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# International Best Practices in Health Insurance Regulation

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## Abstract

Effective regulation of the health insurance market is important in order to check those stakeholder behaviours and practices that lead to market failure that will make it difficult for the system to truly guarantee financial risk protection and optimal health outcomes for enrollees. This paper is a normative attempt to provide a menu of regulatory approaches considered to have the potential to promote a well-functioning health insurance industry in Nigeria with application in countries at similar stage of health systems development.

Experiences from different country health insurance regulatory environments were highlighted using information from grey literature. Official documents relating to the establishment and operations of Nigeria's National Health Insurance Scheme (NHIS) as well as Nigeria's health financing and health policy documents were also reviewed. Additionally, author's experiences in participating in Nigeria's health sector reform programme over more than a decade ago were also brought to bear on the topic. The article is substantially derived from a paper the author presented at a health insurance strategic policy and practice dialogue organized in 2014 in Lagos Nigeria by the Lagos Chamber of Commerce and Industries (LCCI).

Health insurance regulation derives substantially from the law establishing the country's health insurance in which the roles and responsibilities of stakeholders involved in the operation of the health insurance market are clarified. Nevertheless, it will appear somewhat difficult to prescribe any generic set of global best practices for the regulation of the insurance industry anywhere, given the heterogeneity of country situations and contexts. Rather, some critical success factors that stand a chance to promote effective and sustainable regulation of the health insurance industry are recommended here. One of such factors include the position that a country's health insurance regulatory agency ought to be run as a specialized government's agency with personnel that does not have to come from the civil service bureaucracy.

All considered, there is no 'iron-cast' template for international best practices in health insurance regulation as each country needs to adopt measures that fit its contexts and peculiarities.
Keywords: Health Insurance, Regulation, International Best Practice, Market failure

## Introduction

The value of health insurance is rooted in the unpredictability of medical spending.[1] Hence, health insurance spreads the risks of health spending across many individuals by pooling risks and expenditures.[2] However, a health insurance market have some inherent failures that do not allow it to optimally pool and spread risks in order to effectively protect all population groups against the unpredictable risks of health spending and potentially incurring catastrophic expenditures. These factors are causes of market failure in the health insurance market.[3]

Effective regulation of the health insurance market is therefore important so as to address various gaming behaviours from different stakeholders in addition to the effects of information asymmetry, externalities, cream skimming, adverse selection and moral hazards, among others on the health insurance market – factors that lead to market failure.[3] Left unchecked, those factors will in turn constrain any health insurance scheme from achieving optimum health financing outcomes for the health system.

Anecdotal evidence indicates that use of the word 'market' in describing the interaction between health service consumers (patients) and health service suppliers (providers) elicits much disapproval or disapproval especially among non-economists. As a matter of fact, many inherent features of the health care industry (e.g. information asymmetry, externalities, lack of homogeneity of the health care goods/services, restriction of entry/exit, among others) have been noted to make the health care market a peculiar and imperfect one.[3] Economists have therefore employed both positive and normative approaches in describing the health care market. One of the best explanations so far came from the classical work published by Kenneth Arrow in which he elaborated the reasons why the health care industry ought to be seen and treated as a peculiar and imperfect market as opposed to the conventional, competitive (perfect) markets.[3] Explaining those features of the health care market that make it deviate from the conventional, non-health care markets, Arrow contended that the special economic problems facing medical care are adaptations to the existence of uncertainty in both the incidence of disease and in the efficacy of treatment.[3] The said features, especially information asymmetry, appear to have distorted the proper principal-agent relationship leading to certain gaming behaviours and perverse incentives on the part of especially the health care providers and payers.

The imperfections of the health care market have therefore justified the need for governments' intervention in the health care industry, especially in ensuring the efficient provision of health care public goods and effective regulation of the entire industry. In order to optimize the society's welfare through efficient allocation of the health care goods with utility maximization by consumers and profit maximization by providers and payers, an institutionalal framework for an effective regulation that will ensure mutual accountability by all stakeholders has become imperative.

The discourse will involve the presentation of a brief of Nigeria's journey to the implementation of a social health insurance programme, highlighting a few of the impediments to the achievement of its statutory mandate and then explaining the rationale for effective regulation. Country examples of health care and health insurance regulations will also be explained as well as the imperative of bringing of global best practices to bear in the regulation of Nigeria's health insurance industry.

## Nigeria's Journey to Social Health Insurance

Nigeria's journey to public health insurance dates back to the Lagos Health Bill of 1962 which came as a proposal from one Halevi Committee but for some reasons failed to pass[1]. The idea/proposal subsequently went through several expert review and consultative committees, successive National Councils of Health until some technical input from both the UNDP and ILO provided some operational frameworks for the NHIS. Finally in May 1999, the Decree 35 (later Act 35 of 1999, Laws of the Federation of Nigeria) was promulgated which formally established Nigeria's NHIS. However, the actual nation-wide implementation of the programme took another clear six years to accomplish in June 2005, starting with the formal sector programme involving the federal public servants and workers within the organized private sector.[5]

## Fundamental Impediments to Success

An appraisal of the performance of Nigeria's NHIS against its key mandate of achieving universal health coverage for the country shall be done through the prisms of the Scheme's enabling law; its a priori strategic focus as well as the profile of its institutional and human capacities. One cardinal impediment observed to have contributed to the perceived stagnation of the Scheme's progress has to do with its enabling law that saddled it with such tasks as: (a) marketing health insurance products to the Nigerian populace; (b) expanding insurance

coverage to citizens and residents; and at the same time (c) regulating the implementation of the entire insurance industry. The enormity of the Scheme's mandate was by no means helped by the apparent inadequacy of its human and institutional capacities to deliver. Another initial obvious bottleneck is the absence of a legal instrument that makes enrolment and participation in the Scheme mandatory for all eligible formal sector workers at all levels. Hence, the Formal Sector Social Health Insurance Programme (FSSHIP) of the NHIS as launched in 2005 currently covers only federal public servants, without participation by State and Local Government Area level public servants except [2] of the 36 states. How far the expression of interest to participate from states like Cross River, Enugu and Abia is yet to be seen. Furthermore, there is anecdotal evidence that the participation of the organized private sector in the formal sector social health insurance programme remains abysmally poor and its enforcement virtually non-existent. The aforesaid legislative lacunae have fundamentally constrained the Scheme's ability to fully deliver on its mandate.

**Rationale for Regulation of the Health Insurance Industry**

In a perfectly competitive market, the basic microeconomic behaviour of individual or households (consumers) is to maximize utility from the consumption of goods and services, while firms (providers or suppliers) seek to maximize profits from their supply or provision of goods and services.[4] The reality of the health care market presents a distorted agency in which firm (especially the provider and payers) maximize their profit to the fullest at the expense of the health consumer.

That is, the information asymmetry between the patient (the principal) and the health care provider (the agent) creates some power imbalance in favour of the health care provider that has better health information than the patient and often uses such to the disadvantage of the patient. This comes in form of the much talked about "physician-induced demand" for health care services – whereby the provider recommends investigations or medications of questionable benefit to the patient for his/her (provider's) personal gain. On the flip side, the household (or individual) in need of health insurance often have superior information advantage regarding his/her health state over the firm (insurance company, health maintenance organisation, etc) that seeks to sell the service, thus creating another scenario of information asymmetry that often leads to adverse selection in the private health insurance market. In such a circumstance, health insurance is not sought in anticipation of an uncertain future health care need of the patient but a measure to purchase a coverage for a certain pre-existing health condition. Occasionally, patients may just decide to obtain health care not necessarily because of a real need for it but because of the fact that insurance has substantially reduced the full final price of health care – an action that contributes to inefficient allocation of the health care good and cost escalation. This is the economics of moral hazard in the health insurance industry explained by Pauly.[2]

The need to minimize or eliminate some of the aforesaid gaming behaviours or the tendency to manifest them by stakeholders in the health insurance industry has therefore justified the need to regulate the health insurance market. A former UN Special Rapporteur on the Right to Health, Paul Hunt recently argued that "if a health system is a set of relationships among actors and institutions, accountability is at the core of a well performing health system. If relationships are broken due to lack or weak accountability on the part of the state, or of providers, or of citizens, an environment of mistrust easily evolves and ends in polarization"[6]. By institutionalizing effective regulation of the health insurance market, stakeholder roles and rules of engagement get clarified, consequences for breaches clearly defined and appropriate sanctions for wrong-doing applied fairly and firmly. By so doing, the integrity of the system will be preserved, market efficiency maintained and the health of consumers better served, resulting in better population health.

**Health Insurance Regulation – Country Examples**

In order to arrive at a consensus on a set of desirable global best practices in health insurance regulation, it may be beneficial to highlight what different regulatory environments outside Nigeria look like.

In the United States of America, a completely free, unregulated insurance market actually existed before the enactment of the Patient Protection and Affordable Care Act (ACA). The current regulated health insurance environment in the US ensures, among other things, that: (i) every American (or legal resident) shall buy a health insurance or made to pay a fine for failing to do so; (ii) insurance companies (or health maintenance organisations – HMOs) are mandated by law NOT to deny coverage to any patient due to a pre-existing condition; (iii) subsidies are set aside for those who cannot afford

to buy health insurance; (iv) limits have been imposed on out-of-pocket costs of health care[7]. In essence, the enactment of the Affordable Care Act (ACA) has been argued to be "the latest steps in a continuing shift from virtually no federal regulation of employer-sponsored health insurance to extensively substantive and administrative requirements"[8]. Clear consequences are spelt out for subverting the system.

In Japan, Matsuda stated that "the government regulates almost all aspects of the universal public health insurance system, as the national government sets the fee schedule by developing consensus among stakeholders; gives subsidies to local governments, insurers, and providers to implement its policies; and establishes and enforces detailed regulations for insurers and providers"[9]. In all, as many as 3,500 insurers participate in the public health insurance in which premium is shared by employees and their employers and penalty for non-enrolment is set as two years of premium upon entry into the system when ill. As a matter of fact, benefits package is set as same for all health care plans.

In Australia, there are two regulatory arms – public and private. The Health Insurance Regulations Act 1975 (as amended, 2012) derives substantially from the country's Health Insurance Act 1973 which outlined the roles and responsibilities of all stakeholders in the public health sector. For the private sector, there is a Private Health Insurance Administration Council (PHIAC), established under the Private Health Insurance Act 2007.[10] The PHIAC establishes and requires private health insurers to comply with capital and prudential standards, with Capital Standards aimed at ensuring that insurers are solvent and have enough capital to conduct their operations. It maintains a strong and visible presence in the private health sector so as "to ensure that the health benefits funds operated by insurers are well-run and financially sound.[10] The role of PHIAC was further summarized to imply "protecting consumers of private health insurance by ensuring an industry which is competitive, efficient and financially sound".[10] Periodic fund reviews, quarterly reviews of insurers' financial data and statistics, face-to-face meetings and regular compliance checks are some of the operational strategies to minimize perverse incentives and gaming behaviours among insurers. The objective of both regulatory authorities (public and private) is to ensure a transparent regulation of the complex interrelationships among the health care industry players in terms of compliance and enforcement of the extant health laws with a view to minimizing dissatisfaction among stakeholders and ultimately having a healthy population.

Despite Germany's long history of social health insurance, making its health insurance mandatory for all citizens and permanent residents in 2009 is believed to have contributed towards streamlining the regulatory efforts of its health insurance industry. With universal coverage already achieved for all legal residents, Germany's health insurance is provided by competing, not-for-profit, non-state health insurance funds called "sickness funds" within the statutory health insurance scheme (SHI), or by voluntary substitutive private health insurance (PHI) organized for individuals/households in the upper 10% of the socio-economic ladder. Essentially, a large degree of the regulation of Germany's health insurance industry is delegated to the self-governing bodies of the sickness funds (like the HMOs in Nigeria) as well as the provider associations. However, the Federal Joint Committee, created in 2004, exercises oversight functions over all other regulators.

With universal health coverage for its citizens and no fixed benefits package, much of Norwegian health system is Government-controlled and regulated. Primary health care is funded and provided by its 429 Municipalities with the supervision of inpatient and specialist care vested in the country's four Regional Health Authorities (RHAs).[11] The Norwegian Ministry of Health annually issues a document that instructs the RHAs regarding what to prioritize and achieve regarding specialised health care and then report to the Ministry.

Since 2012, management and regulation of the English National Health Service (NHS) rests with the Central Government agency called NHS Commissioning Board which manages the NHS budget and ensures that the strategic objectives of the NHS by the Secretary of State are met.[12] There is universal health coverage with national public health functions devolved to the local authorities through the Health and Wellbeing Boards.

Established by its National Health Insurance Act 650 of 2003, Ghana's health insurance is regulated by the National Health Insurance Council (NHIC) which is responsible for the accreditation of providers and payers in the system as well as general oversight of the Scheme.[13] According to Gobah and Liang, Ghana's health insurance is "a fusion of the traditional Social Health Insurance and Mutual Health Insurance administered peripherally through 145 district-wide mutual health insurance schemes with a central system at the national level to collect formal sector contributions".[14] Despite

having some 70% of total funding coming from a health insurance levy added to VAT; 23% from formal sector workers' contributions to the Social Security and National Insurance Trust (SSNIT), and 5% comes from Premium payments, Ghana's NHIS has been hotly condemned for the deep inequities which its implementation has created.[15-16]. Data available from Oxfam International shows that whereas 100% of Ghanaians pays for the NHIS through VAT, only 18% of the population benefit from that contribution.[16]

In October 2013, the Rwandan Senate passed legislation for the regulation of the country's health insurance sector. Prior to that, the country's health insurance model has been largely built around mutual health organisations – also called community-based health insurance (CBHI) schemes with AAR as the pioneer player while the public sector is covered by the state-owned RAMA and MMI. A twelve-year evaluation of Rwanda's health insurance scheme in 2012 showed overall health insurance coverage of 96.5% by end of 2012.[17] The expectation is that by the time the new regulatory body fully takes charge, every Rwandan citizen/ resident will have health insurance coverage.

**Applying International Best Practices in Health Insurance Regulation**

Given the experiences in Nigeria's health system performance, it may be tempting to conclude that weak regulatory framework remains the key driver of the snail-speed expansion of health insurance coverage under the Nigerian NHIS. Ordinarily, the coordination of any country's health system poses a set of complex challenges. As a matter of fact, it is important to state that the challenges inherent in Nigeria's operating health system environment are both tough and peculiar. For instance, it is quite difficult to explain the behaviour of 34 (out of 36) state governments and all 774 Local Government Areas in Nigeria regarding their inertia or outright inaction on the adoption of formal sector social health insurance scheme for their workforce – notwithstanding the relative ease of administration of social health insurance schemes?

**Identifying the Critical Success Factors**

It will appear quite difficult to prescribe a set of international best practices for the regulation of the insurance industry anywhere, given the heterogeneity of country situations and contexts. Rather a recommended option is to consider some critical success factors for effective and sustainable regulation of the health insurance industry of any country. Barring some confounding factors, the following steps, in my view, will go far towards improving our chances of success in the implementation and regulation of Nigeria's health insurance industry, both in the short and long-term:

First, any credible step meant to pursue the achievement of an optimal regulatory framework for the health insurance industry in Nigeria should start with a review of our present health insurance law – the NHIS Act 35 of 1999. Gladly enough, that law is currently going through a legislative review at the National Assembly with a view to bringing its provisions in line with global industry standards but within our local context as a country. I wish to contend that it is the responsibility of institutions like the Lagos Chamber of Commerce and Industries (LCCI), Nigeria's health care industry stakeholders and relevant civil society organizations to show enough interest. Their understanding of the content of the current provisions of that law will no doubt enable them to make meaningful inputs into an emerging statute that can guarantee a fairer and more sustainable health insurance practice in Nigeria. In effect, the new law ought to, among other things, consider the unbundling of the function of expanding of health insurance coverage to citizens from that of regulation of the industry – two functions that are enormous in their own rights. Specifically, a new health insurance law ought to explicitly stipulate the NHIS's regulatory functions with a possible creation of a different Agency for the implementation of expansion of health insurance to the citizens. Those steps will no doubt engender a more effective health insurance regulatory function with a clear demarcation of that function from that of coverage expansion to the population, thereby leaving behind some hope for Nigeria's attainment of a universal health coverage.

Second, given the complexity of the health care and health insurance industries; Nigeria's population of some 170 million and a land area in excess of 900,000 square kilometres; it is clear that NHIS as presently run requires an upgrade of its institutional and human capacities, both in number and skills. A health insurance regulatory agency ought to be run as a specialized agency of government with personnel that does not have to come from the civil service bureaucracy. Additionally, it is self-evident to state that only a health insurance regulatory agency within reach of the regulated stakeholders that can adequately stand up to its regulatory responsibilities within the emerging health insurance law. It also goes without saying that it is only a data-driven NHIS that can have timely access to the critical information required for taking timely corrective actions towards addressing

complaints. By so doing, stakeholders' faith in the system will be buoyed and sustained.

Third; in addition to a robust National Health Law, the ability of a health system to apply international best practices in the regulation of its health insurance industry also derives from the ability and willingness of related regulatory bodies to also discharge their assigned functions. For instance, continuous production of competent medical and dental practitioners largely depends on a well-functioning and effective medical licensing board committed to injecting only adequately qualified personnel into the system who on their part, all things being equal, commit to practice within their professional ethos under regulation from the same licensing board. The same goes with the other licensing boards, councils and agencies (like the National Agency for Food Administration and Control – NAFDAC) within the health sector. In essence, international best regulatory practices for the health insurance industry derive substantially from a healthy and dynamic intercourse among a number of factors and players.

Finally, no regulatory function can serve a meaningful, long-term purpose in the absence of a provision for operations research that will provide the necessary feedback to guide quality improvements. Results from periodic performance reviews and operations research will especially help the system to perform effectively and efficiently. For instance, early knowledge of which payers (HMOs, etc) that still have capital adequacy to continue in the health industry will be very important so as to avoid issues of bankruptcy and its implications on the system.

In conclusion, there is no silver bullet for health insurance regulation and as such, the above propositions may not have to be seen as the magic pill for health insurance regulation. Rather, addressing some fundamental constraints of a performing health insurance system like robust legislative framework, other contextual regulations, strong and transparent institutions, smart and competent human resources (right type, right quantity and at the right place), and real-time data of high quality are all essential. Regulations and operations (financing) functions ought not to be housed under one roof and where that is the case, efforts should be made to get them uncoupled so as to ensure proper checks and balances. Finally, if political interference in the operations and regulation of NHIS in Nigeria can be minimized and steps taken to ensure the Scheme's accountability; the trust and cooperation of the key stakeholders in the insurance industry will have the potential to drive the delivery of universal health coverage for Nigeria.

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