Private Health Insurance

Donald W. Light | 2012 | Download PDF

Private health insurance is not as obvious a term as it seems, and for reasons that go to the heart of its purposes and institutional setting. “Insurance” typically refers to charging a small premium from a relatively large population at risk in order to cover, or pay for, unexpected large losses. Automobile insurance against accidents is a classic example. There is usually a *deductible* or uncovered initial amount. The higher the deductible, the lower the premium, because the insurer is therefore not liable for numerous small claims. Much less common in classic insurance is a *co-payment* or proportion of the remaining loss that the insured pays. For example, a €1,000 claim for medical expenses on a health policy with a €500 deductible and 20% copayment would result in the insurer paying €400 and the patient paying €600.

By contrast, health “insurance” (or more accurately health care insurance) is expected to cover nearly everything, not just unexpected large losses; so most health insurance is more like a prepayment subscription for medical services. One would never expect auto insurance to pay for oil changes or the 5,000 mile service, not to mention the expensive 30,000 mile service. Yet if health insurance does not cover preventive tests and measures on our bodies we ask with a sense of outrage, “What kind of health insurer would not pay for prevention?” Of course, there is a classic insurance element in health insurance for the small number of people who incur very high bills and have their costs spread across all policyholders; but health insurance usually covers most routine health care as well, while auto or fire insurance does not.

Further, we expect health insurance to especially cover people with serious health problems or disabilities, while we would question whether auto insurance should cover drivers with serious problems in driving. Unlike most insurance, health insurance is especially for the worst off where large costs are *most* expected. Private health insurance, then, embodies a fundamental contradiction between the corporation wanting to make money by covering fewer losses or reducing the risk of a loss (like insuring middle-aged drivers with a clean record) and being expected to cover everyone for everything, from prevention to organ transplantations.

The word “private” in private health insurance refers to several different distinctions and forms (Maarse, 2006). Generally, it refers to privately held organizations or companies that divide into two different institutional forms: for-profit and non-profit. Some European voluntary health insurance plans and the traditional Blue Cross plans in the United States are non-profit. For-profits differ profoundly because they have to report every three months to investors how much money they are making and how they are planning to make more. Since only ten percent of any population

consumes over 70 percent of all medical expenses, by far the easiest way to make a lot of money to is cover fewer of these people who most need coverage and by delaying or denying bills that patients submit. Thus, private health insurance differs profoundly from social health insurance, based on the solidarity principle that everyone should be covered without actuarial discrimination (Light, 1992; Stone, 1993).

For-profit private health insurers have typically insured healthier groups, which then forces non-profits to follow suit or else go bankrupt by being left with higher risk policy holders. This spiral of covering less risk forced U.S. Blue Cross nonprofits to behave increasingly like for-profits in a competition to see which could cover fewer people most needing coverage. Voluntary private health insurance is ruled by the Inverse Coverage Law: the more one needs coverage for medical bills, the less coverage insurance companies will provide (Light, 1992). Light detailed the documented techniques by which private insurers covered fewer health care needs up front and then paid fewer medical bills once they came in. In the highlighted section below, major ways in which insurance companies in a voluntary competitive market compete are described. These are the techniques that lead to millions of sicker people being denied health insurance in the United States and millions more with health insurance still paying large sums from their household budgets when they have an expensive procedure or drug. For example, a mother will receive bills totally $20,000 in the United States for having a baby, even a healthy one, and even insured mothers willl end up paying about $6,000 in cash for the deductible, co-payments, and charges not covered by their private, voluntary health insurance policy.

Figure 1

Risk Discrimination: Insurer Moral Hazard: Techniques to Minimize Risks Covered, Charge More or Pay Less

Front-end Techniques of Discriminatory Direct Risk Rating

Basic:
Charge higher premiums
Deny coverage altogether
Exclusion clauses for conditions most needing coverage
Redlining entire occupations or industries

Elaborated:
Selective marketing to avoid higher risks
Policy churning (change policy each year)
Within-group exclusion clauses
Renewal underwriting

Techniques of Indirect Risk Rating

Benefit design (to attract some classes and put off others)
Waiting periods (before paying for any existing problem)
Deductibles
Co-payments
Payment or service caps

Techniques to Reduce Claims Paid Once Insured

Claims harassment
-No response, delayed response
-Can't find; send again
-Detail missing or wrong; redo
-Denial of valid claims
– Difficult to read forms; obtuse explanations
-Gotcha Clauses – (e.g. call this number before a procedure)
-Complex procedures, signature protocols, coordination of patient, physician and facility information
-Unwritten rules of procedures and accounting
– Claims "hot potato" (btwn auto and health insurance)
– Exclusion by association (a different problem was affected by an excluded condition, like diabetes)

Phony, fraudulent schemes
Pyramid schemes (take your money and run)

Based on Light, 1992.

"Moral hazard"

The term "moral hazard" has become increasingly prominent in some debates about private health insurance as identifying a core weakness in the idea of insurance. It refers to the risk, from an insurer's point of view, that a policy holder will exploit an insurer through behaviors or misrepresentations that increase the medical bills it has to pay, or by using more medical services than necessary because the insurer is paying the bill. Providers may also do more procedures than necessary. These should be called patient or provider moral hazard to be clear who is causing the hazard. But there is also *insurer moral hazard*, the practices by insurers to pay out less than policy holders have been led to expect, even after taking into account risk selection. These are found in the highlighted section above under "techniques to reduce or delay claims paid out." They include "exclusion by association," when for example a person's cardiac bills are denied because her policy excludes coverage for her diabetes and the insurer claims her heart problems

stem from her diabetes. Outright denial of valid claims has been used by insurers for years, because many lack the will, time and know-how to fight the denial. “Gotcha clauses” are small provisions within policies that provide hidden reasons for not paying claims, like the requirement on page 13 that a policy holder must call a certain number before going to the hospital. No call results in the insurer not paying the hospital bills. These techniques for underpayment are analogous to ways in which patients or providers overcharge. States with strong regulations prohibit most of them; but the incentive of insurers to underpay is much greater than the incentive of the insured to overuse services because millions can be made. There is no evidence that policy holders make themselves sicker or increase their risk by smoking, drinking, or eating in less healthy ways or by behaving more recklessly because they know their medical bills will be paid. Likewise, there is no evidence that drivers drive more recklessly because they are insured – “Why not? I’m insured.” On the other hand, insurers profit handsomely from delaying or refusing to pay for procedures or drugs, or from marketing policies to younger, healthier populations. This can happen even under universal, fair rules, as happened when the major insurer, BUPA, entered the Irish market and drew away younger, healthier policy holders from VHI, a non-profit, quasi-public insurance scheme. BUPA tactics threatened to bankrupt VHI, despite its being a very efficient insurer, and led to a campaign that tightened up the rules to reduce insurer moral hazard (Light, 1998).

Voluntary and mandatory

Voluntary health insurance began when workers at remote sites or doing dangerous work, like coal mining or lumbering, created mutuals, a sharing of medical costs through subscription. These community oriented non-profits did not exhibit the Inverse Coverage Law because they did not seek to maximize profits. Through the 19th century, mutuals played a formative role in the development of health insurance in many countries. Even before Bismarck mandated enrollment for certain classes of workers in 1883, some municipalities and states did. Lloyd George enacted a similar law in 1911 (Roemer, 1991). For profit insurance companies dated back even further to maritime insurance, but they did not enter health insurance until the 1940s, because they thought the cost of medical services was too indeterminate to cover. A ship going down costs a fortune to insure, but it is a defined loss, while who knows what the “loss” might be if one insured a person for medical costs? A partial stroke would result in medical expenses every week for years. Eventually, however, insurance companies realized that even such indeterminate losses had patterns over a population and thus losses could be calculated.

As insurance companies entered the health insurance market, the inherent contradictions described above led most countries to create mandatory rules to prevent companies from not insuring sicker people. Rules include requiring comprehensive coverages, prohibiting loopholes like exclusion clauses for pre-existing conditions, prohibiting companies from not writing insurance for people with serious health conditions, requiring them to renew anyone’s policy (guaranteed

renewal), and limiting discrimination through premium increases or copayments. In short, many countries converted early voluntary sickness funds and mutuals into social health insurance, and others increasingly regulated private health insurers to harness them to the societal purpose of spreading the risk of costly medical procedures. A related development was, and still is, to create a public health insurance scheme to fill in gaps left by private non-profit and for-profit insurers. Thus, one can have countries with combinations of a public health insurance scheme, mandatory social health insurance, and for-profit companies that are restrained or prohibited from competing by covering healthier people or fewer services.

Three different functions

This simple overview becomes much more complicated when one introduces the different functions that for-profit or nonprofit private health insurance may play in a country's health care system. Private insurance may provide *primary coverage*, that is, substitute for social health insurance. The Netherlands uses private insurance in the role. Or, it may provide *supplementary coverage* that tops up regular coverage with quicker service, private rooms, private nursing or additional services. This is the role of private insurance prevalent in the UK, where all policy holders already have coverage through the NHS but want quicker, more complete, and more luxurious medical care. Private policies are limited to primarily acute, elective procedures. These limits can mean that when something goes wrong, there is no coverage so the NHS picks up the bill for repairing the damage. A Kings Fund book recommended that private policies be required to cover procedures plus any post-procedure complications to be fair to both the policy holder and the NHS (Keen et al., 2001).

A third function is *complementary coverage* of services not covered in a national scheme. Thus Medigap policies in the US and private policies in the UK are both supplementary and complementary. Canada's national scheme, Medicare, does not include coverage for outpatient prescription drugs, long-term care and nursing home care, dental services, and services by other providers such as optometrists, physical therapists, psychotherapists, and chiropractors. These constitute about 30 percent of all costs; so Canadian universal health care is not very comprehensive and leaves people at substantial risk. Provinces and private companies offer complementary coverage for these expenses. They have been strictly prohibited from offering top-up or duplicative coverage in the name of equity, though somehow Canadians' fierce defense of equity does not lead them to broaden the national Medicare program to cover all the services above.

Reasons countries like private health insurance

Many developing countries have trouble raising taxes and even more trouble increasing them; so private health insurance seems more palatable than more taxes, even when mandatory (Colombo and Tapay, 2004; Pauly et al., 2009). In

addition, the health insurance is not part of government. Even when it is quasi-public, people prefer it as less politicized and more efficient, though there is no evidence that it is. Yet, private health insurance accounts for only a small percent of coverage in OECD countries, and ten of them have switched from premiums for social health insurance to taxing because it is more equitable, efficient, and helps to hold down costs better (Wagstaff, 2009). If countries cut back on public health and coverages in their mainstream system, private health insurance may play an increasing role.

Many people believe quality is higher through private health insurance, though there is no systematic evidence that clinical outcomes are superior. Private providers are more attentive and take more time in well-appointed offices; but these do not necessarily translate into better outcomes, and private patients may get unnecessary treatments in order to generate more fees. Countries also draw on private health insurance to expand coverage and capacity beyond the public system (Colombo and Tapay, 2004). One can see this in the discrepancy between the percent of the population paying for private health care and the percent of all costs covered. For example, in Canada, 65 percent were covered in 2002, but policies only pay for 11 percent of health care costs. In The Netherlands, 64 percent had supplemental insurance and 28 percent use private health insurance as their primary policy in 2002; but together these pay for only 15 percent of costs.

Another function is to provide a pressure relief valve for greater demands of more affluent sectors. Employers can offer it as a perk for managers. A number of European countries try to make their mainstream system good enough to meet the standards of the upper classes; but they always complain so let them pay more for better services. Other countries regard this approach as a violation of solidarity and equal access. Finally, the rise of managed care as a way to bring the superior managerial skills of the private sector and market discipline to health care meant that private health insurers were regarded as better at containing costs and improving quality. In fact, evidence that private managers or insurers provide clinically superior care or manage costs better is mixed, especially given that the most effective ways to make money are to reduce care or access or coverage (Jasso-Aguilar et al., 2004). Private insurers also “compete” by hiring influential lobbyists and locking in advantages for themselves (for example, see Light, 2001).

In very poor countries, the public health system may be corrupt or antiquated, and taxes are hard to collect. Much health care is paid for out of pocket or through private health insurance schemes. But in many developing countries, public health care worked reasonably well until the World Bank forced them to privatize insurance and facilities (Jasso-Aguilar et al., 2004). In any country, one can use the distinctions and types in this essay as a framework for understanding its use of private health insurance.

Further reading:

A classic written with insight is William A. Glaser, *Health Insurance in Practice: International Variations in Financing, Benefits, and Problems* (Jossey Bass 1991). An excellent overview of functions, benefits, and costs is (Colombo and Tapay 2004). It is one of several working papers on private health insurance at OECD. More recent is (Thomson and Mossialos 2009). Hans Maarse put together an authoritative analysis of private health insurance and services in *Privatisation in European health care: a comparative analysis of eight countries* (Elsevier, 2004). See also his synthesis, (Maarse 2006). Macintosh and Koivusalo have put together a critical collection in Commercialization of Health Care: Global and Local Dynamics and Policy Responses (Palgrave 2005).

References (EndNote Harvard-political science style.)

Colombo, F. Tapay, N. (2004). *Private Health Insurance in OECD Countries: The Benefits and Costs for Individuals and Health Systems*. In OECD Health Working Papers. Paris: OECD.

Jasso-Aguilar, R. Waitzkin, H., Landwehr, A. (2004). Multinational corporations and health care in the United States and Latin America. *Journal of Health and Social Behavior extra issue*, 136-157.

Keen, J., Light, D.W., Mays, N. (2001). *Public-Private Relations in Health Care.* London: The King's Fund.

Light, D.W. (2001). Attempting to make private insurance equitable: the US experience. In *Public-Private Relations in Health Care*, ed. Keen, J., Light, D., Mays, N. London: The King's Fund.

Light, D.W. (1992). The practice and ethics of risk-rated health insurance. *Journal of the American Medical Association* 267, 2503-2508.

Light, D.W. (1998). Keeping competition fair for health insurance: how the Irish beat back risk-rated policies. *American Journal of Public Health,* 88, 745-748.

Maarse, H. (2006). The privatization of health care in Europe: an eight-country analysis. *Journal of Health Politics, Policy and Law*, 31, 981-1014.

Pauly, M., Blavin, F., Mehgan, S. (2009). How private health insurance can work in developing countries. *Health Affairs*, 28(6), 1778-1787.

Roemer, M.I. (1991). *National Health Systems of the World.* New York: Oxford University Press.

Stone, D. (1993). The struggle for the soul of health insurance. *Journal of Health Politics, Policy and Law,* 18(2), 288-317.

Thomson, S. and Mossialos, E. (2009). *Private health insurance in the European*

Union. Brussels: European Commission, Directorate General for Employment, Social Affairs and Equal Opportunities.

Wagstaff, A. (2009). *Social Health Insurance vs Tax-financed health systems – evidence from the OECD*. In World Bank Policy Research Working Papers. Washington DC, WB.