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The Basics of Health Insurance

Millions of Americans are covered by private health insurance, but few understand how their health insurance policies actually work. Perhaps that's because most health insurance policies are purchased for Americans by their employers, or because health insurance is more complicated than other forms of insurance. This paper seeks to answer some of the most basic questions about health insurance. For more information, please visit our website at www.cahi.org.

1. What is the purpose of insurance?
The purpose of insurance today is no different than when insurance products began being sold in London coffee houses to merchant ships traveling back and forth between the New World and the Old World: It's to protect someone from unforeseen risk. It could be the risk of a car accident (auto insurance), damage to a home or property (homeowner's policies) or an untimely death (life insurance). "Unforeseen" is the key word. A risk that has become certain — such as an individual's imminent death — is not unforeseen, and so is usually not an "insurable event." Moreover, standard and customary expenses (e.g., oil changes, tune ups, house painting, etc.) also are not typically covered by insurance because they are routine and predictable.

2. Does health insurance operate like other forms of insurance?
At one time health insurance operated like true insurance. It was financial protection against the expensive medical costs associated with an unforeseen accident or illness, not routine care. However, by the late 1980s, health insurance companies began selling "managed care plans," both through more-restrictive HMOs and less-restrictive "preferred provider organizations" (PPOs). Proponents believed that managing care, not co-payments, was the best way to control costs, and so offered health insurance with little or no cost sharing. As more and more Americans moved to managed care, they gradually came to see health insurance as the primary method — indeed, almost the *only* method — to pay for health care expenses.

This transition to insulating people from almost all costs has lead to what many believe is a "pre-paid health system," in which people's health "coverage" should pay for all of their expenses, even routine expenses they can afford. Thus health insurance is no longer insurance in the true sense of the word.

However, health insurers, employers and third-party administrators are increasingly trying to return health insurance to functioning like real insurance, giving rise to what is called the "consumer driven health care movement."

3. How do people get insurance?
Some 250 million Americans have health insurance coverage, provided by their employers, the government or purchased directly by the individual. The large majority of people with private coverage get it through their employer, also known as "group" coverage. Group coverage is broken down into "small group" (usually thought of as 2-50 employees) and "large group" (more than 50).

Individuals who don't have access to employer-provided coverage usually go to the "individual market" — currently about 18 million Americans — to buy coverage for themselves and their families, just as they do with auto and life insurance.

4. Why is health insurance so expensive?
The largest expense for any health insurance company is health care. As health care costs rise — sometimes by double digits — health insurance premiums also rise. Several factors play a role in these increases: new medical technologies like MRIs and CT scans, new equipment like robot-assisted surgery and laser scalpels, and new drugs and surgical procedures have an impact on costs. And the fact that when people are insulated from the cost of something, they tend to spend more. The greater the insulation, the greater the spending.

Health insurance costs are driven by other factors as well. For example, every state requires health insurance companies to pay premium taxes, which can be up to 4 or 5 percent of collected premium. And the state and federal governments impose numerous mandates requiring insurance to cover a wide range of services and providers.
Some people argue that both the administrative costs and

profits drive up the cost of health insurance. However, there are many nonprofit health insurers, and they generally cannot offer coverage at significantly lower prices. Of course, government insurance programs also have administrative costs, though ironically, the government doesn't track them all, making its coverage look like a better deal.

5. What is the role of a health insurance pool?
Very few people have costly health problems in a given year, but those who do can face significant expenses. To solve this problem, insurers group, or pool, the premiums and risks so that those who experience an insurable event (e.g., an accident or illness) are subsidized by those who haven't. As the number of people in the pool grows, expenses become more predictable and easier to spread across the pool. However, once an insurance pool reaches a certain size, say 25,000 covered lives, there is little additional cost-sharing benefit from adding more people.

6. What is underwriting?
Insurers try to ascertain how much risk (e.g., of a car accident, death or a costly medical condition) an applicant brings to the pool. Underwriting is the process of assessing that risk and then charging an appropriate premium. And yet with regard to health insurance, many lawmakers are eager to eliminate underwriting. Doing so, as several states did when they passed reforms in the individual market in the mid-1990s, almost always destroys an insurance market because it leads to a disproportionate number of high-cost people in the insurance pool. The actuarial challenge — and one that is constantly being considered and debated by the American Academy of Actuaries — is to find a pricing structure so that both the low and high risks see coverage as a reasonable cost for their budgets and the risk they bring.

7. Can health insurers decline to offer coverage?
In the group market, insurers *must accept* any company or employee who applies (known as guaranteed issue). But because it is a group — and because people join the group to work, not specifically for the purpose of getting health insurance — the larger the group the less guaranteed issue is of a problem. Thus, critics who imply that insurers can and often do refuse any applicant are simply not being honest. It doesn't happen in the group market, which represents the large majority of working-age people with private coverage.

In the individual market, insurers in most states can decline an applicant or "rate up" (i.e., charge more) for individuals who bring increased risk to the pool, just as they are allowed to decline a terminal patient who applies for life insurance or a tornado victim from getting a homeowner's policy. Health insurers aren't being cruel when they decline such individual applicants; they are practicing good underwriting principles — because it is no longer an unforeseen risk. And they are protecting the premiums of their current insureds who bought insurance before an unforeseen event occurred. Some states have eliminated health underwriting by allowing anyone to enter the pool regardless of their health status and charging everyone the same (or close to it) premium. As a result, healthy people begin to drop their coverage. And why not? They can get it later if they need it.

No one seriously suggests that life insurers should be required to cover someone just diagnosed with a terminal illness, and the same principle should apply to health insurance policies.

8. Do the uninsurable have an option?
Some 34 states have established nonprofit "high risk pools" as a safety net for the uninsured who have a medical condition and can't get coverage in the private market. Those joining the pool pay between 25 and 50 percent more for coverage than if they were able to buy it on their own, but in most states the health insurers heavily subsidize these pools.

Conclusion: Health insurance can help reduce the risk of paying unpredictably large sums for major medical care. But when policymakers try to turn insurance into something much closer to unlimited, on-demand medical services, it no longer works like insurance. The result is health coverage that becomes unsustainably costly for everyone, the sick and the healthy alike.

Prepared by Merrill Matthews, Executive Director, Council for Affordable Health Insurance, and JP Wieske, State Affairs Director, Council for Affordable Health Insurance

Council for Affordable Health Insurance
127 S. Peyton Street, Suite 210
Alexandria, VA 22314
Phone: 703/836-6200 Fax: 703/836-6550
Email: mail@cahi.org
www.cahi.org