Instructor Resources Sample

This is a sample of the instructor materials for *Health Insurance, Third Edition*, by Michael A. Morrisey.

The complete instructor materials include the following:

- Discussion guides for the end-of-chapter questions
- A PowerPoint slide presentation for each chapter
- A transition guide to the new edition

This sample includes the discussion guide and PowerPoint slide presentation for chapter 1.

If you adopt this text, you will be given access to the complete materials. To obtain access, e-mail your request to hapbooks@ache.org and include the following information in your message:

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Digital and Alternative Formats

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The third edition of *Health Insurance* has integrated the Affordable Care Act (ACA) throughout. Chapter 2, a complete rewriting of the old chapters 3 and 22, provides a detailed summary of the law and the underlying economics. It also introduces some of the empirical research that has appeared over the last five years evaluating the effects of the law. It was moved to this position in the book to provide continuity with the history chapter and to serve as a foundation for the ACA discussion in the rest of the text. You will find that virtually every chapter now has some discussion of the ACA in as much as the law affects most elements of health insurance. A totally revised chapter 19 goes into greater detail on the ACA in the individual market and presents substantial new research on the laws effects.

Because health insurance continues to be a hot political topic, you will find lots of opportunities to introduce discussion topics into your course. The easiest way to find current material is to add your name to free daily news distribution lists. I recommend three:

- **The Daily Consult.** This resource provides summaries and links to the previous day’s stories and always has an interesting graphic: [http://themorningconsult.com/subscribe/](http://themorningconsult.com/subscribe/). (This is my favorite source.)
- **AHIP Solutions SmartBrief.** This service provides public policy, clinical, and industry news of interest to health insurers. It is a little hard to find on the America’s Health Insurance Plans (AHIP) home page, but you can find the signup page by typing “Smart Brief” in the site’s search engine, or you can go directly to [https://www2.smartbrief.com/ahip/index.jsp](https://www2.smartbrief.com/ahip/index.jsp).

Other useful sources for discussion material include the American Enterprise Institute and the Brookings Institution. Their websites provide opportunities to sign up for announcements, reports, and testimony. *Health Affairs* often has timely, easy-to-read reports and an ongoing section on political events that relate to health insurance.

This edition of *Health Insurance* continues to include a list of readings “for the interested reader” at the end of each chapter. In some cases, these would be appropriate to add to the class reading list. Often, they explore a current topic or new research finding in more detail. Summaries of these readings may make good class presentation assignments for students, particularly in doctoral settings. In general, I have avoided listing classic health insurance papers, because most of the students will be in master’s programs and more interested in current events and new findings than in in-depth treatment of fundamental issues.
Part I

Chapter 1

The chapter 1 PowerPoint presentation is one of the few that is nearly an outline of the textbook chapter. It is intended not only to provide a history and an overview but also to serve as a basis on which to discuss topics in later chapters. For example, for the discussion of underwriting and rate making in chapter 6, one can harken back to the discussion in this chapter of Blue Cross being forced by the competition to move toward experience rating. Although I have not done so, one could discuss the backlash against managed care in chapter 11 by reminding students of the physician opposition to workers’ compensation and early prepaid group practice models.

The discussion questions in this chapter—and all of the chapters—serve a variety of purposes. In some instances, they review important concepts; in others, they allow for a discussion of an application, provide relevant examples, or set the stage for the next chapter. Some additions and subtractions have been made from the questions posed in the second edition, but most questions have been carried over.

Chapter 1 Discussion Questions

1. The intended discussion here would revolve around single-hospital plans resulting in both price and service/quality competition within local hospital markets, with the result that the 70-year rising trend in healthcare costs might have been somewhat ameliorated. However, attentive students should quickly note that such hospitals probably would have faced the sorts of physician opposition that arose over workers’ compensation and prepaid group practice, with the upshot that the plans may have evolved into all-hospital plans even if the American Hospital Association had not imposed this as a requirement.

2. The intent of this question is to have the students discuss the nature of the sliding fee schedule, with some doctors winning contracts and many losing them. The bigger issue, however, is that the presence of insurance reduced the out-of-pocket price of health services and resulted in a historically large increase in the demand for services—to the financial benefit of providers generally.

3. This question is intended to get students to discuss the potential of workers taking tax-sheltered health insurance as compensation for giving up taxed money wages. This issue can be linked to current policy debates, but it is also important for helping students studying chapter 4 to understand that, although the income/wealth hypothesis argues that higher-income individuals will buy less insurance, the tax subsidy works in the opposite direction of the pure insurance effect.

4. This question is intended to help the students begin to think about what makes managed care different. The expected answers should revolve around the greater
freedom to choose providers, compared to HMOs. There will likely also be a mention of reduced utilization management.

5. This question is intended to get students thinking about the full price of a physician visit or of a prescription—not just the out-of-pocket payment. We want to encourage discussion of whether having to pay the full price would lead to less use of services and whether there would be health effects.

6. This question is designed to get students to begin thinking about underwriting. The discussion of experience rating suggests that people have differing utilization patterns. There, the creation of distinct risk pools lowers costs for low utilizers. Combining pools (as the ACA does) should make some people better off, but it would also make others worse off.
Chapter 1
History of Health Insurance in the United States
Outline

• Prehistory
  – Industrial sickness funds (new)
  – The Progressive movement

• Great Depression
  – Birth of the Blues ... and of HMOs

• Early growth
  – Price controls, labor law, and the tax code

• Changing times
  – Experience rating, Medicare, Medicaid, and ERISA

• Managed care and beyond

• Affordable Care Act
Prehistory

- Industrial Sickness Funds
- The Progressive Movement
- Workers’ Compensation
- Compulsory Insurance
Industrial Sickness Funds

• Voluntary fraternal, employer, or union funds that typically required a “premium” equaling 1% of wages
  • Withheld from wages or collected by coworkers on payday
• People applied for membership
  • Older age limits, medical examination, and waiting period of several weeks not uncommon
• When ill, one notified the fund
  • Visiting committee to assess ability to work
  • Few days waiting period, often 60% of wages paid
Industrial Sickness Funds

• Earliest funds date from the Civil War
• First survey by federal government estimated some 1,259 nonfraternal funds in 1890
• By the 1908–1917 period, roughly 20% of workers were in a sickness fund
Workers’ Compensation Insurance

• Employers were liable for workplace injury, but the worker had to show that the employer was negligent.

• Employer had three defenses:
  • Worker had assumed the risk
  • Coworker caused the accident
  • Contributory negligence

• 1910 to 1915:
  • 32 states enact legislation
  • Employer buys coverage and accepts full liability
  • Employer retains defenses if it buys workers’ comp
Workers’ Compensation Led to Other Initiatives

• American Association of Labor Legislation Health Insurance Proposal:
  • Cover all manual laborers with income of less than $100 per month
  • Cover medical bills and some income continuation
  • Compulsory contributions from employee, employer, and the state
  • Those not in groups could join voluntarily
  • Disability insurance included

• 1916 to 1919
  • 16 states consider the legislation—none adopt it
1912 to 1920s: Supporters and Opponents

• Organized labor had a mixed position
  • Some supported the proposal
  • Samuel Gompers (AFL) opposed it. Workers knew how to spend their money; the role of the union was to get them more money to spend.
  • Viewed as a ploy to increase physician and hospital prices

• Workers often ignored or opposed the proposed legislation due to existing cheaper coverage in the industrial sickness funds.

• AMA supported the legislation in 1915, but
  • By 1920 was opposed to any compulsory insurance if provided, contributed to, or regulated by state or federal governments
  • Argued insurance interfered with the doctor-patient relationship
  • Workers’ compensation firms hired physicians, and the laws seemed to reduce, not increase, physicians’ incomes
Compulsory health insurance was...

“Un-American, unsafe, uneconomic, unscientific, unfair, unscrupulous legislation supported by paid professional philanthropists, busybody social workers, misguided clergymen, and hysterical women.”

—delegate in AMA House of Delegates
Great Depression

• Birth of Blue Cross and Blue Shield
• Birth of Commercial Insurance
• Birth of Prepaid Group Practice
1929: Baylor University Hospital

• Between 1929 and 1930
  • Receipts drop from $236 to $59 per patient
  • Occupancy rates drop from 71.3% to 64.1%
  • Contributions down by two-thirds
  • Charity care up 400%

• Enrolled 1,250 public school teachers
• 50 cents per month—21 days of care

SINGLE-HOSPITAL PLAN
Growth of Hospital Plans

• 1932
  • Sacramento, CA: ALL-HOSPITAL PLAN

• 1933
  • Some 26 plans in operation
    • Newark and Essex County, New Jersey
    • Cleveland, Ohio
    • St. Paul, Minnesota
AHA Committee on Hospital Service
AHA Hospital Service Plan Commission
AHA Blue Cross Commission

AHA began approving plans in 1933

• Nonprofit
• Improve public welfare
• Dignified promotion
• Cover hospital charges only
• Free choice of physicians
• No competition among plans (1937)
The Problem with Single-Hospital Plans

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 (AHA)
Hospital Service Plans as Insurance

• Most states viewed plans as prepayment of hospital costs, not as insurance
• In 1933, the New York insurance commissioner viewed plan as insurance
  • Need financial reserves
• Enabling legislation
  • Exempt from reserve requirements
  • Rates reviewed by insurance commissioner
  • Majority of directors from hospitals
  • Exempt from premium tax
• By 1939, 25 states had enabling legislation
Blue Shield

“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.”

—physician at AMA convention in 1937

• 1938: first medical service plan (in California)
  • Indemnity plan, free choice of physician

• 1939: AMA begins approving plans
Commercial Insurance

• Did not offer health insurance because hazards must be definite and measurable
• 1934: began offering hospital *indemnity* coverage
• 1938: began offering surgical *indemnity* coverage
• 1946:  
  — 14.3 million with commercial coverage  
  — 24.2 million with Blue Cross coverage
1929: Ross-Loos Clinic

- Prepaid care for 2,000 workers and families of Los Angeles Water & Power
- Prepaid employer medical group
- Contracted with independent medical group
- Comprehensive care
- Founders of Ross-Loos expelled from county medical society and therefore denied access to hospitals
1929: Cooperative Health Plan, Elk Grove, Oklahoma

- Michael Shadid, MD, and Farmers Union Hospital
- Proposed to enroll 6,000 residents at $50 per year

- Physician opposition as unethical
  - Attempted to deprive Shadid of license
  - Expelled Shadid from medical society
  - Shadid had no access to malpractice insurance
  - Kept willing physicians out of Oklahoma via licensure
Medical Opposition to HMOs

• 1933: Kaiser Foundation Health Plan established by Sidney Garfield
  • Hearing before the state board of medical examiners
  • License suspended for unprofessional conduct
  • Overruled by courts

• Milwaukee, Chicago, Seattle group health plan physicians denied membership in the local medical society and denied access to hospitals

• As late as 1959, Kaiser physicians still excluded from San Francisco County Medical Society
1937: Group Health Association, Washington, DC

• Nonprofit cooperative of employees of Federal Home Loan Bank
• Salaried physicians

• AMA could not get federal support against unregulated health insurance
• AMA and local medical society:
  • Launched reprisals against participating physicians
  • Prevented consultations and referrals
  • Persuaded all hospitals to refuse privileges
1937: Group Health Association, Washington, DC

• Justice Department indicts the AMA under the Sherman Antitrust Act in 1938
• Supreme Court holds against the AMA in 1943
• Medical societies lobby and obtain state intervention to ensure physician control of prepayment, 1939–1949 (corporate practice acts)
Why Were Physicians So Opposed?

- Sliding fee schedule
- Price discrimination
  - Maximizing profits
  - Helping the poor
Exhibit 1.1: Economics of Price Discrimination
Early Growth

• The 1940s and 1950s
• The War, Labor Law, and the Tax Code
Exhibit 1.2: Percentage of US Population with Some Form of Private Health Insurance

Source: Data from Health Insurance Association of America (1990).
The 1940s

• World War II, 1941–1945
  • Wage and price controls
  • Health insurance not subject to controls
  • Two million subscribers added per year

• Taft-Hartley Act, 1947
  • Health insurance is condition of employment, subject to collective bargaining
Industry Issues in the 1940s

• Blue Cross Issues
  • Reciprocity and commercial insurance competition
  • Restructuring of Blue Cross Commission to give majority of seats to plans, not hospitals
The Tax Code

• 1943: IRS special ruling holds that health insurance benefits provided by an employer are not subject to federal income tax

• Contradictory special rulings during the 1940s and early 1950s created uncertainty

• 1954: Congress enacts legislation exempting employer-sponsored health insurance from federal taxation of income
  • In 2005, this resulted in “tax expenditures” of $208.6 billion
The Industry in the 1950s

• Accelerating hospital costs and utilization
• Blue Cross Association formed
• Experience rating begins
  • 1952: 3.7% of Blue Cross subscribers in experience-rated plans
Changing Times

- The 1960s, 1970s, and 1980s
- Medicare and Medicaid
- Experience Rating
- ERISA
Medicare and Medicaid

- FRD did not propose a national health insurance program with Social Security because of ongoing physician resistance
- In 1945, Truman proposed a national program that covered everyone
  - Paid with a 4% payroll tax on first $3,600 of wages
- Resulted in 1946 Hill-Burton Act with subsidized construction of hospitals and nursing homes
  - I.e., the AHA-AMA proposal
Medicare and Medicaid: 1950–1960

• Advocates redirected attention to coverage for the elderly
  • Concern that linking to Social Security would undermine the program with much higher costs

• In 1960 Congress enacted the Kerr-Mills bill, which provided federal funds to states to assist in the provision of healthcare to seniors who were receiving welfare benefits
Medicare and Medicaid: 1965 (I)

- Lyndon Johnson wins landslide election in 1965
  - Democrats control both houses of Congress
- Political players
  - Unions: Support plan to link eligibility to Social Security rather than income and to pay for it with a payroll tax
    - Makes highly paid union workers eligible, and costs are disproportionately borne by lower-income folks
    - Compensating differentials, too!
  - AHA/Blue Cross: Support such a plan because it covers expensive seniors, who raise the cost of community-rated Blue Cross plans
    - Helps experience-rated commercial plans less
Medicare and Medicaid: 1965 (II)

• Political players (continued)
  • AMA: Pushed “eldercare” model, which was an extension of Kerr-Mills for seniors
  • Republicans: Favored a voluntary program that was need-based, with financing coming from general tax revenues
Medicare and Medicaid: 1965 (III)

- Wilber Mills (D-Ark) – “Three-Layer Cake”
  - Medicare Part A
    - Eligibility linked to Social Security
    - Paid with an expansion of the payroll tax
    - Covers hospital services
  - Medicare Part B
    - Voluntary program
    - Paid with premiums and general tax revenues
    - Covers physician services
  - Medicaid
    - Federal-state matching program for low-income folks
    - I.e., expansion of Kerr-Mills
Also in the 1960s

- Continued growth of experience rating
- Last Blue Cross plan gives up community rating
- Blue Cross Association endorses experimentation with HMOs
  - Passes with a six-vote majority out of 2,000 votes cast
Experience Rating

“We fought tooth and nail. To the last gasp. But when 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
The 1970s and 1980s

• 1974: ERISA enacted
  • Employee Retirement Income Security Act
  • 15% of the 1,000 largest employers are self-insured by 1975
• 1983: Medicare prospective payment enacted
• 1983–1985: Preferred provider organizations created
• Cost containment issues intensify
• Growth of self-insurance
• Growth of managed care
Managed Care and Beyond

• Types of plans
• Coverage and premiums
• Backlash
Managed Care Types

• Health maintenance organization (HMO)
  • Staff model
  • Group model
  • Network model
  • Independent practice association (IPA)
• Preferred provider organization (PPO)
• Point-of-service (POS) plan
### Exhibit 1.4: Percentage of Insured Workers by Type of Plan

<table>
<thead>
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<th>1988</th>
<th>1998</th>
<th>2008</th>
<th>2018</th>
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<td>Conventional</td>
<td>71</td>
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<td>HMO</td>
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<tr>
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<tr>
<td>POS</td>
<td>—</td>
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<tr>
<td>HDHP</td>
<td>—</td>
<td>—</td>
<td>8</td>
<td>29</td>
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</tbody>
</table>

*Note:* HDHP = high-deductible health plan, HMO = health maintenance organization, POS = point of service, PPO = preferred provider organization.

*Source:* Data from KFF (2018).
Exhibit 1.5: Percentage Increase in Employer-Sponsored Health Insurance Premiums

Note: ESHI = employer-sponsored health insurance, CPI = consumer price index.  
Source: Data from Gabel et al. (2005), KFF (2018).
1990–2000: Premium Increases Decline

• Selective contracting
• Introduction of price competition
  • Limited panels of providers
  • Trade volume for price
2000–2003: Premiums Increase More Rapidly

- Provider consolidation?
- Managed care backlash?
Provider Consolidation

- More hospital providers
  - Less-rapidly increasing prices
- Formation of marketwide networks
  - One-stop negotiating, but
  - Fewer competitors
FTC Commissioner’s Concern

“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, FTC

Chicago, November 7, 2002
Managed Care Backlash

• Selective contracting
  – Limited panels of providers
  – Volume for price
• Demand for choice
  – Growth of PPOs and POS plans
• Utilization management
  – Vocal opposition from providers (and consumers)
  – Did not work anyway
**The Backlash**

- The average number of doctors in an HMO nearly quadrupled between 1990 and 2000.
- The percentage of HMOs that pay for treatment outside their networks tripled to 63%.

Source: data from *Fortune* (October 14, 2002)
2004–2018

- Consumer-directed healthcare
  - Greater use of deductibles
- Expansion of Medicare Part D
  - Prescription drug coverage
- Affordable Care Act
Consumer-Driven Health Care

- Health Insurance
  - $3,000 Deductible
- Uncovered Expenses
  - $1,000 Spending Acct
- Health Savings Account (tax sheltered—rolled over)
2010: The Affordable Care Act—Legislative History

• Democratic House passed bill in November 2009
  • 220/215 with 39 Democrats opposed and 1 Republican supporting
  • Included a public option

• Democratic Senate passed bill in December 2009
  • Straight party-line vote (60/40 Democrats)
  • Less sweeping than house version

• Scott Brown (R) replaced E. Kennedy (D) in January 2010
  • Senate Democrats lost 60 vote filibuster proof majority

• House passed Senate bill intact March 23, 2010
Discussion Questions

• How might the history of US healthcare have been different if single-hospital plans rather than all-hospital plans had been the model Blue Cross adopted?
Discussion Questions

• In what ways did insurance undercut physician income opportunities? Overall, how has health insurance affected the demand for physician and hospital services?
Discussion Questions

• How might tax policy toward employer-sponsored health insurance affect the extent of coverage employers offer?
Discussion Questions

• What features of the PPO have contributed to its rise as the predominant form of managed care for insured workers?
Discussion Questions

• How might a high-deductible health plan and a tax-sheltered health savings account encourage people to be more prudent purchasers of healthcare services?
Discussion Questions

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