Health Insurance Basics: Roles for the Market and Government in Providing, Financing, and Regulating Private Insurance Coverage

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Summary

Both the market and government have important roles in ensuring the availability, affordability, and adequacy of private health insurance. These roles complement one another, but even together the market and government have limitations.

The market provides a variety of insurance products for consumers and employers with different needs and preferences. These products differ on many dimensions, including the breadth of provider networks, amount of beneficiary cost-sharing, and techniques for managing the use of health care services. Large employers, small employers, and individuals have different health insurance options, but all must make tradeoffs between the cost of coverage and desired features.

A strength of the market is its flexibility to adapt over time to changing circumstances. As economic conditions, consumer preferences, and government policies evolve, the market generates different products with different features. The primary limitation of the market is its failure to provide affordable options for all consumers.

The federal government helps ensure access to health coverage through public programs, such as Medicare and Medicaid, and it influences the market for private insurance through tax and regulatory policies. Some tax subsidies help people purchase insurance, and others—including those for Health Savings Accounts—help pay for medical expenses not covered by insurance. By far the largest subsidy is the tax exclusion for employer-provided health benefits. Because of this exclusion, most people get health insurance through work.

Tax subsidies make health insurance and health care seem more affordable for certain taxpayers, but do not provide equivalent support to everyone. In addition, subsides may increase health care spending by reducing the apparent cost of health insurance and health care services.

Regulations affect both access to insurance and the adequacy of benefits. States have primary responsibility for regulating insurance, but the federal government has sought to address selected issues regarding health coverage. For example, the Health Insurance Portability and Accountability Act of 1996 and the Consolidated Omnibus Budget Reconciliation Act of 1985 include provisions that allow certain people to obtain or continue health coverage under certain circumstances. In addition, several federal laws mandate coverage for specific health benefits.

Although regulations provide some protection for consumers, neither federal nor state rules guarantee access to coverage for everyone. In addition, even where regulations require insurers or employers to offer coverage, consumers may find this coverage unaffordable. *This report will be updated.*

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Health insurance coverage facilitates access to health care and protects individuals and families from catastrophic health expenses.[1] Both the market and government have important roles in helping ensure the availability, affordability, and adequacy of private health insurance.

In 2006, about two-thirds of Americans had private coverage, including about 60% with employment-based and 9% with directly purchased health insurance. In the same year, about 27% of the population had government benefits through Medicare, Medicaid, and military health programs. About 16% of the population was uninsured.[2]

The market for private insurance excels in creating new products and adapting to changing demand, but is not set up to ensure that everyone gets coverage. Consumers who are sick or poor may not be able to find adequate insurance at an affordable price, while others may decide that premiums are more than they are willing to pay. If health insurance were another good or service, people might not care about consumers who cannot afford it or choose not to buy it. But many think that health insurance and the health care it pays for are different from other goods and services.

Government helps ensure access to health coverage where the market might not. It does this through public programs, such as Medicare and Medicaid, and through policies that affect the market for private insurance. Federal policies include tax subsidies and regulations. Subsidies make health insurance more affordable for consumers and employers, and regulations help ensure access to insurance and the adequacy of benefits. States play a fundamental role in regulating health insurers and the products they sell. Functions vary by state, and may include licensing insurance companies and agents, ensuring financial solvency through standards and oversight, approving rates, and assessing insurance companies to fund programs for consumers.

Of course, there is no bright line between the market and government. Market limitations prompt government policies, and government policies in turn shape market trends. In addition, differences among state policies and the interaction between federal and state requirements create a complex landscape for consumers, employers, and insurers who wish to buy or provide health benefits.

This report analyzes the roles of the market and government in providing, financing, and regulating private health insurance. It focuses on federal policy, and shows that although both the market and government play important roles, both also have limitations.

[1] For more information about private health insurance, see CRS Report RL32237, *Health Insurance: A Primer*, by (name redacted).

[2] U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2006*, Current Population Report No. P60-233, August 2007, p. 58. More specifically, 67.9% of the population had private insurance (including 59.7% with employment-based and 9.1% with directly purchased coverage); 27.0% had government coverage (including 12.9% with Medicaid, 13.6% with Medicare, and 3.6% with military health care); and 15.8% of the population was uninsured. Some people with private insurance had both employment-based and directly purchased coverage, and some people had both private and government coverage.

The Market

By generating diverse insurance products and by adapting to different and changing conditions, the market for private health insurance provides choices for consumers and employers who have different needs and preferences.

Offering Insurance Products with Different Features

Consumers and employers want affordable yet generous coverage. They also want unfettered access to health care providers and services, but generally they must make tradeoffs between cost on the one hand and generous coverage and access on the other. For example, some may be willing to pay higher premiums in exchange for unrestricted access to health care providers, while others accept restrictions or higher cost-sharing to make coverage more affordable.

To meet demand, the market offers a variety of health insurance products. These products include traditional indemnity insurance, relatively restrictive health maintenance organizations (HMOs), and high-deductible health plans with associated savings accounts. Certain products are characterized by certain features. For example, indemnity coverage is associated with choice of health care providers, while HMOs are associated with restricted choice, including limited provider networks and constrained access to care. In practice, distinctions between the product types are not clear. Any type of product may have nearly any combination of features, including broad or restricted access to health care providers, low or high cost-sharing, and limited or fully integrated programs for managing patients' use of services.

Consumers and employers choose among different products according to their preferences, although individuals, small employers, and large employers tend to have different options. In addition to having more options, large employers can choose between purchasing insurance and self-insuring and buying administrative services from an entity that processes paperwork but does not bear financial risk.

Adapting to Changing Conditions

In addition to providing a variety of products, the market adapts over time to changing circumstances. Health insurance products evolve, and different features become more or less prominent.

In the early 1990s, the trend was toward managed care, with restricted access to health care providers, low beneficiary cost-sharing, and health plan management to limit use of services. These strategies slowed growth in premiums for health insurance, but also led to complaints by patients and providers about restrictions on access to care and interference in the practice of medicine. In response to these complaints, the market began to offer more flexible products with higher premiums. By the late 1990s, with a booming economy and low unemployment, employers were willing to pay more for health insurance in an effort to recruit and maintain a qualified workforce. More recently, as prices have continued to rise, renewed concern by consumers and employers about the cost of health benefits has led to more changes in insurance

products. Given the managed care backlash, these products have fewer restrictions on access to care, and instead rely on higher cost-sharing to influence consumers' use of services.[3]

In addition to responding to changing circumstances, the market responds to policy changes. For example, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) authorized new tax-advantaged accounts to pay for medical expenses not covered by insurance or other reimbursements. These Health Savings Accounts (HSAs) must be paired with high-deductible health plans, and the market has responded by developing such plans.[4] The MMA also established Medicare drug coverage. Private insurers provide this coverage through Medicare Advantage (MA) and stand-alone prescription drug plans (PDPs). Depending on where beneficiaries live, they may be able to choose among one or more MA plans with drug coverage and more than 50 PDP options.[5]

Limitations of the Market

Although private insurers offer a variety of products and respond to changing conditions, they do not serve everyone equally. Premiums and access to health insurance vary across and within geographic markets, and for different consumers and employers. Across markets, premiums vary with differences in the cost of living, in patterns of health care practice, in the mix of medical providers, and in the relative market power of health care providers and insurers. Within markets, premiums vary both because products differ and because individual consumers and employers differ.

Differences in consumer and employer characteristics affect not just premiums, but also access to insurance, including the number, type, and generosity of plan options. Some people and firms have many choices, while others have few. Large firms and their employees tend to have more options than smaller firms and their employees. Many people have no employment-based option, either because their employer does not offer coverage or because they are not working. Lack of employment-based coverage can be a particular problem for high-risk populations—including people who are older, sick, or disabled—as they may have few or no choices in the private market.

A large number of choices may or may not improve insurance coverage. On the one hand, many options increase the likelihood that consumers and employers will find a satisfactory combination

[3] For more on changes in health care and health insurance, see Paul Ginsburg, "Competition in Health Care: Its Evolution over the Past Decade," *Health Affairs*, vol. 24, no. 6 (November/December 2005), pp. 1512-1522.

[4] According to America's Health Insurance Plans (AHIP), as of January 2007, 4.5 million people were enrolled in high-deductible health plans with health savings accounts. See AHIP, "January 2007 Census Shows 4.5 Million People Covered by HSA/High-Deductible Health Plans," April 2007, at http://www.ahipresearch.org/pdfs/Final%20AHIP_HSAReport.pdf. In addition, according to the Kaiser Family Foundation and the Health Research and Educational Trust, in 2007, of firms that offer employee health benefits, 7% provide an HSA option. See KFF/HRET, *Employer Health Benefits, 2007 Annual Survey*, at http://www.kff.org/insurance/7672/upload/EHBS-2007-Full-Report-PDF.pdf.

[5] The number of options varies by region and county. For example, in 2007, beneficiaries in Pennsylvania and West Virginia (a PDP region under Medicare) could choose between 66 PDP options, while those in Alaska had 45 options. See Jack Hoadley et al., *Benefit Design and Formularies of Medicare Drug Plans: A Comparison of 2006 and 2007 Offerings*, Kaiser Family Foundation, November 2006. In addition, depending on their county of residence, beneficiaries can choose between an average of 20 MA plans in 2007. Most, but not all, or these plans include prescription drug coverage. See Medicare Payment Advisory Commission, "Section 10: Medicare Advantage," in *A Data Book: Healthcare Spending and the Medicare Program*, June 2007.

of benefits and costs. On the other hand, the number of options may be irrelevant if prices are burdensome or unaffordable.

The Government

Government plays a role in helping ensure access to health coverage. In 2007, federal spending on Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP) is expected to total $634 billion.[6] These programs serve primarily older, low-income, and disabled people, populations that otherwise would have difficulty finding adequate and affordable coverage in the private market. For vulnerable individuals who lack access to employer-paid insurance, government benefits may be the only viable alternative.

In addition to providing health benefits for vulnerable populations, the federal government uses tax and regulatory policy to influence the market for private health insurance. Tax policy supports access to care through subsidies for insurance and medical care expenses, while regulatory policy supports access by laying ground rules that affect the availability and adequacy of insurance coverage.

Tax Policy

Federal law includes significant tax benefits for health insurance and medical care expenses. In addition to supporting access to care, these benefits have shaped the market for private health insurance. Largely because of tax policy, in 2006 about 60% of Americans got health benefits through work.

Subsidies for Health Insurance

By far the largest health-related tax benefit is the exclusion for employer-paid insurance. For people receiving employer-paid benefits, premium costs are not counted as income and therefore not subject to income and employment taxes. In 2007, the income tax exclusion for employer-paid insurance is expected to be about $100 billion.[7] Employers also do not pay employment taxes on health insurance premiums. These tax benefits help make insurance more affordable for consumers and employers, but they also reduce federal revenue that otherwise could be used for different purposes. In effect, consumers who receive employer-paid insurance transfer part of the cost of coverage to taxpayers.[8]

Other tax benefits for health insurance include a deduction for self-employed taxpayers, and a tax credit for a limited group of individuals who either lost manufacturing jobs or receive payments from the Pension Benefit Guaranty Corporation. These tax benefits serve fewer people than the

[6] U.S. Congressional Budget Office, *The Budget and Economic Outlook: An Update*, August 2007, pp. 12-13.

[7] U.S. Congress, Joint Committee on Taxation (JCT), *Estimates of Federal Tax Expenditures for Fiscal Years 2006-2010*, Joint Committee Print #JCS-2-06, April 25, 2006, p. 39.

[8] For more information on the exclusion for employer-provided coverage and other tax subsidies for health insurance and health care expenses, see CRS Report RL33505, *Tax Benefits for Health Insurance and Expenses: Overview of Current Law and Legislation*, by (name redacted) and (name redacted).

exclusion for employer-paid coverage. In 2007, the deduction for self-employed workers is expected to be about $4.2 billion and the tax credit only about $200 million.[9]

Other Subsidies

Tax benefits also help consumers pay for qualified medical expenses not covered by insurance. Taxpayers who itemize may deduct health insurance premiums and other costs to the extent that qualified expenses exceed 7.5% of adjusted gross income (AGI).[10] Because eligibility depends on high spending relative to income, this deduction limits financial loss for people who face catastrophic costs. In 2007, this tax benefit is expected to be about $8 billion.

People also can use several tax-advantaged accounts to pay for qualified medical expenses. These accounts include Health Savings Accounts (HSAs), Archer Medical Savings Accounts (MSAs), Health Reimbursement Accounts (HRAs), and Flexible Spending Accounts (FSAs). The newest such option, HSAs, is expected to provide about $300 million in tax benefits in 2007.[11]

Limitations of Tax Policy

Although all of these tax benefits help people pay for health insurance and health care, government—like the market—does not serve everyone equally. People may or may not be eligible for various benefits; and if they are eligible, support may or may not affect access.

Because many tax benefits are tied to employment, workers may receive support that is not available to the unemployed. In addition, higher-income workers realize greater tax savings than lower-income workers because tax benefits are based on marginal tax rates. Tax support does not guarantee access, and lack of support does not preclude it. Low-income people may be unable to afford coverage or all of the care they desire, even with support. Conversely, high-income people may be able to buy insurance and whatever care they need, even without support.

In addition to failing to distribute support based on need, tax benefits may increase health care spending. With subsidies, people can afford more insurance than they would otherwise; and with insurance, people may use more care.[12]

[9] JCT, p. 39. For more information on the tax credit, see CRS Report RL32620, *Health Coverage Tax Credit Authorized by the Trade Act of 2002*, by (name redacted).

[10] The medical expense deduction helps people only when their unreimbursed medical expenses exceed 7.5% of AGI *and* their total itemized deductions exceed their standard deduction.

[11] JCT, p. 39. For more information on tax-advantaged accounts, see CRS Report RS21573, *Tax-Advantaged Accounts for Health Care Expenses: Side-by-Side Comparison*, by (name redacted) and (name redacted); CRS Report RL32467, *Health Savings Accounts*, by (name redacted), (name redacted), and Neela K. Ranade; and CRS Report RL32660, *Health Care Flexible Spending Accounts*, by (name redacted).

[12] People use more health care when they are insured primarily because insurance reduces the apparent cost of services at the time people use them. For more information on demand with insurance, see David M. Cutler and Richard J. Zeckhauser, "The Anatomy of Health Insurance," in Anthony J. Culyer and Joseph P. Newhouse, eds., *Handbook of Health Economics, Volume 1A* (Amsterdam: Elsevier Science B.V., 2000), pp. 563-643.

Regulation

Regulatory policy is another tool for influencing the market for health insurance. Regulations affect access to coverage and the adequacy of benefits by setting ground rules for insurance companies and employers that provide health benefits. States have primary responsibility for regulating insurance, but the federal government has sought to address selected issues regarding health coverage. In general, federal regulations do not address premiums.

Access to Insurance

Federal policy does not guarantee access to private health insurance, but it does help certain consumers get or keep access to coverage under certain conditions. For example, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) helps ensure access to new insurance coverage for individuals and their families when the policyholder changes jobs. This protection is called portability. The act also helps ensure continuing coverage when a beneficiary gets sick. HIPAA accomplishes these guarantees by requiring insurers to sell or renew both individual and group insurance policies without regard to health status or claims experience. The law similarly helps small businesses. Insurers that offer coverage in the small group market must accept every applicant without regard to the claims history of the group.[13]

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) also helps ensure access to health insurance. COBRA allows certain workers and family members who lose eligibility for group coverage to continue to purchase this coverage for a limited time period.[14] Under the law, firms that employ at least 20 people must allow beneficiaries to continue health coverage following a qualifying event. For workers, qualifying events include loss of coverage due to job termination, a reduction in work hours, or a firm's reorganization due to bankruptcy; for family members, qualifying events include loss of coverage due to the death of or divorce from a covered employee.

Adequacy of Benefits

In addition to helping ensure access to insurance, regulations address the adequacy of coverage. Almost all such regulations come from the states. According to the Council for Affordable Health Insurance, an industry group, the number of state-mandated benefits currently tops 1,900. These mandates require affected insurers to cover specific health benefits, providers, and patients. Examples include mandated coverage for cancer screening tests, chiropractors, and handicapped dependents.[15]

[13] For more information about HIPAA, see CRS Report RL31634, *The Health Insurance Portability and Accountability Act (HIPAA) of 1996: Overview and Guidance on Frequently Asked Questions*, by (name redacted) et al.

[14] For more information about COBRA, see CRS Report RL30626, *Health Insurance Continuation Coverage Under COBRA*, by Heidi G. Yacker.

[15] Council for Affordable Health Insurance, *Health Insurance Mandates in the States 2007*, at http://www.cahi.org/cahi_contents/resources/pdf/MandatesintheStates2007.pdf.

Federal law includes a few benefit mandates. These mandates regard parity for mental health benefits, hospital coverage following normal childbirth or cesarean delivery, and coverage for prosthetic devices and reconstructive surgery following a mastectomy.[16]

Limitations of Regulation

Regulations may facilitate access to insurance or specific benefits, but they do not serve everyone equally. For example, although HIPAA and COBRA require insurers and employers to offer coverage to certain individuals under certain circumstances, these Acts do not guarantee access to insurance for everyone. In addition, even where regulations require insurers to sell or employers to offer coverage, eligible people may find coverage unaffordable.

Benefit mandates also do not serve everyone equally. Sometimes the issue is uniform protection, and sometimes the issue is variable protection. On one hand, while some argue that benefit mandates help guarantee adequate coverage, others maintain that mandates increase costs and limit coverage options for consumers. On the other hand, because most benefit mandates come from the states, consumers may or may not be protected, depending on where they live. In addition, while policies sold by insurance companies generally must comply with state mandates, firms that self-insure are exempt from the requirements.

Current Policy Initiatives

In the 110th Congress, committees in both the House and the Senate have held hearings and developed legislation regarding access to and the adequacy of private insurance. For example, the Senate Budget Committee has held a series of hearings on health care costs and universal coverage.[17] In addition, committees in both the House and Senate have reported legislation that would regulate private insurance. One set of House and Senate proposals would extend and expand federal requirements affecting mental health coverage under group health insurance policies.[18] Another set would prohibit the use of genetic information by insurers in making enrollment determinations and setting insurance premiums.[19]

State policy makers have been more proactive in pursuing policies to increase the availability and affordability of private health insurance. For example, both Massachusetts and Maine currently are implementing a variety of initiatives with an eye to achieving universal coverage. These

[16] For more information on federal insurance mandates, see CRS Report RL31657, *Mental Health Parity: Federal and State Action and Economic Impact*, by (name redacted) and (name redacted); CRS Report 98-14 EPW, *Newborns' and Mothers' Health Protection Act*, by Sharon Kearney Coleman (available on request); and CRS Report RL31634, *The Health Insurance Portability and Accountability Act (HIPAA) of 1996: Overview and Guidance on Frequently Asked Questions* on HIPAA.

[17] In addition to the Senate Budget Committee, other committees that have held hearings on these topics include House Energy and Commerce; House Small Business and Entrepreneurship; Senate Health, Education, Labor and Pensions; and Senate Finance.

[18] Current requirements for mental health parity are set to expire at the end of this calendar year. In addition to extending current law, proposed legislation would expand requirements on insurance policies that cover both mental and physical illnesses. For additional information, see CRS Report RL31657, *Mental Health Parity: Federal and State Action and Economic Impact*.

[19] For additional information, see CRS Report RL33988, *Genetic Nondiscrimination in Health Insurance: A Side-by-Side Comparison of the Title I Provisions in S. 358 and H.R. 493*, by (name redacted) and (name redacted).

initiatives include insurance market reforms, requirements on employers and consumers, public subsidies for private insurance, and the expansion of public coverage under Medicaid.[20] In California, policy makers continue to debate the merits of different approaches for achieving universal health coverage. These approaches include requiring individuals to have coverage, requiring employers to make contributions for health benefits, and adopting a statewide single-payer system.[21]

Conclusion

Both government and the market have important roles in helping ensure the availability, affordability, and adequacy of private health insurance. The market excels in creating new products and adapting to changing demand, but is not set up to guarantee that everyone gets coverage.

Government complements the market through tax and regulatory policies aimed at improving access to coverage and the adequacy of benefits. Ideally, these policies would reflect widely held social values, but setting priorities is difficult. Should the priority be affordability, and if so, for whom? For consumers and employers purchasing insurance? For taxpayers who subsidize coverage? Or should the priority be facilitating access to benefits? Again, for whom? For workers; for people with lower income; for people who are older, sick, or disabled; or for everyone?

Policymakers face a challenge in improving access to health insurance, while making efficient use of limited public resources and avoiding unnecessary regulations that might hinder market innovation.

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[20] For an overview of reform initiatives in Massachusetts, see CRS Report RS22447, *The Massachusetts Health Reform Plan: A Brief Overview*, by (name redacted). For information about health reforms in Maine, see a description of Dirigo Health at http://www.statecoverage.net/statereports/me14.pdf.

[21] For information on the health coverage debate in California, go to http://www.calhealthreform.org/.