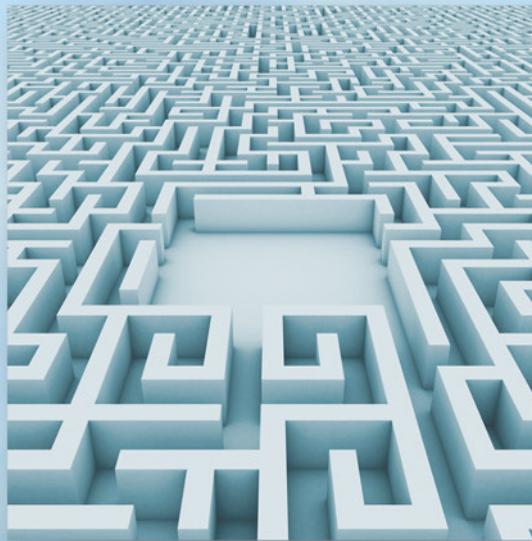


Private Voluntary Health Insurance

Consumer Protection and
Prudential Regulation



Greg Brunner
Pablo Gottret
Birgit Hansl
Vijayasekar Kalavakonda
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THE WORLD BANK

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Foreword

The role of private voluntary health insurance was a central theme during the recent debates and struggle to expand health insurance coverage for 40 million people in the United States. Four billion people in low- and middle-income countries today face the same debate in financing health care for their population.

Opinion is divided into two camps. One camp considers private voluntary health insurance an option to be avoided at any cost. This position is based on the concerns that that such insurance may lead to overconsumption of care, cost escalation, diversion of scarce resources from the poor, cream skinning, adverse selection, moral hazard, and an inequitable, U.S. health insurance-style health care system.

For others, private insurance gives people choice and access to care when needed without long waiting lists, poor care, and rudeness at the hands of public providers employed by Ministries of Health. They also assert that many of the problems observed in private health insurance are equally true for social health insurance and subsidized or free access to government-financed national health services.

Although private voluntary health insurance may have flaws, in many settings it is an option often utilized as an alternative to low-quality and limited range of services existing in their country.

As discussed by the authors of this volume, with good consumer protection and prudential regulation private voluntary health insurance can make a positive contribution to both development goals and health care financing at low- and middle-income levels.

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Preface

On Tuesday, September 16, 2008, the United States government took control of American International Group, Inc. (AIG) to head off the adverse toll the collapse of one of the world's largest financial institutions would have on an already fragile global economy. At the heart of AIG's troubles was not its traditional insurance business but a form of derivative contracts called credit default swaps, sold by the Financial Products Unit of the parent company.¹ (Karnitsching et al. 2008). Derivative contracts derive their value from an underlying financial instrument like a stock, commodity, or index.

AIG failed to appreciate the risks posed by these forms of derivative contracts. Moreover, risk managers, senior executives, and boards of directors did not ensure that they understood the products that were being offered. Finally, government policy makers and supervisors had taken a hands-off approach to the regulation of these products, even though they had become increasingly complex in nature.² These instruments have played a pivotal role in the global financial meltdown that has resulted in the loss of trillions of dollars in individual wealth and countless jobs.

Involvement in poorly understood transactions and little to no oversight is not the exclusive province of AIG. AIG is merely an outsized example of what has happened and can happen without adequate knowledge and experience, governance, risk management, regulation, and government supervision.

In the health insurance context, the consequences extend beyond financial wealth to health, life, and death. Today both the U.S. and European health insurance industries are protected by strong fiduciary safeguards that have been introduced over time in response to concerns about protecting both consumers and the health insurance industry. As a result, in recent history, there have been no spectacular financial failures in the health insurance industry like some of those witnessed recently during the global crisis in the banking and other financial institutions such as AIG.

This was not always the case. During the first half of the 20th century, health insurance policyholders in both the United States and Europe were exposed to risk at time of insolvency of a health insurance fund. Likewise today, the prudential regulation of the health insurance industry in many emerging countries remains weak, leaving consumers vulnerable at the time of financial stress or insolvency.

1. M. Karnitsching, D. Solomon, L. Plevan, and J.E. Hilsenrath, "U.S. to Take Over AIG in \$85 Billion Bailout; Central Banks Inject Cash as Credit Dries Up," *Wall Street Journal*, September 16, 2008.

2. G. Morgenson, "Behind Insurer's Crisis, Blind Eye to a Web of Risk," *New York Times*, September 28, 2008.

- Policyholders needing ongoing medical care who lost coverage because of the insurer's failure could have difficulty finding alternative insurance without government intervention. In an unregulated environment, voluntary private health insurance might be accessible or affordable only for the young and the healthy. Anyone who lost their health insurance would have limited options. This is because insurers could opt to not cover many individuals who have a medical condition or a medical history if the law permitted them to do so. Or, they could decide not to cover individuals who are older—because they are more likely to incur medical claims.

Addressing the problems posed by underwriting to manage risk, in which insurers can exclude people who present a higher risk of making claims has been a challenge for a number of countries with voluntary private health insurance systems. For example, in Chile, private health insurers called *Instituciones de Salud Prestacional (ISAPRES)* were allowed to risk select. Further, no basic benefits package was required from them until a change of regulation in 2005. The absence of adequate consumer protection legislation resulted in the *Fondo Nacional de Salud (FONASA)*, a public sector insurer, covering most of the lower-income population as well as most of the population over the age of 50. In fact the ISAPRES cover less than 18 percent of the population, mostly concentrated in the young and higher income groups while the older, poor, and more vulnerable groups are covered by the public insurer (Gottret, Schieber, and Waters 2008).

- Other policyholders could be limited to an inadequate range of options when accessing coverage. If the law permits, insurers could decide to cover those individuals but permanently or temporarily exclude coverage for specific medical conditions. A person who had a severe leg injury, for example, could be offered insurance coverage that permanently excludes coverage for any treatment of his or her injury. In addition or as an alternative, an insurer could offer coverage but charge a higher premium than it typically charges, making the coverage unaffordable for the average person. Consequently, only those with higher incomes would be able to afford coverage.
- Even healthy policyholders could lose on the quality of their coverage. Often, health insurance coverage gets richer as the person remains continuously insured. Waiting periods, which are common design features in voluntary health insurance products, get completed, and the person is effectively protected against more events, which (s)he may lose when starting a new policy with another insurer.

Health insurance, even if structured as short-term policies with the respective insurance companies, is often regulated in a way that allows the policyholder longer-term expectations for continued coverage. This is usually achieved through regulations on renewability of health insurance policies, or it may also have been offered by the insurance company itself by selling a “guaranteed renewability” product, sometimes at a higher premium than otherwise. Thus,

any “troubled” insurer would have implications not only for the policies that are already in force, but also on their future renewals.

Without government intervention, troubled health insurers in developing countries are often forced to liquidate if they do not have sufficient capital on hand to pay claims or respond to unforeseen expenses. Health insurers are particularly vulnerable when there are no solvency regulations or those regulations are inadequate. The foundation of solvency standards includes initial capital requirements, technical provisions (reserves) for outstanding claims and unearned premiums, and ongoing capital requirements to ensure adequate resources for unforeseen expenses. In addition, limits on the investment of reserves in particularly risky assets (such as derivatives) are critical to maintaining an insurer’s solvency.

As important, particularly in a developing insurance market, is the existence of government supervision to enforce those standards. It has been reported that in Kazakhstan, for instance, a large number of insurance companies failed not long after they were established in large part because of a lack of solvency oversight (Dreschler and Jutting 2005). More recently, in Rwanda more than 90 people were arrested on charges of corruption for the embezzlement of Rwf 230 million (US\$410,000) in the Mutuelle de Santé. The mutuelles are a community-based insurance mechanism that covers about 85 percent of the Rwandan population with a very basic package of health services to be delivered by providers at the local level. The government subsidizes the premium for the poorest segments of the population in this country, which had a per capita income of only US\$305 in 2008. The widespread corruption affecting more than 90 percent of the country’s districts does reflect the need for improved regulation and supervision in the Mutuelle system. However, the large number of arrests reflects that Rwanda, a very poor country with limited institutional capacity, has some system of supervision and accountability that allowed the detection of problems before the mutuelles became insolvent.³

In countries where failures are not an isolated occurrence, conditions often include a lack of coordination among relevant supervisory agencies, insufficient numbers of staff or staff who are not qualified to perform supervisory tasks (perhaps because of low compensation levels), no or cursory review of financial and other statements on a regular basis, no or irregular on-site visits to inspect company records, and inconsistent application of the law across insurers. The ability of supervisors to conduct rigorous monitoring and enforcement is critical to early detection of problems so that corrective action can begin before an insurer becomes insolvent.

3. Mutuelles are not necessarily insurers in Rwanda as they do not all underwrite and manage risk. This distinction will be clarified later in the book.

Insurers can also get in trouble when they fail to evaluate prudently their relationships with reinsurers—insurance companies for insurers. In 1995 a couple of Air Force planes went down in Bolivia. The planes were insured with a company called Phoenix. In supposed compliance with the law, the company had retained the maximum allowable risk based on its capitalization and transferred the remaining risk to a reinsurance company abroad, in Nantes, France. When asked by the supervisory authorities to pay the claims, Phoenix resorted to multiple legal and judicial artifices to avoid compliance. After further investigation by French authorities, the reinsurance company turned out to be only a fax machine in a closet of a party in Bolivia related to Phoenix. All the documentation initially presented to the supervisory authorities regarding the reinsurance company was fraudulent. Bolivian regulation did not require minimum international rating for reinsurance companies at the time. Similarly, in 2005, Legion Insurance Company of Philadelphia, a U.S. health and accident insurance company, was liquidated by insurance supervisors because it had relied too heavily on a reinsurer that was unable to make timely claims payments.⁴

While Legion and Phoenix represent extreme examples, serious problems can nonetheless arise for insurers who are attracted by reinsurer premiums that are too low (i.e., too good to be true) and / or do not perform sufficient due diligence on how the reinsurer manages its risk exposure, if it has a good track record on making timely claims payments, whether it maintains adequate reserves, and if it had realistic business development plans and practices. Insurance companies that fail to do so are vulnerable to reinsurance being an unreliable means of mitigating their own risks. In some countries, supervisors examine whether primary insurers have adequately evaluated the reliability of a reinsurer to which they cede risk or require that reinsurers comply with minimum international risk ratings.

Undesirable behavior in an insurance market is not the monopoly of insurance institutions. Asymmetric information allows people who are sick and require care to seek health insurance coverage (a behavior known as *adverse selection*). Also, people covered by insurance may have a propensity to seek more health care than needed or be indifferent to more-than-necessary services being provided by their health care provider simply because they do not have to pay out of pocket (a behavior called *moral hazard*). Both of these behaviors increase the claims against insurance companies and may lead to increased premiums for other insured.

An added angle for undesirable behavior in the health insurance system lies outside the parties to the insurance contract—the insurer and the insured. This entity, the health care provider, is central to the very concept of health insurance

4. D. Mercado, “Long Term Care Carrier Battles with Reinsurer,” *Investment News*, September 1, 2008, n.p.

as it is the need to pay to the health care provider which requires the insurance mechanism. The health care provider is also prone to “Supply Side Moral Hazard” whereby the provider would want to maximize revenues from an insured patient through more services and more charges for these services, than is usual or necessary. The complication in this case is that the health care providers are also usually outside the regulatory mandate of the insurance supervisors, and any influence on them is at best, indirect, largely based on the provider’s being allowed to participate in the health insurance system. It certainly helps if being part of the insurance system is monetarily critical to the health care providers.

The problems discussed in this introduction are only some examples of the challenges insurers, policyholders, and supervisors confront in the business of health insurance. They each highlight the critical role adequate regulatory standards and oversight play in a vibrant private health insurance market. This book is intended to help countries that are contemplating how to design and implement a legal framework for a private health insurance market. First, it provides an overview of private health insurance, the rationale for insurance regulation, and the institutions involved in administering insurance laws. It then reviews the key standards and protections often used in regulating private health insurance. As part of the discussion on regulatory standards, options for supervisors are noted in certain areas where policy and regulation approaches vary. To illustrate international experience, examples of the regulation of private health insurance from several low-, middle-, and high-income countries are drawn upon throughout the book.

A caveat is in order. Many readers will be looking for evidence of the impact of some of the discussed regulation on the regulatory objectives. Colleague economists will look at least for counterfactuals to assess whether undesired market or institutional behaviors have been absent or reduced in countries with the regulations in place. Though desirable and interesting in certain circumstances, providing such evidence is beyond the scope of this book. The objective of these guidelines is to introduce topics in voluntary health insurance that, according to different international experts, require regulation and supervision. The guidelines propose options for such regulation based on international experience. Which options work best or are cost-effective for each market depends on each country’s own circumstances.

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Acknowledgments

The idea for this volume came over five years ago when discussing the role of private health insurance in developing countries with World Bank colleagues Alexander S. Preker, George J. Schieber, April Harding, and William Savedoff, among others. We acknowledge the absence of a book that could explain the role of regulation and supervision in health insurance in developing countries drawing from lessons from different countries around the world. The book had to be short, simple, and yet underscore all the regulatory issues from both perspectives: consumer protection and prudential regulation. At the same time we discussed that the book should not attempt to be a detailed manual but rather address an audience in charge of policy development at an intermediate level. Understanding the regulatory issues in health insurance should help this audience when planning to develop or modify health insurance regulation. This book attempts to do all this.

The book was prepared under the leadership of Pablo Gottret who brought his experience as an insurance regulator in Bolivia. Nicole Tapay and Greg Brunner brought their experience from the United States, the OECD, and Australia and put together the preliminary drafts. Somil Nagpal, with his experience in health insurance from the India Insurance Regulatory and Development Authority, helped modify and improve previous drafts. Birgit Hansl and Vijayasekar Kalavakonda provided written contributions and were part of the team all along. The manuscript benefited from comments from peer reviewers Alex Preker, Toomas Palu, John C. Langerbrunner, and Rodney Lester. A draft also benefited from comments by Jose Sokol, consultant to the Bank's Quality Assurance Group. The manuscript was prepared under the guidance of Julian Schweitzer and Mukesh Chawla, Director and Sector Manager of Health, Nutrition and Population Anchor of the World Bank. The book would have not gone to print without the encouragement and support of Alexander S. Preker.

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Abbreviations and Acronyms

AIG	American International Group
APRA	Australian Prudential Regulation Authority
CBHI	Community-based health insurance
CMS	Council for Medical Schemes, South Africa
EPS	Entidades Promotoras de Salud, health-promoting organizations, Chile
EU	European Union
FONASA	Fondo Nacional de Salud, Chile
HMO	Health maintenance organization
IAIS	International Association of Insurance Supervisors
IBNR	Incurred but not reported
IRDA	Insurance Regulatory and Development Authority, India
ISAPRES	Instituciones de Salud Previsional de Chile
MPHI	Mandatory private health insurance
NAIC	National Association of Insurance Commissioners
OOP	Out of pocket
OECD	Organisation for Economic Co-operation and Development
PHIAC	Private Health Insurance Administration Council, Australia
PMB	Prescribed minimum benefits
PPO	Preferred provider organization
PVHI	Private voluntary health insurance

CHAPTER 1

Background and Overview of Private Health Insurance

Health care expenditures can be financed through a mix of public resources and private spending. Private spending is a much larger share of total health spending in low- and middle-income countries than in higher-income countries.¹ Moreover, a significant percentage of private spending in those countries is out-of-pocket—direct payments for health care services by individuals. Out of pocket expenditures account for more than 60 percent of the total health care spending in low-income countries and 40 percent of total health care spending in middle-income countries. In contrast, it accounts for only 20 percent of spending in high-income countries (Gottret and Schieber 2006). The higher proportion of out-of-pocket expenditures in lower-income countries means that more individuals in those countries are exposed to the risk that an illness or injury will be catastrophic—so costly as to endanger their financial ability to meet their basic needs such as food and rent payments. In some cases, the resultant indebtedness could be passed on to successive generations.

Low- and middle-income countries are less likely to have extensive public programs that fund access to health services, in part, because so many of their residents work in the informal sector, making it difficult to collect taxes from them (Sekhri and Savedoff 2005). Private health insurance is also less likely to be a significant source of financing for health expenditures in these countries. Nevertheless, low- and lower-middle income countries account for almost one half of the countries with private health insurance markets that contribute more than 5 percent to total health expenditures. While private health insurance is a negligible percentage of spending in most low-income countries, in a few middle-income countries, such as Brazil, Chile, Namibia, South Africa, and Zimbabwe, private health insurance accounts for more than 20 percent of total health spending (Sekhri, Savedoff, and Tripathi 2005)

A growing number of low- and middle-income governments are considering private health insurance as a way of both reducing the risk that individuals will have a catastrophic financial burden and achieving other public health care goals. Among these goals are reducing the financial burden on overstretched public health financing, achieving more equitable access to health care, and improving quality and efficiency in the delivery of health care services (box 1.1).

An important component of a successful private health insurance market, however, is its legal framework. As discussed in detail later in this book, countries

BOX 1.1 COLOMBIA AND INDIA: INTEGRATING PRIVATE HEALTH INSURANCE IN ACHIEVING ACCESS TO HEALTH

Colombia is an example of a country that has integrated private health insurance in its efforts to achieve universal coverage. Under its mandatory health insurance scheme, workers and pensioners and their employers are required to contribute to insurance premiums. The government provides subsidies to individuals who cannot afford to pay the premiums. Individuals select their coverage from a range of public and private health plans. Colombia's efforts to achieve universal coverage through the use of private health insurance continue to be an evolutionary process of reform (Pinto 2008).

In a similar effort in India, both the central and the state governments have introduced several health insurance schemes targeted primarily at the poor, which work through competitively selected private health insurance companies. The premium, entirely or largely funded by the government, provides poor households with access to public and private hospitals. In states like Andhra Pradesh and Tamilnadu, the state-funded schemes cover listed, high-cost (mainly tertiary care) procedures for more than 110 million beneficiaries. The centrally sponsored Rashtriya Swasthya Bima Yojana (RSBY—meaning National Health Insurance Scheme) covered more than 22 million households in November 2010. Its eventual target is coverage of 60 million households (300 million beneficiaries—the entire population living below the official poverty line) for hospitalization risks up to the defined ceiling per household per year.

Source: IRDA 2009; www.irda.gov.in.

regulate insurance companies to counter systemic market failures that lead to an inefficient and inequitable market. In particular, insurance laws are designed to prevent insurers from becoming insolvent and from engaging in unfair practices and discriminatory behavior. When private health insurance serves as a significant source of financing in a nation's health care system, usually insurance laws also include a range of consumer protection laws that enhance both access to the services covered by private health insurers and the adequacy of the benefits provided by the insurer.

WHAT IS PRIVATE HEALTH INSURANCE?

This chapter provides a general overview of private health insurance. It begins with a discussion of the definition of private health insurance and the potential roles of private health insurance as part of a nation's health care financing system. In addition, the chapter reviews the variety of entities that sell private health insurance.

The Organisation for Economic Co-operation and Development (OECD) defines “health insurance” as a “way to distribute the financial risk associated with the variation of individual’s health care expenditures by pooling costs over time (prepayment) and over people (pooling)” (Tapay and Colombo 2004: n.p.). The institution that assumes and pools the risk is an insurer. Essentially, private health insurance involves coverage of a defined set of health services financed through private payments in the form of a premium to the insurer. The insurer, a nongovernmental entity, assumes much or all of the risk for paying for those services. Public health insurance, in contrast, is provided through a governmental entity and is generally funded through payroll or income taxes and general government revenues.

Private health insurance can serve multiple functions. It serves the traditional insurance function of reducing the risk that a person will suffer a significant financial loss relative to income because of the cost of health care services. Generally, a person with health insurance will have less of a financial loss than he or she would otherwise without the insurance. It is also used for the broader social purpose of reducing the risk that a person will not be able to receive needed health care because the cost of the care is unaffordable (Claxton and Lundy 2008). By paying a premium to an insurer, an individual transfers to that insurer some or all of the risk of incurring health care costs due to an illness or injury. In doing so, the individual prepays the costs of some or all of his or her health care needs. Because the actual level of services that the individual will need in the future is unknown, the insurer is at risk that the individual’s health care costs will exceed the amount of the premium that was paid. The insurer knows, however, that some individuals use a lot of health care services while others use less. The insurer, therefore, “pools” together the premiums paid by numerous individuals to pay for the health care expenses associated with that entire group. The premiums contributed by pool members who use fewer health care services, in effect, subsidize the health care costs of pool members who use a higher level of health care services. (Claxton and Lundy 2008).

In some developing countries, health care financing takes the form of prepayment or subscription schemes that do not involve any risk pooling. Payments, for instance, are made in advance for routine and predefined events. Because this book defines private voluntary health insurance (PVHI) to encompass both prepayment and risk pooling, these schemes are outside the traditional concept and supervision of “insurance” and are not intended to be captured here.

FUNCTIONS OF PRIVATE HEALTH INSURANCE

Private health insurance can be mandatory or voluntary. Mandatory private health insurance (MPHI) means that the law requires individuals or employers to purchase private health insurance. In Switzerland, for instance, all residents are required to purchase private health insurance. In Uruguay, all residents not

covered by the publicly funded programs for the elderly and poor must buy private health insurance as well (Sekhri and Savedoff 2005). In contrast, PVHI means that a person or employer can decide to buy health insurance (perhaps as a result of a collective bargaining agreement in the case of an employer). If they do purchase it, they can select the type of coverage, insurer, and duration of contract, within the context of applicable law and regulations. This book focuses on PVHI because private health insurance is voluntary in most markets.

PVHI can be used in a number of different ways depending on the degree to which a country chooses to rely on private health insurance to finance health care. It can be the primary means of financing health care, an alternative to a public program, or a mechanism for individuals to finance what is not covered under a public program. In discussing these roles, this book uses the OECD taxonomy: primary, duplicate, complementary, or supplementary.

- *Primary.* PVHI is primary when it is the only form of health insurance available to an individual. It may be the only form of coverage available because there is no public program. Or, it may be the only form of coverage available because the individual is not eligible for the public program. Alternatively, the individual may be eligible for the public program but decides to opt out of it. Private health insurance is primary in the United States (Tapay and Colombo 2004).
- *Duplicate.* If an individual buys PVHI that offers coverage for health services included under a public program, PVHI serves as duplicate coverage. The individual remains covered by the public program but opts to buy and use private health insurance instead. The private option may offer broader access to providers, levels of services, or perceived better quality of care than under the public program. Individuals are not exempted, however, from making their required contribution toward the public program such as in Brazil where consumers can opt out of using the public program (box 1.2).
- *Complementary.* Private insurance complements coverage under the public program by covering all or part of the costs not otherwise reimbursed. As an example, a public program may pay for only 80 percent of the cost of outpatient surgery. The individual is responsible for paying the remaining 20 percent (called coinsurance). A complementary insurance policy covers some or all of the 20 percent coinsurance payment. In the United States, for instance, beneficiaries with Medicare, the program that finances health care

BOX 1.2 BRAZIL: DUPLICATE PRIVATE HEALTH INSURANCE

Brazil has a system of universal public insurance that is financed from general revenues. The government permits consumers to buy and use private health insurance instead. Many Brazilians have chosen to do so resulting in the public program largely being relied upon by those with lower incomes (Jack 2000).

for the elderly, can buy health insurance called Medicare Supplement that helps them pay for costs not covered by the Medicare program, like coinsurance (table 1.1).

- *Supplementary.* Private health insurance is supplementary when it provides coverage for health services that are not covered by a public program. Depending on the country, it may include services not covered by the public program such as luxury care, elective care, long-term care, dental care, pharmaceuticals, rehabilitation, alternative or complementary medicine, or superior amenity services in the hospital. Health insurers offer PHI as supplemental coverage in many countries such as Canada and Switzerland (table 1.1).

TYPES OF PRIVATE HEALTH INSURANCE

Private health insurance can be offered through a range of entities, including commercial or mutual insurers, health maintenance organizations (HMOs), and community-based health insurance schemes (box 1.3). Indemnity insurers are commercial companies that can be owned by stockholders or by policyholders (called mutual insurance companies). These companies pool risks and pay for the health care services covered under their insurance contract.

Some insurers both pool risks and directly provide or arrange for health care services under managed care plans. These plans offer comprehensive health care services and financial incentives for policyholders to use the services of providers within the plan's network. These plans also structure their insurance products in a way that influences the treatment decisions made by health care providers. HMOs are a type of managed care plan.

In some instances, payment arrangements are made directly between a provider or a group of providers and individuals or employer groups. This may be done by individuals, employers, and providers directly or through an

TABLE 1.1 The Role of Private Health Insurance in West European Health Systems

<i>Role</i>	<i>Coverage</i>	<i>Examples</i>
Substitutive (primary)	For people excluded from or allowed to opt out of statutory health insurance	<i>Excluded.</i> Families with annual incomes over €30,700 in the Netherlands <i>Allowed to opt out.</i> Families with annual earnings over €45,900 in Germany
Complementary	Services excluded or only partially covered by the state such as dental care or user charges	<i>Excluded services.</i> France, Ireland, Netherlands, Spain, United Kingdom <i>Cost sharing.</i> Belgium, Denmark, France, Ireland, Italy, Luxembourg, Portugal, Sweden
Supplementary	Increased choice of provider and faster access	<i>All countries.</i> The main role of private health insurance in Finland, Greece, Portugal, Spain, Sweden, United Kingdom

Source: Mossialos and Thomson 2004.

BOX 1.3 COMMUNITY-BASED HEALTH INSURANCE

Community-based health insurance schemes (CBHIs) are common in many low-income countries. They are broad and diverse, but generally share a few common features. The community is strongly involved in the management of the community-based organization. Policyholders usually elect a group of their members to act as managers. Members participate voluntarily and are from the same community. A shared set of social values binds them. Further, members do not have access to any other form of health insurance (Gottret and Schieber 2006, citing Jakab and Krishnan 2004). CBHIs help cover the costs of health care services through risk pooling, and beneficiaries are involved in the management of community-based schemes, at least in the choice of the health services covered (Tabor 2005).

CBHIs may be “owned” by the community, by government (local or central), by hospitals or clinics, by international nongovernmental organizations (NGOs) or donors, by cooperatives, or trade unions (Tabor 2005 citing Jutting 2002). The institutional structure, capacity of management teams, and community-specific perceptions of risks influence the risk taken on by CBHIs. Almost all CBHIs cover a combination of high-cost and low-incidence health events, and low-cost, frequent events (usually primary care). In cases where a CBHI scheme receives a flat per capita premium and transfers a per capita fee to a provider, the CBHI scheme is essentially a broker and is assuming no risk. However, not all CBHIs transfer all the risk, and some may retain some of the risk—such as transferring a per capita fee to a provider that only covers low-cost frequent events and paying for high-cost, low-frequency events on a per case basis. In Rwanda, in exchange for an annual premium of RF2,500 (US\$8) per family, members receive a basic benefits package. For a capitation payment, the local health center provides health care services and drugs. The basic benefits package also includes ambulance referral and limited treatment at a district hospital. At the time of service, members pay a copayment of RF100 per visit. In addition, the CBHIs contribute 5 to 15 percent of their collections to the district hospital to pay per treatment charges (Tabor 2005, citing Schneider, Diop, and Bucyana 2000). As a corollary, in yet another model, for example, SEWA and ACCORD in India, the CBHI may itself retain the high-frequency, low-cost episodes (e.g., by running its own outpatient clinics) and pass on the higher-risk, low-frequency events (like hospitalization) to a private health insurance provider (Devadasan and Nagpal 2007). CBHI supervisory mechanisms must reflect the diversity in risk assumed by CBHI schemes. Prudential regulation must be effected accordingly.

intermediary, such as a broker, who does not assume any contractual insurance risk liability. Whether the provider serves as an insurer, however, depends on the way in which it is paid. If the payment method is linked to the actual delivery of a predetermined set of services to a specific individual, it is not an insurance arrangement. Discounted payments for providing services, for instance, are

generally not considered insurance risk. Similarly, per diem payments made for each day of a hospital stay are not likely to result in the transfer and pooling of risk. Conversely, other methods of payment do mirror the risks assumed by a health maintenance organization. A provider that accepts capitation payments from individuals or employer groups is an insurer. Under a capitation payment, the provider receives a fixed fee per individual per month to provide all covered services regardless of how many services are provided to any of the individuals covered. The provider assumes insurance risk while providing or arranging for services in the same manner as an HMO (NAIC 1995).

NOTE

1. Low- and middle-income countries are those whose gross national income is less than US\$766 and between \$767 and \$9,385, respectively.

CHAPTER 2

Scope of Regulation

This chapter discusses the principal reasons for regulating health insurance. It also discusses the statutory, legislative, and judicial controls that are used in doing so. In particular, it reviews different approaches countries may want to consider to organize the agencies that will administer insurance laws. Finally, it considers the level of regulation that should be applied depending on whether private health insurance serves as the principal or ancillary source of financing in a nation's health care system.

RATIONALE FOR REGULATION

Private voluntary health insurance (PVHI) can offer protection against catastrophic medical expenses and improve access to health care (Drechsler and Jutting 2005, citing Jutting 2005). There are, however, imperfections in the insurance market that require intervention. To encourage the effective development of PVHI, it will be necessary for policy makers to establish standards that will attempt to correct inefficiencies from market failures and that will achieve desired social objectives, most notably equitable access to health insurance.¹

Market Failures

Market failures can arise from information deficiencies, moral hazard, and adverse selection.

Information Deficiencies

The business of health insurance is very complex. First, insurers engage in a broad range of highly technical tasks. Insurers must conduct underwriting, create insurance products, draft insurance contracts, set rates and collect premiums, manage financial assets, investigate and pay insurance claims and other liabilities, process appeals of claim denials and defend against litigation, implement accounting and other systems, understand and comply with laws, and manage their employees.

In addition, private health insurers that offer managed care plans have a unique set of additional responsibilities since they engage in a range of activities related to the health care provided to its policyholders. These tasks include creating a provider network, negotiating contracts with providers, developing medical and payment policies, performing quality assurance activities, conducting

utilization review to determine if services are medically necessary, and assessing if new medical devices, procedures, or medications are experimental and investigational and therefore should not be covered.

Second, in conducting its business, an insurance company assumes a great deal of risk. In addition to the insurance risk it assumes for its policyholders, it takes on other forms of risk such as the risk of loss that it incurs when it invests the premiums it receives from policyholders (investment risk). Or, it takes on the risk that a provider ultimately does not provide the services they have agreed and been paid to provide for the duration of the contract between the insurer and the provider (credit risk). Consequently, a successful insurance business requires responsible management, expertise, and a great deal of capital. While broader factors in the economy contribute to the challenges insurance companies may face, the International Association of Insurance Supervisors (IAIS) has noted that institutional failures are, in general, caused by lax management, weak corporate governance, poor central controls and supervision, unsound accounting systems, and other infrastructural shortcomings compounded by weaknesses in the legal framework (IAIS 1997). Similarly, a study of 21 companies in financial trouble found that management issues were at the root of the problem (Lorent 2008, citing Ashby, McDonnell, and Sharma 2003).

Information is necessary for a competitive and efficient market. But, the complexity of insurance not only presents management challenges. It also makes it impossible for most consumers to assess adequately if the private health insurer has been structured properly, is run by people with appropriate management skills and expertise, and has adequate resources. Unlike consumer durable transactions (e.g., buying a car, refrigerator, or hi-fi system), the consumer does not buy a product, but a “promise,” and therefore needs some sort of guarantee that the promise will be fulfilled when the time comes.

A key concern is that the health insurer will be able to pay its claims. Since employers, governments, and individuals pay premiums in advance of receiving health care services, the policyholder wants to be sure that the insurance company will have sufficient resources to either reimburse them for payments they have made or to pay medical providers for the services rendered to policyholders. If the insurer does not manage its risk well, it could become insolvent, and insured individuals could experience disruptions in care. In addition, the insurer may be unable to pay health care providers for medical expenses. If another insurer cannot step in to honor the contracts in force, policyholders will have lost their prepaid premiums. Moreover, policyholders will be forced to find other insurance, which they may have difficulty doing. Even if they do find other coverage, they may have to pay considerably more for the new policy. The failure of a private health insurer can have broader market implications as well. It can severely undermine confidence in the health insurance industry, and perhaps in the insurance industry generally, and can result in increased demand for public health insurance, which may strain public health systems and public health budgets.

This point has been reinforced by the OECD Insurance Committee as follows:

In a non-technical sense insurance is purchased in good faith. Consumers implicitly rely on the integrity of the insurers with which they deal. . . . The mission of insurance is security. If the suppliers of the security are themselves perceived as insecure, the system could easily break down. Private insurance cannot flourish without public confidence that it will function as promised. Government's duty is to ensure that this confidence is neither misplaced nor undermined. (OECD 1996: n.p.)

Moreover, buyers are often unfamiliar with the terms and conditions of health insurance contracts. As a result, they may not understand all of the benefits that are provided or excluded under the policy or the fees that they will need to pay when they receive health care services covered by the health insurance policy. Also, they may not understand the conditions under which the health insurer can terminate or rescind their policy or refuse to pay for services they received. Insurance laws seek to address these information gaps by requiring that certain information be included in materials disseminated to policyholders, that provisions be worded in a specific manner in contracts between insurers and policyholders, and that systems be put in place that require insurers to reconsider their decisions to deny coverage for health care services, medications, or supplies received by the policyholder.

Because of the complexity of the business of insurance, consumers rely on the insurer or insurance agent to help them understand the value and stability of what they are purchasing. To protect consumers against insolvencies and unfair insurance practices, those who administer the insurance laws (referred to as supervisors throughout this book) are given the authority to determine, on an ongoing basis, whether an insurer is permitted to offer insurance and has the appropriate expertise and resources to do so. Thus, legislators enact laws that require insurers to obtain a license to operate an insurance business, to have adequate capital to meet liabilities, to engage in fair transactions with policyholders, and to prepare insurance policies that accurately and clearly disclose their terms. These laws also give supervisors the authority to develop appropriate regulations and policies to implement the laws and to enforce them.

Moral Hazard

One concern that can drive up the cost of health care and health insurance is moral hazard. Moral hazard is the propensity for consumers to seek more health care services than they would if they did not have health insurance. It can also exist because of the propensity for providers to provide more services than they would if the individual did not have health insurance (Sekhri, Savedoff, and Tripathi 2005).

Insurers employ cost-sharing strategies to address this problem. They may, for instance, require the payment of a deductible at the beginning of the contract

year (usually the calendar year). A deductible is a fixed dollar amount that an insured person has to pay for services received before the insurer will begin to pay for benefits under the insurance contract. They may also require the payment of coinsurance or copayments after the deductible has been met. Coinsurance is a percentage of the cost of the services received. If an insured individual undergoes surgery, for instance, the individual may have to pay 20 percent coinsurance. That is, the individual will pay 20 percent of the cost the provider can bill for the surgical procedure under its contract with the insurer. In the alternative, the insurer may require that the individual pay a copayment, which is a fixed amount for each visit, procedure, or prescription filled. The insurance may, for instance, require a copayment equivalent to US\$250 when the insured person undergoes a surgical procedure.

These cost-sharing mechanisms provide a financial incentive for the individual to consider whether the service sought is really needed or just wanted. It could have the negative consequence, however, of preventing an individual who is low-income or who needs intensive health care services from seeking needed care because he or she cannot afford the aggregate amount of cost-sharing under the policy. Regulations that specify, to any degree, the benefits packages that can be offered by an insurer will need to balance the real concern posed by moral hazard against the adverse impact cost-sharing can have on an insured individual's financial ability to obtain needed health care.

Adverse Selection

Another key concern or market failure is that some consumers will wait until they are sick before they buy health insurance. This tendency—called adverse selection—can lead to higher losses for health insurers. An insurer can minimize losses if it can avoid covering some or all intensive users of services (Blumberg et al. 2005, citing Berk and Monheit 2001). Insurers use a process called medical underwriting to counter adverse selection and accomplish four specific goals:

- Ascertain the level of risk associated with the person or group applying for insurance.
- Decide if a policy should be sold.
- Decide the terms of the policy.
- Set the premium level for the policy.²

If medical underwriting is permitted, the insurer gathers information to determine whether an individual has a health condition (a preexisting condition), a history of a health condition, or a tendency to engage in activities that could lead to a health condition (e.g., smoking). The medical underwriting process is not limited to an evaluation of health status because other factors also predict future health care costs. Health care expenses, for instance, rise with age. Premiums therefore reflect the impact of age on health care costs. In addition, the

insurer may take into account the potential enrollee's gender, occupation, and geographic location in setting the premium (Claxton and Lundy 2008).

As a result of medical underwriting, to control the risk level within a pool, if the law allows, the insurer may respond to an application for coverage in one of the following ways:

- Decide not to offer insurance coverage (called risk selection).
- Offer coverage, but exclude it for certain conditions permanently (an *exclusion rider*) or for a certain period of time (*pre-existing condition exclusion period*).
- Offer coverage, but at a higher or lower than standard premium rate (Claxton and Lundy 2008).

Left unchecked, medical underwriting could leave most people with poor health without a coverage option in the private health insurance market. If a public program does not exist or they are ineligible for it, they may have difficulties obtaining any health insurance coverage at all.

Inequities that Undermine Social Objectives

Policy makers seek to do more than counter information deficiencies, moral hazard, and adverse selection. They also seek to achieve certain social objectives that cannot be met through, and may be undermined by, market forces. Key objectives include avoiding unfair discrimination based on an applicant's health condition or income status. Because medical underwriting limits access to health insurance for those persons most in need, some jurisdictions have imposed limits on its use. They use a variety of strategies to do so including requiring insurers to issue coverage regardless of the patient's previous medical history. They may also regulate the extent to which insurers can charge higher or lower premiums because of an individual's health status, age, or other factors. These options will be discussed in more detail later in this book.

REGULATORY FRAMEWORK

Insurance regulation is established primarily through a country's legislative body. Administrative agencies, however, are typically delegated broad authority to implement insurance laws and oversee insurance activities. Though not discussed here, judicial decisions can also have a significant impact on insurance regulation.

Statutory Laws

The objectives of regulation are pursued through laws enacted by a country's legislative body. The legislative body passes and amends insurance laws,

establishes and oversees the administrative agency that administers the insurance laws, and approves the agency's budget. In most countries, regulation of private health insurance markets is performed by one or more national or federal supervisors. There are, however, a few exceptions to this trend. In the United States, for instance, insurance regulation is a state function. In Canada provincial governments are responsible for consumer protection and other health-related standards.

In establishing the supervisory agency, it is important that the legislature clearly state the mandate and responsibilities of the entity with supervisory responsibility for private health insurance. Publicly defined objectives foster transparency and provide a basis upon which the public, government, legislatures, and other interested bodies can form expectations about insurance supervision and assess how well the authority is achieving its mandate and fulfilling its responsibilities.

There should also be a clear outline of the institutional framework for supervision. The set of relevant agencies involved in the regulation process and the nature of the relationships among them have to be identified.

Further, IAIS core principles encourage independence for the supervisor by ensuring that it has a clearly defined governance structure, internal governance procedures necessary to ensure the integrity of supervisory operations, explicit procedures regarding the appointment and dismissal of the head and members of the governing body, and clearly defined and transparent institutional relationships between the supervisory authority and executive government and the judiciary. Independence can be fostered if the supervisory authority is financed in a manner that does not undermine its independence from political, governmental, or industry bodies.

Independence is a means to an end rather than an end in itself. The case for granting any supervisory agency a measure of independence is to enhance its effectiveness by ensuring that it is able to pursue and achieve its legislated objectives. In other words, good regulation is primarily about making decisions based on objective criteria directed toward the achievement of objectives specified in the law and free from extraneous considerations and influences. As a general rule, the greater the level of independence, the greater also should be the stringency of accountability.

Administration of the Law

Every country with a private health insurance market needs an office that is responsible for administering its insurance laws to the extent delegated by the legislature. It is this office that oversees insurer compliance with the law, interprets the law's application to insurer practice on a day-to-day basis, and develops rules and policies to implement the law. The agencies or individuals performing these regulatory functions are referred to as the supervisor in this book. The law must clearly specify the limits provided to the supervisory authority in

interpreting the law, for instance, through issuing regulation, mechanisms for appealing regulatory decisions and the circumstances in which supervisory decisions must be appealed to the judicial system. If such clarity is not provided in the law, the consequences could be abuse of authority by the regulatory authority, or lack of action by a very weak authority, due to the legislative vacuum.

Structure

The supervisory responsibility can be structured in a variety of ways. Some countries have an office focused on health insurance in an agency such as a Department of Health or a Department of Finance. Some countries have created a separate insurance agency or a separate health insurance agency. Because health insurance involves another area of specialized expertise that is as complex as insurance—clinical management and health care operations—input from those who are knowledgeable about these areas could be beneficial. Consequently, other countries divide the responsibility for administering health insurance laws between two agencies—one focusing on the health aspects of insurance, and the other on the financial and other prudential aspects of insurance.

The framework that best serves a country depends on the structure of its private health insurance market and the capacities within the country to undertake supervision. The option selected, however, should be amenable to approval through the legislative process, broadly acceptable to key stakeholders (including policy makers, consumers, insurers, and providers), affordable, and feasible to implement.

A large body of literature examines the benefits and costs of specialized versus integrated regulation.³ The general debate is not the subject of this manual. It is worthwhile though to reflect on the pros and cons of each of these options and highlight some countries that have implemented different supervisory structures.

Office within a Health or Insurance Agency

One approach that could be pursued is to integrate supervisory authority into a country's health ministry. Since private health insurance forms an integral part of a nation's health care system, the health ministry could bring to bear its expertise on health matters. However, such a solution would fail to recognize the insurance aspects of PVHI. Because the health ministry is unlikely to have the expertise to supervise an insurance entity, it would be highly unusual for a jurisdiction to rely solely on it to regulate the health insurance market. In many countries, therefore, supervision is placed solely in the hands of the insurance supervisor. In India, for instance, the insurance supervisor has the mandate to regulate and supervise private health insurance. The strong trend among OECD countries is for the insurance supervisor to be responsible for PVHIs. This trend

has been strengthened recently as countries have moved to comply fully with the European Union (EU) Non-Life Insurance Directive which also captures PVHIs. This makes the most sense when regulation seeks only to address prudential matters, such as the financial strength of the private health insurer but pure insurance regulators would face difficulties when regulating and supervising the provider side of the market.

Independent Health Insurance Agency

Institutional arrangements for general insurance supervision are varied but the trend is for the creation of some form of independent agency (either stand-alone or integrated) to undertake the supervision rather than seeing it take place within a government ministry (such as the Ministry of Finance or the Ministry of Health).

Both Chile (box 2.1) and Colombia created stand-alone agencies when they reformed their health systems in the late 1980s and early 1990s. In both countries separate supervisory agencies called Superintendencias were established. In Chile the new Health Superintendence (2005) supervises and regulates all health care financing—both public, the National Health Fund (FONASA), and private, the prepayment entities (ISAPRES) and health care providers, and it has a mandate for consumer protection.

Bifurcated Oversight Responsibility

Yet another option is to break down the supervisory and regulatory functions into a financial component, entrusted, for example, to the finance ministry and a health component, entrusted to the ministry of health. This is the approach used by Mexico (box 2.2).

BOX 2.1 CHILE: SUPERVISION OF PREPAYMENT SCHEME

In Chile, private health insurance is offered by entities called Prepayment Health Institutions (Instituciones de Salud Previsional ISAPRES). The Superintendence of ISAPRES, created in 1990, was replaced in January 2005 by the Health Superintendence. Through this agency, Chile supervises and regulates private insurers, the National Health Fund (the public insurer), and all health care providers (public and private). Its supervisory responsibilities include accreditation, licensing, and monitoring of compliance with the licensing and accreditation standards. The Ministry of Health promulgates regulations. The Superintendence has one chief regulator or Intendent of Providers and one Intendent of Funds and Insurance.

Source: Fuenzalida-Puelma, Kalavakonda, and Caceres 2007.

BOX 2.2 MEXICO: SUPERVISION OF HEALTH INSURANCE ENTITIES

Mexico regulates the health prepayment financial management companies (Entidades Administradoras de Medicina Prepagada) categorizing them as specialized health insurance entities. The National Commission on Insurance and Surety (Comisión Nacional de Seguros y Fianzas, CNSF), the Mexican Insurance Supervisor (who focuses on solvency, actuarial matters, and market conduct), and the Secretary of Health each play a role in supervising these entities. The Secretary (Ministry) of Health supervises the services and products offered by the authorized health insurance entities, and also develops and monitors compliance with health standards.

Source: Fuenzalida-Puelma, Kalavakonda, and Caceres 2007.

An important consideration for determining the approach to pursue is the role or anticipated role of PVHI within the health financing and provision systems. For example, if it is expected to interact significantly with, or replace some parts of, the public health system's financing (as with duplicate or primary coverage, for example), policy makers may choose to give some oversight and regulatory responsibilities to the Ministry of Health or health system supervisor. If instead the PVHI market is expected to have little interaction with the public system (i.e., through coverage of narrow range of uncovered services or luxury or amenity services), the health system supervisory authority may not need to be involved.

Another consideration is the extent to which health care providers' interactions with the PVHI's will be regulated, such as their contracts, financial arrangements, and quality requirements. To the extent health care providers' activities and the quality of care form a part of the supervisory system, an increased role for the health ministry would make sense. In addition, if there are to be tax incentives for the purchase of insurance, such as tax deductions or credits, involving the relevant tax authority is important.

The "small country [financial system] rationale" for creating an integrated supervisory framework may be pervasive in many transition and developing economies. The rationale is based on a desire to achieve economies of scale in regulation. This rationale suggests that, because inevitably human resources for regulation are always thinly spread, centralizing them within one agency is logical. Where resources for supervision are scarce, and a cadre of supervisory professionals is being developed, the argument that all the relevant human capital should be concentrated in a single organization becomes particularly strong. This may involve the creation of a specialist unit within an integrated agency to focus on PVHI, for example, as was done in India by the creation of a specialized health insurance unit within the Insurance Regulatory and Development Authority (IRDA), the statutory insurance sector regulator.

If a bifurcated regulatory structure is not formally used, it is highly likely that the PVHI supervisor will need to work closely with other government agencies, particularly those responsible for the provision of health services. To ensure that agencies work effectively there should be an efficient and timely exchange of information among supervisory bodies. Information-sharing arrangements should facilitate prompt and appropriate action when material supervisory issues need to be addressed.

Responsibilities

The agency that administers insurance laws performs a number of functions that are critical to the administration of those laws and the integrity of the health insurance system. This role requires that the leadership of the supervisory agency have strong management, public relations, and government relations skills. The agency also needs to be staffed with individuals who are skilled at analyzing financial statements, performing actuarial functions, conducting examinations and investigations, handling complaints, and resolving disputes. The staff also needs to be knowledgeable about insurance principles, applicable laws, and how to apply them to individual circumstances.

The key responsibilities of insurance supervisors include (1) the licensing or registration of PVHI entities, agents, and brokers; (2) devising regulations and administrative policies related to financial matters, and insurance products; (3) market conduct; (4) enforcing the laws; and (5) performing the ongoing supervision of the licensed entities. Each of these responsibilities is introduced below and discussed in more detail in the next section.

Licensing and Registration

Jurisdictions require an insurer to obtain a license. Licenses can be issued for indemnity, life, or just health insurance–risk management. Qualifications for these licenses vary according to the risk managed. Higher risks invite stricter qualification requirements. A license gives an entity formal authority to offer insurance in a given jurisdiction. By licensing them, supervisors will know what companies are operating in their jurisdiction and can identify those that are illegitimate. Legislation should establish that all businesses managing health insurance risk should fall under the jurisdiction of the regulator and require appropriate licensing. This would allow the regulator to force the closing of unlicensed insurance ventures that have the potential to defraud the insured population and may generate the insurance industry a bad reputation.

Insurance brokers and agents who sell insurance are required to obtain a license as well so that there is a minimum standard of competence and the supervising agency can weed out any agents or brokers who have committed ethical improprieties in the past. The requirements that apply to agents or brokers are less comprehensive and stringent, however, than those for insurance companies because agents and brokers do not assume any risk.

Financial Regulation

To reduce the risk that an insurance company will be unable to fulfill its contractual obligations, financial standards are also set. These standards include minimum capital requirements. A jurisdiction may require, for instance, that an insurance company initially have \$1,500,000 in net worth and maintain \$1,000,000 in net worth going forward. A jurisdiction may also apply a risk-based capital standard that uses a formula to determine the health insurer's capital requirements based on the risk profile of the organization and to identify need for supervisory action because the insurer is inadequately capitalized. In the United States, minimum capital requirements vary with the type of insurance sold by the insurer (e.g., life, health, auto, workers compensation). Relatively recent state laws establishing "risk-based" capital requirements relate minimum capital requirements to insurers' risk exposure and business practices. For example, an HMO may have lower minimum capital requirements than an indemnity health insurer because the HMO has additional tools for managing risk (Claxton and Lundy 2008). The financial standards that are generally applied to health insurers also include rules related to the company's practices for investing its assets and to the establishment of reserves for claims and other commitments (Claxton and Lundy 2008; IAIS 2003).

Reporting requirements imposed on the licensed entities give supervisors some of the information they need to review the finances, management, and business practices of the company. The supervising agency develops and, when appropriate, revises the reporting instruments that insurers must complete. Quarterly and annual financial statements developed by supervisors, for example, enable them to determine if a company has enough resources on hand to pay claims. Reviewing these forms helps supervisors evaluate whether an insurer meets minimum standards and can provide the coverage it promises its policyholders. The information from the reports filed by the insurance company is supplemented with information obtained through on-site inspections.

On-site inspection enables the supervisor to obtain information and detect problems that cannot be easily obtained or detected through ongoing off-site monitoring. In particular, on-site inspections allow the supervisor to identify problems or irregularities in a range of areas, including asset quality, accounting and actuarial practices, internal controls (including those dealing with information technology and outsourcing), quality of underwriting (both the prudence of the underwriting policy and the effectiveness of its implementation in practice), valuation of technical provisions, reinsurance, and risk management.

Product regulation

The contract between the insurance company and the policyholder prescribes when the insurance company must pay claims. Regulation of the contract reduces the transactional costs for the buyer by requiring or prohibiting certain provisions and requiring standard terms and definitions (Claxton and Lundy

2008) Government intervention is warranted to ensure that product features are transparent and reasonable; thereby facilitating informed choices, effective price competition, and the efficient allocation of resources (ill-informed markets do not generally produce optimal outcomes).

For voluntary health insurance policies, there is a question of whether or not supervisors should design the benefits packages that insurers can offer or mandate that certain benefits be included. In theory, full disclosure of the covered benefits should be sufficient for individual purchasers to compare price and benefits. However, the complexity of medical insurance can make comparisons difficult because the spectrum of benefits that could be covered is almost infinite. In some countries this problem is dealt with by specifying several benefits packages that insurers can offer. Thus, the consumer can compare the price of policies providing stipulated sets of benefits.

The supervisor also has an interest in ensuring that rates are adequate and fair. The proper setting of premium rates by insurers is critical because the premium charged has such a significant impact on both an insurer's ability to meet its responsibilities and a consumer's ability to afford health insurance. Legislators adopt rating laws to make it more likely that an insurer's rates are high enough for it to pay claims, cover administrative costs, and make an appropriate profit without charging excessive or improperly discriminatory rates.

If a jurisdiction chooses to regulate insurance premium rates, supervisors have rate-review responsibilities. Many different approaches could be used:

- Require insurers to use rates set by the insurance supervisor.
- Require insurers to use rates approved by the insurance supervisor.
- Require insurers to file rates with the insurance supervisor prior to use or shortly after they have been implemented.

It is not uncommon for the supervisor to require filing of insurance rates even if such rates are not subject to approval. This is intended to prevent price discrimination as the rate schedules are typically made available to the public so that costs between insurance companies can be compared.

Market Conduct Examinations

Supervisors also need authority to undertake market conduct examinations. Through these examinations, they assess agent licensing, complaint-handling processes, the extent of deceptive or discriminatory sales and marketing procedures, and strategic and operational direction. On-site inspections also enhance the supervisor's ability to assess the competence of the managers of insurers. It is an effective way for supervisors to assess the management's decision-making processes and internal controls. In addition, it provides supervisors the opportunity to analyze the impact of specific regulations and, more generally, to gather information for benchmarking. As a part of these inspections, the supervising agency may require certain materials to be submitted for review, such as

marketing literature, and may ban certain practices such as the distribution of deceptive and discriminatory marketing materials.

Enforcement

The administration of insurance laws also requires the supervising agency to order insurers into compliance, ban certain practices, impose civil penalties, take control of supervision or even certain management functions, and rehabilitate the organization if it appears to be in financial distress, or suspend or revoke an insurer's license to operate because of egregious violations of the law. It is important that the governing statutes clearly provide for all of these mechanisms for enforcing the law.

Resources

It is generally accepted that the supervisory authority should have adequate financial and human resources to enable it to function effectively. The IAIS Core Principles suggest that financial resources can be best guaranteed if the agency has its own budget sufficient to enable it to conduct effective supervision. The supervisory authority also needs to attract and retain highly skilled staff, hire outside experts as needed, provide training, and rely upon an adequate supervisory infrastructure.

Financing independent of the government budget is one means of fostering operational independence for the supervisor. At present, experiences around the world are mixed. In developed countries, there is a trend toward independent financing, usually from the regulated entities. In the developing world, financing comes from the government budget in Argentina, Chile, and Colombia; from insurance industry contributions in Georgia, India, and Peru; and through cofinancing by the government budget and insurers in Slovenia. Where the insurance industry is an important source of financing for the regulator, such financing usually takes the form of a transactional contribution—a levy or cess on the insurance premium (or insurance claims), or through licensing or supervision fee levied on the regulated entities.

To ensure that the staff of the supervisory authority is qualified, trained, and well remunerated, one option to consider is to compete in salaries and benefits with the private sector allowing the supervisor to have its own salary system, outside civil service rules and regulations. Another possible model is to have salaries and benefits comparable to those of the central bank (which are usually the best in the public sector and more competitive with the private sector) or to set the remunerations openly in competition with the private sector.

Breadth of Regulation

Private health insurance can be offered through a range of institutional structures, as discussed. As a general rule, any entity that engages in insurance should

be subject to regulation regardless of whether it describes itself as a “health insurer.” That is, an organization’s activities should determine if it is subject to regulation, not its activity label or its form of organization. South Africa, for instance, takes a functional approach to defining medical schemes focusing on any entity that undertakes liability in return for a premium in connection with the provision or rendering of a health service as health insurance. This approach reflects a desire to protect consumers sufficiently from insolvencies and unfair practices regardless of the source of insurance.

To achieve this outcome the insurance legislation should:

- Include a definition of insurers that capture every type of entity that assumes some form of “insurance risk.”
- Require licensing of all entities that fall under the definition as providing “insurance” and prohibit unauthorized insurance activities.
- Define the permissible legal forms of insurers.
- Allocate the responsibility for issuing licenses.

In some countries, there will be pressure to apply some aspects of regulations on some forms of private health insurance entities but not on others. For example, mutual companies have less access to capital and may seek lower capital requirements. These pressures should usually be resisted not only out of concern that consumers would be unprotected but to promote a “level playing field” where all actors who perform the same function in the nation’s health care financing system are covered by similar rules and to avoid situations in which different standards give some entities a competitive and financial advantage over others. This is the approach used in Europe.

EU law subjects entities whose activities constitute “insurance” within the scope of EU insurance directives and laws to uniform prudential, consumer, and other applicable requirements. This includes mutual companies offering private health coverage, such as those operating in Belgium and France. In the United States, where regulations differ by state, laws differ depending on the legal form of the entity offering the insurance. But some U.S. states have moved toward regulating entities by their function, rather than by corporate form. This trend toward functional regulation is a response to a growing array of entities financing and delivering health care and assuming similar levels of financial risk.

In some circumstances, concessions from the general range of prudential rules are made to foster market development. The outcome of this approach has, however, been troublesome for both insurers and consumers. When Colombia initially established its health reforms, for example, it set higher capital and reserve requirements for commercial for-profit insurance companies than for small cooperative insurers. Too frequently, however, the small cooperative insurers lacked sufficient funds to pay claims. As a result, the country altered its financial standards to make those for cooperative insurers parallel with those of the commercial for-profit insurance companies.

An important consideration is whether and how nonprudential regulations should differ based on certain parameters. As a general matter, when private health insurance serves as a country's primary source of health care financing, the full scope of regulations should be applied—prudential (licensing, reporting, financial standards, and product regulation) and nonprudential (standards, if any, related to access, premium, coverage, disclosure, and complaint handling, and any other regulation related to consumer protection).

The scope of regulation differs in some countries where private health insurance is not the primary source of health insurance but is an alternative source to public programs (duplicate) or covers what public programs do not (supplementary or complementary). Under EU insurance laws, countries cannot prescribe insurer behavior unless private health insurance plays a significant role in that country's health care financing system. While in other countries uniform standards are applied regardless of the function the private health insurer plays in the nation's health care financing system. In Australia, for instance, private health insurance is supplementary. Nevertheless, all insurers are required to *community rate* their premiums, that is, set premiums without considering individual health status (Sekhri and Savedoff 2005).

NOTES

1. For a discussion on principles of private health insurance markets and regulation, see Chollet (1997).
2. Merlis, Mark. 2005. "Fundamentals of Underwriting in the Nongroup Health Insurance Market: Access to Coverage and Options for Reform." National Health Policy Forum Background Paper. Available at http://www.nhpf.org/pdfs_bp/BP_Underwriting_04-13-05.pdf.
3. Briault (1999 and 2002), Taylor and Fleming (1999), and Abrams and Taylor (2000) are prominent examples of the literature that identifies and discusses the costs and benefits of the integrated and the specialized approaches.

CHAPTER 3

Prudential Regulation

Prudential standards, those that “encourage” insurers to operate with care, represent the heart of insurance regulation. This section discusses standards related to licensing and reporting, capital adequacy, and management and governance. In addition, the section discusses approaches used to monitor compliance with these standards and enforce them.

LICENSURE AND REPORTING

To protect policyholders’ interests, it is generally accepted that the supervisor must be able to determine which insurers are allowed to engage in private health insurance activities and to gather information about their operations and status. Supervisors do so by requiring that private health insurers apply for and obtain a license that authorizes them to offer insurance. To obtain information about the licensed insurer’s operations and status, supervisors also require insurers to submit information for review, and sometimes, approval. As discussed in the previous section, the review could involve information on financial status, insurance products, and marketing materials.

Licensure

Licensure requirements are designed to provide a minimum assurance to consumers of the financial soundness and management integrity of the private health insurer with which they are dealing. Insurers are not, however, the only important players in the insurance industry. Agents and brokers also must be licensed to sell insurance. An agent sells insurance to individuals or groups from one or more insurance companies. A broker represents the individuals or groups that buy insurance and does not sell on behalf of a specific insurance company. Because they may be the primary interface between the purchaser and the insurer, it is important that they be knowledgeable and ethical. As would be expected, the licensing standards that apply to them are totally different from those that apply to insurers.

Insurers

In all jurisdictions, any prospective insurer must be licensed before engaging in the business of health insurance. Through this process, supervisors gather relevant information and verify character and management experience prior to

granting a license. For the integrity of the insurance market and the protection of consumers, insurance laws also prohibit unlicensed entities from operating and require that action be swiftly taken to discontinue their insurance operations.

Through the licensure process, supervisors obtain information that helps them assess whether a financial institution will have

- Adequate start-up capital for its proposed volume and nature of business
- Appropriate systems and strategies in place to manage risk
- Experienced management with a reputation for integrity
- Appropriate reporting systems in place
- Appropriate control systems, including auditors, actuaries, and other experts
- Appropriate governance structures.

Assessment of each of these areas is a critical part of the regulatory function. In determining the scope of information to request, regulators may also weigh the value of a given piece of information to the assessment process against the burden and market entry hurdles that the information requirements impose.

Countries differ in whether the license applies only to private health insurance. In some countries, an insurer with either a life or non-life insurance license can offer health insurance. In the Arab Republic of Egypt, health insurance is included in the general or non-life insurance licenses. In India, non-life companies have historically played a predominant role in the health insurance space, even though both life and non-life companies can offer health insurance products. Since 2006, a third category has also emerged, comprising non-life licenses restricted to conduct of health insurance business, thus creating stand-alone health insurers in the country. Other countries, such as Slovenia, require a specific license to offer health insurance.

Regardless of the approach, a detailed framework for licensing needs to be established by supervisors. Box 3.1 summarizes the licensing criteria established by the International Association of Insurance Supervisors (IAIS).

As part of this process, countries generally require submission of significant background materials to demonstrate the company's financial soundness and management competency and character. But, the extent to which there are health insurance-specific requirements varies by country. In Ghana, for instance, in addition to the standard information requested (e.g., copy of the constitution, bylaws, or rules for the schemes operation, names and details of members of governing bodies, evidence of financial security, and the qualifications of those administering or managing schemes), the country also requires information specific to the health aspect of the insurance operation. The information requested includes the proposed health care providers and facilities, the health insurance benefits available under the scheme, and the proposed minimum premium contribution. This broader set of information can be useful to supervisors for many reasons including ensuring that insurers are in compliance with consumer protection laws.

BOX 3.1 IAIS LICENSING PRINCIPLES

Clear, objective, and public licensing criteria require

- The applicant's board members, senior management, auditor, and actuary to meet, both individually and collectively, a range of suitability requirements.
- The applicant's significant owners to be suitable.
- The applicant to hold the required capital.
- The applicant's risk-management systems—including reinsurance arrangements, internal control systems, information technology systems, policies and procedures—to be adequate for the nature and scale of the business in question.
- Information on the applicant's business plan projected for a minimum period (typically three years). The business plan must reflect the business lines and risk profile and give details of projected set-up costs, capital requirements, projected development of business, solvency margins, and reinsurance arrangements.
- Information on the products to be offered by the insurer.
- Information on contracts with affiliates and outsourcing arrangements.
- Information on the applicant's reporting arrangements, both internally to its own management and externally to the supervisory authority.
- For foreign entities, input from the applicant's home supervisory.

Source: IAIS 2003.

Many countries do not request detailed information about the insurer's health operations for licensure purposes perhaps because they want to minimize costs associated with entering the market. The information may, however, be required to be disseminated to individuals who are covered by the insurer or submitted to the supervisory agency at other times for purposes other than licensure. As an example, insurers may be required to make available the list of providers that can furnish services under the policy or, as discussed below, the supervisor may require that the premium be filed or approved before it becomes effective. Reporting and disclosure requirements are discussed later in this book.

Brokers, Agents, or Intermediaries

Persons who sell insurance products to consumers play a critical role in the PVHI market. They can be independent brokers who place policies with multiple companies or agents who represent a specific insurance company. They do not accept any insurance risk but serve as the go-between between the buyer and

the organization that does so. These people—often the consumer’s only face-to-face encounter before buying insurance—serve as an important source of information for individuals as they decide whether to purchase a health insurance policy and which one to select. It is very important that the agents understand the health coverage market, options, and pricing and that they conduct themselves in honestly and ethically. To ensure that these salespersons have sufficient understanding of their products, many countries require agents and brokers, or other intermediaries, to have reached a certain educational level and pass a test or go through an apprenticeship period (see, for example, box 3.2). In addition, background checks, character references, or other pieces of information on the person’s past may be collected.

Many OECD countries have examination and background requirements for agents. These include Austria, Belgium, Canada, Mexico, Poland, Spain, and the United States. In some cases, such as in Australia and Germany, insurance industry trade groups have voluntary codes of conduct or provide professional training. Some countries require agents to provide a guarantee (usually in the form of a bank certificate of deposit or other liquid asset that earns income) for a relatively small amount (equivalent to US\$10,000 in Bolivia). This guarantee must be kept current while the agent is operating in the market and is returned to the agent when retiring from the sector. The guarantee can be used by the supervisor to collect fines for infringement of a regulation. It also serves as a minimum capital requirement to ensure that agents are not companies that will abruptly disappear.

BOX 3.2 SOUTH AFRICA AND SLOVENIA: STANDARDS FOR BROKERS, AGENTS, AND INTERMEDIARIES

Standards set by South Africa and Slovenia for insurance brokers, agents, and intermediaries are typical of governmental efforts to protect insurance buyers.

In South Africa, the Council for Medical Schemes (the “Council”) must accredit anyone administering a medical scheme as an intermediary. The Council must also accredit brokers and may prescribe the amount of, and conditions for receiving, compensation. Regulations specify standards for brokers’ actions as well as educational requirements (grade 12) and required experience level (two years as broker or agreement by broker to supervise apprentice). Broker accreditations are issued for two years.

In Slovenia, general insurance laws apply to PVHI and include detailed requirements regarding the obligations of brokers and agents, including obligations to provide certain information to the policyholder. Agents and brokers must have at least one year of experience and have passed the required examination. Also, they cannot have a criminal record.

Source: Authors.

In the United States, after enactment of a federal health insurance law in 1996, it was noted that some insurers were attempting to discourage the offering of policies to certain high-risk individuals or groups by withholding commissions from agents for sales to such individuals or small groups. Several states took action to combat the practice of unfairly reducing or eliminating agent commissions, and the federal government encouraged the states to use their authority to take appropriate actions against such practices (De Parle 1998).

Supervisory authorities should include education, training, and experience requirements for brokers and agents. Further, an insurer's commission structure should treat individuals and groups neutrally, irrespective of their health status, and not provide incentives or disincentives to the enrolment of high-risk individuals or groups.

Reporting and Filing Requirements

The principal basis for the off-site analysis of an insurer's financial status, contracts, premiums, and operations is the various reports that must be filed with the supervisory authority. The information, which should give insight into the current and prospective status of the insurer, contains most of the information needed to conduct effective supervision. In some instances, the information filed with the supervisor is subject not only to supervisory review but also to supervisory approval.

For effective supervision, supervisors should have legislative authority to establish the content, form, source, and frequency of the information it requires. In addition, supervisors should, at a minimum, have the authority to

- Require auditing, at least annually.
- Request frequent and more detailed additional information whenever a supervisor considers that it is warranted.
- Set out principles and norms regarding accounting and consolidation techniques.
- Determine procedures for valuation of assets and liabilities that should be consistent, realistic, and prudent.

Just as under licensure requirements, in setting reporting requirements the supervisor should strike a balance between the need for information for supervisory purposes and the administrative burden it places on insurers. This balance varies from country to country (box 3.3). Most notably, regulators may want to avoid requiring information that they do not have the capacity to analyze. Further, reporting requirements should be reviewed periodically to assess whether the information being requested has become unnecessary or duplicative. Reporting requirements should apply to all PVHI's licensed in a jurisdiction.

In most countries with adequate supervisory capacity and management information systems (e.g., Colombia, and Bolivia), information is collected periodically

BOX 3.3 PHILIPPINES AND BRAZIL: REPORTING REQUIREMENTS

In the Philippines, insurers are required to submit annual and quarterly financial statements. In addition, supervisors conduct on-site inspections every year or as otherwise warranted. In Brazil, insurers must report more frequently and extensively. In that country, insurers submit annual and semi-annual financial statements and audit reports, quarterly retention limit and auditing questionnaire, and monthly data on underwriting, claims, investments, technical provisions, reinsurance and accounting. Supervisors seek to conduct on-site inspections every three years or more frequently if special circumstances arise or complaints are filed.

Source: OECD 2001, 2003.

from insurance companies in electronic form, based on a unique and mandatory chart of accounts. This allows the supervisor to evaluate all insurance companies on the same basis. The systems also automatically identify whether the information being reported is consistent with general accounting principles. It also allows the supervisor to develop information systems that produce indicators that allow the supervisor to identify problems at an early stage.

A supervisor needs to determine which information to make public and which information to keep confidential. In many jurisdictions, the supervisor has a statutory obligation to prepare and publish industry data and, in some cases, information relating to individual insurance companies. Supervisors with broad responsibilities for consumer protection may also publish information on insurance contracts, coverage, and pricing.

Financial Information

Financial information is the most common information that countries require insurers to submit to supervisors. The information is reviewed to evaluate whether the insurer is meeting and will continue to meet the solvency, liquidity, profitability, and other prudential requirements necessary for the insurer to be able to meet its obligations. The information collected, includes, but is not limited to

- Annual and periodic (e.g., quarterly) financial reports, actuarial and other reports containing information, for instance, on assets, liabilities, investments (securities and real estate), capital, surplus, expenses, revenues, balance sheets, income statements, cash flows, and explanatory notes to financial statements
- Financial information on any subsidiary of the supervised entity
- Certified opinion by actuary or reserve specialist that the company has adequate liability reserves

- Information to assess the appropriateness of reinsurance arrangements through which an insurer transfers some of its assumed risk to a reinsurer to reduce the likelihood that it will have to make a large payout on an insurance claim.¹

Health Insurance Products and Contracts

Countries may have standards for the content of contracts and health insurance products. They may require the inclusion or exclusion of certain provisions in those contracts. The purpose is to ensure clarity in the provisions so that consumers can better understand their insurance contract and ambiguous interpretations can be avoided. In addition, supervisors may, to a certain extent, specify the design of health insurance products. Requiring that insurers file contracts and products allows the supervisory authority to review the form and content of these materials to ensure that they are in compliance with legal standards. Even if they do not dictate any of the content of these materials, in some countries, the supervisory authority may be required to maintain a registry of health insurance contracts and products to verify market conduct and to provide the public with information.

The following approaches can be used with respect to the review of contracts and products offered by PVHI carriers:

- *Prior approval.* In some jurisdictions, contracts must be filed with and approved by supervisors before they can be sold. Contracts are required to be filed prior to use in, for instance, India,² Mexico, Switzerland, and Germany (for substitutive health coverage).
- *File and use.* In other jurisdictions, policy forms must be filed with supervisors but can be sold without formal approval from the supervisor. Countries that use this approach are Austria, Belgium, Bolivia, Germany (except for substitutive coverage), Ireland, and Spain.
- *No filing requirement.* Not all jurisdictions require that contracts and products be filed or approved. Canada, the Netherlands, Portugal, Turkey, and the United Kingdom, for instance, do not impose such requirements.
- *Filing upon request.* A country may choose not to require documents to be automatically filed but may require insurers to file promptly after a request for documents by the supervisors. The U.S. government, for instance, requires employer-sponsored health plans to provide it with a copy of the summary plan descriptions promptly upon its request.

When supervisors review contracts and products, they may focus on such areas as

- General contractual provisions.
- Coverage and benefits explicitly provided for in the contract. These may include modalities for the provision of health care goods and services. For example, lists of providers in their own networks or through outsourcing

arrangements, requests for referrals, fees, coinsurance, copayments and deductibles, and international coverage. Details may also include preventive care, pregnancy controls, and, where applicable, worker's compensation matters in case of work-related accident or illness.

- Exclusions and other restrictions. These should be explicit, clear, and detailed with indication on the treatment of pre-existing illness or health conditions, and maximum coverage.
- The duration of the contract and revision periods (annual, two-year cycles).
- Obligations of the insurer, insured, and beneficiaries.
- Conditions for cancellation of the contract.
- Indications on access to administrative and nonjudicial means of conflict resolution, such as arbitration and mediation.
- Place of business, hours, and basic procedure of any health ombudsman.

Premiums

Similarly, some countries require that insurers file information on premium levels. Premium reviews are designed to assess whether the premiums are adequate, are not discriminatory, and do not violate any legal standards about how they should be set. Prior approval is required, for instance, in Australia, Germany (substitutive insurance), Ireland (for policies offered by Voluntary Health Insurance Board), and Mexico. Some U.S. states require insurers to file premium information for prior approval while others only require filing before use. No filing or review is required in a number of countries, including Austria, Belgium, Canada, Netherlands, Portugal, Switzerland, Turkey, United Kingdom, and some U.S. states.

The filing of financial information discussed earlier in this section is critical to prudential regulation. Gathering information on policy forms and benefits packages, as well as other plan information that is distributed to consumers, is highly advisable so that agencies can track compliance and have a database of existing policies in case questions or problems arise. Periodic and systematic reporting that allows the supervisory authority to gather information on health status indicators and socioeconomic characteristics of private insurers and beneficiaries enables supervisors to build up-to-date and reliable market databases for their own use and that of other applicable supervisory agencies.

The decision about whether to request information about contracts, products, and premiums depends on a number of factors, not least, resources. Reviewing product information, in particular, can be resource intensive. However if supervisors have concerns about market manipulation or the development or dissemination of unnecessarily complex, incomplete, or inaccurate materials, it may be worthwhile for developing countries to devote sufficient resources to review and approve contracts and marketing materials before they are issued. Concerns about the financial stability or fairness of the insurers in setting premiums may

also lead to a decision to review and approve premiums before they are applied. If prior approval is not feasible, however, it may be worthwhile to require that this information be submitted according to a certain schedule or promptly, such as within 15 or 30 days, of the supervisory agency's request.

FINANCIAL OVERSIGHT

Licensure and reporting were the first key components of prudential regulation discussed in this book. The second critical component is oversight of insurer financial solvency. Not all insolvencies can be avoided, but solvency regulations are integral to minimizing the number of insolvencies that could occur. Capital and reserve requirements are the bedrock of solvency standards. Increasingly countries are exploring solvency standards that reflect the risk assumed by the insurer more accurately than they have in the past. Underpinning the effectiveness of any solvency standard are (1) the criterion established through statute and by regulation for assessing solvency so that every insurer calculates them uniformly and (2) the ability of supervisors to take appropriate actions when an insurer cannot meet specific financial thresholds. An insurer's risk-management program is also an integral part of the solvency-prevention process.

Solvency regulation is such a critical function because insurers incur significant risks that could impair their financial stability if not properly managed. These risks include:

- *Insurance risk.* Insurance risk is the possibility that the insurer did not charge high enough premiums to pay health care claims.
- *Investment risk.* Investment risk is the chance that the insurer will receive a poor return on the investment of its assets. This risk is a function of not only the performance of an insurer's assets but also the structure of an insurer's investments. Such risks can have a substantial impact on the asset side of the balance sheet and the company's overall liquidity and can lead to a company's insolvency.
- *Credit risk.* Credit risk is the possibility that a party with which the insurer contracts does not or cannot fulfill its contractual commitment. The party could be a provider that does not deliver services for which the insurer has paid or a reinsurer that does not pay an insurer's claim under a reinsurance contract.
- *Liquidity risk.* Liquidity risk is the possibility that an insurer will not have enough cash or other liquid assets to meet its obligations.
- *Operational risk.* Operational risk is a catch-all category reflecting the range of business risks that can occur, including the possibility that the budget did not accurately reflect actual expenses due to error, incompetence, or fraud and ineffective management or governance.

Other risks that may affect insurers include changes in government policy that increase business expenses. Moreover, health insurance incurs a broader range of risks than other insurers. It not only assumes the risk of unforeseen events but also covers ongoing health care costs incurred by those who buy insurance. All of the risks confronting insurers need to be considered when developing financial solvency standards.

Solvency Requirements

Capital is critical to the financial strength of an insurance company. It serves as a cushion against unanticipated losses. It also enables the insurer to continue operating while problems are being addressed. Confidence in the financial stability of an insurer and the health insurance industry is contingent on an adequate capital base. This book introduces three of the principal components of the financial standards (table 3.1): initial capital requirements, technical provisions (reserves), and ongoing solvency requirements (solvency margins).

Initial Capital Requirements

Minimum initial capital is a condition for granting a license and must be provided before an insurer commences business. In general, insurers are prevented from using the funds for the initial capital requirement to finance start-up costs and are required to invest start-up capital in high-quality assets, so that it would be accessible to support the business when required.

The need for initial capital must be balanced against the desire to encourage new entry. A high minimum capital requirement may give added comfort to policy holders but discourage market entrants. This is particularly true in regions where potential investors with substantial capital are few. Table 3.2 provides examples of different minimum capital requirements across countries.

Technical Provisions (Reserves)

Insurance claims are paid only after the insured events happen while the premiums for insurance policies are paid in advance. Supervisors require

TABLE 3.1 Principal Elements of Solvency Requirements

Initial capital requirements	The amount of capital an insurer is required to hold for initial start-up
Technical provisions (reserves)	The amount of capital an insurer is required to hold, for instance, to cover claims not yet paid or premiums not yet earned
Ongoing solvency requirements (solvency margins)	The amount of capital an insurer is required to hold to ensure its ability to respond to unforeseen losses

Source: Authors.

TABLE 3.2 Examples of Minimum Initial Capital Requirements

<i>Country</i>	<i>Minimum capital</i>	<i>Legal base</i>
Chile (prepayment entities)	About US\$170,000 (Ch\$ 5,000)	Law 18.933, Art. 25
Egypt, Arab Rep.	About US\$435,000 (LE 2,500,000)	Companies incorporated under the Investment Law
Mexico (Health Insurance Company)	About US\$540,000 (Mex\$ 1,704,243)	Agreement 11/05/2006 CNSF, Mexico.
Peru (prepayment entity)	Between US\$197,000 and US\$394,000, depending on the province.)	Law 26.790, Art.57 and Resolution 005–2005.
India	About US\$22 million (Rs 1,000,000,000)	IRDA Act 1999
China	About US\$30 million (Y 200 million)	State Council Regulation on Administration of Foreign-Invested Insurance Companies

Sources: Authors.

Note: CNSF = Comisión Nacional de Seguros y Finanzas; IRDA = Insurance Regulatory and Development Authority.

technical provisions (sometimes called reserves) for outstanding claims or unearned premiums.

Outstanding Claims

Technical provisions include amounts associated with the claims that have been incurred but not yet paid. This situation occurs when the insurer is aware that an individual has received health care services but the insurer has not paid the health care provider or reimbursed the individual for those services. This category may include claims that are under scrutiny by the insurer. Supervisors require insurance companies to hold 100 percent of reserves for claims that occurred and were reported but are unpaid. Outstanding claims encompass more, however, than known claims. They also include claims not yet known, claims incurred but not reported (IBNR). The amount of reserves associated with IBNR is generally estimated based on an insurer's past experience. In addition, the cost associated with the management and settlement of these claims is covered under this technical provision as well (Thorburn 2004).

Various methods can be used for assessing the level of outstanding claims. These methods can involve case-by-case calculations or the use of statistical or actuarial methods. Regardless of the approach, the calculation of technical provisions should be based on a standard methodology for all private health insurers in the country.

Unearned Premiums

Another type of technical provision is for premiums received but not earned. In this instance, the premium is paid in advance but does not become fully earned until a future period. Insurers are required to hold reserves for the unearned portion of the premium received as well (box 3.4).

BOX 3.4 MEXICO AND INDIA: UNEARNED PREMIUM RESERVES

In most countries, insurance laws specify how technical provisions are calculated, such as those for unearned premiums and outstanding claims (including claims incurred but not reported). Different countries use different methods to calculate unearned premiums.

In Mexico, for example, the law requires the daily calculation of an insurer's unearned premium either (1) separately for each policy (daily pro rata basis) or (2) aggregation of premiums for policies with 24 half-month terms (1/24 method) and recognizing the premium as earned every 15 days. Under the latter method, after one month the insurer would recognize that 2/24 of the premium had been earned and that 22/24 of the premium had been unearned. The unearned portion of the premium is held in reserve and invested in liquid assets.

India requires insurers to set aside the higher of 50 percent of the premium income or the 1/365 pro-rata amount, as reserve for unearned premium income (termed the *unexpired risk reserve*), but this has been relaxed to the 1/365 pro-rata method for the health insurance segment until FY 2012–13.

Source: OECD 2003; OECD 2001; IRDA 2011.

Methods for calculating technical provisions are almost universally established by either the country's insurance law or by specific regulations. In some jurisdictions, such regulation is complemented through the application of commercial law.

Ongoing Solvency Requirements

In addition, insurers must ensure that net assets are in excess of liabilities. In other words, insurance laws also need to require that private health insurers have additional and sufficient capital to absorb significant unexpected losses. This measure is commonly referred to as the *solvency margin* or *surplus*.

In the case of private health insurance, until recently, ongoing solvency requirements were often calculated based on some simple measure such as a percentage of an insurance companies' liabilities or the volume of an insurer's business, typically using one or two months of either premium income or outstanding claims whichever was higher. Such was the case in the European Union under its "Solvency I" regime (box 3.5).

Government policies may substantially affect the level of risk managed by an insurer and therefore the size of required solvency margins. For example, if insurance policies are renewed annually and there are no other government regulations, private health insurance will be a very short tail business, and solvency requirements may be modest. However, if policy renewals are made compulsory by the government, the risks take on a much broader and longer-term perspective, and reserves would need to be higher and based on actuarial analysis.

BOX 3.5 EU SOLVENCY MARGIN REQUIREMENTS

Solvency I. Solvency I is the name of the solvency margin requirement adopted by the European Union in 2002. Under this regime, the solvency margin requirements for insurers operating in the European Union are based on a proportion of relevant premiums, claims, or claim-related liabilities (Harrington 2007). Most EU insurers have held considerably more capital than the required solvency margin (Swiss Re 2000). Countries outside the European Union have adopted this approach. The EU solvency margin requirements have been adopted by at least seven Latin American countries (Argentina, Dominican Republic, Guatemala, Nicaragua, Paraguay, Uruguay, and República Bolivariana de Venezuela). In these countries, solvency requirements are based on, or are similar to, the fixed-ratio approach adopted in the EU directives. The latter stipulate the minimum solvency margin to be calculated roughly as follows: For non-life insurance companies, the requirement can be expressed as the higher of the two figures: 16 percent (18 percent up to a certain premium volume) of the annual premiums written and 23 percent (26 percent up to a certain claim volume) of the average annual claims cost incurred (OECD 2003).

Solvency II. Unlike Solvency I, the proposed Solvency II regime will take a risk-based approach. This approach will consider a broader range of risk characteristics and risk-mitigation strategies than Solvency I. It will contain three pillars: quantitative requirements, qualitative requirements, and supervisory reporting and disclosure. The quantitative requirement will include two capital requirements. Each capital requirement will trigger different levels of intervention by supervisors. Qualitative requirements involve standards for risk-management and supervisory activities. Broader disclosure to the public and to regulators will be set forth under the new reporting and disclosure requirements. It is anticipated that Solvency II will become operational in 2012.^a

a. Directive 2002/13/EC of the European Parliament and of the Council of March 5, 2002, amending Council Directive 73/239/EEC as regards the solvency margin requirements for non-life insurance undertakings.

Reserving for solvency margins is also often complicated by government policies toward exclusions of high-risk patients. In the latter case in a number of countries, the government has established schemes to finance high-risk patients, such as the elderly, or has forced the setting of premiums based on community rating rather than individual risk rating, both of which will require higher solvency margins appropriate for the additional risk managed by the insurer.

The global trend is toward more responsive capital models that provide supervisors with the appropriate tools and powers to assess the “overall solvency” of the insurer based on a prospective and risk-oriented approach. As discussed in box 3.5, these models, such as Solvency II in the EU, include not only quantitative elements but also cover qualitative aspects that influence the risk standing of the undertaking, such as managerial capacity and internal risk-control and risk-monitoring

processes. Most Latin American countries (except for Costa Rica) have adopted the EU solvency margin approach but adapted it to their particular markets.

In the United States, an approach called risk-based capital has been developed to apply ongoing solvency standards based on the level of risk assumed by an insurer. The risk-based capital model for health insurers takes into consideration investment risks of the insurer and its affiliates, credit risks, insurance risks, and operational risks. The minimum capital level is calculated, based on a covariance formula that recognizes that the risk of uncorrelated factors taken as a whole is actually less than if they were considered individually and then summed together. For managed care organizations, the formula is adjusted to reflect the reduced variation in medical expenses for managed care arrangements (NAIC 1995).

Assets for Compliance with Solvency Requirements

Regulation must also establish the assets that are acceptable for compliance with initial capital requirements, technical provisions, and solvency margins. Minimum capital requirements require many times the investment that must be held in highly liquid assets such as bank certificates of deposit or cash. However, other types of instruments, for example, debt instruments that are essentially permanent in nature and combine certain characteristics of equity and debt, may provide strength to a health insurer's balance sheet. There has been a growing trend globally in the banking and life insurance sector to recognize these types of subordinated debt instruments in determining compliance with solvency requirements outside startup capital.

A further factor is whether standards should be altered for managed care organizations sponsored by providers that will actually deliver the services as well. Private health insurers that are also providers are attractive because their knowledge about the range of treatment options may make them better equipped to manage costs in a way that least impairs quality. However, the minimum standards that apply to traditional insurers may be difficult for them to meet because the provider may have more fixed assets, such as buildings and equipment, than cash or other liquid assets. Thus, a relevant question is whether these buildings and equipment should be acceptable as part of the initial startup capital. Nevertheless, the risks and complexities of the insurance business are not reduced, and adequate capitalization is critical for an insurer to be successful. To fulfill the objectives of solvency regulation, insurers, including those that are provider-sponsored, need sufficiently liquid assets to meet their obligations. Sufficient liquidity will likely not differ, based on the sponsor of the insurance business. It should be noted, however, that in a few U.S. states, capital requirements are reduced if the provider both insures and delivers a very limited set of services based on a narrow specialty category (such as radiology) (Kelly 1997).

Solvency Control Levels

Solvency control levels act as indicators or triggers for early supervisory action before problems become serious threats to an insurer's solvency. The form of

the solvency control level may be based on capital levels required to (at least) meet the discussed financial standards (initial capital requirements, technical provisions, and solvency margins). That is the amount of assets that supervisors require insurers to have to meet or exceed by a percentage the sum of the required financial standards. For example, insurers may be required to have assets of at least 120 percent of the level corresponding to the sum of the financial standards.

Under the model risk-based capital standards for health insurers designed in the United States, the outcome of calculations can trigger action at five levels of intensity. If, for instance, an insurer reports total adjusted capital of 200 percent or more of minimum risk-based capital, a supervisor need not take any action because the insurer meets the jurisdiction's solvency standards. If, however, the total adjusted capital drops between 150 and 200 percent of minimum risk-based capital, the insurer would be required to submit a comprehensive financial plan identifying its financial problems and its plan for correction. At the other end of the spectrum, if the insurer reports total adjusted capital of less than 70 percent, the supervisor must place the insurer under control. Ironically, an insurer could fall within this category although it has positive capital and surplus. But usually an insurer in this category has insufficient assets to meet liabilities.

A calculation of solvency and the associated supervisory response based on simple measures is a blunt instrument that does not explicitly recognize the different risk levels associated with different types of business, does not take into account uncertainty about the level of reported liabilities, does not explicitly recognize the risks associated with the interaction of assets and liabilities, and may not optimally recognize certain other risks, for example, asset valuation and concentration risk, risk of reinsurer default, or catastrophe risk.

Risk-based approaches such as those of the European Union and, particularly, the United States are more complex. Developing countries may need to balance the trend toward much more sophisticated models for determining the solvency of health insurance companies and their technical ability to apply such methods in their countries. This could be achieved through a graduated approach to implementing new methodologies, perhaps by first applying simple approaches across all private health insurance companies, determining appropriate margins to account for unexpected events, and building up skill in the new techniques within the supervisor. This type of approach reflects a view that implementing a methodology that is beyond the technical capabilities of the insurance companies and the supervisor to understand poses greater threats than using more basic and largely effective methods.

Risk Management

Assessing and managing risks is one of the most important tasks for any private health insurance entity. In many jurisdictions, attention to risk management has been sadly neglected. However, there is a global trend toward a closer focus on how insurers manage their risk. The supervisor can play a significant

role in encouraging PVHI's to improve their overall risk management, as in Australia (box 3.6)

In particular, supervisors should require private voluntary health insurance entities to establish a system for risk management that is

- Consistent with the complexity, size, and composition of their health care financing portfolios
- Sufficient to cover all exposed risk
- Supported by internal monitoring and control mechanisms.

Supervisors are increasingly requiring insurance entities to have a risk-management function responsible for assisting the board, the relevant board committee, and senior management in developing and maintaining the risk-management framework. The risk-management function may be incorporated into a senior role. Larger and more sophisticated private health insurers may establish a specialist risk-management function within the corporate management center instead. Risk management may be only part of the responsibilities of the person performing that function for a smaller insurer with less-complex operations. In such circumstances, a realistic assessment of the time required to undertake this responsibility would usually be applied. The risk-management function should have direct access to the relevant board risk committee or executive management, independently of the business functions.

BOX 3.6 AUSTRALIA: REQUIREMENTS FOR INTERNAL RISK-MANAGEMENT OVERSIGHT

The Private Health Insurance Administration Council (PHIAC) of Australia is an independent statutory authority that regulates the private health insurance industry. Private health insurance policy is set down by the Australian Commonwealth Department of Health and Aging. PHIAC requires an annual statement that an insurance entity organization has a risk-management plan and appropriate implementation of the plan. The directors of insurance companies must declare that comprehensive written policies and procedures and adequate control systems are in place to measure, monitor, and manage operational risk; the board reviews these policies, at least annually, for implementation effectiveness, and to endorse them; the registered organization has adopted the Australian Standard for Risk Management as an accepted measure of appropriate risk-management processes; and, the board has approved the risk-management system in place, understands its contents, receives regular reports on the operation of the risk-management system, and is satisfied with the level of compliance.

Source: Private Health Industry Insurance Administration Council (Australia), "Risk-Management Practices in the Private Health Insurance Industry Guidelines Reviewed March 2004." <http://www.phiac.gov.au/standardsguides/riskmgmt/tmguidelines.pdf>.

As noted, liquidity risk is one of several significant risks confronting private health insurers. Ensuring that it is managed appropriately (through adherence to the applicable solvency requirements and other strategies) is an important part of the risk-management function. An insurer might try to manage its liquidity by delaying payments to providers and policyholders. Payment delays will, however, ultimately undermine confidence in the private health insurance system and impose hardship on providers and policyholders. The supervisor may need to provide guidance about the maximum length of time insurers can take to make payments to ensure that the time taken to settle claims is “reasonable.”

Another critical part of the risk-management function is the management of investment risk. Investment risks are the various kinds of hazard directly or indirectly associated with an insurer’s investment management. Chile (box 3.7) and many countries approach investment risk-management issues by imposing constraints on insurers’ investment policies and procedures by placing restrictions on the categories of assets that may be used to cover technical provisions and the extent to which they may be used for that purpose, and/or by setting specific requirements on the matching of assets and liabilities. Accordingly, appropriate investment risk-management policies are needed. These laws and regulations should address, but may not be limited to

- Limits or restrictions on the amount that may be held in particular types of financial instruments, property, and receivables
- The mixture and diversification by type of security and issuer
- The pricing of the instrument, for instance marking to market (i.e., pricing the value of a security at current market prices) for the case of tradable securities
- The safekeeping and custody of assets
- The appropriate matching of assets and liabilities
- The level of liquidity.

BOX 3.7 CHILE: MANAGEMENT OF INVESTMENT RISK

Chile has established some specific parameters for investment of an insurer’s assets. A maximum of 5 percent of investment assets can be invested in bonds with investment rating below BBB. In addition, 40 percent can be invested in shares with minimum market liquidity, while only 5 percent can be invested in shares with no market liquidity. All investment assets that support technical provisions must be deposited in organizations specializing in custody. Finally, only 20 percent of risk equity and technical reserves can be invested overseas.

Source: OECD 2003.

Insurers have to manage their investments in a sound and prudent manner.³ All insurers should devote considerable attention to making and controlling investment decisions and establishing an investment policy that sets down the overall characteristics for the insurer's investment. A statement of investment policy normally includes the objectives of the portfolio, its risk tolerance, the constraints on the management of the portfolio such as minimum liquidity requirements, and a list of eligible assets or asset classes in which the portfolio may be invested, along with a target asset mix and limits on how much the portfolio may diverge from the target.

In many developing countries, the limited availability of suitable domestic investment options in the financial market leads to concentration risk. The supervisor should seek to encourage diversification wherever possible. The supervisor may also need to be alert to inappropriate investment activities such as investment in high-risk and speculative assets such as real estate. These may have a place in a private health insurer's investment portfolio but should be limited because of high risk and limited liquidity. In some countries, central banks impose limits on investments abroad. For instance, in Chile the maximum investment abroad is 20 percent of required reserves (OECD 2003). Egypt requires that the insurer keep in-country an amount no less than the value of its technical reserves. Vietnam does not permit any overseas investments (Fuenzalida-Puelma, Kalavakonda, and Caceres 2007). Investments abroad are usually required to be made in safe securities such as investment grade commercial debt or government debt from developed countries.

An insurer may want to use certain mechanisms supervisors may want to prescribe to reduce its investment risk. One risk-management technique often explored is derivatives. Derivatives are assets that derive their value from the value of an underlying asset. Derivatives could involve a contract under which one party agrees to buy an asset (like commodities or interest rates) from another party on some future date for a predetermined price or a contract that gives one party the right to buy or sell an asset on some future date for a predetermined price. Some insurers have begun to rely on financial derivative instruments to reduce interest-rate risk and underwriting exposure and increase cash flow (Cummins, Philips, and Smith 1996; Hardwick and Adams 1999).

Derivatives can be a valuable mechanism for transferring investment risk, but they are complex arrangements that require sophisticated knowledge. Of note, they can present a risk of default—if the other party to the contract cannot pay the promised fixed price—and a risk that the underlying value of the asset will move in the opposite direction than the insurer had hoped. The insurer can attempt to reduce its risk if it marks to market (i.e., assigns, for accounting purposes, the current market price of the investment) a derivatives position, but doing so is administratively cumbersome since it would have to be done daily by both parties to the contract.

Supervisors have been lukewarm to derivative activity for fear that poor decisions about derivatives or their management will ultimately impair insurer solvency. The recent financial sector crisis in the United States illustrates the

consequences of an absence of appropriate regulation and supervision of these types of investment. Therefore, supervisors may want to limit the use of derivatives solely to investment-risk management. If either the private health insurance market or the regulatory infrastructure is in the early stages of development, policy makers may want to prohibit the use of derivatives all together.

In assessing an insurer's investment-risk management function, a supervisor should review the insurer's investment-risk management framework, investment policies, and their execution. The supervisor should be satisfied that an insurer understands the risks it bears and has effective procedures for identifying, monitoring, and managing its investment activities to ensure that its assets are consistent with its liability profile.

Mitigation of Risk: Reinsurance

An important tool insurers use to mitigate their insurance risk is the purchase of reinsurance. According to the OECD, an insurance enterprise undertaking insurance with policy holders often transfers some of the risks incurred to other insurance enterprises. These transactions between insurance enterprises are called reinsurance.⁴ In other words, insurers contract with reinsurers to cede some of their risks or exposure for an individual contract or group of contracts in exchange for a premium. Under such a contract, a reinsurer may, for instance, be responsible for paying for a certain percentage of an insured's claims between two specified amounts. There are many different types of reinsurance (box 3.8).

Reinsurance can be proportional or nonproportional. When reinsurance is proportional, the insurer and the reinsurer split the premiums and losses proportionately. When reinsurance is nonproportional, which is the most common

BOX 3.8 COMMON FORMS OF REINSURANCE AGREEMENTS

Proportional reinsurance. An agreement under which the insurer and the reinsurer split the premiums and losses proportionately.

Nonproportional reinsurance. An agreement under which the reinsurer agrees to pay a specified amount to the primary insurer for losses that exceed a specific limit. The most common methods of reinsurance used in the health insurance market are nonproportional.

Excess of loss reinsurance. Under this nonproportional method, the primary insurer pays the amount of a claim up to a specified limit. The reinsurer pays the amount of a claim that is above that limit but less than the amount that it has agreed to reinsure.

Stop-loss reinsurance. Under this non-proportional method, (also known as *aggregate excess-of-loss reinsurance*), the primary insurer is reinsured for a specified amount or ratio of losses incurred during a period of time (such as 12 months).

Source: Authors.

method in the private health insurance market, the reinsurer agrees to pay a specified amount for losses that exceed a specified limit. Nonproportional agreements are most commonly in the form of excess of loss reinsurance and stop-loss reinsurance.

Under an excess of loss reinsurance agreement, the primary insurer pays the amount of a claim up to a specified limit. The reinsurer pays the amount of a claim above that limit but less than the amount that it has agreed to reinsure. To illustrate, primary insurer ABC contracts with reinsurer XYZ to assume responsibility for the amount of all claims exceeding \$10,000 up to \$50,000 ceiling. Maria, injured in a devastating accident that required surgery and other expensive care during a hospital stay, incurs a claim of \$32,000. In this situation, the primary insurer pays the first \$10,000 of her claim. The reinsurer is responsible for paying the remaining \$22,000. (Had her claim exceeded \$50,000, however, the primary insurer would have been responsible for all additional amounts owed on the claim.)

Under stop-loss reinsurance (also known as aggregate excess of loss reinsurance) agreement, the primary insurer is reinsured for a specified amount or ratio of losses incurred during a period of time (such as 12 months). Primary insurer ABC may have contracted with reinsurer XYZ to assume responsibility for 90 percent of losses that exceed 80 percent of the premiums that apply to the 12-month period of January through December. Alternatively, ABC may have contracted with reinsurer XYZ to assume responsibility for 90 percent of aggregate losses that exceed a comparable dollar amount.

The reinsurance market for health insurance is generally quite limited. Some private health insurers, however, do offer reinsurance. Some of them also offer primary health insurance products. In addition, some government entities either own reinsurance companies or have established reinsurance programs to facilitate coverage for certain populations that have had difficulty accessing affordable health insurance, such as small employer groups, the self-employed, or low-income individuals. These programs are funded through premium payments, assessments on insurers, and/or general tax revenues. In the United States, New York state has created a reinsurance program called Healthy NY. The reinsurance program pays 90 percent of an individual's claims between the amounts of \$5,000 and \$75,000. In contrast, the state of Arizona has implemented a program called the Health Care Group of Arizona that requires the reinsurer to pay for an insurer's aggregate losses, such as when aggregate claims exceed 80 percent of total premiums (Belloff et al. 2007).

Reinsurance offers a number of important benefits. Reinsurance permits the private health insurer to reduce its risk exposure since the private health insurer can limit its losses for high-cost medical claims through reinsurance. Because reinsurance reduces the private health insurer's exposure to losses, it enables the insurer to cover more people and charge them a lower premium. As a result, reinsurance can be considered a tool for expanding the availability of coverage. Reinsurance also indirectly impacts the financial solvency requirements that

may apply to private health insurers. Without bona fide reinsurance, minimum capital requirements would likely be higher because the insurers potential claims liability would be greater. Reinsurance can serve as a particularly important tool for insurance companies that are smaller or recently established until they build an adequate risk pool. In some cases reinsurers provide the primary insurer with expertise or services, including underwriting and case management in severe claims.

While reinsurance helps insurers mitigate their insurance risk, it actually increases their credit risk because they are dependent on the reinsurer to honor its commitment. Consequently, supervisors impose requirements on the primary insurer to ensure that the reinsurer is capable of handling the ceded risk. The insurer, for instance, is required to demonstrate that the reinsurance is effective in transferring risk. In addition to convincing the supervisor that effective contracts are in place, the insurer must also show that the reinsurer is in a sound financial position and likely to fulfill its contractual obligation. Typically, the supervisor should seek evidence that the reinsurer has a sound international risk rating. The level of recognition of reinsurance in capital calculations could vary according to the financial strength of the reinsurer. The insurance companies should have comprehensive reinsurance risk management strategies in place.

MANAGEMENT AND GOVERNANCE

To safeguard the interests of present and future policyholders, beneficiaries, and insurance claimants, it is crucial that insurers be soundly and prudently managed. Experience suggests that a significant underlying cause of financial difficulties resulting in insurer bankruptcies or “near misses” can be problems with senior management or shareholders who are incompetent, lack relevant expertise, lack integrity, have conflicts of interest, or participate in inappropriate group decisions. It is therefore important that the senior management, key staff (e.g., auditors and actuaries), and insurer oversight bodies meet certain “fit-and-proper” standards set forth by the supervisory authority. It is also critical that board members and senior management be alert to any conflict of interest that might influence their decisions.

Fit-and-Proper Rules

The purpose of fit-and-proper requirements is to reduce the risk of regulated institutional failure due to incompetent, reckless, or improper risk management by responsible persons⁵ and ensure that beneficiaries are protected. Legislation and regulations for voluntary private health insurers need to identify which key functionaries must meet fit-and-proper requirements. Imposing and overseeing the application of fit-and-proper requirements is an important element of supervision and it involves the ongoing assessment of the fitness and probity related

to the managers and specialists. This means that the supervisory authority need to have by law the powers to disqualify the appointment of key staff members including auditors and actuaries that do not comply with the fit-and-proper requirements.

Meeting the fit-and-proper requirements usually includes the submission of documents to the supervisory authority supporting the competence and knowledge of key personnel and evidence of their experience, abilities, and professional and personal records (see, for example, box 3.9). The supervisory authority should be satisfied that significant owners have the competence needed for their roles and should ascertain whether they have the appropriate ability and integrity to conduct insurance business, taking account of potential conflicts of interest. If they do not, appropriate action should be taken. If the regulator determines that significant owners⁶ no longer meet fit-and-proper requirements, for example, it may require that they sell their interests in the insurer (IAIS 2007, 2005).

Regulations or guidance may also establish rules to prevent conflicts of interest such as requirements for directors to absent themselves for decisions that may cause a conflict or to make public declarations about possible conflicts.

Governance

The meaning of “governance”⁷ varies substantially across contexts and researchers. Broad definitions of governance attempt to encompass all the relevant factors that influence the behavior of an organization. Narrower definitions

BOX 3.9 FIT-AND-PROPER REQUIREMENTS IN SOUTH AFRICA, CHILE, AND INDIA

In South Africa, as part of the registration process, members of the board of trustees or principal officer are required to be “fit and proper” to hold the office in any medical scheme. Fit-and-proper requirements are also required from broker and agents.

In Chile, persons are considered unfit and not proper if condemned for certain crimes, bankrupted, under prohibition or incapacity to conduct businesses, or associated as a board member for five years before the appointment as manager or legal representative of an ISAPRE. Regulations establish that information has to be provided to the health care authority concerning shareholders and their controllers when they have a capital participation of 10 percent or more or are entitled to elect at least one board member. Shareholders and controllers must meet the standard conditions of probity. In India, regulatory provisions for insurance companies prohibit common directors across different entities with links to the insurance business (like an insurance company and an insurance broker), and approval of the regulator is required whenever there is significant change of shareholding and for appointment of the CEO and the actuary.

Sources: Authors.

of governance look specifically at the “control” mechanisms used to hold the entity accountable. These latter definitions are more concerned with such issues as the mechanisms by which board members are elected, the scope and style of government supervision, and the scope of managerial discretion allowed in defining benefits packages, setting premiums, negotiating contracts, investing reserves, and overall risk management.

The literature on governance is quite rich. It demonstrates the need for attention to ownership, selection of board members, and managerial incentives as in the literature on private corporate governance, the importance of capture, responses to multiple principals, and the emergence of vested interests in the literature on public governance. It illustrates the trade-offs that emerge when determining the extent of independence and discretion afforded to agencies (the degree of deregulation). Finally, it shows the importance of publicly accessible information for proper oversight and the roles that can be played by different stakeholders, depending on how oversight is structured (Savedoff and Gottret 2008).

Corporate governance refers to the manner in which a board of directors and senior management oversee an insurer’s business. It encompasses the means by which members of the board and senior management are held accountable and responsible for their actions. Corporate governance includes corporate discipline, transparency, independence, accountability, responsibility, fairness, and social responsibility. Timely and accurate disclosure on all material matters regarding the insurer, including the financial situation, performance, ownership, and governance arrangements, is part of a corporate governance framework. Corporate governance also includes compliance with legal and supervisory requirements.

All private health insurance entities have some form of governing body (a “board”) that has ultimate responsibility for sound and prudent management of the entity. Many jurisdictions have a range of corporate governance rules in place that commonly refer to the composition and responsibilities of the board. Increasingly these rules also apply to the roles of senior management, actuaries, and auditors. Corporate governance rules are often contained in the general corporate law but increasingly these requirements are being tailored to the specific requirements of prudentially supervised private health insurers and are supplemented by requirements in the insurance laws, or by regulations issued by the supervisor.

Some good principles related to the operation of boards are the following:

- The board must have a formal charter that sets out its roles and responsibilities.
- Any delegation of authority must be clearly set out and documented. The board must have mechanisms in place for monitoring the exercise of delegated authority.
- The board must ensure that directors and senior management of the insurer collectively have the full range of skills needed for the effective and prudent operation of the regulated institution and that directors have skills that allow them to make an effective contribution.

- The board should have in place procedures for regularly scheduled assessment of its own performance relative to its objectives and of the performance of individual directors.
- The board should have in place a formal policy on how it intends to renew itself to ensure it remains open to new ideas and independent thinking, while retaining adequate expertise.

Regulations may include requirements about the minimum number of directors, requirements for independence (such as the requirement that a given number of the board members represent minority shareholders), and residency status (which is important if the health insurer is a subsidiary of a foreign company).

Supervisors are increasingly seeking additional control mechanisms to assist them in uncovering potential problems within the health insurance entity or breaches of laws and regulations. One means of achieving this is through the use of capable, independent external auditors and other experts like actuaries. These can provide additional levels of assurance to the supervisor, especially when these independent experts have whistle-blowing responsibilities.

MONITORING AND ENFORCEMENT

Off-site monitoring and on-site inspection are two important facets of insurance supervision.

Off-Site Monitoring

Off-site monitoring is mainly a documentary analytical process that allows the supervisory authority to assess the financial and administrative performance of each insurer. In doing so, the supervisory authority also gets an updated perspective of the insurance market situation.

Off-site monitoring should be used to review the financial condition and performance of the entities engaged in private voluntary health insurance/prepayment. It should include asset checking and liabilities valuation, off-balance sheet exposures, and outsourcing.

It is essential for the supervisory authority to receive information necessary to conduct effective off-site monitoring. This information often serves to identify potential problems, particularly in the intervals between on-site inspections, thereby providing early detection and allowing the supervisory authority to take prompt corrective action before problems become more serious.

On-Site Inspection / Monitoring

On-site inspection provides information that supplements analysis of the reports submitted to the supervisory authorities. Inspectors can be staff of the supervisory

authority or the task can be outsourced to specialists certified and supervised by the authority. On-site inspections can be full scale or be focused on investigating areas of specific concern.

Supervisors must have the authority to perform on-site examinations of the operations and business practices of the health insurer and its agents. Often referred to as “market conduct examinations,” these reviews may include reviews of company operations and management, complaint handling, marketing and sales, agent licensing and conduct, policyholder service, underwriting, and claims. These reviews may be broad reviews of a range of insurer activities, performed periodically, or they may be targeted to specific areas of insurer actions, if, for instance, they are conducted in response to specific complaints.

On-site inspections enable the supervisory authority to

- Verify or capture reliable data and information to assess and analyze the current and prospective solvency of the health-financing entity.
- Obtain information and detect problems that cannot be easily obtained or detected through ongoing monitoring.
- Identify problems or irregularities in areas pertinent to insurance companies or prepayment schemes such as asset quality, accounting and actuarial practices, internal controls (including those dealing with information technology and outsourcing), underwriting quality (both the prudence of the underwriting policy and the practical effectiveness of its implementation), valuation of technical provisions, strategic and operational direction, reinsurance, and risk management.
- Review the competence of the managers of the insurance/prepayment entities.
- Evaluate the insurer’s managerial decision-making processes.
- Assess the effectiveness of internal controls.
- Assess an entity’s exposure to risk.
- Analyze an insurer’s relationships with other companies in the same group or with external entities through outsourcing or contractual arrangements.
- Evaluate compliance with corporate governance requirements.
- Check the sufficiency and adequacy of the information given to the insured and review the timing of payments.

In the United States, state insurance departments generally conduct periodic market examinations of the operations of insurers licensed in their jurisdiction, as well as targeted examinations in certain identified areas. In the health insurance area, a number of issues may arise.

In health care financing, effective inspections may need to include access to outsourced service providers such as parties involved in the purchasing of

health care goods and services. Doing so could be necessary to ensure that the inspection adequately captures information on the arrangements and practices of the insurers when transferring functions, information, and resources to other entities. In cases where the supervisory authority shares or receives complementary supervision with other state entities (such as with the Ministry of Health), coordination needs to take place to accomplish effective inspection and monitoring.

For effective on-site monitoring, the supervisory authority would need to

- Have wide-ranging legal powers to conduct the inspections and gather information deemed necessary to perform its duties.
- Be able to verify information obtained regularly through on-site inspections. This ability should also be granted to external auditors or other suitably qualified parties contracted by the authority.
- Make arrangements with other supervisory authorities, such as the Ministry of Health, to coordinate verification and sharing of information.

Conglomerates

Supervision of private health insurers who are part of a wider insurance group or conglomerate, whether domestic or international, should not be limited solely to supervision of the insurer that falls under the immediate jurisdiction of the supervisor. The operations of other companies in the group or conglomerate, including any holding companies, should be taken into account in assessing the totality of the risk exposures of the insurers, insurance groups, and conglomerates. The fact that such an insurer is part of a group generally alters, often considerably, its risk profile, its financial position, the role of its management, and its business strategy. As a consequence, legal provisions and effective supervision should ensure adequate group-wide assessment and supervisory action.

In some countries, private health insurance operates as a line of business within a broader insurance company structure. In others, private health insurers operate as separate subsidiaries of insurers or under holding companies in broader financial groups. The laws and regulations should allow the supervisor to undertake group-wide assessment and supervision not only of financial indicators such as capital adequacy and risk concentration, but also the management structure, fit-and-proper testing, and legal issues. The groups should have information systems in place not only to serve their internal information needs but also to provide all the information the supervisory authority may require in an adequate and timely manner.

If different parts of the group are supervised by different supervisory agencies the respective responsibilities of each supervisor should be clearly understood and, wherever possible, the supervisory approach should be harmonized to avoid any regulatory arbitrage opportunities. There should be close cooperation and information sharing between supervisors.

Cross-Country Cooperation and Sale of Insurance across Borders

Many insurance companies operate internationally, obtaining licensure in one jurisdiction and the requisite permission to operate in others—this may or may not require additional licensure or certification. A country should have clear requirements for foreign insurers and what they need to do in order to operate within its jurisdiction.

Sale of health insurance policies by international insurers is more commonplace among developing countries than industrial countries. In these cases, the law should provide that the insurer comes under the jurisdiction of the supervisory agency. This can be achieved through requirements which specify that the sale of health insurance policies by foreign insurers “within the country” constitutes the conduct of insurance business, which is therefore subject to the full range of supervision requirements, including licensing, off-site monitoring, and on-site market conduct examinations.

The International Association of Insurance Supervisors (IAIS) has set forth the following key principles for insurers operating across borders:

- No foreign establishments should escape supervision.
- All insurance establishments of international insurance groups and international insurers should be subject to effective supervision.
- The creation of a cross-border insurance establishment should be subject to consultation between the host and home supervisors.
- Foreign insurers providing insurance coverage on a cross-border services basis should be subject to effective supervision.

In addition, it is imperative that information can flow freely between or among supervisors so each is kept apprised of any problematic activity or circumstances. Standards regarding the confidentiality of insurer data should allow for such exchanges.

If a foreign entity is not subject to prudential oversight in its home country (particularly with respect to its capital and reserves), supervisors of a host country must act with an abundance of caution when approving that entity’s application for a license. The IAIS recommends that the granting of a license under that circumstance be accompanied by restrictions that would enable the host supervisor to perform effective supervision such as specific restrictions on activities or requirements for specific guarantees (IAIS 1999).

The supervisory authority is required to take reasonable steps to ensure that any financial and health-related information released to another supervisor regarding private voluntary health insurance/prepayment entities is treated as confidential by the receiving supervisor and that it will be used only for supervisory purposes.

Information-sharing arrangements should facilitate prompt and appropriate action in situations where material supervisory issues need to be addressed.

Insofar as private voluntary health insurance entities have ownership arrangements with local and international firms or groups, supervisors need to share information with respect to potential and actual fraud, money laundering, and the financing of terrorism.

The relationships between the home⁸ supervisory authority and the host⁹ supervisor takes place as follows:

- The home supervisor provides relevant information to the host supervisor.
- The home supervisory authority informs relevant host supervisors of any material changes in supervision that may have a significant bearing on the operations of foreign corporations with financial control over the private voluntary health insurance/prepayment entities licensed in their jurisdictions.
- Where possible, the home supervisory authority informs the host supervisor in advance of taking any action that will affect the foreign corporation with financial control over the private voluntary health insurance entities licensed in the host supervisor's jurisdiction.

In Slovenia, for instance, the authority permits insurance companies licensed in an EU member state to offer insurance in Slovenia provided that notification is received from the supervisory authority of the member state. Notably, in the case of complementary health insurance, the companies must obtain a special approval from Slovenian supervisory authority (ISA). If asked by the authority of the relevant member state, ISA must supervise the company's activities in Slovenia.

Enforcement Actions

Regulated private health insurers inevitably engage in some activity that demands some form of regulatory response from the supervisor. This may arise from a business activity that involves excessive risk, a financial shock that weakens the financial strength of the insurer, or an action that results in the breach of a law, regulation, or guideline. The supervisor therefore needs to take some form of corrective or enforcement action against the private health insurance company. The supervisory authority should have powers to enforce the law and regulations under its control, to institute corrective actions, and to impose sanctions based on clear and objective criteria that are publicly disclosed.

To undertake corrective action, the supervisory authority needs to have the legal and operational capacity to do so. Depending on the nature of the problem detected, a graduated response may be required. If the detected problem is relatively minor, informal action such as an oral or written communication to management may be sufficient. In other instances, more formal action may be necessary. The supervisory authority must have the power to take remedial action in a timely manner when problems are identified. The list of possible infractions is extensive but may include those shown in box 3.10.

BOX 3.10 EXAMPLES OF PUNISHABLE ACTIONS

- False statements in application for license
- Conducting business without license or registration
- Incorrect declaration or refusal of information
- Violation of laws and regulations
- Refusal to implement measures prescribed by the supervisory authority
- Violation of professional secret
- Illegal investments
- Illegal intercompany transactions
- Failure to submit, or to submit on time, a copy of the auditor's report
- Failure to give information, or to give correct or complete information, or to supply it on time
- Failure to give required notice on insolvency
- Misrepresenting or concealing actual financial situation
- Proposing or authorizing distribution of profits in violation of law or the approved business plan
- Violation of the business plan by carrying on business not envisaged in the business plan
- Any conduct endangering solvency
- Violation of provisions regarding guaranties and technical provisions
- Violation of bylaws concerning establishment and principles of operation
- Fictitious balance sheet
- Misrepresentation to the public of type of coverage and underwriting capacity
- Absence of reinsurance with qualified reinsurance institution
- Underwriting risks beyond prudential capacity
- Nonpayment of health providers or other claims

Source: Authors.

The decision-making lines of the supervisory authority should be structured so that action can be taken immediately in the case of urgent need. The supervisory authority must have at its disposal a range of enforcement, corrective, and punitive actions. Powers should be set forth in the legislation and made explicit

in regulations. Managers, members of boards of directors, actuaries, brokers and other intermediaries, and third-party administrators can perform infractions that merit sanctions. Powers may include:

- Restricting an entity's business activities
- Withdrawing or withholding approval for new health insurance underwriting
- Issuing cease and desist orders for unsafe, unsound, or improper practices
- Putting the insurer's assets in trust or restricting disposal of those assets
- Suspending or revoking the licenses
- Removing directors and managers or barring individuals from performing duties for the insurer
- Providing written warning about questionable activities or practices
- Imposing fines
- Imposing managerial intervention via a permanent observer designated by the supervisory authority or the appointment of an "interim administrator" to correct and manage the private health care financing entity temporarily
- Facilitating statutory management, administration, or liquidation of the insurer.

Enforcement tools can also include requiring an increase in capital and the establishment of sufficient technical reserves, demanding implementation of efficient internal control systems, requiring that investments be made in conformity with directives on allowed investment and valued according to pertinent regulations, insisting that insurers honor contractual obligations, and requiring fulfillment of contracted coverage and benefits.

In many developing countries supervision is frequently directed largely to ensuring compliance with legal requirements. In these circumstances pecuniary or monetary sanctions are usually the norm. These might involve daily fines against the company or fines against offending managers or board members. However, the tendency in many developed countries is to move away from compliance-based supervision toward a framework based on cooperative and corrective action rather than legal sanction. The philosophy is to encourage the insurance company to take corrective action before major problems emerge.

There is usually a clear distinction between the exercise of administrative law, which falls under the jurisdiction of the supervisor, and criminal law which falls under the jurisdiction of the courts. Rarely does the supervisor have criminal law jurisdiction. Usually the law requires that the supervisor send to the appropriate legal authority (for example the attorney general or director of public prosecutions) the information regarding activity subject to criminal law provisions (such as fraudulent activity) for this legal authority to proceed with a criminal case.

Failure Management

Supervisors may be faced with the situation where they are forced to close down a private health insurance company because of its weak financial position. A supervisor can have a range of powers to facilitate orderly exits by the private health insurer from the industry.

In some countries, the company's affairs are dealt with using the general law of insolvency for companies. However, due to the specific nature and requirements of the insurance sector, it is more typical for the supervisor to have specific rules concerning the bankruptcy and winding-up of insurance companies in order to protect policyholders. Clear instructions on this matter should be defined in legislation. The legislation covering matters connected with the management of troubled companies should include the standards applied in monitoring insolvency, the basis for being able to do a reorganization by restoring solvency, asset recovery measures, the revocation of licenses, conditions under which the portfolio of insurance policies may be transferred to a sound company, the role of the liquidator, and the ranking of creditors' claims.

NOTES

1. The Council for Medical Schemes is the statutory body that supervises and regulates private health care finance in South Africa. Its manual, *Guidelines on Standard Management Accounts*, includes specimen management accounts, with balance sheets and ratios, that illustrate the range of financial information to be reviewed and assessed.
2. Although the system in India is termed "File and Use," it is actually a prior approval system in which the regulator specifically clears the product before it can be sold.
3. In general, insurance companies involved in private voluntary health care insurance should follow IAIS recommendations on investment.
4. OECD Glossary of Statistical Terms, stats.oecd.org/glossary/search.asp.
5. See Australian Prudential Regulation Authority, "APRA'S Fit and Proper Requirements," 2004, <http://www.apra.gov.au>; and International Association of Insurance Supervisors, "Supervisory Standards on Fit and Proper Requirements and Assessment for Insurers, 2005; <http://www.iaisweb.org>.
6. A *significant owner* is an individual or group of related individuals who own or control a large enough part of a company to influence corporate operations. The definition can vary widely from country to country but a stake of around 15 to 20 percent is often considered significant. "Significant owner" should be defined in the insurance legislation or in regulations.
7. For a detailed discussion of governance see Savedoff and Gottret (2008).
8. *Home jurisdiction* is one in which the parent insurer is incorporated, or in which the head office of a branch is incorporated. *Host jurisdictions* and *supervisors* must be aware of the distinctions between immediate and higher-level home jurisdictions and supervisors,

taking account of the hierarchical corporate structures of many international insurers and insurance groups. Except where specified, the terms home jurisdiction and supervisor, where used, cover both immediate and higher levels (IAIS 2007: 34).

9. *Host jurisdiction* is one in which a branch of a foreign insurer is located; or in which a subsidiary or joint venture of a foreign parent insurer is incorporated (IAIS 2007: 34).

CHAPTER 4

Consumer Protection Standards

This section provides an overview of consumer protection standards that seek to enhance access to and the adequacy and affordability of health insurance. Also reviewed are the role of disclosure requirements and options to consider for handling complaints.

ACCESS-RELATED STANDARDS

In the absence of regulations, insurers may engage in *medical underwriting*, the process of examining an individual's health and claims history and making acceptance and premium decisions according to this information, generally following accepted actuarial principles. Insurers argue that, in voluntary markets, this screening activity is necessary to protect themselves against *adverse selection* (such as when people wait to obtain coverage until they need treatment). In many countries, however, this type of activity has limited access to insurance for people whose health history identifies them as a costly risk for the insurer. Hence, countries must weigh the trade-offs between promoting a market that may largely cover the healthy, versus requiring insurers to accept higher-risk individuals, thus risking lower enrolment by healthy individuals who may not wish to pay the resulting higher premiums.

Countries that seek to minimize the use of medical underwriting and maximize access to private health insurance regardless of health status rely on several strategies to do so, including the following:

Guaranteed access to health insurance. Individuals can be guaranteed access to all of the health insurance products offered by a health insurer or just some of them. Or, the law could require insurers to guarantee access to coverage only for those who apply during a specified time period, such as a particular month or 30-day period (called an open enrolment period).

Guaranteed renewability. Insurers subject to guaranteed renewability standards must renew a policy when it expires regardless of whether the individual has incurred health care costs during the term of the policy.

Limits on the duration of waiting and preexisting condition exclusion periods. Insurers subject to these limits cannot exclude coverage permanently or for a prolonged period of time before it begins to pay for benefits.

Issuance requirements alone do not address the concern of insurer selection, however, because insurers can also effectively exclude certain high-risk

individuals by raising their premiums or limiting the benefits offered (box 4.1). Therefore, many countries impose several other standards on companies to address the overarching concerns about access limitations and to mitigate the adverse effects of the strategies used to limit coverage. These can include limits on the use of medical underwriting in premium calculations and mandated benefits, both described in more detail below.

Guaranteed Issue

Guaranteed access provisions can help ensure that any eligible person can purchase health insurance and cannot be refused coverage by a private voluntary health insurance (PVHI) entity on the grounds of poor health and high likelihood of health services utilization. Many developed countries provide legal remedies against improper discrimination for a new member. These address discrimination based upon age; frequency of health service use; existence of chronic disease, illness, or medical condition; or health insurance benefits claiming history. Discrimination is not limited to refusal to insure an individual presenting high risk. Another form of health-specific discrimination is *dumping*, terminating or transferring membership of the sick and older people. Access standards range along a broad continuum around the globe (box 4.2).

BOX 4.1 CHILE: RISK SELECTION

In Chile, the private insurance market was unregulated for the first 10 years. During this period, private insurers could reject or drop beneficiaries who were older or who had or were likely to have expensive health conditions. Risk selection remains a problem in Chile. Although the country has taken action to strengthen its regulatory infrastructure, insurers continue to target their marketing toward high-income, low-health risk people.

Source: Bitrán and Urcullo 2008.

BOX 4.2 THE CONTINUUM OF ACCESS STANDARDS

Most stringent: guaranteed issuance of all policies. Slovenia (complementary PVHI), South Africa, Ireland, Australia, Croatia (complementary PVHI), United States (small employer market and some state individual markets)

More stringent: guaranteed issuance of one standard policy. Germany (for primary coverage), Netherlands (primary coverage), Israel (supplemental coverage offered by nonprofit insurers)

Less stringent: no issuance standards. Most European Union member countries with the exception of those mentioned above

Source: Authors.

Certain countries require insurers to offer some or all of their health insurance products to every applicant. This is particularly true in countries in which health insurance plays a significant, primary role. Such countries often wish to ensure access to at least one product, if not more. Germany, the Netherlands, and Switzerland require insurers to offer all applicants a standard package, which has generally become a product for higher-risk individuals lacking access to other products. In the United States, all group health insurers and, in a minority of states, individual health insurers, must offer coverage to all applicants either year round or during an open enrolment period.

Even when PVHI is not primary, some countries require insurers to guarantee access to health insurance. In Australia and Ireland, where insurance covers some of the benefits of public coverage but provides access to private providers, the governments require insurers to offer all their products to all consumers (OECD 2004). Slovenia requires complementary insurers to accept all applicants; this requirement does not extend to other types of PVHI coverage. Israel also requires this of its nonprofit sickness funds that offer supplemental insurance. Colombia also requires its private Health Promoting Organizations (EPSs) to accept all applicants for both comprehensive and supplementary policies (Bertranou 1999).

In contrast, a number of countries have chosen not to require companies to underwrite to every applicant. This is particularly true where PVHI plays a limited role. Among OECD countries, such countries include Canada, Mexico, Poland, Portugal, Slovakia, Switzerland (supplementary coverage), Turkey, and the United Kingdom. Unless such insurance plays a significant role in the country, European Union (EU) insurance law prohibits countries from prescribing insurer behavior relating to insurance contract terms, including such issuance requirements. In India, the regulator, faced with the challenge of senior citizens' poor access to voluntary health insurance, has mandated that all health insurance products filed after July 2009 must allow entry at least up to 65 years of age. Although insurers can still underwrite the risks, they need to disclose reasons for denial in writing.

Countries have had varied experiences with issuance requirements. In countries with significant employer and individual markets, more concerns have arisen in the individual market, where individuals' guaranteed acceptance may be inclined to delay purchasing decisions. Some studies in the United States, for example, have shown a decline in coverage after the imposition of such reforms (Fuchs 2004, citing Zuckerman and Rajan 1999). Importantly however, when several different types of regulations are imposed at the same time, it is difficult to isolate whether or to what extent the issuance components of the reforms, as opposed to the premium rate regulation or other factors, are responsible for such declines (OECD 2004, citing Hall 1999). In addition, another study found that such reforms were not responsible for a decline in coverage (Fuchs 2004, citing Buchmueller and DiNardo 1999).

In Australia and Ireland, access standards are well accepted, and debates have centered on rating or risk-equalization measures (OECD 2004). In Israel, the combined issuance requirements, standardization of benefits, and limits

on risk-based rating did not dampen the ability of the nonprofit sickness funds to continue to offer supplemental plans and earn a profit (Gross and Brammli-Greenberg 2004). In the Netherlands, a full 14 percent of the privately insured population purchase the standard plans. The affordability of these policies is aided by a subsidy on other policy premiums that covers half of the cost of this high-risk population.

In contrast, in the Netherlands' supplemental coverage market, where there are no issuance requirements, many persons stay with the coverage associated with their social insurance fund. It is speculated that this lack of movement may be due in part to the ability of the affiliated carriers to exclude persons from coverage or to charge very high premiums or provide more limited benefits. In South Africa, the removal of open enrolment (guaranteed issuance) requirements, along with permission to risk-rate, (Soderland and Hansl 2004) resulted in increased premiums and a lower-risk profile within funds. As a result, the government has since decided to reregulate the industry.

In Chile, some of the first regulations of the Superintendancy of Prepayment Health Institutions (Instituciones de Salud Previsional, ISAPRES) were oriented to reduce risk selection by ISAPRES. The risk-factor tables imposed, based on age and gender, restricted the common practice of many ISAPRES of excluding benefits that could lead to high expenses of insurance plans. Regulations introduced and strengthened in the last 15 years have limited the ability of ISAPRES to make profits by cancelling coverage for members who fall ill, selectively accepting members, confusing potential clients over what is included in plans, or excluding high-cost illnesses from their packages (Savedoff and Gottret 2008).

In countries where PVHI plays a significant role, it is recommended that the government impose some type of access requirement to ensure equitable access for the population. Some type of requirement is also desirable for other types of PVHI, particularly if equitable access is an important policy goal. The precise type of access standard (i.e., all products or one product guaranteed issue) depends on policy maker preferences and goals.

Guaranteed Renewability

Renewability requirements oblige insurers to renew PVHI contracts as long as an enrollee wishes and prohibits the termination of contracts due to claims history or other impermissible causes. Permitted exceptions to such rules generally include fraud or nonpayment of premiums. Renewability requirements can be found in Australia, Chile, Ghana, Ireland, South Africa, the United States, and a number of other countries.

Evidence from some OECD countries suggests that renewability requirements (and voluntary contract conditions providing for renewability) can promote risk pooling within PVHI markets because they enhance coverage security and serve as an incentive for healthier individuals to purchase coverage. Before it was required in the United States, for example, one study found

that purchasers were willing to pay an additional premium for products with this protection (OECD 2004).

In addition, countries vary in the extent to which they permit premiums to be adjusted at renewal, based on individual health or claims experience. This practice—which could undo some of the benefits of renewal by targeting certain individuals for rating hikes—is not used in European Union countries. In the United States, premiums may increase according to the experience of the pool, but most state laws protect against individualized rate hikes based on claims experience.¹

In the case of rating and issuance provisions, the absence of one type of protection could undercut the effectiveness of another (i.e., insurers could deny coverage if they did not want to issue a policy or insurers could make policies unaffordable if they are required to issue them). Renewability standards have less interaction with other provisions and could be put in place independently and still provide benefits to consumers. Conversely, in the absence of renewability requirements, insurers subject to issuance and rating provisions might cancel policies when covering an individual or group that proves to be costly. Hence, issuance and rating requirements are most effective when combined with renewability provisions. Portability standards (described below) can provide added protection for consumers. Yet while the absence of rating and issuance standards would not undercut renewability requirements, renewability standards do not address initial access or premium affordability and stability.

Limits on Waiting Periods and Pre-existing Condition Exclusion Periods

One of the policy challenges in PVHI markets relates to how best to permit insurers to protect against adverse selection while still providing meaningful access to coverage. One commonly used mechanism is to delay the period before an individual will be covered for any services he or she receives after the effective date of coverage. This delayed period is called a *waiting period*. Another commonly used mechanism is to delay when an insurer must begin to pay an individual's health expenses that are related to a condition in existence before applying for health insurance. Both of these mechanisms are used to encourage people to buy health insurance before they become ill or injured. This delayed period is called a *pre-existing condition exclusion period*. In both cases, premiums are paid for the policy even though a waiting or exclusion period applies.

Waiting Periods

The length of general waiting periods differs dramatically (table 4.1). In Australia, for instance, an insurer can impose a waiting period of no more than two months. Ireland permits an initial waiting period of 26 weeks (52 weeks for maternity benefits and for individuals between 55 and 65 years of age). In some instances,

TABLE 4.1 Limits on Waiting Periods and Exclusions for Coverage, Selected Countries

Country	Australia	Ireland	Germany	United States	South Africa	Chile	Israel	Slovenia	Brazil
Limits on exclusions	Yes 12 months	Yes Age-based	Yes 8 months	Yes 12 months or less (employer plans)	Yes 12 months	Yes 18 months	Yes No exclusions (nonprofits)	No	Yes
Limits on waiting periods	Yes 2 months	Yes 26 weeks	Yes 3 months	No	Yes 3 months	No	No	Yes 3 months	Yes 6 months

Source: Authors, based on various sources.

when an individual has had prior health insurance coverage for a specified length of time, waiting periods are prohibited, as in South Africa.

Pre-existing Condition Exclusion Periods

Pre-existing condition exclusion periods can be structured in a number of different ways. The structure depends on three components: (1) how a pre-existing condition is defined, (2) how long the exclusion period for a pre-existing condition can last, and (3) how far back the insurer can look into an individual's medical history to determine if a pre-existing condition existed (called the *look-back period*).

Definition of Pre-existing Condition

The extent to which the consumer is required to have been aware of the condition or have sought medical attention, in order for the condition to be considered pre-existing varies by country. Ultimately, the question centers on whether to limit coverage to conditions that received medical attention, or to include conditions for which the person arguably should have sought treatment, or for which there were clear symptoms. If the definition does not include an objective standard, such as the receipt of a medical diagnosis, it could give insurers more room for subjective assessments regarding whether the enrollee should have known about the condition prior to or at the time of enrolment and could then allow them to exclude a broader category of conditions.

In South Africa, pre-existing conditions exclusion periods are permitted only for conditions for which medical advice, diagnosis, care or treatment was recommended or received within the previous 12-month period and cannot last longer than 12 months. South Africa's standard is considered the objective standard. Prior to a change in federal law in the late 1990s, in some U.S. states the definition of a pre-existing condition was more subjective and focused on whether a "reasonably prudent person" should have sought treatment for the condition.

To illustrate, consider the U.S. state of Texas Health Insurance Pool's definition of *pre-existing condition*: a disease or condition for which the existence of symptoms would cause a prudent person to seek diagnosis, care, or treatment during the six months before the effective date of coverage, or for which medical advice, care, or treatment was recommended or received during the six months before the coverage date. Under this state's high-risk pool definition, a pre-existing condition includes a pre-existing pregnancy or a complication of a pre-existing pregnancy, whether the complication occurs before or after the effective date of coverage. A pre-existing condition does not, however, include genetic information in the absence of a diagnosis of the condition related to the genetic information. This prudent person standard can no longer be applied to group health insurance plans in the United States. These plans must now rely on the more objective standard, which requires diagnosis, treatment, or patient counseling for the condition.

Duration of Exclusion Period

Duration is the second component of the pre-existing condition exclusion period. The U.S. group health insurance market and Australia generally limit exclusions for pre-existing conditions to 12 months. Some countries permit longer exclusion periods such as in Chile where ISAPREs can exclude coverage for pre-existing conditions for up to 18 months. Insurers generally waive the pre-existing exclusion period for group insurance policies in India while for the retail segment, the insurers' council has self-imposed a maximum exclusion period of 48 months for indemnity policies. Ireland permits fairly lengthy exclusions that vary upon the age of the insured: 5 years up to age 55; 7 years for under 60, or 10 years for individuals between 60 and 65 years of age. In some instances, exclusions cannot be applied to certain benefits. In Germany, Ireland, and the United States, for instance, coverage for newborns is required.

In addition to general waiting periods and waiting periods for pre-existing diseases, insurers also use specific waiting periods for certain diseases (regardless of their pre-existing status) to reduce adverse selection. Thus, an insurer may pay for cataract surgery after one year of coverage or a joint replacement only after two years. Often, such specific waiting periods are intended to minimize the impact of pre-existing conditions where the insurer's screening process cannot establish them objectively. However, the regulatory challenge in dealing with specific waiting periods is not very different from the challenges associated with general waiting periods and pre-existing diseases.

Duration of Look-Back Period

The look-back period is the third component of a pre-existing condition exclusion period—how far back in an individual's history an insurer can look to determine if there is a pre-existing condition. In the United States, group health insurers cannot look back farther than six months prior to the commencement

of coverage. In South Africa, the look-back period can extend as long as 12 months, while it can be up to 48 months in India.

Creditable Coverage

Another option to consider when devising a structure for a waiting period or a pre-existing condition exclusion period is whether an individual will receive credit for any prior coverage. In other words, should the insurer be required to reduce the length of the waiting or pre-existing condition exclusion period by the amount of time an individual had continuous coverage before enrolment? In South Africa, for instance, waiting periods are prohibited for individuals who had two years of continuous prior coverage and no more than a 90-day gap in coverage before obtaining new coverage. In the United States, insurers are required to reduce the pre-existing condition exclusion period for the period of time that the individual had prior coverage as long as there was no more than a 63-day gap in coverage. This approach promotes a more competitive market since individuals without continuous coverage can change insurers without fear that they will be without insurance for their health condition for a prolonged period of time. If an individual's job is the source of coverage, as it often is in the United States, it also removes a barrier for individuals who want to switch employers.

Regardless, many countries have concluded that it makes sense to permit insurers to impose exclusions for conditions that existed at time of purchase, as long as their duration is limited. Some countries, such as the United Kingdom, Poland, and Portugal, where private health insurance is not primary, allow coverage exclusions for PVHI. Nonetheless, in some countries, such as Australia, there has been a good deal of consumer confusion around such exclusions, and the government received many complaints. Both government and industry have engaged in efforts to increase consumer awareness about the permissible standards. Clear definitions are therefore important for what constitutes a pre-existing condition as well as the maximum exclusion and look-back period. It is also important to communicate clearly what types of prior coverage can be credited against an exclusion period and how long the individual must have held that coverage.

PREMIUM STANDARDS

Supervisors address several areas when considering premium standards. The first is the loss ratio with a focus on the proportion of premiums used to pay for health care services, supplies and administrative costs. The second is the extent to which premiums are unfair, discriminatory, or unaffordable. Supervisors may consider several options as they determine whether limitations will be placed on how health insurance premiums should be set. This section also discusses those options. In addition, it discusses measures that countries may consider to mitigate some of the adverse consequences of the most restrictive of these options.

Loss Ratios

The ratio of the payments made by the insurer to the premiums earned for the year is called the *loss ratio*. One concern is the extent to which insurers use premiums to pay benefits (or claims) as opposed to administrative costs. A legislature may decide to establish a minimum percentage that must be paid out for benefits, as in New Jersey (box 4.3). In doing so, it ensures that administrative costs or profits do not absorb an excessive percentage of the premium. However, normative setting of premiums or loss ratios also limits the risk / return profile in the industry, which may reduce incentives and hinder further market development and expansion of coverage.

Treatment of Premium Variations

Perhaps one of the most contentious and unsettled areas of private health insurance regulation concerns the question of whether and how governments should regulate the premiums charged by private health insurers. At a minimum, insurance companies' financial reserves and claims payments should be monitored and regulated to ensure that insurers can meet their contractual obligations. In addition, laws should require that premiums be supported by actuarial calculations. If profits are considered excessive over a period of time, the regulator may want to analyze the reasons that may be inhibiting greater entry of insurance companies into the market. Yet beyond that, there is no clear agreement among experts regarding the appropriate interventions. This question is particularly difficult in voluntary markets as these regulations may greatly influence purchasers' decisions about whether to purchase health insurance.

Four main methodologies are used to calculate health insurance premiums:

- *Pure community rating*. This approach uses the fewest rating factors, allowing for variations only according to geography and benefit size. It does not permit the consideration of health status and claims experience in setting premium rates. Consequently, under such a scheme, all employers or individuals are charged the same premium regardless of their past claims experience.

BOX 4.3 NEW JERSEY: PREMIUM LOSS RATIOS

In the U.S. state of New Jersey, regulation requires individual and small group insurers to spend at least 75 percent of premium dollars on medical care. At the beginning of the year when insurers set their premiums, they file a certification that medical claims will exceed 75 percent of premiums. At the end of the year, if the amount spent on medical claims is less than 75 percent of collected premiums, they must issue refunds to enrollees in their health plans to make up the difference.

Source: Families USA, <http://www.familiesusa.org/issues/private-insurance/rate-regulation-51.html>.

- *Adjusted or modified community rating.* This approach permits some variation based on demographic factors, such as age and gender. It does not permit consideration of health status and claims experience.
- *Modified experience rating.* This approach places limits on the extent to which rates may vary based on claims experience or health status.
- *Experience rating.* This approach permits consideration of health status and claims experience in setting premium rates.

Another approach that could be considered is used in Germany and the Netherlands. In those countries, a cap on premiums is imposed for some policies.

The core of the debate on whether restrictions should be placed on the factors that can be considered in setting premiums is the extent to which insurers should be able to consider an individual's health status or "health risk" when determining premiums. On one hand, such an approach may limit the affordability of policies for higher-risk persons. On the other hand, younger or lower-risk persons may find their premiums rising under schemes that prohibit such considerations, leading to a "premium spiral" in which healthier individuals drop coverage, leaving behind an increasingly sicker pool of covered individuals for whom premiums escalate.

Experience rating (risk rating), however, is demanding administratively, necessitating complicated application forms with specific medical questions. Then the plans have to assess the responses and calculate and charge different premiums for different persons. The appropriateness of experience rating depends in part on the size of the group or employer used to make the premium calculations: the larger the number of insured, the larger is the amount of experience and data upon which to make the premium calculations.

In countries that put a cap on premium by law, the premium might not cover the cost of the higher-risk individuals. The Netherlands has addressed that concern by imposing a premium surcharge on those covered under other policies. Another way to address this concern is the introduction of high-risk, low-frequency pools where individuals with such conditions may be transferred. A small proportion of the premium is transferred for coverage of this type of reinsurance. Argentina has experience with this model under its mandatory scheme.

Many countries where PVHI coverage plays a significant role use some type of "community rating" under which risk rating is prohibited, but age or gender or other non-health related factors are allowed. This is the case in Australia, Ireland, the U.S. small employer market in many states and the U.S. individual market in some states. Chile permits the ISAPREs to vary their premiums according to age, gender, family size, and type of policy, but does not permit risk-based rating. Israel prohibits risk rating by insurers offering supplemental PVHI policies. In South Africa, the community-rating scheme was repealed and then reimposed following concerns about risk selection. In Slovenia, the original law was unclear with respect to the permissibility of risk-based rating, leading to different practices by different insurers, but the legal prohibition on risk-based rating has

since been clarified. In contrast, in the case for supplemental insurance markets, EU insurance law prohibits any curtailment of risk rating by regulators.

In the United States, those states with community rating requirements saw some increase in average premiums, but lower premiums for high-risk individuals and higher premiums for lower-risk individuals. The extent of the increases varied by state and by type of coverage plan (with smaller increases seen in some managed care plans). When rating restrictions were phased in over time, premium increases were usually more moderate (Fuchs 2004, summarizing several studies).

Mitigation Strategies

Among the strategies for mitigating risk are risk equalization schemes and late joiner penalties.

Risk-Equalization Schemes

Community rating schemes pose the risk that certain carriers may attract a population with a different proportion of sick or healthy individuals. They would then be forced to charge higher premiums than other insurers and therefore be at a competitive disadvantage, unless compensated in some way for their risk profile. Risk-equalization schemes have been put in place in many countries with community rating schemes in order to try to address this problem. Typically under these schemes insurers with higher-risk profiles receive a transfer of funds from insurers with lower-risk profiles.

These types of mechanisms exist for at least part of the PVHI markets in Australia, Germany, Ireland, the Netherlands, Slovenia, Switzerland (for mandatory coverage), and the United States. Slovenia's scheme has just been implemented and therefore it will take some time to observe and analyze its effects. The scheme seeks to spread the differences in health costs across insurers to account for the different demographic profiles of their members. Every three months, the Ministry of Health issues the "equalization sum." The sum is calculated on the basis of health claims data submitted by the insurance company to the supervisor and plans with higher costs are compensated in accordance with a predetermined formula.

In several countries, age and gender are used to estimate the varying risk profiles, and insurers are compensated according to the extent to which their profile differs from the overall marketplace, as is done in Ireland. Ireland's scheme has been controversial and its implementation delayed at several points. Given the presence of two main insurers in that country—one of them with a significantly larger market share, but a greater number of higher-risk profiles—there is a clear winner and loser to this scheme in the near term, hence heightening the controversy.

In Australia, a scheme equalizes about 79 percent of the cost of insuring people over the age of 65 and those hospitalized for more than 35 days and distributes these funds across insurers with different risk profiles (OECD 2004).

Switzerland's mechanism for its basic mandatory coverage has somewhat reduced incentives for insurers to enroll better risks and avoid those in poorer health. It has thus promoted more fair competition (OECD 2001). In the United States, the use of risk-spreading mechanisms helped moderate the increase in premiums in several states' individual markets (Fuchs 2004).

For countries that impose some limitations on risk-based premiums to ensure access for higher-risk individuals, risk-equalization schemes make it less likely that insurers will be penalized according to their enrollee risk profile. Certainly a benefit of such schemes is that they deter insurers from trying to select their enrollees based on their risk status alone. Nonetheless, there is no perfect mechanism for calculating the redistributions, and these schemes have sometimes been controversial (as in Ireland).

Late Joiner Penalties

To encourage consumers to purchase PVHI and to help protect insurers against adverse selection by individuals who wait until they are sick to purchase PVHI, some countries allow higher premiums to be charged to people who delay purchase until they are sick. South Africa, for instance, considers anyone who is not a member of a medical scheme after age 30 to be a late joiner. The premium penalties increase in increments of nine years according to a schedule defined by regulation. The regulation also provided a "grace period" after implementation of this rule to allow persons to join schemes without such a penalty.

Slovenia is one country that does not include any age-based criteria in its rules. A person who does not purchase a complementary health insurance scheme, once they cease being a dependent on another policy, must pay a premium penalty for joining late. The premium increases by 3 percent for each full year the person does not join a scheme, up to a maximum differential of 80 percent with the standard premium level.

In Australia, insurers can apply a premium increase of 2 percent of base rate per year of age over 30, with a maximum permitted increase of 70 percent. Australia witnessed an increase in those covered by PVHI after the imposition of several reforms, one of which was the age-related premium increase (after the expiration of a grace period following the enactment of the requirement). However, whether this requirement was solely or largely responsible for the increase is not clear because several changes were implemented at the same time, along with an aggressive media campaign (Columbo and Tapay 2003).

Building a penalty for late joiners into the premium rating system creates an incentive for persons to purchase PVHI earlier in life and can help improve risk pooling within the market by encouraging purchase by younger people. A corollary could be incentives to join at an early age, such as longer renewal spans or guaranteed renewals for individuals joining before a particular age, or a lesser risk-equalization liability if someone has been in the health insurance system for a specified number of years. It seems to serve as a useful tool with few disadvantages.

BENEFIT STANDARDS

PVHI markets often develop because they offer the people choices beyond those provided under public programs. Hence, many governments choose not to mandate the benefits to be offered in this market. However, some governments impose restrictions that relate to preserving the integrity of their public program given interactions between public and private coverage. Countries may impose benefits standards to ensure that certain services are covered for everyone and to mitigate any adverse effects against its public programs.

Mandated Benefits

Governments may impose benefits standards in order to ensure that certain benefits are covered, especially when coverage serves a primary or more extensive role. Different regulatory approaches include specifying the benefits that must be covered, as in South Africa and many U.S. states. Alternatively, benefits packages can be standardized requiring insurers to mirror the required offerings in order to enable easy comparison as well as reduce insurers' ability to risk select through the structure of their benefits packages. In markets where insurers have limited ability to exclude individuals through acceptance or premium-related decisions, the scope of benefits packages can serve as a means of attracting certain low-risk populations, and discourage enrolment of high-risk persons by excluding certain services. Hence governments may require all policies to cover certain high-cost benefits or standardized benefits packages in order to prevent this type of risk selection by insurers.

South Africa requires schemes to cover a comprehensive range of specified services, prohibits the use of copayments or deductibles in connection with the provision of any of the prescribed benefits, and requires that the benefits be available from at least one provider or provider network that must always include the public hospital system. This prescribed minimum benefit package (PMB) covers a wide range of diagnostic and treatment services, including HIV/AIDS, but has certain limits on tumor chemotherapy and radiotherapy, organ transplant, and other benefits. It also excludes coverage of any drugs or treatments not registered with the relevant South African authority.

In Slovenia, the benefits offered by complementary health insurance are dictated by the benefits and cost-sharing of the compulsory system. For other types of PVHI, there are no benefits standards.

Australia, Ireland, and some U.S. states also impose minimum benefits requirements. The U.S. Medicare supplement individual market and some U.S. states require all policies to offer one of several standard packages, whereas Germany and the Netherlands require all insurers to offer a standard package in addition to their other offerings (the standard packages must be issued to all applicants and therefore tend to cover higher-risk individuals).

Minimum benefits requirements, such as those in South Africa, still enable plans to have different packages and are hence less stringent than those that require plans to offer identical benefits packages (“standard packages”), such as those found in the U.S. Medicare supplement market as well as some U.S. states. However, consumers can more readily compare costs and benefits when packages are standardized. In South Africa, the minimum benefits requirements were lifted between 1993 and 1998; during that time benefits offerings declined. The requirements were therefore reinstated in 1998.

The Irish government considers its minimum benefits standards an important accompaniment to its community-rating standards—without them, the scope of benefits could lead to risk segmentation among plans, with higher-risk populations gravitating to the more generous plans and the lower risks moving to more limited, basic packages. This would exacerbate the price differential between such plans, given the differences among their covered populations (OECD 2004).

The two main Irish PVHI carriers offer relatively few policies, however, and these plans largely mirror those of their competitors, thus facilitating comparison. The Australian market, in contrast, has a large number of products, making it more difficult for consumers to understand and compare their options (Colombo and Tapay 2003). In the United States, standardization requirements were instituted for the Medicare supplemental market after it was found that many duplicate policies were being sold to elderly beneficiaries, who were not always able to assess their insurance needs (OECD 2004).

Interface between Public and Private Coverage

In some cases, policy makers decide to prohibit plans from covering certain services covered by the public program, in order to promote more equity of access. As mentioned above, Australia prohibits private coverage of outpatient physician services in order to avoid two-tiered access to these services. For the same reason, most Canadian provinces prohibit private coverage of both hospital and physician services (including coverage of copayments for these services). In addition, some countries, including France and the United States, have seen an overall increase in health care utilization when patients have private complementary (copayment) coverage. A decision of the Supreme Court of Canada has thrown the legality of Canada’s prohibition into question, however, holding that Quebec’s prohibition violated the Canadian and Quebec Charters.²

As discussed, some countries have permitted some or all portions of the population to choose between coverage offered by public or social insurers, and that offered by private insurers. Such “opting out” provisions have been found in Germany, for certain upper-income individuals, as well as in Chile. In both Germany and Chile, the private insurers ended up covering a lower-risk population, leaving sicker populations to the public or social insurance system. In Germany, the population covered by primary, private coverage is generally

younger and healthier, single high-earners, or couples with two incomes. The other portion is civil servants (OECD 2004, citing Gress, Okma, and Wasem 2002, citing Mossialos and Thomson 2004). In contrast to the situation in Chile, however, Germans who opt out of the public system generally are unable to re-enter the social insurance scheme.

The risk segmentation present in the Chilean system can be traced to the different regulatory requirements imposed upon different types of insurers—public or private. Public insurance establishes income-based premiums, while private insurers can adjust premiums by age, gender, and number of dependents (but not health risk). As a result, private carriers insure a smaller proportion of older, higher-risk individuals. In addition, several factors have contributed to selection against public insurance. For a time, the privately insured were able to continue to use public insurance as eligibility was difficult to ascertain. Additionally, private health insurance beneficiaries are able to switch back to public insurance, essentially enabling private insurers to “dump” their more expensive risks back onto the public system (Sapelli and Vial 2003).

If countries wish to limit eligibility to their publicly financed system they may want to consider doing so on an income basis, as is the case in the Netherlands, where one-third of the population (the wealthier third) are not eligible for social insurance and must purchase insurance from the private market, or go uncovered. As described above, an “opt-out” option poses the risk that the public system will lose its lower risk populations but retain its higher-risk populations, a problematic combination for the system’s financing.

DISCLOSURE, COMPLAINT HANDLING, AND APPEALS

Insurance contracts often contain technical, detailed provisions that many people may not readily understand.

Disclosure Requirements

To protect consumers, many countries therefore set forth certain requirements to promote insurers’ provision of adequate information to consumers so that they can assess the risks, quality, and relative prices of private health insurance options. Controlling misrepresentation of products, misleading information, bad or inadequate advice, undeclared conflicts of interests, and fraud, is essential to protect consumers. Market imperfections and incompetent and unethical practices can be substantially reduced with information disclosure requirements and codes of business behavior. Furthermore, standards requiring brief summaries of coverage and policy conditions in readily understood language can facilitate consumer understanding of their contractual rights.

In most OECD countries, PVHI insurers are at least required to conform to disclosure requirements applicable to the entire insurance industry, and in

some cases, the government also prepares and distributes information about health insurance (i.e., in Australia and in some U.S. states). This may include general information about consumer rights under their health insurance contracts, plan-specific information related to covered benefits and premiums, or comparative information across plans. In addition, insurer trade associations may develop voluntary codes of conduct focused upon or including provisions on furnishing consumers with insurance-related information, as done in the United Kingdom. Slovenia requires insurers to set forth the general conditions and notifications in plain, understandable language. In addition, the law specifies that insurers must provide notice of several items when concluding insurance contracts. These items include the duration of the contract, amount of the premiums, right to cancel, and title and address of the supervisory authority with which complaints may be filed about an insurance company or broker. Indian health insurers are required to annex a Customer Information Sheet explaining the policy provisions in simple language, make upfront disclosures to prospective clients on scheme renewability, provide for “free look periods”³ in longer-term contracts (three years or more) and provide policy documentation with details on the grievance redressal system and the ombudsman mechanism.

Appeals and Consumer Complaint Handling Procedures

The handling of consumer complaints can be a significant and important supervisory activity.⁴ Consumers may find they are having trouble getting a health claim paid or obtaining the plan’s approval for a particular service or intervention. There are several different models of appeal mechanisms for supervisors and policy makers wishing to help resolve consumer complaints. Some of them are described below. A general structure to consider is a multilayered one that includes an internal complaint-review process within the company for its customers as well as the ability to file complaints or concerns with the supervisory authority. While such processes need not be complex, they do require plans to inform consumers that a complaint or appeal mechanism exists, and how they can reach the relevant parties. In addition, an external, independent review body has been found helpful in resolving disputes, particularly those related to whether a service is covered under the policy (e.g., policies that specify that certain services are to be covered if “medically necessary”).

Internal Insurer Review of Complaints or Appeals

Government may want to mandate that insurers have internal procedures, such as a first- and second-level review within the insurer, for reevaluating claims and other decisions upon request by the insured person. A good mechanism would include making sure the plan provides the insured with clearly understood information about their rights of appeal, and provide for review by persons within the plan not involved in the initial decision.

External Review of Health Plan Decisions

Government can provide for an external body to review health plan decisions upon appeal by a consumer. Such mechanisms typically require consumers to have exhausted internal plan grievance and appeal mechanisms. When decisions involve medical decisions, appropriate expertise should be provided to assist in the final decision making. Often, the review bodies are independent bodies established by law. Sometimes, however, they are appointed by, or located within, a governmental agency (Pollitz, Dallek, and Tapay 1998).

Persons may appeal decisions of the Registrar or Council to the Appeal Board in South Africa. The board is composed of three persons appointed by the Minister of Health. Members must recuse themselves if they have any direct or indirect interest in the outcome of the appeal. In many U.S. states⁵ (Dallek and Pollitz 2000), individuals can appeal plan decisions to an independent expert or government panel. (Often, such appeals may relate to managed care health plans' failure to authorize or pay for certain medical services.) For example, in Pennsylvania consumers must exhaust their plan's internal appeals process and then may file for review with an independent appeal body of disputes involving determinations of medical necessity. The decision process must take no longer than 60 days, and the patient must pay a nominal filing fee (Pollitz, Dallek, and Tapay 1998).

Several OECD countries have independent ombudsman programs that resolve disputes relating to insurance. These include Ireland, Mexico, the Netherlands, Poland, Portugal, Spain, Switzerland, the United Kingdom, and some U.S. states. With the exception of the United States, however, none of these programs specialize in health insurance, but health insurance-related complaints are considered along with other insurance-related complaints. In the Indian experience, the largest share of complaints received by Insurance Ombudsmen and the Regulator have been health insurance-related grievances, which prompted the regulator to come up with several regulatory initiatives to address issues brought out in the complaints.

Supervisory Agency Responsibility for Complaints

Supervisory agencies should generally have procedures for receiving telephone and written complaints from the insured regarding denial of claims. Insurance departments review the facts of the case and contact the insurance company when they find the claim is valid. This type of appeal mechanism benefits from the enforcement authority of the insurance department or authority. It also has the additional advantage of allowing supervisors to record complaints that help them identify problematic behavior by insurers.

In South Africa, the Registrar may resolve complaints or submit it to the Council of Medical Schemes, which is a statutory body established in 1998 by the Medical Schemes Act to provide regulatory supervision of private health financing through medical schemes. In Ghana, the Council or Board of the Nation Health

Insurance Authority must establish a Health Complaint Committee in each of its district offices. These committees shall hear and resolve any complaints submitted to the Council by scheme members or providers and perform other functions as determined by the Council. U.S. state insurance departments handle a wide range of consumer complaints; their volume of inquiries and complaints varies by state. Many factors can affect the volume of consumer inquiries, such as size of the state, the location of enrolled individuals, enrollees' access to phones, the presence of toll-free lines, supervisory resources, and supervisors' professionalism and track record.

Ombudsman Programs

In Australia, the Minister of Health and Aged Care appoints a private health insurance ombudsman. This ombudsman's office investigates and conciliates complaints related to private health insurance coverage and advises on industry practices for improving services to consumers. The Insurance Ombudsman of Ireland Scheme is a non-statutory scheme that provides for the independent settlement of disputes between insurers and their enrollees. The Insurance Ombudsman adjudicates disputes related to insurance policies. By agreement of the member insurers, decisions are binding on insurers that belong to the scheme; policyholders have the option of accepting or rejecting the decision (Department of Health and Children, Ireland 1999).

Quasi Supervisory or Judicial Bodies

In addition to the arbitration mechanisms in insurance contracts, the judicial route, the ombudsman mechanism and grievances to the regulator, Indian consumers of insurance services can also approach district, state, and national consumer commissions that function as quasi-judicial forums to address health care-related consumer complaints. Orders of the National Commission only can be appealed to the Supreme Court (Mahal 2002). Unfortunately, backlogs have arisen in the consumer courts, in addition to the delays experienced in the Indian courts as well (Mahal 2002).

In the Netherlands, decisions about acceptance into a standard insurance scheme policy (conditional on the applicant's meeting certain statutory criteria) are subject to the objections and appeals procedure within the General Administrative Law. Consumers can take their complaints to the Minister of Health, Welfare and Sport and pursue several routes if dissatisfied with the minister's decision. First, the National Ombudsman has authority to determine if the action was appropriate in light of statutory obligations. Consumers can also appeal the insurer's decision to the Regulatory Industrial Organization Appeals Court or the Insurance Act Appeals Committee (however, insurers are not required to make use of the latter and may draw up their own procedure instead).⁶

In the United States, state-level external review programs have been found to be fair and independent sources of review, without necessitating heavy resources

as initially feared. Decisions are generally split evenly between consumers' and insurers' positions. These programs have also appeared to spur improved behavior on the part of plans after complaints in certain areas (Pollitz, Dallek, and Tapay 1998).

It is useful for supervisors to require internal and external review processes in order to ensure that consumers' complaints are heard. In addition, supervisors should accept written and telephone complaints and inquiries from the public and respond to them in a timely fashion.

CONCLUSIONS AND AFTERWORD

As reflected in this book, private health insurance is indeed a complex business. Insurers engage in a broad range of highly technical tasks and assume a great deal of risk in conducting their business. Unlike other forms of insurance, health insurance also involves multiple stakeholders besides the insurer and the insured, including a very important link with the health care providers. Further, insurance institutions have no monopoly on undesirable market behavior; all stakeholders in the system are susceptible to it.

Insurance supervisors thus face a challenging task in regulating this complex industry. The very nature of health insurance introduces market imperfections that require intervention to achieve a range of objectives, varying from access and customer protection to cost containment and solvency of the industry. Often, policy requirements demand that regulators do more than just prudential regulation and countering systemic information deficiencies. Regulators may be required to achieve certain social objectives such as guaranteed access to certain insurance-covered health services which, in turn, requires specific regulation, monitoring, evaluation, and enforcement. Finally, some institutional constraints may affect the efficacy of insurance regulators—the statutory base that gives the “teeth” to the regulators, the extent of coordination among relevant supervisory agencies, the adequacy and competence of staff, and even the institutional strength and timely information from the financial system where resources need to be invested. These are a few of such constraints that can impair supervisors' ability to conduct rigorous monitoring and enforcement activities.

This book attempts to introduce areas and issues in voluntary health insurance that may require the attention of regulators and policymakers. The authors provide them with some options, based on international experience, and drawing on examples from several low-, middle-, and high-income countries. However, insurance supervisors have to consider their own contextual factors and decide whether these options are appropriate for their own circumstances. Moreover, as mentioned in the book, the extent of regulation also depends on the nature of the health insurance industry and the regulatory capacity within each country. This book is not intended as a detailed manual on what, how, or when to regulate health insurance. It is intended, however, to be a useful, concise primer for

policymakers and regulators on the numerous facets involved in regulating this complex business. By drawing their attention toward international experiences, the authors hope they gain some useful insights as they go about their duties. The authors would certainly appreciate feedback from them on the extent to which this intention has been achieved, and on suggested directions for their future work in this area.

NOTES

1. Patel, V., and M.V. Pauly. 2002. "Guaranteed Renewability and the Problem of Risk Variation in Individual Insurance Markets," *Health Affairs*. news.ehealthinsurance.com/.../Vips_HealthAffairs_RenewabilitySept-Oct02.pdf.
2. *Chaoulli v. Quebec (2005)*. Cassels Brock & Blackwell LLP, "Supreme Court Strikes Down Private Health Care Insurance Prohibition in Quebec: *Chaoulli v. Quebec*." www.casselsbrock.com.
3. *Free look period* is the duration within which the policyholder can return the policy and receive a pro-rata refund of the premium paid without any cancellation penalties.
4. The provider-insurer relationship is very important to a well-functioning private health insurance system. Thus, it may also be important for policy makers and supervisors to provide appeal mechanisms for providers; for example, disputes between insurers and providers could relate to billing questions, contract interpretations, the provision of provider-recommended care to enrollees, and other issues. Research on such mechanisms, however, is beyond the scope of this book.
5. As of 2000, 32 states and the District of Columbia.
6. Ministry of Health, Welfare, and Sport, Netherlands, "Health Insurance in the Netherlands: Situation as at 1 January, 2000." <http://www.minvws.nl/>.

APPENDIX

Glossary of Terms

Ability/willingness to pay. Often inappropriately assumed to be equivalent. Willingness to pay (WTP is mediated by ability to pay [ATP] and by individual and cultural aspects that determine the perceived benefit to self and to the community. There are two ways to assess WTP):

- Data on past health care utilization and expenditure
- Contingent valuation methods based on surveys.

Ability to pay (ATP). Largely determined by affordability. ATP for health insurance must be considered in the context of copayments and transaction costs. The concept of fairness may be an important consideration in designing a microinsurance scheme and setting premiums.

Accountability. Result of the process that ensures that decision makers at all levels actually carry out their designated responsibilities and that they are held accountable for their actions.

Actual premium. The premium arrived at by estimating the average benefit payout and adding a safety margin for contingencies.

Actuary. A professional trained in evaluating the financial implications of contingency events. Actuaries require an understanding of the stochastic nature of insurance and other financial services, the risks inherent in assets, and the use of statistical models. In the context of insurance, these skills are often used, for example, in establishing premiums, technical provisions, and capital levels.

Adverse selection. Also called antiselection. Problem of asymmetric information that disturbs the operation of the insurance market, resulting in an inequitable transaction. The insured, knowing the likelihood of events, chooses to insure against only those that pose a strong risk. The insurer, having less information, accepts a contract that does not include premiums for low-risk events. The insured gains from the insurer's inability to distinguish "good" and "bad" risks. Providing asymmetric information allows people who are sick and require care to seek health insurance coverage. Constitutes a key concern for insurers that can lead to higher losses, which is countered by medical underwriting, which minimizes insuring high-risk individuals.

Affordability. See *Ability to pay*.

Agent. Another term for insurer.

Ambulatory care. Outpatient medical care provided in any health care setting except hospitals.

Arbitrage. The simultaneous buying and selling of securities, currency, or commodities in different markets or in derivative forms in order to take advantage of differing prices for the same asset.

Asymmetrical information. Parties to a transaction have uneven access to relevant information that governs an informed choice. Such asymmetry can result in an inequitable transaction in favor of the party with the most information, or it can result in the abandonment of the exchange.

Balance sheet. Statement showing the financial position at a particular point in time (for example, at the end of the financial year), listing all assets and liabilities at that time.

Bayesian method. A method (originally enunciated in 1763) for revising the probability of an event's occurrence by taking into account data as they come to hand. The usefulness of this approach depends on the relevance and power of the additional data.

Beneficiary or principal. The person designated to receive payouts from the scheme. This is typically the policyholder or a family member, but it may be an employer.

Benefit exclusion. Refusal of access to a specific benefit for an insured. Because this exclusion could be subject to abuse if it is based on arbitrary decisions made at the time of claim rather than as set out in the contract, it tends to be regulated. Reasons for exclusion that are typically allowed include a qualifying period and pre-existing illness.

Benefits package or compensation. A list of specific benefits agreed upon in the health insurance contract. While private insurance typically offers modules of benefits from which to choose, microinsurers may offer a standard package for simplicity and fairness.

Beta distribution. Beta is a distribution (first used by Gini, 1911) for a real random variable whose density function is null outside the interval $[0, 1]$ and depends on two strictly real parameters. The shape of this distribution depends on the values of the parameters: it can be U-shaped, or J-shaped, or hat-shaped. For this reason, this distribution is very often used for modeling proportions or probabilities.

Bifurcated oversight responsibility. A specialized regulation system in which the supervisory and regulatory functions are broken into a financial component and a health component.

Binomial distribution. A statistical method for understanding the probability of events that have only two possible outcomes—"success" or "failure." These probabilities are constant. In insurance, the binomial distribution is applied to estimate the number of persons in a community who will seek (ambulatory) care in a given period.

Bottom-up. See *Top-down global strategy*.

Broker. An intermediary who sells on behalf of another.

Capacity. Has two meanings:

- Insurers' ability to underwrite a large amount of risk on a single loss exposure or many contracts on one line of event. Reinsurance enables a greater capacity among primary insurers.
- Organizational and individual skills. Organizational capacity implies appropriate systems for information and management and adequate resources for handling operations.

Capacity building. Increasing organizational and individual skills and establishing frameworks for that increase to continue.

Capitation payment. Under a capitation payment, the provider receives a fixed fee per individual per month to provide all covered services regardless of how many services are provided to any of the individuals covered.

Central limit theorem. States that, as the sample size increases, the characteristics of the sample will more closely approximate those of the population from which that sample was drawn. This theorem is valuable in health insurance as it enables estimates of risk in a population to be based on sample data.

Claim load. The amount of benefits paid to the insureds in a period. Fluctuations in claim load in the short term are covered by contingency reserves and in the long run by contribution increases.

Coefficient of variation. The ratio of the sample *standard deviation* to the *sample mean*. It measures the spread of a set of data as a proportion of its mean. It is often expressed as a percentage. This coefficient enables, for example, estimation and comparison of ranges of likely expenses for various communities.

Coinsurance. An insurance policy provision under which the insurer and the insured share a fixed proportion of costs incurred after the deductible is met, according to a specific percentage formula that facilitates risk sharing between the two parties. In some plans, the insured meets coinsurance obligations through a *copayment*.

Collection rate or compliance rate. The proportion of possible subscriptions from members that the microinsurer collects. Lack of complete compliance can result from cultural as well as economic factors. It may be used as a measure of a microinsurer's efficiency/commercial orientation. Members are more likely to pay contributions if their perceived risk is higher.

Community. A group of people with a common interest. Often implies locality, but can be occupation-, leisure-, or religion-based.

Community-based health insurance scheme. A voluntary community prepayment health insurance scheme for pooling risks. The community's policyholders share social values, are involved in the management of health plans, and elect a group of their members to act as managers. CBHIs are common in many low-income countries, where options are unavailable.

Community financing scheme. See *Community-based health insurance scheme.*

Community participation. Sharing by citizens in any kind of community in communal decision-making processes and definitions of problems.

Community rating. A method for determining insurance rates on the basis of the average cost of providing health services in a specific geographic area. This method ignores the individual's medical history or the likelihood of the individual's using the services. All members of a community pay the same premium without considering individual health status.

Compensation. Benefit payout.

Complementary private insurance. Insurance that provides coverage for all or part of the costs not covered under the public program.

Compliance. Payment of contribution owed by members.

Compliance gap. Difference between contributions due and contributions collected.

Compliance rate. The ratio of actual contributions over potential contributions. See *Collection rate.*

Compulsory insurance. Any form of insurance the purchase of which is required by law. Governments typically require the purchase of liability insurance with respect to three types of potential loss-causing activities: those whose severity could be particularly great, with the possibility of large numbers of innocent persons being harmed because of a single event; those whose frequency is sufficiently great to affect large numbers of innocent persons independently; and those judged to be inherently dangerous.

Confidence interval. A range of values that is estimated to contain the population parameter. To be 95 percent confident that a range contains the parameter requires a larger range than to be 90 percent confident. For example, analysis of data from a community might suggest a 90 percent chance that the number of people seeking hospitalization in a year will be between 1,100 and 1,500, but the confidence interval for 95 percent confidence is 978 and 1,747.

Conglomerate risk. Insurance companies that are participants in financial groups can be exposed to some additional sources of risk, such as (but not limited to) intragroup exposures, contagion, and risk concentration.

Contingency reserves or equalization reserves. Funds held by the insurer that are in excess of expected benefit payouts in order to cover unexpected events (contingencies) that cause fluctuations in benefit payouts. They are typically regulated in order to ensure the insurer's solvency.

Contribution. Payment of an agreed sum of money by a member to a social insurance system in return for specified benefits. The implied assumption is that other sources of income complement members' payments. See also *Premium.*

Contribution base. The amount that would be available to the insurer if all members contributed fully. When contributions are set as a percentage of income, this base relies on full disclosure of income (disclosure rate).

Contribution rate. The percentage of contribution base actually or expected to be collected.

Cooperative. A group of people who have united voluntarily to realize a common goal, by establishing a democratically run company, providing an equitable quota of the necessary capital, and accepting a fair share of the risks and the profits of this company. Members also take an active part in its operation.

Copayment or cost sharing. The fixed amount of medical expenses paid by a member or beneficiary at the time of the visit under coinsurance policy provisions. This amount is the balance remaining after the insurer has paid its portion.

Corporate governance. Set of relationships between a company's management, its board, its shareholders and other stakeholders. Corporate governance also provides the structure through which the objectives of the company are set and the means of attaining those objectives and monitoring performance are determined. It also includes compliance with legal and regulatory requirements.

Cost sharing. See *Copayment*.

Covariance. A measure of the relationship between two variables. Covariance does not specifically imply a cause-and-effect relationship ("causation"), although it may intuitively be inferred to exist, as can its direction. For example, if health problems vary with housing density, it may be possible to infer that density affects health, but the observed covariance of the frequency of schizophrenia with social status may not have a simple unidirectional explanation.

Covariant risk. When events are not independent, the occurrence of one may affect the occurrence of another. For example, the risk of one family member's catching influenza is covariant with that of another family member. Disasters and shocks are classic cases where proximity influences covariation. When insuring against risk of events, the actuary must consider the covariation between those risks.

Cream skimming (preferred risk selection). An exercise whereby an insurer selects only a part of a larger heterogeneous risk group ("preferred risks"), in which all individuals pay an identical risk-adjusted premium. When the insurer reduces its loss ratio compared with the expected average cost that determined the premium, the insurer can retain a profit from cream skimming. This profit depends on the insurer's ability to distinguish several subgroups with different expected costs within the larger group and to predict the (lower) future health care expenditure of individuals in the preferred group.

Credit risk. Most commonly, the risk of financial loss incurred by an insurer when a vendor or service provider ultimately does not provide the services they have agreed upon and have been paid to provide under a binding contract between the two parties. Credit risk may also result from default or movements in the credit rating assignment of issuers of securities (in the company's investment portfolio), debtors (e.g. mortgagors), or counterparties (e.g. on reinsurance contracts, derivative contracts, or deposits) and intermediaries, to whom the

company has an exposure. Sources of credit risk include investment counterparties, policyholders (through outstanding premiums), reinsurers, and derivative counterparties.

Creditable coverage. Credit for any prior insurance coverage that provides for a reduction of the length of the waiting or pre-existing condition exclusion period by the amount of time an individual already had continuous coverage before enrollment.

Cross-subsidies. Amounts effectively paid when the wealthy members pay more than poor, or when the healthy pay the same as the sick for lower expected benefits. The poor and the sick are said to receive cross-subsidies from the wealthy and healthy.

Crude birth rate. A summary measurement of the total number of live births in a specified population at the end of a specific time period (generally one year), divided by the midyear total population count. Expressed as the number of births per 1,000 people within that population.

Crude death rate. A summary measurement of the total number of deaths in a specified population at the end of a specific time period (generally one year), divided by the midyear total population count. Expressed as the number of deaths per 1,000 people within that population.

Declaration rate. See *Contribution base*.

Deductible. A provision requiring the insured to pay part of the loss before the insurer makes any payment under the terms of the policy. Deductibles typically are found in property, health, and automobile insurance contracts. The purpose of establishing deductibles is to eliminate small claims and reduce the average pure premium and administrative costs associated with claims handling. Deductibles can also reduce moral hazard by encouraging persons to be more careful with respect to the protection of their property and prevention of loss. Annual deductibles and waiting periods are the most common forms of deductibles in health insurance contracts.

Defined benefit. The amount, usually formula-based, guaranteed to each person who meets defined entitlement conditions. The formula usually takes into account the individual number of contribution or insurance years and the individual amount of earnings during the same period.

Delphi method or nominal group technique. A method of business forecasting that consists of panels of experts expressing their opinions on the future and then revising them in light of their colleagues' views so that bias and extreme opinions can be eliminated.

Demand. The amount of a good or service that consumers seek to buy at a given price. *Solvent demand* implies the ability to pay as well as the willingness to pay. *Elasticity of demand* is a measure of the responsiveness of total spending on a particular good or service to a change in its price. *Elastic demand* implies that as the price goes up the total expenditure falls. *Inelastic demand* implies that as the

price goes up total expenditure also goes up. Necessities typically have inelastic demand (given an adequate income base). For example, the imperative to have an aching tooth removed means that the dentist is in a position of power to charge a high price; such dental services have inelastic demand, and it is unlikely that a lower price would attract people not suffering from toothache to have a tooth removed. The concept of “necessity” and therefore of what has an inelastic demand is cultural. In some cultures prenatal care may not be considered a necessity. Demand for some procedures may be truncated in poor communities. *Truncated demand* means that although the demand for surgery (for example) is inelastic and does not change with price, above a certain price it becomes zero. As half an operation is not an option, the demand is truncated because of poverty.

Derivative. A derivative is a financial asset or liability whose value depends on (or is derived from) other assets, liabilities, or indexes (the “underlying asset”). Derivatives are financial contracts and include a wide assortment of instruments, such as forwards, futures, options, warrants, swaps, and composites.

Derivative contract. A contract whose value derives from an underlying financial instrument like a stock, commodity, or index.

Dual theory of risk. The theory that describes the attitudes of individuals toward insuring themselves, by weighing on the one hand their wealth and on the other hand their aversion to risk. Two possible modifications could swing the balance in favor of insurance: decreasing the premium or increasing aversion to risk. Even with identical feelings toward monetary loss, individuals would likely adopt different attitudes toward insurance because their feeling is different toward the probability of monetary loss; the higher that assessment, the more attractive insurance is. Consequently, two individuals sharing the same utility index for certain wealth cannot have a different degree of aversion to risk (and the converse).

Dumping. Termination or transfer of membership of the sick and /or older people by the insurer.

Duplicate private insurance. A policy that offers coverage for health services that are already included under a public program. The individual remains covered by the public program but opts to buy and use private health insurance instead in order to obtain broader access or better quality. Individuals are not exempted from making their required contribution towards the public program.

Endemic disease. A sickness habitually present in an area or population.

Epidemic. The occurrence of any disease, infectious or chronic, at a frequency greater than expected, based on prior patterns of disease incidence and prevalence.

Epidemiological transition. The changing pattern of health and disease within a specified population from a predominantly infectious disease pattern of low life expectancy and high mortality, to a predominantly chronic disease pattern of high life expectancy with high morbidity. In the intermediate stage of transition, high survival rates from endemic infectious disease combined with high

rates of chronic illness in survivors results in a “double burden of disease.” The latter is typical of many developing countries.

Epidemiology. The study of any and all health-related issues in specified populations at specified times, including but not limited to the occurrence and frequency of medical conditions, diseases, or other health-related events; identification of the determinants of medical conditions, diseases, health-related events, and health status; the evaluation of medical procedures and diagnostic tests; the evaluation of a health care system; the evaluation of a population’s demand and use of health care services; evaluation of the safety and efficacy of a pharmaceutical product; post-market surveillance of pharmaceuticals to determine product effectiveness and occurrence of side effects or adverse events; and the evaluation of quality of life, access to care, and health status in general.

Equalization reserves. See *Contingency reserves.*

Escrow account management. Implies the use of a special account for managing payments of various obligations. For example, a savings account may be set up to establish funds for paying insurance premiums and loan repayments.

Estimation. The process by which sample data are used to indicate the value of an unknown quantity in a population. Results of estimation can be expressed as a single value, known as a point estimate, or a range of values, known as a confidence interval. The outcome of estimation is the *estimator*.

Excluded population or excluded communities. Typically agricultural, self-employed, or poor people who have neither formal employers nor steady wages as the basis for access to government-run or commercial health insurance. They may also be excluded from housing, education, disaster relief, and other social services. They may also be unable to access financial services or to secure formal recognition of property they control or own, including property obtained under traditional (tribal) law.

Experience rating. A system in which the insurance company evaluates the risk of individuals or groups by examining their health history and claims experience when setting premium rates. *Modified experience rating* places limits on the extent to which rates may vary based on claims experience or health status.

Externalities. Benefits or costs with an impact beyond the parties to a transaction. That impact is not considered in the buy/sell decision and so is not reflected in the price. Pollution is an example of an external cost; safe waste disposal has external benefits.

Fairness. See *Ability to pay.*

Fertility rate. A measure of the total number of live births in a specified population during a specific time period (generally one year) in relation to the midyear total number of women in the specified population. Expressed as the number of live births per 1,000 women within that population.

Fiduciary. A person who holds something in trust for another.

First-line insurer. See *Insurer.*

Fit-and-proper requirements. Rules that reduce the risk of failure of regulated institutions due to incompetent, reckless, or improper risk management by responsible persons and ensure that beneficiaries are protected under legislation and regulations. Such necessary qualities must be exhibited by a person performing the duties and carrying out the responsibilities of his or her position with an insurer. Depending the position or legal form, these qualities could relate to a proper degree of integrity in attitude, personal behavior and business conduct, soundness of judgment, degree of knowledge, experience and professional qualifications, and financial soundness.

Formal sector. The part of the economy / society that is registered with authorities and that is subject to regulations and standards.

Free riding. Exists in health care when persons can benefit from a health care system without contributing to the system.

Gatekeeper. A primary care physician responsible for overseeing and coordinating all of a patient's medical needs. The gatekeeper must authorize any referral of the patient to a specialist or hospital. Except in cases of emergency, the authorization must be given prior to care.

Government failure. Occurs where government does not provide goods and services or an adequate regulatory or support framework for the private sector to provide them.

Gross domestic product (GDP). The annual total value of goods and services produced in a country for use in that country.

Guaranteed access provisions. Rules that can help ensure that any eligible person can purchase health insurance and cannot be refused coverage by a PVHI entity on the grounds of bad health status and/or high likelihood of health services utilization. Legal remedies are provided in many developed countries against improper discrimination for a new member, which address discrimination based upon age, frequency of health service use, existence of chronic disease, illness or medical conditions, or health insurance benefits claiming history.

Guaranteed renewability. Insurers subject to guaranteed renewability standards must renew the policy when it expires regardless of whether the individual has incurred health care costs during the term of the policy.

Health maintenance organization (HMO). See *Managed care plan.*

IBNR provision. Provision for claims incurred but not reported by the balance-sheet date. That is, it is anticipated that a number of insured losses would have occurred and would therefore result in a liability on the insurer upon filing of a claim. The magnitude of this provision can be expected to reduce as the time since the insurance risk on the contract expired extends. The magnitude is also

likely to vary depending on the type of insurance risk covered by any particular class of insurance contract.

Imperfect competition. Occurs in markets or industries that do not match the criteria for perfect competition. The key characteristics of perfect competition are a large number of small firms, identical products sold by all firms, freedom of entry into and exit out of the industry, and perfect knowledge of prices and technology. These four criteria are essentially impossible to reach in the real world.

Income effect. A price reduction that gives buyers more real income, or greater purchasing power for their income, even though money or nominal income remains the same. This price reduction can cause changes in the quantity demanded of the good.

Independence. Two events are independent if the occurrence of one of the events gives no information about whether or not the other event will occur; that is, the events have no influence on each other. For example, falling ill with measles may be independent of being injured in a cyclone.

Induced demand. Demand created by physicians who face inelastic demand and so can set both the price and the level of care. This ability to determine their own income is difficult to control and has great repercussion on health budgets.

Informal risk-protection mechanism. See *Informal sector*.

Informal sector. The part of the society/economy that is not registered with authorities and, whether with legal exclusion or without it (de jure or de facto), is not subject to public regulation and does not benefit from public services or goods. For example, support given by a family, friends, and members of a community in times of loss or illness effectively forms an informal risk-protection mechanism. Despite the presumption that such care is voluntarily given, in some cases (for example, providing care to foster children), payment may in fact be given.

Initial capital requirement. Minimum initial capital that is required to obtain a license, that must be provided before an insurer commences business and that cannot be used to finance start-up costs.

Inpatient. Individual admitted to a hospital for health care and allocated a bed for the duration of that admission.

Insolvency. Inability to meet current expenses from current income plus reserves, leading, in the long run, to bankruptcy.

Institution. Social constructs that contain “rules of the games” and thereby both constrain behavior and enable behavior within those rules. By enabling the individual and organization to understand and predict behavior, the social constructs facilitate economic and social interaction. Institutions include regulations and policies of organizations and governments. They also include community-based traditional patterns of behavior and those that have developed in the face of modernization.

Insurability. A risk is insurable if it is random, and if there is a party willing to accept the risk for an agreed premium and another party prepared to pay that premium (this means it is solvable). This situation implies that the probability is known, it is free of moral hazard and adverse selection problems, that it is a legal proposition, and that the premium is affordable. Practical problems associated with information availability may render otherwise insurable risks uninsurable.

Insurance. Insurance is any activity in which a company assumes risk by taking payments (premiums) from individuals or companies and contractually agreeing to pay a stipulated benefit or compensation if certain contingencies (death, accident, illness) occur during a defined period.

Insurance threshold. Insurers typically request that the insured pay the first part of any claim. This cost sharing is a form of deductible, used to simplify administration by reducing the number of small claims.

Insured. Also called Principal; the end user contracting with an insurer for insurance coverage.

Insured unit. See *Subscription unit*.

Insurer (first-line, primary, or ultimate). The company that contracts with the end user for insurance. The first-line insurer may be the ceding insurer if it chooses to reinsure.

Internal rate of return. The discount rate that makes the net present value of an investment project equal to zero. This is a widely used method of investment appraisal as it takes into account the timing of cash flows.

Late joiner penalties. Payments, often in the form of higher premiums, imposed on consumers who purchase PVHI after they reach an older age, become sick, or do not enroll in a scheme once their coverage by another policy ceases. Protects insurers from adverse selection and encourages consumers to purchase PVHI early.

Law of large numbers. The concept that the greater the number of exposures, the more closely will actual results approach the probable results expected from an infinite number of exposures.

Load. The cost of insurance (administration, finance, and so on) as distinct from payouts (benefits). Efficient companies have a low load relative to benefits.

Local government unit (LGU). The term used in the Philippines to describe public authorities at lower-than-national level (region, province, municipality, barangay).

Macroeconomic. Refers to factors that operate at the national and global levels, for example, exchange rates, inflation rates, and interest rates. The origins of any factors operating at the local level are large scale. Macroeconomic shocks are changes in the large-scale factors that affect the economy and society.

Managed care plan. A scheme that pools risks and directly provides or arranges for health care services.

Mandated benefits. Minimum coverage standards imposed by government in order to ensure that certain benefits are covered, especially when coverage serves a primary or more extensive role. They provide a protection against insurer's risk selection that is discriminatory towards high-risk individuals.

Mandatory private insurance. A system in which individuals or employers are required by law to purchase private health insurance.

Market failure. A condition in which a market does not efficiently allocate resources to achieve the greatest possible consumer satisfaction. The four main market failures are public good, market control, externality, and imperfect information. In each case, a market acting without any government-imposed direction does not direct an efficient amount of resources into the production, distribution, or consumption of the good.

Maximum likelihood estimate (MLE). Provides the best estimate of a population value that makes the sample data most likely. For example, given that a survey of 50 households in a community indicates that 5 percent of individuals have tuberculosis, what is the proportion of tuberculosis sufferers in the community that is most likely to have given rise to this statistic? The MLE techniques enable such calculation.

Mean. Average. It is equal to the sum of the observed values divided by the total number of observations.

Medical underwriting. A process of detailed medical scrutiny of health status used by insurers to counter adverse selection and accomplish four specific goals: ascertain the level of risk associated with the person or group applying for insurance, decide if a policy should be sold, decide the terms of the policy, and decide the premium level for the policy.

Members. See *Subscription unit*.

Microfinance institution (MFI). Provides financial services to the poor on a sustained basis. The services include saving and credit societies, agricultural insurance, property insurance schemes and, more recently, health insurance schemes.

Microinsurance. A mechanism for pooling a whole community's risks and resources to protect all its participating members against the financial consequences of mutually determined health risks.

Microinsurance unit (MIU). A very small finance institution specifically designed to offer health insurance to the poor by pooling risks across a community.

Monte Carlo simulation. A statistical technique in which an uncertain value is calculated repeatedly using randomly selected "what-if" scenarios for each calculation. The simulation calculates hundreds and often thousands of scenarios of a model. Uncertain quantities in the model are replaced with fuzzy numbers to see how that uncertainty affects results. Ideally, the simulation aids in choosing the most

attractive course of action, providing information about the range of outcomes such as best- and worst-case, and the probability of reaching specific targets.

Moral hazard. An insurance-prompted change in behavior that aggravates the probability of an event in order to access benefits, for example, an insured's demanding tests not required on medical grounds (*demand-side moral hazard*). Provider-induced moral hazards include overservicing (supply-side moral hazard).

Morbidity. Refers to illness from a specified disease or cause or from all diseases. It is a change in health status from a state of well-being to disease occurrence and thereby a state of illness.

Mortality. Refers to death from a specified disease or cause or from all diseases.

Multilateral utility. See *Utility*.

Nominal group technique. See *Delphi method*.

Nongovernmental organization (NGO). Generally refers to a not-for-profit or community organization.

Normal distribution. Statistically speaking, values of events fall in a pattern around the average value with known frequencies. For instance, if the average stay in hospital after childbirth is three days, the values of each stay would be distributed around three, some more, some less, approximately symmetrically, with greater concentration around three than around any other number. The normal distribution is a particular distribution of this kind that is rigorously defined mathematically and gives the typical bell-shaped curve when graphed. This distribution is very powerful in enabling insurers to calculate costs and utilization.

Off-site monitoring. Review not involving physical visits to the regulated entities that evaluates the financial condition and performance of these entities, including checking assets and liabilities valuation, off-balance sheet exposures, and outsourcing.

Ombudsperson. An official appointed to investigate individuals' complaints against maladministration, especially that of public authorities.

On-site inspection. A physical examination of a regulated entity to examine if it meets the required contractual standards of all involved parties. This procedure supplements information needed for analysis of the reports submitted to the supervisory authorities. Inspectors can be staff of the supervisory authority or the task can be out-sourced to specialists certified and supervised by the authority. On-site inspections can be conducted on a full scale basis or be focused on investigating areas of specific concern.

Outlier. Denotes events that fall outside the norm. For example, in a "review of utilization" a provider who uses far fewer or far more services than the average is called an "outlier."

Outpatient. Person receiving health care in a hospital without admission to the hospital or accommodation in it. The length of stay is less than 24 hours. The care may be a consultation or a technical act (diagnosis or therapeutic procedure).

Pandemic. A disease that is prevalent throughout a locality or population.

Parameter. A number that describes a characteristic of a population. For example, the life expectancy of men in a community might be 56 years. Health insurance uses statistical techniques to estimate the parameter, and the estimation of the parameter is called the statistic. One sample of 50 men taken from the community might estimate the average age statistic to be 54 years while another sample might estimate it to be 57.5 years.

Pay-as-you-go. Refers to a system of insurance financing under which total expenditure (benefit expenditure plus administrative expenditure) in a given period is met by income (contributions and other sources) from the same period. Pay-as-you-go financed insurance schemes do not accumulate reserves, except contingency reserves; surpluses and deficits translate into increases or decreases in the premium.

Per capita premium. The practice of applying a single premium per head across the population.

Point estimation. An estimate of a parameter of a population that is given by one number.

Poisson distribution. Typically, a Poisson random variable is a count of the number of events that occur in a certain time interval or spatial area. For example, the number of people seeking critical care for malaria in a wet season month in a particular village. The Poisson distribution can sometimes be used to approximate the binomial distribution when the number of observations is large and the probability of success is small (that is, a fairly rare event). This is useful since the computations involved in calculating binomial probabilities are greatly reduced.

Population density. A measure of the size of the population in comparison to the size of a specified geographic area (region, country, province, city). Typically, it is a count of the number of residents per square kilometer.

Pre-existing condition exclusion period. A mechanism that protects the insurer against adverse selection by delaying coverage for health expenses incurred by an individual that is related to a condition the individual had prior to applying for health insurance. The rules governing exclusion period vary, but often can limit coverage to conditions which received medical attention, or conditions for which the person arguably should have sought treatment, or for which there were clear signs or symptoms. Premiums are still due during this exclusion period.

Preferred risk selection. See *Cream skimming*.

Premium. Fee paid by an insured to an insurance company in return for specified benefits. Under social insurance the premium is called contribution. See also *Contribution*.

Premium deficiency reserve. Amount set aside on the balance sheet in addition to unearned premiums with respect to risks to be borne by the insurer after the end of the reporting period. This amount provides for all claims and expenses in connection with insurance contracts in force in excess of the related unearned premiums and any premiums receivable on those contracts. Also provision for unexpired risks.

Prevalence. The total number of cases or people who have a specified disease, health condition, attribute, or risk factor within a specified population at a specific point in time.

Preventive health care. Medical care directed primarily toward early detection and treatment or prevention of disease or ill health (for example, immunizations, prenatal care).

Primary health care. The first level of contact by individuals, families, and communities with the health system, bringing health care as close as possible to where people work and live. The organization of primary health care depends upon the socioeconomic and political characteristics of the country, but should address prevention, curative, and rehabilitation services and include education of the population about major health problems and their prevention and control. Such care may be provided by a variety of health workers, acting together as a team, in partnership with the local community.

Primary insurer. See *Insurer*.

Primary private health insurance. Term is used when private health insurance is the only form of health insurance available to an individual because there is no public option available or one is ineligible for it.

Principal. Denotes the client, in the relationship between an insurer (agent) and the insured (principal). See *Insured*.

Probability. A quantitative description of the likely occurrence of a particular event. Probability is conventionally expressed on a scale from 0 to 1; a rare event has a probability close to 0, a very common event has a probability close to 1.

Probability distribution. The probability distribution of a discrete random variable is a list of probabilities associated with each of its possible values. It is also sometimes called the probability function or the probability mass function. For example, the probability of a woman's delivering a single live baby might be 98 percent, twins 1.78 percent, triplets 0.218 percent, more than triplets 0.002 percent.

Providers. Doctors, nurses, hospitals, clinics, laboratories, imaging facilities, pharmacies, and other deliverers of medical services. The insurer or regulating body typically requires that a provider be qualified or registered in order to be included in a health insurance scheme.

Prudential regulation system. Standards that facilitate proper functioning of insurers through licensing, reporting, financial standards, capital adequacy, and

product regulation, which limit risk-taking of insurance institutions, ensure the safety of depositors' funds, and keep the stability of the financial system.

Public goods. There are two aspects to public goods: it is difficult to prevent non-payers from consuming them (nonexcludable), and their consumption by one party does not affect their consumption by others (nonrival). Vaccination is an example—those who do not pay and are not vaccinated cannot be excluded from enjoying the lower prevalence of disease, and the fact that they are healthy as a result does not affect another's ability to be healthier as a result of the program. Government usually provides public goods, because private businesses do so profitably.

Pure premium. The pure premium can be defined as the average loss per exposure unit for a specific coverage or, more specifically, the product of the average severity and the average frequency of loss. The result is the amount that the insurance company should collect to cover all the losses to be met under the predefined types of coverage.

Qualifying conditions. Requirements for acceptance into an insurance plan; also describes the provisions that must be met before a benefit is payable.

Random variable. A function that provides a single numerical value to a particular event or outcome. The value of the random variable will vary from trial to trial as the experiment is repeated. For example, if 10 people visit a hospital as outpatients in a morning, and 7 of them have injuries rather than disease, the random variable for that event is 0.7. Another example: if the life span of a particular baby born 10 weeks premature in a community is 2 days, 4 hours, and 7 minutes, the random variable of that event is that duration.

Rating. See *Risk rating*.

Reciprocating arrangements. Agreements existing between primary insurers to co-insure, the objective being to stabilize funds. These arrangements are sometimes considered an alternative to reinsurance in that they enlarge the pool and reduce risk variance.

Recovery gap. An excess of benefit payouts over income, when the *compliance gap* is assumed to be zero. The recovery gap is not random and so cannot be solved by reinsurance.

Reinsurance. The transfer of liability from the primary insurer, the company that issued the contract, to another insurer, the reinsurance company. This mechanism allows a diversification of the risk and enlarges the risk-pooling base, thereby reducing the risk of insolvency. However, reinsurance extends only to risk defined in the cession contract (called Treaty). For example, a treaty to cede fluctuations in payouts will not cover the primary insurer against the financial risk of insolvency, for example, because of poorly run or unviable insurance.

Reinsurance premium. The amount charged by the reinsurer to accept an agreed amount of risk.

Reinsurance threshold. Reinsurers typically require that the insurer retains the first proportion of risk for any event. That proportion is the threshold as it is equivalent to the deductible or excess borne by the insured when making a claim against property insurance.

Reinsurer. An insurance company for insurers. A reinsurer offers protection through the sale of a reinsurance contract to a risk-transferring policyholder who is an insurer. If the risk-transferring policyholder is a (re)insurer itself, the risk-assuming insurer is called the reinsurer, and the risk transfer is known as (retro)cession.

Renewability. See *Guaranteed renewability*.

Reserves. Funds set aside to meet unforeseeable liabilities (i.e. an obligation that has not yet materialized) or statutory requirements, and stemming either from shareholders' capital or, in the case of mutuals, members' contributions and from accumulated surplus. Reserves are part of the own funds (in contrast to provisions that support liabilities to parties other than shareholders or other owners. A major financial management goal is to minimize reserves and thus maximize funds available for current use.

Risk. The probability or likelihood that a specified health event (for example, the occurrence of a disease or death) will occur to an individual or population group within a specific period of time.

Risk-based capital model. Applying ongoing solvency standards based on the level of risk assumed by an insurer (including investment, credit, insurance, and operational risks, and weighing out uncorrelated factors to calculate the minimum capital level).

Risk equalization. Provisions under which insurers with higher-risk profiles receive a transfer of funds from insurers with lower-risk profiles. Used in many countries with community-rating schemes.

Risk factor. An attribute (for example, a lifestyle factor or a personal characteristic) or an exposure to an environmental factor associated with an increase in the probability that a specified health event (for example, onset of disease) will occur.

Risk pooling. A health system function in which collected health revenues are transferred to purchasing organizations, and the pooled risk of bearing the financial burden of health services is shared and dispersed over large numbers of heterogeneous contributors. Insurers pool risk through reinsurance.

Risk rating. Calculation of health insurance premiums based on the risk of each client. When the premium is calculated based on the risk not of a single individual but of a group, this is called *community rating* or *group rating*. When the premium is set in relation to the client's income, this is called *income rating*.

Risk segregation. Each individual faces his or her own risks without pooling.

Risk selection. A practice of excluding those who may present a higher risk for the insurer by making more frequent or more costly claims.

Risk sharing. Individuals agree to split the cost of risky events. Insurers share risk through reciprocal relationships and reinsurance. Loan guarantees and insurance are among the many ways of sharing risks.

Safety coefficient. A measure of the difference between the expected annual result of an insurance scheme and the worst possible loss that can be borne. Information on the safety coefficient enables management to make better decisions about reserve levels.

Self-insurance or self-protection. Refers to all the arrangements made by an individual or group to protect themselves from risk. It includes not only saving and establishing contingency reserves but also changing behavior to diminish or avoid risk.

Simulation. The technique of imitating behavior and events during an experimental process. Typically involves a computer.

“Small country [financial system] rationale.” Establishing one centralized, integrated supervisory body due to scarce human resources necessary to administer regulation. Common in many transition and developing economies based on a desire to achieve economies of scale in regulation.

Social capital. Refers to the multidimensional “glue” that binds community members together. While concepts of social capital vary from culture to culture, Putnam (1993) defined it as including trust, community involvement, tolerance of diversity, value of life, and extent of connectivity (socially and professionally).

Social exclusion. Inadequate or unequal participation in social life, or exclusion from a place in the consumer society, often linked to the social role of employment or work.

Social insurance. An insurance program that is shaped by broader social objectives than just by self-interest of each individual principal or agent, while retaining insurance principles that persons are insured against a definite risk.

Social protection. Policies and programs designed to reduce poverty and financial vulnerability. Social protection policies typically focus on labor market policies, social insurance, social assistance, community-based schemes, and child protection.

Social reinsurance. Reinsurance undertaken in pursuit of social goals rather than profit.

Social utility. The gain to society from, in this case, insurance. Where insurance has zero or negative social utility it may be banned; where it has high social utility but low private utility it may be mandated. The choice of rendering a public utility mandatory or not depends on political will or the power of authorities, including community leaders.

Soft budget. A budget with a flexible limit.

Solidarity principle. Applying rules that spread risks and resources across members of a group in a way that provides both insurance coverage and egalitarian distribution. *Risk solidarity* would imply that high-risk individuals receive a subsidy

from low-risk individuals, allowing all risk levels an equal access to health care coverage. Solidarity between high- and low-income individuals, or “*income solidarity*,” implies income redistribution through organized transfers. In insurance, the solidarity principle is juxtaposed to the *equivalence principle*, which implies that the insurer has to break even on each insurance contract, by applying *risk rating*.

Solvable. An insurance transaction is said to be solvable if the risk is observable; there is no antiselection (adverse selection), and the premium is acceptable to both parties.

Solvency margin. Surplus of assets over liabilities.

Solvency requirements. The whole set of statutory requirements or rules as regards the required solvency margin and eligible capital elements to cover the margin. The set includes the performance of the solvency test to prove compliance with these requirements.

Solvent demand. See *Demand*.

Spot market transaction. The “spot market” implies transactions for immediate delivery of services as distinct from the insurance requirement of prepayment against (possible) future delivery of services. Populations that are excluded from health insurance rely on spot payments to access health care.

Standard deviation. A statistical term for a measure of the variability in a population or sample.

Subscription unit. Refers to the people covered by a single membership. This may be the individual (usually in developed economies) or the household (usually in developing economies).

Supervisor. An administrator of insurance laws responsible for supervision of the management of an insurer or intermediary. Also supervisory agency/regulator.

Supplementary private health insurance. Provides coverage for health services that are not covered by a public program, such as luxury care, elective care, long-term care, dental care, pharmaceuticals, rehabilitation, alternative or complementary medicine, or superior amenity services in the hospital (differs per country).

Swaps. See *Derivative*.

Target group. Refers to both current and future beneficiaries of the insurance system. The target group can comprise several subgroups of people with similar characteristics (for example, income, economic sector).

Technical provisions. Funds for outstanding claims or unearned premiums, required by supervisors. Also reserves.

Top-down global strategy. Implies that a public policy, for instance the approach to improving access to health care or health insurance, was directed by a powerful global body to national governments and down through the rank and file

to the community. This contrasts with the “bottom up” approach based on the empowerment of communities.

Transaction costs. The costs additional to the price of a good or service, arising, for example, from search costs, travel costs, marketing and distribution, or transfer of ownership costs.

Ultimate insurer. See *Insurer*.

Underwriter. A company that receives the premiums and accepts responsibility for the fulfillment of the policy contract; the company employee who decides whether or not the company should assume a particular risk; the agent who sells the policy.

Underwriting. The process by which the insurer decides what risks to cover. The profit objectives may conflict with social obligation. For the reinsurer, underwriting considerations determine the risks of the primary insurer that can be accepted for reinsurance, and which the insurer will retain.

Underwriting assistance. Reinsurance companies gather extensive data on the insured and events. They can share this information with insurers to improve the performance of insurers.

Unearned premiums. A type of technical provision for premiums received but not yet earned. Figure on the balance sheet representing the part of premiums written that is to be allocated to the following financial year or to subsequent financial years.

Unilateral utility. See *Utility*.

Uninsurable. See *Insurability*.

Unit cost. The average cost of particular health care treatments. These costs are negotiated between a microinsurance unit and providers. Insurance enables a move away from fee-for-service toward averaging out of unit costs.

Universal coverage. Implies that all members of a country (or a community) have health insurance.

User fees. Charges payable by users, usually at the point of service. See *Spot market transactions*.

Utility. The satisfaction gained from having the desire for goods and services met. Multilateral utility means that several parties benefit from outcomes. These parties can be a group of insureds or the insurer and the insured. Unilateral utility means that only one party gains. The balance between group and individual utility is a delicate component of relations within a community, between insurer/insured, or between insurer/reinsurer.

Utilization. Refers to utilization patterns of medical services in a location over a period. Data on recent utilization, collected at the national and community levels, are a valuable asset in predicting future patterns.

Variation coefficient. See *Coefficient of variation*.

Vector-borne infectious disease. Infections caused by human contact with an infectious agent, transmitted from an infected individual by an insect or other live carrier. For example, malaria is biologically transmitted from an infected individual to a noninfected person by the same mosquito (the vector) biting both people.

Waiting period. A mechanism that protects the insurer against adverse selection without significantly restricting access by delaying the period before an individual will be covered for any services he or she receives after the effective date of coverage. Policy premiums are still paid during this time.

Working capital. Current assets minus current liabilities. It is the capital available for an organization's short-term financing.

Willingness to pay (WTP). See *Ability to pay*.

NOTE

This glossary was adapted from "Glossary of Terms," appendix B in *Global Marketplace for Private Health Insurance: Strength in Numbers*, Alexander S. Preker, Peter Zweifel, and Onno P. Schellekens, eds., 443–59, World Bank, Washington, DC, 2010.

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