



Why not private health insurance?

2. Actuarial principles meet provider dreams

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Abstract

WHAT DO INSURERS AND EMPLOYERS FEEL ABOUT PROPOSALS to expand Canadian health care financing through private insurance, in either a parallel stream or a supplementary tier? The authors conducted 10 semistructured, open-ended interviews in the autumn and early winter of 1996 with representatives of the insurance industry and benefits managers working with large employers; respondents were identified using a snowball sampling technique. The respondents felt that proposals for parallel private plans within a competitive market are incompatible with insurance principles, as long as a well-functioning and relatively comprehensive public system continues to exist; the maintenance of a strong public system was both socially and economically desirable. With the exception of serving the niche market for the private management of return-to-work strategies, respondents showed little interest in providing parallel coverage. They were receptive to a larger role for supplementary insurance but cautioned that they are not willing to cover all delisted services. As business executives they stated that they are willing to insure only services and clients that will be profitable.

Given the theoretical framework previously discussed,¹ what role do insurers see for themselves if the public-private mix in health care financing is changed? We conducted 10 semistructured, open-ended interviews in the autumn and early winter of 1996 with key executives in the private insurance industry (IR, $n = 8$) and employer benefits managers (ER, $n = 2$). Respondents, selected using the snowball sampling technique,² were identified as both knowledgeable and influential in their fields.

The following themes emerged from our interviews:

- *Insurers see themselves as competitive-market business executives, and they are interested in occupying only markets that conform to insurance principles.*

Because insurers operate within a competitive market without a “captive” clientele, neither community-rating nor open-ended entitlement-based coverage was seen as sustainable. One respondent commented on the experiment with partnerships between Medicare and Health Maintenance Organizations in the United States:

The private-sector companies have been making a fortune, just hand over fist, partly because they've put strong managed care principles in place, but also partly because the people who move over to these things tend to be the healthier individuals, and the government is left with the unhealthy population, which costs a fortune... [IR]

Insurers were interested in assuming administrative responsibilities (e.g., managing provincial health plans or information systems) or entering markets “where there is not much serious risk, but people perceive that there is.” “Insurers will provide anything their customers wish to pay for” but only if it is profitable. Sustainable plans must limit risk (e.g., through pre-existing condition limitations or capped benefits) and minimize moral hazard. Both the insurers and providers expressed an interest in an expanded parallel system where employers stand to benefit directly

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from reduced total costs (e.g., improving return-to-work outcomes to trim disability and rehabilitation costs).

- *A private insurance model meets actuarial principles only if it is acceptable to deny care.*

Two respondents (both physicians) favoured a parallel system, arguing that differential access based on one's ability to pay is both inevitable and acceptable, but they also assumed that a parallel tier would not affect our ability to "preserve the integrity and quality of any publicly funded system, whether or not an individual chooses, for whatever reason, to [make use] of it." The other respondents argued that a parallel private model was not workable; "it would ... probably destroy the Canadian health system; ... it would result in an overall increase in health care costs. A mixed market is the worst possible market." [ER]

All respondents strongly supported a role for the government in funding core services to "prevent people from falling through the cracks." "It's critical to keep mandatory catastrophic coverage in place, so there is some basic level of coverage." However, the respondents had difficulty defining that core; at minimum they thought government should provide a safety net for catastrophic expenditures and means-tested assistance for those too poor to pay insurance premiums. They recognized that there would be no market for a parallel system unless publicly financed services were perceived to be inadequate, but they disagreed on whether piecemeal diminishing of quality in the public system was inevitable.

- *As the labour market changes fewer employees are offered full benefits.*

To some extent the health insurance market has tried to adapt to changes in the employment market.

The large manufacturing base has been eroded, and the growth is in services, self-employed, contractual and part-time work, so we can anticipate a much larger proportion of Canadians who fall out of the full-time employed benefit-enhanced workplace. At the same time, employers are ... saying, "we'll cover you for, say, \$5000 per year of supplementary needs. Once you go beyond that cap, you're on your own." [ER]

Some insurers are developing "a-group-of-your-own" risk pool, combining the unemployed, self-employed and downsized. Even when available, these plans usually incorporate pre-existing condition limitations and benefit caps.

Several respondents also noted that smaller businesses would "get hit with higher premiums," because they have fewer resources with which to reduce claims.

Supplementary coverage is most often purchased by large companies that span provincial boundaries. Many of these employers are therefore resistant to interprovincial variation; different benefits plans for each provincial jurisdiction would create administrative difficulties and increase costs.

- *Because employers are increasingly unwilling to assume new benefits costs, certain expenses are unlikely to be picked up by private insurance if they are delisted by government.*

We know physicians want other sources of income, but for government ... to suggest that something could be deinsured to give physicians another source of income and at the same time leave physicians free to charge the private marketplace a significantly higher mark-up than it was charging government is irresponsible. [ER]

I don't think it would be sensible to assume that what is deinsured would be picked up by employers. [ER]

Someone who is planning to shift costs to the private sector shouldn't just assume that insurance will pick that up. [IR]

- *The models being proposed by providers are probably unrealistic.*

The insurers and employer benefits representatives in our sample did not show much enthusiasm for parallel-stream models, for the various reasons discussed. If they are implemented, it was felt that payers would probably not allow business to continue as usual for providers.

I think if you're allowing a deregulated marketplace, then you have to make sure it's deregulated both ways. It's not just deregulated so the professionals can charge employers what they will; it's deregulated so that the employers can negotiate deals with professionals and that professionals are allowed to advertise their fees and enter into special preferred arrangements. [ER]

My personal belief ... is that the private insurance industry [is] not interested in simply being another form of funding for a second tier of health care, that they'd be more interested if the paradigm was redefined, so their involvement would be on a different basis than a typical indemnity approach. [IR]

Conclusion

Proposals for allowing a parallel private insurance tier within a universal health care system are commonly challenged on the grounds of access and equity; analysts argue that priority for scarce health care resources should be based on need and ability to benefit rather than on willingness and ability to pay for those resources. In addition, insurers recognize that competitive markets make it unfeasible to sell unlimited coverage to voluntary purchasers, and employers are reluctant to pick up additional costs. Any insurers motivated by humanitarian impulses would lose business to competitors who played by market rules. Thus, the dream of a "win-win" situation whereby an enhanced private tier would improve access without damaging the public system withers in daylight.

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