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Private Health Insurance in OECD Countries
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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.

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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

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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

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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.

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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 enrolee 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

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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

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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 Issurance
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 Reinbursment 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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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.

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