



Health Insurance: A Primer

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Summary

Given the frequent introduction of legislation aimed at modifying or building on the current health insurance system, understanding the potential impact of such proposals requires a working knowledge of how health insurance is designed, provided, purchased, and regulated. This report provides background information about these topics.

People buy insurance to protect themselves against the possibility of financial loss in the future. Health insurance provides protection against the possibility of financial loss due to high health care expenses. Also, people do not know ahead of time exactly what their health care expenses will be, so paying for health insurance on a regular basis helps smooth out their out-of-pocket spending.

While health coverage continues to be mostly a private enterprise in this country, government plays an increasingly significant role. Especially during the latter half of the 20th century, government has initiated and responded to dynamics in medicine, the economy, and the workplace through legislation and public policies. One of the most recent legislative efforts was passage of the Patient Protection and Affordable Care Act (PPACA, P.L. 111-148). PPACA, as amended, includes provisions to encourage the expansion of health insurance coverage, particularly in the private market, and to establish new federal health insurance standards. When fully implemented, PPACA's private health insurance provisions will affect all major U.S. health care stakeholders, including the federal and state governments, employers, insurers, health care providers, the medical products industry, and consumers.

Individuals and families without health coverage are more likely than those with coverage to forgo needed health care, which often leads to worse health outcomes and the need for expensive medical treatment. Since uninsured persons are more likely to be poor than insured persons, the uninsured are less able to afford the health care they need. Uninsurance can lead to health care access problems for communities, such as increased problems obtaining specialty care. Taxpayers and the nation as a whole are affected through increased taxes and health care prices to cover the uncompensated care expenses of uninsured persons.

Americans obtain health insurance in different settings and through a variety of methods. People may get health coverage through the private sector, or from a publicly funded program. Consumers may purchase health insurance on their own, as part of an employee group, or through a trade or professional association. However, approximately 51 million Americans did not have health coverage in 2009.

Health insurance benefits are delivered and financed under different systems. The factors that distinguish one delivery system from another are many, including how health care is financed, how much access to providers and services is controlled, and how much authority the enrollee has to design her/his health plan. To illustrate, managed care is characterized by predetermined restrictions on accessing services and providers, whereas individual decision-making regarding use of health benefits is a hallmark of consumer driven health care, such as health savings accounts. As economic conditions change, a specific delivery system may gain or lose the interest of affected parties.

This report will be updated periodically.

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Introduction

As health insurance coverage has evolved from an uncommon benefit to a routine one, government's role in subsidizing and regulating that coverage also has changed. While most insured Americans obtain health coverage through the private sector, public entities play an increasingly significant role.

Government's involvement in health coverage expanded dramatically in the latter half of the 20th century:

- A long-standing rule issued by the Internal Revenue Service (IRS) stated that an employer's contributions to employment-based health insurance could not be included in an employee's gross income for tax purposes (Internal Revenue Code, Section 106). This ruling helped spur the growth of employer-sponsored health benefits. The IRS also stated separately that employers could deduct such contributions as part of business expenses.
- Advances in medicine led to escalating consumer demand for newer, better treatments. At the same time, the cost of some treatments increased, which was especially problematic for certain groups of consumers who lacked health coverage. This led to government efforts to assist health care consumers in paying for medical services through social insurance programs.¹
- More and more employees began to work for more than one employer over their lifetimes. Government was called on to address a problem many workers faced: keeping health coverage as workers moved from job to job.

Given the frequent introduction of legislation aimed at modifying or building on the current health insurance system, understanding the potential impact of such proposals requires a working knowledge of how health insurance is designed, provided, purchased, and regulated. This report provides background information about these topics.

What Is Health Insurance?

Definitions and Principles

People buy insurance to protect themselves against the possibility of financial loss in the future. Such losses may be due to a motor vehicle collision, natural disaster, or other circumstance. For patients, financial losses may result from the use of health care services. Health insurance provides protection against the possibility of financial loss due to high health care expenses. Also, people do not know ahead of time exactly what their health care expenses will be, so paying for health insurance on a regular basis helps smooth out their out-of-pocket spending.

¹ Publicly funded health programs generally either provide funding for direct medical services or assist consumers in paying for health care. The latter are included in a broad category of programs based on "social insurance" principles. Social insurance refers to publicly funded insurance programs that are statutorily mandated for certain groups of people, such as low-income individuals.

The concept underlying insurance is “risk” (i.e., the likelihood and magnitude of financial loss). In any type of insurance arrangement, all parties seek to minimize their own risk. In health insurance, consumers and insurers approach the management of insurance risk differently. From the consumer’s point of view, a person (or family) buys health insurance for protection against financial losses resulting from the future use of medical care. From the insurer’s point of view, it employs a variety of methods to minimize the risk it takes on when providing health coverage to consumers, to assure that it operates a profitable business. One method is to cover only those expenses arising from a pre-defined set of services (generally called “covered” services). Another method for limiting risk is to encourage healthier people to obtain health coverage, presumably because healthier people would not need as many medical services as sicker people, leading to fewer claims that the insurer would have to cover.

While the methods employed by an insurer differ from those of a consumer, each has the same goal: to minimize risk in an uncertain future. It is this uncertainty of the future and risk of financial loss which form the context for insurance, and the strategies to make financial loss more predictable and manageable which drive insurance arrangements.

Uneven Distribution of Health Care Expenses

In health care, a minority of consumers are responsible for a majority of expenses. According to analysis of national health care expenditure data, 5% of the population accounted for about half of all health expenditures in 2007, and 10% of the population accounted for nearly two-thirds of expenditures in the same year.² Given the unevenness of health care spending and the improbability of identifying all of the highest spenders before they use medical services, insurers employ various strategies in order to minimize the risk they bear. Examples of such strategies include denying coverage altogether, excluding certain benefits to treat preexisting health conditions, and increasing premiums based on an applicant’s risk (if allowed under law).

Risk Pool and Rate Setting

A function of insurance is to spread risk across a group of people. This is achieved in health insurance when people contribute to a common pool (“risk pool”) an amount at least equal to the *expected* cost resulting from use of covered services by the group as a whole. In this way, the *actual* costs of health services used by a few people are spread over the entire group. This is the reason why insuring larger groups is considered less risky—the more individuals participating in a risk pool, the less likely that the serious medical experiences of one or a few persons will result in catastrophic financial loss for the entire pool.

An insurer calculates and charges a premium in order to finance the health coverage it provides. The premium reflects several components, including the expected cost of claims for health care use in a year, administrative expenses associated with running the plan, and a profit margin.³ If the insurer accurately estimates future costs and sets appropriate premium levels, then that risk

² Kaiser Family Foundation, “Concentration of Health Care Spending in the U.S. Population, 2007,” January 7, 2010, available online at <http://facts.kff.org/chart.aspx?ch=1344>.

³ The premium calculation is further adjusted to reflect a variety of factors collectively known as the underwriting cycle.

pool has reached equilibrium where premiums paid by healthy persons in the risk pool help subsidize the higher-than-average costs of less-healthy persons in the pool.

Risk Pool Composition and Adverse Selection

As noted above, one of the ways insurers attempt to make future costs more predictable is by spreading the risk of a few high-cost individuals across many people. But the number of people in a risk pool is not the only significant factor. Equally as important, if not more so, is the composition of the group.

A consumer's decision to obtain health coverage is based on a variety of factors, such as individual health status, estimated need for future medical care, and disposable income. Consumers with different health conditions, as well as varying degrees of comfort towards risk-taking, will differ on whether they consider health insurance necessary. This is a circumstance that insurers will consider when estimating their expenses to cover future health care use. With this in mind, insurers generally will vary the premiums they charge and the health services they cover (subject to state and federal rules) in order to attract various segments of the population. This flexibility in rate setting and benefit determination is particularly important in a competitive insurance market where insurers try to provide the most attractive rates to increase their market share.

However, some risk pools do attract a disproportionate share of unhealthy individuals. In part, this is because individuals generally know more about their own health conditions (at least in the near term) than anyone else, including an insurer. Therefore, health care consumers have an advantage over insurers in terms of knowing the kind and amount of health services they will use, at least in the short to mid term. This "information asymmetry" between what consumers know compared to what insurers know gives consumers an advantage when looking for health coverage that will meet their future demand for health care. For example, if a consumer plans on obtaining orthodontic care in the near future, that consumer will look for a health plan with generous dental benefits. Information asymmetry is another source of uncertainty that insurers take into account when developing and pricing insurance products.

When a disproportionate share of unhealthy people make up a risk pool, a phenomenon known as "adverse selection," the cost for each person in the pool rises. The higher costs may encourage the departure of healthier members from the group, and discourage the entrance of other healthy people, since healthier people may be able to find cheaper coverage elsewhere or decide that coverage is too costly and become uninsured. In either situation, it leaves an even less healthy group of people in the risk pool, which again causes the cost to rise for the remaining participants. If there is no change in this dynamic, the group may experience a "death spiral" as it suffers substantial adverse selection leading to an increasingly expensive risk pool and possibly dissolution of the pool altogether. Therefore, despite the consumer's information advantage, it does not guarantee access to affordable and adequate health coverage.

Group Market, Nongroup Market, and Medical Underwriting

Health insurance can be provided to groups of people that are drawn together by an employer or other organization, such as a trade union. Such groups are generally formed for some purpose other than obtaining insurance, like employment. When insurance is provided to a group, it is

referred to as “group coverage” or “group insurance.” In the group market, the entity that purchases health insurance on behalf of a group is referred to as the plan “sponsor.”

Consumers who are not associated with a group can obtain health coverage by purchasing it directly from an insurer in the individual (or nongroup) insurance market. Insurance carriers in the nongroup market conduct an analysis of each applicant’s insurability. An applicant usually must provide the insurer with an extensive medical history and, while uncommon, may be asked to undergo a medical exam or provide physical specimens. The information is used by carriers to assess the potential medical claims for each person by comparing characteristics of the applicant to the insurance experience of others with similar characteristics. Once such an evaluation has been conducted, the carrier decides whether or not to provide health coverage and determines the terms for coverage. This evaluation and determination process is referred to as “medical underwriting.”

Medical underwriting is standard practice in the individual insurance market, though a carrier’s ability to reject applicants or vary the terms of coverage are restricted to some degree by federal and state requirements. In the group health insurance market, insurers forgo underwriting in the traditional sense (i.e., reviewing *each* person’s demographics and medical history). Instead, an insurer looks at the characteristics of the collective group, such as its claims history, group demographics, and geographic location. The insurer then charges a premium based on the analysis of the group’s characteristics. There are exceptions to this for very small groups. For example, when a firm with only a handful of employees applies for health coverage, the insurer may choose to review the health conditions of each person in order to establish a premium for the entire group. Or, the insurer may charge a larger premium due to the larger risk attributed to smaller groups, if permitted under law.⁴

Fully Insured vs. Self-Insured Plans

A common distinction made between types of health insurance products is whether they are fully insured or self-insured. A fully insured health plan is one in which the plan sponsor purchases health coverage from a state-licensed insurance carrier. The insurer assumes the risk of providing health benefits to the sponsor’s enrolled members. In contrast, organizations who self insure (or self fund) do *not* purchase health coverage from state-licensed insurers. Self-insured plans refer to health coverage that is provided directly by the organization seeking coverage for its members (e.g., a firm providing health benefits to its employees). Such organizations set aside funds and pay for health benefits directly. Under self insurance, the organization bears the risk for covering medical expenses, and such benefit plans are not subject to state insurance regulations. Firms that self fund typically contract with third-party administrators (TPAs) to handle administrative duties such as member services, premium collection, and utilization review. TPAs do not underwrite insurance risk.

Self-Only vs. Family Coverage

Another common distinction made in health insurance is the tiers of coverage provided under a policy; that is, whether the policy covers one person, a family, or other groupings. Under self-

⁴ G. Claxton, “How Private Insurance Works: A Primer,” Kaiser Family Foundation (KFF) website, April 2002, at <http://www.kff.org/insurance/upload/How-Private-Insurance-Works-A-Primer-Report.pdf>.

only coverage, the holder of the insurance policy is the only person insured. (Self-only coverage is also called individual coverage. Individual coverage in this sense should not be confused with health coverage from the individual insurance market—see discussion above.) Family coverage applies to the policyholder and his or her dependents. Other tiers of coverage include self plus one (two adults), and self plus children.

Administrative Expenses

Costs for administrative functions encompass a wide range of operational activities. Administrative expenses include costs associated with contracting with providers, sales and marketing, enrollment and billing, customer service, utilization review, case management, and other functions. Because of economies of scale, administrative expenses in the group market are a smaller portion of overall costs, compared to those in the nongroup market.⁵

Tax Preference

Health insurance coverage in the United States is provided through a patchwork approach that combines private and public means for providing and paying for health insurance and health care. One of the key pieces of this approach encouraged the growth of employment-based health coverage via the tax code.

Section 106 of the Internal Revenue Code states that employer contributions to employment-based health insurance are not included in workers' gross incomes for tax purposes. This tax preference encourages workers to sign up for ("take-up") health coverage within the work setting. A separate ruling by the Internal Revenue Service clarified that such employer contributions are business expenses and, therefore, deductible from employers' taxable income. Both parties benefit: employers use health insurance coverage as a means to recruit and retain workers, while workers typically get access to more services at better rates (see discussion below). However, economic theory suggests that workers receive reduced wages to compensate for richer benefits.

The tax exclusion of health benefits is one of the primary reasons why health insurance coverage is provided mainly through the workplace in the United States. Approximately two out of three nonelderly (under 65) Americans have employer-sponsored insurance.

Health Insurance Regulation

Health insurance regulation addresses a wide variety of issues: the benefits that must be offered, the individuals to whom the insurance is made available, and the responsibilities insurers have to plan enrollees, to name a few. One of the most contentious issues regarding health insurance regulation is whether it is the responsibility of individual states or the federal government. This distinction is important because federal and state laws governing health plans differ on issues such as patient compensation in courts, consumer access to care, and mandated coverage for certain benefits.

⁵ Given that insurers monitor administrative costs as part of managing their businesses, such information is considered proprietary. Therefore, there are no reliable national estimates of the portion of insurers' expenses attributable to administrative functions.

Primary Responsibility of the States

The regulation of insurance traditionally has been a state responsibility, as clarified by the 1945 McCarran-Ferguson Act. However, overlapping federal requirements complicate the matter with respect to health insurance. Individual states have established standards and regulations overseeing the “business of insurance,” including requirements related to the finances, management, and business practices of an insurer. For example, all states have laws that require state-licensed insurance carriers to offer coverage for specified health care services (known as “mandated benefits”). Because fully insured plans are subject to state-established requirements, those plans must offer those mandated benefits. On the other hand, self-insured plans are not subject to state insurance regulations so they are exempt from such requirements.

Key Federal Laws

Regardless of whether health plans are fully insured or self-funded, they are subject to federal laws. Three federal laws in particular—the Employee Retirement Income Security Act of 1974 (ERISA, P.L. 93-406), the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191), and the Patient Protection and Affordable Care Act (PPACA, P.L. 111-148)—have significant impact on how health insurance is provided.

ERISA outlines minimum federal standards for private-sector employer-sponsored benefits. (Public employee benefits and plans sponsored by churches are exempt from ERISA). Passed in response to abuses in the private pension system, the act was developed with a focus on pensions but the law applies to a long list of “welfare benefits” including health insurance. ERISA requires that funds be handled prudently and in the best interest of beneficiaries, participants be informed of their rights, and there be adequate disclosure of a plan’s financial activities. It preempts state laws that “relate to” employee benefit plans. (In other words, the federal law overrides state laws affecting private-sector employee benefits). This portion of ERISA was designed to ensure that plans would be subject to the same benefit laws across all states, partly in consideration of firms that operate in multiple states. However, state laws still apply for issues which involve the “business of insurance.” The delineation of issues attributable to the phrases “relate to” and “business of insurance” is not clear, and has led to long-standing debates and active litigation over the scope of ERISA preemption.⁶

The core motivation behind the Health Insurance Portability and Accountability Act of 1996 (HIPAA) is to address the concern that insured persons have about losing their coverage if they switch jobs or change health plans (“portability” of health coverage). The act’s health insurance provisions established federal requirements on private and public employer-sponsored health plans and insurers. It ensures the availability and renewability of coverage for certain employees and other persons under specified circumstances. HIPAA limits the amount of time that coverage for pre-existing medical conditions can be excluded, and prohibits discrimination on the basis of health status-related factors. The act also includes tax provisions designed to encourage the expansion of health coverage through several mechanisms, such as authorizing tax-advantaged medical savings accounts and a graduated increase of the portion of premiums self-employed persons may deduct from their federal income tax calculations. Another set of HIPAA provisions addresses the electronic transmission of health information and the privacy of personally

⁶ For more information about ERISA regulation of health benefits, see CRS Report RS22643, *Regulation of Health Benefits Under ERISA: An Outline*, by Jennifer Staman.

identifiable medical information (administrative simplification and privacy provisions, respectively).⁷

The 111th Congress passed comprehensive health reform legislation: the Patient Protection and Affordable Care Act (PPACA, P.L. 111-148). Enacted on March 23, 2010, PPACA, as amended, includes private insurance provisions that impose new requirements on individuals, employers, and health plans; restructures the private health insurance market; sets minimum standards for health coverage; and provides financial assistance to certain individuals and, in some cases, small employers. While many of the private insurance provisions of PPACA will not be effective until 2014, some provisions have already been implemented or become effective. Examples of implemented programs include the temporary high-risk pools for uninsured individuals with preexisting health conditions; a reinsurance program to reimburse employers for a portion of the health insurance claims' costs of their 55- to 64-year-old retirees; and small business tax credits for firms with fewer than 25 full-time equivalents that choose to offer health insurance. Examples of PPACA provisions that have become effective are the health plan requirements to extend dependent coverage to children under age 26, provide coverage for preexisting health conditions to children under age 19, and prohibit lifetime dollar limits on essential benefits. When fully implemented, PPACA's private health insurance provisions will affect all major U.S. health care stakeholders, including the federal and state governments, employers, insurers, health care providers, the medical products industry, and consumers.

Health Insurance Premiums

The most current, publicly available data on employer health benefits found that the average annual premium for self-only coverage was \$5,049 in 2010. The average premium for a family of four was \$13,770.⁸ These average premiums represent a 5% increase in the cost for employer-sponsored health benefits for self-only coverage and a 3% increase for family coverage, compared to the previous year's average premiums. While this signals a reprieve from double-digit increases in recent years, the average premium growth rates still outpaced both wage growth and general inflation.⁹

Why Is Health Insurance Considered Important?

While health insurance coverage is not necessary to obtain health care, it is a useful mechanism for accessing services in an environment of increasingly expensive health care. As health care costs continue to rise, more people need greater assistance with covering medical expenses. Health insurance provides some measure of protection for consumers, especially those who have limited means or greater-than-average need for medical care.

⁷ For more information about HIPAA, see CRS Report RL31634, *The Health Insurance Portability and Accountability Act (HIPAA) of 1996: Overview and Guidance on Frequently Asked Questions*, by Hinda Chaikind et al.

⁸ These averages include both the employer and employee shares of the total premium. The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2010 Annual Survey*, available online at <http://ehbs.kff.org/>.

⁹ From 2009 to 2010, inflation rose by 2.2%, and wages rose by 2.3%. G. Claxton et al., "Health Benefits in 2010: Premiums Rise Modestly, Workers Pay More Toward Coverage," *Health Affairs*, vol. 29, no. 10, October 2010.

Health insurance is considered important also because of the well-documented, far-reaching consequences of uninsurance. For instance, uninsured persons are more likely to forgo needed health care than people with health coverage. This includes forgoing services for preventable or chronic conditions, which often leads to worse health outcomes.¹⁰ Uninsured persons also are less likely to have a “usual source of care,” that is, a person or place identified as the source to which the patient *usually* goes for health services or medical advice (not including emergency rooms). Having a usual source is important because people who establish ongoing relationships with health care providers or facilities are more likely to access preventive health services and have regular visits with a physician, compared with individuals without a usual source.¹¹ Therefore, to the extent that health insurance coverage facilitates access to basic medical services, people without coverage face substantial barriers in the pursuit of the health care they need. For 2003-2004, almost 10% of nonelderly adults with private health insurance identified no usual source of care, compared with around 49% of uninsured, nonelderly adults who reported no usual source.¹²

The negative consequences of uninsurance extend beyond the persons directly involved. For example, the Institute of Medicine found that the insurance status of parents affects the amount of health care their children receive.¹³ Another study has found negative spillover effects of uninsurance to the community at large. For instance, *insured* adults in communities where uninsurance is high are less likely to have a usual source of care compared to insured adults in low-uninsurance communities. And “a higher proportion of insured adults also reported having more problems getting a referral to see a needed specialist in high-uninsurance communities than in low-uninsurance communities.”¹⁴ In addition, many uninsured persons forgo preventive health care and end up developing more serious conditions requiring complex, expensive medical services. Since health coverage is positively related to income, uninsured persons are less likely to be able to afford this level of care. In cases where patients are unable to cover the costs associated with receiving health services, the facilities that provided those services must take it as a financial loss (i.e., uncompensated care). These losses can be staggering. For example, one study estimated that uninsured individuals received approximately \$56 billion worth of uncompensated care in 2008.¹⁵

Ultimately, though, the costs for caring for the uninsured are “passed down to all taxpayers and consumers of health care in the form of higher taxes and higher prices for services and insurance.”¹⁶ Taxpayers are affected because the federal government makes payments to hospitals, which take into account the share of poor people treated. The assumption is that facilities that treat a larger proportion of poor people have a greater problem with uninsurance and uncompensated care. The federal government also provides grants to many health centers and

¹⁰ Kaiser Commission on Medicaid and the Uninsured, “The Uninsured and Their Access to Health Care,” November 2005, at <http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=29284>.

¹¹ J.E. DeVoe, et al., “Receipt of Preventive Care Among Adults: Insurance Status and Usual Source of Care,” *American Journal of Public Health*, May 2003.

¹² National Center for Health Statistics, *Health, United States, 2006*, Table 77, at <http://www.cdc.gov/nchs/data/hus/hus06.pdf#executivesummary>.

¹³ Institute of Medicine, Committee on the Consequences of Uninsurance, *Coverage Matters: Insurance and Health Care*, 2001.

¹⁴ M. Pauly and J. Pagan, “Spillovers and Vulnerability: The Case of Community Uninsurance,” *Health Affairs*, Vol. 26, No. 5, p. 1309.

¹⁵ J. Hadley et al., “Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs,” *Health Affairs*, Web Exclusives, August, 25, 2008.

¹⁶ Institute of Medicine, Committee on the Consequences of Uninsurance, *A Shared Destiny*, 2003, p. 122.

other facilities that serve poor communities. In addition, states and localities fund local health programs, public hospitals, and clinics—facilities that generally serve an uninsured or medically underserved population. Health care consumers are affected by uninsurance because in order for physician practices and hospitals to survive financially they have to make up the losses they sustain. Hospitals and physicians may raise rates for certain services or discontinue unprofitable programs in order to recoup those losses, thereby affecting consumers' pocketbooks and access to services. Uninsurance, then, has negative health and financial consequences for uninsured persons, their families, communities, and the nation as a whole.

Where Do People Get Health Insurance?

Americans obtain health insurance through a variety of methods and from different sources. People may get it through the private sector, or from a publicly funded social insurance program. Consumers may purchase health coverage on their own, as part of an employee group, or through a trade or professional association. A small minority of employees get health insurance at no up-front cost because their employer pays the total premium. However, approximately 51 million Americans did not have health insurance coverage in 2009; that is, around 17% of the total population were uninsured.¹⁷

Employer-Sponsored Insurance

Most Americans obtain health coverage through the workplace. In 2009, approximately 170 million persons had employment-based health insurance, which accounts for nearly 56% of the total population.

Under employer-sponsored insurance, risk pools may be comprised of active workers, dependents, and retirees. Insurers use a number of strategies to increase the likelihood that each risk pool includes a good proportion of healthy individuals, thus avoiding adverse selection. For instance, insurers may restrict employees' opportunities to take-up health coverage or switch health plans by designating a specific time frame each year for such activities ("open enrollment period"). This strategy decreases the likelihood that people will "game" the system by taking up coverage only when they plan on using health services (e.g., for pregnancy and childbirth), and dropping coverage when they no longer plan to access care. Insurers also may require the employer to enroll a certain proportion of the firm's eligible population. Assuming that the eligible population consists of a good percentage of healthy people, requiring a certain proportion of all eligibles to enroll leads to an enrollee population which contains at least some healthy people. Employers also use strategies to encourage insurance take-up by healthy people. For example, employers pay, on average, the majority of health insurance premiums. This practice makes health coverage a more attractive benefit, even to those workers who do not plan to use medical services on a regular basis. By encouraging healthy workers to take-up health insurance, the employer subsidy helps to avoid adverse selection and contributes to the stability and diversity of the risk pool.

¹⁷ U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2009*, September 2010, available online at <http://www.census.gov/prod/2010pubs/p60-238.pdf>.

Advantages

ESI plans retain enrollees better than the individual health insurance market. As previously mentioned, health benefits provided at the workplace are exempt from income and employment taxes, encouraging the growth and continuity of employer-sponsored health insurance. Large risk pools with a good proportion of healthy enrollees tend to be more stable than small pools or those with a higher proportion of unhealthy enrollees. Given the strategies discussed above to discourage adverse selection, insurers assume that ESI pools—particularly large, diverse ones—are relatively stable. Generally, this translates into less volatile costs and better premiums overall in the group market compared to the nongroup market. Also, large ESI groups can use their size to negotiate for better benefits and lower cost-sharing, in contrast to individual applicants in the nongroup market. Plan sponsors negotiate and interact with insurers on behalf of all of their insured members, unlike in the individual market where each consumer must deal with the insurance carrier directly in order to apply for and purchase coverage. In addition, there are economies of scale for enrollees in the group market compared to the nongroup market for administrative functions such as sales, billing, and customer service. For these reasons, workers and their families benefit from receiving coverage through the workplace. For plan sponsors, the main advantage is to use health benefits for recruitment and retention of workers. This is particularly appealing in a growing economy—such as during most of the 1990s—when there may be high demand for workers.

Disadvantages

While there are many advantages to obtaining ESI coverage, there are challenges as well. From the vantage point of the enrollee, one of the biggest disadvantages is the general lack of portability. Because ESI coverage is tied to the job and not the person, any change in employment (such as going from full-time to part-time status, or changing jobs) may alter the health care providers or services to which the worker has access, or disrupt health coverage altogether. Also, in firms that offer health coverage, there is a trade off made between wages and benefits. For workers who do not take up health insurance from those firms, they end up accepting lower wages for a set of benefits they do not use. From the perspective of the sponsor, an underlying challenge is the lack of enrollee awareness of the true costs of health care. Because the sponsor usually contributes to the cost of the premium, enrollees do not bear the full cost of obtaining health coverage. Also, enrollees generally do not have to cover the entire cost of the services they use, since sponsors negotiate for lower rates and better cost-sharing arrangements from insurers. Consumers enrolled in managed care plans particularly are shielded from health care's true costs. Some observers contend that this lack of cost awareness gives little incentive to consumers to utilize medical services prudently, which leads to greater use of services and more health care spending. In addition, sponsors' efforts to constrain their health spending—by increasing the employee share of the premium or cost-sharing—are made even more difficult to justify or implement. Finally, from the perspective of the federal budget, the tax exclusion of employer-sponsored health insurance represents a lost source for Treasury funds. (The Joint Committee on Taxation estimated the FY2010 tax exclusion for employer-paid health insurance, health care, and long-term care insurance premiums to be \$105.7 billion.)¹⁸

¹⁸ For additional information on the tax treatment of health benefits, see CRS Report RL33505, *Tax Benefits for Health Insurance and Expenses: Overview of Current Law*, by Janemarie Mulvey.

Large vs. Small Groups

The group health insurance market consists of insurance products designed for large and small groups. The underlying reason for this distinction is rooted in the inverse relationship between insurance risk and group size (i.e., the risk associated with a group grows as the size of the group shrinks). This concept affects employers' offers of health benefits. For instance, a very large employer often is able to offer multiple health plan options to its members (e.g., the Federal Employee Health Benefit Program (FEHBP)). A large business can leverage its size to get a more comprehensive set of benefits. In contrast, small employers are less able to provide health coverage at all because of the greater risk associated with small groups. Even when small employers do offer coverage, the benefits are often limited. Small employers also are much less likely to self-fund health coverage, since there is a smaller pool for spreading risk and protecting against catastrophic loss. Furthermore, such firms generally do not have the necessary administrative capacity to negotiate with multiple provider groups and handle all the day-to-day operational functions. It is conditions such as these which prompt legislators to develop proposals for expanding small group participation in health insurance; for example, by establishing association health plans, and opening up FEHBP to small businesses.

Association health plans are just one example among the spectrum of entities which bring groups of people together for the purpose of buying health insurance. These entities include trade and professional associations that offer health coverage to their members ("association-sponsored plans"), and small firms that band together to purchase coverage as a group ("health insurance purchasing cooperatives"). The premise behind group purchasing arrangements is to decrease the administrative burden on and increase the negotiating capacity of participants who cannot afford to offer or purchase coverage on their own. Around one-third of small firms buy health coverage through some type of purchasing pool.

Public Programs

While most Americans with health insurance obtain it through the private-sector, tens of millions of people get health coverage through public programs. Below are descriptions of selected federal and state programs which provide payments on behalf of many persons who, due to low incomes or high health care expenses, could not afford health care otherwise.

Medicare

The Medicare program was established in 1965, and is a federal program for persons age 65 and older and certain persons with disabilities. Medicare consists of four parts: Part A, Hospital Insurance; Part B, Supplementary Medical Insurance; Part C, Medicare Advantage and Part D, the prescription drug benefit. The Medicare program provides coverage for a wide range of medical services, such as care provided in hospitals and skilled nursing facilities, hospice care, home health care, physician services, physical and occupational therapy, outpatient prescription drug benefits, and other services. Medicare has been so successful in covering the elderly that the problem of uninsurance usually is described in terms of the under-65 population.¹⁹

¹⁹ For additional information about Medicare, see CRS Report R40425, *Medicare Primer*, coordinated by Patricia A. Davis.

Medicaid and the Children's Health Insurance Program (CHIP)

Medicaid is the main health insurance program for low-income Americans. It is a means-tested program, and applicants must meet financial and other criteria in order to be eligible for services. Everyone who meets the eligibility criteria is entitled to Medicaid benefits available in their state of residence. Medicaid provides coverage for health care and long-term-care services to certain adults (generally parents and pregnant women), children, the elderly, and persons with disabilities. It is jointly funded by federal and state governments, and is administered by the states within federally set guidelines. State Medicaid programs provide a comprehensive set of services, reflecting its diverse enrollee population. These programs must provide a set of federally specified benefits, such as hospital services (both inpatient and outpatient), physician services, nursing home care for ages 21 and over, home health care for those entitled to services from nursing facilities, and certain services for children. States may also cover additional optional services. Some states have used waiver authority under Medicaid to extend coverage to uninsured persons who do not meet the program's categorical and/or financial tests.²⁰

The Children's Health Insurance Program was established in 1997 to allow states to cover uninsured low-income children who are ineligible for Medicaid. In designing their programs, states can choose among three options: expand Medicaid, create a new "separate state" insurance program, or devise a combination of both approaches. States that choose to expand Medicaid to CHIP eligibles must provide the full range of mandatory Medicaid benefits, as well as all optional services specified in their state Medicaid plans. States that establish CHIP programs that are separate from Medicaid choose one of three benefit options. All 50 states, the District of Columbia, and five territories have established some type of CHIP program. CHIP's eligibility rules target uninsured children under 19 years of age whose families' incomes are above Medicaid eligibility levels. States may raise the upper income level for low-income children up to 200% of the federal poverty level, or higher under certain circumstances.²¹

Individual Health Insurance

The individual insurance ("nongroup") market is often referred to as a "residual" market. The reason is because this market provides coverage to persons who cannot obtain health insurance through the workplace and do not qualify for public programs such as Medicare, Medicaid, or CHIP. Consequently, the enrollee population for this private health insurance market is small.

The residual nature of the nongroup market is evident in the demographic make-up of those who purchase coverage from it. The market is over-represented by the near elderly (55-64 years old); a group that has relatively weak attachments to the workplace. The individual market disproportionately consists of part-time workers, part-year workers, and the self-employed, groups unlikely to have access to ESI coverage.²² Also, some people use the nongroup market as a temporary source of coverage, such as those in-between jobs or early retirees who are not yet eligible for Medicare.

²⁰ For additional information about Medicaid, see CRS Report RL33202, *Medicaid: A Primer*, by Elicia J. Herz.

²¹ For additional information about SCHIP, see CRS Report R40444, *State Children's Health Insurance Program (CHIP): A Brief Overview*, by Elicia J. Herz and Evelyne P. Baumrucker.

²² D. J. Chollet, "Consumers, Insurers, and Market Behavior," *Journal of Health Politics, Policy and Law*, February 2000.

Applicants to the individual insurance market must go through robust underwriting. Insurance carriers in most states conduct an exhaustive analysis of each applicant's insurability. An applicant provides her/his medical history, and may undergo a physical exam though this is uncommon. This medical information is used by carriers to assess the insurance risk for each person. From this assessment, insurers decide whether to offer coverage to the applicant, and under what terms. Federal and state requirements restrict somewhat insurers' ability to reject applications or design coverage based on health factors and other characteristics. Nonetheless, some applicants are rejected from the nongroup market altogether, and others who are approved may receive limited benefits or are charged premiums that are higher than those in the group market for similar coverage.²³ Rigorous medical underwriting results in an enrollee population that is fairly healthy (three out of four enrollees report that their health is excellent or very good²⁴), thereby excluding persons with moderate to severe health problems from the private nongroup insurance market.

The Uninsured

Despite the multiple sources of public and private health insurance, millions of Americans are without health coverage. In 2009, nearly 51 million people were without health insurance coverage. For the vast majority of the uninsured, they lack coverage because they cannot *access* coverage (e.g., their employer does not offer health insurance as an employment benefit) or they cannot *afford* it.

Uninsurance is characterized as a problem of the under-65 population, given near-universal coverage of seniors through Medicare. One of the most striking characteristics of persons who lack coverage is that a significant proportion are in low-income families. For instance, among all uninsured persons under age 65, more than half were in poor or near poor families in 2009.²⁵

A defining characteristic of the nonelderly uninsured population is that most have ties to the paid labor force. In 2009, 77% of uninsured persons were in working families. Even more surprising is that 61% of the uninsured were in families with at least one full-time worker.²⁶ While such findings may be counter-intuitive, there are multiple reasons why employed persons and their families may lack health coverage. For example, a worker may be offered health insurance by his/her employer, but declines it because he/she thinks it is too expensive. An employee may work for a small firm which is less likely than a large firm to offer health insurance as a benefit. A low-wage employee, even working full time, is less likely to be offered health insurance at work, and less likely to be able to afford it than higher-wage workers in the same firm. Finally, a healthy worker may be willing to take on the risk of being uninsured and choose not to purchase insurance at all. So despite the dominance of employer-sponsored health insurance, the dynamics of work, insurance risk, and financial resources intersect to impede the coverage of all workers and their families.

²³ M. V. Pauly and A.M. Percy, "Cost and Performance: A Comparison of the Individual and Group Health Insurance Markets," *Journal of Health Politics, Policy and Law*, February 2000.

²⁴ General Accounting Office, "Private Health Insurance: Millions Relying on Individual Market Face Cost and Coverage Trade-Offs," November 1996.

²⁵ Kaiser Family Foundation, "The Uninsured: A Primer," December 2010, available online at <http://kff.org/uninsured/upload/7451-06.pdf>.

²⁶ *Ibid.*

The problem of the uninsured is an ongoing concern to many policymakers and legislators. One persistent topic of debate is the overall number of uninsured individuals and the direction of the uninsurance rate. These issues have generated some controversy over dueling analyses which show slightly different (and sometimes moderately different) findings. But despite the forceful discussions regarding trends in uninsurance, the year-to-year changes in the uninsurance rate actually are small. For example, from 1987 to 2009, the change in the uninsurance rate from year to year has been less than 1%, with the exception of 2008-2009.²⁷ Nonetheless, tens of millions of Americans were without coverage during that time period. Such circumstances beg the questions: why does pervasive uninsurance persist (even during the robust economy of the mid-1990s), and what are the implications for legislation and public policies to expand health coverage?

How Are Private Health Benefits Delivered?

Given the complexity of the health care system overall, it is no surprise that health benefits are delivered and financed through different arrangements. Those arrangements vary due to numerous factors such as how health care is financed, how much access to providers and services are controlled, and how much authority the enrollee has to design her/his health plan. While delivery systems may share certain characteristics, general distinctions can be made based on payment, access, and other critical variables.

Indemnity Insurance

Under indemnity insurance, the insured person decides when and from whom to seek health services. If the services the enrollee receives are covered under his/her insurance, the enrollee or the enrollee's provider files a claim with the insurer. Thus, insurers make payments *retrospectively* (i.e., after the health services have been rendered), up to the maximum amounts specified for each covered service. In this model of health care delivery, the financing of health services and the obtaining of those services are kept separate.

This bifurcated arrangement was unquestioned for a time. But as medical costs began to rise, sometimes faster than other sectors of the national economy, many observers criticized this delivery model as contributing to increasing expenditures. Because providers were compensated on a fee-for-service basis, some argued that providers were not given incentives to provide efficient health care. In fact, some critics accused health care practitioners and institutions of providing an over-abundance of health care in order to generate greater revenue. By the early 1970s, legislators, analysts, and others expressed considerable interest in alternative models, such as managed care models, with cost control as a key feature.

Managed Care

While managed care means different things to different people, several key characteristics set it apart from traditional (indemnity) insurance. One of the main differences is that the service delivery and financing functions are integrated under managed care. Managed care organizations (MCOs) employ various techniques to control costs and manage health service use *prospectively*.

²⁷ Data available at <http://www.census.gov/hhes/www/hlthins/historic/index.html>.

Among those techniques are restricting enrollee access to certain providers (“in-network” providers); requiring primary-care-physician approval for access to specialty care (“gatekeeping”); coordinating care for persons with certain conditions (“disease management” or “case management”); and requiring prior authorization for routine hospital inpatient care (“pre-certification”). MCOs may offer different types of health plans that vary in the degree to which cost and medical decision-making is controlled. As a consequence, enrollee cost-sharing also varies. Generally, the more tightly managed a plan is, the less the premium charged. Other distinguishing features of the managed care approach include an emphasis on preventive health care and implementation of quality assurance processes.

Managed care was touted as the antidote to rapidly rising health care costs. Starting with the passage of federal legislation in the 1970s which supported the growth of managed care (specifically in the form of health maintenance organizations (HMOs)), the number of MCOs grew quickly. Increased market competition among these organizations led to decreases in premiums, in order to gain market share. With high medical inflation in the 1980s and early 1990s, enrollees flocked to these less-costly managed care plans. By the mid-1990s, more insured workers were enrolled in HMOs than any other health plan type, and health insurance premiums had stabilized.

But in the latter half of the 1990s, a “backlash” of sorts against managed care grew.²⁸ Some enrollees had grown weary of provider and service restrictions. Many MCOs that had increased market share through artificially low premiums began to raise them in order to increase revenue.²⁹ Consumers and others accused the managed care industry of caring more about controlling costs than providing health care. Some providers resented the role managed care played in medical decision-making. Many enrollees began to leave HMOs. The industry responded by developing insurance products that were less-tightly managed, but more costly. Some traditional HMOs widened their provider networks and eliminated the gatekeeping function, while employers began to offer plan types that were less tightly managed, such as preferred provider organizations (PPOs). In fact, by the end of the 1990s, more people with work-based health coverage were enrolled in PPOs than in HMOs.³⁰

As the influence of managed care waned and health care costs began to rise at an increasing pace during the late 1990s, the impact on consumers began to be felt. For example, in the employment setting, employers absorbed the extra costs at first in order to recruit and retain workers during the booming economy of the mid to late 1990s.³¹ But as the economy soured, employers began to pass these expenses along to enrollees in the form of greater cost-sharing.³²

²⁸ Richard Kronick, “Waiting for Godot: Wishes and Worries in Managed Care,” *Journal of Health Politics, Policy and Law*, vol. 24, no. 5 (October 1999), pp. 1099-1106.

²⁹ Jon Gabel et al., “Job-Based Health Insurance in 2001: Inflation Hits Double Digits, Managed Care Retreats,” *Health Affairs*, vol. 20, no. 5 (September/October 2001), pp. 180-186.

³⁰ American Association of Health Plans, “Health Plans and Employer-Sponsored Plans,” October 1999. Available at <http://www.ahip.org/content/default.aspx?bc=41|331|366>.

³¹ Jon B. Christianson and Sally Trude, “Managing Costs, Managing Benefits: Employer Decisions in Local Health Care Markets,” *Health Services Research*, pt. II, vol. 38, no. 1, (February 2003), pp. 357-373.

³² Jon Gabel, et al., “Job-Based Health Benefits in 2002: Some Important Trends,” *Health Affairs*, vol. 21, no. 5 (September/October 2002), pp. 143-151.

Consumer-Driven Health Care

By the end of the 1990s, large increases in health costs again became commonplace. With the belief by some observers that the age of managed care was over, they began to search for alternatives. Consumer-driven (or consumer-directed) health care have been offered as one such option.

Consumer-driven health care refers to a broad spectrum of approaches that give incentives to consumers to control their use of health services and/or ration their own health benefits. In the workplace, at one extreme employers may choose to provide an array of insurance products from which workers can choose, while at the other end an employer could increase wages but not offer any health coverage allowing workers to decide how to spend that extra money to meet their health care needs. Within those two endpoints, the consumer-directed approach varies in the degree to which consumers are responsible for health care decision-making.³³

For example, one example that is at the heart of discussions about consumer-driven care is the health savings account (HSA). An HSA, in and of itself, is not a health insurance plan. Instead, it is an investment account in which contributions earn interest tax free. Consumers, their employers, or both may make contributions to HSAs. Consumers withdraw funds on a tax-free basis to cover medical expenses not covered by health insurance. Unused contributions roll over to the next year. HSAs are paired with high-deductible health plans. If the HSA funds are exhausted and the deductible level has not been reached, the consumer is responsible for covering that gap. Once the consumer's spending reaches the deductible level, then coverage from the health plan takes effect. HSAs received a legislative boost when they were authorized in November 2003 by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173).³⁴

While consumer-driven health care can take on many forms, the premise common to all of the approaches is that by making enrollees more responsible for their own health care, it creates incentives for people to use services prudently. The expectation is that greater cost-consciousness on the part of consumers will result in lower overall health costs. In essence, the service and cost control functions administered by MCOs and providers under managed care shifts to enrollees under the consumer-driven health care scenario.

Proponents of consumer-directed health care assert the merit in having people take increased responsibility for their own health care use and expenses. They predict that this approach will lead to better-informed consumers, more appropriate use of health services, and lower overall spending on health care. Opponents express concern that this approach does not recognize the possible range of health conditions in an enrolled population. They argue that these plans benefit the young and healthy who use relatively few services, and, therefore, would not need to expend a great deal of time and energy making these health care decisions. However, these plans impose a greater burden on individuals with moderate to severe health conditions because of their greater-than-average use of medical services.

³³ P. Fronstin, ed., Employee Benefit Research Institute, *Consumer-Driven Health Benefits: A Continuing Evolution?* 2002.

³⁴ For more information about HSAs, see CRS Report RS22877, *Health Savings Accounts and High-Deductible Health Plans: A Data Primer*, by Carol Rapaport.

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