CHAPTER 1

Principles of Health Insurance

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LEARNING OBJECTIVES

- What is health insurance?
- How have the objectives of health insurance evolved over time in the United States?
- In what ways does the United States make health insurance a social priority?

INTRODUCTION

We call it health insurance, but it does not, in fact, insure against poor health. **Insurance** is a guarantee, usually a financial guarantee, against an unforeseen event. But of course, no one, much less an insurer, can guarantee against getting sick or recovering from illness. Instead, insurers write policies that provide financial protection from medical expenses. Health insurance plans pay for a portion of the bill when you are hospitalized, visit a doctor, get blood drawn, have an X-ray or MRI, or fill a prescription. You may use your health insurance even when you are not sick or injured, such as for preventive care. But health insurance is not a guarantee against bankruptcy from medical bills, nor does it compensate for pain and suffering from lost work or leisure time.

Yet even though it cannot guarantee recovery from illness or injury, health insurance serves many purposes beyond paying medical bills, and the government has adopted policies over the years meant to increase the number of people and conditions covered. These policies' features highlight the importance of health insurance in society relative to other types of insurance, such as such as fire, automobile, and homeowners, where insurance is mainly intended to protect consumers from large financial losses.

For example, imagine that you live 20 miles from work and there is no reliable public transportation where you live. You must drive to get to work, meaning that you must be able to afford car payments, gas, maintenance, and auto insurance. If you live in New Jersey, Hawaii, or California, then you may be eligible for government-subsidized auto insurance, but in other states there is no such program. On the other hand, if you cannot afford health insurance, there are myriad programs available nationwide. Every state has a Medicaid program, and the federal Patient Protection and Affordable Care Act (PPACA)—or just the Affordable Care Act (ACA)—provides subsidies for low-income individuals and families to purchase health insurance through the state health insurance exchanges in every state.

Now suppose your sweet but stranger-shy dog, Huxley, has bitten a visitor to your home. You have just moved into an apartment and would

like to purchase renter's insurance. You should not be surprised to find dog bites excluded from coverage, or coverage that includes dog bites limited up to a certain dollar amount. You should not even be surprised to find that the insurer will not write you a policy, because insurance is meant to protect you against something that might happen in the future, not something that has already happened. We will discuss this point in greater detail later. On the other hand, if you already have diabetes and you would like to purchase health insurance, then there are limitations (depending on the type of health insurance) on how long a plan may exclude diabetes from coverage, if it may even exclude this condition at all. Even if you and the insurer already know that you have diabetes when the insurer writes you a new plan, then the insurer still must cover your insulin injections, glucose meter, endocrinologist visits, and so on.

Finally, if you live near dense forests in Northern California, an area ravaged by seasonal wildfires, then you will face a much higher price for fire insurance than in other areas. Similarly, auto insurance costs more if you have been in a collision, because the auto insurer expects you to cost them more based on their experience with you. On the other hand, no matter how sick or injured you are, health insurance plans participating in state exchanges (marketplaces) may not charge you more for a plan. Prices may be adjusted for geography (to account for the higher cost of care in, say, California versus Mississippi), age (but only within limits), smoking status, and whether coverage is for an individual or for a family. Sicker individuals, however, may not be charged more for health insurance.

We prioritize health insurance in a way that we do not prioritize auto insurance, homeowners insurance, life insurance, property insurance, or long-term care insurance. Originally intended to protect consumers against large, unpredictable losses, health insurance has evolved into a system that reimburses consumers even for inexpensive, predictable medical expenses. Why do we not simply save our own money ("self-insure") to pay for physician visits, prescription medications, and routine laboratory tests? Why instead do we pool our money and pay every month to have these services and supplies covered by insurance? This chapter will trace the history and development of health insurance in the United States that led to the system we have in its current form. It will also discuss the principles of insurance and explain why we have a system of health "insurance" that deviates significantly from the traditional definition.

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DEVELOPMENT OF HEALTH INSURANCE IN THE UNITED STATES

The historical context of health insurance is critical to understanding its strong ties to employment and the private sector, and its importance in society over other types of insurance. As we know it today, health insurance is protection against costly, unpredictable medical bills; if medical care is neither costly nor unpredictable, however, then health insurance is not necessary. Indeed, in the first half of the century, when formal medical care did little to advance health and may have done substantial harm, health insurance existed primarily to replace lost income rather than to cover medical bills. The development of health insurance into its current form corresponded with the increasing complexity and expense of medical care and the advance of scientific knowledge.

The link between health insurance and employment in the United States dates to the middle of the nineteenth century, when workers in a newly industrial America began to seek safeguards from the dangers of their jobs. Although the government had sponsored health care plans as far back as 1798, these plans were limited in scope and never intended to be part of a comprehensive, nationwide state-sponsored health insurance system. Instead, employers and unions established their own health insurance plans, primarily to replace lost wages in case of illness or injury, rather than to pay for medical services (Hoffman, 2003; Starr, 1982). In particularly risky occupations, however, such as mining and railroads, employees did purchase insurance to pay for medical services. These workers became part of the first prepaid group plans, paying physicians a fixed monthly fee in exchange for services covering the entire group of employees (Scofea, 1994).

Progressive Era

The Progressive era, from about 1890 to 1920, reinforced the employment-based structure of the U.S. health insurance system (**Figure 1-1**). In 1915 the American Association for Labor Legislation (AALL) proposed a mandatory government-sponsored bill in which low-income employees and their employers would contribute to a subsidized plan to insure against medical bills and lost wages. Higher-income employees would have the option of buying into the plan as well. But this plan was unpopular with several groups. Led by Samuel Gompers, the American Federation of Labor (AFL) opposed the bill on the grounds that labor would lose leverage in negotiations with employers by ceding part of employees' compensation package to a predetermined government benefit package. Insurers opposed the bill because it included insurance against burial expenses, a profitable sector of their business. And finally, although organized medicine, the American Medical Association (AMA), at first supported the bill, they quickly changed course and came out against it, arguing that it would impede physician autonomy and the physician-patient relationship (Scofea, 1994; Starr, 1982).

Employee "sickness funds" during the Progressive era weakened the urgency for mandatory, government-sponsored insurance. Thousands of sickness funds existed, though they covered only a minority of workers. Employees would pool a small portion of their income and distribute funds in the case of illness or injury, mostly to replace lost income rather than to pay medical bills. Though not particularly generous, these funds were effective enough to diminish support for a government plan. As actuarial methods (methods to anticipate the cost of enrollees) advanced, however, insurance plans became larger and more financially stable, and thus a more attractive alternative for employees (Murray, 2007).

Great Depression

Workers and hospitals relied on each other to endure the financial devastation of the Great Depression, further entwining employment with health insurance. In the 1920s economic prosperity had increased demand for health care services, and physicians and hospitals raised fees in response. As a result, medical care occupied an increasingly higher proportion of family income, straining even the middle class (Starr, 1982). But when the stock market collapsed in 1929, workers and hospitals came to rely on each other. They formed mutually beneficial

FIGURE 1-1 Progressive Era Cartoon Endorsing Compulsory Health Insurance in New York State

Reprodcued from Free Speech Radio News. History of U.S. health care reform in images. Retrieved from: http://archive.fsrn.org/content/history-us-health-care-reform-images/5262

contractual arrangements in which unions prepaid for hospital services, thereby guaranteeing income to financially struggling hospitals, while insuring workers against high, unpredictable hospital costs. These contractual arrangements with hospitals were the precursors to Blue Cross plans. Toward the end of the Depression, analogous arrangements with physicians became the precursors to Blue Shield plans.

Also during the Great Depression, employees joined the first integrated prepaid group plans, which would later develop into health maintenance organizations (HMOs). Prepaid group plans differed from Blue Cross (hospital insurance) and Blue Shield (physician insurance) plans because enrollees exclusively used clinics or hospitals owned by the plan. Blue Cross did not own hospitals; rather, it contracted with area hospitals. Similarly, Blue Shield did not own medical clinics; rather, it contracted with area clinics and their physicians. Prepaid group plans, however, built their own clinics and hospitals, and only members of the plan could use these facilities; on the other hand, members could not use other area facilities. Such a plan may sound familiar to you—Kaiser Permanente (Kaiser Foundation Health Plan and Permanente Medical Group) is an example of such a plan. And in fact, Kaiser was one of the earliest integrated prepaid group plans, founded by Dr. Sidney Garber in 1933 to provide on-site care for workers building an aqueduct for shipbuilder Henry J. Kaiser.

With historic levels of unemployment, it might have seemed that the Great Depression would have severed the link between employment and health insurance, but state-sponsored insurance was not a priority for economic recovery. Emerging from the Great Depression, President Franklin Delano Roosevelt's New Deal had excluded a national health insurance option to minimize objection to other

programs, especially Social Security, unemployment insurance, and welfare benefits.

World War II

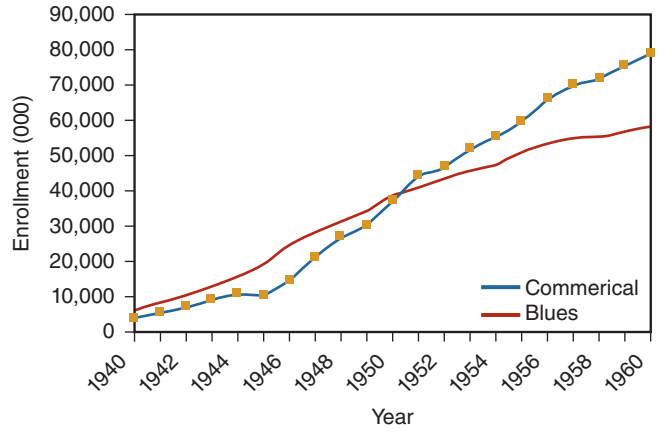
Though health insurance had long been tied to employment, employers had not used it as a recruitment and retention tool until World War II, when runaway inflation, or price growth, led the War Labor Board to impose limitations on wages that employers could offer. These limitations, however, did not apply to fringe benefits, including health insurance. Consequently, while employers could not compete for the best employees by offering higher wages, they could offer more generous health insurance benefits. Under the Wagner Act of 1935, workers were guaranteed the right to collectively bargain for such benefits, and so health insurance became an integral part of employees' compensation package.

Post-War Period

After the war, national legislation further protected employee fringe benefits, strengthening the relationship between health insurance and employment. In 1954, Congress and the Internal Revenue Service (IRS) allowed employers and employees to contribute to employee insurance **premiums** without paying taxes on those contributions. This tax treatment remains largely in effect today, though the 2010 ACA imposed some taxes on health plans with very high premiums. Because there is such a considerable advantage to purchasing insurance through an employer versus through the individual (non-employer) market, employees may find themselves tied to a job they do not want, working when they want to retire or raise children, or purchasing a plan through their employer that is more generous than they would have purchased on the individual market without the tax advantage.

The post-war period also aligned the structures of commercial and Blue Cross plans. Previously on the fringes of the market, commercial plans began to compete more vigorously with the Blues as more unions searched for an insurance carrier, and by 1955 commercial plans covered more enrollees (**Figure 1-2**) (Conrad, 2009). While the Blues set premiums based on health care spending in the entire geographic area (**community rating**), commercial plans set premiums based on spending for just one group or individual (**experience rating**). While community rating is good for people who are sick, it is expensive for those who are healthy; experience rating, on the other hand, does not pool the healthy and the sick together as much as community rating. Experience rating allowed commercial plans to undercut prices in low-spending healthy areas,

FIGURE 1-2 Enrollment in Commercial Versus Blue Cross/Blue Shield Plans, 1940–1960



Reproduced from: Source Book of Health Insurance Data, 1965. New York: Health Insurance Institute, 1966.

leaving the Blues with only the highest cost (sickest) enrollees (Starr, 1982). As nonprofit organizations founded with the purpose of serving the community, the Blues were reluctant to experience rate premiums, which would have left sicker areas with higher premiums, but eventually did so to remain competitive with commercial plans.

The Blues and commercial plans began to resemble each other in how they paid providers as well. Early commercial plans provided coverage by paying **indemnities**—payments *to the subscriber*, usually a fixed amount per hospital day. This payment structure required workers to pay facilities directly; insurers only later reimbursed expenses. Not only were workers thus required to have sufficient cash on hand to pay for medical services but they were also left at risk for the balance of the bill if the indemnity did not cover all of the expenses. Recall that early Blue Cross plans, on the other hand, prepaid hospitals a fixed dollar amount per worker per month. Facilities were required to treat subscribers regardless of ability to pay the balance of the bill. While some Blue Cross plans also provided indemnity insurance, during the Depression the American Hospital Association encouraged all plans to move toward **service benefits**, paying the physicians and facilities directly for expenses after they had been incurred. The Blues were able to take on this additional risk and offer more attractive plans to subscribers because (1) as nonprofits, they did not have to pay taxes; (2) Blue plans were forbidden to compete with each other, and so local plans enjoyed geographic market exclusivity; and (3) relationships with providers were strong, and so favorable rates could be negotiated compared to commercial plans. Yet as commercial plans gained traction by experience rating premiums, the Blues could not take on as much risk and began to offer more indemnity policies (Starr, 1982). After the war, then, commercial and Blue Cross plans looked increasingly alike.

Experience rating and the growing cost of medical care in the middle of the century made health insurance for older, sicker Americans unaffordable. Mid-century was a time of rapid medical progress. Antibiotics, discovered in 1928 and entering widespread use in the 1930s through the 1940s, protected patients against bacterial infections and thus made hospitalization much safer. Public vaccination campaigns for newly discovered vaccines reduced the spread of infectious disease. Mortality from heart attacks and strokes declined with the advent of procedures such as cardiac catheterization in 1959, and antihypertensives and cholesterol-lowering medications (Cutler, 2004). With this medical progress came a higher price tag; medical spending tripled from 1949 to 1964 (Engel, 2006).

But the disappearance of community rating meant that much of this medical progress was out of reach for the elderly and the poor. Experience rating set lower premiums for healthy, low-risk subscribers and higher premiums for sicker, high-risk subscribers. These high premiums were unaffordable for those in the highest-risk groups, and lower-income families were more likely to be uninsured (Starr, 1982).

Medicare and Medicaid

Medicare (health insurance for those 65 and older) and Medicaid (health insurance for the poor) were the public response to this lapse in the private market. President John F. Kennedy had strongly advocated for a national health insurance program for the elderly, but he did not see his legislative vision realized before he was assassinated in 1963. His successor, Lyndon B. Johnson, took up the cause, and under his presidency Congress passed Medicare and Medicaid in 1965. While insurance for the aged was the primary piece of the legislative agenda, advocates for insurance for the poor used the opportunity to pass Medicaid at the same time. But legislators designed the programs in fundamentally different ways. Medicare was an earned benefit for all Americans 65 or older who had worked. The federal government would administer the program and all enrollees would pay the same premium and receive the same benefits. In contrast, Medicaid was not a universal program; rather, only those receiving Aid to Families with Dependent Children (AFDC)—commonly known as welfare—would

be eligible. Further, states and their welfare departments would be responsible for administering the program and receive federal matching funds if they met certain income threshold and benefits criteria (Engel, 2006).

These new programs contributed to substantial health care spending growth. Despite spending controls and a sluggish economy, from 1966 to 1973 health expenditures grew at an average rate of 7.2 percent per year, outpacing GDP growth by 3.2 percentage points. Medical progress, along with newly expanded insurance, contributed to this growth (Catlin & Cowan, 2015). Federal and state governments undertook many policies to rein in this spending. One of the most impactful policies during this time was the 1973 Health Maintenance Organization Act, which encouraged HMOs to enter the market by providing them with funding, overruling state laws prohibiting them, and requiring employers who offered tax-exempt health insurance to offer at least one HMO. Similar to prepaid group plans, **HMOs** pay a fixed fee to providers per patient per month (a **capitation**), thereby setting a "budget" for each enrollee. Enrollees must also consult a primary care "gatekeeper" before using specialty services. In 1970, there were fewer than two million HMO enrollees; by 1992, there were 39 million (Scofea, 1994).

Managed Care

HMOs launched the managed care era. **Managed care** is a set of tools used by **managed care plans** to reduce spending and improve the quality of health care. These tools include imposing out-of-pocket costs on enrollees, contracting with low-cost providers, and limiting coverage for some types of procedures deemed inappropriate. Throughout the 1980s and 1990s, managed care enrollment grew Figure 1-3. Traditional indemnity insurance for health care expenses now constitutes only a tiny proportion of the health insurance market. But HMOs are not the only type of managed care plan. **Preferred Provider Organizations (PPO)** plans, developed in the 1980s, do not prepay for services, but rather contract with "preferred" providers to pay a negotiated rate for services (a **fee-for-service**) after they have been provided. Any providers whose services have not been contracted are out-of-network, or "non-preferred." **Point-of-service (POS)** plans are somewhere in between the two—less restrictive than an HMO, but more restrictive (and thus less expensive) than a PPO.

FIGURE 1-3 **Enrollment in Employer-Sponsored Health Insurance Plans, 1988–2015**

Reproduced from: American Hospital Association (AHA). (2016). Trends Affecting Hospitals and Health Systems: distribution of employer-sponsored health insurance enrollment by type of plan, 1988-2015. Retrieved from http://www.aha.org/research/reports/tw/chartbook/ch1.shtml

Enrollees are generally assigned a primary care gatekeeper and may use an out-of-network provider, provided they pay more out of pocket. Like HMOs, **exclusive provider organizations (EPOs)** have restrictive networks and limited—if any—out-of-network benefits, but unlike HMOs, they usually do not require a primary care gatekeeper. Today, plans generally have features of all three types of plans. HMOs may prepay for primary care services but not hospital services, and PPO plans may require higher out-of-pocket payments for some non-preferred providers. **Table 1-1** highlights the differences among managed care plans, though it is worth repeating that the distinctions have become blurry. For example, while PPO plans pay most of their physicians' fee-for-service, some have experimented with other payment types, including capitation.

In its heyday in the late 1980s and early 1990s, managed care was successful in lowering health care spending and the price of insurance. But selective contracting of hospitals and physicians became difficult as providers responded by joining forces. From 1989 to 1996, there were 190 hospital mergers, beginning with just 6,000 hospitals, over double the number from 1983 to 1988 (Dafny, 2009). Consumers also reacted to managed care. Techniques such as primary care gatekeeping and limiting provider networks led to a managed care "backlash" by the late 1990s (Blendon et al., 1998).

Consumer-Directed Health Care

In order to attract enrollees, insurers were pushed to offer plans with larger networks and fewer restrictions on services. But with more generous plans again came higher premiums, and so another tool emerged: consumer-directed health plans (Figure 1-3). These plans are intended to limit enrollee spending by requiring large out-of-pocket payments before insurance covers expenses. The 2003 Medicare Modernization Act authorized the creation of health savings accounts (HSAs), into which an employer or employee may contribute tax-free dollars for out-of-pocket payments related to such a plan. Under the law, the employee owns the HSA and may thus take it from job to job, or in transitioning to unemployment.

The Patient Protection and Affordable Care Act

Until Congress passed the ACA in 2010, the proportion of non-elderly Americans uninsured at any given time remained steady for decades at around 15 percent. Not since the enactment of Medicare and Medicaid had the uninsurance rate declined so dramatically. The ACA was a landmark piece of legislation intended to expand coverage among non-elderly adults (elderly adults are almost universally covered by Medicare). It required individuals to purchase

TABLE 1-1 Types of Managed Care Plans

Managed Care Insurance Plans	Payment To	Physician Payment (Primary Method)	Primary Care Gatekeeper	Network Restrictiveness
Preferred Provider Organization (PPO)	Provider	Fee-for-service	No	Low
Point of Service (POS)	Provider	Fee-for-service	No	Medium
Exclusive Provider Organization (EPO)	Provider	Fee-for-service	No	High
Health Maintenance Organization (HMO)	Provider	Capitation	Yes	High
Managed Indemnity	Patient	Fee-for-service	No	Low

insurance (individual mandate), large employers to offer insurance or to pay to cover premiums for outside insurance (employer pay-or-play mandate), and gave states the option to receive federal financial assistance to expand Medicaid coverage to everyone under 138 percent of the federal poverty level (FPL), not just those receiving welfare benefits. Thirty-two states have expanded Medicaid. The law also required that each state have a virtual health insurance marketplace, called an exchange, in which people could shop for and purchase standardized plans, with subsidies for those 100–400 percent of the FPL. The federal government and states imposed regulations on health insurance plans to expand access and affordability. Key ACA provisions, including Medicaid expansions, health insurance marketplaces, and the individual mandate to purchase coverage, became effective in 2014. At the end of 2013, just before these provisions were implemented, an estimated 42.7 million people were uninsured, or approximately 15 percent of the population; by 2015, this number had dropped to 25.8 million people, or approximately 10 percent of the population (Carman, Eibner, & Paddock, 2015).

PRINCIPLES OF INSURANCE

As defined at the beginning of this chapter, insurance is a guarantee against an unforeseen event, but health insurance, of course, does not guarantee against unforeseen illness or injury, and covered medical expenses are often anticipated well in advance. In this section, we will discuss the ways in which health insurance in the United States violates many of the principles of "ideal" insurance.

Why purchase health insurance at all? Why not "self-insure"—put aside savings to cover personal, unforeseen expenses? In fact, we all self-insure for at least some events. We save money for when our car breaks down, for when our water heater must be replaced, and for when Huxley makes an unexpected trip to the veterinarian. But the more unpredictable and costly these events become, the more it makes sense to pool our savings with others to cover these expenses—in other words, to purchase insurance. Imagine if it cost $100,000 to fix your car or $40,000 to replace your water heater, or $50,000 to pay Huxley's veterinarian. Very few people could afford these bills, even if they happened infrequently. But if we pooled our money together, then we could collectively afford them—as long as most people's cars did not break down.

Insurers rely on the fact that not all enrollees will actually use their insurance, but sometimes it is difficult—both for the insurer and the enrollee—to know how much care will be used. As the quotable baseball player Yogi Berra famously said (or is attributed to have said), "It's tough to make predictions, especially about the future." Insurers charge a premium based on two components: one component, the **actuarially fair premium**, is based on enrollees' predicted costs (the frequency and costliness of their medical care); the other component is the **loading charge**, an additional cost that the insurer charges to administer claims and make a profit.

Insurers can charge loading costs because enrollees are **risk averse**—they dislike unpredictability and prefer a certain outcome over an uncertain one. The more risk-averse enrollees are, the more they are willing to pay to avoid risk—in other words, the higher a premium beyond the actuarially fair premium they are willing to pay. Premiums are a small but certain financial loss that risk-averse people would prefer to pay rather than to gamble on a potentially catastrophic hospitalization. Note that there are reasons beyond a low degree of risk aversion that people are unwilling to pay for health insurance every month. People may not be able to afford premiums, or they may underestimate their expected medical costs. Insurers rely on risk aversion to charge a high enough premium to cover administrative expenses and earn a profit; there are not too many **risk-loving** people who prefer a gamble when it comes to their health care finances.

We expect sicker people to join plans with more generous benefits and higher premiums, and healthier people to join plans with skimpier benefits and lower premiums. This phenomenon, the sorting into plans based on health status, is called **selection**. Insurers attempt to price

plans accurately based on enrollees' prior health costs and family histories, such that plans with sicker enrollees have higher premiums and plans with healthier enrollees have lower premiums. But two factors prevent insurers from pricing plans entirely accurately: (1) enrollees generally know more about their health than insurers; and (2) regulations and other organizational factors may prohibit insurers from charging higher premiums for sicker enrollees. **Adverse selection** is a type of selection in which health plan sorting is *caused* by such incomplete or asymmetrical information between insurers and enrollees. What makes this selection *adverse* is that, without enough information about enrollees' health costs, insurers cannot accurately price premiums. Costly enrollees may sign up for a plan whose premium is too low to cover the costs of the plan.

Adverse selection happened in the post–World War II era when commercial plans began to experience rate premiums, drawing off healthier enrollees to whom they could offer lower rates. The Blues, whose mission limited them to community rating, were not able to cover the costs of the remaining, sicker enrollees, and eventually had to follow suit and experience rate premiums as well. The ACA requires plans in the state exchanges to community-rate their premiums, but at the same time states may limit insurers' premium increases. As a result, adverse selection may prevent some insurers from offering health insurance under ACA regulations.

In an attempt to prevent adverse selection, many insurers previously limited coverage for pre-existing conditions—illness or injury present even before coverage begins. Limiting such coverage is consistent with the traditional definition of insurance. What if you wanted to purchase insurance for a car that had already broken down, for a water heater that needed replacement, and for a dog that had broken its leg? Would an insurer sell you coverage for these events? Not likely. Insurance is protection against events that have not yet happened.

So why do insurers offer coverage for diabetes, chronic heart disease, and lower back pain to enrollees who already have these conditions? In fact, the ACA required that almost all plans—with the exception of older, individual (non-employment-based) plans—cover pre-existing conditions. We previously noted that health insurance has expanded beyond its original function—to protect against unpredictable financial losses—because of the importance that society places on health. The requirement that insurers community-rate premiums and cover pre-existing conditions at the risk of adverse selection is an example of this expansion.

We require people to sign insurance contracts for only one year, so if someone becomes sick or knows that they will need a medical procedure in the upcoming year, then they can sign up for a plan that covers these expenses during the next open enrollment period. A hypothetically "ideal" insurance contract would begin at birth, bind the enrollee for life, and cover every potential health condition that currently exists and that could exist in the future. In this case, there would be no "pre-existing" conditions and no selection into more generous health plans based on illness (Arrow, 1963).

Another puzzle is why health insurance covers such small claims (requests from providers for payment)—$50 for an office visit, $100 for a blood test, $80 for a 30-day supply of generic medication. Premiums include not only the cost of medical care but also the cost of administering claims, so for inexpensive services like office visits and blood tests, wouldn't it be cheaper to just self-insure? If it costs $10 to administer each claim, then administration accounts for 20 percent of an office visit claim ($10 divided by $50), 10 percent of a claim for a blood test ($10 divided by $100), and 8 percent of a claim for a 30-day supply of generic medication ($10 divided by $80). In contrast, $10 is a negligible proportion (0.03 percent) of a $30,000 knee surgery. The larger the medical bill, the smaller the proportion of that bill that is attributable to administration.

One explanation for why insurance covers small claims is that insurers negotiate prices with providers (hospitals, physicians, and pharmacies) that individuals do not have the power to negotiate

themselves, so even for small claims like office visits and blood tests, consumers rely on insurance for payment. Consumer-directed health insurance is in part intended to save money on these small claims by giving enrollees the benefit of the negotiated rate but requiring large out-of-pocket payments before insurance covers expenses. The role of the health insurer as a negotiator is another example of its expansion beyond its original function of collecting premiums and paying out benefits.

Finally, precisely because insurance protects enrollees against risk, having insurance may encourage enrollees to use more care or behave more recklessly, a phenomenon called **moral hazard**. Health insurers thus have yet another role—to design benefits and review utilization to limit moral hazard. Many tools are available: insurers can impose **copayments** (a fixed cost per episode of care, such as a doctor's visit for hospitalization), **coinsurance** (a fixed percentage of the cost of care, such as 10 percent or 20 percent of the cost of a doctor's visit), **deductibles** (a fixed amount that the enrollee must pay before insurance covers expenses, commonly used in consumer-directed health plans), and annual and lifetime **limits** on covered expenses. Insurers can also restrict patients to a narrow network of providers that is willing to offer a lower price to the insurer. Other tools include **utilization review**, an evaluation of the cost and medical necessity of care. An example of utilization review is **prior authorization**, a requirement that enrollees seek approval from an insurer before obtaining medical services (**Table 1-2**).

Health insurance in the United States is far from the hypothetical ideal in which only large, unpredictable health conditions are covered. It has expanded beyond its original role replacing lost income, and now resembles a gym membership more than traditional insurance such as auto or homeowners, which have adhered more closely to the ideal. At a gym, dues are paid every month. In return, you can visit the gym—or not. If you would like to join a fancier gym with gleaming new equipment and nice showers, then you must pay more. Some gyms offer additional services à la carte—you may pay extra for yoga classes, massage, towel service, or for a smoothie at the café downstairs. Gyms curb overuse by limiting use of machines to 30 minutes and restricting attendance in classes. Analogously to a gym membership, you (or your spouse, parents, or the government) must pay a premium to join a health insurance plan. Generous plans with more in-network providers and covered services are more expensive. You may purchase additional services or supplies à la carte, such as a prescription drug that is not covered or services from an out-of-network provider. Some plans even have add-ons such as dental and vision services. The origins and development of health insurance in the United States help to clarify why it adopted such peculiar features and a pivotal place in U.S. society.

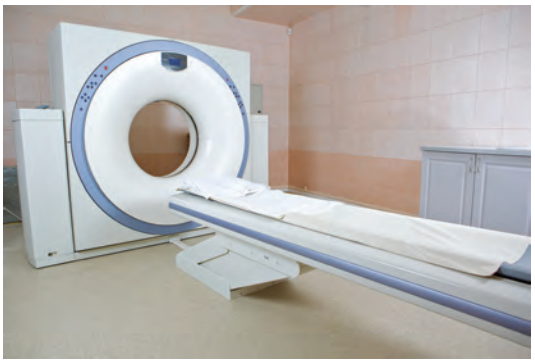


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TABLE 1-2 Insurer Tools to Manage Two Major Market Failures

Moral Hazard	Adverse Selection
Out-of-pocket payments	Experience rating
• Deductible	Limit coverage for pre-existing conditions
• Coinsurance	Open enrollment
• Copayments	
Annual and lifetime limits	
Utilization review	
• Prior authorization	

Summary

It is not feasible to offer insurance against the possibility of getting ill, or even to guarantee full recovery for someone who has become sick or injured. In many cases, such as with chronic disease and the gradual decline that comes with age, illness is not a well-defined event, and medical care is not the only factor that contributes to good health. Social, environmental, political, and genetic factors are also predictive of illness and injury, but insurance cannot guarantee a safe and healthy life. Thus health insurance is not really health insurance at all but actually *medical care* insurance—a guarantee against unpredictable, costly medical care bills. Because of the importance that society places on health, however, medical care insurance also covers predictable, not-so-costly bills as well, despite the risk of adverse selection and moral hazard.

There are tradeoffs in health insurance as with any limited resource. Premiums can be equally distributed across the population, as with community rating, or can be efficiently distributed across the population proportionate to expected cost, as with experience rating. Insurance benefits can be generous, covering a large number of people and conditions, or can be less costly. The trend in the United States has been toward emphasizing premium equality and generosity of coverage, rather than efficiency and affordability. Insurance has become the mechanism by which society transfers money from the healthy to the sick.

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