A Health Insurance Overview

How does the health insurance market work?

Health insurance spreads the cost of care among large groups of people. In that way, insurance premiums paid by one person help to pay for the care of others. In any large group in any year, most people are healthy and use few health services. A minority (about 20 percent) account for the majority (roughly 80 percent) of health care spending for the group. Because it is likely that every person at some point will get sick, be injured, or even become disabled, sharing this risk is a critical part of insurance.

Health insurance markets work best when a large group of relatively healthy people buy insurance and pay their premiums year after year. Insurance markets do not work well when healthy people do not participate in great numbers and the primary purchasers of health insurance are those who will require expensive care. Indeed, insurers prefer to sell coverage to groups formed for reasons other than to purchase insurance, such as employer groups.

In addition to spreading financial risk, health insurance has another important function - guaranteeing access to health care services. Doctors and hospitals are more likely to care for people when they are assured they will be paid. Numerous studies have shown that people without health insurance receive far fewer health services (or delay needed health care) compared to the insured. Thus health insurance not only protects us from catastrophic expenses, it also secures access to important routine, preventive, and primary care services.

Who are the uninsured?

Despite the clear importance of health insurance, almost 50 million non-elderly Americans are uninsured (or 19 percent of the non-elderly population).

- Most of the uninsured have low incomes, below 200 percent of the federal poverty level (or $44,700 for a family of four).
- Most of the uninsured are full-time workers, and their family members, whose jobs don't offer health benefits.
- This is a changing group of people; many people who are uninsured one year are insured the following. And millions of people who have insurance today may be counted among next year's uninsured. An estimated 32 percent of Americans and their families had a gap in health insurance for at least one month, and 87 million people were uninsured at some point during 2007 and 2008.

Not all insurance is alike

It is important to note that having insurance (See "How do people get insurance?" for more information) doesn't necessarily mean people have health security. In addition to the uninsured, an estimated 25 million Americans are under-insured; that is, they have insurance, but it is not
adequate to protect them from catastrophic medical expenses or to secure access to needed care. The leading cause (approximately 50 percent) of personal bankruptcy in the U.S. is high medical expenses. The majority who cite this reason for their bankruptcy had health insurance. Thus, not only the presence of insurance, but the adequacy of insurance, is critical for health insurance to provide the protection consumers expect and need.

Who buys individual health insurance?

About 6 percent of people under age 65 are covered by an individual (or non-group) health plan. The individual health insurance market is sometimes referred to as a residual market. This is where people go to buy health insurance when they don't qualify for insurance under a group health plan, or when they aren't eligible for a public program such as Medicare or Medicaid.

Even though it isn't a large percentage of the overall market, people often need individual health insurance for themselves or their families when they work in jobs that don't offer health benefits, are between jobs, or when they are self-employed even if only for a period of time. In addition, people who retire before the age of 65 (when Medicare eligibility starts) may need individual health insurance. People who are divorced or widowed can end up in the individual insurance market, as do some young adults when they first become too old to be on their parents' policies.

What does individual health insurance cost?

The cost of individual health insurance currently varies enormously, depending on what the policy covers; the age, gender, and health status of the person buying it; and geographic location in which it is sold, among other things. Beginning in 2014, health plans will no longer be allowed to charge higher premiums based on gender or health status. The only factors by which health plans will be able to vary premiums will be age, tobacco use, family size, and geographic area.

Individual insurance coverage is more expensive than group health insurance. Individual policy premiums include the cost of marketing, broker commissions and other administrative costs associated with selling policies to one person at a time. By contrast, in group health plans and public programs, these costs are spread over large numbers of people. In addition, individual health plans don't enjoy the same employer subsidies and tax benefits as group health plans.

What does individual health insurance cover?

Individual health insurance is often much less comprehensive than group health plans, with higher deductibles and co-payments covering fewer benefits. For example, insurance for prescription drugs and mental health care may be restricted.

Beginning in 2014, the Affordable Care Act (ACA) will require all new individual health plans to cover an essential benefits package designed to mirror the typical employer-based health plan. The plan must include, at a minimum:
- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

The ACA also requires plans offering the essential health benefits package to limit the cost-sharing they charge. Specifically, plans providing essential benefits will be prohibited from imposing an annual cost-sharing ceiling that exceeds the limits that apply to high deductible plans. Currently, those limits are $5,950 per year for individuals and $11,900 per year for families.

**How is individual health insurance sold?**

Currently, individual health insurance is almost always sold by brokers, and is medically underwritten. However, the ACA will change the way health insurance is marketed and sold. The ACA will create a web portal to allow consumers to shop for and compare plans, and creates health insurance Exchanges that will provide a "one-stop-shop" for enrollment in private or public insurance.

**Group Plans**

**Who has employer-based group health plans?**

Some 157 million Americans get health insurance through an employer-based group health plan - the most prevalent source of health insurance coverage. Group health coverage is popular for several reasons:

- Group health insurance benefits are usually comprehensive, compared to those in individually purchased plans. For example, nearly all (99 percent) of group health plans cover prescription drugs, and about 76 percent offer home health benefits. These benefits are less likely to be available under individual plans.

- In group health plans, people have greater legal protections. For example, it is illegal for any group health plan to refuse to cover a member of that group or their dependents because of their health status. On the other hand, most states allow insurance companies to deny applicants based on health status in individual plans (until 2014, when the ACA requires all plans will to cover anyone who applies).
• Group health benefits provided through an employer are not subject to income tax, unlike wages. This tax break is significant and increases with income.

• Dollar for dollar, group health plans are less expensive. Insurers save administrative and marketing costs when they sell a single policy to an entire group, so the plan is less costly than insurance for an individual. These savings and other economies of scale help make group plans more economical for consumers.

• For insurers, the risk-spreading function of health insurance is easier to accomplish through group policies. Insurers worry that people applying for individual coverage may put off buying health insurance until they expect to use it. This idea, called "adverse selection" means the average individual policy holder is more likely to have health issues so health costs are more expensive. By contrast, when an insurer sells a single policy to an employer, the insurer can be more confident that the group of employees, formed for reasons unrelated to health, should have health costs similar to the average in the general population.

Group health plans are categorized by their size and sold in either small group or large group markets. They are also distinguished by the insurance arrangement of the employer - fully insured and self-insured. Finally, while most group health plans are established by employers (or employee organizations, such as unions) other kinds of non-employer groups are recognized in some states.

The distinction between group and individual coverage is important because consumer protections under group plans are generally much greater. In addition, people leaving group health plans to get new insurance usually have more protections than people moving from one individual policy to another.

**Health Insurance Products**

A variety of health insurance plans are sold in the U.S. Each type of coverage has different restrictions on the choice of providers and access to services. These plans include indemnity and managed care products. Two other types of plans are high-deductible plans with a health savings account and Blue Cross Blue Shield plans.

• What is managed care?
• What is indemnity insurance?
• What are high-deductible plans paired with a savings account?
• How are Blue Cross Blue Shield plans different from other insurance products?
How can I tell what kind of plan I have?

It can be challenging for consumers to distinguish between types of plans. Even indemnity policies today often include some managed-care features, such as a requirement for consumers to obtain prior authorization before obtaining non-emergency hospital care. Similarly, some managed care plans are relaxing their prior-approval requirements for care in certain circumstances. It can be confusing to know which rules apply and when. Thus, it is very important to carefully read one's policy and member information in order to use coverage appropriately and get access to covered benefits.

A 2010 survey of employer plans (the kind that most Americans have) found the majority (58 percent) of people are enrolled in preferred provider organizations (PPOs), followed by health maintenance organizations (HMOs) (19 percent), high-deductible health plans with a savings option (13 percent), point-of-service (POS) plans (8 percent), and conventional indemnity plans (1 percent).

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