

The OECD Health Project

Private Health Insurance in OECD Countries



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ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT

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Foreword

The OECD initiated the Health Project in 2001 to address some of the key challenges policy makers face in improving the performance of their countries' health systems. A desire for real progress and a recognition of important gaps in the information needed to undertake change led to political commitment and support across countries for a focused cross-national effort. The three-year initiative provided member countries with multiple opportunities to participate in and learn from component studies focused on pressing health policy issues. Countries also benefited from the information and exchanges that occurred, first at the kick-off conference in Ottawa, Canada in November 2001, and at no fewer than 20 subsequent meetings of officials and experts in venues ranging from Paris to The Hague to New York.

Performance improvement requires grappling with difficult questions. What can be done to ensure that spending on health is affordable today and sustainable tomorrow? What is needed to improve the quality and safety of health care, and to ensure that health systems are responsive to the needs of patients and other stakeholders? How should equitable and timely access to necessary care be supported? And perhaps the most challenging question of all: what can be done to increase value for money?

The Health Project offered a means for officials in member countries to learn from each others' experiences in tackling these questions, to draw upon the best expertise available across OECD member countries and within the OECD Secretariat, and to break new ground to support health-system performance improvement in the future. It encompassed nearly a dozen studies addressing key policy issues pertaining to human resources in health care, new and emerging health technologies, long-term care, private health insurance, health-care cost control, equity of access across income groups, waiting times for elective surgery, and other topics that are central to the policy concerns of OECD member countries. It was not possible to address every issue important to Health Ministries in the course of the Project, but the issues that were chosen were ones considered to be of the most pressing importance.

The Health Project built on the foundation of the OECD's work in health statistics and health policy that has been carried out under the purview of various committees and working parties across the OECD. An important contributor to the success of the Health Project was its horizontal approach. Work in progress was discussed by experts and Delegate groups with a variety of important perspectives on health policy issues. The project benefited from the guidance and support of an ad hoc group on health, made up of Delegates from member countries, and the specialised expertise of various OECD directorates was employed in tackling issues. The Directorate for Employment, Labour and Social Affairs took the lead in coordinating the work conducted in horizontal co-operation with the Economics Department, the Directorate for Science, Technology and Industry, and the Directorate for Financial and Enterprise Affairs.

From my own political experience, I know how significant the results of this Project will be for policy makers at the most senior levels of government. There are no governments within the OECD or beyond which will not derive important benefits from this work as they all struggle to meet varying challenges in the field of health care. It is apparent that there are few one-off solutions or quick fixes. But this Project has demonstrated that benchmarking within and across countries, and sharing information can bring new ideas together and help policy makers meet those challenges.



Donald J. Johnston
Secretary-General of the OECD

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- In ELS, the principal author was Francesca Colombo, while management and support were provided by Victoria Braithwaite, Elizabeth Docteur, Martine Durand, Nathalie Gosselin, Jeremy Hurst, John Martin, Marlène Mohier and Peter Scherer.
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Preface

This report is the first-ever comparative analysis of the role and performance of private health insurance (PHI) in OECD countries. It offers policy insights on the role of private markets and governments in financing health systems that are relevant for both OECD countries and non-members. The analysis focuses on a set of policy questions, such as the impact of PHI markets on access to coverage and care, their contribution to health system responsiveness, and implications for cost and efficiency of health systems. Policy makers will also find an assessment of useful governmental interventions. Regulatory mechanisms, financial incentives, and broader health policy interventions that can help deliver equity, efficiency, and responsiveness from different health insurance mixes are analysed.

The report starts with an analysis of PHI markets and identifies policy issues arising from their interdependence with public health coverage schemes. It then reviews trends and challenges arising from regulation of private health insurance markets. It continues with an assessment of the impact of PHI against health policy objectives, discussing costs and benefits related to private health insurance in different insurance mixes. The analysis identifies strengths but also areas where private health insurance might detract from health system performance. Governmental interventions that can help private health insurance markets to promote health systems' performance and useful practices for the development of an efficient and equitable health insurance market are also presented.

The report is based on multiple sources of information. Primary data were collected through a questionnaire of PHI markets statistics and a questionnaire on regulation. Information was also obtained from OECD *Health Data*, policy documents and administrative data supplied by OECD countries' authorities, and a comprehensive review of the academic literature. Several case studies were carried out to gain an in-depth understating of the PHI markets in selected OECD countries that feature a prominent role for private health insurance. Case studies involved a visit to the country where all main stakeholders were interviewed. Several issues for further research have emerged. The study highlights shortfalls in existing data and information sources that hamper efforts to assess fully the implications of PHI markets for health-system performance.

Executive Summary

Governments in several OECD countries have used or considered using private health insurance (PHI) as a policy lever to promote certain health system goals, such as reducing financing pressures on public health systems, promoting individual choice and improving efficiency. Policy expectations for PHI, the size of PHI markets, and their impact on health systems, vary to a great extent across OECD members.

The role and structure of PHI markets vary across OECD countries

Private health insurance is primarily distinguished from public coverage programmes by its funding through non-income related premiums, paid usually on the basis of a contract between a private party and an insurance entity, as opposed to taxes or social security payroll contributions.

PHI performs different roles, impacting upon health systems in both positive and less advantageous ways. PHI is a source of primary coverage for specific population groups in the United States (72% of the population has PHI), the Netherlands (28%) and Germany (9%). PHI mainly duplicates universal coverage in Australia, Ireland, New Zealand and the United Kingdom – among others – thereby offering a private alternative to public systems. Nearly half of the Australian and Irish populations purchase a private health insurance policy, representing the largest duplicate PHI markets. It complements financing from public programmes by paying for cost-sharing in many OECD countries, especially in France (where PHI covers over 90% of the population) and in the US Medicare supplement (“Medigap”) market. And PHI supplements public systems by financing goods, services and providers, such as pharmaceutical products in Canada. Supplementary PHI covers 65% of the population in Canada, 80% in Switzerland, and 90% of the socially insured in the Netherlands. Often, within each OECD country, PHI plays one main function, together with other less prominent roles. PHI is purchased by over 30% of the population in a third of OECD members.

Policy makers often look to PHI markets as an alternative or additional source of funding for publicly financed health systems, especially when these budgets are stretched to capacity and face increasing demands. Yet the vast majority of health financing in OECD countries continues to be derived from public sources, which account, on average, for 72% of total health expenditure (THE), compared to 6.3% for private health insurance and 19% for out-of-pocket payments (OOP). Only in the United States does its contribution exceed a third of total health expenditure (35%). However, PHI remains a significant funding source (above 10% of THE) in the Netherlands, Canada, France, Germany and Switzerland.

PHI does not appear to substitute for out-of-pocket payments. Although countries with the highest share of financing total health expenditure from PHI (such as the United States, Canada, Germany and France) rely less on out-of-pocket expenditure to finance health cost than the OECD average, this relationship does not hold for the OECD area as a whole. There is no correlation between the share of health financing accounted for by PHI and that accounted for by out-of-pocket payments.

The roles PHI performs, the size of the market and the contribution to financing health care vary greatly across countries. Countries with significant PHI markets often have a tradition of private health financing and insurance markets. PHI dimensions and functions are shaped by the design of statutory health coverage and delivery systems, as well as by direct government interventions in PHI markets. The presence of employer-based PHI often explains high levels of private coverage (as in the United States, Canada, and France), while other countries are seeing growth in their employer group market (as in the Netherlands and Ireland). Consumer desire to obtain more and faster care and population satisfaction with publicly funded services also influence demand for private health insurance.

The development of PHI markets does not seem correlated with economic development. Usually PHI is purchased by higher-income persons, and is also more common among better-educated individuals and the employed. However, PHI market size – determined by share in total health expenditure or share of population covered – does not have a strong link to the level of economic development measured by a country's per capita GDP. OECD countries with the fastest-growing economies have not necessarily seen a rise in the prominence of PHI markets.

Within individual national markets, there are substantial differences in insurers' market behaviour. These include the structure of benefit offerings, premiums and their method of calculation, cost-sharing arrangements, and insurers' relationship to health care providers. For-profit and not-for-profit insurance entities in particular, often have different market strategies and practices, although competitive forces can push insurers to converge in their market approach.

The diversity of coverage experiences also seems to suggest that there is no particular set of services that are better "insurable" by public or private carriers. However, higher-cost individuals, such as the elderly and those with chronic conditions, are more typically covered by public or subsidised private coverage, even in countries where PHI plays a primary role.

[Access to health coverage and health care](#)

The contribution of PHI to *access to health coverage* has varied depending on how large a PHI market has developed, how broad the pool of risks is for which it provides financial protection and the scope of regulations of coverage and delivery systems. Despite large gaps in population or services covered by public systems, PHI markets have failed to develop enough to provide significant financial protection in countries such as Korea, Mexico, Greece or Turkey. Several factors, ranging from lack of a history of health insurance markets to cultural preferences, are plausible explanations.

Even where they have developed, access to coverage remains one main challenge facing private health insurance markets. Under light or little regulation, risk selection is typical of

PHI markets and higher-risk individuals face access difficulties in obtaining and affording policies. Several OECD countries, especially those where PHI plays a primary or significant role, have intervened to promote availability and affordability of insurance.

Access problems assume more critical dimensions for the attainment of health-system performance goals when there are large gaps in public coverage systems. Primary coverage offers financial protection to population groups without access to public coverage programmes in the United States and the Netherlands, although in the United States many remain uninsured, and many of them report that this is because insurance is not affordable. Access to complementary coverage against large co-payments is nearly universal in France, in part thanks to a government programme introduced in 2000 to provide government-funded complementary cover to low-income individuals. Conversely, a fifth of US Medicare beneficiaries does not have complementary PHI, and thereby still faces significant coverage gaps. Even in supplementary or duplicate systems, PHI may cover medically needed goods and services. In Canada, for example, supplementary PHI covers much of the cost of outpatient pharmaceuticals, which are not generally covered by the publicly financed programme.

Clearly, when public cover is not comprehensive or universal, access to PHI has enhanced access to care. PHI has offered enhanced access to timely care for those with PHI cover, improving the quality of life of those insurees who would otherwise experience lengthy waiting times. However, there is no clear evidence that waiting times are reduced in the public sector.

Access is often not equitable across income-groups, largely because PHI is typically purchased by high-income groups. For example, in duplicate systems, PHI furnishes a level of care, choice and speed of access to care above what is afforded by public systems. Where the private sector offers higher remuneration levels to providers than public systems do, this encourages high service volumes and productivity. However, this can lead to resources being diverted from the public system, which can reduce access to care for those who cannot afford private health insurance. Quality and quantity of publicly financed services might suffer as a consequence, especially when providers' responsibilities and obligations to public patients are not clearly defined and monitored, and providers' incentives are not aligned to accord equal treatment to public or private patients. Policy makers have in some systems regulated the possibility for PHI insurees to enjoy a superior level of care and choice in order to minimise risks of creating a "two-tiered" system, as in the case of the Netherlands. But this carries trade-offs with responsiveness goals.

Choice and responsiveness

Private health insurance has enhanced *choice and responsiveness* of health systems in many OECD countries. First, the very opportunity to buy PHI inherently offers consumers an additional level of choice with respect to financing certain health care services and providers on an out-of-pocket basis, as in the case of primary PHI markets in the United States and the Netherlands, and supplementary PHI in Canada. Second, PHI has often improved individuals' choice over health providers and timing of care in most countries with duplicate PHI markets. The scope of this added choice depends, however, on the regulation of delivery systems, the freedom of choice already existing within public systems, and insurers' contractual terms with providers. Third, most PHI markets offer a

wide array of products to consumers, allowing them to tailor their risk and product preferences, although the precise nature of the choices depends upon insurers' strategies and product regulation. Consumers are thus able to select benefits and cost-sharing arrangements that suit their needs and wishes. Often, private health insurers have quickly incorporated new benefits into their products in response to newly created gaps in public coverage systems and to the development of new technologies. In general, demand pressures upon insurers have led them to innovate and tailor their offerings to individuals' demands, although insurers' responsiveness has varied across OECD countries.

Clearly, for consumers to exercise meaningful choice, insurers' marketing and product informational materials need to be transparent and enable comparisons across the market. Consumers have complained about the quality of product information at the point of sale in some countries. Governments and voluntary bodies have addressed this concern by disseminating comparative information on the quality, features and cost of health plans in some countries, such as in the United States and in Switzerland's mandatory insurance market.

Furthermore, there are trade-offs between responsiveness and access concerns. An abundance of product choices has the potential to heighten risk segmentation within a PHI market, if higher-risk individuals select generous benefit and cost-sharing packages, as evidence from some OECD countries seems to indicate. While PHI has offered privately insured individuals innovative and flexible coverage approaches in many OECD countries, policy makers have sometimes limited the scope for insurers' flexibility and innovation to avoid more vulnerable groups being priced out of PHI markets. For example, standardisation of benefit packages – as is mandated in the US Medicare supplemental (“Medigap”) market – is a way to promote consumers' ability to make informed choices as well as to reduce certain risk-selection activities. However, particularly if statutory or regulatory standards do not enable standardised packages to be readily updated, changes or innovation in response to market changes might be inhibited.

Quality of care

There is only weak evidence that PHI has promoted the delivery of *high-quality care* in the OECD area. In most countries, private health insurers have not engaged in significant efforts to influence the quality of the health care services they finance, and the impact on quality of care has probably been minimal in most OECD countries. A combination of factors explains this trend, ranging from the lack of regulatory and financial incentives for insurers, to resistance by consumers to restraints on individual choice, and providers' resistance to the introduction of a new source of influence on decisions over appropriateness of care.

The United States has been the only OECD country where private insurers have been substantially involved in directing and overseeing certain aspects of care delivery. Pressure from employers and purchasers for cost-effective care supported the development and spread of managed care techniques to improve health care quality in the US PHI industry, including selective networks of approved providers, pre-approval of certain services, and the promotion of preventive care. Despite indication of some effectiveness in promoting quality of care, the overall evidence of the impact of managed care on quality of care is mixed. PHI does not appear to have fundamentally changed clinical processes yet. Payment

incentives that do not consistently reward plans' or employers' efforts to improve quality and inadequate quality-measurement and reporting systems, explain the still limited and non-systematic impact of PHI on quality improvements. PHI may actually not be the best lever to improve health care quality, particularly where its role in a health system is small. Insurers may be reluctant to invest in quality enhancement that may benefit their competitors. If insurers are to play a role, they need adequate incentives, regulatory or financial, to invest in quality-improvement initiatives and foster value-based competition.

Health expenditure

PHI has not significantly assumed *financing burdens* from the public sector. Private health insurance has injected financial resources into health systems, encouraging an expansion in capacity and services. For example, PHI has provided additional revenue streams for hospitals and physicians, particularly in cases when public system activity is subject to price and reimbursement limits and providers engaged in privately financed practice enjoy greater rate flexibility (as in Germany, Ireland, Australia, the United Kingdom, among others). This has represented a particular advantage when public budgets are rationed and public sector services face prolonged waiting times. However, cost shifting from publicly to privately financed providers in systems with duplicate PHI has remained small. Private insurees have continued to rely upon publicly financed hospital services. Privately financed hospitals have often focused on a limited range of elective services, leaving the responsibility for more expensive services or populations to public programmes. In OECD countries that have prioritised eligibility to public insurance to lower-income and vulnerable groups (the United States, the Netherlands, Germany), public spending on health as a percentage of GDP is not lower than in countries that provide universal public coverage. This can be partly explained by the concentration of health-care needs – and thereby cost – among a small fraction of the population that is generally publicly insured, such as the elderly, chronically ill, and long-term disabled. Delisting of services from public coverage, another strategy to shift cost onto the private sector, has generally remained confined to less expensive services, such as dental care and optical services.

Private health insurance has also often added to *total health expenditure*. Most OECD countries apply less tight governmental control over private sector activities and prices, compared to public programmes and providers. Private insurers tend to have less bargaining power over the price and quantity of care as compared with public systems, particularly single-payer ones. Countries that have multiple sources of primary coverage, including those with significant PHI market size, tend to be those with the highest total health spending levels per capita, such as the United States, Switzerland, Germany and France. Cost control is more problematic to achieve in multiple payer systems because payers have less bargaining powers over providers on the price and quantity of care.

PHI has also added to *public health spending* in some cases. Countries that grant significant public subsidies to private health insurance, as Australia, France and the United States, have faced considerable pressures on their public budgets. Where PHI covers cost-sharing on public coverage systems, as in France, utilisation increases raise the cost of publicly financed health systems. There is also evidence of PHI-induced utilisation increases in the public sector of systems where PHI plays a duplicate or supplementary role. Public and private financing do not operate in isolation. Rather, they are intertwined by complex financial and real flows, as well as incentive structures.

Efficiency

While private health insurance is often viewed as a tool to enhance *efficiency*, the evidence reviewed in this study has revealed a still small contribution of PHI in this respect. Several reasons explain this performance. Insurers need to sustain high administrative costs in order to attract and retain insurees, provide them with a diversity of insurance plans, and negotiate multiple contractual relationships with providers. Furthermore, in several OECD countries, insurers have faced few incentives to manage care cost-effectively, due to a combination of desire not to restrict individual choice, providers' resistance, and the cost of implementing such action.

Difficulties in extracting efficiency improvements from PHI markets are also due to incentives created by competition across insurers. Not all PHI markets feature strong competitive pressures. Insurees' mobility is often limited, thus insurers often face weak demand signals. When competition actually occurs, it has not necessarily developed on price and quality grounds. It is attractive for insurers to employ cost-shifting and selection of risk as a means of insurer competition and protection against adverse selection, rather than improving the cost effectiveness of care provided to insurees. Moreover, insurers' competition does not necessarily result in lower cost if the PHI industry is fragmented vis-à-vis providers' market power, and these latter face little pressure to enhance quality and cost-effectiveness of care.

Useful practices can help to direct PHI markets to good performance

Policy makers have addressed some of the challenges posed by PHI markets through a variety of interventions – including regulation of the role of PHI, access and benefit-related standards for PHI insurers, disclosure requirements and fiscal incentives directed to PHI markets, and broader policies towards private sector providers. A number of useful practices has been identified:

- A combination of insurance and rating rules can be an effective means to alleviate some access-related PHI challenges. Access-related standards help to promote insurance coverage for high-risk individuals, and may be particularly useful in primary PHI markets. The need for these interventions often depends on the comprehensiveness of the PHI benefits they apply to, and the extent to which the costs of any high-risk coverage are cross-subsidised by other private insurees or by other financing sources. If publicly funded systems provide adequate access to needed health services, policy makers may question the need for such interventions in their PHI markets.
- Fiscal incentives and subsidies can boost the purchase of PHI and shape its market structure by reducing the net price of insurance policies for individuals, thereby potentially increasing take-up. However, compared with other types of policy interventions, fiscal incentives and subsidies may not be the most cost-effective way to increase take-up of insurance among certain populations. In addition, especially if large incentives are needed to spur purchase of PHI, the cost to public revenues needs to be weighed against the savings in public health spending associated with increased PHI take-up.

- When PHI creates access disparities between those with and those without PHI cover, policy makers can intervene by regulating the roles that PHI is permitted (or prohibited) to have; regulating price differentials between publicly and privately financed medical practice; specifying providers' obligation to public patients and monitoring compliance with those obligations. This is especially important where PHI has a duplicate role or where public systems confront prolonged waiting times.
- When cost sharing in public systems is high, PHI enhances access to care. Yet, if PHI offers full coverage of high cost-sharing levels on public programmes, insurees do not retain awareness of cost and PHI encourages moral hazard-induced utilisation, creating trade-off with cost-containment goals. Maintaining at least some modest cost sharing helps to minimise undesired cost consequences of complementary PHI.
- Policy makers can maximise effective choice within PHI markets by fostering readily understood comparative information and product disclosure requirements. Disclosure requirements can work together with benefit standards to promote and reinforce consumers' understanding of their PHI products and coverage options. Some limits on benefit packages, or their standardisation, may be appropriate, particularly if products are sold to vulnerable population groups, such as the elderly and chronically ill. Yet, benefit standardisation reduces insurers' ability to innovate and tailor products to individuals' demands.
- Policy makers can maximise cost shifting between the public and private sector by encouraging private insurees not to rely on public systems for PHI-covered services. Applying cost-control measures within the overall health system, including the private sector, improves the ability to control cost within PHI markets.
- Incentives or regulatory requirements might encourage PHI markets to improve cost-effectiveness of care, for example by removing insurers' obligations to contract with all providers, or providing incentives for insurers to be involved in preventative care or care management. Improved consumer information could facilitate effective competition among insurers. Systems to compensate insurers with a worse risk structure can help reduce insurers' incentives to select good risks, thus promoting equitable risk pooling. However they can also remove or reduce incentives for insurers' efficiency.

Chapter 1

Introduction

This chapter provides an introduction to this report. It explains why OECD has undertaken a study on private health insurance, and the policy relevance of the analysis. It also illustrates the analytical framework underpinning all chapters. This framework applies both to the review of private health insurance markets, and to the analysis of their impact on health system performance. The chapter also describes the methodology adopted, as well as the sources of information that were gathered. It finally explains how the report is structured.

1. Why an OECD study on private health insurance?

Policy makers in OECD health systems face many challenges, but the question of how best to finance their health care systems remains at the forefront of their concerns with no easy answer at hand. This question is particularly complex because it involves balancing several policy goals, ranging from the equity of financing to the need to ensure adequacy and sustainability of funding.

The relative merits of private health insurance (PHI) as a health financing option have generated considerable attention among policy makers over the past few decades, although starting from diverging viewpoints. For example, proponents have lauded the potential for PHI to reduce cost pressures confronting OECD health systems and to improve their efficiency and responsiveness to individualised needs. Concurrently, critics have denounced PHI markets' tendency to price vulnerable groups out of the market and undermine governments' efforts to regulate the cost of health systems. Policy makers' goals for PHI – including its desired role within health systems – also vary tremendously, and involve considerable trade-offs.

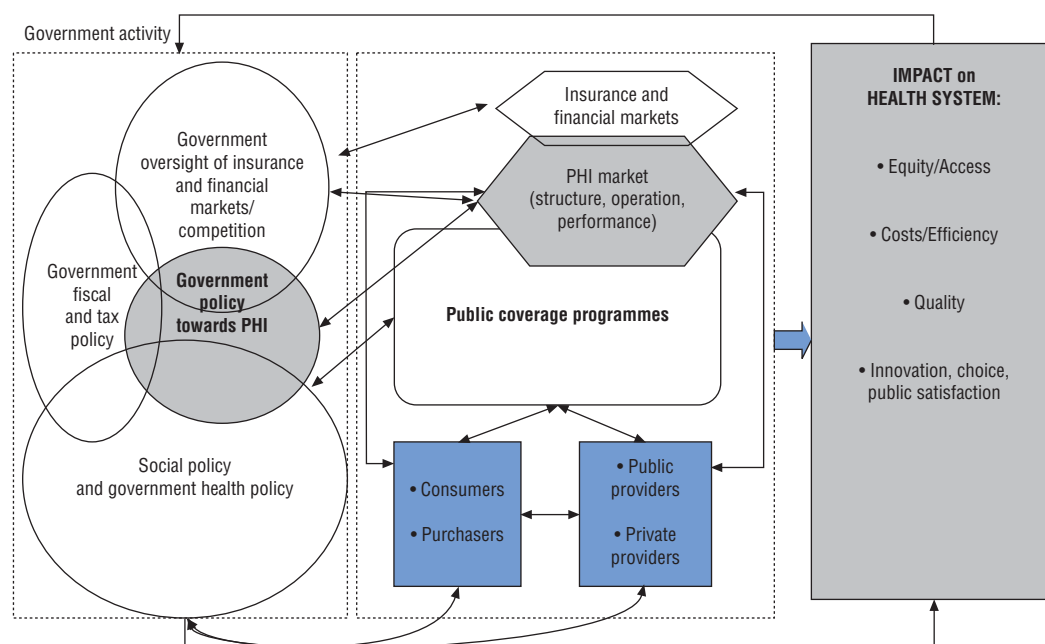
This study explores the relative advantages and drawbacks of PHI markets, within the context of different policy goals and health system roles. It sets forth the main findings of an OECD analysis of private health insurance markets, their interactions with publicly financed health schemes, and their impact on health systems as a whole.¹

2. Analytical framework and scope of this study

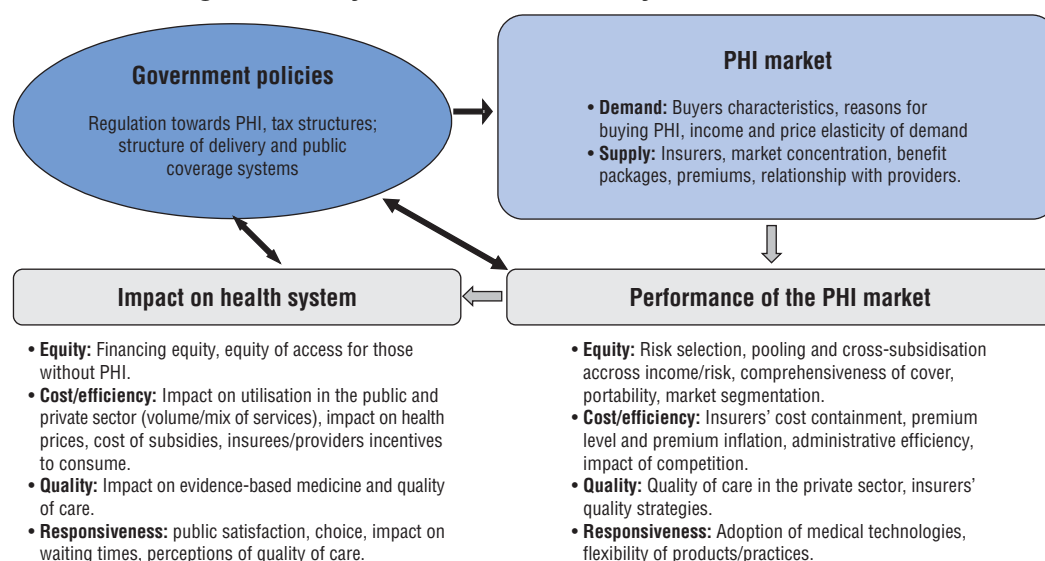
Figures 1.1 and 1.2 set forth the analytical framework used for this study. Government occupies a central role in shaping health insurance markets and their impact on health systems. Its influence is felt not only through its direct interventions towards private health insurers but also through broader government policies towards health and social systems, tax and benefit arrangements and insurance markets.

PHI markets do not operate in isolation. Rather, as shown in Figure 1.1, they interact with public coverage systems and sometimes overlap in the services they provide and the population they serve. Private health insurers enter into contractual arrangements with insurees, and, in some cases, with providers of services. The interaction among these structures and actors, and the financial flows and other resources across them, affect health system performance.

The impact of PHI on health systems can be measured along several key dimensions. Policy makers aim to maximise a set of policy goals, including micro efficiency (health improvement and responsiveness to consumers for any given level of health expenditure), macro efficiency (the level of health expenditure which equates the marginal benefit of services to the marginal cost), and equity (fair distributions of health, health care utilisation and health expenditure across their populations). Instrumental goals include, among others, the development of an environment conducive to innovation in health care

Figure 1.1. **Analytical framework for the OECD private health insurance study**

Source: OECD.

Figure 1.2. **Key variables for an analysis of PHI markets**

Source: OECD.

financing and provision, as well as the promotion of consumer choice. Judgements about the relative importance of these goals vary across countries.²

This study assesses the role of private health insurance as it interacts with public health insurance schemes, examining its related advantages and disadvantages and impact upon health systems. It analyses and identifies those conditions that most favour the development of an efficient and equitable health insurance market. As part of this

overall evaluation, the study examines the social, economic, financial and regulatory characteristics of different mixes of public and private health financing.

The development of PHI markets has depended on the history and culture of OECD member countries, governmental or policy maker priorities, and certain philosophical or ideological preferences. Evidence about the effects of different types of health financing institutions has also shaped policy makers' views towards the desirability of private health insurance – yet arguably to a more limited extent. Values vary sharply across OECD countries on the priority to be given to individual choice, private initiative, solidarity, and collective or public institutions in health care systems. As a result of these and other factors, there is considerable variation in the scope and role of private health insurance across OECD countries. Variations in history, values and institutions, likely limit the scope of lessons to be drawn from comparing experiences with PHI across countries. Nevertheless, certain subgroups of OECD countries display sufficient similarity in their insurance mixes to make international comparisons fruitful. In addition, there are a number of challenges which arise in most or all OECD countries with PHI markets.

3. Methodology of the study

PHI refers to heterogeneous private health financing schemes and approaches across OECD countries. Yet the meanings attributed to “public” and “private” health insurance are not uniform. In order to carry out analysis on PHI, a typology of health insurance schemes has been developed, delineating the precise scope of the study and classifying the interaction between public and private health insurance (OECD, 2004b). The line between public and private health insurance has been drawn according to the main source and mechanisms of financing – with private health insurance being defined as health coverage derived mainly through private, non-income related payments.³

Data used in this study have been gathered using multiple sources and different information collection mechanisms. Primary data were collected through two survey instruments sent to national authorities of all OECD countries: a statistical questionnaire on private health insurance markets,⁴ and a regulatory questionnaire on governmental interventions towards PHI.⁵ An extensive literature survey was also conducted. In addition, country-specific case studies have been undertaken to examine the role and impact of PHI on health-system performance in selected OECD countries.⁶

4. How this report is structured

The four chapters which follow this introduction present the primary analytic results of the OECD Study on Private Health Insurance in member countries.

Chapter 2 analyses the diversity of private health insurance arrangements across OECD countries, explaining influences behind the heterogeneity of functions, sizes and structures of markets. It defines private health insurance, elaborates upon the roles it plays within the health financing systems of OECD countries, and assesses the main features of PHI markets. Chapter 2 also highlights several aspects of PHI markets and their interaction with public systems that can give rise to potential opportunities and challenges for health system performance.

Chapter 3 describes the range of government interventions and regulations towards PHI markets, highlighting their connection with identified policy goals and challenges. It includes analyses of the impact of some of these interventions, when available. It also

highlights challenges arising from the regulation of particular roles of PHI, as well as those that occur more commonly across PHI markets.

Chapter 4 assesses the impact of PHI markets on health systems and their performance. This includes an analysis of the contribution of private health insurance to access to health insurance, as well as any effect on the equity of financing and of access to health care. Private health insurance's contribution to choice, responsiveness and innovation is assessed. The chapter also analyses the impact of PHI on public and total health cost, as well as on health system efficiency. While the analysis draws mainly from evidence gathered from a selected number of OECD countries (case study countries and others with prominent PHI markets), it also highlights some of the parallel and divergent experiences of some other countries.

Chapter 5 synthesises and sets forth the key policy conclusions and lessons derived from the analyses contained in the preceding chapters. It highlights the extent to which private health insurance has contributed to, or detracted from, the attainment of health system objectives. The chapter also draws attention to those governmental interventions that have been particularly successful in addressing challenges arising from PHI markets. It closes with some forward-looking reflections on the opportunities and risks presented by PHI markets, highlighting some areas meriting further investigation.

Notes

1. The study on private health insurance is one component of a larger OECD Health Project that has investigated several areas of health systems' performance. The main findings from the Project component studies are described in the Project's final report *Towards High-Performing Health Systems* (OECD, 2004a).
2. This analytical approach is consistent with a framework for assessing the performance of health systems, which was developed for the overall OECD Health Project.
3. Chapter 2 includes the definitions and typology used in this study.
4. The questionnaire collected data on premiums, claims, population coverage, share of total health expenditure covered by private health insurance and market structure.
5. Both questionnaires were distributed to relevant authorities from all OECD member countries. As multiple ministries or agencies are often involved in the oversight of PHI markets within OECD countries, responses have been co-ordinated amongst relevant ministries or agencies. Reliable estimates, or data from non-governmental sources, were included in the absence of governmental data.
6. Case studies were carried out in Australia, Ireland, and the Netherlands (Colombo and Tapay, 2003 and 2004a; Tapay and Colombo, 2004). A study on the health insurance system and prospective role for private health insurance in Slovakia was also carried out (Colombo and Tapay, 2004b). These studies include in-depth analyses of the role and impact of PHI in each system, informing the comparative analysis contained in this report. Each case study involved focused, structured interviews with main stakeholders and an extensive review of academic, policy and technical material relating to the country's health insurance mix and PHI market.

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Chapter 2

The Role of Private Health Insurance in Mixed Systems of Health Care Funding

This chapter describes the heterogeneity of experiences with private health insurance across OECD countries, and identifies clusters of countries where PHI presents common features and factors explaining differences in PHI markets across OECD countries.

In particular, this chapter addresses the following questions:

What is private health insurance? What roles does PHI play within the health financing systems of OECD countries? What are the characteristics of PHI markets in different OECD countries: What is the size of PHI markets? How are health risks insured by public or private insurance systems? Who buys PHI and what drives demand for PHI? Who supplies PHI, and how are PHI markets structured? How is the relationship between insurers and providers? What recent trends can be observed in PHI markets? What factors explain differences in development of PHI markets and roles?

1. Introduction

Private health insurance (PHI) refers to diverse health care funding arrangements in different national contexts. There is a large heterogeneity of experiences with private health insurance across OECD countries, not only for levels of population coverage and prominence in financing health systems, but also in terms of characteristics of demand and supply of private health insurance.

This chapter provides an overview of PHI markets in OECD countries. It explains the role that PHI plays in the health economy of member countries, and describes recent or significant trends. While recognising that drawing a line between different coverage types may at times not be clear-cut, this chapter sets forth a conceptual framework for distinguishing public from private health insurance, and for analysing the interaction between PHI and public health coverage systems. It then describes key characteristics and trends in PHI markets, such as levels of population and types of risk covered, the demand for PHI, and the structure of the market. Explanatory factors behind differences in market developments – ranging from historical developments to the degree of comprehensiveness of public coverage and intensity of policy support towards PHI markets – are then outlined.

2. A taxonomy of health insurance types¹

2.1. What is health insurance

Health systems are financed through a variety of mechanisms, of which health insurance is one. Health insurance can be defined as a way to distribute the financial risk associated with the variation of individuals’ health care expenditures by pooling costs over time (pre-payment) and over different individuals (pooling) (Table 2.1). It differs from out-of-pocket payments which do not pool risks nor pre-pay for health care costs. Medical savings accounts, conversely, provide only for pre-payment, although they are often coupled with an insurance scheme.

Table 2.1. Alternative options for financing health care

		Prepayment	
		NO	YES
Pooling	NO	Out-of-pocket payments	Medical Savings Accounts
	YES	Spontaneous charity	Health Insurance

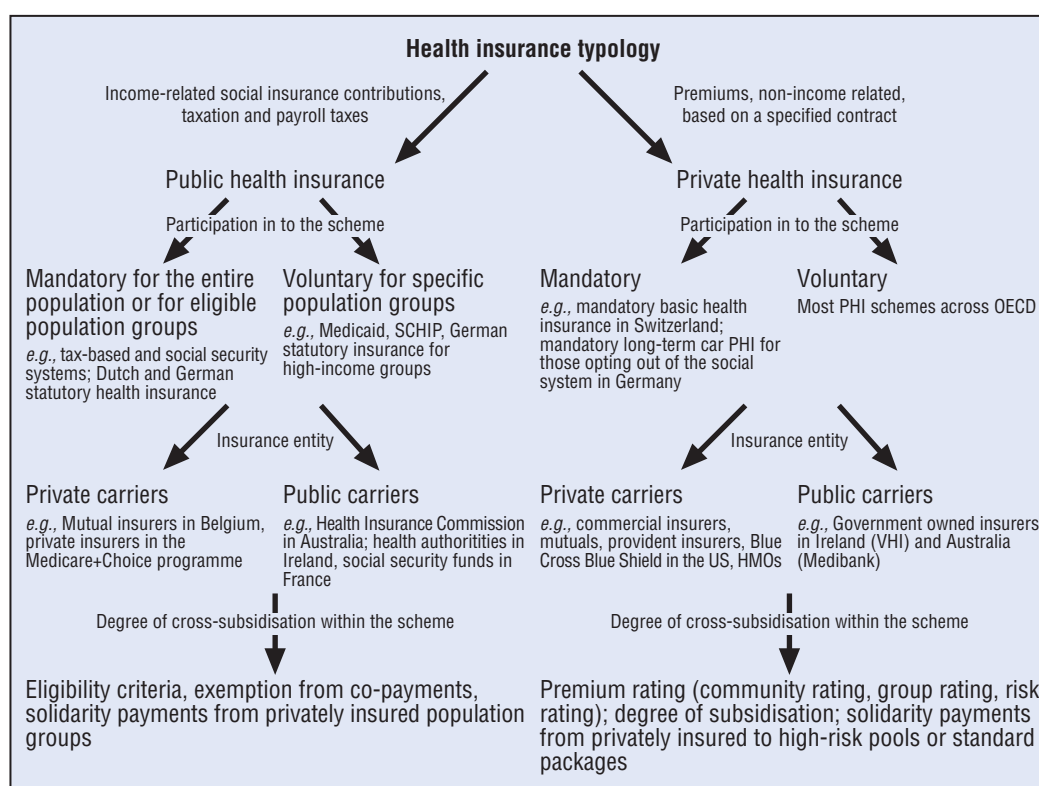
Notes: *Pre-payment*: Collection and management of revenues so that contributions for the health care system are collected from individuals prior to (and independently from) the utilisation by individuals of health services. *Pooling*: Collection and management of revenues in such a way to ensure that the risk of having to pay for health care is borne by all members of the pool and not by each contributor individually (WHO, 2000).

Source: OECD (2004a).

2.2. Public and private health insurance

Health insurance arrangements differ in the degree of cross-subsidisation (across time, risks and income groups) inherent in the scheme, the ownership and management of the scheme, the level of compulsion in participation, and the sources of funding (OECD, 2004a). In this report, the main method of financing health care coverage serves as the primary distinction between public and private health insurance (Figure 2.1). *Public health insurance* includes health coverage mainly financed through taxation or income-related payroll taxes including social security contributions.² *Private health insurance*, by contrast, is coverage of a defined set of health services financed mainly through private non-income related payments (premiums) made to an insuring entity or mutual pool.³ This insurance guarantee is usually set forth in a contract between a private party and the insurance entity that spells the terms and conditions for payment or reimbursement of health services. The insuring entity assumes much or all of the risk for paying for the contractually-specified services.

Figure 2.1. **Typology of health insurance arrangements**



Source: OECD.

PHI arrangements can differ along several variables (OECD, 2004a). It is generally, but not always, of a voluntary nature, although participation may be set forth by the conditions of employment. It includes group schemes, usually covering employees of a company, as well as individual contracts. PHI can be supplied by a variety of insurance entities, usually private, which sometimes establish a direct relationship with providers. Premiums are typically risk-rated; however, as a result of regulation or voluntary insurers' practices, they

may be adjusted for the average risk of a group or a community (the latter is often termed “community-rating”). Varying government policies impact upon the way PHI is regulated, and the levels of subsidies directed towards these schemes (see Chapter 3).

Certain health-sector reforms have blurred the boundaries between private and public health insurance, for example by regulating and subsidising PHI extensively.⁴ Furthermore, some financing schemes may not be easily classified as public or private on the basis of the criteria chosen for this report. Other ways to distinguish public from private health insurance can be proposed and are indeed used in the literature and by governments. These distinctions can be based, for example, on the public or private nature of the entity administering cover; the existence of a profit motive driving insurers offering it; the voluntary or statutory nature of cover;⁵ the extent to which an insurance entity actually bears risk; insurers’ flexibility to base their decisions upon business practices, which depends on the intensity of regulation; and whether coverage falls under general insurance law or laws specific to health insurance.⁶ A few of these factors are discussed in Box 2.1 below.

2.3. Private health insurance interacts with public coverage systems in different ways

PHI can have different roles in mixed systems of funding health care. Such roles are either the result of specific regulation requiring or prohibiting certain types of private health cover (see Table 2.2, p. 35), or the effect of strategic insurer behaviours. The role of private health insurance *vis-à-vis* public health insurance depends upon two primary variables: whether individuals buying PHI are also eligible for part of public health insurance systems; and whether PHI offers cover for *health care services* that are already covered by public health insurance or, for individuals without public health insurance, by a PHI policy representing their primary form of cover (Figure 2.2). The four different functional categories under which PHI can be divided are defined in Box 2.2.

PHI plays a leading role in financing health care in a few OECD countries and a supporting role in many others. In a few countries, it is a main pillar of financing basic health care for large or significant sections of the population, who are either not eligible for public health insurance or have chosen to opt out of such cover (principal/substitute function). In a number of countries with universal public insurance for basic health care, PHI provides duplicate cover that parallels some or all of the cover guaranteed by public insurance systems (duplicate function). In many countries with universal health cover for basic care, PHI offers supplementary insurance for risks outside the basic or publicly insured package (supplementary function). Finally, in a number of countries with public insurance, PHI offers complementary cover for the cost sharing required by the public system (complementary function). In most OECD countries, PHI has more than one function, although usually one prominent or main role can be identified in all countries.

3. Characteristics of private health coverage in OECD countries

3.1. Different functions of PHI across public-private financing mixes in OECD countries

OECD governments have adopted three different approaches to ensure broad population coverage. A first group of countries has achieved universal or near-universal cover through a national public health system (*e.g.*, the Nordic, Mediterranean and Eastern European countries, Canada, Australia, New Zealand, Korea, Japan). A second group of countries has promoted basic public coverage only for specific population groups, leaving

Box 2.1. Examples of complexity in classifying health insurance as public or private

Nature of carriers of health insurance coverage

There is a distinction between the (public or private) nature of the provider of insurance, and the health financing method used to fund a health insurance arrangement. Sometimes public programmes contract with private insurers to offer coverage to the publicly insured, such as in the case of the US Medicare + Choice programme.¹ In this case, private insurers relieve the public sector of some of the burdens of administration, in such areas as claims processing. Social security schemes can be administered and provided by private institutions, such as mutual companies in Belgium or sickness funds in the Netherlands. Conversely, government-owned insurers can also provide private health insurance. VHI Healthcare (formerly the Voluntary Health Insurance Board) is a state-backed organisation that until 1996 operated as monopoly provider of PHI in Ireland. Medibank Private, the largest not-for-profit health fund in Australia, was established by the Federal Government in 1976 and has become an autonomous Federal Government Business Enterprise since 1998. In some cases, the same insurance entity may offer different types of cover, for example sickness funds or their affiliates in the Netherlands, Belgium and Switzerland offer both statutory health insurance and voluntary private health insurance. The control over the way resources are collected (income tax or social security contributions through payroll premiums), rather than the public or private nature of the insurer, is more important in determining whether insurance is public or private for the purpose of this study. The nature or legal status of the insuring entity may nonetheless be more relevant for supervisory purposes, especially when the identity of the supervising governmental body varies by type of insurer.

Government financing of private or voluntary health insurance

Private health insurance, or segments within the PHI market, may receive public subsidies. In some cases, the purchase of health insurance policies is financed predominantly by public sources, either because of large tax-incentives or because the premiums of certain low-income individuals are greatly subsidised. The schemes nonetheless share several other features of private health insurance, particularly the main method for collecting funds (premiums), or administration by private insurance entities, applicable regulatory regime, role of the insurance arrangement in relation to public insurance systems, and so forth. In France, a government universal health insurance programme (CMU) provides eligible low-income individuals with publicly funded complementary health insurance coverage.² The premiums for such complementary cover are entirely subsidised through government resources. The insurance scheme is administered by the social security insurers as well as complementary insurance entities (“mutuelles”, private insurance companies or provident institutions). Its benefits and conditions of cover are regulated.

Government regulation of PHI markets and similarity to public health insurance

Private insurance schemes, or segments within the PHI market, may be extensively regulated in a manner not dissimilar from public health insurance. In the Netherlands, some high-risk individuals who are not eligible to social health insurance coverage can buy standardised PHI policies (so-called WTZ) where benefits, premium levels, and enrolment conditions are regulated by the government (see Chapter 3 for more details of the WTZ scheme). Insurers' exposure to risk is minimal. In Switzerland, individuals are mandated to purchase basic health insurance from private sickness funds applying non-income related, flat rate premiums. The provision of basic insurance is regulated in a manner similar to social security schemes in other OECD countries, *e.g.*, the benefit package is standardised, premiums are community-rated, and enrolment is open (Colombo, 2001).

Box 2.1. Examples of complexity in classifying health insurance as public or private (cont.)

Government employees' schemes

The government funds health coverage of civil servants through private insurers in some countries. These schemes share many traits with private employer-sponsored coverage, despite them being largely financed through public sources. In Germany, public employees are reimbursed by the government for most of their health care bills and receive PHI coverage for the remainder (European Observatory, Germany, 2000). Civil servants and their dependents in Spain receive health coverage from private mutual funds. They can opt to receive such coverage from private commercial insurers, with the state continuing to act as a third payer (European Observatory, Spain, 2000).

Is all private health insurance voluntary?

In most OECD countries, PHI has a voluntary nature, while public systems are mandatory for at least some sections of the population. However, there can be cases of private health insurance for which participation is mandated. Switzerland, for example, had relied on voluntary PHI as principal source of health coverage until the 1996 Federal Health Insurance Law (LAMal) mandated basic coverage for the entire population. Similar proposals for extending primary health insurance to all in the Netherlands would establish a mandatory private health insurance system (Dutch Ministry of Health, Welfare and Sport, 2002). In Korea, the purchase of insurance to cover health-related expenditure in case of car accident is mandatory. Finally, individuals that opted out of the sickness fund system in Germany (as described later in this chapter) are obliged to purchase long-term care insurance from private insurers. Even when participation in private health insurance arrangements is not mandatory by law, it can be imposed by the conditions of employment, for example by general agreements or employer-specific conditions.

1. Under the Medicare+Choice programme, private health plans participate in the US public health programme for the elderly, Medicare, on a risk or cost-reimbursement basis.
2. The "Couverture Maladie Universelle" (CMU) can also be seen as an example of a public health insurance programme administered by private entities. It provides basic coverage to limited population groups that were uninsured until the introduction of the CMU in 2000, as well as subsidised complementary coverage.

Figure 2.2. Functions of private health insurance in relation to public coverage schemes

		Eligibility to public health insurance	
		Individuals have public cover	Individuals do not have public cover
Health services covered by PHI	PHI covers medically necessary curative services typically covered under the public system	Duplicate PHI	Primary PHI: – Substitute – Principal
	PHI covers cost sharing applicable to public coverage systems	Complementary	
	PHI covers top-up health services not included in public systems or primary PHI	Supplementary	

Note: Insurance policies may bundle different types of cover together.

Source: OECD (2004a).

Box 2.2. Definition of functions of private health insurance

Primary private health insurance: private insurance that represents the only available access to basic health cover because individuals do not have public health insurance. This could be because there is no public health insurance, individuals are not eligible to cover under public health insurance (principal cover), or they are entitled for public coverage but have chosen to opt out of such coverage (substitute cover):

- **Principal:** private insurance for health costs, which for the insured individual represents the *only available access* to cover where a social security scheme does not apply. This includes employer's compulsory schemes if cover is privately insured or self-insured.
- **Substitute:** private insurance for health costs, which *substitutes for cover which would otherwise be available* from a social insurance or publicly financed insurance or employer's scheme.*

Duplicate cover: private insurance that offers cover for *health services* already included under public health insurance. Duplicate health insurance can be marketed as an option to the public sector because, while it offers access to the same medical services as the public scheme, it also offers access to different providers or levels of service. It does not exempt individuals from contributing to public health insurance.

Complementary cover: private insurance that complements coverage of publicly insured services or services within principal/substitute health insurance, which is intended to pay only a proportion of qualifying care costs, by covering all or part of the residual costs not otherwise reimbursed (*e.g.*, co-payments).

Supplementary cover: private health insurance that provides cover for additional health services not covered by the public scheme. Depending on the country, it may include services that are uncovered by the public system such as luxury care, elective care, long-term care, dental care, pharmaceuticals, rehabilitation, alternative or complementary medicine, etc., or superior hotel and amenity hospital services (even when other portions of the service (*i.e.* medical component) are covered by the public system).

* Other institutions, researchers and laws (such as the EU Directives) adopt different definitions of functions of private health insurance than those adopted in this report.

Source: OECD (2004a).

other groups the option to buy private health insurance, self-insure or be uninsured (*e.g.*, the Netherlands, Germany, and the United States). A third approach, represented by Switzerland, is to ensure universal coverage by compelling the entire population to buy basic health insurance. Only three OECD countries have not attained universal health insurance: the United States, Mexico and Turkey.

While PHI plays one main role in each OECD country, it often has one or more additional functions. Moreover, even where PHI plays a similar function, there can be large differences in terms of benefits and population covered, or, more generally, market structures.

Primary role of PHI

In the United States, the Netherlands, Germany, and for minor population groups in Belgium, Spain and Austria (Box 2.3), PHI plays a primary role in providing basic health insurance for individuals lacking public health cover, either because they are not entitled to publicly financed coverage (principal PHI) or because they have chosen to opt out of it

Box 2.3. Primary PHI in Belgium, Spain and Austria

Other examples of primary PHI policies can be found in Belgium, Spain and Austria; in these countries, these types of policies play a minor role.

In **Belgium**, self-employed individuals are covered by the social security system only for so-called “major risks” such as hospitalisation, while “minor risks” (ambulatory care, dental care, drugs) can be covered through PHI offered by mutuals (which provide social health insurance) or by commercial insurers. About 12% of the Belgian population were self-employed in 1999, and about 85% of them bought PHI for minor risks (European Observatory, Belgium, 2000).

In **Spain**, civil servants and their dependents (4.6% in 1997¹ are covered under a special system by mutual funds, within which they are given the option to choose care provided by the National Health System or coverage through private health insurance. According to estimates, between 50% and 85% of this population group opts for PHI. In addition, the statutory system does not cover a minority of the population (about 1%, including certain employment categories such as independent lawyers), 60% of which buys primary insurance (Mossialos and Thomson, 2002). According to two different estimates, 3.9% had substitute PHI in Spain in 2000 (Ministry of Health, Spain, 2003) and 4.9% in 2002 (data from UNESPA, December 2003).

In **Austria**, some self-employed persons can opt out of the social security system, provided their relevant professional categories purchase substitute PHI for them, and about 0.1% of the population is insured under such arrangements.

1. European Observatory, Spain (2000), citing data from the 1997 National Health Survey.

(substitute PHI). There are differences in the population groups that buy primary PHI in each of these countries.

Both the United States and the Netherlands provide publicly financed health coverage for eligible population groups, while leaving others responsible for buying private health insurance themselves. In both countries, PHI also plays a supplementary and a complementary role.

In the United States, Medicare furnishes social insurance to qualified elderly and disabled persons (including the vast majority of those age 65 and above) or about 13.4%⁷ of the population. Medicare entitles beneficiaries to hospital care, physician services, and other services (subject to co-payments and deductibles).⁸ In addition, two tax-financed public programmes, Medicaid and the States Children’s Health Insurance Programme (SCHIP), provide insurance to eligible low-income families with children, disabled and low-income elderly and covers 10.4% of the population, while military schemes cover 3% of the population. Individuals can also buy PHI from competing insurers. About 72.4% of the population has some form of PHI cover, most of which (64.1% of the population) is obtained through employer-sponsored plans. Overall, 86% of the US population has some coverage against health care cost, while about 14% of the population did not have any form of cover in 2001. In the Netherlands, about a third of the population – 31% in 2001 (Ministry of Health, Welfare and Sport, 2002) – relied on private health insurance for principal coverage. This population segment is, by statutory rules, not eligible for the public sickness-fund insurance. Access to PHI for high-risk individuals within this group has been facilitated by

the creation of the WTZ scheme, a regulated niche of the Dutch primary PHI market that provides standardised PHI policies at regulated prices to eligible high-risk individuals. Unlike the United States, there is virtually no portion of the population uninsured in the Netherlands.⁹

While the Dutch primary PHI system is often compared to the German one, there is one important difference in the way individuals choose to buy such cover. Germany is the sole OECD country that allows large population groups, corresponding by and large to individuals above an income threshold,¹⁰ to opt out of social health insurance provided by sickness funds and to buy a private health policy. Individuals eligible to opt out can still choose to remain insured with a sickness fund. Once they opt out, however, there are by and large prohibited from returning to the social health insurance system. In total, an estimated 9.6% of the population has opted out in 2002 (PKV, 2003), while 14% of the population, while eligible, choose not to do so.¹¹

The Swiss health insurance system is perhaps unique across OECD countries. The population is covered through basic health insurance, which has been made mandatory for the entire population since 1996.¹² The provision of mandatory coverage by private insurers (virtually all of which are not-for-profit sickness funds) is heavily regulated: enrolment is open, premiums are community rated at the level of each insurer, the benefit package is standardised, and movement across insurers is free (Colombo, 2001). Insurers providing mandatory coverage can also furnish supplementary voluntary policies, like sickness funds in the Netherlands, through affiliated insurers. Offerings of supplementary PHI were conversely prohibited to social insurers in Germany until recently.

Primary PHI creates some unique policy challenges. First, unregulated primary markets create access challenges as they represent the sole form of cover for certain population groups. High-risk groups may face risk selection by insurers, while insurers are concerned that people, who are not obliged to purchase PHI, will buy insurance only when they need care. When eligibility to public health insurance is linked to income or group thresholds, targeting errors and rules around movements in and out of public versus private coverage may be complex to optimise. Primary PHI markets tend to be more heavily regulated. For example, there are often special regulations or governmental programmes providing access to coverage for high-risk individuals, as in many US states, the Netherlands and Germany. Within primary markets, insurers have high exposure to risk and health costs. It is therefore in some of these markets that they have both the incentives and, sometimes, the opportunity to restrict the coverage they offer to higher-risk persons in order to reduce cost. Analysis of differences in utilisation between public and primary PHI are also relevant to understand the impact of PHI on access to care and cost.¹³

Duplicate role of PHI

The main characteristic of duplicate PHI is that it provides people already covered by public health systems with a private alternative coverage for the same sets of services, most often furnished by different providers. Duplicate PHI is therefore common in OECD countries where there is a separation between publicly funded providers, such as public hospitals and doctors in public practice, and privately funded providers, such as private hospitals and doctors operating in private practice.¹⁴ Typically, duplicate PHI exists in countries where eligibility to public coverage is based upon residency rather than affiliation by employment categories. These are the so-called Beveridge-style or tax-

funded health systems – such as the United Kingdom, Nordic countries, Australia, New Zealand and the Mediterranean countries.

Australia and Ireland are the most significant cases of duplicate insurance in OECD countries. Large population segments (over 40%) have PHI, which also accounts for a similar share of total health expenditure. Private health insurance allows individuals to insure treatments received in private hospitals and treatments provided in public hospitals to individuals electing to be “private patients”.¹⁵ Doctors in both countries often have appointments both in the public and private sectors, representing different revenue streams. People buy private health insurance primarily because it provides increased choice over providers and timely care. Both countries regulate and subsidise the provision of private health insurance. Other countries with duplicate PHI feature lower population shares (*e.g.*, 35% in New Zealand, 15% in Portugal, 10% in the United Kingdom). Duplicate insurance is offered by insurers who have no or limited involvement with the public systems’ insurers or purchasing entities.

For the most part, OECD countries either entirely allow or prohibit duplication of public coverage systems (Table 2.2). In Canada, most provinces forbid private health insurers from covering any medically necessary hospital, inpatient and outpatient physician services which are provided by the publicly financed system. The rationale for such prohibition is to avoid the creation of a two-tiered system with differentiated access to services based upon insurance status and to prevent the public sector from subsidising the private sector (Flood and Archibald, 2001). On the other hand, other OECD countries have no prohibition on duplication, although hospital coverage in tax-funded systems seems to be the predominant context where duplicate insurance develops. The Australian approach to duplicate private health insurance presents some unique elements. Australia prohibits private health funds from duplicating coverage for out-of-hospital services for which public health insurance (Medicare) pays a benefit. In addition, PHI covers only a share of private in-hospital medical costs, the so-called “gap” between the actual fee charged by the doctor and the share reimbursed by Medicare (which is based on a government schedule). This reveals a desire to avoid differentiated access to care based on insurance status for outpatient coverage and to promote some sort of universality of access to private coverage and private hospital care (Colombo and Tapay, 2003).

In duplicate PHI markets, public and private health financing systems run parallel to each other and are often linked by a complex set of interactions. There are real and financial flows across the two systems, particularly when doctors carry out public and private practices and when the private system receives direct or indirect public subsidies. Duplicate PHI is often seen as instrumental in reducing cost pressures on public systems by shifting demand and cost from public to private hospitals and providers. While enhanced choice is intrinsic to the nature of duplicate PHI markets, this type of cover also raises policy concerns, for example linked to differences in access to care across publicly and privately insured individuals. These issues create challenges related to the opportunity cost of maintaining duplications and the need to address trade-offs between competing policy goals.

Complementary role of PHI

Most OECD countries require co-payments or other cost sharing for services provided by public systems (Table 2.3), but most have small complementary PHI markets. For this type of cover, market size is in fact linked to the magnitude of co-payments. Limited PHI

Table 2.2. **Permitted role of private health insurance**

	Duplicate	Complementary	Substitute/Primary	Supplementary
Australia	- PROHIBITED: coverage of out-of-hospital services for which a Medicare benefit is payable - REQUIRED: coverage of rehabilitative care; and 25% of private medical inpatient cost - ALLOWED: hospital charges	- PROHIBITED: GP/Primary care and long-term care - ALLOWED: all other services	Not applicable	- PROHIBITED: Supplementary policies (ancillary PHI) cannot cover services for which a Medicare benefit is payable - REQUIRED: coverage of rehabilitative care - ALLOWED: all other services not included in Medicare benefit schedule (dentistry, optical, physiotherapy)
Canada ¹	PROHIBITED: All publicly funded services (Hospital, GP/primary, specialist and dental care)	- PROHIBITED: GP/Primary and Specialist care - ALLOWED: all other non publicly funded services	Not applicable	ALLOWED: all services not publicly funded
Germany	ALLOWED but there is no market	ALLOWED: in/out patient care, dentistry, pharmaceuticals, rehabilitative care and home care	- REQUIRED: long-term care for people opting for private cover - ALLOWED: all services covered by sickness funds for eligible individuals opting for private cover	ALLOWED: all services not funded by sickness-funds coverage
Ireland	REQUIRED: All PHI policies must cover minimum benefits for Hospital and specialist in-hospital care	REQUIRED: Coverage of statutory co-payments on hospital and in-hospital specialist care non-medical-card holders	- PROHIBITED for dentistry, pharmaceuticals, long-term, rehabilitative and home care - ALLOWED: PHI can cover primary GP service for non-medical card holders	ALLOWED: dental care, alternative medicine, home care and luxury services
Netherlands	- PROHIBITED: Long-term care and home care - ALLOWED: All other services, but there is no market	- PROHIBITED: Long-term care and home care - ALLOWED: All other services	- PROHIBITED: Long-term care and home care - REQUIRED: Hospital and specialist - ALLOWED: All other services	ALLOWED: dental care, alternative medicine.
Poland	ALLOWED: All services	ALLOWED: Pharmaceuticals, long term and rehabilitative care	Not applicable	ALLOWED: All services not publicly covered
Portugal	ALLOWED: All services		Not applicable	ALLOWED: All services not publicly covered
Spain	ALLOWED: All services	- ALLOWED: Pharmaceuticals - PROHIBITED: All other services	ALLOWED: All services for civil servants opting out of the public system	ALLOWED: All services not publicly covered
Switzerland	Not applicable	PROHIBITED: All services under basic mandatory insurance	REQUIRED: All services defined in a basic health insurance package	ALLOWED: All services not insured under basic cover
United States	Not applicable	ALLOWED: Medicare Supplement market	- REQUIRED: minimum benefits in some States - ALLOWED: All services	ALLOWED: All services

1. There is some variation by province in Canada.

Source: OECD Regulatory Questionnaire on Private Health Insurance and other official source.

Table 2.3. **Cost-sharing policies in public schemes for basic health coverage**¹

Degree of cost-sharing in per cent and in USD or EUR

	General practitioner	Specialist	Drugs	Inpatient care	X-ray and pathology
Australia	For 25% of bills, average of USD 5. General patient reimbursed 85% of schedule fee if not bulk billed.	For 71% of bills, average of USD 8. Patient reimbursed 85% of schedule fee if referred.	Maximum AUD 23.70 (around USD 18) per prescription for general patients for drugs on the PBS Scheme.	None.	Included in specialists' bills.
Austria	20% of the population pays between 10% and 20% of doctor's fee.	Same as for GPs.	USD 4.50 per prescription.	For insured persons: USD6 per day/maximum 28 days per year. For dependents: USD 10-USD 13.50 per day/maximum 28 days per year.	Same as for GPs.
Belgium	25%, reduced to 10% for vulnerable groups.	Same as for GPs.	Flat rate plus 1/20/30/50%; 100% for drugs on negative list.	USD5-USD6 per day, USD2-USD3 for vulnerable groups. Increased after 90 days.	
Canada	None.	None.	Discretion of Provinces.	None.	None.
Czech Republic (2000)	None.	None.	Generics covered. Non-generics reimbursed if no alternative.	None.	None.
Denmark	None, except for under 3% of the population.	None, except for under 3% of the population.	Flat rate plus: 50/70/100%.	None.	None.
Finland	There is an annual maximum fee of EUR 22 for a 12-month period. If the annual fee has not been paid, the fee is EUR 11 per visit. This fee may be collected for a maximum of three visits during the calendar year. Fee for visits outside normal opening hours is EUR 15 per visit. Fees are not collected from persons under the age of 18.	Visit to the outpatient department is EUR 22 per visit, free of charge in the psychiatric outpatient treatment unit.	SII reimburses part of the cost of medicines prescribed by the physician or dentist. SII pays 50% of all medicine costs in excess of a fixed minimum per purchase (EUR 10) or, more rarely, nearly all medicine costs (scheme members with certain specified conditions qualify for a 75% or 100% refund of costs exceeding EUR 5). All non-covered medicine costs in excess of EUR 604.72 in a year are covered by SII. Drugs administered during inpatient care are included in the daily fee.	Health centre: EUR 26 per day, EUR 12 per day in the psychiatric unit. Fees may be collected from a person under the age of 18 for only seven bed-days per calendar year. Hospital: EUR 26 per day, EUR 12 per day in the psychiatric unit. Fees may be collected from a person under the age of 18 for only 7 bed-days per calendar year. Day surgery is EUR 72 per procedure. Long-term (> 3 months) institutional care in a health centre or in a hospital: Fees according to solvency. Fees may constitute a maximum of 80% of the client's income. There must remain, for the personal use of the client, a minimum of EUR 80 per month. Fees may be collected from a person under the age of 18 for only seven bed-days per calendar year.	None.
France	30% ²	30% ²	0% for some drugs; 35% for most drugs, 65% for "comfort" drugs or those without proven therapeutic value.	EUR 11 per day plus 20% of total cost for first 30 days up to a ceiling of EUR 200.	40%
Germany ³ (2004)	Fee of EUR 10 per quarter covers all visits during the quarter. Preventive measures are exempt from practice fees.	Patients who are referred by one doctor to another pay no additional practice fees, as long as the referral falls within the same quarter.	Co-payment amounting to 10% of the price, but no less than EUR 5 and no more than EUR 10 per medication.	Co-payment of EUR 10 per day, limited to a maximum of 28 days in a calendar year.	None.
Greece	None.	None.	0/10/25%	USD 15	–

Table 2.3. **Cost-sharing policies in public schemes for basic health coverage**¹ (cont.)

Degree of cost-sharing in per cent and in USD or EUR

	General practitioner	Specialist	Drugs	Inpatient care	X-ray and pathology
Hungary (2002)	None.	Co-payment if no referral from medical doctor (except emergency).	0/10/30/50 or 100%; some drugs based on reference price system.	Co-payment for long-term care in hospitals (may be covered, depending on income level), co-payment for above-standard “hotel services” in hospitals.	None.
Iceland ⁴	USD 9	USD 17 plus 40% of the rest of the cost.	0, 12.5%, 25%	None.	USD 13
Ireland ⁵	None for Category I (35% of population); those in Category II pay for GP services.	As for GPs.	No charge for Category I; reimbursement for Category II of any cost over USD 21 per month.	No charge for Category I; Category II: USD 17 per day subject to a maximum of USD 166 in any 12 month period.	None for Category I.
Italy	None.	Maximum of USD 41	Free for Category I medication; 50% for Category II; both Categories I and II are free to exempted persons; 100% for Category III medication.	None.	Up to a maximum of USD 41.
Japan ⁶	30% (younger than three years, 20%).	Same as for GPs	30% (younger than 3 years, 20%).	Same as for GPs	Same as for GPs (outpatient) or inpatient care.
Korea	“Outpatient fees” as follows: 30% if seen in clinic, 40% if hospital; 55% if general hospital.	“Outpatient fees” as follows: 30% if seen in clinic, 40% if hospital; 55% if general hospital.		20% of inpatient care (“hospitalization fees”).	
Luxembourg	5%	5%	0% or 20%	Flat rate between EUR 10 and EUR 15	
Mexico	No cost sharing for the members of the social security schemes (these cover around half of the population). For Ministry of Health Facilities, which are open to all the population, the Ministry of Finance sets indicative rates of cost sharing that depend on household income, but the rates applied can vary among states and hospitals.				
Netherlands	None.	None.	Prescription drugs reimbursed when judged to be of pharmaceutical value and cost-effective. Full reimbursement for those products for which no alternatives are available. Those similar to other reimbursed products are subject to reimbursement limit. Resulting co-payments are approximately 0.5% of total costs, as industry generally sets prices to avoid co-payments. Over-the-counter medicines not covered, even when prescribed.	None.	None.
New Zealand	Extra billing.	Outpatients USD 3-USD 17.	USD 2-USD 8 with stop loss.	None.	Out-patients USD 3-USD 17.
Norway	USD 11	USD 16	25% if on blue ticket, maximum USD 43 per prescription.	None.	X-ray USD 11.

Table 2.3. **Cost-sharing policies in public schemes for basic health coverage¹** (cont.)

Degree of cost-sharing in per cent and in USD or EUR

	General practitioner	Specialist	Drugs	Inpatient care	X-ray and pathology
Poland (1999)	None.	None.	Basic drug list: flat fee = 0.05% of min. wage; suppl. list = 30-50% of cost of drug. Patients w/ chronic disease or war veterans fully or partially reimbursed.	None.	None.
Portugal		USD 91-USD 213	0/30/60/100% depending on drug category.	USD 30	
Slovak Republic (2000)	None.	None.	Category I: fully covered. II: Same drugs as above, different manuf. partially reimbursed. III: out of pocket.	None.	None.
Spain	None.	None.	0%, 40%. Pensioners and long-term ill largely exempt. ⁷	None.	None.
Sweden	USD 13-USD 20 per visit. Maximum visiting fees per 12 months, USD 120 (including fees to GPs).	USD 26-USD 40 per visit. Maximum visiting fees per 12 months, USD 120 (including fees to GPs).	Patient pays 100% up to USD 120, after that, patient pays in three steps: 50%, 25% and 10% of the cost. Maximum patient fees for pharmaceuticals per 12 months USD 240.	Maximum USD 10 per day where some county councils have variations in costs, depending on age, income, etc. Local variations also with regard to maximum inpatient fees. Fees for inpatient care are not included in the high-cost protection system for outpatient care.	None.
Switzerland ⁸	10%	10%	10%	CHF 10 per day (about USD7) if single.	10%
Turkey	None.	None.	10% retired; 20% active	None.	None.
United Kingdom	None.	None.	USD 9 per prescription or free with a "season ticket" of USD 130. Many persons exempt.	None.	None.
United States (2004) ⁹	20% in excess of the USD 100 deductible. Also a USD 66.60 monthly premium for coverage of physician services.	20% in excess of the USD 100 deductible. Also a USD 66.60 monthly premium for coverage of physician services.	100%	USD 876 deductible first 60 hospital days; USD 219 co-payment per day for days 61-90; USD 438 per day beyond 90 days. USD 109.50 per skilled nursing facility stay day 21-100.	Same as doctors.

1. Approximate amounts in US dollars or euros, converted at nominal exchange rates. Information refers to the most recent data available, ranging from the late 1990s to the present. Some changes arising from most recent reforms may not have been included.
2. 30% of the agreed fee schedule (doctor conventionné) and more if there is overbilling. Co-payment may be less if covered by complementary insurance which normally covers part of the co-payment including the overbilling. Complementary insurance covers over 80% of the population. Vulnerable groups and long-term ill may have zero co-payment.
3. Overall co-payment ceiling per year is 2% of gross income (1% for chronically ill patients). No co-payments for those < 18 years of age.
4. Maximum for the year in the charging scheme.
5. About 40% of the population has private health insurance that generally covers general practitioner fees above a relatively high threshold, consultant/specialist fees above a certain threshold and private and semi-private accommodation. Tax relief at the marginal rate is available on unreimbursed medical expenses above a certain threshold.
6. In Japan, there is a dedicated mandatory public health system for those aged 75 and over and those aged between 65 and 74 with severe disability. From October 2002, cost sharing is 10% (20% for those with income above certain amounts).
7. Patients with chronic illness pay 10% up to maximum of 400 pesetas (USD 2.75) per prescription.
8. Plus a yearly flat rate of CHF 300 for adults, SFR 0 for children. From 1986 higher rates can be chosen up to CHF 1 500 in exchange for a lower premium. The excess of 10% pertains to the amount exceeding the flat rate but only up to a maximum amount of CHF 700 per year for an adult of CHF 350 per year for children.
9. Applies to 13% of population (elderly and disabled) who are beneficiaries of public Medicare programme. Lower deductibles if in HMOs.

Source: Information supplied by OECD member countries or obtained from official publications.

coverage of cost sharing exists in several countries such as Ireland, Denmark, Germany, Sweden, Italy and Luxembourg, among others, where complementary cover is packaged together with other PHI types. France and the United States are the only OECD countries with significant complementary markets.

In France, PHI reimburses patients for cost sharing required by the mandatory social security system, as well as the cost of medical goods and services not included in the social benefit package or for which public reimbursement is well below market prices (Buchmueller and Couffinhall, 2004).¹⁶ Individuals are required to pay co-payments ranging from a modest per-diem for inpatient care, to 30% of physician conventional fees and up to 65% for some drugs. The main motivation for buying complementary health insurance is therefore to limit exposure to out-of-pocket expenditures, rather than increase choice over providers or timely care. Complementary health insurance is offered by non-profit mutual associations, provident organisations, and for-profit commercial insurers. The large majority of the French population has this insurance, often through employers. With the introduction of a public programme to subsidise the purchase of PHI by low-income groups (the CMU), the percentage of the population with complementary health insurance rose from 86% in 1999 to 92% in 2002 (*ibid.*).

In the United States, persons eligible for Medicare can buy supplemental Medigap policies covering co-payments and gaps on coverage offered by Medicare. Employers often offer Medicare supplemental policies to their retired employees. The individual Medigap market is heavily regulated, for example insurers are only allowed to sell standardised policies, the renewal of policies is guaranteed, and policies must be issued to all applicants during a six-month open enrolment period at the time of eligibility. Poor Medicare beneficiaries also receive supplemental coverage through Medicaid (17% of Medicare beneficiaries). Over two-thirds of Medicare beneficiaries receive supplemental coverage through individual and/or employer purchased policies.¹⁷ Employer supplemental coverage is often more generous than individual Medigap policies.

Complementary health insurance markets raise significant trade-offs for policy makers. The rationale for allowing or promoting coverage of cost sharing is to reduce inequity in access due to co-payments, which are large in France and under the US Medicare programme. However, as far as co-payments are used as a policy tool to moderate demand within public systems, coverage by private health insurance offsets the benefits of cost sharing. This is why governments sometimes prohibit such a role. In Switzerland, for example, coverage by voluntary health insurance of cost sharing on mandatory health insurance is not allowed.

Supplementary role of PHI

All OECD countries where PHI markets exist have some type of supplementary benefits or policies. Supplementary health insurance covers a wide range of different services across OECD countries, depending on what the public insurance system does not provide, and the insurers' definition of "health benefits". Typical services not covered by public health systems are optical, dental, physiotherapy, cosmetic surgery, luxury services and improved hotel and accommodation amenities in hospitals.

While in several cases supplementary benefits are packaged together with other types of cover, in a few countries there are "pure" supplementary policies that are sold and advertised differently from other products. This is the case of Canada, where most

provinces prohibit other coverage types; Canada is unique among OECD countries in its broad restrictions on the scope of PHI coverage. A large share of the population, estimated at 65% in 2000 is covered by supplementary PHI, which is mainly offered via employers. Benefits covered can include dentistry, long-term and rehabilitative care, home care and alternative medicine. Importantly, PHI covers outpatient prescription drugs that are not publicly covered in most Canadian provinces. In this role, PHI contributes significantly to total health expenditure. In Australia, ancillary PHI policies are sold separately from duplicate hospital policies, although most people buy both types of cover together.

Supplementary PHI markets raise a number of questions. The first is why a market develops for services that public systems do not consider necessary to insure. Supplementary PHI may well insure nonessential services, or conversely give individuals access to services that should arguably be included in the public cover because they involve significant financial risk or medical necessity. People will face different pros and cons related to choices to buy PHI or to self-insure. There are also likely to be interactions between services covered by PHI (for example dental care) and services covered by public systems (for example drugs needed after a dental treatment), which policy makers need to consider when reviewing decisions whether to include services under public coverage. If supplementary PHI is packaged with primary social insurance and is offered by the same entities or their affiliates – as in the Netherlands, Belgium and Switzerland – different regulatory regimes in these two segments may magnify insurers' incentives to select good risks from social health insurance.

3.2. Expenditure on private health insurance and public-private mix of health financing¹⁸

PHI is not the most prominent method of financing health expenditure across OECD countries

Public financing is the dominant form of health financing in all countries but Korea, Mexico and the United States (Table 2.4). It accounted, on average, for 72% of total health expenditure (THE) across OECD in 2000.¹⁹ The public financing share increased during the 1970s, then stabilised and slightly decreased in the 1990s, with countries showing a convergence in the share of public spending. Private, out-of-pocket payments (OOP) accounted on average for 18.7% of total health expenditure in 2000,²⁰ representing about three-quarters of total private financing. Out-of-pocket payments as a share of total health expenditure have slightly increased over time.²¹

Private health insurance accounted for an average of only 6.3%²² of total health funding in 2000 (4.9% excluding the United States). The average does not include countries for which data are not reported (nor estimated) which comprise, with a few exceptions,²³ not very significant markets. Large variation exists across countries. In the United States, private health insurance accounted for 35% of THE in 2000. Canada, France, Germany, the Netherlands and Switzerland²⁴ also finance a meaningful share of total health expenditure through private health insurance (10-15%). Australia, Austria, Ireland, and New Zealand belong to a third group of countries with notable levels of PHI financing (between 4% and 10%). The contribution of PHI in all other countries for which data are available remains below 4% of total health expenditure. Notably, the United States is the only OECD health system where health financing is predominantly reliant upon voluntary health insurance. Even there, however, PHI contributes less than half of total health expenditures. With the exception of Canada, the high PHI-share cluster includes countries whose health systems

Table 2.4. **Health expenditure by source of financing, 2000**

Percentage of total health expenditure

	Public expenditure on health	Private health insurance	Out-of-pocket payments	All other private funds
Australia	68.9	7.3	18.5	5.4
Austria	69.4	7.2	18.8	4.6
Belgium	72.1	..	..	..
Canada	70.9	11.4	15.8	1.9
Czech Republic	91.4	0(e)	8.6	0
Denmark	82.5	1.6	16	0
Finland	75.1	2.6	20.4	1.9
France	75.8	12.7	10.4	1
Germany	75	12.6	10.5	1.8
Greece	56.1	..	..	..
Hungary	75.5	0.2	21.3	3
Iceland	83.7	0(e)	16.3	0
Ireland	73.3	7.6	13.5	5.6
Italy	75.4	0.9	22.6	3.1
Japan	78.3	0.3	16.8	4.5
Korea	44.4	..	41.3	..
Luxembourg	87.8	1.6	7.7	1.2
Mexico	47.9	0.6	51.5	0
Netherlands	63.4	15.2	9	12.4
New Zealand	78	6.3	15.4	0.4
Norway	85.2	0(e)	14.3	0.5
Poland	70	..	..	..
Portugal	68.5	..	..	0.1
Slovak Republic	89.4	0(e)	10.6	0
Spain	71.7	3.9	23.5	0.9
Sweden	85	..	..	..
Switzerland	55.6	10.5	32.9	1
Turkey	..	..	..	..
United Kingdom	80.9	..	..	..
United States	44.2	35.1	15.2	5.6
OECD average (22)	73.5	6.3	17.7	2.5

Notes:

(e) Zeros ("0") have been estimated in cases where data were not reported but the sum of all other sources of financing amounted to 100%. While some PHI might exist in these countries, the size of the market is negligible.

.. indicates that reliable data is not available.

"All other private funds" include health expenditure incurred by corporations and private employers providing occupational health services, expenditure by non-profit institutions serving households; benefits provided for free by medical care providers and health expenditure incurred by the rest of the world.

"OECD average" includes all countries for which data are available or zeros were estimated. It excludes Belgium, Greece, Korea Poland, Portugal, Sweden, Turkey and the United Kingdom.

Some of the countries for which estimates for private health insurance for 2000 are unavailable have data available for other years: Portugal (1.5% in 1997); Turkey (0.7% in 1994); and the United Kingdom (3.3% in 1993).

Source: OECD Health Data 2003, 2nd Edition.

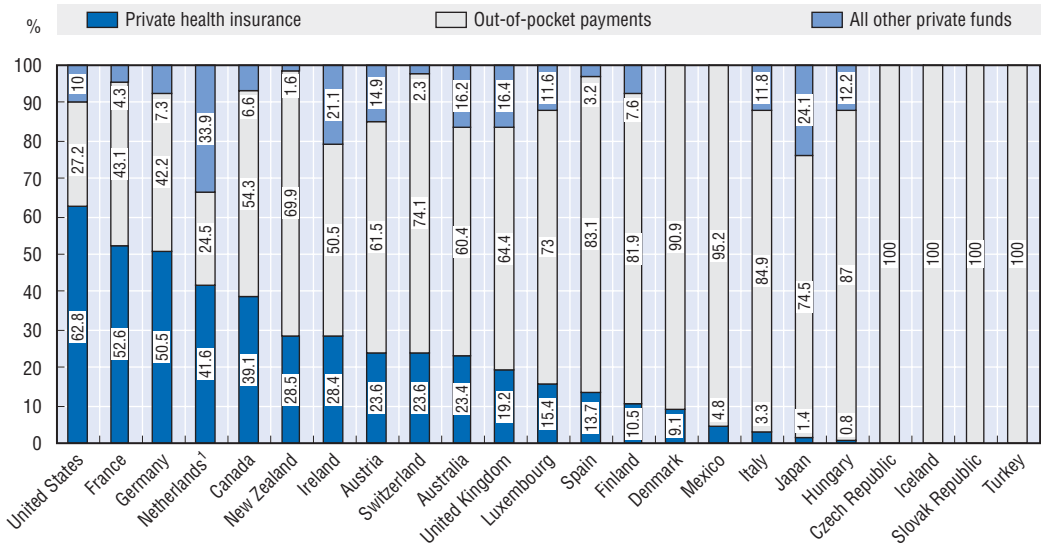
cover the entire population or large segments of it through social security or social health insurance. The third cluster of countries, with the exception of Austria, are tax-financed systems.

Private health insurance accounts on average for 24% of total private health financing²⁵

There are large cross-country variations in the extent to which PHI finances private health expenditure (Figure 2.3). High PHI-share countries (with PHI over 10% of THE) tend to be those which finance THE less from out-of-pocket expenditures, both as percentage of

Figure 2.3. **Breakdown of private financing of health expenditure, 2000**

Countries ranked by contribution of PHI to total private health expenditure



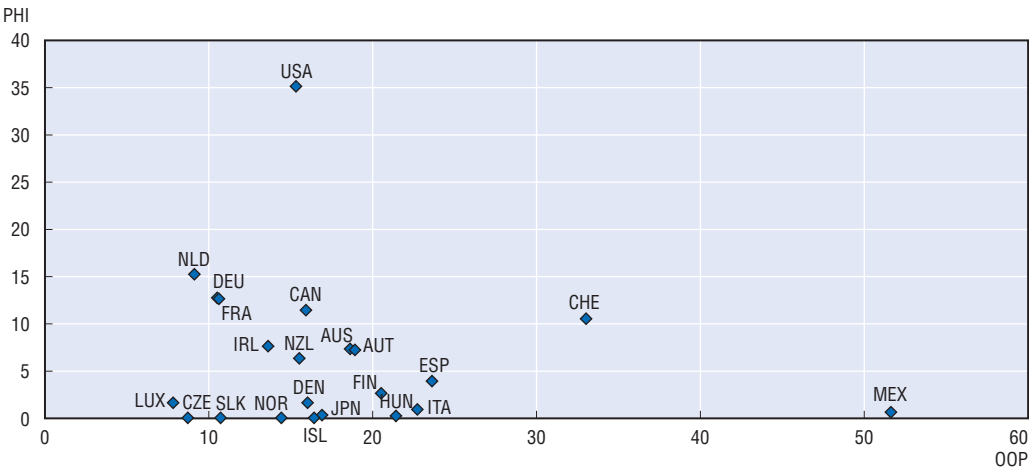
1. The relative high value for “other private funds” for the Netherlands is explained by the inclusion of administration costs of private health insurers.

Source: OECD Health Data 2003, 2nd Edition.

total private health expenditure²⁶ and as percentage of total health spending.²⁷ This does not however imply the existence of an inverse relationship between the share of PHI and out-of-pocket expenditure in financing health spending for the OECD area as a whole (Figure 2.4).²⁸ There is also no necessary relationship between high PHI-share and low public health spending²⁹ (Figure 2.5).

Figure 2.4. **Out-of-pocket payments (OOP) and private health insurance, 2000**

Percentage of total health expenditure

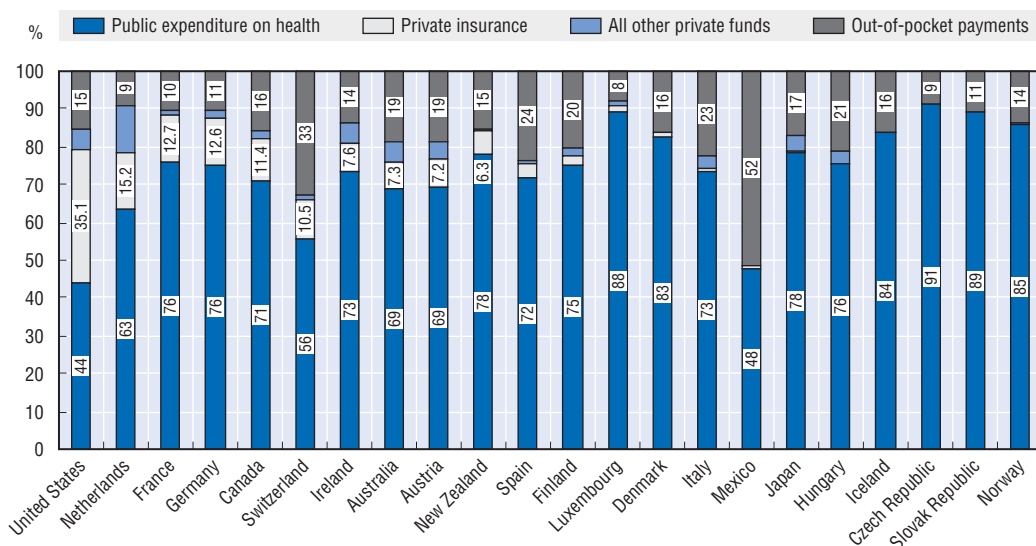


Note: The linear trendline equation is $y = -0.1371x + 8.6814$, with $R^2 = 0.0259$. There is therefore no relationship between out-of-pocket payments as a share of total health expenditure and PHI as a share of total health expenditure. This also applies when the United States is excluded. The equation becomes $y = -0.0979x + 6.6266$, with $R^2 = 0.0351$.

Source: OECD Health Data 2003, 2nd Edition.

Figure 2.5. **Health expenditure by source of funding, 2000**

Countries ranked by share of PHI in total health expenditure



Source: OECD Health Data 2003, 2nd Edition.

The absolute size of markets varies largely

Absolute and per capita funding through private health insurance also varies substantially in OECD countries (Table 2.5 and Figure 2.6). There is a positive but weak

Table 2.5. **Levels of PHI premiums and claims, 2000**

Million, USD PPP

	Premiums	Claims
Australia	5 403	4 990
Austria	1 274	983
Belgium	818	681
Canada	13 528	11 699
Czech Republic	102	24
Finland	56	40
Germany	22 035	14 484
Greece	21	n.a.
Hungary ¹	23	6
Ireland	669	542
Italy	1 569	716
Japan ²	225.4	n.a.
Luxembourg	13	n.a.
Mexico	1 409	1 014
Netherlands	5 389	4 860
New Zealand ¹	354	n.a.
Poland	311	115
Portugal	294	284
Slovak Republic	3	1
Spain	3 545	2 884
Sweden	967	n.a.
Switzerland	3 688	2 84
Turkey ¹	434	295
United Kingdom	4 048	3 228

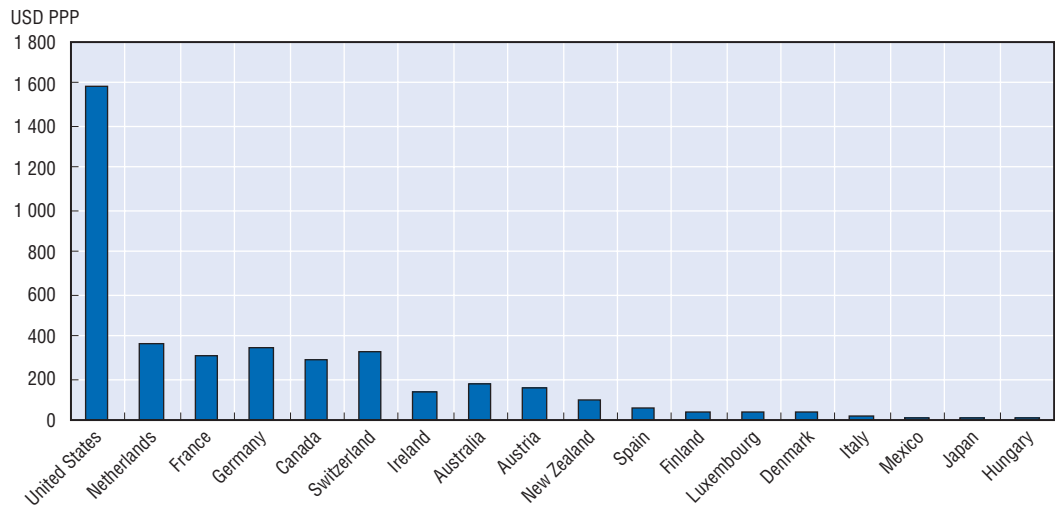
n.a. not available.

1. Data from 1998.

2. Data from 1999.

Source: OECD Statistical Questionnaire on Private Health Insurance.

Figure 2.6. **Per capita expenditure on private health insurance, 2000**
Countries ranked by share of PHI in total health expenditure



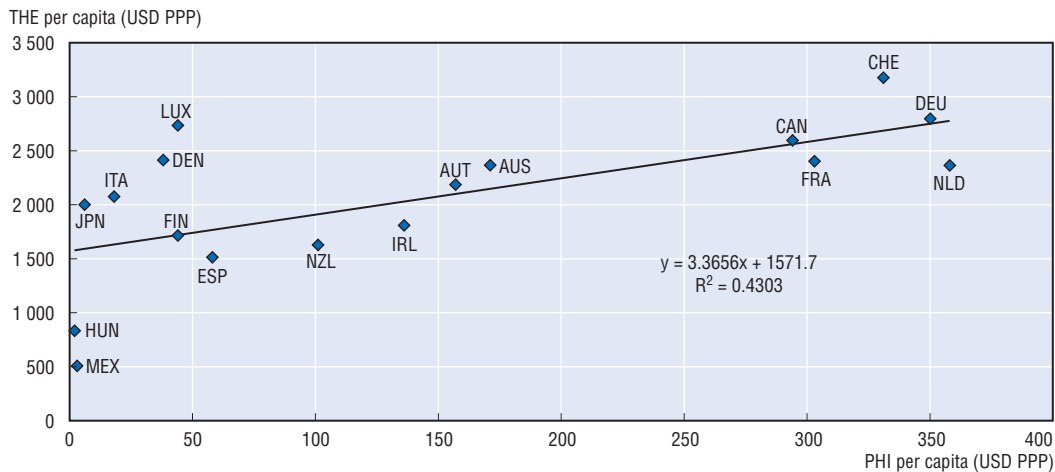
Source: OECD Health Data 2003, 2nd Edition.

relationship between financing through PHI and total health expenditure (Figure 2.7).³⁰ As shown in Figure 2.8, not all countries with high per capita spending on health have a high PHI share in total health expenditure.

The contribution of PHI to total health expenditure increased slightly between 1990 and 2000

The lack of time series data for several OECD countries hinders trend analysis of the contribution of PHI to financing health expenditure. Table 2.6 shows the evolution of PHI, out-of-pocket expenditure and public financing as a share of total health expenditure for 12 countries for which data are available for 1990 and 2000. The share of private health

Figure 2.7. **PHI and total health expenditure (THE) per capita, 2000**

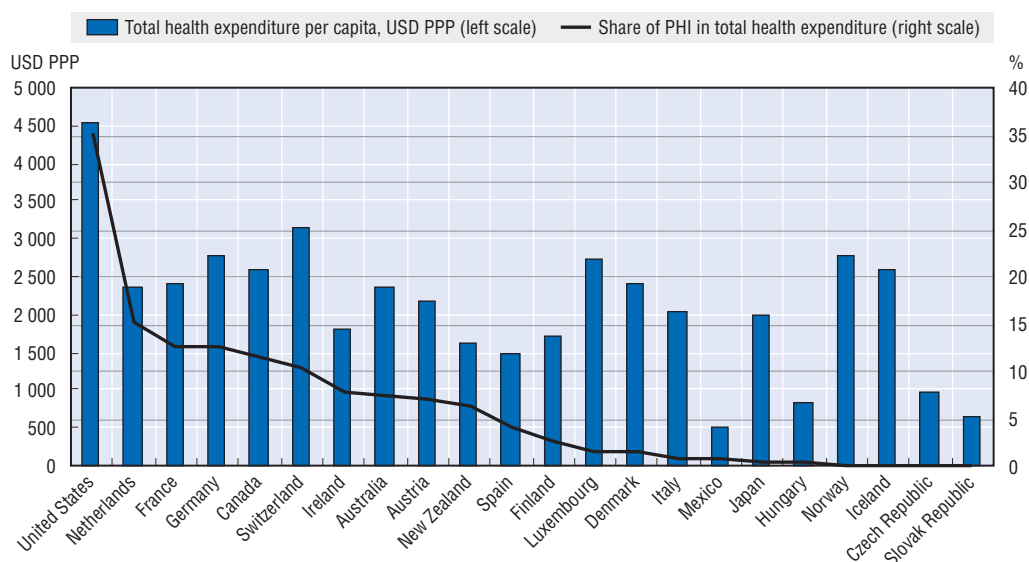


Note: The United States is excluded. If the United States is included, the equation becomes: $y = 1.9258x + 1759.4$ with $R^2 = 0.6281$.

Source: OECD Health Data 2003, 2nd Edition.

Figure 2.8. **Per capita spending on health and share of PHI in total health expenditure, 2000**

Countries ranked by share of PHI in total health expenditure



Source: OECD Health Data 2003, 2nd Edition.

insurance rose on average by 1% (from 8.5% to 9.4%), while out-of-pocket expenditure increased by 0.7% (from 17.2% to 17.9%). Public health financing decreased by 1.4% (from 70.6% to 69.2%). PHI is becoming a more important source in financing THE in certain OECD countries (such as Canada, Germany and New Zealand) possibly due to cost containment measures applied to public health systems and increased coverage of services previously paid for out-of-pocket. In other countries, however, the importance of PHI in funding total and private health

Table 2.6. **Out-of-pocket payments (OOP), PHI and public health financing, 1990 and 2000**

Percentage of total health expenditure

	Private health insurance		Out-of-pocket payments		Public health spending	
	1990	2000	1990	2000	1990	2000
Australia	11.4	7.3	16.6	18.5	67.1	68.9
Canada	8.1	11.4	14.4	15.8	74.5	70.9
Denmark	1.3	1.6	16.0	15.9	82.7	82.5
Finland	2.1	2.6	15.5	20.4	80.9	75.1
France	11	12.7	11.4	10.4	76.6	75.8
Germany	7.2	12.6	11.1	10.5	76.2	75.0
Ireland	9.1	7.6	16.5	13.5	71.9	73.3
Italy	0.6	0.9	15.3	22.6	79.3	73.4
New Zealand	2.8	6.3	14.5	15.4	67.1	63.4
Spain ¹	3.7	3.9	18.7	23.5	78.7	71.7
Switzerland	11	10.5	35.7	32.9	52.4	55.6
United States	34.2	35.1	20.1	15.2	39.6	44.2
Average (12 countries)	8.5	9.4	17.2	17.9	70.6	69.2

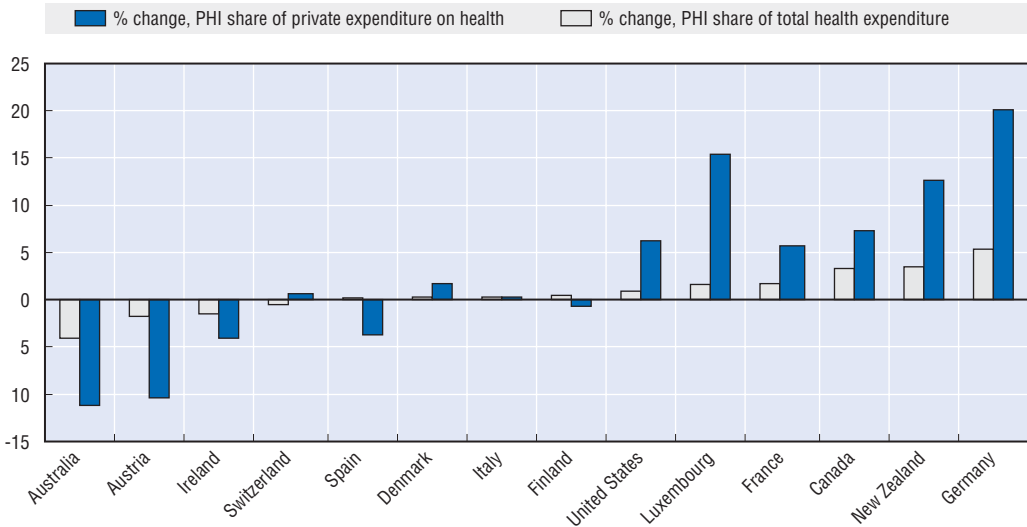
Note: This table includes only countries where reliable data on PHI, OOP and public spending were all available for 1990 and 2000.

1. For Spain, OOP payments refer to 1991 instead of 1990.

Source: OECD Health Data 2003, 2nd Edition.

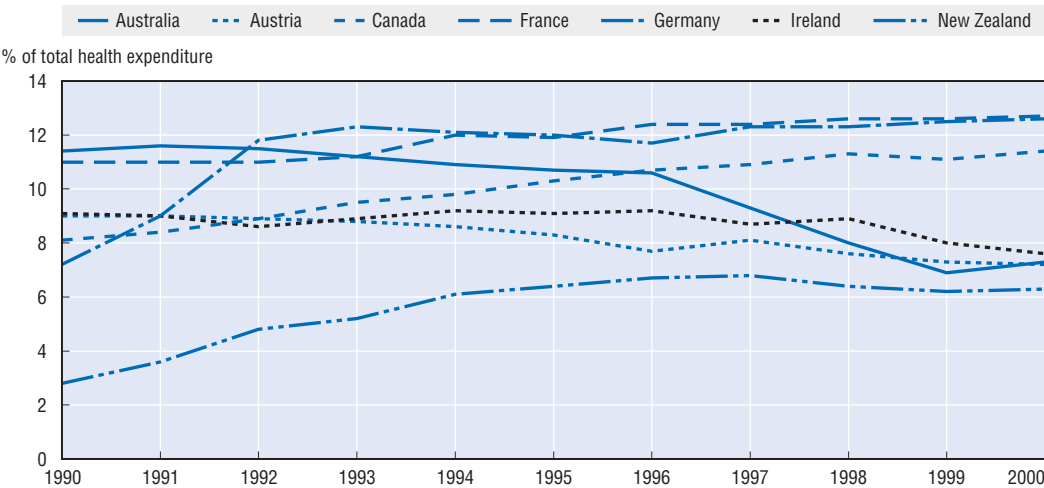
Figure 2.9. **Change in the share of total health expenditure and of private health expenditure accounted for by PHI, 1990-2000**

Countries ranked by the magnitude of the change of PHI as a share of total health expenditure



Source: OECD Health Data 2003, 2nd Edition.

Figure 2.10. **Evolution of financing through PHI in selected OECD countries 1990-2000**



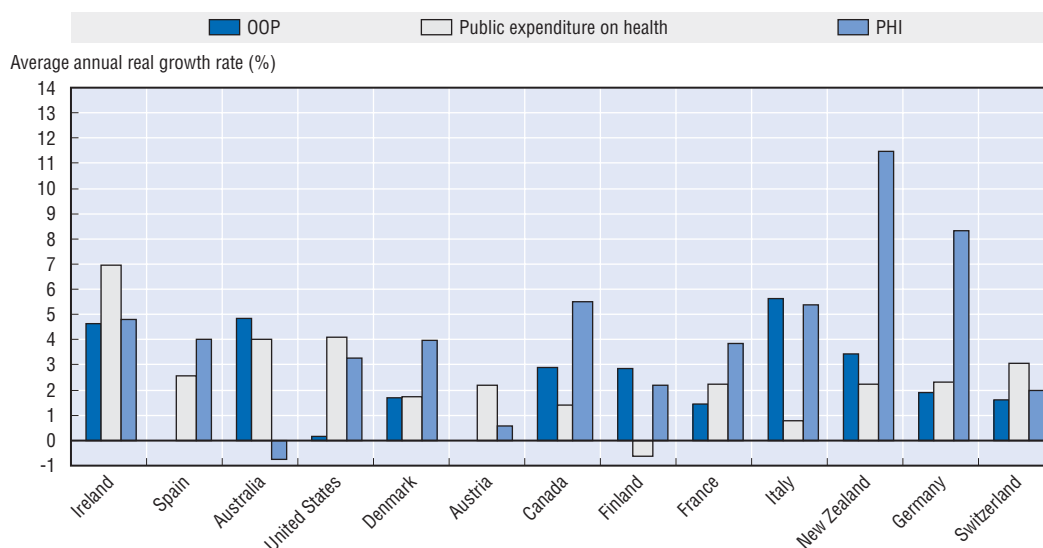
Source: OECD Health Data 2003, 2nd Edition.

expenditures has decreased over time (e.g., Austria, Ireland³¹ and Australia) (Figures 2.9 and 2.10). There is also no clear pattern of substitution between out-of-pocket spending and private health insurance over time, nor a convergence towards similar share of private health insurance and out-of-pocket expenditures in THE across OECD countries.

Figure 2.11 shows the average real growth rates of PHI, out-of-pocket payments and public health funding per capita over the period 1990-2000. Only about half of the countries, but most notably New Zealand, Germany and Canada, show higher PHI growth rates than public health expenditure.³² This has not necessarily paralleled economic growth.

Figure 2.11. Real growth of PHI, out-of-pocket payments (OOP) and public health expenditure per capita, 1990-2000

Countries ranked from high to low average real growth rate of GDP per capita



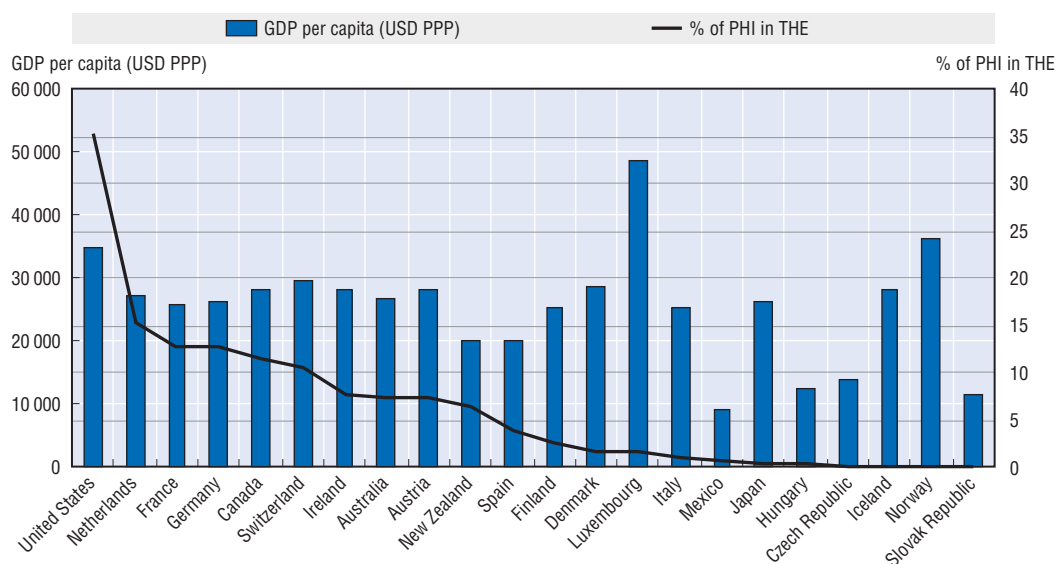
Source: OECD Health Data 2003, 2nd Edition.

Financing by PHI is not correlated to GDP

Funding through PHI does not increase with GDP, and the share of total health expenditure accounted for by PHI does not necessarily expand as economies develop. There is no evident link between level of economic development and share of total health expenditures financed by PHI (Figure 2.12), both including and excluding the main outlier, the United States (Figure 2.13). This is also true when considering trends. Economic growth

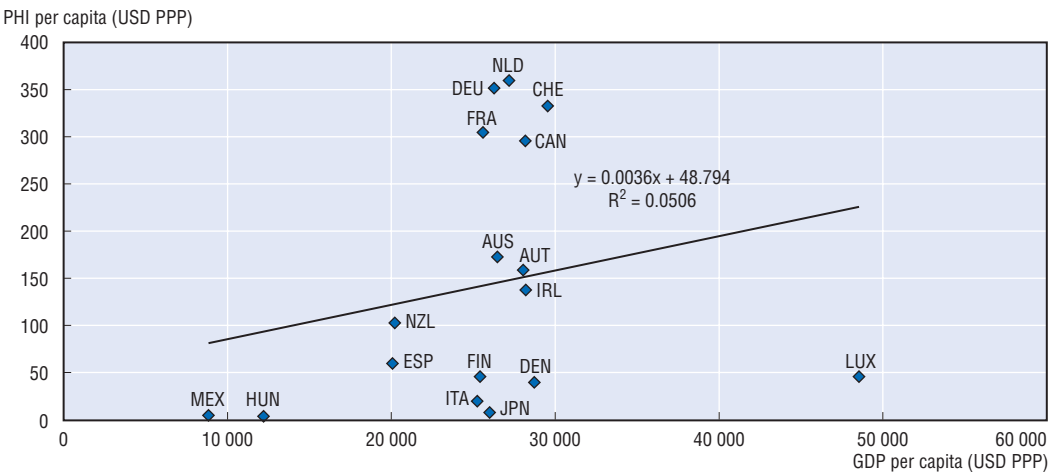
Figure 2.12. GDP per capita and share of PHI in total health expenditure (THE), 2000

Countries ranked by share of PHI in total health expenditure



Source: OECD Health Data 2003, 2nd Edition.

Figure 2.13. PHI per capita and GDP per capita, 2000



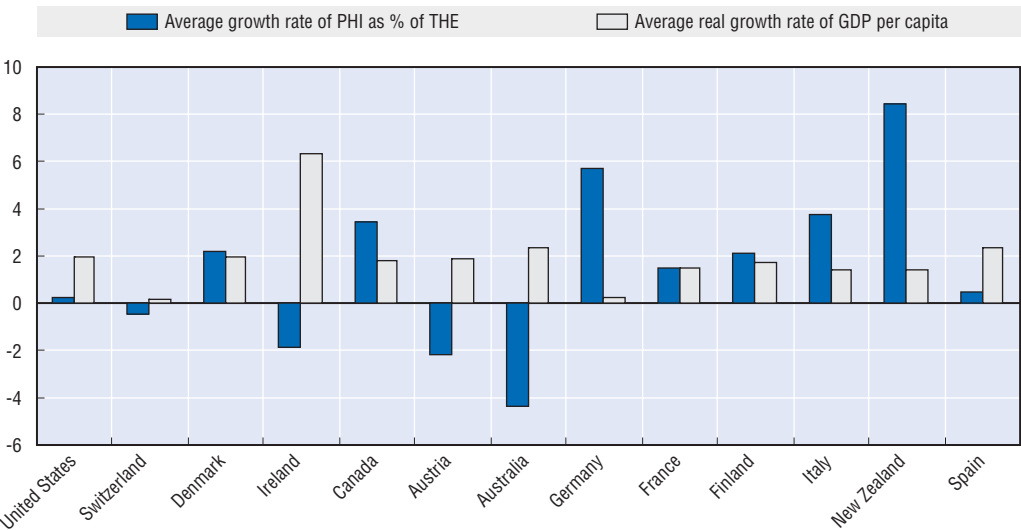
Note: The United States is excluded. If the United States is included, the equation becomes $y = 7.1935x + 24476$, with $R^2 = 0.1004$

Source: OECD Health Data 2003, 2nd Edition.

has resulted in an increase in the prominence of PHI in financing THE in some countries but not in others (Figures 2.14 and 2.15). However, one low-income and high-growth OECD country, New Zealand, experienced the highest increase in the THE share financed by PHI.

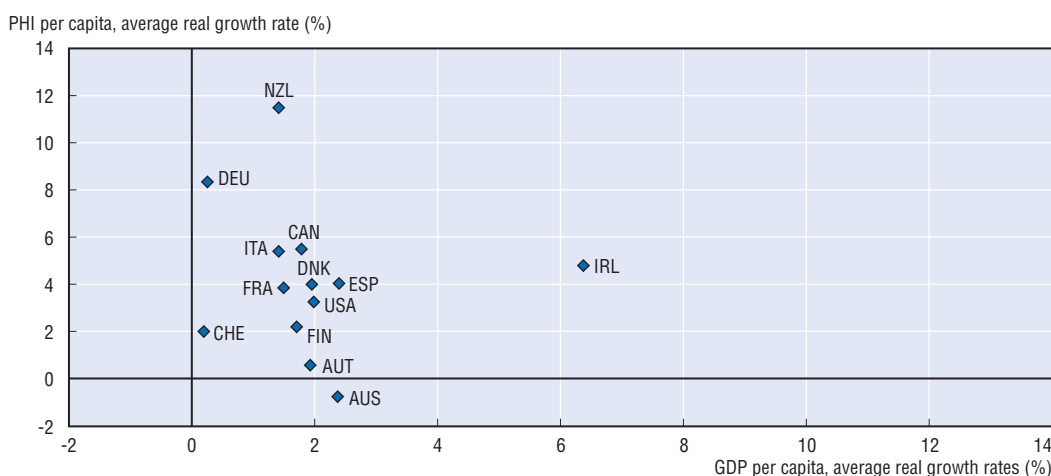
The above-mentioned trends have some implications for health systems performance. The reduction in financing through public sources arguably reduces the progressivity of health financing structures. However, the extent to which PHI is purchased by high-risk and low-income individuals, which varies considerable by countries (see Section 2.4.2.), affects the impact of current trends on financing equity. No clear trend in the degree of progressivity of the funding mix emerges in the OECD area, as various sources of financing health care may be becoming more or less progressive as a result of reforms.³³

Figure 2.14. Average growth rate of PHI (percentage of total health expenditure) and of GDP per capita, 1990-2000



Note: Countries are ranked by level of GDP per capita, USD PPP.

Source: OECD Health Data 2003, 2nd Edition.

Figure 2.15. **Average real growth rates of per capita PHI and GDP, 1990-2000**

Note: The linear trendline equation is $y = -0.2518x + 4.685$, with $R^2 = 0.014$. There is therefore no relationship between average real growth rates of per capita PHI and per capita GDP.

Source: OECD Health Data 2003, 2nd Edition.

The evolution of financing sources may also impact incentives for expenditure growth. There is a negative correlation between public share of health care expenditures and the share of GDP accounted for by THE, though this correlation is weak when excluding data from the United States (Tuohy et al., 2001).³⁴ Similarly, as shown in Figure 2.7, there is positive correlation between PHI and THE per capita, which is however weak when excluding data from the United States. Population covered by PHI – as described below – is not clearly linked to total health expenditure, although countries with either a high share of PHI in THE or high population covered by PHI tend to have high health spending. In order to better understand the impact of PHI on health spending, it is important to review incentives created by PHI market structures and by the interaction of privately and publicly financed segments of health systems, as examined in Chapter 4.

3.3. Levels of population covered by PHI

Table 2.7 shows the proportion of the population covered by private health insurance. On average, around 30% of the population has at least one type of PHI in OECD countries,³⁵ with great variation across countries. OECD members can be grouped along *different clusters* of population coverage. In France, Switzerland, the United States, the Netherlands and Canada, over 60% of the population has PHI. Private coverage ranges between 30% and 60% of population in Australia, Austria, Ireland, the Netherlands (for a different type of insurance), New Zealand and Belgium. PHI insures between 10% and 30% of the population in Germany, Portugal, Spain, Italy, Finland and the United Kingdom. Finally, a number of other countries have small or negligible population coverage (e.g., Turkey, Mexico, Denmark).

Market sizes are not clearly linked to one particular role of PHI within the system, nor are they linked to coverage by public insurance, because private insurees often have some public cover, apart from the case of primary PHI. For example, high-coverage countries include a variety of PHI roles. While Australia and Ireland have significant levels of PHI coverage, other duplicate PHI markets tend to be smaller (e.g., the United Kingdom, the

Table 2.7. **Coverage by public schemes and private health insurance in OECD countries, 2000**

	Public health expenditure as % of THE ¹	Public system coverage ¹	Eligibility for public coverage ²	PHI as % of THE ¹	Population covered by PHI, % ³	Types of private coverage
Australia	68.9	100	All permanent residents are eligible for Medicare (the tax-financed public health insurance system). Eligible persons must enrol with Medicare before benefits can be paid.	7.3	44.9 40.3 ⁴	Duplicate, Complementary Supplementary
Austria	69.4	99	Almost all labour force participants and retirees are covered by a compulsory statutory health insurance. Social assistance claimants and prisoners receive health benefits and services from the state authorities. 1% are without coverage.	7.2	0.1 31.8	Primary (Substitute) Complementary, Supplementary
Belgium	72.1	99	Compulsory statutory health insurance includes one scheme for salaried workers and one scheme for the self-employed people (about 12% of the population in 1999). The latter excludes coverage of “minor risks” such as outpatient care, most physiotherapy, dental care and minor operations.	n.a.	57.5 ^a	Primary (Principal), Complementary, Supplementary
Canada	70.9	100	All population is eligible for public coverage financed by Federal and Provincial taxation.	11.4	65 (e)	Supplementary
Czech Republic	91.4	100	All permanent residents are eligible for statutory health insurance coverage.	0 (e)	Negligible	Supplementary
Denmark	82.5	100	All population is eligible for public coverage financed by State, County and Municipal taxation.	1.6	28 (1998)	Complementary, Supplementary
Finland	75.1	100	All population is eligible for public coverage financed by State and Municipal taxation.	2.6	10	Duplicate, Complementary, Supplementary
France	75.8	99.9	The social security system provides coverage to all legal residents. 1% of the population is covered through the Couverture Maladie Universelle (CMU).	12.7	86 (92 including CMU)	Complementary, Supplementary
Germany	75	90.9	All employed people and their dependents are covered by statutory health insurance coverage. This does not include self-employed individuals and civil servants. Employees with an income above an income threshold can opt out of the social sickness fund system. Fulfilling certain requirements, social security insurees can choose to “stay in” the public system on a voluntary basis even if they are allowed to opt out of the system. Self-employed may also join on a voluntary basis.	12.6	18.2 of which: 9.1 9.1 ^b	Primary (Substitute) Supplementary, Complementary
Greece	56.1	100	All population is eligible for public coverage, financed by a combination of taxation and social health insurance contributions.	n.a.	10 ⁵	Duplicate, Supplementary
Hungary	75.5	100	All permanent residents are eligible for statutory health insurance coverage. Only 1% of the population was not covered in 1999.	0.2	Negligible	Supplementary
Iceland	83.7	100	All permanent residents are eligible for statutory health insurance coverage.	0 (e)	Negligible	Supplementary
Ireland	73.3	100	All resident population is eligible for public hospital coverage, financed by general taxation. Only about one third of the population with medical cards is eligible to GP and other outpatient coverage.	7.6	43.8	Duplicate, Complementary, Supplementary
Italy	73.4	100 (1997)	All population is covered by the National Health Service system, financed by general taxation.	0.9	15.6 (1999) ⁵	Duplicate, Complementary, Supplementary

Table 2.7. **Coverage by public schemes and private health insurance in OECD countries, 2000** (cont.)

	Public health expenditure as % of THE ¹	Public system coverage ¹	Eligibility for public coverage ²	PHI as % of THE ¹	Population covered by PHI, % ³	Types of private coverage
Japan	78.3	100	All population is covered by a statutory social health insurance system.	0.3	Negligible	n.a.
Korea	44.4	100	All population is covered by a statutory social health insurance system.	n.a.	n.a.	Supplementary
Luxembourg	87.8	99	All population is covered by a statutory social health insurance system, apart from civil servants and employees of international institutions (1%).	1.6	2.4	Complementary, Supplementary
Mexico	47.9	45-55 (e) ^c	Public social security schemes cover all the population working in the private formal sector and government workers, <i>i.e.</i> excluding independent self-employed workers, informal sector workers and unemployed people. From 2004, the System of Social Protection in Health offers a new public health insurance scheme that has been implemented to provide voluntary public health insurance to the population previously excluded from social security.	2.5 (2001)	2.8	Duplicate, Supplementary
Netherlands	63.4	75.6	Eligibility to statutory health insurance is determined by income. Individuals above a threshold are not covered (28.9% in 2000).	15.2	92 of which: 28 64 (e) ^b	Primary (Principal) Supplementary
New Zealand	78	100	All population is eligible to public coverage financed by general taxation.	6.3	35 ⁶	Duplicate, Complementary, Supplementary
Norway	85.2	100	All population is eligible to public coverage financed by State, County and Municipal taxation.	0 (e)	Negligible	n.a.
Poland	70	n.a.	All eligible groups are entitled to statutory health insurance cover. People who are not specified in the eligible groups by the Act of 6 February 1997 can purchase the social health insurance voluntarily.	n.a.	Negligible	Supplementary
Portugal	68.5	100	All population is covered by the National Health Service system, financed by general taxation.	1.5 (1997)	14.8	Duplicate, Complementary, Supplementary
Slovak Republic	89.4	100 (1999)	All population is covered by a statutory social health insurance system.	0 (e)	Negligible	Supplementary
Spain	71.7	99.8 (1997)	Almost all the population is covered by the National Health System, financed by general taxation. Civil servants and their dependents are covered through a special scheme. A minor group of self-employed liberal professionals and employers are uncovered.	3.9	13 of which: 2.7 ⁷ 10.3 ⁷	Primary (Substitute, Principal) Duplicate, Supplementary
Sweden	85	100	All population is covered by a statutory social health insurance system, financed by local taxes and state grants.	n.a.	Negligible	Complementary, Supplementary
Switzerland	55.6	100 ^d	All permanent residents are mandated to purchase basic health insurance.	10.5	80 ^d	Supplementary
Turkey	71.9 (1998)	66 (1997)	Population coverage through three social security schemes for private sector employees, blue collar public sector employees, self-employed persons and retired civil servants.	0.7 (1994)	< 2 ⁸	Complementary, Supplementary

Table 2.7. Coverage by public schemes and private health insurance in OECD countries, 2000 (cont.)

	Public health expenditure as % of THE ¹	Public system coverage ¹	Eligibility for public coverage ²	PHI as % of THE ¹	Population covered by PHI, % ³	Types of private coverage
United Kingdom	80.9	100	All UK residents are covered by the National Health Service system, financed by general taxation.	3.3 (1996)	10	Duplicate, Supplementary
United States	44.2	24.7	Individuals eligible to public programmes include those older than 64 and severely disabled (Medicare), poor or near poor (Medicaid) and poor children (SCHIP). Eligibility thresholds to Medicaid are set by states.	35.1	71.9	Primary (Principal) Supplementary, Complementary

n.a. Indicates not available.

(e) Indicates that figures are estimated.

Negligible indicates a proportion covered of less than 1%.

PHI: Private health insurance.

THE: Total health expenditure.

CMU stands for “Couverture Maladie Universelle”, a publicly financed programme providing complementary health insurance to eligible low income groups.

- a) For Belgium, data include voluntary PHI policies for hospital care offered by sickness funds as well as PHI policies offered by commercial companies. They exclude policies for hospital care that are compulsorily offered by several sickness funds to their members, that guarantee insureds a limited lump sum (mostly less than 12.4 euros per day: Office de Contrôle des Mutualités et des Unions Nationales de Mutualités, 2002, *Rapport Annuel*, p. 81) and covered about 67% of the population in 2000.
- b) For the Netherlands and Germany, the data refer to supplementary PHI policies purchased by individuals who belong to the social health insurance system. Some of the individuals with primary PHI are also covered by supplementary PHI, which are sometimes packaged with primary PHI policies.
- c) These coverage figures relate to social security schemes, which include workers in the private formal sector and civil servants. Important to note that public health expenditure as % of THE includes all public health spending, i.e. both social security spending and other public spending, such as resources used to finance health care provision for the uninsured population through the states' health services. Estimates vary depending on the source used; population survey data report lower figures, official administrative data report higher figures but no roster of individuals covered by the social security system is available.
- d) For Switzerland, data on PHI refer only to voluntary private health insurance coverage. Mandatory health insurance covering the entire population is reported in OECD Health Data as public coverage, although it is a border line case.

Source: Specific data sources have been indicated below; information was also supplied by OECD member countries or obtained from official publications.

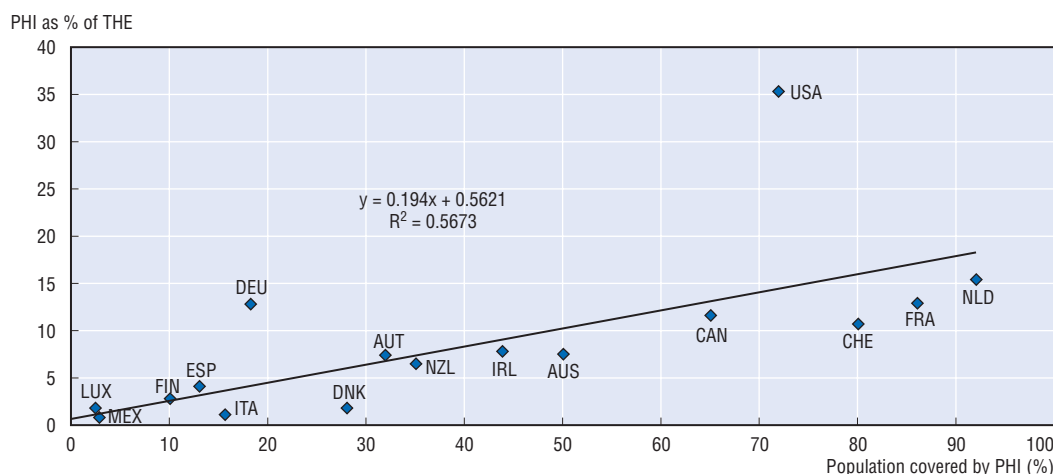
1. OECD Health Data 2003, 2nd Edition, 2000 data unless otherwise indicated.
2. OECD Regulatory Questionnaire on Private Health Insurance, 2003 and other official sources.
3. OECD Statistical Questionnaire on Private Health Insurance, 2000 data, unless otherwise specified.
4. PHIAC (2002), *Operations of the Registered Health Benefits Organisations Annual Report 2001-02*. Data refer to June 2001.
5. Mossialos and Thomson (2002), *Voluntary Health Insurance in the European Union*.
6. European Observatory on Health Care Systems (2001), *Health Care Systems in Transition*, New Zealand.
7. Ministry of Health, Spain (2003), *National Health Survey 2001*. According to another estimate population coverage was 16.2% in 2002 (11.3% duplicate and 4.9% substitute) (Data from UNESPA, December 2003).
8. UK Trade & Investment, Health Care & Medical Market in Turkey, www.tradepartners.gov.uk/healthcare/turkey/profile/overview.shtml; note this figure does not distinguish between PHI alone and PHI offered as riders to life insurance policies.

Mediterranean and Nordic countries). Countries where individuals have PHI as primary coverage are spread across different coverage clusters.³⁶

There is a positive, not very strong, correlation between the level of population covered by PHI and the share of total health spending accounted for by PHI (Figure 2.16). There is also a weak correspondence between countries with high coverage and those with high expenditure on health (Figure 2.17). On the other hand, the role played by PHI seems to be a large determinant of PHI's funding contribution. For example, the share of PHI in total health spending tends to be similar in countries where PHI plays the same role and involves a comparable population size (*e.g.*, Australia and Ireland). Also, despite similar levels of population participation in PHI markets, the share of PHI in total health spending differs substantially between countries where PHI has a primary role (*e.g.*, the United States) and countries where it has a non-primary role (*e.g.*, Canada). Countries with different roles and levels of coverage, sometimes have analogous shares of PHI in THE, as in the case of Germany and France. The high PHI spending in Germany for a smaller population covered can be explained by the substitute role of PHI. Overall, the observed patterns indicate that the link between the share of population covered by PHI and its share in THE is in part the result of the functions that private health insurance plays within the health system.

While time series on population covered by PHI are limited to a few OECD countries, no uniform trend appears. Patterns are influenced by country-specific conditions. In Australia, the level of population covered by PHI declined steadily since the mid-1980s and throughout the 1990s, due to the establishment of universal public insurance in 1984 and a process of adverse selection in the market. Government policies to support private insurance have redressed levels of population coverage to over 40% since 2000 (Colombo and Tapay, 2003). In Ireland, a booming economy and the increasing provision of PHI as a work-related benefit are responsible for an uninterrupted growth in population coverage from 22% in 1979 to 48% in 2002, despite an expansion in the generosity of public cover (Colombo and Tapay, 2004a). Fluctuations in participation in the United States PHI market

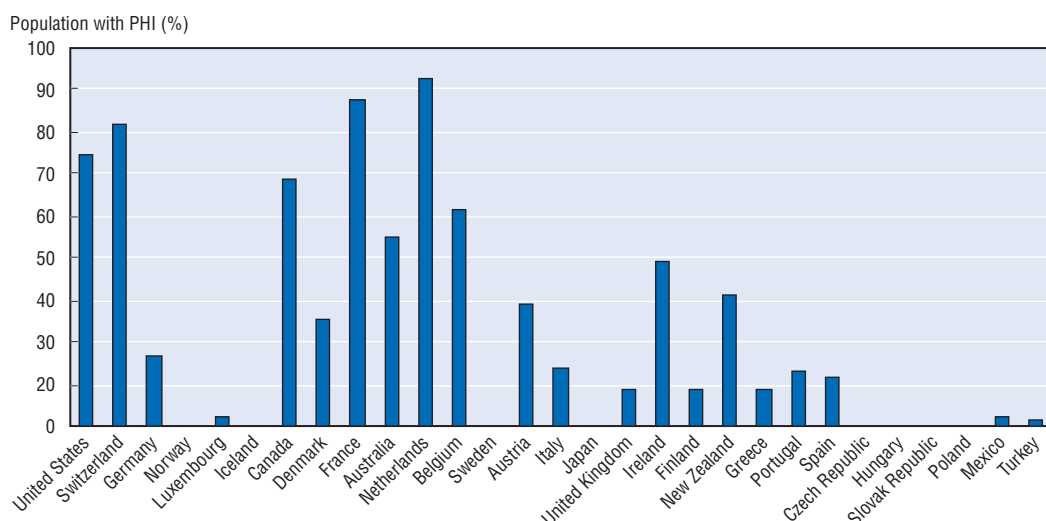
Figure 2.16. **Population covered by PHI and PHI share in total health expenditure (THE), 2000**



Note: For countries with more than one level of coverage depending on type of PHI policy, the percentage of population covered by PHI used here includes all individuals who have at least one PHI cover.

Source: OECD Health Data 2003, 2nd Edition; OECD Statistical Questionnaire on Private Health Insurance; other official data supplied to OECD.

Figure 2.17. **Population covered by PHI, 2000**
Countries ranked by total health expenditure per capita (USD PPP)



Note: Coverage data for Denmark refer to 1998. The percentage of population with PHI includes all individuals with at least one type of PHI cover. In the Netherlands, 28% of the population has primary cover, but an additional 64% has supplementary policies. Data for Switzerland refer to voluntary coverage. In Germany, 9.1% has substitute cover, and another 9.1% buys supplementary PHI. Australia includes individuals with hospital cover and a minority of individuals purchasing only ancillary PHI. Spain includes primary, duplicate and other PHI cover.

Source: OECD Health Data 2003, 2nd Edition; OECD Statistical Questionnaire on Private Health Insurance.

reflect variations in affordability by population groups and the relative stability of the labour market, as most individuals receive PHI through their employer. In France and the Netherlands, population coverage has been fairly stable and high, reflecting a certain propensity to buy insurance by the population.

Levels of population coverage have implications for market stability, particularly in countries where the profile of people buying private health insurance is spread across different risk cohorts. They also may affect insurers' drive and ability to better monitor and control cost, as well as their incentives to selectively cover different types of risks.

3.4. Benefits covered by PHI

PHI covers different benefits across OECD countries, both in terms of health services and providers. There is no typical benefit package, although there are similarities within PHI roles. Services and providers covered may or may not match those covered by public systems, reflecting health system structures, specific regulation and market strategies by insurers (Table 2.8). In particular, the scope of PHI packages is strongly influenced by the scope of public coverage and PHI's resulting role in the health system. Policies representing the primary form of coverage for population segments tend to be the most comprehensive and often resemble basic cover in public insurance programmes.³⁷ Those that duplicate public coverage also include similarly comprehensive benefits, but usually for a more limited range of providers, and cover additional benefits such as choice of doctor and treatments in private hospitals.³⁸ Supplementary and complementary policies are more limited and often varied in scope, though they are in several countries packaged and sold together with principal or duplicate PHI. The diversity of coverage experiences seems to indicate that there is no type of service that is per se more or better "insurable" by public or

Box 2.4. **Benefits covered by private health insurers**

Private health insurance covers, in almost all OECD countries, “small risks”, ancillary and supplementary services such as dental and optical services, choice of provider, upgraded hospital accommodation, and luxury services. Often, these services are not provided, or only partly reimbursed, by public coverage systems. Coverage of home care, alternative medicine, long-term care and pharmaceuticals vary in relation to the generosity and structure of public health insurance.

Most, but not all, PHI policies cover **hospitalisation** expenses to some extent. All public coverage systems pay for hospitalisation, with differences in cost sharing required by individuals. Primary PHI always covers this benefit. Duplicate PHI usually covers hospital expenses for treatments received in privately financed hospital facilities. In Australia and Ireland, PHI also reimburses the hospital charges for patients electing to be treated privately within public hospitals. Duplication of hospital-related cost is often attached to other benefits such as enhanced choice of provider and, if public systems are characterised by waiting times, faster access to care. The type of hospital expenses paid for by PHI depends upon the level of development of the private delivery sector. Often, private hospitals in these countries provide predominantly elective or simple surgery. In social-insurance based health systems such as Germany, the Netherlands, Poland, Korea, Japan, Austria, France and Belgium, PHI usually pays for upgraded accommodation in hospitals but the cost of hospital treatment is usually covered by public systems, regardless of treating hospitals.

A similar differentiation emerges with respect to coverage of **GP and specialist services**. These services tend to be included in publicly financed packages. Their coverage by private insurers depends upon specific regulation, the structure of the delivery system, and other factors. Doctor’s services are included in principal PHI policies. Conversely, PHI insurers are not allowed to provide medical cover in Canada, and, with the exception of so-called in-patient medical gaps,* this coverage is currently prohibited in Australia. In Ireland, while two-thirds of the population do not have public GP coverage, private insurers provide limited protection against such cost, although new primary care products are developing. This may indicate that GP benefits are sometimes perceived to be services for which insurance protection is less important. The function of pre-payment of health service cost, rather than the risk-pooling function, may be more relevant for GP than hospital benefits. PHI may subject coverage of specialists to gatekeeping by a GP, as in US managed care plans, or may allow direct referral to specialists, as in several EU countries.

Private health insurance pays for **cost sharing** applicable to public health systems in several but not all OECD countries. This coverage often depends on health system regulation. While this is the main benefit offered by complementary health insurance in France, and is also a substantial component of the US Medicare Supplemental market, it is forbidden or restricted in other countries such as Canada. In Switzerland private voluntary health insurance cannot cover statutory co-payments on the mandatory health insurance system.

Benefits can be provided in **cash or in kind**. The cost of care can be directly billed to the individual, who then claims a cash reimbursement from the insurer. This constitutes for example the practice in Belgium, Denmark, France, Germany, the Netherlands, Australia, and the United States for a segment of the market. Insurers may also have direct arrangements with providers under which individuals receive benefits in kind or invoices are settled directly. For example this is often the case when insurers have contractual arrangements with providers and in managed care settings.

Many PHI policies, including those providing treatment in kind, tend to include some out-of-pocket expenditure – such as deductibles, co-payment, reimbursement ceilings and other cost-sharing. The level of cost sharing that insurers apply can be influenced by government regulation as well as insurers’ strategic choices to cost control, and vary to a large extent across OECD countries. Very limited data are available on the amount of out-of-pocket expenditures paid on PHI products across OECD countries.

* Medical gaps refer to the difference between the fee charged by a medical specialist for an in-patient treatment and the share that is reimbursed by the public system, Medicare, on the basis of scheduled fees.

Table 2.8. **Examples of benefits covered by public coverage systems and by PHI**

Public coverage	Private coverage
Australia ¹	• Duplicate: hospital, specialist in-hospital, and rehabilitative care; increased choice of doctor and hospital; faster access. • Complementary: co-payments for pharmaceuticals and medical gaps on in-hospital specialist care (difference between fee charged and Medicare reimbursement). • Supplementary: dentistry, pharmaceuticals, rehabilitative care, alternative medicine, home care, physiotherapy and luxury services.
Austria ³	• Increased choice of doctor; hospital care; dental care; alternative medicine; pharmaceuticals; outpatient care.
Belgium ^{2, 3}	• Substitute: minor risks for the self-employed. • Complementary: co-payments for non-reimbursed in/outpatient costs. • Supplementary: caregiver costs (loss of independence); supplementary hospital costs; luxury services.
Canada ¹	• Supplementary: dental care, pharmaceuticals, long-term care, rehabilitative care, alternative medicine and home care.
Czech Republic ³	• Supplementary: presently a very small market. This includes coverage for foreign nationals who are not eligible for the compulsory coverage and for services not provided under the state system (<i>e.g.</i>, cosmetic surgery or some categories of dental care, care abroad).
Denmark ^{2, 3}	• Duplicate: access to private hospitals in Denmark and abroad, faster access. • Complementary: co-payments for drugs, dental care, physiotherapy, spectacles, etc.
Finland ²	• Duplicate: hospital care (private and public); private care for children; faster access and increased choice of provider.
France ²	• Complementary: co-payments and cost sharing on public system (pharmaceuticals, specialist, GP, hospitals). • Supplementary: home help, luxury services (private room), dental and optical care.
Germany ¹	• Substitute: hospital care; GP/Primary; pharmaceuticals; specialist; dental care. • Substitute: long-term care. • Supplementary: specialist care (doctor choice); extra dental care; alternative medicine; luxury services.
Greece ³	• Duplicate: private hospitals, physicians in private practice, private diagnostic centres. • Supplementary: services not included or partially included in the statutory system.
Hungary ³	• Complementary: drug co-payments. • Supplementary: care abroad, preventive health, dental, medical aids and rehabilitation.
Ireland ¹	• Duplicate: hospital care, specialist; increased choice of provider; fast access to care. • Substitute: GP/Primary care, medical diagnostics and outpatient specialist care (population without a medical card). • Supplementary: alternative medicine; luxury services; non reimbursed pharmaceuticals.
Italy ^{2, 3}	• Duplicate: hospital care (private hospitals); increased choice of provider and fast access. • Complementary: co-payments (ticket moderateur, per diem charge in hospital). • Supplementary: non-reimbursed services; dental care.
Japan	• Duplicate: hospital, specialist in-hospital, and rehabilitative care; increased choice of doctor and hospital; faster access.

Table 2.8. **Examples of benefits covered by public coverage systems and by PHI (cont.)**

	Public coverage	Private coverage
Korea	• Hospital care; primary care; specialist care; pharmaceuticals; dental care.	
Luxembourg ^{1, 2, 3}	• Hospital care; primary care; specialist care; pharmaceuticals; dental care.	• Complementary: hospital co-payments. • Supplementary: pre, post-op and convalescence; dental prostheses; surgical treatment abroad; non-reimbursed expenses; Luxury services (private room).
Mexico ¹	• Hospital care; GP/Primary; specialist care; dental care; pharmaceuticals.	• Catastrophic expenses products only cover major hospital interventions; other health insurance products cover hospital care, GP, specialist care, dentistry, pharmaceuticals, long-term care, rehabilitative care, alternative medicine, home care and luxury services, and some preventative services.
Netherlands ²	• Hospital care; GP/Primary; specialist care; dental care (minimal); pharmaceuticals; long-term care.	• Primary: hospital care, GP, specialist care, pharmaceuticals. • Supplementary: dental care, alternative medicine and luxury services.
New Zealand ³	• Public hospital care; ambulatory care/primary care (with co-payments); pharmaceuticals (co-payment for out-patient Rx).	• Duplicate: elective care in private hospitals, fast access, choice of doctor. • Complementary: contributions towards GP fees. • Supplementary: luxury services.
Norway ³	• Public hospital care; GP/Primary; specialist care; pharmaceuticals (tiered co-payment); dental care (for children).	• Duplicate: private hospital and specialist care.
Poland ¹	• Hospital care; GP/Primary; specialist care (when patient is referred); pharmaceuticals; dental care (for children under 18 and pregnant women).	• Supplementary: extra amenities.
Portugal ^{1, 2}	• Public hospital care; GP/Primary care; specialist care; pharmaceuticals. • Dental care.	• Duplicate: private hospital care, GP, specialist, choice of doctor and speed of access. • Supplementary: additional dental care; ophthalmology; pharmaceuticals. • Complementary: co-payments.
Slovak Republic	• Hospital care; GP/Primary care; specialist care; pharmaceuticals. • Dental care.	• Supplementary: travel insurance.
Spain ^{1, 2}	• Public hospital care; GP/Primary; specialist care; pharmaceuticals (co-payments – Pensioners exempt); dental care (co-payments).	• Duplicate: private hospital care and specialist; increased provider choice; speed of access; private dental • Supplementary: additional dental care; luxury services.
Sweden ²	• Hospital care; Primary/GP; specialist care; pharmaceuticals.	• Duplicate: private hospital care and specialist; faster access to elective outpatient care. • Complementary: co-payments. • Supplementary: dental care; non-reimbursed pharmaceuticals; alternative treatment.
Switzerland ^{1, a}	• Hospital care; GP/Primary; specialist care; pharmaceuticals; dental care.	• Supplementary: luxury services; choice of doctor; upgraded accommodation; extra amenities.
Turkey ³	• Hospital care; GP/Primary; specialist care; pharmaceuticals; dental care (prostheses for private employees and dependents, more coverage retired civil servants).	• Complementary: coverage of co-payments on public systems. • Private hospital care.
United Kingdom ¹	• Public hospital care; GP/Primary; public specialist care; pharmaceuticals; dental care.	• Duplicate: private hospital care and specialist care, dental care. • Supplementary: long-term care and alternative medicine home care.
United States ¹	• Hospital care; GP/Primary; specialist care; some state variation exists for Medicaid and SCHIP.	• Primary: hospital care, GP, specialist care, dental care, pharmaceuticals, long-term care, rehabilitative care, alternative medicine and luxury services. • Complementary: co-payments on Medicare, pharmaceuticals and other gaps.

a) For Switzerland, data on PHI refer only to voluntary private health insurance coverage. Mandatory health insurance covering the entire population is reported in *OECD Health Data* as public coverage, although it is a border line case.

Sources:

1. OECD Regulatory Questionnaire on Private Health Insurance, 2003.
2. Mossialos and Thomson (2002).
3. European Observatory on Health Care Systems, *Health Care Systems in Transition. Various countries.* Information was also supplied by OECD member countries or obtained from official publications.

private coverage. There are nonetheless some trends towards a greater reliance on public or subsidised PHI for those facing higher health care cost, such as the elderly and those with chronic conditions, even where PHI plays a significant or primary role.

Both services and providers covered by private health insurance have implications for health system performance. In particular, they directly affect the ability of PHI to enhance choice over the providers, conditions and timeliness of care. They affect providers' and individuals' incentives to consume health care by providing coverage for services and cost that may otherwise have to be paid for out-of-pocket. They may also impact upon medical practice, particularly in countries where public and private delivery systems are linked to different funding sources. Doctors practising in both sectors will behave differently depending on the incentives and restrictions they face in the publicly and privately financed segments of their activities. These aspects will be analysed in more detail in Chapter 4.

4. Demand for private health insurance

4.1. Determinants of demand for PHI

Several factors can influence demand in a voluntary PHI market: price, perceived value of private cover, risk aversion, individuals' income and education are among the key factors. Evidence of determinants of demand for PHI is restricted to a few selected countries, usually with significant PHI markets, for which studies are available.

Demand for private health insurance appears to be relatively price inelastic in several countries, although there is large variation. Some studies on demand determinants indicate a relative price inelasticity of demand for principal PHI in the United States. This may be explained by the primary role of employers, rather than individuals, in purchasing insurance. Unemployment is indeed a more important factor affecting decisions to buy coverage, especially for more educated people (Glied and Jack, 2003). However, estimates vary to a large extent. Tax subsidies for PHI, and variation in tax regimes, affect demand for PHI by modifying the net price of insurance. The elimination of tax subsidies in the United States is estimated to have had a significant impact on the number of individuals having access to group insurance (Henderson and Taylor, 2002; Thomasson, 2003).

While price may intuitively be a more important determinant of purchasing decisions when PHI is purchased on top of public coverage, countries display variation in elasticity. Reduction in tax advantages in Quebec resulted in a decrease in employer-sponsored health insurance in Canada, especially in small firms (Stabile, 2001; Finkelstein, 2002) and in New Zealand (Bloom, 2000). Conversely, in Ireland demand for PHI has proven to be rather price inelastic despite continuous premium increases and a reduction in fiscal advantages (Department of Health and Children, 1999; Nolan and Wiley, 2000). In Australia, the responsiveness to large government fiscal incentives has been limited by low price sensitivity (Butler, 2002) although opposing views have been expressed (Harper, 2003; Access Economics, 2002). In Spain and the United Kingdom, PHI appears to be insensitive to premium variations, including withdrawal of tax subsidies (Costa and Garcia, 2000; Emmerson et al., 2001).

Income is found to be a strong determinant of insurance decisions in many countries (Harmon and Nolan, 2001; Barrett and Conlon, 2001; Costa and Garcia, 2000; King and Mossialos, 2002). This may suggest that, at least where public insurance guarantees basic coverage, PHI products are purchased by individuals as luxury goods for which, *ceteris*

paribus, demand increases as individual income increases. Where PHI represents a primary form of coverage, lower demand among less wealthy populations may be a consequence of broader eligibility to public insurance programmes for low-income groups.

The actual or perceived quality of publicly financed services affects decisions to buy PHI policies. In OECD countries where consumer surveys have been carried out, such as in Ireland and Australia, factors such as long waiting, uncertainty over receiving a publicly financed treatment, and increased provider choice are leading reasons for buying private health insurance (Watson and Williams, 2001; ABS, 1998). However, analysis of such a link is complicated by the lack of clear indicators of “quality” of public coverage. In the Netherlands, decisions to “delist” services, such as for example dental care, have not resulted in substantial change in levels of population coverage by supplementary PHI, although the PHI market responded to this delisting by adding dental services to coverage packages. Waiting lists have been found to be associated with demand for private health insurance in the United Kingdom and Spain (Besley *et al.*, 1998 and 1999; Jofre-Bonet, 2000), although there may be a time lag between the time when waiting has actually arisen in public systems and the time when private insurance is purchased (King and Mossialos, 2002).

Health status can also be a determinant in decisions to buy private health insurance. For example, individuals expecting to become ill, or who already have a health condition may be more likely to purchase insurance. This is a particularly important concern because PHI markets are characterised by asymmetry of information. The stability of the market is endangered if only high-risk individuals buy private cover, particularly when insurers do not have the ability, or the tools, to protect themselves from adverse selection or to risk-rate.³⁹ Evidence indicates that, in some markets, (bad) health status may have influenced and encouraged decisions to purchase insurance. For example, during the 1990s, the decline in population coverage in Australia had been found to be associated with health risk, with losses of participation in PHI markets among the younger, lower-risk populations (Hopkins and Kidd, 1996; Barrett and Conlon, 2001). There is evidence that employer-sponsored HMO plans in the United States – which often impose more restrictions on utilisation of services – may experience some favourable risk selection when compared to less restrictive plans.⁴⁰ On the other hand, in other countries, such as Ireland and Germany, individuals in good health are more likely to buy cover, which can be explained by the predominant purchase of PHI by high-income groups. Similarly, the probability of buying PHI has been found to increase with good health in Ireland, Italy, Portugal, Spain and the United Kingdom, contradicting the hypothesis of adverse selection in certain PHI markets (Jones *et al.*, 2002), probably as a result of the link between better education and PHI coverage.

4.2. Characteristics of subscribers of PHI

Table 2.9 illustrates the characteristics of subscribers and the distribution of PHI cover across different population groups in OECD countries.

In virtually all OECD countries, PHI is predominantly purchased by high-income individuals. This is clearly the consequence of eligibility to mandatory public or social coverage on the basis of income and/or employment category in Germany, the Netherlands, and Spain. In the United States, poor population groups and all seniors are eligible to public Medicaid or Medicare coverage, respectively, while the uninsured population is comprised largely of the working poor and near poor (Kaiser Commission on Medicaid and the Uninsured, 2003). In other PHI markets, private insurees tend to belong to higher-income groups. In several countries, PHI is offered as part of an employment

Table 2.9. **Characteristics of PHI subscribers across OECD countries**

Australia ¹	- Income: Higher-income brackets more likely to subscribe (22% of low-income individuals). - Age: Coverage increases with age peaking at 45-54 years. - Region: Coverage varies across regions (44% in Western Australia versus 22% in Victoria).
Austria ²	- Income: Those in higher income brackets more likely to subscribe. - Employment: About half of subscribers are self-employed. Another 40% are civil servants or salaried employees. - Region: Urban residents are more likely to subscribe. (50% of Carinthia residents are insured compare to 17.5% of Burgenland residents in 2001).
Belgium ³	Employment: About 76% of the self-employed are covered by mutuals for small risk insurance. Other self-employed are covered by DKV Belgium.
Canada ³	Employment: Coverage highly linked to employment status.
Czech Republic ³	- PHI plays a minor role covering less than 1% of inhabitants. - Purchased primarily by certain foreign nationals and people travelling abroad.
Denmark ²	- Employment: Subscription is predominantly tied to employment. - Age: Students, children and the elderly are less likely to subscribe. - Health Status: PHI favours those without pre-existing conditions.
Finland ³	Age: PHI usually covers children (25% of children and 6.7% adults covered in 1996).
France ²	- Income: PHI enrolment and quality of insurance significantly related to income. - Employment: The employed and retired more likely to be covered than the unemployed. Occupational status: 59% of unskilled workers have no or little PHI but only 24% of executives and professionals in 2000. - Age: Young adults and the elderly are less likely to be insured.
Germany ^{2, 4}	- Income: Those in higher income brackets more likely to subscribe. - Employment: Coverage not linked to employment. 1% of the unemployed have PHI (2001). - Age: Women, young, single or married couples more likely to buy PHI. Children account for 15.6% of membership, while women for 32.2% and men for 52.2%. - Geography: PHI purchasers are more likely to reside in the old Lander (10.1% coverage rate) compared to the new Lander (3.6%) (2000). - Gender: 52% of women and 32% of men are covered by PHI (1999).
Greece ²	- Income: Medium to high earners more likely to subscribe. - Employment: Subscribers are predominantly employers, professionals, civil servants, white-collar workers and managers working for large private companies and banks. - Age: Most subscribers 35 to 45 years old (2001). - Region: Typically live in urban areas.
Ireland ²	- Income: Coverage linked to household income [8% in bottom decile, 70% in top decile (2001)]. - Employment: Coverage highest for professionals and managerial social classes (70% covered) compared to semi and un-skilled workers (11%) (1995). - Region: Coverage higher in Dublin and lowest in small towns and rural areas. - Social status: Higher educational level and married status associated with coverage. - Health status: Those in poor health less likely to be privately insured.
Italy ²	- Income: Those in higher income brackets more likely to subscribe. - Employment: Subscribers are usually managers and professionals [64% of the privately insured are high-level managers while 9% are blue collar workers (2001)]. - Age: Non-linear relationship between age and insurance status with 42 years of age being the age at which probability of coverage the highest. - Region: Most subscribers live in north-east or central Italy. - Social status: Highly educated people more likely to be covered.
Luxembourg ²	The 30-35% of the population without PHI are mostly foreigners residing there (2001).
Netherlands ⁵	- Income: Primary coverage for 1/3 of the population who earn above a set income threshold. - Employment: Employers provide PHI for 20% of the population, or 63% of those with PHI.
New Zealand ^{3, 6, 7}	- PHI covers 33-37% of the population. Coverage has been declining over the past years. - Age: A disproportionate amount of young and health population dropping PHI since mid-1980s. - Income: 13% of households in the lowest income band and 63% in the top band purchase PHI.
Portugal ²	- Income: Purchasers are mostly from high-income groups. - Employment: Coverage higher among the working population, especially professionals and the self-employed. - Age: Typical subscriber is 28-34 years old. - Region: Typical subscriber lives in urban area.
Slovak Republic ⁸	PHI insignificant. Only purchased by travelers.

Table 2.9. **Characteristics of PHI subscribers across OECD countries (cont.)**

Spain ²	- Income: Those in higher-income brackets more likely to subscribe (30% of the highest-income group and 3% of the lowest-income group covered by PHI in 2001). - Employment: Coverage is higher among the employed, with employers and the self-employed more likely to purchase insurance than employees. - Education: Higher education level is linked with higher coverage rates. - Region: Coverage rates vary by region, and is higher in urban than in rural areas.
Sweden ^{2, 3}	- PHI plays a minor role covering less than 1% of inhabitants. - Private companies in the service sector are the most likely to purchase PHI.
Turkey ^{3, 9}	- PHI plays a minor role covering 1% of the population. - Employment: Over half of the privately insured are offered this benefit by their employer.
United Kingdom ²	- Employment: Participation varies by occupational status. (22% of professionals and 23% of employers and managers had PHI in 1995 compared to 1% of unskilled manual workers). - Age: Coverage highest among the middle-aged. - Geography: Insurees more likely to live in London and the southern region. (11% of the population covered in Greater London, 14% in the South East, 10% in South West and only 4% in Scotland in 2000).
United States ¹⁰	- Income: Those in higher income brackets are more likely to be covered (41.2% in the lowest bracket compared to 90.1% in the highest). - Employment: 64% has employment-based PHI. Coverage rise with work experience. - Education: Coverage rates rise with education level. - Ethnicity: Blacks and Hispanics less likely to be covered by PHI than Whites and Non-Hispanics. - Age: PHI coverage peaks in the 45-65 age cohorts; lowest among the elderly and young adults. - Region: Variation by region (79% of those residing in the Midwest; 68.2% in the West).

Notes: Data unavailable for Japan, Korea, Mexico, Switzerland. PHI is very limited and breakdown of coverage is therefore not available in Hungary, Norway and Iceland.

Sources: Information was supplied by OECD member countries or obtained from official publications. Other specific data sources are:

1. Colombo and Tapay (2003).
2. Mossialos and Thomson (2002).
3. European Observatory on Health Care Systems, *Health Care Systems in Transition* (various countries and years).
4. PKV (2003).
5. Tapay and Colombo (2004).
6. Bloom (2000).
7. New Zealand Household Economic Survey 1997/1998.
8. Colombo and Tapay (2004b).
9. Kisa (2001).
10. US Census Bureau (2001).

contract, and sometimes this benefit is provided only to senior employees. Private health insurance is also more frequently purchased by individuals with higher education levels and employment conditions, which also tend to be correlated to income.

The distribution of population coverage across different age cohorts is not homogeneous, most likely as a consequence of differences in public sector coverage, regulation, varied employer offerings of PHI, diverse levels of dependent coverage by PHI policies, and other factors. In Finland, children are the most likely to be covered by PHI (Mossialos and Thomson, 2002). In several OECD countries where PHI is provided as a condition of employment, coverage is highest among middle age cohorts (e.g., United States, United Kingdom, Ireland, Portugal, Sweden, and Italy). In Australia and New Zealand, throughout the 1990s, the average age of the privately insured population increased as younger and healthier individuals dropped insurance. The fact that the PHI market in Australia is essentially an individual rather than a group market may be responsible for high levels of population coverage by older age cohorts, as younger persons may have less incentive to purchase insurance. The prevalence of voluntary PHI among the elderly varies substantially across countries (Singer *et al.*, 2003). For example, almost the entire elderly population in the United States buys voluntary private

insurance (with the exception of those who receive supplemental coverage through Medicaid), mainly because of gaps in the public Medicare programme, such as the lack of a pharmaceutical benefit,⁴¹ limits on hospital coverage, and high deductibles and cost sharing. Conversely, PHI coverage by the elderly is very low in Italy (3.2%), and fairly low in the United Kingdom (11.6%) and Germany (15.9%). Coverage levels in Germany and the United Kingdom do not differ from the overall population coverage by PHI.

4.3. Group versus individual purchasers of PHI

Employers play a prominent role in paying for or negotiating PHI in several OECD countries. The presence of an employer group market does not appear to be linked to any particular PHI role (Table 2.10). Employers are also behind much of the growth in PHI coverage in some OECD countries. In the United States, principal PHI is provided as a work-related benefit for 88% of the privately insured population (Docteur *et al.*, 2003). In Canada, supplementary PHI is almost exclusively furnished by employers.⁴² In the Netherlands, Ireland, the United Kingdom and Portugal, employers' role in offering private coverage is large and has been widening over the recent years.⁴³ About half of all PHI contracts in France have an employment link.

In some OECD countries, most notably the United States, preferential tax treatment for employer-provided PHI has influenced employers' decisions to offer PHI for employees.⁴⁴ On the other hand, tax treatments may also discourage employer-sponsored PHI, as in the case of Australia, where the weak employment link may be partially explained by its fringe benefit tax. In Germany, the high-level of social security contributions may act as a deterrent for employers to sponsor PHI coverage for their employees (Datamonitor, 2000). Tax advantages such as those provided to employers in the United States and to insurees in Australia are also subject to debate over their opportunity cost and impact (Henderson and Taylor, 2002; Deeble, 2003).

Employer-sponsored PHI presents advantages for employees. Employers are able to negotiate better coverage solutions. For example, in the Netherlands, where regulation of private markets is limited, employers sometimes negotiate limitations on coverage exclusions. They also play an important role in fostering voluntary agreements with insurers for improving portability of private coverage when insurees lose or change their jobs (Tapay and Colombo, 2004). In France, insurance offered through employers tends to be more comprehensive than individual policies. In addition, employers are often able to negotiate cheaper premiums, which tend to be community rated within the firm, and fewer exclusions, based on the spread of risks within a large group. They may also pay for part or the entire premium on behalf of their employees and sometimes their dependents too.⁴⁵ The premiums of group policies are entirely paid for by employers in Greece, Italy, Sweden, Austria and Denmark. In Spain, this type of fringe benefit is especially offered to certain senior employees (Mossialos and Thomson, 2002), while in the United Kingdom it is more common in large companies. In the United States, employers generally pay between 84% (single) and 73% (family) of the cost of employees' medical benefits.⁴⁶

The extent of choice offered to employees with regard to their private health insurance – for example whether participation is compulsory or voluntary and the number and types of policies offered – varies by country and employer. In Canada and France, about half of employer-sponsored contracts (which represent half of the PHI market) require employee participation (Finkelstein, 2002; Buchmueller and Couffinhal, 2004). In the United States, employers often offer workers a choice of health plans, including furnishing “cafeteria type

Table 2.10. **Group and individual purchasers of PHI**

	Policy type (%) ¹		Additional information
	Group ^a	Individual	
Australia	0	100	Predominantly individual market due to historical reasons and disincentives of the fringe benefit tax system. Employers sometimes contribute to individual PHI. ²
Austria	21	80	Group policies are employer-paid and gained market share between 1996-2000. ³
Belgium	63(e) ⁴	37(e) ⁴	Commercial PHI policies are predominantly purchased by groups.
Canada	93(e)	7(e)	Group health, dental care and disability plans partly or wholly paid for by employers (who can deduct cost of PHI from taxable income) are increasingly popular. Group coverage is also available to professional and trade associations, students, creditors and travellers. While historically there was no market for individual PHI policies, this market has been growing. Travel PHI has more than tripled in the past decade to represent almost one-fifth of today's individual PHI market.
Czech Republic	0	100	
Denmark	...	Mainly	The main mutual insurer in the market (Sygeforsikringen Denmark, with a 96% market share) offers mainly individual insurance policies. Group policies are employer-paid and account for more than 80% of commercial policies. ³
France	52	48	Group policies lost market share during the 1990s. 23.6% of PHI policies (about half of group policies) are a compulsory component of an employee's contract. ³ Provident institutions offer mainly group contracts (mandatory group contracts account for half of their activity). In the life and health insurance industry, PHI represents less than 5% of total revenue with group and individual contracts accounting for comparable numbers of contracts. ⁵
Germany	7 ³	94	Employers can only contribute to substitute PHI policies offered by private health insurers which specialise in health.
Greece	Mainly		Between 1989-1995, individual policies increased by 64% and policies purchased by groups increased by 106%. ³ All group policies are employer-paid.
Ireland	49 ⁶	51 ⁶	During the 1990s, group policies gained an increasing share of the PHI market. The number of people having their PHI premiums entirely met by their employers has grown over time. ⁷ In 2000, 20%-25% of group policies are employer-paid. ³
Italy	26 (1999) ³		All group policies are employer-paid. ³
Luxembourg	...	Mainly	In 2000, 95% of commercial policies and 100% of mutuals were purchased by individuals. During the 1990s, group policies gained an increasing share. ³
Mexico	56	44	Some group PHI offered by Specialised Health Insurance Institutions (ISES) involves no insurance risk undertaken by ISES, who only perform an administrative function.
Netherlands	60(e)	40(e)	During the 1990s, group policies gained an increasing share of the PHI market and now account for over half of all policies. ³ Employers play a significant role in the offering and financing of private health insurance. The proportion of the privately insured with group coverage (not including those with WTZ coverage) has been steadily increasing from 34.4% in 1980 to 62.4% in 1998. Employers provide supplemental private coverage to those covered by sickness funds to a lesser extent. Employers often pay up to 50% of the premiums for their workers, but do not always provide their employees with a choice of benefit packages. ⁸
Poland	0	100	
Portugal	76	24	During the 1990s, group policies gained an increasing share of the PHI market and now account for a large majority of the market. ³
Slovak Republic	0	100	
Spain	15-18 ^{3, 9}		During the 1990s, group policies gained an increasing share of the PHI market. ³
Sweden	90	10	During the 1990s, group policies gained an increasing share of the PHI market. ³
Switzerland	17	84	Predominantly individually-purchased PHI policies. However, voluntary daily cash-benefit insurance covering loss of income due to illness is generally taken up as group insurance and covers the obligations they have to continue paying wages in the event of illness or injury. ¹⁰
Turkey	64	36	
United Kingdom	67(e) ¹¹	33(e) ¹¹	Estimate based on "subscriber" numbers (heads of family rather than "persons covered"). ¹ During the 1990s, group policies gained an increasing share of the PHI market. Approximately 59% of PHI policies are purchased by employers. ³
United States	94	6	Employer-sponsored PHI covers 58% of the population; individual policies 5%. ¹²

Table 2.10. **Group and individual purchasers of PHI (cont.)**

(e) Estimates based on the proportion of gross premiums accounted for by group and individual PHI, based on OECD Statistical Questionnaire on Private Health Insurance, 2000 data.

a) Employer-administrated health insurance with no employer contribution, professional of other associations' plans may or not fall within the definition of the group policy depending on the country and its legal framework.

Sources: Information was supplied by OECD member countries or obtained from official publications. In addition, specific data sources include:

1. OECD Statistical Questionnaire on Private Health Insurance, 2000 data, unless otherwise specified.
2. Colombo and Tapay (2003).
3. Mossialos and Thomson (2002).
4. Data refer only to commercial companies. European Observatory on Health Care Systems (2000, Belgium).
5. Buchmueller and Couffinhal (2004).
6. Health Insurance Authority (2003).
7. Colombo and Tapay (2004a).
8. Tapay and Colombo (2004).
9. OECD Statistical Questionnaire on Private Health Insurance, 1998 data.
10. Colombo (2001).
11. OECD Statistical Questionnaire on Private Health Insurance, 1999 data.
12. Kaiser Family Foundation, 1999 and 1998 www.statehealthfacts.kff.org.

plans".⁴⁷ The extent of choice often varies by employer size in the United States, with most of the largest employers (with 5 000 or more employees) offering a choice of plan (80%) but most small employers (3-199 workers) offering only one plan (69%) (The Kaiser Family Foundation and Health Research and Educational Trust, 2003, p. 3). While employers' offering of plan choice has the advantage of allowing individuals to better tailor their coverage and cost preferences, it may create risk segmentation within employment-based purchasing.⁴⁸ Consumer-driven models of employer-sponsored health insurance – such as defined contribution plans (see Chapter 4) – also represent ways for employers to limit their liability over choice of plans (Henderson and Taylor, 2002).

Group policies such as those with an employment link also have advantages for insurers. Employer groups – especially those of larger employers – tend to be healthier and younger than the average population. Administrative costs are lower both because of economies of scale in administering group insurance and because of the more contained advertising and often distribution costs. This is reflected in lower prices of group policies, for a given set of benefits covered, compared to individual contracts. Lower pricing may also reflect a strategic behaviour by insurers, who face more competitive pressures within group markets.

Unlike most other OECD countries,⁴⁹ the US employer-based PHI market is generally divided into a small and a large group market, with different characteristics and different regulations (Box 2.5).

Group policies sponsored by non-employer groups also exist. Group policies may be purchased through associations, purchasing pools, trade unions, or other non-employer-based groups. Typically, individuals buying these policies have to pay the premium themselves, although they benefit from discounts offered on group policies. For example these types of policies accounted for 10% in the UK market in 2002, and for about half of all group policies in Ireland (Mossialos and Thomson, 2002).

Some OECD countries have predominantly individual PHI markets, such as Korea, Australia, Poland, Luxembourg, the Czech Republic, Spain, Austria, and Germany. Individual markets across OECD countries tend to have somewhat higher administrative costs and, in countries where risk-rating is permitted, high-risk individuals may face

Box 2.5. Small and large group markets in the United States

Under federal law, the small employer market is defined as employers with 2-50 employees, and states also have the option of including self-employed individuals within their small group markets. The small group market has historically suffered from greater access and accessibility problems. Their smaller risk pools made them more vulnerable to changes in employee health status and insurers often engaged in fairly aggressive rating and risk selection practices.

In an effort to address these challenges, beginning in the 1980s and culminating in a federal law enacted in 1996, a series of state-level and federal reforms imposed more stringent issuance and rating-related requirements on this market. Currently, under federal law, insurers must offer all their products to all small employer applicants. Rating practices, however, vary by state.

A federal law enacted in 1974 (ERISA) also contributed to a more segmented US employer health plan market. The law permitted employers to self-fund their employee health coverage and thereby be exempt from state laws applicable to health insurers. This option was particularly attractive for employers that were large enough to have a meaningful risk pool and assume the risk of their own coverage (although there is no size requirement in the law). It was also appealing to those operating across state lines who wanted to offer uniform health benefit packages to their employees. As a consequence of the different risk characteristics and regulations of these markets, the employer group market became increasingly diverse. It was composed of many large self-funded employer plans and diverse state-regulated insured plans (including managed care plans) offered to small employers and to those large employers wishing to purchase insured products.

expensive premiums on inception, or on renewal. Voluntary community-rated individual markets face a higher risk of premium “death spirals” if the younger and healthier people do not join or pull out of coverage, spurring further premium increases as higher health risks are left in the pool. As individuals have lower bargaining power over insurers, insurers’ may recoup discounts on group markets through their individual contracts. Crowding out of individual health insurance markets by group policies may be taking place in the Netherlands (Schut and van Vliet, 2001).

5. Supply of PHI and market characteristics

5.1. Insurers and market structures

A variety of insurance entities operate in PHI markets. These include commercial for-profit insurers, not-for-profit funds, mutual and provident associations, or other types of entities permitted to offer insurance under applicable law (Table 2.11). While these entities tend to be “private”, PHI can also be sold by public entities, such as in the case of state-owned insurers as Medibank in Australia and VHI in Ireland. Most European markets have historically been dominated by non-profit provident and mutual association insurers, although commercial entities are gaining market shares, for example in France, the United Kingdom, Denmark and Ireland (Mossialos and Thomson, 2002). The United States also has a history of insurance by not-for-profit carriers.

PHI is sold entirely by specialist insurers in Australia as well as in Ireland and Germany, and almost entirely in Switzerland. In Australia, there is a legal requirement that insurers selling PHI be specialised. Such a requirement has historically existed also in

Table 2.11. **Characteristics of insurers offering private health coverage**

	Types of health insurance organisations ¹	Additional comments ²
Australia	Indemnity insurers; non-profit and for-profit plans; mutual associations (most health funds are incorporated not-for-profit mutual associations).	3 insurers: 57% of market. 44 health funds in the market (2000). 100% of insurers specialise in health.
Austria	Indemnity insurers, non-profit and for-profit plans. Mutual companies are not active in the private health insurance business.	8 insurers: 100% of market. 49.7% by one insurer. Trend toward insurer concentration during the 1990s. ³ About 5% of insurers specialise in health.
Belgium	Mutual associations (sickness funds) or commercial insurers. All sickness funds (but one entity that does not offer PHI) are private, legally independent, non-profit. Substitute PHI is only provided by sickness funds (mutuals) and DKV Belgium.	7 insurers : 81.5 % of market. 14% of commercial insurers specialise in health. 36 insurers undertaking and 77 sickness funds (2002).
Canada	Indemnity insurers. Non-profit vs. for-profit plans.	No insurer has more than 15% of the market. 100% of insurers do not specialise in health.
Czech Republic		4 insurers: 73% of market. 2 with > 15%, 1 > 40%. Three-quarters of insurers do not specialise in health.
Denmark ⁴	The PHI market is dominated by the mutual (non profit) association (<i>Sygeforsikringen Danmark</i>).	<i>Sygeforsikringen Danmark</i> has a 96% share of the market (1.5 million people).
Finland		3 Insurers: 62% of market ³ (PHI is insignificant).
France	Mutual associations, commercial insurers and provident associations account for < 60%, > 20% and 15-20% of market respectively. ⁴	118 private (mutual and commercial) insurance companies operate in the French PHI market. 56% of insurers specialise in health. ³
Germany	Indemnity insurers, including joint-stock companies and mutual societies. All substitutive PHI is sold by specialist health insurers.	No insurer with > 14%. 14 insurers: 82% market by premium income; 50 private health insurers offer substitute and supplementary insurance, covering 99.9% of the market. In addition, there are around 45 other very small and usually regional private health insurers. ⁵
Greece		5 insurers: 70.4% of market. A trend toward insurer concentration during the 1990s. ³
Hungary	Mutual funds. ⁶	4 insurers: 89% of market (1999).
Iceland	Non specialist life insurance companies.	In 2002, 4 domestic life insurance companies were offering private health and life insurances.
Ireland	Indemnity insurers, non-profit plans and mutual associations.	2 insurers: 94.9% of market. 100% of insurers are specialist.
Italy	Commercial insurers, mutual associations. Mutual associations generally have lower premiums and their markets are low-middle income people. Commercial insurers usually sell their individual policies to mid to high-income earners. ⁶ 0.8% of insurers are specialised. Health insurance companies are 60% for-profit and 40% not-for-profit. ³	6 insurers: 50% of market. ³ Trends toward insurer concentration during the 1990s. The private for-profit insurance market has grown rapidly since the early 1980s. Mutual insurance funds cover about 300 000 people. Corporate and collective funds are organized by employers or professional categories for their employees or members. ⁶ 100% of insurers are non specialist. ¹
Korea ¹	81% of insurers are non specialist.	3 insurers: 81.2% of market.
Luxembourg		4 insurers: 77% of market. ¹ Trend toward insurer concentration during the 1990s. ³
Mexico	Mutual associations or insurers. Specialised Health Insurance Institutions (ISES) similar to managed care organisations offer comprehensive health coverage, while non-specialist insurers offer catastrophic health cover products.	4 insurers: 73.2% of market. 28 companies with the authorisation from the Ministry of Finance to offer insurance products. Insurers are both non specialist and specialised institutions (ISES), selling different product.
The Netherlands	Mutual associations or insurers. 75% of insurers are non specialist in health.	5 insurers: 50% of market. 47 insurers who offer principal cover. No insurer with more than 15% of the market. 27 sickness funds also offer supplementary PHI.
New Zealand	Mutuals, friendly societies, not-for profit and for profit companies. ⁷	5 insurers: 64.08% of market. Southern Cross has an estimated 75% of market share. ⁶
Poland	Indemnity insurers, and mutual associations or insurers.	29 non-life insurance companies were licensed in the scope of sickness insurance and 18 of them operated on the market. 31 life insurance companies conducted accident and sickness insurance supplemental to the other classes of life branch (out of 34 licensed).
Portugal	Indemnity insurers, managed care plans (operated by non-life multi-branch insurers) and mutual associations or insurers.	21 insurers, with 5 insurers: 64% of market. 1 insurer 47.4% of market. 100% of insurers are non specialist. ¹ Trend towards insurer concentration during the 1990s. ³

Table 2.11. **Characteristics of insurers offering private health coverage (cont.)**

	Types of health insurance organisations ¹	Additional comments ²
Slovak Republic	Indemnity insurers	Some non specialist insurance companies provide supplementary health insurance. One company provides private health insurance on commercial basis to persons who are not cover by social security scheme. Its share on non-life insurance market was less than 0.2 %.
Spain	Indemnity insurance and “benefits in kind” insurance (public limited companies, mutual companies and cooperatives). 87% of insurers are health specialist.	10 Insurers: 83% of market. Trend toward insurer concentration during the 1990s. ³
Sweden		5 insurers: 85 % of market. 80% of insurers are non specialist
Switzerland	Indemnity insurers, non-profit vs. for-profit plans and mutual associations or insurers. ¹ Sickness funds (non-profit) offer basic health insurance (109 in 1998) and voluntary cash benefits insurance. About half offered voluntary PHI in 1998. Other commercial insurers operate solely in the voluntary PHI market. ⁸	10 insurers: 70% of PHI market.
Turkey	Indemnity insurers	10 insurers: 89 % of market. All insurers are non specialist.
United Kingdom	Indemnity insurers, including non-profit and for-profit plans run by mutual association and shareholders companies respectively. Non-indemnity insurers, typically for-profit, offer cash plans.	4 insurers: 80% of market. 36% of insurers specialise in health. ³
United States	Indemnity insurers, managed care plans, non-profit vs. for-profit plans, mutual associations or insurers. The insuring entity can be a commercial (stock or mutual) insurer, a non-profit Blue Cross-Blue Shield plan (BCBS) (in States that still have them), a fraternal benefit society, a prepaid plan offered by health care providers, an employer-funded plan (single-employer or multiple-employer), or arrangements where more than one entity participates in the risk.	Group market: HMOs 42% of premiums, BCBS 39%, commercial insurers 19%. Individual market: HMOs 20% of premiums, BCBS 57%, commercial insurers 23%. Almost every health insurance organisation can offer either managed care benefits, indemnity benefits, or “preferred provider” or “point of service.”

Sources: Specific data sources have been indicated below; information was also supplied by OECD member countries or obtained from official publications.

1. OECD Regulatory Questionnaire on Private Health Insurance.

2. OECD Statistical Questionnaire on Private Health Insurance, 2000 data, unless otherwise specified.

3. Mossialos and Thomson (2002).

4. Buchmueller and Couffinhal (2004).

5. PKV (2003).

6. European Observatory on Health Care Systems.

7. Health Funds Association of New Zealand.

8. Colombo (2001).

Germany, although it was lifted for foreign EU companies following the adoption of EU directives into German Law (Mossialos and Thomson, 2002). Insurers wishing to benefit from 50% employer contribution for substitute insurance are still required to be specialised in Germany. In Ireland, besides the VHI, one other specialist company and three smaller vocational undertakings operate in the market. In Switzerland, voluntary PHI is predominantly sold by specialised sickness funds who also offer mandatory health insurance, while commercial insurers cover a minority of the market (Colombo, 2001). In all other OECD countries, PHI is predominantly or entirely sold by non-specialist insurers. Requirements that insurers be specialised, such as in the case of Australia, are meant to guarantee the separation of PHI from other types of insurance and protect the interests of purchasers of PHI products in case of insurer insolvency. Within the EU, insurers are required to account for and operate “health and accident” and other “classes” of insurance as separate business lines.

While PHI is offered by multiple insurers in all OECD countries, there are significant differences in their number and market concentration. Arguably, these may impact upon

the level of competition existing within the market. Only in a few OECD countries do a large number of insurers operate in a rather dispersed PHI market, such as in the case of the United States, Switzerland, France and Spain. While there is a relatively large number of insurers in Australia and the Netherlands, a few of them capture the majority of the insured population. One insurer dominates the Irish market. A second insurer – still occupying today a minority position – entered the market following its opening to competition in 1994. In other OECD countries, the PHI market tends to be concentrated in the hands of a small number of large insurers.

Theoretically, for-profit and not-for-profit insurers could be expected to maintain different market conducts as they respond to different financial and social incentives. Thus, for example, not-for-profit insurers would tend to apply community-rated premiums and open enrolment for applicants even in the absence of regulation compelling them to do so. Conversely, for-profit insurers would be expected to be more conscious of return-on-investment, profit and dividend policy and to use risk assessment and market segmentation more intensively. Different legal requirements for different types of plans can mandate different behaviour by non-profit insurers, as was often the case in the United States. While there is a dearth of evidence from several OECD countries concerning the extent to which these market segments behave differently, there are some interesting examples from selected countries.

In France, the entry of commercial insurers into the complementary PHI market in the 1980s prompted many mutual associations (“mutuelles”) – especially those operating in the individual market – to adopt similar practices to those of commercial insurers in order to minimise risks of being adversely selected against. Both commercial insurers and mutuelles now vary non-group prices according to subscriber age (Buchmueller and Couffinhal, 2004), although, differently from many for-profit insurers, mutuelles in France do not select risks and operate more according to the logic of non-profit organisations. In the United States, non-profit Blue Cross and Blue Shield plans generally practiced community rating as a product of their charter or applicable law. Facing increasing competition from for-profit insurers, a few plans experienced financial difficulty. Some state policy makers responded by imposing similar requirements upon non-profit and for-profit plans, at times loosening the standards applicable to the non-profit plans, and at times making all plans subject to more stringent requirements. In the Netherlands, on the other hand, the co-existence of commercial and non-profit insurers seems to have had a different effect, i.e., commercial insurers apply seemingly less stringent risk rating requirements than they are legally permitted to do. In several EU markets, insurers, whether for-profit or not-for-profit show similar market conduct.⁵⁰ EU law generally requires countries to subject all health insurers to uniform treatment unless differences are justified in the public interest.

In some OECD countries the market structure and ownership of insurers may pose some challenges to the functioning of the market. For example, competition in the Irish insurance system is arguably limited by the presence of only two players. Yet, even in markets with many players, it can be challenging to establish “healthy” competition on the basis of efficiency and quality levels as insurers may find risk selection a profitable ground for competition. The dominant market position and corporate status of the state-owned insurers in Ireland and Australia (VHI and Medibank) raise questions about what links, if any, these insurers should maintain with the government, and the consequences of any such association for competition.⁵¹ In the Netherlands and Switzerland, the involvement

by affiliated insurers in differently regulated social and private health insurance compartments may pose challenges for competition and consumer mobility in both the social and private insurance systems.

5.2. Relationship between PHI insurance carriers and health care providers

The relationships between insurers offering PHI and providers of care can be broken down into three main categories across OECD countries: an indemnity/reimbursement model, contractual arrangements between providers and insurers (with no integration), and more integrated health delivery systems. These models may simultaneously exist in the same country, for examples in the United States all types of relationship with providers can be found on the market (Box 2.6). Methods of paying doctors and hospitals, degree of selectivity in reimbursing providers, and contents of contracts vary across countries and insurers. They are influenced by regulation and insurers' strategic practices.

Indemnity insurance

Within several OECD countries, particularly those where markets are very small or insignificant, insurers have a contractual relationship with insurees but not directly with providers. In this case, by necessity, reimbursements take place between insurers and individuals who claim reimbursement of cost after treatment. Insurers may impose ceilings on the amounts reimbursed to insurees, either on single claims or through annual reimbursement limits. They may also set a schedule with maximum fees they will reimburse for different treatments. Typically, individuals are reimbursed on a per-service, treatment, or case basis, reflecting the way providers within the private sector are paid. Any cost in excess of insurers' reimbursement is the responsibility of the individual, and insurers actually leverage this as a way to limit their cost exposure. Most insurers operate on an indemnity basis in Belgium, France, Germany, Luxembourg, and Canada. In the United States, traditional indemnity insurance now represents a small portion of the PHI market as there has been a blurring of the division between indemnity and managed care plans. In the Netherlands, where insurers also tend to operate on an indemnity basis but can theoretically contract with other providers on an individual basis, they are obliged to pay for care provided by all hospitals.

Contractual arrangements between providers and insurers (with no integration)

Insurers engage in contractual relationships or stipulate agreements with providers in some PHI markets. With the exception of the United States, where provider payment arrangements are more varied, insurers typically pay providers on a fee-for-service basis and prices are the main negotiation item.⁵² Other delivery conditions such as volumes, type and quality of care are less the subject of contractual agreements or negotiations. Insurers can contract with all providers or may enter into selective contracts with a more limited subset of them. In this latter case, insurers may still reimburse patients if they choose to use a non-contracting provider, but the patients generally receive a lower reimbursement or face higher cost sharing in this case. This occurs in the United States under "preferred provider organisations" (PPOs) or under the "point-of service" options of health maintenance organisations (HMOs). Negotiations with providers can take place on an individual basis or on a collective basis (between associations or group of insurers and providers). They may involve only private providers, or also extend to public hospitals in some countries (Table 2.12).

Box 2.6. Indemnity insurance and managed care in the United States

One major distinction in health insurance products, particularly relevant to the US market, is the difference between traditional fee-for-service indemnity insurance and managed care. Under the former, the insuree chooses freely treating providers, claiming a reimbursement from their plan for the cost of treatment received. Insurers may carry out reviews to check whether a service is part of covered benefits, but no other efforts to manage care are made. Conversely, under managed care plans, insurers select and monitor providers and the service they render through a variety of tools such as selective contracting, utilisation management, clinical guidelines, restrictions on treatments, incentives and information directed to consumers to promote the use of cost-effective providers or services. Individuals tend to have more restricted choice of provider under these arrangements, especially if they wish to receive the maximum level of reimbursement under their contract. The term managed care was originally linked to more tightly controlled integrated models such as health maintenance organisations (HMOs), but has evolved to include less stringent arrangements.

Until the early 1990s, traditional indemnity fee-for-service insurance was dominant in the US market, however, it experienced a rapid decline during the 1990s and only 7% of workers had such coverage in 2001 (Gabel *et al.*, 2001). Managed care plans became the dominant form of health coverage, and insurers and employers increasingly relied on these plans' more stringent controls as a means of containing cost. Yet providers and consumers resisted managed care's restrictive practices, and, together with employers, demanded more flexibility from these coverage arrangements (often referred to as the "managed care backlash"). Health plans responded by modifying their practices, for example, by loosening controls over provider choice and access to care. As a consequence, the difference between traditional indemnity and managed care plans became increasingly blurred, and plans combined characteristics and tools of both coverage types (Docteur *et al.*, 2003).

Preferred-provider-organisations (PPO) contract with providers who generally participate in more than one network, and now enrol 48% of workers (Gabel *et al.*, 2001). Physicians are usually paid on a discounted fee-for-service basis under these arrangements. A variety of new insurance schemes have emerged with larger networks of participating providers and more coverage of out-of-network providers. For example, under so-called "point-of-service" (POS) plans (often offered in combination with HMO coverage), insurers also cover the cost of care supplied by providers outside the network, although at a higher cost for insurees. Their market share has increased from 14 to 22% (Gabel *et al.*, 2001). Finally, provider service organisations (PSOs) represent coalitions of providers carrying out the functions of a health plan, and can be seen as providers' response to control over their practices (Docteur *et al.*, 2003). Some states require these plans to be licensed under the same or similar laws as HMOs.

Definition of different types of managed care in the United States:*

Managed care is a term originally used to refer to the prepaid health care sector (*e.g.*, HMOs) where care is provided under a fixed budget and costs are therein capable of being "managed." Increasingly, the term is being used to include *preferred provider organizations* (PPOs) and even forms of indemnity insurance (or fee-for-service insurance) that incorporate preadmission certification and other utilisation controls.

Box 2.6. Indemnity insurance and managed care in the United States (cont.)

Integrated models: HMOs. An HMO is a health care system that assumes or shares both the financial risks and the delivery risks associated with providing comprehensive medical services to a voluntarily enrolled population in a particular geographic area, usually in return for a fixed, prepaid fee. Pure HMO enrollees use only the prepaid capitated health services of the HMO panel of medical care providers. Open-ended HMO enrollees use the prepaid HMO health services but, in addition may receive medical care from providers who are not part of the HMO panel. There is usually a substantial deductible, co-payment, or coinsurance associated with use of non-panel providers.

- **Group model HMO.** An HMO that contracts with a single multi-specialty medical group to provide care to the HMO's membership. The group practice may work exclusively with the HMO, or it may provide services to non-HMO patients as well. The HMO pays the medical group a negotiated per capita rate, which the group distributes among its physicians, usually on a salaried basis.
- **Staff model HMO.** A type of closed-panel HMO (where patients can receive services only through a limited number of providers) in which physicians are employees of the HMO. The providers see members in the HMO's own facilities.
- **Network HMO.** An HMO model that contracts with multiple physician groups to provide services to HMO members; may involve large single and multi-specialty groups.
- **Individual Practice Association (IPA).** A type of healthcare provider organisation composed of a group of independent practicing physicians who maintain their own offices and band together for the purpose of contracting their services to HMOs, PPOs, and insurance companies. An IPA may contract with and provide services to both HMO and non-HMO plan participants.

Point-of-service plan. A health plan that allows members to choose to receive services from a participating or non-participating network provider, usually with a financial disincentive for going outside the network. More of a product than an organization, POS plans can be offered by HMOs, PPOs, or self-insured employers.

Preferred provider organisation. A PPO is a type of medical plan where coverage is provided to participants through a network of selected health care providers (such as hospitals and physicians). The enrollees may go outside the network, but then pay a greater percentage of the cost of coverage than within the network.

* Source: National Center For Health Statistics: www.cdc.gov/nchs/dataawh/nchsdefs/list.htm.

In the Netherlands, Australia and Ireland, private insurers reimburse insurees for health services delivered by virtually all providers. This occurs either because they have established contracts with all providers, as in Ireland, or because, in the absence of a contract, they act as indemnity insurers (in the Netherlands) or pay a default payment to non-contracted providers (as in Australia). Only some private insurers enter into individual contracts with providers in the Netherlands. Instead, provider fees are the object of collective negotiations between provider associations and insurers, in which both sickness funds and private insurers participate. These negotiations are subject to significant government-determined parameters as negotiated fees cannot exceed national tariff limits. In Ireland and Australia, prices are agreed in individual negotiations with providers (although physician contracts are often standardised). In Ireland, the state-owned VHI exerts a strong bargaining power over reimbursement levels and other insurers follow prices set by VHI. In Australia, smaller

insurers have formed a common organisation to increase their bargaining power in contractual arrangements with providers. In both Australia and Ireland, pro-competitive regulation prohibits providers from negotiating collectively with insurers. Selective contractual arrangements between insurers and providers also exist in other OECD countries, for example some insurers do so in Austria, Portugal and the United Kingdom, among others (Mossialos and Thomson, 2002). In the United Kingdom, insurers generally directly pay providers, with whom they may also have negotiated agreements.

Integrated health care delivery systems⁵³

Within integrated health care systems, insurers often create, own or contract with a network of affiliated hospitals and providers to provide a full range of health care services to their members. These insurance schemes therefore combine health financing and delivery systems under the same entity. Integrated health delivery systems include certain types of “managed care”⁵⁴ functions in the United States and some cases of insurers linked with hospitals in France, Spain and Greece. In Mexico, specialised Health Insurance Institutions (ISES) have started to operate since regulatory reforms at the end of 1999 required all institutions offering health insurance (with the exclusion of catastrophic health coverage products) to be specialised.⁵⁵ ISES operate in much the same manner as do group-model HMOs in the United States. They own, or contract with, providers’ networks, provide preventative and health promotion services, review utilisation of the health services provided, and manage the medical resources and healthcare delivery services available to their members, including referrals.

Integrated health systems often form a part of managed care plans. The original models of such integration are HMOs in the United States. HMOs manage and coordinate delivery activities by providers by employing or contracting with health care providers and subjecting them to controls over delivery patterns. Within HMOs, professionals can be paid according to methods ranging from salary, capitation, blended capitation and fee-for-service remuneration, and discounted or full fee-for service arrangements. HMOs use a mix of economic incentives, protocols and guidelines in order to influence health care delivery and contain cost.

These types of organisations were widespread in the United States in the 1990s, and at this time, managed care plans seemed to have some success in moderating health prices. Consumer backlash against more restrictive practices, together with providers’ attempts to regain their primacy in medical decision-making, led insurers to back away from the more stringent managed care models and loosen their managed care arrangements and procedure approval requirements. Today, fully integrated models, such as staff-model HMOs, are only a minority of insurance arrangements in the United States (e.g., Mayo, Kaiser Permanente). Practices have also evolved within the more heavily integrated systems. There is less emphasis on the use of economic leverage to control delivery patterns, and greater weight placed on quality of care, patients’ safety, rewarding of performance, patient-driven care and involvement of the medical profession.⁵⁶

Do insurers influence private provision?

The extent to which private insurers influence medical practice varies across the three models. For example, indemnity-type insurers perform primarily as reimbursement agents and generally do not, nor seek to, influence providers’ practices and prices. Some indemnity insurers, as for example in the United Kingdom, have developed some pre-authorisation,

cost containment and post-audit systems, especially where electronic claims management and direct provider-payment systems have been developed. In fully integrated models, ability to control cost and delivery conditions is at a maximum, and may have levels of control similar to public integrated models (such as the NHS in the United Kingdom). However, insurers' ability to influence medical practice depends not only upon insurers' choices and strategic behaviours, but also upon other factors. Notably, regulation can also shape the relationship between insurers and providers⁵⁷ (Table 2.12).

Policy makers may impose *restrictions on privately financed providers' practice*. For example, some countries restrict doctors' ability to charge private insurees above fixed fee levels. In the German primary PHI market, doctors are allowed to charge private insurees fees above the regulated prices charged to social insurees.⁵⁸ This also happens for some doctors in France and in the United States, among others. Conversely, in the Dutch primary PHI market, the same level of regulated fees applies to both socially insured and privately insured patients, thus limiting insurers' ability to compete upon the basis of provider payment levels. In Australia, private funds are not allowed to cover the medical cost of out-of-hospital treatments for which a Medicare benefit is payable. Insurers can however negotiate coverage of part or the entire "gap" between the private fee charged by the doctor for in-patient care and the benefit paid by Medicare (Colombo and Tapay, 2003).

Regulation also shapes providers' activities in the private sector. For example, governments may delimit public hospitals' ability to treat private patients and doctors' ability to serve both public and private patients. Private patients are admitted to public hospitals in Australia, Portugal, Ireland and the United Kingdom. In Ireland, all PHI plans are required to reimburse private treatments in public hospitals as part of minimum benefit regulations. In Australia, private hospitals arguably have large volumes of activities because the cost of inpatient medical services provided to private patients is in large part reimbursed by the public system.⁵⁹ In Ireland private hospitals do not receive direct public subsidies, although they benefit from other indirect subsidies. Doctors' are prohibited to practice in both the public and private sectors in Sweden, Luxembourg, Greece and Italy, which is conversely permissible in other EU countries (Mossialos and Thomson, 2002), as well as Australia and New Zealand.

Furthermore, governments can also impact providers' activities by restraining insurers' ability to contract with providers. For example, a regulatory obligation for insurers to contract with all providers exists in the basic mandatory health insurance system of Switzerland – although the removal of this obligation is being debated (Colombo, 2001). In Australia, while health funds can contract selectively with hospitals, they also face an obligation to pay a default payment to all hospitals with which they have not entered into contractual agreement (Colombo and Tapay, 2003). Some US states require managed care plans to contract with "any willing provider". While enhancing choice, these requirements have been heavily debated as they can curtail plans' ability to control costs and also may limit their ability to select providers according to quality-based criteria.

The extent to which private insurers influence medical practice has implications for health system performance, particularly cost-efficiency, quality of care and, in part, equity of access to care. Regulatory requirements relating to private health care delivery and insurers' contracts with providers also affect PHI's impact on the health system. The influence of different relationships between insurers and providers on performance, and the effect of regulation on these arrangements, is analysed in Chapter 4.

Table 2.12. Regulated interaction between PHI insurers and health care providers

	Main type/model	Regulation on insurers with respect to providers	Regulation on providers with respect to PHI
Australia	• All insurers have contracts with hospitals; very limited selective contracting. • Insurers mainly negotiate fee levels (usually per diems) with hospitals. Insurers negotiate “no medical gap” arrangements where doctors agree to receive a certain fee as full payment for services delivered to insurees.	• Insurers must pay a default payment to all non-contracted providers. • Insurers must cover 25% of the Medicare benefit schedule for inpatient medical treatments (75% paid by Medicare). Insurers may cover the “gap” in excess of Medicare fee schedule for inpatient treatments. • Insurers cannot cover out-of-hospital services for which a Medicare benefit is payable.	• Common in Australia for physicians to work in both public and private sector. • Doctors establish their fees freely. • Public hospitals can have private beds.
Austria	• GPs and hospitals have selective contracts with insurers.	None	• Physicians employed in public hospitals can treat private patients. • Fees vary between states. • Public hospitals can have private beds.
Belgium	• Indemnity insurers, reimburse insurees.	None	• Dual practice allowed but most physician are self-employed and private. • Public hospitals cannot have private beds.
Canada	• Indemnity insurers.	• Insurers cannot cover medical or hospital services provided by the public system.	• Doctors practicing in the private sector cannot see public patients.
Czech Republic	• Indemnity insurers.	None	• Public hospitals cannot have private beds.
Denmark	• Mainly indemnity insurers, but insurers are involved in some selective contracts with providers.	None	• Dual practice allowed.
Finland		None	• Dual practice allowed.
France	• Indemnity insurers. • Reimburse insuree on the basis of fixed fee schedule. • No contracting with providers.	None	• Dual practice allowed. • Public hospitals cannot have private beds.
Germany	• Indemnity insurers: insured individuals pay the bill and gets reimbursed by insurer. • Private health insurers usually do not contract with health care providers.	None	• Dual practice allowed. • Public hospitals may have private beds. • Doctor must follow fee scale when treating private patient but there's flexibility in calculation of charges for each medical service provided.
Greece	• Mainly indemnity insurers, but insurers are also involved in some selective contracts with providers.	None	• Dual practice allowed. • Physicians working part time in social security funds can work in the private sector. • NHS physicians are not allowed to work in the private sector (except afternoon outpatient clinics). • Public hospitals cannot have private beds.

Table 2.12. **Regulated interaction between PHI insurers and health care providers (cont.)**

	Main type/model	Regulation on insurers with respect to providers	Regulation on providers with respect to PHI
Ireland	Insurers have contracts with providers.	Insurers are obliged (under min. benefit regulations) to provide cover in respect to semi-private accommodation charges for their members within public hospitals; must also cover the statutory charge applicable to private patients who attend public hospitals with Category II eligibility.	- Dual practice allowed. - Public hospitals can have private beds.
Italy	Mainly indemnity insurers, but insurers are also involved in some selective contracts with providers.	None	Public hospitals cannot have private beds.
Luxembourg	Indemnity insurers, reimburse insurees on the basis of fixed fee schedule.	None	- Dual practice not allowed. - Public hospitals cannot have private beds.
Mexico	ISES own or contract with provider networks; general insurers offering catastrophic health cover can operate as pure indemnity insurers or contract with a network of providers.	Professional credentials of doctors and accreditation of hospital facilities serving policy holders required for ISES.	- Dual practice allowed. - Public hospitals do not have private beds.
Netherlands	Indemnity insurers, government determines fee schedule and fixes budgets for hospital.	Insurers cannot contract with providers to provide preferential access to PHI insurees.	- Dual practice allowed. - Public hospitals cannot have private beds.
New Zealand	Insurers have contracts with providers or act as indemnity insurers.	None	Dual practice allowed.
Portugal	Selective contracts with providers, and some managed care.	None	- Dual practice allowed. - Public hospitals can have private beds.
Spain	- Benefits in kind: integrated with providers (insurers own hospitals) and/or contract with providers (86% of premiums). - Indemnity insurance: 8% of premiums.	None	- Dual practice allowed, provided there is no work schedule conflicts. - Public hospitals cannot have private beds.
Sweden	Insurers have some selective contracts with providers.	None	Dual practice allowed.
Switzerland	- Insurers contract with all providers (basic health insurance). - Indemnity or contract in supplementary PHI.	- Insurers must contract with all providers in basic health insurance. - Some selective contracting is allowed in HMO-type basic insurance policies.	- Dual practice allowed. - Public hospitals can have private beds.
United Kingdom	- Indemnity insurers (insurers can set maximum benefits they will reimburse). - Selective contracts with providers (non-exclusive). - Some evidence of “provider partnership” schemes, where providers agree to charge up to the maximum benefits reimbursed by insurers’ and respect other quality criteria.	None	- NHS consultants can undertake private practice up to 10% of their NHS income. If 10% limit is exceeded, they will lose 1/11th of their NHS salary. - Public hospitals can have private beds, but “pay beds” in NHS hospitals limited by Health Ministry. - Surgeons and anaesthetists time working in private sector out of from main NHS contracts is limited.
USA	- Indemnity insurers. - Contractual arrangements (PPO, POS). - Integrated models (HMOs).		Most individuals employed by public hospitals can work in private sector on their own time.

Source: OECD Regulatory Questionnaire on Private Health Insurance, 2003. Other official data sources supplied to OECD were also used.

5.3. Product variation

In addition to traditional reimbursement or prepaid health coverage arrangements, PHI markets in OECD countries sometimes offer other insurance (or quasi-insurance) products that pay for part or all of the costs of certain health services or adverse health. Some of those are described below.

*Medical Saving Accounts (MSA)*⁶⁰

The only OECD market where such products developed, though to very limited extent, is the United States. MSAs products often offer tax advantages in return for individuals or employers establishing a separate account for health expenses – a “MSA”. While technically not health insurance, MSAs are typically combined with catastrophic insurance products, and can be used to cover the cost of deductibles or other non-covered health costs. Proponents of these products laud their potential to provide consumers with increased control over, and sensitivity towards, health expenses.

The US Health Insurance Portability and Accountability Act (HIPAA) established the possibility for self-employed individuals or employees of small firms to buy a voluntary, tax-exempt individual account, which has to be purchased in combination with a high-deductible health insurance plan (Jefferson, 1999). Payments into and from this account are regulated. The popularity of this product has been rather limited, despite several initial offerings by the industry.⁶¹

A second type of MSA product is supposed to be offered by insurance companies as one alternative plan within Medicare+Choice. It combines a high-deductible insurance plan with an individual account. The market for such products has however not yet developed, possibly because of the complex regulation, slowness in approval of high-deductible plans by Medicare (in the case of Medicare HMOs), and limited consumer interest (Hanvoravongchai, 2002; US General Accounting Office, 1998).

While several studies had predicted the advantages and drawbacks of MSAs prior to their introduction, assessment has been hampered by their low diffusion. A few studies evaluating the experience of MSA indicate that cost savings are possible, although MSA benefit the wealthy and healthy most (Hanvoravongchai, 2002; Jefferson, 1999). Critics also find that MSAs can further segment the insurance pool, taking resources out of the pool and providing individuals with tax-subsidised resources for less necessary or luxury health services.

*Private long-term care (LTC) insurance*⁶²

Currently, private long-term care insurance markets are not much developed. This is due in part to the presence of comprehensive public LTC insurance systems in some countries (Japan, the Netherlands, and Luxembourg), and in part to a combination of low demand⁶³ and limited supply.⁶⁴

Long-term care insurance entitles insurees to the payment of non-curative long-term care when it becomes medically necessary. In some countries, private LTC products are sold as part of disability and disease-specific coverage within general and life insurance (Australia, Spain). Private LTC products can be subject to the same regulatory requirements as private health insurance (Canada, Japan, and Switzerland) or separate ones (United States, Australia). Benefits can consist of reimbursement for incurred cost (United States), payment of a fixed amount (Australia, Japan, France and some US products), or regular

payments (United Kingdom). Premiums are typically set to allow pre-funding of future costs. They are relatively high (for the actual risk) when an insuree is young, and relatively low (for the actual risk) when an insuree is old. In Canada, private LTC insurance is often purchased through employers.

The insurance markets with the longest history of offering private LTC insurance are the United States and France (Scor, 2003).⁶⁵ Even here, however, private insurance is used only little to cover the cost of long-term care. In the United States, less than 10% of total LTC costs are paid through private LTC insurance,⁶⁶ despite tax advantages for its purchase. The two markets feature some notable differences. The French market provides fixed-indemnity products that pay monthly annuities once the need for LTC has arisen. Three insurers provide over 80% of all products, and about half of purchasers are covered through group policies. In the United States, products mainly provide for reimbursement of expenses for care and services received at home or in a nursing home. Insurers may set daily or monthly limits to benefit payments. The reimbursement model used by insurers in the United States exposes them to larger risk of cost escalation and is the most complex to manage and administratively costly (Scor, 2003). At the same time, private LTC insurance may cover the largest proportion of costs actually incurred when reimbursement is cost-based, rather than a fixed fee unrelated to actual service costs.

In Germany, 10% of the population – corresponding by and large to those who have purchased substitute PHI – is obliged to purchase private long-term care cover equivalent to that offered by the social system. The German government established a mandatory LTC insurance system in 1995. Individuals with social health insurance receive such coverage from their sickness fund, while those privately insured must purchase it from private insurers.⁶⁷ The population covered by private LTC insurance is therefore directly related to the size of the substitute PHI market, although the former market is slightly larger.⁶⁸ Private LTC insurance is strictly regulated to make the coverage equivalent to that offered by sickness funds. The definition of “need” is the same across the two compartments, as well as the definitions of the benefits. Premiums cannot vary by gender nor exceed the maximum contribution under social compulsory LTC insurance. There is also a comprehensive system of financial equalisation of premiums, benefits and profits across private insurers.

In other countries, private LTC markets are less significant. LTC products have been sold since the 1990s in Japan, but their growth was slowed by the introduction of compulsory public LTC insurance. Existing products play a supplementary role to statutory coverage. The United Kingdom guarantees limited state coverage for LTC costs, and take-up of private LTC policies is low, despite its being offered by several insurers. Policies are generally pre-funded/saving-type products, providing regular payment of benefits upon strict medical assessment of failures to perform three activities of daily living (ADLs). Other markets starting to offer private LTC products include Italy, Spain and Belgium (Scor, 2003). Overall, evidence suggests it is unlikely that voluntary private LTC markets will develop to significant extent in most OECD countries in the near future.

Disease-specific insurance, income replacement, cash plans

Disease-specific and critical illness products provide a lump-sum to beneficiaries who have been diagnosed with a certain critical illness. The payment is often provided from the onset of the illness until the death of the insurees or the end of the illness, in a manner equivalent to a life insurance policy which pays out prior to one's death. Other types of

products include income replacement (which entitles the insuree to payments replacing part or all of their lost income in the case of events such as temporary or permanent disability). Cash plans are written on a non-“life” basis and pay the insurees a small daily or weekly cash amount in the case an insured event occurs, such as a day in any hospital. Sometimes these plans offer small fixed cash contributions for ophthalmic prescriptions, dental treatment and childbirth, for example, but the amounts are not intended to indemnify costs. Because benefits are relatively low, and are available in conjunction with public sector treatment, premiums are generally affordable. In the United Kingdom, for example, such schemes are popular among voluntary industrial groups. The benefits provided under such plans, however, are not connected with, or linked to, the overall costs of a particular episode of illness.⁶⁹

Data on the prevalence of many of these products is poor or unavailable. In Korea, about half of the PHI market is represented by disease-specific products that provide cash benefits in case the insured person develops certain critical illnesses such as cancer (OECD, 2003b).⁷⁰ These products usually provide benefits based on the diagnosis of major illness, which do not depend upon medical utilisation. In some cases, insurees who do not develop the illness may nonetheless withdraw a cash amount. Income replacement policies are sold in several countries, including Belgium, Canada, Germany, Japan, Ireland, the United Kingdom and Switzerland. Cash schemes, usually hospital cash schemes, are also furnished in Japan, Austria, Turkey, the United Kingdom, and Ireland.⁷¹ The United States also has a market for hospital indemnity or specified disease policies.

5.4. Premium setting

PHI premiums can be set based on applicants’ risk profile, the average risk of a group, or the average risk of a community covered by an insurer. Premium rating is regulated in several OECD countries. For example community rating is mandated by regulation in Ireland, Australia and certain US States.⁷² In the absence of regulation, insurers often rate premiums on the basis of prospective actuarial risk of an individual or group of policyholders, and, in employer-sponsored coverage, on the basis of the average risk of a group as indicated by recent “experience”.

For-profit and not-for-profit insurers may follow different practices as they respond to diverse sets of incentives and aims. For example, when mutual insurance companies in Belgium apply community-rated premiums in their offerings of supplementary PHI and PHI for small risks to self-employed individuals, they do so without being required by regulation. Conversely, sickness funds, which are private entities also offering PHI, are obliged to use community rating by the Mutuality Code,⁷³ although they are free to limit the community to specific population groups. Not-for-profit insurers in the United States such as the Blues, used to apply community rating and some still do so. Within Europe, there is variation in the extent to which solidarity principles are applied by mutual insurers (Mossialos and Thomson, 2002). Insurers, including both commercial and not-for-profit, may take into account several factors, ranging from age and sex, to health status and area of residence, when they calculate premiums.

6. Why does a heterogeneity of PHI market sizes and roles exist across OECD countries?

The analysis provided in this chapter has revealed a large diversity of experiences with PHI across OECD countries. Several factors explain the differences in PHI roles and in market developments, some of which are synthesised below.

6.1. Historical reasons

The varying roles of PHI stem first of all from the historical roles of private health care and coverage in OECD health systems, and the incremental fashion in which some countries attained universal or near universal coverage. Public health coverage systems have developed “on top of” or alongside pre-existing voluntary health insurance arrangements in several countries, and the role of private insurance then shifted to reflect changes in public entitlements and other regulations relating to the permitted scope of PHI. Several countries where PHI plays a prominent role today – such as the United States, Australia, Ireland, the Netherlands and France – have a tradition of private coverage and financing.

In Australia, for example, until 1974, the health system relied upon voluntary health insurance provided by private funds, subsidised by the government, and regulated under the 1953 National Health Act (Colombo and Tapay, 2003). Following a “social assistance model”, entitlement to publicly financed health services was first made available only to eligible low and middle income groups in Ireland, leaving the most affluent persons responsible for financing health costs privately (Colombo and Tapay, 2004a). The state-owned VHI was established in 1957 to furnish PHI to the wealthiest 15% of the population who were not eligible to public hospital coverage. The Netherlands has a long tradition of private health financing that can be traced back to medieval guilds that offered financial protection against illness or death. Before World War II, there was no governmental role in health insurance (Tapay and Colombo, 2004).

While in the aftermath of World War I many OECD governments were moving towards state-sponsored universal coverage, the United States continued to rely upon private prepayment plans for providing health coverage. Blue Cross was born in the late 1930s, and group health insurance started to become part of collective negotiations after World War II (Henderson and Taylor, 2002). Health insurance continued to be provided on a voluntary basis, and no government mandate to purchase cover was introduced. *Mutuelles* have operated in France since the mid-19th century. In 1900 there were roughly 13 000 *mutuelles* and by the start of World War II, two-thirds of the population had coverage for illness through such plans. They had a role in the management of an initial Bismarkian social insurance system introduced in 1930, but not in the management of the social security system established in 1945 (Buchmueller and Couffinhal, 2004).

6.2. The central role of government policies

Perhaps the most important factor influencing the size and functions of PHI across OECD countries is public policy, in particular, public health care policy, in each country.

Decisions about comprehensiveness of public coverage and borders of PHI

Government decisions about statutory and public systems shape the borders of private financing in three main ways.

First, governments prioritise the types of risks that are to be publicly financed, leaving others to be privately insured or self-paid. Such decisions often reflect an underlying philosophy about what risks, benefits or patients are best insured by the public sector and where public resources should be allocated. Despite heterogeneity across OECD countries, the categories of risks that public systems cover break down according to *population groups*,⁷⁴ the *types of providers* and the *type of health goods or services*.⁷⁵ Comprehensiveness of public coverage has directly affected the extent to which PHI markets have developed, because PHI has focused on insuring individuals, health services or providers not publicly covered. In some OECD countries, voluntary health insurance arrangements have been crowded out by social and public programmes.⁷⁶ At the same time, universal, comprehensive public cover has not always removed the potential for a PHI market.

Second, policy makers sometimes make explicit decisions about the permitted roles of private health insurance. These decisions often reflect policy concerns about the undesirable impact of some PHI roles on health system performance, such as in the case of prohibitions on duplicate PHI in Canada and on the duplication of public coverage of out-of-hospital services in Australia. Otherwise, PHI roles are directly shaped by private initiative and PHI functions are typically carved out of the eligibility gaps in statutory insurance.

Third, the structures and regulation of health delivery systems also shape PHI roles. Notably, the structure of financing public and private providers influences the extent to which private finance may duplicate public coverage. Where public insurance finances services provided by doctors and hospitals regardless of their public or private legal status, PHI usually does not duplicate these services – although it may cover fees above the government fee schedule, as in the case of Australia for private inpatient medical treatments. Similarly, where individuals are given freedom of choice of doctor in their public system, and physicians accept the levels of public reimbursement as payment in full, there is limited scope for duplication of such services by PHI. Doctors' ability to operate both in publicly financed and privately financed practices and physician and hospitals' ability to charge different prices within the two sectors for the same set of treatments affect whether duplicate PHI markets develop, and their performance.

Policy relevance of PHI and extent of government interventions to promote its role

Some countries design explicit policies towards PHI markets because they believe that a well-designed public-private mix delivers superior social outcomes. Despite the fact that PHI plays somewhat different functions in Australia, Ireland, the Netherlands, Switzerland, and the United States, private health insurance can be described as a main pillar of the health system in each of these countries, and is recognised by the governments as such. In these countries, government policies are often based on the premise that PHI will continue to play a vital part in the overall funding of health care. PHI represents the object of explicit public policy interventions. These countries share several policy concerns, while other concerns are more particular to specific PHI roles. As a result, they have used a combination of similar and different regulations and fiscal instruments to move PHI markets towards desired social outcomes. The effectiveness of these interventions has varied.

In another group of “minor role” countries, government health policies focus primarily on the organisation and functioning of the public health system. The role of private health insurance is considered less critical to the achievement of health policy goals, and the PHI

market is often neither stimulated nor regulated explicitly, apart from the area of prudential standards. Market penetration is often low, as in the case of Northern European and Mediterranean countries. These countries may nonetheless be interested in a larger involvement of private health insurance in financing health care, as may be countries where PHI is virtually non-existent, such as in some of the Eastern European countries. For example, there is very little to no PHI in Poland, although legislation provided for the possibility to establish private health insurance schemes after 2002.⁷⁷ Despite the creation of a legal framework for PHI in 1993 and the introduction of government subsidies, so far few insurers have been established in Hungary. The low demand for PHI has been attributed to comprehensive statutory health insurance coverage, and a preference to make informal payments rather than purchase PHI (European Observatory, Hungary, 1999). A similar case is offered by Slovakia (Box 2.7).

In the few countries that fall somewhere in between the categories of “major” and “minor” role regulations may be limited. This is the case of France, except in the case of mutual insurers. In Germany, the government regulates substitute coverage more heavily, and had imposed stricter controls on all PHI contracts prior to the application of the EU directives. In Canada, despite government interventions to circumscribe the scope of PHI coverage, there are significant tax advantages for employers offering PHI, and the large majority of the population has some insurance to cover permitted benefits.

6.3. The role of other actors

Employers

In several OECD countries, employers encourage the purchase of PHI and may actually represent a leading factor in the expansion of coverage. In the United States, Canada, the Netherlands and France, private health insurance is predominantly sponsored by employers, and levels of population covered by PHI are high compared to other OECD countries. Economic growth and the increased provision of PHI as a work benefit help to explain the expansion of PHI coverage in Ireland, even during a time when entitlements to publicly funded services became more generous. A larger role for employers in buying private insurance can have positive implications for equity of access and for the comprehensiveness of cover. It may, however, affect the characteristics of remaining individual policies and lead to a more fragile individual market. It can also augment competitive pressures exercised upon insurers as employers exert their purchasing power in negotiations with insurers. Employers often are also savvy purchasers, closely examining value for money in their employee-benefit decisions.

Consumers

Obviously, consumer preferences are a key determinant of demand for PHI. Propensity to buy insurance varies. Even in primary insurance markets such as the United States and the upper-third income bracket in the Netherlands, there are striking differences. About 14% of the US population is uninsured, while this is the case for less than 1% in the Netherlands. Furthermore, over 90% of those with social insurance in the Netherlands purchase some type of supplementary coverage, underscoring an apparent cultural preference and, possibly, a higher degree of risk-aversion. While uninsurance is largely a problem faced by the poor and near poor working population in the United States, some of the uninsured in the United States have incomes above 200% of the federal poverty level⁷⁸ (Kaiser Commission on Medicaid and the Uninsured, 2003). Although the absolute cost of

Box 2.7. Potential role for PHI in Slovakia

Since 1994, the Slovak health care system has been based upon a Bismark-style mandatory social health insurance scheme. Health insurance contributions are income-related, set at 14% of the assessment base, and shared between employers (10%) and employees (4%). The State pays for all inactive persons, including dependents, elderly, soldiers, and the disabled (approximately 60% of the population). There are five social insurers operating nation-wide, for two of which the State guarantees solvency. One of these covers about two-thirds of the population. Public health expenditure represents the main source of health funding (89% of THE in 2001). Out-of-pocket expenditure is the only source of private financing, and includes large, unmeasured informal payments. PHI is virtually non-existent. Slovakia spent 5.7% of its GDP on health in 2000 (OECD *Health Data* 2003), one of the lowest health spending levels in OECD countries.

Over the last decade, Slovakia has been involved in reforming its health sector in order to solve its many problems (underfunding, inefficient delivery, poor management, lack of market incentives, and low accountability). The new strategy for health sector reform intends to reform the social health insurance system, reducing the benefit package covered by mandatory health insurance and permitting voluntary private health insurance. Other measures to be implemented include the privatisation of all state-owned facilities and insurers, price de-regulation, and the introduction of patient co-payments (Pazitny and Zajac, 2001).

PHI is expected to play mainly a supplementary role, covering services delisted from mandatory health insurance. Some duplication of services provided by public health insurance appears also to be envisioned, at least with respect to coverage providing improved timeliness of access to care. Insurers will also be permitted to offer PHI for co-payments in the public health insurance system and other out-of-pocket costs. They will also be able to cover the higher fees of providers outside the network(s) contracted by social health insurers for compulsory coverage. Regulation of PHI is expected to remain minimal. Both social health insurers (through private affiliates) and commercial insurers would be able to offer private health insurance.

The proposed role for PHI might offer some opportunities, but also create some challenges. It is envisioned that the development of a PHI market will help formalise informal payments and make certain hidden phenomena, such as waiting times, become visible. Under-the-table payments would be substituted by open queues, transparent fees, and open rationing as a mechanism to equilibrate demand and supply. However, the lack of history and tradition of PHI in Slovakia may deter a PHI market from developing. Individuals are not used to buying insurance policies and seem to have limited trust towards insurers as buyers of health services. They may prefer direct buying of services from doctors, through informal payments, to paying third-party payers, which act as intermediaries between patients and doctors. They may have no guarantee and little trust that paying an intermediary insurer would assure quality care (Murthy and Mossialos, 2003).

In addition, even if a market develops, PHI might accentuate inequities in access to care unless its role is clearly defined. For example, in the absence of transparent information and clear rules for prioritising access to care, there is a risk of reduced access to care for those who do not have PHI, particularly if PHI is allowed to cover the waiting times and higher fees of doctors delivering faster treatments. This may produce incentives for providers to discriminate among patients on the basis of income expected from different patients. For this reason, a strict separation of the financing of public and private health services, transparent rules for allocation of doctors' time between public and private work, and explicit access rules would be needed.

Source: Colombo and Tapay (2004b).

premiums and the greater degree of public coverage in the Netherlands may be one explanatory factor, other more difficult to explain cultural inclinations are likely to have a role. Social-political beliefs seem to be related to purchase of PHI by individuals in the United Kingdom (Mossialos and Thomson, 2002).

Consumer preferences also reflect perceptions regarding the quality of private and public health provision and financing systems. Differences in entitlements to public cover influence such perceptions. The perceived value of private cover also reflects dissatisfaction with public system performance. Waiting times in public hospitals increase population uncertainty about their ability to receive needed care in a timely fashion in several countries, such as the United Kingdom, Ireland and Australia and are a leading factor in the demand for PHI. Finally, an increasingly strong preference for individual choice appears to drive decisions to purchase PHI, especially in those countries where choice of provider is cost-free only for the privately insured.

Insurers

Finally, a PHI market will not develop unless there is private initiative behind it. Strategic behaviours by insurers affect how markets develop. Insurers may decide not to offer a product, or to enter a market, if it is not considered viable, or profitable, in the long-term. In Ireland, despite the fact that two-thirds of the population are not publicly covered for GP services, insurers have historically offered limited primary care benefits and subjected them to large deductibles, possibly reflecting the difficulties of containing moral hazard in that segment and lower cost, compared to inpatient services. Markets have also responded differently to modifications in the generosity of public system coverage. Private health insurers in the Netherlands promptly covered dental benefits in supplementary PHI products after they were delisted from sickness-fund insurance in the 1990s, but may have more difficulty doing the same if other benefits are delisted. However, large levels of out-of-pocket payments under the Korean national health insurance system have not resulted in the development of complementary health insurance. Despite somewhat limited public cover of long-term care benefits in several OECD countries, the development of such products is confined to a limited number of OECD markets, and is still in an embryonic stage in others.

Notes

1. The discussion under this section largely draws from OECD (2004a).
2. Often, the terms “public” and “social” health insurance are used interchangeably. However, there is technically speaking a distinction between the terms. While the former refers to a certain way of collecting resources and sources of funds, the latter refers to a notion of “redistribution” across different risk and income cohorts. Typically, (public) social health insurance schemes include statutory programmes, financed through income-related contributions usually collected by employers and employees, which are managed either by public, private or semi-private insurance entities. Private health insurance can also serve a “social” nature, for example when it receives public subsidies and is regulated in a manner to promote extensive cross-subsidisation across different risk-cohorts. See also Adema and Einerhand (1998), Adema (1999), and Pearson and Martin (forthcoming) for an analysis of the growing role of private social benefits across OECD countries.
3. Governments may however give individuals means-tested subsidies to the purchase of insurance, as in the case of primary insurance in Switzerland and complementary insurance in France.
4. Dror (2000) discusses how there has been a convergence between public and private health insurance arrangements. As a result of reform, the former have introduced changes that go in the

direction of reducing solidarity, for example by increasing cost sharing under public health insurance schemes. Conversely, regulation of private health insurance increases the degree of cross-subsidisation across risks and enhances the “social” nature of such schemes.

5. This is for example the approach used by Mossialos and Thomson (2002).
6. This report has chosen to adhere to a criterion based on financing method and main financing source because this seems to be more relevant from a perspective of health policy. Policy makers look at PHI as a possible way for financing health care which involves a lower tax burden than other financing methods. The criterion chosen enables to include all the health insurance arrangements that are relevant to policy discussion.
7. All data on population coverage in the United States are from: US Census Bureau, Current Population Survey, March 2001.
8. Legislation enacted at the end of 2003 enables Medicare beneficiaries to obtain prescription drug coverage, subject to premiums, coverage limitations and cost sharing (except for certain low-income persons who are exempt from premiums and subject to reduced cost sharing), beginning in 2006.
9. Less than 1% of the Dutch population does not have any health insurance at all. This group consists mostly of illegal residents and groups refusing insurance because of religious reasons (Gress et al., 2002, p. 7).
10. Three main groups can be covered by primary PHI in Germany: the self-employed who are excluded from the social security system, civil servants, and employees above an income threshold (Gress et al., 2002).
11. Such limited level of opting out has been explained by several factors. First, while PHI may be convenient for single and young individuals, social health insurance offers cheaper family coverage by including dependants. Second, PHI policies are rated on the basis of risk and age of entry while social health insurance contributions are income-related, thereby offering cheaper coverage for high-risk individuals. Third, once individuals have chosen to opt out of the social health insurance system, they cannot opt back into social health insurance upon becoming ill, for example in old age. This protects the social health insurance system against adverse selection, while representing an uncertainty factor than may deter people from opting out (Thomson and Mossialos, 2002; Gress et al., 2002).
12. The 1994 Health Insurance Law (LAMal) took effect in 1996. It mandated primary coverage for the entire population and created a regulatory separation between this type of cover and that applicable to voluntary health insurance policies.
13. Regulatory responses to such challenges as well as the impact on performance of primary and other PHI types are reviewed in Chapters 3 and 4 respectively.
14. In several OECD countries, doctors can operate both public and private practice (see Table 2.12). Sometimes, private hospitals receive some public funding and viceversa, however these constitute only a minor proportion of overall funding.
15. In Ireland, a share of total acute care beds in public hospitals (20%) has been designated for private patients, usually treated in semi-private or private room. In Australia, there is no a priori allocation of beds to private or public patients, and individuals opting to be treated as private patients have the sole advantage of choosing their own doctor.
16. This type of coverage is referred to as “assurance complémentaire” (as opposed to statutory cover under social security arrangements).
17. McCardle et al. (1999, Figure 1) citing Eppig and Chulis (Fall 1997). 30% of Medicare beneficiaries have employer-sponsored supplemental coverage, 28% individual Medigap and 4% a combination of employer and individual coverage; 19% rely on Medicare alone.
18. For a more comprehensive description of data and trends on health expenditure and financing across OECD countries, see OECD (2003c). Data are drawn from OECD *Health Data* 2003.
19. Based on 27 countries. It excludes Belgium, Slovak Republic and Turkey, for which data for 1990 are not available to make meaningful comparisons with 2000 data. Source: OECD (2003a).
20. Based on 23 countries for which data are available. It excludes the United Kingdom, Turkey, Sweden, Portugal Poland, Greece and Belgium. Source: OECD *Health Data* 2003.

21. For the 19 countries for which data are available, OOP as percentage of THE increased from 19.1% in 1990 to 19.8% in 2000. Conversely, their importance in total private health financing has been slightly diminishing from 75.3% to 73.2% (OECD, 2003a).
22. Unweighted average for the 22 OECD countries for which reliable data are available or estimated. Data exclude Belgium, Greece, Korea, Poland, Portugal, Sweden, Turkey and the United Kingdom.
23. Such as the United Kingdom and Belgium.
24. Data for Switzerland refer to voluntary health insurance and do not include basic mandatory health coverage.
25. Based on 22 countries for which reliable data are available or estimated for 2000.
26. For example, PHI as a share of total private health expenditure (TPHE) in 2000 was 63% in the United States, 53% in France, 51% in Germany, and 42% in the Netherlands.
27. For example OOP as a share of THE in 2000 was 15.2% in the United States, 10.4% in France, 10.5% in Germany, 9% in the Netherlands.
28. Countries with low level of OOP spending as percentage of THE do not necessarily have high levels of PHI (e.g., Luxembourg, Czech Republic). Australia and Austria also have a prominent PHI market, but this does not go with low levels of OOP spending.
29. High levels of PHI financing are not necessarily accompanied by a low share of public health spending (with the exception of the United States). Countries with a low share of public health financing include an equal mix of high-PHI share countries (e.g., the United States) and high-OOP share countries (e.g., Mexico, Korea).
30. If data from the United States are excluded, the relationship is weaker.
31. In the case of Ireland this has risen due primarily to particularly strong growth in public expenditure in recent years.
32. The literature has examined the issue of crowding out of private finance by public health expenditure, finding that an increase in public finance crowds out private spending (e.g., Cutler and Gruber, 1996). Tuohy *et al.* (2001) examine the opposite case. They find that a 10% increase in the level of private spending is associated with declines of between 1 and 3% in the level of public spending in the future. The crowd out of public spending by private spending is however not taking place in the hospital sector, suggesting that the relationship between growth in public and private financing may be different in different sectors of the health system. The analysis, however, does not enable to distinguish the relative importance and impact of PHI versus OOP. Nor does it examine the different contributions of public and private expenditure to financing THE growth.
33. See for example discussion by Wagstaff *et al.* (1999) on equity of financing across several OECD countries.
34. The analysis was carried out based on *OECD Health Data for 1997*. This suggests that countries with primarily public financing are more able to control health care costs than countries with greater private financing.
35. This average is based on population coverage data reported in Table 2.7 for 26 countries (excluding Korea, Sweden, Turkey and the United Kingdom). For countries where different types of coverage estimates exist depending on type of insurance, data included refer to the proportion of individuals with at least one type of cover.
36. 72% in the United States; 31% in the Netherlands, about 9% in Germany; 10% in Belgium (self-employed without social coverage for minor risks); about 5% in Spain.
37. In the Netherlands, there is a strong convergence between coverage by social and primary PHI: most PHI packages offer a similar scope of benefits to social insurance, though many offer additional benefits as well. However, this only occurs as a result of government interventions in the case of the standard package (which is required to largely mirror the benefits contained within the social insurance package). In several OECD countries these policies may be subject to regulatory requirements.
38. Benefit packages in duplicate PHI such as Australia and Ireland resemble public coverage systems.
39. Adverse selection refers to the phenomenon when a disproportionate number of high-risk individuals apply to join or belong to a certain insurance pool, whether that of a particular insurer or product. Under such a scenario, individuals whose premiums exceed the level of their individual risk exit insurance, thus reducing risk pooling and increasing the costs of coverage for remaining individuals.

40. Nicholson *et al.* (2003) found that those switching from a non-HMO to an HMO used 11% fewer medical services in the period prior to their switch than those who remained in non-HMO plans and this lower use persisted when they were enrolled, as compared to those already enrolled.
41. On December 8, 2003, a Medicare prescription drug benefit bill was passed into law. It provides significant prescription drug assistance to 14 million low-income Medicare beneficiaries with incomes below 150% of the federal poverty level, and catastrophic drug protection for all 40 million beneficiaries. The voluntary outpatient prescription drug benefit starts in 2006, with an estimated USD 420 annual premium and USD 250 deductible. Beneficiaries pay 25% of drug expenses up to USD 2 250, the entire bill between USD 2 250 and about USD 5 100, and 5% of any remaining drug expenses. Low-income beneficiaries get subsidies for premiums and out-of-pocket expenses (www.cmwf.org/programs/topten_2ndpg.asp).
42. According to Finkelstein (2002), 97% of the Canadian market is group market.
43. The growth of the Portuguese PHI market between 1996 and 1999 was mainly due to group policies. In the Netherlands, the group market grew from 34.5% of all policies in 1980 to 54% in 1998. In the United Kingdom, strong corporate performance has driven an increase in employer-sponsored PHI, from 48% of all policies in 1993 to 59% in 2002 (Mossialos and Thomson, 2002).
44. The existence of a strong link between tax treatment and offerings of PHI as a work-related benefits has been highlighted by several studies, for example: Finkelstein (2002) and Stabile (2001) for Canada; Henderson and Taylor (2002) and Gruber (2001) for the United States. In France, the cost of PHI is a tax-deductible expense for employers when enrolment by employees is mandatory (Buchmueller and Couffinhal, 2004). See also Chapter 3 for an analysis of tax advantages towards PHI.
45. For example, in Germany employers may offer access to group policies (although not directly providing insurance cover) whose premiums are cheaper than those on individual contracts.
46. See the Kaiser Family Foundation and Health Research and Educational Trust (2003, p. 3).
47. So-called cafeteria plans include work-related fringe benefits where individuals are given a choice of the area where they want to spend benefits (e.g., child care, health care, etc.).
48. Bundorf (2003) examines the effects of offering choice in employment-based purchasing groups in the United States, finding that greater availability of choice increased the proportion of workers covered by the plans offered by employers but also resulted in a reduction in the generosity of the plans and premium shifting across individual and family policies.
49. In most OECD countries individual and group policies are subject to uniform requirements. This is not the case in the United States, where most states' individual markets have different characteristics and regulation from employer markets.
50. Variations by insurance type may exist nonetheless. For example, in Italy commercial insurers sell individual policies primarily to medium to high-income people, while mutual associations favour middle to low income purchasers. The application of solidarity principles across EU member states vary (Mossialos and Thomson, 2002).
51. VHI Healthcare is to be transformed into a state-owned public limited company, but its corporate status is still unclear. While Medibank Private Ltd is owned by the Australian government, it does not have a special relationship with the government, per se, as it has to comply with the same regulatory requirements as every other health fund.
52. In Australia, in an effort to better control costs, some main players are moving towards negotiating case-based payments with private hospitals.
53. "Integrated delivery system" or "integrated health care delivery system" include organised systems of health care providers to span a broad range of health care services. See Blakeslee, A. (2003), "Managed Care Terminology", in *Managed Care* (Cornell) at <http://trochim.human.cornell.edu/gallery/blakeslee/cornell.htm> and Box 2.6.
54. Managed care plans usually involve three key components: oversight of the medical care given; contractual relationships and organisation of the providers giving care; and the covered benefits tied to managed care rules (Integrated Healthcare Association, IHA *Managed Care Fact Sheets: Overview*, Walnut Creek, CA, www.ih.org).
55. 12 ISES had authorisations to operate in Mexico in 2004. ISES covered 2.9% of the privately insured population in 2002, while the rest of the PHI market is represented by catastrophic health products (GMM) offered by general insurers. GMM have large deductibles that can be waived or reduced if individuals choose to receive services from a network of providers (hospitals and doctors) with whom the general insurer has a contract. In this latter case, insurers operate in a manner similar to PPOs in the United States.

56. See for example Lawrence (1997) and Goldsmith (2002) on the Kaiser Permanente experience.
57. More detailed discussion on regulation is included in Chapter 3, while Chapter 4 discusses the impact of some of these systems' structures on performance.
58. German doctors can charge all private insurees fees that are 1.7 to 2.3 times higher than the fee schedule for private medical services set by the Ministry of Health (Mossialos and Thomson, 2002).
59. While 75% of the Medicare component of the fee-for-service paid to medical specialists working in private hospitals or working privately in public hospitals is paid by the public system, this represents only 19% of the total cost of private hospital treatment. The Medicare payments are made to the specialists directly and do not subsidise the private hospitals themselves (PHIAC, 2002).
60. Medical Saving Accounts are individual saving accounts providing for pre-payments of health care expenditure. See Hanvoravongchai (2002) for an analysis of the international experience with MSAs.
61. Possible reasons for limited diffusion include the complexity of the product, making it of limited appeal to consumers, and generally low demand. This type of MSA+ High-deductible product was supposed to be discontinued after 2002, although current proposals include making this type of product permanent and reduce restrictions applicable to it (Hanvoravongchai, 2002).
62. An OECD project also reviews member countries' experiences with public and private long-term care insurance (OECD, 2005). Some of the information in the paragraphs below has been gathered as part of this project.
63. Private LTC products are complex and their premiums can represent a significant opportunity cost for individuals. Furthermore, individuals may not feel the need to buy such a policy when young, and the price of private LTC policy is often higher, and may hence be unaffordable, for the elderly. However, there may be some demand for LTC products supplementing public LTC coverage. For example, in Spain one survey indicates that about 16% of the population would be willing to purchase such insurance (Costa-Font, 2002).
64. Private LTC markets are difficult for insurers, given complex and unpredictable actuarial issues surrounding premium calculations as well as difficulties in maintaining a diverse insured population over time. It is also complex for regulators, who are confronted with new or changing markets.
65. There are over 6.5 million long-term care insurance policyholders in the United States and over 1.5 million in France (Scor, 2003).
66. OECD Questionnaire on Long Term Care.
67. People who are voluntarily insured at a sickness fund, because they have not chosen to opt out of the public system, can opt between LTC policies offered by a private insurer or by their sickness fund.
68. All the members of the two mutuals that cover the employees of public railway company and the now privatised postal services company are also obliged to take out private compulsory LTC insurance. This is why there is about 1 million people more with private LTC insurance than those with substitute PHI.
69. In many cases, this type of coverage overlaps with, and duplicates, other health insurance coverage for the same event or illness.
70. The other half of the market is comprised of compulsory insurance against car accidents, which also pays a fixed cash amount to the patients once an accident takes place.
71. Source: OECD Statistical Questionnaires on PHI, responses from various countries; and Colombo (2001).
72. A more comprehensive discussion of different approaches towards regulating premium rating across OECD countries is included in Chapter 3.
73. Article 2 of the Law of 6 August 1990 on mutuals and national unions of mutuals.
74. Most OECD countries have universal coverage. Otherwise, eligibility to public coverage is based on socio-economic and demographic groups (such as in the case of limited income-based eligibility to public health insurance in the Netherlands and Medicaid in the United States), or is based on age (as Medicare in the United States).

75. For example, certain products or services are not covered by public health systems, perhaps because they are regarded as non-essential or discretionary, such as non-prescription pharmaceuticals, dental and optical treatments, or alternative medicine in several countries.
76. For example, the establishment of a basic mandatory health insurance system with comprehensive benefits in Switzerland in 1996 induced a shrinking in the size of voluntary PHI market. In Australia, drops in the level of PHI membership followed the introduction of universal health insurance (Medicare) in 1984.
77. European Observatory on Health Care Systems, Poland (1999). Polish employers sometimes stipulate arrangements with providers to provide health services to their employees. These activities seem to operate similarly to HMOs in the United States, but are employer-specific and small. They also bear resemblance to efforts of US self-funded employers who contract with a network of providers and fund employee care.
78. 16% of those with incomes between 200 and 299% of the Food Poverty Line are uninsured, as are 6% of those with incomes above 300%.

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Chapter 3

Government Regulation of PHI in OECD Countries: Scope, Trends and Challenges

In comparing OECD countries' experiences with different regulatory approaches, this chapter examines the contribution of certain regulatory structures and provisions to the achievement of key goals of health system performance, namely: equity, efficiency, choice and innovation, responsiveness and quality of care. The impact of such regulation is reviewed, however, predominantly for case study countries.

1. Introduction

Governments intervene to a greater or lesser degree in different private marketplaces and their actions, or absence of action, are dependent upon several factors. These include the importance of private activity in government economic or social policy, ideological and political approaches to government intervention generally, government resources, and other factors. The need for intervention and the content of particular laws and regulations are also informed by past market failures and any other problems that may have arisen in the absence of certain governmental requirements. More specific questions regarding the scope and content of regulations depend upon the particular service being provided by the private markets, the extent to which the government or other non-private actors provide similar or overlapping services, and policy makers' view on the potential usefulness of certain interventions.

In the case of insurance generally, there is consensus across OECD countries that financial conditions of private insurance carriers must be overseen, and certain minimum requirements set forth in law – although the details of some of these requirements may vary. Consistent with this trend, all OECD countries with PHI markets regulate the general financial conditions of private health insurance companies (OECD, 2002). However, beyond the area of financial and prudential standards, regulatory approaches to PHI markets vary across OECD countries with respect to their scope, focus and approach. Nonetheless, when governments have chosen to address similar challenges, parallels and differences in their regulatory methods emerge. This chapter reviews some of the key regulatory interventions in this area and compare countries' interventions and experiences.

Examination and comparison of the scope and content of PHI regulation across OECD countries has revealed that the scope and type of government intervention is often linked to the prominence of PHI in the health system – in terms of population coverage and/or its contribution to health financing. The particular public/private financing mix in a country, and the role of PHI within this mix, are also key factors. However, in other cases, interventions seek to address challenges that arise in PHI markets generally, and appear to be less connected to the particular role of PHI coverage in relation to the public system. Additional factors include the historical importance of private financing in the health system, the historical role of the government or not-for-profit sector with respect to PHI, the impact of cross-national standards (especially in the case of European Union member countries), and policy maker priorities.

Several countries impose requirements relating to access to PHI coverage, premiums, and the content of the insurance contracts themselves, as described further below. In some cases, governments have decided to impose some of these requirements on certain types of carriers, or certain segments of the PHI market, but not upon others. However, there is a trend across OECD countries towards similar treatment of entities performing similar functions. These trends arise out of concerns to promote equitable treatment and fair competition within a marketplace with diverse types of carriers.

Challenges arising from financing the health care costs of high-risk persons have led to government interventions in the public and private health care coverage markets. There is diversity across OECD countries in the extent to which PHI covers some of the more costly health care services, or the coverage of high-risk persons and the chronically ill, and in no country is PHI the sole source of health coverage for the entire population. However, where certain or significant pieces of the population must rely on private health coverage, governments have generally intervened, in some similar and some varying ways, to assure access to coverage and further related policy goals. At times, governments have also required cross-subsidies between public and private insurance, the presence of tax-financed or subsidised high-risk pools, or other means of compensating for the health costs of high-risk persons. Risk-equalisation programmes accompanying certain rating restrictions seek to compensate insurers for the possible effects of adverse selection. In addition, some laws and regulations explicitly delimit the role of PHI or the scope of its coverage *vis-à-vis* the publicly financed programmes. These limitations seek to clearly define the permitted scope of private and public health coverage, and may also seek to avoid certain undesirable secondary effects, such as inequity of access to services or moral hazard-induced utilisation. They also may reduce the potential for PHI to cover high-risk services, thereby explicitly apportioning certain health risks between the public and private sector (Table 3.1).

A range of additional government interventions also impact the functioning, success, transparency and competitiveness of different PHI markets. For example, many countries provide incentives for the purchase of private health insurance through the tax system or through premium structure-related requirements. These incentives can significantly affect the types of insurance markets that develop, and assist in the affordability of coverage. However, with few exceptions, these incentives alone have not been sufficient to address some persistent affordability challenges in PHI markets, in which middle and upper income purchasers usually play a predominant role.

EU member countries have less individual discretion in designing the regulations applicable to PHI than some of their OECD counterparts, as their requirements must conform to applicable EU law. These restrictions will also influence the activities of EU accession countries as well since they will be subject to these same requirements in the near future. Under EU law, PHI products are subject to the same insurance directive as other non-life insurance products. These requirements focus on competition, companies' freedom to offer services across EU countries, as well as financial standards. Material requirements regarding PHI contracts are prohibited by EU law, with the exception of a few countries where such standards may apply to certain types of PHI coverage pursuant to an exception to the broader restrictions.

2. Applicability of PHI regulation

2.1. Trends towards uniform treatment of health insurance entities

In crafting and implementing PHI-related regulations, policy makers must identify the types of entities and coverage they wish to subject to certain standards and requirements (Table 3.2). This determination involves considerations of the type of health insurance entities in their PHI markets, the type of coverage available or potentially offered (in terms of its benefits, provider choice, extent of care management), as well as the presence of any submarkets facing particular challenges (such as separate

Table 3.1. **Key PHI-related laws and regulations**

	PHI insurers must issue all or certain products	Requirements for contract renewal	Portability protections	Consideration of health-risk-related factors permitted in premium setting	Risk-sharing or risk-adjustment requirements/mechanisms
Australia	Yes. All products.	Not applicable (Contracts have infinite terms).	Yes	Lifetime Health cover permits calculation based on age of entry.	Yes. Risk equalisation scheme funds benefits for those over 65 years of age and those experiencing over 35 days of hospitalisation per year.
Austria	No	No	No	Yes	No
Canada	No	None	No	No	In Quebec, for private drug insurance plans for high drug claims in excess of specified dollar amounts.
Germany	Yes. Access to standard tariff policy.	Effectively, for substitutive cover, as it is offered on a lifetime basis. For other types of coverage, cancellation by insurer is prohibited after a certain number of years.	Yes, if moving from social to private insurance. Limits on general waiting periods and specified limits on coverage exclusions for certain conditions.	Substitutive cover must be offered on a lifetime basis; premiums determined by age of entry and gender (and benefits); health status risk surcharge may be imposed (except for civil servants switching from public cover to standard tariff). New entries may not be charged less than already insured of same age (not including ageing reserve). Premium cap: substitutive coverage.	PHI contracts include an option to impose a surcharge to pay for premium cap on standard tariff package, but this option has not been invoked. Insurers participate in a risk equalisation scheme for standard tariff policies, as the number of aged insurees varies across companies.
Ireland	Yes. All products.	Yes. "Lifetime cover" requirement.	Yes	Introduction of premiums differentiated according to age at policy inception is permitted by law but regulation is required in order for it to be implemented.	Yes. Risk equalisation system being implemented.
Mexico	No	Requires insurers to specify if there is compulsory renewal, and, if so, the maximum age for renewal.	No	Limits on age-based variation established through a legally established premium range.	No
The Netherlands	Yes. Standard package for elderly and high-risk.	Policies generally include an automatic one-year extension unless notified by the insured.	Insurer voluntary code requires ability to convert from group to individual policies on same general terms; voluntary code also promotes portability between group plans. No exclusions permitted for WTZ policies.	Premium for WTZ package subject to limitation. Limit is above average premium levels in the PHI market. No limits for supplemental coverage.	Compensation scheme between social insurance and PHI where privately insured pay a contribution to cover for social insurance covering more of the health care costs of the elderly. Pooling scheme for WTZ scheme pools costs exceeding WTZ premiums, and divides and spreads this cost through surcharge imposed on all privately insured.
Poland	No	None	No	Yes	No
Portugal	No	None	No	Yes	No
Slovak Republic	No	None	No	Yes	No
Spain	Yes for civil servant substitute coverage.	Yes for civil servant coverage.	No exclusions permitted for civil servant coverage.	Yes; some entities set premiums according to age groups and others base them upon the criteria for mutuals.	No

Table 3.1. **Key PHI-related laws and regulations** (cont.)

	PHI insurers must issue all or certain products	Requirements for contract renewal	Portability protections	Consideration of health-risk-related factors permitted in premium setting	Risk-sharing or risk-adjustment requirements/mechanisms
Switzerland	Yes for primary coverage. No for supplementary coverage.	Yes for primary cover. No for supplementary cover (Colombo, 2001).	No exclusions permitted for primary cover; allowed for supplementary cover.	No variation by health status is permitted under primary coverage; there are is some variation permitted for children and students, and for geographic area. Permitted for supplemental coverage.	Yes. A risk equalisation fund compensates insurers for cost differences in primary coverage arising from risk, based on age and gender factors. Continuation of risk equalisation scheme after 2006 is under debate.
Turkey	No	No	No	Yes	No
United Kingdom	No	No, but it is the traditional practice.	No regulatory limits.	Yes	No
United States	Yes. Some products and markets.	Yes.	Yes for group contracts; some states require it for individual contracts.	Many states restrict health status-based rating ("experience rating") in small group market and some require community rating with varying degrees of permitted variation by age, gender and geography. Individual market requirements vary. Some states require community rating in the Medicare supplement market.	Many states have voluntary risk equalisation schemes in their small group markets; some are mandatory. Some states have risk equalisation in individual markets. 30 states offer high risk pools (coverage offered by separate pools, often subsidised by charges on insurers or other taxes) (Chollet, 2002).

Source: OECD Regulatory Questionnaire on Private Health Insurance.

small employer or individual PHI markets). For the most part, entities offering privately financed insurance coverage for a defined set of health services in OECD countries are increasingly subject to similar treatment by regulators. This trend reflects a desire to promote a “level playing field” where all actors are playing by similar rules. This action can also help promote risk pooling by keeping most private health financing activity (apart from out-of-pocket costs) within the insurance pool.

In some cases, there has been a history of different, and at times more stringent, requirements for certain entities in return for tax or other advantages, some of which continue to this day. For example, some non-profit plans in the United States, and mutual companies in France, Belgium, and other European countries, operated according to more stringent access and premium-related standards (either voluntarily – such as through their organisational code) or by legal requirement or agreement; in return, they received tax or fiscal advantages. However, in some cases their different standards put them at a competitive and financial disadvantage in markets where other types of health insurance entities were subject to less stringent requirements. Policy makers in the United States sometimes responded by imposing similar, more stringent requirements on other entities operating in the market, particularly in the wake of financial difficulties experienced by these plans, such as those experienced by Blue Cross Blue Shield plans in New Hampshire, New York and New Jersey in the United States, among others. Conversely, however, EU law generally requires similar treatment of all health insurance entities, but resulted in a loosening of standards for some players, such as mutuals, that were previously subject to stricter requirements. Under this harmonisation, consumers may lose some of the local social advantages that had been available from particular types of insurers in certain countries (Palm, 2002, pp. 206-207).

2.2. History of different treatment

EU law has required that entities whose activities constitute “insurance” within the scope of EU insurance directives and laws be subject to uniform prudential, consumer and other applicable requirements. This includes mutual companies offering private health coverage, such as those operating in Belgium and France. In some cases, resolution of issues related to the application of the EU directives involved legal action, interventions by the European Court of Justice and subsequent amendments to national laws. In the case of France, the European Court of Justice held that France had violated several EU directives, including the third non-life insurance directive (discussed herein) by not transposing these directives into their laws governing mutuals.¹ The French government ultimately resolved the issue by amending its Mutuality Code to incorporate EU principles, including a change in tax treatment so that certain tax advantages are now available to any insurer applying social criteria to risk assessment, rather than to mutuals alone. However, at the same time, certain solidarity principles for mutual companies were codified into French law, therefore now making them legal requirements. These include, notably, prohibitions on exclusions for pre-existing conditions, the consideration of individual health status in premium calculations, and a requirement that policies be renewable (Mossialos and McKee, 2002, p. 158).

In the United States, historic differences in the origins, functions and practices of, and expectations for, different types of health insurers, such as managed care plans, indemnity plans and non-profit plans, led to a situation where different statutes and standards were being applied to different types of health insuring entities. However, over time, these

entities began performing increasingly similar functions. More health plans began using managed care tools in order to try to control costs and utilisation; at the same time, managed care plans provided increased flexibility relating to provider choice. Hence, the distinctions between traditional health maintenance organisations (HMOs) and other types of fee-for-service plans became increasingly blurred. Yet, because of their separate origins and history, several licensing statutes sometimes applied to the activities of a single entity, or different laws applied to similarly functioning entities. As part of an effort to simplify these laws, as well as an attempt to assure a “level playing field” for competition among plans, several US states have enacted new laws merging and clarifying the applicability of their laws, and basing them on *plan structure and functions*, rather than plan type.² Hence, the approach in many states in the United States is now similar to the general uniform approach towards PHI regulation in other OECD countries.

2.3. Self-funding

For the most part, OECD countries do not permit entities to assume risk in connection with the private financing of health services unless they are licensed as health insurers. With the exception of self-funded employers in the United States and Canada, and limited examples in other OECD countries, “self-funding” of health care costs by entities not licensed as insurers is not permitted. Country-specific details, and examples of exceptions to this trend, are summarised in Table 3.3. Key concerns with self-funding include the absence of financial standards to assure financial soundness (*e.g.* in the case of US self-funded employer plans), its impact on competition among entities performing similar functions, the deleterious effects this activity may have on countries’ attempts to promote solidarity across risk categories, among other concerns.

On the other hand, the essential deregulation of a significant portion of the US employer health plan market demonstrates both the potential and limits to efforts to exempt health coverage entities from certain health insurance regulation. This deregulation occurred when a federal law exempted self-funded employer health plans from state-based health insurance regulations and subjected them instead to very minimal federal regulation. Importantly, the effects of this exemption gave organisations increased flexibility to offer similar products across geographic areas because they could avoid locally applied PHI benefit standards. Some of the large, more sophisticated self-funded employers have become leaders in private efforts to promote health plan cost-efficiency, accountability and quality. They also benefit from economies of scale and their medical loss ratios (ratios of claims to premiums) are often in the high eighty to ninety percentage (Hall, 2000, p. 174). Yet smaller operators who seek to benefit from this exemption, but are of a size that may limit their ability to bear the risk of high-cost claims, face a higher-risk of insolvency, and of an inability to pay claims. In addition, consumers lost the advantage of some protections that had been imposed by policy makers, and health insurance risk pools³ became further fragmented. The exemption also led to efforts to circumvent state laws by employers to “reinsure” a significant portion of their health care costs and, in some cases, retaining very little risk themselves (Hall, 2000, p. 178).⁴ Hence, these entities were not truly self-funding, but nor were they participating in insurance risk pools.

Australia and Ireland had seen some employer efforts at self-funding, but these efforts were found to be illegal (Australia) or stopped through legislative clarification (Ireland).⁵ Irish law now clarifies that any employer coverage of inpatient services constitutes health insurance, hence recognising that such employer activity could otherwise undercut the

Table 3.2. **Scope and variation in regulation of health insurance entities**

	Is PHI sold in your country?	Under what regulatory or market classification does PHI fall?	Types of health insurance organisations ¹	Same or different government regulations applicable (depending on type of organisation)
Australia	Yes	Life and Health	Indemnity insurers Non-profit vs. for-profit plan Mutual associations (most health funds are incorporated mutual associations (not-for-profit))	All private health funds are regulated in the same way under the NHA (National Health Association)
Austria	Yes	Life and Health	Indemnity insurers, managed care plans, non-profit plans	No differential treatment
Canada	Yes	Accident and Sickness	Indemnity insurers Non-profit vs. for-profit plans Insurers	Common requirements apply to all
Germany	Yes	Health Insurance	Indemnity insurers (public limited companies and mutual societies)	In Germany, private health insurance is offered by public limited companies and mutual societies. Both are subject to the same requirements of health insurance contract law, health insurance supervision law and other specific health insurance regulations (<i>e.g.</i> , financial and solvency requirements, methods of premium calculation). General insurance supervision law applies in principle to both, however there are specific regulations for mutual societies included in general insurance supervision law (§ 15 to § 53 b VAG). But these regulations refer to the different legal form of mutual societies and concern mainly membership rights.
Ireland	Yes	Life and Health	Indemnity insurers, Non-profit vs. for-profit plans and mutual associations or insurers	Generally all insurers operating in the market are subject to the same treatment. The EU Directive 73/239/EEC granted the Voluntary Health Insurance Board a derogation from the solvency requirements for authorised insurers. It exceeds the EU's minimum requirement though not that of the national authority which is set at 200% of the EU minimum. ²
Mexico	Yes	Accident and Health	Mutual associations or insurers	Same
The Netherlands	Yes	Accident and Health	Mutual associations or insurers ³	Same
Poland	Yes	Life and Health/ Accident and Health	Indemnity insurers, Managed care plans and mutual associations or insurers	Same
Portugal	Yes	Accident and Health	Indemnity insurers, managed care plans ⁴ and mutual associations or insurers	Same
Slovak Republic	Yes	Accident and Health ⁵	Indemnity insurers	Same
Spain	Yes	Other ⁶	Indemnity insurance and “benefits in kind” insurance is offered by Public limited companies, mutual companies and cooperatives.	Different legislation exists depending upon the legal form of the company (Not dependent upon the type of product)
Switzerland	Yes	Accident and Health	Indemnity insurers, managed care plans, non-profit vs. for-profit plans and mutual associations or insurers	Same
Turkey	Yes	Accident and Health	Indemnity Insurers	Same

Table 3.2. **Scope and variation in regulation of health insurance entities** (cont.)

	Is PHI sold in your country?	Under what regulatory or market classification does PHI fall?	Types of health insurance organisations ¹	Same or different government regulations applicable (depending on type of organisation)
United Kingdom	Yes	Life and Health ⁷ Accident and Health ⁸	Indemnity insurers, Non-profit and for-profit plans, Mutual association or insurers	Same
United States	Yes	Life and Health Accident and Health Other ⁹	Indemnity insurers, Managed care plans, non-profit vs. for-profit plans, mutual associations or insurers ¹⁰	Separate regulatory frameworks still exist in many cases, but substantive standards have converged

- This column includes responses by OECD member countries to the OECD Regulatory Questionnaire on Private Health Insurance. It is recognised that some of these categories are not mutually exclusive. For example, an indemnity insurer could also be a non-profit plan, a mutual, or a for profit carrier.
- There are a limited number of small long-established non-commercial restricted membership undertakings covering less than 5% of the market, that are to be given the option of not participating in risk equalisation. However, if they exercise this choice their members would lose portability (open enrolment) rights on leaving the insurer concerned.
- Permits to operate in private health insurance are required by the Pension and Insurance Authority (supervision authority). Since private health insurance companies in the Netherlands do not use ageing reserves and calculate their premiums on an annual, the health insurance is classified as “accident and health” non-life insurance, rather than as long-term “life” insurance.
- Operated by non-life multi-branch insurers.
- Classification:
 - A6: Accident or sickness insurance, when representing supplementary insurance to class 1 through 4 policies,
 - B1: Accident insurance:
 - a) with lump-sum settlement
 - b) with repeated settlement
 - c) with combined settlement
 - d) traveller's accident insurance,
 - B2: Sickness insurance
 - a) with lump-sum settlement
 - b) with repeated settlement
 - c) with combined settlement
 - d) contractual insurance with supplementary insurance.
- The health class is considered as an independent class within the risk classification by classes. The health class includes health assistance (“benefits in kind”). In accordance with what is stated by the First Additional Provision in the 30/1995 Act, the benefits in this class can be: at a flat rate, indemnity and a combination of both.
- Critical illness, long-term care and income replacement.
- Health cost indemnity and health care cash schemes.
- Terminology varies from state to state. “Accident and health” is the older term; “life and health” is now more common, but it's more of an “umbrella” regulatory structure since life coverage and health coverage are usually written by separate corporations. It is common for casualty insurance authorisation to include health insurance authorisation, but most property and casualty companies do not actually write this line. Disability insurance is generally regulated as a “health insurance” line but does not fall within the definition of “private health insurance” above. Two additional lines of business that do fall within the Questionnaire's definition of “private health insurance” but are regulated separately are long-term care insurance and Medicare supplement insurance. Medicare supplement insurance covers certain general health care expenses that are not paid by the national health care programme for the elderly.
- Almost every type of health insurance organisation can offer either managed care benefits, indemnity benefits, or hybrid benefits such as “preferred provider” or “point of service”. The insuring entity can be a commercial (stock or mutual) insurer, a non-profit Blue Cross – Blue Shield plan (in states that still have them), a fraternal benefit society, a prepaid plan offered by health care providers, an employer-funded plan (single-employer or multiple-employer), or various arrangements where more than one type of entity participates in the risk.

Source: OECD Regulatory Questionnaire on Private Health Insurance.

Table 3.3. **PHI entities not licensed as health insurers**

	Risk-bearing entities financing health care:			Entities performing administrative functions (relating to PHI) who do not bear risk:	Description of their regulatory requirements:
	Description of entity:	Standards that ensure financial health:	Regulatory structure:		
Australia	Employer “top up” schemes for coverage of deductibles, co-payments and ancillary benefits	None	Schemes subject to approval of Ministry of Health	Small number of entities (<i>e.g.</i> , billing agencies working for physicians and hospitals, to coordinate payments, promoting uniform billing; often part of a hospital)	Administrative guidelines relating to management and maintenance of funds held in trust.
Austria	None	n.a.	n.a.	No	n.a.
Canada	Employer self-funded plans	Health insurers are subject to regulatory oversight	Federal and provincial insurance regulators	Third-party administrators	Some standards similar to those applicable to insurers in areas such as privacy.
Germany	None	n.a.	n.a.	Civil servants receive direct reimbursement from their employer for at least 50% of the costs of medical and hospital treatment	None
Ireland	None ¹	n.a.	n.a.	None	n.a.
Mexico	None	n.a.	n.a.	Yes	No specific requirements
The Netherlands	None	n.a.	n.a.	None	n.a.
Poland	Employer “subscription system”; employer clinics	None	None	None	n.a.
Portugal	None	n.a.	n.a.	Yes	No specific requirements
Slovak Republic	None	n.a.	n.a.	None	
Spain	None	n.a.	n.a.	n.a.	n.a.
Switzerland	None	n.a.	n.a.	None	n.a.
Turkey	None	n.a.	n.a.	None	n.a.
United Kingdom	None ²	n.a.	n.a.	Yes	No, other than law applying ordinarily to consumer matters and to intermediaries.

Table 3.3. **PHI entities not licensed as health insurers** (cont.)

	Risk-bearing entities financing health care:			Entities performing administrative functions (relating to PHI) who do not bear risk:	Description of their regulatory requirements:
	Description of entity:	Standards that ensure financial health:	Regulatory structure:		
United States	Employers that “self-insure” and health benefits provided under other insurance arrangements such as workers’ compensation, property insurance and automobile insurance	Indirect regulation exists in the form of requirements imposed on the licensed health plans dealing with the provider groups	Except for HMOs, ³ the regulatory framework for risk-bearing entities is usually the state-based regulatory framework for health insurers, with some modifications. Some federal regulation of portability standards and self-funded plans.	Yes	Most states require third-party administrators (TPAs) to be licensed. Licensed insurers also often act as administrators for other risk-bearing entities, particularly for self-insured employers (“administrative services only” or “ASO” contracts).

n.a. not available.

1. In the community rated indemnity market, such a development would weaken the system, reducing the “pool of good risk”. However, there are some providers of cash plans that are not health insurance contracts, focusing on primary care cover.
2. But a few employer self-insured plans are constituted as “Trusts” (UK meaning – “foundations”) and tax rules are designed to give equivalent treatment.
3. Health maintenance organisations are difficult to describe in general terms, since they range from provider-sponsored organisations furnishing most services directly to entities that are functionally identical to “preferred provider” managed care health insurers. Generally, they are subject to regulation comparable to but different in some ways from health insurer regulation, and in almost all states this is done by the insurance department. In addition, because of their hybrid provider-insurer status, they are often subject to concurrent (or in a few cases exclusive) regulation by state health departments. For plans exempt from state regulation, no federal license is required, and substantive federal regulation is extremely limited; in particular, there is no solvency oversight (although Taft-Hartley plans have some financial accountability requirements under federal labour law).

Source: OECD Regulatory Questionnaire on Private Health Insurance.

principles and requirements of the national PHI laws, including community rating. Currently, Australia only permits limited self-funding by employers, for coverage of limited benefits (“top up schemes”).

Employer collaborations with health insurers in some countries carry some of the benefits of “self-funding”, without removing these employees from insured risk pools. For example, in the Netherlands and the United Kingdom, employer groups’ premiums are sometimes negotiated in a way that may reflect the prior years’ experience, meaning that the employers bear a type of risk for their previous experience, and their premium rates can reflect the health claims of the individual employer, rather than of all those employers insured with a particular insurer, as they would under a self-funded plan. A similar mechanism can exist when insurers offer different products to employers and calculate premiums based on the experience of those employers’ individual products. Insurers in the United States often offer such tailored products. Australian health insurers also offer tailored products of special interest to particular groups, including employers, yet these products must be available at the same premiums to all members of the community.

2.4. Entities performing administrative functions relating to PHI

In at least six OECD countries, there are entities that do not bear financial risk but perform certain administrative functions relating to PHI (Table 3.4). For example, in Australia, there are billing agencies that seek to coordinate billing across providers and payers and promote uniform billing; these are often part of a hospital. In the United States, “third-party administrators” (TPAs) often perform administrative functions for self-funded employer plans; licensed insurers can also perform this function. Most US states have a separate licensure process for these entities (generally not too extensive); in some other countries, there are requirements governing certain activities of such entities, such as those relating to maintaining funds held in trust, privacy requirements or laws relating to intermediaries. Generally, OECD countries have not reported extensive requirements for these entities. There may nonetheless be a need to monitor these activities to determine if they develop “insurance” characteristics, and therefore should be subject to prudential regulations and other relevant health insurance standards.

2.5. Policies whose benefits are not tied to particular service costs

Several OECD countries, including those countries that otherwise have a very minimal private health insurance market, have markets for “cash benefit” policies (see Chapter 2). These policies, sometimes referred to as hospital benefit policies, are often structured to pay a set amount of money upon the occurrence of a certain event, such as a hospitalisation. There are also policies insuring against “specified diseases” whose benefits may be triggered – or begin to be triggered – upon diagnosis of a certain illness. These policies may also essentially duplicate benefits covered under other policies if the person already holds PHI coverage for the health care services risk whose occurrence triggers the payment of cash benefits. Their benefits are not tied to the actual cost of health services related to the particular illness, but rather often offer additional financial support to help persons bear some of the costs that may accompany an adverse health event. Advantages to these policies often include very low premiums. However, these policies have historically had some history of high administrative costs; regulators in many US states have responded by specifying minimum loss ratios for this type of coverage, including New York,⁶ among others.

Table 3.4. **Entities involved in publicly financed coverage**

	Entities licensed under private health insurance laws providing coverage under publicly funded coverage:	Entities (primarily involved in the financing of publicly financed coverage) offering coverage beyond the scope of publicly financed coverage:
Australia	Private health insurance funds may provide coverage for the difference between the MBS fee (public coverage) and the amount charged by a medical practitioner for services rendered as part of hospital treatment.	None
Austria	None	None
Canada	None	None
Germany	None	None
Ireland	Insurers provide cover of private treatment that can be availed of within the public hospital system.	None ¹
Mexico	None	None
The Netherlands	Yes	Yes
Poland	None	n.a.
Portugal	None	n.a.
Slovak Republic	None	n.a.
Spain	Within public financing, most civil servants belong to a special regime within the Social Security managed by their Mutual Companies (MUFACE, MUGEJU, ISFAS), belonging to different Ministries (Public Administration, Justice and Defence). The management system of these Mutuels allows their beneficiaries to opt for, at the start of each year, receiving healthcare services either through a Private Healthcare Entity or through the National Healthcare System (choice between public or private provision). For the rest of the population covered, the provision is offered by the National Healthcare System, that, in certain cases, following its own criteria, contracts for services of private centres. Here, the beneficiary does not have the choice between public or private provision.	In terms of its activity within the health care class, these same insurance entities are not limited to just offering that type of activity, but also can extend their activity to the subscription of private insurance policies in the health class different from the previous type.
Switzerland	Yes	Yes
United Kingdom	None	n.a.
United States	Both the Medicare (elderly) and, in many states, the Medicaid (indigent) programmes have options under which benefits may be provided by private insurers. However, insurer participation in the Medicare Programme has decreased significantly in recent years. Generally the particular government programme in question (for example, the federal employee plan or Medicaid and state-administered medical assistance programmes for the poor) will have lead oversight.	No

n.a. not available.

1. However the Health Authorities responsible for the delivery of public health services also provide private hospital services and insurers use these services and services provided separately by private hospitals.

Source: OECD Regulatory Questionnaire on Private Health Insurance.

Some countries have limited or prohibited this activity for health insurers. In Australia, health insurers are prohibited from offering such coverage, although other insurers may offer such coverage. Sale of these policies to vulnerable populations, such as the elderly Medicare eligible population in the United States, can be particularly problematic because they can result in the purchase of duplicate or unnecessary policies by persons not familiar with PHI market offerings (US General Accounting Office, 1994). In Ireland, these plans are not subject to the same statutory requirements (i.e. open enrolment, community rating) as health indemnity plans. However, the government is monitoring this market, particularly given the potential for these plans to mirror benefits of indemnity plans and potentially threaten this market (Ireland Department of Health and Children, 1999). To the extent to which this market mirrors the indemnity market, but is subject to less stringent requirements, it could undermine risk pooling within that market. Also, persons holding such coverage wishing to move to indemnity coverage could face waiting periods (while they would have received credit against the imposition of such waiting periods had they held prior indemnity coverage) (*op. cit.*).

3. Regulation relating to access to PHI coverage and covered health services

3.1. Standards assuring broad access to PHI coverage

In addition to determinations relating to public programme scope and eligibility, governments may influence the range of health risks borne by PHI markets through standards regarding the acceptance of applicants and coverage of certain risks or conditions. The role played by PHI influences these discussions as the social consequences of PHI coverage are different in different public/private mixtures of health coverage. As discussed in Chapter 2 above, a primary goal of insurance is to pool risk across different risk cohorts. Hence, PHI coverage is most consistent with this underlying insurance principle if it pools risk across a broad population of varying health risks. This is particularly important where private health insurance is considered a prominent pillar of a health system, because such requirements seek to ensure broad access to such coverage. Secondly, these requirements also reflect policy makers' views on the range of health risks that PHI should cover, and/or the conditions under which it should be asked to cover a broad range of health risks. The risk of adverse selection in voluntary insurance markets is a legitimate concern that must be weighed in developing such access standards. Finally, cultural differences and policy maker priorities influence governmental actions.

One major source of variation among regulatory approaches towards PHI concerns whether private health insurers are permitted to consider health status (or proxies) in making acceptance and other determinations, such as premium calculations. When consideration of health status is permitted in premium setting, it is commonly referred to as "risk rating"; "community rating" commonly refers to prohibitions on considering such factors, or limitations on their use, in premium calculations (such as when age is not permitted to be considered, or is permitted within limits). While some countries do not limit such activities, others restrict insurers' use of health status-related information, or even outright prohibit it. A key debate in this area concerns whether the consideration of health status-related factors in acceptance and pricing decisions is an appropriate activity for PHI insurers in some countries, or simply a mechanism through which inappropriate risk selection (sometimes referred to as "cream skimming") can secure competitive advantage. This question is intertwined with discussions concerning whether certain common insurance practices should be applicable to private health insurance.

PHI insurance-related requirements

One common access-related approach addresses insurers' ability to accept or reject applicants for PHI coverage. Guaranteed issuance ("GI") requirements (sometimes also referred to as "open enrolment") generally require insurers to accept all applicants for coverage. These standards can apply during a restricted time period ("open enrolment period") or apply at all times; they also may be focused on providing access to a limited or unlimited number or types of PHI coverage packages. In some cases, as in the United States and the United Kingdom, insurers are permitted to apply a one-time "waiting period" before coverage becomes available, even when they otherwise are required to issue coverage (as in the US small employer market). Importantly, and as detailed in other subsections herein, these issuance requirements are often implemented together with other related protections, a technique which can improve the effectiveness and sustainability of individual standards.

Seven OECD countries apply guaranteed issuance requirements to all or a portion of their PHI marketplace:⁷ Australia, Germany, Ireland, the Netherlands, Spain, Switzerland and the United States. In most of these countries, PHI plays a prominent role, in terms of health financing or population coverage, although in some, PHI only plays a primary role for part of the population, as in Spain and Germany. In addition, in all of these countries, PHI plays either or both a duplicate and primary role. While other countries with duplicate coverage do not apply such requirements (e.g., the United Kingdom, Spain), no country in which PHI plays a primary role fails to apply such requirements to at least part of its PHI marketplace. This would seem to indicate that government intervention is prompted by the extent to which PHI plays a prominent role in a health care system, acting as a sole source of coverage, or a source of important services also covered publicly, such as the hospital services in the Irish and Australian PHI market.

However, only in the case of Ireland and Australia, small employer group coverage in the United States, and private mandatory coverage in Switzerland are these requirements consistently applicable to most or all primary health insurance products, at all times. Some US states, such as New York, also impose this requirement upon insurers offering individual coverage. In the other cases, the GI requirements are tailored to certain products or more limited submarkets, such as civil servant coverage, or only apply during a limited timeframe, as detailed further in Table 3.5. In the United States, Ireland and Australia, access requirements are also extended to some supplementary or complementary coverage. This indicates that policy makers in some countries have determined that – even where PHI plays a narrower role – the PHI markets may benefit from some similar interventions. In contrast, this is not the case for supplementary coverage in Germany and the Netherlands, or for duplicate coverage in Spain, where the requirements are limited to those PHI products offering primary coverage. Yet these trends also may arise from restrictions under EU law (discussed in Section 3.9.2 below) – and the contours of permitted exceptions – rather than stemming primarily from policy makers' explicit view that purchasers of only these types of PHI coverage might benefit from these interventions.

More restricted access requirements

In a voluntary PHI market, there is a legitimate concern that broad access requirements may result in certain individuals waiting to purchase coverage until they need it – resulting in adverse selection and reducing incentives for those of lower health risk to purchase PHI coverage. At the same time, policy makers often balance this concern

Table 3.5. **Guaranteed issue or open enrolment requirements**

Requirements that PHI insurers issue all or certain products to all applicants (at all or limited times):	
Australia	Yes. Applies to all private health insurers ("funds"). Cash benefit products not classified as health insurance.
Austria	No
Canada	No
Germany	Yes. Access to standard tariff policy must be given to persons who had substitutive coverage for at least 10 years and have reached the age of 65 years, or have reached age 55 and have an income below specified level or meet some other narrow criteria. Also must provide access to civil servants with prior public coverage who switch to this policy within six months of becoming civil servant, if they would face risk surcharge due to health status in other policies. Indirect Requirement on some products: substitutive standard package (standard tariff) must be offered for employer contribution (50%) requirement to apply. Requirement to accept persons moving from different insurer only applies if changing to a policy providing equal coverage.
Ireland	Yes
Mexico	No
The Netherlands	Yes. Some products (Standard package for elderly and high-risk).
Poland	No
Portugal	No
Slovak Republic	No
Spain	Yes. Only for those insurers participating in programme for civil servants who opt out of public coverage.
Switzerland	Yes for private mandatory basic coverage; No for voluntary coverage.
Turkey	No
United Kingdom	No
United States	Yes. Some products/markets: All products offered through small employers (2-50 employees, self-employed in some states). Medicare supplement – To some products during specified timeframe (some states require more availability). Blue-Cross Blue Shield plans in some states.

Source: OECD Regulatory Questionnaire on Private Health Insurance.

against a desire to promote access to coverage, which may be a particular challenge for high-risk individuals in the absence of some governmental intervention.⁸ They also may consider whether certain submarkets could best benefit from these requirements, while they may not be appropriate for others, either because they do not face similar challenges, or because their regulatory framework seeks to promote access to coverage through different means.

As noted in Table 3.5, some countries (or parts of the country, in the case of the United States) strike the balance between these competing concerns by assuring access in a more limited fashion. For example, in Germany and the Netherlands, as well as in some individual markets in the United States (such as Massachusetts, Ohio, and Iowa), access to one or a limited number of insurers' products is assured by law for certain populations under particular circumstances,⁹ but insurers are not required to offer all of their products to all applicants. In the German PHI substitute market, German health insurers must offer standard contracts (comparable to standard cover under social insurance) at a set premium to persons 55 or older with income below a certain level, and those 65 years and above (as long as persons have at least ten years of prior primary insurance). Civil servants and the disabled must also be offered standard contracts (for a six-month period of time in the case of civil servants). In addition, insurers wishing to benefit from the legal requirement that employers' reimburse 50% of the cost of coverage (social and private) must offer a standard product conforming to the standard tariff requirements.

In Spain, broad access requirements are limited to mutual companies offering coverage to civil servants who opt out of the system, but these mutuals must make all of

their products available to the relevant population. In the United States, unlike the case of the small employer market, the large employer market is not subject to such requirements, and approaches to access in the individual market have varied greatly. This is likely due to the fact that the large employer market has suffered from fewer challenges in terms of access to insurance coverage, and the fact that many large employers self-fund their coverage and therefore rely on insured products less. At the same time, in the case of its individual market, debates continue regarding the best way to balance access and affordability concerns in this small and shrinking voluntary market segment. In the US Medicare supplemental individual coverage market (“Medigap”), the complementary market for those covered by Medicare, federal law requires that all plans (required to be standardised) be offered to all applicants for six months following their eligibility for Medicare.¹⁰

Box 3.1. Examples of approaches to access to PHI coverage

Open enrolment periods:

- United States: Medicare supplement coverage (“Medigap”): guaranteed issue for six months upon eligibility for Medicare (Complementary Standard Policies).
- Ohio individual market: annual open enrolment period (primary; two standard policies).

Guarantee issue of limited products at all times:

- Netherlands primary/principal.
- Germany primary/substitute (requires offer of standard product at capped premium to certain populations).
- Spain primary/substitute.

Broad guaranteed issue requirement (all products/all times):

- Australia and Ireland (duplicate and supplemental coverage).
- US small employer market.
- Some US individual markets.

Separate programme outside the PHI market:

- Risk pools in 29 US states.

Challenges and successes relating to such issuance requirements

The most significant ongoing debates and challenges relating to issuance requirements in certain OECD countries’ PHI markets involve policies sold in individual markets. As a general matter, in the United States, the implementation of reforms in the employer group market has been less controversial than the individual market, and for the most part, group market reforms have focused on the more vulnerable small group market. Small employer reforms, which often also included rating reforms and limits on pre-existing condition exclusions, did not result in a significant influx of high-risk subscribers, as some had feared (Hall and Lawlor, 2001, pp. 638-655). Furthermore, reforms relating to premium setting have accompanied several of these reforms (in order to address the impact of pricing on access) and have been the subject of more controversy than the insurance requirements themselves, as discussed later herein. This is perhaps due to the

fact that insurers could adjust for risk through premiums (Hall, 1999a) if issuance requirements are not followed by rating reforms. In the US small group market, reforms that included guaranteed issue, limits and restrictions on the exclusion of pre-existing conditions and restrictions on consideration of health status in rating reforms (with various degrees of stringency) appear to have halted the erosion in coverage levels and in the scope of benefits in that market (Hall, 1999b). There are different assessments of the impact of such regulations on coverage levels, with some noting no improvement in coverage, and others noting modest improvements or some declines. These small group reforms have not, however, dramatically increased coverage levels (in the United States) (Hing and Jensen, 1999, pp. 692-705).¹¹

On the other hand, limits on the consideration of health status factors in insurer issuance decisions have been somewhat controversial in the US individual market. Several studies indicate there were some reductions in covered lives following the implementation of issuance reforms together with pure community rating (Hall, 1999c; State Planning Grant Consultant Team, 2002, p. 11). However, as discussed further in discussion of rating reforms below, there is some dispute with respect to the causes of these declines, especially when one compares results with enrolment trends in markets without such reforms. This suggests that other factors may have been instrumental in the declines in coverage levels. In addition, certain implementation factors impact the near and long-term outcomes of the reforms. For example, the US state of Kentucky exempted association coverage from its reforms, thereby inducing a shift in its individual market to this type of coverage, and leading insurance carriers to exit its community rated market (Kentucky Department of Insurance, 1997).

On the other hand, if issuance requirements are put in place in the absence of premium rating-related requirements, they are likely to be less effective in promoting access to coverage, as insurers can vary rates according to the health status of applicants for coverage. In one case where issuance standards were not accompanied by rating requirements – a federal standard requiring access to certain persons moving from individual to group coverage – access has sometimes been severely limited by insurers' charging much higher premiums for those of high health risk (140-600% of the standard rate) (US General Accounting Office, 1998, p. 9).

An additional complexity in measuring the impact of various reform laws relates to the desired policy outcomes. Should priority be placed upon increases in overall coverage levels, or should the focus be upon improved availability and affordability for high-risk persons, even if changes result in younger and healthier persons dropping insurance? One study noted that New York's individual market reforms resulted in premium increases but broad availability for those of high health risk, turning the market into a type of "high-risk pool". These reforms have resulted in less coverage by younger and healthier persons. Nonetheless, the market has stabilised and has not faced the adverse selection "death spirals" experienced in some other US states (Hall, 1998a). Hence, determining the success of these reforms depends in part upon whether one looks at overall coverage numbers, or the presence of significant high-risk persons in coverage (Pauly and Nichols, 2002, pp. 325-344).

In Australia and Ireland, guaranteed access standards are well accepted and date back to their inclusion in original PHI-related legislation. Recent debates in Australia have centred on the structure of rating requirements. In Ireland, recent legislation (2001) has

given the government the authority to alter the rating structure and permit some age-based variation, although this has not been implemented to date. Interestingly, individual coverage is a significant (Ireland) or majority (Australia) element of their PHI markets, and hence their PHI risk pools may be less fragmented than those in other countries with smaller individual markets, such as in many US states. The presence of large individual markets may also argue for an even more critical role for issuance requirements in certain countries, because fewer persons benefit from the broader risk pooling that often accompanies group markets.

More limited issuance reforms, such as requirements that insurers offer at least one standard package to high-risk or elderly individuals, appear to have less a detrimental effect on the availability of less expensive coverage for those of lower health risk, but do not provide choice of coverage options for those of higher health risk. In many cases, these policies require insureds to pay a higher premium than their lower-risk counterparts.¹² Depending upon whether premium levels benefit from some cross-subsidies, such requirements may also fragment risk pooling within the PHI market. Nonetheless, there are contrasting experiences in different countries. The Netherlands' limited access requirements, under which all insurers must offer standard plans to certain high-risk individuals (WTZ plans), have resulted in significant access by persons of high-risk (680 000 or about 14% of privately insured population). The affordability of this coverage and financing equity within the market is aided by a required cross-subsidy by the other privately insured. However, in the Netherlands' supplemental coverage market, some persons wishing to switch social insurers find it difficult to purchase comparably priced supplementary packages (often offered in conjunction with social health insurance). This may be due to a change in their risk status since they initially purchased the coverage. Some of these challenges may stem, at least in part, from the absence of comparable issuance requirements in this supplementary coverage market.

In Germany, the standard tariff package is purchased by far fewer persons (3000 persons in the year 2000, or 0.04% of persons with private primary PHI) (Gress et al., 2002). However, this lower number reflects the structure of eligibility for public programme coverage and limitations on opting back into the public programme once persons have chosen to be covered by PHI. In addition, in Germany, all population segments are eligible for social insurance, unlike the case in the Netherlands. Thus, in Germany, while upper-income persons can opt for private health insurance, it is not their sole potential source of health coverage; civil servants – who are not eligible for social insurance unless they previously had such coverage and meet certain conditions – are also often covered by PHI (see Gress et al., 2002, p. 8).¹³

Access requirements relating to interaction with public programme coverage

A few OECD countries restrict access to public coverage based upon persons' private insurance status (Table 3.6). These limits generally seek to avoid risk selection against public programmes or to avoid reductions in existing private coverage levels. Germany's public/private mix is particularly susceptible to the risk of bearing more high-risk cases than PHI because it gives high-income individuals the ability to opt out of public cover. Younger and healthier persons meeting the income threshold (particularly if they are without dependents) may find it financially advantageous (at least in the near term) to purchase PHI and, indeed, this group opts out of public coverage to a greater degree. A recent study indicated that half of those opting out are young, single, high earners or

Table 3.6. **Limits on scope or availability of PHI related to public programme coverage**

	Requirements relating to private coverage access that depend upon whether a person already has publicly financed coverage	Limits on PHI's permitted scope (covered services or providers) in connection with public programme coverage	Portability standards between public and private coverage	Limitations on a persons' ability to participate in public or private coverage (depending on whether they already have coverage from one or the other coverage sources)
Australia	No (Duplicate coverage allowed and constitutes significant market).	Yes	No	No
Austria	No	No	No	No
Canada	No	Yes. Prohibition on private coverage of hospital and physician services illegal in 6 of 10 provinces (Flood and Archibald, 2001, pp. 825-830).	No	
Germany	Yes. Only persons above specified income threshold can opt out of social insurance.	No	If a person cancels his/her private health insurance contract in order to re-enter the public system (by taking up gainful employment with an income below the limit), and this return fails (because the person loses job), the private health insurer must accept the person into the former contract, within a period of 12 months of cancellation.	Yes. Once opt out of social coverage, limited opportunity to opt back in exists (if income falls below ceiling). After 55 years of age, people cannot re-enter the public system even if their income falls below contribution ceiling or in cases of unemployment <i>except</i> if they had been members of the public system for the previous five years and compulsory membership for at least 2.5 years.
Ireland	No (Duplicate coverage allowed and constitutes significant market).	No	No	No
Mexico	None	No	No	No
The Netherlands	No	No	Yes. Private health insurers must accept high risk persons for WTZ package if they meet specified criteria and are not eligible for social insurance. Low-income elderly have a limited opportunity to opt into social insurance.	Required to participate in social insurance if income is below threshold; not permitted if income exceeds threshold.
Poland	No	No	No	No
Portugal	No	No	No	No
Slovak Republic	No	No	No	No
Spain	Double coverage allowed (Persons with publicly financed system can also access private coverage).	No	No	No
Switzerland	No	No	No	No
Turkey	No	No	No	No
United Kingdom	No	No	No	No
United States	Yes. Under Medicare rules, employer coverage must be primary, with gaps filled in by Medicare as secondary coverage.	Federal law prohibits duplication of Medicare coverage.	Public coverage considered "prior coverage" for purpose of avoiding new exclusions in private coverage.	Yes. Coverage under state children's health insurance programme is limited to those without health coverage.

Source: OECD Regulatory Questionnaire on Private Health Insurance.

married couples with double incomes, and the other half are civil servants (Gress *et al.* citing Mossialos and Thomson, 2001). The concentration of lower-risk persons in the German primary PHI market may be a partial explanation for the lower purchasing rates for the standard tariff package since persons in this market are less likely to face denials or higher premiums based on risk status. In a partial effort to protect its public system from further migration of lower risks, German law generally prohibits those persons opting out of social cover from re-entering the social insurance scheme. In Germany, premiums for the standard policy are tied to the average contribution rate for social cover and deficits incurred can be compensated through a pooling mechanism across private insurers.

In the Netherlands, the low-income elderly who had been insured by PHI have a limited opportunity to opt into social insurance. In Spain, the vast majority of civil servants opt out of the public system and hence their private insurance schemes have succeeded in attracting a broad risk profile. However, those covered by PHI in Spain are not exempt from the taxes that fund the public system and hence can not opt out of financing the public health coverage system.

In the United States, where a majority of the population is dependent upon PHI for primary coverage, policy makers have structured eligibility requirements for certain public programme coverage in an effort to minimise displacement of existing private insurance by public coverage. These efforts seek to target public resources where they are most needed. For privately insured workers and spouses who are 65 or older and otherwise eligible for public coverage under Medicare, many private employer plans must first cover the health costs, before their Medicare benefits are triggered. Medicare is therefore the “secondary payer” in these situations, covering portions of the costs not covered by the private plans. An examination of experience with this mandate found weak compliance with its provisions, however. This highlights challenges of enforcing such requirements in a diffuse health insurance system, such as in the United States (Glied and Stabile, 2001, pp. 239-260). In the case of the State Children’s Health Insurance Program (SCHIP) for low-income children, which expands coverage to children from families with incomes above the limits for the public Medicaid programme, children are not eligible for this programme if they have private insurance.¹⁴

3.2. Renewability requirements

In most OECD countries, PHI contracts are issued on an annual basis as a matter of industry practice. This has the advantage of providing consumers with a known time period during which they can rely on the protection of the purchased benefit package at the agreed upon premium. One exception is Australia, where contracts are issued in perpetuity; in this case, the timing of any changes to policies, benefit packages and premiums is less predictable than is the case for contracts issued for defined terms. (However, requirements for government approval of such changes provide some protection.) The second exception is Germany, where substitute coverage must be issued on a “life” insurance basis, with premiums based upon age-at-entry, and reserves (“aging reserves”) set aside to help cover expenses later in life.

In a number of countries, insurers offer policyholders the right to renew policies, as a matter of industry practice, sometimes specifying the time period during which such action must be taken. This is the case in the Netherlands, Spain and the United Kingdom. In Spain, this industry practice is reinforced by regulation in the case of civil servant coverage. Some governments require PHI insurers to renew coverage (often with some

exceptions for fraud or non-payment). The goal of such interventions is to assure that policies are not cancelled on the basis of claims experience or other health-status related factors, which could undermine both continued access to coverage and the intended risk-pooling function of insurance. It also encourages the purchase of insurance by those of lower risks as it provides a real advantage to joining when in good health (Patel and Pauly, 2002, pp. 280-282). Similar to the case with issuance requirements, renewability of PHI policies (or its effective equivalent – coverage issued on a lifetime basis – in the case of Germany) is generally required in countries where PHI plays a prominent role [Ireland, United States, Spain (duplicate market) and Germany (substitute market)].¹⁵ In other cases, less stringent renewability protections are imposed. For example, in the case of certain types of supplementary policies, Germany prohibits cancellation after the policy has been in force for a specified time.¹⁶ Germany and the United States, and other countries, permit the issuance of short-term policies. For example, foreign travel insurance is offered in many European countries, including certain Eastern European countries with less developed PHI markets, such as Slovakia. On the other hand, short-term policies may cover a more comprehensive range of benefits; for example, in the United States, persons may buy such coverage during brief periods between jobs where they receive employer-sponsored coverage. In the case of such products, policy makers may want to be sure that these policies are not serving as a means to circumvent renewability standards imposed on most comprehensive benefit policies. Details concerning renewability requirements in many OECD countries are set out in more detail in Table 3.7.

Impact of renewability requirements

Evidence suggests that renewability requirements, whether voluntary or required, can promote risk pooling within PHI markets because the enhanced coverage security they provide provides an incentive for individuals of lower health risk to purchase insurance. Even before it was required in the United States, one study found that a majority (80%) of individual insurance purchasers were willing to pay an additional premium for contracts with this feature (Patel and Pauly citing Pauly et al., 1999, pp. 28-44).

One difference in insurer behaviour with respect to plan renewability relates to whether the insurer subjects all persons with the same policy to the same premium adjustment at the time of renewal or whether they adjust premiums based upon individual health or claims experience. In other words, do insurer renewability practices include a type of premium stability protection? In EU countries, renewals take place without new risk assessment of individuals' health status or claims experience. However, premiums may increase in line with age rating, as occurs in the United Kingdom, or based upon the experience of the pool of individuals insured with that policy, as in the United States, or due to general health cost inflation.¹⁷ With a couple of exceptions, US state insurance laws generally include such rating-related renewal protections within their laws (Patel and Pauly, 2002, p. 284), thereby preventing their renewability requirement from being “undone” by a rating practice. A study which tracked the prevalence of such requirements in the United States found that explicit requirements specifying this rating protection were easier to enforce (*op. cit.*, pp. 286-287).

Evidence of the experience with renewal and renewal-related provisions is less available in other OECD countries. The inclusion of such provisions within several regulatory frameworks would seem to indicate that policy makers sometimes find guaranteed renewability of PHI policies to be a necessary and desirable protection.

Table 3.7. **Renewability requirements**

	General duration of contracts issued:	Government requirements relating to duration of contracts:	Requirements relating to renewal of contracts:	Different regulatory requirements that apply to short-term policies:	Benchmarks or government monitoring relating to insurers' activities re. renewability:
Australia	In perpetuity	None	n.a.	None	None
Austria	Varies	No	No	No	No
Canada	Annual	None	None	None	None
Germany	Only foreign travel insurance is considered short-term, substitute health insurance is issued on a long-term ("life") basis.	Substitute health insurance is issued on a long-term ("life") basis.	No cancellation permitted by the insurer in case of substitutive cover issued on a "life" basis. For other types of coverage, cancellation by insurer is prohibited after a certain number of years (<i>e.g.</i> , three years for private daily allowance insurance).	Short-term policies can be agreed for a fixed contract period; funding requirements differ for such policies.	None
Ireland	Annual		Yes. "Lifetime cover" requirement applies to persons once they have taken out cover.	n.a.	n.a.
Mexico	Annual	None	Requires insurers to specify if there is compulsory renewal, and, if so, the maximum age for renewal. If the insurer commits to renewal of the policy under the terms of the contract, it must use established criteria to avoid selective discrimination.	None	None
The Netherlands	Annual	None	Policies generally include an automatic one-year extension unless notified by the insured (two months before contract end). (Once negotiated, cannot be terminated but for non-payment.)	None	None
Poland	Annual	None	None	None	None
Portugal	Annual	None	None	Yes, if health insurance employs life insurance techniques, it must establish an ageing provision.	None
Slovak Republic	No information available.	No information available.	No information available.	No information available.	No information available.

Table 3.7. **Renewability requirements** (cont.)

	General duration of contracts issued:	Government requirements relating to duration of contracts:	Requirements relating to renewal of contracts:	Different regulatory requirements that apply to short-term policies:	Benchmarks or government monitoring relating to insurers' activities re. renewability:
Spain	Annual	None	Yes for civil servant coverage, the insurer must renew the coverage if insured wishes. For other policies, usual practice is possibility of contract renewal with both insured and insurer able to refuse renewal two months before end of contract period. Health insurance policies usually do not permit insurer to rescind contract while insured is undergoing treatment.	None	None
Switzerland	Annual	None	None	None	None
United Kingdom	Annual (Individual) (Corporate contracts may be for longer periods.)	None (Based on traditional practice).	No, but it is the traditional practice. (One recent entry into the market reportedly applies an age limit for renewal.)	None	None
United States	Annual	None	Yes	Yes, in some states, coverage under short-term policies is limited to one year.	None

n.a. not available.

Source: OECD Regulatory Questionnaire on Private Health Insurance.

3.3. Standards to protect insurers from adverse selection while promoting access to PHI coverage

Voluntary PHI markets (and, therefore, most PHI markets,) may be particularly susceptible to adverse selection. For example, there is the risk of “hit and run” PHI purchases, where persons purchase PHI when they anticipate a need for a particular health service or when they become ill, and then drop coverage if their need lessens. Such activity could undermine PHI insurers’ ability to truly perform a broad, risk-pooling function.

The risk of adverse selection may be heightened if PHI insurers are subject to general access requirements, such as the issuance requirements described above. Insurers often employ several tools to try to reduce the risk of adverse selection; these include general waiting periods, benefit exclusions, or exclusions of coverage for “pre-existing medical conditions”. Pre-existing condition exclusions seek to guard against purchases at time of need by limiting coverage of services for a particular condition that existed at the time of purchase. Such tools may, however, have undesirable access implications, by unduly limiting persons’ ability to insure for needed services. Consequently, some countries place explicit restrictions on their use.

At least eight OECD countries¹⁸ (United States, Australia, Ireland, Germany, Netherlands, Spain, Switzerland and Mexico) have placed some limitations on insurers’ ability to impose exclusions on coverage of pre-existing conditions, exclusions for specific populations (i.e. newborns) or more general exclusions, for at least some coverage types or benefits (e.g. Germany places time limits on exclusions relating to specified services). In several of these cases, policy makers also seek to avoid any negative impact these exclusions may have on consumer mobility between insurers, by not allowing the re-imposition of certain exclusions if persons maintain continuous coverage. Furthermore, some but not all of these countries enable insurers to impose targeted exclusions if a person moves to a more generous coverage package. On average, these provisions limit exclusions to 12 months or less. However, Ireland permits exclusions based on pre-existing conditions lasting up to five to ten years, depending upon the age of the insured. By permitting such long exclusions, Ireland’s provisions have emphasised protecting insurers against adverse selection, but they restrict access to coverage for pre-existing conditions to a much larger extent than similar provisions in other OECD countries. Waiting periods and targeted pre-existing condition exclusions are sometimes used in conjunction with one another, as is permitted in the United States, Ireland and the United Kingdom, for example. While Germany also permits general waiting periods, it limits them to three months.

All of the countries with guaranteed issuance provisions have accompanied these requirements with some types of limits on pre-existing condition exclusions, at least for the segment of the market that is subject to the strict access provisions (Table 3.8). As is the case with access-related provisions, these limits are clustered in countries where PHI plays a duplicate or primary role, perhaps revealing heightened policy maker attention and oversight of PHI markets in cases where they play such more significant roles. In some countries these limitations are applied more broadly across the PHI market, as is the case in Germany, and the US employer market. Australia specifically exempts ancillary coverage from these requirements; this may reflect a view that coverage of such services performs a less essential function.

Table 3.8. **Portability protections (relating to pre-existing condition exclusions)**

	Limits on exclusions of particular benefits/health conditions based on prior or ongoing health conditions	Definition of pre-existing conditions:	Portability between insurers: permitted length of coverage gap without reimposition of pre-existing condition exclusion
Australia	Health insurers can impose a maximum 12-month waiting period for hospital treatment for conditions that are considered to be pre-existing. ¹ A two-month waiting period for other benefits is permitted.	A pre-existing ailment is an ailment, illness or condition, the signs or symptoms of which, in the opinion of a medical practitioner appointed by the health fund, existed at any time during the six months prior to the member joining a hospital table or upgrading to a higher level of cover.	When transferring between broadly comparable products within or between insurers, insurees must be given credit for any waiting period that has been served. ² Waiting period can be imposed for higher level of benefits in new coverage. These portability protections are not required to apply to ancillary benefits.
Austria	No	n.a.	No
Canada	Not for PHI. Industry guidelines protect disabled individuals from losing employer disability benefit because employer changes carriers.	n.a.	Voluntary standards under group insurance guidelines (CLHIA) protect plan member from loss of coverage due to change of carrier.
Germany	Three month maximum on general waiting period; eight month maximum for specified services (childbirth, psychotherapy, certain dental care) (applies to medical expense insurance, daily allowance insurance and hospital daily allowance). Coverage of newborns is required.	Particular conditions that can be excluded are specified in law; otherwise only general waiting period is permitted.	If moving from statutory (public) health insurance to private health insurance, credit is given for continuous period of coverage if no more than two-month gap between coverage. Risk surcharge and waiting period may be applied for any additional benefits.
Ireland	Initial waiting period of 26 weeks, 52 weeks for maternity; 52 weeks for those of or over 55 and under 65. For pre-existing conditions: 5 years for under 55, 7 years for under 60, 10 years for over 60 and under 65. Protection provided for newborn coverage (if premium paid within 13 weeks).	Pre-existing condition: an insured person's medical condition, the date of onset of which is determined on the basis of medical advice to have been prior to the date he or she is first named in a health insurance contract other than where the insured person is an infant and has been so named within 13 weeks of his or her date of birth.	13 weeks. In case of upgrade in cover: Two years for those under age 65, five years for those age 65 and over, with respect to more generous coverage.
Mexico	None, depends on contracts. Coverage of pregnancy or newborn coverage cannot be excluded as a pre-existing condition.	Depends on contracts.	Depends on contracts.
The Netherlands	No legal requirement for most policies. WTZ policy does not allow exclusions.	n.a.	Insurer voluntary code requires ability to convert from group to individual policies on same general terms.
Poland	No	n.a.	n.a.
Portugal	No	n.a.	n.a.
Slovak Republic	No information	No information	No information
Spain	Grace periods permitted in most contracts, according to contract. They are not permitted for civil servant primary coverage through mutuals.	Specified in contract except for civil servant coverage which is subject to special rules and which prohibits exclusions.	n.a.
Switzerland	Basic health insurance (mandatory) is required to cover standard benefits, and accept all applicants without reservation (Colombo, 2001). No limitation for non-basic coverage.	n.a.	n.a.

Table 3.8. **Portability protections (relating to pre-existing condition exclusions) (cont.)**

	Limits on exclusions of particular benefits/health conditions based on prior or ongoing health conditions	Definition of pre-existing conditions:	Portability between insurers: permitted length of coverage gap without reimposition of pre-existing condition exclusion
United Kingdom	No regulatory limits. Insurers often have prior exclusions upon policy inception, but not upon ongoing renewal. Newborns registered at birth generally accepted without reservation.	No statutory or regulatory definition. Varies by insurer.	n.a.
United States	Yes, in employer group market, maximum 12 months exclusion; some states have shorter limits. No federal limits on group plan waiting periods unconnected to pre-existing condition. Limitations vary by state in individual market. Group policies may not exclude pregnancy and must cover newborns and adopted children. U.S. Medicare Supplement: Maximum six months exclusion, with credit given for prior coverage.	For group plans: A condition for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 month period (shorter time period in some states) ending on an individual's enrolment date in the plan. Standards vary by state for individual coverage.	In order to avoid reimposition of pre-existing condition exclusion when changing coverage, there must not be a break in coverage of 63 days or more. When moving to more generous coverage, a pre-existing condition exclusion can be imposed if previous plan did not cover prescription drugs, mental health, substance abuse, dental care, or vision care.

n.a. not available.

1. Pre-existing ailment (PEA) rules: the PEA rules are conditions which are imposed on health funds to: enable funds to establish waiting periods to deter “hit and run” contributors – contributors with existing ailments who take out private health insurance for the duration of treatment for the ailment and then drop the cover; and too limit discrimination against any contributors who have a PEA. The rules enable health funds to impose a maximum 12-month waiting period for hospital treatment for ailments, illnesses or conditions that are considered to be pre-existing. A pre-existing ailment is an ailment, illness or condition, the signs or symptoms of which, in the opinion of a medical practitioner appointed by the health fund, existed at any time during the six months prior to the member joining a hospital table or upgrading to a higher level of cover.
2. However, in the case of lifetime health cover, where persons are charged different amounts based upon age of entry to an insurer, continuity of membership among and within funds can be preserved for a cumulative period of two years over a person's lifetime.

Source: OECD Regulatory Questionnaire on Private Health Insurance.

Benefits and challenges relating to exclusion limitations

Pre-existing condition exclusions, even when limited, can be confusing for consumers. For example, the Private Health Insurance Ombudsman (PHIO) in Australia, who handles and receives PHI-related complaints, found that consumers continue to experience difficulty with such product limitations (PHIO, 2002, p. 25). Similarly, the PHI Complaints Commissioner (PHICC), within the Australian Competition and Consumer Commission, has received many complaints in this area. They indicated that many members may not be aware that a limitation can be imposed irrespective of whether the ailment was diagnosed or the member knew about treatment need, and learn of this when they are refused benefits. The Commissioner found that increased member education in fund materials and at time of purchase could help increase consumer awareness (PHICC, 1998, p. 13). The industry has informally agreed to establish increased procedures relating to consumer information in this area.

Regulatory limitations on pre-existing condition exclusions reflect policy makers' attempts to balance the need to prevent adverse selection, with the desire to assure access to covered services. Indeed, the various approaches indicate that countries have struck somewhat different balances between these concerns. The Australian requirement arguably goes beyond preventing adverse selection, because it permits funds to exclude conditions of which the member may not be aware.¹⁹ Ireland's requirement has a similar potential. This is mitigated in both cases by the requirement that a medical practitioner determine if the condition had been present six months before. Australia also requires the medical practitioner to determine that *signs or symptoms of the condition* existed at the time the policy was issued, an issue not addressed in the Irish requirement and arguably seeking to ensure that the consumer had some level of awareness that they may have a medical concern. Another approach is that taken for group policies in the United States, where the condition must have been diagnosed or treated (or medical advice received) in order to be considered "pre-existing".²⁰ This approach is arguably a more objective requirement, but it doesn't include conditions where symptoms existed but medical advice was not yet sought. In some other cases, policy makers prohibit all such exclusions (e.g., Netherlands WTZ standard policy, Spanish civil servant coverage).

These limitations are one type of constraint on insurers' ability to limit access to benefits for higher-risk persons. At the same time, they provide protection to insurers and seek to promote purchase of PHI for persons who may not anticipate a particular health care need. They have been particularly applied in countries that have also imposed broader coverage access standards. Interestingly, in some cases the application of these limits has resulted in some plans removing all such exclusions altogether, or imposing shorter exclusion periods. In the United States, after imposition of a 12-month maximum exclusion, several employer plans eliminated exclusions altogether (perhaps for administrative simplicity). Only 42% of plans imposed the maximum limitation period, and the remainder had shorter (22%) or no exclusions (36%) (Huth, 1999).

These limitations can also benefit persons who change jobs in systems where health coverage is often tied to employment, as in the United States. In fact, in the United States, it was estimated that as many as 21 to 25 million people could be affected by the federal portability standards enacted in 1996 (US General Accounting Office, 1995, pp. 6-7). Such standards now protect persons changing jobs from the re-imposition of pre-existing condition exclusions if they maintain coverage without a significant lapse in coverage. It

thereby enables job mobility by persons who might otherwise not change employment due to concern relating to coverage of pre-existing conditions.²¹ The law does not require employers to offer health insurance, however, so some “job-lock” may remain for those who might otherwise change jobs – but for the fact that the prospective employer does not offer health coverage.

Among standards imposed on PHI markets in the United States, portability protections that limit pre-existing condition exclusions appear to be among the less controversial requirements (Hall, 1999d, p. 12).

3.4. PHI premium-related requirements

The extent to which OECD countries impose premium-related restrictions on health insurers (Table 3.9) varies along similar lines as issuance-related requirements. All countries where PHI plays a primary role impose some premium-related requirements on at least part of their PHI markets.²² This is also true for two countries where PHI plays a duplicate role (Ireland and Australia), as well as the case of complementary and supplementary Medicare coverage in some US states. In some cases, these limits restrict or prohibit the consideration of individual health status factors in the calculations of premiums in the entire PHI market (Australia, Ireland, US small employer market in most states and some individual markets). Others impose a cap on premiums, tied to average costs in the private market (Netherlands) or in the public coverage system (German substitute coverage for standard tariff packages).²³ In the Netherlands, the privately insured pay a surcharge to help cover the higher costs of the privately insured elderly (along with those of other high-risk persons in the Netherlands). An additional surcharge is imposed on the privately insured in the Netherlands, to compensate for the higher proportion of the elderly within social insurance. In all of these cases, these limits are imposed together with insurance-related requirements. This would seem to highlight policy makers’ awareness that these types of limits can work in conjunction with other standards in order to help assure access to coverage.

In Germany, the premiums for private substitute health insurance are funded on a life insurance basis. This means that premiums are calculated according to a mathematical model involving ageing reserves; premiums thus have to include a savings amount to account for rising health expenditures due to age. The savings elements are accumulated separately and accrue interest.²⁴

The prevalence of rating-related restrictions in markets where PHI plays a primary role, and in some additional markets where its role in the health system may be considered a prominent one, highlights the extent to which governments have chosen to intervene in this area. Certain markets without such requirements have evidenced access problems for those of higher-risk. This was the case in the Netherlands in the 1980s before the creation of its WTZ scheme for higher-risk persons. In the case of the individual health insurance market in the United States, individuals of poor health historically and currently face challenges in accessing private coverage.²⁵

Trade-offs and challenges

In assessing the impact of, and desirability of different types of premium-related requirements, policy goals and the trade-offs of different approaches must be considered. The two main approaches to providing affordable coverage to those of high health risk through the PHI market – a capped premium for a standard package or premium

Table 3.9. **Premium rating-related requirements: consideration of health risk-related factors**¹

	Permitted	Permitted with limits	Prohibited	Legally required or governmental mechanism(s) for apportioning or adjusting risk among private health insurers?
Australia	No, except for age	Lifetime health cover provides for transfer of certified age of entry between health funds. Continuity of membership (for this purpose) can be preserved during periods of non-membership for a cumulative period of two years over an individual's lifetime.	Not completely.	Yes. Risk equalisation scheme funds benefits for those over 65 years of age and those experiencing over 35 days of hospitalisation per year. All health fund members contribute a portion of their premiums to fund this mechanism.
Austria	Yes, no limitations apply.	n.a.	n.a.	No
Canada	Yes	Actuarial standards require pre-funding of services	No	In Quebec, all private drug insurance plans are covered by a private pooling mechanism that pools high cost drug claims in excess of specified dollar amounts.
Germany	Yes, with requirements for substitutive cover	Substitutive cover must be offered on a lifetime basis; premium determined by age of entry and gender (and benefits); health status risk surcharge may be imposed (except for civil servants switching from public cover to standard tariff). New entries may not be charged less than the already insured of same age (not including ageing reserve). Long-term care insurance may not consider gender in premium calculations. Premium for standard (substitutive) package may not exceed average maximum contribution for public cover (150% of this maximum for couples); compulsory long-term care premiums also limited to maximum premium for social long-term care insurance (non-compulsory cover so limited after five years of insurance cover).	No	Yes. PHI contracts include an option, though, to raise a surcharge in order to pay for the premium cap in the standard benefit package, but so far, this option has never been used.) Insurance companies participate in a risk equalisation scheme for the standard benefit package, though, as the number of aged insured varies over the companies. Insurers offering compulsory long-term care must also participate in a system of risk equalisation for premiums (based on age for premiums as well as gender for ageing provisions). Risk equalisation is also possible for claims but has not been necessary to date.
Ireland	No	Introduction of premiums differentiated according to age at policy inception is permitted by law but requires regulation before it can be implemented.	Yes	Risk equalisation system being implemented. Age and gender serve as initial proxies for risk profile; may consider health care utilisation at a later date.
Mexico	Yes	Age-based variation limited through a specified premium range.	No	No

Table 3.9. **Premium rating-related requirements: consideration of health risk-related factors**¹ (cont.)

	Permitted	Permitted with limits	Prohibited	Legally required or governmental mechanism(s) for apportioning or adjusting risk among private health insurers?
The Netherlands	Yes, except for WTZ (primary) standard coverage package.	Premium for WTZ package subject to cap. Limit is above the average premium levels in the PHI market. Non-WTZ policies may consider risk factors.	No	Compensation scheme between social insurance and PHI where privately insured pay a contribution to cover for social insurance covering more of the health care costs of the elderly. Pooling scheme for WTZ pools costs exceeding WTZ premiums, and divides and spreads these costs through surcharge imposed on all privately insured.
Poland	Yes	No	No	No
Portugal	Yes	No	No	No
Slovak Republic	Yes	No	No	No
Spain	Yes	No pre-established rates criteria. Some undertakings segment their portfolio and set their rates according to age groups, geographical areas, etc.; others apply the same rates for the totality of their portfolio.	No, except for maximum premiums for substitutive coverage (standard tariff)	No
Switzerland	Yes for supplementary or complementary coverage; no for basic (mandatory primary) package	Yes, some variation allowed to reflect geographic variation in health costs	Premiums cannot vary by health risk for basic (mandatory) health insurance	Yes. A risk equalisation fund for basic insurance compensates insurers for cost differences arising from risk, based on age and gender factors.
United Kingdom	Yes	Yes	No; premiums may be calculated on the basis of employer group experience, or groups of insureds assigned to different rating groups on the basis of medical questionnaires; premiums generally only increase within these groups and not on the basis of individual experience.	No
United States	Not for large group plans (with more than 50 employees). Requirements for small group plans and individual policies vary by state.	Many states restrict health status-based ("experience rating") in small group market and some require community rating with varying degrees of permitted variation by age, gender and geography. Individual market requirements vary. Some states require community rating or otherwise regulate premium calculations in the Medicare supplement market.	Depends on the submarket.	Many states have voluntary risk equalisation schemes in their small group markets; some are mandatory. Some states have risk equalisation in individual markets. 30 states offer high risk pools (coverage offered by separate pools, often subsidised by charges on insurers or other taxes). These high-risk pools often restrict premiums (often between 125% and 200% of standard market rate) (Chollet, 2002, pp. 349-352).

n.a. not available.

1. This table primarily details rating practices at time of policy purchase, but sometimes also specifies practices at time of policy renewal.

Source: OECD Regulatory Questionnaire on Private Health Insurance.

requirements imposed on all products offered in the broader PHI market – have certain strengths and disadvantages. When premium limits are restricted to a standard package, policies for those of lower risk are less affected by the premium requirements, and may remain more affordable for those of lower health risk. This may have the advantage of keeping more low-risk persons in the broader insurance pool. However, in these cases, the extent to which higher-risk persons benefit from a broader risk pool depends upon the existence of a cross-subsidy or other mechanisms by which the premiums of lower-risk persons contribute to those of higher-risk persons (see discussion of risk-equalisation mechanisms below). In the case of requirements applicable to the PHI market more broadly, attention must be paid to the risk of adverse selection from new applicants – or those wishing to purchase more generous coverage – in a voluntary market. These types of requirements have the advantage of providing equity in the charges faced by all privately insured population groups, and also provide greater choice to all insured persons. However, younger or healthier persons may be less willing to subsidise the costs of those of higher health risks, and may choose to exit – or never enter – the market, resulting in less risk pooling and higher costs for those remaining in the pool. This challenge is a fairly common one in community rating schemes applicable to individual markets – whether primary or duplicate.

For example, in Australia and certain US states, age-based premium variation was introduced into community rating standards as a means of encouraging persons to purchase coverage earlier, and retain it. In the United States, states that permitted some age-based or other flexibility under their community rating scheme fared better in terms of continued insurer participation and less adverse selection effects than those with “pure” community rating (Hall *et al.*, 1999). In Australia, this regulatory change (“lifetime cover”) was accompanied by an extensive advertising campaign and is generally credited for the substantial increase in the number of persons with PHI that followed the implementation of these standards in 2000.²⁶ Time will reveal whether this mechanism is successful in maintaining coverage levels. Ireland recently passed legislation (Health Insurance Amendment Act, 2001) permitting the introduction of age-based premium variation (based only upon age at entry), although this has not yet been implemented.

The success of premium-related requirements also depends on the structure of the public/private mix and cultural factors; in some cases, these may reduce the risk of adverse selection by applicants. In Germany, eligible upper-income persons who do not opt out of public coverage remain in the public system. Furthermore, there are strict limits on PHI insureds’ ability to opt back into the public system. Hence, the system generally does not allow persons to move in and out of public and private coverage schemes. This protects both public and private coverage from the adverse selection that might result if persons could move back and forth depending upon the perceived financial advantage. In Switzerland, the mandatory nature of primary basic coverage prevents adverse selection (although some may still exist when persons choose between different basic insurance products). In the Netherlands, even without a mandate, the vast majority of those ineligible for public coverage purchase primary PHI, and most persons with social insurance purchase supplemental private coverage.²⁷ Furthermore, age distribution within the insured and broader population affects the risk of premium spirals, such as that experienced in Australia before the implementation of lifetime cover. Ireland has seen a trend of increasing PHI coverage since 1980 and has faced less dramatic premium

increases. Its younger overall population may contribute to its this experience (Colombo and Tapay, 2004a).

An additional confounding factor in assessing the impact of premium-related requirements is the difficulty of separating the impact of reforms from the effects of other changes in the health system or the economy. For example, in the United States, New York State had enacted “pure” community rating (no risk-based premium variation permitted) in its small employer and individual PHI market in 1993. Modest declines in coverage levels in the small group and individual markets subsequent to the implementation of these reforms are often attributed to the stringency of the reforms, particularly because the reforms resulted in significant increases in the premiums of younger individuals. However, coverage trends in the states which enacted no reforms or more limited reforms are similar to those in New York, thereby calling into question the extent to which the reductions in coverage levels could be attributed to the reforms (Buchmueller and DiNardo, 1999).

Despite efforts to stabilise and restrict variation in PHI premiums, most OECD countries face challenges arising from overall premium increases, which are often reported as a key policy concern in the area of PHI.

Risk-equalisation schemes

Most OECD countries that impose rating-related restrictions or caps on parts or all of their PHI market accompany these requirements with some mechanism to redistribute risk among insurers. Such mechanisms exist in at least some parts of the PHI markets in Australia, Germany, Ireland, the Netherlands, and the United States. A specialised pool for high-cost drug claims is also in place for all private insurers in the supplementary health insurance market in the Canadian province of Quebec. This type of mechanism can help deter competition based upon risk selection and protect certain insurers who cover a greater proportion of persons with high health costs. It can also ease the transition to more stringent access requirements by providing some assurance to insurers who may fear an inflow of higher-risk applicants under such reforms.²⁸ The prevalence of these mechanisms in primary PHI markets also indicates some consensus among certain OECD countries that premium restrictions alone – especially in voluntary individual primary PHI markets – are not likely to distribute risk evenly across insurers in the absence of such mechanisms.²⁹ In some cases, these mechanisms also seek to enhance affordability by subsidising the cost of higher-risk populations.

In the US small group market, several states have voluntary pools through which insurers can prospectively cede certain individual risks that they anticipate will exceed a given level of claims. These often include a very small proportion of the insured market. Others, such as Connecticut, require participation and have resulted in more distribution of risk across the small group market, because the compulsory assessment to cover excess losses by the pool encourages insurers to cede high-risks into the pool (Hall and Lawlor, 2001, p. 649). In some cases, pools can encourage cross-subsidies across group and individual markets. New York state has two risk-adjustment mechanisms in its individual and small group market; one accounts for demographic variation (with age and gender factors) and another pools risk based on the occurrence of certain high-cost claims (by diagnosis). The demographic pool does not capture the full extent of risk differentiation and a more sophisticated methodology is under development. The diagnosis-related pool has high administrative costs and is not being fully utilised (Hall, 1998a). While the mechanisms can cause tension, they have helped redistribute at least part of the risk

between insurers and appear to have contributed to some market stability in small group markets (Hall and Lawlor, 2001, p. 653).

New Jersey accompanied its community rating requirements with a loss assessment programme for sharing losses in the individual market; it also required group carriers to offer individual policies and enrol a target number of people, or share in the cost of any losses incurred in the individual market. The package of reforms – which included guaranteed issue of 6 standard products (insurers may only offer these products), guaranteed renewal, community rating and limits on pre-existing condition exclusions – resulted in an expanded and active individual market, with more insurers, improved choice and evidence of price competition (Swartz and Garnick, 2000, pp. 45-70).

In the Netherlands, a premium surcharge on the broader PHI market cross-subsidises and helps compensate for the higher cost of those covered by the WTZ scheme. Nearly half of its costs are covered by this surcharge. The German government has statutory authority to require group insurers offering substitute coverage to participate in a risk-equalisation scheme to help finance the cost of care for the elderly covered by the standard tariff package, although this has not been necessary to date. The risk-equalisation scheme in Australia pools 79% of the cost of over-65 members and insurees who were hospitalised for more than 35 days, and equalises such cost across funds with different risk structures.³⁰ Both the Australian and Netherlands' risk-equalisation mechanisms have been subject to some criticism that they do little to encourage insurers to manage costs, because the system reimburses retrospectively for differences in actual cost, thereby compensating less efficient insurers as well as those with worse-than-average risk structures. In Australia, insurers retain some of the risk of high cost care; hence, the Australian scheme may pose less risk of compensating insurer inefficiencies than the Netherlands' WTZ scheme. Switzerland has also implemented a risk-adjustment scheme in connection with its basic mandatory private insurance. While this mechanism is limited to few risk factors, it has been recognised to reduce – albeit only in part – incentives for insurers to enrol better risks and avoid covering those with poorer health status – and thereby to promote fair competition across insurers (Colombo, 2001, p. 41).

The implementation of Ireland's scheme has been controversial, although it is now being put into practice. The presence of two main insurance carriers in that market, and the likely identification of the carrier to receive money through such a mechanism, likely added to the level of political contention. In comparing risk profiles across insurers, the Irish system will initially use age and gender as a proxy for its risk profile, and then compensate insurers according to the extent to which their risk profile deviates from that of the market overall. While the scheme may consider utilisation factors in the future, there is consideration that such a factor will result in insurers' sharing efficiencies (Ireland's Health Insurance Authority, 2003, p. 14), rather than benefiting from their individual efforts to curtail inappropriate utilisation of health services. The creation of such a factor also carries technical challenges. In any event, the Irish system will not be triggered if there is a differential of less than 2% between insurers, and is discretionary for the government when differences are between 2 and 10%, and above 10%.³¹ Given its recent and ongoing implementation, analysis of the effect of Ireland's mechanism must await further experience.

High-risk pools

An additional approach in place in 29 states in the United States involves the creation of a separate programme – a “high-risk pool” – to provide coverage for those who are unable to obtain it in the individual insurance market. These programmes are often subsidised through premium taxes, and sometimes through additional taxes (such as a cigarette and tobacco tax). Some states have high levels of enrolment (Minnesota 6% of individually insured population, Nebraska and Oregon with about 3%), whereas enrolments in other programmes are much lower. Levels of coverage (in terms of benefits and cost sharing) also vary and certain high-risk costs may not be covered. Premiums for these pools are generally higher than market rates by 125-200% (Chollet, 2002, pp. 349-352) and usually only cover 40-60% of the operating funds for such pools (Abbe, 2002, pp. 345-348). In the states with higher levels of enrolment, funding is improved and products tend to mirror those available in the group market (Chollet, *op. cit.*). Importantly, while these pools are often favoured by proponents of a more private approach to challenges in the US individual market, this approach actually represents a more public approach than programmes relying on cross-subsidies within a market solely funded by private premiums because around half of the risk pools’ needed resources come from public funds. Some have advocated an increased government role in covering the costs of high-cost claims. It has been argued that a government reinsuring entity for persons whose health costs are in the top 2-3% of the health care distribution would reduce insurers’ incentives for risk selection and promote efficiency (Swartz, 2002, pp. 380-382).

Most OECD countries identify PHI premium increases among their greatest policy challenges arising from PHI markets. This section has summarised the range of tools and approaches employed by OECD countries seeking to address some of the access and equity challenges that arise from PHI premium differentiation and increases. When PHI has a particularly prominent role in a health system, policy makers have found it particularly important to act in this arena. There is, however, no clear consensus with respect to a single practice or set of practices that best address those challenges. Approaches vary from market-wide premium controls, premium caps on a limited number or type of policies, the use of risk-equalisation mechanisms alone or in combination with one of the preceding tools, and high-risk pools. As set forth herein, each approach carries certain advantages and disadvantages but has met with some success in addressing certain challenges. While some of the increases arise from different premiums charged to different risk groups, or arguably are connected to certain premium-related reforms, PHI premium increases are also linked to rising health costs – which pose a challenge in most countries. Hence it is important that policy makers consider this link when they seek to tackle undesirable increases in PHI premiums, recognising that this issue is both market-specific and connected to broader health care cost challenges.

4. Benefit standards for PHI policies

Most OECD countries do not regulate the benefits to be provided by PHI insurers. This may stem from their desire to promote maximum insurer flexibility, a generally light PHI regulatory structure, or EU legal restrictions on the imposition of such standards within PHI markets generally (with some exceptions), among other reasons. However, some governments intervene in this area in order to assure the offering of certain benefits, spread the burden of costlier benefits across the market, avoid risk segmentation and promote product comparability, among other concerns. When there is government

intervention, as is the case in several countries, the regulations generally take one of two forms.

- “Minimum benefit” requirements. These require PHI carriers to cover certain specified health care services. Ireland and Australia impose such requirements on duplicate coverage, as do most US states for primary coverage; and
- “Standardised benefit package” requirements. These involve specifying the precise contents of benefit packages, sometimes including covered services and cost sharing related standards. Sometimes insurers are limited to offering these packages, as occurs in the US Medicare supplement individual market, and some US states; in other cases, standard packages seek to assure the availability of affordable coverage – often focusing on the elderly (as in Germany) or high-risk persons (as in the Netherlands), but the marketplace may offer other products as well. This tool is less widely employed.

Apart from specifying benefits to be included in PHI, the “minimum benefit standard” approach does not restrict insurers’ ability to offer different packages, nor to vary the structure of coverage in various ways. This approach can therefore provide for more choice of coverage package while assuring coverage of certain services. At the same time, such standards do not address consumers’ ability to compare coverage packages and cost across or within insurers.

State-level mandated benefit standards have been a source of debate in the US PHI market, but appear to be less controversial in Australia and Ireland. In the United States, these requirements are often cited as a cause of higher premiums. Estimates of the impact on premiums vary; for example, recent studies estimated that New York’s mandated benefit laws, among the more stringent in the United States, increased premiums by 12.2% (Novak, 2003), whereas another state’s standards, Texas, was estimated to result in group premium increases of about 6.2-6.5% (Albee et al., 2000). Such estimates are difficult to perform, however, because insurers may have voluntarily offered such benefits even if they had not been required to do so, due to demand or other factors, such as encouraging certain preventive care. Thus, the standards may not really increase premiums to the extent sometimes claimed. As certain benefits have different degrees of potential health impact (*op. cit.*), policy makers must weigh these factors as well.

In Ireland, benefit requirements originated as standards for the state-owned insurer, VHI, and have been extended to new market entries (to date only one additional insurer). They focus on requirements relating to hospital coverage, but also include detailed payment schedules. The current schedules could be simplified to provide more flexibility with respect to reimbursement arrangements between insurers and providers (Irish Department of Health and Children, 1999, p. 55). The Irish government also considers minimum benefits an important component of the community rating scheme, by limiting the scope of benefit package variation which might be targeted to low-risk persons. These concerns are balanced with the desire to avoid undue interference with insurer commercial freedoms (*op. cit.*, p. 56).

Market history can also play a significant role in determining the range of PHI benefit plan options in any given market. For example, while both Ireland and Australia regulate their duplicate PHI markets through the imposition of mandated benefit requirements, they show different experiences with respect to the range of insurer offerings. In Australia, consumers may choose from among many different and innovative products; however, the existence of a large number of products may be confusing to consumers, thus effectively

restricting choice.³² Insurees seem also to experience confusion about benefit limitations and exclusions as they may not understand the rules related to different products (Colombo and Tapay, 2003). The Australian government has sought to improve consumers' understanding of PHI policies through several initiatives.³³ In contrast, in Ireland, the two main insurers offer few products, with around five main benefit package offerings each; these plans largely mirror each other, thereby facilitating consumer plan comparison and selection. Despite these relatively narrow plan options, consumers report satisfaction with the range of products and services offered by their private health insurers.³⁴ Hence, some limitation in the number of products may have positive effect on consumers' ability to compare available PHI products without causing dissatisfaction. A great number of benefit package offerings, on the other hand, may lead to consumer confusion and dissatisfaction.

Standardised defined benefit packages products sometimes arise out of a desire to assure that at least one comprehensive benefit package is available to all persons in countries where PHI plays a primary role. They can also assist efforts to improve consumers' ability to compare insurer offerings and price, and also sometimes to reduce risk selection by benefit design – particularly if all the standard packages have relatively comparable benefits, thereby appealing to lower and higher-risk persons alike. Outside of packages required to be offered at a set premium to high-risk persons, such as in Netherlands, or for certain elderly and defined populations in Germany, the United States is the only OECD country where some parts of its PHI market require the offering of standardised packages. Very few markets limit insurers to the sale of permitted benefit packages, such as in New Jersey's individual market. In this latter market, however, these requirements, together with other reforms, actually resulted in increased choice of carriers. The standardisation was accompanied by a buyer's guide developed by a board overseeing the individual market reforms, which included comparative premium information. Evidence suggests that price competition has occurred among carriers, with a number of plans having premiums within 15% of the lowest premiums (Swartz and Garnick, 2000).

In the US small employer market, many states required the offering of two standardised plans, but did not restrict insurer offerings to these packages. Access to these coverage options does not appear to have significantly increased, as these plans have not sold well.³⁵

In the US Medicare supplemental ("Medigap") market, policies sold to individuals must be one of ten standardised packages.³⁶ The standardisation of policies had several goals, including increasing product comparability, and reducing the extent to which duplicate private health insurance policies were being sold. Prior to the implementation of the standardisation requirements, there had been concerns about the sale of unnecessary multiple health insurance policies to elderly Medicare beneficiaries. In fact, it was estimated that, in 1991, about 3 million elderly beneficiaries paid about USD 1.8 billion for policies likely involving duplicate coverage (US General Accounting Office, 1994). In 1990, the sale of duplicate policies was prohibited, along with the imposition of standardisation requirements. A review of experience with Medigap plans ten years after imposition of standardisation standards reveals that these requirements improved consumer understanding, but did not result in lower premiums as a consequence of enhanced price competition. There has been a reduction in Medigap-related complaints received by state government officials, and a consequent reduction in government staffing levels devoted to this market (Fox et al., 2003, pp. 132-133). This is especially important for coverage of more

vulnerable populations, such as the elderly, for whom health plan selection may pose particular challenges.

In summary, product choices can provide insurers with another means to fragment the insurance pool in the absence of standardised benefits – to possible detrimental effect. For example, carriers may seek to avoid high-cost enrollees by generously covering some types of services attractive to lower-risk persons, such as preventive care, while limiting more expensive coverage needed by less healthy persons. They can also tailor policy deductibles and cost-sharing requirements to the preferences of specific types of people (Swartz, 2001, pp. 133-145) in a way that might segment insured persons according to risk – since the higher-risk would likely wish to avoid higher cost sharing. When deciding whether and how to regulate the benefits offered by private health insurers policy makers must weigh their desire to promote choice against the risks of consumers' inability to make meaningful comparisons across insurer offerings, and the risk of weakening solidarity via further market segmentation by product.

4.1. Benefit standards relating to interaction with public programme coverage

Most OECD countries do not restrict the scope or range of benefits that PHI insurers may offer. However, some countries have done so, particularly in order to steer the market's interaction with public coverage. A majority of Canadian provinces prohibit PHI coverage of outpatient, inpatient and dental benefits covered by their public programmes (with the exception of outpatient pharmaceutical coverage). Australia does not allow PHI to cover out-of-hospital physician services covered by its public programme. However, in Australia, funds are able to pay an unlimited amount of reimbursement above the government-set fee schedule for medical costs related to inpatient stays by private patients. Benefit plans for complementary and supplementary private coverage offered to individual Medicare beneficiaries in the United States are standardised and are generally designed to cover cost sharing under the public programme, with different degrees of generosity of benefits. The Netherlands does not permit PHI to cover long-term care and home care services, which are covered under a universal public programme.

The benefit-related limitations in Australia and Canada have not dampened PHI's potential to cover a significant level of services in these markets. Notably, in Australia, higher-cost hospital services can be covered by PHI and, in fact PHI covers a similar level of health expenditures to Ireland, where PHI plays a similar duplicate role. In Canada, despite the broad prohibitions on the benefits PHI can offer, PHI covers one of the largest shares of total national health expenditures among OECD countries. This can be attributed to the large degree of drug coverage provided by PHI carriers, and its significant employer group market.

In Australia, the government benefit restrictions arise from a desire to promote equity of access to care and avoid the creation of a “two-tiered system”. However, this policy has not been extended to medical care received on an inpatient basis, thereby only addressing part of the coverage and provider market. In fact, government PHI policy arguably supports the development of private hospitals by reimbursing specialists for services performed in private hospitals. In Canada, the broad benefit prohibition appears to stem from a desire to avoid creating incentives for physicians to opt out of the public system or to bill patients above publicly reimbursed levels by restricting patients' ability to benefit from insurance for such charges. In Canada, the prohibition on PHI is coupled with a requirement that physicians practicing privately cannot be reimbursed by the public system (Flood and

Archibald, 2001, pp. 825-830) – a strong incentive for public practice. Hence, in Canada, the government's approach has sealed off the publicly financed systems from influences that might reduce its universality.

5. Disclosure requirements

The complexity of PHI markets – and its impact on the functioning of a competitive PHI market and consumer awareness – is often cited as a key challenge in connection with PHI markets.³⁷ Disclosure of policy terms and conditions to purchasers, and a summary of key terms in readily understood language, can make an important contribution in this area. If information is presented in a readily comparable form, purchasers will be better able to compare products and prices and to understand the benefits they are purchasing. It can also help prevent a situation where consumers only become aware of less favourable policy terms when a claim is denied or conditioned in an unexpected fashion.

As a general matter, PHI-related disclosure requirements in OECD countries range from very specific targeted requirements, to a reliance on industry practice or voluntary standards (Table 3.10). For the most part, OECD countries require insurers to disclose to potential purchasers the terms and conditions of their PHI contracts. In some cases, these arise out of disclosure requirements applicable to insurers generally. Australia, Portugal, Germany and the United States have disclosure requirements specifically targeted to health insurance. Nonetheless, in Australia, health fund rules are generally very lengthy and are not provided in their entirety to insured persons upon their purchase of a PHI contract. This appears to be an exception to the general trend in other OECD countries, where entire contracts and any additional relevant terms are provided to purchasers.

In some cases, disclosure requirements are targeted to specific aspects of health insurer practices, particularly if there is a history or potential for consumer confusion. For example, Australian PHI consumers have raised concerns about the quality of product information provided at the point of sale and use, and the sale of products not suitable for the purchaser. Several government and industry initiatives have sought to improve health fund-related information. For example, publications available through the health funds, providers and the PHI Ombudsman provide information designed to assist consumers making decisions regarding PHI in Australia. Funds also must notify insurees of any changes in fund benefit plans prior to their taking effect. However, Australia's PHI ombudsman also publishes several brochures on specific areas of health insurance coverage, such as pre-existing ailment rules. Concerns had also arisen regarding consumer familiarity with the potential for incurring out-of-pocket costs, or “medical gaps”. In response to this concern Australia now requires all funds to offer a policy that does not include the potential for unexpected costs due to differentials in charges and costs incurred and public and insurers' reimbursement levels – a “no gap” policy.³⁸ The Government also produces a brochure on this issue and several other areas related to PHI policies. Portugal has specific disclosure requirements for health insurers who require a medical examination as a condition of acceptance.

In some cases, the particular disclosure requirements vary based upon the PHI role. In the case of substitute coverage in Germany, the insurer must provide an information sheet on the differences between public and private health coverage, and the government has developed an official information sheet on this topic, available on its website.

Table 3.10. **Disclosure/Information requirements**

	Requirements (governmentally established) relating to information that that private health insurers must provide to individual purchasers (before/after sale of policy):	Government incentives to encourage information disclosure in the PHI market:	Governmental agencies providing information brochures (or web-site or other mechanism) for consumers to help explain their PHI options:	Requirements relating to information that insurers must give to employers/ group purchasers:	Governmental oversight body ¹ of private health insurers:
Australia	Funds must take reasonable steps to notify each affected contributor, of changes to health fund rules before they take effect; Product disclosure requirements of the Trade Practices Act 1974. Government and industry developed a template for voluntary “key features guides” for PHI and vast majority of funds now offer such a guide.	Government has proposed that industry develop a voluntary code of conduct to govern provision of information to consumers. The Government is prepared to regulate in this area if a national voluntary code isn’t implemented by end of 2004.	Brochures on the Governments private health insurance reforms. The private patients’ hospital charter Information brochure on the pre-existing ailment waiting period in private health insurance Government website: www.health.gov.au . Other organisations assisting consumers in this area: PHIAC ² PHIO ³	None	DOH: Primary oversight responsibility for health funds. PHIAC: Oversees financial operations and membership details of health insurance companies. PHIO: Handles the resolution of complaints and disputes against health funds.
Austria	No	No	No	No	Financial Market Authority.
Canada	None	None	None	None	OSFI ⁴
Germany	Standard information requirements exist for all classes of insurance, specifically relating to health insurance (substitute); pre-contractual – insurers must issue an information sheet that explains the different principles on which the public and private health insurance systems are based; contractual – older policy holders (> 60) must be made aware of tariffs which include equal classes of benefit as did previously agreed terms of contract. ⁵	If insurer fails to provide the consumer with information required by law, the policyholder has the right to contest contract.	Official information sheet from the Supervisory authority: website: www.bav.bund.de/de/fuer-verbraucher/faq .	Requirements are the same for both individual and group policy purchasers.	FSA ⁶
Ireland					
The Netherlands	None	None	None	None	MOF, MOH
Mexico	Article 36 – Insurance law ISES (specialised health insurance companies) must deliver an informative brochure to policyholder with the policy.	None	CONDUSEF ⁷ (currently developing a webpage).	YES	

Table 3.10. **Disclosure/Information requirements** (cont.)

	Requirements (governmentally established) relating to information that private health insurers must provide to individual purchasers (before/after sale of policy):	Government incentives to encourage information disclosure in the PHI market:	Governmental agencies providing information brochures (or web-site or other mechanism) for consumers to help explain their PHI options:	Requirements relating to information that insurers must give to employers/group purchasers:	Governmental oversight body ¹ of private health insurers:
Poland	General terms of insurance contract should be voluntarily delivered by insurance company before concluding contract.	None	Office of the Ombudsman of Insured.	None	Insurance and Pension Funds Supervisory Commission supervises insurance companies only. Other private entities offering private health cover are beyond Commission's jurisdiction.
Portugal	All conditions must be written clearly and be perfectly intelligible. In addition special clauses exist where acceptance is subject to a medical examination. ⁸ There are also specific requirements depending upon type of contract: renewable contracts ⁹ and long-term health contracts. ¹⁰	None	None	In addition to requirements for individual policies, the policy must also clearly state the duties and rights of the policyholder, the insured, the beneficiary and the insurer, the date when contract will take effect and the length of contract.	
Slovak Republic	None	None	None	None	None
Spain	No specific requirements for health insurance. However, general insurance provisions apply such as those included in the Insurance Contract act specifying minimum content that policies must contain <i>i.e.</i> specifying dates of contract, etc.	None	None	No specific requirements for health insurance. However the general requirements specify that information can reach the insured either directly from insurer or through policy-holder, depending upon the agreement.	Ministry of the Economy; Director General of Insurance and Pension Funds. If the insurer offers a product offering "benefits in kind" a report from the Health Ministry is required.
Switzerland	None	None	None	None	Federal Office of Private Insurance, Federal Dept. of Justice and Police, for supplemental insurance.
United Kingdom	None	Yes – requirements of this kind are applied to members of the association of British insurers by ABI "Codes of practice", as a condition of membership. Some such requirements will become enforceable through the General Insurance Standards Council.	None	None	None

Table 3.10. **Disclosure/Information requirements** (cont.)

	Requirements (governmentally established) relating to information that private health insurers must provide to individual purchasers (before/after sale of policy):	Government incentives to encourage information disclosure in the PHI market:	Governmental agencies providing information brochures (or web-site or other mechanism) for consumers to help explain their PHI options:	Requirements relating to information that insurers must give to employers/group purchasers:	Governmental oversight body ¹ of private health insurers:
United States	State variation.	None	Many state insurance departments publish Shopper's Guides.	State law varies but most require the provision of documents such as a summary plan description, evidence of coverage, claim forms, etc.	Yes. State insurance departments, some state health departments; limited jurisdiction for DHHS (Dept. of Health and Human Services), DOL (Dept. of Labour) and Treasury Dept.

- Has the authority to request and receive information from health insurance companies or other private entities providing private health coverage.
- Private Health Insurance Administration Council.
- Private Health Insurance Ombudsman.
- Office of the Superintendent of Financial Institutions.
- All details specified in the act: 10 a section 1 VAG.
- Financial Supervisory Authority.
- The National Commission for the Protection and Defence of Financial Services Users (Comisión Nacional para la Protección y Defensa de los Usuarios de Servicios Financieros – CONDUSEF) is a public decentralised agency, the purpose of which is to promote, advise, protect and defend the rights and interest of the persons who utilise or hire a financial product or service offered by the Financial Institutions operating within the Mexican territory, with the aim to create and foster as well, an adequate culture among users, regarding said financial operations and services.
- The insurance undertaking shall provide the applicant with the following information before the examination is performed: an exhaustive list of medical examinations, tests and analysis to be performed; entities which may or should perform the said clinical acts; whether the costs of such acts are to be borne by the insurance undertaking or not and, if so, how the money will be refunded; the circumstances, if any, under which the insurance undertaking is entitled to demand a refund on the expenses it has incurred or to refuse to pay an applicant's expenses and the entity to which the results or reports of the clinical acts should be sent.
- The contract must state that the insurer only guarantees agreed reimbursements during the contract period and the terms of compensation if the contract is not renewed.
- In addition to above, also state the terms of extinguishing the right to guarantee, extending the guarantee beyond the terms of contract and adjusting premiums.

Source: OECD Regulatory Questionnaire on Private Health Insurance.

Disclosure in the Irish market has been influenced by its history of a single carrier, VHI, and the relatively recent arrival of a new entry. The larger insurer has a limited number of products it generally offers, and its new competitor offers similar products. Each insurer distributes summary information on its products. An examination of consumer understanding of their health plans in Ireland found that few consumers thoroughly understand their plan details, and claimants and the elderly display a higher degree of awareness of plan details. Nonetheless, most consumers indicate they are satisfied with their understanding of their private health coverage (Amarach Consulting, 2003, pp. 27-31).

Improved consumer understanding of their health care coverage entails significant and targeted effort. One US state, New Jersey, recently made a concerted effort to improve availability of health plan related information. Its government allocated resources to education on health insurance, a toll-free number for information was established, a buyer's guide with premium comparisons was developed, and information was made available on a government website, together with other outreach efforts. While price competition exists in this market, enrollees still displayed little understanding of their coverage several years after implementation of reforms and accompanying information efforts. This experience displays the ongoing challenges to helping consumers understand their health coverage options (Garnick and Swartz, 1999, pp. 456-470).

6. Quality standards

Most OECD countries impose few or no requirements on health insurers relating to the quality of health care they finance (Table 3.11). Quality-related requirements have historically been the purview of professional self-regulation, together with governmental standards imposed on providers; hence, a combination of government and voluntary professional standards generally apply. This approach – and its focus on providers, rather than health financing bodies – is also consistent with the limited involvement of health insurers in decisions around the delivery of health care in most, but not all, OECD countries.

The most significant exception to this trend is the United States, where insurers, particularly “managed care” companies, have been more involved in directing and overseeing certain aspects of care delivery. In a few other countries, a minority of insurers have become involved in the quality of services they finance, developing measures of clinical outcome and quality standards for contracted providers. As a consequence, regulators in the United States have found it appropriate to address certain aspects of private insurers' involvement in the quality of care. For example, many states require carriers to credential their participating providers, which often involves verification that they meet certain professional requirements. In addition, there are standards relating to the timeframes and expertise for insurers who require prior approval of certain services, such as hospitalisation. These standards often require a quick turnaround of decisions involving urgent care and also impose timelines for decisions; they also often specify a required type of expertise for the decision makers. These regulatory interventions stem from the link between the activities of certain types of health insurers and health care delivery and its quality.

Managed care plan practices with direct links to decisions regarding the delivery of care, particularly pre-approval requirements for hospitalisation and certain health care services, together with restrictions on provider choice, were some of the major causes of

Table 3.11. **Standards imposed on insurers relating to the quality of care financed by PHI**

	Standards concerning quality of care provided to PHI insurees	Regulation on PHI insurers' prior approval of health care services	Regulation on PHI insurers' monitoring of quality of care of providers under contract	Standards for HMO and managed care plans related to quality of care	Government-set performance measurements tied to quality of care financed by PHI	Non-government performance measurements tied to quality of care financed by PHI
Australia	Yes. Australian Health Ministers' Conference and the Australian Council for Safety and Quality in Health Care oversee the quality of Australian health system. In 1999, the national health performance committee was set up to develop and maintain a national performance measurement framework for health system improvement. In the private sector, the Private health Industry Quality and Safety Committee has developed arrangements to assess quality in private hospitals.	No. In general, health funds do not provide prior approval of health care services, nor determine whether care is medically necessary – except in the case where a member is not covered for treatment relating to a pre-existing ailment (applies in first 12 months of policy), in this case the health fund's medical practitioner will decide whether the ailment is pre-existing.	Providers must hold a hospital provider number issued by the state/territory government.	No	Yes. In progress: the government are working with industry to develop national performance benchmarks for health funds. Possible inclusions; complaints, population coverage, benefits paid and management expenses.	No
Austria	No	No	No	No	No	No
Canada	No	No	No	No	No	No
Germany	No	No	No	No	No	No
Ireland	No	No. But there are specific waiting periods set regarding cover for pre-existing conditions.	No. But providers must satisfy standards in relation to services delivered and standard of accommodation.	No	Yes. Some public hospitals are pursuing accreditation, there is medical training and development of doctors and consultants in the public system (the latter also works in the private system).	Yes. Some private hospitals are also pursuing accreditation.
Mexico	Yes	Yes. Established by the Health Ministry and National Surety Commission should be notified.	Yes. Corresponding authorisation must be granted by the General Health Council.	No	Yes	No
The Netherlands	No	No	No	No	No	No
Poland	No	No	No	No	No	No
Portugal	No	No	No	No	No	No

Table 3.11. **Standards imposed on insurers relating to the quality of care financed by PHI** (cont.)

	Standards concerning quality of care provided to PHI insurees	Regulation on PHI insurers' prior approval of health care services	Regulation on PHI insurers' monitoring of quality of care of providers under contract	Standards for HMO and managed care plans related to quality of care	Government-set performance measurements tied to quality of care financed by PHI	Non-government performance measurements tied to quality of care financed by PHI
Slovak Republic	No	n.a.	n.a.	n.a.	n.a.	n.a.
Spain	No insurer standards; applicable quality standards apply to both public and private healthcare providers.	Yes	n.a.	n.a.	n.a.	n.a.
Switzerland	No	No	No	No	No	No
United Kingdom	No. But provider facilities used by privately insured patients must satisfy statutory "care standards" – a policy strongly supported by insurers.	No. Insurers have begun to negotiate "preferred care pathways" with medical professional and other groups, and to incorporate similar codes of practice in their non-contractual agreements with providers.	No. However insurers have developed their own accreditation standards.	n.a.	n.a. But general consumer protection provisions apply to the "performance" of insurers.	No. But certain insurers monitor "outcomes" and consumer satisfaction in respect to providers used.
United States	Yes	Yes. Varies between states but generally medical professionals are initially required, then a specialist. Utilisation decisions in general must be made in two days.	Yes. There are specific standards in respect to verifying providers' credentials.	n.r.	No	Yes. Some private organisations set voluntary standards for quality of health plans. The health plan must meet those standards in order to obtain the organisation's certification. Some states "deem" those certified health plans as having met state standards.

n.a. not available.

n.r. not relevant.

Source: OECD Regulatory Questionnaire on Private Health Insurance.

the “backlash” by providers and consumers against managed care that occurred in the mid- to late 1990s in the United States. Many plans re-examined the effectiveness and cost savings derived from some of their utilisation management activities and made changes in the scope or requirements of such plans. For example, one survey of managed care plans in the United States found that 44% of plans had made major changes to their utilisation management activities since 1998 – including both loosening and strengthening of certain controls. Common changes included eliminating advance approval requirements for hospital admissions and certain outpatient procedures, as well as for specialist referrals. At the same time, many plans coupled these changes with strengthened review requirements for specified procedures and expanded or refined disease management programmes (Felt-Lisk and Mays, 2002, pp. 211-213). However, to the extent to which managed care plans retain procedures with direct links to the quality of care, such as utilisation review, standards for insurer activity in this area appear to be appropriate. A combination of governmental and voluntary accreditation standards represents the current status of managed care plan oversight and regulatory efforts in the United States.

Box 3.2. Voluntary efforts to bolster quality of care

Several voluntary accreditation organisations monitor health plans’ quality performance in the United States. These include the National Committee on Quality Assurance (NCQA) and the Utilisation Review Accreditation Commission (URAC). Some US states have incorporated these organisations’ review processes within their state laws. In these cases, state governments perform some oversight function but rely heavily on the reviews of these outside entities. There has also been an effort to prepare report cards comparing plan performance (see NCQA’s Health Plan Report Card).

7. Tax or monetary incentives relating to PHI

In addition to, or instead of, direct regulation of an insurance market, a government may wish to direct or shape a PHI market by offering certain tax incentives. For example, the offering of governmental fiscal or tax advantages may partly address affordability – and hence – access concerns. In addition, incentives targeted to one part of the market, such as the employer group market, can influence the overall direction, shape and size of a PHI market, as was the case for tax incentives for employer-sponsored health insurance in the United States (Joint Economic Committee, 2003). However, fiscal incentives can be costly and governments may choose not to provide these incentives if they find that the cost outweighs the advantages. This may particularly true in countries with small PHI markets where its policy relevance is minimal. Nonetheless, at least half of OECD countries have chosen to provide a range of incentives and subsidies to encourage the purchase of PHI by individuals or employers. At least fifteen OECD countries (Australia, Austria, Belgium,³⁹ Canada, France, Germany, Greece, Ireland, Italy, Luxembourg, Mexico, Netherlands, Portugal, Spain and the United States) provide some type of tax incentives for purchasers of PHI (Table 3.12). They range from very significant incentives, such as Australia’s 30% premium tax rebate, to less significant income tax deductions for PHI premiums. Deductions from taxable income are the most common form of incentive offered to purchasers, although some countries impose limits on the amount of deduction or on the type of policies eligible for the deduction, as in Austria, Germany, Greece, Italy and

Table 3.12. **Tax and monetary incentives**

Tax incentives for purchasers of PHI	
Australia	30% premium rebate to individual purchasers of ph insurance. Medicare Levy Surcharge on taxable income of high income earners who do not take out private health insurance ¹
Austria	Single people (deduction limited amount and available up to an income threshold) and sole earners (subject to limit) can deduct 25% of PHI premiums from their taxable income. Firms can deduct employer-paid premiums from tax (Mossialos and Thomson, 2002, Table 16, p. 91).
Belgium	Self-employed people can deduct premiums for substitutive PHI from taxable income Firms can deduct employer-paid premiums from tax (Mossialos and Thomson, 2002, Table 16, p. 91).
Canada	Tax credits, allowances, deductions and exclusions.
Denmark	Firms can deduct employer paid premiums from tax (Mossialos and Thomson, 2002, Table 16, p. 91).
Finland	None (Mossialos and Thomson, 2002, Table 16, p. 91).
France	Employees can deduct amount PHI premiums paid by employers from taxable income (Mossialos and Thomson, 2002, Table 16, p. 91).
Germany	Premiums for PHI as well as contributions for social insurance are deductible up to a limit. Health care costs that have not been covered by the insurance carrier may be deducted up to a maximum amount depending on income (For those born after 1957: additional max. amount of EUR 184 applies to contributions to a voluntary nursing care insurance).
Greece	PHI premiums are deductible from taxable income up to a maximum deductible amount (EUR 587 per year).
Ireland	Tax allowances: Applicable to all taxpayers, deducted by insurers at the standard tax rate, limited to health insurance premiums for registered health insurance undertakings. Tax relief is also available for out-of-pocket medical expenditures not covered by PHI, at the higher "marginal" rate. Rebates: If not claimed as a tax allowance. From 1 January 2004, employers are to pay "Employers Pay Related Social Insurance Contributions" (PRSI) on a broad range of "benefits in kind" provided to employees, including employer-paid health insurance premiums.
Italy	PHI premiums for group commercial policies and all (group and individual) mutual policies are deductible from taxable income at standard rate up to a ceiling (EUR 1 250) (Mossialos and Thomson, 2002, Table 16, p. 91).
Luxembourg	Individuals can deduct mutual PHI premiums from taxable income up to a ceiling (ceiling for all insurance premiums) (Mossialos and Thomson, 2002, Table 16, p. 91).
Mexico	Tax allowances: Amount of tax allowance equals the premium amount, there is no limitation or additional requirements.
The Netherlands	Tax Credits: Tax credit for young disabled (< 65). Credit deducted from tax that persons (entitled under Wajong law) have to pay = EUR 500 (2002). Tax allowances: Healthcare costs are income tax deductible (costs directly related to illness or invalidity). Must exceed a certain threshold (11.2% of income with a max of EUR 5 594 (2002) in order to become deductible. Premiums for private (industrial) disability are deductible.
Portugal	Tax allowances (deduction from income tax, not taxable income): 25% premium amounts, limit EUR 71.75 for single persons, EUR 143.50 for married persons for each child an extra EUR 35.88 (Mossialos and Thomson, 2002, Table 16, p. 91).
Spain	No tax on insurance premiums (re: all policy subscribers). Employees/workers (Income Tax): The premiums or quotas paid by companies to insurance entities are not considered as earned in kind up to a limit: Limits: EUR 360, 61 per year (individual); EUR 1.202, 02 per year, (if the insurance includes the spouse or dependents). The amount in excess is considered in kind income. Employers: (Corporate Tax) premiums paid are considered deductible expenses. If the taxpayer (in business activities) is the insured: (Income Tax), the amount of the premium is deductible in the direct estimation regime under the same terms of the Corporate Tax.
Slovak Republic	No provision.
United Kingdom	None for individuals nor firms (since 1997), although firms can deduct premiums from taxable profits: (Mossialos and Thomson, 2002, Table 16, p. 91).
United States	Tax Credits: 60% of premium applicable to trade-displaced persons on Qualified Health Insurance products (Health Insurers must be licensed). Tax allowance, deductions or exclusions: 100% deduction for employers and employees for group health insurance policies; 85% for self-employed; other health care expenses (including premiums) can be deducted when they exceed a certain income threshold.

1. Medical Levy Surcharge (MLS) was introduced in 1997 to encourage high-income earners to purchase phi and remove some of the burden from the public hospital system. The surcharge is additional to the compulsory Medicare Levy.

Source: OECD Regulatory Questionnaire on Private Health Insurance unless otherwise specified.

Luxembourg. Portugal provides direct reductions in the amount of taxes owed, rather than reducing taxable income, although this reduction is limited to 25% of premiums or a flat amount (which varies based upon family size). The Netherlands and the United States (for its individual market only) further limit their tax deductions to those health care costs that exceed a certain income threshold, and include premiums among the costs that may be deductible. At least eight OECD countries (Austria, Belgium, Canada, Denmark, Ireland, Italy, Spain and the United States) provide a significant incentive for employers to offer

health insurance by excluding employer contributions for employee health care coverage from income (at least up to a maximum, as in Spain) for the purpose of determining payroll, federal and state income taxes (Custer, 1999, pp. 13-26). Perhaps even more significant is the question of whether employees are subject to taxes on the premiums paid by the employers. Several countries immunise employees from such taxation, making this benefit particularly attractive for employees and hence encouraging participation in the benefit; these countries include the United States, France, and Spain (up to a limit). In the United Kingdom, contributions are tax-deductible by employers but the premium benefit may be taxed in the hands of employees as if it were salary.

7.1. Impact of PHI-related fiscal incentives

Countries should weigh the costs of PHI-related tax advantages against their benefits in determining whether to implement or continue such incentives

The costs and benefits of PHI-related tax advantages have been the subject of debate in some countries. Assessing the impact of incentives on take-up of insurance is difficult, since insurance purchase depends not only on the price elasticity of demand, but also on the responsiveness to other factors such as the perceived quality of public and private insurance. Furthermore, tax advantages, particularly when significant, have opportunity costs and often a regressive impact on health care financing.

The US experience highlights both the impact of tax subsidies in shaping the development of a PHI market, as well as their potential cost if PHI serves as a primary source of coverage for the majority of the population. In the United States, the employer health benefit tax exclusion has supported the private health coverage market, with significant expansions taking place in the group market from the 1940s through the 1980s. The employer coverage market is the primary source of coverage for non-elderly Americans (90% of the non-elderly population with PHI obtained it through employment-based plans in 2000).⁴⁰ Some evidence suggests fairly low price sensitivity of demand, even when employees are offered significant premium subsidies (Gruber and Washington, 2003). Conversely, according to one estimate, removing the subsidy would result in a loss of coverage for about 16.5 million individuals (20 million would no longer have employment-based insurance but about 3.5 million would purchase it in the individual market) (Custer, 1999, pp. 13-17).

Yet this influence comes at a large cost. The exclusion is the largest tax expenditure for the federal government; the estimated expenditure for fiscal year 1999 was 76.2 billion USD. It has also been argued that the tax preference is regressive as it benefits higher-income individuals, as the potential value of the deduction increases with income as a consequence of the progressive tax structure. Another analysis suggests however that lower income persons and those in poor health benefit disproportionately as they might otherwise remain without insurance (*op. cit.*, pp. 13-14).

Tax deductibility of employer health insurance can also have a significant effect in systems with universal public primary coverage. In Canada, employer contributions to health insurance plans are deductible from the employer's corporate income tax base (it is also not taxable to the individuals) for the purpose of federal income tax, as well as that of most provinces. PHI covers out-of-hospital prescription drugs, dental care and semi-private or private hospital rooms, among other benefits. The tax subsidy has been found to have a significant effect on demand for PHI, with estimates indicating that removal of the

subsidies would result in a 20% decline in levels of supplemental health insurance (Stabile, 2001, pp. 941-942).

Among certain European countries, the presence of a significant employer group PHI market sometimes correlates with the presence of tax advantages for employers offering PHI coverage, or to employees with respect to employer contributions. For example, in Denmark, where the group market constitutes at least 75% or more of policies purchased, the government permits employers to deduct the cost of premiums from their taxes. The vast majority (90%) of Sweden's small PHI market represents group policies, and employees can deduct employer-paid premiums from their costs (Mossialos and Thomson, 2002). Over 60% of commercial PHI policies in Belgium are employer-sponsored, and employer tax advantages are available there as well. Austria and Spain also accord tax advantages to employers offering PHI, but their group markets are more modest in size (21% to 15-18%, respectively) [OECD Statistical Questionnaire on Private Health Insurance, 2000 Data (Austria), 1998 data (Spain) and Mossialos and Thomson (2002)].

In the case of duplicate coverage in Ireland, individuals' ability to deduct health insurance premiums from their taxes has been limited to the standard rate, in order to improve the equity of this tax advantage, which previously had been provided at marginal rates.⁴¹ Changes in the tax treatment of PHI for insurees are not currently under consideration.

Certain regulatory interventions may be more effective than tax incentives in accomplishing certain goals

Australia implemented a premium rebate and certain rating reforms within a short time frame of each other – prompting questions with respect to their individual effect. Many analysts feel that the Australian 30% premium rebate was less instrumental than the introduction of age-adjusted premiums (referred to as “lifetime cover” in Australia) in spurring the purchase of PHI, although there is considerable debate on these issues.⁴² Given the large cost of the rebate, there has also been considerable public discussion about its efficiency and opportunity cost.⁴³ Since several regulatory changes and incentives were implemented in a very short period of time in Australia, and price and non-price factors might have added up to a compounding effect (Colombo and Tapay, 2003). Overall, it is likely that both price factors (tax penalty, rebate, premium loadings after age 30) and non-price factors (fear that the cover by Medicare would be inadequate, belief that premiums would not increase for those buying PHI, increased saleability of products) contributed to the large increase in PHI membership (*ibid*). Moreover, the impact of incentive policies on long-term PHI membership is uncertain. Recent data show that levels of PHI coverage has slightly declined from 45.6% at the end of September 2000 to 43.3% at the end of September 2003. On the other hand, in Australia, employer-sponsored health coverage is subject to a fringe benefit tax, a factor which has weighed against the development of a significant group market in this country.

Subsidising the cost of employer-sponsored coverage may not be an effective tool for targeting those who remain uninsured in some countries. Furthermore, while tax benefits for individually purchased coverage may help address problems surrounding a lack of insurance in primary PHI markets, it probably will not resolve it. For example, in the United States, it alone is unlikely to solve the problem because evidence suggests that even fairly generous tax credits will result in insurance purchases by only a portion of those currently without cover. For example, one analysis suggests that a tax credit of USD 2 000 (single)/

USD 4 000 (family), implemented to address certain concerns, would likely result in coverage for about 30% of the uninsured (Gruber and Levitt, 2000, pp. 72-85).

In sum, the presence of fiscal advantages for employer-sponsored coverage can greatly promote the growth of that PHI market. However, the use of individual tax incentives as a means to promote access and affordability have demonstrated some, but limited effect. In order to promote significant increases in individual PHI purchase, significant government subsidies are likely needed. Even then, unless persons are able to obtain a policy in the PHI market, broad access across risk cohorts will still remain thwarted, as discussed in Section 3.1. Hence, a combined strategy of fiscal incentives or subsidies and regulatory standards to promote access would appear have the best potential of significantly increasing access to PHI in several countries. This has particular policy importance for nations where PHI plays a primary role and certain population groups do not have access to public coverage.

8. Fair trade standards and mechanisms to address consumer concerns

8.1. Competition-related standards

In most OECD countries, health insurers are subject to the same laws relating to competition and antitrust as other industries (Table 3.13). In Australia, however, in addition to the activities of the Australian Competition and Consumer Commission (ACCC) (which promotes competition and fair trade generally), there are certain processes that seek to foster and protect competition within the private health insurance industry. The Private Health Insurance Administration Council focuses on several areas of PHI activity and must approve transfers of business from one fund to another, or transfers of one fund to another. In addition, the Minister for Health and Ageing must approve mergers between health funds. The Irish Health Insurance Authority also seeks to facilitate competition among health insurers as it implements the country's risk-equalisation scheme.

As discussed earlier, several types of PHI access-related standards seek to promote fair competition among health insurers by reducing the potential for insurers to compete based upon attracting better risks.

Mechanisms to address consumer concerns

Most OECD countries have both governmental and independent mechanisms for responding to consumer complaints regarding health insurers (Table 3.14). In many cases, additional independent bodies, often referred to as "Ombudsmen," have been established (either voluntary or by statute) to help consumers resolve disputes with insurers. In several cases, these entities focus exclusively on health insurance-related complaints (e.g., Australia, Germany, Switzerland and most US states).⁴⁴

Such mechanisms can provide a less costly means of redress than litigation and can serve to bolster confidence in insurance and PHI markets. For example, a survey of persons who had used the services of the Australian Private Health Insurance Ombudsman found they had a high degree of satisfaction with its services (PHIO, 2002, p. 29). This type of mechanism can also provide feedback to policy makers concerning areas that may need further policy intervention. The United States, despite an overall low rate of appeals to external review entities, has a successful history of resolving complaints and outcomes have not been heavily weighted towards consumers or towards the PHI industry. In most states examined, about half or less than half of the disputes have been resolved in favour

Table 3.13. **Competition policy**

	Requirements which address the promotion of competition, that apply to health care insurers:	Do generally applicable antitrust laws and procedures apply to health care insurers?	Must mergers and acquisitions between health insurers and health plans be approved?	Applicable processes, government agencies with jurisdiction, and general description of categories of criteria applied:	Are there competition-related rules specifically applicable to health insurers?	Are there special procedures or requirements for the conversion of non-profit health insurance carriers to for-profit status or mutual health insurance companies to non-mutual status?
Australia	The ACCC is the independent statutory authority responsible for compliance with, and enforcement of, the Trade Practices Act (1974) Act is to enhance the welfare of Australians through the promotion of competition and fair trading and provision for consumer protection. The Act proscribes certain anti-competitive conduct and unconscionable, misleading, deceptive or false trading practices. For further information on the role of the ACCC, refer to the glossary attached to this survey.	Yes	Yes The Minister for Health and Ageing must approve the merger of health funds. However, take-overs do not require such approval.	Process regulated by the National Health Act (NHA): Health funds registered under the NHA must apply (in the approved format) to PHIAC for the transfer of one fund to another, or for the transfer of business from one fund to another, and provide details of the proposed transfer scheme in the application; PHIAC must approve the transfer, except in certain circumstances (<i>e.g.</i> fund is being wound up, investigated or has been placed under administration). The transfer Scheme proposed as part of the merger application must provide for the transfer of contributors from one fund to another, or other matters proscribed; and PHIAC may refuse to approve a transfer scheme until such alterations are made to the Scheme to meet the Council's requirements.	n.a.	Yes The NHA requires health funds to notify the Department of any changes to articles of association, constitution or health fund rules. A transition from not-for-profit to for profit requires such a notification. A Registration Committee established under the NHA may also be convened to consider such proposals. The transition from mutual to non-mutual status also requires notification but under proposed reforms the government will no longer scrutinise changes to Articles of Association or Fund Constitutions.
Austria	No information provided.	No information provided.	No information provided.	No information provided	No	Yes
Canada		Yes. Competition Act applies to health insurers, as it does to other firms, to prohibit arrangements that will lessen competitors with respect to prices or markets.	Yes	Includes OSFI and government including Department of Finance.	No	Yes: must apply to Minister of Finance

Table 3.13. **Competition policy** (cont.)

	Requirements which address the promotion of competition, that apply to health care insurers:	Do generally applicable antitrust laws and procedures apply to health care insurers?	Must mergers and acquisitions between health insurers and health plans be approved?	Applicable processes, government agencies with jurisdiction, and general description of categories of criteria applied:	Are there competition-related rules specifically applicable to health insurers?	Are there special procedures or requirements for the conversion of non-profit health insurance carriers to for-profit status or mutual health insurance companies to non-mutual status?
Germany	Unfair competition law applies to health insurers as it applies to any other industry.	Yes. A nationwide cooperation between all health insurers operating on the German market, refusing to offer coverage for deductibles in the statutory system, for instance, would be considered as unlawful restriction of market forces. The same would apply if health insurers agreed to not reimburse certain medical procedures any more, to reduce reimbursement for physicians' bills etc.	Yes	Federal Antitrust Authority. A merger will not be approved if the new company exercises market control.	No	Yes. Approval of the Federal Financial Authority is necessary.
Ireland	Enactment of the Health Insurance Act, 1994 opened the market to competition. The legislative framework now includes a provision that allows a three year exemption from risk equalisation to new market entrants. In considering whether implementing risk equalisation is warranted, the Health Insurance Authority and the Minister are required to have regard to "the best" interests of health insurance consumers, including the need to maintain the application of community rating across the market and to facilitate competition between undertakings.	Yes: Health Insurers are subject to the same laws as other companies, in respect to competition.	Yes	This has not arisen, but the Minister for Enterprise, Trade and Employment, and related offices, <i>e.g.</i> , the Competition Authority would have specific responsibilities in relation to proposed mergers between organisations/businesses.	No	No

Table 3.13. **Competition policy** (cont.)

	Requirements which address the promotion of competition, that apply to health care insurers:	Do generally applicable antitrust laws and procedures apply to health care insurers?	Must mergers and acquisitions between health insurers and health plans be approved?	Applicable processes, government agencies with jurisdiction, and general description of categories of criteria applied:	Are there competition-related rules specifically applicable to health insurers?	Are there special procedures or requirements for the conversion of non-profit health insurance carriers to for-profit status or mutual health insurance companies to non-mutual status?
Mexico	No					
Netherlands		Yes	Yes	Yes	No	No
Poland	No specific regulation for health insurers.	Yes	Yes	Insurance and Pension Funds Supervisory Commission Office for Competition and Consumer Protection Mentioned bodies approve mergers and acquisitions under provisions specified in legal acts.	No	No
Portugal		Yes	Yes	As any other mergers and acquisitions between insurance companies	No	No
Spain	General regulation on the protection of competition.	These are also the result of the application of the general regulation.	Yes	Mergers between insurance entities require an administrative authorisation. The specific insurance legislation is applied and in matters not provided for in the latter the legislation regarding PLCs is applied. In terms of the participation regime of an insurance entity, the specific insurance legislation that includes EC legislation is applied.	No	Yes. Specific insurance legislation deals with the transformation of companies. As in the case of insurance entity mergers, the issues not treated specifically by this legislation, are treated under the legislation concerning PLCs.
Switzerland	Competition Law.	Yes. Anti Trust law is applicable.	Yes	Commission of Competition	No	Yes. Commercial Law.

Table 3.13. **Competition policy** (cont.)

	Requirements which address the promotion of competition, that apply to health care insurers:	Do generally applicable antitrust laws and procedures apply to health care insurers?	Must mergers and acquisitions between health insurers and health plans be approved?	Applicable processes, government agencies with jurisdiction, and general description of categories of criteria applied:	Are there competition-related rules specifically applicable to health insurers?	Are there special procedures or requirements for the conversion of non-profit health insurance carriers to for-profit status or mutual health insurance companies to non-mutual status?
United Kingdom	The largest health insurer has been prevented from further enlarging the interest of the holding company in UK hospitals, following a reference to competition authorities. There remain restrictions within that company on the sharing of commercially-sensitive information between insurance and (existing) hospital subsidiaries.	Yes. The policy is designed to prevent "abuse of dominant position". This does not imply that a dominant position cannot be fairly "used", provided it does not damage competition or is demonstrably in the "public interest".	No, not in general principle.	As for all insurance, supervisors would take a close interest in merger activity and might wish to see revised business plans as for a start-up.	No	No. Any such requirements are not specific to health insurers or to Friendly Societies offering health insurance Certain kinds of insurer involved in health insurance would need Court clearance for any changes of status involved in a merger – again, this derives from their special corporate structure not their health insurance activity.

n.a. not available.

Source: OECD Regulatory Questionnaire on Private Health Insurance.

Table 3.14. **Mechanisms addressing consumer questions and complaints regarding PHI**

Mechanisms in place for the government to handle consumer questions or complaints regarding insurance carrier activities and their powers:			Are they specialised in health insurance?	Does the system distinguish between questions and complaints and whether and how complaints are categorised?
	Governmental tracking:	Independent “ombudsman” programmes or programmes for external review of consumer claims:		
Australia		The Private Health Insurance Ombudsman (PHIO) was established in 1995 to deliver high quality information and dispute resolution service to consumers and medical providers (decisions not binding). Also, the Australian Competition and Consumer Commission has broad responsibility for eliminating anti-competitive and unfair market practices, as well as associated consumer protection.	Yes, No (ACCC)	The PHIO categorises complaints by the degree of effort needed for their solution. The categories used are as follows: Disputes: the highest level of complaint where significant intervention is required ¹ Grievances: moderate level of complaint ² Problems: moderate level of complaint not requiring mediation ³ (Legislation has been recently introduced to increase the PHIO’s powers).
Austria	Yes, including telephone assistance by regulatory staff.	Yes.		
Belgium	Office de Contrôle des Assurances.	Ombudsman de l’union Professionnelle des Entreprises d’assurances.	No	No distinction.
Canada		Canadian Life and Health Insurance. OmbudService: adjudicates but decision isn’t binding.	No	Questions and complaints are distinguished and categorised in an annual report.
Germany	Federal Financial Supervisory Authority.	The Association of Private Health Insurers established an “ombudsman” programme in 2001.	No/Yes	The system distinguishes between complaints and questions. Government’s complaints are classified as follows: – affected insurer – number of complaints – reason for complaint (making of the contract, contractual issues, claims handling, termination of contract) and the complaints are broken down into: – cases which were justified/not justified – cases where the complainant could be helped/ could not be helped – cases in which the supervisory authority was not the competent body to address

Table 3.14. **Mechanisms addressing consumer questions and complaints regarding PHI** (*cont.*)

Mechanisms in place for the government to handle consumer questions or complaints regarding insurance carrier activities and their powers:			Are they specialised in health insurance?	Does the system distinguish between questions and complaints and whether and how complaints are categorised?
	Governmental tracking:	Independent “ombudsman” programmes or programmes for external review of consumer claims:		
Ireland	Department of Health and Children.	The Office of the Insurance Ombudsman is funded by the Insurance Industry and adjudicates on cases submitted. Membership is voluntary but its decisions are binding on insurers participating in the scheme. The person making the complaint is not bound by the decision. The Health Insurance Authority also accepts inquiries and complaints.	Yes	No distinction but enquiries/representation/ complaints submitted to Department and Health Insurance Authority. Complaint process to the Insurance Ombudsman. Both Health Insurers are members.
Mexico	The national commission for the protection and defence of financial services users (CONDUSEF) is a public decentralised agency. ⁴		No	This agency distinguishes between questions and complaints.
The Netherlands		The “Ombudsman Schadeverzekeringen” programme is carried out outside the regulatory authority and is fully private. They give advice or strong recommendations to private insurance companies which they in general execute. Their authority is not final. One can always decide to go to court.	No	No
Poland	The Office of the Commission of Insurance and Pension Fund Supervision and the Minister of Finance are responsible for clearing up the misunderstandings concerning complaints against insurance undertakings.	Ombudsman of the insured is appointed to examine complaints against insurance undertakings.	No	No
Portugal	Yes (but no details given in the Questionnaire).	None	No	The system distinguishes between questions and complaints.
Spain	There has been a Claims Department in the Directorate-General of Insurance and Pension Funds for many years, and it remains in place. As a last resort, the Supervisory Authority will analyse and resolve claims.	In 1995, the “Defensor del Asegurado” (Insured Defender) was created, enabling insurance entities, whether individually, grouped by types of insurance, geographical proximity, volume of premiums or any other criterion, to appoint entities or independent experts of acknowledged standing as insured defender to rule on claims against entities, submitted <i>voluntarily</i> for a decision. ⁵	No	
Switzerland	Yes	Ombudsman der sozialen Krankenversicherer can resolve claims relating to mandatory PHI.	No	No info

Table 3.14. **Mechanisms addressing consumer questions and complaints regarding PHI (cont.)**

Mechanisms in place for the government to handle consumer questions or complaints regarding insurance carrier activities and their powers:			Are they specialised in health insurance?	Does the system distinguish between questions and complaints and whether and how complaints are categorised?
	Governmental tracking:	Independent “ombudsman” programmes or programmes for external review of consumer claims:		
United Kingdom	FSA rules require all firms to have internal procedures for handling complaints from consumers, and to co-operate fully with the Ombudsman.	The Financial Ombudsman Service (FOS) provides consumers with a free, independent service for resolving disputes with financial service firms. FOS decisions are binding on the insurer but not the consumer.	No	Will attempt to resolve by mediation and then move to adjudication. The National Association of Insurers formally tracks complaints (made to them or reported by insureds) to ensure resolution and to maintain statistics. Relatively few unsolved complaints in this area.
United States	Each state and federal agency has their own mechanisms to handle consumer complaints and experiences with health insurance policies/plans.	Not at the federal level for employment-based group health plans, but policies sold subject to state regulation are often subject to external review. ⁶ Several voluntary industry efforts provide or accredit such systems.	Yes	The Department of Labour has many mechanisms through which consumer questions and complaints regarding health insurance may be addressed. At a departmental level, the Office of Compliance Assistance responds to inquiries relating to all agencies within the Department of Labour, including EBSA. ⁷ 32 states and D.C have mechanisms for addressing complaints relating to managed care plans.

- Disputes are dealt with by contacting the health insurer, hospital, doctor, or other service provider about the matter. Issues in this category will have previously been the subject of dispute between the complainant and the respondent and not have been resolved. The Ombudsman attempts a resolution through conciliation by telephone or in writing.
- Grievances are dealt with by investigating the complainant's grievance directly and providing additional information or a clearer explanation. The provision of an explanation by the Ombudsman as an independent third party is generally sufficient to conclude the complaint.
- Problems are dealt with by referring the complainant back to the health fund or service provider. This occurs when the Ombudsman considers that the complainant has not made sufficient endeavour to resolve the issue with the provider, or where the Ombudsman is able to suggest another way to approach the issue.
- Whose purpose is to promote, advise and protect the rights and interest of the individuals who use or hire a financial product or service offered by the financial institutions operating within the Mexican territory. It also has the aim to create and to foster an adequate culture among users, regarding said financial operations and services.
- There was a major legislative change in 2000 in this field (claim management and formalities) whose essential lines can be summarised as follows: All insurers must (it is obligatory) design a system which allows them to deal with claims against them, based on one of the options referred to in the Private Insurance Act – Insured Defender, Customer Service Department – and, if neither of these exists or, if they do not have authorities assigned to rule on a claim brought, the party concerned, policyholder/insured/beneficiary or third party affected must file their claim with the company's central departments.
- External Review Programmes (ERPs) provide an independent review of a health plan's decision to deny, reduce or terminate care. They are meant to address concerns about managed care incentives that might lead to the inappropriate denial of care, and to help restore public confidence in managed care. In May 2000, there were ERPs in 32 states and the District of Columbia. In addition, many private health plans have announced that they will voluntarily provide their enrollees access to external review when care is denied. Further, the National Committee on Quality Assurance (NCQA), a private body that accredits HMOs, has expanded its accreditation standards to require plans to make available external review of medical necessity denials, effective in July 2000. In October, 1999 the American Accreditation Healthcare Commission/URAC, another private accrediting body, announced its intention to accredit external review organisations to encourage their voluntary use by private health plans (Source: Pollitz, Dallek and Tapay (1998)).
- At an agency level, the Employee Benefits Security Administration (EBSA), within DOL, strives to provide assistance to participants, beneficiaries, employers, plan sponsors, service providers, and the general public in receiving and providing health benefits governed by ERISA. This is accomplished through various forms of participant and compliance outreach, education and technical assistance programmes. In particular, EBSA provides education and assistance to health plan participants, beneficiaries and other consumers about their rights under the law and where to go for assistance in helping them obtain benefits that have been improperly denied. EBSA's participant and compliance, outreach and education activities are carried out by ten regional offices and various office components within the national office. Outreach and education services are provided through various means – EBSA websites, media releases, publications, fact sheets, speeches, seminars, etc. Participant technical assistance is primarily provided by benefit advisors located in the regional offices and in the Office of Participant Assistance and Communications (“OPAC”) Division of Technical Assistance and Inquiries in the national office. In addition, EBSA's Office of Health Plan Standards and Compliance Assistance (OHPSCA) administer Part 7 of Title I of ERISA. OHPSCA provides compliance assistance and responds to questions and complaints received from individuals throughout the regulated community. EBSA's Office of Regulations and Interpretations answers inquiries under the other Parts of Title I of ERISA that often are raised with respect to group health plan coverage.

Source: OECD Regulatory Questionnaire on Private Health Insurance.

of the consumer. In a few states, over 60% of the cases were ultimately held in favour of the consumers (Pollitz *et al.*, 1998, Table 1). In the case of the Irish Ombudsman, who considers a range of insurance-related grievances (including but not limited to health insurance), 59% of the cases were adjudicated in favour of the company, and 41% in favour of the complainant (Insurance Ombudsman of Ireland, 2001, p. 17).

9. Compliance and enforcement frameworks, cross-national standards and shared jurisdiction

9.1. Compliance and enforcement frameworks

There are a range of enforcement tools that government officials may be able to invoke to monitor and encourage compliance and penalise non-compliance, if they are accorded the authority to do so (Tables 3.15 and 3.16). In most countries the health insurance supervisory authority may impose civil monetary penalties and orders to cease business. Several also can place an entity under government receivership, impose criminal penalties or order for corrective action. Governments also may review PHI products for compliance with legal requirements as a matter of standard practice. In at least five countries [Australia, Ireland (for largest carrier), Mexico, Switzerland, and some US states], regulators also review certain or all PHI products prior to their sale.⁴⁵ These or similar requirements had been in place in more countries prior to the EU insurance directives, which now generally prohibit this type of contract control. However, in Germany, substitute PHI products must be filed with regulators prior to their sale, although prior regulatory approval is not required.

Several OECD countries had not taken any significant actions against private health insurers in their countries. In Australia, the Competition Commission (ACCC) has, however, taken action against eight funds for false, misleading and/or deceptive advertising. In addition, questions surrounding consumers' ability to file lawsuits against health plans have been a topic of intense policy debate and state-level policy intervention in the United States, particularly when their actions have allegedly affected medical outcomes, as may be the case for managed care plans (Butler, 2001).⁴⁶

In addition to formal actions, regulators are often able to resolve issues through discussions and informal investigations with companies.

9.2. Cross-national standards (EU Law)

EU law has had an important influence on the scope of European PHI markets, particularly in the past decade. As in other areas, policy makers in EU member countries must craft any PHI-related policy and regulation within the permitted structure and standards of EU law. The primary standard applicable to PHI markets, the EU third non-life insurance directive, seeks to promote competition while safeguarding certain consumer interests.

Specifically, under the directive, member countries must permit the offering of insurance products by insurers based in other member states, subject to certain conditions. The Directive focuses on protecting the financial condition of companies, and thereby seeks to assure the ability of insurance entities, including health insurance companies, to continue to deliver contractually promised benefits.

This focus on prudential supervision required a shift in PHI regulatory focus and scope in some European countries. Prior to the application of the EU's third non-life insurance

Table 3.15. **Enforcement and compliance frameworks and mechanisms**

	Description of product review for compliance with laws:	Description of review and/or approval of policy premiums	Is the product sale/marketing overseen?	Are there examination and background requirements for agents?
Australia	Currently, all changes to private health insurance products offered by funds are assessed for their consistency with the National Health Act. ¹	Under the NHA, private health insurance funds are required to submit notification of any changes in premiums to the Secretary of the Department of Health and Ageing for consideration by the Minister. ² The Minister may disallow increases for specified reasons. Reduced scrutiny for increases at or below CPI.	Yes, the NHA includes standards for representations relating to PHI. Product sales and marketing (including the actions of agents and brokers) are also regulated via the ACCC and the Trade Practices Act 1973.	No. However, the private health insurance industry has agreed to develop a voluntary code of conduct designed to ensure that customer service staff, agents and brokers are appropriately trained, and have up to date information when dealing with consumers.
Austria	Product is reviewed and must be filed before sale but prior approval before sale is not required.	No review.	No	Yes
Belgium	Product review but prior approval not required.	No	Refer to the law of 27 March 1995 relating to intermediaries in insurance and the sale of insurance.	Yes
Canada	No	No	On a complaints basis	Yes
Germany	Prior review for substitutive health insurance. Filing but no prior review for other products. (Before the third non-life EU directive all products needed prior approval.)	Yes, as far as substitutive health insurance is concerned: The technical calculation bases are reviewed. No. For other products (Before the third non-life EU directive the premiums needed prior approval.)	No. Not by the FSA but general trade supervision requirements are applicable.	No, but insurance companies and their trade associations provide professional training and issue certificates.
Ireland	Review but no prior approval required.	Yes for schemes offered by the Voluntary Health Insurance Board ("VHI"). No ³	Yes. The Health Insurance Act permits the implementation of regulations relating to advertising and promotion of health insurance business.	n.a.
Mexico	Prior approval required.	Yes	Yes. Article 23 of the Insurance law states that the insurance agent must have authorisation from the Insurance and Surety National Commission.	Yes: The technical capacity of insurance agents is evaluated by exams.
Netherlands	No review.	No	No	No
Poland	Yes: the product must be filed before sale without requiring prior approval.	Yes. An insurance contract is examined to check conformity with the Civil Code and its insurance activity.	No	Agents must have a permit from the Commission of Insurance and Pension Fund Supervision.
Portugal	No review.	None	None	
Slovak Republic	No information.	No information.	No information.	No information.

Table 3.15. **Enforcement and compliance frameworks and mechanisms (cont.)**

	Description of product review for compliance with laws:	Description of review and/or approval of policy premiums	Is the product sale/marketing overseen?	Are there examination and background requirements for agents?
Spain	Product review but no prior approval or file and use requirements.	NR	Yes. Both the sale of products and their marketing are subject to the supervision by the Directorate-General of Insurance and Pension Funds.	Yes, exams for brokers and companies are required to train agents. ⁴
Switzerland	Yes, prior approval required.	No	Yes	No
Turkey	No	No	No	No
United Kingdom	No prior approval required.	No	Yes. Sales and marketing are covered by Industry codes of practice overseen by the ABI and GISC.	No, but some insurers have their own rules of conduct and will only deal with agents and intermediaries who abide by these rules.
United States	Depends on State whether prior review is required.	Varies by state	Yes. Many states require filing of advertising materials.	Yes, in general, agents must pass an examination before first being licensed. The agent can then become licensed in another state based on reciprocity.

1. Where the Minister for Health and Ageing is of the view that a change: would or might result in a breach of the NHA or of a condition of registration of a fund; imposes an unreasonable or inequitable condition affecting the rights of any contributors; or might, having regard to the advice of PHIAC, adversely affect the financial stability of the fund, the Minister may declare, in writing, that the change shall not come into operation. However, on 11 September 2002, the Minister announced that the Government would introduce measures to allow private health funds to be more innovative and responsive to the needs of members by streamlining the existing arrangements for the regulation of products. The requirement for funds to seek approval from the Department of Health and Ageing for each product change will be removed under these new arrangements. The new arrangements will reduce the administrative burden on funds, thereby increasing funds' efficiency. Members' interests will be protected by measures which include the strengthening the powers of the PHIO, and increasing scrutiny of the overall performance of the funds on a number of key indicators, including membership, management-expense-ratios, reports from the Ombudsman and premiums. Subject to Parliamentary process being completed, the new arrangements are expected to come into effect in July 2003.
2. In summary, premium increases can be disallowed if the Minister considers a premium change: might result in a breach of the Act or a condition of registration; would be detrimental to the rights of fund members; would adversely affect the financial stability of a fund; or in the case of an increase, would be contrary to the public interest. A declaration in relation to public interest must be tabled in each house of Parliament and must set out the grounds on which increase in rates of contributions would be contrary to the public interest. The Minister also has the power to give a direction to a health fund with respect to the rates of contributions to be paid by contributors. However, on 11 September 2002, the Minister for Health and Ageing announced that funds seeking premium increases at or below the Consumer Price Index (CPI) would be subject to streamlined processes, resulting in reduced scrutiny of their premium increase request. Any fund seeking a premium rise bigger than the annual CPI would continue to have its claim scrutinised closely by the industry's independent regulator, PHIAC. PHIAC will continue to assess proposed premium increases by all funds in terms of prudential requirements.
3. Premium price control is not part of the overall regulatory framework. However the Voluntary Health Insurance Acts, that apply only to the Voluntary Health Insurance Board, require it to submit proposed premium increases to the Minister for Health and Children in advance. He has the power to prevent proposed increases by giving reasons to the Board for not implementing proposed increases.
4. In the case of brokers there are examination requirements. In the case of agents: the insurer entities shall take the necessary steps to train their agents, to this end establishing training programmes setting out the requirements to be met by insurance agents at which such programmes are aimed, and the resources to be used in the implementation thereof. The documentation for the training programmes and their implementation is to be made available to the Directorate-General of Insurance and Pension Funds which may demand any necessary modifications to be made to the content thereof and to the resources needed to organise and impart them in order to adjust them to the training requirement referred to previously. In terms of mediation, there is a specific regulatory Act 9/1992, of April 30th in Private Insurance Mediation "Ley 9/1992, de 30 de Abril, de Mediación en Seguros Privados" that must be adapted in certain points after the enforcement of the Community Directive on Mediation.

Source: OECD Regulatory Questionnaire on Private Health Insurance.

Table 3.16. **Regulatory tools used by governments for non-compliance**

	Description of regulatory tools used in the case of non-compliance:					Of these tools, are any unique to PHI?
	Civil monetary penalties:	Orders to cease business:	Government receivership:	Criminal penalties:	Other:	
Australia	Yes	Yes	Yes	Yes	Yes ¹	The non-health insurance industry has been through a process of review with the implementation of Financial Services Reform legislation. This has established markedly different regulatory regimes for non-health insurance organisations.
Austria	Yes	Yes		Yes		No
Canada	Yes	Yes	Yes	Yes	No	No
Germany	No	Yes	No ²	Yes	Yes ³	Yes ⁴
Ireland	Yes	Yes				Yes. Given the “common good” nature of voluntary private health insurance in Ireland, the regulatory framework applicable to health insurers, (other than those relating to solvency, a matter for the Department of Enterprise, Trade and Employment,) relates primarily to the protection of the “common good”.
Mexico	Yes	Yes	No	Yes	Yes. Intervention of the company and/or revocation of corresponding authorisation.	No
Netherlands	Yes	Yes	No	Yes	No	No
Poland	Yes	Yes	Yes	No	No	
Portugal		Yes		No	Yes. Administrative monetary policies.	No
Spain	No	Yes	Yes	No	Yes ⁵	No
Switzerland	Yes	Yes	No	No	No	Yes. State regulations on health law.
United Kingdom	No	No ⁶	No	No	No ⁷	No
United States	Yes	Yes	Yes	Yes	Yes. State insurance department may issue an order to take corrective action.	No. The same tools apply to other lines of insurance.

Table 3.16. **Regulatory tools used by governments for non-compliance** (cont.)

1. If there is a clear breach of these requirements then the enforcement provisions that are established throughout the NHA may apply. These include: the power to fine officers of recalcitrant health funds; de-registration of a health fund if it changes its rules so that it can no longer conduct the health benefits fund in accordance with the NHA; the appointment of inspectors, placement of health funds under administration and winding up funds; and a variety of other specific penalties.
2. However, the petition for the institution of insolvency proceedings against an insurance undertaking may only be filed by the supervisory authority, § 88 VAG.
3. The supervisory authority may take any orders which are appropriate and necessary to prevent or remedy any irregularities.
4. In case adequate allocations to the provisions for profit-related premium refunds are not made the supervisory authority may require the insurer to submit a plan to secure appropriate allocations (§ 81 d section 2 VAG refers to private health insurance operated in the same way as life insurance).
5. As an example, and among others, the following measures can be adopted: Demand of the insurance entity the presentation of restructuring, financing, rehabilitation plans; “blockage of assets”; temporary substitution of administrative bodies of the insurance entity; Administrative sanctions; independently or combined with special control measures, the insurance entity or its administrators can be sanctioned.
6. A failing insurer, of any “class”, would first be monitored, then would be required to cease accepting new business. A portfolio transfer would then be negotiated with official influence, failing which existing cover would lapse without recourse.
7. Depending upon the specifics of the case, moral, publicity, restitution, damages, or “specific performance” may apply as for any consumer contract.

Source: OECD Regulatory Questionnaire on Private Health Insurance.

directive, private health insurers in the EU were subject to two basic models of regulation: contract control or prudential supervision. Contract control includes requirements relating to the types of contracts and premiums that can be offered (Mossialos and McKee, 2002, pp. 149-153). Now, material requirements regarding PHI contracts are prohibited by EU law, with the exception of a few countries where certain types of PHI coverage are exempt from these restrictions or can be justified on the basis of certain EU legal standards. In the case of these latter countries, as detailed further herein, the Directive seeks to provide governments with some flexibility to ensure that PHI products dovetail with, and do not undermine, the structure and financing of national health systems.⁴⁷ As detailed herein, the evolution of PHI-related regulations under the EU directives highlight the benefits and limits of a predominantly prudential regulatory structure for PHI. It also highlights strengths and weaknesses of tying regulatory flexibility to PHI's particular role within countries' public/private financing mix.

As mentioned above, the directive includes some provisions to allow for the specific national contexts and role that PHI plays within the EU system. Particularly relevant to the health care insurance area is the condition that insurance products not “conflict with statutory provisions protecting the *general good* in the member country.”⁴⁸ However, this provision does not give member states complete discretion with respect to the requirements it may impose on health insurers. It requires that such provisions be applied *without discrimination* and that they be *objectively necessary and in proportion to the objective pursued*.

Furthermore, the Directive provides particular flexibility with respect to cover that can be substituted either “wholly or in part” for cover under national social security systems (see note 48). Recital 24 of this directive specifically indicates that measures to protect the general good “may provide for open enrolment, rating on a uniform basis according to the type of policy and lifetime cover... by requiring undertakings offering [voluntary private health insurance] to offer standard policies in line with the cover provided by statutory social security schemes at a premium rate at or below a prescribed maximum and to participate in loss compensation schemes”. Thus, the Directive would appear to highlight the potential permissibility of several of Ireland's provisions relating to its PHI market, notably open enrolment, community rating and the risk-equalisation scheme. In fact, Ireland (duplicate), Germany (substitute) and the Netherlands' (primary) PHI systems – or parts of these systems – have retained several protections as a consequence of the flexibility afforded under these provisions.

However, the interpretation of the meaning of the term “general good”, particularly as applied to proposed requirements not yet scrutinised by the Commission or the Court of Justice of the European Union, remains an area of significant uncertainty, and hence raises challenges for crafting any suggested changes to existing PHI regulatory regimes in member States. Specifically, any changes or additions in contract-related requirements for PHI may raise questions under EU requirements depending on their specific contours and relation to the nation's health system. This may be true even in instances where the permissibility of an existing scheme under EU law is well accepted or understood.⁴⁹

In addition to the above-described questions relating to the permitted scope of the “general good” exception, another area of EU law may affect government action relating to PHI markets. Certain EU rules, notably “state aid” and procurement rules, seek to ensure that governments do not foreclose national markets nor unjustifiably restrict competition.

To this end, they severely constrain both direct state action, and indirect action (through preferential procurement contract awards) (Hatzopoulos, 2002, p. 138). “State aid” rules apply when a public body offers a direct or indirect financial advantage to an undertaking. Certain state action providing advantages towards private health insurers, as well as other types of health insurance funds, may be considered “state aid” – and hence generally prohibited under EU law – if it meets certain legal criteria.⁵⁰ Indeed, questions have arisen concerning the compatibility of certain PHI-related regulation with EU state aid rules.⁵¹

The European Commission recently held that Ireland’s risk-equalisation scheme conformed to state aid rules. The reasoning of this decision sheds some light on the permitted scope of EU government action relating to PHI markets, under EU state aid principles. Importantly, it noted that the Irish risk-equalisation (RE) scheme could be qualified as a state aid in the sense of the EC Treaty [Article 87(1) EC]. Notably, it is a measure initiated by the state, creating a fund to be financed through compulsory contributions, and compensating some schemes for costs that they must bear under normal market conditions. While this might be considered to accord an “advantage” to these schemes,⁵² upon examination of its function and structure, the Commission concluded that the RES does not constitute state aid within the meaning of Article 87(1) of the EC Treaty. The Commission also held that if it were assumed that the compensation provided by the RES constituted state aid, these aid elements could be considered compatible with the common market [pursuant to Article 86(2) of the Treaty]. The Commission found that the RE scheme is a necessary underpinning to the government’s policies towards PHI (open enrolment, community rating and lifetime cover). It assures the appropriate sharing of risk across the market and promotes a level playing field for competing insurers within the particular structure and constraints of the Irish PHI system. It also held that the scheme is designed to effectuate these transfers in a fashion proportional to its goals. It does not require that insurers necessarily be compensated for every imbalance. The RE scheme also includes provisions that seek to maintain an incentive for insurers to cover services in a cost-efficient manner by limiting the extent to which health status can be used as a risk factor and through calculating any transfers using the costs of the insurer making the payment. Hence, in determining whether a government intervention provides an unfair advantage in violation of state aid rules, the Commission takes a multi-pronged and contextual approach. Its considerations include the nature of particular interventions, the impact of the rules within the specific PHI market and regulatory structure, and the extent to which the interventions are narrowly tailored to achieve their purpose (see European Commission, State Aid N. 46/2003).

Overall, EU law sets forth limits and parameters for government regulation in insurance generally, with particular implications for the area of PHI. As currently constructed, most PHI markets in the European Union do not qualify for the exceptions for which more extensive government regulation is permitted. As such, most regulation of the content of PHI contracts and insurer issuance and rating practices are prohibited. These limits place meaningful barriers to policy makers’ ability to consider enhanced roles for PHI, and also restrict their ability to address access and other challenges that may arise in PHI markets. Given the unique challenges that arise in PHI markets, enhanced flexibility to impose targeted substantive standards on PHI carriers could enhance policy makers’ ability to respond to challenges that arise in this area.

Table 3.17. **Division of responsibilities among governmental bodies involved in the regulation of PHI**

	Description of main regulatory bodies of PHI:	Is PHI subject to regulation by those authorities that oversee publicly financed coverage?	Additional quasi-governmental, non-government, voluntary or industry based associations involved in setting standards for the industry:
Australia	Department of Health and Ageing – primary responsibility for PHI. The Private Health Insurance Administration Council (PHIAC) – prudential regulator for health funds. The Private Health Insurance Ombudsman (PHIO) delivers information and offers a dispute resolution service to consumers and medical providers. The Australian Competition and Consumer Commission (ACCC). Australian Securities and Investments Commission (ASIC) is an independent body administering corporate law and Australian Financial markets. The Health Insurance Commission (HIC)(premium rebate).	Yes: the Department of Health and Ageing is responsible for the regulation of PHI and publicly funded coverage and services. The HIC administers Medicare (public) and a range of other health and allied programmes including Pharmaceuticals Benefits Plan and the 30% rebate on PHI.	Government activities: PHI registration requirements, the NHA (National Health Act) also regulates the standard of treatment provided in hospitals publishes a Private Patients' Hospital charter and has introduced best practice guidelines for pre-existing ailment waiting periods. Non-government – Private Health Industry Quality and Safety Committee (PHIQS). Voluntary/Industry Associations: Many private health industry bodies have developed a range of industry "codes of practice" which set voluntary standards for the industry.
Austria	On April 1, 2002 the Austrian Financial Market Authority (FMA) assumed its powers and responsibilities under the Financial Market Supervision Act (FMABG) and supervises Insurance as one of its tasks.	No information provided.	No information provided.
Canada	Federal (Office of the Superintendent of Financial Institutions – OSFI) standards and supervision in the area of prudential standards accepted by all provinces except Quebec; provincial regulators impose consumer protection and marketing standards, as well as others.	No	Canadian Life and Health Insurance Association (CLHIA).
Denmark	Insurance Business Act regulates the supervision of insurance companies.		
Finland	The Insurance Contracts Act is applicable to private health insurance contracts. The providers are regulated by the Insurance Companies Act and Insurance Funds Act.		
France	Insurance undertakings are governed by the Insurance Code (commercial companies). Provident societies are governed by the Social Security code (private non-profit entities). Mutual Insurers are governed by Mutual Insurance Code (non-profit organisations).		
Germany	Insurance contract law : Federal Ministry of Justice Insurance Supervision Law: Federal Ministry of Finance Supervision of private insurers: Federal Financial Supervisory Authority. ¹	No	Association of Private Health Insurers.
Greece	EU Directives.		

Table 3.17. **Division of responsibilities among governmental bodies involved in the regulation of PHI (cont.)**

	Description of main regulatory bodies of PHI:	Is PHI subject to regulation by those authorities that oversee publicly financed coverage?	Additional quasi-governmental, non-government, voluntary or industry based associations involved in setting standards for the industry:
Hungary	Supervisory Authority of Financial Services.		
Ireland	Minister and Department of Health and Children, protection of the “common good” (<i>i.e.</i> community rating, open enrolment and lifetime cover). Department of Enterprise, Trade and Employment, Insurance generally and solvency requirements of health insurers (with the exception of VHI). Health Insurance Authority, Advisory role to Minister for Health and Children and significant functions in relation to risk equalisation arrangements.	Yes: The Minister and Department of Health and Children are responsible for the public health system as well as PHI.	Office of the Insurance Ombudsman, financed by the Insurance industry, adjudicates disputes referred by both parties and decisions are binding on the insurers.
Italy	Insurance Supervisory Authority .		
Japan	Financial Supervisory Authority .		
Mexico	Insurance and Surety National Commission.	Yes: The Ministry of Health.	The Mexican Association of Insurance Companies (AMIS) and Medical Associations set standards through committees and working groups. The government consults these standards although they are not considered official data.
Netherlands	Ministry of Finance, The Insurance Supervisory Board supervises non-life insurance companies. Enforcement of the Competition Act by the Dutch Competition Authority.	Ministry of Health regulates premiums for WTZ policies.	ZN (Association of Dutch health Insurers) set guidelines on Health Insurance Governance for sickness funds. The Insurance Supervisory Board supervises non-life insurance companies.
Poland	No information	No	No
Portugal	No information	No	No
Slovak Republic	No information	No	No
Spain	Insurance entities operating in the private health insurance sector are included in the 30/1995 Act on Private Insurance Regulation and Supervision, however, the Supervisory Authority is the Directorate General of Insurance and Pension Funds (dependant from the Ministry of Economics).	Yes: If the insurer operates in the type of “benefits in Kind” the business plan must include the technical means at the disposal of the company for this coverage. In terms of the adjustment of these technical means with regards to the “in kind” provision offered by the insurer, a report from the Health Ministry is required.	No
Sweden	Financial Supervisory Authority (Finansinspektionen).		
Switzerland	Federal Social Insurance office and Federal Private Insurance Office.		The Scientific board for medical ethics and the Association of Private Health Insurers.
Turkey	General Directorate of Insurance (Under secretariat of Treasury).	No	No

Table 3.17. **Division of responsibilities among governmental bodies involved in the regulation of PHI (cont.)**

	Description of main regulatory bodies of PHI:	Is PHI subject to regulation by those authorities that oversee publicly financed coverage?	Additional quasi-governmental, non-government, voluntary or industry based associations involved in setting standards for the industry:
United Kingdom	Financial Supervisory Authority.		The Association of British Insurers (ABI) produces various Codes of Practice which are binding on its member companies. Around 95% of insurance business in the UK is written by ABI members. In addition, the General Insurance Standards Council (GISC) is a voluntary regulatory body originally set up by the insurance industry in 2000, but run independent of the industry. It also operates codes of practice, binding on GISC member companies that affect virtually all UK private medical insurers. Membership in the GISC is set to change from being voluntary to being compulsory.
United States	Most private health insurance is regulated almost entirely by State regulators. However, self-funded employer insurance plans come under the jurisdiction of the Dept. of Labour, and in many states, agencies other than insurance depts. (usually Health Departments) have some or all responsibility for HMOs. The federal Centres for Medicaid and Medicare Services (CMS), as well as the Treasury Dept., and DOL also have some authority with respect to portability standards and, in the case of the Treasury Dept., related tax and employer plan standards.	Yes, in some cases a state health dept. may regulate HMOs and also regulate the Medicaid program. State HMO regulation generally applies to HMOs offering coverage through the Medicare Plus Choice program. Centres for Medicare and Medicaid Services oversee Medicaid (jointly with states) and Medicare programmes but also have responsibility <i>vis-à-vis</i> Medicare supplement and portability standards if states do not regulate private health insurers according to federal standards.	Some private organisations set voluntary standards for quality of health plans and certify plans according to these standards. Some states then classify those certified health plans as having met state standards. The federal Medicare programme recognises some of these private organisation's standards, if met, as credit towards Medicare certification.

1. However, a very small number of private insurers are supervised by Länder authorities (local authorities).

Source: OECD Regulatory Questionnaire on Private Health Insurance and OECD (2000) for Austria, Denmark, Finland, France, Greece and Hungary.

9.3. Government agencies or levels of government with PHI regulatory authority

In most OECD countries, the regulation of PHI markets is performed by one or more national or federal level regulators, with EU level standards and oversight added in the case of EU member countries (Table 3.17). However, notable exceptions to this trend are the United States, where insurance regulation remains a state (non-federal) government function, and Canada, where regulation is shared by the federal government (prudential standards) and provincial governments (consumer protection and other standards). In the United States, the federal government can and has intervened in insurance markets, but in the absence of specific intervention, the authority remains with the states. Examples of minimum US federal standards in the area of PHI include health insurance portability and Medicare supplement. Self-funded employer health plans are also exempt from US state-level health insurance regulation. Additionally, Canadian provinces can impose different requirements in the area of PHI, and indeed there is provincial variation in the extent to which PHI insurers are permitted to cover outpatient and hospital services also covered publicly.

However, even when federal governments have exclusive authority to regulate PHI, multiple government agencies often share authority in this area. Interestingly, when PHI plays a more instrumental role in countries' health systems, the insurance supervisory authority (often the Ministry of Finance) often shares power with the health agency. In these cases, prudential supervision is often performed by the insurance authority, while the health ministry is often delegated oversight over certain specified health policy-related standards. Examples of such shared authority include Australia, Ireland, Spain, the Netherlands and the United States.⁵³ In all of these cases PHI has a prominent role. In some cases, however, the general insurance supervisory authority has sole regulatory authority over this market, as in the United Kingdom, Germany and several other countries.

The involvement of multiple agencies has the advantage of drawing from the varied expertise of different parts of the government. However, overlapping jurisdiction also demands enhanced coordination.

Notes

1. Judgment of the European Court of Justice, 16 December, 1999, Commission of the European Communities vs. French Republic. Failure to fulfil obligations-Non transposition of Directives 92/49/EEC and 92/96/EEC-Direct insurance other than life assurance and direct life assurance, Case C-239/98 (European Court reports 1999, Page I-08935).
2. See e.g., Ohio's Managed Care Uniform Licensure Act, which licenses "health insurance corporations" by function. *Assuring Financial Solvency: From Risk-Based Capital Standards to Oversight of Down-Stream Risk*, Presentation by Stephanie Lewis, Institute for Health Policy Solutions, and Kip May, Deputy Director, Ohio Dept. of Insurance, 1998 Workshop, "Structuring Health Insurance Markets: Protecting Consumers and Promoting Competition", Agency for Health Care Policy and Research, Rockville, MD (www.ahrq.gov/news/ulp/ulpmarkt.htm).
3. Health insurance risk pools refer to the group of individuals across which health insurance costs are pooled. When these become more numerous (i.e. if the broader risk pool "fragments", and especially if these pools become small, such as when costs are only spread among the members of one of many insurance products, the risk for market and price instability augments.
4. See also NAIC Stop Loss Insurance Model Act, which sets forth standards to try to restrict such activities by limiting the extent to which health insurers can pass risk along to stop loss carriers. States enacting this or similar laws have faced legal challenges in some cases, however, and the law is not settled in this area.

5. Health Insurance (Amendment) Bill (2001), Ireland, Section 4, "Any arrangement entered into by an employer whereby he or she agrees to reimburse or discharge the whole or a part of fees or charges which have been or may be incurred by an employer in respect of the provision to the employee or such a dependent of hospital in-patient services shall be deemed to be a health insurance contract for the purposes of this Act..."
6. See 11 NYCRR 52, 22nd amendment to Regulation 62.
7. Information provided is drawn from 18 country responses to the OECD Regulatory Questionnaire on Private Health Insurance and Colombo (2001). The concept of "community rating" in Australia incorporates guaranteed access to services provided by health funds.
8. For example, during the 1980's, access to high-risk individuals was problematic in advance of the creation of the WTZ programme for such persons in the Netherlands. See Okma (1997, pp. 105-106).
9. For example, in Massachusetts, insurers must offer standardised plans to all applicants; in Ohio, two plans must be offered during open enrolment period; in Iowa, a standard package must be offered to applicants with 12 months of prior coverage.
10. This "open enrolment period" begins at the beginning of the first month that persons are both age 65 and enrolled in Medicare Part B. Centers for Medicare and Medicaid Services and the National Association of Insurance Commissioners (2003).
11. Hing and Jensen (1999) founds coverage improvements. This contrasts with other studies that found no coverage effect of these reforms.
12. For example, the US state of Ohio allows indemnity insurers to charge 250% more for open-enrolment plans. See Hall (1998b).
13. Around 7.5 million people are covered by substitute PHI in Germany.
14. Academy for Health Services Research and Health Policy (2001) sets forth some of the issues relating to measuring "crowding out" of public programme coverage, as well as the policy implications for coverage expansions.
15. In the case of the Netherlands, policies generally include an automatic one-year extension and cannot be terminated but for non-payment.
16. In Germany, the specific length of time policies must be held before renewal is required depends upon policy type.
17. OECD Regulatory Questionnaire on Private Health Insurance, UK response.
18. This tally includes those countries that provided responses to the OECD regulatory questionnaire.
19. A pre-existing condition is defined under Australian law as a "condition, the signs or symptoms of which, in the opinion of a medical practitioner appointed by the health fund, existed at any time during the six months prior to the member joining the fund.
20. US Federal Law defines such conditions as "a condition for which *medical advice, diagnosis, care, or treatment* was recommended or received within the 6-month period (shorter time period in some states) ending on an individual's enrolment date in the plan".
21. It has been reported that about 20% of persons who had reported being "locked" in jobs due to health care cite pre-existing conditions as the reason for not changing jobs (US General Accounting Office, 1995, pp. 8-9).
22. The standards in the United States vary by state and this is not true in all states; particular variation occurs in the individual market.
23. In Germany, there is provision for a risk-equalisation scheme among substitute insurers to help cover the costs for assuring the premium cap under the standard tariff if the current surcharge imposed for this purpose is not sufficient. This has, however, not been necessary to date (OECD Regulatory Questionnaire, German response).
24. OECD Regulatory Questionnaire, German response.
25. See e.g., Beauregard (1991) cited in US General Accounting Office (GAO/HEHS-95-257) which found that, in 1987, 1.6 million people under age 65 had been denied private health insurance due to poor health; Pollitz et al. (2001) highlights challenges in obtaining coverage faced by persons with certain health conditions.
26. The percentage of the Australian population covered by PHI rose from 30% in 1999 to 45% in 2001 (Colombo and Tapay, 2003).

27. This fact, taken together with the average low-level of out-of-pocket liability within PHI products, and a generally high rate of purchase of other types of insurance, may also highlight a general cultural tendency to insure in health care and other areas as well.
28. Hall and Lawlor (2001, pp. 638-655) note that smaller insurers could be more likely to remain in a state with adjusted community rating and guaranteed issue, if there is a reinsurance pool.
29. The importance of combining these mechanisms has been recognised by experts. For example, Dutch experts have indicated that "[I]n order to eliminate the adverse effects of the selection induced by the rate restrictions, these restrictions have to be supplemented with an adequate risk-adjustment mechanism" (Van de Ven et al., 2000, p. 337).
30. In April 2003, the Australian government announced that it would update the current reinsurance arrangements with a "risk-based capitation" system of reinsurance. This system is intended to support community rating while providing greater incentives for improved health fund efficiency; reinsurance support under this model is based upon average costs of hospitalisation rather than actual costs. Under this scheme, funds which reduce the costs of a particular age or sex cohort to a below-average level will profit from the difference between their actual costs and average costs.
31. In the latter case, unlike the case when differentials are between 2 and 10%, the Health Insurance Authority is not required to develop and make a recommendation to the Minister. However, the Minister still must consult with the Authority and consider insurer representations (Ireland's Health Insurance Authority, 2003, p. 10).
32. In Australia, products are self-contained within the particular states or territories in which they are issued. Thus, an insurer offering the same product in different states will have several products from a regulatory perspective, even though they are in fact the same offering. This characteristic of the Australian market means that an insurers' total number of products, on a national basis, may exceed the actual number of benefit packages it offers. That being said, many parts of the Australian PHI market are indeed characterised by significant plan choice.
33. Australian government initiatives include: 1) publication of information on contributors' responsibilities and what they can reasonably expect from health insurers and providers (a "Private Patients' Hospital Charter"); 2) development, together with industry, of an informational guide to accompany PHI products to help consumers with their health plan selection ("Key Features Guide"); and 3) a proposal that would require the PHI Ombudsman to publish an annual report on fund performance on a range of indicators ("State of the Health Funds Report").
34. A recent survey indicated that most Irish PHI consumers report being either very satisfied, or satisfied, with the range of products and services offered by their PHI insurer. Amarach Consulting (2003, p. 32).
35. Hall et al. (1999). These standards are now less meaningful given the federal requirement that all small group policies be issued to all applicants.
36. Policies sold through employers are not subject to these requirements, nor is coverage offered through managed care "Medicare + Choice" plans, which includes Medicare covered services, together with supplemental coverage designed at the plans' discretion. This summary does not include any upcoming changes to the standardisation requirements that may or may not be mandated or brought about by the newly enacted US federal Medicare legislation.
37. Australia noted that it had received consumer complaints indicating difficulty comparing fund products (Australia response to OECD Regulatory Questionnaire). The UK Office of Fair Trading has issued two reports (1996, 1998) examining consumer understanding of their PHI products. Both reports found it important to improve disclosure. They recommended a clear summary of policy terms in standard format. They also suggest a clear warning about the likely increase in PHI premiums (Office of Fair Trading, 1998). One expert on the US market noted that lack of awareness about coverage costs – where to get it, what policies are appropriate – is a fundamental barrier to the growth of the individual health insurance market. Government assistance, easier enrolment processes and services to aid purchasers would enhance growth of this market (Patel, 2002, pp. 367-371).
38. Under such policies, funds cover the "medical gap", the difference between the fee charged by doctors for private health services and the combined health insurance and Medicare benefits for those services (Colombo and Tapay, 2003).
39. In Belgium, the deduction is limited to the self-employed.
40. Henry J. Kaiser Family Foundation (2002), Chartbook, Exhibit 2.1, citing Kaiser Commission on Medicaid and the Uninsured and the Urban Institute, 2001, based on verified data from March

Current Population Surveys, 2000 and 2001 (United States). 90% figure derived from percentage total of non-elderly with employer or “other” non-Medicaid coverage, divided by percentage total of non-elderly with employer coverage.

41. The standard tax rate recently was reduced from 27% to 20%.
42. Several analysts have emphasised the relatively smaller impact of the rebate, as opposed to that of lifetime cover. For example, Butler estimates that the 1997 Private Health Insurance Incentive Schemes (PHIS) had very little or no impact, and that the premium rebate increased membership from 30% to 32.2%. See also: Hall *et al.* (1999), Hopkins and Frech (2001), Willcox (2001) and Deeble (2003). However, others have argued that the rebate is a meaningful and important part of government policy to support the purchase of PHI. See *e.g.* Harper (2003) and Access Economics (2002).
43. Subsidising PHI may be desirable if it finances efficient hospital provision. Researchers have debated whether public hospitals are more or less efficient than private hospitals. Duckett and Jackson (2000) find that, for a similar case-mix, public hospitals are 10% less costly than private hospitals. Others have argued that a more efficient way of sustaining private care would be by subsidising private hospitals rather than private cover (Deeble, 2003; Vaithianathan, 2002).
44. External review programmes in place in 32 US states focus particularly upon complaints relating to managed care plans.
45. In an effort to promote PHI product innovation and industry efficiency, Australia has introduced legislation to replace several aspects of the current system of regulation with a system of monitoring health fund performance, through the identification and use of several key indicators.
46. Medical malpractice insurance raises separate regulatory and policy challenges and has been the subject of policy interventions in some OECD countries.
47. Health coverage forming part of social security systems is explicitly excluded from the EU insurance directives. Mossialos and McKee (2002, p. 151), citing Article 2(1) (d) Directive 73/239/EEC (Council of the European Communities, 1973).
48. European Commission Interpretive Communication (2000/C 43/03).
49. For example, Netherlands current WTZ scheme is generally accepted to be permitted under EU law, but the legality of changes in the regulation of its PHI market may not be as clear.
50. The determination of whether a health insurance fund is an “undertaking” within the meaning of EU law is a complicated question that weighs several factors, including the organisation’s objective, whether it is compulsory, the extent to which benefits are delivered on a needs basis vs. according to contribution, its freedom to set contribution amounts and the degree of state control over the entity’s decision making, degree of active management of funds, and whether it is in competition with private insurance companies (Hatzopoulos, 2002).
51. See *e.g.*, letter of 9 October, 2002 to Mr. David Deacon of Internal Market DG, EC, from the Irish Authorities, detailing Irish Government’s view relating to the legality of the risk-equalisation scheme under several areas of EU law.
52. European Commission, State Aid N. 46/2003, “risk-equalisation scheme in the Irish health insurance market”, Letter from the European Commission to Ireland’s Minister for Foreign Affairs, Brian Cowen, TD, p. 9.
53. In the United States, this shared authority takes place at the state level, especially for managed care plans; many state health departments share health plan oversight with Insurance Departments. It also takes place at the federal level, with some health plan-related authority shared between the Centres for Medicare and Medicaid Services, the Treasury Department and the Department of Labour.

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Chapter 4

The Impact of Private Health Insurance on Health System Performance

This chapter aims to: 1) assess the impact of PHI on health systems and their performance; 2) identify the factors explaining the variation in performance across different systems of financing health care and across PHI markets. It does this by seeking answers to the following questions:

- *How does PHI affect access to health services and timely care across people with different levels and types of health insurance coverage? What is PHI's influence on the equity of health financing?*
- *What is PHI's role in health system choice of provider and benefits? Do private insurers have a role in promoting innovation in health care and, if so, how?*
- *Have insurers implemented activities to improve health care quality?*
- *How does PHI affect health system expenditure?*
- *What implications does PHI have for health system cost-efficiency?*

1. Introduction

The impact of private health insurance on health systems has long sparked interest and controversy among policy makers and experts alike. The private sector may have the ability to find more responsive and efficient answers to policy challenges facing health systems, and might enable governments to cut public health sector costs. However, these possible benefits depend on the capacity of PHI to deliver equitable outcomes and efficiently manage health care costs. This capacity is not clear, as multiple competing insurers can be administratively costly. Also, in some cases competition may develop around undesirable activities – such as risk selection – rather than focussing on service, quality and efficiency. Building upon the descriptions and analysis of PHI markets and their regulation presented in Chapters 2 and 3,¹ this chapter seeks to shed light on these issues.

The chapter is structured in five main sections. It begins by identifying opportunities and risks related to the financial protection and coverage afforded by PHI, including PHI's influence on financing equity. It also discusses its contributions to enhanced access to health care services and timely care. The second section highlights the ways and circumstances in which PHI heightens consumer responsiveness – such as through increased choice – and the links between PHI and innovation in health care provision, technology, and benefit offerings. Third, the chapter investigates the extent to which private insurers contribute to efforts to improve the quality of health care. The final two sections analyse the impact of PHI markets on health care costs – public, private, and within the health system overall – as well as their impact on health system cost-efficiency. Trade-offs confronting policy makers are also identified.

2. Impact of private health insurance on access to health coverage and care

In many countries, consumers and policy makers look to PHI as a means of improving available access to health coverage and care services – and in some cases – to enhance access to particular services. This section highlights some of the accomplishments of PHI markets in access to coverage and care, while highlighting ongoing or remaining challenges, such as equity in financing.

2.1. PHI affords financial protection but challenges remain

PHI has served as a source of health insurance coverage

In most OECD countries, PHI markets offer coverage alongside comprehensive public coverage, and in some systems they play a prominent role. The scope of public coverage influences PHI roles in the system, which range from providing benefits that are not covered publicly, to furnishing enhanced choice or responsiveness relating to benefits that are also publicly covered.² Governmental policies encouraging or requiring PHI coverage, a strong cultural predisposition to insure, linkages between PHI and public programme comprehensiveness, and/or a high degree of employer-sponsored group coverage explain higher participation levels in PHI markets in these countries.

PHI provides a primary source of insurance in systems with targeted, non-universal access to publicly financed health care coverage, as in the Netherlands, the United States, and, to a lesser extent, Germany and Spain (see Chapter 2). Yet the presence of a significant PHI market, with comprehensive benefit offerings, does not alone assure broad access to private primary insurance. For example, while a portion of the populations of both the Netherlands and the United States rely on voluntary PHI markets for payment of health care expenses, there are only few uninsured individuals in the Netherlands, while in the United States 14% of the population is not covered by health insurance.³ Variation in the take up of primary PHI across the two countries can be explained by differences in premium affordability (constituting a large share of disposable income for many low-income uninsured in the United States), cultural preferences, and the success of standard policies for high-risk individuals in the Netherlands.

However, in some other OECD countries without universal public coverage – or where there are significant out-of-pocket payments – PHI still plays a relatively small role or has failed to develop. For example, while the Korean National Health Insurance system pays for 44% of total health cost, a significant degree of out-of-pocket expenditure remains (41% of total health expenditure in 2000; see *OECD Health Data 2003*, 2nd edition). Limited development of a private health insurance market could be explained by the lack of a history of private and voluntary coverage in Korea, where individuals have historically financed health expenditures out of their pocket, dating back to the time prior to the establishment of public health cover (OECD, 2003a). Similarly, in Mexico, about half of the population does not have public health coverage, yet a meaningful PHI market has not developed in this country, in part because premiums are unaffordable for the majority of the uninsured population. Nor has a large PHI market developed in other countries, where public coverage is not comprehensive in scope or eligibility, such as Turkey. In such countries, the cost of PHI premiums, as well as a lack of a history and familiarity with private health insurance partly explain the absence of a PHI market.

Levels of PHI coverage are a policy issue in some countries more than others

The implications of low levels of PHI coverage depend in part upon its role within the health system. In primary markets and where cost sharing in public systems is large, lack of insurance protection generally implies lack of any type of health coverage. In supplementary markets, conversely, if PHI largely covers luxury and amenity health services, low levels of PHI coverage raise less concern. Differential access to complementary and duplicate PHI can be problematic, as was the case in France prior to the introduction of the CMU (Box 4.1). As this example shows, where uninsurance is considered problematic, policy makers have taken steps to improve access to coverage.

Supplementary PHI markets have generally raised fewer policy concerns or stimulated less policy interventions. There can nonetheless be challenges arising from those markets as well. For example, in the Netherlands social and supplementary coverage are often offered together in one package to consumers, with a single bill. Yet sickness funds offering supplementary PHI can refuse to accept applicants or charge higher rates based upon their health status. These factors have contributed to limited consumer mobility within both social health insurance and the supplementary PHI market (Tapay and Colombo, 2004).⁴

All Canadian provinces have effectively limited the role of PHI to a supplementary one, but otherwise subject the PHI market to few governmental requirements.⁵ Nonetheless, the PHI market plays a significant role, insuring outpatient drugs for which there is only

Box 4.1. Improving access to PHI where public coverage gaps exist

In the case of primary PHI markets, policy makers have generally taken steps to improve access to PHI – often through access standards or “safety net” programmes as described in more detail in Chapter 3. In the United States, while there is a high degree of primary PHI purchase, there is a significant uninsured population. There is a large debate about approaches to improve access to needed coverage for this large population segment, spanning from the expansion of public programmes to tax advantages towards PHI purchase, particularly by individuals (Docteur *et al.*, 2003). PHI access requirements, high-risk pools and tax incentives have ameliorated some problems, but considerable challenges remain. In the Netherlands, a combination of a cultural preference to insure and government interventions seeking to minimise wide variation and escalation of PHI premiums, assured PHI access for those of high risk. These factors, as well as the availability of supplementary policies from social insurers’ affiliates, appear to explain the extensive level of PHI purchase (Tapay and Colombo, 2004).

French and US policy makers have taken steps to improve access to private complementary insurance. In each case, these initiatives were later combined with expansions of public coverage or subsidies in order to assure access to benefits that were previously exclusively covered by PHI or paid for on an out-of-pocket basis. In response to concerns about disparities in access to complementary coverage for lower-income populations, and their implications for access to health care services, the French government instituted a programme, *Couverture Maladie Universelle* (CMU), which offers highly subsidised complementary coverage to those who meet certain income requirements (Buchmueller and Couffinhal, 2004). Through a combination of significant employer sponsorship (about ½ of PHI policies), individual purchase and the CMU, France has attained 92% complementary coverage.

In the United States, the individual “Medigap” market has historically not provided significant prescription drug coverage, despite coverage gaps in the publicly financed Medicare programme. This contrasts with the Medicare supplemental insurance furnished in the employer-sponsored market, which often provides such coverage. The growing cost and need for prescription drugs has led to challenges for insurers and self-funded employers offering such coverage, as well as those purchasing it. Those insurers offering a permitted, but limited, prescription drug benefit in the individual market have often suffered from adverse selection and consequent premium spirals have sometimes occurred (Tapay and Smolka, 1999). State and federal governments, recognising the importance of complementary coverage to help cover cost sharing under the public Medicare programme, took steps in the 1980s and 1990s to promote access to such coverage for beneficiaries.¹ Other more recent federal regulatory changes provided enhanced flexibility to insurers wishing to offer different “Medigap” benefit packages. Growing out-of-pocket prescription drug expenditures by the elderly, particularly among those lacking supplemental insurance coverage, led the US federal government to enact legislation² adding a prescription drug benefit to Medicare, and implementation of this benefit is under way.

1. For example, the US Omnibus Reconciliation Act of 1990 included guaranteed insurance and benefit package requirements, and loss ratio standards for “Medigap” complementary private health insurance.

2. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

some public coverage for certain low-income populations. Despite PHI’s constrained role, the Canadian government has chosen to promote its sale through tax incentives.

Finally, although duplicate PHI covers services also available under public insurance, some countries have placed priority on shaping and promoting this type of PHI market.

Australia and Ireland promote equitable access to this coverage market through a range of insurance, premium-related and fiscal initiatives (Colombo and Tapay, 2003 and 2004a). The high level (nearly 50%) of population coverage contributes to the policy attention it receives. Conversely, in the United Kingdom and other duplicate markets, PHI is only lightly regulated and is purchased by a much smaller proportion of their population.

Despite government and employer interventions, barriers to access to PHI remain

In many OECD countries, employers play a significant role in enhancing levels of PHI coverage by subsidising or fully paying PHI premiums. Employers are often able to negotiate better coverage packages, also PHI is usually considered a tax-deductible business expense for employers and a tax-free benefit for employees.^{6, 7} While employer-provided PHI may raise labour costs, it certainly plays an important “social role” by facilitating access to PHI in several OECD countries and also promoting risk pooling within and across employers. In the United States, 63% of the US non-elderly population receive their coverage through employer plans (Kaiser Family Foundation, 2003) and an additional group of retirees have employer-sponsored coverage (whether primary or supplementary). In France, complementary PHI provides a significant group market (Buchmueller and Couffinhal, 2004).

Several barriers to access to PHI persist, despite government and private sector initiatives to improve access to private insurance. Ongoing premium increases present a key challenge. In the United States, premiums for employer-sponsored PHI increased by 11% in 2001, much above inflation, a sharp reversal from the low rates of growth that had occurred from 1994 to 1998 (Trude et al., 2002). In Ireland, the average PHI premium growth rate has been more than twice the increase in inflation, and above the average growth in nominal per capita income in the period 1981-2003 (Colombo and Tapay, 2004a). Such sharp rise in relative PHI premia may lead to less stable PHI enrolment patterns.

PHI premium volatility has compounded the challenge of ongoing premium increases, making costs less predictable for employers and individuals, as in Australia and the United States.⁸ On the other hand, the rate of PHI premium increases in Ireland has been more stable over the past decade, with premium increases for the largest insurer ranging from 6% to 9.4% between 1993 and 2003.⁹ Irish PHI coverage levels have been steadily increasing from 1980, mainly spurred by economic growth and the role of employers in sponsoring PHI (Colombo and Tapay, 2004a). Governments in some OECD countries have intervened to promote affordable PHI premiums, or to moderate variation in premiums across PHI markets. However, many approaches raise tradeoffs between promoting affordability and preserving broad access, and encouraging a competitive insurance market.

Low-income groups are more exposed to affordability challenges. For example, in Ireland, cost is the main reason the uninsured, mainly concentrated among the less affluent societal groups, do not buy PHI (Colombo and Tapay, 2004a). In France, where there is a significant government subsidy to assist lower-income populations in purchasing private complementary insurance, about 8% of the population remains without complementary coverage, as many have income exceeding eligibility for the subsidy, but still cannot afford to purchase PHI (Buchmueller and Couffinhal, 2004). In the United States, two-thirds of the uninsured population have incomes below 200% of the federal poverty level, while only a small fraction of those with incomes above 300% of this threshold are uninsured (Kaiser Commission on Medicaid and the Uninsured, 2003a and 2003b).¹⁰

PHI can be difficult to access in markets where insurers are able to reject applicants with greater anticipated health needs. The Netherlands faced such access concerns in their primary market before the government implemented a safety-net programme for higher-risk persons ineligible for social health insurance. Less healthy persons seeking individual insurance in the United States are ensured access to coverage in many states, through mechanisms such as guaranteed issue requirements, voluntary offering of so-called “open enrollment” policies by Blue Cross and Blue Shield Plans in a number of states, and the availability of high-risk pools in 31 states. However, protections for high-risk persons vary across states and affordability may remain a barrier to coverage for many. EU law does not permit governments to regulate private insurance contracts and impose access-related standards, except in cases where PHI plays a primary or alternative role to a compulsory social cover scheme. Yet the absence of explicit access standards guaranteeing access to PHI in many EU countries has resulted in access barriers in non-primary PHI markets.¹¹

Adverse selection by applicants is an inherent risk in voluntary PHI markets, and some PHI markets suffer from its effects more than others. As a result, certain PHI products, insurers or the PHI market overall may have a risk pool that is less healthy than the population. This challenge can combine with premium increases to create so-called “premium death spirals”: these occur when premium increases lead healthier persons to lapse insurance, and less healthy people remain in an increasingly costly risk pool, creating affordability challenges (Box 4.2).

Box 4.2. Experiences with adverse selection in selected PHI markets

The Empire Blue Cross/Blue Shield non-profit insurer experienced a premium death spiral in individual market in the US State of New York, resulting in severe financial difficulties for the company. This “Blues” plan was required to cover all applicants, but other commercial health insurers were not subject to this same requirement, thereby exacerbating the adverse selection into this plan (Buchmueller and DiNardo, 1999). These factors led to an overhaul of the health insurance regulatory framework in that state. Insurance and premium-related requirements, among others, are now imposed evenly across all types of insurance.

French mutual insurers offering complementary coverage in the individual market also suffered from adverse selection when commercial insurers entered the market in the 1980s, although this posed fewer problems than the competition between Blues’ plans in the United States and commercial carriers in New York and other US states. Historically, *mutuelles* (not-for-profit mutual insurers) had dominated the market and had operated in a manner that strongly emphasised the principle of solidarity, traditionally charging a single rate and level of benefit coverage to all subscribers, and using non-price strategies (such as denial) for limiting their exposure to high-risk consumers. In contrast, the private insurance companies that entered the market practiced risk-based pricing, varying premiums with age and according to the results of medical questionnaires. They also offered a wide range of benefit packages with the goal of inducing consumers to self-select on the basis of risk and used other risk-selection strategies, such as excluding certain consumers from certain plans. Today, both *mutuelles* and commercial insurers vary non-group prices according to subscriber age, yet *mutuelles* still tend to make use of fewer age categories than do commercial carriers. They are also prohibited by the *Code de la Mutualité* from using sex or health status variables in calculating premiums, although tax incentives now encourage other insurers to do the same. Also, most *mutuelles* now offer a range of contracts, varying in generosity, though fewer different options exist than with private insurers.

PHI offers a potential source of coverage for long-term care costs but market development is slow

PHI has the potential to cover part of individuals' long-term care (LTC) costs, which can contribute both to chronic medical care costs and high-dependency accommodation. Consumer demand to date has nonetheless been limited in most OECD countries.¹² Demographic and labour market changes, such as an ageing population and the increasing participation of women in the workforce, are likely to increase the need for formal coverage of LTC cost in the future. In some countries, policy makers have made a choice to finance such cost collectively. In others that do not have public LTC coverage, out-of-pocket payments and informal caring continue to be the dominant forms of financing long-term care cost.

Despite a growing role in a limited number of countries, private long-term care insurance is currently not a major source of financing long-term care in any OECD member country (OECD, 2004). This can partly be attributed to the complexity of the product. Insurers have to make sensitive actuarial calculations of premiums and related long-term expenditure projections. There are also challenges in maintaining premium stability. Maintaining a diverse insured population over time may be problematic. Consumers' understanding of this market is limited: they must make complex calculations about the pros and cons of purchasing such insurance, or relying on self-funding, depending upon their different income levels. Regulators are confronted with new or changing markets and products. Its development is also hampered by the high cost of policies (especially relative to younger groups' perceptions of their level of risk and elderly populations' often fixed incomes).

A few countries have had some experience with private long-term care insurance. Yet, even in these countries, people continue to rely predominantly upon the public sector and out-of-pocket payments for the financing of long-term care services (Box 4.3).

Determinations relating to whether to finance long-term care expenditure through public or private sources of funding remain country-specific decisions, based on policy objectives, policy and cultural priorities, population groups or services targeted for public funding, and available resources. Nonetheless, in the absence of public coverage of LTC cost, and if private LTC markets develop in their countries, policy makers may wish to consider intervening to regulate access and benefits, and establish consumer protection mechanisms for these policies and their method of sale. This may increase consumer confidence in buying private LTC insurance. Given the links with policy in the areas of private pension and disability coverage, coordinating policy efforts in these areas within countries, and learning from other nations' experiences, would be important.

2.2. PHI has enhanced access to health services but posed challenges to equity of access

PHI enhances access to needed care for those with no or incomplete coverage

Primary PHI promotes access to needed care and financial protection for certain population groups in those countries where there is no universal, publicly financed coverage.¹³

PHI also enhances access to care when existing public coverage leaves significant gaps in clinically needed goods or services. For example, in Canada claims for prescription drugs and dental services, which are not covered by the public system, accounted for 82% of total PHI claims in 2000.¹⁴ Those with PHI also gain better access

Box 4.3. Private long-term care in selected OECD countries

Germany, France and the United States have had some experience with private long-term care insurance markets. Germany provides an interesting example of a mix of public and private insurance for long-term care. German law requires that the portion of their population not covered by the social insurance programme who purchase private health insurance also buy private long-term care insurance and caps the level of premiums that can be charged, after an introductory insurance period in some cases, with variation according to age of purchase.¹ A private market has also developed to complement the social long-term care insurance system. In France, there have been a large number of policies sold (about a million), a large percent of which are purchased through group contracts. While employer health plan sponsorship may promote coverage, it also raises issues of portability and continued access when employment or premiums change. In addition, benefit levels are currently fairly low and generally do not cover the costs of a loss of autonomy, or cover close to the cost of institutional long-term care. Individual contracts are, however, on average more generous in their benefits (Assous and Mahieu, 2001). In the United States, increasing numbers of persons are purchasing long-term care insurance. According to the Health Insurance Association of America, there was an 18% average increase in market size each year between 1987 and 2001. Federal and state governments promote its purchase with tax incentives. However, these policies are often expensive and, when purchased individually, carry high administrative costs. Recent research indicates that only about 6 to 7% of the elderly in the United States have private long-term care insurance policies (American Academy of Actuaries, 1999), and that about 5% of long-term expenditures are financed by private insurance.² Studies also highlight the relatively small proportion of the US population likely to be able to afford such private coverage.³

1. The law on long-term care insurance became effective on January 1st, 1995. Premiums for persons who were obliged to take out long-term care insurance on January 1st, 1995 are limited to the maximum premium for social long-term care insurance. Premiums for persons who were obliged to take out private LTC insurance after this are capped after five years.
2. Braden et al. (1998) cite PHI coverage of nursing home expenditures as 4.9% of total expenditures in this area.
3. According to Joshua Wiener, "private long-term care insurance will grow, but will remain a niche product. Most studies find that only 10% to 20% of older people can afford private long-term care insurance and that is unlikely to change much over the next decade" (*Caring Magazine*, June 2000, also available on the National Association of Home Care and Hospice website, www.nahc.org).

to needed care where cost sharing on public systems is large. In France, by reducing (and in some cases eliminating) out-of-pocket costs, PHI significantly increases medical care utilisation for physician services and prescription drugs (Buchmueller and Couffinhal, 2004). More comprehensive contracts also significantly reduce the cost of goods such as eyeglasses, contact lenses and dental work. The *Couverture Maladie Universelle* (CMU) has reduced a former pro-rich bias in the distribution of access to health care (van Doorslaer et al., 2004). Similarly, evidence from the United States shows that PHI coverage of Medicare's gaps, such as prescription drugs and cost sharing, increases health service utilisation and beneficiaries' timely access to medically needed care (Neuman and Rice, 2003; Medicare Payment Advisory Commission, 2002).

Clearly, the question of the right balance between improving access and controlling moral-hazard from over-utilisation of services becomes prominent in the case of complementary PHI coverage, raising trade-offs. For example, by expanding complementary coverage via the CMU, the French government chose to enhance equity of access to care (Buchmueller and Couffinhal, 2004).

PHI has increased service capacity

Private health insurance has injected financial resources, which has contributed to the financing of additional capacity and services in some health systems.

Duplicate PHI has provided financing for capacity development in the private hospital sector in some countries. The extent to which PHI finances private-sector capacity is likely to be one factor explaining cross-country variations in levels of waiting.¹⁵ For example, Ireland has longer waiting times for elective surgery than Australia, despite similar levels of private coverage (Hurst and Siciliani, 2003). This can be partly explained by the larger role played by PHI in financing treatments delivered in private hospitals in Australia, especially for elective surgery (Box 4.4). In countries where duplicate PHI covers a less significant portion of the population, but where some private insurers have purchased hospital facilities, such as in the United Kingdom and Spain, PHI has boosted capacity somewhat.¹⁶

Box 4.4. Does private health insurance reduce waiting times?

Patients in several OECD countries can experience long waiting for publicly financed elective surgery (Hurst and Siciliani, 2003). The most notable examples of large PHI markets allowing patients to bypass waiting by accessing different providers are duplicate PHI in Ireland and Australia (Colombo and Tapay, 2003 and 2004a) and the United Kingdom. Australia especially views private cover as the main mechanism for shifting demand across the public and private hospitals sectors. Ireland has instead placed emphasis on the role of the public system in addressing waiting concerns, and has promoted some, albeit limited, public purchasing of capacity from private hospitals (under the National Treatment Purchase Fund).

Given the similar role and level of PHI cover, a plausible explanation for longer waits in Ireland than in Australia is the different way PHI contributes to the financing of care in the two countries. In Australia, PHI spurred the development of a large private hospital sector and helped fill its capacity. An increasing proportion of overall elective surgery is being carried out by private hospitals. In Ireland, conversely, most private treatments are still delivered in public hospitals. The private hospital sector is less developed than in Australia, in part because doctors themselves favour the public system and in part because private insurers have not supported capacity increases in private hospitals in Ireland. The overall availability of hospital beds and specialist doctors is higher in Australia than in Ireland. This suggests that capacity may be a more critical factor explaining differences in waiting than the financing mix.

Despite such cross-country differences, it is not clear to what extent PHI has reduced waiting times in the two countries over time. In individual circumstances, PHI creates quicker access to care, and it can help reduce waiting in the public system by encouraging the development of private sector capacity. However, the impact of PHI on waiting times at the aggregate level depends on several factors, among which: the evolution of demand and need; changes in the overall supply of care; the way people are added to/removed from the waiting list; whether those receiving privately financed care were included in the public waiting list. The ability of PHI to reduce capacity pressures in the public system may also be constrained because larger PHI membership lifts overall utilisation rather than just shifting demand from the public to the private hospital system. PHI has steadily grown in Ireland since 1957, reaching 48% of the population in 2002. Waiting times have not decreased over time, although recent data show some sign of reduction. In Australia, PHI coverage jumped from 30% in 1997 to 44% in 2001. Some recent Australian data show a decline in waiting, but other sources show little improvement.

Private health insurance is also likely to have financed the development of overall capacity in systems without waiting times. By covering the share of cost not reimbursed by the social security system, PHI has helped to finance doctor and hospital treatments in France. In the United States, private health insurance has also furnished substantial financing to hospitals.

PHI has often financed the delivery of larger treatment volumes by offering higher payments to providers. Financial incentives linked to payment mechanisms exert a direct impact upon doctors' productivity.¹⁷ This has contributed to an increase in the volumes of private hospital treatments in several countries where doctors have both public and private sector engagements. Policy makers in many OECD countries allow differential doctors' payments¹⁸ between public and private practice and permit dual appointments in order to keep the workforce motivated. Similarly, some countries including Australia and Ireland, allow public hospitals to treat privately financed patients. This provides a mechanism to improve revenue collection because public hospitals can draw on this private financing source. It also assures better retention of doctors within the public sector due to this additional income stream, while providing private patients with free choice of doctor and upgraded hospital accommodation.

Duplicate PHI has enhanced insurees' access to timely hospital care but has not necessarily decreased waiting for those without PHI

In OECD countries with no observed waiting times for elective surgery – such as the United States, France, Switzerland, Japan, Belgium and Germany – all insured individuals enjoy timely access to care irrespective of whether their main form of coverage is public schemes or private insurance. These countries generally have insurance-based systems (public or private), where money follows the patient, specialists are paid on a fee-for-service basis rather than being salaried, and there are lower overall constraints on activity than occurs in health systems with tight caps on activity and spending (Siciliani and Hurst, 2003).

Conversely, PHI has enhanced access to timely elective care for privately insured individuals in countries where it has a duplicate function and private delivery facilities with additional capacity have developed.¹⁹ In these cases, PHI enhances enrollees' peace of mind, reduces their anxiety and pain, and possibly improves their health outcomes when waiting times are very long.²⁰

Ireland, Australia, and the United Kingdom are the most notable examples of enhanced access to timely elective care through PHI, although faster access for the privately insured occurs also in Denmark, Italy, Spain, and New Zealand among others. Demand for private health insurance and waiting times for elective surgery are strongly linked in some of these countries (Hurst and Siciliani, 2003; Mossialos and Thomson, 2002; Colombo and Tapay, 2003 and 2004a). Those who lack PHI have comparatively less choice of provider and timing of care, unless they opt to pay for such care out-of-pocket.

Governmental policies significantly influence the ability of privately insured individuals to obtain faster access to care. Allowing public providers to treat both private and public patients, and to receive different remuneration levels for these separate activities, can encourage their involvement in the private sector and the development of a PHI market offering access to more timely elective care. For example, the growth of privately financed facilities alongside publicly financed hospitals has encouraged, and

been influenced by, PHI's stepping in with products offering improved access to timely care, as in Australia. PHI can also sometimes provide quicker access to care within public facilities, as in Ireland for elective surgery.

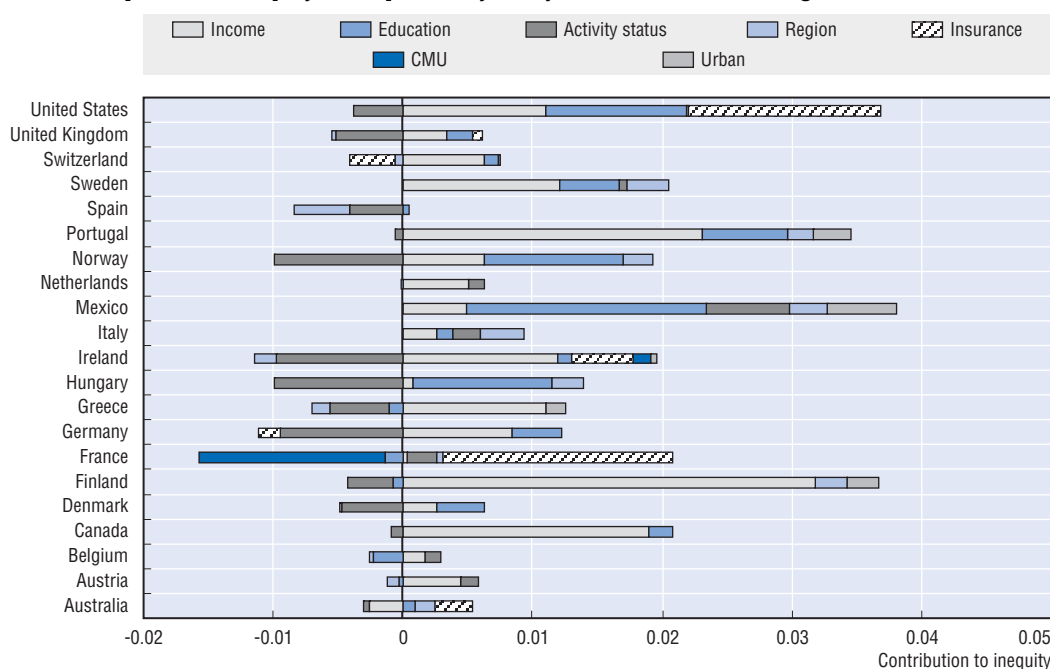
The ability of PHI to reduce demand pressures and waiting times on the public system has nonetheless proven to be constrained. Increases in the population covered by PHI in Australia and Ireland have not resulted in unambiguous reductions in the level of waiting (see Box 4.4). PHI has not only shifted demand across public and private hospitals but has also increased overall demand.²¹ This offsets in part the shift of demand and utilisation between public and private hospitals, thereby limiting the impact on waiting times. In some countries, incentives created by higher payment levels in PHI markets have also encouraged providers to maintain long queues in the public system or refer patients to their own private facilities in order to sustain their private practice (Hurst and Siciliani, 2003; Rodwin, 1993; DeCoster et al., 1998; Yates, 1995; Evans, 2000; Robinson, 1999, p. 67). There may also be concerns, particularly in systems with limited supply of doctors, that private payments raise incentives to reduce doctors' availability in public systems.

PHI has created differential access to health services in some countries

While PHI has improved access to needed services and timely care in some countries, it has also created differences in access to care based on insurance status in most systems with significant PHI markets. Evidence from a comparative study on utilisation of health services indicates that private health insurance, which is predominantly purchased by and for higher-income groups, encourages a “pro-rich” distribution of physician use in Ireland, France, the United States, and to less extent, in Australia and the United Kingdom (Figure 4.1)

Figure 4.1. Equity in access to doctors' visits

Decomposition of inequity in the probability of any doctor visit, i.e. excluding need contributions



Note: A negative contribution means that the effect is to lower inequality in doctors' visits favouring the rich (a positive contribution has the opposite interpretation).

CMU: Couverture maladie universelle.

Source: Van Doorslaer et al. (2004).

(Van Doorslaer et al., 2004).²² In Ireland, Italy, Portugal, Spain, and the United Kingdom, access to private health insurance has also been found to have had a positive effect on the probability of visiting a specialist (Jones et al., 2002).

Variation in access to care between those insured exclusively by private or public coverage, or those insured by some combination of the two, often stems from the financial incentives created by different types and levels of health coverage. First, utilisation increases with comprehensiveness of insurance, as shown by the RAND Health Insurance Experiment (Manning et al., 1987)²³ and by the experience of other OECD countries. Hence, when PHI covers benefits in addition to those covered by existing public programmes, it likely results in higher utilisation. Second, where PHI gives individuals access to providers that they cannot finance through public coverage, it affords them an increased level of care, as in Ireland, Australia, the United Kingdom, and other countries with duplicate PHI. Third, different payment mechanisms for publicly and privately insured patients can encourage providers to furnish more services in the private sector.²⁴

But countries vary in the extent of government concern over such differences

Some OECD countries promote differential treatment of individuals based upon their insurance status, others emphasise the need to guarantee equity. In Ireland and Australia, for example, policy makers view PHI as a means to offer a level of care or choice above that of the public system to those willing to pay premiums. Inequities in access to care linked to insurance status have caused concern in Ireland when these have occurred in public hospitals, because access to treatment in these facilities is supposed to be provided without regard to insurance status. Conversely, in the Netherlands, concerns over inequities in access to care have led policy makers to make different policy choices. Despite the existence of private delivery and waiting times for elective care, the Dutch public/private health financing mix is designed to channel patients towards the same type of care irrespective of their insurance status.

Equity issues also arise when doctors operate in both public and private practice. Where physicians' payments on behalf of privately insured individuals are higher, this may modify the elasticity of the medical supply between public and private practice, resulting in a reduction in the quantity and quality of physicians' time devoted to public patients.²⁵ If informal payments are common, policy makers may wish to promote PHI as part of a desired shift towards a more formal payment structure. This is what some countries in Eastern Europe, such as Slovakia, would like to accomplish, although this also creates its own set of challenges (Colombo and Tapay, 2004b).

In those systems where differentiated access to care according to insurance status is not deemed acceptable, or perceived as a risk, policy makers have intervened in various ways. Some have regulated prices charged for privately financed patients, or established explicit rules for access to care and requirements on doctors' engagement in public and private practice to minimise the risk of inequities. However, the effectiveness of such approaches varies, requiring monitoring as well as strengthening in some cases. Notably, diverse payment systems may result in preferential treatment being accorded on the basis of patients' insurance status, even where systems are designed to avoid such risk (Box 4.5).

Box 4.5. Promoting equity of access to health care services and enhancing choice through a combination of public and private health coverage options: compatible goals?

Policy makers in OECD countries have placed different levels of priority upon assuring equity of access to health care services and promoting choice of health coverage and providers through PHI. Many have sought to promote choice of coverage options, and of health care providers, through PHI. The Netherlands place a premium on equity of access and its health system is designed to minimise differences in access to care based upon types of health insurance. The structure of the Irish, Australian and British universal public systems reflect the priority that these countries have historically placed upon equity of access to care. However, privately financed patients (often those with PHI coverage) enjoy enhanced access to health care services in private facilities and this enhanced access is supported to different extents by their governmental authorities and regulatory systems.

Equity of access to health care across health systems or within publicly financed hospitals is often ensured by certain rules of access to care. In the Netherlands, both publicly and privately insured patients are placed on the same waiting list. Hospitals and doctors do not earn more when treating private patients as prices are regulated and uniform across publicly and privately insured patients. In Ireland, 20% of the beds in public hospitals are designated for private patients' use. However, emergency admissions are made without consideration of insurance status. In such cases, individuals without PHI may be treated in a private bed if all public beds are occupied, and vice versa. The Irish government monitors access to publicly financed services in order to ensure continued access to medically necessary care for the entire population. In Australia, no a priori allocation of public hospitals' beds between public and private patients exists, and admission to public hospitals is unaffected by whether or not individuals elect to use private health insurance.

In some OECD health systems, policy makers have regulated the extent to which doctors – whether salaried or under contract with public authorities – can engage in private practice.* For example, doctors are prohibited from practicing in both the public and privately financed health sectors in Canada, Sweden, Luxembourg, Greece and Italy in order to limit the risk that they would neglect their publicly financed patients. The new NHS contract offered to consultants in the United Kingdom in 2003 was also introduced with the purpose of reducing this risk. In Ireland, the consultants' collective contract also specifies a commitment to public practice.

Despite governmentally imposed rules to promote equity of access to care, disparities in access to health care do persist across many OECD countries. These are mostly the result of incentives for preferential treatment of privately insured patients created by diversity in provider payment systems for doctors treating both public and private patients. In Ireland and the Netherlands, for example, there seems to be some continuing inequity in the use of specialists according to insurance status and, in the case of Ireland, longer waiting for outpatient services by publicly insured individuals, when compared to their privately insured counterparts. Also in Ireland, varied trends in the utilisation of public hospital facilities by public and privately insured patients have given rise to concerns that private patients might receive priority treatment for elective surgery. In contrast, this does not seem to have been as much of a concern in Australia. Some public hospitals have sought to encourage patients to elect to use their PHI policy, by offering to waive any out-of-pocket expenditures that private patients may face on their insurance policies.

Box 4.5. Promoting equity of access to health care services and enhancing choice through a combination of public and private health coverage options: compatible goals? (cont.)

Overall, design characteristics of the health systems and their regulation reflect, in part, different values relating to the need to guarantee equity versus the acceptability of promoting differential treatment of individuals based upon their insurance status. There seem to be conflicting philosophies on the question of whether PHI should inherently “add value” by offering a level of care or choice above that of the public system or whether the same type of care and choice should be assured to all – irrespective of whether they are covered by private or public systems. Varied payment mechanisms for public and private patients might encourage providers to accord preferential treatment according to patients’ insurance status. Policy makers may wish to establish explicit access rules to minimise such incentives and need to monitor their application.

* “Private practice” for physicians refers to the ability to accept private payments, whether paid through PHI or on an out-of-pocket basis.

2.3. PHI systems affect equity of health financing in different ways

Equity of financing in PHI markets depends upon premium rating, market structures and regulation

While PHI premiums may in some countries be subsidised, they are not adjusted by income and are therefore a regressive form of financing compared to public systems financed largely from income-based contributions. Premium rating restrictions and other programmes can improve risk pooling by health and age categories.

In Australia, Ireland, the Swiss basic health insurance and some US States, community rating encourages cross-subsidisation across health risk factors and sometimes across age categories. In some US States, high-risk pools offer coverage to high-risk persons below cost and are mainly subsidised by premium taxes on insurers. These pools counterbalance financing inequities within the PHI market, although they operate separately from it. France also promotes risk-based pooling by according tax advantages to private health insurers who do not consider risk factors in setting premium and acceptance decisions, and promotes income-based pooling through its CMU programme (Buchmueller and Couffinhal, 2004). In the Netherlands, insurers are required to issue a standardised, comprehensive policy to high-risk persons at a maximum rate. The cost of this insurance is significantly subsidised by a premium surcharge imposed on the other privately insured.²⁶ In addition, there is a cross-subsidy between the PHI market and social insurance coverage, through a charge on the privately insured that compensates for the age disparities between the two systems. These cross-subsidies counterbalance the otherwise low level of financial support from the healthier to the less healthy within the Dutch PHI market, where premiums can be determined on a risk-related basis (Tapay and Colombo, 2004).²⁷

Yet governmental efforts to enhance equity in PHI financing may be undercut by adverse selection by applicants that can exist in voluntary PHI markets, as described in Box 4.2. The greater role of employer group insurance in some PHI markets enhances financing equity as such groups often negotiate premium discounts and display internal “solidarity”. However, the development of a large employer-sponsored group market may fragment the broader PHI risk pool – resulting in higher premiums and less solidarity

within the individual market, as some evidence from the Netherlands seems to indicate (Schut and van Vliet, 2001). There is also a significant debate on the relative advantages of the individual and employer-sponsored PHI markets in the United States and the impact on effective pooling. Many US experts acknowledge the benefits accorded by employer-sponsored PHI in terms of pooling and financing equity. However, others highlight that removing the significant tax advantage for employer plans, and a levelling of the tax advantages with individual plans, might create a more level-playing field across the insured market and enhance financing equity.^{28, 29}

Out-of-pocket payments in PHI reduce financing equity

PHI plans in many countries, like many public coverage programmes, apply some cost sharing to individuals, either in the form of co-payments, deductibles, or co-insurance. While insurers use these methods as a tool to reduce moral hazard and contain utilisation in PHI markets, these out-of-pocket payments can make financing via PHI policies more regressive, unless there are lower co-payments for low-income persons or subsidies as under the French CMU programme. In addition, while the presence of policies with different degrees of cost sharing enables insurers to better satisfy individuals' preferences, it often segments the PHI market and reduces risk-spreading – because healthier insurees tend to prefer policies with higher cost sharing. Insurers can also limit their financial liability by imposing reimbursement limits or maximum benefits on covered services and products. Individuals will have to pay out of their pocket if the providers they use charge higher fees than such maximum benefits.

Data on the extent to which insurers apply co-payments or other forms of cost sharing on PHI policies are generally not available for most OECD countries. It therefore represents an area where further information and data collection could prove useful. The Netherlands has relatively low rates of out-of-pocket health expenditures, and its PHI market also has low cost sharing.³⁰ While cost sharing is higher in Ireland, its PHI market has low rates of self-insurance for hospitalisation services. Irish consultants report that nearly all of their private income comes through PHI for inpatient care (Colombo and Tapay, 2004a). In France, cost sharing on PHI policies is low. The degree of self-financing in the health system varies depending upon the item considered, for example, it is higher for dental and physician services compared to inpatient services (Buchmueller and Couffinhal, 2004).

Those with PHI in the United States have recently been facing increased financing burdens, due to changes in insurer and employer offerings as well as an increased emphasis on individual responsibility in public policy. To respond to rising health care and premium costs, some employers have transferred expenses to employees via higher premiums, co-payments and coinsurance. Other employers have also reduced benefits (Levit et al., 2004). Insurers, on their side, have increasingly controlled health care costs by relying on demand-side mechanisms, such as insuree cost sharing and reduced benefits, as opposed to supply-side measures, including managed care techniques (Tollen and Crane, 2002). Managed care techniques employed by insurers have become looser, although many still use at least some control over the supply of health care services (e.g., pre-approval of non-emergency hospitalisation). Plans are also increasingly offering insurees enhanced provider choice, while this may be accompanied by increased cost to the insurees.³¹ Recent legislation and regulation has promoted mechanisms which enhance individual responsibility for health care costs, yet several of these run the risk of reducing financing equity (Box 4.6).³²

Box 4.6. Trends towards increasing individual choice and responsibility for health care expenses in the United States

In recent decades, US policy makers have provided several tax-related mechanisms through which employers and individuals can increase individuals' discretion and responsibility for their health care expenses. Recent federal and state legislative and regulatory action has increased the number and variety of these financing options. Yet, the net benefit to consumers and employers of these actions remains a subject of debate among US policy makers and experts.

Since 1979, US employers have been able to offer their employees “flexible spending accounts” (FSAs). These mechanisms enable employees to set aside a tax-deductible amount of money – up to a maximum amount set by the employer – on an annual basis to pay for non-reimbursed health care expenses. Separate FSAs can be set up to cover: 1) health insurance premiums; 2) qualified medical expenses and 3) dependent care expenses. There are no requirements relating to the health plan and employees, employers or both can contribute to the accounts, although they are most often funded by employees. Money unspent at the end of the year cannot be carried over to the following year, however, nor can individuals take the funds with them if they change employers.

Employers' “cafeteria plans” allow participants to select among cash and one or more qualified non-taxable benefits. They provide an additional means to increase employee control over their health insurance expenses and benefits. In practice, these plans give employees some choice in designing their benefit packages. Employees can be allotted a predetermined number of dollars, credits or points with which they may purchase benefits. Examples of benefits that can be offered in a cafeteria plan include health, dental, and life insurance, accidental death coverage, disability coverage and vacation leave (American Federation of State, County and Municipal Employees, AFSCME, 2001). FSAs are a type of cafeteria plan.

“Medical savings accounts”(MSAs) are tax-exempt accounts into which individuals can save money exclusively for future qualified medical expenses; these funds can generally be carried over the years. They are structured to accompany a high-deductible, catastrophic insurance policy. Recent US federal laws have sought to extend the use of MSAs, particularly within the small employer self-employed markets, and within the federal Medicare programme. Some US states have also enacted legislation to promote the use of similar accounts. However, such vehicles have generated limited consumer interest to date (Docteur et al., 2003).

Under “health spending accounts”, an employer or employee puts a specific amount of money in the employee's account to pay for certain types of services, such as doctors' fees and drug costs. These accounts are usually accompanied by a high-deductible insurance plan.

An additional option, “defined benefit plans” or “defined contribution health plans” are a relatively new concept under which employers agree to provide employees with a set amount of money with which they can purchase a health insurance plan or cover health expenses – thereby providing employees with the ability to purchase a plan of their choice (Saleem, 2003).

The US Treasury Department has since June 2002 authorised “health reimbursement arrangements” (HRAs). HRAs permit the employee to accumulate money for future healthcare needs such as retirement healthcare expenses. HRAs are similar to “flexible spending accounts” (FSAs) except that unused dollars may be rolled-over into the next year. They are also similar to Medical Savings Accounts (MSAs) except that HRAs are funded by employers, are available to employers of all sizes, and HRAs are flexible in design (www.benefits.net/hra/).

Box 4.6. **Trends towards increasing individual choice and responsibility for health care expenses in the United States (cont.)**

Finally, the recently enacted Medicare legislation¹ created a new type of tax-favoured account, “Health savings accounts” (HSAs). Individuals covered by certain types of high-deductible health plans can use these accounts to pay for certain “qualified” medical expenses for themselves and their qualified dependents (Employee Benefits Institute of America, 2003).

If some of these mechanisms become more widespread, they could have implications for financial equity in the primary PHI market in the United States. For example, MSAs may reduce risk pooling across the larger population, and possibly provide less longer-term benefit to higher-risk persons, whose expenses will exhaust the resources within the MSAs each year. Similarly, to the extent health expenses are drawn from individual funds rather than from resources pooled through insurance, as with HSAs, flexible spending accounts and some defined benefit plans, there is less redistributive financing. Given a choice of insurance products, lower-risk persons may gravitate to lower-cost coverage options with higher cost sharing, while higher-risk persons are less likely to join similar plans. The coverage pools could become increasingly fragmented according to persons’ health status.²

On the other hand, these mechanisms have the potential to promote increased individual awareness of, and sensitivity to, health care costs, with a potential dampening effect on health care costs. Since several of these mechanisms permit persons to pay for items that might otherwise not be covered (such as luxury health care items), it is not clear whether these mechanisms will lead to higher-cost health services (Nichols et al., 2004).

1. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173 (Dec. 8, 2003).

2. If employers respond to increased insurance costs by offering only high-deductible plans, coverage pool fragmentation, but not the redistribution of health-care financing burdens to high-cost individuals, would be avoided.

Some countries have adopted policies to improve financing equity in PHI markets. These include efforts to reduce significant cost-sharing requirements on private insurance or to regulate the permitted range of insurer-imposed cost sharing. For example, while many US states provide insurers with significant flexibility in the area of cost sharing, some require PHI carriers to offer a number of policies with limited cost sharing, and in a few cases (such as in New Jersey’s individual market), restrict the sale of PHI policies to a limited number of standard policies.³³ In Australia, policy makers sought successfully to reduce unexpected out-of-pocket payments through new legislation in 2000 (Box 4.7). In addition to reducing risk of unexpected payments, these measures promote more equitable financing within PHI – since out-of-pocket costs represent the least equitable source of health financing – at the expense, however, of creating moral-hazard incentives for insurees.

The impact on financial equity of fiscal and financial incentives for the purchase of PHI varies

Fiscal incentives for the purchase of PHI have mixed implications for financing equity. First, as far as PHI is predominantly purchased by high-income groups, tax advantages on PHI have a generally regressive impact on overall health system financing.³⁴ However, this

also depends on the particular type of fiscal incentive. For example, the premium rebate in Australia provides the same level of monetary relief regardless of the income of the covered person, and, for any given policy, greater relief as a percentage of disposable income for less wealthy groups. In Ireland, insurance premiums are tax-deductible at the standard rate – a generally more regressive fiscal incentive than a rebate. PHI is nonetheless predominantly purchased by higher-income individuals, thereby it has an overall regressive impact on total health financing.

Box 4.7. Australian measures to limit unexpected out-of-pocket payments for the privately insured

Unexpected out-of-pocket expenditures by those covered by PHI can significantly reduce the financial security otherwise afforded to purchasers of PHI and thereby represent a major concern for consumers buying PHI. In Australia, individuals were exposed to unexpected expenditures both on hospital charges and on medical fees, as providers' were able to charge higher fees than those reimbursed by the public insurer, Medicare, or by private insurers.

Legislation to minimise the potential for such unanticipated gaps has included a mix of policies requiring or allowing funds to cover the medical gap¹ and policies encouraging price agreements between hospitals and funds to eliminate the hospital gaps (the difference between the fees charged by hospitals and the reimbursement by insurers).

In 1995, the Federal Government passed legislation to allow funds and providers to negotiate reimbursement levels involving no further gaps for insurees. The idea was to encourage funds to enter into contracts with selected providers in return for those providers accepting the benefit level offered by the fund as full payment. The reform made contracting with funds the predominant payment model for private hospitals. An increasing number of private hospital facilities now have contracts with health funds which eliminate (or at least reduce) the quantity of hospital fee gaps. Most privately insured patients now face only the co-payments or front-end deductibles.

Concerning medical gaps, legislation introduced in 2000 required all PHI insurers to offer at least one hospital insurance policy involving no medical gaps for patients. This legislation permitted health insurance funds to reimburse doctors for the portion of in-patient fees above the government reimbursed share, on the basis of agreements between funds and doctors. Each fund suggests a medical schedule (which offers prices higher than the government-set rates). If a doctor accepts to charge the suggested fees, the fund reimburses all or a "known" part of the gap between the fee and the share reimbursed by the government. The doctor maintains discretion concerning whether to charge the proposed fee or a different one, but is obliged to obtain the patient's "informed financial consent" before delivering a treatment involving higher fees than the reimbursement by the fund.

The new "gap cover" arrangement has resulted in a significant improvement in the number of in-hospital medical services that are provided with no gap payment.²

1. A share of private in-patient medical costs is paid by public health insurance, Medicare, in Australia (equal to 75% of a government-set fee schedule). Funds were first required to cover the remaining 25% of the government-set fee schedule, before being allowed to cover the "gap" between the fee charged by the providers and the government-set fees.

2. Yet an increasing proportion of PHI products include a front-end deductible (56% at the end of 2002).

Source: Colombo and Tapay (2003).

In a few countries financing equity is also affected by the interaction between particular fiscal incentive vehicles, and the characteristics of various PHI submarkets. The fact that, in the United States, health care benefits are only exempt from income taxation when provided through employer-sponsored plans has both positive and negative effects for financing equity. On the positive side, it has promoted a significant employer-sponsored coverage market which now covers the vast majority of the privately insured. This market generally has less risk segmentation than the individual market since it is less prone to adverse selection. Employer coverage pools are prohibited by law from excluding persons on the basis of health status.³⁵ However, US employers are permitted to limit their coverage offerings to certain segments of their worker populations. This may disadvantage lower-income workers and individuals, including part-time workers.

The ability to choose PHI over public coverage may diminish the risk pooling within public insurance

When persons are given the option to choose between publicly and privately financed coverage, this moves expenditure from public to private financing, but the interaction between publicly and privately financed programmes has given rise to some problems. Countries providing this option include Germany, for higher-income persons, and Spain, for civil servants. “Opting out” can have an impact on the risk profile within the public system. In the case of Germany, the privately insured tend to be younger and healthier, thereby depriving the social risk pool of some of the less expensive risks and thereby resulting in higher premiums for those who have social insurance. The number of people switching to social health insurance was only a third of those moving to private health insurance from sickness funds in 2002 (PKV, 2003). Germany has imposed strong limits on the ability to opt back into social coverage as part of an effort to protect the risk pool within social funds. It also has the authority to trigger a risk-equalisation mechanism that would require certain privately insured to cross-subsidise some of the cost of coverage of the elderly under the standard tariff policy, although to date this has not been deemed necessary. Nonetheless, concerns remain regarding the impact of this “opting out” option on the breadth of the social insurance risk pool.

While the US Medicare programme does not technically provide enrollees with the option to “opt out” of public coverage, elderly Medicare beneficiaries may choose to receive their publicly financed coverage through private “Medicare+Choice” carriers. They sometimes receive additional benefits, such as drug coverage, through this choice. Historically, however, Medicare+Choice plans have enrolled healthier, lower-cost individuals than the traditional fee-for-service Medicare programme (Dallek et al., 2003), leaving a larger proportion of less healthy individuals in the traditional programme. These differences in risk profiles have raised challenges for the allocation of different payment levels for participating health plans.

3. Influence of PHI on health system responsiveness

Private health insurance is often marketed or viewed as a coverage mechanism that increases responsiveness to consumer needs. This section looks at the extent this occurs across OECD countries, considering two main aspects of responsiveness: consumer choice and innovation.

3.1. PHI has enhanced choice but barriers to consumers' exercise of meaningful choice remain

PHI offers purchasers improved choice of providers in several systems

Private health insurance has enhanced choice of health care providers and care settings in several OECD countries, although in most cases, it has done so for a limited population segment. The extent to which PHI enhances provider choice for its purchasers depends upon the structure of the health delivery system and, in particular, the degree of provider choice already afforded by public systems.

Duplicate PHI – such as that available in Australia, Ireland and the United Kingdom – provides enrollees with more choice of the timing of care and a broader choice of providers because it reimburses the cost of care in private hospitals that are not publicly funded, or only partly so. Furthermore, private insurers generally do not selectively contract with providers in these countries, thereby typically providing unrestricted choice of doctors and hospitals across the private sector, although this advantage is at times more pronounced for elective care than for other types of treatments.³⁶

In the United States, the degree of added choice of provider afforded by PHI varies by plan type (indemnity versus managed care) and specific private plans' offerings. US private primary coverage plans feature differing degrees of provider choice. Health maintenance organisations (HMOs) often restrict provider options, preferred provider organisations (PPOs) less so, while indemnity plans generally provide free consumer choice.³⁷ The extent of provider choice can also vary within subsections of the market, depending upon whether the coverage is offered by a large employer, a small employer, or is individually purchased. The level of enhanced choice afforded by PHI also depends upon the public programmes that serve as the basis for any such comparison.³⁸

In those OECD countries where the majority of the population is publicly covered and affords unrestricted choice of provider, PHI affords the same or similar level of choice of providers as public programmes. This broad provider choice occurs more frequently in countries with social health insurance. For example, in the primary PHI markets in the Netherlands and Germany, PHI has not resulted in much additional choice of provider for its enrollees, because public coverage already offers broad choice of provider. This is surprising in the case of Germany, where private and social insurers reimburse providers at different levels (often higher in the case of private insurers),³⁹ but perhaps less surprising in the Netherlands, where no such variation occurs.

PHI markets provide an additional option for financing health care

The very presence of a PHI market affords consumers in most OECD countries with another way to pay for health care services. In the absence of such a market, they may not have any ability to insure against health costs not covered publicly and would have to rely on out-of-pocket payments and personal savings to cover these costs. By offering an array of different products, private health insurance markets can also increase consumers' choice of financial protection and benefits schemes – especially when choice is accompanied by accessible and usable information to compare options.

Yet, the availability of more coverage options does not necessarily bring to more effective consumer choice. PHI markets in Australia and the United States, for example, are characterised by a broad choice of covered benefits and levels of cost sharing, often making it difficult for consumers to understand their options. Better availability of information on

health care and health care coverage options could significantly aid in this regard.⁴⁰ Furthermore, when PHI products offer a wide range of cost-sharing arrangements, and differ in the extent to which they cover expensive services, product choice can undermine risk pooling within the market. In contrast, in Ireland's PHI market, where most insurer offerings focus on five similar packages, a high degree of consumer satisfaction is reported (Health Insurance Authority, 2003; Watson and Williams, 2001). This indicates that a wide selection of health care insurance products may not be necessary in order to provide consumers with meaningful and satisfactory choices.

Choice options available to PHI members are not always clear or easily exercised

Readily understood comparative information on PHI insurers and products is often not generally available, thwarting consumers' ability to take meaningful advantage of PHI product choice. Recognising challenges in this area, policy makers and the private industry in several OECD countries have taken steps to improve information and comparability in PHI markets, and hence to enhance meaningful choice. PHI-related disclosure requirements range from very specific and targeted legal requirements, to a reliance on industry practice or voluntary standards. For example, the Australian government prepares informative brochures on several topics related to private health insurance plans. Comparative information on the features and costs of health plans is also disseminated by the government or voluntary bodies in parts of the US primary market and in Switzerland's mandatory insurance market.

Consumer choice of insurers is also hampered by barriers to switching stemming from insurers' practices and market characteristics. In particular, the ability of insurers to select risks and limited portability of private cover⁴¹ may reduce consumers' ability to choose or switch health insurers. For example, in the Netherlands, choice among private insurance packages is difficult to exercise as insurers offering both primary and supplementary PHI can select risks and decline to cover pre-existing risks, although a voluntary agreement between employers and insurers has improved portability in the group segment of the market. The concentration of the PHI market also influences the availability of choice of insurer. Consumers in Australia may choose among a much greater number of insurers than in Ireland, and regulation has enhanced portability protections countries.⁴² Nonetheless, most individuals tend to stick to the same insurer in both countries, possibly because of the high transaction and informational costs of changing insurer, and an absence of comparative information on various aspects of insurers' performance.

Evidence from several OECD countries suggests that safeguards – whether implemented through regulation or voluntarily developed industry standards – and improved information disclosure are needed to enhance individual choice in a private health insurance market. Standardisation of benefit packages – as is mandated for the US Medicare supplemental (“Medigap”) coverage – is a way to promote consumers' ability to make informed choices as well as reduce certain risk-selection activities.⁴³ Individuals also need transparent information and suitable consumer protection regulation to become confident in, and knowledgeable about, the products they are buying. Indeed, while authorities in several countries operate to solve complaints and improve market transparency, including through Ombudsman programmes, some challenges to choice remain. These concern, for example, the quality of publicity by insurers and consumers' understanding of the terms and conditions of their cover.

3.2. PHI has promoted innovation

Insurers have responded to consumer demand by tailoring products, finding innovative and flexible coverage solutions, modernising benefit designs and quickly adopting coverage of new benefits. Following removal of dental services from the social insurance package in the Netherlands, health insurers promptly responded by covering these benefits. In the United Kingdom, as demand for PHI is linked to excess waiting times, some insurers have designed low-cost products covering only elective treatments for which the waiting is large. In Ireland, insurers have recently started to offer primary care products to fill gaps in eligibility to public coverage for two-thirds of the population. In several OECD countries, private insurers tailor the premiums to individual needs by varying levels of cost sharing and benefits covered on different policies.

The presence of multiple purchasers (both public and private) has been a factor stimulating the adoption and diffusion of medical technologies in the United States. Competition in the hospital sector, which is in part encouraged by competition between multiple insurers,⁴⁴ encourages the early adoption and a fast rate of diffusion of technologies. Both enrollees of public programmes and private insurees may benefit from the higher intensity of treatments delivered by US hospitals. PHI markets are also often credited with higher responsiveness than public programmes in making reimbursement decisions about new and emerging technologies, although there is limited evidence as to whether this has happened in practice. The implications of rapid adoption and diffusion of technology are nonetheless not always clear, including their impact on quality and health outcomes, indicating the need for careful assessment of their value for money.

While PHI has offered individuals innovative and flexible coverage approaches in many OECD countries, policy makers have sometimes intervened to limit the scope of insurers' activities, through various regulatory tools. This is because insurers face incentives to use product variation as a means of improving their risk profile, for example this may have occurred in Australia. Standardisation of benefit packages, while it promotes consumer ability to make informed choices, restrains insurers' capacity to innovate and respond to market demand. More generous standard benefit packages can also be subject to adverse selection. If insurers are not required to offer all standard products, some may consequently drop such coverage. Moreover, if statutory or regulatory rules do not enable standardised packages to be readily updated, innovation in response to market changes might be inhibited.⁴⁵ Equity concerns have also prompted policy makers in the Netherlands to discourage some insurer-supported innovations in health care provision for fear that they would create inequities in access to care between privately insured individuals and those without it.⁴⁶

Demand pressures upon insurers have led them to innovate and tailor their offerings to individuals' demands. These pressures arise from competition – as insurers fear that they would lose clients if they do not react similarly to their competitors – and from the lack of a statutory obligation to purchase cover in most PHI markets. Even a monopolist insurer faces pressures to improve responsiveness to consumers' desires if take-up of insurance is on a voluntary basis, especially when PHI is not a primary form of cover, and individuals may perceive coverage to be less essential. Policy makers have nonetheless sometimes limited the scope for insurers' flexibility and innovation in order to avoid having more vulnerable groups being priced out of PHI markets.⁴⁷ This is especially the case in countries where PHI plays a more significant role, either in terms of population covered or health financing share. PHI markets raise trade-offs between innovation and access concerns.

4. PHI markets and quality of care

Traditionally, responsibility for quality assurance in the delivery of health care services has rested with the medical profession and provider community, but monitoring and improving quality of care has become a priority issue for policy makers confronted with evidence of quality problems in many OECD countries. Several countries have started to intervene by reforming institutions of professional self-regulation or increasing regulatory oversight of the medical sector. Further instruments to influence quality of care, including a larger role of purchasers and greater involvement by the public, are also emerging (Mattke, 2004). This section examines what role, if any, private insurers have in promoting quality of care in OECD countries.

4.1. With exceptions, private insurers have not served as an impetus for quality improvement

In most OECD countries, private health insurers have not significantly influenced the quality of the health care services they finance. Several factors are likely to contribute to this trend. First, efforts to improve quality typically require significant resource investments, which may not be warranted in these countries where PHI plays a limited role. In addition, such interventions often result in efforts to steer consumers to certain providers, which may restrict choice and be unwelcome in countries where consumer demand for PHI is linked to its provision of additional provider choice. Policy makers have seldom established quality-of-care standards for private insurers. Instead, policy attention with respect to quality is generally focused upon providers as the accountable parties. Quality of care is also often self-regulated by the provider community or voluntary accreditation bodies. Significant political resistance on the part of providers is likely to accompany the introduction of an additional – and non-provider – actor into this realm.

One important exception to this trend, however, has occurred in the United States, where certain insurers and self-funded employer-sponsored health plans, particularly “managed care” plans, have been very involved in directing and overseeing certain aspects of care delivery. By exerting more leverage over the care they purchase, insurers seek to secure a competitive advantage through products offering good quality and value for money. These efforts have largely stemmed from a combination of market developments, voluntary accreditation efforts, and consumer and purchaser demands including important employer-based activities.⁴⁸ State-based governmental efforts have also provided important regulatory impetus to these trends. Insurer efforts have often focused on reducing the provision of unnecessary care and promoting preventive care, where appropriate. Their activities have ranged from selective networks of approved providers, pre-approval of certain services, and the implementation of disease-management programmes. Similar initiatives have been active or are emerging in a small number of other countries, but on a smaller scale, as in the United Kingdom, Ireland and Australia.⁴⁹

Public or private insurer involvement in the delivery of care introduces an additional player into the provider-patient relationship. US managed care plans’ involvement in approving the delivery of specific interventions gave rise to some of the most vehement opposition by consumers and providers, and at times raised quality concerns,⁵⁰ resulting in what is often termed the “backlash” against managed care. It is important that insurers’ efforts to manage care aid – and do not harm – the quality of health care. In order to make sure insurer practices do not put patients at risk, many US states impose quality-related requirements on health plans. For example, there are standards relating to the timeframes

and decision-maker expertise for insurers who require prior approval of certain services, such as hospitalisation, prior to its delivery.⁵¹ There is also significant, successful effort to prepare report cards comparing plan performance, through the privately developed Health Plan Employer Data and Information Set (HEDIS) which enables purchasers in the United States to compare plan performance according to standardised measures. These efforts, however, are still not applied systematically.

While managed care markets have demonstrated some effectiveness in promoting quality of care, the overall evidence of the impact of managed care in the United States, when compared to indemnity insurance, is mixed. Recent literature reviews have highlighted that managed care has not yet fundamentally changed clinical processes or uniformly improved quality of care (Miller and Luft, 1997 and 2002). Plan characteristics, arrangements with providers, and quality controls are heterogeneous across plans and continue to evolve, while prevention and disease-management programmes are not used by all plans. Furthermore, payment incentives within US managed care plans do not always reward plans' or employers' efforts to improve quality. These factors, along with providers' own success in improving quality of care and still inadequate quality-measurement and reporting systems, explain the still limited impact of PHI on quality improvements, even where insurers have sought to implement activities in this area. Nonetheless, some private health plans have led efforts to promote the delivery of quality care (Box 4.8).

In addition, PHI may not be the best lever to improve health care quality, particularly where its role in a health system is small. The extent of the need for PHI to play a role in promoting health care quality has also been questioned. In many OECD countries, insurers have had neither the levers nor the incentives to invest significant resources in this area. This is particularly true where they cover less significant risks, as in the case of many supplementary or complementary markets. Such efforts involve a significant investment of resources on the part of insurers, and enrollees may bristle at limitations on provider choice, which thereby limit insurers' ability to selectively contract based upon quality-related criteria. Insurers need adequate incentives, regulatory or otherwise, to invest in quality-improvement initiatives and foster value-based competition. They may also need to provide consumers with assurances that restrictions on provider choice will enable them to access high-quality providers.

5. Impact of PHI on health systems' cost

There is substantial interest in understanding the implications of private health insurance for health systems' cost. This section analyses the contribution of PHI markets on this dimension of health system performance, focusing on two main questions: whether PHI markets have reduced public sector costs; and PHI's impact on overall health expenditure.

5.1. *PHI has removed little cost pressure from public health financing systems*

Several OECD countries have encouraged the development of PHI markets in order to shift cost pressures from public health systems to the private sector. Policy makers have done so in three main ways. First, PHI is allowed to duplicate universal public coverage, such as in the case of Australia, Ireland, and the United Kingdom, among others. Second, governments in Germany, the Netherlands and the United States have established income or population-based eligibility criteria for public health insurance, or permitted certain

Box 4.8. Private health insurer quality initiatives in the United States

In the United States, certain managed care plans have led important efforts in quality promotion. However, recent evolutions in the managed care market (particularly since the late 1990s) have diminished many plans' tight control over care delivery.

Evolution of managed care: quality promotion through integrated provision and financing schemes

While the growth of managed care is often linked with efforts to rein in health care cost trends, these plans' arrangements with providers also provided them with the leverage and ability to promote quality of care to a greater degree than indemnity plans, whose structure focused on reimbursement of care rather than on its delivery. Indeed, certain quality-related efforts by private health plans have demonstrated plans' ability to improve the quality of health care services they finance. For example, findings of the National Committee on Quality Assurance (NCQA) revealed that managed care plans performed better than their fee-for-service counterparts on several key quality indicators, such as screening for certain cancers and the prescription of beta-blockers for discharged hospital patients following a heart attack. Studies comparing managed care plans with indemnity plans also found that managed care enrollees received similar or better services in several key areas.¹ But other studies point to more mixed results. One study found that evidence from fifteen studies showed an equal number of significantly better and worse HMO results, compared to non-HMO plans.² Another study found that, for four out of five quality indicators, individuals in Massachusetts managed care organisations fared better or no worse than their counterparts in fee-for-service plans.³

Recent market changes reduced some plans' leverage over quality of care

Some managed care plan practices, together with restrictions on provider choice, led to pressure by providers and consumers for plans to loosen some of their controls on care and provider choice. Common changes included the elimination of advance approval requirements for hospital admissions and certain outpatient procedures, as well as for specialist referrals. At the same time, many plans coupled these changes with strengthened review requirements for specified procedures and expanded or refined disease management programmes.⁴ At the moment, the extent to which US private health plans actively promote the quality of the health care they purchase for their members varies significantly.

1. American Association of Health Plans (1999).

2. Miller and Luft (1997).

3. Paramore and Elixhauser (1999).

4. Felt-Lisk and Mays (2002).

populations to opt out of public coverage. Third, policy makers may decide to permit or encourage the development of a supplementary PHI market, as for prescription drugs in Canada, or "delist" certain services from public coverage, as in the case of dental care in the Netherlands and Australia. While in principle PHI can help shift cost from the public sector, a review of the evidence indicates that this has not occurred substantially to date.

PHI has had little cost-shifting effect in duplicate systems

The cost-shifting potential of duplicate PHI has proven to be small. This stems from three main factors. First, while private insurers cover the same persons and services financed publicly, the mix of treatments provided in the private and the public sector

differs, as the former typically concentrates on elective treatments. Second, the privately insured continue to use publicly financed health services, even if they hold private coverage. Third, some countries sustain certain costs for achieving any cost shifts, for example when considerable public subsidies are directed towards PHI markets.

In Ireland and Australia, for example, differences in case mix between publicly and privately financed providers have reduced the ability of PHI to reduce public sector costs. Private hospitals concentrate on treating elective care surgery, while the cost of more expensive care, such as complex cases and emergency services, rests with the public system (Box 4.9). PHI in Australia covers nearly half of the population and the private

Box 4.9. PHI and hospital expenditure in two duplicate private health insurance markets

Ireland and Australia have the largest duplicate PHI markets in the OECD area. In both countries, the increase in private hospital utilisation that results from PHI coverage has not reduced demand in the public hospital sector by the same proportion. The extent to which PHI coverage has helped finance “latent” demand or has promoted unnecessary utilisation is debated.

In Australia, PHI enrolees continue to utilise public hospitals. Deeble (2003) cites data according to which up to 55% of insured people using a public hospital do not declare that they have PHI coverage and choose to be treated as public patients. In Ireland, many private patients are treated within private wards in public hospitals, set aside for privately financed patients. Public financing covers a portion of the costs of such private beds.

PHI also appears to have promoted an increase in overall utilisation and treatment intensity in Australia and Ireland, yet only part of such increase represents a shift of demand from publicly financed activity. In Australia, procedure rates after a heart attack have been shown to be two to three times higher for privately insured patients than for publicly insured patients (Robertson and Richardson, 2000). Savage and Wright (2003) also indicate that moral hazard in the Australian PHI system leads to an increase in the expected length of a hospital stay. Some of the PHI-induced utilisation also derives from individuals who would, in the absence of PHI, self-finance private care, thereby not using the public system altogether (Vaiththianathan 2000). In Ireland, the fact that private patients in public hospitals are not charged the full economic cost of their stays may distort preferences regarding the use of public versus private hospitals. Existing evidence, albeit limited, indicates that people with private cover might receive more intensive treatments and more volumes of treatments than public patients in Ireland (Harmon and Nolan, 2001; Nolan and Wiley, 2000; Wiley, 2001).

Cost savings in publicly financed hospitals are also offset by public subsidies for PHI purchasers. In Australia, where there is a 30% tax rebate on PHI premiums, increases in PHI membership and utilisation directly affect public health care-related expenditures. The cost of this rebate on PHI premiums for the fiscal year 2000-01 was AUD 2.2 billion (or about 6% of total government funding of health care). The Medicare subsidy for private in-hospital medical treatments and the subsidy for Pharmaceutical-Benefit-Scheme listed-medicine also raise taxpayer cost. In Ireland, revenues received from PHI for public hospital services may be suboptimal due to the policy of charging fees below full cost in public hospitals. As a consequence, demand does not distribute efficiently across available capacity, and private hospitals may not be efficiently utilised. Public funds also subsidise premiums through tax relief accorded to PHI purchasers in Ireland.

hospitals sector, which is largely financed by PHI, carries out as much as 50% of overall elective surgery. Yet private insurers' claims for hospitalisation represented only 16% of total hospital's expenditure in 2001-2002 (AIHW, 2002). The lower unit cost of hospital PHI claims mostly results from differences in the case mix across public and private hospitals rather than greater efficiency of the private hospital sector (Duckett and Jackson, 2000). Cost savings in publicly financed hospitals are also diminished by the cost of public subsidies accorded to purchasers of PHI in these two countries.

Public health spending remains high in countries with primary PHI markets

Despite the presence of significant primary PHI markets in the United States and the Netherlands, and sizeable opting out from social health insurance into substitute PHI market in Germany, public health care spending as a share of GDP is fairly high in these countries. This may be traced in part the eligibility structure for public programme coverage.

Primary PHI in the United States, the Netherlands and Germany covers younger population groups, while higher-risks and/or older cohorts, representing the large majority of total health spending,⁵² are enrolled in public programmes. For example, Medicare in the United States covers the elderly, certain disabled persons and those with end-stage renal disease. In Germany, it is the younger and healthier individuals, within the high-income population eligible to opt out of sickness fund coverage, that have chosen to buy PHI (Thomson and Mossialos, 2002).⁵³ In the Netherlands, where eligibility is income-based, the public system still ends up covering a larger proportion of the elderly (Tapay and Colombo, 2004), although the privately insured pay a surcharge to compensate for this differential.⁵⁴ Public health expenditure would be higher in the three countries if all population groups were covered by the public system. However, an opting-out mechanism, as in Germany, also reduces public-sector revenues deriving from social health insurance contributions.⁵⁵

Supplementary PHI helps finance health care services not covered publicly

"Delisting" services from public scheme cover helps to limit public sector cost.⁵⁶ But those services which are typical candidates for delisting, such as optical and dental care services, do not generally account for a large share of health systems' cost. Table 4.1 illustrates total and public spending for dental, pharmaceuticals, inpatient and physician health services in several OECD countries. It shows how dental care, which is predominantly financed through private sources in the majority of OECD countries, accounts for less than 10% of total health expenditure. Furthermore, it is often politically challenging to delist services from public coverage. It can be particularly challenging to delist services that are more expensive, because persons needing the benefits in question will face a potentially large out-of-pocket burden if such coverage is diminished. Delisting discussions have therefore often centred on services that may be deemed alternative or less medically necessary, or which may be more readily paid for on an out-of-pocket basis by a majority of the population.

The extent to which the cost of non-publicly covered services is picked up by private insurers, as opposed to out-of-pocket financing by individuals, varies by country (Tables 4.2 and 4.3). In the Netherlands and Australia, a large segment of the population buys PHI policies offering coverage for dental care either only partly (Netherlands) or not at all covered publicly (Australia). In France, PHI covers over half of private dental expenditures,

Table 4.1. **Total and public spending on different health care services, 2000**

Percentage of total health expenditure

	Dental		Inpatient care		Physician care		Pharmaceuticals	
	Total expenditure	Public services	Total expenditure	Public expenditure	Total expenditure	Public expenditure	Total expenditure	Public expenditure
Australia	5.2	1.1	42	32.9	13.1	10.4	12.4	7.1
Austria	9.9	4.3	38	31	20.8	14.8	14.9	11.3
Canada	7.5	0.4	30.5	26	13.5	13.3	15.7	5.5
Denmark	6.5	2.4	54.3	51.1	15.3	9.4	8.7	4.3
Finland	6.1	2	39.9	36.6	24.2	19.5	15.5	7.8
France	5	1.7	42.3	39.1	12.7	9.5	20.4	13.2
Germany	7.8	4.9	36.6	29.2	10.2	8	13.6	9.4
Hungary	4.3	1.3	28.8	27.7	4.4	4.3	n.a.	18.8
Iceland (1999)	7.2	1.6	52.4	52.4	13.8	10.4	n.a.	n.a.
Japan	6.5	5.1	37.9	33.9	27.3	22.5	n.a.	18.8
Luxembourg	3.1	3.1	40.7	37.8	17.3	17.3	12.1	9.9
Netherlands	3.8	1.1	44.6	35.7	8.6	5.5	10.1	6.1
Slovak Republic	4	4	26.4	26.4	3.1	3.1	34	28.1
Switzerland	6.6	0.5	46.8	26.9	14.3	8	10.7	6.5
United States	4.7	0.2	27.6	16.2	22.5	7.5	11.9	2.2

Source: OECD Health Data 2003, 2nd Edition.

thereby replacing costs that otherwise would have had to be covered through out-of-pocket expenditure (Buchmueller and Couffinhal, 2004). In Canada, where two-thirds of pharmaceuticals expenditure is privately financed, 38% of private pharmaceutical expenditure is paid for by PHI and 68% is paid out-of-pocket (Table 4.3).

5.2. PHI has increased total health expenditure, and at times public expenditure, in several OECD countries

Private health insurance markets have resulted in increased overall health expenditure in several OECD countries. First, by bringing more financial resources into the health care system, PHI raises total health expenditure. Second, cost-control measures such as global budgets, price regulation and capacity controls have been applied to the public sector in virtually all OECD countries. Conversely, with the exception of the Netherlands, private health insurers have not been subject to such centralised, governmental controls of health care costs. This has generally resulted in less tight control over privately financed activities and prices. Third, as noted above, private insurers in most OECD countries do not have the same bargaining powers over the price and quantity of care provided to insurees as public systems do, although within concentrated PHI markets insurers can exert stronger pressure, as in the case of Ireland.⁵⁷ Policy tools such as global budgets, which have at least temporarily helped public systems to contain costs in several countries (Mossialos and King, 1999), are hard for private insurers to negotiate or may not be options at all. Alternatives that might be more readily available to private insurers, such as selective contracting, are still relatively rarely employed across OECD countries, although they are used by some PHI carriers in the United States and a few other countries have agreements to the same effect.

Expenditure control is also harder to achieve in systems with multiple payers, including most PHI markets,⁵⁸ and those with fragmented relationship between providers and payers. While these systems offer opportunities for insurers to experiment with innovative practices, purchasers have a weaker bargaining position relative to providers

Table 4.2. **Breakdown of private insurers' and households' expenditure by type of care**

	Percentage					
	In-patient care	Out-patient care	Dental care ¹	Medical goods dispensed to out-patients	Pharmaceutical and other medical non-durables ²	PHI as % of total private expenditure (2000)
Australia						
PHI	60.4	17.9		5.2	0.9	
OOP	14.2	36.7	<i>n.a.</i>	44.8	30.4	22.3
Canada						
PHI	3.6	46.0		35.1	34.5	
OOP	18.1	28.5	<i>n.a.</i>	50.6	39.0	37.1
Denmark						
PHI	0.0	86.6	61.6	13.4	0.0	
OOP	12.6	37.9	22	47.1	30.1	5.8
Germany						
PHI	29.9	29.8		12.5	9.6	
OOP	25.3	21.8	<i>n.a.</i>	47.7	27.7	31.2
Hungary						
PHI	0.0	27.7	16.9	51.9	51.9	
OOP	10.4	40.4	24.8	46.8	39.4	1.0
Korea						
PHI	94.1	5.3		0.6	0.6	
OOP	17.0	54.9	<i>n.a.</i>	28.1	20.2	5.4
Mexico						
PHI	100	0.0		0.0	0.0	
OOP	18.6	45.3	<i>n.a.</i>	37.9	37.9	5.0
Poland						
PHI	10.5	83.9		0.0	0.0	
OOP	3	30.8	<i>n.a.</i>	62.8	58	1.5
Spain						
PHI	12.2	72.9		0.0	0.0	
OOP	9.9	51.2	<i>n.a.</i>	38.9	24.9	14.1
Switzerland						
PHI	59.0	15.4		6.7	3.1	
OOP	39.6	40.5	<i>n.a.</i>	13.6	11.5	23.8
Turkey						
PHI	20.0	19.9		9.3	8.7	
OOP	6.3	44.5	<i>n.a.</i>	33.5	30.4	11.8

Notes: Data were collected as part of the pilot implementation of a System of Health Accounts. For some countries, the data differ from those provided to the OECD as part of OECD Health Data. Data refer to the following years: 1999 for Canada, Denmark, Poland; 2000 for Australia and Turkey; 2001 for Germany, Hungary, Korea, Spain and Switzerland.

OOP: Out-of-pocket expenditure; PHI: Private health insurance.

1. Dental care is a component of out-patient care, for which a breakdown is also shown.

2. Pharmaceutical and medical supplies are a component of medical goods dispensed to out-patients, for which a breakdown is also shown.

Source: Orosz and Morgan (2004).

than single-payer or integrated national health systems do, especially when insurers do not bargain collectively with providers. Shifting expenditure onto other payers, whether public systems or other private insurers, is furthermore a more attractive strategy for insurers than controlling expenditure. Systems with many payers who bargain collectively with providers of health care, such as Germany, may also be more effective in controlling expenditure than those characterised by atomised negotiations (Reinhardt et al., 2004).

In the United States, private insurance has been less effective than the public Medicare programme in controlling overall expenditure. Growth in per enrollee payments for a comparable set of services in private health insurance outpaced Medicare

Table 4.3. **Breakdown of type of care expenditure by private insurers and households**

Percentage						
	Private expenditure by type of care	In-patient care	Out-patient care	Dental care ¹	Medical goods dispensed to out-patients	Pharmaceutical and other medical non-durables ²
Australia	PHI	48.6	13.6		3.8	1.0
	OOP	32.4	79.4	n.a.	94	97.1
Canada	PHI	9.5	51.4		32.3	37.9
	OOP	69.9	46.4	n.a.	67.7	62.1
Denmark	PHI	0	12.3	14.7	1.7	0
	OOP	100	87.7	85.3	98.3	100
Germany	PHI	40.7	51.7		17.0	21.3
	OOP	44	48.3	n.a.	83	78.7
Hungary	PHI	0	0	0.7	1.2	1.4
	OOP	87.9	94.9	98.9	98.8	98.6
Korea	PHI	27	27		0.1	0.2
	OOP	71.5	91.1	n.a.	99.9	99.8
Mexico	PHI	22.2	0		0	0
	OOP	77.8	100	n.a.	100	100
Poland	PHI	5.4	5.4		0	0
	OOP	94.6	95.7	n.a.	97.6	97.4
Spain	PHI	n.a.	0		0	
	OOP	65.6	79.8	n.a.	100	n.a.
Switzerland	PHI	31.7	31.7		13.6	8.1
	OOP	66.2	89.1	n.a.	86.4	91.9
Turkey	PHI	29.1	29.1		3.7	4.0
	OOP	58	78.1	n.a.	86.3	89.7

Notes: Data were collected as part of the pilot implementation of a System of Health Accounts. For some countries, the data differ from those provided to the OECD as part of OECD *Health Data*. The sum of private health insurance and out-of-pocket expenditure for each category of care does not add up to 100 because of other private health expenditure (e.g. rest of the world, corporation). Data refer to the following years: 1999 for Canada, Denmark, Poland; 2000 for Australia and Turkey; 2001 for Germany, Hungary, Korea, Spain and Switzerland.

OOP: Out-of-pocket expenditure; PHI: Private health insurance.

1. Dental care is a component of out-patient care, for which a breakdown is also shown.

2. Pharmaceutical and medical supplies are a component of medical goods dispensed to out-patients, for which a breakdown is also shown.

Source: Orosz and Morgan (2004).

performance over the period 1970-2000, reflecting the higher payment rates to providers paid by private insurers (Boccuti and Moon, 2003). While managed care reduced growth in private insurance premiums in the 1990s (Box 4.10), they have resumed double-digit growth since 2001 (Levit *et al.*, 2004). This is partly because the managed care backlash has weakened care management initiatives by insurers. The US health care system also features higher health care prices than any other OECD country (Docteur *et al.*, 2003). This can be partly explained by the presence of multiple competing payers, who drive the higher rates of diffusion of technologically advanced services (McClellan *et al.*, 2002).

PHI also risks increasing public expenditure on health. This is because, while PHI may serve as an independent source of health funding, its effects are rarely entirely disconnected from the publicly funded system. Subsidies to private health cover – as in Ireland, Australia and the United States – increase public sector expenditure and have an opportunity cost, sometimes increasing overall utilisation levels as well. Even in the absence of direct or indirect subsidies, PHI has given rise to higher public expenditure in several countries with a significant PHI market because of the way the market interacts with the public system.

Box 4.10. Managed care in the United States: impact on health expenditures

In the mid-1990s, the rapid rise in managed care in the United States helped to slow down the growth of private health expenditure, at least in the short term. Two reviews of research results on various dimensions of performance by HMOs, revealed that premium growth in managed care have been significantly slower than in traditional insurance (Miller and Luft, 1997), and that HMOs appear to make use of fewer resources (Miller and Luft, 2002). While there is no clear difference in the use of physician visits, HMOs make less use of expensive resources compared to non-HMOs and enrollees have shorter length of stay in hospitals. Research also shows that there are community-wide effects associated to HMO penetration. Higher HMO or HMO/PPO penetration rates are associated with less use of expensive resources and lower employer health plans premiums. For example, one study of California hospitals found that, between 1983 and 1993, hospital expenditures grew 44% less rapidly in markets with high HMO penetration than in those with low penetration (Robinson, 1996). Another (Baker *et al.*, 2000) found that total costs for employer health plans are about 10% lower in markets that have HMO market share above 45% than they are in markets with HMO enrolments of below 25%. Some studies have also documented a spillover effect in which markets with high managed care penetration rates have lower rates of cost growth under indemnity coverage. On the other hand, managed care plans can have an impact on the number of competing health plan entering the market because developing provider networks involves high costs which create entry barriers for new plans (Nichols *et al.*, 2004).

This is especially the case in complementary PHI markets. PHI coverage of cost sharing on publicly financed health services, as in France and the United States Medicare Medigap system, removes price signals and incentives to consume care parsimoniously, resulting in an overall increase in demand and public system utilisation (Imai *et al.*, 2000; Christensen and Shinogle, 1997; Buchmuller and Couffinhal, 2004).⁵⁹ In addition, when PHI is offered by employers and its cost is in part or entirely invisible to insurees, as in the case of about half the PHI contracts in France, insurees' lack of awareness of PHI cost can also increase incentives to consume (Box 4.11). Obviously, if public programme cost sharing is high, as in the US Medicare programme, complementary coverage by PHI promotes access to care.⁶⁰

There is also evidence of PHI-induced utilisation increases in the public sector in duplicate systems. In New Zealand, privately treated patients generate some costs that are in fact met by the public system, such as laboratory tests and prescriptions drugs. In Australia, allowing private insurers to cover the difference between inpatient fees charged by doctors to privately financed patients and the regulated share reimbursed by Medicare (the so called medical "gap") seems to have had an initial inflationary effect. While it is too early to assess the longer-term impact of this measure, introduced in 2000, covering the gaps risks removing price signals and increasing moral hazard incentives. This can raise both public and total cost because Medicare finances a large share of the cost of private hospital treatments (Colombo and Tapay, 2003).

Even when PHI's role is more "segregated" from public systems, as in the case of supplementary cover, PHI sometimes impacts utilisation of publicly financed services. In Canada, much of the expenses of supplementary PHI goes towards coverage of prescription drugs not covered by the universal public health coverage programme. According to one

Box 4.11. The impact of complementary PHI on utilisation in France

Complementary health insurance reduces the out-of-pocket cost of health care, creating essentially first euro coverage for physician services and prescription drugs. More comprehensive contracts also significantly reduce the cost of goods such as eyeglasses, contact lenses and dental work. A number of studies indicate that complementary health insurance has a significant impact on health care utilisation in France, across a range of health services.

PHI coverage and trends in physician services use

A recent study found that, controlling for socioeconomic and demographic characteristics and detailed measures of health status, adults with complementary insurance were 86% more likely to visit a physician within a one-month period than those without insurance (Buchmueller *et al.*, 2004). This difference is comparable to differences between insured and uninsured adults in the United States, where the insured/uninsured differential in out-of-pocket costs is much greater.

PHI coverage and pharmaceutical spending

Another study, using data from 1998, found a strong relationship between complementary insurance coverage and spending on prescription drugs (Dourgnon and Sermet, 2002). Holding constant the effects of age and sex, individuals with complementary insurance were 10% more likely than individuals without this coverage to have any prescription drug use during a one-month period. Among people with any pharmaceutical expenditure, mean spending was actually 10% higher for individuals without complementary coverage. One explanation for this pattern is that private insurance coverage in France induces expenditures on drugs for less serious conditions (France has the highest per capita rate of pharmaceutical spending in Europe).

PHI coverage and ambulatory care expenditures

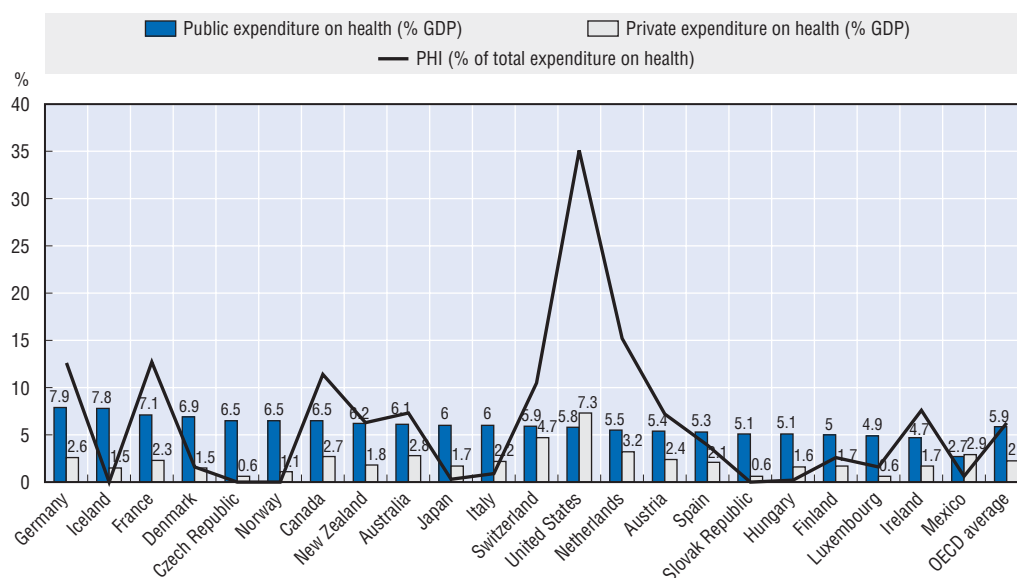
One recent study using data from 2000 found that, holding health status and other factors constant, total ambulatory expenditures for CMU beneficiaries and individuals with private insurance were 40% and 26% higher, respectively, than for individuals without complementary coverage (Raynaud, 2003). Holding constant other factors, complementary coverage is found to increase the probability of having any expenditure on optical care (among people needing glasses) by 84%. In the case of dental care, the results indicate that, all else equal, individuals with complementary coverage are between 38% (private coverage) and 50% (CMU) more likely to have at least one visit compared to someone without such coverage. The estimated effect on total spending on dental care is 22% for private coverage and (a statistically insignificant) 5% for the CMU. Another study on dental care found that, holding constant demographic characteristics and the reason for the visit, individuals without complementary health insurance were over three times more likely to report having gone without care than those with insurance (Gerard and Henry, 2002).

Source: Buchmueller and Couffinhal (2004).

study, privately insured individuals see doctors more often – at public expense – in order to get a prescription for the drugs that are covered by PHI (Stabile, 2002).⁶¹

Finally, several countries with significant PHI markets, including the United States, do not spend less on public health systems as a share of GDP than do other countries (Figure 4.2). They also tend to have higher private health spending. For example, in Germany, France, Australia and Switzerland, both public spending on health and private spending on health are higher, as a share of GDP, than the OECD averages. In the United

Figure 4.2. **Public and private health spending as a share of GDP and expenditure financed by PHI, 2000**



Source: OECD Health Data 2003, 2nd Edition.

States, public spending is around the OECD average, although private spending is much higher. In the Netherlands, the public share is slightly lower than the OECD average, although total and private spending is higher.

The magnitude of PHI impact on total and, in some cases, public health expenditure depends on several factors. These include: whether cost-control measures apply to the entire system or are limited to public coverage system only; the concentration of the PHI market and the bargaining powers of insurers vis-à-vis providers, which influences the ability of insurers to exercise strong purchasing power over providers; the cost of public sector subsidies to the private insurance market, and to what extent these are compensated by any cost savings in the public system; and the role played by PHI in the system.

6. PHI and health system cost-efficiency

The final area of health system performance considered in this chapter is health system efficiency. This is examined using three main indicators: the impact of PHI on health system competition; its implications for administrative costs; and its contribution to cost effectiveness of care.

6.1. Achieving value-based competition has proven difficult

Policy makers in several OECD countries have promoted competition in health insurance markets as a tool to extract better efficiency and responsiveness from their health systems. Competition is viewed as the mechanism to stimulate performance improvements because private insurers seek to attract and retain insurees and, often, to maximise profits or surpluses. Germany, the Netherlands and Switzerland have also encouraged regulated competition in their social or basic mandatory health insurance systems in order to improve patients' choices and encourage insurers to reduce cost. Their experience shows interesting insights into the challenges that arise from competition in

regulated insurance and funding systems (Box 4.12). Such insights are applicable to PHI markets where governments have imposed rules in order to promote “fair” competition and to minimise competition based upon risk selection. While a comprehensive analysis of competition in health insurance markets is beyond the scope of this report, this section sheds some light on this complex issue.

**Box 4.12. Competition in statutory health insurance markets:
some European experiences**

During the 1990s, Germany, the Netherlands and Switzerland introduced reforms in their social health insurance systems to enhance freedom of insuree’s choice and stimulate price competition. The reforms in the three countries are useful to analyse competition in PHI markets too. First, the Swiss basic mandatory health insurance system is a border-line case between PHI and public coverage. While financed through private individual premiums, it is heavily regulated, sharing features common to social health insurance in the Netherlands and in Germany. Secondly, new reforms planned in the Netherlands will introduce a mandatory PHI system for the entire population similar to the current Swiss basic health insurance system. Third, similar regulatory tools to those introduced in the three countries have been used by PHI regulators in other OECD countries.

Common rules

The rules governing the Swiss basic mandatory health insurance system and the German and Dutch social insurance schemes share the following common elements:

Insurers must accept all applicants (sometimes referred to as “open enrolment”) and applicants have unrestricted choice of insurer.

Insurers in the three systems set their own premiums, at least in part. In Germany, income-based contribution rates varied greatly across sickness funds even before free insurer choice was introduced. In the Netherlands, funds are allowed to fix a small flat-rate premium on top of income-related social insurance contributions. In Switzerland, insurers charge individual premiums, but these are required to be community rated within each fund.

Risk equalisation operates across insurers in the three countries. The German system is based on age, gender, family size, invalidity status and income. In the Netherlands, a central solidarity fund collects income-related contributions and makes risk-adjusted capitated payments to insurers on the basis of age, gender, region and employment status. In Switzerland, funds are compensated retrospectively for differences in health expenditures due to the age and gender structure of the population insured by each fund.

However, there are also some differences across the three systems concerning the relationship between insurers and providers. In Switzerland, insurers are compelled to conclude a contract with any willing provider. In the Netherlands, insurers are allowed to contract selectively with providers in order to negotiate prices below the government-regulated fees (although this rarely occurs as yet). In Germany, on the other hand, sickness funds jointly negotiate contracts with providers. In addition, while insurers offering statutory health cover can also offer voluntary supplementary PHI via associated insurance companies in the Netherlands and Switzerland, this was not permissible in Germany, until recently.

Box 4.12. Competition in statutory health insurance markets: some European experiences (cont.)

Evidence of the impact of competition in these health insurance markets

Competition in the three health insurance systems has yielded some interesting results. For the most part, changing insurers is most common among younger persons and those in better health status (and not very extensive overall). Germany has seen a larger degree of switching activity across sickness funds and this is due to a larger employer role in stimulating employee's choice, larger differences in contribution rates and higher price consciousness. On the other hand, transaction cost, ties between social/basic and supplementary health products, low consumer sensitivity to insurers' performance, and lack of adequate comparative information on insurers hamper mobility across insurers in the Netherlands and Switzerland. Effective and fair competition has not developed, even where switching occurs more frequently, as in Germany. Insurers have incentives to compete on selective marketing, and risk-equalisation systems do not adequately compensate insurers with worse risk structures. Insurers also do not compete on the basis of productivity as they do not selectively contract with providers nor implement managed care tools. While selective contracting with providers has been permitted in the Netherlands, such opportunities have hardly been used.

Source: Colombo (2001); Gress et al. (2002); Schut et al. (2003); Tapay and Colombo (2004).

Competition in several OECD markets is still underdeveloped

Several factors have reduced the extent of competition in PHI markets in many OECD countries. Individual switching across insurers has been hindered by high transaction costs. In some countries, this has been complicated by the lack of portability of private cover, as in the Dutch supplementary health insurance market, and the absence of readily understood comparative information on available products, prices and insurers' performance, as in most OECD countries. In Ireland, Australia and the Netherlands, the level of individual switching of PHI plans across insurers is small. In addition, the size of PHI markets, particularly where this is not the main source of coverage for the population, may limit opportunities for insurers to enter the market with long-term viability, thereby reducing the extent of competition. In Ireland, only two main insurers offer PHI and one has a significantly larger market share. In Denmark, the main insurer on the market has a market share of over 90%. Markets are concentrated in several other OECD countries as well. For historical reasons, some PHI markets are dominated by insurers that draw membership from given regions, employment groups, or other groups.⁶² Also, in some cases, as in the United States, insurers' receive licenses at the state level and product availability can thereby be tied to the location of the license. Finally, where PHI plays a smaller role in financing individuals' health care, such as in many supplementary or complementary PHI markets, the financial implications of choosing one insurer over another are not as significant for insurees, thereby reducing sensitivity to the comparative performance of insurers.

When there is competition, it may not necessarily develop on price and quality grounds

Where it actually occurs, competition among private health insurers has not automatically delivered performance improvements in PHI markets.

In part, this is because, when this is permitted by regulation, insurers have appeared to compete by selectively offering coverage, certain benefit packages, and/or favourable

premiums, to applicants who represent “better risks”. Insurers have also incentives to shift the cost of certain risks onto other payers (public payers and other insurers) who are less able to exclude applicants with worse risk, particularly in markets where PHI is the only or main form of coverage for population groups. Governmental limits and voluntary codes of practice have sought to limit such activities in some countries.⁶³

In the United States, the degree of competition across PHI carriers, and the grounds upon which it takes place, differ across sub-markets and location.⁶⁴ This complicates analysis of links between competition in insurance markets and health system performance.

Pressure from rising health care costs has recently driven insurers and employers in a few countries to increasingly shift the cost of employer-sponsored schemes onto insurees by raising cost sharing and reducing the comprehensiveness of PHI policies (Tollen and Crane, 2002). These cost-shifting strategies can reduce the extent to which insurers compete on price and quality ratios. In the United States, PHI carriers who administer (but not insure) health plans on behalf of self-funded employers⁶⁵ enrolled 36% of participants in US employment-based plans in 1997 (EBRI, 2000). In this instance, carriers can compete on the basis of administrative efficiency and the provider networks they offer, but they do not assume the financial risks of furnishing health coverage. In the US Medicare+Choice programme, private insurers tend to attract lower risks (OECD, 2004) (Box 4.13). In the individual PHI market, insurers often face incentives to risk-rate based upon individual

Box 4.13. **Competing private plans in the US Medicare+Choice programme**

The US Medicare+Choice programme is aimed at enhancing health coverage options available to Medicare enrollees while at the same time leveraging competition in the PHI market to extract cost savings and efficiency improvements for the public system. Medicare+Choice provides Medicare beneficiaries with the option to enrol in several different types of private plans, most of which are managed care plans, as an alternative to the traditional fee-for-service Medicare programme. Medicare pays the plans a monthly capitation fee for each enrollee. Conversely, in the traditional programme, Medicare pays doctors and hospitals directly.

Evidence suggests that the programme – at least to date – has not met some of the initial expectations (Berenson, 2001). Enrolment slowed, and even declined after an initial growth. The range of products offered dropped and premiums started to rise. Several plans pulled out of the programme as they did not find it financially attractive. This created a number of inconveniences for consumers, as some enrollees lost their benefits and possibly had to change doctors.

Enrolees of Medicare, which include many vulnerable individuals, have few incentives to make active switching choices, particularly as they can always opt back into the traditional programme, where benefits and premiums are standardised and choice of providers and treatment is larger, upon developing serious conditions. Private plans tend to accept relatively healthy retirees and benefit from favourable risk selection. As the Medicare pricing system only bluntly adjusts for differences in health risks between those enrolled in the traditional programme and those in managed care plans, private plans are advantaged at the expense of public financing (OECD, 2004). Furthermore, the Medicare programme pays HMOs more than it would have paid for traditional Medicare enrollees (Gold, 2003) of similar risk profiles. Geographical diversity also poses challenges to the functioning of the programme, due to the disparity in plan availability across different geographic locations. For example, it does not work well in rural areas where providers' density is low, and it requires specific market conditions, such as the existence of adequate provider competition.

health status and to target their marketing in a similarly selective fashion. Furthermore, despite initiatives to improve the availability of comparative plan information, information furnished to insurees is inadequate to entice individuals to vote with their feet. All of these dynamics are an obstacle to value-based competition.

Evidence in other OECD countries also points to the difficulty of extracting health system performance improvements from competition within PHI markets. In Ireland, a recent entry into the PHI market has attracted a significant portion of the younger and healthier enrollees. Competitive pressures have not significantly encouraged this recent entry, nor the insurer with the largest market share, to enhance care and cost management to date (Colombo and Tapay, 2004a). In Australia, the proliferation of products and PHI carriers' freedom to change conditions of cover at will, may provide these insurers with opportunities to direct individuals to certain products according to their level of risk or health status. This can create avenues for insurer competition by risk selection rather than quality-price improvements.⁶⁶ In France, despite significant consumer mobility in the complementary PHI market, there is little evidence that insurers have engaged in efforts to improve the cost-efficiency of care. In fact, competitive pressures deriving from the entry of commercial insurers into the market seem to have induced non-profit mutual insurers to apply stricter actuarial assessments. This pressure is similar to that experienced by some of the US non-profit Blue Cross/Blue Shield plans, which are only sometimes permitted to risk-rate or exclude conditions (Buchmueller and Couffinhal, 2004).⁶⁷ Competitive market dynamics can also pose pressures on successful insurers (Box 4.14).

Employers and providers affect competition in PHI markets and its impact on health systems.

Employers can both stimulate and hinder competition, and influence the grounds on which insurers compete. Employers are powerful purchasers of group PHI. They are also

Box 4.14. Benefits and challenges of competition in insurance markets: a comparison of Kaiser Permanente with the UK National Health Service

The US health plan “Kaiser Foundation Health Plan” and its hospitals are integrated with independent physician group practices. The experience of Kaiser Permanente shows both the potential benefits and the challenges of competing insurance markets. One study compared Kaiser Permanente to the efforts of the British NHS system (Feachem et al., 2002), which also operates an integrated health system, but which is not insurance-based. After adjusting for differences in the covered population, Kaiser is found to spend roughly the same amount of resources on a per capita basis as the NHS, while delivering more services and operating with shorter waiting times for access to specialist services and hospital admissions. The study found that Kaiser achieves such performance by better integration across the system, better hospital management and use of information technology. A plausible explanation for the difference between Kaiser and the NHS is that pressures from competing insurers encourage Kaiser to search for more efficient solutions, to be more cost-conscious and to match costs to revenues. The study findings, however, have been questioned by other analysis (Talbot-Smith et al., 2004). At the same time, Kaiser is also encountering difficulties in competing with other insurers in the United States. Its ability to provide good-quality care has attracted higher risks and resulted in adverse selection by applicants.

Source: Adapted from OECD (2004).

theoretically more likely to be price-sensitive and actively search for better-priced insurers and policies (Mossialos and Thomson, 2002).⁶⁸ The presence of both an individual and an employer-sponsored market in a country may also create incentives for plans to segment the PHI marketplace and recoup premium discounts on group policies from individual contracts. Employer-sponsored coverage, particularly when employers pay all or a significant share of the health care costs, also isolates people from the real cost of health insurance premiums, thereby reducing individual cost sensitivity and their incentives to choose the lower-priced insurer, if indeed employees have the option to do so. One study of the Fortune 500 firms offering primary private health coverage in the United States found that only 9.6% of employers offered a cost-conscious choice to employees (Enthoven, 2003).⁶⁹

There is a complex interplay between competition in health care insurance and delivery markets. The market structure and competitive behaviours of insurers influence providers' responses. In the United States, the penetration of managed care, particularly in the second half of the 1990s, spurred consolidation in the hospital sector in order to strengthen these providers' marketing power *vis-à-vis* multiple managed care plans operating in their areas (Pauly and Nichols, 2002). Similarly, reorganisation of private hospitals in Australia enhanced providers' ability to negotiate jointly with insurers, as Australian antitrust regulation does not permit hospitals to negotiate jointly with insurers unless they are part of the same corporate structure (Colombo and Tapay, 2003).

Providers' market power in the context of competing insurers affects the extent to which the PHI market can be expected to promote efficiency and the provision of high-quality care. More competition across insurers does not necessarily result in lower cost if the PHI industry is fragmented in its relationships with providers. In fact, while the particular structure and concentration of the PHI market in Ireland reveals relatively low PHI competitors, its concentrated market structure has helped competing insurers maintain low private hospitals prices and reimbursement levels (Colombo and Tapay, 2004a). The results of a recent study on sixty communities in the United States revealed that one prerequisite for market forces to drive efficiency improvements is the presence of "vibrant" price and quality competition among providers, underpinning competitive health insurance markets (Nichols *et al.*, 2004). The study highlights how market forces driving efficiency are inhibited if providers exercise dominant market power, leading them to enforce high health services prices and shielding them from insurer-pressure to improve quality and cost effectiveness of care.

Multi-payer social-insurance systems with competing insurers have also faced challenges

Finally, multi-payer social-insurance systems have also faced challenges when the same insurance entities are offering both social and PHI products, as occurs in the Netherlands and Switzerland through private affiliates of social insurers. While legally separate, these entities share administrative efficiencies and sometimes offer combined social and private insurance packages, whose separation is either invisible to consumers or impractical for them. While individuals can in principle freely switch to another social health insurance, portability protections do not apply to private health insurance. This can reduce competition among social insurers by limiting mobility of insurees' in social health insurance markets (Colombo, 2001; Tapay and Colombo, 2004). Furthermore, enrollee health status information gathered through social coverage can be used by private insurer affiliates to identify bad risks. Germany has, until recently, prohibited social insurers from offering private coverage to reduce these risks.

Box 4.15. Risk-compensation mechanisms

In health systems with competing health insurers, especially where premiums cannot be risk-rated, insurers face incentives to exclude worse risks. Compensation mechanisms either among insurers or between insurers and the government/regulator can help maintain solidarity. Such systems exist in the Swiss basic health insurance and in the Australian duplicate market. They have been foreseen to operate in the PHI market in Ireland and in the planned universal PHI system in the Netherlands (Ministry of Health, Welfare and Sport, 2002). There are a number of risk-compensation methods at work in the US market, including reinsurance programmes in the small employer market and high-risk pools in the individual market, both of which spread costs among all carriers in these markets. They also exist in social health insurance, for example in Germany and the Netherlands. The US Medicare market has introduced risk-adjustment mechanisms to account for uneven enrolment of low-risk and high-risk beneficiaries in participating private plans.

Risk compensation can take different forms. Equalisation can be centrally determined on the basis of a capitation formula adjusted by predictors of individual health care expenditures, as in the present Dutch social health insurance system. Insurers can be left to determine at the start of the period the fraction of their insurees whose costs will be pooled. Pooling might apply only to a percentage of insurees' costs, as in the Australian PHI market, to a regulated level of benefit coverage, as is likely to be the case for Ireland, or to the totality, as in Switzerland. Another method consists of compensating all plans for insurees' costs above a certain threshold. Finally, risk compensation can consist of risk-sharing arrangements between insurers and a central fund, where insurers do not bear the risks of financial deficits nor benefit from financial surpluses. Each of these mechanisms creates different incentives for risk selection, efficiency, and cost containment. The choice of type will depend upon the relative importance attributed to these policy objectives.

A good compensation mechanism should not adjust for the degree of insurer efficiency, otherwise insurers will find their efforts to be cost-effective penalised. A balance between prospective and retrospective compensation should be considered. Mechanisms based on retrospective compensation of differences across insurers' health expenditures might prevent insurers from seeking efficiency gains. On the other hand, prospective compensation formulae might unjustly make insurers responsible for cost differences that are not within their control capacity.

A risk-compensation mechanism is effective if it makes the insurers' marginal cost of selecting risks higher than the marginal benefit. The mechanism should calculate compensation on the basis of enough risk-adjusters to make it costly for insurers to predict the likelihood of individual health expenditures better than the compensation formula does. If insurers can easily derive a more accurate prediction, they will be able to identify costly cases and exclude them. Risk-adjusters can include socio-demographic factors (*e.g.*, age, sex, income, region); prior utilisation and diagnostic information (*e.g.*, diagnostic-related groups); disability and functional health status (*e.g.*, severe disability measured by Activity of Daily Living or Instrumental Activities of Daily Living); indicators of chronic medical conditions (*e.g.*, indicators on conditions more frequently associated with high consumption of medical services). The socio-demographic group of risk-adjusters, though easy to apply, does not have as high a predictive power as the other sets of indicators.

The risk-compensation mechanism should not incorporate too many risk factors. This might make insurers believe that their efficiency gains are used to cross-subsidise inefficient insurers. Modelling techniques could help determine the point beyond which adding an extra risk factor does not improve the explanatory capacity of the risk-compensation formula at the margin. Consideration should also be given to practical concerns, particularly the possible resistance of insurers should the compensation mechanisms be perceived to discourage their efficiency efforts.

Source: Adapted from Colombo (2001).

Some policy tools can facilitate fair competition although there are costs

Policy makers can monitor and facilitate fair competition in health insurance markets. Nonetheless, they also face conflicting choices between stimulating competition and innovation while protecting equity, particularly for vulnerable groups. For example, risk-equalisation schemes help discourage competition among private insurers based upon risk selection or selective marketings and exclusions. However, if the mechanisms compensate insurers for differences in costs arising from their own inefficiencies, risk compensation dampens insurers' incentives for cost-effective management of high-cost cases. Regulation of the relationship between providers and insurers also has trade-offs. Compelling insurers to provide all providers with a minimum level of reimbursement (or a default payment) or to conclude contracts with any willing provider guarantees insurees choice. Yet, such obligations reduce the levers available to health insurers to negotiate selectively with providers over the price and quantity of care. Regulation to standardise insurers' products favours comparability and price competition, discouraging risk selection or segmentation via insurees' choice of product best matching their risks. However, it also depresses insurer's ability to respond to market changes by innovating and tailoring products to consumer needs. Finally, while comparative information on plans' performance helps inform consumer choice, if the means by which insurers are compared are based on a narrow set of indicators or inaccurate data, plans may target efforts on selected areas subject to measurement, to the detriment of other aspects of performance.

6.2. Private health insurers generally incur high administration costs

Private insurers face high overhead costs. Marketing, policy management and underwriting represent the largest fraction of administrative expenses, but insurers also incur the cost of billing, product-innovation, agents' commission and distribution. Where insurers enter into arrangements with health care providers, multiple contractual negotiations add to insurers' administrative burdens. It is no surprise, therefore, that private insurers have higher administrative costs (per person insured and as a fraction of total cost) than do public health coverage programmes. In the United States, administrative data (cited, for example, in Woolhandler et al., 2003) show that the average administrative costs of private insurers (11.7% in 1999) exceed those of the public programmes Medicare (3.6%) and Medicaid (6.8%). Similarly, the administrative cost of Medicare in Australia (3.7% in the year 2001-02) is well below the PHI industry average (11.1%). Some funds have been more successful than others in keeping administrative costs to levels comparable to the single-payer public programme (Colombo and Tapay, 2003).⁷⁰ High average administrative costs for private insurers are also found in other OECD countries, such as the Netherlands (10.4%), Canada (13.2% in 1999), Ireland (9.7% in 2002)⁷¹ and Germany (14% in 2002).⁷²

Administration costs are larger in multiple-payer systems compared to those with single payers. This is partly explained by duplication in functions, for example in provider contracting and claim processing, and the need to account for the high administrative costs incurred by providers. In the United States, for example, the segmentation of coverage and financing sources contributes to the large administrative expenses borne by providers and private health insurers (Davis and Cooper, 2003). While little evidence is available concerning the optimal level of administrative overhead in different coverage systems, one study found that there is no clear indication that systems with higher administrative costs lead to improved health care quality and outcomes

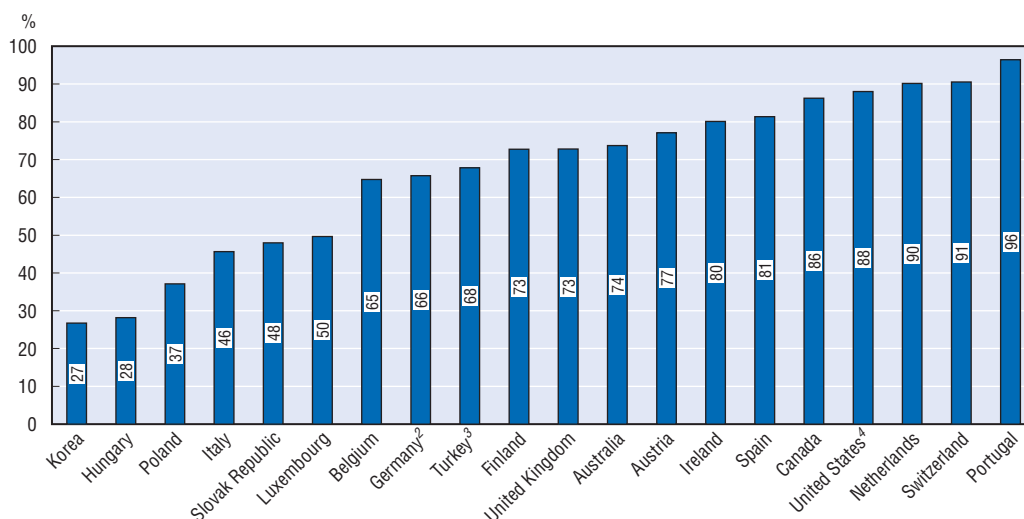
(Woolhandler *et al.*, 2003). The question of the appropriate level of administrative costs for public and private health insurance is an area that could benefit from further analysis.

Loss ratios, which represent the share of private health insurance premiums absorbed by the cost of health care service claims, display large variations across OECD countries (Figure 4.3). While these data reveal the portion of health insurance premiums paying for health care services (*i.e.*, it includes operating overhead, financial charges, contribution to solvency, surpluses and losses), and could therefore be used as an indicator of insurer efficiency, the data should be interpreted with caution, particularly when international comparisons are concerned. Organisations calculate and categorise expenses in different ways,⁷³ and accounting practices for reserves and expenses vary across countries.

6.3. Insurers have implemented few initiatives to enhance the cost effectiveness of health care

In the majority of OECD countries, private insurers have not implemented significant measures to enhance the cost effectiveness of care. In the United States, however, insurers have actively sought to influence health care delivery patterns, volumes and costs.⁷⁴ The impact of such managed care practices on health system performance has been mixed (Miller and Luft, 1997 and 2002). Employers purchasing policies have often not rewarded cost-effective and economical health care (Enthoven, 2003). Moreover, the backlash against managed care has shown some of the constraints and resistance private insurance markets may face if they seek to promote improvements in the cost-efficiency of health care delivery. At the same time, it highlights private health insurers' ability to respond to consumer demand, by modifying unpopular practices.

Figure 4.3. **Loss ratios¹ in selected OECD countries, latest available year 2000-2002**
Percentage of PHI premiums



1. Loss ratios represent the share of insurance premiums absorbed by the cost of health care service claims.
2. Because of the funding method used in Germany, part of the premium not required for risk coverage when the insured is still young is set up as an ageing reserve to be used in later years.
3. Administrative costs for PHI cannot be derived from loss ratios as they are calculated for all the branches that one company operates, rather on the basis of the individual branches.
4. In the US "Medigap" coverage market, premiums have to be set to achieve minimum loss ratios. Some states also impose minimum loss ratio standards on carriers offering primary PHI coverage. In a limited number of states, primary coverage sold in the individual market is subject to the rate loss ratio guarantees.

Source: OECD Statistical Questionnaire on Private Health Insurance.

In other OECD countries, private insurers rarely influence the quantity, quality, and appropriateness of care provided. Where plans negotiate contractual arrangements with providers, as in Australia and Ireland, negotiation takes place on the basis of service prices but at present rarely touch upon other care delivery conditions.⁷⁵ In other large PHI markets, such as Germany, Canada, France and the Netherlands, insurers are not involved in managing care, as they are mostly contracted to reimburse patients with limited involvement with providers. This also occurs in smaller PHI markets across the OECD area. Professional provider associations, for their part, typically strongly resist any involvement of insurers in decisions relating to patients' care. The regulation of the provision of health care generally supports a leading role of professionals in this area. Some limited health prevention and promotion initiatives are being implemented,⁷⁶ but insurers generally have few incentives or lack the capacity to implement these programmes. Other tools, such as utilisation review, clinical guidelines, restrictions on treatments, incentives and information directed to consumers to promote the use of cost-effective providers or services, are used in only few OECD countries outside the United States.

Several explanations for the limited involvement of insurers in managing care are plausible, including, among others, complexity and cost, resistance by the medical profession, lack of incentives, and the desire not to restrict individual choice and lack of legal or institutional capacity.

First, tools for managing care can be costly and complex for insurers to implement successfully. They require sophistication in practices, and insurers may have limited incentives to invest in their application, especially if they do not expect significant gains, or anticipate opposition by stakeholders such as professional associations.⁷⁷

Second, selective contracting is not widespread. In several OECD countries, negotiations between providers and public purchasers have traditionally occurred on a collective basis. The desire not to restrict individual choice of provider, regulatory requirements and reimbursement practices also explain the lack of selective provider contracting. Even where they are involved in individual negotiations with providers, insurers have preferred to apply similar contractual formulae to all contracted parties, possibly with only some slight price differences across providers. They therefore have not leveraged the potential of more selective contracting to strengthen their ability to negotiate on the volume and quality of care, nor on quality standards, clinical practices, and special programmes for high-risk individuals.

Third, insurers face few incentives to manage high-risk and high-cost cases in several countries, because their exposure to risk and cost is generally small where PHI does not have a primary role, or where it makes a minor contribution to financing costly care. Management of care – and its cost effectiveness – is not a significant activity for insurers in Australia, Ireland, France, as well as in countries with smaller PHI markets.

Finally, regulatory instruments geared to prevent “unfair” competition and limits on insurance access carry the risk of reducing incentives for insurers to manage care. Mandatory or voluntary pooling, or risk-equalisation arrangements, can help spread the cost of caring for less healthy populations.⁷⁸ But they carry trade-offs and raise technical challenges. While they promote equitable risk pooling across insurers, they do not encourage insurers to manage care if they compensate inefficient insurers for their higher costs. Some OECD countries are seeking to refine these arrangements as part of an ongoing effort to strike a balance between these two objectives.⁷⁹

Notes

1. This chapter draws largely from case studies and focused country background work carried out in selected OECD countries. It also provides evidence from some other countries with prominent PHI markets, for which documentation and data are available.
2. Australian and Irish duplicate markets cover nearly half of the population. Dutch and Canadian supplementary PHI markets have even wider scope (93% of the socially insured in the Netherlands, 65% of the population in Canada), as do the French and US complementary markets (over 90% of the French population, and about 2/3 of US Medicare beneficiaries). Other significant markets, offering a combination of different coverage types, include Belgium (57%), Austria (32%), Denmark (28%), and New Zealand (35%). In other countries, PHI markets are small or negligible (*e.g.*, Turkey, Mexico, the Czech Republic, the Slovak Republic, Hungary, Japan, Sweden, Norway, Iceland Luxembourg and Poland). Countries with medium coverage levels include Germany, Portugal, Spain, Italy, Finland and the United Kingdom. See Chapter 2 for more details.
3. A portion of the US non-elderly uninsured could be eligible for public programmes, such as Medicaid or the State Children's Health Insurance Program (SCHIP), but have not enrolled in this coverage. For example, there remains a group of uninsured children who are eligible for Medicaid or SCHIP, but have not enrolled [US Centers for Medicare and Medicaid Services (CMS), 2001]. In many cases, however, uninsured persons are not eligible for public coverage and do not have employer-sponsored or individual coverage. Often, this occurs because they cannot afford it, or their employers do not offer PHI or cost sharing makes PHI still expensive.
4. Nonetheless, no governmental intervention has been implemented in the Netherlands to address the concerns that have arisen in this supplementary PHI market yet. The "Rocard report" (European Parliament, 2000), identifies some potential concerns with private supplementary health insurance sold in Europe and called for further study of the matter.
5. Six out of ten Canadian provincial governments have legislation prohibiting private coverage of physician and hospital services and some other services also covered publicly (Flood and Archibald, 2001).
6. Though not always. Employer-funded PHI is subject to fringe benefit tax in Australia.
7. Austria, Belgium, Canada, Denmark, Italy, and Spain also offer fiscal incentives for employer-provided PHI.
8. For example, the rate of premium growth for employer-sponsored coverage in the United States ranged from a low of 0.8% in 1996 to highs of 18% in 1989 and 11% in 2001 (Williams *et al.*, 2002).
9. With one notable exception, 2002, when premiums increased by 18%. Prior to 1996, there was only one primary private health insurer in Ireland, the Voluntary Health Insurance Board (VHI), a state-owned insurer whose premium increases are subject to government approval.
10. On the other hand, while in the Netherlands there is a high degree of purchase of private supplementary insurance among those with social insurance (93%), who are in the lower two-thirds of the income strata, it is not known whether the remaining uninsured 7% includes mainly the poorest group.
11. Mossialos and Thomson (2002, pp. 43-44) note several limitations of the EU third non-life insurance directive, including problems for member states that attempt to reach a compromise between deregulation and consumer protection, and the lack of clear evidence to suggest that competition has benefited the consumer by lowering prices and increasing choice.
12. Most private long-term care insurance markets are voluntary, except for Germany, where purchase is mandated for those with private primary health insurance and for civil servants without insurance against sickness.
13. In the United States, evidence suggests that uninsured individuals obtain fewer primary and preventative services and wait to receive treatment until they need emergency care – which hospitals are under obligation to provide (Docteur *et al.*, 2003).
14. These data are collected as part of the OECD Statistical Questionnaire on Private Health Insurance (response form Canada).
15. Capacity is indeed a key factor behind cross-country variations in waiting times across countries (Siciliani and Hurst, 2003).
16. In Spain the public sector has purchased capacity from the private sector in some regions, while in the United Kingdom, after some initial experiences, this has not continued.

17. See Simoens and Hurst (2004) for a discussion of the effects of different payment methods on doctors' productivity.
18. Such as allowing doctors to charge higher fees to private patients. Differences also exist when doctors are paid on a salary or capitation basis for their public practice, and on a fee-for-service basis in their private practice.
19. In such systems, public health coverage is tied to public delivery structures (such as public hospitals and doctors in public practice), while a parallel private sector caters to individuals paying out-of-pocket or through their PHI policy.
20. Available evidence indicates that moderate waiting times for non-life-threatening conditions (three to six months depending on condition) do not worsen patients' health and surgical outcomes, while longer waits can be more problematic (Hurst and Siciliani, 2003).
21. It is unknown how much of the higher utilisation induced by private health cover is due to latent need – spurred, among others, by the ageing of the population and increased demand for better care – or to unnecessary demand resulting from moral hazard. The impact on health outcomes has also not been fully investigated.
22. The study analyses the extent to which adults in equal needs for health care appear to have equal rates of medical care utilisation. The distribution of care is considered as “pro-rich” if, after standardising for needs differences, there appear to be inequities in medical care utilisation that favours the rich.
23. This study is broadly cited as evidence of several dynamics within health coverage schemes, including the risk of moral-hazard-induced utilisation under increasingly comprehensive health insurance coverage. The Rand study also found that cost sharing imposed by health insurance is equally likely to reduce the use of medically effective services, as it is to lower the use of those services which medical experts deem to be less effective or ineffective. This is why policy makers need to balance tradeoffs between increasing access to needed care and controlling moral-hazard-induced utilisation.
24. In Australia, France, Germany, Ireland and several other OECD countries, PHI can pay for additional fees above the government fee schedule for in-hospital private treatments.
25. While this concern has been raised in several countries, such as the United Kingdom and Ireland, evidence that this has occurred in practice is limited. See, for example, Evans (2000) and Robinson (1999).
26. The maximum rate for the standard policy (WTZ) in the Netherlands is based upon the average rate in the private market, but is slightly higher.
27. The premium rating cap and cross-subsidy applicable to the standard, WTZ, policy is an exception to the rules otherwise applicable to the premiums offered by PHI carriers in the Netherlands.
28. See for example the discussion and expert papers summarised in Feder and Burke (1999).
29. Risk-pooling mechanisms, which subsidise insurers with poor-risk pools, are discussed below (Box 4.15).
30. This could be explained with broadly applicable cost controls, which eliminate out-of-pocket costs for the socially insured and reduce them for the privately insured.
31. For example, “point-of-service” plans provide insurees with the choice between higher coverage of contracted “preferred providers” and reduced coverage of the services of other providers.
32. Nonetheless, despite these increased financing burdens, the relative share of health care costs assumed by individuals has not shown a dramatic shift. In fact, at least as of 2000, consumer out-of-pocket expenditures composed a smaller share (17.2%) of overall US health spending for health services than was the case in 1990 (22.5%) and PHI assumed a slightly greater burden (34.6% 2000, vs. 33.4% in 1990) (US Centers for Medicare and Medicaid Services, 2000).
33. For example, New York State law requires HMOs selling policies in the individual market to offer two standardised managed care packages. In particular, they must offer a choice between a standard HMO and a “point-of-service” plan. Such a requirement does not apply to group health insurance. Both the HMO and point-of-service (POS) standard policies offer comprehensive coverage, including hospital and physician care, maternity care, preventive checkups and immunisations, and prescription drugs (Georgetown University Health Policy Institute, NY guide, dated 2000). In New Jersey's small and individual health insurance market, insurers must offer, and are limited to offering, five standardised plans with specified maximum deductibles and co-payment (New Jersey Department of Banking and Insurance, 2004).

34. For example, one analysis indicated that 50% of the Australian PHI premium rebate benefits the top 20% of taxpayers and only 25% of the rebate benefits the bottom 60% (Colombo and Tapay, 2003 citing Smith, 2000 and 2001).
35. This prohibition is imposed by the federal Health Insurance Portability and Accountability Act (HIPAA), enacted in 1996.
36. Private insurers and providers tend not to operate along the entire continuum of care in duplicate PHI markets.
37. Within “pure” traditional HMOs, enrollees can only receive health services of the HMO’s panel of medical providers. In PPOs, enrollees can access the services of a selected network of providers, and may go outside the network by paying a greater percentage of costs on an out-of-pocket basis. In indemnity insurance plans, choice of provider is unrestricted and insurees generally claim reimbursement from insurers, although, in some cases, providers may seek reimbursement directly from the insurer. The current marketplace is witnessing plans which combine features of two or more of these plan types. See Chapter 2 for more details on different types of plans in the United States.
38. The US traditional Medicare programme offers virtually unlimited provider choice, while Medicare enrollees can elect to obtain their coverage through a privately administered managed care plan. Many public Medicaid enrollees also join a managed care plan with limited provider networks. Thus, in the United States, the degree of provider choice depends more on particular plan characteristics and relationships with providers, rather than whether one’s coverage is public or private.
39. PHI insurees in Germany can choose to be treated by senior hospital consultants, and alternative practitioners not covered by the public system.
40. The importance of expanding the range of comparative coverage information in the United States is emphasised in Nichols *et al.* (2004).
41. Regulation can help enhancing portability of cover. For example, the United States passed legislation in the mid-1980s establishing rules under which individuals in the employment-based market may switch insurers.
42. Insurees do not have to serve additional waiting periods provided benefits are not upgraded in the transfers to a new fund.
43. In fact, these problems were found in the US Medicare supplement market prior to the standardisation requirements enacted in 1990.
44. McClellan *et al.* (2002) argue that reliance on competition among insurers and providers in the United States resulted in physicians trying to attract patients through intensity of treatment, amenities and other aspects of quality, while hospitals also attracted patients and physicians by similar mechanisms.
45. In order to avoid standard packages becoming out-of-date, regulators can be provided with enhanced flexibility to update such packages (such as specifying them through regulations that can be changed, rather than by statute).
46. In the Netherlands, employers have tried to address certain shortages in supply, through initiatives such as employer clinics to help speak employees’ re-entry into the workforce. Insurers stepped in to cover services offered in employer clinics. However, the government was concerned that this might result in inequalities in access according to willingness to pay, and prohibited such initiatives (Tapay and Colombo, 2004).
47. These include, for example, restrictions on insurers’ ability to impose exclusions on pre-existing conditions, premium-related requirements, benefits standards and restrictions on insurers’ ability to selectively contract with providers.
48. See, for example, efforts of the National Committee on Quality Assurance in the United States (a private, voluntary body in which insurers widely participate) to develop Health Plan Employer Data and Information Set “HEDIS” report cards, assessing plan performance in several key areas. In addition, the “Leapfrog Group” is one of the organisations advocating for performance-based payments in the United States (www.leapfroggroup.org/). The organisation comprises a large number of public and private organisations that provide health care benefits, including private health insurers and large employers who “self-insure” their health care costs. Working with providers, the Leapfrog Group seeks to identify problems and propose solutions to improve quality and patient safety in urban area hospitals. It represents more than 34 million health care consumers in all 50 states. Several of their members have led the drive for purchaser-driven health care plan quality improvements and continue to devise innovative mechanisms for promoting quality of employer and individually funded health care in the United States.

49. In the United Kingdom, one insurer has set up partnership agreements with most providers. Doctors agreeing to charge no more than the maximum benefits paid by the insurer and to fulfil a range of personal quality criteria receive from the insurer an annual 10% supplement for all their qualifying charges to insured patients. In Australia, some large funds organise diabetes educational programmes to encourage patients to pursue preventative care and less costly outpatient treatments. In Ireland, insurers are experimenting with clinical indicators and care pathways.
50. For example, there was concern that pre-authorisation requirements might take too long and therefore compromise the provision of care, or that appropriate exceptions to such standards need to be made in the case of emergency room treatment.
51. While parts of these standards seek to assure insurance coverage of certain care, they also seek to assure that insurer decision-making processes are timely and performed by persons with the appropriate expertise, thereby not compromising the provision of timely and quality care.
52. Between 60 and 75% of health expenditures are associated with people with chronic conditions (Enthoven, 2003).
53. The structure of the opting-out mechanism in Germany reduces public-sector revenues deriving from social health insurance contributions; at the same times, it saves social insurance the health expenditure sustained by this population group.
54. The public-private health financing mix in the Netherlands is likely to change if current plans to move to a system of mandatory private health insurance for the entire population are enacted. The proposed changes are to include the following regulatory safeguards: a governmentally defined, minimum, basic level of coverage that must be offered by all insurers; a requirement that all insurers wishing to participate in the administration of the basic insurance scheme accept all applicants (at least for the basic insurance package); a prohibition on insurer differentiation of premiums according to age, gender, health status or similar criteria; and redistribution of premiums according to the level of risk borne by each insurer (Letter from Dutch Minister of Health, Welfare and Sport, H. Hoogervorst, to European Commissioner, Mr. F. Bolkestein, 8 October, 2003, DWJZ-2418668).
55. This is why in Germany there are limits to the ability of those choosing to buy substitute PHI to opt back into social health insurance.
56. The fact that some health services are not covered under the general public health care programme does not always preclude their being financed by other levels of government or other government programmes, however. For example, in Canada, certain prescription drugs for some categories of low-income persons are funded by provincial governments as additional benefit programmes.
57. In Ireland, there are two main large insurers operating on the market, while the private hospital industry is rather fragmented and comprised of relatively small hospitals. This has resulted in monopsonistic insurers exercising relatively strong bargaining powers over providers, which has helped insurers negotiate lower doctors' fees and private hospital payments. Insurers have furthermore not encouraged capacity development in the private hospital sector. Private insurees utilise to a large extent public hospitals, for which insurers reimburse on a per diem basis, fixed by the government and representing a fraction of real cost. In other OECD countries, as for example in Australia, insurers have not exercised a similar strong pressure on prices and capacity levels in the private delivery sector.
58. The United States, Switzerland and Germany, all of which have health systems based on multiple competing insurers, represent the largest percentage of GDP devoted to health care among OECD countries (OECD Health Data 2003).
59. In the case of the US Medicare programme, co-payments can be substantial (20% of permitted charges). In France, PHI covers co-payments that are minimal in nature for inpatient care, while public reimbursement is lower (65% and 72% respectively) for medicines and physician services (Buchmueller and Couffinhal, 2004).
60. In fact, evidence confirms that Medicare complementary coverage enhances beneficiaries' access to medically necessary care (Neuman and Rice, 2003).
61. In the case of services where there is less of a link with publicly funded services (i.e. no need for a related doctor visit such as is needed for a prescription), as is the case with dental care, no utilisation impact on the public sector was found.
62. This is the case, for example, of social insurers offering PHI coverage in Belgium and the Netherlands. In many European countries, insurers operating on the market are predominantly provident or mutual associations, who historically have offered PHI following solidarity principles, without risk assessment on inception, although this is no longer always the case.

63. However, the uneven application of some of these standards has sometimes resulted in an “uneven playing field” for competition, in which some insurers shift the cost of certain risks onto those payers (whether public or private insurers) who engage in less risk selection.
64. Health coverage markets in the United States include state-based markets as well as the individual, small employer and large employer PHI markets (the latter of which often also self-fund their coverage).
65. These contracts are often referred to as “administrative services only” (ASO) contracts.
66. Certain Australian funds are developing initiatives to introduce consideration of quality outcomes in contractual arrangements with providers. This may stimulate competition on the basis of quality-price ratios.
67. Insurer actions have sought to avoid adverse selection by enrollees, which occurs when insurers attract a disproportionate share of higher-risk individuals compared to their competitors.
68. Where most of the employer-market is in the hands of brokers, for example, these regularly compare offerings.
69. By contrast, many UK employers ask insurers to design group PHI schemes that incorporate special cost-containing measures.
70. The private industry average also shows significant variation across carriers, with administrative expenses ranging from 1% to over 20%, some of which are comparable to those of single-payer public programmes. Such large variation could be in part due to differences in the definition and classification of expenses. Funds with membership restricted to certain employment categories also have lower average administrative costs, averaging 7.7% compared to 11.3% for funds with open membership, which reflect their lower underwriting cost.
71. These data refer to the main government-owned insurer, VHI. Administrative costs for the second main insurer, BUPA, are not known.
72. Includes both underwriting and other administrative costs (PKV, 2003).
73. For example, in the United States, health maintenance organisations (HMOs) may treat administration associated with salaried medical staff as claims, whereas commercial carriers will treat the cost of making such payments to providers as administrative expenses.
74. Managed care plans tend to have detailed contractual or employment relationships with health care providers. Approaches for controlling costs and influencing provision used by managed care plans include requiring pre-authorisation for services, particularly specialist visits and hospitalisations, and selective contracting with providers who are willing to accept the plan’s payment arrangements. Managed care tools also include health prevention and promotion initiatives, management of chronic conditions, utilisation review, clinical guidelines, restrictions on treatments, and incentives/information directed to consumers to promote cost-effective providers or services.
75. This may change in the future. For examples, a couple of insurance funds in Australia have been looking at the possibility to introduce performance-based contracting with hospitals.
76. For example, some PHI insurers in Australia have instituted programmes for the management of diabetes and other chronic conditions. One insurer in Ireland is pioneering guidelines for hip replacement and same-day treatments. Another insurer negotiates a specified list of conditions for which a certain coverage needs to be available and also classifies appropriate procedures for day treatments. In both countries, certain controls are exerted on an ad hoc basis for very specific high-cost drugs or treatments, where insurers may decide whether and how much to reimburse cost.
77. There is a trade-off between the costs of cost-containment measures and the costs thereby saved. Pre-authorisation systems, for example can be effective, but are relatively expensive to run efficiently.
78. As, for example, in the Netherlands and Australia.
79. For example, Australia is updating its current reinsurance arrangements with a new system that seeks to enhance incentives for improved health fund efficiency; under this scheme, reinsurance support will be based on average hospitalisation costs, rather than actual costs, and funds that successfully reduce costs of a particular age or sex cohort below the average will benefit from the difference.

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Chapter 5

Conclusions and Policy Lessons

This final chapter summarises the main findings of this report. It focuses, in particular, upon policy lessons arising from the analysis of the impact of private health insurance on health system, including policy objectives such as equity and access, responsiveness and choice, quality of care, cost control and cost efficiency. This chapter also highlights useful practices that can help policy makers ensure that PHI markets make a positive contribution to the performance of health systems.

1. Introduction

This study has assessed evidence on the effects of PHI in different national contexts. It has also drawn conclusions about strengths and weaknesses of private health insurance, and thus contributed to the policy debate over the role of PHI and its implication for health system performance. In doing so, the study has identified factors behind favourable or undesirable performances of PHI markets, and the impact of PHI on health systems broadly. This concluding section summarises the main results and policy lessons arising from the study. It also indicates useful practices that can help policy makers ensure that PHI markets make a positive contribution to the performance of health systems.

2. The analysis of PHI markets in OECD countries reveals a large heterogeneity of experiences

This report has analysed the diversity of PHI markets in dimensions such as market size (in terms of population covered or PHI's share in total health expenditures), functions within the health system, types of insurers and their market conduct, regulatory frameworks and fiscal environments.

2.1. Market sizes differ, are not correlated to GDP levels and are weakly related to total spending on health

PHI accounts, on average, for 6.3%* of total expenditure on health (THE) and covers, on average, about 30% of the population in OECD countries. However, its importance in funding OECD health systems and levels of population covered by PHI vary significantly. There is some, but not complete, overlap between countries with a high share of PHI financing of total health expenditure and a large privately insured population. Countries with the highest shares of PHI financing (above 10%) show lower shares of out-of-pocket expenditure in total health expenditure. However, there does not appear to be a strong inverse relationship between the importance of PHI and out-of-pocket expenditure in financing health spending for the OECD area as a whole. Market size – determined by the share in total health expenditure or the share of population covered – does not appear to have a strong link to the level or growth of the economy across OECD countries. Significant PHI market size, in terms of population covered or contribution to total health expenditure, tends to be found in countries with the highest health spending levels per capita.

2.2. PHI functions depend on the interaction with publicly funded systems

PHI markets have largely developed around public health coverage systems. The interaction between public and private coverage determines what functions PHI plays. While PHI represents the sole form of health coverage for significant population segments in a few

* Unweighted average for 22 OECD countries for which reliable data are available or estimated for 2000. It excludes the following countries: Belgium, Greece, Korea, Poland, Portugal, Sweden, Turkey and the United Kingdom.

countries (primary and substitute functions), in most OECD countries PHI plays a supporting role to public systems (duplicate, complementary or supplementary functions). Different PHI roles give rise to specific policy challenges. The function played by private health insurance is therefore a good unit of analysis of the impact of PHI on health system performance. While PHI tends to cover certain typical services, there is diversity across OECD countries in both the health services and providers accessible by privately insured individuals. Such diversity reflects the scope of public coverage, and is affected by regulation and insurers' strategies. The diversity of coverage experiences seems to indicate that there is no type of service that is *per se* more or better "insurable" by public or private coverage. There are nonetheless some trends towards greater reliance on public or subsidised private coverage for individuals facing higher health care cost, such as the elderly and those with chronic conditions, even where PHI plays a significant or primary role.

2.3. A combination of historical and policy-related factors affects the development of PHI markets

The heterogeneity of experiences with PHI within OECD countries is the result of several factors. History matters. Many of the countries where private health insurance has a prominent role have some tradition of private financing and private provision of health services. Public policy is nonetheless the likely primary determinant of the role and the size of current PHI arrangements in most OECD countries. Rules under public and statutory health systems shape the borders of PHI markets and to a large extent determine their role. Private health insurance typically focuses on coverage of eligibility gaps based on categories of individuals, health services or providers not covered by public health systems. The structure and regulation of health delivery systems – for example price regulation in the public and private sectors, doctors' ability to practice in both sectors, public hospitals' ability to treat privately financed patients and private hospitals' financing arrangements – have also impacted upon the size and roles of PHI markets. The prominence of PHI has been buttressed by government interventions directed at PHI markets in several OECD health systems. Governments have used regulation and fiscal instruments to steer and encourage PHI markets. The effectiveness of policies aimed at increasing market size and fostering quality outcomes has differed widely. Likewise, markets have shown different levels of responsiveness to changes in the expansion of public system coverage. PHI markets can also grow due to consumer demand for better choice and more comprehensive cover, even where there is little stimulation through policy levers.

2.4. Demand for PHI is linked to income and gaps in public systems, and is fostered by employers

While PHI market size is not linked to the level of economic growth of a country, high-income groups are more likely to purchase private health coverage in most countries. Real and perceived quality gaps in public coverage and delivery systems can serve as an impetus for PHI purchases. Waiting times, increasing demand for choice, and perceptions of inadequacy of public systems are leading motivations in some OECD countries. Where public cover is not provided, primary PHI policies are purchased mainly to minimise the financial risks associated with illness. Cultural factors and differences in risk aversion across national contexts also account for a higher inclination to buy private cover in some countries.

Employers play an important and growing role in sponsoring private health cover as a work-related benefit. A large part of private health insurance policies in OECD countries with the highest levels of PHI population coverage are provided through the workplace. Employers appear to be more powerful agents than individuals in negotiating coverage conditions with competing insurers and benefit from greater risk pooling than do purchasers of individual policies – with larger employer groups accruing particular advantage from such pooling. There can, however, be downsides to employer purchase of PHI, including the potential for it to insulate individuals from the real costs of coverage and care.

2.5. Diverse markets supply PHI but competition is limited

Different types of insurers operate in OECD PHI markets. Private health cover can be offered by specialised health funds and non-specialised insurers and these can in turn be either for-profit or not-for-profit. The number and type of insurers affect the intensity of competition. Several OECD markets are concentrated and dominated by few carriers, which tend to control the market with limited consumer switching. In countries with both group and individual coverage, employer-sponsored markets tend to be more price competitive than individual markets, because of the bargaining power exercised by employers and of insurers' desire to attract large groups. It is also challenging to establish incentives for "healthy" and equitable competition among PHI insurers, as they face incentives to concentrate on good risks, thereby failing to cover more vulnerable individuals. The presence of for-profit and not-for-profit entities has resulted in an evolution in insurers' practices in some markets, as non-profit or mutual companies operating according to more solidarity-based practices risk being disadvantaged by adverse selection. Nonetheless, in several OECD countries, insurers behave similarly regardless of their profit orientation. The involvement by private health insurers who are affiliates of social insurers in differently regulated statutory and voluntary health insurance compartments may pose challenges for competition and consumer mobility in both the public and private insurance systems.

3. PHI has contributed differently to health system performance

PHI markets raise trade-offs between choice and innovation, on the one hand, and access and cost concerns, on the other hand.

3.1. PHI has enhanced access to care and financial protection but raised some equity concerns

PHI has offered a primary source of coverage for population groups ineligible to public programmes, and contributed to provide insurance protection against other public system coverage gaps. It has helped to inject resources into health systems, enabling an expansion in capacity and services. It also enhanced access to timely care in some systems experiencing prolonged public sector waiting times. Differential payments for doctors involved in publicly versus privately financed practice stimulate higher productivity and satisfaction. However, all of these advantages have depended upon the structure and regulation of coverage and delivery systems, insurers' strategic behaviours, and the role that PHI plays. PHI is not always affordable and accessible. Several barriers to access to PHI exist and PHI is becoming more expensive relative to general inflation. It is unknown how much of the higher utilisation induced by private health cover is due to latent need or to unnecessary demand resulting from moral hazard, and its impact on health outcomes has

also not been fully investigated. Clear trade-offs have also emerged. When resources and supply are scarce, it may be efficient to ration services on the basis of willingness to pay, for example through voluntary purchase of PHI. However, inequities arise as well. The advantages offered by PHI in terms of access to care have actually created inherent disadvantages for those populations without private health insurance. The extent of government concerns over such differences in access varies by country. Policy makers must often balance trade-offs between equity concerns and a desire to promote enhanced choice and access through PHI. PHI also offers a potential source of coverage for long-term care costs but market development has been slow due to a combination of low demand and limited supply.

Useful practices and policy recommendations

When policy makers consider two-tiered accessibility to care by insurance status to be undesirable, they can choose to intervene to help minimise the risk of certain inequities. Explicit rules can be set to assure equity of access to services, for example by allocating elective care on the basis of a single waiting list for both publicly and privately insured patients, or guaranteeing that all providers treat all patients in the same care settings and are subject to the same reimbursement levels. Providers' responsibilities with respect to publicly insured patients can also be clarified and monitored. Furthermore, provider discretion to treat patients differently depending upon their insurance status can be minimised by assigning the management of waiting lists to a disinterested party. Limits in access to PHI coverage can be addressed by programmes offering meaningful insurance to those who are unlikely to have access to affordable coverage in the PHI market. Examples of these are well-funded high-risk pools offering affordable, comprehensive coverage, or other safety net schemes providing standard PHI policies to eligible high-risk individuals. Regulatory standards on all or a portion of the PHI market can also enhance access. In the absence of public coverage of long-term care (LTC) cost, policy makers may wish to consider intervening to regulate access and benefits, and establish consumer protection mechanisms for these policies. This may increase consumer confidence in buying private LTC insurance.

3.2. PHI markets have enhanced choice and innovation but created trade-offs with access concerns

PHI enhances choice in several ways. First, the very opportunity to buy PHI often inherently offers consumers additional choice with respect to financing their health care. Secondly, PHI frequently improves individuals' choice over health providers, treatments, and timing of care – although the scope and nature of this added choice depends upon the regulation of supply in public systems, standards for insurer practices, as well as insurers' strategies. PHI markets also typically offer an array of diverse coverage plans, with different benefits and cost-sharing features. Insurers have responded to consumer demands by tailoring products, finding innovative and flexible coverage solutions, and quickly adopting coverage of new benefits. However, some of the added choice afforded by PHI carries trade-offs, and may call for government intervention, such as in the area of product disclosure. Policy makers have sometimes limited the scope for insurers' flexibility and innovation in order to avoid limitations in access to PHI coverage for more vulnerable groups. PHI markets clearly raise trade-offs between innovation and access concerns.

Useful practices and policy recommendations

While PHI has enhanced choice in several OECD countries, the extent to which this has occurred depends on several factors. Health system structure, provider reimbursement systems and the scope of provider choice afforded by public and private coverage arrangements influence whether – and to what degree – private health cover furnishes added choice of benefits, providers or other advantages. The lack of regulatory safeguards and of adequate comparative information concerning PHI products has restrained individual choice in many PHI markets. Governments or voluntary bodies in some countries have disseminated comparative information on the quality, features and cost of health plans. In the absence of effective voluntary efforts, regulations can improve PHI's ability to enhance choice of insurer and of benefit packages, while safeguarding access to care for both the privately and publicly insured. The availability of a small menu of insurance products, either due to limited insurer offerings or as a consequence of regulations limiting insurers' potential products, does not necessarily mean choice is limited in a harmful way. In fact, it can enhance individuals' understanding of PHI products and improve their confidence. Policy makers need nonetheless to weight trade-offs between improving ability of consumers to make informed choices and enabling insurers to innovate in response to market changes.

3.3. With exceptions, private insurers have not served as an impetus for quality improvement

Private health insurers can promote the delivery of high-quality care if they utilise tools to influence the delivery of health care, such as selective contracting based upon quality indicators, or other means. They have not done so in most OECD countries, however, with the exception of some activities to improve quality of care by managed care plans especially in the United States, where evidence on outcomes is mixed. Pressure from employers and purchasers for cost-effective care has supported the development and spread of these techniques within the PHI industry, as have regulatory requirements in some states. In other countries, however, insurers have not yet attempted to modify clinical practice patterns and influence the provision of evidence-based care. This is not entirely surprising, given the limited involvement of private health insurers in decisions around the delivery of health care in most OECD countries, either because of the way the health system is structured, or because of what role and activities insurers are permitted to have, or because of limited insurers' financial and regulatory encouragement to do so. The lack of adequate incentives that reward quality care, such as value-based provider payments, and inadequate information are among the reasons why insurers still do little in this area.

Useful practices and policy recommendations

There is not one unique path to improve quality of care, and much is still unknown about what works best. PHI may actually not be the best lever to improve health care quality, particularly where its role in a health system is small. The question of whether insurers are the appropriate entities to engage in quality improvement efforts depends upon the countries' health systems structure and policy makers' choices. Where quality-related activities have been promoted by private insurers, they have not been accompanied by the right incentive framework, stimulating inconsistent changes in clinical patterns and medical practices. Sometimes these activities have been accompanied by unpopular

restrictions on provider choice or access to care, and in some cases have led to undesirable outcomes, meriting regulatory oversight to ensure the delivery of medically necessary and appropriate care. Regulatory oversight is in fact needed to guarantee that minimum quality standards are maintained and ensure the delivery of medically necessary and appropriate care. Adequate financial or fiscal incentives might also be necessary to entice insurers to implement quality initiatives. Policy makers can also provide leadership by reforming payment systems to reward quality of care within public programmes. Quality-reporting systems need strengthening, which could require direct supply or subsidisation by the public sector. Finally, policy makers need to consider how best to promote and co-ordinate public and private sector quality improvement efforts.

3.4. PHI has resulted in higher public and total health expenditure

Private health insurance has not shifted significant cost from the public to the private sector. Some cost shifting occurs in systems with duplicate PHI markets, although this impact is limited because insurees often continue to utilise the public system for the most expensive services. It also has had less impact in systems with small PHI markets and has been offset by public subsidies in others. Most delisted services have been ancillary or marginal benefits, hence this has had limited impact on public sector cost. Private health insurance has also resulted in higher public and total health cost in most countries where it has a prominent role, as a result of higher health prices (including elevated reimbursement levels that may also spill over into public programmes), increased utilisation, or both. Obviously, the desirability or acceptability of cost increases depends upon what benefits result from this higher health care expenditure.

Useful practices and policy recommendations

Multiple factors influence the extent to which private health insurance impacts upon the cost pressures on health systems. Cost shifting will be more effective if people buying PHI do not rely on public health systems for services covered by PHI. The savings arising from cost shifting also needs to be weighed against the cost of any subsidy directed towards PHI markets. The role that PHI plays in the system, particularly the nature of the interaction between public and private health coverage, also affects cost within the health system overall. Prohibiting PHI from covering all or some cost sharing imposed by public systems helps to contain cost because it maintains individual cost-awareness. However, it may compromise goals relating to access to care in the absence of adequate exemptions from cost sharing for low-income groups. Finally, the way private health insurance is regulated, and particularly the structure of any cost controls, affects overall health systems' cost. Cost-control measures implemented within the overall health system may improve the ability to control cost within private health insurance markets.

3.5. The contribution of PHI markets to health system efficiency has been low

While private health insurance is often viewed as a tool to enhance efficiency, the evidence reviewed has revealed that PHI has not contributed much to health system performance in this area. This has occurred for several reasons. First, insurers incur higher transaction and administrative costs in order to attract and retain insurees, and provide them with a diversity of insurance plans. Multiple contractual negotiations with providers have also added to insurers' administrative burdens. Second, insurers' desire not to restrict individual choice, requirements to reimburse all providers in some countries, and the cost

of engaging in serious activities to manage care cost effectively have deterred insurers from engaging in significant efforts to influence the cost effectiveness of care in most OECD countries. Conversely, where managed care has operated for several years, as in the United States in the 1990s, providers and consumers have opposed many of the most restrictive practices – some of which contributed to the plans' earlier success in controlling cost. Difficulties in extracting efficiency improvements from PHI markets are in part due to incentives created by competition across insurers. Achieving value-based competition has proven difficult. In the absence of regulation, and sometimes even despite regulation, insurers often compete through cost shifting and selection of risks.

Useful practices and policy recommendations

Incentives or regulatory requirements may be necessary in order to assure the appropriate balance between insurer cost-control efforts and the delivery of appropriate and needed health care services – a particular issue in primary markets. Regulatory interventions may also be needed if policy makers wish to use PHI markets as a lever for improving cost effectiveness of care, for example by permitting selective contracting, removing obligations to contract with all providers, or providing incentives for insurers involved in preventative care or care management. This is because insurers may otherwise lack incentives to invest in such activities or to maintain adequate standards in this area. Policy makers designing risk equalisation systems also need to carefully assess the trade-offs between promoting equitable risk pooling and the maintenance of incentives for insurer efficiency. While striking a balance between these two goals is difficult in practice, some principles may help design effective risk equalisation systems. Better regulatory safeguards and improved information disclosure are also needed because of market imperfections such as information asymmetry and insurers' incentives to select risks. Individuals need transparent information and consumer protection regulation in order to become confident in, and knowledgeable about, the products they are buying. Improved consumer information can facilitate more meaningful competition among insurers, although it does not in and of itself remove the risk that vulnerable groups could be priced out of the market.

4. Policy makers' interventions in PHI markets: remaining challenges to achieve policy goals

PHI's contribution to health system goals largely depends upon health system structure, insurers' strategic behaviours and governmental interventions. Some intrinsic characteristics of unregulated PHI markets, such as information failures or asymmetries and incentives for insurer risk selection, present important challenges.

Policy makers have sought to address these issues through a variety of interventions – with mixed success. Countries with significant PHI markets generally regulate PHI markets more heavily, although EU law restricts, with some exceptions, the ability of most EU countries to impose non-financial standards on PHI markets. Regulations can address certain challenges, but may also raise their own difficulties. Interactions between interventions, and the extent to which regulations have “loopholes” that can undercut their effectiveness, may also need to be addressed through regulation. Finally, the timing and manner of implementation can also affect their impact and success.

4.1. Regulation can promote access to PHI

OECD countries have utilised a range of regulatory tools to promote access to PHI coverage across population groups, particularly for those with higher anticipated health costs. PHI markets without such requirements or targeted interventions often present access problems for high-risk individuals. Lack of access is a particularly important concern where PHI plays a primary role, or where policy makers consider it important to afford individuals a private alternative to public coverage systems. Issuance requirements are one primary tool to improve access to PHI coverage. Yet requirements relating to policy insurance alone are not sufficient to promote access to coverage. For this reason, countries often couple access requirements with standards relating to PHI premiums. Additional regulatory tools can bolster the effectiveness of access and premium-related requirements. For example, renewability requirements are a useful and fairly straightforward means of promoting continuity of coverage and risk pooling. Access-related standards pose particular challenges as they are inextricably intertwined with affordability challenges – which are linked to broader health care cost-control concerns.

4.2. Regulation can improve consumer confidence in PHI markets

Governments can shape the scope of PHI markets by imposing standards or limits on the benefits that PHI insurers can offer. Policy makers within OECD countries have generally adopted interventions falling into two broad categories. First, they can specify required benefits through minimum benefit standards. A second approach to regulating benefits, and promoting product comparability, is the requirement that insurers offer a limited number of specified benefit packages. Disclosure requirements can work together with benefit standards to promote and reinforce consumers' understanding of their PHI products and coverage options. Consumer confidence in PHI markets and their coverage can also be strengthened by mechanisms which provide policyholders with cost-free or low-cost means to appeal certain plan decisions, when insurees have not been able to resolve disputes through plan internal appeal and complaint mechanisms.

4.3. The effectiveness of regulation requires constant monitoring and flexible adaptation

The efficacy of regulatory instruments ultimately depends upon industry compliance and governments' ability to both monitor plan conformance with standards and impose penalties for non-compliance. To this end, OECD countries invoke a range of tools, including policy review, civil monetary penalties, and requirements for corrective action, among others. PHI markets are commonly regulated by multiple agencies, drawing from relevant government departmental expertise, and thereby maximising the input of relevant government expertise and enforcement efforts. PHI markets are also generally subject to broader competition standards. The division of government responsibilities can vary without compromising regulatory efficacy, as long as it permits the development of well-designed regulation and promotes government's ability to respond in a quick and flexible fashion to market developments.

4.4. Governments can use other instruments and approaches to foster desired policy goals

Tax incentives or advantages connected with the purchase or offering of PHI have encouraged and shaped the development of PHI markets in several OECD countries,

although price elasticity of demand for PHI varies widely across OECD countries. The impact and desirability of individual tax incentives, however, have been the objects of debate on equity and cost grounds. While such fiscal incentives can shape purchase patterns, they alone are less likely to address some of the more entrenched challenges of PHI markets – namely access challenges due to insurer underwriting practices – particularly those that restrict acceptance and increase premiums based on enrollee or applicant health status. Voluntary standards or less stringent benchmark standards can form a useful part of regulatory approaches, although the potential effectiveness of the latter remains untested. Several ombudsman programmes and industry disclosure standards, among others, have been instituted on a voluntary basis by industry accord, or on a plan-by-plan basis. Benchmark standards can be an innovative approach for government oversight meriting further monitoring. Deregulation has the advantage of utilising less government resources and providing the industry with free rein to innovate. Policy makers may also be less concerned with access and equity-related issues arising from supplemental or complementary markets, and decide to leave these markets largely unregulated. As described herein, such a decision will likely result in access and risk selection challenges, in the absence of voluntary industry adherence to certain solidarity principles.

Useful practices and policy recommendations

A combination of insurance and rating reforms can be an effective means to alleviate some access-related PHI challenges. However, challenges relating to PHI affordability and access are likely to persist as they are often the product of complex interactions within the PHI market and between the PHI market and other players in health systems. Policy makers thus need to continue to devise creative solutions to these problems. Regulations, particularly when carefully designed and implemented, can help stabilise markets and promote risk-spreading and fair competition. Fiscal incentives and subsidies can also boost the purchase of insurance and shape a market structure by reducing the net price of insurance take-up. However, untargeted subsidies do not enable cross-subsidisation across individuals of different risk, while the targeting of fiscal subsidies is complex to implement. Furthermore, given price elasticity of demand, investment of significant financial resources may be needed, in some cases beyond the levels of current tax or fiscal advantages. Where publicly-funded systems provide meaningful and adequate access to needed health services, the need for such regulatory and fiscal interventions is debatable. Yet where PHI provides the only available coverage, such action is essential if affordable health coverage is to be available to all.

5. Conclusions

Private health insurance presents both opportunities and risks for the attainment of health system performance goals. For example, in countries where PHI plays a prominent role, it can be credited with having injected resources into health systems, added to consumer choice, and helped make the systems more responsive. However, it has also given rise to considerable equity challenges in many cases and has added to health care expenditure (total, and in some cases, public) in most of those same countries.

The impact of PHI on OECD health systems stems in part from the incentives PHI markets create for various health system actors. However, several variables, such as PHI market characteristics and structures, the function that PHI plays within the health

system, and policy interventions, have a substantial impact upon its actual performance. In many cases, the degree and types of government interventions influence whether challenges arise or are successfully addressed.

Private health insurance is one of many instruments that can help promote health system responsiveness, further governments' health system goals and meet consumer and societal demands. Given trade-offs that often arise in this area, however, some may decide that PHI's benefits are not worth their accompanying costs. Yet most OECD countries have, and will continue to have, some type of PHI market. For many, a key policy question is therefore how best to make use of PHI markets – what role and significance should PHI have within a given health system – rather than the question of whether any market should exist. Country responses to this question will vary, depending upon policy priorities and the historical and health system context. For example, policy makers may have explicit goals for primary PHI markets, and design and impose policies targeted to this type of coverage. At the same time, they may choose not to invest significant resources in regulating other types of PHI, concentrating instead on encouraging equity of access through public coverage. Consumer demand will also influence market developments and help shape policy makers' thinking.

As emphasised in this report, the advantages and disadvantages of PHI often depend upon its role within health systems and its interaction with public coverage. Key strengths and weaknesses arising from different PHI roles are:

- A system based on competing primary private insurers can improve responsiveness and consumer choice, but this will come at increased cost. Where private health insurance is primary for certain population groups, ensuring access to affordable coverage will be an important policy consideration. However, regulations to address common primary market failures and promote equity have costs, both in terms of government resources, as well as in terms of diminished insurer flexibility and ability to innovate. Furthermore, it may be particularly challenging to assure adequate access to private coverage for vulnerable populations.
- Duplicate PHI markets can improve systems' responsiveness when policy makers consider it efficient to ration public health expenditure. Yet, this type of insurance generally results in differences in access to care and coverage according to insurance status. The degree of differential access that occurs, and the extent to which these access variations are perceived to be equity challenges vary depending, in part, on the policies used to regulated PHI. In addition, while it can help reduce some of the capacity pressures faced by public health systems, it does not significantly reduce public health expenditure.
- In the presence of significant cost sharing within public systems, complementary health insurance helps ensure access to needed care. However, full private coverage of public sector cost sharing encourages moral hazard-induced utilisation. Unless some cost sharing is retained to maintain individual cost awareness, PHI coverage hinders efforts to control public systems' outlays.
- Supplementary PHI markets are less intertwined with public coverage systems, in contrast to other PHI roles. Supplementary coverage of services removed, or delisted, from public coverage can shift expenditure from public to private. However, insurees' utilisation of supplementary services may still be linked to publicly financed services, resulting in increased public costs as well. Also, since PHI markets generally have less

universal reach than public coverage, decisions to delist services need to balance the desire to reduce public sector cost with the equity implications of no longer covering certain services publicly.

PHI also raises certain challenges that cut across its different roles. For example, access to PHI coverage can be an important social objective also in systems with universal coverage, where policy makers wish to offer consumers an alternative to universal publicly-financed providers, or where certain medically necessary health services and products are not covered publicly. Policy makers will need to intervene in order to assure PHI access for high-risk groups. In doing so, they can choose from a range of tools. They need to balance the sometimes competing goals of access and the maintenance of a broad and diverse pool of covered lives, particularly in voluntary markets. In addition, governments and insurers should make further strides to ensure meaningful disclosure of policy terms and better dissemination of information in order to enable consumers to make informed decisions between competing PHI products. This would enhance consumer understanding as well as promote transparency and more meaningful competition. Even then, sometimes too great a choice may hamper purchasers' ability to make informed coverage decisions. Policy makers need to address these issues or risk undermining their stated goals.

This report has provided an overview of some of the more effective instruments and system designs employed by OECD countries with diverse insurance mixes, as they seek to address challenges raised by mixed funding arrangements, encourage access to PHI and bolster consumer confidence in these products. It has highlighted the advantages and disadvantages of various approaches, including the demonstrated strengths and limits of certain fiscal and regulatory instruments, as well as the implications of using one tool in lieu of another. Problems arising from PHI markets can be ameliorated through government intervention, although several issues continue to pose challenges, including how to maximise the effectiveness of various actions. The report has also drawn attention to a number of trade-offs that policy makers must balance when deciding how to best promote their particular policy choices through a mixed public-private insurance system.

It is important to be realistic about the potential benefits of competitive PHI markets and what they most likely will not achieve. For example, cost containment within health systems is often best achieved through means other than an expansion of private health insurance's role. Unregulated PHI markets, especially in the absence of other mechanisms to offer affordable coverage to high-risk persons, are inadequately equipped to promote access to coverage for people with chronic conditions and other high-risk persons. On the other hand, serious consideration ought to be given to the value of health system responsiveness, an area where private health insurance has contributed positively to health system performance. Whether or not it is intended or desired, PHI markets interact with health provision and delivery systems in several ways, some of which are advantageous and others less so. The role of PHI should be structured around policy goals for health financing, as well as broader health systems' policy objectives, to ensure policy coherence. Flexible policy making is also needed to address promptly any problems and undesirable outcomes that may emerge from the interaction of PHI markets with public systems.

Some important questions also merit further investigation. For example, the impact of private health insurance on quality of care is still under-researched. The mechanisms

through which competition in PHI markets can foster health system efficiency are also not well understood. There is limited information about the role of PHI markets in adopting and diffusing new and emerging medical technology, and the way this process interacts with technology assessment in public systems. The pros and cons of private long-term care insurance, as opposed to public health financing, also deserve closer investigation, as clearly do the links between private pension and disability coverage, on the one hand, and PHI markets, on the other. The public at large would benefit from enhanced and expanded efforts to educate them about health coverage options, and the implications of coverage decisions. Furthermore, improved availability of data on private health insurance markets would help to improve policy making and comparative analysis on PHI across OECD countries. Finally, there is room for further reflection regarding how best to strike a balance between the sometimes competing goals of ensuring equity, promoting flexibility, and preserving efficiency incentives within PHI markets. While the desired and permitted role for PHI remains a country-specific policy choice, answers to these and other questions would advance evidence-based policy making in this area.

List of Acronyms

AARP	American Association of Retired Persons
ABI	Association of British Insurers (United Kingdom)
ACCC	Australian Competition and Consumer Commission (Australia)
AFSCME	American Federation of State, County and Municipal Employees (United States)
AHIP	America's Health Insurance Plans (United States)
ASIC	Australian Securities and Investments Commission (Australia)
ASO	Administrative Services Only (United States)
AWBZ	De Algemene Wet Bijzondere Ziektekosten (Exceptional Medical Expenses Act, Netherlands)
CLHIA	Canadian Life and Health Insurance Association (Canada)
CMS	Centers for Medicare & Medicaid Services (United States)
CMU	Couverture Maladie Universelle (Universal Health Coverage, France)
CPI	Consumer Price Index
CONDUSEF	Comisión Nacional para la Protección y Defensa de los Usuarios de Servicios Financieros (National Commission for the Protection and Defence of Financial Service Users, Mexico)
DG	Directorate General
DHHS	Department of Health and Human Services (United States)
DOHA	Department for Health and Ageing (Australia)
DOHC	Department for Health and Children (Ireland)
DOL	Department of Labor (United States)
EBSA	Employee Benefits Security Administration (United States, Department of Labor)
ERP	External Review Programs (United States)
ERISA	Employee Retirement Income Security Act (United States, Department of Labor)
EU	European Union
FMA	Financial Market Authority
FMABG	Finanzmarktaufsichtsbehördengesetz (Financial Market Supervisory Act, Austria)
FOS	Financial Ombudsman Service (United Kingdom)
FSA	Financial Supervisory Authority (Germany)
FSAs	Flexible Spending Accounts (United States)
GDP	Gross Domestic Product
GI	Guaranteed Issuance
GISC	General Insurance Standards Council (United Kingdom)
GP	General practitioner
HEDIS	Health Plan Employer Data and Information Set (United States)
HIC	Health Insurance Commission (Australia)
HMO	Health Maintenance Organisation (United States)
HIPAA	Health Insurance Portability and Accountability Act (United States)
HIPPA	Health Insurance Privacy and Portability Act (United States)

HRAs	Health Reimbursement Arrangements (United States)
HSA	Health Savings Accounts (United States)
IPA	Individual Practice Association (United States)
ISES	Instituciones de Seguros Especializados en Salud (Specialised Health Insurance Institutions, Mexico)
ISFAS	Instituto Social de las Fuerzas Armadas (Social Institute for the Army, Spain)
LAMal	Loi Fédérale sur l'Assurance Maladie (Federal Health Insurance Law, Switzerland)
LTC	Long-term Care
LSE	London School of Economics
MBS	Medicare Benefits Schedule (Australia)
MLS	Medical Levy Surcharge (Australia)
MOOZ	Medefinanciering oververtegenwoordiging oudere ziekenfondsverzekerden (Act on Co-financing the Overrepresentation of Elderly on the Sickness Fund Scheme, Netherlands)
MSA	Medical Savings Accounts (United States)
MUGEJU	Mutualidad General Judicial (General Mutual for the Judicial System, Spain)
MUFACE	Mutualidad General de Funcionarios Civiles del Estado (General Mutual for Civil Servants, Spain)
NAIC	National Association of Insurance Commissioners (United States)
NCQA	National Committee on Quality Assurance (United States)
NHA	National Health Act (Australia)
NYCRR	New York State Codes Rules and Regulations
OECD	Organisation for Economic Co-operation and Development
OHPSCA	Office of Health Plan Standard and Compliance Assistance (United States, Department of Labor)
OPAC	Office of Participant Assistance and Communications (United States, Department of Labor)
OOP	Out-of-pocket expenditure
OSFI	Office of the Superintendent of Financial Institutions (Canada)
PEA	Pre-Existing Ailment
PHI	Private Health Insurance
PHIAC	Private Health Insurance Administration Council (Australia)
PHIIS	Private Health Insurance Incentive Scheme (Australia)
PHIO	Private Health Insurance Ombudsman (Australia)
PHIQS	Private Health Industry Quality and Safety Committee (Australia)
PLC	Public Limited Companies
PPO	Preferred Provider Organization (United States)
PRSI	Pay Related Social Insurance Contributions (Ireland)
PSO	Provider service organization (United States)
RE	Risk Equalisation (Scheme)
SCHIP	State Children's Health Insurance Program (United States)
THE	Total expenditure on health
TPA	Third Party Administrators
TPHE	Total private expenditure on health
URAC	Utilization Review Accreditation Commission (United States)
VHI	Voluntary Health Insurance (VHI Healthcare, Ireland)
WTZ	Act on Access to Insurance (Netherlands)
WHO	World Health Organisation
ZFW	Ziekenfondswet (Health Insurance Act, Netherlands)
ZN	Zorgverzekeraars Nederland (Association of Dutch health Insurers, Netherlands)

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