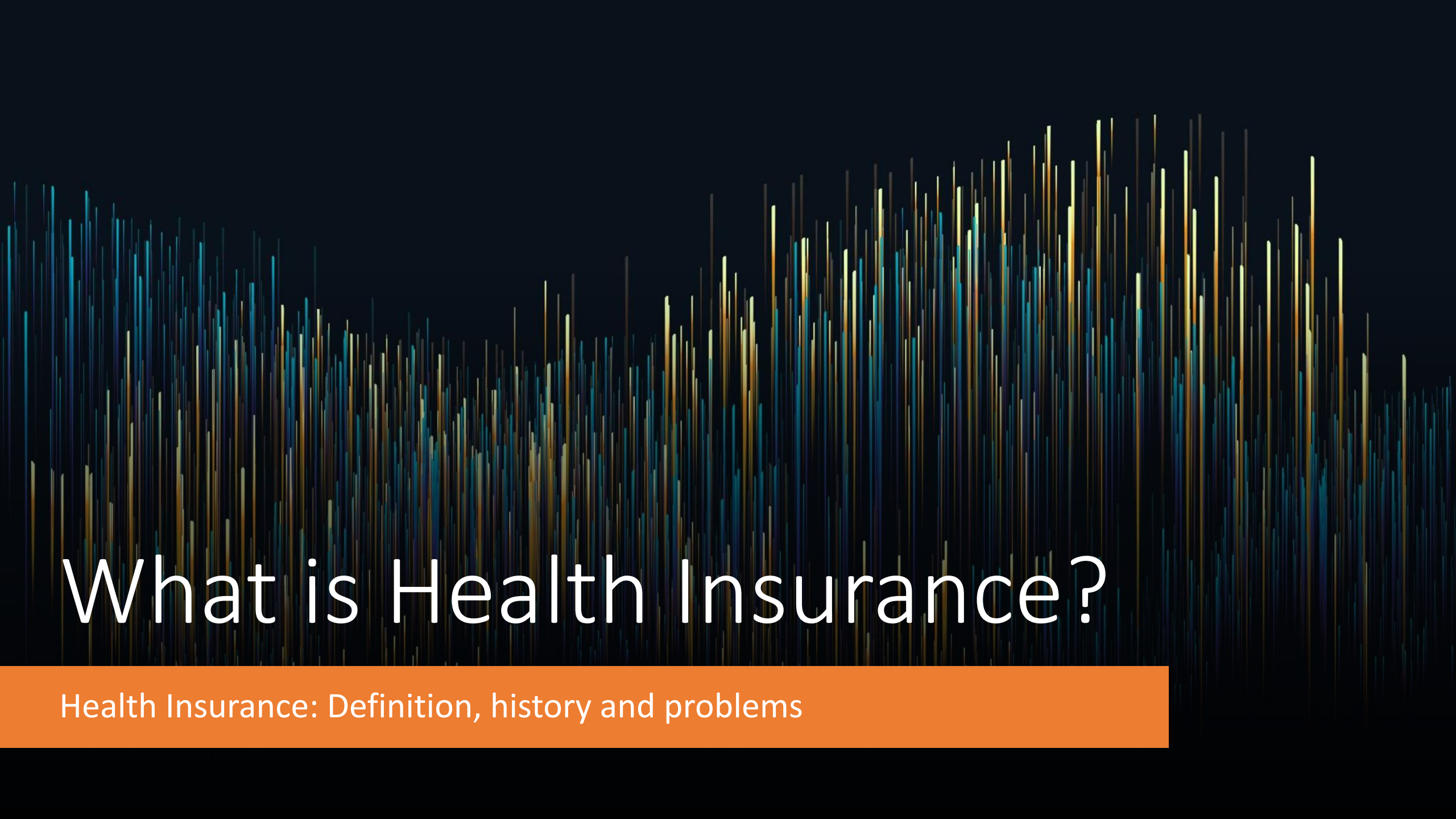


What is Health Insurance?

Health Insurance: Definition, history and problems

What is Insurance?

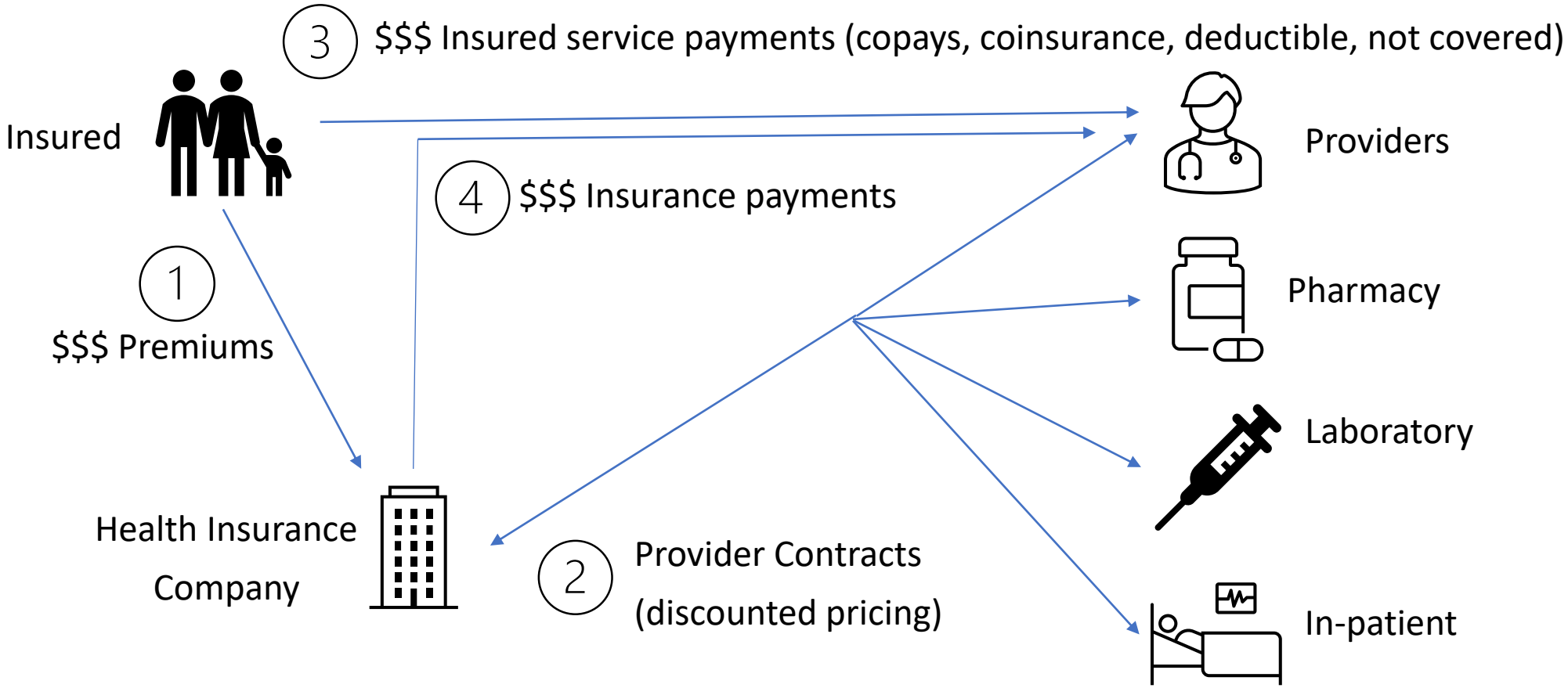
The Definition of Insurance

- Insurance is an agreement between an insurer and an insured in which the insured receives **financial protection** from the insurer for the losses the insured may suffer *under specific circumstances*.
- Three parts:
  - Who (the parties): The insurer and the insured.
  - What (the financial protection): What is being paid.
  - When (the specific circumstances): When is payment required to be paid.
- The agreement to compensate for loss is called “indemnification.”

Health Insurance as Insurance

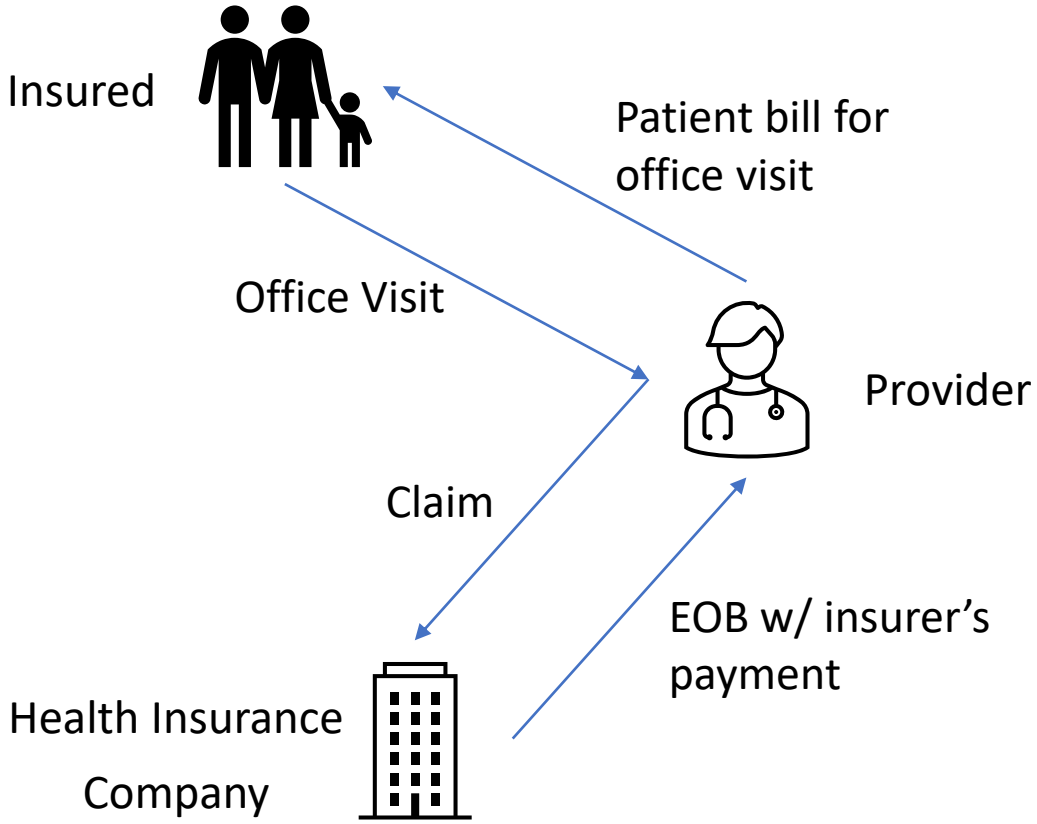
- The insurer is the health insurance company.
- The insured is the patient.
- The financial protection is some payment of health costs.
- The specific circumstances can be:
  - Which services are provided, (some services are not covered).
  - Which providers are seen, (patients required to see “in-network” providers).
  - When services are provided, (some services only provided annually).
  - Have prerequisites for service been met, (prior authorizations, referrals, etc.).

How Insurance Works



Provider Claims

- When the insured sees a contracted provider, the discounted payment is typically split between the insured and the insurer.
- The provider must submit a claim for the insurance company to process, which generates an EOB (explanation of benefit) telling the provider and the patient how much the provider will be paid.
- Provider reimbursement varies based on complexity of service and services provided.



The History of Health Insurance

1900s: The Beginnings…

- Surgical procedures for removing tumors, infected tonsils, appendectomies and gynecological operations introduced.
- Hospitals were transformed from places for the dying to scientific institutions valuing antiseptics, cleanliness and the ability to address pain.
- The modern health care industry began, complete with questions as how to address costs.

The First Insurance: 1929

- Baylor Blue Cross Plan
- Offered coverage for 21 hospital days to Texas school teachers for $6 a year ($110 in today's dollars/$5.23 per hospital day).
- A non-profit with one flat rate without regard to gender, age or health history.
- Traditional insurance companies felt that health insurance was not a viable market.
- Upon Blue Cross' success, traditional carriers introduced rated plans that forced Blue Cross to abandon non-profit.

Employer Plans Start: 1940s and 1950s

- World War II saw health insurance offered to employees to circumvent wage controls.
- From 1940 to 1955, health insurance coverage in the United States grew from less than 10 percent of the population to almost 70 percent.
- In 1954, the tax code was amended to exclude employer contributions to employees' health insurance, which effectively provided a government subsidy to employer-based coverage.

Government Acts and Consolidation: 1960s, 1970s and 1980s

- Medicare and Medicaid were introduced in 1966.
- The federal government championed HMOs in the early seventies as effective alternatives to greater government intervention.
- Corporations began the integration of hospital systems in the 1980s.

The Business of Health Care: 1990s and 2000s

- Hospital systems began to consolidate outpatient physician clinics.
- Health care costs rise dramatically.
- Today's Medicare Advantage structure started in 1997 to promote private administration of Medicare.
- Federal guidelines also changed in 1997 to allow for direct-to-consumer advertising of pharmaceuticals, resulting in a five-fold increase in pharmaceutical advertising through 2004.

Problems with Health Insurance

Problems

Health insurance is complicated.

- Large insurers cover MANY individuals and groups for MANY health conditions with MANY conditions and limitations.
- Providers must follow a cumbersome list of rules for services, including using the “correct” coding for diagnosis and treatment.
- Patients must navigate through in-network and out-of-network providers, which affect copayments, coinsurance and coverage.

Providers are at the end of the food chain.

- Insurers get premiums prior to coverage and insureds get services prior to the provider receiving full payment.
- If anything goes wrong in the claim payment process, the provider is left fighting for payment after premiums have been paid and services provided.

More Problems

Health insurance is unlike other insurance.

- Health cannot be indemnified.
- Getting well is invaluable to patients, but not insurance companies.
- Health insurance is too engrained with health care.
- Imagine how convoluted auto insurance would be if every gas station trip, car wash and wiper blade change was billed through auto insurance.

Health insurance has an inherent conflict.

- Insurers contract with insureds to pay for health care, but insurers are for profit companies.
- The most profitable insurer contracts with the most patients but pays the least amount for claims.

Even More Problems

The healthcare market continues to consolidate.

- While consolidation in healthcare has been pitched as cost effective, consolidation in healthcare has almost always increased costs.
- For example, a procedure performed in a provider's office can be billed more than 300% if the provider is owned by a hospital FOR THE SAME SERVICE.

Increased regulation in healthcare favors a corporate approach.

- Healthcare providers have to deal with HIPAA, OSHA, Medicare Fraud, Waste and Abuse, IT Security and regulations for controlled substances, prescribing, dispensing, etc.

Conclusion

Effective health insurance was always going to be a challenge due to the inability to indemnify health.

Corporate insurers taking profit from the healthcare market further complicates effective health insurance.

While health insurance started as small, self-insured plans, today's health insurance is controlled by corporate entities that drive up costs with little competition.

Patients find themselves with increased costs, decreased coverage and mounting frustration.

Providers find themselves either working for corporate practices that dictate care or for independent practices that are facing decreased reimbursement and increased compliance.