

Why Is Healthcare Insurance Not Provided To The Deprived?

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Over the last few years, it has been observed that individuals who need health insurance have a low chance of buying it as it is only available for people who do not need it. However, the introduction of the Affordable Care Act gave such individuals relief because insurers sold health insurance to any individual who was willing to buy it. To understand why health insurance companies denied insurance coverage for people who were sick and in need of it, the paper discusses private sector markets providing health insurance, factors that determine the insurance premiums, and determinants of health insurance premiums in the private sector.

Different Private Health Insurance Markets

Several private health insurance markets can be considered when answering the issue of the denial of health insurance to an individual who needs it most from insurance companies, as discussed below:

Individual Market

Sometimes, the individual market is referred to as the market of the last resort because of the need where individuals are not allowed to access health insurance coverage. The market does not consider a group of health plans sponsored by employers. In the individual market, the entire premium is paid without considering the benefit of the employer's contribution. It is purchased mainly through the Internet or by a broker.

Employment-Based Insurance Market

It is the most significant health coverage for the private health insurance market. However, the market restricts employees from leaving their jobs, and they are primarily committed to one particular job opportunity. Since they fear that they may lose coverage for preexisting conditions, the situation is referred to as a job lock. According to Kiil (2019), the employment-based market does not help employees qualify for their savings and premium tax credits once they change their jobs. Significantly, the market considers nonelderly people who can do the job who, as the years advance, need health insurance badly as they cannot secure health insurance coverage because they cannot work.

Health Insurance Exchanges Market

This market is an organization in every state where people purchase health insurance. In this market, people buy health insurance complying with Patient Protection and ACA (Affordable Care Act). The market offers different health plans to participate in and provides sufficient information to help them understand the options provided by the organization (Paul, 1995). Significantly, the market is restricted to individuals on the exchange, where the income level is between 133%- 400% of the federal poverty level. In such a scenario, individuals with income levels below 133% and above 400% of the Federal poverty level are restricted from health insurance coverage. For a reason, it is seen why health insurance is denied to people who need it the most.

Determinants of Health Insurance Premiums in the Private Sector

Generally, an employer pays the insurance premiums on behalf of his/her employees. However, the premiums are determined by the claims experience and loading charges in private health insurance coverage. Here is to delve into the details of how premiums are determined in healthcare:

Loading Charge

The determinants account for 15% of private health insurance premiums. The Charge is reflected in the administrative costs, insurance company's profits, and marketing strategies incurred when handling insurance claims. Similarly, the Charge represents the premium section above the expected amount of healthcare expenditure that an insurance company usually pays. In private health insurance, loading charges are built according to the insurance policy, and it covers unanticipated losses, which are higher for individuals prone to health risks. (Paul, 1995)

Claims Experience

The determinant accounts for 85% of private health insurance premiums. It indicates the number of claims submitted by members of the employee group, and it is multiplied by the average cost for each claim. Claims experience is portrayed as the expenditure portion of the premium, and it is referred to as the medical minus ratio. However, the experience-rated premium is determined by claim experience in a specific employee group. (Hopkins & Kidd, 2020)

Meanwhile, increasing coinsurance and deductible rates decreases treatment costs and employees' use of services in hospitals. The determinant shows that similar employee groups may claim experience where one group has lower insurance claims than the other due to lower loading charges. However, in larger groups, more significant claims are offset by premiums from employees who do

not make any claims or make more minor claims. In such a scenario, an insurer must maintain higher reserves and increase loading charges for small groups of employees. (Paul, 1995)

Factors that Determine Insurance Premiums

The factors that exert influence on insurance premiums in the health insurance sector are discussed below:

Adverse selection

This factor indicates that high-risk individuals tend to obtain insurance or have more valuable information than the other negotiating party. An example is when an individual requires a heart plant but has no health insurance. In such a scenario, the insurer bases the claim experience of the person on another person at similar risk or age. The insurer raises the insurance premiums to protect him from adverse selection and avoid such cases. In some instances, insurers examine and analyze individual health status before selling health insurance.

Medical Loss Ratio

This factor is used as an indicator to keep a check on the quality and efficiency of health care. According to Magri et al. (2019), a higher medical loss ratio (MLR) leads to more premium payout in dollars for medical services. In MLR, other factors, such as several cost-containment methods used by insurers, are also considered. In price-competitive health in the insurance market, premiums paid are higher, reducing the market share of an insurance company. (Paul, 1995)

Community Rating

This factor requires insurers to apply a modified form of community rating to determine the premiums. For instance, premiums paid under each health plan vary according to age, family status, and state geography. ACA requires premium difference to be medium (neither greater nor less than actual cost differences).

In conclusion, the information presented shows that people who get insurance are the ones who do not need it. Based on the discussion about different private health insurance markets, it has been shown that people who get insurance are already employed. Meanwhile, such people may not need insurance, but they are forced to do so by insurance markets. The determinants and factors for insurance premiums provide evidence that insurance requires individuals with claims experience and loading charges, which are not typical for unemployed people due to low incomes.

References

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