2 Basic Concepts of Health Insurance

Objectives

After completing this module, you will be able to:

- define insurance and indemnity health insurance;
- define risk, underwriting, and pricing;
- explain fee-for-service compensation and deductibles, coinsurance, and copayments; and
- identify the main cost control methods used by indemnity health insurance.

Until the last few decades, most health coverage in the United States was indemnity insurance. Before we begin to learn about today’s health plans, it is important to understand some basic concepts of this traditional coverage. Why? Some health plans still retain certain characteristics of indemnity insurance, and many health plan designs and features were developed to address problems in indemnity insurance.

Insurance

Insurance is a way of protecting against the risk of financial loss. An individual or business enters into a contract with an insurance company by purchasing an insurance policy. The person or business pays a relatively small, fixed amount (a premium) to the insurer at regular intervals (such as monthly or yearly). In exchange, if the person or business incurs a financial loss covered by the insurance policy, the insurer makes a payment (a benefit) or payments to cover or help cover this loss. (The insurer is said to “indemnify” the insured against the loss, hence indemnity insurance.)

Insurance enables people to protect themselves against the possibility of losing a large, unpredictable amount of money by paying much smaller, set amounts over time. For instance, a homeowner can pay annual fire insurance premiums of a few hundred dollars so that if her home burns down she will not have to pay hundreds of thousands of dollars to replace it.

In indemnity health insurance, if a person covered by a policy (an insured) incurs medical expenses covered by the policy, the insurer pays benefits to pay those expenses or reimburse for them. By paying monthly premiums, the insured protects herself against the risk of having to pay thousands, or tens of thousands, of dollars for treatment of a serious illness out of her own pocket.

Individual and Group Insurance

Insurance can take the form of individual or group coverage. In individual insurance a private person buys a policy from an insurer. He is the policyholder (the party to the insurance contract), he pays the premium, and he (and in some cases his dependents) are insured. In group insurance a business buys a policy that covers its employees, or an association or union buys a policy for its members. The policyholder is the business,
association, or union; the employees or members and often their dependents are insured; and while employees or members may pay all or part of the premiums, they do so through the policyholder.

Risk and Underwriting

Risk

In insurance, risk is the possibility of a covered financial loss. In health insurance, it is the possibility (or probability) that a person will incur a healthcare expense covered by the policy. While it is usually impossible to predict if and when a particular individual will need healthcare and how much that care will cost, it is possible to project with reasonable accuracy how much care will be needed by a sizable group of people over a certain period. Heath insurance works by bringing together such a group and collecting enough from them in premiums to pay for the care of those group members who need it.

To charge enough in premiums to cover benefits (and other costs), an insurer must be able to predict the loss rate for a population of insureds—how much the insurer will pay in benefits. Insurers are able to project loss rates by looking at past populations of insureds with similar characteristics (age, gender, occupation, location, etc.), the illnesses and injuries they suffered, and the amount of medical expenses they incurred.

Underwriting and Pricing

Underwriting and pricing (rating) are the processes by which an insurer decides whether to offer a policy to an individual or group, and if so, on what terms and at what premium rate. The insurer seeks to ascertain the risk presented by an applicant, so that it can avoid unacceptable risks and charge a premium rate sufficient to cover the likely loss rate.

In individual health insurance the underwriter seeks to find out whether the individual applicant has any health conditions or medical history that makes him much more likely than average to need medical care. If a person is very likely to need extensive care in the near future, the insurer may deem him uninsurable and decline to issue a policy. If he presents only a somewhat high risk, the insurer may issue a policy at a higher-than-average premium or exclude coverage for a preexisting condition.

In group insurance the underwriter seeks to determine if the applicant group has any characteristics that make it likely to have a higher-than-average loss rate (see below). For large groups the underwriter may look at the group’s past health insurance claims as an indication of its future loss rate. If group’s loss rate is likely to be high, the insurer must charge a higher-than-average premium rate.

Underwriters must be alert to the possibility of adverse selection (also called anti-selection). Adverse selection can occur when people have the option of enrolling in health insurance or not. This happens in the individual market and in group insurance where employees pay all or part of the premium and therefore have the right not to participate. In such cases people who are more likely than average to become ill, because they are older or in poor health, are more likely to choose coverage. If this occurs, the covered group will have a higher-than-average loss rate, and if premiums are based on average loss rates, they may be insufficient to cover benefits.
Note that the Affordable Care Act of 2010 (ACA), commonly called healthcare reform, will have an important impact on underwriting and pricing. As of 2014 health coverage will generally have to be offered on a guaranteed issue basis—that is, an individual’s current health or medical history cannot be considered in the decision to offer coverage or in setting the premium. Preexisting condition exclusions will not be permitted (effective 2010 for children, 2014 for adults). However, these restrictions apply to broad health coverage; individual medical underwriting will still be used for specialized products such as long-term care insurance. (ACA is discussed in greater detail toward the end of the course.)

Factors in Group Health Insurance Underwriting

- **Age.** Older people of course incur more medical expenses than younger people, so an older-than-average employee group will have a higher-than-average loss rate.

- **Sex.** Females incur more medical expenses than males, so an employee group that is majority female will have a higher-than-average loss rate.

- **Occupation/industry.** Some occupations and industries involve dangerous activities or unhealthy conditions, and people engaged in them are more likely to suffer injuries or become ill. The loss rate for such employee groups will be high.

- **Location.** Medical practices and prices vary from region to region, and costs are generally higher in cities than in rural areas. This may affect the loss rate of a group.

- **Group size.** Larger groups spread risk over more people. As a result, larger groups tend to have a loss rate close to the average, while smaller groups are more likely to diverge from the average.

- **Participation.** If only a small percentage of eligible employees choose to enroll in a group plan, the risk of adverse selection is high. That is, the insured group will likely include a disproportionate number of people who need healthcare. (For this reason insurers usually will not issue a policy unless a minimum percentage of employees enroll.)

Basic Features of Indemnity Health Insurance

**Provider Choice**

In traditional indemnity health insurance, when an insured needs healthcare, she can go to any physician, specialist, hospital, or other healthcare provider she chooses. She does not have to use a provider affiliated with a network, nor will she pay more if she uses a non-network provider, as is the case in some health plans.

**Benefit Payment**

Under an indemnity policy, an insured receives care from a provider, the provider charges her for the services rendered, she submits to her insurer a **claim** (a request for payment based on the terms of the policy), and the insurer reimburses her. Or more
commonly, the insured assigns benefits to the provider—under assignment of benefits, the provider bills the insurer directly, and the insurer reimburses the provider.

Typically in indemnity insurance, the provider bills the insurer her usual fee for the service she performed, and the insurer pays this amount. This system is known as fee-for-service (FFS). There are limits, however—typically, an insurer will not pay a fee considerably higher than the usual and customary charge for the service in the locality.

Cost-Sharing

While indemnity insurers generally pay providers' fees, this does not mean that insurers cover all healthcare costs and insureds pay nothing. Indemnity health insurance policies generally have cost-sharing—insureds must pay a portion of the expenses they incur. In indemnity insurance cost-sharing usually takes the form of a deductible and coinsurance.

- **Deductible.** The insured must pay a specified dollar amount of expenses covered by the policy before the insurer begins paying benefits. For instance, if a policy has a $500 annual deductible, each year the insured must pay for the first $500 of covered medical expenses. Once this is done (that is, the deductible is satisfied), the insurer pays benefits for any additional covered expenses for the remainder of the year.

- **Coinsurance.** After the deductible is satisfied, the insurer pays a percentage of covered medical expenses, and the insured pays a percentage. For instance, the insured might pay 20 percent coinsurance and the insurer the remaining 80 percent.

**Example:** Mark is covered by an indemnity health insurance policy. It has a $500 annual deductible and 20 percent coinsurance. At the beginning of the year, Mark is hospitalized and incurs $5,000 in medical expenses covered by his policy. **What amount of these expenses will Mark pay? What amount will the insurer pay?**

Mark pays the first $500 (the deductible). Of the remaining $4,500, he pays 20 percent coinsurance, or $900, for a total of $1,400 dollars. The insurer pays the other $3,600.

There is another form of cost-sharing, not typical of indemnity insurance but common in health plans—**copayments.** A copayment is a flat dollar amount a plan member pays for a certain service, not a percentage of the cost of that service.

**Example:** Jake is a member of a health plan. Whenever he sees his primary care physician, he makes a $10 copayment. The amount is always $10 regardless of the actual cost of the services the physician provides.

The purpose of cost-sharing is to hold down the cost of health coverage by reducing the amount the insurer pays in benefits, and also to give insureds an incentive not to use healthcare services unnecessarily. To return to the example of Mark, if he paid no cost-sharing, he would have no reason not to go to the doctor for every minor complaint and to request as many tests and services as the doctor would provide. But if he has to pay
part of the cost of any healthcare services, he is likely to request care only when he really needs it.

Cost Control

As the cost of healthcare rose in the late 20th Century, causing health insurance premiums to go up, insurers took various steps to contain costs and hold down premiums. Some of these were successful and have been adopted by health plans, and others laid the groundwork for approaches used today.

Coordination of Benefits

A coordination of benefits (COB) provision of a health insurance policy is designed to prevent duplication of benefits when a person is covered by two policies (such as a child whose parents both have employer-sponsored coverage that includes dependents). Under a COB provision, one policy is considered primary and the other is secondary. The primary policy pays all the benefits it normally would, and if there are any expenses not covered by the primary policy but covered by the secondary policy, the secondary policy pays additional benefits. In this way, no benefits in excess of the actual expenses incurred are paid.

**Example:** Amelia is covered by both her father’s and her mother’s employer-sponsored group health insurance policy. Amelia receives healthcare services costing $1,000, all of which are covered by both policies. Her father’s policy has 30 percent coinsurance, so it pays $700. Her mother’s policy has 20 percent coinsurance, so it pays $800. But both policies have COB provisions, and the father’s policy is the primary policy. So the father’s policy pays $700 (the normal benefit), and the mother’s policy pays $100 (the difference between the normal benefit and what has already been paid by the other policy).

Increased Cost-Sharing

Increasing deductibles and/or coinsurance has two affects.

- It shifts healthcare costs from the insurer to the insureds, and because the insurer is paying less in benefits, it can charge a lower premium.

- It increases the incentive that insureds have not to use healthcare services unnecessarily. This reduces healthcare expenditures, making it possible to hold down premiums.

**Example:** Karen is covered by a group indemnity health insurance policy sponsored by her employer. The policy has a $500 annual deductible and 20 coinsurance. The premiums Karen and her employer pay have been increasing significantly every year. In an effort to hold down these increases, the insurer proposes increasing the deductible to $1,000 and coinsurance to 25 percent. Since the insurer will pay less in benefits, it will be able to charge less. So Karen and her employer will pay a lower premium, but Karen will pay more out of her own pocket for healthcare. And because she pays more, she has a greater incentive to seek care only when she really needs it.
Increases in cost-sharing can be seen as a precursor to consumer-directed health plans, discussed later in this course. These plans have high deductibles, so that insureds have a strong incentive to use healthcare prudently and to choose the most cost-effective providers.

**Cost Containment**

Cost containment measures are designed to lower healthcare expenditures (thereby holding down health insurance benefits and premiums) by ensuring that the medical services provided to insureds are necessary, appropriate, and cost-effective. For instance, before nonemergency surgery is performed, a second opinion from another physician might be sought to make sure that the surgery is necessary and is the most medically effective and cost-effective way to treat the condition. Steps are also taken to see that the most appropriate and cost-effective levels of care and care settings are used—for instance, it may be just as medically effective and safe and much less expensive to perform a certain procedure on an outpatient basis rather than admitting the patient to a hospital. Many other cost-containment strategies, such as utilization management, medical management, and case management, are discussed later in this course.

**Preventive Care and Wellness**

In the past many indemnity health insurance policies did not cover some preventive care services, such as annual checkups, immunizations, and screenings for medical conditions. But it is relatively easy and inexpensive to prevent many conditions or cure them if they are detected early but difficult and expensive to treat them in later stages. Insurers began to realize that it is more cost-effective in the long run to pay for preventive care services and encourage insureds to use them.

Insurers also began to take note of the correlation between behaviors such as smoking, lack of exercise, and overeating and certain medical conditions. In response, they began to establish wellness programs, which help pay for smoking cessation, fitness, weight-loss, and similar programs. As with preventive care, wellness programs are cost-effective in the long term. For instance, it costs much less to help an insured pay for a weight-loss program than to treat diabetes later.

**Conclusion**

As healthcare costs increased, companies offering indemnity health insurance took a number of steps to control expenditures and hold down premiums. But these measures did not prove to be sufficient. As a result, types of health coverage that integrate the financing and delivery of healthcare—such as health maintenance organizations (HMOs)—were introduced. And other types of health plans that monitor and control costs and quality in a variety of ways—such as preferred provider organizations (PPOs), point-of-service (POS) options, and managed indemnity plans—were developed. In this course we will explore the array of health plans available today.