



## Choosing a regulatory framework for private health insurance

In a consultation paper released February 16, the Quebec government chose to follow a very restrictive interpretation of the Supreme Court ruling in the *Chaoulli* case. The government document suggests providing guaranteed access for certain treatments and permitting private insurance only for knee, hip or cataract surgery. However, it would be well worth broadening the discussion to include a model the court decision hinted at, namely duplicate insurance covering all types of health care.

Duplicate insurance covers medical care for persons who nonetheless retain access to the public system (and are required to contribute to it through their taxes) but who wish to be treated in a parallel private system<sup>1</sup>. This Note examines practical ways of establishing such insurance and indicates regulatory pitfalls to be avoided.

### Providing protection against risks

It is important to recall what insurance consists of. It involves covering oneself, through the payment of premiums, against unforeseen events that can cause substantial financial loss. Based on predictions concerning the probability of a given event occurring, insurance companies issue policies requiring premiums that provide adequate compensation for expected outlays. This is how the risks incurred by a group of individuals are pooled.

Insurance provides for a transfer of resources over time, from periods when insured persons are healthy and paying premiums to periods when they are ill and receiving benefits, as well as between insured persons who are ill and those who remain healthy. The latter also derive benefits from their coverage: they have bought peace of mind.

Individuals may have insurance preferences that vary according to personal characteristics: aversion to risk, age, occupation, family status, current or expected state of health based on family



history, and so on. Insurance companies should be able to offer different applicants the policies that suit them best.

Regulatory goals that go against the basic logic of insurance will obviously have perverse effects. It is important to understand that the purpose of insurance is to cover yourself against risk rather than against certainty. Just as motorists cannot insure themselves against automobile accidents after their occurrence, you cannot logically expect that a person who already has an illness could

take out insurance to cover the cost of care.

Countries with private health insurance use various types of more or less restrictive regulation, aimed primarily at making insurance accessible and at dealing with how to finance the expenses of persons at high risk. They focus on two factors in particular: insurance premiums and, to a lesser degree, the content of policies.

### Regulating insurance premiums

Since insurance companies sell risk coverage, they normally require higher premiums when they judge that a customer presents a higher risk. Governments can impose uniform premiums (or “community rating”) as opposed to premiums that vary based on risk or individual characteristics. Premiums can then be set according to a community’s average estimated risk.

1. For more on this topic, see the Economic Note titled “Using private insurance to finance health care,” published by the MEI in November 2005 and available at [http://www.iedm.org/uploaded/pdf/nov05\\_en.pdf](http://www.iedm.org/uploaded/pdf/nov05_en.pdf).



The purpose of such a measure is to make it easier for persons at high risk to gain access to insurance. Australia, Ireland and several U.S. states have experimented with this type of regulation.

A fixed-premium system such as this has some major drawbacks compared to a risk-rated system, however.<sup>2</sup> With insurance companies prevented from varying their premiums based on individual risk, the “low risks” (healthy people) have to subsidize the “high risks” (people who exhibit risky behaviour or who have family histories of illness, etc.). In the short term, low risks pay more than they would with variable premiums while high risks pay less.

This transfer is quite different from what happens normally in a given risk category between people who are ill or injured and everyone else. As noted above, this type of transfer underlies the very concept of insurance and has no effect on individual behaviour. On the contrary, community rating alters demand for insurance based on each person’s risk category.

Low risks will thus tend to go uninsured or underinsured while high risks are likelier to insure themselves and to seek more extensive coverage. This raises average risk for customers and increases outlays by insurance companies. The result is higher insurance premiums.

What happens in the long term is that high risks will end up paying nearly the same premiums as they would in a risk-rated system and low risks will insure themselves less. This is not very efficient from an economic or social standpoint. When insurance companies can, in contrast, use available information to set premiums, they are better able to offer a range of policies meeting the varied needs of individuals who wish to insure themselves.

However, the non-existence of regulations that impose community rating does not mean premiums will necessarily be determined solely by individual risk or that persons at high risk will be excluded or will have to pay exorbitant amounts. In Belgium, for example, mutual insurance companies apply uniform premiums for supplementary insurance (covering extras or services uninsured by the public system), and for insuring self-employed workers against minor risks, without being obliged to do so. Conversely, sickness funds are required to apply uniform rates but have the right to limit insurance coverage to given groups.<sup>3</sup>

Forms of insurance providing for greater risk sharing between individuals at a given time and for risk sharing over time have been developed voluntarily in several countries. This applies in particular to group insurance and to policies with guaranteed renewability. In the former case, insurance companies may find it advantageous to offer policies with uniform premiums for certain groups of persons as a way of lowering administrative costs or broadening their customer base. Group insurance offered in connection with employment is already well established in the supplementary insurance field in Canada.

In the latter case, guaranteed renewal insurance was developed to attract young, healthy customers in particular. It establishes uniform premiums over time and maintenance of insurance for persons who later become high-risk customers.<sup>4</sup> It guarantees, for example, that someone who contracts a chronic illness or suffers a serious injury after taking out an insurance policy (or after a certain time) remains insurable under the same terms. Premiums may increase with age or general price rises but do not go up with changes in individual risk from one year to the next.

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In Australia, age-based premium adjustment with lifetime cover was introduced in 2000 to encourage young customers to take out insurance and retain it over the years. This formula limits somewhat the perverse effects of community rating. In the United Kingdom and Spain, it is traditionally practised voluntarily. In the United States, it is currently obligatory for individual insurance. A study has shown, however, that 80% of insurance policies contained similar renewal conditions long before the legislation.<sup>5</sup> These types of insurance are worthwhile for insurance companies as well as for employers, employees and self-employed workers. They could be developed voluntarily for duplicate insurance.

Making insurance accessible is an admirable goal, but for insurance to remain profitable, regulations must not go against rational risk management or the very notion of insurance. Imposing uniform rates does not work in achieving this aim, though other measures adopted voluntarily do have this beneficial effect.

2. See in particular Mark Pauly, *Statement Before the Joint Economic Committee*, September 22, 2004, available at [http://jec.senate.gov/\\_files/PaulyTestimony.pdf](http://jec.senate.gov/_files/PaulyTestimony.pdf).

3. Organisation for Economic Co-operation and Development, *Private Health Insurance in OECD Countries*, 2004, p. 78.

4. See in particular Vip Patel and Mark V. Pauly, “Guaranteed Renewability and the Problem of Risk Variation in Individual Health Insurance Markets. A Way to Stabilize Coverage with Less Government Interference,” *Health Affairs*, August 28, 2002, available at <http://content.healthaffairs.org/cgi/content/full/hlthaff.w2.280v1/DC1>.

5. See the website of the U.S. Department of Labor at [http://www.dol.gov/ebsa/faqs/faq\\_consumer\\_hipaa.html](http://www.dol.gov/ebsa/faqs/faq_consumer_hipaa.html) and Mark Pauly, *op. cit.*



### Examples of benefits provided by the BUPA insurance company in Ireland

Plan (annual premium)	Essential (€312)	Health Manager (€655)	Health Manager Gold (€1643)
Diagnostic tests (MRI, CT or PET scans, etc.)	Yes	Yes	Yes
Private room in a public hospital	No	Yes	Yes
Private room in a private hospital	No	Yes (€126 deductible per hospital stay)	Yes (no deductible, includes two high-technology clinics)
Accommodation costs for maternity	Up to €1,700	Up to €2,700	Up to €3,000
Postpartum convalescence if sought by a specialist	Up to €30 per day	Up to €60 per day	Up to €75 per day
Healthline	No	Yes	Yes
Deductible or copayment for services below	€250 for an individual policy	Half of expenses to a maximum of €7,650 per year	Half of expenses to a maximum of €7,650 per year
Visit to a general practitioner	Up to €20 per visit	No limit	No limit
Physiotherapy	Up to €20 per visit	No limit	No limit
Visit to a specialist	Up to €51 per visit	No limit	No limit
Cancer screening	Up to €30 per year	No limit	No limit
Health check every two years	No	Yes	Yes
Sports health screen	No	No	Yes

Source: BUPA Ireland website, <http://www.bupa.ie>, visited on January 11, 2006.

policies in Ireland). Some U.S. states require a set of standardized benefits. No country limits coverage to a very small number of services as proposed by Quebec's minister of Health in his recently released consultation paper.

Regulating the content of insurance makes it less flexible and less attractive, for suppliers and applicants alike. Requiring minimum coverage has the effect of inflating premiums and limiting access to insurance. This ranks among the causes of higher health care costs in the United States.<sup>6</sup> Furthermore, limiting insurance to certain very specific treatments, such as those with the longest waiting lists, would restrict the possibility of sharing risks, thereby reducing considerably the attraction of insurance.<sup>7</sup> Private health insurance and health care services will develop in any case by focusing first on the sectors where waiting times are longest and the needs greatest. It is up to consumers and

suppliers, however, to find a point of equilibrium based on their means and their preferences.

## Regulating the content of insurance policies

Another form of government intervention consists of regulating the content of insurance policies. In most OECD countries, there is little or no regulation of the benefits that private health insurance must offer. In some cases, however, there is regulatory involvement in guaranteeing coverage of certain expenses. Australia and Ireland, for example, set minimum benefits for duplicate insurance applying to hospital services, and several U.S. states have similar requirement for primary insurance, covering persons who do not have access to a public system. Beyond these minimums, companies are free to offer more generous coverage (see the Table for examples of insurance

## Financial participation and tax considerations

Another factor in insurance policies is the financial participation of insured persons in the form of deductibles, copayments, etc. This often differs from one country to the next and even within countries from one company to another. It generally goes almost unregulated. An efficient insurance system should contain financial incentives that motivate insured persons to reduce the risks they incur by altering their behaviour and making more

6. See the Economic Note titled "Two myths about the U.S. health care system," published by the MEI in June 2005 and available at [http://www.iedm.org/main/show\\_publications\\_fr.php?publications\\_id=101](http://www.iedm.org/main/show_publications_fr.php?publications_id=101).

7. For Quebec, a legal issue arises here regarding compliance of such restrictions with the Supreme Court ruling.



responsible decisions. This type of system would include, for instance, a copayment portion in addition to deductibles and variable premiums.<sup>8</sup> When costs are paid entirely by third parties (such as governments or insurance companies), patients are less likely to stay informed or to compare the costs of the various solutions that are available.

A final issue concerns the tax treatment of private health insurance premiums. In countries where duplicate insurance is sold, governments often provide tax or cash incentives, whether in the form of tax deductions or reimbursements for part of the insurance costs. In Ireland, for example, premiums are partly deductible, whereas in Australia a rebate equal to 30% of premiums is provided to individual policyholders.

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In Quebec, the payments currently made to insurance companies to cover medical or hospital costs as well as a series of other medical expenses provide the right to a non-refundable tax credit.<sup>9</sup> This deduction is, however, quite small. In 2005, the cost for the Quebec government of all tax credit measures for medical expenses came to \$265 million, or about 1% of budgeted spending on health and social services.

It is difficult offhand to put a number on the added costs the government could incur if private health insurance were to develop. This depends on factors such as premiums and the number of people who take out policies. However, in considering the potential savings resulting from use of the private sector, these costs could very well turn into gains. Patients who use private insurance for private-sector health care will save the government much larger amounts than any deductions. In Australia, the cost of reimbursing 30% of premiums has been estimated at \$2.2 billion, or 6% of public health care spending, whereas savings resulting from the shift in demand from the public to the private sector have been estimated at \$3 billion.<sup>10</sup>

## Conclusion

The recent Supreme Court verdict cleared the way to eliminating the public monopoly on health insurance in Quebec. The government should avoid restricting the scope of this ruling and should consider implementing a regulatory framework that would enable people in Quebec to take full advantage of the development of new private insurance.

8. The experiences of the Rand Corporation show that the choice of patients can affect total spending and that demand for health care is cost-sensitive. See David Cutler and Richard Zeckhauser, *The Anatomy of Health Insurance*, NBER, Working Paper No. 7176, June 1999, available at <http://www.nber.org/papers/w7176>.
9. The rule governing these credits is that one can deduct 20% of the portion of expenses exceeding 3% of family income.
10. Ian Harper, *Preserving Choice. A Defence of Public Support for Private Health Care Funding in Australia*, Harper Associates, April 2003, available at <http://www.medibank.com.au/pdfs/PreservingChoice.pdf>.



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