This is a sample of the instructor resources for *Health Insurance, Second Edition*. The complete instructor resources include

- an instructor's manual with teaching notes and answers to the end-of-chapter discussion questions,
- PowerPoint slides for each chapter, and
- a transition guide to the new edition.

This sample includes the PowerPoint slides and the teaching notes and answers to discussion questions for Chapter 1.

If you adopt this text, you will be given access to the complete materials. To obtain access, email your request to <u>hapbooks@ache.org</u> and include the following information in your message:

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- The use of the text (primary, supplemental, or recommended reading)
- A contact name and phone number/e-mail address we can use to verify your employment as an instructor

You will receive an e-mail containing access information after we have verified your instructor status. Thank you for your interest in this text and the accompanying instructor resources.

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Teaching Suggestions

As you have seen, the second edition of this book has introduced a lot of new material on the Patient Protection and Affordable Care Act (ACA). Not only are there the two full chapters, but many of the others have sections, sidebars, and discussion questions related to the ACA. The implementation of the ACA means it will be an exciting time to teach the course. The problem will be dealing with so much material in the press and in the research literature.

The easiest way to find such material is to add your name to free daily news distribution lists. I recommend three:

- *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 search engine, or go directly to https://www2.smartbrief.com/ahip/index.jsp.
- *Kaiser Daily Health Policy Report.* This service provides a summary and links to health policy stories in most major newspapers, congressional hearings, agency reports, and so forth. Sign up at www.kaiserhealthnews.org/Daily-Report.aspx.
- *The Daily Consult*. Summaries and links to the previous day's stories and always an interesting graphic: http://themorningconsult.com/subscribe/.

Other useful sites for discussion material are the American Enterprise Institute and the Brookings Institution (particularly for tax policy issues related to health insurance). Their websites provide opportunities to sign up for announcements, reports, and testimony. *Health Affairs* has already provided a number of early analyses of the effects of the ACA, and I expect we will continue to find easy-to-read papers there that will be accessible to most students.

This edition has added a list of readings at the end of each chapter "for the interested reader." 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 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 program and more interested in current events and new findings than in in-depth treatment of fundamental issues.

Part I *Chapter 1*

Chapter 1 of the Instructor's Resources is one of the few PowerPoint presentations that is nearly an outline of the textbook chapter. It is intended not only to be 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. While 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 and all the chapters serve a variety of purposes. In some instances they review important concepts, in others they allow for a discussion of an application or example of a concept, and in still others the question is intended to set the stage for the next chapter.

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 understand that while 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 have 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 to think 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.

History of Health Insurance in the United States

Chapter 1



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, and ERISA
- Managed care and beyond

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 gov't 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* he 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) was opposed. 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 ignore 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 it appeared that the laws reduced, not increased, 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 & 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 percent
 - Contributions down by two-thirds
 - Charity care up 400 percent
- 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, NJ
 - Cleveland, OH
 - St. Paul, MN



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 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 have 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, OK

- 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, 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, 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)

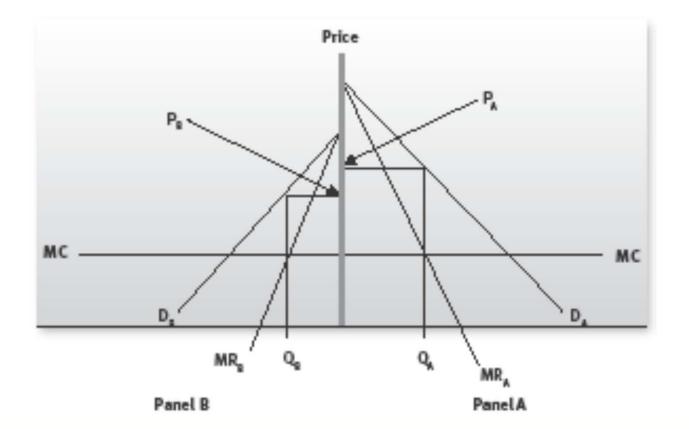


Why Were Physicians So Opposed?

- Sliding fee schedule
- Price discrimination
 - Maximizing profits
 - Helping the poor



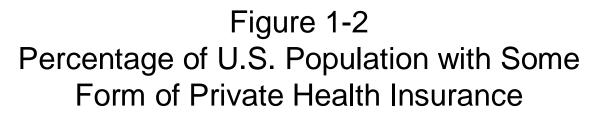
Exhibit 1.1: Economics of price Discrimination

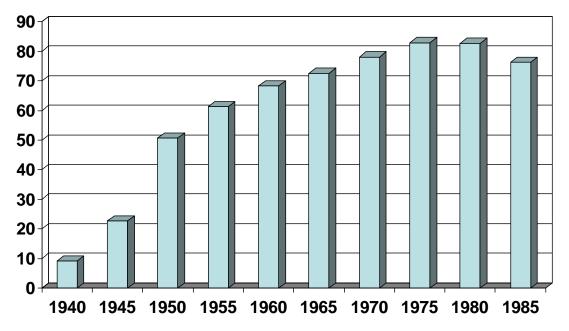


Early Growth

The 1940s and 1950s The War, Labor Law, and the Tax Code







Source: adapted 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 over the 1940s and early 1950s created uncertainty
- In 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

- Blue Cross national contracts problematic
- Accelerating hospital costs and utilization
- Blue Cross Association formed
- Experience rating begins
 - 1952—3.7 percent of Blue Cross subscribers in experiencerated plans



Changing Times

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



Medicare & Medicaid

- FRD did not propose a national health insurance program with Social Security due to 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 & nursing homes
 - i.e., the AMA proposal

Medicare & Medicaid: 1950-1960

- Advocates redirected attention to coverage for the elderly.
 - Concern that linking this to Social Security would undermine the program with much higher costs.
- In 1960 Congress enacted the Kerr-Mills bill that provided federal funds to states to assist in the provision of healthcare to seniors who were receiving welfare benefits.

Medicare & Medicaid: 1965 (a)

- Lyndon Johnson wins landslide election in 1965
 - Democrats control both houses of Congress
- Political Players:
 - Unions: support plan to link eligibility to Soc. Sec. rather than income and to pay for it with a payroll tax
 - Makes high paid union workers eligible & costs 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 & Medicaid: 1965 (b)

- Political Players (continued):
 - AMA: pushed "eldercare" model, which was an extension of Kerr-Mills for seniors
 - Republicans: favored a voluntary program that was needbased with financing coming from general tax revenues

Medicare & Medicaid: 1965 (c)

- 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 percent 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 Consumer-Directed Health Plans



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 1.3: 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			81/0	19%

Source: Data from Kaiser/HRET (2012)

Exhibit 1.4: Percentage Increase in Employer-Sponsored Health Insurance Premiums

20 18 15 12.9 **1**4 Percentage Change 12.2 12 11.2 10.9 10 3 10 9.5 9.2 8.5 8.2 5.9 53 5 3.8 0.8 0 1998 2000 2010 1990 2008 1992 19912 1996 2006 2012 2002 -3987 2004

Source: data from Gabel et a. (2005) and Kaiser Family Foundation/HRET (2012)

← ESHI --- CPI

2000 - 2003

• What Happened to Premiums?

– 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."

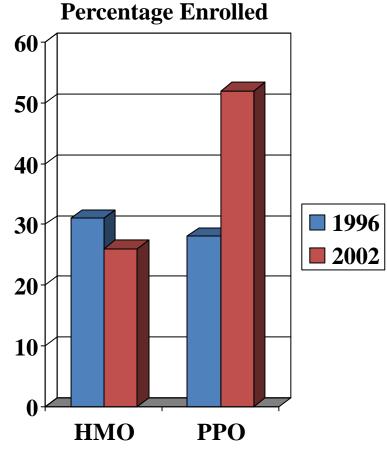
—Timothy J. Muris, Chairman, FTC Chicago, November 7, 2002

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



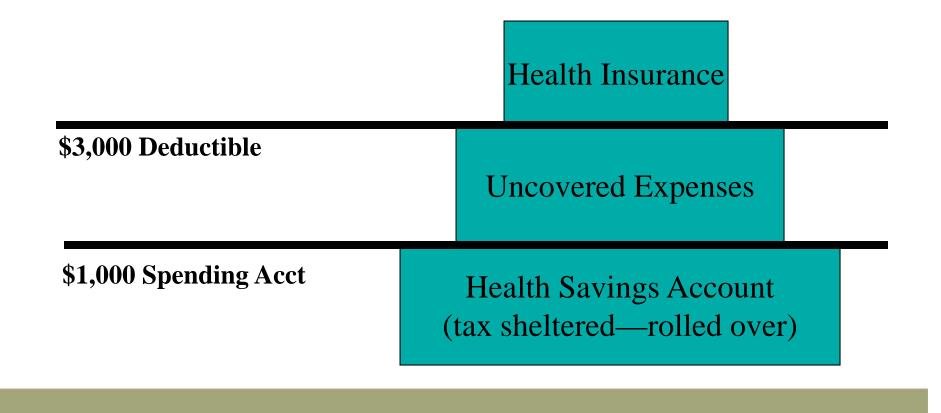
- The average number of doctors in an HMO nearly quadrupled between 1990 and 2000
- The percentage of HMOs that pay for treatment outside their networks tripled to 63%.

Source: data from Fortune (October 14, 2002)

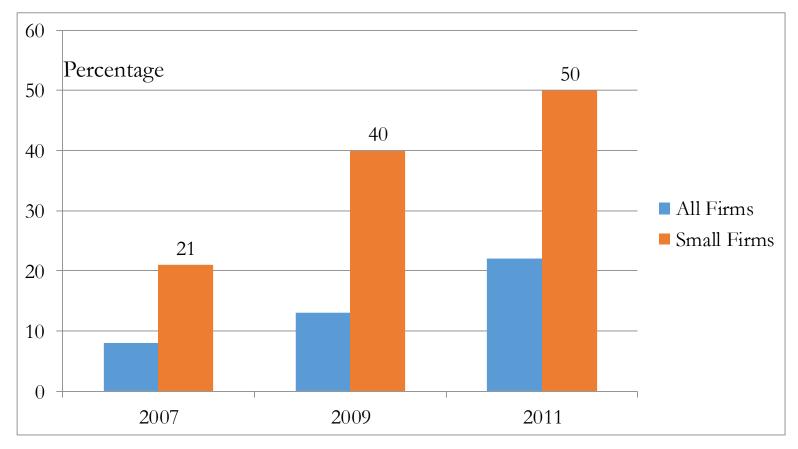
2004-2012

- Expansion of Medicare Part D
- ACA 2010
- Consumer-Driven Health Care?
- Greater use of deductibles
- "New" Managed Care?

Consumer-Driven Health Care



Percentage of Covered Workers in a Plan with a General Annual Deductible of \$1,000 or More



Kaiser/HRET Survey of Employer Sponsored Health Benefits, 2007-2011

"New" Managed Care

- Limited panels of providers with selective contracting
- Less use of explicit utilization management
- Access to network prices for out-of-pocket payments
- Limited choice but lower price



• 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?

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

• How might tax policy toward employersponsored health insurance affect the extent of coverage employers offer?

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



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