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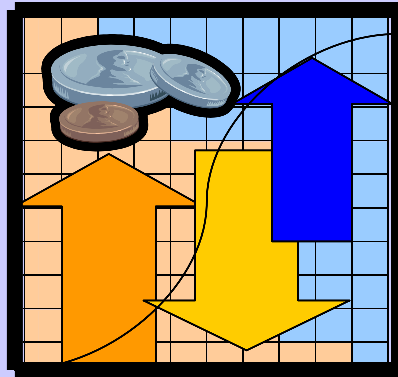

# Regulation Private health insurance to Serve the Public Interest

## Policy Issues for Developing Countries

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# Regulation Private health insurance to Serve the Public Interest

## Policy Issues for Developing Countries

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# I. The Challenge of Managing Private Insurance Markets

Private health insurance accounts for a larger share of health spending in developing countries than is commonly recognized (67). Thirty-eight countries in the world have private health insurance markets which contribute over five percent to total health expenditures; almost half (47 percent) of these are in the low and lower-middle income categories. In some countries, such as Brazil, Chile, Namibia, South Africa and Zimbabwe, private insurance contributes more than 20 percent of total health spending(67). As Figure 1 shows, the role of private health insurance in health financing is not correlated to a country's income level.

The increasing interest in private insurance in developing countries in recent years, is spurred, in part, by the fact that out-of-pocket payment for health services is positively correlated with households incurring catastrophic expenditures(76), and policy makers wish to provide financial protection for their citizens through pre-payment and risk pooling mechanisms. The General Agreement on Trade in Services (GATS) which calls for opening markets in the service sectors including insurance has also stimulated interest in this area.(48;75).

Though private health insurance is one way to provide financial risk protection for health expenditures, insurance markets are subject to a variety of market failures which are compounded in the case of insurance of health services. Evidence from countries with well established private health insurance markets shows that most intervene in the market to protect consumers and promote public health objectives of equity, affordability and access to health services. Through policies, incentives and regulations they essentially "conscript private insurance to serve the public goal of equitable access"(42).

Effectively managing the private health insurance market is particularly important for developing countries in which private coverage may be the only form of financial protection available to the population. To health experts this argues for strong government stewardship of the market and a robust regulatory framework. However, any type of regulation inevitably raises the opportunity for unintended distortions in the efficient functioning of the market and it is worthwhile to discuss the special features of the health insurance market which justify active intervention.

This paper begins by defining private health insurance as it exists today, and discusses the need for a strong regulatory framework. It then provides a model for regulatory policy and highlights interventions to guide policy makers, using country examples.

## A. Methods

This paper is based on a review of selected literature and gathers experiences from a wide range of countries with strong regulatory practices. It also relies on the direct experience of the authors in managing private health insurance plans. Though most of the experiences cited are from high or middle-income nations they provide valuable insight on how to regulate private coverage. We assume a working knowledge of the basic concepts of insurance markets; for more information on how these markets function and glossaries of terms, Abel-Smith(9), Cutler(29), Chollet and Lewis(22) and Söderland (68), among others, provide excellent overviews. PHRplus provides a broad glossary of health financing terms which can be accessed online (10).

This paper is intended as a practical guide for policy makers and does not include a legal framework or attempt a rigorous evaluation of the field. It is also beyond our scope to cover the regulation of health services providers which is a large and diverse area that has been addressed by others(1;4;5;58).

Empirical evidence shows significant variation in the effectiveness of specific interventions based on factors such as the context in which the health insurance market operates, the role that private insurance plays, the history from which private insurers evolved and the policy objectives of the government. Hence, it is difficult to draw definitive conclusions, and the experiences cited should be used as a guide rather than as a scientific evidence base.

## B. What Is Private Health Insurance?

The basic function of heath insurance is to provide "access to care with financial risk protection"(45). Within this function are three sub-components: collection of funds, pooling of funds and purchasing of services.

All types of insurance perform these three functions and there are several ways to distinguish public from private insurance based on how each of these sub-functions is carried out. The definition used in this paper distinguishes private insurance from public insurance based on pooling of funds or the 'financing agent', corresponding to the definition for 'private prepaid plans' used in the system of National Health Accounts (73;74). In this definition, public insurance is funded through taxes, either general or social security taxes, whereas private insurance is provided through the direct payment of premiums to insurers. This category includes voluntary insurance, and mandatory insurance if it is not in the direct control of government; for-profit insurers, non-profit and community based insurers; and insurers providing primary or secondary coverage (primary insurance serves as the main form of risk pooling for those enrolled; while secondary insurance complements cover provided by a publicly funded system)(67). Although this makes regulation challenging, it reflects the reality of the increasingly varied private insurance arrangements found today. A review of insurance arrangements around the world shows that the boundaries between public insurance and private insurance are becoming increasingly blurred. Figure 2 suggests the spectrum of arrangements we find classified along three key dimensions(67):

- Enrolment: whether insurance is mandatory or voluntary;
- Underwriting/pricing: whether contributions are risk-rated (minimal risk transfer), community-rated (transfers between healthy and sick), or income-based (transfers between higher income and lower income individuals);
- Organizational structure: whether management of the scheme is commercial for-profit, private non-profit, or public/quasi-public.

Although private and public insurance are often discussed in terms of extremes, the most common arrangements are actually found in the centre. On the dimension of enrolment, while private insurance tends to be voluntary this is not always the case. In Switzerland and Uruguay the purchase of private cover is mandatory (similar to public insurance systems), whereas in Mexico the new public insurance scheme (known as Seguro Popular) is voluntary (10). In the dimension of pricing, though private insurance premiums have traditionally been risk-rated, increasingly regulators are mandating community rating

which increases risk pooling between the sick and the healthy. Variations are even more pronounced in the organization of insurance schemes. In Australia, India and Ireland for example, the largest “private” insurance companies are publicly owned. This overlapping of private and public features results from active government intervention in the insurance market. Yet private insurance is extensive in countries that have well developed regulatory schemes in part because regulations reflect active and expanding markets, but also because regulation is, paradoxically, necessary for private health insurance markets to grow.

### C. The Need for Policy Intervention in Health Insurance Markets

The case for public intervention in health insurance is based a number of factors, including the rationale for regulating financial institutions in general, market failures specific to health insurance, the public's interest in preserving the health of its citizens and potential policy objectives to address the unequal distribution of income and health risks.(63) Each of these is discussed below.

The need to regulate financial institutions is well recognized. Regulations must correct for systemic risks and instability, and protect consumers from unscrupulous insurers (19;37). Carmichael and Pomerleano in The Development and Regulation of Non-Bank Financial Institutions(19) and the OECD in Insurance and Private Pensions Compendium for Emerging Economies(19;39) provide minimum regulatory requirements for private insurance institutions.

Basic to insurance coverage is the concept of 'insurable risk'. Ideally an insurable risk should be static (i.e. it should not vary significantly over time); losses should be 'accidental' and not within the control of the insured; an individual's exposure to the risk should be unpredictable, but exposures for a population should be predictable; and this should result in prices that are affordable to those who would need coverage against the risk. (56)

Health insurance presents greater complexity. Health risks are not static, they change over time and in the long term, everyone will require health services; exposures to health risks are often in the control of the individual; and medical advances keep changing the definition of the 'risks' that are actually being insured. All this leads to unpredictability in assessing exposures to health risks and the subsequent costs of those risks. In addition to the challenges above, insurance markets are subject to a number of market failures which are well-known to economists and extensively studied in the literature (11;64). Some of these stem from information asymmetry about health risks and costs which leads to adverse selection and risk selection.

Adverse selection occurs because insurers have less information about an individual's health status than the individual. To protect themselves from this unknown risk, they will tend to set insurance premiums above what they otherwise might. In voluntary markets, this will result in healthier individuals not buying health coverage because their cost will be higher than the potential benefits. Sicker individuals will still choose to buy insurance resulting in a higher than expected average level of risk in the insurance pool. Rating methods which are redistributive and promote equity, tend to exacerbate this problem. This will drive insurance prices even higher resulting in greater adverse selection. At the extreme, adverse selection can lead to the collapse of the market.(28) Risk selection (which is also referred to as cream skimming) occurs when insurers try to counter adverse selection or maximize profit by discouraging sicker individuals from

purchasing insurance or by finding ways to insure only lower-risk individuals. Whereas adverse selection leads to rising premiums and a growing concentration of high-risk individuals in an ever decreasing market, risk selection leaves those who are sickest without adequate insurance, even when they are willing to pay for it. Consequently, without public intervention, private health insurance markets will not efficiently match supply to demand. Regulations that can mitigate adverse selection and risk selection include requiring mandatory purchase of coverage, requiring insurers to accept all applicants, limiting exclusions and waiting periods, and implementing risk equalization schemes. The public sector can also subsidize coverage for those at higher risk for ill health through high risk insurance pools and public reinsurance. Approaches to addressing adverse selection and risk selection through policy interventions are discussed below.

Another problem that prevents insurance markets from functioning effectively is the tendency for insured individuals to use more services than if they were not insured. This tendency, called moral hazard, raises the costs of coverage. Co-payments or other forms of cost sharing (deductibles, co-insurance) are often introduced to offset this problem; however, they may work against efforts to minimize financial barriers to getting necessary health care.

In health care the problem of moral hazard is compounded because it can also be practiced by doctors who may over-prescribe medications or order unnecessary services, knowing that the insurer and not the patient will be paying. This supplier-induced demand decreases the affordability of coverage and dampens insurance demand. Insurers may use different provider payment mechanisms – such as capitation and case rates – to provide an incentive for providers to control costs. But introducing such payments may affect the insurer's ability to attract clients or engage providers. These mechanisms may also encourage the provision of poor quality care, potentially requiring consumer protection through quality assurance regulations to avoid under-provision of care.

Beyond the difficulties enumerated above, health insurance has one further characteristic requiring consideration of public action. If left alone, health insurance markets will not provide enough coverage in cases where society values the provision of health care services to all its members beyond the effective demand. Societies may want to ensure greater access to health services when (1) they are considered a merit good – that is, society as a whole values their provision more than any individual member – or (2) they involve externalities – that is, consumption by individuals has effects on others. In the first case, the decision to assure equitable access to care is a political one that reflects social values. In the second case, policies to ensure equitable access may be justified, for example, to reduce the spread of untreated contagious diseases, maintain productivity in workplaces that are affected by absenteeism, or protect hospitals from the costs of treating uninsured individuals. Policy makers can address these concerns in several ways. They can have the government directly produce certain health services – as occurs with public vaccination campaigns or providing dental care in schools; they can directly finance certain health services – by offering to pay for contagious disease testing; and they can mandate that insurers include a core package of health services that are viewed to be in the public interest.

As the above shows, private health insurance markets represent a case where regulation can potentially lead to a better outcome than a laissez-faire approach. However, public

intervention is no panacea for market failures. It has its own associated costs that need to be evaluated relative to its benefits, and regulations that are introduced to address one problem may exacerbate another.

Policy makers must balance the sometimes competing goals of consumer protection and choice, promoting equity, and health services cost containment. Table 3 provides a summary of these key objectives and the potential tools which can be used to address them.

**D. Should Different Forms Of Private Health Coverage Be Regulated Differently?**

In addition to the broader conditions for effective insurance markets, such as contract law, judicial review, labour codes, and financial regulations focusing on solvency and licensing, many developed countries subject health insurance to 'material regulations' addressing the types of policies insurers can sell, how they price policies, arrangements with providers and more(40).

Over-regulation can strangle a market as easily as laissez-faire approaches can undermine the market's capacity to serve public policy goals. The extent to which governments should provide only light regulation of insurers rather than more stringent controls was addressed by the European Commission as a precursor to creating an open market for trade in the European Union (EU). The EU issued a directive that health insurance should only be subject to financial regulations except where a "general good" could be demonstrated(52). It is clear that a "general good" can be demonstrated in policies that provide primary coverage for the population, but in purely supplemental policies the concept of "general good" is less evident. Many developed countries have chosen to regulate secondary insurance more lightly than primary insurance, whereas others apply stringent financial and material regulations to both.

Another aspect of insurance that affects the scope of regulation relates to the boundaries of private health insurance. Third-party indemnity schemes are universally recognized as "insurance", but many other organisational forms that assume health expenditure risks have emerged including HMOs and prepaid plans. Frequently these different forms face different regulations, but as long as they are insuring individuals against the risk of assuming large financial costs for medical care, they are operating in the same market. If public policy fails to encompass all these organisational forms within the same regulatory framework, it will be possible for firms to evade controls by reconstituting themselves within the most weakly regulated segment of the market. Differentiation may also raise costs to consumers by protecting inefficient insurers and leave certain classes of consumers with weaker quality of care or financial solvency protections. In some cases, well-designed regulations will automatically accommodate differences among insurers. For example, reserve requirements can be related to the scale of potential claims and, by implication, the size of the insurer. In other cases, differentiation may be justifiable as a transitional measure – a pragmatic response to markets that are highly segmented, have extremely uneven distributions of providers or where insurance institutions are still incipient.

Of particular concern to developing countries is how to regulate community, mutual or non profit insurers. In an effort to encourage their growth and for a variety of historical and political reasons, these insurers have either been excluded from regulation or been subjected to light regulation through differentiating capital and reserve requirements or exempting them from standards for quality of care or financial disclosure.

However, weak regulation can backfire if such insurers cannot fulfil promises to pay claims or lose credibility over the kind of care they offer. This is illustrated by the case of Colombia, in which the 1993 health reform initially established lower capital and reserve requirements for small cooperative insurers than for commercial for-profit firms to encourage their development. When it became clear that this policy exposed consumers to greater risk (i.e. these small insurers were more likely to have insufficient funds to pay claims) without necessarily improving the supply, equity or efficiency of insurance services, the financial standards were brought into line with those for other segments of the market.

If community insurance schemes are to be eventually integrated into the wider health insurance market, the population will be better served by regulations that equalize their protections with those enjoyed elsewhere. In developed markets, the trend is towards similar regulations for all insurers regardless of scale, ownership or mandate. (55). Regulation in health insurance is justified to achieve public policy objectives or correct specific market failures; when it is designed instead to advance one particular institutional form over another, these objectives tend to be compromised.

## II. Key Regulatory Questions

In developing a regulatory scheme to address the issues noted above, five key questions are proposed which policy makers should address. The questions focus on the interaction of the key actors in the health insurance market: insurers, consumers and providers (Figure 4). As the diagram shows, policy interventions in each of these areas are interrelated and effective regulation must ensure coherence between each area.

1) Who Can Sell Insurance?
2) Who Should be Covered?
3) What Should be Covered?
4) How Can Prices be Set?
5) How Should Providers be Paid?

In most developing countries, private insurance will serve as the primary form of coverage for the population and the discussion below focuses on regulating primary insurance, not secondary policies.

The following sections address each of these questions in greater detail. In each section, areas marked **'Of Particular Importance'** highlight specific policy tools which have shown to be successful in developed markets. Figure 5 provides a summary of the questions.

### 1) Who Can Sell Insurance?

Even the most laissez-faire governments must establish policies regarding what kinds of businesses can be active in financial markets. These policies benefit both clients and firms, offering consumer protection and ensuring a viable insurance market. Policy makers need to answer the following questions in setting these policies:

- What will be the importance of private insurers in the health financing system?

  If they are an important source of financing and will cover large numbers of people, more extensive consumer protections become an important consideration. OECD

countries where private insurance plays an important role often impose more stringent regulations than those where private insurance is a small share of the market(55).

- To what extent is private insurance being encouraged as a way to provide greater choice to consumers or to make the public system more responsive through opt-out provisions?

  If increased consumer choice is a priority, then less regulation may be appropriate. On the other hand, opt-out mechanisms which allow individuals to purchase private coverage with their public contributions require considerable monitoring to prevent a negative impact on the overall health care system.

- How much competition should be encouraged?

  Managing the level of competition is important in emerging markets. Too many insurers make oversight difficult and can threaten the viability of the insurance pool, whereas insufficient competition can negate the benefits of a market.

- How much collaboration should be encouraged among insurers?

  In general, insurers should not be allowed to collude in setting prices or to share information– particularly about clients' health risks. But the insurance market works better when there is transparency in operations and more information is available about general costs and actuarial risks. In setting reporting and disclosure requirements, regulations must strike an appropriate balance between protecting proprietary data and the importance of gathering information about the health needs of the population, utilization of services, and costs

## A. Of particular importance

1. ***Ensuring sound financial condition and solvency*** forms the bedrock of insurance regulation. Insurers need sufficient reserves for reimbursing medical costs and also to cover the time lag between when a potential compensable medical event occurs and when the claim is submitted to the insurer for payment (claims incurred but not received or IBNR). In new markets, insufficient reserve requirements can cause serious problems because rates of utilization are largely unknown, growth in membership continues to increase reserves needed, processes to submit and adjudicate claims may be slow or in development, and provider prices may not be stable. This means that reserve requirements must be set sufficiently high to discourage poorly capitalized insurers from entering the market and must be reviewed annually to ensure continued solvency. However, if requirements are set too high, this will limit the amount of competition in the market

**Box 1: Financial Condition and Solvency**

In 1999 *Lebanon* introduced health insurance legislation to increase solvency requirements to protect the viability of its insurance market and protect consumers. Companies are required to have capital of $800,000 to operate. It is anticipated that this will reduce the number of market players from over 80 to 15-20(35).

Managed care and other plans that selectively contract with providers avoid some of the issues related to processing claims because they require the provider to bill the insurer rather than having the patient pay the provider and then seek reimbursement. Well-structured provider contracts specify billing requirements, timeliness of billing and provider fees thus reducing financial uncertainty. As a result of this, and combined with state guaranty funds for managed care, many states in the *United States* (U.S.) require lower reserves for managed care plans than for indemnity plans. U.S. managed care regulations often contain extensive provider focused quality assurance and access requirements, though this varies by state(17).

and may discourage non-profit and community insurers from participating. One option for countries wanting to increase expansion of community insurers is to provide government guaranty funds and public reinsurance.

2. ***Competition*** promotes consumer choice and innovation and should result in lower costs for purchasers. Uncontrolled competition though can lead to a plethora of small insurers without an adequate membership base to support the risk they are assuming, resulting in unnecessarily high administrative costs, fragmented risk pools, insolvency and consumer confusion. Countries differ in how much competition they choose to foster with some limiting the number of insurers in the market and others fostering a freer market approach.
3. ***Consumer protection*** rules cover disclosure requirements for policies and marketing practices to ensure that buyers understand what they are purchasing. They also include grievance procedures for addressing problems. These rules are distinct from patient protection legislation which governs contracts between insurers and providers. Consumer protection regulations are quite common in developed markets and often build on general consumer protections.
4. ***Opt-out provisions*** have been adopted by some countries wishing to encourage private insurance as an alternative to publicly financed health care, to relieve pressure on the public system, or to make the public system more responsive(22). These provisions allow individuals to redirect their health care related taxes to private insurers. However, whenever people are allowed to opt out of the public system it leads to a differentiation of insurance pools by income and health risk. In general, this means that those remaining in the public system will be poorer and less healthy(12). This can result in a downward spiral in the public system since less money is available to treat these sicker patients. This segmentation can be compensated by explicit risk equalisation and subsidy schemes, but the risk of overloading and under funding the public system may continue to be a problem.

**Box 2: Competition and Consumer Protection**

*Australia's* private insurance market has had very limited competition with the largest private insurer, Medi-Bank, a state-owned scheme. Other insurers have entered in recent years but competition is limited due to Medi-Bank's dominant position(24). Until 1994, *Ireland* had only a state-owned monopoly insurer, VHI, selling private insurance. Although a second private insurer has now entered the market it is still a minority player(25). Both countries are trying to encourage some competition to promote innovation and better pricing.

By contrast, the *U.S.* market is characterised by hundreds of insurers of varying sizes and status. Some are not-for-profit, such as Kaiser Permanente and some of the Blue Cross/Blue Shield plans; others are for-profit, such as Aetna or Prudential, while still others are state-owned such as many county Medicaid insurers. Licensing of health insurers is delegated to the states and only a few insurers are actually national players with a presence in most states. Some smaller insurers were founded by physician or hospital groups and operate in a limited geographic area. The cost to the system of such a plethora of insurers is significant with, administrative costs ranging from 5 percent to 30 percent and the long-term viability of many small insurers at risk(66).

Many *U.S. states* require prior approval of all marketing and enrolment materials. California, among others, has established an independent body to address grievances that can not be resolved through the insurer's grievance procedures(17).

## 2) Who Should be Covered?

Choices regarding who should be covered give policy makers the opportunity to guide the breadth and diversity of the insurance risk pool, the level of participation in the market, and influence how rapidly the market will grow. They also address issues of adverse selection and risk selection. The following key policy questions should be addressed:

- How broadly should coverage be extended? Will private insurance be mandatory or voluntary?

  Though private insurance is traditionally characterised as voluntary, it can be made mandatory for the entire population or for certain segments, such as the formal sector. Mandatory coverage reduces the risk of adverse selection but may be politically unpopular and difficult to enforce in the informal sector.

> Box 3: Opt-out
>
> In *Germany*, those who earn above a certain income, are self-employed, or are civil servants can opt out of the social insurance system and purchase private insurance. To protect its public system, regulations have been introduced that make it very difficult for those who opt-out to re-enter the public system. As a result only 8 percent of the population chooses to purchase private coverage. These are usually individuals in good health or double income couples(34)

- What will be the basis of affiliation with insurers (group vs. individual/family)?

  Group affiliation is preferable because it spreads health risks more evenly across insurers. Grouping by place of employment is common because members are easy to identify and payments are readily linked to earnings. However, affiliation through employment may also limit labour mobility and make it difficult to sustain coverage during economic downturns and high unemployment. Individual/family insurance may be more suitable where a large informal sector exists, but it can also be much more expensive to administer and runs the greatest risk of adverse selection.

- If coverage is voluntary, how can low risk people be encouraged to join the risk pool to cross-subsidise those who are at higher risk for ill health?

  This is a fundamental issue in voluntary markets in which rating methods or other mechanisms to promote equity make it more costly for low risk individuals to purchase coverage. Explicit incentives are often required to encourage broader risk pooling in the market.

- To what extent will private insurance be used to provide coverage for high-risk persons? If private insurers will cover high-risk individuals, how can they be encouraged to do this while protecting the viability of the insurance market?

  It is important to note that no developed country, not even the United States, uses voluntary private insurance to cover the poor or elderly. Other categories of high risk individuals though, may be part of the risk pool and unless there are explicit safeguards for both insurers and individuals these groups will be left without affordable coverage. If high-risk persons are covered by public programs and are not part of the private insurance market, then fewer restrictions may be needed.

**A. Of particular importance:**

1. ***Mandatory coverage*** can, arguably, be justified in health care because most people will use health services at some point and there is societal benefit to an equitable distribution of payments for these services(52). Mandatory coverage can reduce the opportunity for adverse selection and mitigate some of the problems in voluntary markets. In countries that envision private insurance as a path towards a public insurance system, mandatory coverage can be an effective transition mechanism with schemes initially applying to specific groups such as formal sector employees, and later expanding to other parts of the population. In developed countries where private insurance plays a prominent role, or where it is the primary coverage for certain segments of the population, it is either explicitly mandatory or receives such favourable tax incentives that it has become virtually universal.

**Box 4: Coverage Options**

In *Uruguay*, those who fall between certain income bands (between US$600-$1800 annually) are mandated to purchase private cover. This encompasses the working class. Those in higher income brackets can purchase additional voluntary cover(3).

In 2003 *Saudi Arabia* introduced compulsory private health insurance for expatriates. This will be implemented in a 5 phase program and ultimately allow coverage of Saudi nationals as well. The first phase will require employers with over 500 employees to provide private insurance coverage. This will be gradually extended to employers with fewer employees(70).

In *Australia* recent reforms require that those with individual incomes over US$30,000, or families making over US$60,000, purchase private insurance or pay an increased tax of 1 percent of their income (24).

2. ***Group affiliation*** through employers and labour unions has been the historic basis of private insurance in many countries. Generally, in group policies all members pay the same premium regardless of age or health status and most group policies are either mandatory for the whole group or stipulate that a significant portion of the group must enrol. Insurers prefer group insurance because it limits adverse selection and consumers benefit from the stronger purchasing power that employers and labour unions can exert on their behalf. In markets where private insurance plays a dominant role, group coverage is common.

3. ***Incentives for low risk individuals to purchase coverage*** are often necessary in voluntary insurance markets, particularly when rating methods do not allow insurers to set 'actuarially fair' premiums. Most countries with prominent private insurance markets offer tax advantages to those who purchase private cover, but some countries have found that more attractive schemes are needed to encourage those who might not participate in the risk pool, to purchase coverage(42).

**Box 5: Affiliation Options**

In the *U.S.,* the majority of health insurance is sold through employment groups with almost all employers with over 200 employees offering group health insurance as a part of the employment package(42). Large employers in some regions of the U.S. such as the Pacific Business Group on Health and the National Business Group on Health have further consolidated their power by negotiation of insurance coverage on behalf of their members, resulting in increased quality, lower costs and stronger consumer protection(6;7).

Group policies constitute well over 50 percent of total policies sold in *Denmark, Ireland, the Netherlands, Portugal, Sweden and the United Kingdom*(53).

In *Ireland and the Netherlands* employers have been able to encourage portability of health coverage when employees lose or change jobs(53).

The Yashasvini public/private partnership in India has been able to enrol 1.65 million individuals since it started in June 2003 by focusing only on affiliation through farmers associations.(65)

4. ***Insuring high risk individuals*** is often difficult in private markets and many countries use publicly funded schemes to cover these groups(31;55). If high risk persons are to be covered by private insurance, insurers can be required to do this through guaranteed issue and renewal requirements, and protected from adverse selection through subsidised high risk pools, reinsurance, and risk equalisation schemes. Some argue, though, that these types of protections can decrease incentives for insurers to actively monitor utilization of patients and practice prudent cost controls, leading to inefficiency in the system(68). These strategies are discussed

> **Box 6: Incentives to Participate**
> To encourage the purchase of coverage in its shrinking private insurance market, *Australia* instituted legislation in 2000 that provides a 30 percent tax rebate to those who purchase private cover. In addition it has introduced a life time community rating plan in which those who join after 30 years of age pay a premium over base rates for each year they remain uninsured, encouraging people to enter earlier and stay in the risk pool(24)

5. ***below:***

- Guaranteed issue and renewal require that all individuals be offered coverage regardless of health status, and protect those who become sick from having their coverage terminated. Guaranteed issue can apply at all times or to certain periods in the year called "open enrolment" periods(55). These methods are most effective if rating requirements or price ceilings are specified to prevent insurers from charging unaffordable premiums for high-risk individuals. However, they also have the danger of leading to insurer insolvency so they are often coupled with high-risk pools that provide subsidies for insuring high risk individuals, or risk adjustment policies to equalise costs of care among insurers(68)
- Subsidised high risk pools allow individuals with existing and potentially high cost medical conditions to be insured at affordable premiums. The subsidy is financed through general taxes or through levies on insurers.
- Reinsurance protects individual insurers from insolvency by spreading risk among other insurers in the market. Reinsurance can be purchased by an individual insurer through a contract with a reinsurance company that then assumes some portion of its risk, or it can be required by the government and financed through levies on insurers. Reinsurance is common in developed insurance markets.
- Risk adjustment or equalisation systems(23;68;71) are intended to compensate insurers who have enrolled populations with higher than expected health care costs. Mechanisms can be established to create transfers from insurers with lower than expected costs to those with higher than expected costs. The challenge for such mechanisms is to compensate insurers only for the differential in costs associated with the distribution of health risks and not the differential resulting from inefficiency in management.

## 3) What Should Be Covered?

This third set of regulations defines the basic benefits that insurers must offer and addresses societal values around health as a merit good. These requirements are intended to protect consumers from unreasonable exclusions and also address problems with adverse selection and risk selection. Benefit designs also determine how much financial protection will be provided and can control for moral hazard. Key decisions that policy makers must consider in this area are:

> **Box7: Insuring High Risk Individuals**
> Guaranteed issue and renewal are required in *Australia and Ireland* for all private health insurance(24;25).
>
> In the *U.S.*, federal law through the Health insurance Portability Act (HIPAA), requires guaranteed issue in the small group market which is the most volatile, because a group may be as small as two people(20)
>
> The *Netherlands* has created two mechanisms to ensure that high-risk individuals are not excluded from private insurance pools. First, all individuals in the Netherlands are enrolled in a catastrophic insurance fund (AWBZ) which covers high cost and long-term care and provides a safety net for insurers. Secondly, there is a mandatory reinsurance pool to which all insurers must contribute(33;34).
>
> *Australia* has adopted a government sponsored reinsurance scheme that allows funds to be transferred to those insurers who have a greater proportion of individuals who are high utilisers of services(42). In this scheme, those insurers who have a disproportionate share of patients with long hospital stays receive a transfer from those with a lower share of these patients. Because private health insurance in Australia is limited to covering inpatient care, over 50 percent of insurers' medical costs are for these types of patients(24;42).
>
> *South Africa* has analysed the use of high risk pools and risk equalisation schemes to expand coverage to high risk individuals(27;68). Actuarial analyses conclude that high risk pools would be effective to guarantee access while ensuring low premiums(27).

- What benefits, if any, should be mandated?

  Primary insurance often contains a core set of benefits to provide adequate financial protection for those who purchase coverage. These may mirror what a publicly funded package would include. However, mandating benefits increases the costs of basic packages and can make insurance unaffordable for some.

- How important is consumer choice and customisation to meet the needs of different groups?

  If consumer choice is a policy goal, fewer restrictions on benefits may be appropriate. The attractiveness of offering choice needs to be weighed against the confusion and inefficiency that can occur when myriad plans with minor differences are offered. In addition to the difficulties this presents consumers in knowing what they are purchasing, excessive customisation can lead to higher costs associated with administering multiple benefit designs, and create fragmented, unsustainable risk pools.

- What mechanisms will be used to curb unnecessary demand of services from consumers while providing appropriate access to those who need care?

  Consumer induced demand can be addressed through various cost sharing mechanisms, but this must be balanced with ensuring that those who can not afford to share in health care costs still receive needed services.

## A. Of Particular Importance

1. ***Mandating core benefits*** is important if private insurance is intended to be a primary source of coverage for large segments of the population. At a minimum insurance coverage should provide financial protection against significant health expenses. However, the emergence of chronic conditions and the clear benefits of early detection and prevention have resulted in gradual expansion of health insurance packages to cover benefits that would not be considered true insurance arrangements. Standardizing benefit packages or requiring minimum benefits restrains insurers from designing packages to attract only lower risk individuals. But it also limits innovation and the range of plans available in the market; a standard plan may be too costly for some and offer the wrong mix and level of services for others which can limit participation in voluntary markets.

2. ***Limited coverage of pre-existing conditions, contract exclusions and waiting periods*** are stipulated in most policies to discourage adverse selection and keep premiums affordable. But if these restrictions exclude care for more common high cost conditions, little financial protection is provided. Consequently, in many developing countries people may not be able to buy insurance for high cost diseases such as AIDS or cancer, which are often the very conditions for which insurance is most needed. Most developed countries allow exclusions for certain conditions in primary insurance policies but set boundaries on what can be excluded and for what period.

Exclusions and waiting periods can be particularly problematic whenever the insured moves from one plan to another. Regulations that require portability partially mitigate this problem by stating that individuals only face exclusions for pre-existing conditions and waiting periods the first time they enrol. After that, insurers must accept individuals with no waiting periods or exclusions as long as insurance coverage was continuous. Portability of this kind is particularly important where insurance is employment based because it

**Box 8: Benefits Packages**

One insurer in *South Africa*, Discovery Health, has created a unique package that has a premium with two separate components: about two-thirds of the premium pays for the true “insurance” functions and one-third is set aside as a medical savings account to cover the typically “prepaid” portion of insurance coverage. This package has been so successful that Discovery Health is now the second largest insurer in South Africa and is expanding to the U.S. and the U.K.(54).

Most health insurers in the *Netherlands* have voluntarily created insurance packages that mirror social insurance benefits. In addition, the Health Insurance Act mandates a Standard Package that insurers must offer to those who meet certain conditions such as: those who must leave the social insurance program, persons who are uninsured and did not know that they were high risk, those who have recently moved to the Netherlands and were insured elsewhere and the elderly who had previous private insurance. The price of the Standard Package is set at an affordable rate that is below the actual cost requiring mandatory cross subsidies between this plan and other plans offered by insurers(26;34).

*Germany* has a Standard Tariff private insurance package which provides a core set of benefits with premiums pegged to public insurance premiums for those over 55 years of age or with low incomes, who are not eligible for social insurance.(34;42)

In *Australia,* insurers can only cover inpatient care because insurance is intended to relieve the burden on public hospitals. (24;42) In *Belgium* insurers can not cover co-payments in the public system, which are intended to limit over-utilization of services(53).

**Box 9: Coverage Restrictions**

In the *United States*, plans purchased through employer groups sometimes do not impose waiting periods or limit waiting periods to specific conditions such as maternity services. Forty-five of the 50 states have imposed restrictions on the exclusion of pre-existing conditions(42). National legislation (HIPAA) requires uniform waiting periods on pre-existing conditions which, along with other provisions, allow people to change jobs without losing coverage and enable those who lose employment to temporarily retain coverage(61).

In *Germany,* waiting periods are limited to three months for most conditions and eight months for certain conditions such as maternity care, psychotherapy and orthodontics. New-borns and those who transfer from social insurance funds are covered immediately(42).

allows people to change jobs without losing coverage.

3. ***Patient cost sharing*** through mechanisms such as deductibles, co-payments, co-insurance and payment ceilings is generally introduced to discourage excessive service use and keep insurance premiums lower(4). However, co-payments may disproportionately reduce service utilisation among the poor and discourage people from seeking preventive services that would avoid the subsequent need for costly curative care(51). Also, insurance is only effective if it covers a substantial share of health service costs. Many countries have experimented with the appropriate use of these mechanisms to strike a balance between providing effective financial protection and assuring affordable premiums(14;21;47;49;77).

**Box 10: Patient Cost Sharing**

Several studies have found that demand for preventive services is more likely to decrease as a result of co-payments. Since preventive services are relatively inexpensive and can minimise downstream health care costs, some *United States* managed care plans reduce co-payments for pre-natal care, well baby check-ups and screenings.

Several health insurers in the *United States* are implementing differential co-payments to encourage use of higher quality providers. One has developed a matrix of quality and cost measures on which it evaluates providers. Patients who use these providers have lower co-payments than those who use other providers. Another uses measures of physician quality to offer lower co-payments for those who select higher quality providers. Aetna is implementing similar programs(50).

### ***4) How Can Prices be Set?***

Regulating how private companies can price their products is a significant governmental intervention and can have unintended consequences. In health insurance markets pricing policies are particularly difficult to design because there are so many competing objectives: affordability, equity, viability, as well as avoiding adverse selection, risk selection and moral hazard.

Rating policies have a significant impact on equity and guide the extent of risk pooling. They also protect the viability of the market by ensuring that insurers use the same pricing method at least for some of their plans, and thus compete on the same basis. Otherwise some insurers will use risk rated premiums to attract lower risk individuals, while others may attract more than their fair share of the sick, resulting in an unstable market. In setting pricing policies key issues include:

- To what extent is private insurance intended to promote equity through subsidisation between high and low risk individuals, and the rich and the poor?

  In efficient markets insurers will wish to charge “actuarially fair premiums" which are related to the amount of risk the insurer is assuming. Such premiums do not provide the cross-subsidies necessary to ensure equity and can make insurance unaffordable for high-risk populations. Other forms of rating, such as community rating, are more equitable but decrease the attractiveness of coverage for low-risk individuals who are paying more than market value for the services they use.

- Are premiums intended to cover current costs of care (“pay as you go”)(33) or are they intended to provide reserves for future health care expenditures?

  Instability in price of insurance premiums is a particular problem where government intervention on provider prices and utilization of services is minimal. Capital premium setting mechanisms can improve the predictability of premiums because, like life insurance policies, they include a reserve for future costs of health care.

## A. Of Particular Importance

1. ***Methods used to calculate premiums*** have an important effect on equity and affordability. At one end are income-based contributions, more commonly used in social insurance systems, which promote equity by sharing risk across the rich and poor. In private insurance, community rating which imposes a single average premium for all individuals in a region or group promotes solidarity by sharing risk across the healthy and the sick. At the other extreme is risk rating, which charges premiums based on an individual's health risk profile estimated from personal characteristics such as age, gender and behaviours, or actual use of services. Along this spectrum are a range of mixed methods for calculating premiums.

In principle, equity is best served by rating methods which share risks between the healthy and the sick, but unless insurance is mandatory and all insurers are required to use the same rating method, healthier individuals will leave this kind of insurance pool. As a result, premiums will increase for those who remain and threaten the viability of the market.

**Box 11: Setting Premiums**

*Australia and Ireland* require all insurers to community rate premiums even though they provide only supplementary insurance(24;25).

*Chile* has established a mandatory contribution for public insurance coverage equal to a fixed share of earnings. Since individuals can opt out of the public insurance system, higher income individuals can buy private insurance with their mandatory contribution that is unaffordable to others. (12).

*Germany* has adopted a unique system of level lifetime rating which operates like a full life insurance policy in that premiums are calculated based on age, gender and health status when one joins the plan. Premiums are designed to cover current health care costs as well as accumulate reserves to fund health costs associated with old age. Although, in theory, premiums should not increase substantially over time, unanticipated medical cost inflation has resulted in an upward adjustment in recent years. Germany also offers large rebates for those who do not use medical services over defined time periods(34).

Insurers in the *Netherlands* can risk-adjust premiums to a limited extent with the exception of the Standard Package mentioned above. Studies show no difference between for-profit and not-for-profit insurers in how they choose to rate(34).

*South Africa* requires all medical schemes to community rate premiums and has introduced a system of unfunded lifetime community rating which levies penalties on those who become part of the insurance market later in life(43).

Many states in the *United States* mandate community rating or do not permit fully risk rated premiums for small groups (42). Since group insurance is the norm in the United States, community rating for individuals within a group is a common practice. (42) .

### 5) How Should Providers be Paid?

Some would argue that the question of provider payments does not fall under the rubric of insurance regulation. However, purchasing is one of the key subcomponents of financing, and provider payment methods directly address the problems of supplier induced demand. When insurers are passive, as in traditional third party indemnity coverage, there is a tendency for consumers to demand more health care and for providers to induce more health care than might otherwise be justified(13;60;68).

Where passive insurance arrangements have contributed to cost escalation, a variety of active purchasing and risk sharing arrangements between providers and insurers have developed to better align incentives. This has further led to integrated insurer and provider arrangements such as managed care plans where insurers are actively involved in overseeing the care provided to enrolees.

Controlling provider charging practices can also have an effect on the amount of financial protection actually offered through insurance. Some studies show that rather than reducing out-of-pocket spending for consumers, insurance can paradoxically lead to an overall increase in out-of-pocket payments when providers respond by raising their prices to insurers and patients(32).

Policies and regulations governing provider fees are new in many developed insurance markets and interventions cover how providers are paid, how much they are paid, and how care is delivered. Policy questions relevant in this area are:

- What impact will prices in the private sector have on prices in the public system?

  To the extent that the same providers serve both the public and private sectors, cost inflation in the private sector may increase overall prices in the health care system. On the other hand, with effective controls, allowing providers to charge more in private practice can be used to subsidise the public system.

- How can price inflation resulting from insurance be constrained?

  To ensure that insurance actually provides financial protection, provider charging practices can be addressed through public policy as well as through individual insurance contracts.

- How can provider induced demand be reduced while maintaining access and quality? How much risk can be appropriately transferred to providers and how should this be structured?

  Considerable research has been done in the area of provider payment mechanisms and their impact on provider-induced demand. Abel-Smith, Hastings, Laffont, Pauly, Ransom and Stearns (9;36;46;59;62;69), among others, provide useful information on this topic.

- Is consumer choice of providers a key policy objective or will insurers have freedom to practice active purchasing and provider selection?

  Encouraging insurers to strategically purchase from higher quality, cost-effective providers can limit cost escalation, but also restricts freedom of provider choice and can be politically difficult to implement.

- To what extent is the introduction of private insurance intended to foster more coordinated delivery models for care?

  The introduction of private coverage can be used to create incentives for providers to form linkages or vertically integrate, which can improve continuity of care for patients. Managed care plans that do this have been shown to have a positive impact on cost and quality of health care(18;66).

**A. Of particular importance:**

1. ***Provider fee schedules and salaries*** paid by private insurers can be regulated to contain costs, to encourage the provision of particular services, or to encourage competition. If public providers are permitted to augment their incomes through private practice, it may divert staff away from the public system resulting in less access to care for public patients. Establishing a common fee schedule for payment of physicians that applies to both private and public insurers may mitigate this problem. On the other hand, allowing providers to work in private practice without fee regulation can subsidize the public sector by allowing lower public wages.

2. ***Sharing risks and rewards with providers*** and constraining supplier-induced demand may be even more important in controlling costs than strategies aimed at reducing consumer demand. Aligning incentives between payers and providers gives providers a financial stake in the viability of the system. Mechanisms such as global capitation transfer significant amounts of risk from the insurer to the provider. Ensuring that providers can manage this risk and do not become insolvent is an important public policy concern.

3. ***Rules limiting differential pricing and balance billing to patients*** help to ensure that insurance coverage will continue to provide adequate financial protection. These rules mean that providers can not charge insured patients more than uninsured patients and that they can not seek additional payment from patients above what the insurer is paying.

**Box 12: Provider Payments**

The *Netherlands* has a single provider network which serves both publicly and privately funded consumers. Providers are private entities but must negotiate a fee schedule with the government that applies to both their public and private patients(34).

*Germany* regulates fees charged by providers in its social insurance system, but allows providers to charge higher fees to private insurers. This is a conscious attempt to keep social insurance fees low by creating cross-subsidies from private insurers to the public sector. As a consequence, costs per member for private insurance in Germany have increased an average of 40 percent more than equivalent costs for those in the social insurance system(16).

Several studies in the *United States, Norway and Canada* suggest that payment of physicians through salaries results in more check-ups, mammography, immunizations, pap tests and hypertension screening(36). There is also evidence that salaried doctors have lower productivity and over-refer patients to specialists, making the system less cost-effective than it appears(9;15;38;41).

Recent studies in *Denmark and the United States* show that capitation payments decrease the number of procedures and hospitalization rates compared to fee-for-service payments(44;59;62;69).

One of the most positive outcomes of sharing risks and rewards with providers through capitation has been the development of more integrated models of care delivery and disease management in the *United States.* These have been shown to provide less expensive and, in many cases, higher quality care(66)

Summary

Each country must decide to what extent it wants to intervene in the natural functioning of the market based on its public policy goals, health priorities, politics, and culture. As the above examples show, there is strong justification to actively regulate and monitor private insurance. Policy makers should not underestimate the effect of a private insurance market on the publicly funded system. On the negative side, an active private insurance market may drive up prices for publicly funded services, lure providers away from the public system, and generate excessive demand that limits provision of needed medical services. On the positive side, a private insurance market can provide financial protection for some segments of the population, strengthen the health system's institutional capacity, give people greater access to higher quality services, encourage responsiveness by providers, and introduce innovations that promote quality and cost-effectiveness. The key to minimizing the negative tendencies of the market and capitalizing on its potential rests in responsible government stewardship of market forces. Building the capacity to exercise this stewardship effectively is the focus of the next section.

## III. What institutional capacity is required to implement an effective regulatory structure?

Defining the actors, rules and context for the private insurance market is only the first step. No design can work if it is not implemented. If the framework is well designed, it should be easier to implement but the institutional capacity to steer a private insurance market is never simple. It requires skilled people, functioning institutions and good governance. Before discussing the main elements required to develop the institutional capacity to implement efficient and equitable insurance markets several broad points need to be emphasized which relate to three key regulatory constraints faced by policy makers(46). First, developing institutional capacity is not restricted to strengthening a single government office. Steering private insurance markets to serve public policy goals involves many different tasks that do not necessarily have to be done by a single actor. For example, if accreditation of providers is required it can be carried out in a number of

ways: a public agency could be established, a professional association could be charged with the responsibility, or several accreditation firms could be created similar to the way private companies rate bonds or companies that are publicly traded. Similarly, there may be tasks that are better combined under one organization, such as collection, collating and processing different kinds of information, while others might be better separated, such as auditing being in an independent agency.

The second point is the importance of collecting reliable data and information. Regulators cannot function without data on the financial and operational performance of all insurers, public and private, non-profit and for-profit. The collection of data in health also allows policy makers to ensure that both public and private resources are effectively deployed to address the highest disease burden.

The third point is that insurance markets are dynamic. This means that beyond establishing mechanisms for routine monitoring and specialized audits an intelligence capacity is required to investigate, analyse, and solve problems that will arise over time. An advantage of markets, by definition, is that they allow many actors to take independent initiatives to innovate and compete. But this very advantage is also the crux of the difficulty in supervising the market. Regulators always have to stay one step ahead of the people and firms they regulate.

**A. Key Elements in Developing Institutional Capacity**

Organizations do not implement public policy, people do. Therefore, whether they work for the public sector or not, a well-functioning market requires people with a variety of professional skills. A partial list might include accountants, actuaries, data processors and managers, financial analysts, auditors and investigators, medical experts and public health professionals.

To attract qualified people, keep them motivated, and reduce the temptation to serve the interests of insurers over citizens, it is best if the institutions that employ them pay at or above the wages received by people with comparable skills in the private market. If this is difficult, and it is commonly problematic for public institutions ruled by civil service codes, an alternative strategy is to hire promising people early in their careers and seek to instil in them a sense of public service and loyalty. Human resource planning should proceed with the full understanding that there will be a regular flow of staff out of these functions into the private market and they will need to be replenished with new recruits. The tasks that these people will carry out can be grouped into four general categories: legislation and licensing, monitoring, auditing and intelligence.

*Legislation and Licensing* focuses on setting up the legal framework for health insurance and verifies whether insurers who enter the market comply with regulatory requirements(40).

*Monitoring* includes procedures for insurance firms to report financial status, health services utilized by clients, and grievances or conflicts. At a minimum a regulatory entity will require financial information from insurers regarding their reserves, risk categories of their investments and cash flow. Information on utilization patterns, enrolment, claims experience, IBNR and administrative costs is also important and can be used to forecast whether an insurance company might be at risk of failure so that early actions can be taken. Health services information is also required including provider lists; licenses and accreditation certificates to ensure quality; and location of all providers to verify geographic access. Grievances and conflicts will arise and proper procedures must be

established such as internal ombudspersons, arbitration boards, regulatory review, or as a last resort, legal actions. Grievance procedures should include some recourse to outside agencies such as the regulator or a separate medical body to ensure adequate consumer protection. All grievances should be acknowledged and reported on a standard basis and this information should be made publicly available(17;39).

*Auditing* is necessary because insurance markets are decentralized and institutions that are guiding that market must rely heavily on compliance with the reporting requirements enumerated above. In different countries the degree of compliance will vary, but in no country will it be 100 percent. In this regard, regulation of the insurance market shares many of the problems faced by tax administrators. The only way to improve compliance or keep it from deteriorating is to make certain there is a non-trivial risk that non-compliance will be detected and punished.

Two kinds of auditing processes are highly complementary. The first is automatic and focuses on cases that surpass certain significant limits. For example, it may be appropriate to require detailed audits of the largest insurers on a rotating basis or of particularly large financial transactions. The second must be randomized as it assures that every insurer has some risk of being audited and facing potential consequences. If truly randomized, the results of these audits can be used to determine what kinds of abuses may be being practised in the market and how widespread they are.

The role of *intelligence* is critical for adapting to changing market behaviours and adjustments in public policy goals. It requires people and institutions to utilize the information provided by those monitoring and auditing the insurance market and combines this "internal" information with "external" data whether related to the overall condition of financial markets, the degree of insurance market concentration, insurance coverage in the population, or health outcomes. Certain key elements of this steering function should be carried out by a high-level government office because they constitute the essence of policymaking.

**Box 13: Institutional Options**

In *Chile* and *Colombia*, specific public agencies (*Superintendencias*) have been established at the national level and given responsibility to regulate private health insurance agencies. In both cases the regulatory agency has powers to monitor and sanction firms for failure to comply. In general the emphasis has been on financial conditions, solvency, and scale and consumer protection rather than on quality of health care or equity. In recent years this emphasis has begun to shift(22).

*Morocco* has established a regulatory body, the National Health Insurance Agency (ANAM) to coordinate private and public insurers. This body also monitors national contracts between insurers and providers ensuring consistency in prices, data, quality and implementation of best practices(8).

*Uruguay* has an extensive regulatory framework to manage its mandatory private insurance program which covers 60 percent of the population(57). The Ministry of Public Health monitors the operations of for profit institutions while the Ministry of Economy and Finance is responsible for non-profit insurers*(22).*

In *Brazil*, insufficient regulation by the government, led the trade group for prepaid group practice, *Associacao Brasileira de Medicina de Grupo* (ABRAMGE) to create its own regulatory agency. Some of the goals of this regulatory body include providing guidelines to reduce false advertising and fiscal irregularities.(2).

Many states in the *United States,* as well as *Chile's Superintendencia de ISAPRES* use the internet as a form of public dissemination on the costs and quality of insurers(30).

*B. Institutions, Accountability and Governance*

No specific institutional forms are universally preferable because the context within which they will operate is so different. The institutions created and charged with carrying out the various tasks discussed above will vary depending on the type of legal system (e.g. common law,

Napoleonic codes), the degree of market competition, the likelihood of private supply responses to identified functions, the effectiveness of the civil service, and domestic political volatility and institutions.

Regulation of all forms of health insurance, such as indemnity coverage and HMO, is best invested in one agency focusing specifically on health. Regulating health insurers involves ensuring quality and accessibility of services provided, not just financial oversight, and this is best done by a separate health insurance body.
Institutional independence from political interference is a second element in assuring good governance. Examples for assuring institutional integrity can be found in most countries like those that guarantee central bank independence. Arrangements include staggered appointments for agency heads that are longer than the normal terms for elected office and do not coincide with elections. Perhaps more than any other aspects, decisions regarding forms of governance require balancing the benefits of independence. This is achieved mainly by protecting regulators from being "captured" by insurers against the benefits of responsiveness to officeholders and accountability to the public.

Finally, countries need to be openly vigilant regarding the potential for fraud, abuse and corruption. This is not specific to private insurance markets as corrupt practices occur in all kinds of health systems, whether public or private. However, for countries that are dealing with private insurance markets for the first time, provision needs to be made for stemming the emergence of new forms of fraud and abuse. Public transparency is an important tool to prevent capture by special interests and limit fraud. This involves making as much information public as possible through open hearings on regulations, special decisions, standards and performance, financial information on those who assume particularly sensitive responsibilities and publication of all licensing information.

## IV. Conclusions

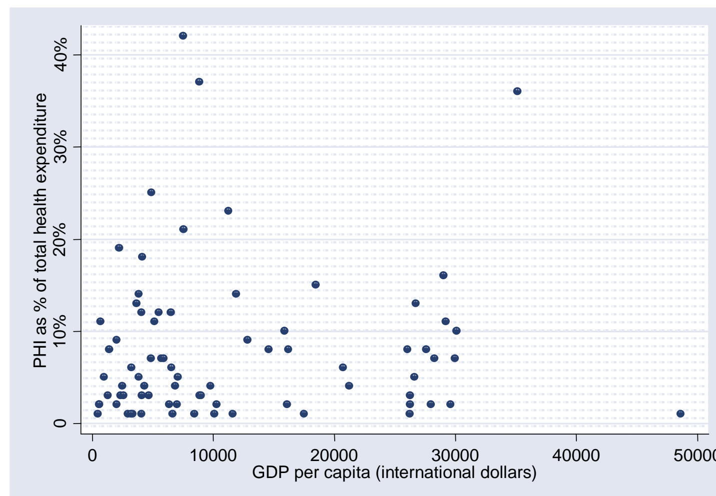
Moving towards risk pooling in health systems financing is important in promoting equity and protecting households from incurring catastrophic health expenditures (72). In most developing countries regressive out-of-pocket payments represent a majority of total health spending and countries must find multiple ways to encourage the transition towards financing methods which provide adequate financial protection for their people(72). Historically, private health insurance has been important in moving towards universal publicly funded coverage in many Western European countries. As this paper shows, policy makers in developing countries may be able to benefit from this experience by introducing regulated private coverage which can provide social protection for workers and their families, create the basis for larger risk pools, and build institutional capacity for managing future public insurance structures. In developing countries where tax revenues are limited, it can relieve the burden on the public sector, allowing limited public funds to be focused on purchasing care for the most vulnerable populations, while those who are able, can contribute to their health care costs. Figure 6 shows one path towards achieving universal coverage using private insurance as a transitional mechanism when public funding is low, and as a supplementary form of financing as public funding increases. Ensuring that private insurance serves the public interest requires active stewardship of diverse players. This is a capability that many developing countries have historically not cultivated choosing instead to directly finance and operate publicly owned facilities. In the past two decades, however, there has been a growing and largely successful trend in developing countries towards divestiture of traditionally government controlled industries, such as energy, telecommunications and transport. This trend is relevant to health insurance since it develops the skills and structures needed for stewardship of all types of

markets.

Although regulating health markets presents certain unique challenges these should not be more difficult than operating an efficient, high quality public system of hospitals and clinics. In fact oversight and regulation of health care rather than its direct provision, may conform more closely to the comparative advantages of governments. Undoubtedly the most difficult aspect of stewardship is enforcement. But most countries are already laying the foundation for enforcement in other areas of governance: establishing the rule of law, promoting transparency, and establishing an independent judiciary. Good governance will evolve over time and along with it enforcement of regulation in health markets.

Debate in the international health community on the role of private coverage has often been characterized by an easy dismissal of private insurance as fundamentally undesirable and destined to erode equity and efficiency in health care. But as this paper shows, a wide range of tools and experiences are available to regulate private insurance markets so that they will play a positive role in the development of equitable health systems. Policy makers should actively engage in understanding the value of these tools and in employing them to serve the needs of the public.

**Figure 1: Relationship between Private Health Insurance as a Percentage Total Health Financing and GDP**




Source: World Health Organization, National Health Accounts 2001; **R = .0031**

**Figure 2: Spectrum of Arrangements Between Privately funded and Publicly funded Coverage**

***Privately funded Insurance*** ←——————→ ***Publicly funded Insurance***

| **Enrollment:** Voluntary-Mandatory | Voluntary | Voluntary | Voluntary | Voluntary | Mandatory | Voluntary | Mandatory | Voluntary | Mandatory | Mandatory |
|---|---|---|---|---|---|---|---|---|---|---|
| **Contributions:** Risk Rated-Income Rated | Risk Rated | Risk Rated | Community Rated | Community Rated | Community Rated | Income Rated | Community Rated | Income Related | Income Related | Income Related |
| **Management :** Private for profit-public | For Profit Commercial | Non-Profit Commercial | Non-Profit Community | Public | Non-Profit Commercial | Non-Profit | For Profit Commercial | Public | Non-Profit Commercial | Public |
| Examples | AIG/Tata India. | BUPA in U.K. | SEWA in India | Medibank in Australia | Collective Heath Care Institutions (CHCI) in Uruguay | Various ISAPRES in In Chile | Various in Switzerland | Seguro Popular in Mexico | Various in Netherlands | Slovenia |

**Figure 4: Model for Policy Intervention: Key Questions**

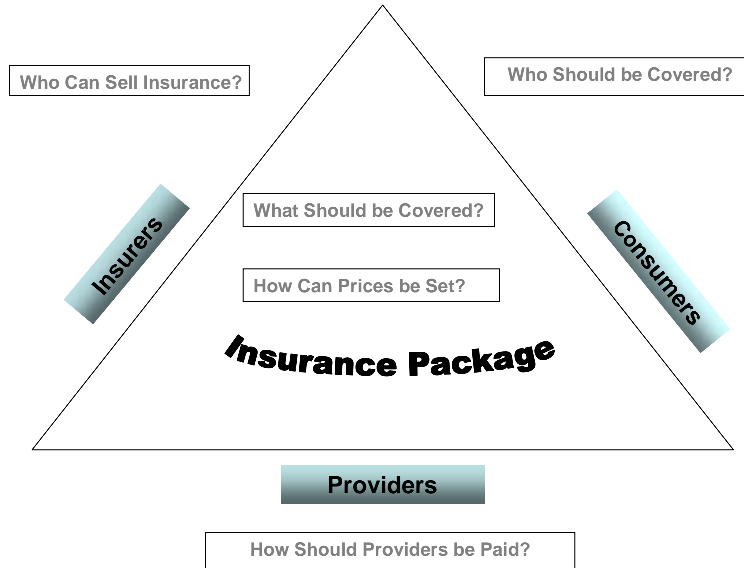


**Figure 5: One Path Towards Universal Coverage**

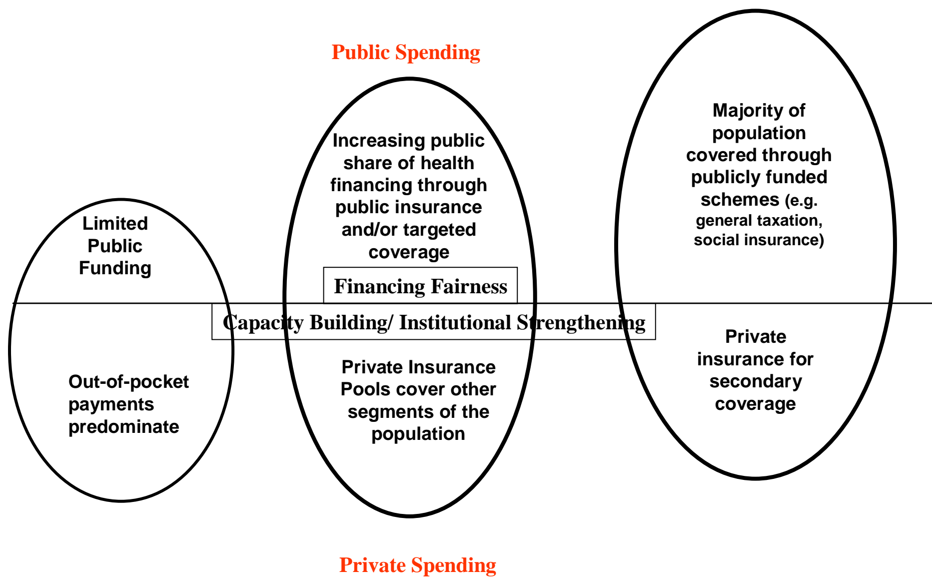


**Figure 3: Policy Goals, Objectives and Instruments**

| Policy Goal | Policy Objective | Potential Policy Instruments to Address Objectives |
|---|---|---|
| **Protect consumers** | Ensure financial solvency of insurers | 1. Establish sufficient minimum capital and reserve requirements. Review reserve requirements as insurance plans grow in size.<br>2. Establish financial reporting requirements and ensure transparency in reporting. |
| | Promote manageable competition in market to encourage affordability and consumer choice | 3. Establish reserve requirements which allow different types of insurers to enter the market e.g. non-profit, community, managed care plans. May need to establish publicly funded guaranty funds if these insurers are less well capitalized.<br>4. Establish rules against monopolistic pricing. |
| | Promote transparency and fairness in transactions between consumers and insurers | 5. Establish disclosure requirements for policies and ensure that their content is understandable to consumers.<br>6. Monitor advertising and sales practices to ensure consumer protection.<br>7. Provide independent mechanism to resolve consumer grievances. |
| | Ensure insurance packages provide adequate financial protection | 8. Define at least one standard benefit package that all insurers must offer and require insurers to set premiums for this package in similar way (e.g. community rating). |
| | Address issues of merit goods and externalities in health care | 9. Directly provide or purchase health care interventions that are defined as public goods through public funds.<br>10. Ensure that minimum benefit package contains those items that are considered public goods.<br>11. Subsidize insurers through public funds to provide coverage for public goods. |
| **Promote Equity** | Minimize adverse selection and encourage broader risk pooling | 12. Require insurance to be mandatory at least for certain categories of households.<br>13. Encourage group enrolment through employer groups, associations, cooperatives, labour unions.<br>14. Create incentives for low-risk individuals to join the insurance pool (e.g. tax incentives, rebates, life-time rating methods)<br>15. Permit defined waiting periods for pre-existing conditions.<br>16. Permit insurers to require enrolees to disclose medical history. |

**Figure 3: Policy Goals, Objectives and Instruments**

| Policy Goal | Policy Objective | Potential Policy Instruments to Address Objectives |
|---|---|---|
| | Minimize risk selection or cream skimming and encourage broader risk pooling | 17. Cover high risk individuals through publicly funded programs.<br>18. Provide mechanisms to protect insurers such as high risk pools, reinsurance, risk equalization schemes.<br>19. Require guaranteed issue and renewal along with pricing guidelines which do not make premiums unaffordable for sicker individuals.<br>20. Limit exclusions and waiting periods to the first time that an individual purchases continuous insurance coverage. |
| | Establish premium setting guidelines that promote cross-subsidies between healthy and sick and/or between income levels | 21. Require community rating to promote cross-subsidies between healthy and sick.<br>22. Encourage income based contributions where feasible to promote cross-subsidies between high and low income individuals (most often done only in social insurance). |
| **Promote cost-containment** | Reduce supplier induced demand | 23. Encourage provider payment mechanisms which share risks and rewards with providers such as case rates, pre-diems and capitation. With these, establish quality requirements and methods to monitor under-utilization of services. |
| | Reduce consumer induced demand (moral hazard) | 24. Allow consumer cost sharing through deductibles and co-payments. Monitor cost sharing practices to ensure that they do not limit access to needed services and that they provide adequate financial protection. |

Source: Adapted from Roberts, M.J. (2004). Getting Health Reform Right: a guide to improving performance and equity. Oxford; New York, Oxford University Press.

**Figure 5: Summary of Key Policy Questions**

| | Key Policy Issues |
|---|---|
| **Who Can Sell Insurance?** | 1. What will be the importance of private insurers in the health financing system?<br>2. To what extent is private coverage being encouraged as a way to provide greater choice to consumers and make the public system more responsive through opt-out provisions?<br>3. How much competition should be encouraged?<br>4. How much collaboration should be encouraged among insurers? |
| **Who Should be Insured?** | 1. How broadly should private coverage be extended? Will coverage be mandatory or voluntary?<br>2. If coverage is voluntary, how can low risk individuals be encouraged to join the risk pool?<br>3. To what extent will private coverage be used to insure high-risk individuals? If insurers are expected to enrol high-risk people, how can they be encouraged to do this while protecting the viability of the market?<br>4. What will be the basis of affiliation in insurance plans e.g. group, individual/ family? |
| **What Should be Covered?** | 1. What benefits, if any, should be mandated?<br>2. How important is consumer choice and customization to meet the needs of different groups?<br>3. What mechanisms will be used to curb unnecessary demand of services from consumers while providing appropriate access to those who need care? |
| **How Can Prices be Set?** | 1. To what extent is private insurance intended to promote equity goals through combining high and low risk individuals, and the rich and poor in common pools?<br>2. Are premiums intended to cover current costs or provide a reserve for future health expenditures? |
| **How Should Providers be Paid?** | 1. What impact will prices in the private sector have on prices in the public system?<br>2. How can price inflation resulting from insurance be constrained?<br>3. How can provider induced demand be reduced while maintaining access and quality? How much risk can be appropriately transferred to providers?<br>4. Is consumer choice of providers a key objective or will insurers have freedom to practice active purchasing?<br>5. To what extent is the introduction of private insurance intended to foster more coordinated delivery models of care? |

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