

Analyzing the Current State and Challenges in the Economic and Practical Aspects of Private Health Insurance in the United States

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Abstract. The expansion of healthcare insurance coverage in the United States is a multifaceted outcome, achieved through a range of concerted initiatives and strategies. These efforts encompass not only government policies and reforms but also the contributions of various healthcare providers and insurers. However, private insurance, mainly provided by employers, remains the most prevalent form of coverage. Therefore, it is imperative to study the status of private healthcare insurance. This examination aids policymakers in understanding insurance plan specifics and limitations. Additionally, analyzing current trends and challenges, such as escalating costs and competition, offers valuable insights for future policy. The study found that healthcare insurance coverage has seen a general increase in the United States. Short-term trends show growth in both public and private insurance, while long-term preferences lean towards public insurance due to recent pandemics. Private insurance, however, maintains stability. Private insurance still has notable coverage limitations, emphasizing the need for services to be necessary and appropriate, resulting in exclusions, administrative complexities, and high costs. The multi-insurer system in the U.S. leads to duplication and increased operational expenses compared to single-payer systems. Policymakers must adopt effective measures to address these issues and enhance healthcare insurance's affordability and accessibility for the future.

Keywords: Private health insurance, the United States, insurance coverage, limitations, costs.

1. Introduction

In concerted efforts by various stakeholders, the healthcare insurance coverage in the United States has been gradually improving. Generally, the federal government administers a national healthcare insurance program for senior citizens and disabled individuals. Additionally, military personnel and socioeconomically disadvantaged groups receive healthcare subsidies. Moreover, individual states have implemented diverse healthcare insurance plans. Notably, within this diverse landscape of healthcare insurance options, private insurance predominates, offering the widest coverage and primarily provided by employers. The conversation about insurance persists, and it led to a renewed pinnacle of discourse in the wake of unexpected pandemics. The current model of private insurance, as a crucial element in safeguarding public health, requires reevaluation to meet the needs of its beneficiaries. A growing body of literature consistently provides evidence of consumers encounter difficulties when utilizing their health insurance coverage. These difficulties often stem from the fact that their existing private health insurance plans frequently fall short in meeting their healthcare needs and adequately covering their incurred costs [1]. The obstacles become markedly heightened when considering individuals who are classified as the most vulnerable within society, emphasizing their urgent requirement for health insurance that is both comprehensive in coverage and financially accessible [2]. This vulnerable demographic often faces a multitude of socio-economic and health-related disparities, making the availability of affordable and extensive health insurance an imperative component in addressing their unique needs and ensuring equitable access to quality healthcare services. Moreover, the challenge of acquiring insurance plans offering sufficient risk protection is particularly acute for elderly individuals and low-income groups, leading to their often-excessive healthcare expenditures attributed to intricate insurance-related concerns [3, 4].

Additionally, substantial prior research has primarily focused on specific issues within private insurance. For instance, according to a recent survey, many individuals with workplace-provided insurance have reported facing challenges related to healthcare affordability for themselves or a family member in the past year [5]. In conclusion, the private healthcare insurance industry in the United States faces numerous challenges, yet comprehensive analyses of the current state of private insurance are limited, making the present study a valuable contribution.

For government authorities, a thorough examination of the current state of private healthcare insurance is particularly crucial. Such a comprehensive investigation aids in gaining a horizontal understanding of the scope of healthcare services, limitations, and quality standards encompassed in private insurance plans, as well as the commitment to disease prevention, diagnosis, treatment, and post-recovery care. Concurrently, the private healthcare insurance industry continues to evolve. Scrutinizing contemporary trends and addressing prevalent challenges, including rising costs, limitations, competitive dynamics, and more, not only contributes to anticipatory insights for future transformations but also provides valuable guidance for policymakers and corporate entities.

2. Current Private Health Insurance Status

2.1. Changes in the Percentage of Private Health Insurance Enrollment

The report, encompassing data from January to June 2022, reveals a noteworthy trend wherein a substantial majority of individuals (61.4%), spanning all age groups, possessed private health insurance coverage during the time of the survey. Specifically, adults between the ages of 18 and 64 exhibited the highest prevalence of private coverage, trailed by children aged 0 to 17 years, and finally, adults aged 65 and above [6]. This data not only highlights the significant role of private health insurance during this period but also sheds light on the trends observed in private health insurance coverage among adults aged 18-64 over the course of multiple years. To view the statistics from a shorter term, there has been a positive trend in reducing the uninsured rate for this age group, with the percentage of uninsured individuals decreasing from 13.5% in 2021 to 12.1% in the first half of 2022 [6]. This decline suggests that efforts to enhance accessibility to private health insurance or alternative coverage options may have played a role in improving healthcare access for adults aged 18-64. The percentage of adults aged 18-64 with public coverage remained relatively stable, showing a minor increase from 21.7% in 2021 to 21.8% in the first half of 2022. Additionally, a slight upward shift was observed in the percentage of adults with private health insurance coverage. Specifically, this proportion increased from 66.6% in 2021 to 68.1% in the first half of 2022 [6]. Although this increase is not statistically significant, it does indicate a positive trajectory for private coverage. This may be influenced by factors such as an improved economic landscape or more accessible private insurance options. More specifically, the relatively short-term increase in private insurance coverage from 2021 to 2022 could be attributed to the economic recovery observed after the impact of the COVID-19 pandemic [7]. As companies regained financial stability, they likely found themselves in a better position to extend private insurance coverage to more of their employees. Moreover, increased hiring activity could have led to a larger workforce eligible for such coverage, consequently contributing to the rise in private coverage percentages.

Taking a longer-term perspective, analyzing the trend from 2019 to the first half of 2022 unveils a more comprehensive narrative. Over this period, the uninsured rate among adults aged 18-64 demonstrated a consistent decline, dropping from 14.7% in 2019 to 12.1% in the first half of 2022. Furthermore, the percentage of adults aged 18-64 with public coverage exhibited an upward trajectory from 20.4% in 2019 to 21.8% in the first half of 2022[6]. This indicates that government-sponsored health programs have effectively provided coverage for an increasing proportion of the population within this age group. Nevertheless, it's noteworthy that the data reveals a different pattern in private coverage percentages when comparing the longer timeframe from 2019 to the first half of 2022, as opposed to the shorter period observed. The discovered trend of the pronounced increase in public coverage and the stable nature of private coverage between 2019 and 2022 can indeed be linked to

the global pandemic and its widespread economic implications. The tumultuous economic climate brought on by the COVID-19 crisis resulted in substantial job losses, business closures, and financial instability. Consequently, individuals might have turned to public insurance options, often facilitated by government initiatives, as a safety net during uncertain times. This increase in public coverage could reflect the need for accessible healthcare options among those directly affected by economic hardship. In contrast, the relatively stable private coverage percentages over this period might indicate that private insurance offerings remained consistent even amid economic turbulence. Despite the challenges brought on by the pandemic, companies likely recognized the importance of maintaining employee benefits, including private health insurance, to ensure the overall well-being of their workforce. Nonetheless, the eligibility for all private insurance benefits relies on one's employment status. Over a two-month period from February to April 2020, the unemployment rate surged dramatically from 3.5% to 14.7%. Individuals who acquire insurance either independently or through their employers may encounter the potential of losing their coverage due to factors like layoffs, business closures, or employers ceasing to provide insurance [8].

Overall speaking, the fluctuation in private insurance coverage from 2021 to 2022 can indeed be attributed to the economic recovery and its positive impact on businesses' ability to provide coverage. The rise in public coverage and the stability of private coverage percentages between 2019 and 2022 can largely be attributed to the COVID-19 pandemic's influence on the economy. This leads to the evident inference that individuals incline towards public insurance alternatives when grappling with the aftermath of the pandemic or significant occurrences, indicating a potential avenue where government support can alleviate medical uncertainties. Nonetheless, the unwavering nature of private coverage percentages also underscores companies' commitment to upholding employee benefits even amid trying circumstances.

2.2. The Limitations of Private Insurance Coverage

Private health insurance offers limited coverage, and ascertaining the extent of one's healthcare insurance involves a complex process influenced by various factors. Initially, coverage is determined based on the categories of medical services that are eligible for reimbursement through the insurance plan. Additional criteria are used to further define the coverage. For instance, a criterion might stipulate that services must be provided by a licensed physician or carried out under a physician's explicit directive. Physicians play a central role in determining the scope of health insurance coverage [9]. Furthermore, the coverage is contingent upon the specific settings where medical services occur, including hospitals, emergency rooms, and outpatient facilities.

Most importantly, the coverage is constrained by the principle that payment is provided only for conditions under which specific healthcare services, treatments, or interventions are considered essential and suitable within the context of medical care. Prevention and rehabilitation receive less emphasis, with the focus primarily on diagnosing and treating illnesses and injuries [10]. If certain services are deemed unnecessary or inappropriate by insurance companies, they are explicitly excluded. Additionally, certain categories of services, such as those related to "nervous and mental conditions," are treated differently and may be excluded [10]. Preexisting conditions of policyholders are not covered.

As a result, the major drawback of private insurance is the potential for increased financial burden. Individuals who require medical care falling within the coverage gaps specified by these insurance policies are left responsible for paying for specific medical services.

Insurance reimbursements for medical services, even when covered, are subject to predefined limitations, including restrictions on visit frequency, hospitalization duration, and total claim amounts. Some insurance companies strictly adhere to their approved fee schedules [11], which means that if a doctor's charges exceed this limit, the patient is responsible for the difference. Once deductibles are met and co-insurance is subtracted, insurance payments commence. However, if the insured person's total out-of-pocket expenses for the year reach a specific limit (annual maximum liability), the insurance company may increase the coverage to provide more financial relief.

These limitations and adjustments have a certain impact on the practical effectiveness of insurance. The presence of restrictions and limitations might influence patients' medical decisions, as they need to consider whether they can afford expenses exceeding the limit. Furthermore, the concept of annual maximum liability may encourage some policyholders to seek medical care early in order to reach the maximum limit by the end of the year, thereby obtaining more insurance reimbursements. From a positive standpoint, the concept of annual maximum liability is beneficial for patients' health, as they can access necessary treatments promptly when health issues arise without worrying about bearing high costs beyond the limit. However, from another perspective, this situation might lead to policyholders overutilizing medical resources, especially as the end of the year approaches. This could result in a higher demand for medical services, potentially burdening healthcare institutions and causing resource strains.

Given the intricate interplay of coverage definitions, exclusions, and limitations, insurance coverage standards exhibit significant uncertainty. In such cases, physicians and patients often remain uncertain about coverage until they receive the final bills.

2.3. The Fixed Costs of Private Health Insurance

Numerous factors contribute to the complexity of healthcare administrative expenses in the United States. In comparison to countries like Australia, Canada, Germany, and the Netherlands, private insurance plays a larger role in the U.S. Roughly two-thirds of the total expenses borne by private insurance companies are directed towards functions that contribute to increased costs within private insurance, encompassing activities such as underwriting and marketing [12]. When compared to countries with a single-payer healthcare system, the United States' healthcare system is inherently more expensive. The multi-insurer system in the United States increases operational costs due to duplicated claims-processing and the division of the insured population into smaller groups [13]. Additionally, healthcare providers face elevated sunk costs when verifying eligibility and managing copayments, referrals, and approvals [14]. Moreover, the existence of multiple insurers makes it challenging to implement a lump-sum global budget payment method for hospitals. However, the concept of a global budget payment is a healthcare payment model designed to streamline and simplify the financial aspects of healthcare delivery. In this model, healthcare providers receive a fixed budget or payment for a specific period, such as a year, to cover all patient care expenses within their organization. This payment structure is particularly effective in eliminating the need for extensive billing and detailed cost accounting for individual patients and insurers [12].

Unless the government can control the rising healthcare costs, expanding coverage will face limitations. The reality of cost escalation has constrained the growth of benefits over the past decade. This situation has led to strict regulations, expanded exclusions in healthcare insurance, and reduced reimbursement amounts. In fact, the current situation is moving farther away from the original goal of covering essential services for recovery and maintaining health due to the fundamental issue of costs. To control costs, there are two main approaches. The first approach involves reforming insurance companies and restructuring insurance models based on employment. This restructuring aims to transition our healthcare system towards vertically integrated health plans, unifying various aspects of healthcare services within a single system. The second approach involves directly overseeing healthcare service providers and setting rates for their services. In this approach, the focus is on regulating and managing costs directly related to healthcare services, ensuring controlled and consistent rates charged by providers. Currently, researchers are in a debate between these two approaches. However, regardless of which approach is taken, without addressing the cost issue, genuine improvement in healthcare insurance coverage cannot be achieved [9].

3. Discussion

The overall increase in health insurance coverage is a positive signal that society is progressing and improving. While sudden economic conditions may have slowed the coverage rate of private

insurance, it is still on the rise, indicating a growing emphasis on individual health concerns [15]. For the private health insurance industry, there should also be a proactive response to people's needs and the resolution of existing issues. From a broader perspective, government control of rising healthcare costs is crucial to prevent the continual constriction of private insurance companies' business expansion opportunities, which, if left unchecked, could lead to limitations on insurance coverage that do not align with society's healthcare needs. Policymakers often propose subsidizing employee portions of employer-provided health insurance premiums as a viable strategy in response to these challenges, recognizing that individuals demonstrate price sensitivity in their choices among various health insurance plans [16]. This implies that subsidies might lead some people to choose more expensive plans, potentially increasing healthcare costs.

Apart from the challenges mentioned earlier, limitations in insurance coverage and increased premiums can also result from subjective decisions made by insurance companies, including factors like market dynamics and competition within the health insurance market. Specifically, even for the same health insurance plan, some companies may experience positive profit impacts during certain periods, potentially earning more profits. However, these companies may later face higher insurance rate increases [17]. This suggests that, although they may have profited during a certain period, they later need to increase insurance costs to address additional costs or risks. Additionally, the research indicates that in certain companies and regions where there is less competition or a monopoly of a few health insurance companies, there may be more significant increases in insurance rates [17]. This indicates that health insurance companies have more market power in these regions and can freely raise premiums because patient choices are limited, and they struggle to find more competitive options from other insurance companies. There is no evidence to suggest that high-profit companies face higher premium increases, as they have increased benefits in some aspects [18]. Therefore, these issues may require regulatory and policy interventions to ensure fairness and accessibility in the health insurance market.

This study also has some limitations. For instance, it is primarily based on existing data and literature, limiting its scope to the availability of this data and the range of literature. At the same time, the study is primarily qualitative, relying on literature reviews and conceptual analysis. This may restrict in-depth exploration of quantitative data and statistical relationships, potentially missing some insights that quantitative research could provide.

4. Summary

Overall, in the United States, there has been a general increase in healthcare insurance coverage, albeit with significant variations. In the short term, both forms of insurance have shown an upward trend. However, in the long term, due to the impact of recent years' pandemics, there is a growing preference among the public for public healthcare insurance, while private healthcare insurance maintains a stable trajectory. Private healthcare insurance in the United States has notable coverage limitations due to the core principle that services must be considered necessary and appropriate, leading to exclusions of certain preventive services and more. Challenges in the management and processing of medical services and expenses can also influence patients' decisions. Furthermore, the high administrative costs in the U.S. private healthcare insurance system are a prominent issue. Compared to countries with single-payer systems, the multi-insurer system in the U.S. results in duplicated claims processing and increased operational costs. Policymakers need to adopt wiser policy measures to ensure that healthcare insurance can comprehensively meet people's needs. From these three points, it is evident that there are several shortcomings in the current U.S. private healthcare insurance system. Therefore, future scholars and policymakers should focus on improving the affordability and accessibility of healthcare insurance.

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