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# Health Insurance

## I. INTRODUCTION

Health Insurance, insurance designed to pay the costs associated with health care. Health insurance plans pay the bills from physicians, hospitals, and other providers of medical services. By doing so, health insurance protects people from financial hardship caused by large or unexpected medical bills.

People obtain health insurance from private organizations or from government agencies. All industrialized countries other than the United States have government-funded national health insurance systems that provide health insurance for virtually everyone. Countries with national health insurance generally consider access to health care to be a basic right of citizenship.

In the United States private organizations have traditionally provided the vast majority of health insurance coverage. The U.S. government operates some publicly funded health insurance programs but access is limited to specific groups, such as the poor and the elderly. Most Americans obtain private health insurance through their places of employment.

Americans pay the cost of health insurance in a variety of ways. Workers may pay for private health insurance by authorizing their employers to deduct a specified amount from their paychecks. Alternatively, individuals may work for employers who pay the direct costs of health insurance. People who do not receive health insurance through their jobs or through government programs can purchase private health insurance policies by paying premiums directly to an insurance company.

## II. SOCIAL ISSUES IN THE UNITED STATES

### A. Access to Health Insurance

In 2000 the U.S. Census Bureau reported that about 38.7 million people in the United States (about 14.3 percent of the population) lacked health insurance coverage. Those without insurance are usually self-employed, work part-time, or work in low-wage jobs, so they lack access to low-cost, employer-sponsored group plans. Many of these workers cannot afford to purchase individual health care insurance, but they do not qualify for coverage under government programs for low-income Americans. For example, almost half (47.5 percent) of full-time workers in low-wage jobs were uninsured in 2000. Nevertheless, even without insurance, these individuals may be able to receive care without charge or at reduced rates in government-run hospitals.

Although millions of Americans lack health insurance because they cannot afford it, many others cannot buy health insurance because insurers consider them at especially high risk of needing expensive health care. Insurers assess the risks posed by applicants for insurance and then group applicants into similar classes of risk. Americans who are considered average or better-than-average risks can usually purchase insurance policies at a relatively affordable price. When an applicant presents too much risk, however, private companies consider it difficult or even impossible to offer insurance coverage to that person.

For example, some private companies will not offer coverage to an individual with a known predisposition to develop cancer because he or she presents a high risk of needing expensive treatment. Also, the few companies willing to insure such high-risk individuals will charge higher premiums to assume the risks. Increased premiums often make the insurance policy unaffordable to high-risk individuals. Even worse, occasionally no insurance company will offer a policy to a person who presents an exceptionally high risk of needing expensive medical care, such as a person infected with the virus that causes acquired immunodeficiency syndrome (AIDS).

Some insurance companies have introduced clauses to their policies that are designed to keep costs down by denying access to private insurance for anyone who already suffers from significant medical conditions. Introduction of *preexisting condition* clauses in insurance policies became especially widespread in the 1980s and early 1990s. Many workers found it virtually impossible to change jobs if any member of their families had a serious health problem because

preexisting condition clauses in their new employer-sponsored plan would deny them access to insurance coverage. The Congress of the United States addressed this problem by introducing the Health Insurance Portability Act of 1996, which requires most employer-sponsored plans to accept transfers from other plans without imposing a preexisting condition clause.

## B. Insurance Costs and Quality of Health Care

The costs of health care have increased dramatically for consumers and insurers, particularly during the 1980s and early 1990s. For example, in 1980 Americans spent \$247.3 billion on health care. By 1999 that figure had more than quadrupled to \$1.2 trillion.

One reason costs have risen is that Americans are living longer than ever before, and older people generally require more health care. In 1900 the average American had a life expectancy of about 50 years. In 2000 the average life expectancy was about 76 years. During the 20th century, the number of persons aged 65 or over increased 11 times. The elderly comprised only 1 in every 25 Americans in 1900, but represented 1 of every 8 Americans in 1994. When older Americans join an insured group, the whole group's health care risks—and costs—rise accordingly.

Advances in medical technology have also driven up the costs of health care and insurance. Medical procedures such as computerized tomography (CT) scans, magnetic resonance imaging (MRI) scans, and arthroscopic surgery are commonplace today, but they did not exist until the 1970s. Although such new technology sometimes allows health care providers to introduce less-invasive and less-expensive treatments, more often it provides new but expensive ways to treat conditions that were previously untreatable.

Increased use of health care has also led to a growth in health care costs. Americans are more likely than ever to seek professional health services for medical problems. For example, in 1991 there were an estimated 669.7 million visits to doctors' offices, or 2.7 visits per person. In 1999 there were an estimated 757 million visits to doctors' offices, or 2.8 visits per person. Many Americans today seek medical care for treatment of sexual impotence, attention-deficit hyperactivity disorder, and other problems that previously were not always considered health problems. Just as increased demand pushes prices up in other industries, increased demand for health care leads to escalating medical costs.

## III. REASONS FOR HEALTH INSURANCE

Health insurance protects people from financial loss caused by the high cost of medical care. The cost of a one-day stay in a hospital—excluding the cost of all other health care services—can exceed \$1000 in some parts of the United States. A hospital stay that includes the cost of surgery and other physician services can easily produce bills exceeding \$10,000. Health care costs of this magnitude pose substantial risks to most families' financial well-being.

By combining, or *pooling*, the risks of many people into a single group, insurance can make the financial risks associated with health care more manageable. Experts can reasonably predict the health care costs of a large group, even though they cannot know in advance how much health care will be required by any given individual. Through insurance, each person who buys coverage agrees to pay a share of the group's total losses in exchange for a promise that the group will pay when he or she needs services. Essentially, individuals make regular payments to the plan rather than having to pay especially large sums at any one time in the event of sudden illness or injury. In this way, the group as a whole funds expensive treatments for those few who need them.

Many people believe that in addition to providing financial stability, health insurance can promote good health. Supporters of this idea claim that by lowering the personal cost of services, insurance induces individuals to seek health-maintenance services more regularly than they otherwise would, thereby heading off potentially serious illnesses.

## IV. TYPES OF PLANS IN THE UNITED STATES

Most Americans selecting private insurance plans choose either an indemnity plan (also known as a fee-for-service plan) or a type of managed care plan. *Indemnity plans* allow subscribers to go to any doctor, hospital, or other health care provider, and the insurance company and the patient then share the cost. *Managed care plans* deliver health care services by designated providers in addition to paying part of the cost of those services. However, the distinctions between indemnity plans and managed care plans have become increasingly blurred. For example, some indemnity plans offer incentives to subscribers who choose certain kinds of health care providers. At the same time, some managed care plans allow subscribers to visit a range of health care providers not employed directly by the plan.

The United States Department of Health and Human Services oversees publicly-funded programs that provide limited health insurance for some Americans. The Medicare system provides coverage for elderly people and for people with

qualifying disabilities. The Medicaid program provides coverage for some low-income Americans.

## A. Indemnity Plans

Until the 1970s the vast majority of people in the United States with health insurance were covered under indemnity plans, more commonly known as fee-for-service plans. Under this type of plan, the patient may visit any health care provider, such as a doctor or hospital. The patient or the medical provider then sends the bill to the insurance company, which typically pays a certain percentage of the fee after the patient meets the policy's annual deductible. For example, a fee-for-service plan might pay 80 percent of a medical bill. The patient would pay the remaining 20 percent of the bill—an amount often called *coinsurance*—of the bill. Most indemnity plans contain provisions to increase coverage to 100 percent (rather than 80 percent) in years when medical bills become unusually large.

Owners of fee-for-service insurance plans generally prefer this type of insurance because it allows the greatest flexibility in choosing health care providers. For example, a participant in a fee-for-service plan typically is free to seek health care from specialists or to enter a hospital without first obtaining approval from the insurance company. Members of managed care plans often have less flexibility in their choice of doctor or hospital.

## B. Managed Care Plans

Managed care plans modify the traditional fee-for-service system of providing funds for medical care. Instead of focusing on paying the costs of treating illnesses and injuries as they arise, managed health care plans operate under the philosophy that it is better and more cost-efficient to prevent illness and injury in the first place. Accordingly, managed care organizations finance medical care in a way that provides incentives for patients to maintain good health. For example, managed care plans may reimburse patients for treatments to help them stop smoking, while most indemnity plans will not.

Managed care plans also attempt to make both patients and doctors aware of the costs associated with their health care decisions. Advocates of managed care claim that by emphasizing health maintenance and illness prevention, managed care organizations reduce the number of expensive medical treatments in the long run. For example, unlike many traditional indemnity plans, managed care plans generally cover the costs of regular immunizations and physical exams.

Managed care was developed in the United States in the early 1970s and quickly became widespread. By the mid-1990s most Americans were insured by managed care plans. Managed care health insurance plans include (1) health maintenance organizations, (2) preferred provider organizations, and (3) point-of-service plans.

### B.1. Health Maintenance Organizations

Health maintenance organizations (HMOs) agree to provide whatever medical services are required in exchange for the plan participant's monthly premium payment. HMO members generally receive excellent coverage of routine health care services, but they often face restrictions on their choices of doctors and hospitals. Services provided by HMO member physicians and facilities are covered almost in their entirety. Services provided by nonmember physicians and facilities are not covered at all except in emergencies or when specialized care is needed and the referral is authorized in advance.

The way in which an HMO is organized determines which health care providers are available to its members. A *group practice association*, such as the Kaiser Permanente Medical Care Program, is both an insurer and a provider of health care services. It hires health care providers as employees and builds its own hospital facilities. Members of a group practice association may arrange for any physician employed by the group to be their *primary care physician*—their first contact for health care. An *independent practice association* establishes a contractual relationship with doctors and hospitals to provide services to its members. In a group practice association and in an independent practice association, patients who require specialty care usually may obtain referrals to see specialists only within the HMO, unless the specialty care needed is not available within the group.

### B.2. Preferred Provider Organizations

Preferred provider organizations (PPOs) combine characteristics of traditional insurance plans and HMOs. PPOs establish contractual agreements with health care providers, who accept lower fees for services rendered to PPO members. The PPOs distribute lists of these participating providers to their members, who then select a primary care provider. This primary care provider is the patient's first contact for health care, providing health care services as well as referrals to specialists. PPO members who use the services of participating providers will generally receive more generous benefits than those who choose the services of health care providers not on the preferred list. Essentially, a PPO offers its participants some coverage for any doctor or hospital they choose, but participants' costs will be higher if they go outside the network of preferred providers.

### B.3. Point-of-Service Plans

Point-of-service (POS) plans combine aspects of indemnity health insurance policies with some elements of PPOs. Like PPOs, point-of-service plans establish contracts with health care providers who agree to offer services to plan members. Unlike PPOs, which require participants to select a preferred provider in advance, point-of-service plans allow participants to choose at the time they need health care whether to seek treatment within the plan's network of health care providers or outside the network. Expenses for services received outside the network are reimbursed, usually after the patient pays a specified deductible amount and a *coinsurance* percentage. The benefits are exactly the same as in a PPO plan if the services are provided by a health care provider on the preferred list. The benefits are exactly the same as an indemnity policy if the health care provider is not on the preferred list.

### C. Government-Funded Plans

Established by the U.S. Congress in 1965, Medicare and Medicaid offer basic health care coverage to qualified individuals, but these programs do not always provide access to comprehensive medical treatment. Limited funding for these programs can also lead to long waiting periods for nonemergency procedures.

#### C.1. Medicare

Medicare is a health insurance program in the United States that helps provide access to health services for citizens 65 years of age and older. It also provides health coverage for people under age 65 who have certain disabilities, such as kidney disease. Medicare is funded primarily by federal payroll taxes and by monthly premiums paid by participants.

As with other U.S. government health programs, Medicare provides a foundation of insurance, but it also leaves gaps in the services it covers. As a result, many Americans covered by Medicare choose to purchase private insurance—sometimes called “Medigap” insurance—to supplement Medicare’s coverage. While some employers offer supplemental coverage to their retired workers, many individuals purchase coverage designed to supplement Medicare when they first become eligible for the Medicare program.

Because insurance is regulated on a state-by-state basis, Medicare supplement policies can vary from one state to the next. However, in the 1980s the National Association of Insurance Commissioners persuaded many states to require that health insurance companies offer a core Medicare supplement policy called *Plan A*. Many insurance companies also offer nine additional plans (*B* through *J*) that feature increased benefits—and costs. For example, only the three most expensive plans (*H*, *I*, and *J*) cover the cost of prescription drugs.

#### C.2. Medicaid

Medicaid programs provide medical coverage for some people with low incomes, especially children and pregnant women. Depending on individual state eligibility requirements, Medicaid may also provide coverage for adults with certain disabilities. State programs that meet federal guidelines qualify to receive federal funding that pays for most of the program’s cost. These guidelines use federal statistics that define the *poverty level* (minimum level of income below which households are considered poor) to help states determine which low-income families are eligible for Medicaid.

As originally conceived, any household that fell below the federal poverty level would qualify for Medicaid benefits. In practice, however, budget shortfalls have forced states to vary eligibility standards for Medicaid. In a particular budget cycle, for example, a given state might set its eligibility requirements at 80 percent of the federal poverty level. For that year, households earning 79 percent of the federal poverty level could receive government-paid health care, but those earning 81 percent could receive no Medicaid benefits.

Advocates for the poor have led calls for Medicaid reform that would reinstate health insurance for all Americans below the federal poverty level. Between 1989 and 1995 the state of Oregon made changes in health care policy that many other states considered a model for national Medicaid reform. Oregon passed several pieces of legislation—collectively known as the Oregon Health Plan—that shifted its Medicaid requirements away from a mechanism that divided the population falling below federal poverty-level standards. Instead of asking who among the poor should receive state assistance with medical costs, the state asked what services the poor should receive, since there were not enough resources to provide all services to all qualified citizens. The Oregon Health Plan became the first state plan to limit public funding for certain health care services, but in doing so it expanded basic services to virtually all of the state’s poor citizens.

## V. DISABILITY INSURANCE

Another type of health insurance coverage is disability insurance, which replaces workers' income when an accident or illness prevents them from performing their jobs. Disability insurance is less common than medical coverage, but it can be important to assure future financial security for any family that depends on each paycheck to meet its financial obligations. Benefits are generally structured to pay a proportion of a person's actual earnings, usually from 40 to 60 percent. Short-term disability insurance covers up to six months of disability. Coverage for longer than six months is called long-term disability insurance. Most disability insurance policies limit coverage to a maximum period of time—such as to age 65—that determines the term of the policy.

A few U.S. states operate a system of public short-term disability coverage. The states collect payroll taxes from all workers to fund these programs. Employer-sponsored group plans can also provide disability insurance, but most employer-provided disability insurance ends when workers change jobs.

## VI. OBTAINING COVERAGE

People can obtain private health insurance coverage as a member of a group or as an individual. Both group plans and individual plans may offer coverage in either a managed care program or in a fee-for-service program. Most Americans receive group coverage through their employers, although some Americans join group plans through unions, professional associations, and other organizations that offer group insurance policies. People who obtain health insurance as individuals are typically self-employed, or they work for small companies that do not provide insurance. Elderly and some low-income Americans may qualify for the government-funded health insurance programs Medicare and Medicaid.

### A. Group and Employer Plans

Groups of people who have something in common other than their need for insurance often can join forces to purchase group health insurance. For example, individuals who all work for the same employer may join a group health insurance plan sponsored by their employer. Group plans typically have lower administrative costs than do individual health insurance plans, so they are able to charge individual subscribers lower monthly premiums. They also offer significant tax advantages in the United States.

Approximately two-thirds of American families obtain health insurance coverage through employer-sponsored group plans. Employers usually cover some or all of the cost of group health insurance for plan participants. Most employer-sponsored programs are with managed care programs, although many employers offer workers a choice of managed care or fee-for-service plans.

The Consolidated Omnibus Budget Reconciliation Act (COBRA), enacted by the U.S. Congress in 1985, requires most U.S. companies to allow employees, their spouses, and their dependent children to stay on the company's medical plan after eligibility would normally end. This law requires companies to provide health coverage to workers who are laid off, to ex-spouses of workers after a death or divorce, to children of workers who reach the plan's cutoff age, and to others in certain circumstances.

However, COBRA allows the terms of plan participation to change, so companies almost always require participants in these circumstances to start paying the full cost of coverage. Nevertheless, COBRA provides many people with important safeguards. Under the provisions of COBRA, health insurance coverage continues without interruption, the cost may be substantially less than an individual plan, and coverage is guaranteed to be available for either 18 or 36 months (depending on the event that qualified the individual for COBRA benefits in the first place). In addition, this coverage continues regardless of any changes in the beneficiary's health conditions. The regulations outlined in COBRA also apply to workers covered by self-insured plans.

### B. Individual Plans

Individuals who do not have access to less expensive group plans can buy policies directly from health insurance companies. Approximately 10 percent of Americans purchase individual health insurance policies to cover medical costs.

## VII. FEATURES OF HEALTH INSURANCE POLICIES

Nearly all health insurance policies in the United States share a few common features, regardless of whether the policies are purchased by individuals or through an employer. These features generally define the extent of benefits provided by a given health insurance policy.

### A. Deductible

Health insurance policyholders pay a specified amount of money each year for medical services before the insurance policy pays anything at all. This amount is called the *deductible*. For example, a person who selects a policy with a \$500 deductible agrees to pay the first \$500 of medical costs in a given year. Likewise, the insurance company agrees to pay some or all costs that exceed \$500. Policies with a low deductible generally charge a relatively high monthly fee—called a *premium*—to maintain the insurance account. Policies may express the deductible in terms of per-person and per-family amounts. For example, the policy might provide for a deductible amount of \$250 per person, but it might also set a maximum deductible of \$500 per family when more than one person in the family has incurred medical expenses.

#### B. Coinsurance

Many insurance policies also require policyholders to pay a certain portion of medical costs that exceed the deductible. This extra amount is called the *coinsurance* figure. For example, consider a person who has already paid her policy's deductible for the year and then has a diagnostic test that costs \$100. If that person's health insurance policy sets the terms of coinsurance at 20 percent, the insurance company must pay \$80 of the bill for the test and the policyholder must pay \$20. Policies that do not require a coinsurance payment usually charge subscribers a relatively high premium.

#### C. Copayment

Most managed care policies require policyholders to make a modest payment—called a *copayment*—toward the cost of services for each visit to a health care provider. Copayments are usually \$10 or less. Although the amount of money collected from copayments may contribute little toward the actual cost of medical services, it does force some cost onto consumers in a way that provides incentives against overusing the health care system. These policies also assume that unless patients pay something for the services they receive, they place little value on those services. Indemnity plans typically do not require policyholders to make a copayment in addition to the deductible amount.

#### D. Premium

Insurance policies charge a certain monthly amount—called a *premium*—to maintain an insurance contract. The premium is the payment an individual policyholder makes in exchange for the promise of financial assistance for medical costs. The premium charged for the insurance reflects the value of the benefits received. For example, insurance with a \$500 deductible generally has a lower premium than insurance with a \$250 deductible.

#### E. Terms and Limits

Most health insurance policies limit coverage to services that the insurance company defines as both “reasonable and necessary.” These terms are key to understanding the policy's benefits because they define whether particular services are within the scope of coverage.

Insurance companies carefully determine what they consider to be “reasonable” costs of medical services. To do this, an insurance company gathers statistics on what health care providers in a particular area typically charge for identical or similar services. That information helps the company determine the amounts it considers to be reasonable. For example, many insurance policies cover payment for an office visit to a doctor. If 90 percent of the doctors in a particular geographical area charge \$60 or less for an office visit, an insurance company might logically decide to limit its policy's coverage of office visits to the first \$60 in charges. When a particular patient's doctor charges \$75 for an office visit, the insurance company may send the patient a bill—known as a *balance billing* charge—for the additional \$15. Some benefit programs, such as Medicare, may not hold patients responsible for balance billing charges.

Insurance companies also determine what they consider to be “necessary” medical treatments. Health insurance contracts limit coverage to services that are considered important to maintaining sound health. For example, services such as cosmetic surgery usually are not considered necessary except in specific circumstances, such as after a disfiguring accident.

#### F. Out-of-Pocket Maximum

Health insurance policies define the maximum amount that an individual or family must pay each year for deductibles and coinsurance combined. This amount is called the *out-of-pocket maximum*. For example, a policy with a \$250-per-person deductible might have a \$1,000 limit on the total amount that a person would have to pay in both deductibles and coinsurance.

#### G. Lifetime Policy Limit

Some health insurance companies establish *lifetime policy limits* that define the maximum amount the insurer agrees to pay for a policyholder's medical expenses. For example, a policy with a \$500,000 limit pays up to \$500,000 toward covered medical expenses over the life of the policy. A policy covering as much as \$1 million or more of medical expenses usually does not cost the policyholder much more in premiums than one with \$250,000 or \$500,000 limits. The difference in cost is so slight because the probability of needing the highest amounts of coverage is very small. If the cost of medical services exceeds the lifetime policy limit, the insured person is liable for the difference, regardless of the limits set by the out-of-pocket maximum.

#### H. Preexisting Conditions

When a policyholder has medical conditions before being issued a health insurance policy, these are referred to in the new policy as *preexisting conditions*. Many newly issued policies contain a clause that limits the amount the insurance company will pay for services related to preexisting conditions. The precise limit can be expressed in this clause as a dollar amount, as a period of time for which benefits are limited, or as a permanent exclusion of coverage for particular services related to the conditions. By including such clauses, private insurance companies can make limited insurance available even to people with known health problems. At the same time, these clauses protect the company and the other members of the policy group from the likelihood of paying large bills associated with new policyholders' preexisting conditions.

### VIII. LEVEL OF COVERAGE

The extent to which an insurance policy will cover specific health care services varies considerably based on the level of benefits outlined in the policy. Because each person has different medical needs and risks, no one level of health insurance coverage is right for everyone. Some of the most common levels of coverage available in the United States include comprehensive medical insurance, hospital-surgical insurance, catastrophic health insurance, specified disease insurance, and long-term care insurance.

#### A. Comprehensive Coverage

*Comprehensive* medical insurance is a single plan that combines coverage for both doctor and hospital charges. Most medical services are covered by comprehensive policies, although even comprehensive plans limit benefits for certain specific conditions. They also may not cover services associated with preexisting conditions.

#### B. Hospital-Surgical Coverage

*Hospital-Surgical* policies provide separate limits for hospital charges and for physician charges associated with a hospital stay. A hospital-surgical plan usually limits its benefits to cover a relatively low amount of medical costs, so most people consider it only in conjunction with a more comprehensive policy.

#### C. Catastrophic Coverage

*Catastrophic* health insurance—also known as *major* medical insurance—is a policy of health insurance with a relatively high deductible, often as high as \$500 or \$1000. Although catastrophic health insurance policies offer coverage only beyond this high deductible amount, they can help people avoid bankruptcy in the event of a catastrophic illness or injury that requires expensive medical treatments. Because catastrophic health insurance policies have a high deductible, they typically charge policyholders relatively low monthly premiums.

#### D. Specified Disease Policies

Some insurance companies offer *specified disease* policies that cover only one illness, such as cancer. These plans offer no benefits at all for medical costs associated with any disease other than that specified in the policy. Therefore, most people who purchase these policies also need to be covered by a more comprehensive policy. Some of these policies provide only for the treatment of the specified illness and exclude from their benefits package the costs of diagnosing the disease.

#### E. Long-Term Care Policies

Americans increasingly buy *long-term care* policies to cover nursing home costs. Medicare and most private medical insurance policies cover *medically necessary* services such as care while recuperating from surgery, but they do not pay for the so-called custodial care offered by nursing homes. In about 80 percent of American families, at least one family member will eventually need long-term care. The average annual cost of a nursing home stay in the United States is

around \$40,000. Long-term care policies can help families meet these high medical expenses incurred by the elderly.

## IX. SPECIFIC BENEFITS

Each health plan or insurance policy must define what kinds of medical services are covered by insurance. These policies must also explain limitations or exclusions of coverage for specific services. In addition, insurance policies define the kinds of medical care providers that are covered by insurance. For example, covered providers usually include physicians and hospitals, but the policy's terms may also include coverage for nurse practitioners, midwives, chiropractors, and naturopaths.

Almost all health insurance plans cover the cost of diagnostic tests, prescription drugs, and other items necessary to provide care in hospitals. Some policies also provide coverage for such things as prescription drugs to be taken outside of hospital settings.

### A. Inpatient Hospital Care

Hospitals provide *inpatient care* when they admit a patient for an overnight stay. Most comprehensive health insurance policies cover the costs of inpatient care as long as that level of care is considered necessary to treat the patient's condition.

*Hospital indemnity* policies pay a specified dollar amount per day of inpatient care, regardless of the cause of the hospitalization. The amount paid by the insurer varies neither with the services provided nor with the expense of those services. The benefit amounts paid by hospital indemnity policies are generally quite low when compared with the typical cost of a hospital stay.

### B. Outpatient Care

Patients who do not require an overnight hospital stay receive *outpatient care*, which is generally covered by comprehensive policies. Outpatient care could be provided in a doctor's office, a neighborhood clinic, or in a hospital if the patient is sent home the same day. For example, patients often will come to the hospital the day before surgery so that doctors can perform blood tests. Simple surgeries like a tonsillectomy (a procedure to remove the tonsils) usually can be performed on an outpatient basis. Even very sophisticated surgeries like a cochlear implant (a device used to stimulate the auditory nerve in deaf people) often do not require a hospital stay. To encourage patients to make cost-effective use of the health care system, health insurance plans—particularly managed care plans—often include financial incentives to use outpatient services whenever possible.

Treatment of mental illness is commonly performed on an outpatient basis, but insurance coverage is often limited for such services as psychotherapy. For example, private insurers generally pay 80 percent of the cost of most outpatient medical services, but they traditionally limit reimbursement for psychotherapy to 50 percent or less of its cost. Also, many insurers limit their coverage of psychotherapy to a specified maximum dollar amount or to a maximum number of visits.

Many insurance policies will offer coverage of health care performed in the patient's home by an approved medical provider. Home health care benefits are generally limited to medically necessary services that are part of a treatment plan prescribed by the patient's doctor. Some policies also cover hospice care that allows a terminally ill patient to receive health care services at home or in an approved hospice center instead of in a hospital.

### C. Emergency Care

Most insurance policies cover emergency care provided in hospital emergency departments, but they generally discourage overuse of emergency room visits by requiring the patient to make a copayment. Health insurance policies also usually offer limited coverage for ambulance transportation to emergency rooms.

### D. Substance Abuse and Alcoholism Treatment

Most comprehensive policies offer limited coverage for treatment of alcoholism and other forms of substance abuse. These policies generally pay a percentage of the cost for treatment performed by an approved facility or counselor, but benefits are usually limited to a maximum amount paid over a specified period.

### E. Alternative Medicine

An increasing number of health insurance policies provide benefits for so-called alternative medicine—that is, for therapeutic practices and treatments that lie outside the mainstream of Western medical care. Policies that cover alternative medicine may provide benefits for such treatments as acupuncture, chiropractic care, therapeutic massage, and naturopathy (treatments that avoid drugs and surgery in favor of natural remedies). Advocates of alternative medical practices believe that they can provide safe, natural approaches to treating illnesses or injuries that conventional medicine has had limited success in curing, such as chronic pain and drug addiction.

## X. HISTORY IN THE UNITED STATES

Health insurance in the United States is a relatively new phenomenon, dating to the time of the Civil War (1861-1865). Early forms of health insurance mainly offered coverage against accidents arising from travel, especially by rail and steamboat. The success of accident insurance paved the way for the first insurance plans covering illness and injury. The first insurance against sickness was offered by Massachusetts Health Insurance of Boston in 1847. Insurance companies issued the first individual policies offering disability insurance in 1890.

The first modern group health insurance policy was issued in 1929, when a group of teachers in Dallas, Texas, contracted with Baylor Hospital for room, board, and medical services as needed in exchange for a monthly fee. Many life insurance companies entered the health insurance field in the 1930s and 1940s, and the popularity of health insurance grew quickly. In 1932 nonprofit organizations called Blue Cross or Blue Shield first began to offer policies of group health insurance. Blue Cross and Blue Shield were the first programs that established contracts directly with health care providers, who would then offer services to subscribers at reduced rates. Originally, Blue Cross plans covered the cost of hospital care, whereas Blue Shield plans covered doctors' bills. Eventually, however, both Blue Cross and Blue Shield plans began covering all health care services.

Employee benefit plans became a widespread source of health insurance in the 1940s and 1950s. Increased union membership at U.S. factories enabled union leaders to bargain for better benefit packages, including tax-free, employer-sponsored health insurance. Wage freezes imposed during World War II (1939-1945) also drove the growth of employee benefit plans. Unable by law to attract scarce workers by increasing wages, employers instead enhanced their benefit packages to include health care coverage.

Government programs to cover health care costs began to expand during the 1950s and 1960s. Disability benefits were included in social security coverage for the first time in 1954. When the government first implemented Medicare and Medicaid programs in 1965, private sources paid 75 percent of health care costs in the United States. By 1995 that number had dropped to only 53.8 percent.

Throughout most of the 1980s and 1990s the majority of employer-sponsored group insurance plans switched from fee-for-service plans to managed care plans. As a result, most Americans with health insurance were enrolled in managed care plans by the mid-1990s. For example, in 1980 only 9.1 million Americans were enrolled in health maintenance organizations. By 1995 that figure had risen to 46.2 million. Employers made the change to managed care as part of an effort to improve the quality of health care for their employees while also monitoring the cost of providing insurance.

In 1993 President Bill Clinton presented to the U.S. Congress a health care reform plan that would guarantee health insurance for all Americans. Under the leadership of the president's wife, Hillary Rodham Clinton, the Democratic Clinton administration's special commission on health care reform claimed that in addition to providing universal health insurance, the proposal would stem the rapidly rising cost of health care. Republican leaders in Congress fiercely opposed the plan for being too expensive and for imposing excessive governmental regulations on health care. Opponents of the plan also attacked it for restricting patient choice of health care providers and for placing an undue burden on small businesses by forcing them to provide health insurance for their employees. In 1994 members of Congress introduced a variety of alternative proposals, but the administration never reached a compromise with Republicans, and Clinton's health care reform package never became law.

In 1996 Congress passed the Mental Health Parity Act, a law that requires employers with more than 50 workers to offer health plans that set yearly and lifetime limits for mental health care at the same level as limits for physical health care. Despite these important safeguards for workers, the law allows employers in some states to eliminate coverage of services to treat mental illness altogether. Also, the law allows employer-sponsored plans to charge higher deductibles and copayments to workers seeking mental health care.

Congress also passed the Health Insurance Portability and Accountability Act in 1996. This legislation extends the basic provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) by further protecting individuals from losing their health insurance when they move from one job to another, become self-employed, or have preexisting medical conditions. However, the Health Insurance Portability Act does little to ensure the overall quality or comprehensiveness of insurance offered by employers.

## XI. HEALTH INSURANCE IN CANADA

In Canada, a publicly financed health care system called Medicare provides comprehensive coverage for every Canadian citizen. Sometimes referred to as a *single-payer* system, the Canadian health care plan pays everyone's medical bills using tax money from provincial and federal sources. Each individual province manages the delivery of health services to its citizens, but all of the various provincial and territorial health insurance systems are linked through adherence to the Canada Health Act, a set of health care standards set at the federal level. The federal government also directs a variety of initiatives to prevent disease and to promote health.

Canadians may also purchase private health insurance to supplement the government plans. However, private health insurance in Canada is restricted from offering coverage for services already provided by provincial health plans. Despite these limitations in coverage, increased restrictions of Medicare have led many Canadians to obtain private health insurance.

### A. Origins of National Health Insurance

Before the late 1940s private sources paid for the vast majority of health care in Canada. In 1947 the province of Saskatchewan introduced a public insurance plan to cover the cost of hospital services for its citizens. The federal government introduced a program in 1956 to develop hospital insurance plans in all provinces. In this program, the federal government offered to share with the provinces the costs of hospital and diagnostic services. By 1961 all ten provinces and the two territories in Canada had established public insurance plans that provided universal coverage for at least inpatient hospital care.

In 1962 Saskatchewan introduced public medical insurance to cover services by physicians outside hospitals. The federal government established the comprehensive medical care program, called Medicare, in 1968. By 1972 all of the provincial and territorial health care plans had expanded to cover physicians' services.

### B. Canada Health Act

In 1979 a federal government study found that doctors in some provinces were charging patients an extra fee to supplement the amount they were paid by the government plan. The study determined that these supplemental user fees had created an unequal system that threatened to limit access to health care for low-income citizens. The Canadian Parliament responded to these concerns by passing the Canada Health Act in 1984. This legislation reaffirmed the government's commitment to a universal, comprehensive, and publicly administered health insurance system. Today, the Canada Health Act continues to define the central principles of the Canadian health care system.

Despite general public satisfaction with Canada's health insurance programs, increased health care costs, coupled with declining federal government support have threatened the ability of these programs to meet the country's medical needs. For example, limited public resources for health care often force Canadians to wait a substantial period of time for nonemergency medical treatments. The waiting time to see a medical specialist can be especially long. Some critics of the public health care system believe that better access to private insurance could alleviate many of these problems. These critics have called on the government to encourage further development of private health care options that could supplement the public programs.

## XII. HEALTH INSURANCE IN OTHER COUNTRIES

Germany introduced the first national health insurance program in 1883. Other industrialized countries adopted government-funded health insurance systems in the early 20th century. Most of these programs grew extensively after World War II (1939-1945), but some have always offered more extensive coverage than others.

Many countries—such as Brazil, Mexico, Russia, and Sweden—directly employ physicians who treat patients in government-operated facilities. In other countries—such as Britain, Norway, and Spain—governments pay private physicians who may also practice outside government-funded programs.

Government-funded health insurance systems increasingly offer incentives for people to seek supplementary coverage through private insurance companies. For example, in 1998 China introduced a program designed to guarantee government-sponsored health insurance for all workers, but this program also imposes ceilings on annual reimbursements to insured individuals. To make up for the shortfall in government subsidies, employers that can afford to do so are encouraged by the government to subscribe to supplementary health insurance plans through private companies.

Australia also encourages citizens to join private health plans. The Australian government has long guaranteed basic health insurance for its citizens through its Medicare plan, but many Australians have traditionally chosen to subscribe to more comprehensive private plans. As health care costs rose in the 1980s and 1990s, however, many Australians abandoned private health insurance for Medicare. For example, in 1984 about 50 percent of Australians used the Medicare system, but by 1996 that figure had risen to 67 percent. This increased burden on public funds led to proposals in 1997 for government subsidies for low-income Australians who subscribe to private insurance.

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