

# Overview of Regulatory Approaches in Private Health Insurance Markets in Industrialized Nations

## Findings from OECD Study

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\*Presentation presents views of presenter and does not represent views of OECD nor Novartis. Based on research performed jointly with Francesca Colombo, OECD.



# OECD Countries Vary in Their Regulatory Approaches

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- **Consensus on need for minimal financial standards**
- **Some approaches are specific to role of PHI**
- **Other approaches address common challenges (often relating to access or past market failures)**
- **Challenges in covering high-risk persons particularly strong in individual and voluntary markets**

# PHI May Be Seen As Playing 4 Major Roles

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- **Primary (NL, US, CH)**
- **Duplicate (UK, AUS, IR)**
- **Complementary (FR, US)**
- **Supplementary (Many EU countries)**

# Varied Treatment of PHI Carriers Has Led to Trend Toward Uniform Treatment

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- **More stringent standards for non-profit insurers sometimes led to market failures or unfair competition**
- **Trend towards similar functions across health insurers supports more uniform treatment**
- **Most countries do not permit employers to “self-fund”**

# OECD Countries Vary in Their Regulatory Approaches

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## Level of Regulation Often Follows Role

- **Primary Coverage:** Often most highly regulated (e.g. NL, US, IR, GER)
- **Duplicate Coverage:** Variation in level exists (UK vs. Australia and Ireland)
- **Complementary Coverage:** Sometimes limit benefit packages (US); access standards (FR, US)
- **Supplementary:** Often Lightly Regulated/Some Limits vis-à-vis public system (CA)

# OECD Countries Vary in Their Degree of Regulation

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## Level of Regulation Often Follows Role

- Benefits often regulated for primary coverage; less so for other types (except US/Medicare, Duplicate coverage Aus, Ir)
- Renewability required most often for primary coverage (GER, Ire, NL, Sp(primary), CH, US)
- Guaranteed Issue: (AUS, GER (standard tariff), IR, NL, Spain (primary), CH (mandatory), US (some states, small employer market))

# Regulation Also Reflects Policy Objectives:

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Set clear policy objectives for PHI

Determine potential benefits of PHI market (whether it exists already or not):

- Assess **interactions with public coverage/delivery systems**
- Assess **value to be assigned to choice**
- Assess **acceptability of access** according to by willingness or ability to pay
- Assess **desired level of individual responsibility for uncovered services/providers**
- Assess importance of equity of access for all

# Variation In Access Standards

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- **Guaranteed access of limited products (NL, GER, Spain: primary coverage)**
- **Open enrolment periods (US Medigap; Ohio individual market)**
- **Broad Guaranteed issue requirement (Aus, Ireland, US small employer, CH)**
- **Separate program for high risk (US (29 states), NL to some extent)**

# Variation In Results for Certain Access Standards

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- **Guaranteed access of limited products**
- **NL-wide purchase: 14% of private coverage;**
- **GER-low level of participation (.04% of privately covered)**
- **Broad Access Standards:**
- **NY-more coverage of high risk, reduced coverage of young and healthy**

# Other Mechanisms to Minimize Adverse Selection- Balanced with Access Concerns

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- **Preexisting condition exclusion periods (8 OECD countries; typical to accompany access standards)**
- **Benefit Requirements (Min. benefits: IR, Australia; standard: NL, GER, US Medigap)**
- **Renewability: Commonly required for primary coverage (Germany-lifetime policy; US, Spain (primary) or done as a matter of industry practice (NL, Spain, UK); duplicate coverage (required Ire; lifetime policy-Aust)**

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# Premium Related Standards

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- **Most Controversial—Raises Issues of Whom is to be Assured Coverage and Who Should Participate in Cross-Subsidy**

- **“Community Rating” Standards restrict consideration of health status; may permit consideration of age (as inducement to purchase/proxy for risk)**

**(Aus, CH, Ir, Few US States, GER (primary-cap and premium determined by age of entry), NL(cap for high risk program)**

# Premium Related Standards: Impact

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- **Premium Limits for Standard Package Leave More Flexibility in Market for Low Risk but Raise Issues of Cross-subsidization**
- **Age-based variation in community rating more successful than “pure” community rating in some U.S. states**
- **Mandatory nature of coverage (CH) or broad purchasing trend of voluntary (NL) can reduce potential for premium spirals**

# Premium Related Standards: Impact

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- **Limits in US small group market appear to have reduced erosion in coverage**
- **Age-based variation in community rating more successful than “pure” community rating in some U.S. states**
- **Mandatory nature of coverage (CH) or broad purchasing trend of voluntary (NL) can reduce potential for premium spirals**

# Challenges with Community Rating Include Risk Adjustment/Competition Issues

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- **Most countries with rating standards have a mechanism to cross-subsidize across insurers based upon risk**
- **Special pool for high cost drug claims: Quebec**
- **US small group market-state voluntary pools to distribute costs of high risk persons**
- **New York has 2 high risk pools-age/gender; high-cost claims**

# Fiscal Incentives

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- **At least 1/2 of OECD Countries Provide for Some Incentive for PHI Purchase**
- **Income Tax Deductions Most Common**
- **Most generous incentive is Australian 30% premium rebate**
- **Some countries incentivize employer coverage (Austria, BE, CA, DK, Ire, IT, SP, US)**
- **Some impose a limit on deduction or allowance (Spain, Portugal, Greece, Austria, Germany, Luxembourg (fixed amount or percentage)) or require a threshold to be met before deduction (Netherlands, US)**

# Costs of Incentives Can Be Significant

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- **US exclusion is a Large Tax Expenditure (76.2 billion)**
- **Not Clear How Sensitive Demand is to Incentives, especially to those without coverage**
- **Effectiveness of Australian rebate debated; age-adjusted premiums with built-in penalty for late purchase may have been as effective**
- **Incentives for Individual Coverage often have limited effect on take-up; incentives for employer coverage can have significant impact on development of market**

# Interaction with Public Coverage May Raise Issues

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- **German law prevents persons who have “opted” out of social insurance to reenter system**
- **Netherlands provides limited ability of elderly who’d been privately insured to enter social insurance**
- **Some countries limit overlap with public coverage (CA prohibits coverage of outpatient and inpatient services covered publicly; Australia prohibits private outpatient coverage)**

# Disclosure/Consumer Understanding

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- **Varied standards**
- **Clear policy language important**
- **Consumer-friendly benefit summary helpful**
- **Standards sometimes focused on problem areas (i.e. potential out-of-pocket costs)**

# Responding to Consumer Complaints

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- Many OECD Countries have independent “Ombudsman” programs to help respond to or adjudicate complaints against health insurers
- Some apply to all insurers; others focus on health insurance
- In addition to helping insureds, can highlight policy issues or problems

# Enforcement/Oversight

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**Policy Filing and Review:** Policy filing requirement common; prior review (required before sale) less common (Mex., some U.S. states, Germany (subst.), CH)

**Who Can Sell:** About half of countries require examination or certificate for those who sell insurance

**Marketing Standards:** Many countries have standards regarding advertisement and promotion

**Enforcement Tools:** Civil Monetary Penalties; Orders to Cease Business; Criminal sanctions (some)

# Enforcement/Oversight

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**Government Agencies:** Some functions are shared between health and insurance supervisory authorities (Australia, Ireland, some US states, Mexico, Netherlands, Spain)

**Private Bodies:** Trade associations often set Voluntary Standards

# Then, choose approach

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## How much intervention?

- EU Directive limits regulation beyond solvency:
- Australia, Ireland, some U.S. States intervene to a greater degree, as well as other countries with primary coverage markets

## What type of intervention?

- Regulation, fiscal instruments, or both?
- Outcome-oriented regulation (Australia)
- Voluntary standards can be useful (Ombudsman)

## What tools?

- Access standards, benefit regulation, contract limitations
- Type of tax/fiscal advantage
- Other subsidies

# Monitor Impact of Interventions

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**Establish means of monitoring impact of regulation**

**Provide means for government to respond to negative or unanticipated outcomes**

**Improved data on population coverage and types of coverage may help policymakers**

# Is It Possible to Prioritize Among Standards?

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- **Important to be Aware of Different Mechanisms to Select Risks (Rating, Refusing Coverage, Exclusions); Preferable to Address All or may undercut standards**
- **Important to Build Confidence in New Market: Protections against cancellation and ability to enforce contracts are important; some investment in public education is worth consideration**
- **Prior review of policies and premiums among more resource intensive standards;**
- **Carefully consider how to handle consumer complaints in light of resources and culture (how to submit complaints, staffing)**

# Looking Forward to Questions and Discussion!

