

CHAPTER 12

Facilitating and Safeguarding Regulation in Advanced Market Economies

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This chapter provides an overview of regulation of private health insurance in advanced market economies, particularly the United States. It considers the implications of such regulation for low-income countries that seek to expand the role of private health insurance in financing medical care. Suggestions are offered for achieving an appropriate balance between “facilitating regulations,” which create a positive environment for private health insurance in low-income countries, and “safeguarding regulations,” which protect consumers and serve other public policy interests. Particular attention is devoted to regulation aimed at avoiding the destabilizing effects of potentially inadequate premiums in relation to insurers’ promised payments. A second focus is regulation of private health insurance rates and risk selection. Two approaches for dealing with high-risk persons are contrasted: (1) significant restrictions on rating and risk selection (community rating) that subsidize rates to the high-risk insured by increasing rates for the low-risk insured and (2) full risk rating apart from narrowly targeted limitations on risk selection, along with guaranteed-issue, high-risk pools with subsidized rates.

INTRODUCTION

The discussion below assumes that the potential demand for private health insurance (PHI) in many low-income countries (LICs) is large enough in principle to support a voluntary PHI market and that economically efficient development of private health insurance is viewed as attractive in some LICs. The discussion largely ignores possible conflicts and tensions between public health insurance and private health insurance and the debate over whether certain levels or types of benefits should be required of private health insurance.

An underlying premise of the discussion is that appropriate economic regulation and “best” regulatory practices cost-effectively mitigate demonstrable market failures in relation to outcomes that would be likely in a reasonably competitive market characterized by (1) large numbers of sellers with relatively low market shares, low-cost entry by new firms, or both; (2) low-cost information to

firms concerning the cost of production and to consumers concerning prices and quality; and (3) an absence of material spillovers (that is, all costs are internalized by sellers or buyers).¹ Pursuit of other objectives, such as equity or solidarity, should at least strive to balance perceived benefits against attendant deadweight costs. (The problem of how to promote efficiency when regulation arises endogenously from a political process in which groups press for policies with private benefits less than social costs is considered in chapter 4.)

Market structure and ease of entry generally are conducive to competition in most modern insurance markets in advanced market economies. But costly and imperfect information and externalities justify several forms of PHI regulation. Concern with affordability of health insurance and associated access to medical care also influences regulation, as does the interplay between private and public health insurance in countries where private health insurance augments or substitutes for public coverage.

The successful development of a robust PHI market to help finance medical care in LICs that desire such a result, with or without public insurance, will require reasonably effective contract enforcement and an economic and political environment that encourages investment of domestic and foreign capital to back the sale of private health insurance.² This chapter's main message, presaged in the analyses and insights of Mark Pauly and Peter Zweifel in this volume, is that regulations that encourage demand for coverage and the entry and expansion of private health insurers will facilitate development of private health insurance. The major focus should be to establish a minimal system of solvency regulation and other regulations that likewise help ensure that buyers obtain what they have been promised. However, significant limitations on PHI pricing and risk selection should generally be avoided. Absent sufficient resources to fund basic public coverage for the poor or to subsidize their purchase of private coverage, the best achievable outcome for many LICs in the near and intermediate term is for private health insurance to expand among citizens willing and able to pay for coverage.

OVERVIEW OF REGULATION IN ADVANCED MARKET ECONOMIES

PHI regulation in advanced market economies is administered by a government agency or agencies that implement statutory requirements, usually with the authority to establish administrative rules and procedures.³ A brief description of the major regulated activities follows.

Licensing of insurers and agents/brokers. Governments grant, renew, and revoke licenses for insurers, agents, and brokers to conduct business. Regulation often stipulates conditions for unlicensed insurers to conduct certain business.

Solvency. Solvency regulation includes solvency monitoring, capital requirements, other controls on insurer behavior (for example, investment regulations),

and, in many cases, establishment of policyholder protection schemes to pay specified claims against insolvent insurers.

Pricing and risk selection. Many governments significantly restrict PHI pricing and risk selection (underwriting), including limits on rate differentials among different buyers, guaranteed-issue requirements, and guaranteed-renewability rules. Some governments require insurers to obtain prior regulatory approval of certain rate changes.

Contractual provisions. Many governments regulate most contract language by requiring certain contract provisions and prohibiting others. Some governments mandate minimum coverage provisions. Prior regulatory approval of health insurance policy forms is common in the United States.

Market conduct. Insurance regulators often enforce legislation dealing with market conduct and unfair trade practices, such as provisions related to unfair claim settlement practices and potentially deceptive sales practices by insurers and agents.⁴

Information disclosure. Many governments make available consumer buying guides and other information about PHI contracts. In the United States, many jurisdictions provide premium rate comparisons, and some publish counts of consumer complaints against health insurers.

Most of the above activities are generally viewed as “safeguarding.” Their main function is consumer protection or the achievement of related policy goals. Many safeguarding regulations, especially solvency regulations, also play a facilitating role: they promote consumer confidence and trust in private insurance and therefore increase the demand for coverage. Insurance firms that wish to prosper in the short and long run have significant incentives to support institutions and regulations that play such a role.

SOLVENCY REGULATION

Private health insurers face a variety of risks, including underwriting risk, asset (market) risk, and interest rate risk. Underwriting risk can be significant for private health insurers, especially relatively small companies. Premiums are based on predicted claim costs; realized costs may be substantially higher due to unexpected increases in the utilization or cost of medical care. Once events giving rise to claims have occurred, health insurers’ provisions for unpaid claim liabilities may prove deficient. Asset risk is often modest, reflecting relatively large investments in government or high-rated corporate bonds. Credit (counterparty) risk largely arises from reinsurance transactions. Private health insurers and health maintenance organizations (HMOs) that contract downstream with medical care providers often face significant credit risk associated with provider promises to provide prepaid services, especially under capitation arrangements.

Given uncertainty about future claim costs and other risks, private health insurers often hold significant amounts of capital as a buffer against bad outcomes. Holding capital involves three types of costs, which increase premiums needed to supply coverage (by increasing premium loadings, see chapter 3): (1) required compensation to owners for bearing risk; (2) tax costs, which vary significantly across countries; and (3) agency costs. In advanced market economies, investors can diversify among numerous securities at relatively low cost. The expected risk premium necessary to compensate investors in private health insurance is likely small, given that variability in claim costs is generally diversifiable by investors. With immature capital markets in LICs, required compensation for risk bearing will tend to be higher, increasing the premiums private health insurers will need to charge. Depending on the country, double taxation of returns from investment of capital to support the sale of policies significantly increases the cost of capital and the prices needed to offer coverage.⁵ Agency costs arise from the possible divergence between the interests of managers and those of investors. Managers may invest or appropriate funds for their own purposes, reducing returns to investors. As a result, investors are motivated to increase monitoring of management and to require higher expected returns. Given less developed governance mechanisms in LICs, agency costs will likely be higher than in advanced market economies.

Private health insurers in advanced market economies generally reduce their risk and thus economize on holding costly capital by diversifying underwriting risk across policies of a given type and region, across types of policies, and geographically. They also often transfer significant amounts of risk to reinsurers, thus achieving additional risk spreading, including across national borders, and reducing the aggregate amount of capital by insurers and reinsurers. Given these influences, an institutional and regulatory environment that promotes diversification by investors, reduces the agency and tax costs of capital, and encourages insurer risk reduction through diversification and reinsurance will greatly facilitate development of private health insurance in LICs.

All advanced market economies regulate the solvency of insurance entities. Many partially guarantee obligations of insolvent insurers, thus protecting policyholders from the full effects of insurer failure. Before elaborating on these arrangements, it is useful to highlight private market incentives for solvency in most advanced market economies. Those incentives ultimately determine the safety and soundness of private health insurance.⁶ First, absent comprehensive government guarantees, policyholders generally prefer to deal with financially strong insurers and, up to a point, are willing to pay the higher premium rates that greater financial strength requires. Second, policyholders can be matched with financially strong insurers through insurance intermediaries (agents, brokers, advisers), private ratings of insurers' claims-paying abilities (and ratings on insurers' debt obligations, which generally are subordinated to policyholder claims), and (for business coverage) knowledgeable corporate staff who oversee risk management and insurance programs. Third, insurance investment, produc-

tion, and distribution often involve the creation of sizeable firm-specific assets, commonly known as franchise value, which could diminish or evaporate if the insurer experiences severe financial difficulty. Protecting those assets provides a significant incentive for adequate capitalization and other forms of risk management.⁷

In view of these influences, efficient risk management by insurers balances the benefits of holding more capital and more effectively managing risk (for example, higher premiums and preservation of franchise value) against the tax and agency costs of capital and frictional costs associated with other risk management methods.⁸ Low risk of insolvency generally results, but eliminating insolvency risk is too costly (as is emphasized in chapter 3).

Motivation for Solvency Regulation and Protection

Some form of solvency regulation is desirable, despite private incentives for safety and soundness because of costly and imperfect information and potential externalities, both to protect some consumers from excessive insolvency risk and to promote confidence in private insurance markets.⁹ Consumers' willingness to pay premiums *ex ante* for private health insurance that promises future payments contingent on health outcomes depends critically on reasonable expectations that those promises will be fulfilled. The upfront payment of premiums in exchange for the insurer's promise to pay later also provides substantial opportunities for fraud and theft. Even advanced market economies with highly developed solvency regulation have experienced problems in this area. In the United States, for example, numerous private insurance entities that offered "self-funded" coverage to small employers claimed that they were exempt from state insurance regulation, simply engaged in fraud, or both and became insolvent in the 1990s (see Wells 2003). That experience continues to influence debate about proposed legislation to facilitate expansion of private health insurance offered by group or association plans to small employers (see American Academy of Actuaries 2005).

With solvency regulation, policyholders who would find it difficult to assess insurer insolvency (or who might have little incentive to do so on their own or using brokers or advisers) in effect delegate responsibility for monitoring solvency to regulators. Regulatory monitoring might detect insurer financial problems early enough to prevent insolvency. In other cases, monitoring can help regulators intervene before the deficit between an insolvent insurer's assets and liabilities becomes large. Some degree of regulatory restrictions on insurer risk taking (for example, investment limitations and capital requirements) could be efficient for this reason.

Limited, government-mandated protection of individual and small employers' claims against insolvent health insurers is also likely to be efficient in advanced market economies, at least in view of costly and imperfect information and possibly negative spillovers for other parties (such as public payers).¹⁰ As suggested

above, insurers have a collective interest in bonding promises to pay claims. Given costly and imperfect information and in the absence of guarantees, insolvencies might damage some financially strong insurers' reputations, which could motivate insurers to participate in a joint guaranty system. Government-mandated guaranty systems reduce free-rider problems and obviate antitrust concerns that might otherwise arise with privately initiated and managed guarantees.

Main Features of Solvency Regulation

Solvency regulation for private health insurance and other forms of insurance in the United States, the European Union, and other advanced market economies generally has most or all of the following features:

- monitoring of compliance with asset/liability valuation and financial reporting rules, including rules for allowing insurers to receive balance sheet credit for reinsurance purchases;
- enforcement of rules that restrict risk taking (for example, restrictions on permissible investments);
- enforcement of capital requirements;
- solvency monitoring (early warning) systems to identify troubled companies;
- guaranty systems to pay a portion of claims against insolvent insurers; and
- supervision, rehabilitation, and liquidation of financially troubled insurers.

The design of efficient solvency regulation necessarily confronts difficult trade-offs. Beyond some point, lowering insolvency risk through tighter regulatory constraints, such as higher capital requirements, inefficiently increases the total costs of insurance (as noted in chapter 3). Regulatory monitoring and controls to reduce insolvency risk involve direct costs, such as regulators' salaries and the costs of collecting, processing, and analyzing data. In addition, they produce indirect costs, for example, by distorting the decisions of some financially sound institutions in ways that increase their costs.

A trade-off also exists between protecting customers against loss when private insurers fail and creating incentives for private insurers to be safe. Protection against loss leads to some degree of moral hazard. It reduces policyholders' demand for lower insolvency risk and their incentives to seek out financially strong insurers, thus in turn dulling insurers' incentives to hold more capital and manage risk effectively. Even well-designed government (or government-mandated) guarantees may increase insolvency risk. Accurate risk-based premiums for guaranty protection in principle could mitigate the dulling effects of guarantees on incentives for safety and soundness, but they are infeasible in practice.

State-mandated guarantees of some of insurers' obligations began to develop in the United States in the late 1960s and expanded rapidly in the 1970s (in conjunction with proposed federal government guarantees). Almost all state guaran-

tees rely on ex post assessment funding mechanisms, which enhance incentives for financially strong insurers to press for effective solvency regulation if unexpected increases in the costs of assessments are borne in part by insurers rather than shifted to customers or taxpayers.¹¹ U.S. guarantees are limited, which helps reduce moral hazard. The health insurance guarantees generally provide coverage for up to \$100,000 per person, but most states exclude HMOs from coverage. In addition, self-funded group plans offered to employees by medium-size to large employers, which account for a large proportion of private coverage, are exempt from state regulation and guarantees.

Capital Requirements

Traditional regulatory capital requirements for insurance specified absolute minimum amounts of capital necessary to conduct business. These amounts often varied by type of coverage (non-life versus life) and type of entity (stockholder-owned versus mutual). The modern trend has been to supplement these absolute minimums with risk-based capital requirements, which link minimum capital to measures of the insurer's risk. Current absolute capital requirements in the United States average around \$2 million, varying from several hundred thousand dollars to \$5 million or more. In the 1990s, the National Association of Insurance Commissioners (NAIC) developed U.S. risk-based capital requirements for property-casualty and life insurers. These requirements were followed by specific requirements for health insurance specialists (HMOs and health insurance companies subject to state insurance regulation).

Because government-mandated guarantees of health and other insurers' obligations are modest and market discipline is reasonably strong in most advanced market economies, the potential benefits of stringent capital requirements are small. Potential costs to insurers and policyholders of stringent requirements, which arise from distorting decisions of sound insurers, are comparably large. As a result, risk-based capital requirements generally should be designed not to bind the decisions of most insurers, and simple requirements are likely to be as effective as more complex rules.¹² As long as capital requirements are sufficiently loose, however, unnecessary complexity is relatively harmless (although it does increase compliance costs).

U.S. risk-based capital requirements employ different formulas for property-casualty insurers, life insurers, and health organizations. Most states have adopted the property-casualty and life insurer requirements. The requirements are fairly loose; most insurers hold substantially more capital than the amounts that would trigger some form of regulatory intervention. Many states have yet to adopt the NAIC's risk-based capital requirements for health organizations. The reasons may be that the regulations were only recently developed and that their adoption is not required under the NAIC's program for accreditation (certification) of a state's solvency regulation. In addition, health-risk-based capital standards have produced lower ratios of actual capital to risk-based capital for many

more health organizations than for property-casualty and life insurers. In 2000, for example, 24 percent of health organizations subject to state insurance regulation had capital less than 200 percent of the risk-based capital standard, the percentage threshold for requiring an entity to submit a plan of action to regulators for improving its capital position, compared with 2 percent of life insurers (Bell 2003). However, in 2002 the fraction for health organizations had declined to 12 percent, and the aggregate risk-based capital ratio for health organizations was 460 percent, compared with 455 percent for property-casualty insurers and 649 percent for life insurers. The NAIC has periodically proposed raising the capital thresholds for increased regulatory monitoring or intervention, but insurers have generally opposed such a move.

The U.S. risk-based capital formulas are complex (Academy Joint Risk-Based Capital Task Force 2002). The NAIC's formula for health organizations specifies four major risk categories: asset risk, credit risk, underwriting risk, and miscellaneous business risks. The specific risk weights for items in each category and the formulas for aggregating the resulting capital charges are complex. The latter include nonlinear combination of various factors to allow crudely for diversification.¹³

For the present, European Union (EU) insurers' "solvency margin" requirements, which have been substantially harmonized across EU member states for many years, are much simpler than U.S. risk-based capital standards. The solvency margin requirements (as amended in 2002; see European Union 2002a, 2002b) are expressed as relatively simple proportions of relevant premiums, claims, or claim-related liabilities. Most EU insurers generally have held considerably more capital than the required solvency margin (Swiss Re 2000). Although the case can be made that the requirements' relative simplicity and lack of stringency are appropriate in view of the degree of market discipline in insurance (Harrington 2004a), the European Union is moving toward complex, risk-based capital requirements and regulation with many similarities to bank capital regulation.

Implications for Low-Income Countries

Solvency regulation could play important facilitating and safeguarding roles in the development of private health insurance in LICs. In particular, some minimum level of solvency regulation will help establish trust and confidence in private health insurance, which in turn will increase demand and stimulate the supply of coverage.

If potential consumers have little education, the potential benefits of minimum solvency regulation may increase. As suggested elsewhere in this volume (chapters 3 and 4), however, the optimal level of insolvency risk could generally be higher in LICs, because quality in the form of lower insolvency risk is plausibly a normal good. Lower demand for coverage with negligible insolvency risk, given its higher cost, favors relatively low and simple minimum capital requirements for private health insurers in LICs, at least initially and in the absence of a government-mandated system of partial policyholder protection in the event of insurer failure.

Creation of regulatory environments that will attract financially strong insurers will require establishment of appropriate systems for informative financial reporting by private health insurers. Attention should also be paid to possible mechanisms for facilitating private health insurers' risk management, thus reducing their need for costly capital. That task might involve facilitating laws and regulations, such as a limited exemption from any otherwise applicable antitrust law, that permit and encourage private health insurers to engage in cooperative pooling and analysis of claims data to benchmark cost estimates. Such cooperation could increase the accuracy of claim cost forecasts that provide the basis for pricing and thus lower insurers' risk, reduce the likelihood of low but unsustainable prices, and facilitate entry by smaller insurers.¹⁴

Although insurer cooperation in developing benchmark cost estimates could create concern about possible noncompetitive behavior, that risk is likely of secondary importance in LICs compared with the risks and consequences of inadequate prices. Cooperative arrangements played an important role in facilitating development of stable property-casualty insurance markets in the United States and other advanced market economies. The arrangements' lack of importance in U.S. health insurance could reflect, in part, the dominance of health insurance provided by large employers and relatively large health insurers that were originally associated with medical care providers.

REGULATION OF PRICING AND RISK SELECTION

Absent regulatory restrictions, private markets for health and other types of insurance produce premium rates commensurate with insurers' expected costs of providing coverage to a given policyholder. Competitive health insurance premium rates will continually adjust in an attempt to incorporate accurately all information that predicts claims costs (and that can be observed or obtained at relatively low cost), including age, gender, and health status. Although adverse selection might cause coverage to be completely unavailable in narrow circumstances, private insurance markets inherently gravitate toward offering coverage to all buyers who are willing and able to pay premiums commensurate with the insurers' expected costs of providing coverage.¹⁵

The philosophy and approach to regulation of PHI prices and risk selection vary widely across advanced market economies, in part due to variation in the scope of public versus private coverage. Although some regulation of prices and risk selection can plausibly be rationalized as a response to problems arising from asymmetric information, much of this regulation is intended to shield high-risk consumers, low-income consumers, or high-risk and low-income consumers from PHI rates that would otherwise be unaffordable or impose significant hardship. Two broad approaches for dealing with the tension between cost-based premium rates and affordability are (1) significant restrictions on pricing and risk selection, such as community rating, that subsidize the high-risk insured by

increasing rates for the low-risk insured and (2) full risk rating apart from narrowly targeted limitations on risk selection, along with guaranteed-issue, high-risk pools with subsidized rates.

Diversity of Approaches in the United States

U.S. jurisdictions vary widely with respect to guaranteed-issue requirements, rating restrictions, limits on exclusion of preexisting conditions, and whether the state has mandated a subsidized high-risk pool. Beginning in the late 1980s, many states adopted restrictions on risk selection and pricing in small group health insurance markets, often requiring each insurer to offer coverage at a rate that does not reflect the health of individual employees, restricting the magnitude of rate increases at renewal, and limiting a new insurer's ability to exclude coverage for preexisting conditions. In 1996 the U.S. Congress enacted the Health Insurance Portability and Accountability Act (HIPAA), which (nominally) required guaranteed renewability in the small group market for employers with 2 to 50 employees (without restricting rate increases). HIPAA also required states to guarantee access of coverage for persons who lose coverage, and it contained restrictions on the use of preexisting condition exclusions.

Table 12.1 shows the number of U.S. jurisdictions that employed various restrictions on rating and risk selection in the *individual* health insurance market in recent years. Five states (Maine, Massachusetts, New Jersey, New York, and Vermont) required guaranteed issue of all products to all residents by all insurers. New Jersey, New York, and Vermont required pure community rating (rates can only vary by benefits provided and geographic location within the state, and thus not by age, gender, or health status). Maine and Massachusetts required adjusted community rating (rates can vary by age). Two other states (Oregon and Washington) required adjusted community rating; guaranteed issue is required for certain populations. Another 19 states had some guaranteed issue requirements, most often for persons eligible for coverage continuation under HIPAA,

TABLE 12.1 Selected Pricing and Risk Selection Restrictions for Individual Health Insurance among 51 U.S. Jurisdictions as of 2005

<i>Type of restriction</i>	<i>Number of jurisdictions</i>
Guaranteed issue of all products to all residents by all insurers	5
Guaranteed issue to selected residents	21
Pure community rating (cannot rate on age, gender, or health status)	3
Adjusted community rating (rating on age permitted)	4
Limitation on variation in rates due to health status	8
Guaranteed renewable at rates not based on individual health status	48
High-risk pool (guaranteed issue at subsidized rates)	32

Source: Abbe 2005; Georgetown University Health Policy Institute 2004; Patel and Pauly 2002.

and eight states significantly restricted (without prohibiting) variation of rates in relation to health status.

Guaranteed issue and rating restrictions may allow some individuals to purchase coverage who otherwise might find it difficult to find a willing insurer. But the restrictions' predominant motivation and function is to lower premium rates for buyers with relatively high expected claim costs by charging above-market premium rates for buyers with relatively low expected claim costs. This strategy helps higher-risk persons afford coverage and accordingly receive the types and quality of medical care that flow to insured persons.

However, significant restrictions on rating and risk selection in private health insurance can

- increase average premiums as some lower-risk buyers reduce or drop coverage (due to adverse selection induced by the restrictions);
- destabilize the market for coverage with a substantial reduction in coverage availability;
- require (a) additional restrictions and regulations that attempt to ensure a stable market where many or most insurers provide coverage to observably high-risk buyers despite inadequate premium rates and (b) potentially elaborate risk adjustment or other mechanisms to spread losses on higher-risk buyers broadly among insurers and lower-risk buyers (see van de Ven and Ellis 2000);
- require additional restrictions and regulations to keep insurers from tailoring coverage offerings and services to segment buyers according to risk—that is, to reduce regulatory-induced “cream skimming” (see, for example, Hall 2002); and
- reduce incentives for persons to purchase insurance while healthy and to behave in ways that improve their health and reduce their need for and cost of medical care.

An alternative approach is narrow targeting of government intervention to mitigate affordability problems, along with reliance on private insurer pricing and risk selection. In addition to narrow interventions related to preexisting conditions, important strategies in the United States include (1) establishing a high-risk pool to guarantee coverage to persons with chronic health conditions at subsidized rates and (2) promoting or mandating guaranteed renewability of coverage (at rates that do not reflect individual health status).

As shown in table 12.1, 32 U.S. jurisdictions had a high-risk pool as of 2005. These jurisdictions included all jurisdictions with no other guaranteed-issue requirements. The pools generally are designed to provide subsidized coverage to a relatively narrow, high-cost segment of the public. They typically provide coverage (through private third-party administrators, usually with a choice of plans) to persons who experience some difficulty finding an insurer willing to offer coverage, persons with specified medical conditions, and HIPAA-eligible

persons (Abbe 2005). Some pools allow purchase by any person facing increased nonpool premiums. Premium rates generally are capped at 12 to 150 percent of typical rates for comparable nonpool, individual coverage.

High-risk pools invariably experience large average deficits per enrollee. The deficits commonly are recouped through pro rata assessment of all health insurers in the state, sometimes with partial or full offsets against insurers' premium tax obligations. Employer-sponsored, self-funded plans cannot be assessed. Some pools receive small assessments from hospitals or other providers. A few pools receive direct government subsidies; some receive earmarked subsidies to reduce premiums charged to lower-income enrollees.

With guaranteed renewability, an insurer must renew coverage, regardless of the health of the insured. The premium rate can be increased to reflect the average experience for the insured's rating class. It cannot be increased on an individual basis to reflect possible deterioration in the individual's (or covered dependents') health. Thus, by preventing individual experience rating, guaranteed renewability provides insurance against rate increases due to deterioration in an individual person's health compared with the average health status for persons in the same rating group (average health status generally reflects age, gender, and perhaps other factors), albeit at a higher premium than for contracts without guaranteed renewability (see Pauly, Kunreuther, and Hirth 1995; Patel and Pauly 2002; also see Cochrane 1995). As shown in table 12.1, most U.S. jurisdictions require that individual health insurance be guaranteed renewable. A large proportion of individual health insurance was purchased on a guaranteed renewable basis in the United States before renewability was required (Patel and Pauly 2002).

In contrast to individual health insurance contracts, many small group health insurance contracts either were not guaranteed renewable or often resulted in large rate increases at renewal, reducing small employers' protection and incentives to offer group medical coverage. Why mechanisms that promote guaranteed renewable health insurance for individuals without a regulatory mandate (such as front-loading of premiums; see Pauly, Kunreuther, and Hirth 1995) are less effective for small group insurance is unclear. One possibility is that higher switch costs for individual policyholders than for small groups enhance the viability of guaranteed renewability by discouraging sufficient numbers of low-risk policyholders from switching insurers to obtain lower rates (see Harrington and Miller 2002; also see Crocker and Moran 2003).

Approaches in Other Advanced Market Economies

Motivation to restrict pricing and risk selection of private coverage is greater in some U.S. jurisdictions than in many EU and Organisation for Economic Cooperation and Development countries. Countries with relatively small private health insurance markets nonetheless often require guaranteed issue and guaranteed renewability (lifetime coverage), prohibit rating based on health status, and employ risk-adjustment mechanisms.¹⁶

The European Union's third non-life insurance directive permitted insurers to provide coverage throughout the European Union and in effect prohibited various types of rating and risk selection restrictions for private health insurance; the focus of regulation was instead primarily on solvency. According to Thompson and Mossialos (2004), supplemental private health insurance is almost entirely subject to financial (solvency) regulation only. An exception is Ireland, which requires community rating, open enrollment, and lifetime coverage and may require private health insurers to participate in a risk-adjustment scheme.

Significant limitations on pricing and risk selection also are employed in the Netherlands (for coverage of high risks under the Medical Insurance Access Act, see Tapay and Colombo 2004) and Germany, where private coverage substitutes for public coverage for relatively high-income persons. These exceptions are linked to article 54.1 of the EU directive, which allows insurance regulation for the "general good" where private coverage "serves as a partial or complete alternative to health cover provided by the statutory social security system" (as quoted by Thompson and Mossialos 2004, 4). The Netherlands' two-tier public-private system is being replaced by universal basic coverage, subject to open enrollment, community rating, and a risk-adjustment scheme (Tapay and Colombo 2004).

Implications for LICs

The costs of designing, administering, and enforcing significant restrictions on rating and risk selection in private health insurance would be considerable in LICs, even assuming sufficient administrative capacity and expertise.¹⁷ Artificially high rates for lower-risk buyers would reduce their demand and push up average rates, further aggravating affordability problems and encouraging a greater number of low-risk persons to forgo coverage. Moreover, a move toward significant restrictions on rating and risk selection, including any requirement that insurers obtain regulatory approval of rates charged, would substantially slow or even kill PHI development as a result of compliance costs, reduced profit potential, and increased regulatory uncertainty.

Apart from restrictions that might be necessary in some countries to coordinate and align public and private coverage, restrictions on PHI rating and risk selection should be avoided in LICs. Once a viable market has been established, and as income grows, LICs may find it desirable to encourage guaranteed renewable coverage and to consider adoption of a narrowly targeted high-risk pool with subsidized rates.¹⁸

CONCLUSIONS

Development of robust PHI markets in LICs will require a reasonably effective system for enforcing contracts. An economic and political environment that encourages the investment of domestic and foreign capital to back the sale of

insurance will facilitate establishment of such a system. Regulation of private health insurance in LICs should focus on encouraging demand for coverage and otherwise facilitating the entry and expansion of private health insurers. The central component of regulation should be a minimal system of solvency regulation. The second priority should be minimal oversight of contract language and claims resolution to help ensure that buyers generally obtain what they are promised when they purchase insurance. Significant limitations on PHI rates and risk selection generally should be avoided.

NOTES

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1. See Breyer (1982). Regulatory tools are necessarily imperfect, even apart from rent-seeking behavior by interested parties. Regulation always involves direct and indirect costs, and it risks unintended consequences.
2. Under suitable circumstances, multinational insurers will likely play an instrumental role in promoting the growth of private protection.
3. In many jurisdictions, the courts also have a significant effect on contractual relations between insurers, policyholders, and medical care providers through interpretation and enforcement of contract provisions.
4. Allegations of deceptive or misleading sales practices also may be subject to litigation and resolution by the courts.
5. See Harrington and Niehaus (2003) for detailed analysis of tax costs of capital in the United States.
6. See Harrington (2004b) for a detailed discussion in the context of insurance and banking.
7. The seminal theoretical treatment of this issue in the insurance literature is Finsinger and Pauly (1984).
8. Swiss Re (2000) emphasizes the trade-off between capital (safety and soundness) and capital costs.
9. Demand by some consumers is inherently insensitive to insolvency risk (even without government guarantees), due, for example, to legal requirements that compel judgment-proof parties to buy liability insurance or to cover workers for workplace injuries.
10. Because systemic risk is relatively low in insurance markets (see Harrington 2004a), the potential advantages of government guarantees of insurers' obligations are reduced.
11. Many states allow life and health insurers to offset all or a portion of assessments against state premium taxes, which likely reduces incentives for monitoring.
12. See Harrington (2004a) for a detailed discussion. This point obviously conflicts with the modern trend toward increasingly complex insurer capital requirements in advanced market economies.

13. Evidence suggests that the U.S. risk-based capital standards are not closely related to insolvency risk despite their complexity (Grace, Harrington, and Klein 1998).
14. See Hanson, Dineen, and Johnson (1974). As noted in chapter 4, Dror (2002) emphasizes problems of cost estimation for community-based insurance schemes. Sekhri, Savedoff, and Tripathi (2005) do not agree with the view that information sharing and cooperative analysis could be beneficial.
15. See chapter 2 for further and related discussion.
16. See Task Force on Private Health Insurance (2003, tables 2 and 3).
17. Peter Zweifel also makes this point in chapter 3.
18. As suggested in chapter 2, government-mandated basic or core benefits in LICs would likewise slow or even halt development of private health insurance. For a contrasting view, see Sekhri, Savedoff, and Tripathi (2005). They advocate mandatory core benefits if private health insurance is intended as a primary source of coverage.

REFERENCES

- Abbe, Bruce. 2005. "Overview: State High Risk Pools Today." www.SelfEmployedCounty.org.
- Academy Joint Risk-Based Capital Task Force. 2002. "Comparison of the NAIC Life, P&C and Health RBC Formula." American Academy of Actuaries, Washington, DC.
- American Academy of Actuaries. 2005. "FAQs on AHPs." *Issue Brief*, March.
- Bell, Rowen. 2003. "Health Regulatory Update." BlueCross BlueShield presentation, San Diego, CA, September 11.
- Breyer, Stephen. 1982. *Regulation and Its Reform*. Cambridge, MA: Harvard University Press.
- Cochrane, John. 1995. "Time-Consistent Health Insurance." *Journal of Political Economy* 103 (3): 445–73.
- Crocker, Keith, and John Moran. 2003. "Contracting with Limited Commitment: Evidence from Employment-Based Health Insurance Contracts." *RAND Journal of Economics* 34: 694–718.
- Dror, D. M. 2002. "Health Insurance and Reinsurance at the Community Level." In *Social Reinsurance: A New Approach to Sustainable Community Health Financing*, eds. D. M. Dror and A. S. Preker, 103–24. Washington, DC: World Bank.
- European Union. 2002a. Directive 2002/12/EC of the European Parliament and of the Council Amending Council Directive 79/267/EEC as Regards the Solvency Margin Requirements for Life Assurance Undertakings. Brussels, March 5.
- . 2002b. Directive 2002/13/EC of the European Parliament and of the Council Amending Council Directive 73/239/EEC as Regards the Solvency Margin Requirements for Non-Life Insurance Undertakings, Brussels, March 5.
- Finsinger, Jorg, and Mark Pauly. 1984. "Reserve Levels for Profit-Maximizing Insurance Firms." Reprinted in *Foundations of Insurance Economics*, eds. G. Dionne and S. Harrington. Boston: Kluwer Academic, 1991.

- Grace, Martin, Scott Harrington, and Robert Klein. 1998. "Risk-Based Capital and Solvency Screening in Property-Liability Insurance: Hypotheses and Empirical Tests." *Journal of Risk and Insurance* 65 (June): 213–43.
- Georgetown University Health Policy Institute. 2004. "Summary of Key Consumer Protections in Individual Health Insurance Markets." www.HealthInsurance.org.
- Hall, Mark A. 2002. "HIPAA's Small Group Access Laws: Win, Lose, or Draw." *Cato Journal* 22 (1): 71–83.
- Hanson, J., R. Dineen, and M. Johnson. 1974. *Monitoring Competition: A Means of Regulating the Property and Liability Insurance Business.* Supplement to National Association of Insurance Commissioners Proceedings. Milwaukee, WI: National Association of Insurance Commissioners.
- Harrington, Scott. 2004a. "Capital Adequacy in Insurance and Reinsurance." In *Capital Adequacy beyond Basel: Banking, Securities, and Insurance*, ed. Hal Scott, 87–122. London: Oxford University Press.
- . 2004b. "Market Discipline in Insurance and Reinsurance." In *Market Discipline: The Evidence Across Countries and Industries*, ed. C. Borio, W. Hunter, G. Kaufman, and K. Tsatsaronis, 159–73. Cambridge, MA: MIT Press.
- Harrington, Scott, and Tom Miller. 2002. "Competitive Markets for Individual Health Insurance." *Health Affairs: Web Exclusive*, W359-W362, October 23.
- Harrington, Scott, and Greg Niehaus. 2003. "Capital, Corporate Income Taxes, and Catastrophe Insurance." *Journal of Financial Intermediation* 12: 365–89.
- Patel, Vip, and Mark Pauly. 2002. "Guaranteed Renewability and the Problem of Risk Variation in Individual Group Insurance Markets." *Health Affairs: Web Exclusive*, W280-W289, August 28, 2002.
- Pauly, Mark, Howard Kunreuther, and R. Hirth. 1995. "Guaranteed Renewability in Insurance." *Journal of Risk and Uncertainty* 10 (2): 143–56.
- Sekhri, Neelam, William Savedoff, and Shivani Tripathi. 2005. "Regulation of PHI to Serve the Public Interest: Policy Issues for Developing Countries." Discussion paper draft, October 12, World Bank, Washington, DC.
- Swiss Reinsurance Company. 2000. "Solvency of Non-Life Insurers: Balancing Security and Profitability Expectations." *Sigma* 1.
- Tapay, Nicole, and Francesca Colombo. 2004. "PHI in the Netherlands: A Case Study." Working Paper 18, Organisation for Economic Co-operation and Development, Paris.
- Task Force on Private Health Insurance. 2003. "Summary of Main Findings." Prepared for the Directorate for Financial, Fiscal, and Enterprise Affairs Insurance Committee, Organisation for Economic Co-operation and Development, Paris.
- Thompson, Sarah, and Elias Mossialos. 2004. "Regulation of PHI in the European Union: The Implications of Single-Market Legislation and Competition Policy." Paper presented to the European Health Policy Group, Fifth European Conference on Health Economics, London, September 9–11.
- van de Ven, W., and Randall Ellis. 2000. "Risk Adjustment in Competitive Health Plan Markets." In *The Handbook of Health Economics*, eds. A. J. Culver and Joseph Newhouse, 756–845. Amsterdam: Elsevier.
- Welles, Ed. 2003. "Rip-offs Uncovered." *Fortune Small Business*, May 24.