CHAPTER

1

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 early 2000s, healthcare costs rose more rapidly as a result of both this backlash and provider consolidation. Cost containment strategies shifted toward insured individuals paying more out of pocket through the use of high-deductible health plans, often with tax-sheltered health savings accounts. The Affordable Care Act (ACA) was enacted in 2010 and largely implemented in 2014. It required most US residents to have health insurance, provided penalties for those who did not obtain coverage, and offered subsides for private coverage or expanded Medicaid eligibility to lower-income individuals. Judicial, legislative, and administrative actions continued to affect the law in its first decade.

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 pattern 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 even into the 1960s. 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, 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, 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 1 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 nonfraternal funds existed in 1890. By the Progressive Era, Murray (2007) estimates that 20 percent of industrial workers were members of a sickness fund. 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 rounds of tariff increases that reduced worldwide demand for goods and services. In the United States, the Hawley-Smoot Tariff Act 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.

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 implies 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 whether 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 endure.

Local hospitals were affected by the Depression like other firms. 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 Kimball, 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 approval required 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 (PPO). 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 fact explains 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. In other words, 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

By the 1930s, Commercial life, casualty, and maritime insurance had long existed. Think of Lloyd's of London, established in the 1680s to provide maritime insurance. 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 did not 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 approach 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. Like 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 a physician lacked access to a hospital to provide care.

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.

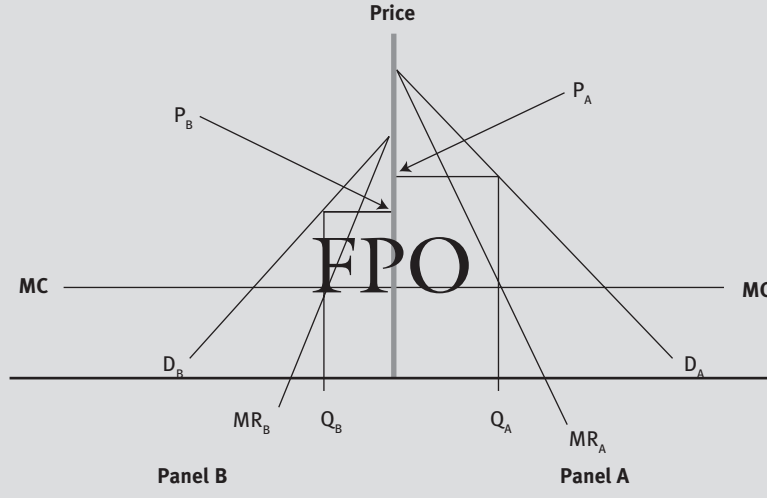
In 1937, Group Health Cooperative in Washington, DC, was a nonprofit cooperative of Federal Home Loan Bank employees. It had salaried physicians. The AMA and the local medical society engaged in reprisals against participating physicians, prevented consultations and referrals, and persuaded all hospitals 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?

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.

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

EXHIBIT 1.1 Economics of Price Discrimination



(continued)

their current doctor and joining the new group practice plan. Physicians might argue (and did) that they had patients who could not 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, and they may be true, 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.

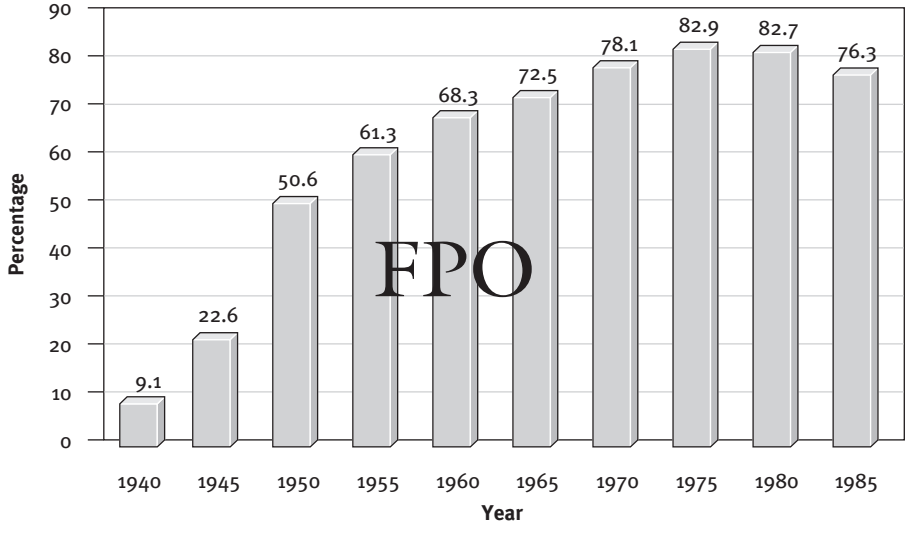


EXHIBIT 1.2 Percentage of US Population with Some Form of Private Health Insurance, 1940–1985

Source: Data from Health Insurance Association of America (1990).

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 D. Roosevelt administration set wages in each industry, beginning in 1942. Firms, competing for labor, attracted many women into the labor market for the first time. The Labor Board determined that health insurance was not to be considered a wage. This decision meant firms could complete for scarce labor by offering health insurance to their employees along with wages.

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 (2013) 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 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 Blue Shield plans after 1954 (Health Insurance Association of America 1990).

The 1960s and 1970s

The insurance functions of Blue Cross Blue Shield plans were pretty simple in their early years. The plans engaged in community rating, which meant that all the subscribers to 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 technique 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 many of 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)

Experience rating was the commercial insurers' comparative advantage and largely explains their growth in market share beginning in the 1950s. 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 Seventy-Fourth Congress enacted Social Security in 1935, the program did not include any health insurance provisions. They did so in part because of the strong physician opposition to government-sponsored health insurance that had emerged during the Progressive Era and that 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 Representative 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. 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, 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 other age groups. 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 Representative 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 bill supported by the AHA and unions 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 was refocused exclusively on physician and ambulatory services and 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 Medicaid program, in which the federal government matches state funds. The final vote on the legislation is summarized in exhibit 1.3. While the Democrats had clear majorities in both houses, the legislation passed with considerable Republican support. President Johnson signed the legislation in former President Truman's hometown of Independence, Missouri, in July 1965.

EXHIBIT 1.3 Voting on Medicare and Medicaid

	Yes	No	Not Voting
Senate			
Democrats	57	7	4
Republicans	13	17	2
Senate Total	70	24	6
House			
Democrats	237	48	8
Republicans	70	68	2
House total	307	116	10

Source: Reprinted from Social Security Administration (2019).

The Employee Retirement Income Security Act 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 law 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. Thus, medium-sized and even small firms could be self-insured. (The ability of small firms to self-insure became a means for small firms to avoid the community rating of the ACA. See chapter 2.)

These events happened while 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 2016, nearly 58 percent of insured workers were in a self-insured plan (Fronstin 2018).

Ironically, ERISA also spurred more state insurance regulation. Prior to 1974, virtually no state insurance mandates for coverage existed (Jensen and Morrisey 1999). 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—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, the second common type, 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 and hospitals in the local market. Each physician group and hospital sees a significant number of the HMO's subscribers, but the providers 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 hospital or 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 hospitals and 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 the hospital's 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 1.4 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 early in the 2010s, conventional plans only enrolled less than 1 percent of insured workers. PPOs enrolled only 11 percent of insured workers in 1988 and had 49 percent by 2018. 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 2018 they enrolled 29 percent (KFF 2018).

EXHIBIT 1.4
Percentage of Insured Workers by Type of Plan

	1988	1998	2008	2018
Conventional	71	14	2	<1
HMO	18	20	30	16
PPO	11	34	58	449
POS	—	22	12	6
HDHP	—	—	8	29

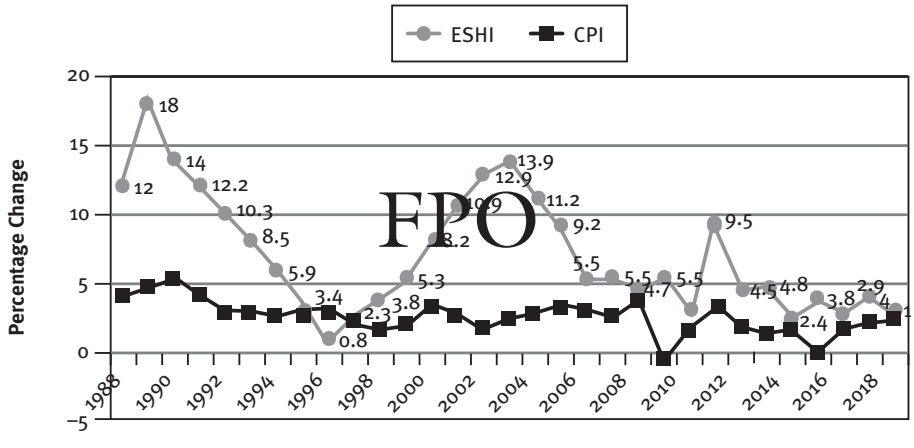
Source: Data from KFF (2018).

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 1.5 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 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 9.2 percent in 2006, then leveling off at a growth rate of about 5 percent through the remainder of the decade. The past few years have seen increases of less than 4 percent (Gabel et al. 2005; KFF 2018).

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. Town and colleagues (2005) note that between 1990 and 2000, 100 or more hospital mergers occurred in 8 of those 11 years. Physicians joined somewhat larger medical groups but also entered into joint marketing arrangements. These actions arguably had the

EXHIBIT 1.5 Percentage Increase in Employer-Sponsored Health Insurance Premiums



Source: Data from Gabel et al. (2005), KFF (2018).

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, "Everything Old Is New Again: Health Care and Competition in the 21st Century," remarks before the Seventh Annual Competition in Health Care Forum, 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 evolution, 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 eligibility 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, at least in the states that did not expand Medicaid under the ACA.

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 were 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 George W. 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. The program had the odd feature that it provided good coverage for modest expenditures and for large (catastrophic) expenses but provided little coverage for expenses in between. This gap in coverage is referred to as the *donut hole*. The ACA subsequently limited the effect of the donut hole.

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 a

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 1.4, 8 percent of insured workers had an HDHP in 2008, but by 2019 this percentage had grown to 29 percent.

The Legislative History of the ACA

The ACA is generally regarded as the most sweeping piece of healthcare legislation since the enactment of Medicare in 1965. The legislation came about following the inauguration of Barack Obama in 2009 after an election campaign in which healthcare reform was a key issue. The Obama administration favored legislation that would include a public option that would establish a government insurance program to compete with private plans.

Both houses of Congress worked on bills throughout the summer and early fall of 2009. The Democratic-controlled House of Representatives passed its bill in November on a close vote, 220–215, with 39 Democrats opposing the bill and 1 Republican supporting it. The bill included the public option and a more active role for the federal government. The Democrats had a 60-vote filibuster-proof majority in the Senate with the inclusion of two independents who caucused with the Democrats. However, senators are much more independent minded and less subject to party discipline. The Senate bill was not as sweeping as that of the House. It did not include the public option, it left greater discretion to the states, and it would provide coverage to fewer uninsured people. The bill ultimately passed 60–39 on a straight party line vote on December 24. In both houses, the issue of coverage for abortion services was contentious.

Several months prior, in August 2009, Senator Edward Kennedy (D-MA) died. The Massachusetts governor appointed an interim senator who voted for the bill in December. A special election was held, and Republican Scott Brown was elected; he took his seat in early January 2010. His opposition to the legislation meant that the Senate no longer had a

filibuster-proof majority. Therefore, a conference bill reconciling the two versions of the legislation would not pass the Senate. As a consequence, the House passed the Senate bill. A related bill of "fixes" to features of the bill was subsequently passed as a reconciliation bill, requiring only a majority in the Senate, and the act was signed by the president on March 23, 2010. See *Encyclopaedia Britannica* for Levy's (2019) straightforward presentation of the legislative history.

As we discuss in some length in the next chapter, the ACA required most citizens and permanent residents to have health insurance. Moreover, premiums could not be based on the health status of individuals. It also required firms with 50 or more employees to offer coverage, and it expanded Medicaid to low-income individuals aged 19–64. Subsequently, 27 states filed suit challenging the constitutionality of the individual mandate and the requirement that the states expand their Medicaid programs. In June 2012, the Supreme Court ruled 5–4 that the individual mandate was constitutional under Congress's taxing power but that the states could not be forced to lose federal funding for their existing Medicaid program if they did not implement the Medicaid expansion. Approximately 40 percent of the states decided not to expand their Medicaid programs.

While most features of the ACA did not go into effect until 2014, several began in 2010. These included a provision that allowed children under 26 to be covered under their parent's employer-sponsored health plan, and a short-term national high-risk pool that was envisioned to provide coverage for those with preexisting conditions, prior to the full implementation of the act.

The initial open enrollment period was marred by substantial computer and website problems with the federal exchange. States that set up their own insurance exchanges had a mix of both success and failure of implementation as well. In the first year exchange enrollment was estimated at 8 million and 12.2 million by 2017 (Centers for Medicare & Medicaid Services 2017). Medicaid expansion estimates are a bit harder to estimate. However, the Medicare Payment Assessment Commission estimated that by 2017, 14.9 million ACA-eligible in the 31 states that expanded coverage enrolled (Medicaid and CHIP Payment and Access Commission 2017).

Over the course of the 2010s, there were a series of delays to selected elements of the ACA, and the Republicans argued that the government should repeal the legislature, or perhaps repeal it and replace it with an alternative. With the election of Donald Trump and Republican majorities in both houses of Congress in 2016, there were changes in the implementation of the ACA through executive order and changes in some features by congressional action. The most important of these was the Tax Cuts and Jobs Act of 2017 that set the individual penalty for not having health insurance at $0.00. We will discuss the ACA in detail in chapter 2.

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 on the basis of price among patients with different demands for care.
- The growth of health insurance over the middle of the twentieth 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 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 Programs 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 contract selectively.

- 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 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 the 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?
6. In what ways might a law that does not allow differential premiums based on health status affect the demand for insurance?

For the Interested Reader

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