



**Congressional
Research Service**

Informing the legislative debate since 1914

Private Health Insurance: A Primer

April 18, 2023

Congressional Research Service

<https://crsreports.congress.gov>

R47507



Private Health Insurance: A Primer

In general, a health insurance plan is an agreement that a plan enrollee will pay specified amounts in return for coverage of certain health care benefits (often, as furnished by certain health care providers). Private health insurance—offered by private-sector insurance companies and/or sponsored by employers and other entities, such as unions—is the most common form of health coverage in the United States.

Knowledge of various core concepts (e.g., how plans are obtained and financed, how different types of plans are regulated) may help Members of Congress understand the current private health insurance system and inform their consideration of potential impacts of any legislation aimed at modifying this system. This report explains these core concepts and highlights significant intersections between them (e.g., between premiums and other plan features).

Private health insurance coverage involves numerous stakeholders, including consumers, employers and other group plan sponsors, insurers, the federal and state governments, and health care providers. Their roles are interrelated and complex. For example, consumers and/or employers may pay insurers for *coverage*; consumers and/or insurers then pay providers for health *care* benefits as they are furnished. The federal government has several roles, including regulating private health insurance and providing tax benefits related to private health insurance.

Consumers with private health insurance generally obtain their coverage through either, or occasionally both, of the following sources: an employment setting (*group plans*) or directly from an insurer (*nongroup plans*). Group plans may be *fully insured* or *self-insured*, and fully insured plans may be purchased in the *large-group* or *small-group markets*. The *nongroup market* (also called the *individual market*) and the small-group market include plans sold on and off the *health insurance exchanges*. The report discusses these terms and other terminology used to distinguish plans.

Private health insurance plans are subject to federal and/or state requirements. Federal requirements on private health coverage may apply to large-group, small-group, self-insured, and/or nongroup plans. The Departments of Health and Human Services, Labor, and the Treasury have overlapping jurisdiction over private health insurance and coordinate implementation efforts with respect to private health insurance requirements. State-level private health insurance requirements may apply to large-group, small-group, and nongroup plans but generally do not apply to self-insured group plans.

Common features of private health insurance plans are premiums, covered benefits, cost-sharing requirements, and provider networks. In each of these areas, specific details (e.g., required cost-sharing amounts) may vary across plans, subject to federal and state requirements.

- A *premium* is the price consumers and others (e.g., employers) pay to obtain health coverage. Since a given premium is the price for coverage, that amount reflects plan features such as covered benefits, cost-sharing requirements, and provider networks.
- *Covered benefits* are the health services (e.g., physician visits, surgeries) and items (e.g., prescription drugs) that a plan will help enrollees pay for.
- *Cost-sharing requirements* (or *out-of-pocket costs*) are the amounts consumers pay their providers as consumers use their covered benefits. Private health plans generally include the following cost-sharing requirements: *deductibles*, *coinsurance*, and *co-payments*, up to *annual out-of-pocket limits*.
- Most plans have a *provider network*, which refers to a set of health care providers and facilities that the insurer has contracted with to furnish covered benefits to enrollees of the insurer's plan(s) in return for negotiated payments. For an enrollee, coverage and cost sharing for benefits may be contingent on the benefits being provided by an *in-network provider* (as opposed to an *out-of-network provider*).

Appendixes in this report provide information on risk (i.e., the likelihood and magnitude of financial loss), which is a core concept underlying insurance, as well as data on enrollment and premiums for certain types of group and nongroup plans.

R47507

April 18, 2023

Vanessa C. Forsberg,
Coordinator
Analyst in Health Care
Financing

Ryan J. Rosso
Analyst in Health Care
Financing

Bernadette Fernandez
Specialist in Health Care
Financing

Contents

Introduction	1
Private Health Insurance Overview	1
Private Health Insurance Stakeholders and Roles	2
Types of Private Health Insurance Plans	2
Common Features of Private Health Insurance Plans	4
Premiums	4
Covered Benefits	4
Cost-Sharing Requirements	5
Provider Networks	7
Obtaining and Financing Private Health Insurance Coverage	8
Group Plans	8
Nongroup Plans	9
Federal and State Regulation of Private Health Insurance	10
Plan Types for Purposes of Private Health Insurance Regulation	10
Federal and State Regulatory Roles	11

Figures

Figure A-1. Private Health Insurance Enrollment, by Selected Plan Types, 2013-2022	14
--	----

Tables

Table 1. Types of Enrollee Cost Sharing for Covered Benefits in Private Health Insurance Plans	6
--	---

Appendixes

Appendix A. Private Health Insurance Enrollment and Premium Data	13
Appendix B. Health Insurance Risk	17

Contacts

Author Information	19
--------------------------	----

Introduction

The predominant form of health coverage in the United States is, and historically has been, private health insurance. Americans generally obtain private health insurance coverage through either—or occasionally both—of the following sources: an employment setting (*group plans*) or directly from an insurer (*nongroup plans*). See **Appendix A** for private health insurance enrollment data.

Congress frequently considers legislation aimed at modifying the current health insurance system. A knowledge of various core topics related to private health insurance may help in assessing the potential impact of such proposals. These topics include common types of plans, key features of plans (e.g., premiums, cost sharing), how consumers obtain and finance plans, and how the federal and state governments regulate plans. This report discusses these topics and provides other information on private health insurance, including on different types of private health insurance stakeholders (e.g., consumers, employers), the concept of risk, and enrollment and premium data.

This report focuses on plans offered by private-sector employers and plans sold by private health insurers directly to consumers. This includes health insurance offered through the federal and state health exchanges (also known as *marketplaces*). Although governmental employers also may offer private health insurance, this report does not focus on such plans.¹

This report also does not address public programs such as Medicare and Medicaid, which are health coverage programs administered by the federal and/or state governments for eligible individuals. Some beneficiaries in public programs obtain their coverage through commercial insurers contracted by those programs (e.g., Medicare Advantage, Medicaid managed care plans), but such plans and programs are not private health insurance.²

A companion to this report is CRS Report R45146, *Federal Requirements on Private Health Insurance Plans*, which describes federal statutory requirements related to the topics explained below (e.g., premiums, covered benefits) as well as other topics (e.g., price transparency).

Private Health Insurance Overview

Generally, a health insurance plan is an agreement that a plan enrollee will pay specified amounts in return for coverage of certain health care benefits (often, as furnished by certain health care providers).

Because the need and cost for future health services cannot be perfectly predicted, consumers seek health insurance to obtain financial protection against future expenses. By obtaining insurance, a given consumer transfers part of the risk of future health expenses to the insurer. This risk transfer means an insurer has accepted responsibility for covering some portion of future health care costs for the consumers enrolled in its health plans. Consumers and insurers each

¹ For information about plans for governmental employees, see CRS Report R43922, *Federal Employees Health Benefits (FEHB) Program: An Overview*; the section on self-insured, nonfederal governmental plans in CRS Report R46003, *Applicability of Federal Requirements to Selected Health Coverage Arrangements*; and the section on congressional member and staff coverage in CRS Report R44065, *Overview of Health Insurance Exchanges*.

² For information about these programs, see CRS Report R40425, *Medicare Primer*, and CRS Report R43357, *Medicaid: An Overview*. Some TRICARE plans also may be offered through the private sector, as discussed in CRS Report R45399, *Military Medical Care: Frequently Asked Questions*.

continue to hold some risk under insurance, which still may lead to financial loss. For a discussion of insurance risk in the context of health care, see **Appendix B**.

Private Health Insurance Stakeholders and Roles

The private health insurance landscape involves numerous stakeholders and interrelationships. This includes, but is not limited to, the following examples:

- *Consumers*, or *enrollees* (both individuals and families), obtain health insurance coverage to help pay for routine and unexpected health services.³
- Most *group plan sponsors* are *employers*, which offer and usually subsidize health benefits to attract and retain employees. Other entities (e.g., unions) also may sponsor coverage.
- *Insurers* sell insurance plans through which they help pay for enrollee health benefits,⁴ in return for premium amounts collected, with the objective of operating a viable business.⁵ Insurers set the terms and conditions of their plans, subject to applicable requirements.
- *Federal and state governments* have overlapping, but not uniform, authority to regulate private coverage (e.g., by imposing solvency, consumer protection, and other types of requirements), administer health insurance exchanges, and provide tax benefits related to private health insurance.
- *Health care providers* furnish benefits (i.e., health care services and items) to enrollees in return for payments, with the objective of operating a viable business. Plan and/or enrollee payments to providers depend, in part, on whether the furnished benefits are covered by the enrollee's plan. *Providers* include individual practitioners, such as physicians; facilities, such as hospitals; and other entities, such as pharmacies and labs.⁶
- Other types of stakeholders also are relevant to the private health insurance landscape. For example, drug manufacturers and medical equipment companies produce and supply health care items (e.g., prescription drugs, insulin pumps, hearing aids) to health care providers or, in some cases, directly to consumers.

Types of Private Health Insurance Plans

With the array of stakeholders and variety of insurance needs, the insurance industry has developed a diverse range of coverage options. Plans may vary in several ways.

One major distinction, including for purposes of federal regulation, is that private health insurance includes *group plans* (largely made up of *employer-sponsored insurance*) and *nongroup plans* (i.e., plans a consumer purchases directly from an insurer). Group plans may be *fully insured* or *self-insured*, and fully insured plans may be purchased in the *large-* or *small-group*

³ In general, this report uses the term *consumers* to include both those seeking coverage and those enrolled in coverage. By contrast, the report uses the term *enrollees* when discussing participants in a plan.

⁴ For simplicity, this report generally uses the term *insurers* to include insurance *carriers*, or *issuers*, and other state-licensed firms.

⁵ Nonprofit organizations also provide health insurance. Even if these organizations do not have a profit motive, they are interested in containing expenses to remain viable.

⁶ Many insurers contract with health care providers to furnish covered benefits to enrollees. Some insurers integrate their insurance functions with their own health care delivery systems.

markets. The nongroup market (also called the *individual market*) and the small-group market include plans sold on and off the *health insurance exchanges*—the individual exchanges and Small Business Health Options Program (SHOP) exchanges, respectively. All of these plan types are discussed further in the “Obtaining and Financing Private Health Insurance Coverage” and “Federal and State Regulation of Private Health Insurance” sections below.

Some terminology distinguishes plans according to certain features. These distinctions generally can apply to both group and nongroup plans. Following are explanations of some terms that commonly appear in policy or trade discussions (this selection of terms is not intended to be comprehensive). See the next section of this report, “Common Features of Private Health Insurance Plans,” for further discussion of general concepts mentioned here, such as provider networks; covered benefits and medical management approaches; and cost sharing, including deductibles.

- Plans may provide *self-only* coverage (i.e., covering only a single enrollee, or *policyholder*) and/or may provide coverage for a policyholder and his or her dependents (i.e., different variations of family plans, including, for example, coverage for a policyholder and spouse).
- Plans vary in terms of how they cover enrollees’ access to providers and services, including through the use of provider networks and medical management approaches. For example, *preferred provider organizations* (PPOs) generally provide coverage for enrollees to see out-of-network providers, whereas *health maintenance organizations* (HMOs) may not.⁷
- *Major medical* plans provide comprehensive health benefits, as compared with *limited benefit* plans. The specific covered benefits may vary across major medical plans.⁸
- Some plans are *high-deductible health plans* (HDHPs; i.e., plans that have higher deductibles than other health insurance plans). When certain requirements are met, HDHPs can be combined with health savings accounts, which are tax-advantaged accounts that individuals can use to save and pay for medical expenses that insurance does not cover.⁹

Health insurance companies also may offer services and products other than private health insurance plans. For example, insurers may offer an administrative services only arrangement (e.g., enrollment and consumer support functions) to plan sponsors that directly finance the health benefits they offer. Insurers also may offer other products and services to employers and other insurers, including management of certain “carve out” benefits, such as prescription drugs;¹⁰ assistance in developing provider networks; and more.

⁷ Definitions of plan types such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs) can vary. See, for example, HealthCare.gov, “Health Insurance Plan and Network Types: HMOs, PPOs, and more,” at <https://www.healthcare.gov/choose-a-plan/plan-types/>. Although HealthCare.gov is a health insurance exchange website, these plan types are not limited to the exchanges.

⁸ One example of a limited benefit plan is an *excepted benefit* plan, such as a dental-only or vision-only plan. For more information on these and other types of plans, see CRS Report R46003, *Applicability of Federal Requirements to Selected Health Coverage Arrangements*.

⁹ For more information on health savings accounts, see CRS Report R45277, *Health Savings Accounts (HSAs)*.

¹⁰ For example, one insurer may contract with another company to separately cover or otherwise manage a set (or carve-out) of its covered benefits, such as its prescription drug or mental health benefits.

Common Features of Private Health Insurance Plans

Most private health insurance plans include premiums, covered benefits, cost-sharing requirements, and provider networks. In each of these areas, specific details (e.g., required cost-sharing amounts) may vary across plans, subject to federal and state requirements.

Federal requirements may apply in each of these areas and may differ by plan type (e.g., large group, small group, self-insured, and nongroup). State requirements also may apply in each of these areas, with regard to the types of plans that states may regulate.¹¹

Premiums

A *premium* is the price consumers and others (e.g., employers) pay to obtain health coverage. Premiums can vary across plan types, by geography, and by other factors. Premium variation also may reflect the roles of the federal and state governments in regulating private health plans. Given all of the factors that affect the calculation of premiums, an average premium provides limited insight into premiums across plans at the national or even state level. However, **Appendix A** discusses certain premium data for group health plans and individual exchange health plans.

Premiums are paid to insurers (see the “Obtaining and Financing Private Health Insurance Coverage” section below).¹² Insurers use premium revenue to pay health care providers, which furnish covered benefits to plan enrollees. Often, providers submit *medical claims* to insurers containing information about the services and items provided and the amount requested for payment. Insurers also use premium revenue to pay for expenses associated with administering the plans, including taxes and fees. In simple terms, premium revenue that exceeds the sum of medical claims and administrative expenses would result in profit; revenue that is insufficient in covering those costs would result in a loss.¹³ Of the various expenses paid using premium revenue, medical claims is the largest component.¹⁴

Because a given premium is the price for coverage, the premium amount reflects plan features such as covered benefits, cost-sharing requirements, and provider networks (see discussions below). As the majority of premium revenue pays for medical claims, the relationship of plan features to potential claims costs may directly affect a given premium. For example, a plan that covers many benefits—which has the potential to lead to numerous medical claims—likely would have a higher premium than a plan that covers few benefits, all else equal.

Covered Benefits

Covered benefits are the health services (e.g., physician visits, surgeries) and items (e.g., prescription drugs) that a plan will help enrollees pay for. Covered benefits may differ by plan, subject to applicable federal and state requirements. For example, most major medical plans

¹¹ See “Federal and State Regulation of Private Health Insurance” in this report.

¹² Technically, insurance premiums are paid to insurers. However, employers and other group plan sponsors may decide to provide health coverage through self-insurance. Under this arrangement, employees may still be required to provide contributions to enroll in a self-insured plan (which may be described to the employee as a “premium”), but such contributions are not insurance premiums, per se. See “Plan Types for Purposes of Private Health Insurance Regulation” for a discussion of self-insured group plans.

¹³ For example, see American Academy of Actuaries, “Premium Setting in the Individual Market,” March 2010, at https://www.actuary.org/sites/default/files/files/publications/premiums_settings_mar2010.pdf.

¹⁴ Jared Ortaliza, Krutika Amin, and Cynthia Cox, “Data Note: 2022 Medical Loss Ratio Rebates,” June 1, 2022, at <https://www.kff.org/private-insurance/issue-brief/data-note-2022-medical-loss-ratio-rebates/>.

cover inpatient hospital stays, but coverage details may vary widely across plans. Common variations include whether and what cost-sharing requirements apply to a given benefit and whether a benefit is covered both in network and out of network. The following sections discuss these concepts. Benefit coverage also can vary in terms of *frequency*, such as a maximum number of hospital days or provider visits covered within a certain time period, or in terms of *setting*, such as inpatient versus outpatient facilities.

Medical management requirements (also called *utilization management requirements*) are another common component of plan design as related to benefit coverage. In general, medical management requirements include different types of standards or processes through which plans aim to ensure appropriate use of covered benefits and to control costs. Examples include the following:

- Some plans require enrollees to obtain *prior authorization* from the plan, or approval of benefit coverage before receiving care (such as a routine hospital stay), as a condition of covering specified benefits.
- Some plans require that primary care physicians provide *referrals* for certain specialty care before the plans will cover such specialty care.
- Before some plans will cover certain benefits (e.g., a certain brand-name drug), the plans may impose a *step therapy* requirement (sometimes called a *fail first* requirement) that an enrollee first try certain other benefits (e.g., a generic version of the drug).

Even without specific medical management requirements such as those described above, a plan's coverage of a given benefit generally will depend on the benefit being deemed *medically necessary* for a given enrollee. Plans may defer to a health care provider's recommended treatment plan as an indication of medical necessity and permit coverage of a benefit for an enrollee. In some cases, plans may conduct reviews of the medical claims that providers submit for payment. If the plan makes a determination that a service or item was not medically necessary, it will deny payment for the service or item.¹⁵

Cost-Sharing Requirements

Whereas premiums are the amounts consumers pay to obtain health coverage from insurers, *cost-sharing requirements* (or *out-of-pocket costs*) are the amounts consumers pay to their providers as consumers use the benefits covered under their plans. Private health plans generally include the following cost-sharing requirements for enrollees: *deductibles*, *coinsurance*, and *co-payments*, up to *annual out-of-pocket limits* (see **Table 1**).¹⁶

In general, for a given benefit, an enrollee may have cost-sharing responsibility for some, all, or none of the payment to the provider. The plan is responsible for the rest of the costs of the covered benefits, in the form of payments to the provider based on medical claims the provider submits to the plan.

Just as plans may vary in their coverage of benefits, plans also may vary in their cost-sharing requirements (overall or with regard to a given benefit), subject to applicable federal and state

¹⁵ If coverage is denied based on medical necessity (or for any other reason), enrollees or providers may choose to appeal. See the "Enrollee Information and Appeals" section of CRS Report R45146, *Federal Requirements on Private Health Insurance Plans*, for more information.

¹⁶ Also see the "Cost-Sharing Requirements" section of CRS Report R45146, *Federal Requirements on Private Health Insurance Plans*, for further information on concepts introduced in this section.

requirements. For example, cost sharing for a given benefit (e.g., a minor procedure) may vary depending on the provider or the setting in which the benefit is furnished (e.g., inpatient or outpatient). In addition, a cost-sharing requirement for a given benefit can include more than one component, such as physician fees, facility fees, and the costs of items provided. A hospital stay, for example, may involve cost-sharing charges for physician services as well as facility fees, among other charges as relevant to benefits provided.

In some cases, including where required by law, plans are named or identified in ways that help differentiate the relative generosity of their coverage. For example, certain plans use metal levels (bronze, silver, gold, and platinum) to indicate their *actuarial value* (AV). AV is an estimate of the “percentage of total average costs of covered benefits” that a plan will pay and thus is the counterpart to average enrollee cost sharing.¹⁷ In other words, the higher the AV percentage (e.g., 90% AV for a platinum plan versus 60% for a bronze plan), the lower the cost sharing for plan enrollees overall. AV is not a measure of plan generosity for an enrolled individual or family, nor is it a measure of premiums or benefits packages.

Table 1. Types of Enrollee Cost Sharing for Covered Benefits in Private Health Insurance Plans

	In General	Additional Details
Deductible	<p>An amount that an enrollee must pay for covered benefits, before the plan’s coverage begins, in a plan year.</p> <p>In general, the enrollee pays 100% of the cost of covered benefits until meeting his or her deductible. These payments add up to the deductible amount.</p>	<p>Some benefits are covered <i>pre-deductible</i>, by law or plan design. For example, even if the deductible has not been met, a plan may cover a primary care visit with a certain co-payment and must cover specified preventive services without cost sharing.</p> <p>Plans may have higher or lower deductibles or none at all. Plans may have an overall deductible and/or separate deductibles for different types of services (e.g., for medical services and for prescription drugs). Certain high-deductible health plans are associated with health savings accounts.</p>
Co-payment and Coinsurance	<p>The share of costs, as a fixed dollar (co-payment) or percentage (coinsurance) amount, that an enrollee pays for covered benefits.</p> <p>For example, an enrollee may have a \$30 co-payment for certain types of office visits and 10% coinsurance for certain surgical procedures. In each case, the plan covers the rest of the covered benefit’s cost.</p>	<p>If a benefit can be furnished by different types of providers or in different settings, co-payments and/or coinsurance may vary, depending on these factors. For example, the co-payment and/or coinsurance for a sick visit may be different if the visit occurs at an emergency department, urgent care facility, or primary care provider’s office.</p>
Out-of-Pocket (OOP) Limit	<p>The total amount that an enrollee may generally pay in cost sharing in a plan year.</p> <p>If an enrollee’s total cost sharing (including deductible, coinsurance, and co-payments) reaches this threshold, the plan generally will pay 100% of the cost of that enrollee’s covered benefits for the rest of the plan year.</p>	<p>Plans may have higher or lower OOP limits and/or separate OOP limits for different types of services, up to an overall federally set maximum.</p>

¹⁷ See the definition of *actuarial value* in the glossary posted on HealthCare.gov at <https://www.healthcare.gov/glossary/actuarial-value/>. Although HealthCare.gov is a health insurance exchange website, this definition is not limited to plans sold on the exchanges.

Source: Congressional Research Service.

Notes: If a consumer is enrolled in a plan with one or more family members (rather than a self-only plan), the plan may include cost-sharing requirements—up to certain limits—for each enrollee, as well as cumulative cost-sharing limits for the covered family member(s). Coverage and cost sharing also may vary for benefits furnished by out-of-network providers.

Provider Networks

Most plans have a *provider network*, which refers to a set of health care providers and facilities that the insurer has contracted with to furnish covered benefits to plan enrollees at specified prices. For each provider where such a contract exists with a particular insurer, that provider is considered part of that insurer’s provider network (i.e., is an *in-network provider*). In instances where such a contract does not exist, the provider is considered an *out-of-network provider*.

As stated above, plans’ coverage of benefits provided to an enrollee may be contingent on the benefits being provided through a provider network (i.e., by an in-network provider). Some plans generally do not cover care furnished by out-of-network providers, subject to federal or state requirements.¹⁸ In those plans, *covered benefits* generally may be furnished only by in-network providers. (In other words, the plan generally would not cover a benefit if received from an out-of-network provider, meaning the enrollee would be responsible for the entire bill.) For plans that cover out-of-network care (in addition to in-network care), cost-sharing requirements (e.g., co-payments) typically differ based on whether the provider is part of the plan’s provider network. In general, cost sharing for a service provided by an in-network provider is lower than cost sharing for the same service provided by an out-of-network provider.

To establish a network, insurers negotiate and establish contracts with hospitals, physicians, provider organizations (e.g., group practices), and other types of providers and facilities (e.g., laboratories). Given the variations in the way contracts may be negotiated, it is possible for a facility to be in network but for certain providers operating within such facility to be out of network.

Insurers establish provider networks to help control costs and to provide plan enrollees with access to quality care. The providers within a plan’s network and/or the size of the network, which federal and state requirements may affect, can play a role in consumer decisions to enroll in such plan. Providers may choose to enter into contracts with insurers and generally agree to charge reduced amounts for care to plan enrollees; in turn, the plan steers enrollees toward the provider, because enrollees pay less to receive benefits from an in-network provider than they would pay to receive similar benefits from an out-of-network provider. In other words, providers typically face a price-volume tradeoff when considering whether to join a provider network.

In short, plans’ use of provider networks, the number and types of providers that plans include in their networks, and plans’ coverage of benefits obtained in- and out-of-network may vary, subject to federal and state requirements.

¹⁸ See the “Health Care Provider Interactions” section of CRS Report R45146, *Federal Requirements on Private Health Insurance Plans*, regarding certain federal requirements regarding care furnished by out-of-network providers.

Obtaining and Financing Private Health Insurance Coverage

Consumers with private coverage generally obtain their coverage through either, or occasionally both, of the following sources: an employment setting (group plans) or directly from an insurer (nongroup plans). This section provides additional information on these sources of coverage.

This section also discusses the financing of private coverage. Who pays for coverage depends on the type of plan, if there is a plan sponsor (e.g., an employer that offers health benefits to employees and dependents), and the consumer’s unique circumstances.¹⁹ Typical payers for private coverage include consumers, employers (and other plan sponsors), and/or government.²⁰

Group Plans

Group plans refer to health benefits provided by employers and other entities (e.g., unions, associations) that sponsor such benefits (*plan sponsors*). Eligibility for group coverage is limited to individuals who are part of the group, by virtue of either their own employment or their relationship to an employee (e.g., spouse, to the extent that a sponsor makes the group plan available to family members).

Plan sponsors may provide health benefits directly or through plans sold by insurers.²¹ Small employers—generally, those with up to 50 employees—also may be able to buy plans on their state’s exchange (see text box: “Health Insurance Exchanges”). Plan sponsors purchasing coverage from insurers, including via the small business exchanges, may use agents or brokers to do so. Plan sponsors providing health benefits directly also may use agent or broker services to assist in arranging such benefits.

Payers for group plans generally include employers and employees. Although a health insurance premium typically is the price for a month’s worth of insurance, employee contributions are often deducted from wages on a biweekly basis.²² For those eligible for and enrolled in employer-sponsored coverage, employers typically make contributions that cover most of the premium amount. In 2022, employer contributions covered approximately 83% of premiums for self-only plans and approximately 72% of family plan premiums, on average.²³ Employees cover the remaining share of premiums.²⁴ See **Appendix A** for additional premium data.

¹⁹ This financing discussion concerns paying for private health insurance *coverage* (i.e., paying premiums to insurers), not paying providers for health care benefits obtained by plan enrollees. Regarding the latter, see discussions of plan medical claim payments and consumer cost-sharing payments to providers in the “Common Features of Private Health Insurance Plans” section earlier in this report.

²⁰ Although state and local governments may provide subsidies toward the cost of health insurance, this report solely discusses the federal government’s financing role.

²¹ That is, plan sponsors may *self-insure* their benefits or may purchase a *fully insured* plan, as discussed in “Plan Types for Purposes of Private Health Insurance Regulation.”

²² U.S. Bureau of Labor Statistics, “Length of Pay Periods in the Current Employment Statistics Survey,” updated October 13, 2022, at <https://www.bls.gov/ces/publications/length-pay-period.htm>.

²³ Kaiser Family Foundation (KFF), *2022 Employer Health Benefits Survey*, October 27, 2022, at <https://www.kff.org/health-costs/report/2022-employer-health-benefits-survey/>.

²⁴ *Ibid.* KFF’s survey captures both employee premiums for fully insured plans and employee contributions for self-insured plans under the umbrella term *premiums*.

The federal government also can be considered a payer for group plans, in terms of tax exclusions and other tax policies for employers and employees.²⁵ *Employer* premium contributions are excluded from an employee's gross income and therefore are not subject to income or payroll taxes. As such, workers receive a tax advantage by purchasing coverage through an employer. *Employee* contributions are often made on a tax-advantaged basis through a cafeteria plan, which allows employees to reduce their taxable salary and instead put such money, pretax, toward a qualified benefit.²⁶ The tax exclusion and other tax policies encourage workers to sign up for (*take up*) health coverage within the work setting but result in forgone revenue in terms of the federal budget.²⁷

Nongroup Plans

Instead of obtaining coverage as part of a group (e.g., through an employer), consumers may purchase a health plan for themselves (and their dependents) directly from an insurer. Consumers in this instance purchase insurance from the nongroup market, also called the individual market. The nongroup market is sometimes referred to as a residual market, because it provides coverage options to individuals and families who may not be able to obtain coverage through the workplace (e.g., because their employers do not offer coverage, the consumers are not eligible for their employers' coverage, or the consumers are self-employed) and do not qualify for public programs such as Medicare, Medicaid, or the State Children's Health Insurance Program.

The nongroup market consists of plans sold through the individual exchanges (see text box) and plans sold by insurers outside of the exchanges. Whether a consumer purchases coverage on or off the exchange, he or she may do so directly from an insurer; via an agent or broker; or, in the case of the exchanges, with the help of certain publicly funded assisters.²⁸

Payers for nongroup plans generally include consumers and the government. Enrollees pay the entire premium for nongroup insurance, unless they qualify for subsidies.²⁹ Currently, the federal government provides eligible individuals and families with financial assistance in the form of a tax credit that reduces consumers' spending on premiums for exchange plans.³⁰ As of February 2022, 90% of enrollees in the individual exchanges received advanced payments of the premium tax credit.³¹ See **Appendix A** for additional premium data.

²⁵ For more information on the employer-sponsored health insurance tax exclusion and cafeteria plans, see "Exclusion of Employer Contributions for Health Care, Health Insurance Premiums, and Long-Term Care Insurance Premiums" in CRS Committee Print CP10005, *Tax Expenditures: Compendium of Background Material on Individual Provisions—A Committee Print Prepared for the Senate Committee on the Budget*, 2022.

²⁶ *Ibid.*

²⁷ U.S. Congress, Joint Committee on Taxation, *Estimates of Federal Tax Expenditures for Fiscal Years 2020-2024*, JCX-23-20, November 5, 2020.

²⁸ For a brief discussion of agents, brokers, and other assisters, see CRS Report R44065, *Overview of Health Insurance Exchanges*. This report also includes information relevant to small employers participating in the Small Business Health Options Program (SHOP) exchanges and to consumers and employers purchasing plans outside the exchanges.

²⁹ Consumers and the federal government are the most common payers of nongroup plan premiums, and consumer subsidies are generally for exchange plans only. There are exceptions. For example, charitable organizations or other entities may contribute toward nongroup premiums. There are also different ways that employers can contribute toward employees' nongroup premiums (e.g., through an individual coverage health reimbursement arrangement).

³⁰ See CRS Report R44425, *Health Insurance Premium Tax Credit and Cost-Sharing Reductions*.

³¹ See Table 1 of Centers for Medicare & Medicaid Services (CMS), *Effectuated Enrollment: Early 2022 Snapshot and Full Year 2021 Average*, September 2022, at <https://www.cms.gov/files/document/early-2022-and-full-year-2021-effectuated-enrollment-report.pdf>.

Health Insurance Exchanges

Both nongroup plans and plans sold to small groups may be offered on and off the *health insurance exchanges*. The exchanges are government-run marketplaces that facilitate the purchase of private health insurance plans offered by private health insurers that choose and are certified to participate.

In the individual exchanges, eligible consumers can compare and purchase nongroup plans for themselves and their families. In the Small Business Health Options Program (SHOP) exchanges, small employers can compare and select group plans to offer to their employees. For more information about the exchanges and the plans sold on them, see CRS Report R44065, *Overview of Health Insurance Exchanges*.

Federal and State Regulation of Private Health Insurance

Both the federal and state governments regulate private health insurance. Federal and state requirements may vary by type of plan.

Plan Types for Purposes of Private Health Insurance Regulation

Federal requirements on private health insurance generally are structured to apply to some or all of the following types of plans: fully insured group plans offered by large employers (i.e., *large-group plans*), fully insured group plans offered by small employers (i.e., *small-group plans*), self-insured group plans, and nongroup plans.³² Requirements for the nongroup and small-group plans apply to plans sold on and off the health insurance exchanges.

In general, state regulations also may apply to some or all of the above plan types, except for self-insured group plans.

Fully Insured Group Plans. When group plan sponsors purchase coverage from insurers and offer it to their employees or other groups, these plans are referred to as *fully insured*. The *group market* is divided into segments based on size: the small-group market and the large-group market.

- **Small-Group Plans.** For purposes of federal requirements that apply to the group market, states may elect to define *small groups* or employers as those with 50 or fewer individuals (e.g., employees) or groups with 100 or fewer individuals.
- **Large-Group Plans.** The definition for *large group* builds on the small-group definition. A large group has at least 51 individuals or at least 101 individuals, depending which small-group definition is used in a given state.

³² For example, a requirement on “a group health plan and a health insurance issuer offering group or individual health insurance coverage” would apply to all of these types of plans; a requirement on “a health insurance issuer that offers health insurance coverage in the individual or small group market” would apply only to small-group and nongroup plans. See 42 U.S.C. §300gg-13 and 42 U.S.C. §300gg-6, respectively.

Self-Insured Group Plans. When group plan sponsors provide health benefits directly (instead of purchasing coverage from an insurer), these plans are referred to as *self-insured* or *self-funded*.³³ Employers or other plan sponsors that self-insure set aside funds to pay for health benefits directly,³⁴ and they bear the risk of covering medical expenses generated by the individuals covered under the self-insured plan. Groups of any size may self-insure, and federal requirements on self-insured plans generally do not depend on group size.

Nongroup Plans. As explained above, the nongroup (or individual) market is where consumers may purchase a health plan for themselves and their dependents directly from an insurer (i.e., not through a plan sponsor). For the most part, nongroup plans are fully insured; this report discusses them as such.

Other. Certain types of plans meet a federal definition of health insurance but are exempt from compliance with some or all federal health insurance requirements that otherwise would apply. Such plans include, for example, *grandfathered plans*, *excepted benefit plans*, and *short-term, limited duration insurance*.³⁵

Federal and State Regulatory Roles

States are the primary regulators of insurers, as codified by the 1945 McCarran-Ferguson Act.³⁶ Health plans offered by state-licensed insurers are subject to state health insurance requirements. Such requirements on private health insurance may apply to some or all of the following: fully insured large-group plans, fully insured small-group plans, and nongroup plans. Because self-insured group plans are financed directly by plan sponsors, such plans generally are not subject to state health insurance requirements.

The federal government also regulates state-licensed insurers and the plans they offer.³⁷ Federal health insurance requirements typically follow the model of federalism: federal standards establish a minimum level of requirements (*federal floor*), and states may impose additional requirements on insurers and the plans they offer, provided the state requirements neither conflict with federal law nor prevent the implementation of federal requirements.

In addition, the federal government regulates self-insured plans as part of federal oversight of employment-based benefits. Federal requirements applicable to self-insured plans often are established in tandem with requirements on fully insured plans and state-licensed issuers. Nonetheless, fewer federal requirements overall apply to self-insured plans compared with fully insured plans.

Federal requirements on health plans are primarily codified in three statutes: Title XXVII of the Public Health Service Act (PHSA), Part 7 of the Employee Retirement Income Security Act of 1974 (ERISA), and Chapter 100 of the *Internal Revenue Code* (IRC). Although the health

³³ Although this method for providing health coverage is referred to as *self-insurance*, it is technically not insurance. Instead of an insurer bearing the risk by providing fully insured plans, the plan sponsor bears the risk. For a discussion of risk in health insurance, see **Appendix B**.

³⁴ Set-aside funding is put into a *claim fund* from which medical claims are paid. Plan sponsors may require employees to provide contributions (equivalent to a monthly premium) to enroll in self-insured coverage.

³⁵ For more information on these and other types of plans, see CRS Report R46003, *Applicability of Federal Requirements to Selected Health Coverage Arrangements*.

³⁶ 15 U.S.C. §§1011 et seq.

³⁷ For more information on the federal regulation of private health insurance plans, see CRS Report R45146, *Federal Requirements on Private Health Insurance Plans*.

insurance provisions in these statutes are substantively similar, the differences reflect, in part, each statute’s applicability to private plans. The PHSAs’ provisions apply broadly across private plans, whereas ERISA and the IRC focus primarily on group plans. The Departments of Health and Human Services, Labor, and the Treasury—given their overlapping jurisdiction over private coverage—coordinate implementation efforts with respect to these private health insurance requirements.³⁸

³⁸ With respect to health insurers, the Public Health Service Act (PHSA) allows states to be the primary enforcers of the federal private health insurance requirements, but the Secretary of Health and Human Services assumes this responsibility if the Secretary has determined a state has failed to “substantially enforce” the federal PHSA provisions. For more information on enforcement of private health insurance requirements, see CRS Report R46637, *Federal Private Health Insurance Market Reforms: Legal Framework and Enforcement*.

Appendix A. Private Health Insurance Enrollment and Premium Data

This appendix provides selected data on private health insurance enrollment and private health insurance premiums. In each case, data are provided from sources that allow for particular comparisons (e.g., across plan types).³⁹ Enrollment data are presented by self-insured plans, fully insured plans, and nongroup plans (offered both on and off the health insurance exchanges). Premiums information is presented for group plans generally and for nongroup plans sold on the individual health insurance exchanges.

U.S. Private Health Insurance Enrollment Data

Mark Farrah Associates, which aggregates health insurance data from the National Association of Insurance Commissioners and various other sources, estimated that 189.4 million individuals had private health insurance in the first quarter of 2022.⁴⁰ Most of these enrollees (124.9 million individuals) were covered under a self-insured group plan; 46.5 million individuals were covered under a fully insured group plan (large and small group).⁴¹ A much smaller population (18.0 million individuals) was covered under a nongroup plan, which includes major medical plans offered on and off the health insurance exchanges.⁴²

Overall, private health insurance enrollment has slightly increased over the past decade (**Figure A-1**); the total number of enrollees increased by 4.2 million from the first quarter of 2013 to the first quarter of 2022. Over this period, self-insured group plan enrollment increased by 14.2 million individuals, fully insured group plan enrollment decreased by 15.5 million, and nongroup plan enrollment increased by 5.5 million.

Various factors may have contributed to these changes over time. For example, the rates of employers offering different types of health insurance (i.e., fully insured plans and/or self-insured plans) have fluctuated over time, as have the rates of employees working for employers offering different types of health insurance. In addition, the establishment of the health insurance exchanges and corresponding financial assistance created incentives for eligible individuals to purchase nongroup health insurance.⁴³ Changes in private health insurance enrollment also may relate to broader demographic and economic factors, such as changes in overall population, changes in workforce participation, and consumers' eligibility for coverage through public programs such as Medicare or Medicaid.

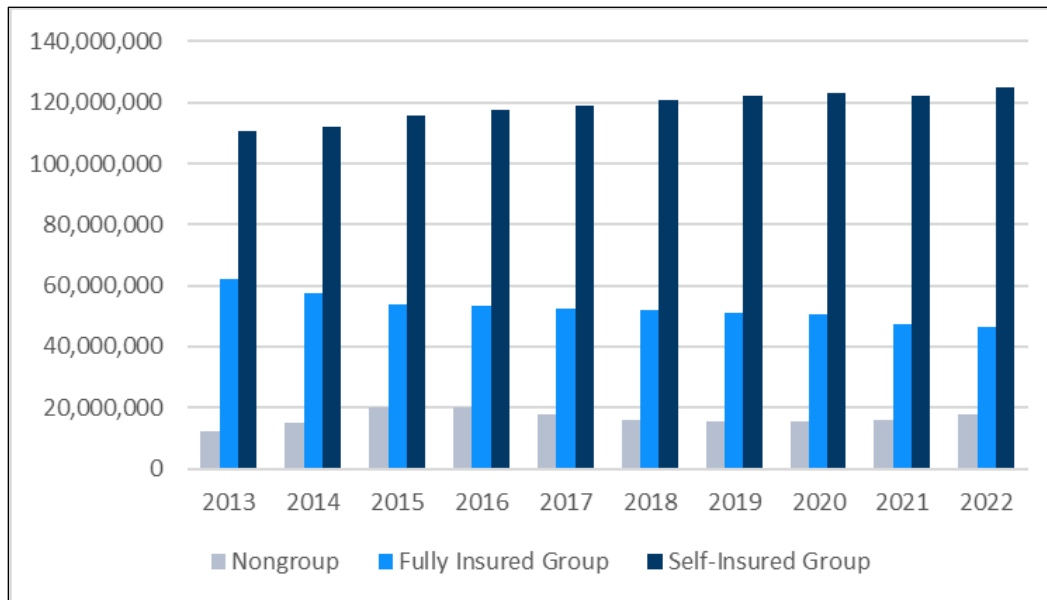
³⁹ Other resources may provide different estimates than shown here, using different data sources and/or methods. See, for example, CRS In Focus IF10830, *U.S. Health Care Coverage and Spending*, which includes estimates of group and nongroup private health insurance enrollment as compared with other types of enrollment, based on certain U.S. Census Bureau data. Also see federal estimates of health insurance exchange enrollment, premiums, and other data compiled in CRS Report R46638, *Health Insurance Exchanges: Sources for Statistics*. Caution should be used when comparing private health insurance estimates from different resources, given potential variations in data sources and methodologies.

⁴⁰ Mark Farrah Associates, "Health Coverage Portal," accessed February 22, 2023, at <https://www.markfarrah.com/>.

⁴¹ This data source does not differentiate large-group and small-group enrollment.

⁴² This data source distinguishes enrollment for individual major medical plans and other types of nongroup plans, such as short-term, limited-duration and limited-benefit plans. See "Types of Private Health Insurance Plans" in this report for additional discussion of certain plan variations.

⁴³ See Agency for Healthcare Research and Quality (AHRQ), Exhibits 1.7 and 1.8, in *Medical Expenditure Panel Survey Insurance Component Chartbook 2021*, AHRQ Publication No. 22(23)-0056, October 2022, pp. 34-35, at https://meps.ahrq.gov/data_files/publications/cb26/cb26.pdf.

Figure A-1. Private Health Insurance Enrollment, by Selected Plan Types, 2013-2022

Source: Congressional Research Service analysis of Mark Farrah Associates data, available by subscription at Health Coverage Portal, <https://www.markfarrah.com/>. Accessed February 22, 2023.

Notes: Enrollment is associated with the first quarter of a given calendar year. **Nongroup** enrollment includes major medical plans offered on and off the health insurance exchanges. **Fully insured group** enrollment includes large-group and small-group private-sector plans. **Self-insured group** enrollment includes private-sector plans. See “Obtaining and Financing Private Health Insurance Coverage” and “Federal and State Regulation of Private Health Insurance” for discussion of plan types.

U.S. Private Health Insurance Premium Data

Different estimates of average premiums can provide useful contextual and trend information on such private health insurance costs,⁴⁴ but actual plan premiums depend, in part, on plan design. Caution should be used in comparing average premiums across plan types, or across different geographical areas, given potential variations in plans that would affect premiums. This includes plan variations due to applicable federal and state requirements. In addition, the group plan and individual exchange premium estimates below are calculated in different ways, which limits their comparability.

Group Health Plan Premiums

The Kaiser Family Foundation (KFF) conducts an annual survey of private and nonfederal public employers with three or more employees, and this survey provides group health plan premium data.⁴⁵ According to the survey, in 2022, the average annual premium for covered employees with

⁴⁴ As explained earlier in this report, other types of private health insurance costs include the out-of-pocket costs that plan enrollees pay providers and the medical claim payments that plans pay providers as enrollees use covered benefits in a plan.

⁴⁵ Group health plan premium data in this section are from Gary Claxton et al., *Employer Health Benefits 2022 Annual Survey*, Kaiser Family Foundation (KFF), October 2022, at <https://www.kff.org/health-costs/report/2022-employer-health-benefits-survey/>. See Figures 1.10, 1.11, 1.12, 1.12, 6.1, 6.4, and 6.5. Also see the KFF report for additional data and for data source and methodology details.

self-only coverage was \$7,911 and the average annual premium for covered employees with family coverage was \$22,463. These amounts represent total premiums, including both employees' and employers' contributions. Average health insurance premiums have increased since 1999, with average family coverage premiums growing at a faster rate than those for self-only coverage.⁴⁶

The distribution of health insurance premiums among covered employees is also notable. In 2022, approximately 17% of covered employees with self-only coverage were enrolled in a plan with a premium below \$6,000 and approximately 25% were enrolled in a plan with a premium of at least \$9,000. With respect to family coverage in 2022, approximately 26% of covered employees with family coverage were enrolled in a plan with a premium below \$19,000 and approximately 21% were enrolled in a plan with a premium of at least \$26,500.

As stated earlier, it is common for employers to subsidize the premiums of the plans they sponsor.⁴⁷ In 2022, KFF estimated that for the average annual premium for covered workers with self-only coverage (\$7,911), employers contributed an average 83% (\$6,584) and covered employees contributed an average 17% (\$1,327). Covered employees contributed more for family coverage. In 2022, for the average annual premium for covered workers with family coverage (\$22,463), employers contributed an average 72% (\$16,357) and employees contributed an average 28% (\$6,106). The percentage of premiums paid by covered workers generally has been stable since 1999, though, as noted, average health insurance premiums have increased overall.⁴⁸

Premiums for Nongroup Plans on the Individual Exchanges⁴⁹

In the individual exchanges nationwide, per preliminary estimates from the Centers for Medicare & Medicaid Services (CMS), the average total premium per month was \$586.56 for plan selections made as of February 2022.⁵⁰ This amount consists of the total premiums for the month, including amounts paid by enrollees and any subsidy amounts, divided by total enrollees for the month.⁵¹ This average amount has varied—but increased overall—since first published in 2017.

Note that actual consumer premiums may vary widely based on numerous factors. Such factors include a consumer's plan selection, the factors by which an insurer is permitted to vary premiums (i.e., consumer age, tobacco use, individual versus family enrollment, and geography), and consumer eligibility for subsidies.

⁴⁶ The data relied on for this statement were not adjusted for inflation.

⁴⁷ See "Group Plans" in the "Obtaining and Financing Private Health Insurance Coverage" section of this report.

⁴⁸ The data relied on for this statement were not adjusted for inflation.

⁴⁹ Medical loss ratio data can be used to calculate an average nongroup premium for the entire market. For example, Milliman calculated an earned premium, on a per member per month basis, for the nongroup market for 2020. See Figure 2 in Milliman, *Commercial Health Insurance: Detailed 2020 Financial Results and Emerging 2021 Trends*, July 11, 2022, at https://www.milliman.com/-/media/milliman/pdfs/2022-articles/7-18-22_commercial-health-insurance-2020-financial-result.ashx. However, this report focuses on marketplace premiums.

⁵⁰ Centers for Medicare & Medicaid Services (CMS), "Effectuated Enrollment: Early 2022 Snapshot and Full Year 2021 Average," September 2022, at <https://www.cms.gov/files/document/early-2022-and-full-year-2021-effectuated-enrollment-report.pdf>.

⁵¹ This or a similar definition of *average total premium per month* is provided in the CMS Effectuated Enrollment Snapshot each year, all of which are listed in Table 2 in CRS Report R46638, *Health Insurance Exchanges: Sources for Statistics*. See, for example, the 2018 snapshot or the spreadsheet accompanying the 2022 snapshot.

As estimated by CMS regarding plan selections as of February 2022, most individual exchange enrollees (90%) received a federal subsidy (premium tax credit, or PTC) to lower their premium costs. Consumers' PTC amounts depend on several factors, including income, family size, and the cost of plans in their areas.⁵² Early year estimates regarding PTC eligibility or amounts, and regarding average total premiums, may be subsequently revised.⁵³

⁵² For more information on premium tax credit (PTC) calculations and amounts and for certain PTC data, see CRS Report R44425, *Health Insurance Premium Tax Credit and Cost-Sharing Reductions*.

⁵³ When consumers file their tax returns for a given year, the amount of advance subsidy payments they received in that tax year is reconciled with the amount they should have received. See CRS Report R44425, *Health Insurance Premium Tax Credit and Cost-Sharing Reductions*.

Appendix B. Health Insurance Risk

The concept underlying insurance is *risk*—that is, the likelihood and magnitude of financial loss. Given the uncertainty of costs and spending in the future, risk forms the context for insurance.

Under any type of insurance, involved parties seek to minimize their own risk. An individual (or family) seeks health insurance to protect against financial losses resulting from the future use of health care. By obtaining insurance, a consumer transfers part of his or her risk to an insurer—an entity licensed by a state to sell and issue insurance policies in that state. This transfer of risk means an insurer has accepted responsibility for covering some portion of future health care costs for the consumers enrolled in its health plans, in accordance with the terms and conditions of those plans. Just as consumers purchase insurance to protect themselves from financial loss, insurers employ strategies to predict and manage risk. Such strategies are major drivers of insurance arrangements.

Premiums and the Transfer of Risk

A premium is the price consumers (and other payers, such as employers) pay insurers to obtain health coverage. An insurer accepts risk from a consumer in exchange for a premium. An insurer uses the premium amounts collected (*premium revenue*) from plan enrollees (and entities that provide premium contributions, such as employers) to pay medical claims for health care services and items furnished to enrollees. In addition to paying claims for covered benefits, insurers may have negotiated the prices for such benefits with certain providers (i.e., in-network providers), which can result in lower prices compared with what they would have been without negotiation. These insurer activities may reduce a given consumer’s overall out-of-pocket spending on health care compared with what he or she would have spent without insurance.

The payment and collection of premiums come with their own risks for consumers and insurers. Consumers generally must pay premiums to obtain coverage (with exceptions for certain individuals who qualify for full subsidies) regardless of how much or little health care they actually use. A consumer who needs (or seeks) very little or no health care may find the total sum of paid premiums exceeds the minimal cost for the few services the consumer received. However, a risk-averse consumer still may consider insurance valuable regardless of his or her actual use of health care; for such a consumer, insurance’s value is in the transfer of risk to an insurer to cover a portion of potential health costs. In contrast, a consumer who needs many health services or items (or expensive services or items) may find that the insurer’s payment of medical claims and negotiation of lower prices is worth the amount the consumer must pay toward premiums.

The fundamental risk to an insurer is that total premium revenue is insufficient to cover medical claims and the expenses associated with administering the plan, leading to financial loss. Given this risk, insurers employ various methods (in compliance with applicable federal and state law) to manage the risk they bear with the objective of running a profitable business.⁵⁴ Medical management is one such method that insurers commonly use to manage risk.⁵⁵

⁵⁴ Nonprofit organizations also provide health insurance. Even if such organizations do not have a profit motive, they nonetheless are interested in containing expenses to remain viable.

⁵⁵ See the “Covered Benefits” section of this report, which includes discussion of medical management techniques.

Risk Pools and Premium Setting

Insurers set the premiums they charge for their plans. A given premium amount accounts for various factors (e.g., amount, duration, and scope of covered benefits) and incorporates the insurer’s estimates of future medical claims and administrative expenses.

Fundamental to the premium calculation is consideration of the applicable *risk pool* (i.e., the “group of individuals whose estimated medical costs are combined to calculate premiums”⁵⁶). A risk pool may be determined based on the entity seeking coverage (e.g., a large firm offering health benefits to its employees and their dependents), according to applicable law, or based on other factors.⁵⁷

Both the composition and the size of a risk pool are important considerations for calculating premiums.

To understand the importance of composition to calculate premiums, it is helpful to consider the function of insurance, which is to spread costs across plan enrollees. The proportion of high to low spenders in a given risk pool directly affects the extent to which the pool can subsidize the higher-than-average costs of relatively sicker enrollees with the premium revenue collected from healthier enrollees. There is a long-standing observation that a small percentage of health care consumers account for the majority of spending in a given year.⁵⁸ From the insurer perspective, a favorable risk pool would consist mostly of low spenders, allowing the remaining premium revenue collected from such enrollees to be spent on the higher medical claims generated by a few high spenders. As the percentage of high spenders in a pool increases, it adversely affects the ability of low spenders in the pool to subsidize the costs of the additional higher spenders. If an insurer estimates future medical claims and administrative expenses to be less than actual claims and expenses (i.e., assumes a healthier risk pool), then total premium revenue may not cover those costs. Conversely, a risk pool with very few high spenders (relative to estimates) would more likely be able to cover the claims and administrative expenses generated by the plan enrollees.

Because the higher health care costs for a few enrollees are spread over a group, the size of the pool affects the level of risk that the insurer bears. In general, the more enrollees in a risk pool, the less likely that a few enrollees’ high claims costs will result in catastrophic financial loss for the insurer. For this reason, insuring larger groups is considered less risky for an insurer, all else equal.

Enrollment Considerations and Adverse Selection

A consumer’s decision to enroll (or not enroll) in health coverage reflects various factors specific to the individual (or family), including health status, estimated need for future medical care, risk aversion, disposable income, and access to subsidies (e.g., employer premium contributions and government subsidies). Individuals who expect to use many health services are more likely to obtain coverage in the first place and to seek out coverage with richer benefits than individuals

⁵⁶ American Academy of Actuaries, “Risk Pooling: How Health Insurance in the Individual Market Works,” July 2017, p. 1, at <https://www.actuary.org/sites/default/files/files/publications/RiskPoolingFAQ071417.pdf>.

⁵⁷ As an example of applicable law, insurers offering plans in the nongroup and small-group markets are subject to a *single risk pool* requirement. For more information, see CRS Report R45146, *Federal Requirements on Private Health Insurance Plans*.

⁵⁸ Emily M. Mitchell, “Statistical Brief #540: Concentration of Healthcare Expenditures and Selected Characteristics of Persons with High Expenses, U.S. Civilian Noninstitutionalized Population, 2019,” February 2022, at https://www.meps.ahrq.gov/data_files/publications/st540/stat540.shtml.

with few medical needs. This phenomenon, known as *adverse selection*, results in an enrollee population that is sicker than the general population and consequently generates higher-than-average medical claims. Because of the higher costs associated with adverse selection, an insurer may increase premiums to cover those costs.

The addition of low-risk individuals to the risk pool can counter the effects of adverse selection. Employer-provided health benefits help accomplish this aim by incentivizing broad participation in health coverage. Typically, employers offer health benefits for employee recruitment and retention purposes, but a generous employer subsidy for such coverage affects consumer enrollment decisions, which in turn affect the risk pool. Generally, employers that offer health benefits cover a majority of the premium amount.⁵⁹ This generous subsidy increases the appeal of coverage even for those who do not anticipate much use of covered benefits, prompting the addition of low-risk individuals to the risk pool. Adding low-risk individuals helps keep premiums more affordable and stable for all individuals in the risk pool.⁶⁰

Author Information

Vanessa C. Forsberg, Coordinator
Analyst in Health Care Financing

Bernadette Fernandez
Specialist in Health Care Financing

Ryan J. Rosso
Analyst in Health Care Financing

Disclaimer

This document was prepared by the Congressional Research Service (CRS). CRS serves as nonpartisan shared staff to congressional committees and Members of Congress. It operates solely at the behest of and under the direction of Congress. Information in a CRS Report should not be relied upon for purposes other than public understanding of information that has been provided by CRS to Members of Congress in connection with CRS's institutional role. CRS Reports, as a work of the United States Government, are not subject to copyright protection in the United States. Any CRS Report may be reproduced and distributed in its entirety without permission from CRS. However, as a CRS Report may include copyrighted images or material from a third party, you may need to obtain the permission of the copyright holder if you wish to copy or otherwise use copyrighted material.

⁵⁹ See **Appendix A**.

⁶⁰ American Academy of Actuaries, "Wading through Medical Insurance Pools: A Primer," September 2006, at https://www.actuary.org/sites/default/files/files/publications/pools_sep06.pdf. Although some information in this resource is outdated (e.g., regarding certain exclusions of pre-existing condition coverage), see the discussion on page 2 of employer premium subsidies as an "anti-selection" strategy.