



# Health Insurance: The Major Financing Mechanism for the U.S. Health Services System

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## Chapter 6

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# Objectives

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- Provide an overview of insurance concepts
- Discuss health insurance
- Discuss specific concepts, and a description of the evolution of insurance as a major funding mechanism for health services
- Discuss private, public social insurance and other types of insurances
- Discuss the regulation of insurance
- Discuss pending and proposed reforms for health insurance



## Overview

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### Introduction

- For second half of the twentieth century, health insurance was the major financing mechanism for health services in the United States.
- Both private and ***public or social insurance had origins in the 19th century***, but neither cover a substantial proportion of the general population for other than work-related injuries until after World War II.



# General Insurance Concepts

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- In the purest sense, *insurance* is defined as a mechanism to protect against unpredictable loss (Wilensky et al. 1984).
- The basic function of insurance is to spread infrequent, large losses over a wide base (Light 1992).
- As part of the contractual relationship established by an insurance policy, the insurer sets a premium, to be paid monthly, annually, or on another basis, to cover the specific set of losses against which it is insuring the individual or group.



# Concepts Specific to Health Insurance

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- Unlike most other industrialized countries in the world, the United States don't have *national health insurance* or an ***alternative system of universal coverage***.
- ***Financial access*** to U.S. health service is achieved through ***private or public health insurance***, or through ***other government-sponsored programs***.



# Concepts Specific to Health Insurance

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- *Health insurance* initially was **limited** to *inpatient hospitalization*, an infrequent and other large loss that is often unpredictable.
- In the last several decades, the concept of **health insurance** has been *expanded* to embrace the majority of interactions with the health services system, including physicians' services, mental health, dental, and vision services.



# Risk Assessment

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- As is generally true of insurance, health insurance includes risk assessment – the *process of modeling and calculating the expected expenses of one class of person or people relative to others.*



# Direct and Indirect Risk Adjustment

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- **Direct risk adjustment**
  - includes medical **underwriting and redlining**.
  - Medical underwriting is a process used by insurers to determine to whom, under what conditions, and for what price a policy is issued.
- **Indirect risk adjustment**
  - include instituting co-payments for certain services, **limiting package by excluding certain procedures, tests, or pharmaceuticals** from coverage; or *placing caps or ceiling on the level* or total services.



# Evolution of Health Insurance as the Primary Mechanism for Financing Health Services

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- Although the use of health insurance as the major financing mechanism for health services in the United States did not occur until World War II, the private health insurance industry originated a century earlier.
  - In 1850, the *Franklin Health Assurance Company* of Massachusetts offered coverage for medical expenses for *bodily injury* that *did not result in death*
  - 1860 *Travelers Insurance Company of Hartford* began to offer *medical expense coverage* on a basis resembling the present form of health insurance.



# Private Health Insurance

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- Although private health insurance policies were available to some employed populations as early as the mid-1850s, ***private health insurance as a benefit of employment was not widely available until the World War II era.***
- By the 1920s, however, changes were occurring in the economy, in the sophistication of the medical care sector, and in the expectations of the workforce that created a more favorable climate for the ***growth of private health insurance.***



# Private Health Insurance

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- ***School teachers and Baylor University Hospital in Dallas, Texas, are credited with stimulating in 1929 the growth of employer-sponsored private health insurance.***
  - As the Depression took its toll on voluntary hospitals, they began to offer hospital service contracts to employed groups as one way to secure financial stability.
  - Under a service contract, the insurer guarantees payment for services ***directly to the hospital***, and the ***payment often covers the full bill.***



# Growth of Commercial Health Insurance

- Although *commercial insurers* began offering indemnity coverage against hospital expenses on a group basis in 1934 and expanded this coverage to surgical bills four year later, *provider-organized health insurance plans* were dominant prior to World War II.



# Availability of Health Insurance in Small Business

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- Although full-time employees in mid- to large – sized businesses have come to expect health insurance as a benefit or employment, employees in ***smaller firms (fewer than 100 employees) may not have health insurance as a benefit.***
  - Nearly half the labor force works in firms of fewer than 100 employees (Kronick 1991).



# Retiree Health Insurance

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- ***Retiree health insurance*** has been an important benefit to some in the workforce, especially those working in larger companies of ***2000 or more employees***.
- Several kinds of insurance are included in the ***retiree health category***:
  - ***Employer-sponsored group coverage***
  - ***Individually purchased Medisup policies***
  - ***Publicly sponsored coverage such as Medicaid.***



# Health Insurance a Major Cost of Doing Business

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- Far from being solely a fringe benefit used to attract a stronger workforce, the provision of employee health insurance is currently a major expense of doing business.
  - Business health spending a share of total labor compensation was 8.5 percent for state and local government and 6.2 percent for private industry in 2001, up from 2 percent in 1965 (USDHHS 202).



# Measures to Contain the Costs of and Expenditures for Health Insurance

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- To contain the costs of and expenditures for providing health insurance, employers have instituted a number of measures:
  - employee cost sharing
  - reducing the scope of covered benefits, reducing or eliminating coverage for dependents
  - capping the total expenditures available per insured person
  - offering fewer fee-for-service and more managed care options, requiring authorizations before the use of services
  - self-funding their own insurance programs.



# Cost Sharing

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- Employers instituted cost sharing as a way to control utilization of and thus expenditures for health services.
- ***Cost sharing*** may require the insured to ***pay part of the premium, pay a deductible before coverage*** becomes effective, make co-payments of a fixed dollar amount for services such as prescription drugs, or to pay co-insurance, a fixed percentage of the total costs.



# Limiting Scope of Benefits

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- Employers may limit or *reduce the scope of benefits provided* to an insured as another way to contain costs.
- *Limits* may be put on the number of *out-patient mental health visits an insured* may obtain, for example, and certain services or procedures such as heart-lung transplants may not be covered by particular policies.
- *Reducing or eliminating* the *health insurance coverage of an employee's dependents* is another way of limiting the benefit package.



# Caps on Insurance Expenditures

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- Employers may contain their expenditures by offering policies that have caps on the total expenditures for covered services for an individual in a specified coverage period or lifetime.



# Controls on Utilization of Services

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- Directly controlling the utilization of services by *requiring prior authorization, second opinions for surgery, or precertification for a nursing home stay* are **additional methods** used by employers to contain their health of employees covered by group health insurance was governed by some type of utilization management.



# Self-Funded Insurance

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- Increasingly, employers who have a large enough workforce are choosing to self-fund their health insurance programs.
  - In self-funded – sometimes referred to as self-insured – programs, the employer assumes the responsibility of defining a benefit package and paying directly for covered services, thus reducing or eliminating the need for an insurance company.



# Individual Health Insurance Policies

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- Individuals *may not be covered by employers-sponsored health insurance because their employer does not offer it, they do not qualify for it, they are self-employed* or not in the workforce, or for other reasons.
- These people may choose to purchase individual coverage.



# TRICARE

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- The TRICARE program, which provides medical care to military dependents and retirees, originated from two governmental programs:
  - the Emergency Maternal and Infant Care Program (EMIC) of 1943 – a wartime measure to provide maternal and infant care benefits to the wives of active duty servicemen – and its successor program, the Dependents Medical Care Program.



# Medicare

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- The Medicare program, created by Title XVIII of the Social Security Act, was established in 1965 to pay for health services for *people age 65 and older*.
- Medicare was one of two compromises – the other was *Medicaid – effected following the inability to secure national health insurance*.
- *Social health insurance* was endorsed as early as 1912 by presidential candidate *Teddy Roosevelt*, but had foundered on opposition from organized medicine, within Congress, and from other sources.



## Cont:

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- Initially aimed at the population age 65 and older – because age 75 was then the mandatory retirement age as well as the age for social security eligibility
- ***Medicare*** was expanded in **1972** to include ***people of any age with end stage renal disease (ESRD) and in 1973*** to include people of ***any age who met Medicare's definition of disability.***



# Eligibility for Medicare

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- Currently, people earn *eligibility for Medicare* principally by participating in the workforce and *contributing to the Social Security System for 40 calendar quarters*.
  - *The 1972 amendments* to the Social Act, effective in July 1973, permit *most people age 65 years and older who are ineligible for hospital insurance* to enroll voluntarily by paying a monthly premium (USDHHS/HCF 1990).



# Special Categories of Private Health Insurance

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- Several special categories of *private health* insurance are worthy of note: "*dread disease*" policies, policies for specific services, and long-term care (LTC) insurance.
  - "*Dread disease*" policies cover a specific disease type such as *cancer*.
  - Policies may be purchased for specific services such as prescription drugs.
  - These policies are sold almost exclusively on an individual rather than group basis.



# LTC Insurance

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- ***Insurance*** for ***long-term care*** is a relatively recent phenomenon in the U.S. market
  - As of 1994, only about 6 percent of the elderly had LTC policies to assist them with long-term care – primarily nursing home – expenses
  - The HIAA (2002) estimates that 5.8 million LTC policies were sold between 1987 and 1988, with 300,000 being sold in 1998.



# Private Health Insurance Summary

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- *Private health insurance* finances the health services of nearly ***two-thirds of the U.S. population.***
- The majority of this ***coverage*** occurs through group insurance, with larger employers being more likely than smaller ones to offer health insurance as a benefit.



# Private Health Insurance

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- ***Private health insurance*** focuses largely on those in the *workforce* and their ***dependents and, in some instances, on retirees from the workforce.***
  - For the small proportion of the population that can afford them, individual health insurance policies are also part of the private health insurance market.



# Medicaid Expenditures

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- Medicaid enrollees – *aged, blind, and disabled; low-income children; low-income adults; and others* – with the proportion of expenditures directed to each group.
- ***Children constitute 45 percent of all Medicaid enrollees*** but absorb just over 14 percent of the Medicaid enrollees
- States have the option to establish Medically Needy programs to pay for the health services of those who are categorically eligible for Medicaid but whose income and/or assets exceed the state's established levels.
- Thirty-eight states, the District of Columbia, and five territories have Medically Needy programs and receive federal matching funds for this population.



# Medically Indigent Programs

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- States may also establish programs for the *medically indigent* that may cover similar benefits to those provided to Medicaid enrollees.
- State programs for the medically indigent do not receive federal Medicaid matching funds.



# State-Sponsored Health Insurance Programs for Uninsurables

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- People with chronic, expensive to treat health conditions are sometimes unable to obtain private health insurance because they are considered to be high-risk by insurers.
  - Since 1976, 30 states have developed pools of high-risk individuals and subsidized their coverage.
  - These states high-risk insurance plans are financed by premiums paid by the insured and often by an assessment on other insurance plans doing business in that state.



# Workers' Compensation Insurance

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- As the U.S. economy became *more industrialized* in the early part of the *20<sup>th</sup> century*, public concern increased as the number and *extent of industrial accidents removed workers from the workforce and their livelihoods*.
- By 1907, 26 states had passed employer liability acts declaring the employer's legal obligation to provide for safety in the workplace.
- The next year the Federal Employer's Liability Act was passed for the same purpose.



# Viatical Settlements

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- In 1989, stimulated in part by the number of ***AIDS patients*** with life insurance policies who had exhausted other assets to pay for their health services, the concept of viatical settlements was introduced into the U.S. health services system.



# People Without Private or Public Health Insurance

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- Despite the extent of *private health insurance coverage* and the steady growth and expansion of some public health insurance programs, particularly Medicare and vendor payment programs such as Medicaid, an estimated (***15 to 20 %***) ***of the U.S. population does not have health insurance for some or all of any given calendar year.***



# Regulation of Health Insurance

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- The regulation of health insurance, particularly private health insurance, occurs primarily at the state government level as a result of the 1945 McCarran-Ferguson Act.



# ERISA

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- The 1974 Employee Retirement Income Security Act (ERISA) provides a federal framework for ***regulating employer-sponsored pension and welfare plans***, including ***health plans***, whether established by employers, employee organizations such as unions, or both.



# COBRA 1985

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- The 1985 *COBRA (Consolidated Omnibus budget reconciliation Act)* established the opportunity for employees with *group health insurance coverage who lost their jobs due to work-related (e.g., divorce, death)* reasons to retain their health insurance coverage *for up to 36 months if they pay the premium plus an additional administrative charge.*



# State Regulation of Health Insurance

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- The sale of and reporting on all types of ***insurance is regulated by state governments***, often by a state insurance commission or comparable entity.
- Key insurance regulatory activities include ***monitoring the insurer's financial solvency, reviewing premium rates, reviewing policies, and investigating consumer complaints and insurer marketing practices***



# Proposed changes in the U.S. Health Insurance Industry

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- *Health insurers* are *central to the financing of health services in the United States* and are central in discussions about how and why the system should change.
- Employers are active in supporting reforms, and politicians at all governmental levels are also proposing reforms.



# Tiered Benefit Design

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- ***Employers*** who sponsor employee health insurance have ***worked with insurers or insurance consultants to redesign part or all of the benefit packages*** in an effort to ***force employees to become more cost-conscious in their decision making.***



# HealthMarts

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- New forms of group health insurance purchasing arrangements such as HealthMarts are emerging.
  - The purpose of such proposed entities as *HealthMarts is to enable the small group market to function more like a large group market.*
  - Healthmarks seek to permit pooled purchasing and to **amend ERISA to preempt mandated state benefits**



# Play or Pay

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- The political system has influenced or attempted to influence the health insurance industry in other ways.
- In an effort to increase the availability of health insurance to the workforce, many states, as well as the successful Health Security Act of 1993, considered instituting a “play or pay” mandate to employers.



# Medical Savings Accounts

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- **Medical savings accounts (MSAs)** are tax-deferred *accounts set up to pay for routine medical expenses* and are designed to cover the predictable front-end *costs of preventive care and diagnostic services*.



# Vouchers and Tax Credits

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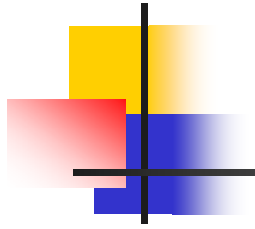
- *Politicians and others* have also expressed interest in *vouchers or refundable tax credits as* additional ways to *increase access to health insurance.*



# Health Insurance Flexibility and Accountability Initiative

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- In August 2001 the *Bush Administration* introduced the *Health Insurance Flexibility and Accountability Initiative* to *give states greater flexibility in covering low-income uninsured populations.*



# Questions

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