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# The Evolution of Health Insurance in America: A Look at the Past, Present, and Future of an Increasingly Dynamic Industry

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**Introduction**

From the origins of health insurance in the form of 20<sup>th</sup> century sickness insurance to the widespread ramifications of the recent passage of the Patient Protection and Affordable Care Act (PPACA), the health insurance industry in America has undergone an unprecedented amount of change throughout its relatively short history. Over the past century, rising medical costs as well as an increased demand for medical care have led to the rapid growth of the health insurance industry. What began as a relatively simple system has grown increasingly complex with the introduction of new plan designs, such as HMOs and CDHPs, and increasing government reform to accommodate the dynamic nature of healthcare. The goal of this thesis is to outline the evolution of health insurance in America by providing insight into the past, present, and future of this industry. This thesis will follow the evolution of health insurance beginning with its origin and inception to the current state of the industry in light of the recent passage of PPACA. Special attention will be devoted to the origins of health insurance, the creation of Blue Cross and Blue Shield, the government's establishment of Medicare and Medicaid, changes in plan design, and the potential implications of the recent passage of PPACA. Moreover, this thesis will demonstrate how key trends such as rising medical costs and increasing demand for health care have both shaped the health insurance industry throughout its evolutionary history and catalyzed the current desire for reform and its formulation under PPACA.

## **The Origins of Health Insurance**

Health insurance resembling the policies that are in effect today was not truly created until the 1920s; however, the origins of health insurance can be traced back to sickness insurance funds that were common in the early 20<sup>th</sup> century in America (Tewes 1). Prior to the 1920s, medical technology and the entire healthcare system in the U.S. were fairly rudimentary. Due to the archaic nature of healthcare, medical costs were low. Since the costs associated with health care were so low, health insurance was rather unnecessary for Americans in the early 1900s; however, what did present a potential high cost to families and individuals during this era was the lost wages that could result from sickness and injuries (Thomasson). In order to combat this potential loss, which could cripple the livelihood of families if the primary breadwinner were to become sick or injured, sickness funds were created and sponsored by employers and unions. Industrial sickness funds were usually run by employers or union leaders and generally required employees to pay a low initiation fee as well periodic dues. If an employee became sick or injured, he would notify the fund manager and receive benefits barring the approval of a union committee or physician. While many European nations at the time made sickness funds mandatory for certain industries and trades, the U.S. did not follow suit since such an act was seen as an intrusion into business and states' affairs (Roberts 7).

In addition to consumer reluctance to purchase health insurance due to low medical costs in the early 1900s, commercial insurance companies were also reluctant to offer health insurance policies to employers and individuals due to several issues. One of the major problems that commercial insurers found concerning health insurance was moral hazard, the idea that people with health insurance would be more likely to participate in activities that could jeopardize their health than those without insurance, thus increasing claims. The other major issue was adverse

selection, the concept that individuals in poor health would be more inclined to demand health insurance to cover medical costs than healthier individuals, thus leading to higher claims paid by the insurer and a higher risk pool of policyholders. While moral hazard and adverse selection impact all forms of commercial insurance in some way, commercial insurers in the early 1900s felt they lacked the data and knowledge necessary to calculate risks and price health insurance policies accordingly based on these two concepts (Thomasson). Thus, both the public's reluctance to purchase health insurance as well as the unwillingness of commercial insurers to offer a product that it could not accurately price would hinder the creation of health insurance policies until these attitudes evolved due to changes in the healthcare industry.

### **Initial Efforts for a National Health Insurance Program**

Despite the reluctance of both individuals and commercial insurers to consider health insurance, there were efforts in the early 1900s to make national health insurance a priority, especially one such effort that fell under the Progressive movement. In 1906, the American Association of Labor Legislation (AALL) led such an effort to create a compulsory health insurance program in America modeled after compulsory insurance programs offered in certain European nations at the time: "The bill limited coverage to the working class and all others that earned less than \$1200 a year, including dependents. The services of physicians, nurses, and hospitals were included, as was sick pay, maternity benefits, and a death benefit of fifty dollars to pay for funeral expenses...Costs were to be shared between workers, employers, and the state" (Palmer). While the bill found support among the American Medical Association (AMA), it was opposed by the American Federation of Labor on the basis that it "would weaken unions by usurping their role in providing social benefits" (Palmer). Moreover, the bill was also opposed by

the majority of commercial insurers who felt that the death benefit included in the bill would lead to decreased demand for life insurance policies offered by the commercial insurers which were a major source of profit (Palmer). Ultimately, the bill failed due to the large amount of opposition and lack of support from politicians at the time. The issue of a national compulsory health insurance program itself would be largely set aside until the 1930s.

Throughout the 1920s, the increasing cost and utilization of health care would help catalyze the transition from sickness funds to health insurance. Both advances in medical technology and increased educational standards for doctors improved the public's perception of healthcare and hospitals. This coupled with the general migration of the public from rural areas to urban centers led to increased demand for health care in the U.S. However, advances in technology as well as the increasing demand for medical care also led to the rising cost of health care. As a result, the costs associated with health care grew to occupy a larger portion of American's budgets, and medical costs began to be seen as more serious problem to individuals and families than the threat of lost wages that an illness could cause (Thomasson).

In order to address this mounting issue, an independent group of fifty economists, physicians, and other interest groups formed the Committee on the Cost of Medical Care (CCMC) in 1926. In addition to conducting research on the affordability issue of health care in America, the CCMC also published estimates of health care expenditures in the U.S. and supported several ideas that were controversial at the time, including: "group medical practices so that doctors could coordinate patient care and share the expense of facilities and equipment; networks of clinics in rural areas; and the concept of health insurance" (Roberts 8-9). Additionally, the CCMC recommended the devotion of more natural resources to medical care and in regard to health insurance, the organization supported the creation of voluntary health

insurance policies rather than a compulsory system. Due to the ramifications of the CCMC's proposal for physicians, the bill was opposed by the AMA and others on the basis that it would interfere substantially with the physician-patient relationship and that it could lead to the regulation of physician compensation (Roberts 9). This staunch opposition toward health insurance from the AMA as well as other issues surrounding the nation at the time in light of the Great Depression is believed to be one of the causes for Franklin Roosevelt's decision to not include a national compulsory health insurance program within the Social Security Act of his New Deal. Other issues such as unemployment insurance and old age benefits had taken precedence (Palmer).

### **Health Insurance in America: The Birth of the Blues**

In the late 1920s at the onset of the Great Depression, hospitals that were once full of patients faced difficulties due to a general lack of patients or the inability of patients to pay their medical bills. As a result of this growing issue, hospitals sought new ways to attract patients and cover their costs. Once such hospital, the Baylor Hospital in Dallas, Texas, introduced a novel payment plan that would revolutionize healthcare in America. For a small fee of \$.50 a month, Baylor Hospital agreed to pay for up to 20 days of hospital care for school teachers if three-quarters of the teachers in the school system signed up for the plan: "A teacher who broke her ankle during Christmas vacation in 1929 became the first person to file a claim under modern hospital insurance" (Roberts 10). Similar prepaid hospital service plans spread across the nation since they were seen as advantageous to both subscribers to the plans and the hospitals that offered them; guaranteeing patients lower costs should they need hospital services while also ensuring that hospitals had a steady stream of income which was paramount to their financial

solvency during the Great Depression. Together, these plans began to adopt the Blue Cross symbol used by a similar plan introduced in St. Paul, Minnesota and by 1938, over 2.8 million people were enrolled in some form of a Blue Cross plan (Thomasson).

In order to create more uniformity among the Blue Cross plans as well as reduce price competition among hospitals, the American Hospital Association (AHA) passed guidelines requiring that subscribers to these plans be allowed free choice of physician and hospital. Because Blue Cross plans were considered to be in society's best interest at the time, they "benefited from special state-level enabling legislation allowing them to act as non-profit corporations, to enjoy tax-exempt status, and to be free from the usual insurance regulations" (Thomasson). This legislation also allowed Blue Cross plans to not have to organize under the same laws for insurance companies, an act which would have forced the plans to maintain reserve requirements that would have been difficult since the plans had few financial resources (Thomasson).

Both the fear of a national compulsory health insurance program as well as the increasing popularity of Blue Cross plans, which physicians believed would lead to hospitals providing insurance for physician services, led physicians to reluctantly consider providing their own form of prepaid services. In 1934, the AMA adopted a series of principles created in order to prevent hospitals from underwriting physician services and to ensure that voluntary health insurance would remain under physician control (Thomasson). In 1939, the first prepaid plan for physician services was created and offered to employees earning less than \$3,000 for a fee of \$1.70 per month. Just as in the case of prepaid hospital plans, more prepaid physician plans began to follow under the encouragement of the AMA. Also, in a similar manner to Blue Cross plans, these prepaid physician service plans were allowed to operate as non-profit organizations exempt



from taxes and insurance regulations (Thomasson). The affiliation of these plans became known as Blue Shield in 1946. Blue Shield covered both medical and surgical physician services to hospitalized subscribers. Plans were set up to either directly reimburse physicians for services or in a manner that physicians “received the difference between their actual charges and the amount for which they were reimbursed by Blue Shield” (Thomasson). Premiums for both Blue Cross and Blue Shield plans were charged based on community ratings so that subscribers paid roughly the same amount regardless of age, gender, or medical factors (Roberts 11). The large growth in enrollment in both Blue Cross and Blue Shield plans that would occur throughout the 1930s and 1940s would soon garner the attention of large commercial insurers interested in participating in this new, lucrative market.

### **The Development of Commercial Health Insurance**

After viewing the success of the non-profit Blue Cross and Blue Shield plans and seeing continued consumer interest and demand for health insurance, commercial insurers began to view the health insurance market as potentially lucrative. The prospect of offering health insurance policies to groups of employees rather than individuals mitigated the risks of adverse selection and moral hazard that had previously kept commercial insurers from offering health insurance policies. Moreover, since commercial insurers would not operate as non-profit organizations, they could use experience rating to charge premiums to groups rather than the community rating that was required for Blue Cross and Blue Shield plans (Thomasson).

Unlike community rating which requires equal premiums for subscribers regardless of age, gender, or medical factors, experience rating allows insurers to charge different premiums to different groups of people based on factors such as age and health status. Thus, commercial

insurers would be able to charge lower premiums to younger, healthier groups, while charging higher premiums to older groups that may have higher claims based on health status.

Furthermore, experience rating both compensated insurers for taking on higher risk groups while also allowing the commercial insurers to compete with Blue Cross and Blue Shield plans for the business of healthier groups through charging lower premiums that often undercut those offered by the non-profit plans (Thomasson). With the entrance of commercial insurers into the health insurance market, the number of people enrolled in health insurance plans grew from roughly 20 million in 1940 to 140 million in 1950 (Thomasson). Enrollment in commercial health insurance plans would eventually surpass enrollment in Blue Cross and Blue Shield plans in the 1950s, leading the nonprofit plans to eventually abandon community rating in order to compete (Roberts 11).

### **Medicare, Medicaid, and Increased Accessibility to Health Insurance**

Despite the dramatic increase in enrollment in health insurance plans due to the growth in Blue Cross and Blue Shield plans as well as the entrance of commercial insurers into the market, the availability of health insurance did not increase uniformly among the U.S. population as certain groups of individuals such as seniors and the indigent would find difficulty in trying to access health insurance for themselves. The same experience ratings that made health insurance profitable for commercial insurers also made it difficult for senior citizens as well as the unemployed to obtain health insurance. Although a few efforts had been made throughout the 1950s in order to increase senior access to affordable health care, many of these efforts failed or did very little to cover the large costs that seniors faced in order obtain health care or health

insurance (Roberts 12-13). A serious effort to reduce the costs of health care for the poor and the elderly would not come about until the political landscape shifted in the 1960s.

In 1965 under the presidency of Lyndon Johnson and a Democratic majority in Congress, Medicare was passed as a federal program with uniform standards covering U.S. citizens automatically at age 65. Medicare consisted of two main parts upon its passage, Part A, which was a compulsory hospital insurance program that seniors were automatically enrolled into at age 65, and Part B, which provided supplemental insurance for physician services (Thomasson). In order to ensure that physicians would treat the elderly enrolled under Medicare and not refuse them service, Medicare included a provision to reimburse physicians for their services at their usual rates. Physicians were also granted the ability to bill patients directly which left Medicare to reimburse enrollees a portion of the fees and for the patient to cover the difference. Medicare would be funded primarily by payroll taxes, income taxes, and subscribers' premiums for Medicare Part B (Thomasson).

Included with the Medicare bill was Medicaid, a means-tested program set-up to provide medical resources to the impoverished. Unlike Medicare, which provided automatic enrollment for individuals upon reaching age 65 and was largely regulated by the federal government, Medicaid eligibility requirements and benefits were set by the states with the federal government solely providing minimum standards (Roberts 13). States received Medicaid payments from the federal government based on the state's per-capita income relative to the national per-capita income (Thomasson). Both Medicare and Medicaid would see numerous revisions following their passage in order to cope with the dynamic nature of the healthcare industry as well as the soaring costs of healthcare.

With the passage of Medicare and Medicaid, along with further advances in medical technology and prescription drugs, health care costs began to increase rapidly. The cost of medical services rose 7.9% annually in the five years following the passage of Medicare and Medicaid (Roberts 14). Both Medicare and Medicaid quickly exceeded their estimated costs soon after their passage and modified payment methods intended to reduce these costs were not accepted or passed by Congress initially (Roberts 15). Based on the large number of Medicaid recipients that greatly surpassed legislators' estimates, Medicaid eligibility requirements were eventually modified in 1967 by the federal government. However, in the decades to follow, Medicaid would be expanded to cover a larger user base beyond the low-income women and children of which its traditional user base primarily consisted (Roberts 15).

Medicare would also undergo modification in the decades to follow. In the early 1980s, due to the increased growth of Medicare claims expenditures, the traditional reimbursement method for Medicare was replaced by a fee schedule based on diagnosis groups in order to prevent physicians from using price discrimination and charging unreasonable fees (Tewes 3). More recently, in 2003 under the presidency of George W. Bush, the Medicare Prescription Drug Improvement and Modernization Act was passed narrowly by Congress. This act included Medicare Part D, which was a prescription drug plan for seniors that included cost sharing up to a certain benefit limit, and Medicare Part C, which allowed for the creation of Medicare Advantage Plans that would be offered by private health insurers to compete with traditional Medicare plans by often including all of the Medicare supplements within one plan (Tewes 3).

### **Evolution of Plan Design: From HMOs to CDHPs**

The soaring costs associated with health care that caused a modification of both Medicare and Medicaid would also come to impact traditional health insurance plans offered by

commercial insurers. In order to still offer health insurance to consumers without charging excessive premiums to compensate for the soaring costs of health care, insurers began to develop new types of policies that sought to reduce costs through the use of deductibles, co-payments, coinsurance, and healthcare networks. One such new form of policy was the concept of the Health Maintenance Organization (HMO).

HMOs are networks of care that provide an array of medical services for a prepaid fee. By participating in an HMO, a subscriber could receive all the medical services that they needed within one network of physicians, hospitals, and specialists. In addition to paying a premium for this service, the subscriber might also be required to pay a deductible or copayment for some of the services along with some form of coinsurance. However, if the subscriber were to go to someone outside of their HMO network, their health care would either not be covered, or the patient might have to pay a much larger portion of the bill than if they remained in their network (Murphy 184). Proponents of the HMO saw it as a means of creating integrated networks of primary and specialty care that would be more efficient and cost-effective due to the coordination of care that would occur within the HMO (Murphy 184-185). One such proponent of the HMO was Richard Nixon, who in 1971 called on Congress to establish grants and loan guarantees to facilitate the creation of more HMOs (Roberts 17). Although the legislation passed by Congress did not fully meet Nixon's goals for the HMO largely due to opposition from the AMA, Nixon did achieve success in the form of a 1972 amendment that allowed HMOs to enroll Medicare and Medicaid patients, as well as 1973 legislation which granted \$325 million to help with the proliferation of HMOs (Roberts 17).

Another evolution in health insurance plan design was the creation of the Preferred Provider Organization (PPO) in the late 1980s. Similar to the HMO, a network or organization of

preferred providers was set-up, and subscribers to the plan were given an incentive to use the providers within the PPO in the form of lower coinsurance for medical services. Unlike the HMO, a subscriber with a PPO plan could still voluntarily choose to see a physician or specialist outside of the network by forgoing the financial incentive and paying a higher coinsurance rate of roughly 10-20% more (Murphy 182). Despite the goal of the PPO to increase patient volume to providers within the network, which would aid insurers in reimbursement negotiation, the minimal financial incentive that was offered was often not sufficient enough to persuade subscribers to only use the medical services of providers within the PPO. Moreover, the PPO provided no limitations on the referral of patients to specialists whose medical services were often more costly and resulted in larger claims for health insurers (Murphy 182).

One manner of removing some of the major issues that had plagued the PPO plan was the development of the Point of Service (POS) plan and the concept of a network gatekeeper. POS plans make use of a primary care physician (PCP) who takes on the role of a network gatekeeper. PCPs would be offered financial incentives for controlling medical resources and limiting referrals to specialist, something which the PCP had sole control over. In this way, the PCP acted as the entry point for a subscriber to an entire network of health care involving other specialists when necessary. While the POS was successful in some ways through the limiting of more costly, specialized healthcare, the high administrative costs associated with the role of the network gatekeeper often offset these savings (Murphy 183-184).

Although the creation of managed health care plans such as the HMO, PPO, and POS was somewhat successful in mitigating the ever increasing costs of health care in the U.S., public backlash arose against these managed care plans throughout the 1980s and 1990s. Concerns arose among participants in HMO, PPO, and POS plans that managed care plans were leading to

an overall decrease in the quality of health care due to the cost-cutting goals of insurers and provider that set up these managed care networks. Moreover, participants feared that provisions such as gatekeepers would lead to decreased accessibility to specialists should the participants need them in light of a serious medical condition. A general fear arose that health plans and providers were more concerned about saving money rather than providing the best quality of medical treatment to participants in managed care plans (Blendon et al. 83-84).

Based on this backlash against managed care plans, insurers sought further means to reduce their expenditures and assuage the backlash against managed care through the creation of consumer-driven health plans. Proponents of consumer-driven health plans sought to entrust the consumer with a much larger role in choosing medical services and insurance with the overall goal of lowering the costs of health care while improving the quality (Roberts 25). The first such form of a consumer-driven health plan was the flexible spending account (FSA). The consumer would be allowed to deposit a portion of his compensation on a pre-tax basis into an account that could be used to pay annual health expenses other than premiums. Thus, the consumer would be able to choose both how and where to spend the money in the account, and any money not spent would be returned to the employer who did not have to pay Social Security or Medicare taxes on any money placed into the FSA by the employee (Murphy 190-191).

An improvement to the FSA which was authorized by Congress in 1996 was the medical savings account (MSA) (Roberts 25). The MSA was coupled with a traditional plan or PPO and included a large deductible which could be paid for through money held in the MSA. Any money that was not spent could be carried over to the next period, and money could be deposited into the account on a pretax basis (Murphy 191). Another form of consumer-driven health plan that came about around the same time as the MSA was the health reimbursement account (HRA).

Unlike the FSA and MSA, the HRA was funded by the employer as the employee was not permitted to contribute to the account. Similar to the MSA, money in the HRA was meant to cover the higher deductible of the PPO or indemnity plan associated with the HRA (Murphy 191-192). One final evolution of consumer-driven health plan was the health savings account (HSA) which was created as a provision of the Medicare Prescription Drug, Improvement, and Modernization Act passed in 2003 by President George W. Bush (Roberts 25). The HSA can be funded by both the employee and employer on a pre-tax basis up to a certain limit. Similar to the MSA and HRA, the HSA was often paired with a PPO plan with a high deductible, which was to be covered by money in the HSA. Money can be withdrawn from the HSA on a tax-free basis to cover a list of eligible healthcare expenses. Moreover, unspent funds in the account can be carried over until retirement at which point it can be used on retiree health insurance premiums (Murphy 193). The HSA provides the consumer with the incentive to choose where and how money in the HSA is used as well as to save money in the HSA since it can be carried over up until retirement and is owned by the employee.

### **Healthcare Reform in America**

Despite the introduction of Medicare and Medicaid as well as the evolution in plan design, the cost of health care continued to soar throughout the 1900s and 2000s, and over 45 million Americans remain uninsured due to both the cost and limited accessibility of health insurance (Levy). Moreover, efforts to address these mounting issues through the passage of universal healthcare and/or healthcare reform throughout the 1900s under President Clinton would prove to largely be unsuccessful. Healthcare reform would not be considered seriously until the inauguration of President Barack Obama in 2009.



In September 2009, legislation for what would eventually lead to the passage of the Patient Protection and Affordable Care Act (PPACA) was first introduced in Congress. Unlike many previous efforts at reform, which had considered the formation of a national compulsory health insurance program, President Obama sought a government health insurance program that would compete directly with private insurers, thereby offering the public multiple options (Levy). Such a provision was included in the Affordable Health Care for America Act, which was passed by the House of Representatives in November of 2009. However, the Senate, who sought a more conservative reform of health insurance, removed the public option from their version of the bill, which was passed in December 2009 (Levy). The two bills were reconciled in March 2010, and PPACA was signed in to law by President Obama on March 23, 2010. PPACA would face opponents immediately after its passage in the form of Republicans in Congress who sought to repeal the bill along with the attorney generals of multiple states who sought to bring PPACA to the courts in order to challenge several provisions within the bill that they deemed to be unconstitutional.

PPACA as it currently stands contains a multitude of provisions within it that attempt to accomplish three major goals: increasing the transparency of health care, increasing the accessibility of health care, and increasing the affordability of health care. These provisions, which have already impacted and will continue to impact both individuals and businesses began to take effect in January of 2010 following the bill's passage in March.

The first major goal of PPACA, increased transparency, focuses on concerns surrounding the accountability of both providers and private insurers in regard to health care and health insurance plans. This goal was first addressed in 2010 through the creation of a process made in conjunction with the states through which private health insurers must address unreasonable

premium rate increases. Additionally, a 2010 provision required new health plans to implement an external review process through which consumers could appeal health plan decisions (Implementation Timeline). Both of these provisions sought to make health insurers more accountable for their decisions regarding health plans. An additional provision which took effect in 2011 was the requirement for health plans to report the medical loss ratio (MLR) associated with their plan, which takes into account the ratio of premium dollars spent on medical claims. Under PPACA, if the MLR associated with an insurance plan is not above a level of 85% for large commercial health plans or 80% for small group and individual health plans, the insurer must provide a rebate to the policyholders (Implementation Timeline). Requiring the insurer to report the MLR associated with their plans was seen as a means of holding insurers accountable for the rates they charge in light of their actual claims expense, since these ratios could be easily viewed by the public and state departments. Finally, a provision that further addresses the goal of increased transparency that went in effect in 2012 was the requirement for insurers to provide a uniform summary of benefits and coverage to all applicants and enrollees so that policyholders would be more aware of the aspects of their health care coverage (Implementation Timeline).

The second major goal of PPACA, increased accessibility to health care, is accomplished through provisions that attempt to further expand health care coverage to Americans in the form of increased access to health insurance and the broader inclusion of benefits within health insurance plans. One such provision to increase health care accessibility through PPACA that took effect in 2010 was the extension of dependent coverage for adult dependent children up to age 26, which allows dependents that would have normally been forced to purchase their own form of health insurance to remain on the plan of their parents, thereby allowing them easier access to health insurance. Another 2010 provision addressing accessibility was the creation of a

temporary program to provide health insurance to those with pre-existing conditions that would normally be denied coverage or charged exorbitant rates (Implementation Timeline). An additional provision of PPACA that took effect in 2010 required new health plans to include minimum coverage for certain preventive services identified by a task force without cost sharing provisions such as copayments or coinsurance. This inclusion of certain preventive services was seen as a means of increasing accessibility to health care coverage and was later extended to Medicare and Medicaid. Medicaid will be further addressed through a provision extending coverage to all individuals with incomes up to 133% of the federal poverty level. This expansion will initially be covered entirely by the federal government (Chaikind, et al. 2). One final, major provision under PPACA that seeks to increase accessibility to health care coverage is the creation of state health insurance exchanges administered by governmental agencies or non-profit organizations in 2014. These exchanges will be open to individuals and small business with less than 100 employees. The exchanges will offer plans with different benefit levels and will be open to both private insurers and non-profit plans. Plans offered on the exchanges must meet certain minimum requirements, are limited to certain premium rating regulations, and must be guaranteed issue regardless of health status and preexisting conditions (Implementation Timeline).

The final major goal of health insurance, increased affordability, is accomplished through several provisions that seek to address and mitigate the rising costs of health care and health insurance. One of the provisions that took effect in 2010 addressing the issue of affordability was the small business tax credit which made providing health care coverage to employees more affordable by granting tax credits to businesses with less than 50 employees and less than \$50,000 in average annual wages that provided health insurance to employees. Another 2010

provision within PPACA included a rebate to address the Medicare Part D coverage gap, thereby increasing the affordability of prescription drugs to retirees. The year 2011 brought additional provisions under PPACA that sought to further address the issue of affordability of health care. Medicare was further addressed through the additional closing of the Medicare Part D coverage gap by providing subsidies and discounts on drugs purchased within the gap, through eliminating cost sharing for preventive services, and through restructuring payments under Medicare Advantage (Implementation Timeline). Further provisions that will be enacted in the coming years to address the affordability issues include premiums credits that will be offered to certain consumers that use the exchange to purchase health insurance provided they meet certain income requirements (Focus on Health Reform), and new premium rating guidelines that require insurers to be limited to a three to one rating variation based on age, no rating based on gender, and a one and a half to one ratio based on tobacco use (Implementation Timeline).

One additional provision under PPACA to be implemented in 2014 addressing the affordability issue that has undergone the most debate and stands as one of the main reasons why PPACA could be deemed to be unconstitutional by the U.S. Supreme Court is the individual mandate. Under the individual mandate, U.S. citizens and legal residents are required to have some form of qualifying health coverage. If an individual does not have a form of health care coverage by 2014, they will be forced to pay a “tax” penalty equal to the maximum of \$695 per year or 2.5% of household income barring a few exceptions. This penalty will be phased in starting in 2014 and will be increased according to cost-of-living adjustments following 2016 (Focus on Health Reform). Much of the controversy surrounding PPACA involves the individual mandate since it introduces the question of whether Congress has exceeded its powers to regulate interstate commerce outlined in the U.S. Constitution by requiring U.S. citizens to purchase

health insurance or otherwise face a “tax” penalty (Liptak). While some view the mandate as a necessary means to ensure that premiums do not spiral out of control due to adverse selection, others view the mandate as Congress overstepping its boundaries.

## **Conclusion**

Throughout the past century, healthcare and the health insurance industry have undergone an unprecedented amount of change. From the origins of health insurance in the form of employee sickness funds, to the development of Blue Cross and Blue Shield Plans and the subsequent rise of commercial health insurance plans, the health insurance industry has evolved considerably since its origin. The advancement of medical technology, rising costs of health care, increased demand for health insurance, and government policies have all tremendously impacted the health insurance industry. Nevertheless, health insurance continues to evolve as seen through the push for consumer driven health plans and the recent passage of PPACA. Regardless of the decisions made by the U.S. Supreme Court this June, the issues of accessibility and affordability that have surrounded health insurance since its inception will continue to play a significant role in both the economic, social, and political landscape of the 21<sup>st</sup> century.

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