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A Discussion of Private Health Insurance Markets in 10 OECD Countries

J. Bradley Karl

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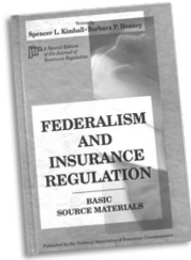

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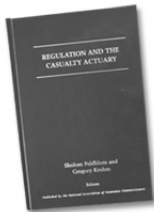

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A Discussion of Private Health Insurance Markets in 10 OECD Countries

J. Bradley Karl*

Abstract

The Patient Protection and Affordable Care Act (ACA) will undoubtedly change the nature of private health insurance market operations in the U.S. As such, insight regarding the operations of private health insurance markets is important to regulators, policymakers and all health insurance market participants. This paper helps to provide such insight by providing information relating to the private health insurance market operations of 10 member countries of the Organisation for Economic Co-operation and Development (OECD). Data and information from sources such as The Commonwealth Fund, the OECD, the World Bank and the European Observatory on Health Systems and Policies are combined to provide detailed country-specific discussions of private health insurance market operations. The information presented in this paper can be used to provide insight into the current and future operations of the changing U.S. private health insurance market.

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Introduction

The enactment of the Patient Protection and Affordable Care Act of 2010 (ACA) initiated changes that are unparalleled in history of the U.S. health insurance market. The regulations stipulated in the ACA are far-reaching and are likely to transform the U.S. health insurance market (Harrington, 2010). Among the most significant and discussed changes are the individual mandate to purchase health insurance coverage, mandated policy benefits, Medicaid expansion, the implementation of health insurance marketplaces/exchanges and the mandate that health insurers meet minimum medical loss ratio requirements. These, and all provisions of the ACA, will undoubtedly have short-term and long-term effects on every participant in the health insurance market, including regulators.

The provisions set forth in the ACA are such that the private health insurance market will be heavily relied upon to provide Americans with health insurance coverage. As the provisions begin to take effect, federal and state regulatory bodies must, therefore, be vigilant of the nature of the private health insurance market as they perform their respective regulatory duties. Regulatory decisions surrounding the ACA, such as the nature of health insurance marketplaces/exchanges or health insurance policy characteristics, will have consequences for private health insurance market operations and, ultimately, the health care of millions of Americans. As such, it is important for all market participants, especially those with regulatory authority, to have perspective on private health insurance market operations and, in particular, the nature of the interaction between private health insurance markets and government health care regulations.

One way to gain this perspective is to evaluate the role of the private health insurance market in countries outside the U.S. The role of the government in insuring the population against the financial burden of poor health varies greatly among countries around the world and, as a consequence, the role of the private health insurance market also varies greatly. For example, in certain countries, the private health insurance market is relied upon as the primary method for insuring the population, while, in other countries, the role of the private health insurance market is ancillary to government programs. Information regarding how the private health insurance market interacts with government health insuring programs in countries outside the U.S. — as well as the associated consequences for the insurers, insureds and additional market participants — is, therefore, a valuable asset to regulators as they carry out their duties, in the presence of the ACA.

This paper endeavors to inform regulators, public policymakers and other health insurance market participants of the roles, operations and characteristics of private health insurance markets in 10 countries: Australia, Canada, Denmark, France, Germany, Italy, Japan, the Netherlands, Switzerland and the United Kingdom (UK). Particular focus is given to the juxtaposition of private health insurance markets and government health insuring programs. The paper also

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provides information regarding regulations, insurance coverage rates, insurer operations and other health insurance market-specific characteristics in these countries. The countries included in the paper were selected because they are comparable to the U.S. in many respects, such as development and wealth, but all differ in terms of the private health insurance market operations and their role relative to government programs. The countries' relative homogeneity, in terms of economic conditions, and heterogeneity, in terms of private health insurance market operations, allow for relevant cross-country perspective on private health insurance markets abroad.

The information presented in this paper is important to regulators, public policymakers and all health insurance market participants in the U.S. as they consider the current and evolving role of the private health insurance market in the ACA era. In order to facilitate comparisons among different countries, this paper employs the Organisation for Economic Co-operation and Development's (OECD) method for classifying private health insurance markets and, thus, highlights an important framework that can be used for examining private health insurance market operations. Utilizing current data and information, the paper provides an up-to-date perspective on health insurance markets by presenting relevant and concise overviews of various private health insurance market operations. The paper also identifies many sources of information and data pertaining to various aspects private health insurance market operations, and is a useful source of current information to any regulator, researcher, policymaker or participant in private health insurance markets.

First, this paper begins with a discussion of the approach used to provide perspective on international health insurance markets. Next, the private health insurance market of each of the 10 countries is individually discussed in detail. Finally, this paper concludes with a discussion of the benefits of perspective relating to the differing roles of private health insurance markets around the world.

Data and Analytical Framework

The countries discussed in this paper are a subset of countries belonging to the OECD, and this analysis focuses on OECD member countries for several reasons. First, numerous prior studies that have evaluated health insurance markets at the country-level examine OECD member countries and use data from the OECD database (e.g., Fare, Grosskopf, Lindgren and Poullier, 1997; Or, 2000; Retzlaff-Roberts, Chang, and Rubin, 2004; Hadad, Hadad and Simon-Tuval, 2011). Also, because the OECD is largely comprised of developed nations with mature markets, the use of OECD countries facilitates inter-country comparisons among a set of countries similar to the U.S. in terms of development and wealth. Finally, the data reported by member countries and included in the OECD database allow for a more detailed discussion of a given country's health insurance market.

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The paper utilizes the OECD's health care financing data from 2009 through 2012,[1] depending on the variable, and the specific years of the data are provided in the respective table.[2] The scope of this paper required additional quantitative and qualitative information relating to the private health insurance markets of OECD member countries, such as regulatory constraints, insurer characteristics and policy benefits.[3] The additional information included in this paper was acquired from various country-level reports and databases published by the OECD, the European Observatory on Health Systems and Policies, The Commonwealth Fund and the World Bank, and all sources are referenced in the ensuing section.[4] Finally, the additional information from all various sources was combined with the OECD health care financing data. Thus, the 10 countries discussed in this paper represent the intersection of all relevant and available data and information provided by the various sources.[5]

Because there exists considerable heterogeneity among countries, in terms of the operations of private health insurance markets, it was necessary to employ a private health insurance market taxonomy that facilitates comparisons of

1. The current OECD database is available for download on the OECD's website and includes various data related to the health of a country's population, as well as data regarding a country's health care financing scheme. Data are available for various years from 1960 through 2012. Upon acquisition of the OECD database, it was found that certain member countries reported insufficient data related to health care financing, which limited the number of countries available for discussion in this paper.

2. The figures reported in this paper reflect the most recently available data for a given variable.

3. While the OECD health data (2013) provides valuable information regarding a country's health care financing mechanism, the analysis in this paper required additional data that is not provided in the OECD health data (2013). For example, to assess country-specific regulatory information, it was necessary to acquire descriptive, qualitative information from sources such as the European Observatory on Health Systems and Policies. While matching the OECD health data (2013) with information from other sources ultimately resulted in the reduction of countries discussed in this paper, it was necessary to achieve the aim of the paper.

4. Note that there exist many studies that consider topics related to country-level health care financing topics, but fewer studies have specifically considered private health insurance markets. Also, reliable data and studies regarding international health insurance markets are relatively limited. Given the nature of the quantitative and qualitative data required for the scope of this paper, it was necessary to limit the sample of countries to the 10 discussed here.

5. It is a common practice in the literature relating to country-level analyses of health care systems to analyze a single country or a subset of countries. Many prior studies consider only a single country when examining topics such as health care system performance, health insurance markets or the health of a population (e.g., Colombo and Tapay, 2003; Tapay and Colombo, 2004). Other studies that simultaneously consider multiple countries often analyze a subset of countries associated with various organizations, such as the OECD, the World Health Organization (WHO) or the World Bank (e.g., Davis, Schoen and Stremikis, 2010; Schoen, Osborn, Squires, Doty, Pierson and Applebaum, 2010). Data limitations, both qualitative and qualitative, are a frequently cited reason for analyzing a subset of countries, especially when the research relates to health insurance markets. The analysis of a subset of countries in this paper is, therefore, consistent with the literature relating to country-level analysis of health care systems.

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private health insurance markets.[6] This paper, therefore, follows the taxonomy employed by the OECD and others (e.g., Colombo, 2007) that classifies a private health insurance market relative to the role of the public health care mechanism.[7] Here, the private health insurance market of a given country can be classified as primary, duplicate, complementary and/or supplementary[8] and, for the purposes of this paper, are defined as follows:

A private health insurance market is primary if it provides the only access to health insurance for a part or all of a country's population.[9]

Duplicate private health insurance markets are markets "that offer coverages for health services already included under government health insurance, while also offering access to different providers (e.g., private hospitals) or levels of services (e.g., faster access to care)."[10] That is, if private health insurers provide coverage for services for which the government program already provides first-dollar coverage, then private health insurance markets are classified as duplicate (Paris, Devaux, and Wei, 2010).

Complementary markets offer private health insurance "that complements coverage of government/social insured services by covering all or part of the residual costs not otherwise reimbursed (e.g., cost-sharing, co-payments)."[11]

Supplementary private health insurance markets provide "coverage for additional health services not at all covered by the government/social schemes."[12]

To summarize, this paper discusses the private health insurance market operations of a subset of OECD member countries. Combining all the available and relevant data and sources required for the scope of this paper yields the final subset of 10 countries discussed in this paper. In an effort to facilitate cross-country discussions and comparisons, the private health insurance markets of the 10 countries are classified based on their function relative to the government program. Using this classification scheme, as well as additional country-specific health insurance market information, the paper then combines a variety of sources

6. Private health insurance is an arrangement "financed through private health premiums, i.e. payments that a policyholder agrees to make for coverage under a given insurance policy, where an insurance policy generally consists of a contract that is issued by an insurer to a covered person." (OECD 2013) Employer self-insured plans are also considered private health insurance.

7. See Appendix A for a brief description of the role of the government in the provision of health care among the 10 countries discussed in this paper.

8. Note that the definitions for "duplicate," "complementary" and "supplementary" were acquired from the OECD (2013).

9. The definition of "primary private insurance" in this paper differs slightly from that of the OECD. This paper considers countries that mandate the purchase of health insurance policies from competing insurers as having a primary private health insurance market. This is done to highlight the predominate role that private health insurance markets have in certain countries. Note that, among the 10 countries considered here, the discrepancy between the OECD's definition and the definition in this paper is only pertinent to the Netherlands and Switzerland. Note also that all other classifications used in this paper do not differ from the classifications given by the OECD (2013).

10. OECD (2013).

11. OECD (2013).

12. OECD (2013).

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to provide descriptions of the private health insurance markets in Australia, Canada, Denmark, France, Germany, Italy, Japan, the Netherlands, Switzerland and the UK.

Private Health Insurance Markets in 10 OECD Countries

Overview

Table 1 provides summary demographic information of the 10 countries discussed in this paper and includes information regarding the U.S. for comparison purposes. Japan is the only country with a population exceeding 100 million; seven countries have populations between 10 million and 100 million and two countries have populations of less than 10 million.[13] All countries are ranked in the top 25 in terms of gross domestic product (GDP) per capita, suggesting similarities in terms of economic development and prosperity.[14] A simple standardized comparison of means indicates that, with the exception of the U.S., no drastic disparities exist among countries in terms of life expectancy and mortality (given as "years lost").[15] Further, with the exception of Japan, there is no statistically significant difference in mean cancer rates and the perception of overall health among the 10 countries.[16] While the information presented in Table 1 does not substantiate a relation between market structure and health status, it suggests a degree of homogeneity among the countries discussed in this paper, in terms of economic development and health. Examining the heterogeneity of private health insurance markets among a sample of similarly developed and healthy countries is likely of greater value to policymakers attempting to gather insight into the various

13. While the 10 countries have smaller populations than the U.S., there is no direct observable trend between population size and the classification of the private health insurance market. Thus, perspective on the roles of international health insurance market is still relevant to the U.S. despite larger populations.

14. A standardized comparison of mean indicates that, among the 10 countries discussed here, the only country with a statistically significant difference in mean GDP per capita is Switzerland.

15. Life expectancy is measured as the average life expectancy at birth, in years, for females in a given country. The measure of mortality, "years lost" is a variable calculated by the OECD that quantifies potential years of life lost, per 100,000 females, in a given country due to preventable deaths.

16. "Cancer rates" is defined as the number of cancer instances per 100,000 persons in a given country. Perception of health is measured as the percentage of the population of a given country with a perceived health status greater than "good."

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costs and benefits associated with a given level of reliance on private health insurance markets.[17]

Table 1:
Country Characteristics

Country	Pop.	GDP PC	Std. Diff	Life Expect.	Std. Diff.	Years Lost	Std. Diff	Cancer	Std. Diff	Perc. Health	Std. Diff.
Australia	22,647	44,462	0.55	84.2[a]	0.27	2,038.0[a]	(0.65)	314.1[d]	1.00	91.7[e]	0.35
Canada	34,181	42,693	0.25	83.3[c]	(0.34)	2,504.7[c]	0.46	296.6[d]	0.43	93.6[a]	0.49
Denmark	5,505	41,388	0.03	81.9[a]	(1.28)	2,379.6[a]	0.16	321.1[d]	1.22	83.6[a]	(0.22)
France	63,724	35,845	(0.91)	85.7[a]	1.28	2,283.8[c]	(0.07)	300.4[d]	0.55	89.5[a]	0.20
Germany	81,212	40,394	(0.14)	83.2[a]	(0.40)	2,208.5[a]	(0.25)	282.1[d]	(0.04)	89.9[a]	0.23
Italy	59,101	32,512	(1.48)	85.3[a]	1.01	1,807.0[a]	(1.20)	274.3[d]	(0.30)	94.9[a]	0.58
Japan	127,498	35,204	(1.02)	85.9[a]	1.41	2,030.0[a]	(0.67)	201.1[d]	(2.68)**	43.5[b]	(3.08)**
Netherlands	16,778	42,938	0.29	83.1[a]	(0.47)	2,263.0[a]	(0.12)	289.9[d]	0.21	92.6[a]	0.42
Switzerland	7,955	52,063	1.85*	85[a]	0.81	1,934.0[b]	(0.90)	269.3[d]	(0.46)	89.1[a]	0.17
United Kingdom	63,209	35,819	(0.92)	83.1[a]	(0.47)	2,537.3[b]	0.54	269.4[d]	(0.46)	89.9[a]	0.23
United States	316,266	49,965	1.49	81.1[a]	(1.81)	3,446.8[a]	2.70**	300[d]	0.54	95.7[a]	0.64
Mean		41,207.55		83.80		2,312.06		283.48		86.73	
Standard Deviation		5,881.17		1.49		420.68		30.74		14.03	

This table provides summary information for select country characteristics of the 10 countries discussed in this paper. The U.S. is included to facilitate comparisons. The column title "Pop." contains the population, in millions, for a given country in 2012 and was obtained from the OECD health data (2013). "GDP PC" provides the gross domestic product, per capita, for a given country in 2012 based on Purchasing Power Parity (PPP). Data in "GDP PC" were obtained via the World Bank database, accessed in July 2013. "Life Expect." is the average life expectancy at birth, in years, for females in a given country and data were obtained from the OECD health data (2013). "Years Lost" is a variable calculated by the OECD, and given in the OECD health data (2013), that quantifies potential years of life lost, per 100,000 females, in a given country due to preventable deaths and is measure of premature mortality. "Cancer" is the number of cancer instances, per 100,000 persons in a given country and is given in the OECD health data (2013). "Perc. Health" is the percentage of the population of a given country with a perceived health status greater than "good" and is provided by the OECD health data (2013). "Std. Diff" is the difference between the mean value and a given value for a particular characteristic in a given country scaled by the population standard deviation. The "Std. Diff" for a given characteristics in a given country is provided in the column immediately following the given characteristic.

Note: The information presented here represents the most recently available data. However, due to data limitation in the OECD health data (2013), uniformity of years is not possible and the years of the given data are denoted as follows:

a 2011.
b 2010.
c 2009.
d 2008.
e 2007.

If a data element is not assigned a superscript, the year is 2012.
* Denotes significance at the 10% level.
** Denotes significance at the 5% level using population standard deviation.

17. For example, comparing the private health insurance markets of two well-developed countries with similar populations is likely to provide more valuable information to U.S. regulators and policymakers than comparing the private health insurance markets of a well-developed country and a poorly developed country.

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Table 2 provides summary information regarding the countries' health care financing expenses. In contrast to the U.S., total expenditures on health as a proportion of GDP never exceed 12% and range from 8.9% to 11.9%. When total health expenditures from all private sources (e.g., out-of-pocket payments, private non-primary insurers, non-profits, etc.) is scaled by total health expenditures in a given country, Switzerland has the largest figure (35.1) while the Netherlands has the smallest (13.4). Finally, when private health insurance expenditures on health care are scaled by total health care expenditures, there is a 12.9% difference between the smallest figure (Italy) and the largest figure (France).[18] To the extent that different roles of private health insurance market may influence health care spending from various sources, Table 2 suggests that regulators and other health insurance market participants may benefit from an improved understanding of private health insurance market operations in countries outside the U.S.

Another important observation in Table 2 is that mean relative total health care expenditures, mean relative private health expenditures and mean relative private health insurance expenditures in the U.S. are all much larger than any of the 10 countries discussed in this paper. A standardized comparison of means indicates that this difference is statistically significant from the other countries. This observation is likely of interest to policymakers in the U.S. because it highlights the dramatic difference in the cost/benefit trade-off of the U.S.'s largely private system relative to that of other countries.

18. Note that, in the Netherlands and Switzerland, the figure for private health insurance expenditures does not include primary private health insurance expenditures. This is due to the nature of the reporting in the OECD health data (2013).

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Table 2:
Expenditures on Health Care

Country	Tot. Health Exp. to GDP	Std. Diff	Pct. Private Health Exp.	Std. Diff.	Pct. Private Ins. Health Exp.	Std. Diff
Australia	8.90%	(0.98)	32.2[a] %	0.62	7.8[a] %	(0.14)
Canada	11.20%	0.02	29.6 %	0.37	12.3 %	0.37
Denmark	10.90%	(0.11)	14.7 %	(1.01)	1.8 %	(0.82)
France	11.60%	0.19	23.2 %	(0.22)	13.9 %	0.55
Germany	11.30%	0.06	23.5 %	(0.19)	9.4 %	0.04
Italy	9.20%	(0.85)	22.2 %	(0.31)	1 %	(0.91)
Japan	9.60%	(0.68)	17.9 %	(0.71)	2.4 %	(0.75)
Netherlands	11.90%	0.32	13.4[b] %	(1.13)	5.2[b] %	(0.43)
Switzerland	11%	(0.07)	35.1[b] %	0.89	8.6[b] %	(0.05)
United Kingdom	9.40%	(0.76)	17.2 %	(0.78)	3 %	(0.68)
United States	17.70%	2.85**	52.2 %	2.47**	33.8 %	2.80**
Average	0.11		0.26		0.09	
Standard Deviation	0.02		0.11		0.09	

This table provides summary information regarding health care spending in a given country for the year 2011 (unless otherwise noted). All information in this table was obtained from the OECD health data (2013). "Tot. Health Exp. to GDP" is the amount of total expenditures on healthcare, from any source, scaled by gross domestic product. "Pct. Private Health Exp." is defined as the amount of private expenditures on healthcare, from any source (i.e., private insurance companies, out-of-pocket payments, charities, etc.), scaled by total expenditures on healthcare from all sources. "Pct. Private Ins. Health Exp." is the total amount of expenditures on health from private insurance companies, scaled by total expenditures on healthcare from all sources. The figure does not include life and long term care insurance schemes but does include employer self-insured health benefits. "Std. Diff" is the difference between the mean value and a given value for a particular characteristic in a given country scaled by the population standard deviation. The "Std. Diff" for a given characteristics in a given country is provided in the column immediately following the given characteristic.
Note: The figures shown for the Netherlands are scaled by total current expenditures on health due to data limitations in the OECD health data (2013).
a 2010.
b Excludes expenditures for primary health insurance policies.
* Denotes significance at the 10% level.
** Denotes significance at the 5% level using population standard deviation.

Table 3 provides more detail regarding the different roles of the private health insurance market. In three countries, private health insurers provide primary health insurance coverage for some or all citizens in a country. Three countries have private health insurance markets that duplicate coverages under the government scheme, four have markets that complement the government scheme and seven countries have markets that are supplementary in nature. Note that, in the majority of countries, the private health insurance market occupies multiple roles. More detail regarding the role of the private health insurance market is provided in the ensuing country-specific discussions but, viewed in its entirety, Table 3 shows the extent of heterogeneity among countries, in terms of the role of the private health insurance market.

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Table 3:
Functions of the Private Health Insurance Market

Country	Primary	Duplicate	Complementary	Supplementary
Australia		X		X
Canada				X
Denmark			X	X
France			X	
Germany	X*		X	X
Italy		X		
Japan			X	X
Netherlands	X**			X
Switzerland	X**			X
United Kingdom		X		

This table indicates the function of the private health insurance market in a given country. The function of the private health insurance market is the role of the private health insurance market, relative to the role of the government, in providing health insurance coverage.
Source: OECD (2013) for all classifications and all countries except primary in the Netherlands and Switzerland and duplicate in Italy, which were hand classified.
* Certain persons may opt out of the government program and receive primary private coverage.
** The government mandates the purchase of private health insurance as the primary source coverage.

Table 4 provides information regarding the role of the private health insurance market in providing health insurance coverage to the population of a given country. The proportion of the population that is covered by a complementary, duplicate or supplemental health insurance policy, given in “coverage rates,” varies widely from country to country. In all countries where information is available, there exists an individual private health insurance market and many countries also have a group health insurance market. In certain countries, life insurance products also serve to provide protection against health risks by, for example, providing lump-sum cash benefits in the event of a lengthy hospital stay or the diagnoses of a specified disease. Also not reported in Table 4 is that reports from The Commonwealth Fund and the European Observatory on Health Systems and Policies indicate that for-profit and not-for profit insurance companies operate in all 10 countries, though the market share of for-profit insurers varies greatly among countries.

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Table 4:
Overview of Private Health Insurance Market Characteristics

Country	Coverage Rates	Individual Market	Group Market	Life Insurance Component
Australia	50%	Yes	No	Yes (e.g., disability and chronic illness benefits.)
Canada	67%	Yes (10%)	Yes (90%)	Yes (e.g., disability and chronic illness benefits)
Denmark	55%	Yes	Yes	No
France	90%	Yes	Yes	N/A
Germany	20%	Yes	Yes	Yes (e.g., permanent disability benefits)
Italy	15%	N/A	N/A	N/A
Japan	> 50%*	Yes	Yes	Yes (e.g., cancer/specified disease insurance)
Netherlands	90%	Yes (56%)	Yes (44%)	No
Switzerland	> 50 %*	Yes	No	N/A
United Kingdom	11%	Yes	Yes	Yes (e.g., critical illness)

This table describes various country-level characteristics of the private health insurance market of a given country. "Coverage Rates" indicates the proportion of the population that purchase complementary, duplicate, or supplemental private health insurance policies. Note that, for the Netherlands and Switzerland, coverage rates for primary policies are excluded from this figure because primary private coverage is mandated by law. Primary private coverage rates are also excluded from the German figure for ease of comparison with other countries, but approximately 10% of Germans are covered by primary private health insurance policies. "Individual Market" indicates whether there is a private individual health insurance market and, when the information is available, reports the proportion of the private health insurance market that is attributable to individual policies sold. The information in the "Group Market" column is the same as in the "Individual Market" column, except that the information relates to group health insurance. "Life Insurance Component" indicates whether insurance companies offer life products containing a health insurance element and, where applicable, provides example of role of life insurance products. "N/A" denotes that information was not available in the source.
Sources: Information reported in "Coverage Rates" is from Commonwealth Fund (2012). All other information is from OECD (2013).
* Source reported that the "majority" of persons purchase coverage from private insurance companies.

Considering the broad view of the nature of private health insurance markets highlights the many differences that exist among countries' health insurance market operations. Differences among countries, in terms of the role of the private health insurance market, spending, coverage rates and regulatory constraints, provides regulators and all health insurance market participants the opportunity to gain perspective on the current operations of private health insurance markets in other countries. To provide a more robust view of international health insurance markets, the ensuing subsection provides country-specific discussions of private health insurance markets in 10 OECD countries. Most of the information referenced in the country-specific discussion is given in Table 1 through Table 4, and sources for all other information are provided at the end of each country-specific discussion.

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Country-Specific Discussions

Australia[19]

For-profit and not-for-profit health insurers provide insurance products that both duplicate and supplement health care services available under the national health insurance scheme. Private insurers may contract with hospitals and practitioners, and they provide privately insured persons with greater choice among private hospitals and specialists practitioners, relative to persons not privately insured. Private insurance policies also provide coverage for various services not covered under the public option, such as dental, optometric, chiropractic and pharmaceutical services. The market is dominated by individual policies, and life insurance products sold in the country often contain a health element, such as lump-sum benefits for chronic medical conditions or diseases.

Private health insurers are regulated, within a legislative framework, by the Private Health Insurance Administration Council and they must be a Registered Health Benefit Organization. Private policies in Australia are community rated and, while the purchase of private policies is voluntary, government incentives encourage purchases. For example, individuals and families with income levels below certain thresholds receive a subsidy for private health insurance, while individuals and families with income levels above certain thresholds are taxed a surcharge if they do not purchase private health insurance. In addition, the federal government pays rebates on private health insurance premiums. Lifetime Health Coverage, which provides reduced lifetime health insurance premiums if purchased before the age of 31, also encourages the purchase of private health insurance in Australia.

As noted in Table 4, approximately 50% of the population is covered by a private health insurance policy. Specifically, as of June 2013, 47.0% of Australians had duplicate private coverage for hospital coverage and 54.9% had supplemental private health insurance. Among the 10 countries considered in this paper, Australia has the lowest ratio of healthcare expenditures to GDP (8.9%) but has one of the highest ratios of private health care expenditures to total health care expenditures (32.2%). In addition, private health insurers' expenditures on health care account for approximately 7.8% of total health care expenditures.

19. Information acquired from the following sources was combined to describe Australia's private health insurance market: Australia's Private Health Insurance Administration Council (2013); OECD health data (2013); World Bank data (2013); OECD (2013); Table 1 in The Commonwealth Fund (2012); Paris, Devaux and Wei (2010); Healy, Sharman and Lokuge (2006).

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Canada[20]

The primary function of the private health insurance market is to supplement coverages not available in Canada's universal health care program. Provincial regulations prohibit and/or discourage private health insurers from providing policies that duplicate coverages available under the public option by, for example, providing coverage for faster access to publicly funded services. Instead, for-profit and not-for-profit insurers provide policies that cover the costs associated with services such as prescription drugs, dental care or private hospital rooms, which are not available under the public option. Group health insurance policies — available through employers, professional associations and similar organizations — account for approximately 90% of the private health insurance market.

Regulation of the Canadian private health insurance market occurs at both the federal and provincial level. Common regulatory constraints include measures to ensure policyholder indemnification, promulgation of disclosure and other insurer operational requirements, and determining the nature of the services allowed to be covered by private health insurers. However, certain financial incentives exist to incentivize the purchase of private health insurance or reduce the cost burden associated with the purchase of private supplementary health insurance. In the majority of provinces and territories, premiums and benefits receive preferential tax treatment and, for example, contributions to employer-sponsored health insurance plans are tax-deductible.

As of 2012, approximately 90 life and health insurance companies operated in the country and provided supplementary health insurance policies to the population. Total premiums collected by Canadian life and health insurers for health plans amounted to approximately $31 billion in 2012. As noted in Table 3, approximately two-thirds of Canadians (or approximately 23 million persons) are covered by a private health insurance policy. Relative to the other countries, Canada has a higher level of total health expenditures to GDP (11.2%), a higher level of total private expenditures on health to total expenditures on health (29.6%) and a higher level of private insurance expenditures on health (12.3%).

Denmark[21]

The function of the private health insurance market is to both complement and supplement the wide range of services available in Denmark's universal health care program. Demand for private health insurance policies that provide for complementary coverage — such as reimbursement for cost-sharing in the

20. Information acquired from the following sources was combined to describe Canada's private health insurance market: OECD health data (2013); World Bank data (2013); OECD (2013); Marchildon, G.P. (2013); Canadian Life and Health Insurance Association (2013); Table 1 in The Commonwealth Fund (2012); Paris, Devaux and Wei (2010).

21. Information acquired from the following sources was combined to describe Denmark's private health insurance market: OECD health data (2013); World Bank data (2013); OECD (2013); Table 1 in The Commonwealth Fund (2012); Olejaz, Juul Nielsen, Rudkjobing, Okkels Birk, Krasnik and Hernandez-Quevedo (2012); Paris, Devaux and Wei (2010).

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statutory system, dental services or prescriptions — has been growing since the 1970s. The complementary private health insurance market is dominated by a not-for-profit mutual organization. However, for-profit commercial insurers provide policies that supplement publicly available services, such as, for example, by providing coverage for treatment at private health care facilities. Demand for such supplementary health insurance policies has greatly increased since the early 2000s, and the majority of persons with supplementary health insurance obtain coverage via an employer.

While the Danish Financial Services Authority regulates insurance companies in Denmark, insurers providing health insurance products are afforded a degree of regulatory latitude. For example, insurance premiums are competitively determined and insurers may also decline insurance applicants who suffer from a preexisting medical condition. The supplementary private health insurance market has also benefited from tax incentive legislation enacted in 2002. The legislation made health insurance premiums tax deductible for employees as well as employers, and is partially attributed to the rise in demand for supplementary health insurance products. Further, while there exists little policy debate regarding complementary private health insurance, the tax incentives surrounding the supplementary health insurance market have been a subjective of policy debate.

Denmark's total health care spending as a percentage of GDP was 10.9% in 2011, and is fifth among the countries considered in this paper. However, Denmark is one of the lowest in terms of relative private expenditures on health (14.7%) and relative private insurance expenditures on health (1.8%). Despite the relatively lower private expenditure levels, approximately 55% of the population is covered by a private health insurance product. The not-for-profit mutual provider of complementary insurance policies covered around 2.1 million persons in 2011. The supplementary insurance market, which is dominated by seven for-profit insurance companies, provided policies that covered approximately 1 million persons in 2009, up from less than 50,000 persons covered in 2001. The supplementary health insurance market also provides policies that provide lump-sum benefits in the event of specified diseases or illnesses.

France[22]

France's universal statutory health insurance (SHI) program provides a broad range of services to residents and, as such, the private health insurance market complements the SHI. Private health insurance policies reimburse policyholders for cost-sharing expenses incurred in the SHI and for the costs of additional services, such as dental and vision services, for which the SHI provides little coverage. While certain policies also provide limited coverage for supplementary and duplicate services, such as coverage for a private rooms or ophthalmologic

22. Information acquired from the following sources was combined to describe France's private health insurance market: OECD health data (2013); World Bank data (2013); OECD (2013); Table 1 in The Commonwealth Fund (2012); Chevreul, Durand-Zaleski, Bahrami, Hernandez-Quevedo and Mladovsky (2010); Paris, Devaux and Wei (2010).

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surgeries, the major function of the private health insurance market is complementary. Individual and group policies are available and, in many cases, employers bear a portion of employees' private health insurance premiums. Two categories of not-for-profit health insurers (mutual insurance companies and provident institutions), as well as for-profit commercial health insurers, participate in the market and each category of insurer has developed market niches in terms of the nature of policy coverages and policyholder characteristics.[23]

The federal regulation of private health insurers differs among the categories of insurers. Mutual insurance companies are regulated by the Mutual Insurance Code and are required to avoid premium differentiation among insureds, as much as possible, in the presence of competition from other insurers. Because provident institutions specialize in providing group health insurance to firms that require employees to enroll in private health insurance, these not-for-profit institutions are regulated by the Social Security Code and the Commercial Insurance Code. Commercial insurers are regulated by the Commercial Insurance Code and are permitted to use a wide array of factors, including health status, in the underwriting process. In 2000, legislative efforts directed the SHI to offer complementary health insurance, at no cost to persons below certain income thresholds, which is financed through a premium tax on private health insurance contract. However, the government also provides financial incentives for the purchase of private health insurance via tax deductions for employees and rebates for employers.

Total private health care expenditures scaled by total health care expenditures were 23.2% in 2011. France ranks high among the 10 countries in terms of relative total health care spending (11.6%) and relative spending by private insurers (13.9%). In fact, relative to the other countries, private health insurance products play a significant role in insuring the population in France. Approximately 90% of persons are covered by a private health insurance policy. In 2008, 74.3% of the population held a policy from a mutual or a provident institution and approximately 27.4% of the population was covered under a policy from a commercial insurer.[24]

Germany[25]

Health insurance is mandatory for all citizens and most persons obtain coverage through the statutory health insurance (SHI) scheme via not-for-profit

23. For example, compared to commercial for-profit insurers, mutual insurers rely less on risk in determining rates. As such, mutual insurance companies insure a greater portion of the elderly population relative to commercial-for-profit insurers.

24. The figures do not sum to 100% due to the fact that one person may hold multiple contracts from different companies.

25. Information acquired from the following sources was combined to describe Germany's private health insurance market: OECD health data (2013); World Bank data (2013); OECD (2013); Table 1 in The Commonwealth Fund (2012); Blumel (2012); Busse (2011); Paris, Devaux and Wei (2010); Busse and Riesberg (2004).

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health insurance funds. These so-called sickness funds reimburse providers for services rendered to insureds, including preventative services, inpatient and outpatient care, dental and vision care, and prescription drugs. However, civil servants, self-employed persons and persons with income exceeding a certain threshold may choose to opt out of the SHI and instead obtain primary health insurance coverage from private health insurers. In the private health insurance scheme, for-profit and not-for-profit insurers provide policies based on lifetime underwriting, and individual and employers bear the cost of premiums. Private insurers also offer a variety of contracts with coverages that supplement and complement SHI coverage.

Private insurers are permitted to charge risk-related premiums and may underwrite based on factors such as age, sex and medical history. Individuals may choose among insurers and switching to an alternative health insurance company is not prohibited. However, federal regulation of the private health insurance market often addresses policyholder insurability and cost. For example, because, in many cases, persons opting into the private insurance market are not permitted to opt back into the SHI, private insurers are required to offer basic insurance benefits for persons unable to afford the private insurance premium and unable to return to the SHI scheme. In addition, aging reserves for the lifetime contracts must be transferable to another insurer if a privately insured policyholder changes insurers or is cancelled by their current insurer.

In 2011, Germany's proportion of total health care expenditures to GDP was 11.3%, making it third-highest among the countries in this paper. In 2011, expenditures on health care from private sources scaled by expenditures on health care from all sources were 23.5%. Relative expenditures from private insurers on health care were 9.4%. Approximately 10% of persons elect to receive primary private health insurance. In addition, approximately 20% of persons obtain supplementary or complementary coverage in the private health insurance market. In 2010, there were 24 for-profit health insurers and 19 not-for-profit health insurers operating in the marketplace.

Italy[26]

The universal public health care system provides all residents with coverage for a large number of number of services deemed as required for essential care. Private insurers play a duplicative role by, for example, providing access to private services and shorter waiting times or providing greater provider choice than publicly insured persons. For-profit commercial insurers, as well as not-for-profit mutual insurers, both operate in the market and provide group insurance contracts, as well as individual insurance contracts.

26. Information acquired from the following sources was combined to describe Italy's private health insurance market: OECD health data (2013); World Bank data (2013); OECD (2013); Table 1 in The Commonwealth Fund (2012); Paris, Devaux and Wei (2010); Lo Scalzo, Donatini, Orzella, Cicchetti, Profili and Maresso (2009); Colombo (2007).

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The private health insurance market is often regulated at the regional level and the nature of regulation may differ among different regional jurisdictions. Regulatory constraints generally permit a degree of discretion in the underwriting process. For example, insurers that provide individual policies are permitted to rate premiums according to risk, including health status. Commercial insurers are also permitted to offer group and individual policies with eligibility restrictions for age or dependents. The government also permits premiums paid to group commercial health insurers, as well as any mutual insurer, to be tax-deductible up to a pre-specified limit. Additional tax incentives are also offered for costs associated with complementary health insurance policies.

Among the 10 countries considered here, Italy's relative total health care expenditures of 9.2% is the second-lowest. Private health care expenditures from all sources accounted for approximately 22.2% of total health care expenditures in 2011, but the private health insurance market only accounted for 1% of those expenditures. Further, Italy's private health insurance market is not just small in terms of expenditures. Only 15% of the population is covered by some form of private health insurance product, making Italy's private health insurance market the second-smallest, in terms of population coverage, of all countries considered in this paper. Also of note is that few insurers specialize in health insurance and the majority of insurers offering health products also offer other non-health insurance products.

Japan[27]

Japan provides universal health care to residents through a statutory health insurance program composed of non-competing public and employer-based insurance funds. Benefits under this public scheme include inpatient care, outpatient care, certain dental services and mental health care, and the private health insurance market plays a complementary and supplementary role. Private supplementary health insurance policies are offered by for-profit life insurance companies and pay a lump-sum benefit when the privately insured person is hospitalized for a certain amount of time or is diagnosed with a specific disease. The marketplace also occupies a complementary role by offering coverages for out-of-pocket expenses incurred in the public scheme.

Regulation of insurers is the responsibility of the Japanese Ministry of Health, Labour, and Welfare. Private health insurers are afforded a degree of underwriting latitude and private insurance applicants are subject to health screenings and may be denied coverage due to health status. The group health insurance market is small due to employers' role in the statutory system. Complementary and supplementary health insurance policies are usually individual policies sold in conjunction with other life insurance products. Premiums paid by individual for

27. Information acquired from the following sources was combined to describe Japan's private health insurance market: OECD health data (2013); World Bank data (2013); OECD (2013); Life Insurance Association of Japan (2012); Table 1 in The Commonwealth Fund (2012); Paris, Devaux and Wei (2010); Tatara and Okamoto (2009).

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health insurance products are tax-deductible up to a certain income threshold and the demand for the supplementary, lump-sum policies largely exceeds that of the complementary policies.

Total health expenditures equated to approximately 9.6% of Japan's GDP in 2011. Total health expenditures from private sources accounted for 17.9% of total health care expenditures, and health insurance expenditures accounted for approximately 2.4% of total expenditures on health care. However, private health insurance products in Japan are widely held. Approximately 25 million independent medical life insurance policies were in force in 2011, while, in that same year, approximately 70 million life insurance policies contained a rider that pays benefits in the event of hospitalization for sickness or accident. In addition, approximately 1.68 million persons held a complementary medical care insurance policy in 2011.

The Netherlands[28]

Since 2006, all persons residing in the Netherlands are required to purchase health insurance from private health insurance companies. As the primary source of health insurance for all residents, the private insurance market is required to provide a basic benefits package that includes coverage for general practitioner services, hospital services, certain dental services and pharmaceuticals. Private health insurers also serve a supplementary role by providing policies that cover services not mandated in the basic package, such as dental care or optometric services. While the market is dominated by not-for-profit insurers, in terms of market share, both for-profit and not-for-profit insurers offer individual and group health insurance policies. The policies can be structured to reimburse the physician directly or to indemnify the insured for services paid to providers.

The mandatory basic health insurance scheme is regulated under the Health Insurance Act, which stipulates a community rating system that precludes underwriting based on health status. All applicants for primary health insurance coverage must be accepted by insurers. This statutorily determined premium is paid by insureds directly to the health insurer of their choice and an additional income-based premium is paid by employers to a health insurance fund that aids private insurers in the risk-adjustment process. There are fewer regulatory constraints for supplementary policies, and insurers are permitted to underwrite based on risk and may charge differential premiums. Supplementary policies may also vary in terms of the nature of policy benefits. Health insurance premiums are generally only tax-deductible for certain groups, such as the chronically ill. Note that insureds are free to choose insurers for both the mandated benefits policy, as

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28. Information acquired from the following sources was combined to describe the Netherland's private health insurance market: OECD health data (2013); World Bank data (2013); OECD (2013); Table 1 in The Commonwealth Fund (2012); Wesert, van den Berg, Zwakhals, de Jong and Verkleij (2010); Schafer, Kroneman, Boerma, van den Berg, Westert, Deville and van Ginneken (2010); Paris, Devaux and Wei (2010).

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well as the supplementary policy, and there has been an increase in competition among private health insurers since 2006.

In the Netherlands, total health care spending as a proportion of GDP was 11.9% in 2011, ranking the highest among all 10 countries. Excluding expenditures related to primary health insurance coverage, relative private expenditures on health and relative private health insurance expenditures on health were 13.4% and 5.2%, respectively. Approximately 99% of all persons receive primary health insurance coverage from private health insurers. Supplementary health insurance policies are also held by more than 90% of the population. Individuals often purchase the supplementary policies from the same insurer that provides the primary policy. Also of note is that the private health insurance market is concentrated and the four largest health insurance companies had a combined market share of approximately 88% in 2010.

Switzerland[29]

In 1996, universal health coverage was mandated through a statutory health insurance scheme that requires that all residents purchase health insurance from competing not-for-profit insurers. Mandated benefits of primary insurance policies typically include inpatient care, outpatient care, certain preventative services and prescription drug costs. Private health insurers also occupy a supplementary role by providing policies to cover services not covered in the mandated benefits package, such as various dental services or long-term care. Because supplementary health insurance policies may be provided by for-profit insurers, many not-for-profit insurers participating in the statutory scheme also have a for-profit division that sells supplementary and duplicate policies.

Regulation of the statutory health insurance scheme occurs at the federal level through the Federal Office of Public Health. Companies providing non-statutory health insurance products are regulated by the Swiss Financial Market Supervisory Authority. Cantons (equivalent to states in the U.S.) and other municipalities also have varying degrees of regulatory responsibilities. For the statutory system, all premiums are subject to regulatory approval and insurers may underwrite based on limited factors, including region, age and deductible level. Insurers providing supplementary policies, in contrast, may base underwriting decisions on a variety of factors, including health status. Of note is that the law prohibits insurers from denying supplementary coverage to applicants based on information obtained though participation in the statutory scheme, which is possible because a given insurer may sell statutory or supplemental health insurance policies.

In 2011, the total expenditures on health scaled by GDP were 11% and private expenditures on health scaled by total expenditures on health were 35.1%. Expenditures from private supplementary health insurers amounted to 8.6% of

29. Information acquired from the following sources was combined to describe Switzerland's private health insurance market: OECD health data (2013); World Bank data (2013); OECD (2013); Table 1 in The Commonwealth Fund (2012); Camenzind (2012); Camenzind and Squires (2011); OECD/WHO (2011); Paris, Devaux and Wei (2010).

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total expenditures on health. All residents are required to obtain primary health insurance coverage from private health insurers and there are almost no uninsured persons in Switzerland. There is also considerable demand for supplementary private health insurance policies and the majority of the population purchases these policies. In addition, demand for private health insurance of any kind is at the individual level and individual policies must be purchased for each dependent.

United Kingdom[30]

The UK's universal National Health System (NHS) provides a wide range of health insurance services to all ordinary residents. As a result, the function of the private insurance market is to provide policies that largely duplicate services available in the NHS. While dominated by not-for-profit insurers, the private market consists of for-profit and not-for-profit insurers that offer group and individual health insurance policies. A majority of privately insured persons obtain coverage through employers and the typical policy covers "acute conditions," generally defined as conditions that are likely to respond quickly to treatment. More specifically, while insurers are free to determine the benefits package offered, the typical policy includes coverage for surgery, a variety of inpatient service and hospital rooms and excludes coverage for services such as general practitioner services, organ transplants, dental services and emergency care. Policies providing coverage for services above acute conditions are sold by private insurers and are typically more expensive than the standard policy.

While regulation of private insurance products and pricing is relatively negligible, the UK Financial Services Authority regulates health insurers in areas such as capital adequacy, consumer welfare and product sales. Individual and group insurers are allowed a degree of latitude in the underwriting process and pricing decisions can be based on age, sex, smoking status, occupational status or health status. The exclusion of coverage for preexisting conditions is permitted in the individual health insurance market, but individual policies must guarantee the option of renewability at the end of the policy period. In addition, there are limits on charges for profits, administrative expenses and other loading factors. While there are limited financial incentives given to private health insurance purchasers (e.g., tax deductions, etc.), regulatory flexibility, in terms of product offerings, has allowed insurers to develop products aimed at mitigating consumers' insurance costs. For example, there is increasing focus on overall health management and early detection and diagnosis of health conditions and diseases.

Expenditures on health care relative to GDP amounted to 9.4% in 2011. The UK ranks relatively low in private health care expenditures among the countries considered in this paper, with private expenditures on health care equal to 17.2% of total health care expenditures. The size of the private health insurance market is

30. Information acquired from the following sources was combined to describe the United Kingdom's private health insurance market: OECD health data (2013); World Bank data (2013); OECD (2013); Table 1 in The Commonwealth Fund (2012); Harrison (2012); Boyle (2011); Harrison, Gregory, Mundle and Boyle (2011); Paris, Devaux and Wei (2010).

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relatively small, in terms of expenditures, and only 3% of total expenditures on health care were from private health insurers. In addition, only 11% of the population is covered by a private health insurance policy, which is the lowest coverage rate for all 10 countries discussed in this paper.

Discussion

The 10 countries considered in this paper are well-developed and relatively prosperous nations, yet there exists considerable heterogeneity among the countries' private health insurance markets. Some countries rely heavily on the private market to provide health insurance to the population, while other countries rely little on the private health insurance market. The proportion of a country's population that is covered by a non-primary private health insurance product varies from 11% to approximately 90%. Other market characteristics — such as the role of for-profit health insurers, product designs, regulatory constraints and the importance of individual and group markets — also differ from country to country. Examining the private health insurance operations of individual countries may, therefore, be one method of gaining perspective and information on health insurance market operations, in general. Such perspective and information may be of value to regulators, policymakers and other U.S. market participants as they encounter the changing landscape of health insurance market operations brought about by the ACA.

The private health insurance taxonomy discussed in this paper is one potential tool that may help guide regulators and other market participants in efforts to acquire insight into private health insurance market operations outside the U.S. For example, further study of markets that allow competing providers to provide primary health insurance coverage, by stipulating mandated insurance purchases and guaranteed insurability, might be useful for considering various aspects of the U.S. market in the post-ACA era. Here, examining how factors such as insurer performance, health care expenditures, health care quality or provider selection were influenced when countries enacted a primary private health insurance market may provide regulators with important insight into the costs and benefits of the ACA for insureds and insurers. Countries with primary private health insurance markets also have varying roles for group and individual insurers, varying roles for for-profit insures and varying product designs that — if considered by regulators, policymakers and academics — may provide additional perspective on U.S. health insurer operations.

As the U.S. health insurance market continues to change, perspective and information regarding non-primary private health insurance markets might also be of value. If, going forward, private insurers play a large supplementary, duplicative or complementary role in the U.S. health insurance market, then regulators could turn to other countries for insight into private health insurance market operations in the U.S. Here, for example, research that addresses the

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relation between supplementary markets and factors such as consumer demand, provider access and health care costs in countries outside the U.S. might be one source of information for market participants to reference when evaluating policy decisions. Regulators and policymakers might additionally also benefit from research that examines issues such as health care utilization, insurer performance or consequences of regulatory constraints in complementary health insurance markets. Further, because the function of the existing private health insurance market in the U.S. is partially complementary, considering complementary private health insurance markets in other countries might also aid regulators' and lawmakers' decisions regarding insuring programs currently in existence.

Even without explicitly considering the function of the private health insurance market, regulators may benefit from information and research regarding additional market characteristics of international private health insurance markets. The considerable heterogeneity among countries' private health insurance markets — in terms of factors such regulation, coverage design, firm characteristics and financial incentives — affords regulators and policymakers an opportunity to gather more insight regarding private health insurance market operations. Such insight, when combined with additional sources of information, might help guide future policy decisions. For example, to the extent that health insurance marketplaces/exchanges, regulations surrounding medical loss ratios and other ACA mandates influence the market dynamics of not-for-profit and for-profit insurers in the U.S., research relating to operations, regulations, performance and consequences for policyholders of health insurer profit status in other countries might help guide and inform policy and regulatory decision-makers in the U.S. Similarly, country-specific health insurance market information and research — examining such topics as regulatory constraints, the role of life insurers, the role of group and individual health insurance or the nature of the benefits packages provided by insurers — could provide additional insight for U.S. policymakers, regulators and other market participants.

Going forward, the health insurance coverage of millions of Americans will be provided by the private health insurance market as prescribed by the ACA. As such, it is important that regulators and other market participants utilize various methods in order to effectively monitor, examine and evaluate the operations of private health insurance markets. There is little doubt that regulators will have many tools at their disposal when evaluating the operations of private health insurance markets in the U.S. Examining the function of private health insurance markets outside the U.S., as well as additional characteristics of international health insurance markets, is one potentially valuable source of information for regulators and all health insurance market participants.

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Appendix A

The Role of Government in Health Insurance

Country	Government Role
Australia	URA
Canada	URA
Denmark	NHS
France	SHI
Germany	SHI
Italy	NHS
Japan	SHI
Netherlands	SHI
Switzerland	SHI
United Kingdom	NHS

Source: Commonwealth Fund (2012).

This appendix provides information regarding the role of the government in the provision of health care for the population of a given country. “URA” denotes a country with a universal public insurance administered at the regional level. “NHS” denotes a country with a national health service. “SHI” denotes a country with a statutory health insurance program.

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