Opting Out of Mandatory Health Insurance
In Latin American Countries

Implications for Policy and Decision Making
in Russian Federation

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March 2003

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Document of the World Bank
This paper explores the Latin American structure and experience on “opting out” from mandatory health insurance, focusing on the following aspects and impacts that could be useful for policy decision-making in the context of Russian Federation insurance reform proposals, including:

- Access and quality;
- Utilization;
- Impact on public insurance programs, especially costs;
- Regulatory apparatus necessary;
- Any policy initiatives to change the regulation in the past or present; and,
- Issues related to social insurance and pension insurance funds.

**Opting Out Concept**

In principle, everybody has to participate in mandatory health insurance: public and private employees, the self-employed, pensioners, students, and the unemployed. There maybe legal exceptions, such as the military (Chile) that would keep their own parallel health care financing and delivery system. In other cases, retired military personnel participate in the national social health insurance system (Israel) with contributions paid by the Ministry of Defense on behalf on behalf of the pensioners. Large State enterprises may keep their own health care financial schemes contracting services with both the private and the public sector (Petroleos de Mexico) after signing agreements with the Mexican Institute of Social Security that de facto allows the opting out.

To opt out is to decide to leave or withdraw. Opting out from mandatory health insurance is the faculty given by Law to individuals (and also it could be to employers for their employees when employer-based group health insurance is permitted) to leave the compulsory health insurance system and seek health care financing privately, under the conditions established in the same Law and its regulations.

Opting out could be established in full, meaning that no financial solidarity contribution is made to the national social health insurance system (Chile), where the 7% of mandatory health insurance contribution goes in full to the private sector; or partial, with a solidarity contribution to the national system (Peru), where the 1% employer’s contribution goes to the Peruvian Institute of Social Security, and the employee’s contribution (8%) goes in full to the private system of health care financing.

The following are the essential features of opting out:

⇒ *Opting out is financial.* In principle, it means “no payments, no benefits”, that is, if there is no payment of contributions to the social health insurance system, there is no access to the social insurance financing for health care goods and services.
Opting out is temporary, for as long as the individual has a valid private health insurance policy.

Opting out is not absolute, it does not mean forgoing the benefits of a right to health care to be paid eventually by the State, regardless of contributions, or to return to the mandatory health insurance system.

Opting out is not definitive. In countries with an established (usually Constitutionally-based) right to health care, one can secure public health care services in case of illness or infirmity excluded from private health insurance financing and also in catastrophic cases not covered by private insurance policies.

Opting out is not unconditional, the reason being that health care entails benefits in kind (goods and services) that cannot be denied by the State to its population in need as the health care financier and provider of last resort.

Rationale

Opting out from mandatory health insurance has gain adepts since openly established in Chile (1980’) as part of the drastic social security reform that aimed, among others, at privatizing the health care financing and delivery. In addition, in many developing countries, and also in transitions economies, there is an emerging although modest private sector for the financing of private health care largely unregulated (pre-payment schemes, some formal health insurance offered by general insurance companies to life insurance clients, and health insurance proper). In countries with a formal private health insurance and where middle and high incomes of the population and large corporations purchase private health insurance, double payments to the public system and to the private plans lead to consider the adoption of opting out policies. The emerging private health care delivery system (small clinics, laboratories, individual and group practices by physicians) needs access to private financing and these vested interests exercise considerable influence in favor of opting out.

The main arguments to justify opting out from mandatory health insurance are:

Encouragement private sector financing through private health insurance. Opting out policies stimulates opportunities for the private sector encouraging the development of private health insurance. People leaving the mandatory system need to seek formal health insurance coverage in the private sector. This is usually demanded by the Law as condition to opt out from the public system.

Reduction of employment costs by eliminating double coverage. In most countries, employers and employees pay mandatory health care contributions. Chile, where only employees contribute, is an exemption. In some cases, employers pay contributions to public mandatory health insurance and to voluntarily private supplementary schemes. When there is double payment, employment costs are higher. Opting out policies would eliminate this double payment.
⇒ *Strengthening the private provision of health care.* Private health care financing makes investing in private health care delivery attractive. Private financing allows capital investments in clinics, laboratories, and high tech medical equipment leading to the modernization of the health care sector. Competition among health care providers flourishes and this increases efficiency. This market-based competition also serves to select the more qualified providers that will access to private sector financing, ensuring quality of care.

⇒ *Relief of pressure on public budgets.* With less people demanding health care goods and services from the public financing and delivery system, more resources are available in the public sector to provide coverage to those in the mandatory system.

**Impacts on Revenues and Equity**

The counter-rationale arguments are not against opting out as a matter of principle. Opting out policies raise questions of equity when total financial opting out from the mandatory system is allowed.

⇒ *Loss of high/medium income for SHI.* The most critical effect of opting out policies is that the social health insurance system is deprived from the contributions of medium and high incomes. Whatever the percentage of these contributions they are extremely significative since they are based on payroll income. A 7% of a medium income represents many 7% of minimum or average incomes. The reality is that public health care spending is not fixed and continues to expand. The loss of revenue gradually degrades the financial sustainability of the social health insurance system.

⇒ *Need for fiscal subsidies.* The loss of income from opting out means less revenues to finance health care goods and services for the majority of the population. Inevitably, less financing available means the increasing impoverishment of public health care provision. Thus, the resulting the need for fiscal subsidies to compensate the social health insurance system for the loss revenues. Regrettably, experience shows that fiscal subsidies do not take place, and if its does, its is insufficient. In Chile, for instance, the loss of income by the social health insurance system has not been effectively replaced with transfers from income generated by general taxation.

⇒ *Abandonment of solidarity.* Opting out means the decline of cross subsidies from the affluent to the poorer. In essence, the abandonment of the principle and praxis of solidarity. Requiring some (1, 2 or 5%) compulsory solidarity contribution when opting out serves to keep the principle of solidarity alive.

⇒ *Inequities.* Opting out institutionalizes a dual system of health care financing and provision. Because there are many forms of direct and indirect subsidizing of the private health care system for the more affluent, the opting out policy institutionalizes an inequitable health care system. Allowing voluntary private health insurance on top of mandatory health insurance avoids this issue. But, it is
unappealing to the medium and high-income populations since it involves double payment for health insurance, and the adoption of opting out policies would tend to satisfy these politically and economically influential populations.

⇒ Private health insurance for the more affluent. There is no question that opting out has a positive impact in the development of private health care financing, provided it is properly regulated. The expectations of population to have access to financial coverage with private health insurance, however, should be moderate. Private health insurance will be available mainly to medium and high incomes, and not to mainstream workers and employees. They will not be able to afford the cost of the premiums. Private health insurance is a business and not a form of social protection. As such, private insurance companies will reach for the healthy and affluent, and hopefully young, to minimize losses (payment of claims). The health insurance industry will also impose its own terms and conditions into health insurance policies, with exclusions, strict pre medical conditions, waiting periods, co-payments and deductibles, if possible. Therefore, private health insurance needs to be properly (although not cumbersomely) regulated. An overly regulated insurance industry or subject to legal, fiscal or bureaucratic barriers that preclude its development as business for profit will not flourish.

Impacts on the Delivery of Services: Access, Quality, and Other Issues

Access and Quality

Access: opting out institutionalizes a dual health care system based on income differentials. One, the social health insurance system, for the majority of the population with access mostly to public health care providers and for a defined package of services (basis benefits package), and only to limited private providers under contract with the social health insurance system; and, another private one for those that can afford private health insurance with access mainly to private health care providers usually to a broader scope of services depending on the health insurance plan purchased, and to limited but quality public providers (usually tertiary care) under contracts. In Chile, the average income of people opting out towards the private sector is seven (7) times the average income of those that remain in the public health care financing system.

Quality: private financing usually brings with it the provision of increased good quality of care. It comes at a cost, though. Private financing is not interested in financing basic packages of care. The administrative cost involved in managing basic health insurance polices is too high and barely profitable, if at all. Private insurance businesses are interested in financing the basic package (sometimes required by law, as it has been proposed in Russia) provided that they can also sell additional packages that are the ones that bring with them most of the quality of care (availability of longer lists of qualified providers to select, more coverage of goods and services, better clinics and diagnostic laboratories), all at additional premiums for the insurer. It is here where the private financing business lies. The predictable consequence is that overall health care expenditures increase, as private insurance practices induce the supply and demand of health care goods and services at escalating costs.
Utilization

International experience with opting out in developing countries is modest, as should be expected. Only those with sufficient income (medium and higher incomes) can afford opting out and seek the private health care financing.

In Chile, a middle-income country with a substantial middle class, opting out to private health insurance at its peak (1998) was accessible to only 27% of the population, with almost ¾ of the population relying on the national social health insurance system. With later recession and increase in unemployment, this figure has gone down to close to 23%. For medium income individuals and families it is not unlikely that one of the first items to be discarded if the work/income situation change is regular payments for private health insurance premiums. In Peru, private health care financing utilization is less than 7% (1997), and it is substantially less today given the economic situation in the country. For the sake of comparison and to strengthen the notion of the limitation in coverage of private health care financing, in Mexico, supplementary private health insurance is estimated to cover around 10% of the population.

What utilization of private health insurance could be expected in Russia if full opting out is approved? A reasonable expectation would be from 10% to 30%. A simulation should be conducted to have a more accurate estimate.

Impact on Public Insurance Programs

The impact of opting out policies on social health insurance is huge, and devastating. The loss of medium and high incomes inflicts a substantial damage into the overall revenues of the mandatory health insurance system. This means lower operating budgets for social health insurance. Ministries of finance would tend to be reluctant to make transfers from general tax revenues to compensate for the loss revenues. Health care expenditures are not fixed, and the diminishing financial resources translate into low quality of publicly financed and provided care, queues, and, inevitably, to under-the-counter payments.

In Chile, the difference between per-capita expenditure in the public and private sectors is significant, $65 and $250, respectively, representing a reduction in public sector financing out of general taxation from 80% of total revenues to less that 40% (1990).

Additionally, since nothing can preclude people that have opted out to come back to the social health insurance system, their coming back means further financial constrains into the system. And it is not unusual for middle-income people to go back to the national health care system if work and income conditions change. The very affluent will always rely on the private sector.

Policy Initiatives to Change Past or Present Regulations

Once opting out is institutionalized it creates powerful vested interests. On the one hand, the development of the private health care financing industry, health insurance and other financing modalities, and on the other the elite of private providers that have access to private health care financing. Once established, these interests are very difficult to fight. Therefore,
not many initiatives are found to change the dual system, aside fine-tuning it. Chile is a case in point.

Issues Related to Social Insurance and Pensions

Pensions. In funded pension systems, where the risk for pension age income rests with the pensioner and said income depends on the contributions accumulated and their income return, it is for the pensioner to purchase h/her social health insurance. If the pension is bellow or only above the minimum income, the State needs to provide with some kind of subsidy. In Chile, it is estimated that 50% of the work force will not have sufficient social security, and that a ¼ of the population will receive too small a pensions, and will have to rely on State minimum pensions at 75% of poverty level (minimum wage), and access the social health insurance system, the National Health Fund, for basic health care financing.

In pay-as-you-go pension systems, the following issues are matters that need to be regulated by the Pension Fund:

- Who should pay for the health insurance contributions for pensioners? Usually, it is the Pension Fund, by deducting the health insurance contributions corresponding to the pensioner from the pension payment. An option is for the Pension Fund to pay both the pensioner’s contribution (deducted from the pension income) and additional contribution out of the general income of the Pension Fund in a proportion to be determined.
- How much should pensioners pay for social health insurance contributions?
- Should some pensioner’s contributions be subsidized depending of the level of the pension income?
- Should Pension Funds pay for social insurance contributions for individuals with medium/high income that have private health insurance policies?

Unemployment. A major issue in social protection policy is to determine how to provide access to health care financing for the unemployed. Many options can be found, such as unemployment insurance, and social funds intended to alleviate poverty and unemployment finance projects targeting the chronic poor, including some basic health care. For instance, Chile's FOSIS, created with the explicit purpose of targeting the chronic poor, has a bank for its own projects alongside financing it receives from communities; Peru's FONCODES, also created to attack structural poverty, has launched a massive school-desk manufacturing program, for which it identifies small vendors and contracts the supply directly.

But these programs do not finance health insurance contributions. Since free health care does not exist, subsidies and fiscal transfers are needed to serve the unemployed population, subsidies and transfers not always available, and when available, sometimes not in full and timely.

Informal sector. Few countries have programs to attract the people in the informal sector to make contributions to social health insurance. Even when programs do exist, lack of information and bureaucratic barriers has been a problem for their implementation. A major
deterrent is fear that tax authorities would be notified of names, addresses and of any income declared for purposes of calculating social health insurance contributions. In Mexico, informal sector workers are entitled to social health insurance benefits in exchange for a nominal annual payment, but implementation has been not significant due to the problems noted above.

*Flexible employment.* For people working under flexible labor market schemes (part-time, work at home) it is hard to participate in the social health insurance system. First, sometimes their status is not clear. Most employers will use civil contract in the form of services contracts to avoid paying social contributions. Workers under this condition will be excluded from participating in the social health insurance system as employees. And, it is unlikely that they would have sufficient income to purchase private health insurance, with the exception of high level professionals. Second, even if employers do sign labor contracts under flexible employment rules (new rules in force or new ones about to be incorporated into labor codes in many developing and transition economies), the status of these workers may not be clear for the social insurance fund.

How to calculate the contributions for people in “flexible employment” if they are not full time employees? Based on hours worked? How to determine the rates and the benefits they are entitled to?

*Irregular employment.* For those with irregular formal employment, the situation is also complex. Professionals may have access to private health insurance when employed. If having opting out, what happens during the interim period between jobs? What happens if the income from the next job does not allow purchasing private health insurance? How to maintain continuity in the social health insurance system?

**Other Issues**

*Contribution rates.* Determining the contribution rates of employers and employees should be explicit and incorporated into the Law. Contributions rates should not be left for annual budgetary laws to decide. This brings with it uncertainty and makes business planning difficult. Also, the burden of health insurance contributions should be place upon both employers and employees, and avoid the Chile model in which only employees contribute. In opting out, the full or at least 50% of employers contributions should be considered solidary contributions. Likewise, individuals opting out should make some solidary contribution to the mandatory health insurance system to subsidize the ones that stay in the system and to have made some contribution to the social system in case they return to it.

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<th>EXAMPLES OF CONTRIBUTIONS TO HEALTH INSURANCE</th>
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*Private financing industry development.* An opting out policy needs to be accompanied by other policies and legislative and institutional measures aiming at creating the conditions for
the consequent development of private health care financing and its regulation, the expansion of private provision of health care goods and services and its regulation, and the general regulation, supervision and control of the private health care sector.

Conditions need to be established for the development of the health insurance industry. Normally, this means reforming the general insurance legislation or the enactment of a specific Health Insurance Law. Norms may need to be introduced, and some may mean amendments to civil and commercial codes on corporate form for health insurance companies (usually joint stock companies), minimum capital and reserves requirements, ownership avoiding restrictions of foreign ownership, reporting, accounting, auditing; and on health insurance polices, exclusions, restrictions, claims procedures, rights of the insured, and the like.

One should have in mind that formal health insurance is NOT the only way for the private sector to financed health care. Forms of the so-called managed care or pre-payment schemes, better to be identified as subscription health care plans, should also be considered from the onset and regulated appropriately.

*Private health care financing regulation and supervision.* A specialized insurance regulator should regulate health insurance. An option is to have a specialized and relatively independent Health Insurance Supervision Department within the State Insurance Supervisory Authority. Another option is the creation of a separate Health Insurance Superintendency model, following the Chile model, although the Chilean experience has been mixed with private sector having exercised too much influence in the Superintendency (unlike the case of the Pensions Superintendency).

The primary business of health insurance companies is to manage financial risk, not to provide direct health care goods and services. Consequently, they are regulated as specialized insurance companies, and not by the ministries of health as if they were a kind of health care establishments.

Being health insurance a very special type of insurance, it should be separated from life insurance, to avoid the cross subsidizing of one with the other.

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**PRIVATE HEALTH INSURANCE**

A. TYPES:
- **Reimbursement**, where health insurance companies provide repayment for defined health care expenditures incurred by the insured.
- **Subscription**, where health insurance companies manage pre-paid premiums for a certain type and volume of heath care goods and services provided by one or more contracted health care providers.

B. BASIC FEATURES
- Business of insurance conducted by health insurance companies incorporated under Commercial Law, General Insurance Law, and the Health Insurance Act.
- Licensed by the State Insurance Authority.
- Regulated and supervised by the State Insurance Authority.
Subscription healthcare plans are usually not considered to be the business of insurance *strictu sensu* and are not required to be conducted by health insurance companies when the primary business of subscription is the administration of the provision of health care goods and services financed with pre-payments, and *not* the financing of said goods and services. When the volume of the business increases to a level to be defined in regulations by the State Insurance Authority, the subscription business becomes a primary business of insurance and it is regulated as such.

The regulatory authority needs to pay due attention to administrative costs incurred by the private health insurer to avoid inflating the premiums. Also, it is critical to limit the number of plans to be offered by the private sector. In the case of Chile, with some 3,000 different plans, the cost of administering and marketing them is disproportionate.

**SUBSCRIPTION HEALTH CARE PLANS**

**BASIC FEATURES:**
- Business of managing the provision of health care goods and services on a pre-payment basis.
- Conducted by legal persons.
- Licensed by the State Insurance Authority as subscription health care companies.
- Regulated and supervised by the State Insurance Authority.

**Socio-Economic Correlations**

There are many correlations that need to be taken into consideration regarding opting out. For instance, the following:

- **Income.** Only those with high or medium income can afford opting out and purchasing private health insurance.
- **Labor status.** Only those in the formal labor market or high income self-employed will have access to private health insurance.
- **Urban vs. Rural.** Most likely, private health insurance will be available in urban and relatively developed areas.
- **Education.** Most likely people having at least completed secondary education will understand and have the means to opt out.
- **Discrimination.** Experience seems to show that the elderly and females in fertile age are discriminated by the private sector with higher premiums.

In sum, some of the policy issues to be discussed are the following:

- Should financial opting out be allowed at all?
- If financial opting out is allowed, should it be total or partial, meaning the requirement of making some regular solidarity contributions to the social health insurance system in order to opt out?
- Which are the conditions under which opting out is allowed?
• Which are the minimum conditions, if any, for returning to the mandatory health insurance system?
• How to compensate the mandatory health insurance system for the loss of revenue from the contributions of those that opt out?
• How contributions rates for employers and employees are determined, including solidarity contributions, if any?
• Will private health care financing be provided only by health insurance companies or also by subscription plans?
• How will private health care financing be regulated, supervised and controlled?