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Health Insurance: A Primer

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Summary

People buy insurance to protect themselves against possible 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 medical services. Health insurance then provides protection against the possibility of financial loss due to health care use. In addition, since people do not know ahead of time exactly what their health care expenses will be, paying for health insurance on a regular basis helps smooth out their spending.

While health insurance continues to be mainly a private enterprise in this country, government plays an increasingly significant role. Especially during the latter half of the 20th century, the government both initiated and responded to dynamics in medicine, the economy, and the workplace through legislation and public policies. For example, the Internal Revenue System clarified that employer contributions to employee health benefits are exempt from taxation, which encouraged the growth of employment-based health coverage. 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, which will be updated, provides basic information about those topics.

The negative consequences of uninsurance are well-documented. Persons 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 overcrowding in emergency rooms. Furthermore, individual states and the nation as a whole are affected through increased taxes and health care prices to cover uncompensated care expenses.

Americans obtain health insurance in different settings and through a variety of methods. People may get it through the private sector, or from a publicly-funded 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 insurance premium. However, nearly 44 million Americans did not have health coverage in 2002.

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, indemnity insurance is characterized by open access to services, whereas service use restrictions are hallmarks of managed care plans. And as economic conditions change, a specific delivery system may gain or lose the interest of affected parties.

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Introduction

Health insurance coverage dominates many state and federal health care discussions. As health coverage evolved from an uncommon benefit to a routine one, government's role in subsidizing and regulating that coverage also changed for workers, employers, and insurers. Although health insurance continues to be mainly a private enterprise in this country, public entities play an increasingly significant role.

Government's involvement in health coverage expanded dramatically in the latter half of the 20th century. Public policies and legislation initiated or responded to dynamics in medicine, employment, and other areas.

- 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 health care increased, which was especially problematic for certain groups of care consumers who lacked health coverage. This led to government efforts to assist consumers in paying for health care 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 they 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 basic information about those topics.

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[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.

What Is Health Insurance?

Basic Definitions and Principles

People buy insurance to protect themselves against possible 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 medical services. Health insurance then provides protection against the possibility of financial loss due to health care use. In addition, since people do not know ahead of time exactly what their health care expenses will be, paying for health insurance on a regular basis helps smooth out their spending.

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, so as 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.

While the methods employed by an insurer differ from those of a consumer, each person or entity has the same goal: to *minimize* risk in an uncertain future. It is this uncertainty of the future and risk of 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 a study that looked at the distribution of health care spending, 5% of the population accounted for over half of all health expenditures, and 10% of the population accounted for around two-thirds of those expenditures.[2] Such findings were consistent for selected years spanning three decades. Given the uneveness of health care spending and the impossibility of identifying all of the highest spenders before they use medical services, insurers employ various strategies in order to minimize the risk they take on.

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[2] Marc L. Berk and Alan C. Monheit, "The Concentration of Health Care Expenditures, Revisited," *Health Affairs*, vol. 20, no. 2, (Mar./Apr. 2001), pp. 9-18.

Risk Pool and Rate Setting. The main objective of insurance is to spread risk across a group of people. This objective is achieved in health insurance when people contribute to a common pool ("risk pool") an amount at least equal to the average *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 persons 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 rate (i.e., a "premium") in order to finance the health coverage it provides. The premium generally reflects several factors, including the expected cost of claims for using services in a year, administrative expenses associated with running the plan, and a risk or "profit" charge. The premium also will vary depending on if it buys self-only coverage or family coverage (see later discussion). If the insurer accurately estimates future costs and sets appropriate premium levels, then claims for that risk pool should be reasonably predictable over time. In other words, the premiums paid by healthy persons in the risk pool help subsidize the costs of less-healthy persons.

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 high costs for a few people across many people. But the number of people 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 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 the cost 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 statues) 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 people generally know more about their own health conditions than any other person or entity, such as an insurer. Health care consumers typically are the best-informed about when they will need medical care and what kind of services they will need. The "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. This asymmetry is another source of uncertainty which insurers take into account when developing and pricing insurance products (or health plans).

When a disproportionate share of unhealthy people make up a risk pool, a phenomenon known as "adverse selection," the average 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 average 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 professional association or 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 insurance market, the entity that purchases health insurance on behalf of a risk pool is referred to as the "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 exhaustive analysis of *each* applicant's insurability. An applicant usually must provide the insurer with an extensive medical history and often undergo a physical exam. This information is used by carriers to assess the potential medical claims for each person by comparing characteristics of the applicant to the loss 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 conditions for coverage. This evaluation and determination process is called "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 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, demographics (e.g., industry of firm and age distribution of enrollees), and geographic location — to conduct the insurance risk and loss analysis. 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.[3]

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[3] G. Claxton, "How Private Insurance Works: A Primer," Kaiser Family Foundation (KFF)
(continued...)

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 sponsor purchases health coverage from a state-licensed insurer (also referred to as an insurance carrier). The carrier assumes the risk of providing covered services 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 (e.g., employing firm) seeking coverage for its members (e.g., employees). Such organizations directly take on the risk for covering medical expenses, and such plans are not subject to state insurance regulations. Thus, a large employer that self funds employee health benefits acts as both sponsor and insurer for that coverage. 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 whether the policy covers one person or a family. Under self-only coverage, the holder of the insurance policy is the only person insured. (Self-only coverage sometimes is referred to as individual coverage. Individual coverage in this sense should not be confused with health coverage from the individual insurance market — see discussion below.) Family coverage applies to the policyholder, her/his spouse, and children.[4] Self-only and family policies may differ from each other in terms of the services they cover and the cost-sharing they impose.

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. The estimate of administrative expenses as a percent of claims often is used as a measure of operational efficiency. For large firms that self-insure, administrative costs make up 5-11% of claims, compared with 33-37% for insurers of small firms.[5] In the nongroup market, administrative expenses are often higher on a per-person basis compared to the group market.

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[3] (...continued)
website, Apr. 2002, at [http://www.kff.org/insurance/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14053].

[4] Policies vary on the requirements children must meet (e.g., age, martial status, etc.) in order to become eligible for or stay on a family policy.

[5] Rose C. Chu and Gordon R. Trapnell, "Study of the Administrative Costs and Actuarial Values of Small Health Plans," Small Business Research Summary no. 224, at [http://www.sba.gov/advo/research/rs224.pdf], Jan. 2003

Tax Preference

Unlike most industrialized countries, the United States does not guarantee health coverage to all of its citizens. Instead, it relies on a patchwork approach which combines private and public means for providing and accessing health insurance and health care. One of the key pieces of this patchwork 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 employees' gross incomes for tax purposes. This tax preference encourages works 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 employees typically get access to more services at better rates (see discussion below). However, employees generally receive reduced wages to compensate for richer fringe benefits.

The tax exclusion of fringe benefits is one of the primary reason why health coverage is provided mainly through the workplace in this country. Approximately two out of three nonelderly (under 65) Americans have employment-sponsored insurance (ESI). Moreover, of nonelderly persons with private health insurance coverage, approximately nine out of 10 obtain it through the workplace.

Health Insurance Regulation

Regulation occurs at multiple points in the process of providing health coverage. 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 their health plan enrollees are a few of those issues. The most common distinction (and one of the most contentious areas) in the regulation of health insurance 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 compensation in courts, access to care, and mandated coverage for certain benefits.

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 Statutes. Regardless of whether health plans are fully-insured or self-funded, they all are subject to a number of federal laws (e.g., the Americans with Disabilities Act). Two of these federal laws, the Employee Retirement Income Security Act of 1974 (ERISA, P.L. 93-406) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191), 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 generally are exempt from ERISA). Passed in response to pension abuses, the Act was developed with a focus on pensions, but the law applies to a long list of "welfare benefits" including health insurance. The Act 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. ERISA preempts state laws for issues 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." Given the ambiguity of the phrases "relate to" and "business of insurance," the ERISA preemption is an area of heated debate and active litigation.[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 denied, 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 a demonstration project for tax-advantaged medical savings accounts and a graduated increase of the portion of premiums self-employed persons could deduct from their federal income tax calculations. Another set of HIPAA provisions addresses the electronic transmission of health information and the privacy of personally-identifiable medical information (administrative simplification and privacy provisions, respectively).[7]

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[6] For more information about ERISA, see CRS Report RS20315, *ERISA Regulation of Health Plans: Fact Sheet*, by Hinda Chaikind.

[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, Jean Hearne, Robert Lyke, Stephen Redhead and Julie Stone.

Why Is Health Insurance Considered Important?

While health insurance coverage is not necessary to obtain health care, it is a vital mechanism for accessing services in an environment of increasingly expensive health care. As health care costs rise — at times outstripping the rise in wages — 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.

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.[8] Uninsured persons also are less likely to have a "usual source of care;" i.e., a person or place identified as the source to which the patient *usually* goes for health services or medical advice (not including emergency rooms). In 2002, while only one-tenth of all adults with private health insurance identified no usual source of care, almost half of all uninsured adults had no usual source.[9] Having a usual source is important because people who establish ongoing relationships with health care providers or facilities are more likely than persons without a usual source to access preventive health services and have regular visits with a physician.[10] Therefore, to the extent that health insurance coverage facilitates access to medical services, people without coverage face substantial barriers in the pursuit of the health care they need.

The negative consequences of uninsurance extends beyond the persons directly involved. The Institute of Medicine found that the insurance status of parents affects the amount of health care their children receive.[11] In places with crowded emergency rooms, increasing uninsurance rates can add to that problem, since uninsured persons have fewer places from which they can get general health services outside of emergency departments (EDs), compared to people with health coverage. Overcrowding in EDs, in turn, leads to longer waits for all patients seeking emergency care. Moreover, 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 health care

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[8] Kaiser Commission on Medicaid and the Uninsured, "The Uninsured and Their Access to Health Care," KFF website at [http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=29284], Dec. 2003.

[9] National Center for Health Statistics, *Health, United States, 2002*.

[10] 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.

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

providers gave approximately $35 billion of uncompensated care to the uninsured in 2001.[12]

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."[13] Taxpayers are affected because the federal government makes payments to hospitals — for patients enrolled in certain programs — 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 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, states, and the nation as a whole.

Where Do People Get Health Insurance?

Americans who are not elderly obtain health insurance in different settings and through a variety of methods (see **Table 1**).[14] 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 insurance premium (both the employee and employer shares of the premium). However, nearly 44 million Americans did not have health coverage in 2002.[15]

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[12] J. Hadley and J. Holahan, "How Much Medical Care Do the Uninsured Use, and Who Pays for It?," Health Affairs Web Exclusive, Feb. 12, 2003.

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

[14] Health coverage often is discussed in terms of the under-65 population, given that virtually all of the elderly get health coverage through one source: the Medicare program.

[15] U.S. Census Bureau, *Current Population Survey*, 2003. The number includes all uninsured persons, including the elderly.

Table 1. Health Insurance Coverage of the Nonelderly by Type of Insurance, 2002

	Coverage distribution	Millions of persons
Total population	100.0%	250.8
Group market	64.2	161.0
Nongroup market	6.7	16.8
Medicare	2.3	5.8
Medicaid	11.9	29.9
Tricare/CHAMPVA*	2.8	6.9
No health insurance	17.3	43.3

Source: Employee Benefit Research Institute estimates of the 2003 Current Population Survey.

Note: Columns may not add to totals because persons may receive insurance coverage from more than one source.

* Tricare (formerly known as CHAMPUS) is a program administered by the Department of Defense for military retirees as well as families of active duty, retired, and deceased service members. CHAMPVA, the Civilian Health and Medical Program for the Department of Veterans Affairs, is a health care benefits program for disabled dependents of veterans and certain survivors of veterans.

Employer-Sponsored Insurance

Even though examples of health insurance in this country stretch back almost 200 years, most Americans did not have health coverage until the latter half of the 20th century.[16] The demand for more workers during World War II and a wage freeze imposed by the National War Labor Board generated great interest in employer-sponsored insurance (ESI) as a worker recruitment and retention tool.[17] Buoyed by legislation and court rulings declaring the tax exemption of fringe benefits, and support from unions for work-based coverage, health insurance became a pervasive employment benefit.

In 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"). Such a 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 birth),

[16] See timeline from Employee Benefit Research Institute's (EBRI) "History of Health Insurance Benefits," EBRI website, Mar. 2002, at [http://www.ebri.org/facts/0302fact.htm].

[17] Health Insurance Association of America, *Fundamentals of Health Insurance*, 1997.

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 usually pay part (or, in very few instances, all) of the total premium. This practice makes health coverage a more attractive benefit, even to those who do not plan to use medical services on a regular basis. Overall, insurers may assume that not all people in ESI risk pools take-up health coverage for reasons primarily related to personal health status or immediate demand for medical care.

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 more stable. Generally, this translates into less volatile costs and better overall rates in the group market compared to the nongroup market. Also, large ESI groups can use their size to negotiate for better benefits and 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 such administrative activities 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 coverage to recruit and retain 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 access. 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 contributes to the cost of the premium, enrollees do not bear the full cost of obtaining health coverage. More importantly, 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 in particular 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 greater overall health care expenditures. In addition, sponsors' efforts to constrain their health care spending — by increasing the employee share of the premium or employee 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.

Large vs. Small Groups. The group insurance market often is thought of as consisting of 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. On the other hand, 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 entities generally do not have the necessary administrative capacity to negotiate with multiple provider groups and handle all the day-to-day operational functions conducted by insurers. It is conditions such as these which prompt legislators to develop proposals for expanding small group participation in health insurance; for example, targeting association health plans and health marts, and opening up FEHBP to the small group market.

Association health plans and health marts are examples of 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 pooling 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.[18]

Public Programs

While most Americans with health insurance obtain it through the private-sector, tens of millions of people get their medical care paid for 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.

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[18] For additional information, see CRS Report RL31963, *Association Health Plans, Health Marts, and the Small Group Market for Health Insurance*, by Jean Hearne.

Medicare. The Medicare program was established in 1965, and is a federal program for seniors (65 years and older), certain nonelderly persons with disabilities, and persons with end-stage renal (kidney) disease. Medicare currently consists of three parts: Part A, Hospital Insurance; Part B, Supplementary Medical Insurance; and Part C, Medicare Advantage, formerly referred to as the Medicare+Choice program. Together, Parts A and B cover many medical services, such as care provided in hospitals and skilled nursing facilities, hospice care, home health care, physician services, physical and occupational therapy, and other services. The then Medicare+Choice program, added three decades after Medicare was established, was created to expand the availability and diversity of managed care plans that cover all Part A and B services. P.L. 108-173 added a new Part D to the Medicare program. Effective in 2006, Medicare beneficiaries may access outpatient prescription drug benefits through Part D.

A large majority of Americans age 65 and older are automatically entitled to coverage under Part A and do not have to pay a premium because either they or their spouse paid Medicare payroll taxes on their past earnings. (Even if an elderly person did not pay Medicare taxes, she/he may be able to purchase Part A coverage.) Part A also provides coverage for certain nonelderly persons who receive Social Security cash benefits. Enrollment in Medicare Part B is voluntary for eligible individuals. For most persons who are entitled to benefits under Part A, they are enrolled automatically in Part B, but they are given the option to decline coverage. The small minority of people who do not have automatic enrollment may request enrollment in writing. All Part B enrollees pay a monthly premium for coverage.

Since its creation in the mid-1960s, Medicare has provided health coverage to tens of millions of Americans, and in 2003 had 40 million enrollees. The program has been so successful in covering the elderly that the problem of uninsurance usually is described in terms of the under-65 population.

Medicaid and the State Children's Health Insurance Program (SCHIP). Medicaid is the main health insurance program for very low-income Americans. It 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. Medicaid 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, home health care for those entitled to services from nursing facilities, and certain services for children. States also have the authority to cover additional services. Some states have used their waiver authority under Medicaid to extend coverage to uninsured persons who could not meet the program's financial tests. Medicaid is a means-tested program and applicants must meet financial and other criteria in order to be eligible for program services. Everyone who meets the eligibility criteria is entitled to Medicaid benefits.

The State Children's Health Insurance Program was established in 1997 to allow states to cover certain low-income children. 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 SCHIP eligibles must provide the full range of Medicaid benefits, as well as all optional services specified in their state Medicaid plans. States that establish SCHIP 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 SCHIP program. SCHIP'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.[19]

Individual Health Insurance

The individual insurance ("nongroup") market is often referred to as a "residual" market. The reason being that 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 SCHIP. 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.[20] 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.

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 usually must provide her/his medical history, and often undergo a physical exam. This information is used by carriers to assess the potential medical claims for each person. Federal and state requirements restrict somewhat insurers' ability to reject applications or design coverage based on health factors (such as benefit exclusions for certain pre-existing health conditions). 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.[21] Rigorous underwriting results in an enrollee population that is fairly healthy (three out of four enrollees report that their health is excellent or very good[22]), thereby excluding

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[19] For additional information about SCHIP, see CRS Report RL30473, *State Children's Health Insurance Program (SCHIP): A Brief Overview*, by Elicia J. Herz and Peter Kraut.

[20] D. J. Chollet, "Consumers, Insurers, and Market Behavior," *Journal of Health Politics, Policy and Law*, Feb. 2000.

[21] 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*, Feb. 2000.

[22] General Accounting Office, "Private Health Insurance: Millions Relying on Individual (continued...)

persons with moderate to severe health problems from the private nongroup insurance market.

State High-Risk Pools

Many states have high-risk pools, which are nonprofit entities that provide health coverage to persons with high health care expenses. Generally, such persons are denied coverage in the individual insurance market because of their health conditions and/or predicted use of costly medical services. If they are not eligible for public programs (e.g., their incomes may exceed the financial eligibility criteria), they have very few options for obtaining care. As of December 2002, 30 states run high-risk health insurance pools.[23] These programs tend to be small and eligibility varies by state. While some state high-risk pools have successfully provided health coverage to high-risk people, many programs are beset by accessibility, adequacy, and affordability problems.[24]

The Uninsured

Despite the various private and public sources of health insurance, millions of Americans are without health coverage. In 2002, there were almost 44 million people without health insurance coverage.[25] For the vast majority of the uninsured, it is 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 the near-universal coverage of seniors through Medicare. The nonelderly uninsured population differs from the insured population on a number of key demographic factors. One of the most striking characteristic of persons who lack coverage is that a significant proportion are in low-income families. For instance, among all uninsured persons under age 65, over half were in poor or near poor families in 2002.[26] Moreover, among nonelderly persons who are poor, a full one-third lacked health insurance coverage, compared to less than one-fifth of the poor who received coverage through the workplace.[27]

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[22] (...continued)
Market Face Cost and Coverage Trade-Offs," Nov. 1996.

[23] States with high-risk pools: AL, AK, AR, CA, CO, CT, FL, IL, IN, IA, KS, KY, LA, MD, MN, MS, MO, MT, NE, NH, NM, ND, OK, OR, SC, TX, UT, WA, WI, and WY. A map of state high-risk pools is available at [www.statehealthfacts.org].

[24] For additional information about state high-risk pools, see CRS Report RL31745, *Health Insurance: State High-Risk Pools*, by Julie Stone.

[25] U.S. Census Bureau, *Current Population Survey*, 2003.

[26] The poverty level for a family of four in 2001 was an annual income of $18,104.

[27] For additional information, see CRS Report 96-891 EPW, *Health Insurance Coverage: Characteristics of the Insured and Uninsured Populations in 2002*, by Chris Peterson.

A surprising characteristic of the uninsured is that over 80% are persons with ties to the paid labor force, or dependents of such persons. Even more surprising is that over half of the uninsured were workers with full-time, full-year status, or the dependents of those workers. 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 the risk of being uninsured and choose not to purchase insurance. 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.

The problem of the uninsured is a paramount health care concern to many policymakers and legislators. One of the topics of ongoing debate is the overall number of uninsured 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 2002 (the last year of available data), the change in the annual uninsurance rate *usually* was one-half of 1%, or less.[28] 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 Health Benefits Delivered And Financed?

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

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[28] Data available at [http://www.census.gov/hhes/hlthins/historic/index.html].

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 expenses. 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*. 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.[29] Some enrollees had grown weary of provider and service restrictions. Many MCOs that had increased market share through artificially-low premiums began to

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[29] Richard Kronick, "Waiting for Godot: Wishes and Worries in Managed Care, " *Journal of Health Politics, Policy and Law*, vol. 24, no. 5 (Oct. 1999), pp. 1099-1106.

raise them in order to increase revenue.[30] 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.[31]

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.[32] But as the economy soured, employers began to pass these expenses along to enrollees in the form of higher premiums and greater cost-sharing.[33]

Consumer-Directed Health Plans

By the turn of the millennium, 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-directed (or consumer-driven) health plans 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, consumer-directed plans vary in the degree to which consumers are responsible for health care decision-making.[34]

For example, one type of health benefits option that is at the heart of discussions about consumer-driven health care is the personal care account (PCA). Typically,

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[30] Jon Gabel, et al., "Job-Based Health Insurance in 2001: Inflation Hits Double Digits, Managed Care Retreats," *Health Affairs*, vol. 20, no. 5 (Sept./Oct. 2001), pp. 180-186.

[31] American Association of Health Plans, "Health Plans and Employer-Sponsored Plans," Oct. 1999.

[32] 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, (Feb. 2003), pp. 357-373.

[33] Jon Gabel, et al., "Job-Based Health Benefits in 2002: Some Important Trends," *Health Affairs*, vol. 21, no. 5 (Sept./Oct. 2002), pp. 143-151.

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

employers pair PCAs (also called health reimbursement accounts (HRAs)) with a high-deductible health plan. Employers designate a set amount of money in the PCA for their employees to spend on health services. (For instance, under the recently added PCA option in FEHBP, enrollees can use up to $1,000 if they have self-only coverage, or $2,000 for those with family coverage.) If the PCA 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 that high-deductible plan takes effect.

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 plan scenario.

Proponents of consumer-directed plans 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.