, and they were not subject to state premium taxes.

ERISA resulted in a quiet revolution in the health insurance industry. Heretofore, large firms were usually experience-rated through an insurer. This meant, in essence, that a firm was responsible for its own claims experience and paid the insurer to administer the plan. If such a plan was “fully credible,” meaning that its premiums were based solely on its own claims experience, the move to self-insurance was a no-brainer. The firm bore the same claims risk, but now it could shop for a less costly claims administrator, or it could undertake those activities itself and, in the process, avoid state premium taxes of 2 to 4 percent. Moreover, somewhat smaller firms could incur the claims risk over some range of losses and buy stop-loss coverage for big individual claims or for aggregate claims that exceeded some threshold. Medium-sized and even small firms could be self-insured.

These events happened at the same time that mainframe computer processing was rapidly dropping in price. In the 1960s, large conventional insurers had comparative advantages in both bearing claims risk and in claims processing. They lost both in the 1970s. ERISA meant that there was potential entry into the risk-bearing segment of the business. Efforts to extract more than competitive returns from this segment would lead to the entry of many self-insured employers providing their own coverage. The advent of low-cost mainframe computing meant that the claims-processing segment was also competitive. If the large insurers attempted to charge more than competitive processing fees, new providers would appear and undercut them. Indeed, a new industry emerged—third-party administrators (TPAs) that handled the claims processing of self-insured firms. Insurers opened new lines of business as well, such as ASOs (administrative services only).

Through these lines, they also provided claims-processing services to self-insured firms. By 2011, 57 percent of insured workers were in a self-insured plan (KFF HRET 2012).

Ironically, ERISA also spurred more state insurance regulation. Prior to 1974, virtually no state insurance coverage mandates existed (Jensen and Morrissey 1999a). However, by the close of 2011, more than 2,200 individual insurance mandates existed (Council for Affordable Health Insurance 2012). Providers and concerned citizens often ask the state legislature to require insurance companies operating in the state to include specific coverage. They may, for example, demand that in vitro fertilization be covered like other procedures. In the period prior to ERISA, proponents of such legislation faced opposition, typically from large employers. However, after ERISA, larger employers were unaffected by such laws, and the legislative scale tipped toward the proponents.

The 1980s, 1990s, 2000s, and 2010s

Managed Care and Selective Contracting

The 1980s saw rapid increases in health insurance premiums, driven by new medical technology and cost-based reimbursement systems used by insurers and the Medicare program. In 1983, Congress changed the way Medicare paid hospitals. Rather than paying based on allowable costs, the new system introduced prospective payments, in which hospitals were paid a fixed price based on the diagnosis of admitted patients.

At about the same time, and for the same reasons, the private health insurance industry was changing as well. Prepaid group practice plans, now called HMOs, began to enroll more subscribers, and new forms of managed care, preferred provider organizations (PPOs), and point-of-service (POS) plans were developing.

Managed care plans take three general forms. The first are HMOs. These are insurance companies, meaning that they bear claims or underwriting risk. Similar to a conventional insurance plan, they are responsible for the cost of covered medical care provided to a subscriber. If these costs exceed the premium collected, the plans are still obligated to provide the care. A conventional insurance plan typically allows the policyholder to receive care from any licensed provider. In contrast, an HMO has a panel of providers, and the HMO is only responsible for the cost of the care from these providers.

Traditionally, HMOs have had four models. Staff model HMOs hire their physicians and usually own their own hospitals. The original Group Health Cooperative in Seattle is an example of a staff model HMO. Such

models are rare. Group models are somewhat more common. In this form, the HMO-insurer contracts with a single physician group that provides all the clinical services rendered to the HMO subscribers and typically provides care only to the HMO's subscribers. Kaiser-Permanente is the classic example of a group model—Kaiser is the health insurer, and it contracts exclusively with the Permanente medical group. Third is the network model HMO. In this case, the HMO-insurer contracts with several physician groups in the local market. Each physician group sees a significant number of the HMO's subscribers, but the groups also see patients from other insurers. Network model HMOs are the most common. The fourth HMO model is the independent practice association. This model emerged as a response by local medical societies to the growth of HMOs. Under this model, the HMO-insurer provides services through a large panel of physicians throughout the community. These community physicians typically only see a small number of the HMO's subscribers.

Note that none of this discussion has focused on the form of physician payment. At one time, it was argued that physicians in HMOs were salaried employees or that they were capitated—that is, paid a monthly fee per patient. In fact, the payment arrangements between the HMO-insurer and the participating physicians vary enormously.

PPOs were developed in the 1980s, partly in response to ERISA and the shift to self-insured, employer-sponsored health plans. PPOs are often not health insurers because they frequently do not bear underwriting risk. Instead, they are coordinators of contracts. In principle, a PPO is easy to establish. One approaches a local hospital and negotiates a price below hospital billed charges in exchange for encouraging (future) subscribers to use this hospital. One similarly obtains agreements from physicians who have privileges at this hospital. These hospitals and physicians are “preferred providers.” One then goes to self-insured employers and asks them if they would like to pay less for hospital and physician services. They, of course, would like to do so. The employers agree to allow their employees to use the preferred providers for a smaller out-of-pocket payment per visit than is required for other providers. One then executes a contract between the employer and the participating providers and manages the set of contracts for a per-member-per-month fee. This structure is typical of PPOs.

Many insurers, of course, also offer a PPO product. In some cases, these products are simply contracting vehicles, and the insurers bear no underwriting risk. In other cases, the PPO may bear such risk as it contracts with networks of providers and sells coverage to employer groups and individuals.

POS plans are hybrids of HMOs and PPOs. HMOs observed that people seem to prefer choice, and PPOs allow their members a wider choice

of providers. HMOs responded by creating new plans that allow their members to use nonpanel providers if the members are willing to pay more out-of-pocket per visit. The members can decide at each “point of service” whether they wish to use a panel provider or nonpanel provider. PPOs observed that HMOs tended to assign each member to a primary care provider, who provided continuity of care and who had to approve referrals to specialists. They responded to HMOs by establishing plans in which their members had assigned primary care gatekeepers. These, too, are called POS plans. In the 1980s and 1990s many insurers offered conventional coverage as well as all three forms of managed care plans. Today, conventional coverage has almost disappeared.

Exhibit 1.3 shows the growth in managed care and the commensurate shrinkage of conventional insurers. As recently as 1988, conventional insurers held a commanding share of these workers—71 percent. By 2012, conventional plans only enrolled less than 1 percent of insured workers. PPOs enrolled only 11 percent of insured workers in 1988 and had 56 percent by 2012. HMO and POS enrollment peaked in about 2000 and has declined since. As discussed later in the chapter, high-deductible health plans (HDHPs) emerged in the mid-2000s. These plans are often combined with a tax-sheltered health savings account. They first appeared in national surveys in 2006 with 4 percent of the insured workforce; by 2012 they enrolled 19 percent (KFF and HRET 2012).

The 1980s through to the present day have been a roller coaster of successes and failures for managed care and private health insurance more generally. Much of this tumult can be summarized by examining the trends in health insurance premiums over the period. Exhibit 1.4 tells the story. In the late 1980s, premiums for employer-sponsored health insurance were increasing at 18 percent per year, much faster than general inflation. The rates of increase declined precipitously over the first half of the 1990s, so much so that, by 1996, premium increases were virtually nonexistent and well below

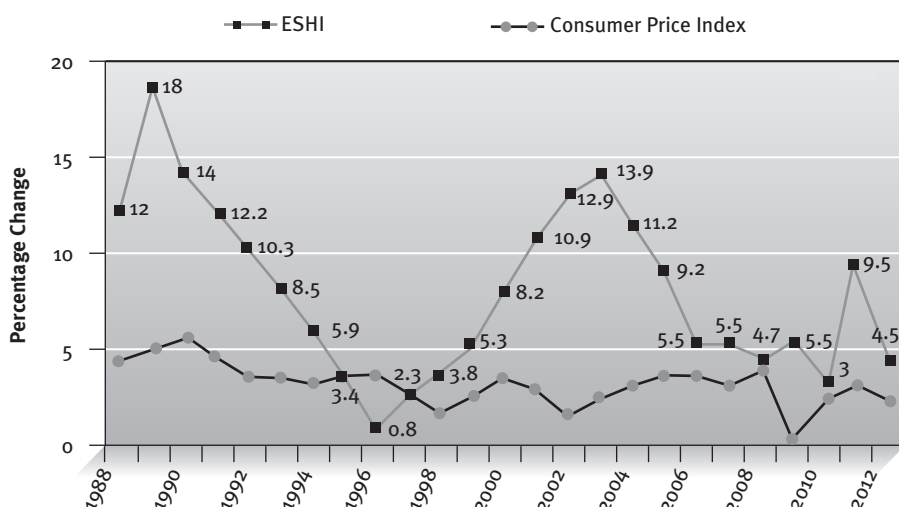
EXHIBIT 1.3
Percentage
of Insured
Workers by
Type of Plan

	1988	1998	2008	2012
Conventional	71	14	2	<1
HMO	18	30	20	16
PPO	11	34	58	56
POS	--	22	12	9
HDHP	--	--	8	19

SOURCE: Data from KFF and HRET (2012).

EXHIBIT 1.4

Percentage Increase in Employer-Sponsored Health Insurance Premiums



SOURCE: Data from Gabel et al. (2005), KFF and HRET (2012).

inflation. In real terms, health insurance premiums had declined. Premiums began to increase again in the latter half of the 1990s and peaked in 2003. However, they were still increasing at about 7.7 percent in 2006, then leveling off at a growth rate of about 5 percent through the remainder of the decade (Gabel et al. 2005; KFF and HRET 2012).

What happened? As we discuss in considerable depth later in the book, the first half of the 1990s can be characterized as the success of selective contracting by managed care plans. By entering into contracts with only some providers in a local market, the plans were able to negotiate lower prices. When there were more hospitals, for example, HMOs and PPOs were able to get lower prices. Two things happened subsequently, and their relative importance has yet to be fully identified.

First, providers began to consolidate. A handful of hospitals closed; many more joined hospital systems. Bob Town and colleagues (2005) note that between 1990 and 2000, 100 or more hospital mergers occurred in eight of those 11 years. Physicians joined somewhat larger medical groups but also entered into joint marketing arrangements. These actions arguably had the effect of reducing competition in local provider markets and reducing the ability of managed care plans to negotiate lower prices. Indeed, the federal government has obtained court decisions breaking up some physician marketing arrangements and has continued to challenge hospital mergers. In 2004 the Federal Trade Commission and the Department of Justice jointly issued the report *Improving Healthcare: A Dose of Competition*.

In the past year, the Commission has reached settlement with five groups of physicians for allegedly colluding to raise consumers' costs. . . . The alleged conduct I have described is naked price fixing, plain and simple.

—Timothy J. Muris, Chairman, Federal Trade Commission,
Chicago, November 7, 2002

Second, providers and consumers precipitated a backlash against managed care plans. In addition to selective contracting, managed care plans have used a variety of utilization management techniques to try to control utilization. These methods include preadmission certification and concurrent review of hospital admissions and “gatekeeper” primary care providers who limit access to specialists. Managed care plans were also accused of preventing physicians from discussing more costly treatment alternatives and forcing new mothers and other patients to leave the hospital before it was medically prudent.

The upshot was that some, perhaps many, consumers wanted access to a greater choice of providers as a way of ensuring better care for themselves, if needed. As a result, narrow-panel HMOs expanded to allow greater choice, and PPOs, with their much broader provider panels, became the preferred plan type. The irony in this, as we will see in Chapter 9, is that remarkably little evidence indicates that the utilization management techniques used by managed care plans have effectively reduced utilization. However, the broader provider panels clearly meant that managed care plans could not take full advantage of selective contracting. One cannot trade a high volume of patients for a lower price if one cannot channel patients toward a limited number of selected providers. Thus, managed care plans appear to have shot themselves in the foot through their efforts at utilization management.

Expansions of Medicaid and Medicare

The 1980s saw the expansion of Medicaid for children and pregnant women. The most important of these expansions occurred in 1988, 1989 and 1990 when Congress extended Medicaid coverage to pregnant women and children up to age 6 with household incomes below 133 percent of the federal poverty level (FPL). Congress also phased in coverage at 100 percent of the FPL for children between the ages of 6 and 18. States were also allowed to provide coverage to these groups at higher levels of the FPL if they chose to do so. Together these changes are often referred to as the SOBRA expansions, based on the relevant omnibus budget reconciliation act. These

expansions are important not only because of the expanded eligibility they mandated, but also because they reflect a more aggressive role played by the federal government in setting federal standards across all states.

In 1996, the Clinton administration and Congress enacted welfare reform measures that limited the amount of time a person could receive cash assistance welfare benefits under Aid to Families with Dependent Children (AFDC). This law also had significant implications for Medicaid because Medicaid eligibility for many low-income groups had been tied to AFDC eligibility. As a consequence, low-income eligibility for Medicaid now is independent of welfare status but is tied to what eligibility would have been under the old AFDC.

The following year Congress enacted the State Children's Health Insurance Program, now called CHIP. This legislation expanded established eligibility for insurance coverage to children in lower- to moderate-income families. The legislation allows states to extend coverage to children up to 300 percent of the FPL. The federal government provides a more generous matching formula for this program, so from the state's perspective, the expansions are relatively inexpensive. The states also had substantial flexibility in establishing the CHIP program. Roughly one-third of the states simply expanded Medicaid eligibility, another third established totally separate CHIP programs, and the remaining states used a combination of new and expanded Medicaid.

Medicare was also expanded in these years. During the Bush administration, Congress enacted Medicare Part D, the most significant expansion of Medicare since its inception. Beginning in 2006 the legislation provided seniors the opportunity to buy private prescription drug coverage that was similar to Part B (physician coverage) subsidized from general federal tax revenues.

Consumer-Directed Health Plans

In the private sector, a new approach to health insurance was introduced in the mid-2000s, the consumer-directed health plan. This approach coupled an HDHP with a tax-sheltered health savings account (HSA). With an HDHP, an enrollee must incur healthcare costs of perhaps \$1,500 to as much as \$10,000 before the plan begins making any payments on her behalf. Legislation enacted in 2003 allowed people to establish HSAs in conjunction with such plans. HSAs allowed people to deposit funds tax-free in the account and then withdraw them to pay for healthcare services on the way to satisfying the deductible in the policy. Unspent money in an HSA could be rolled over without penalty to the next year. Advocates argued that this arrangement gave people insurance protection against catastrophic health events but also allowed them to see the full price of routine services. Consumers would then

have an economic incentive to shop more carefully for value in healthcare, only purchasing care that was worth its price to them. As shown in Exhibit 1.3, 8 percent of insured workers had an HDHP in 2008 but by 2012, this percentage had grown to 19 percent.

As we discuss in some length in Chapter 3, 2010 saw the enactment of the ACA. This law introduces major changes into the US health insurance markets. It requires virtually all US citizens and legal residents to purchase health insurance, providing significant subsidies for those with low income and penalties for those who fail to purchase coverage. The law also allows for the dramatic expansion of the Medicaid program to provide coverage to those aged 19 through 64 by reducing payments to the Medicare program and introducing or expanding a number of taxes. At this writing, the health insurance and healthcare markets are digesting this mammoth law and evaluating what it means for them.

Summary

- Private health insurance in the United States began as efforts by hospital and physician providers to deal with the revenue consequences of the Great Depression.
- The forerunners of managed care plans emerged at the same time as conventional insurance but were subject to serious challenge by physicians, who were concerned about the potential loss of income from the inability to price-discriminate among patients with different demands for care.
- The growth of health insurance over the middle of the 20th century was spurred primarily by the tax-exempt status of employer-sponsored health insurance. Wage and price controls during World War II, the rise of labor unions, and the declaration of health insurance as a proper focus of collective bargaining were other key factors.
- Commercial insurers were successful in the insurance market because they introduced experience rating, which allowed them to offer lower-priced coverage to groups with lower expected claims experience. The rest of the industry followed suit.
- The enactment of Medicare in 1965 expanded insurance coverage to older Americans. The current Medicare program reflects the nature of private health insurance in the 1960s. The allowable cost reimbursement system, largely borrowed from the provider-designed Blue Cross and Blue Shield plans, entrenched cost-based reimbursement for 20 years.

- The passage of the Employee Retirement Income Security Act (ERISA) in 1974 led to the growth of self-insured employer health plans and all but ensured competition in the risk-bearing segment of the conventional insurance market.
- The growth of managed care in the 1980s and 1990s was the result of the introduction of selective contracting as a response to growing healthcare costs. Selective contracting introduced price competition into healthcare markets.
- Medicaid and Medicare were both dramatically expanded in the 1980s through the 2000s. Medicaid and Children's Health Insurance Plans provided greater eligibility for children under age 19. Medicare was expanded to include prescription drug coverage.
- The 1990s and 2000s saw consolidation among healthcare providers and a backlash against the utilization management of managed care plans. Both actions undercut the ability of managed care plans to selectively contract.
- Consumer-driven health plans offering a high-deductible insurance plan and a tax-sheltered health spending account emerged in the mid-2000s and grew to enroll about one-seventh of the insured workforce.
- The Patient Protection and Affordable Care Act of 2010 introduced the requirement that individuals purchase health insurance and expanded the Medicaid program to coverage low-income adults.

Discussion Questions

1. How might the history of US healthcare been different if single-hospital plans rather than all-hospital plans had been the model Blue Cross adopted?
2. In what ways did insurance undercut physician income opportunities? Overall, how has health insurance affected the demand for physician and hospital services?
3. How might tax policy toward employer-sponsored health insurance affect the extent of coverage employers offer?
4. What features of a PPO have contributed to its rise as the predominant form of managed care for insured workers?
5. How might a high-deductible health plan and a tax-sheltered health savings account encourage people to be more prudent purchasers of healthcare services?

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