Private health insurance

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What is VHI?

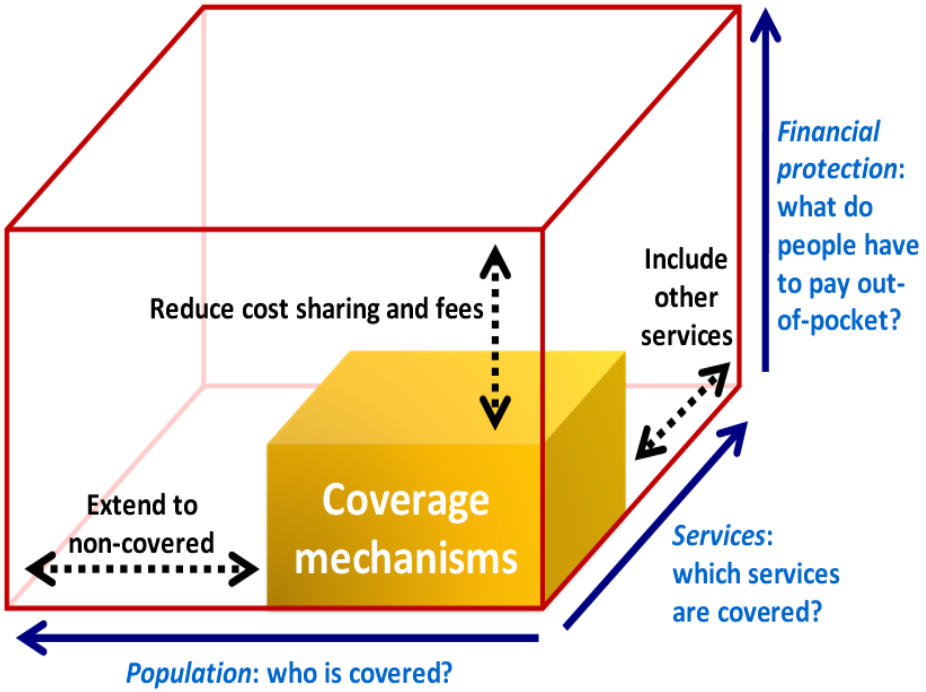
Health insurance that is taken up and paid for at the discretion of individuals or employers (including the state as employer) on behalf of individuals.

It can be offered by public or quasi public bodies and by for profit and non profit private organisations.

Policy goals for VHI

- relieve fiscal pressure on public budgets
- strengthen health system performance
- address gaps in coverage

- other goals?



What role for VHI?

Market driver	VHI role	VHI covers	Examples
population coverage	substitutive	groups excluded or opting out	Germany
service coverage	complementary (services)	excluded services	Netherlands
cost coverage	complementary (user charges)	statutory user charges	France/Slovenia
consumer satisfaction	supplementary	faster access & consumer choice	Ireland

Why is role important?

Interactions, regulation, impact on performance…

Source: Mossialos and Thomson (2004), Foubister et al (2006)

Is VHI the right policy tool?

- will VHI cover important coverage gaps?
- will those who need VHI have access to it?
- can this be achieved without undermining value in public spending on health?
- i.e. without making those who rely on statutory coverage worse off

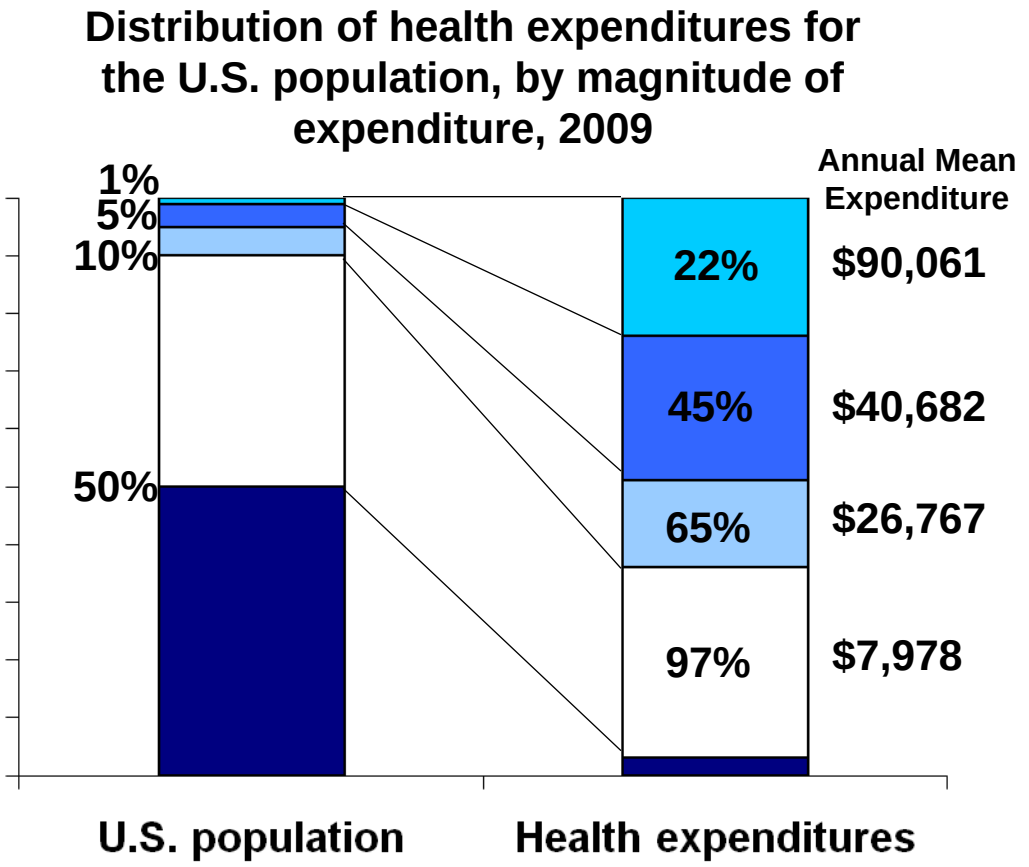
Key research findings

- cross-country variation in VHI role, policy design, market size, impact
- VHI is unlikely to relieve fiscal pressure
- assumptions about superior efficiency of private insurers do not hold
- complexity, importance of national context

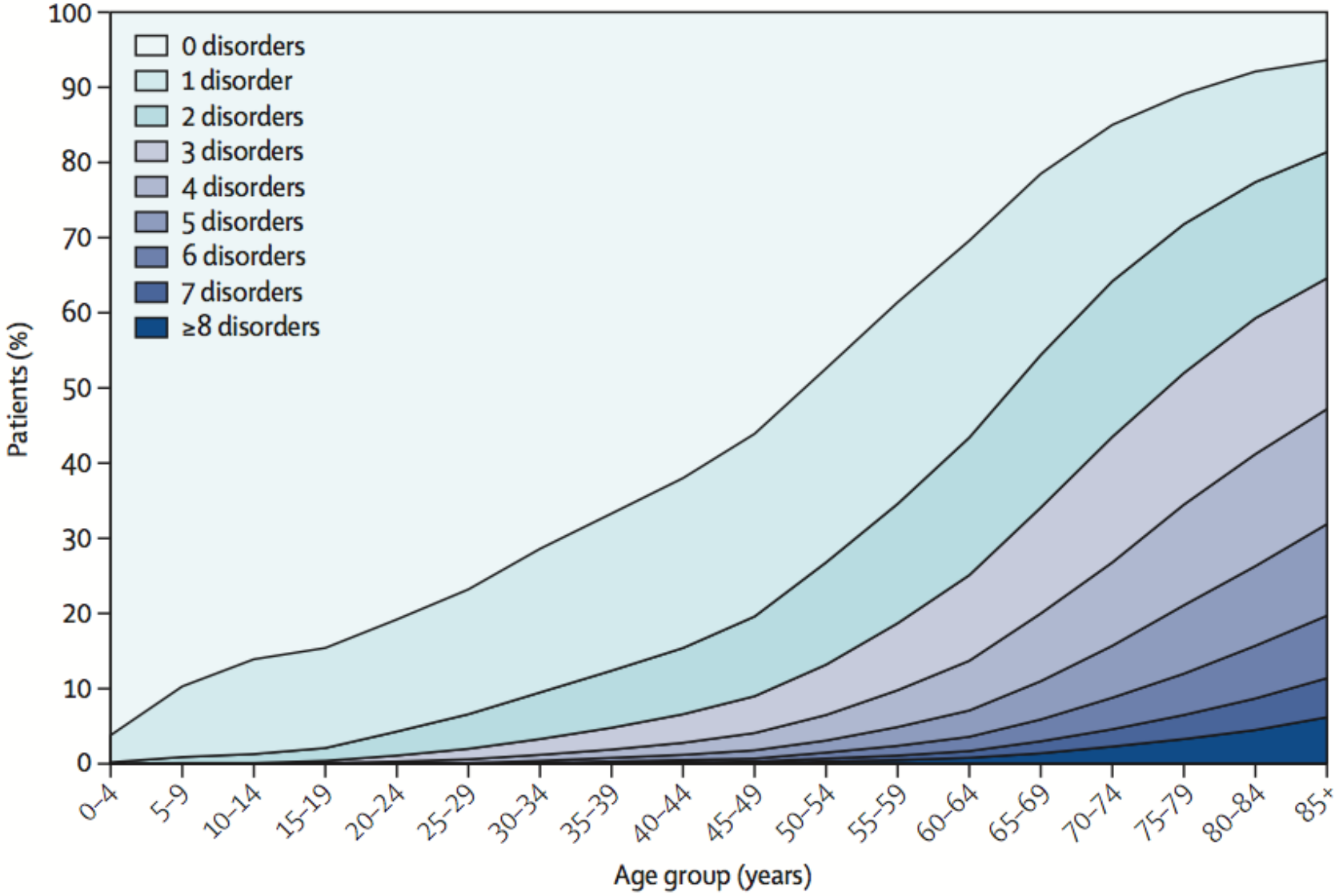
Source: EC 2002, OECD 2004, EC 2009, Thomson and Mossialos (eds) 2014 forthcoming

For Savings, Go Where the Money Is

- 10% of patients account for 65% of costs
- Focus efforts on patients with highest costs
- Three part strategy:
  - Primary care/delivery system reform
  - Payment reform
  - Health information technology

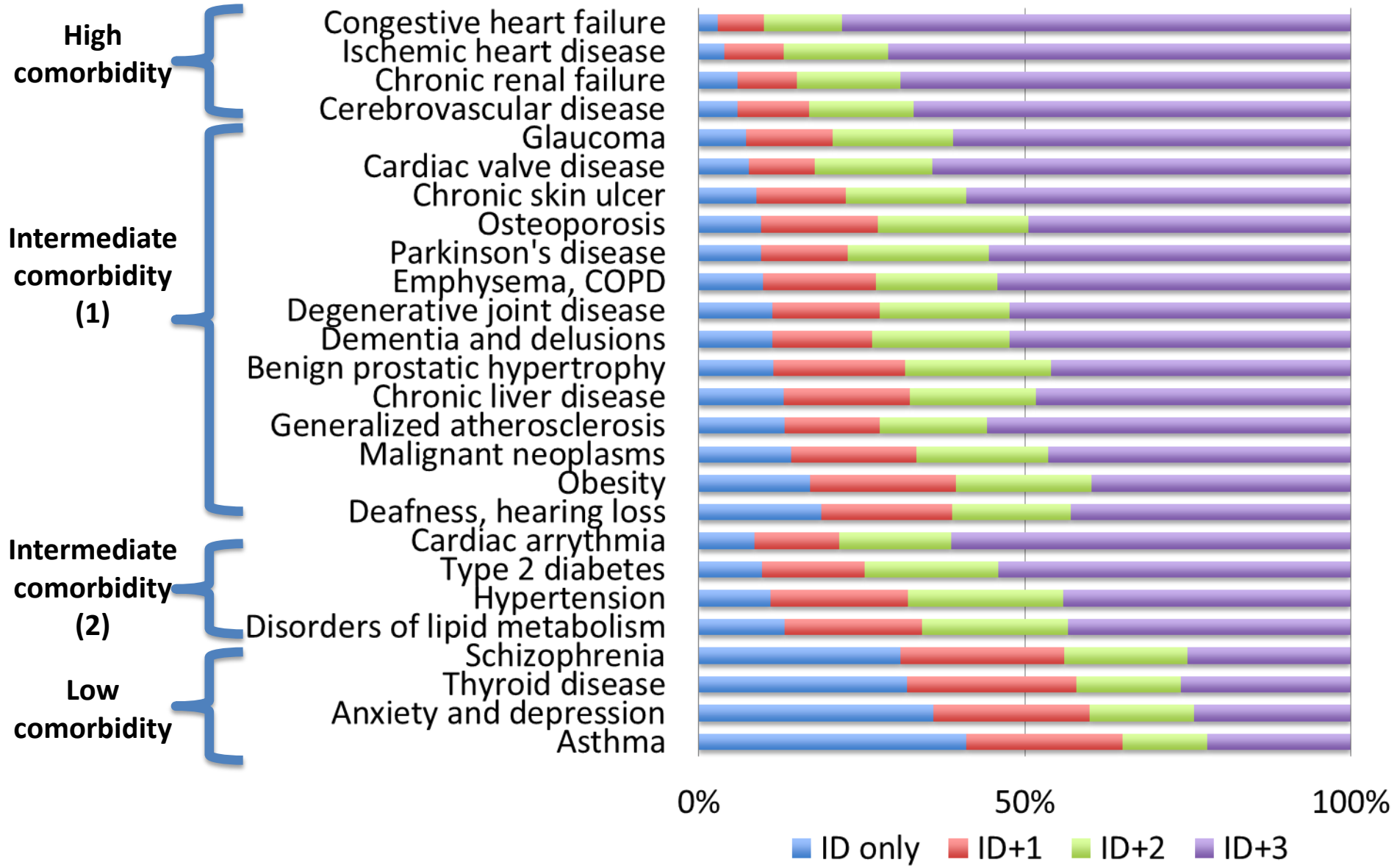


Number of chronic disorders by age group



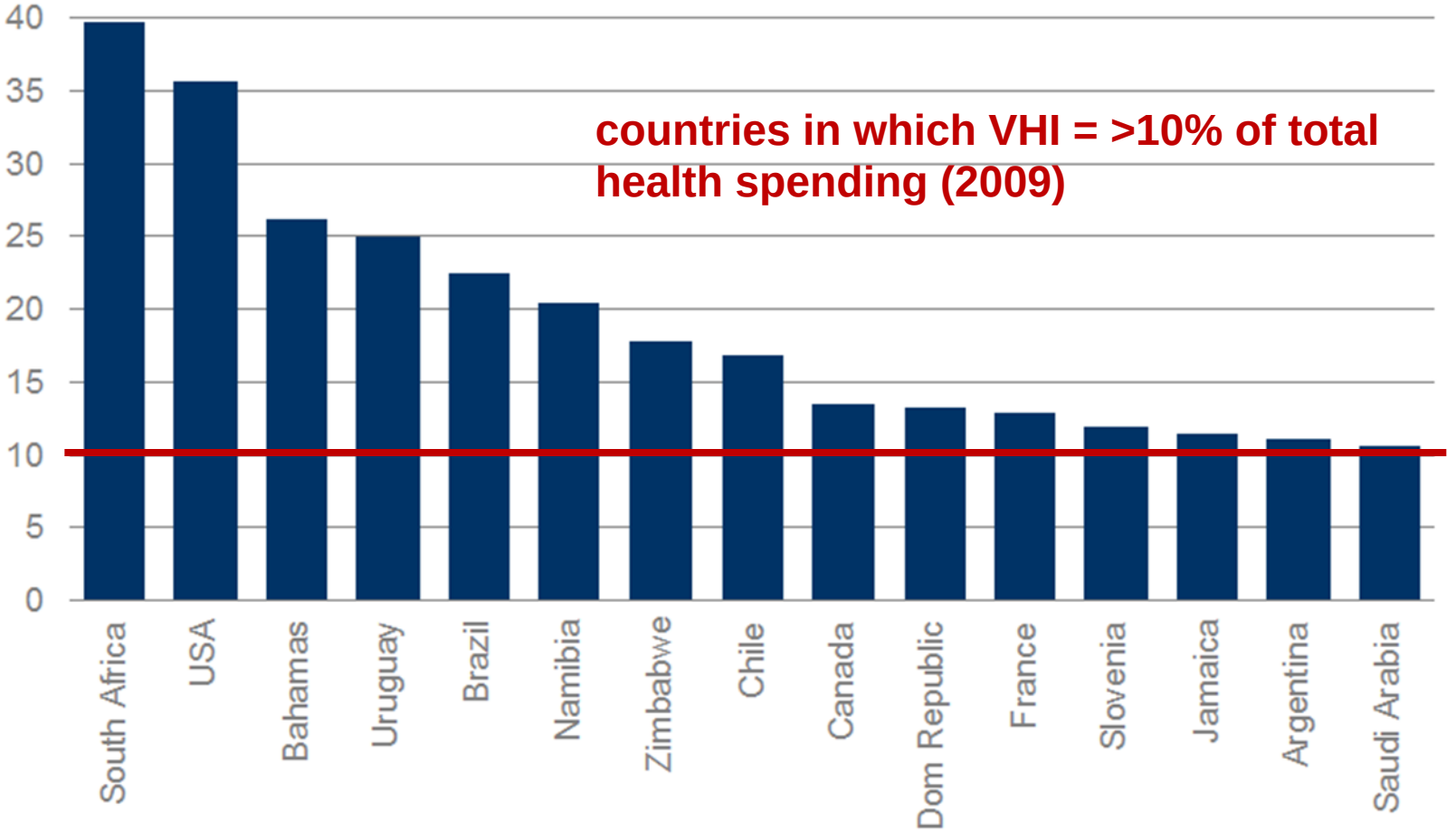
Source: Barnett et al. 2012. Lancet 370: 37-43.

Case-frequency distribution of chronic diseases by number of comorbidities



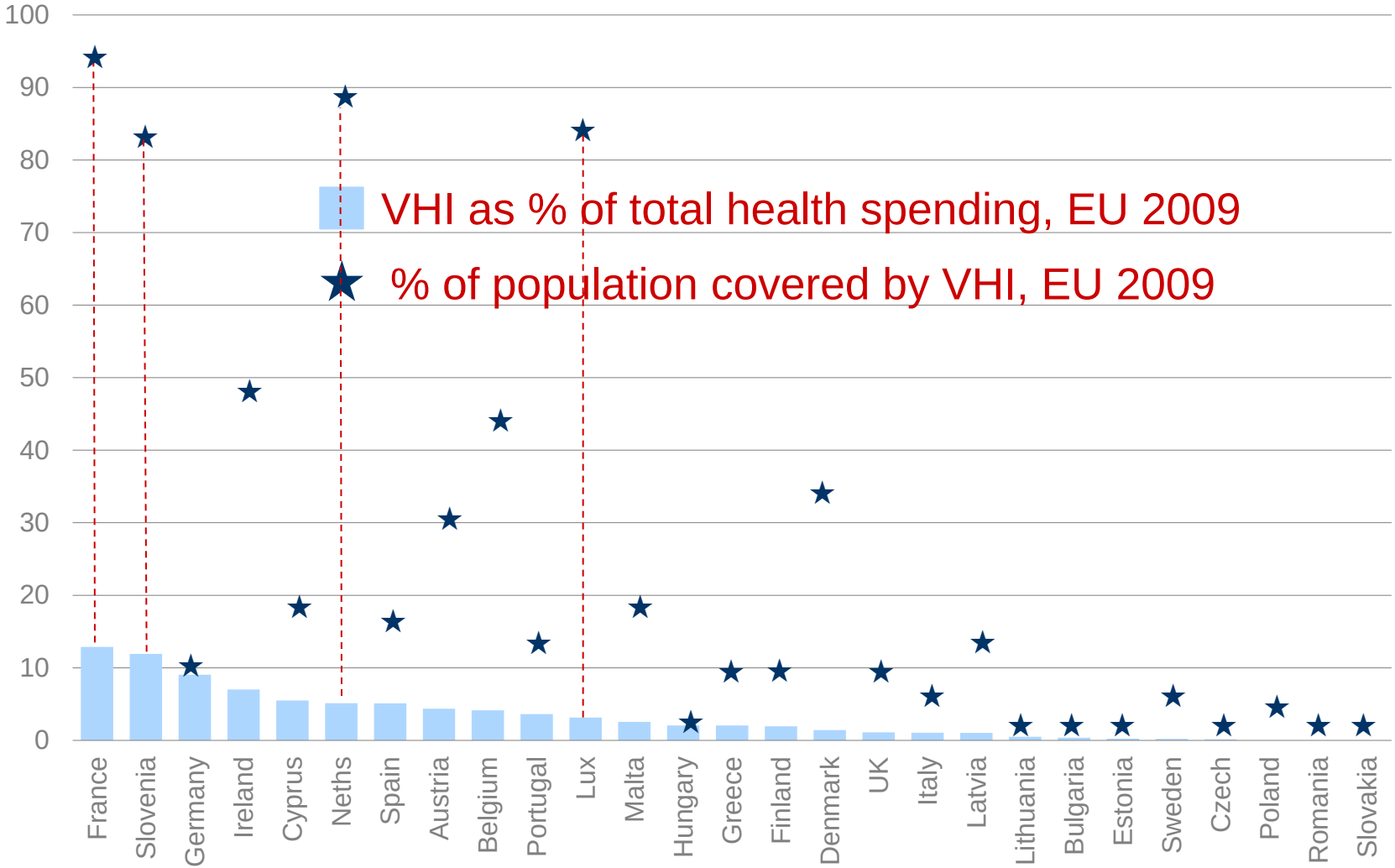
Source: García-Olmos L, Salvador CH, Alberquilla Á, Lora D, et al. (2012). PLoS ONE 7(2): e32141.

There are very few large VHI markets globally



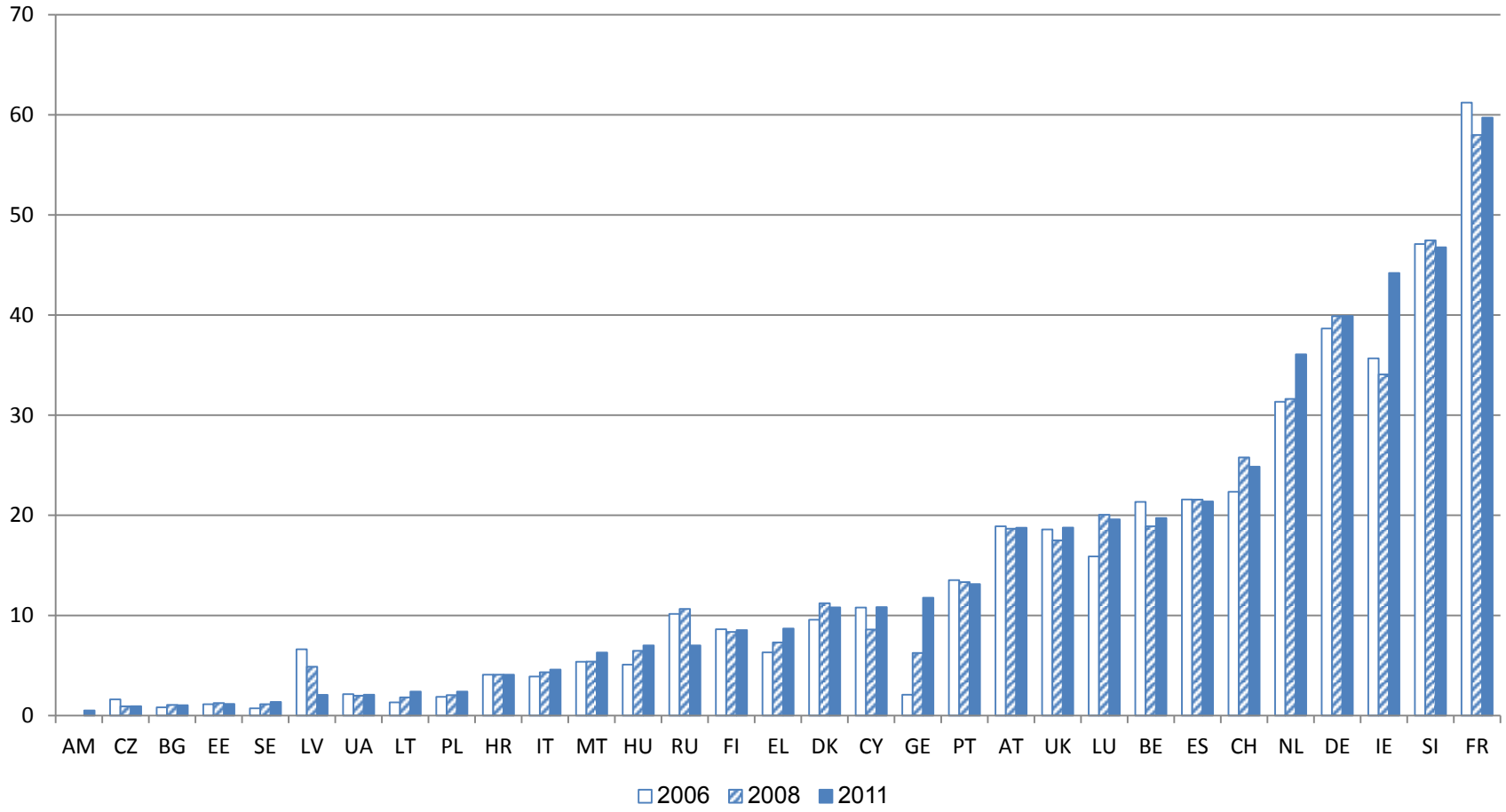
Source: WHO data

Large variation in market size: spending & coverage



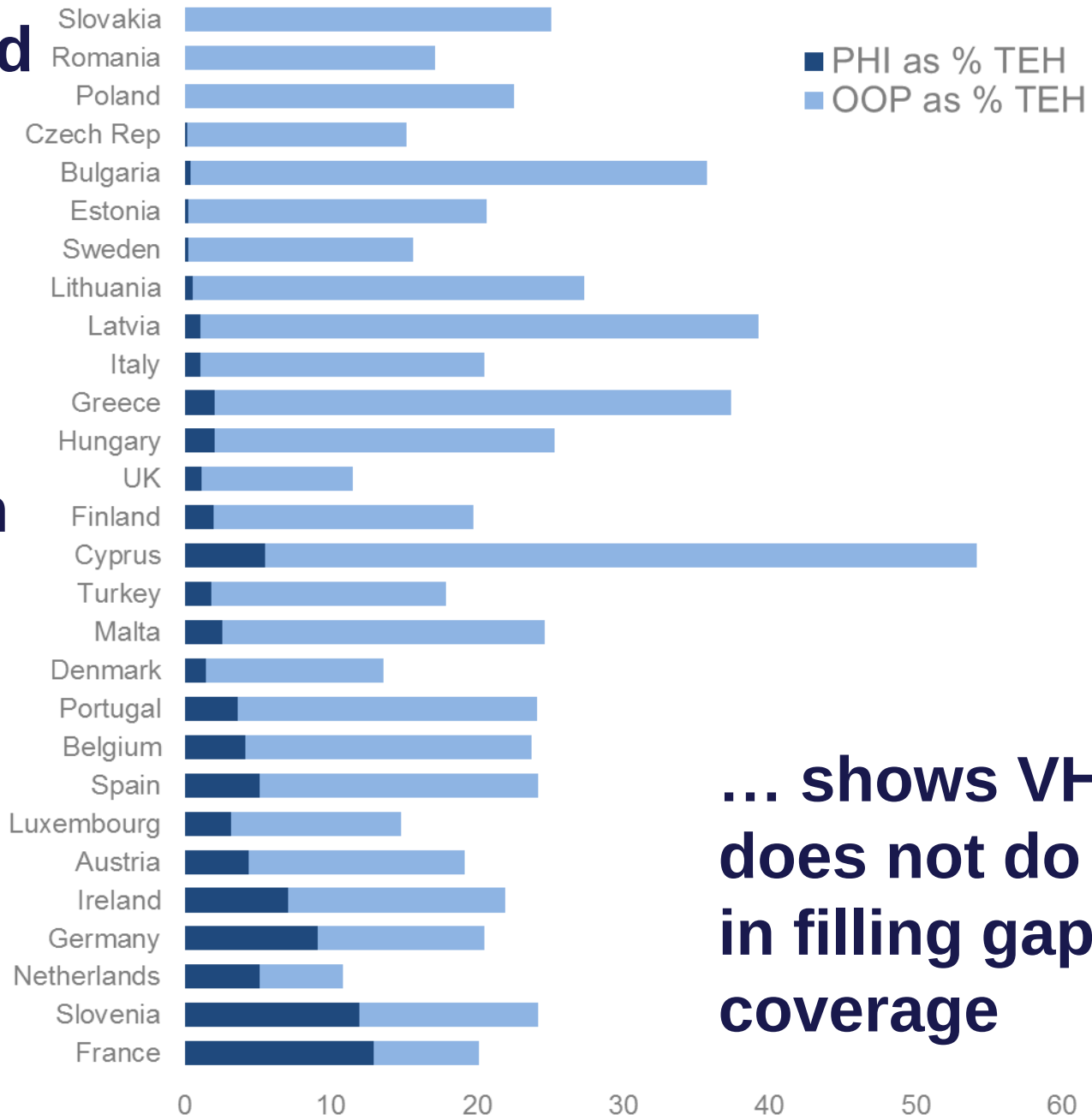
Source: Thomson 2012 forthcoming

Spending through PHI as a % of private health spending, 2006-2011



Source: WHO (2013).

VHI ranked by % of private spending on health (from low to high) in 2009 …



… shows VHI does not do well in filling gaps in coverage

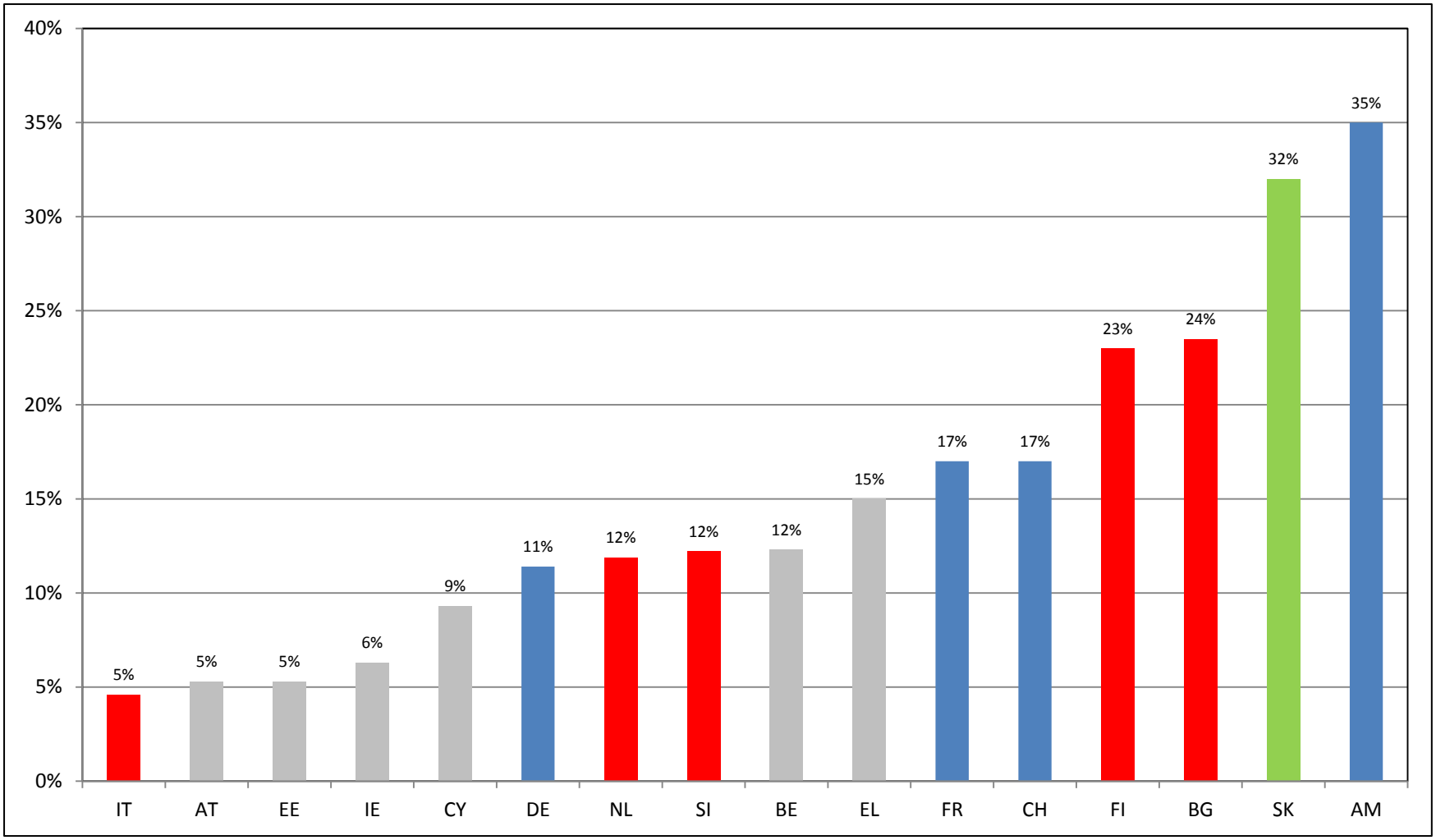
Source: WHO data

VHI may undermine health system performance

- VHI may draw resources away from publicly financed health care:
  - risk segmentation
  - skews distribution of public resources
- no evidence of superior efficiency of private insurers (administration, purchasing)

Source: Thomson 2014 forthcoming, Thomson and Mossialos (eds) 2014 forthcoming

PHI administrative costs as a % of premium income, latest available year*



Source: Data provided by country experts.

Notes: Green = positive trend (increase); red = negative trend (decrease); blue = no change; grey = no information available.

For Armenia only general administrative costs for all insurance business was available (not PHI specific). For Belgium, data includes PHI but also health related insurance, such as dependence insurance and guaranteed income insurance. For Estonia, data includes commercial insurance only. For Ireland, data is for Vhi Healthcare only.

*2011 data for: Armenia, Austria, Bulgaria, Greece, the Netherlands, and Slovakia. 2010 data for: Belgium, Cyprus, Estonia, Finland, France, Germany, Ireland, Italy, and Slovenia. 2009 data for: Switzerland.

Netherlands: non-medical costs of insurers in 1998 (€ per capita)

Costs	Sickness funds	Private insurers
Efficiency costs	3	2
Selection costs	10	28
Other costs	47	59

Source: Douven and Westerhout 2000

Substitutive VHI?

Requirements

- careful design: ‘exclusion’ better than ‘opting out’
- regulation for affordable access to VHI
- monitoring, political will

Risks

- risk segmentation
- loss of contributions (from richer people)
- inadequate financial protection
- equity concerns (access to care)
- EU legal challenges
- no fiscal relief

A near extinct species

Regulation intensified in Netherlands, Germany

Netherlands: age distribution (%)

Age	Population	ZFW	Sub VHI + WTZ
0-19	24.4	21.3	30.9
20-64	62.0	63.4	59.0
65+	13.6	15.2	10.1
Total	100.0	100.0	100.0

Vektis 2000

Risk segmentation and differences in health care use in Germany

Prevalence of:	Public plan	VHI
People aged 65+	22%	11%
Chronic disease*	23%	11%
Self-reported poor health*	21%	9%
GP contact*	81%	55%
Specialist contact (outpatient)	47%	45%
Difficulty paying for outpatient Rx*	26%	7%
Waiting time for gastroscopy	36 days	12 days

*Statistically significant after controlling for differences in age, gender and income

Source: Mielck and Helmert 2006, Schneider 2003, Lungen et al 2008

Germany: why do so few high-earning employees opt out?

- premiums risk rated
- dependants not automatically covered
- benefits fragmented
- employers' contributions capped
- benefits usually in cash (not kind)
- providers charge higher prices
- premiums rise steeply with age

Germany: state intervention

- over 55s cannot return to GKV (1994 + 2000)
- standard policy for all over 55s insured for at least 10 years
- better information for subscribers (2000)
- income threshold raised (2002)
- 10% surcharge on new premiums to fund ageing reserves (2000)

Individual insurance - Germany

All privately insured persons pay an additional 10% premium [Zuschlag] between the ages 21 and 60. These payments are accumulated in an additional ageing reserve, the amount of which is used as from the age of 65 to mitigate, or even fully compensate for, future premium increases.

90% of the investment income in excess of the technical interest earned on the ageing reserve is split and accumulated partly in another additional ageing reserve and partly in a special reserve for premium refund.

Individual insurance - Germany (2)

The company uses the special reserve for premium refund to make additional contributions to those older people who, because of their age when the new legislation was enacted in 2001, may otherwise not have been able, or not be able, to accumulate enough money for mitigating future premium increases after their retirement. This measure is temporary and stops in 2025.

The additional ageing reserve built on the accumulated additional premiums is portable, but not that built on the investment income in excess of the technical interest earned on the ageing reserve**s**.

In case of death or termination all ageing reserves are credited to the insured community. There is no cash surrender value.

Complementary VHI covering user charges?

Requirements

- user charges must be high
- regulation for affordable access to VHI
- careful design to avoid undermining value in public spending

Risks

- inadequate financial protection
- equity concerns
- efficiency concerns
- EU legal challenges to public policy to secure access (France, Slovenia)

Large markets very rare

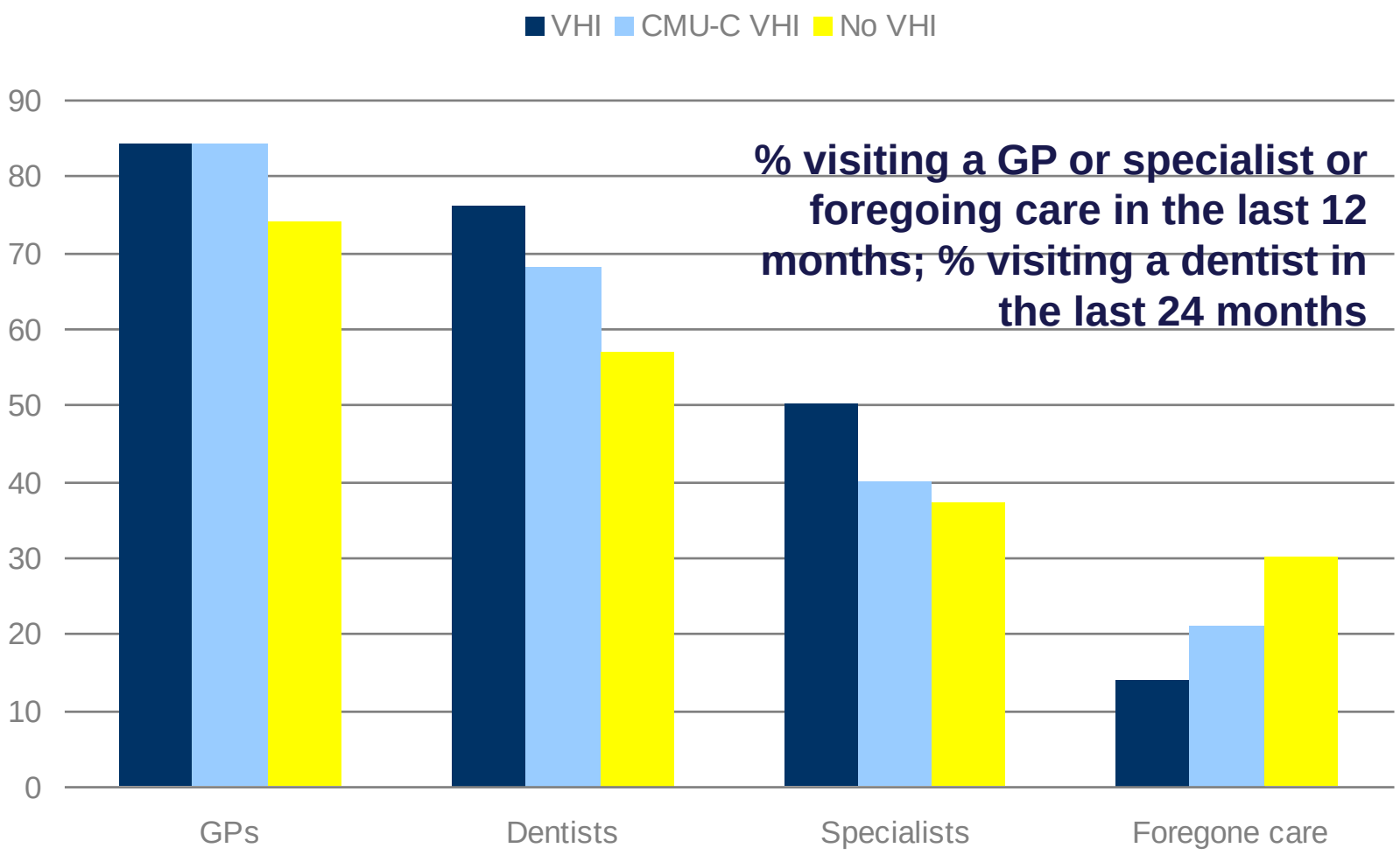
Regulation has intensified over time

France: growing policy concerns

- still 4 million people without VHI (financial barriers most common reason for not having VHI)
- the quality of VHI coverage has declined
- regressive VHI premiums: 3% of income for the richest quintile, 10% of income for the poorest quintile
- income-related inequality in likelihood of having VHI and quality of VHI coverage
- variation in care use and foregone care by VHI status
- high transaction costs
- may undermine value-based user charges policy

Source: Couffinhal and Franc 2014 forthcoming

Variation in use of health care by VHI status, France (2008)



Source: Perronin et al 2011

Complementary VHI covering excluded services?

Requirements

- technical, financial resources for priority setting, HTA
- political will to define statutory benefits

Risks

- no market will develop
- financial protection and equity concerns
- conditional sale undermines competition (Netherlands, Switzerland)

Large markets very rare!

Insurers may not develop products unless there is significant population coverage to spread risk

Canada - Background

- **Complementary** for services not covered by public insurance, such as drugs and dental
  - 95.5% of population has some sort of **extended health insurance coverage** that includes drugs and dental
  - Other products include: Hospital insurance only; Prescription drug insurance only; Dental only insurance; Long-term care and disability insurance; Accidental death and dismemberment insurance
- 12.8% of Total Spending on Health
- 43.4% of Private Spending on Health (Pharmaceutical care 60%, Dental 95%)
- Until recently, seen as having a very limited role in health system

Drivers of increased policy focus on PHI in Canada

1. Emergence of long waiting-times in the mid-1990s for common, high-profile services
   - Increasing pressure to introduce private supplementary insurance as a way to increase sustainability and decrease waiting times within the public system
2. Growing importance of pharmaceuticals which are not covered under Canadian Medicare
   - Push toward public-private financing for drugs

Increasing interaction between publicly and privately financed components leading to unequal access

Key Regulatory Issues

- Regulation is **weak** with limited policy focus on the private market in Canada
- Regulations **prohibit** private insurers from covering publicly insured medical and hospital services
- Provinces have **limited the growth** of private insurance as physicians must either operate only in the public or only in the private market and cannot charge fees higher than those charged in the public scheme
- **Increasing pressure** to relax the regulations on private health insurance due to long wait times.
  - 2005: Supreme Court ruled that Quebec's prohibition on private insurance for publicly insured services, in the presence of unreasonable wait times, violated the Quebec Charter of Rights and Freedom.
  - Quebec Government responded by passing legislation that guarantees maximum wait times for approximately 50 procedures, opening door for national policy on prohibiting private insurance for publically covered procedures

Key Performance Issues

- Relatively small since plays limited, complementary role in financing
- Plays no role in medically necessary physician and hospital services
- Impact in the drug and dental sectors
- Provinces have found it difficult to expand public coverage of prescription drugs and continue to rely on the private market for coverage, even though there is increasing concern about the rising prices of drugs.
- Dental care generally is not considered to be a source of financial risk.
- Inequity in use of specialists with strong income-related gradients in use.
- Drug expenditure is pro-rich among working age individuals as they are more likely to have private coverage.

- PHI has undertaken almost no efforts to improve the quality and efficiency of health care services as functions largely as bill-payer
  - Administrative costs for PHI are higher than in public sector (13.2% vs. 1.3%)

Private health insurance products in Canada

Insurance product	Description	Population covered in 2011 (000s) (Proportion of Population Covered)	
		Group policies	Individual policies
Extended health care insurance	Covers the following services where they are not publicly insured: hospital services, prescription drugs, non-physician providers, vision care, travel insurance and other miscellaneous services.	32,200 (95.5%)	664 (2.0%)
Hospital insurance only	Covers only non-medically necessary hospital ancillary services.	639 (1.9%)	123 (0.4%)
Prescription drug insurance only	Covers community-based prescription drugs.	22 (0.1%)	3 (0.0%)
Dental insurance	Covers community-based dental services.	21,600 (64.1%)	28 (0.1%)
Critical illness insurance	Provides a lump-sum cash payment on the first diagnosis of one of several contractually specified conditions.	1,100 (3.3%)	
Long-term care insurance	Provides contractually specified payments for those who can no longer function independently due to physical or cognitive impairment and/or ageing.	317(0.9%)	79 (0.2%)
Long-term disability insurance	Provides income replacement at a contractually specified rate in the event of long-term disability.	10,689 (31.7%) - 9,600 insured policies - 1,089 uninsured policies	884 (2.6%)
Short-term disability insurance	Provides income replacement at a contractually specified rate in the event of short-term disability.	4,600 (13.6%) - 2,200 insured policies - 2,400 uninsured policies	32 (0.1%)
Accidental death and dismemberment insurance	Provides a contractually specified cash payment in the event of death or loss of one or more body parts as a result of an accident.	22,100 (65.5%)	2,300 (6.8%)

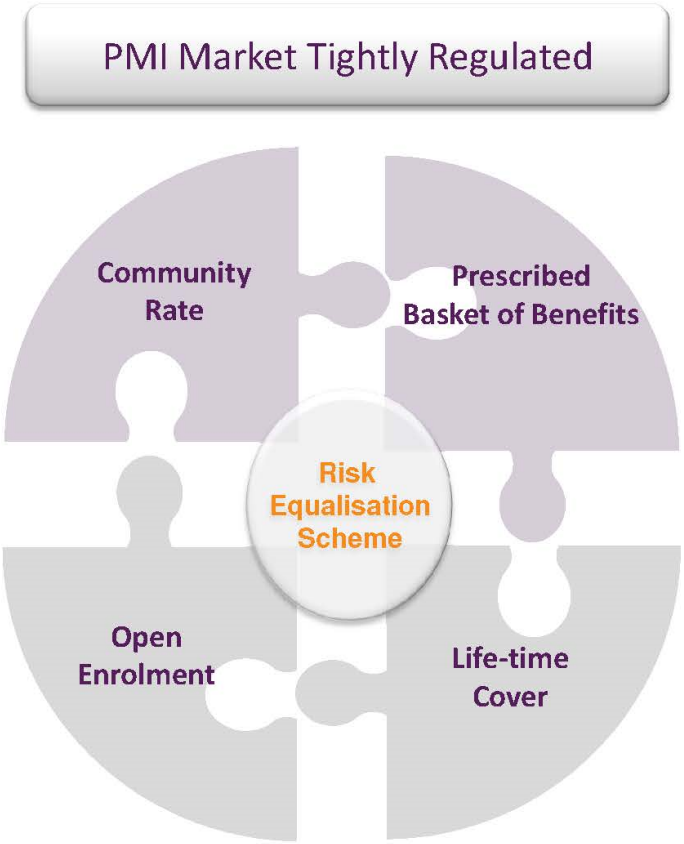
Source: Coverage figures obtained from Canadian Life and Health Insurance Association (2013)

VHI in the UK: value for money?

VHI in the UK usually excludes:

- pre-existing or chronic conditions
- accident and emergency admission
- normal pregnancy and childbirth, kidney dialysis, organ transplants, HIV/AIDS, outpatient drugs and dressings, infertility treatment, preventive treatment, drug abuse, self inflicted injuries, cosmetic surgery, gender reassignment, mobility aids, experimental treatment and drugs, war risks and injuries arising from hazardous pursuits . . .

Supplementary PMI- Ireland



- Risk-rating prohibited

  No discrimination on basis of age, gender, health

- High-level of Prescribed Benefits

  Broadly all public hospital procedures

- Life-Time Cover & Open Enrolment

  Insurers cannot refuse cover or renewals

- Anti-Selection Measures

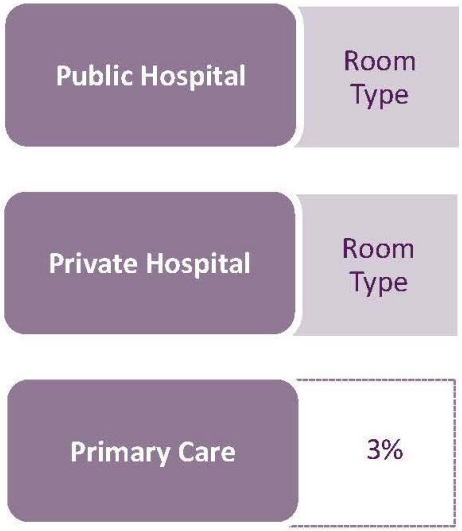
  Limited 'waiting periods' to prevent selection

PMI - Ireland

> *… PMI Products across the market provide comprehensive cover for hospital treatment with very limited cover for primary care*

Average PMI premium circa €1,100 pa

Approx €880 net of 20% relief tax



- Benefit for all treatments in a covered hospital / clinic
- Generally full-indemnity / direct payment to hospitals/consultants…
- But, trend towards excesses and co-pays
- No requirement to cover all facilities
- Small primary care element (co-pays)
- No cover for LTC

Ireland - Public Policy Perspectives

> *…Voluntary PMI is embedded in the Irish health system as part of a public-private mix of healthcare funding and service delivery*

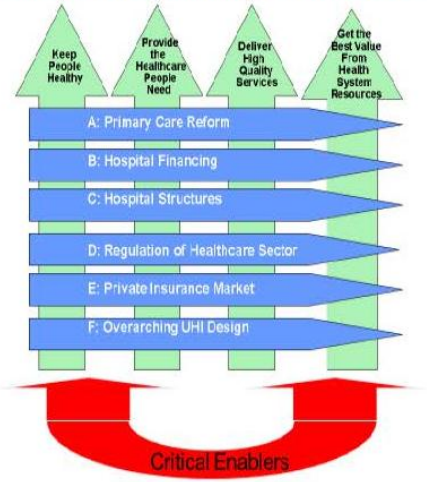
- PMI contributes €2.3b to the Irish healthcare economy – circa 10-15% of health spend
- Additional source of income to public hospitals, circa 10%
- State has access to private infrastructure without the capital investment
- Creates a two-tier health system – but…
- Materially frees-up capacity in the public system for non-private patients
- Delivers social goals in terms of inter-generational solidarity & health status
- Limits to the extent of alignment with policy goals, e.g. prevention, integrated care, etc.

>>> Government plans to evolve voluntary PMI into mandatory universal health insurance

Future Public Policy Perspectives

> *…. Government plans implement a universal mandatory model where competing private insurers purchase services from competing public and private healthcare facilities*

To develop an efficient and effective single-tier health service which promotes the health and well-being of the population and which provides equitable access to high quality care on the basis of need.



Source : Depart of Health (2013)

Key Design Principles

- Single-tier
- Mandatory cover for basic package
- Competing private insurers
- Competing public and private providers
- Premium based on economic circumstances
- Insurers allowed to sell 'top-up' products

>>>In parallel,

- Free GP cover funded through social insurance
- Supply-side initiatives to improve efficiency and quality

Risks with VHI

- VHI may not address major problems and may create new challenges
- VHI may exacerbate fiscal pressure (especially substitutive VHI)
- VHI may undermine value in public spending

- the larger the market, the larger the challenges

Source: Thomson 2014 forthcoming, Thomson and Mossialos (eds) 2014 forthcoming

Key messages

- proceed with caution, clear principles
- **clarity** about goals
- **complementarity**: how best to combine public and private resources to achieve health policy goals – requires understanding of how VHI interacts with the health system
- **careful policy design**: anticipate & minimise risks
- **capacity** for regulation and oversight

Public policy towards VHI: policy design and regulation

VHI as health policy tool

- will VHI cover important coverage gaps?
- will those who need VHI have access to it?
- can this be achieved without undermining value in public spending on health?

- policy design is as important as regulation

Regulatory goals, approaches, examples

Goal	Approach	Examples
Market stability	Financial	▪ solvency margins ▪ reporting requirements
Consumer protection	Material	▪ marketing practice ▪ relations with providers
Access	Material	▪ open enrolment ▪ lifetime cover ▪ community rating ▪ premium review, approval, caps ▪ mandated (minimum) benefits ▪ prohibit exclusion of pre-existing conditions

Source: Chollet and Lewis 1997

Is regulation for access necessary?

- is VHI covering important gaps in coverage?
- no, focus on consumer protection: transparency, product differentiation
- yes, who should regulate what and how?
- nature of regulation affected by role, market structure, politics, capacity, legal constraints

Source: Chollet and Lewis 1997, Thomson and Mossialos 2009 and 2014

Access rules in the EU - PMI policy conditions

Country	Is there an age limit? (typical age limit)	Is there open enrolment?	Can insurers exclude pre-existing conditions?	Type of VHI contract available (annual or lifetime)	Does group cover end at retirement?	Can group cover be converted to individual contract at retirement?
Austria	Yes (65-70)	No	Yes	Lifetime	Yes	Yes
Belgium	Usually not (65)	Yes	Yes	Lifetime	Yes	Yes
Denmark	Mutual plans: Yes (60)	No	Yes	Quarterly	No	Not applicable
	Commercial plans: Yes (60)	No	Yes	Annual	Yes	
France	Usually No	Usually yes	Usually no	Annual	Yes	Yes
Germany	Substitutive plans: No	Yes	Yes	Lifetime	No	Not applicable
	Non-substitutive plans: No	No	Yes	Lifetime	No	Not applicable
Ireland	No	Yes	No	Annual	Yes	Yes
Italy	Mutual plans: Yes (65-75)	No	No	Annual and lifetime	No	Not applicable
	Commercial plans: Yes (65-75)	No	Yes	Annual and lifetime	Yes	
Netherlands	No	Yes	Yes	Annual		
Portugal	Yes (60)	No	Yes	Annual	Varies	
Sweden	Usually no	No	Yes	Annual	Yes	
Switzerland	No	No	Yes	Annual	No	Not Applicable
United Kingdom	Yes (for new contracts)(65, sometimes 74/75).	No	Yes	Annual	Usually Yes	

PHI tax incentives and disincentives (1)

Country	Tax incentives for employment-based PHI		Tax incentives for individual PHI	Tax incentives for insurers	Tax disincentives or reductions of incentives for individuals or employment-based PHI	Tax disincentives or reductions of incentives for insurers
	Employer	Employee				
Austria	Premiums up to €300 year per employee are deductible from corporate income tax if all employees in the company are covered [	Premiums up to €300 per year per employee are exempt from being taxed as a benefit in kind if all employees in the company are covered	25% of individual PHI premiums are tax deductible as special expenses up to a total of €2920 per year for single households, up to €5840 for households with one earner and up to €7300 for households with at least three children; this only applies to households with annual incomes lower than €36 400; beyond this amount, deductions are reduced linearly up to an income limit of €60 000 per year, after which there is no tax relief	None	None	Tax on PHI premiums of 1%
Belgium	None	None	Individual hospitalization insurance providing protection superior to standard insurance policies (e.g. policies covering pre-existing diseases for hospitalisation in double or common room, without additional premium or waiting period) are exempt from the 9.25% tax on PHI premiums (applicable to commercial insurers)	None	None	Tax on PMI premium of 9.25% for commercial insurers Tax on PHI premiums extended to mutual societies (since 2010)
Denmark	Supplementary PHI premiums are deductible from corporate income tax if all employees in a company are covered (since 2002)	None	None	None	None	Tax exemption removed except for policies covering preventive services and employment related health needs (2012)

PHI tax incentives and disincentives (2)

Country	Tax incentives for employment-based PHI		Tax incentives for individual PHI	Tax incentives for insurers	Tax disincentives or reductions of incentives for individuals or employment-based PHI	Tax disincentives or reductions of incentives for insurers
	Employer	Employee				
France	Fiscal rebates for employers that buy and offer group contracts to their employees; Favorable tax treatment for group PHI since 2009	Premiums are deductible from taxable income (since 2004)	None	Solidarity based contracts with no limit on pre-existing conditions or health questionnaires are subject to lower taxes on premiums– 7% (2002) Tax incentives extended to responsible contracts (coordinated care pathways with a designated gatekeeper) (2004)	None	Taxes on premiums have been increased for all PHI contracts; for "responsible contracts", the rate has gone from complete exemption to 3.5% (2010) and 7% (2011); tax rate for other contracts is currently set at 9%.
Germany	All insurance premiums (not just PHI) are tax deductible The amount of health insurance premiums (for SHI and PHI) that may be deductible increased (2010)	All insurance premiums (not just PHI) are tax deductible The amount of health insurance premiums (for SHI and PHI) that may be deductible increased (2010)	All insurance premiums (not just PHI) are tax deductible The amount of health insurance premiums (for SHI and PHI) that may be deductible increased (2010)	None	None	None
Ireland	PHI premiums granted tax relief at source at the basic rate of income tax (20%); the rate was reduced from marginal rate over two tax years (1995/96 and 1996/97) to make it less regressive	None	None	None	Employer-paid premiums taxed as benefit in kind Tax relief had been granted at the marginal rate but this was reduced to the standard rate over two tax years (1995/96 and 1996/97)	None

Key messages

- anticipate potential constraints to appropriate and effective regulation
- monitor the market
- do not think of VHI in isolation: anticipate interaction with the health system and align incentives across the whole system

Regulatory responses

Problem	Consequences	Possible solutions?
Adverse selection	little risk pooling, no market, only some insured	education, subsidies, compulsion
Risk selection	no insurance for some groups	open enrolment, community rating, risk rating
Moral hazard	overuse, oversupply	cost sharing, ‘managed care’
Info asymmetry	no price competition	standardised benefits