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An Introduction to Health Insurance: What Should a Consumer Know?

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April 30, 2015

Congressional Research Service

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www.crs.gov

R44014

Summary

Congress has seen a renewed interest in the market for private health insurance since the passage of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended). This report provides an overview of private-sector (as opposed to government-provided) health insurance. It serves as an introduction to health insurance from the point of view of many consumers under the age of 65. No background in health insurance is assumed, and all terms are defined in the body of the report.

A consumer may find the purchase of health care inherently different from some other purchases. Health care can be expensive, and many relevant details concerning future health care may not be known when the consumer is choosing an insurance plan, including when over the course of a year (if at all) health care will be purchased, which services will be needed, and the costs of those services. These characteristics of purchasing health care decrease the consumer's ability to plan financially and increase the consumer's exposure to financial risk. The purchase of health insurance reduces the risks and unpredictability inherent in paying for health services.

An employed consumer may obtain health insurance from his or her employer if health insurance is offered by the employer (known as employer-sponsored insurance, or ESI) as a fringe benefit. All consumers may purchase health insurance directly (perhaps through an insurance agent or broker) from private insurance firms. In addition, all consumers may obtain health insurance through insurance exchanges, or marketplaces. Exchanges facilitate transactions between buyers and sellers of insurance but are not insurers.

Health insurance plans can differ across many dimensions, including coverage, costs, flexibility in choosing providers, special features, and generosity. Two specific health insurance plan types that may be of interest to Congress are consumer-directed health care (CDHC) and value-based insurance design (VBID). Both these plan types have the potential to lower aggregate health care (however measured) by providing incentives for consumers to seek less care, or less expensive care.

Which particular health insurance plan a consumer chooses depends on a number of factors, including the expected health of those covered by the plan, the price of the plan and of the medical services it provides, the consumer's income, and the prices of the other goods and services the consumer wishes to purchase. In addition, because some health insurance plans are tied to employment, the consumer's status as an employee also influences (and is influenced by) his or her choice of health insurance.

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Introduction

Congress has seen a renewed interest in questions related to the market for private health insurance since the passage of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended). Recent health insurance marketplace changes include a different way to purchase health insurance (exchanges) and a new system of categorizing the generosity of plans' health coverage based on the names of various metals (e.g., bronze and silver).¹ Some consumers may face different choices of health insurance plans than in the past. Not all consumers are comfortable with the various concepts governing which health insurance plan might be best for them.

This report provides an overview of private-sector (as opposed to government-provided) health insurance. It serves as an introduction to health insurance from the point of view of consumers under the age of 65 who purchase a health insurance plan.² No background in health insurance is assumed, and all terms are defined. The report therefore can be viewed as an introduction to the more comprehensive discussion of health insurance found in the Congressional Research Service (CRS) health insurance primer.³

What Is Health Insurance?

This section of the report covers the differences between a consumer's purchase of health care and his or her purchase of other goods and services. For example, budgeting for health care expenses may be more difficult than budgeting for other services. The purchase of health insurance reduces the risks and unpredictability inherent in a consumer's health care expenses. The consumer pays for a health insurance policy and then is subsequently (partly) reimbursed for his or her future expenditures on health care.⁴

The Challenges of Purchasing Health Care

A consumer may find the purchase of health care different from some other purchases. For example, a consumer buying a gallon of milk each week often knows in advance what kind of milk he or she wants and the approximate price of each variety of milk. In addition, expenditures on milk are rarely an especially high proportion of the consumer's monthly spending.

¹ The precious metal designation corresponds to minimum actuarial value, which is discussed later in this report (see "By Actuarial Value"). In addition, more information is available in CRS Report R43854, *Overview of Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (ACA)*, by (name redacted) and (name redacted).

² The purchased plan may or may not cover additional members of the insured's family. Those who are at least aged 65 (and some disabled individuals) are eligible for the federal entitlement program Medicare.

³ See CRS Report RL32237, *Health Insurance: A Primer*, by (name redacted) and (name redacted).

⁴ This report deals only with private health insurance. Therefore, it does not cover public-sector programs such as Medicare, Medicaid, the State Children's Health Insurance Program (CHIP), and military health insurance. It also does not cover specialty insurance plans, such as those that cover vision, dental, or a specific disease (i.e., cancer).

The consumer's decision to purchase health care, however, is more complicated. Health care can be expensive, especially for major illnesses or injuries. In addition, the consumer may not know in advance when (if at all) over the course of a year he or she will purchase the health services, what services he or she will need, and how much the services will cost. Each of these characteristics of health care decreases the consumer's ability to plan financially and increases the exposure to financial risk.

Few other goods and services have these characteristics. When a consumer thinks about other large expenditures, four years of college might come to mind. However, the potential students and their parents know when college expenses will become due well in advance of the due date. It is much easier to predict that Junior will need \$20,000 in August 2015 to pay freshman tuition than that Junior will need \$5,000 to pay for health care after he breaks his leg skiing over winter break.

Health care also may differ from other types of unpredictable expenditures. If a consumer were unexpectedly invited to a black-tie event, she may decide to purchase a gown. Even though this purchase was unpredictable, the cost of the gown often is a much smaller percentage of her monthly income than the cost of most medical treatments. Finally, consumers are likely to know what types of gowns (and milk) they prefer. They may be less clear whether they need a cast or a splint to repair their injured ankle. Consumers therefore are more likely to rely on their doctors' opinions when using health care than on their grocery clerks' opinions when buying milk. All these features increase the financial riskiness and unpredictability associated with using health care.

Health Insurance Can Help Consumers Manage Risk

The purchase of health insurance reduces the risks and unpredictability inherent in a consumer's cost of health care. Typically, a consumer selects a particular health insurance plan just before the start of the health insurance plan year and then pays a monthly premium to the health insurer.⁵ In return, if the consumer receives health care over the course of the year, the health insurer may pay some (or all) of the costs, depending on the details of the plan. For example, if the consumer does use health care, he or she often has to pay something out of his or her own pocket. The level of out-of-pocket (OOP) expenses varies across health insurance plans. Although health insurance may never make health care free of charge for the consumer, it often results in lower OOP expenses, especially when evaluated over the entire term of the plan.⁶

Not all holders of health insurance end up using health care over the year. However, when considered over a multiyear period, health insurance may help a consumer manage the risk associated with a large potential financial loss from health care costs.⁷

⁵ Insurers are also sometimes referred to as *insurance firms* and *insurance carriers*. A *premium* is the price of a health insurance plan.

⁶ The *term* (length) of many health insurance policies is one year.

⁷ Insurers also manage risk when providing health coverage to consumers to assure that their businesses are profitable. One type of risk management involves having a mix of consumers with different health statuses enrolled in each insurance product. The healthier consumers will be lower-cost enrollees, and the less-healthy consumers will be higher-cost enrollees. Were it permitted by federal and state law, an insurer would prefer to cover only the healthy.

Consumers also may buy health insurance because they may be required either to maintain health insurance coverage or pay a penalty. In other words, many consumers face a *mandate* to be insured.⁸

How Can a Consumer Purchase Health Insurance?

A consumer may obtain health insurance from an employer (or other group) or individually from another source.

From an Employer or Other Group

Some consumers obtain health insurance plans offered by employers to their employees and their employees' dependents as fringe benefits.⁹ When employees obtain health insurance through their employer, the cost of the health insurance plan often is shared between the employee and the employer.¹⁰ In addition, other groups whose members share a common bond, such as labor unions and some other associations, can offer members an opportunity to purchase health insurance through the group.

If an employee purchases insurance offered through his or her employer (employer-sponsored insurance, or ESI), the employee enrolls in a plan through the employer without interacting with salespeople and other representatives of health insurers. ESI is therefore relatively easy to obtain. If an employee does not want to accept an offer of group insurance, he or she is free to purchase health insurance from another source.

When a consumer with ESI leaves his or her place of employment for any reason, that consumer may lose health insurance. Those who retire any time after reaching the age of 65 usually will be eligible for Medicare, the federal health insurance entitlement program for those with disabilities and those aged 65 and older.¹¹ Consumers terminated from employment without cause generally are eligible for COBRA, a federal program through which certain terminated consumers may continue to receive their ESI for a period of time as long as they pay the total cost of the insurance plan.¹² Consumers also may be eligible for other federal and state health insurance programs or can choose to purchase private insurance that is not from a group.

⁸ For more information, see CRS Report R41331, *Individual Mandate Under ACA*, by (name redacted).

⁹ Many employees receive two forms of compensation from their employers: wage (or salary) income and fringe benefits. Examples of fringe benefits include subsidized health insurance, subsidized day care, free coffee, and discounts on public transportation.

¹⁰ Both the employer and the employee receive tax advantages from employer-sponsored insurance; for more information, see CRS Report RL32237, *Health Insurance: A Primer*, by (name redacted) and (name redacted).

¹¹ For a comprehensive guide to Medicare, see CRS Report R40425, *Medicare Primer*, coordinated by (name redacted) and (name redacted).

¹² COBRA takes its name from Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272). Under COBRA, employers are required to permit employees and family members to continue their group health insurance coverage at their own expense, but at group rates, if they lose coverage because of designated work- or family-related events.

Not from a Group

Consumers who are not offered or who do not purchase group insurance may use insurance brokers and agents, including web-based brokers, to learn about health insurance plans.¹³ Brokers and agents are licensed by the states and generally are paid on commission by insurers. Agents work with one insurer, whereas brokers can work with more than one insurer.

Consumers may purchase health insurance policies either directly from insurers (perhaps represented by brokers and agents) or from exchanges, which sell the insurers' plans. Insurance exchanges serve as marketplaces for health insurance plans in that they facilitate transactions between the buyers of insurance (consumers) and sellers of insurance (insurers). In general, consumers must use exchanges in their states of residence.¹⁴

How Do Health Insurance Plans Differ?

Health insurance plans can differ in terms of their coverage of consumers and services, their costs to the consumers (and consumers' dependents or employers, if relevant), special features, and generosity, among other properties.

By Coverage

Covered Individuals

The consumer may buy a health insurance plan covering one person, a family, or other groupings. Under self-only coverage, the consumer is the only person insured. Family coverage applies to the consumer and any spouse and/or dependents. Other possibilities include self plus one and self plus children.¹⁵

If their parent's health insurance plan covers children, children can be added to their parent's plan until they turn 26 years of age. Those children under the age of 26 can join or remain on their parent's plan even if they are married, not living with a parent, attending school, not financially dependent on a parent, or eligible to enroll in their own employer's plan.

Many consumers with ESI obtain and renew their employer's plan during open enrollment season. During *open season*, consumers can change health insurance policies. Outside of open season, consumers cannot change their health insurance plan unless they experience a qualifying life event. *Qualifying life events* include marriage, moving to a new state, divorce, and childbirth. Open season in the exchanges is similar to open season in ESI.

¹³ For more information, see CRS Report R43243, *Health Insurance Exchanges: Health Insurance "Navigators" and In-Person Assistance*, by (name redacted).

¹⁴ The exchanges described here are used by individuals. A second type of exchange, a Small Business Health Options Program (SHOP) exchange, is not covered in this report. For more information, see CRS Report R43771, *Small Business Health Options Program (SHOP) Exchange*.

¹⁵ Any particular consumer may not have access to all of these coverage options.

Covered Services

A consumer might use a variety of health care services over the course of the year. Office visits to a health care provider may include routine well-adult exams, nonroutine flu care, and urgent treatment for bone breaks.¹⁶ The consumer might require X-rays and laboratory tests at some visits. More serious matters may require treatment at a hospital. Some consumers may need medical equipment, others may need a recovery program for substance abuse, and still others may find a single prescription treatment sufficient.

Given the breadth of possible health care, a consumer probably will not find a health insurance plan that covers all possible care. For example, almost no policies cover health care that is not deemed medically necessary by the insurer. *Medically necessary care* is “needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.”¹⁷ For example, reconstructive breast surgery following a mastectomy performed as part of breast cancer treatment is medically necessary (as well as required by law).¹⁸ In addition, health insurance generally covers breast augmentation to correct a congenital defect in breast development. However, it generally does not cover breast augmentation for cosmetic purposes. Not all insurers consider the same medical goods and services to be medically necessary.

Even among services widely agreed to be medically necessary among insurers, consumers will find that not all health insurance plans cover the same health services. In addition, the specifics of the covered service may differ across plans. For example, plans may differ across coverage of the number of routine maternal visits and the conditions under which a caesarean section is a covered service. Similarly, the consumer may choose among plans that cover eating disorder treatments differently.

By Costs

Premiums

Consumers pay *premiums*, which are the prices of private health insurance plan coverage for a given period of time. Premiums are owed whether or not the consumer actually seeks health care during the time covered by the plan. Consumers who purchase insurance policies directly from insurers or through the exchanges (for individuals) almost always pay the entire amount of the premium themselves. Many consumers who purchase ESI share the premium cost with their employers. In other words, the consumer pays for part of the premium (generally through payroll deductions) and the employer pays for part of the premium (using funds that are not part of an individual’s hourly wages or annual salary).¹⁹

¹⁶ A health care provider is any individual who provides health care; doctors, nurse practitioners, licensed practical nurses, and physical therapists are examples of providers.

¹⁷ This definition is found at <https://www.healthcare.gov/glossary/medically-necessary>, a government website managed by the U.S. Centers for Medicare & Medicaid Services.

¹⁸ This coverage is mandated by the Women’s Health and Cancer Rights Act, Title IX, Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1998, P.L. 105-177.

¹⁹ Hourly wages and annual salary are the conventional forms of compensation by the employer to the employee. The statement applies to all forms of compensation. This discussion ignores the effect of the employer’s premium costs on (continued...)

Certain consumers who purchase health insurance through the exchanges may be eligible for *premium tax credits*. These credits reduce the price of the premium by returning part of its dollar value as a portion of the consumer's income tax refund. Eligibility for the tax credits depends on whether the consumer is eligible for various types of health insurance plans and on family income.²⁰

Cost Sharing

Cost sharing refers to the part of the costs for health services covered by the insurance plan that is paid by the consumer (or the person responsible for the consumer's bills). Deductibles, coinsurance, and co-payments are examples of cost sharing.

A *deductible* is the amount of money an insured consumer may be required to pay the medical care providers OOP (over the term of the insurance policy) before receiving any benefits from the health insurance policy. In other words, the consumer must spend up to the deductible OOP on covered services before the health insurance plan will begin to pay its part of health costs for most covered health services. A consumer is therefore required to *meet the deductible* before the insurance plan contributes to the costs of his or her health care. *Preventive medical services* are certain covered services not subject to deductibles (or any other form of cost sharing) when received from in-network providers.²¹ In addition, not all health insurance plans have a deductible, and plans may have different deductibles for different types of services.

The consumer may pay *coinsurance*, which is a percentage of the total amount billed to the consumer. For example, consider a consumer whose chest X-ray is billed at \$150. A 20% coinsurance rate means that the consumer pays \$30 and the insurer pays \$120 (both to the provider) for the X-ray. These calculations assume that the consumer has met the deductible. If the deductible has not been met, the consumer must pay his or her bill in full until the deductible is met.

Alternatively, the consumer may pay a flat-rate *co-payment*. For example, a \$20 co-payment for that chest X-ray would mean that the recipient must pay \$20 to the provider OOP for the same X-ray, assuming the consumer's deductible has been met. The insurer would then pay \$130 to the provider. Once again, if the deductible has not been met, the recipient must pay the amount remaining until the deductible is met.²²

(...continued)

the wages received by the employees; the last section of this report, "Employment Issues," provides more information.

²⁰ For more information, see CRS Report R41137, *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA) in 2014*, by (name redacted) and the chart at <https://www.healthcare.gov/qualifying-for-lower-costs-chart>.

²¹ Grandfathered health insurance plans may impose cost-sharing requirements on preventive care. Grandfathered health insurance plans are plans in which a consumer was enrolled on March 23, 2010, and that meet a few additional criteria. For more information, see CRS Report R41166, *Grandfathered Health Plans Under the Patient Protection and Affordable Care Act (ACA)*, by (name redacted). A network is a group of providers that have agreed to provide health care under specified terms to those consumers who have signed up for a particular insurance plan. For more information on networks, see the section "By Networks and Flexibility in Choosing Providers."

²² In this example, \$150 is assumed to be at or under the maximum allowable charge of the insurer. The maximum allowable charge is the amount considered full payment by the insurer for this particular policy.

A consumer who requires a significant amount of health care may reach a high level of OOP spending. A maximum *OOP limit*, however, sets a cap on consumer spending. Once a consumer reaches the OOP spending limit, the insurer is responsible for all billed costs owed by the consumer for covered services from in-network providers.

Consumers who are eligible for premium tax credits through the exchanges also may be eligible for *cost-sharing subsidies* through the exchanges. These subsidies reduce the costs associated with the use of covered services. As with the tax credit, eligibility for the cost-sharing subsidies depends on whether the consumer is eligible for various types of health insurance plans and on family income.

Select benefits of three representative health insurance policies are roughly characterized in **Table 1**. The plans are an ESI plan obtained as a fringe benefit from the consumer’s employer, an individual insurance plan purchased directly by a consumer from an insurer, and an individual insurance plan purchased by a consumer through an exchange.

Table 1. Comparison of Select Cost-Related Concepts, by Health Insurance Plan Type, 2015

	ESI Purchased as Employer Fringe Benefit^a	Individual Plan Purchased from Insurer	Individual Plan Purchased Through Exchange
Premium	Permitted	Permitted	Permitted
Premium Tax Credit	Not available	Not available	Available to those meeting income and other requirements ^b
Premium Contributions from Employer	Available, if offered by employer	Not available	Not available
Coverage of Preventive Health Services with No Cost Sharing	Required for in-network providers ^c in non-grandfathered plans ^d	Required for in-network providers ^c in non-grandfathered plans ^d	Required for in-network providers ^c in non-grandfathered plans ^d
Cost Sharing	Permitted	Permitted	Permitted
Cost-Sharing Subsidy	Not available	Not available	Available to those meeting income and other requirements ^b
Maximum Out-of-Pocket Limit	\$6,600 for an individual plan and \$13,200 for a family plan, unless the plan is grandfathered ^d	\$6,600 for an individual plan and \$13,200 for a family plan, unless the plan is grandfathered ^d	\$6,600 for an individual plan and \$13,200 for a family plan

Sources: CRS Report R42069, *Private Health Insurance Market Reforms in the Affordable Care Act (ACA)*, by /name redacted/ and /name redacted/. The source for the final row is <https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/>.

Notes:

- a. ESI stands for employer-sponsored insurance.
- b. The other requirements are whether the consumer is eligible for a government-sponsored health insurance plan, an ESI plan, a plan in the individual market, or a grandfathered plan.
- c. A network is a group of providers that have agreed to provide health care under specified terms to those consumers who have signed up for a particular insurance plan.
- d. Grandfathered health insurance plans are plans in which a consumer was enrolled on March 23, 2010, and that meet a few additional criteria. For more information, see CRS Report R41166, *Grandfathered Health Plans Under the Patient Protection and Affordable Care Act (ACA)*, by /name redacted/.

In summary, the consumers' costs differ in at least two respects. First, premium tax credits and cost-sharing subsidies are only available for plans purchased through an exchange (for individuals), and not through a private insurer or through ESI. Second, only consumers with ESI can have part of their premiums paid for by their employers.

By Networks and Flexibility in Choosing Providers

Before a consumer can use health care, he or she must decide from which providers to seek care. Some insurance plans do not provide financial incentives to influence the consumer's choice in any way. Other plans tie the provider that the consumer uses to the level of cost sharing the consumer faces. In particular, some consumers may want to use providers in their health plan network. A *network* is a group of providers that have agreed to provide health care under specified terms to those consumers who have signed up for a particular insurance plan. Many health plans decrease the consumer's cost-sharing obligations if they use in-network providers. It is thought that the health insurers can negotiate lower prices with their in-network providers. This is because the in-network providers are willing to accept lower prices because their pool of potential patients increases as the providers join the network. The in-network consumers then face lower cost sharing if they stay in-network. In contrast, in some cases, the consumer will owe 100% of the provider's bill for an out-of-network visit.²³

Several broad categories of health plan types and their associated networks exist. The following plan descriptions are generalizations.²⁴ Health plan rules may differ from what is indicated; for example, a plan that usually does not cover health care received out-of-network often does cover such care when the only provider qualified to perform the care is out-of-network.

- Indemnity insurance allows the insured consumer to decide when and from whom to seek health care. There is no network of providers; a consumer may see any service provider and owe the level of cost sharing specified by the insurance plan. The consumer's indemnity insurance plan typically has some combination of higher premiums and greater cost sharing (relative to the other insurance plan types) as a way for the consumer to pay for the flexibility of provider choice and the relative inability for the insurer to control costs.

²³ *Balance billing* is the process of billing the patient for the difference between what the insurer reimburses and the provider charges. Consumers who use out-of-network providers may be subject to balance billing.

²⁴ Not all insurers use these terms when describing their plans.

- Health maintenance organizations (HMOs) usually require that consumers see in-network providers to face the lowest cost-sharing levels for their OOP expenses for covered services. The consumer picks (or is assigned) a primary care provider when he or she joins the HMO.²⁵ Visits to specialists often require referrals (e.g., permission) from the consumer's primary care providers in order for the insurer to cover the visits. Network size varies across HMOs, as do the rules covering when the insured may go outside the network and receive coverage for medical services. The consumer's HMO insurance typically features some combination of lower premiums and lower levels of cost sharing (relative to the other health insurance plan types) to compensate for the restrictions on provider choice and to incorporate the insurer's ability to control costs.
- Preferred provider organizations (PPOs) offer intermediate amounts of consumer flexibility in provider choice to be eligible for full coverage. PPOs are associated with a given network. PPOs permit the insured to choose their own primary care providers and to visit specialists without a referral. Most PPOs will cover health care supplied out-of-network, but the cost sharing faced by the consumer will be higher than it would have been if the insured remained in-network. On average, PPOs typically feature intermediate premiums and levels of cost sharing (relative to the other health insurance plan types) because there are restrictions on provider choice in order to obtain the lowest levels of cost sharing and because the PPO insurer has weaker methods for cost control than does the HMO insurer.

Consumers may have mixed feelings about networks. Some may like the lower OOP expenses. However, some might discover that their chosen providers are not members of their particular network. In this case, a consumer might change providers, pay more OOP to use an out-of-network provider, or change to a health insurance plan with a different network.

By Special Features

The "Cost Sharing" section above described select standard cost-sharing features of private health insurance. Some plan types, however, have specialized objectives. Two of these specialized plan types are consumer-directed health care (CDHC) and value-based insurance design (VBID). Both plan types have the potential to lower aggregate health care spending by reducing individual health spending. These plan types are designed to make consumers more aware of the costs of health care and lower consumers' OOP spending for especially valuable types of health care.

Consumer-Directed Health Care

CDHC encompasses any health care plan that provides monetary incentives for the consumers to become more active in their care by becoming well-informed and choosing practitioners and treatments that best suit their medical needs at the lowest possible costs. One prominent feature of CDHC is price transparency; the consumer is encouraged to find out what his or her OOP expenses will be for a potential health service. High-deductible health plans (HDHPs) are one type of insurance plan associated with CDHC. Consumers are thought to be especially sensitive

²⁵ A primary care provider is responsible for the consumer's primary (as contrasted with specialized) care.

to price in these plans because the consumers are spending 100% their own money until the high deductible is met.

Consumers with HDHPs sometimes have Health Savings Accounts (HSAs), which are tax-preferred savings accounts used to pay for unreimbursed qualified medical expenses such as health insurance deductibles, co-payments, and qualified services not covered by insurance.²⁶ HSAs are thought to encourage consumers to better save for their health care in retirement because any funds in the HSA accumulate from year to year.²⁷ Moreover, the combination of HDHPs and HSAs is thought to provide additional incentive for consumers to be more active in their care and to purchase the best possible medical services for the lowest possible cost because consumers may keep all the funds in the HSA and use them to pay for health care in retirement.

Value-Based Insurance Design

VBID reduces cost sharing for those health care goods and services that have strong evidence of relatively high clinical benefits.²⁸ VBID also may increase cost sharing for those health care goods and services with strong evidence of relatively low clinical benefits. In short, if a health care service provides substantial benefits for a particular group of consumers (or all consumers), the cost of the service for those consumers (or all consumers) should be lower.²⁹

Consumers who might benefit from VBID insurance plans typically have predictable expenses for recurring health care with high clinical benefits. Consider a consumer with diabetes who takes long-lasting insulin. This type of insulin has a high clinical benefit, but it can be costly to the diabetic consumer. The principles of VBID suggest that health insurance plans have lower cost sharing for insulin than for other drugs. Therefore, the drug with the high clinical benefit becomes less expensive for diabetic consumers, who in turn become more likely to follow their prescribed dosing regimen because of the lower-than-usual cost.

By Actuarial Value

A consumer looking for a health insurance plan might want to compare plans by premiums and pick the plan with the lowest premium. Premiums, however, are not the only factor to consider when evaluating any particular plan; cost sharing, covered services, the composition of the network, and other factors also might matter. In addition, higher premiums may be associated with lower cost sharing and not with more comprehensive benefits. In this case, comparing premiums would not be an accurate comparison of plan benefits. Instead of premiums, actuarial

²⁶ The Internal Revenue Service determines whether a particular service is *qualified*. For more information, see Internal Revenue Service, *Health Savings Accounts and Other Tax-Favored Health Plans*, Publication 969, January 22, 2014, at <http://www.irs.gov/pub/irs-pdf/p969.pdf>.

²⁷ For more information on the incentives provided by high-deductible health plans and Health Savings Accounts, see archived CRS Report R41426, *High-Deductible Health Plans and Health Savings Accounts: An Empirical Review*, by (name redacted).

²⁸ The information in this paragraph is from A. Mark Fendrick, Dean G. Smith, and Michael E. Chernew, “Applying Value-Based Insurance Design to Low-Value Health Services,” *Health Affairs*, vol. 29, no. 11 (November 2010), at <http://content.healthaffairs.org/content/29/11/2017.abstract>.

²⁹ A value-based insurance design (VBID) plan may or may not be explicitly labeled as such. Any plan in which the level of cost sharing varies with the benefit of the medical service may be viewed as a VBID plan.

values sometimes are used to compare health insurance policies because the plan's actuarial value is a better measure of plan comparability than is the plan's premium.

A health insurance plan's *actuarial value* is a summary measure of the plan's benefit generosity. It is expressed as a percentage of health care expenses for a standard population and a standard set of covered services estimated to be paid by the insurer. Two plans are actuarially equivalent if the estimated percentages of health care expenses paid by the plan for a given population are approximately equal. Nevertheless, two plans can be actuarially equivalent even though the details of their covered benefits and cost sharing differ.³⁰

Which Health Insurance Plan Might Be Best for a Particular Consumer?

Some consumers might be able to choose from a large number of health insurance plans. A particular consumer's best plan depends on a number of factors, some of which have been discussed. This final section brings together several of the concepts introduced in the report.

Health Issues

Perhaps the most straightforward component of a consumer's selection of a health insurance plan concerns how many consumers the plan will cover. For example, is a self-only or family plan preferable? Another fairly straightforward consideration is the choice of health care providers. If the consumers to be covered already have chosen providers, or if they want to be able to choose providers at a later date (perhaps when they become sick), they need to investigate the network status of providers. The consumers can decide to restrict their choice to plans with networks in which their current providers participate, pay the higher OOP expenses associated with the use of out-of-network providers, or find new (in-network) providers.

It would seem like calculating which plans are affordable might be fairly straightforward for the consumer, because the consumer can find out the potential premiums and general levels of cost sharing before purchasing a plan. In addition, the consumer also has some idea of his or her (expected) income, assets, and other items that he or she might want or need to buy. However, affordability encompasses much more than premiums, cost sharing, and maximum OOP expenses. In particular, the consumer cannot know his or her OOP costs in advance. Despite the presence of clear cost-sharing rules, it is virtually impossible for the consumer to know how much and what type of health care he or she will need over the course of the year. Children may or may not get an ear infection, and an adult may or may not get colon cancer. A minor cough could turn out to be a cold, where no visit to a provider is needed, or it could be the flu, where a visit to a provider might be needed. As discussed in "The Challenges of Purchasing Health Care," a

³⁰ Some health insurance policies are required to meet one of four levels of actuarial value. More specifically, plans offered in the individual and some small-group markets (both inside and outside exchanges) have this requirement. Each level is designated by a precious metal and corresponds to a specific actuarial value, as follows: bronze, 60% actuarial value; silver, 70% actuarial value; gold, 80% actuarial value; platinum, 90% actuarial value. As the plans move from bronze level to platinum level, all else equal, cost sharing generally decreases and premiums generally increase. In short, consumers usually must pay more for health insurance policies that cover more of their costs.

consumer can only approximate his or her health status and use of health services over the year, and therefore can only roughly approximate the affordability of various health insurance plans.

Employment Issues

In some cases, ESI offers the best value for health insurance policies.³¹ But although there are advantages to obtaining ESI coverage, there are challenges as well. From the vantage point of the consumer, 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 plans, health care providers, or services to which the worker has access.³² Indeed, the consumer may no longer be offered ESI after an employment change. In addition, the consumer's total compensation package may change when the employer offers ESI. Employers that offer health coverage may pay their employees lower wages because the employer uses the remainder of the employee's compensation package to pay for part of the employee's health insurance premiums. Workers who do not take up health insurance from their firms therefore may end up accepting lower wages for a set of benefits they do not use.

In short, determining which health insurance plan might be right for a particular consumer is far from simple. It involves, among other things, developing a sense of both what health care usage is likely to be over the term of the health insurance plan and the connections between health care and employment issues.

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Acknowledgments

The author thanks Joy Grossman and (name redacted) for comments on earlier drafts of this report.

³¹ Consumers who are relatively young and healthy might find options that are better for them through another source of health insurance.

³² This scenario would occur when the providers associated with a worker's old network are not participants in any of the plans offered by the new employer.

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