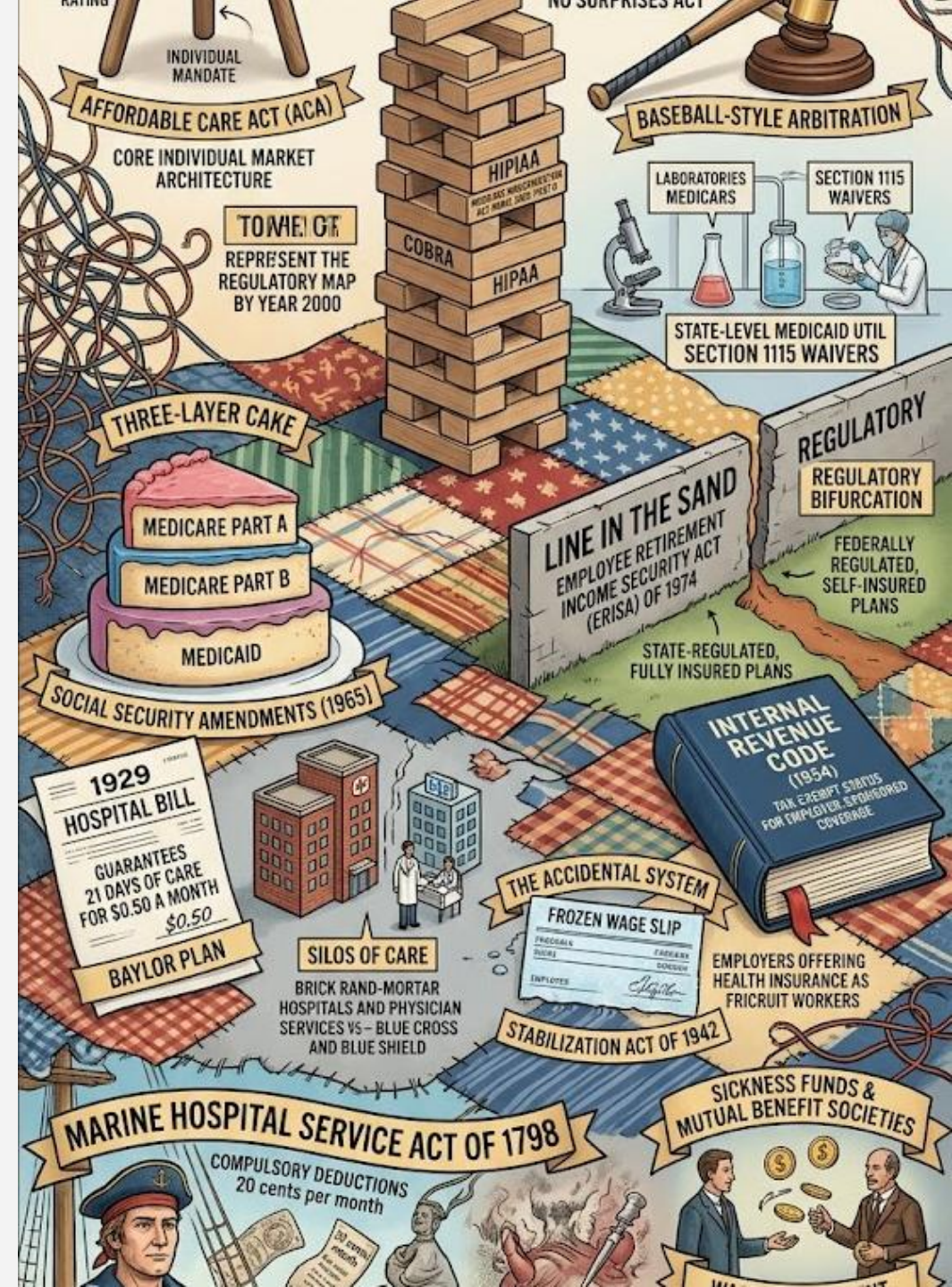


What A Tangled Web

How 250 years of health care developments have shaped regulation of health coverage in the U.S. and given us the patchwork system we enjoy today

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Where we're going

Never tell me the odds ...

Origins

First
Fights

The
Wartime
Turn

The 1965
Pivot

1970s
Plumbing

The MMA &
the ACA



Origins, 1798–1929

Prepayment before insurance — and why commercial insurers stayed away



The Marine Hospital Service Act of 1798

Compulsory before it was cool



20¢/month payroll deduction on merchant seamen funded a hospital network for sick and disabled sailors.

Prepayment, not a formal risk transfer – more like Social Security than health insurance

1800s Medicine

A non-system, often hazardous. And that's just the pricing ...

What patients faced

- Bloodletting, mercury, opium, and surgery without anesthesia or antisepsis.
- Medical intervention frequently produced negative outcomes.
- Care delivered at home; hospitals were almshouses where the poor went to die.
- Most coverage was fraternal sickness funds — wage replacement, not medical reimbursement.

Why insurers stayed away

- No standardized diagnoses; no reliable cost data.
- Catastrophic claims were unpredictable but small relative to other lines.
- Moral hazard: providers and patients colluded on "sickness" definitions.
- Industrial-sickness insurers reported <3% of premiums going to actual medical expenses.

Sickness funds, fraternalism, and the earliest health products

Still not insurance, though.

- Mutual-aid societies (Odd Fellows, Knights of Pythias, ethnic and immigrant lodges) pooled small contributions for sickness and burial benefits.
- Industrial sickness funds emerged in railroads, mining, and textile mills — often employer-organized, often non-actuarial, often insolvent.
- Early commercial products were "industrial insurance" — door-to-door weekly-premium policies focused on burial costs.
- Hospital indemnity products began appearing late 19th century but covered only fixed daily benefits, not the actual cost of care.
- Result: by 1900, coverage existed; risk transfer for the actual cost of medical care did not.

The Flexner Report (1910) and the quality pivot

The Proto-Actuarial Report

Abraham Flexner, funded by the Carnegie Foundation, surveys every U.S. and Canadian medical school.

Found most were unaccredited diploma mills with no laboratory training and no hospital affiliation.

Within 20 years, half of U.S. medical schools close. Physician supply tightens; physician income rises.

Combined with new science (anesthesia, antisepsis, X-ray, sulfa, eventually penicillin), medicine becomes effective enough — and expensive enough — to be worth insuring.



First Fights, 1915–1939

National health insurance,
The coalition that killed it,
And the Blues



The AALL bill (1915–1920): for it before they were against it

The American Association for Labor Legislation's compulsory state health insurance model

The AMA

- Initially endorsed compulsory health insurance — saw a steady payer.
- Rank-and-file physicians reversed once they realized fixed reimbursement would pay less than charity-patient fee-for-service.
- Established the AMA's century-long opposition reflex.

Organized labor

- Samuel Gompers (AFL) opposed.
- Logic: a public benefit would undercut the unions' role in providing welfare benefits.
- Pattern: any benefit "given" reduces the leverage of the body that fights to win it.

Commercial insurers

- Saw a federal scheme crowding out their nascent industrial-insurance business.
- Joined by post-WWI nativists who tied any "compulsory" program to Bismarck's Germany.
- Bill defeated in every state that considered it. Coalition collapses by 1920.

Baylor, The Blues, The Enabling Acts, and an Actuarial Maxim

As professional medicine grew – and socialized medicine fell – a market had a need, and the rest is ... history?

1929 — Baylor Hospital, Dallas: 21 days of inpatient care for \$6/year. The first true prepaid hospital plan. Becomes the prototype for Blue Cross.

1939 — California Physicians' Service launches the prototype for Blue Shield: prepaid physician services.

State legislatures pass "Enabling Acts" granting the Blues non-profit corporate status, tax exemptions, and exemption from the standard insurance reserve requirements that applied to commercial carriers.

The structural baseline?

- Community rating
- Guaranteed issue
- Provider-controlled boards

1932 — Committee on the Costs of Medical Care: 10% of families bore 41% of all medical costs. The risk distribution that justifies insurance is finally documented.

The 1939 status quo: Mostly hospital-only, voluntary, state-regulated

Actuaries? Still not a lot to do for health coverage.

- Coverage is overwhelmingly hospital-only, and overwhelmingly community-rated.
- Commercial carriers stay out of the market — the Blues' tax and reserve advantages make competition uneconomic.
- Coverage is sold to groups (employers, fraternalists) rather than individuals — the modern "group market / individual market" split has its origins in the early days of health coverage.
- Regulation is entirely state-based. There is no federal involvement of any kind – at least not yet.

The Wartime Turn, 1942–1954

How two accidents — a wage freeze and a tax-code rewrite — set boundaries for half of America



1942 Stabilization Act: wage controls force the pivot to benefits

The single most consequential health policy decision of the 20th century was made in an ... IRS ruling letter?



1942 — Stabilization Act freezes wages to control wartime inflation. Employers cannot compete for scarce labor on salary.

1943 — IRS rules that employer contributions for employee health insurance are not "wages" for the freeze, and are not taxable income to the employee.

Employers begin offering health benefits as a competitive lever. Enrollment in private health insurance roughly triples between 1942 and 1945.

1954: the Internal Revenue Code formalizes the deal

If you can't beat 'em, regulate 'em.

What the Internal Revenue Code Did:

- Section 106 — Employer contributions for employee health coverage are excluded from gross income, permanently.
- Section 105 — Employer-paid medical reimbursements are tax-free to the employee.
- Section 125 (added 1978) — Cafeteria plans let employees pay their share with pre-tax dollars.
- No cap on the exclusion. No income test.

Why it still matters

- Largest tax expenditure in the U.S. federal budget — approximately \$200B+ in income-tax-only terms (JCT), more if payroll-tax effects are included.
- Regressive: the higher the marginal tax rate, the larger the subsidy per dollar of benefit.
- Architecture that returns in §223 (HSAs), §7702B (LTC combo), §1557 — the tax code as a parallel insurance regulator.
- Every later reform fight is shaped by the invisible scale of this subsidy.

1945–1949: Truman tries, and a phrase is born

Wherein the AMA/Labor/Insurance triumvirate keeps batting 1.000

1945 — Truman proposes a single national health insurance program covering all Americans, financed by payroll tax.

- The AMA hires Whitaker & Baxter — the first modern political consulting firm — for a \$4.7M campaign (a fortune at the time).
- Their innovation: stop arguing the policy. Brand the program "socialized medicine." Tie it rhetorically to the Soviet Union at the start of the Cold War.
- The Truman plan dies in committee in 1949. The phrase "socialized medicine" enters the permanent vocabulary of federal health policy.

Comprehensive national health insurance does not get a serious legislative hearing again for sixteen years.

States Take the Wheel

Who actually regulates insurance — and why it took a Supreme Court accident to settle it



South-Eastern Underwriters to McCarran-Ferguson to NAIC

How the states secured their primacy by lawsuit, statute, and institution

The case (1944)

- U.S. v. South-Eastern Underwriters Ass'n, 322 U.S. 533.
- Supreme Court holds insurance IS interstate commerce, and is therefore federally regulable.
- Fifty state insurance departments are suddenly out of work.

The statute (1945)

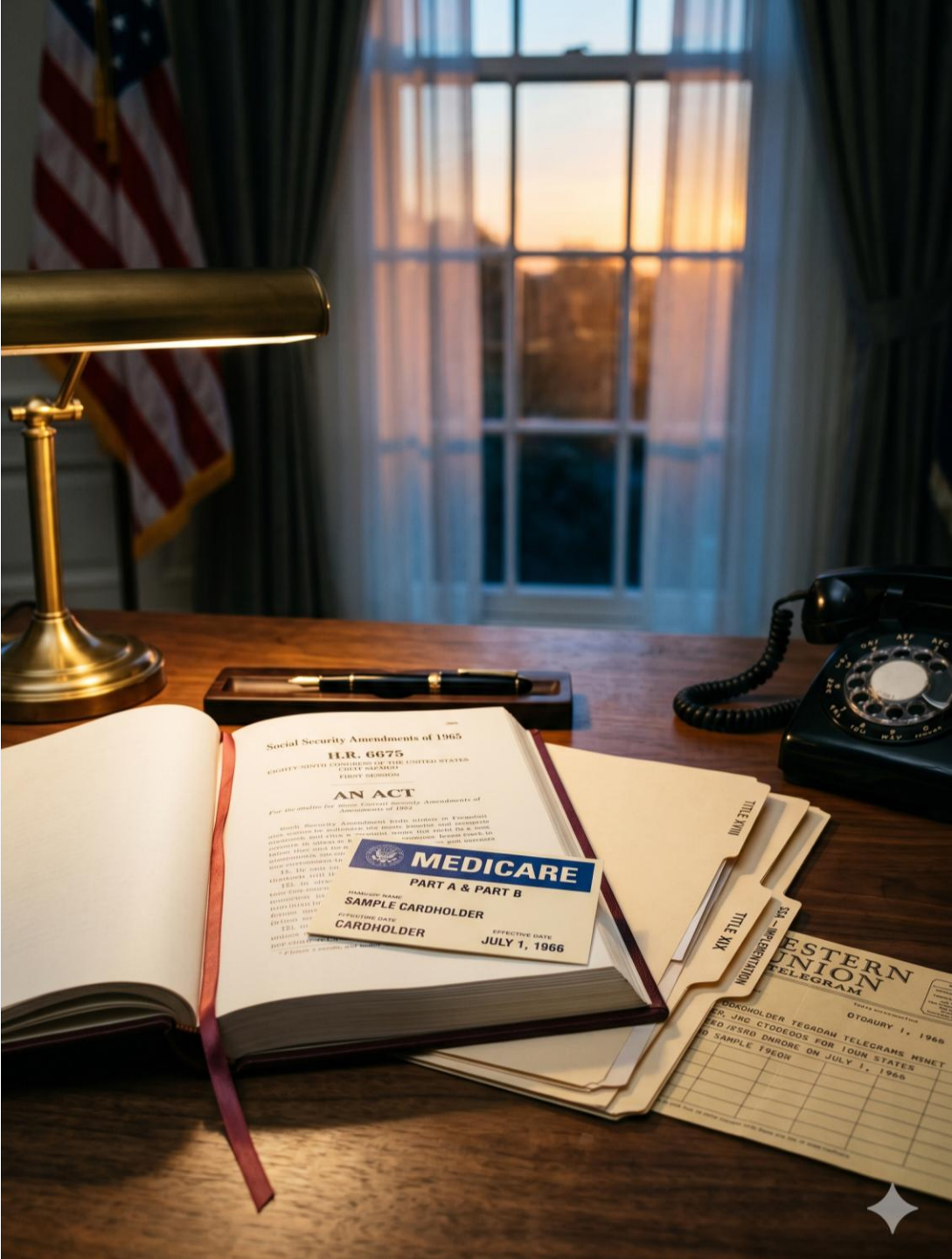
- McCarran-Ferguson Act, Pub. L. 79-15.
- Returns insurance regulation to the states by statute.
- Narrow federal carve-out only for Sherman & Clayton antitrust.
- A defensive statute, not a first-principles design.

The institution (NAIC)

- National Association of Insurance Commissioners.
- Model laws, model regulations, accreditation, actuarial standards.
- De facto national coordinator without federal authority.
- Every federal health statute since has to reckon with state primacy.

The 1965 Pivot

Medicare, Medicaid,
and the architecture
we still live in



How Medicare and Medicaid actually got passed

It turns out compromise didn't used to be a dirty word ...



President Johnson signing the Medicare program into law, July 30, 1965. Shown with the President (on the right in the photo) are (left to right) Mrs. Johnson; former President Harry Truman; Vice-President Hubert Humphrey; and Mrs. Truman. *Photo courtesy of LBJ Presidential Library.*

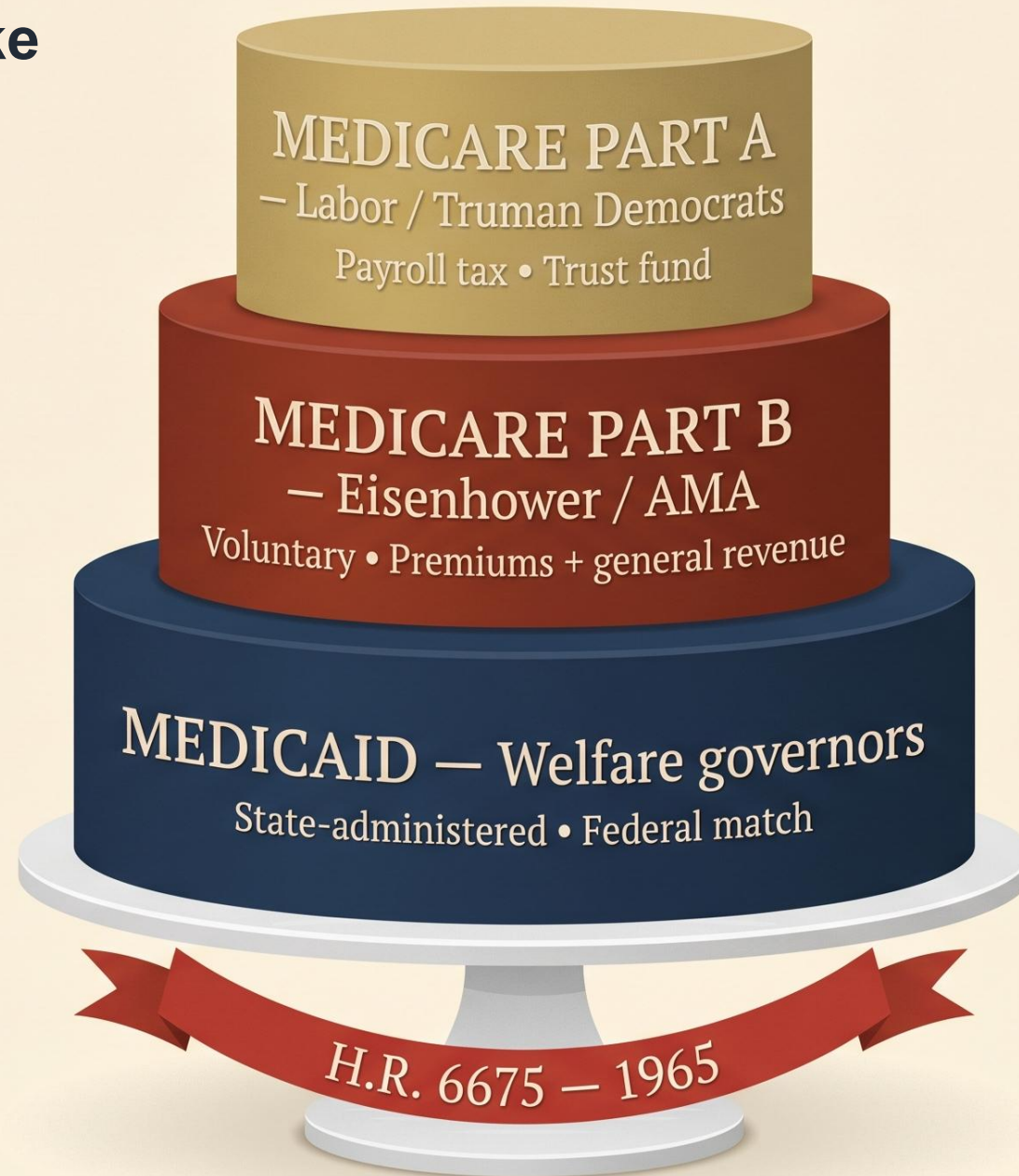
Post-Truman, Democratic strategy shifts to "narrow the population."

- Insure the elderly, most sympathetically / hardest for the private market to cover.
- Original 1965 proposal was hospital insurance for those 65+, financed by payroll tax.
- House Ways & Means Chair Wilbur Mills combines three proposals from three coalitions previously seen as alternatives.

The result is a bigger program than any single coalition asked for — and politically harder to dismantle than any of the parts would have been on their own.

The Three-Layer Cake

Three programs,
three coalitions,
one man,
one bill



"Reasonable cost" reimbursement

Wherein an actuarial bogeyman is born

To get the AMA and the AHA to acquiesce, Medicare reimbursed hospitals on their reported costs plus a return on capital — "reasonable cost" reimbursement.

- Hospitals had every incentive to expand cost categories. Medicare paid; nobody pushed back.
- Medicare expenditure growth runs 15%+ annually through the 1970s. The Hospital Insurance trust fund is projected near insolvency by the early 1980s.
- This is the proximate cause of the 1983 prospective payment system (DRGs) and the 1989 RBRVS — and the entire managed-care policy arc that follows.

Pay-for-cost without volume controls is the actuarial accelerant. Every subsequent payment reform tries to break that loop.

The other thing 1965 did: enforced civil rights

What good is a massive economy-altering bill good for if not a vehicle for enforcing other huge statutes?

Title VI of the Civil Rights Act of 1964: no program receiving federal financial assistance may discriminate on the basis of race, color, or national origin.

- Hospitals had been desegregating slowly and unevenly under *Simkins v. Cone* (1963). Title VI's enforcement mechanism was quiet but decisive: federal funds, conditioned on certified compliance.
- Medicare gave HHS a massive new revenue stream to condition. By the end of 1966, more than 1,000 hospitals had desegregated to qualify for reimbursement.
- This is the template for an enforcement architecture that recurs across U.S. health regulation: federal funding as the lever, administration policy priorities as the constraint.
- Returns in HMO Act federal qualification, in §1557 nondiscrimination, in Medicaid maintenance-of-effort, and in the IRA's drug-pricing penalties.

1970s Plumbing: HMOs and ERISA

A cost-control rebrand and the most consequential preemption clause in federal law



The HMO Act of 1973 and the Rebrand of Capitated Care

Nixon gets managed care across finish line with a little help from some friends



By 1970, U.S. medical inflation is 12%+. Nixon needs a cost-control story that doesn't look like the price controls his administration is imposing elsewhere.

Paul Ellwood reframes prepaid group practices as "Health Maintenance Organizations" — the word "maintenance" carries the entire political argument.

The HMO Act creates

- Federally-qualified HMO status
- Grants and loan guarantees
- A "dual-choice" mandate requiring large employers to offer an HMO alongside their indemnity plan.

Importantly, state insurance regulators are preempted for the first time since McCarran-Ferguson — but not the last.

ERISA 1974: a pension law that rewrote health coverage

The Employee Retirement Income Security Act says what about health coverage?

What Congress intended

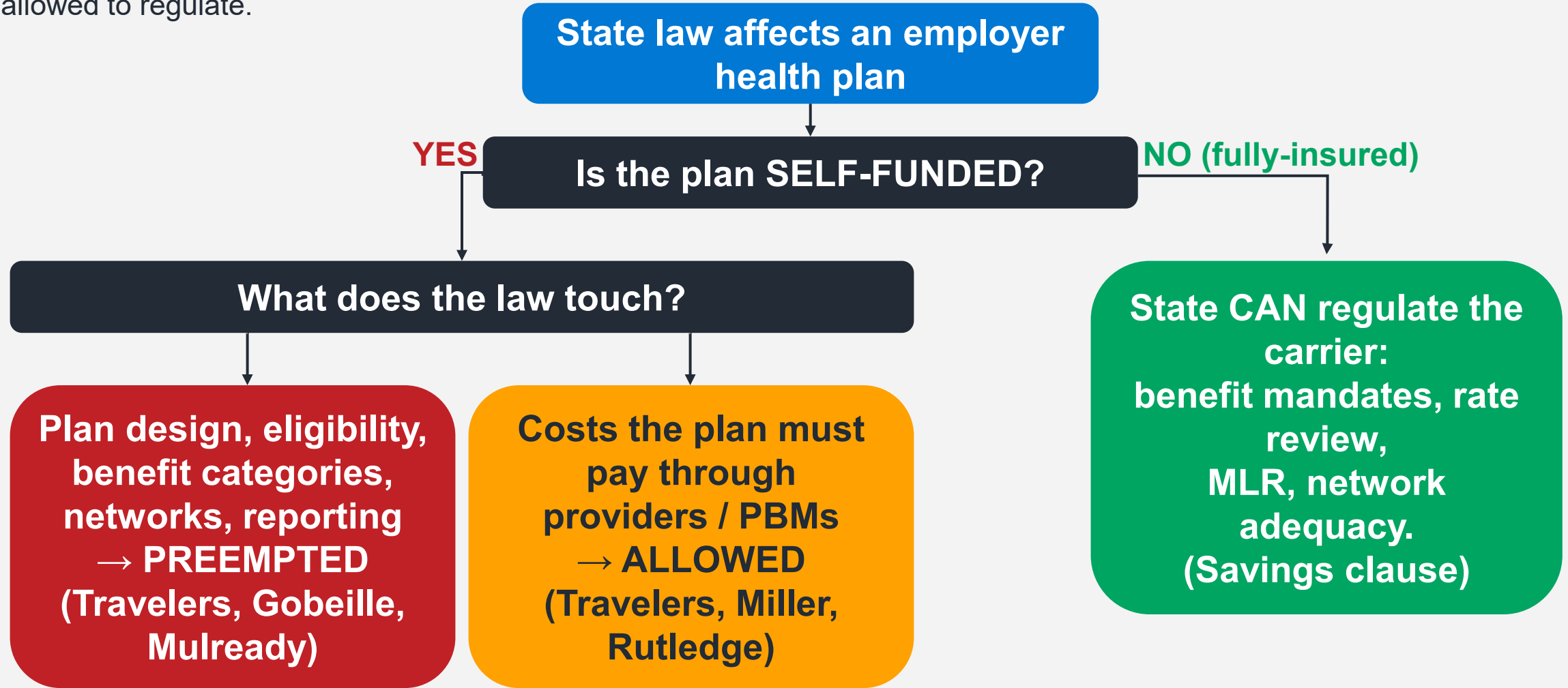
- Address pension-plan failures (the Studebaker default, 1963).
- Establish vesting rules, fiduciary duties, and federal pension reporting.
- Health plans were folded in as "employee welfare benefit plans" almost as an afterthought.
- Goal: uniform federal rules for multi-state employers.

What §514 did to the states

- ERISA "shall supersede any and all State laws insofar as they relate to any employee benefit plan."
- Savings clause preserves state regulation OF INSURANCE.
- Deemer clause: a self-funded plan cannot be "deemed" insurance for state-law purposes.
- Net result:
 - self-funded employer plan = federal-only
 - fully-insured = state via the carrier
 - Same employer, same employees, two regulators.

ERISA preemption — a working flowchart

If the law touches the plan document, ERISA is a shield. If it just changes the bill from the pharmacy or hospital, the state is allowed to regulate.



The Patchwork Era, 1980–2000

Cost control, coverage gaps, and incremental reform when comprehensive reform fails

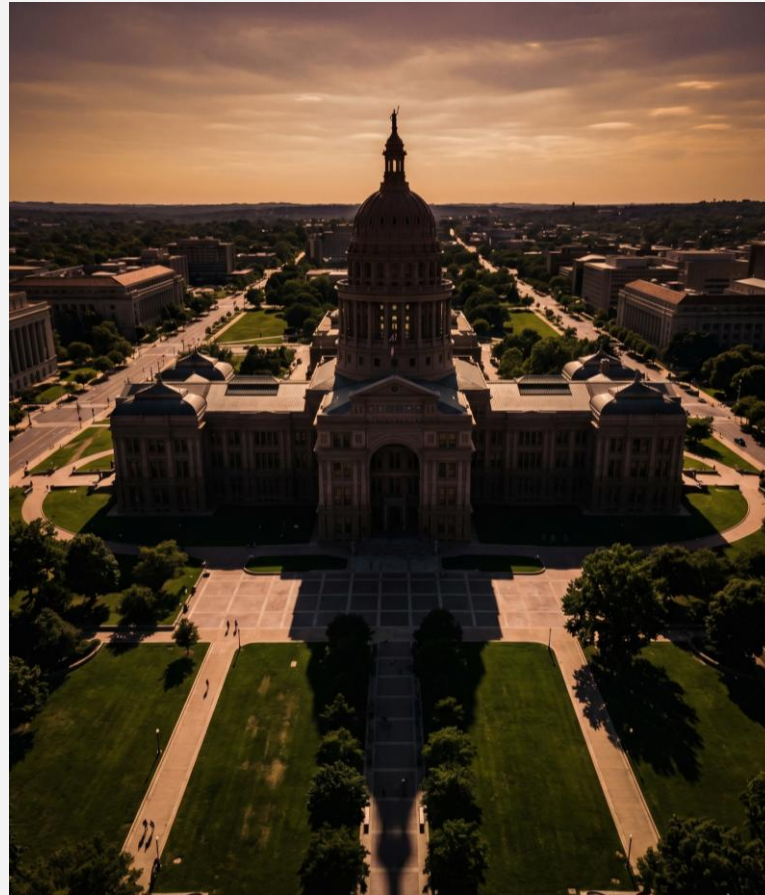


Medicaid Managed Care, From California Experiment to OBRA and the BBA

Once again, a need arises, the states experiment, the federal government formalizes.

1971 — California rolls out Prepaid Health Plans for Medicaid: capitated managed care to control costs. Loose oversight produces enrollment fraud, undertreatment, and a U.S. Senate investigation by 1973.

1981 — OBRA creates §1915(b) freedom-of-choice waivers and §1915(c) HCBS waivers. States can mandate managed care, with HHS approval.



1987 — TEFRA creates §1903(m) requirements: enrollment safeguards, marketing rules, actuarial soundness.

1997 — BBA finally lets states use mandatory managed care without a §1115 or §1915(b) waiver for most populations.

By 2010, the majority of Medicaid enrollees are in managed care.

The 1980s coverage acronyms — fast tour

Three federal reforms; HIPAA is the structural one

COBRA (1986)

- Continuation coverage for 18+ months after job separation.
- Premium up to 102% of the group rate.
- Adverse selection typically makes the actual claim cost 150–200% of the group rate.

Medigap standardization (OBRA 1980–1990)

- Ten standard plan letters (A–J originally).
- First major federal use of NAIC model law as a federal floor.
- MDRP drug rebates added in the same OBRA cycle.

HIPAA (1996) — the callout

- Pre-existing condition limits, portability between jobs.
- First federal data-privacy framework for health information.
- First major federal incursion into substantive private-insurance regulation — a federal floor under ERISA's preemption.
- Sets the template for the ACA 14 years later.

1993–1997: comprehensive reform fails, incrementalism delivers

What failed

- The Clinton plan (1993–1994): managed competition with employer mandate, regional alliances, comprehensive benefits.
- Same coalition that killed AALL and Truman: AMA, insurers, small business, the "Harry and Louise" ads.
- Bill never reaches a floor vote. Democrats lose Congress 1994.

What passed (because the big bill didn't)

- HIPAA (1996) — portability, pre-existing conditions, privacy.
- Mental Health Parity Act (1996) — annual & lifetime dollar limits only.
- BBA / SCHIP (1997) — block-grant children's coverage; first major federal entitlement on a capped-allotment design.

Together: federal regulation can expand without comprehensive reform.

The MMA and the ACA

The patchwork becomes the strategy



The Medicare Modernization Act of 2003: three things in one bill

An MA rebrand, a drug benefit, and an HSA experiment

Medicare Advantage

- Rebrand of Medicare+Choice with payment increases.
- Plan-level capitation; bidding against a benchmark.
- Enrollment grows from ~5M (2003) to over half of Medicare beneficiaries by 2024.
- Sets up risk-adjusted payment as the dominant Medicare model.

Part D

- Outpatient drug benefit delivered through private plans.
- Famous "donut hole" built in to fit a CBO 10-year score of ~\$395B.
- Noninterference clause: HHS prohibited from negotiating drug prices.
- Clause survives until the 2022 Inflation Reduction Act.

HSAs

- IRC §223. Tax-advantaged accounts paired with high-deductible plans.
- Federal government's most direct import of defined-contribution philosophy into health.
- Unusually prescriptive for a tax statute — qualifying plan's minimum deductible and OOP max set in statute and indexed by IRS.

The Many-Legged Stool

How the ACA's smorgasbord of reforms create a whole that stands on its own

Guaranteed Issue + Community Rating

Insurers must accept all applicants and may not price on health status. Resolves the pre-existing-condition problem.

Individual Mandate + Subsidies

Premium tax credits up to 400% FPL plus a tax penalty for not enrolling — together solve the adverse-selection problem the first leg creates.

Essential Health Benefits + Medical Loss Ratio

A federal benefit floor and an 80/85% MLR prevent insurers from competing by stripping coverage or padding administrative spend.

Remove any one leg — guaranteed issue without a mandate is the AALL problem; a mandate without subsidies is unenforceable; benefits without an MLR floor is the pre-2010 individual market.

Patterns the 250-year argument keeps producing

States experiment → federal government formalizes

- California PHPs → OBRA 1981 → BBA 1997 Medicaid MC.
- Massachusetts coverage → ACA exchanges.
- NAIC HMO Model Act → HMO Act of 1973.
- NAIC Medigap → OBRA 1990 standardization.
- When the pattern fails (LTC Partnerships → CLASS), it fails because the federal version skipped the state-experiment phase.

Adverse selection is the binding constraint

- AALL failed because it lacked an enforcement mechanism.
- COBRA cost 150–200% of group because of selection.
- CLASS sank because the voluntary enrollment couldn't outrun the selection.
- ACA needs all three legs — guaranteed issue, mandate + subsidies, benefit floor — to survive selection.

Every voluntary reform faces it. Every successful program solves it ... or sidesteps it.

The patchwork is not an accident. It is the equilibrium produced by 250 years of federal–state, public–private, employer–individual, and statutory–regulatory negotiations.

Questions?



Thank you!

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