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Voluntary (Private) Opt-Out Insurance: Is it Good for Russia?

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Granting a "right" to opt out of the mandatory health insurance system is a notion that needs to be assessed carefully. The proposed voluntary insurance opt out is considered as a substitute to mandatory insurance. Opting out means that the insured employee has the choice to stay in mandatory insurance or to opt out into voluntary insurance which can be provided by the same insurance fund under the condition of separate accounts or by private insurance. The range of benefits under voluntary insurance may or may not be broader than under mandatory and the insured person may have to pay additional premiums.[1]

Expected Impacts

The new proposal put forth by the Government is potentially dangerous for several reasons. The Bank has reviewed the experience in other countries of the world, such as Germany, Netherlands, Egypt, Israel, Peru and Chile. It has found that the Government should expect several negative impacts, including the:

- Favoring of the rich and healthy in well-off urban areas such as Moscow and St. Petersburg, while it discriminates against poorer regions and discriminates against sick and vulnerable groups;
- Creation of a "two-tier" system of quality and access in the delivery of services, whereby the high income groups have one level of services, while the others have a lower level of services. Yes, care for all could be provided in government-owned facilities, but international experience suggests physicians will tend to order services according to the type of insurance coverage;
- Lowering of health status, not improving it, overall, by providing lower level care to the majority under public insurance;
- Destabilizing the existing private health insurance market. This could happen in two ways. First, private insurers may adjust benefits to accommodate expected care needs, driving up the cost and discouraging healthy groups to join. A second way could be when healthy and high income groups already enrolled in private insurance unexpectedly become sick and need care. In this scenario, premiums will be increased, forcing the relatively healthy out of the market. This, in turn, could force higher premiums by insurers for those left in the pool who need care, creating a kind of never-ending "death spiral" of premium increases seen in other countries such as the United States;

[1] Voluntary insurance is mentioned it the following paragraphs of the proposed Federal Law On Mandatory Health Insurance in the Russian Federation:
Art 6: Employed citizens shall have the right to voluntarily refuse to participate in the mandatory health insurance system on the condition of their execution of voluntary health insurance agreements that meet the requirements of the federal law and comply with the procedures instituted by such law. In this event such citizens cease to be insured under the mandatory health insurance system.
Art.20: The health insurance organizations practicing mandatory health insurance shall not have the right to practice any other insurance operations with the exception of voluntary health insurance.
Art 22: to keep records of mandatory health insurance financing under the procedures established by the budget laws of the Russian Federation, and in case of performance of operations under voluntary health insurance to keep segregated records of financing under mandatory health insurance and voluntary health insurance;
Art 24: note of withdrawal from the mandatory health insurance system complete with information about the voluntary health insurance policy.
Art. 34: e) voluntary contributions by legal entities and natural persons.

- Leaving privately-insured people who are sick without coverage. Private insurers in all countries are known to drop coverage in events of catastrophic or costly care, leaving the government or the health insurance Funds to pick up the costs;
- Eroding current social health insurance revenues – by 10 to 30% -- as well as erode the structure of social solidarity. ***The Bank estimates that the insurance Funds could lose between 10 and 30 billion rubles, using 2003 estimates***. This loss of revenues will require a new infusion of government revenues to cover the relatively sick left in the public system;
- Encouraging corruption. This type of health financing model requires a strong governance and regulatory framework by the Government of private insurers to work effectively. Otherwise, insurers could easily abuse patients and families in terms of money and quality of services.

While not explicit in the legislation, there is an expectation that private insurers will market to large employers which may wish to organize health insurance for its own employees. But there are no provisions for government protection of quality in employer-provider contracts. For example, employer-based private insurance could lower levels of quality in an attempt to save money for the employer, or it could drop critical services from its package of benefits.

As for individuals who wish to opt-out, they may find it difficult to purchase such coverage. Private insurers don't really want or prefer individuals alone buying coverage (this is a problem in other countries including the United States) because of risk selection issues. Private insurers prefer covering groups to better spread risks. As a result, the private insurers could be expected to raise premium rates higher then necessary for individuals seeking private insurance policies.

Regardless of groups or individuals, there is the additional issue of coverage of costly services. Is there any real expectation that private insurers would cover areas such as end-stage renal failure and terminal cancer care? They typically do not do so in other countries.

Understanding the New Proposal

Some Russian leaders[2] have pronounced the new proposal as similar to what is now found in Germany. However, German insurance experts indicate that GoRF-proposed voluntary health opt out insurance is different than the German model. In Germany, the model varies in the following ways:

- opting out is dependent upon income or profession (e.g., civil servants);
- opting out depends upon a certain income threshold – once reached, the insured person can stay voluntarily in mandatory insurance or leave to private insurance. If the insured person decides to stay in the public system, he/she is recorded as publicly insured and with the same rights as insured persons under mandatory insurance. In the case of opting out, he will be uninsured and will find private insurance;
- under private insurance, the benefit packages can be selected. Mandatory insurance funds do not have the possibility to provide substitutive or supplementary private insurance, as in Russia now;

[2] Mr. Zurabov of the Pension Fund has indicated in public forums in Moscow that the GoRF is following in the footsteps of Adolf Hitler, who implemented voluntary opt-out for private insurance in Germany in 1941. Hitler was not well-known for strengthening principles of social equity or social solidarity.

- the decision to opt out is principally a life long decision. Return to the public system is only possible under certain circumstances. The privately insured are under the close regulation of the private insurance industry. In Russia, patients will have the choice to "run" from mandatory to voluntary and back again, undermining the risk pools in both public and private sectors.

Several points of regulation and governance would be needed:

- coverage: before exiting the public MHI system, and receiving the relevant tax deduction, a person should meet the indispensable condition to have a private policy;
- benefits: the VHI program shall be at least of the same scope and cover the same types of health care as in the basic MHI program, if not exceed it;
- re-entry: an individual should retain the right to recover membership in MHI if quality or costs are not adequately provided under the private insurance market. Insurance failures will no doubt occur, and the Government will need to have a back-up fund for fiscal viability of the public system; to avoid moral hazard, a waiting time for services and/or a higher rate could be considered
- new legislation regulating private insurance would be needed, as well as development of technical capacity to actually assure implementation of the regulatory framework. This is briefly outlined below.

Is Russia Ready?
The Immediate Need for Private Health Insurance Regulation

Many of the risks and disadvantages of private insurance can be addressed, at least to some extent, through the imposition of appropriate, enforceable and enforced regulatory requirements. Table 1 (see below) provides a listing of regulatory issues for any country implementing health insurance**.** The draft legislative language addresses many of these, so the list can be used as a checklist for implementation purposes.

Below is a brief summary of some of the more prominent issues confronting GoRF, and a discussion of possible mechanisms to address some of the concerns that could emerge in its private health insurance markets.

1. Addressing the Potential for Risk Fragmentation. Policymakers should encourage the largest possible pooling arrangements while maintaining a competitive market of insurers.[3] Large pools can bring together individuals of diverse risks. Requiring insurers to accept all applicants will address risk fragmentation. On the other hand, in order to help prevent adverse selection against insurers, the Government may want to consider limiting the timeframe during which insurers must accept applicants, such as through the use of an annual "open enrollment" period. Requirements relating to the "renewability" of coverage can also help assure that consumers are provided the opportunity to continue their coverage after they become sick.[4]

[3] World Health Report 2000, Health Systems: Improving Performance (Geneva, Switzerland: 2000).
[4] Small size of some regions makes it all the more important to be sure that pooling is across multiple regions to better assure it functions in a reasonable manner.

Table 1
Regulatory Issues for Implementing
Private Health Insurance

Financial and Non-financial Standards for Market Entry and Operation	*Rules for Reporting and Exit of HI Plans*	*Employer/Consumer Protections and Mechanisms to Improve Fairness*
1. Capital and surplus requirements 2. Common accounting and actuarial practices 3. Reinsurance requirements 4. Approved business plan 5. Citizen/residency of owners 6. Lawful organization forms 7. Prohibited products	1. Regular reporting of financial and market information 2. Use of accounting and actuarial professions to conduct on-site examinations 3. Notice to policyholders and financial plan for paying incurred but not reported expenses 4. Guaranty funds	1. Language and marketing of contracts 2. Provider-plan relations 3. Guaranteed issue/renewal 4. Community rating 5. Rate review/approval 6. Mandated/standard benefits

2. Affordability Concerns. Affordability of coverage is one of the more challenging issues for both public and private financing mechanisms. Rating restrictions that prohibit or restrict the use of risk factors in the calculation of premium charges can help equalize the costs across the system. The GoRF may need to examine creative methods of risk equalization or other ways to encourage risk distribution. Private insurance will create multiple tiers of quality and service across groups. If the Government wishes to address some of the inequities that arise between high and low-income Russians, they may want to consider some method of cross-subsidization based on income levels. This could include direct subsidies to help lower income individuals and families pay for coverage.

3. Administrative Costs. In the U.S. Medicare supplemental private market and in the EU private supplemental insurance markets, there have been a history of concerns about the extent to which premiums are spent on administrative costs.[5] Since the 1980's in the U.S., there have been a series of state and federal laws to regulate insurer loss ratios in the Medicare supplemental coverage market. Notably, these laws still permit a significant amount of premiums to be spent on administrative expenses. For example, as of 1991, the loss ratio requirement was 60 percent for policies sold to individuals and 75 percent for policies sold through groups (allowing for 40 percent and 25 percent administrative costs, respectively). The experience is similar in the EU countries. Because of the potentially small market in Russia, this could be a problem in this country as well. Loss ratio standards often permit a significant amount of premiums to be allocated toward administrative expenses. Furthermore, even if specified loss ratio standards are mandated, and insurers comply with them, these regulations do not necessarily provide insurers with any incentive to further increase the proportion of premiums being spent on health services. Given limited health care resources, policymakers should consider the potential that significant expenditures paid to private insurers may move outside of the traditional provider-based health care system. This may lead to further instability in funding.

[5] Mossialos, E. and Thomson, S.M.S. "Voluntary Health Insurance in the European Union," London School of Economics, Discussion Paper 19, Health Observatory, London, May 2001.

4. Information Disclosure. The extent to which consumers and employers can compare plans is an important piece of a competitive market. If they are unable to compare the value of packages by readily comparing benefits and costs, it may undermine market forces and also result in the purchase of inappropriate coverage. Policymakers may want to ensure that certain aspects of the plan and its operation are disclosed in the coverage contract. They also may want to help ensure that the information is presented in a readily understood, and if possible, comparable fashion.

5. Ability to Challenge Insurer Decisions. The establishment of mechanisms for consumers to complain about and appeal insurer decisions — both regarding claims payment and access to care — can help promote confidence in the private system. The establishment of such procedures internal to the plan can be very useful and regulatory standards for such procedures may help assure that issues are resolved within a reasonable timeframe. Some have found it useful to establish mechanisms for external review of decisions involving access to medical care.[6] Furthermore, some countries and some states within the United States have set up an ombudsman office to handle certain complaints.[7] This office might operate outside of the typical regulatory office. Alternatively agencies may want to create a similar function within the agency itself.

6. Assuring Plan Solvency. Ideally, the GoRF could devote resources and technical expertise to assuring that insurance companies are in a financial position to deliver on their promises. In the absence of these requirements, there is significant risk of financial trouble -- resulting in insurers' or providers failing to receive the reimbursement they were guaranteed in their coverage contract. A government also may want to develop a safety net mechanism to protect insurers in such a case, yet this might require the allocation of significant resources to a backup or "guaranty" fund. The Government will want to examine the financial standards applicable to other types of insurance and ascertain when these might appropriately be applied to health insurance products. It likely would make sense for the relevant government agency to coordinate or utilize existing regulatory expertise in the area of financial standards. Regular reporting requirements, and systems to analyze company financial data and indicate when companies are in trouble, can help avert the hardship of insolvencies. However, these types of reporting requirements can require the development and maintenance of significant expertise at the regulatory level and should not be underestimated.[8]

Health Sector Board or Supervisory Structure Needed?

The Government might want to establish a new "Health Sector Board" or "SuperIntendency" organization found in some countries such as the Netherlands or in Latin America already, composed of both public and private insurers and health

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[6] *See* Pollitz, K., Dallek, G., Tapay, N., "External Review of Health Plan Decisions: An Overview of Key Program Features in the States and Medicare"(Menlo Park, CA, The Kaiser Family Foundation).

[7] For example, Ireland has such a program. Ireland White Paper at 66., Section 6.10: "The Insurance Ombudsman of Ireland Scheme-which is a non-statutory scheme-provides for independent settlement of disputes between policy holders and insurance companies."

[8] An examination of the costs of regulation is beyond the scope of this paper but is an area that merits further investigation as the policy debate continues in Russia. The costs and expertise required to regulate private health insurance should be an important consideration in future discussions.

sector stakeholders, which will oversee implementation, and begin to examine the strategy for current and future private health insurance. The concept and creation of such a group can help oversee design and implementation of the private health insurance program for Russians.

Beyond the implementation, the Bank sees the Board as needed and as playing a pivotal role in coordinating public and private sectors, setting standards, developing independent analysis of manpower and infrastructure needs for the country, and so on. The Health Sector Board should be viewed as a long-term structure that plays a role for many years in an evolving sector.

A better relationship between private health insurance organizations, an insurance supervisory authority and the mandatory health insurance system is also needed to encourage the involvement of private health care financing. These documents fail to mention whom and on what has regulatory authority over the mandatory health insurance system. So far, several entities intervene, such as the MinFin and Ministry of Health (MOH), the Federal Health Insurance Fund, and others. But a new body could be clearly entrusted with the regulation, licensing, supervision and control of the system.

Does the German Experience Suggest Anything for Russia?

In Germany, the high income and healthy groups move out of public insurance. Persons in mandatory sickness fund are higher (around 10 million) than the of privately insured (around 7.5 million). Higher income families with only one wage-earner stay in public insurance sickness funds, and do not move to private insurance. Private patients pay more than patients in the mandatory funds, which to some extent cross-subsidized costs. However, clinics and physicians *must treat* both mandatory and private patients.

Germans just increased the threshold for individuals to opt out in order to reduce the negative impact of this provision for their insurance system. Why? It is a matter of demographics. Historically, demographics patterns allowed lowered costs within the public mandatory system. More recently, there have come to be fewer young (healthy) people being net contributors and more elderly (requiring increased pay-outs). The salary thus has had to be raised to keep more net contributors in the mandatory system.[9]

Second, the private insurers are in trouble as well with premiums rising and elderly increasingly shopping for better prices. The private insurance market has become unstable, and some companies could experience a risk spiral – healthy people leave companies with increasing premiums leaving only the sick. Coupled with the decline in assets in the stock markets, many companies may find it difficult to pay out for services. The Government would (in the end) be stuck with unpaid bills.

As with pensions, a well-functioning system will be heavily dependent upon demographics and economic growth. But again, in Russia, the negative population growth and one of the highest Gini coefficients (measures of income inequality) in the world will conspire to render the mandatory system nonviable almost immediately.

[9] For more discussion, see Markus Schneider "The German Health Care System and Voluntary Opt Out Insurance," World Bank, March 2003.

What About Other International Experience?

The experience with opting out in Chile and Peru is similar -- medium and higher incomes in the formal labor market drop out of the social health insurance system and purchase private health care financing. In Chile, average incomes of those opting out has been seven (7) times higher than those remaining in the public insurance system. Since these are the higher incomes in the country, their level of contributions is also high and the benefits are only for the private sector, depriving the public health care system of these incomes and inhibiting solidarity. High income earners remain in the private sector; medium income earners return to the public system as soon as there is reduction in income, temporary unemployment, new individual or family consumer priorities (housing, cars, vacations). One of the first items to be put aside is private health insurance premiums. The result is that people who had left the social mandatory health insurance system come back based on the right to free health care without having contributed in the interim. The Government is left to find additional revenues to cover these groups.

On the delivery side, a clear two-tiered system of access and quality has quickly developed. In Chile, per capita expenditures for private health care has been four (4) times as much as in the public system. There were efforts to shut out some from the private system. There was some discrimination of elderly and females in fertile age groups, with private insurers raising premiums to these groups.[10]

Opting out and risk selection by private insurers have blown up the social health insurance systems for pensioners and self-employed in The Netherlands in the 1970s. Currently the re-modeling of the system into one type of insurance with one package is considered, i.e. getting rid of the current distinction between public and private insurance.

Policy Recommendation

Opting out should not be allowed. This is clearly the best and preferred policy course. But, if there is a political decision to grant opting out, regulations should clearly define the conditions for it to happen. For instance, requiring individual or family income 200% above average income as declared for tax purposes as a minimum. The tax deduction should only be partial, (for example, 50%, of social contributions for health insurance, or a percentage based on income with a cap for higher incomes), or not at all, to make sure that opt-outs fulfill their social obligation with partial or full contributions to the social mandatory health insurance system.

[10] For more information see Hernan Fuenzalida, "Opting Out of Mandatory Health Insurance in Latin American Countries," World Bank, March 2003.