

the Blue Cross and Blue Shield plans after 1954 (Health Insurance Association of America 1990).

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, Medicare, Medicaid, and ERISA: The 1960s and 1970s

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

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

This was the commercial insurers' approach. They offered lower premiums to groups with low claims experience. Blue Cross and Blue Shield were forced to switch from community rating or face a future in which they were the insurer of only the highest-cost subscribers. In the 1960s, the last Blue Cross plan gave up community rating.

The 1960s saw the enactment of the Medicare and Medicaid programs, during the Lyndon Johnson administration. Medicare provided coverage for hospital and physician services to those over age 65 who were covered by Social Security. With the lens of today's private health insurance plans, Medicare looks strange. This is because, as Congress cast about for an insurance model to follow, it focused on the Blue Cross and Blue Shield

models of the time. It created separate hospital (Part A) and physician (Part B) coverage that reflected the nature of the coverage under each type of plan. It also followed Blue Cross and Blue Shield in paying hospitals based on costs and physicians based on their allowable charges.

Medicaid is a joint federal-state program designed to provide coverage to the poor. It was essentially an expansion of the 1960 Kerr-Mills Act. The federal government specified the nature of coverage and eligibility across broad parameters, but allowed the states considerable flexibility in deciding how much of each type of service was to be covered and what income threshold was to be used for eligibility. The federal contribution was pegged to the relative poverty in a state and ranged from 50 percent in the most affluent states to 83 percent in the poorest.

The key event in the 1970s with respect to private health insurance actually was triggered in December 1963, when the Studebaker Corporation closed its U.S. 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 to bail out future pension plan defaults. The legislation also included a relative handful of provisions dealing with "welfare plans"—that is, health insurance plans.

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

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

individual claims or for aggregate claims that exceeded some threshold. Medium- and even small-sized firms could be self-insured.

These events happened at the same time that mainframe computer processing was rapidly dropping in price. In the 1960s, large conventional insurers had comparative advantages in both bearing claims risk and in claims processing. They lost both in the 1970s. ERISA meant that there was potential entry into the risk-bearing segment of the business. Efforts to extract more than competitive returns from this segment would lead to the entry of many self-insured employers providing their own coverage. The advent of low-cost mainframe computing meant that the claims-processing segment was also competitive. If the large insurers attempted to charge more than competitive processing fees, new providers would appear and undercut them. Indeed, a new industry emerged—third-party administrators (TPAs) that handled the claims processing of self-insured firms. Insurers opened new lines of business as well, such as ASOs (administrative services only). Through these lines, they also provided claims-processing services to self-insured firms. By 2001, 50 percent of insured workers were in a self-insured plan (Gabel, Jensen, and Hawkins 2003).

Ironically, ERISA also spurred more state insurance regulation. Prior to 1974, there were virtually no state insurance coverage mandates (Jensen and Morrissey 1999a). However, by the close of 2005, there were over 1,800 individual insurance mandates (Council for Affordable Health Insurance 2006). 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.

Managed Care and Beyond: The 1980s, 1990s, and 2000s

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 system Medicare used to pay hospitals. Rather than paying based on allowable costs, it introduced the prospective payment system, 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 health maintenance organizations (HMOs), were beginning to enroll

more subscribers, and new forms of managed care, preferred provider organizations, and point-of-service plans were developing.

There are three general forms of managed care plans. The first are HMOs. These are insurance companies, meaning that they bear claims or "underwriting" risk. Like 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, they 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, there have been four HMO models. Staff model HMOs hire their physicians and usually own their own hospitals. The original Group Health Cooperative in Seattle is an example of a staff model HMO. Such models are rare. Group models are somewhat more common. In this form, the HMO-insurer contracts with a single physician group that provides all the clinical services rendered to the HMO subscribers and typically provides care only to the HMO's subscribers. Kaiser-Permanente is the classic example. Kaiser is the health insurer. It contracts exclusively with the Permanente medical group. Third is the network model HMO. In this case, the HMO-insurer contracts with several physician groups in the local market. Each physician group sees a significant number of the HMO's subscribers, but the group also sees patients from other insurers. Network model HMOs are the most common. The fourth HMO model is the independent practice association (IPA). This model emerged as a response by local medical societies to the growth of HMOs. Under this model, the HMO-insurer provides services through a large panel of physicians throughout the community. These community physicians typically only see a small number of the HMO's subscribers.

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

Preferred provider organizations (PPOs) developed in the 1980s, partly in response to ERISA and the shift to self-insured employer-sponsored health plans. PPOs are often not health insurers because they frequently do not bear underwriting risk. Instead, they are coordinators of contracts. In principle, a PPO is easy to establish. One approaches a local hospital and negotiates a price below hospital billed charges in exchange for encouraging (future) subscribers to use this hospital. One similarly obtains agreements from physicians who have privileges at this hospital. These 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 is a stereotypic PPO.

Many insurers, of course, also offer a PPO product. In some cases, these 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.

Point-of-service (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. Today, many insurers offer conventional coverage, as well as all three forms of managed care plans.

Table 1-1 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—73 percent. By 2005, conventional plans only enrolled 3 percent of insured workers. PPOs enrolled only 11 percent of insured workers in 1988 and had over 60 percent by 2005. 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 consumer-driven health plans

TABLE 1-1
Percentage of
Insured
Workers by
Type of Plan

<i>Type of Insurance Plan</i>	<i>1988</i>	<i>1995</i>	<i>2000</i>	<i>2005</i>	<i>2006</i>
Conventional insurance	73%	27%	8%	3%	3%
Health maintenance organization (HMO)	16%	28%	29%	21%	20%
Preferred provider organization (PPO)	11%	25%	42%	61%	60%
Point-of-service (POS) plan	—	20%	21%	15%	13%
High-deductible health plan (HDHP)	—	—	—	—	4%

SOURCE: Data from Claxton et al. (2006).