Session H6

International Issues in Private Sector Health Insurance Supervision

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Global (and generic) view

We all know our own territories too well!
Can we see in an international context?

- Possible Objectives
- Different Priorities
- Historical evolution
- Tools

Possible Objectives of H.I. Supervision

Menu

- Solvency - insurers meet all their obligations
- "Regular" market - prosperous insurers so they continue to offer and extend cover and also choice (prospect of profit?)
- Effective competition (anti-trust) - avoidance of "cartel"
- Trading fairly - insurers present their cover and prices in a fair and understandable way to the customer
- Guarantee of access - open enrolment, lifetime renewal
- Affordability - price controls - e.g. prohibition of age-rating
- Integration with social insurance - e.g. allowing opt-outs from public system but ensuring private sector gives cover that is sufficient
- Balancing of clinical independence and the effectiveness of bulk purchaser
- Indirect objectives relating to healthcare supply-side
- Protection of "injured" insurer - or from future injury?

Different Markets have different priorities

How to choose from Menu?

- Every supervisor wants solvency!
- Is there a public healthcare system that caters for everyone?
- Is healthcare insurance regarded as just another retail consumer item?
- Define clearly if additional obligations are placed on insurers in some market, or market segment
- Style of supervision tends to respond to current problems (with a lag!)
- What condition is one or other market segment seen to be in? Insurers too dominant? Over-regulated - availability of insurers offering coverage is in decline?
- Evidence of “cartel”?
- What concerns consumers and can the concerns be alleviated by supervision?
- Some choices are in conflict - freedoms to ensure commercial returns *versus* obligations that infringe underwriting practices regarded as the norm in life and casualty lines

History plays a big part

Typical private sector H.I. - evolved, not designed!

- Supervision regime is also itself a product of that evolution
- There may have been insurers deemed to need protection as changes unfold
- There may have been customers not fully covered if exposed to the unfettered operation of the market
- Have implicit promises been understood in the minds of customers - can Supervisors cater for these - or is Supervisor's role to debunk them?
- Public systems may have been overlaid on historical private market segments. The overlay may have ignored the private sector or have tried to integrate to varying degrees: substitutional / duplicative / "franchise" model.
- Mis-selling - has it occurred - is it feared? Is H.I. damned by association with other lines of insurance?

Supervision in broad sense

What Holistic view *Who?*

- Insurance contract law (federal / state)
- Solvency requirements
- Product rules or approvals
- Advertising rules
- Competition (anti-trust) law
- Rules on access / availability
- Risk compensation schemes
- Custom & Practice

- Insurance Supervisor
- government Finance department/ministry
- government Health department/ministry
- Advertising authority
- Competition (anti-trust) authorities
- Dedicated private health insurance authority
- Insurance industry associations
- federal / state - European Commission / member state

Available Tools (1)

Provisions, capital adequacy, solvency rules

- Characteristically not complicated (cf. other lines) - liabilities are short-tail and medical expenses are typically 12 month renewable
- High frequency, small amounts - little risk of catastrophic amount (exception is indemnity in US?)
- Embarrassment for supervisor of failing / failed health insurer is less than for failure of a typical casualty insurer (or especially failure of a life insurer)?

- Policyholder compensation schemes

Available Tools (2)

Benefit controls

- Typically will occur because private health insurance is being allowed in place of a state-provided minimum cover. State will not want someone falling through a “gap”
- Another situation is where younger are subsidising older subscribers (see price controls) and a minimum set of benefits avoids that the young self-insure a quantum of their cover to reduce their subsidy payment
- A mandated price is meaningless unless there is mandated cover

Every product must have a minimum set of benefits

An insurer must offer a minimum product

Usually minimum is defined by a narrative - but it could also include monetary minima

Available Tools (3)

Price Controls

- Earnings related structures - this is social insurance by franchise - arguably not part of “private sector health insurance” at all
- Direct - e.g. the state mandates the price
- Indirect - the price “floats” but there are restrictions on insurers applying rating procedures selectively between different applicants
- Rating restrictions will require same treatment within an age band - within a geographical zone - within a sub-population

Available Tools (4)

Access provisions

- Intent is to make cover available to people for whom it would be (in the absence of these provisions) impossible or prohibitively expensive

Open Enrolment into a minimum product

Open Enrolment up to a certain age

Medical evidence inadmissible

Guaranteed renewal

Available Tools (5)

Risk adjustment schemes in private sector

- Uncommon outside public sector - the notable risk adjustment schemes in Germany and Netherlands are to facilitate national compulsory schemes of contribution - essentially this is social insurance
- Australian “Reinsurance” fits the theoretical actuarial model supplying cross-subsidy to insurers who would otherwise be rendered uncompetitive due to carrying unprofitable legacy business that is subject to price control
- Episodic experiments or suggested elsewhere - New York State, Ireland, South Africa

Many of the difficulties are common

- Solvency - always the compromise between caution and expensive capital base (this is not peculiar to health insurance)
- Defining benefit controls while at the same time wanting to leave customers and insurers to exercise choice - benefit controls can conflict with well-motivated cost containment
- Price control - involves value judgements which impact on subsidies within market place. In some cases customers can “vote with their feet” if they don’t agree to these judgements
- Denial of rating and selection to insurers has to be done carefully so they will remain active in a market segment
- Risk adjustment involves value judgements about whether and how much assistance is warranted, for how long, to companies with legacy business

Inherent contradictions

- Solvent insurers - but insurers who are liberal when their subscribers need help
- Member entitlements akin to a free public system - but those systems are often facing financial crisis!
- Widest possible coverage for subscribers - but need to promote supply-side reform at the same time
- Ambition not matched by market's willingness to pay
- Innovation sought - but legacy insurers must be protected
- Price control not supported by other measures
- Does "open access" facilitate "hit and runs"?

Conclusions

Additional Support Material

European Union

Netherlands

Ireland

United States of America