From the Field

Developing Commercial Health Insurance in China: The CIRC-NAIC Joint Seminar on Health Insurance

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In late 2006, the Chinese government appointed a high-level inter-ministerial commission—composed of fourteen government agencies, co-chaired by the National Development and Reform Commission and the Ministry of Health—to develop a blueprint for China's healthcare system. One party to that process, China's Insurance Regulatory Commission (CIRC), has developed a program of cooperation with its US counterpart, the National Association of Insurance Commissioners (NAIC). To provide input to policymaking, representatives of CIRC, NAIC, private insurers in China and the US, as well as Chinese and American scholars of health insurance gathered in Yichang, Hubei, PRC, on 18-19 June 2007, for a joint seminar on the role of commercial health insurance in the Chinese and US healthcare systems.

The first section of this field report provides a brief description of China's health care reforms in the past decades. The second section highlights the progress and challenges to date in developing commercial health insurance in China, and the final section summarizes the recommendations that the NAIC Commissioners provided to CIRC in 2007 at this critical juncture in China's health policy reforms.

Background on China's Health Care System Reforms

During China's socioeconomic transition from a centrally planned to a market-based economy, the health sector underwent controversial changes: reduced government financing, collapse of risk pooling for much of the population, and increasing pressures on government-run healthcare facilities to generate revenues from user fees by over-prescribing profitable services like drugs and high tech diagnostics. Meanwhile, China's once outstanding population health indicators – with life expectancy above that predicted for its per capita income in 1980 -- stagnated at the national level, with increasing disparities between urban and rural, coastal and inland, richer and poorer communities. During the reform era (1980 to today), two-thirds to three-quarters of the Chinese population have lacked any health insurance coverage, with especially high rates of uninsured in rural areas. High out-of-pocket spending and over-prescribing led to barriers

to access and high financial burdens, especially for poor patients. A 2005 report by a government agency declared that China's health care reforms had been "basically a failure." Observers both outside and inside China have sometimes voiced surprise that commercial insurance did not fill the void of collapsed community financing (see e.g. Liu and Rao). More recently, the Chinese government has launched social insurance programs—the New Cooperative Medical Schemes (NCMS) for rural residents and new insurance schemes for the urban uninsured—albeit with continued high patient cost sharing.[1]

What role commercial insurance will play in supporting and supplementing these new social insurance programs, as well as in the existing Basic Medical Insurance (BMI) programs for urban employees, remains unclear. Controversy about the role of commercial insurance in China is at the forefront of the discussions about how China will achieve its ambitious goal of universal basic coverage.

This report diverges from some of the proposals within China for a government-led health care system that excludes commercial health insurance entirely. But the recommendations are consistent with much of the debate, which differs in views about the extent to which commercial insurance can and should complement social insurance risk pooling for basic health services. Moreover, the recommendations include points that go beyond the role of commercial health insurance to touch upon broader regulatory and population health objectives, such as promoting wellness, further taxing tobacco, and fighting fraud to achieve equitable targeting of public subsidies.

The NAIC report to the CIRC reflects the views of the US insurance commissioners and others with experience regulating a vibrant commercial health insurance market. It does not by any means suggest that China should replicate the US system. Rather, the report suggests that experience from the US can be tailored to help China fill its own goal of an equitable, efficient system of coverage for all.

The Role of Commercial Health Insurance in China

The joint seminar on health insurance opened with welcoming speeches by *Meng Zhaoyi*, Director General, International Department, CIRC, and *Walter Bell*, Chairman of the NAIC.

Director *Meng* first welcomed everyone and expressed anticipation of a rewarding exchange of views, especially at this crucial time for China's healthcare system development. He discussed international experience with commercial health insurance as part of healthcare system development, stating that commercial insurance should help with three challenges: achieving universal coverage, spurring high quality programs such as health maintenance, and complementing other components of the healthcare system to serve diverse social needs. Looking at China's health system reforms through the lens of

[1]For recent overviews of China's health sector reforms, see Ma, Lu, and Quan (2008) and Wagstaff and Lindelow (2008).

commercial insurance, he said health system reforms are high on the policy agenda in China, and the complex issues boil down to how to guarantee equity and efficiency. A 2006 report that China's healthcare reforms were basically a failure was inspired by the manifest problems of inequalities and high costs; many important groups, including most rural residents, are not insured, leading to vicious cycles of illness-induced poverty. But international experience shows that commercial insurance is an effective supplement for healthcare coverage, raising efficiency and counteracting rigidities. Finding the appropriate functions of government and market is a challenge. Director Meng expressed a desire to promote US-China exchanges and together encourage appropriate development of commercial health insurance in China.

Walter Bell, Chairman of the NAIC, expressed appreciation for CIRC's organizing the forum, at this special location of Yichang, the Three Gorges Dam. He briefly described NAIC-CIRC cooperation since the 2002 Memorandum of Understanding, noting that the insurance industry will play a role in "building a harmonious society" in China (a key goal articulated by China's top leaders). Chairman Bell then provided a brief preview of the presentations by US participants, emphasizing that the seminar was an opportunity for us all to learn together.

The remainder of the first day of the joint seminar focused on insurance industry development and national policy in China and the US.

In "Health Insurance Industry in China," *Fang Li*, Deputy Director General of the Life Insurance Department of CIRC, discussed developing commercial health insurance as an important way for the insurance industry to contribute to building a socialist harmonious society in China. She noted that although in the US the industry evolved somewhat autonomously, with regulation co-evolving with the industry, in China, development is government-led, so it is important for government to show support for a sector or industry. She reviewed some international experience with commercial insurance in France, Canada, Holland, and claims processing for US Medicare and Medicaid, emphasizing the positive role that it plays. In China, health insurance industry development can contribute to building a strong market-based economy and developing rural areas, including supporting the New Cooperative Medical System (NCMS) health insurance system expanding in China. Commercial health insurance has expanded at an annual rate of 32% in recent years, with total premium revenues over 37 billion RMB Yuan; CIRC has supported specialization, with products including disease insurance, comprehensive health insurance, long term care insurance, and disability insurance. Commercial insurers have played a role in supporting basic social insurance programs, such as by providing administrative support for some local NCMS programs as well as for some 'medicaid' programs for the poor. Private insurers also play a role in providing supplementary insurance to urban social protection schemes.

Looking forward, Director Li noted that there is a great need for more research, more specialization, and improved regulation to protect the interests of the insured. To support the broader health policy reform process in China, there is need for an official definition of commercial insurers' role, and specific policies such as having urban social insurers

leave the market for supplementary insurance to commercial insurers, and considering tax subsidies for individual and firm purchase of health insurance.

The next presentation, entitled "Health Insurance Development in Xiamen, Fujian Province, China," was given by *Xue Jiang*, Deputy Director General, Xiamen Branch, CIRC. Since 1997, Xiamen City has developed a system of supplementary commercial insurance coverage for 100% of registered urban employees, covering expenses above the maximum covered by social insurance (53,000 RMB) up to a ceiling of 150,000 RMB per patient per year, with a 10% co-insurance rate. The premium was 52.8 RMB in 2007, with 16.8 RMB of the premium paid by Xiamen's social insurance bureau.

Xiamen's system progressed through several distinct development stages. From 1997 through 2002, they used fixed-term contracting out for supplementary insurance, which proved to be not flexible enough as circumstances changed. Then for three years (2003-2005) they tried an administrative services only model, but government complained that insurers were no longer bearing any risk so they had lost their insurance function. Since 2006, Xiamen has used a model of third party administration with a risk-bearing band (if the medical loss ratio is above or below a specified threshold). Director Xue gave examples of how funds are administered, their claims auditing processes and steps toward utilization review, etc. He closed by noting that the industry will develop IT and play an important role in expanding coverage. Xiamen has passed laws to expand health insurance coverage to all residents, including the elderly and children, to be the pioneer locality in China to achieve universal coverage.

The joint seminar then turned to the US experience. *Kim Holland*, Commissioner from Oklahoma, presented "Commercial health insurance in the US." Regulation of insurance is the joint responsibility of federal and state governments. Insurance coverage includes not only commercial insurance policies, but also large social insurance programs such as Medicare, Medicaid, and other safety nets. Salient problems include high spending and millions uninsured.

In the discussion period, NAIC representatives asked for a general description of China's healthcare delivery system: is there a shortage of providers? The Chinese representatives responded that although there are shortages in some rural areas, overall in China it is more an issue of affordability rather than availability. There may be a possibility of using something like community health centers in the US, which charge based on a sliding scale to help low income patients.

Participants also discussed why commercial insurance in China largely focuses on dread diseases rather than comprehensive coverage, and how portable coverage is in the US. And there was an extensive discussion of the relationship between tax subsidies and cost growth. The CIRC representatives said that Professor William Hsiao of Harvard School of Public Health, well known and respected in China for his expertise on health economics in general and China's system in particular, had strongly recommended against tax exemptions for firms to offer health insurance, saying this contributed to rapid

and wasteful spending increases in the US. Commissioner Oxendine said that he felt tax incentives were critical for expansion of insurance at an earlier period, but the US made a "big mistake" to give subsidies only to firms (employers) and not to individuals (employees). Many participants noted that cost growth is complicated and a global challenge. The US now is seeking checks and balances, partially with more consumer-directed plans and a health promotion focus (e.g. no soft drinks in schools, incentives for healthier lifestyles).

A representative of Taiping Life Insurance (Tan Weimin) asked about marketing costs in the US, remarking that they could be as high as 30-40% of premium in China "because the industry is so competitive" (i.e., many companies competing for the single intermediary who controls a firm's business). Dirk Visser and others said that in US, marketing costs can be as low as 1%, for small groups can range from 5-12%, and for the individual market at most 20-30% of premium. China needs full disclosure to facilitate competition, especially if these high commissions recur annually, which would be "unheard of" elsewhere; perhaps it would help to focus on multi-year renewals.

Finally, participants discussed China's healthcare system development and balancing cultural traditions (such as Traditional Chinese Medicine) during the reforms.

The afternoon session opened with Commissioner *John Oxendine* of Georgia speaking on "Health insurance development in the states." Commissioner Oxendine spoke about managed care in the US and patient reaction against it, touching both upon the low patient co-payments (so patients wanted more) and the contracting environment (managed care only works when there is a surplus of providers to support selective contracting). He spoke about the need for tax exemptions to be "across the board" rather than only for employers, as in the US, which distorts the market. Commissioner Oxendine also discussed recent initiatives in telemedicine and teleradiology (especially for prenatal care), including in his own state of Georgia. Finally the Commissioner discussed trends in consumer-driven health insurance products in the US.

The day concluded with a series of academic presentations on research and international perspectives. First, Professor *Zhu Minglai* of Nankai University presented "Discussion on trends of health insurance development in China." Professor Zhu provided a brief overview of health insurance coverage in China, followed by a discussion of the role of commercial health insurance internationally and currently in China. Professor Zhu conveyed his belief that the international evidence strongly supports an active role for commercial insurance and the use of tax subsidies (such as US "tax expenditures") as a necessary stimulus for the development of commercial health insurance.

Next, *Karen Eggleston* of Stanford University (formerly UCLA) presented "Global perspective on health insurance reforms: Public/Private Mix." Professor Eggleston discussed international experience, primarily among OECD countries, in the mix of public and private insurance and its regulation, focusing on incentives for competition and the associated problem of risk selection ("cherry picking") and how this problem is regulated in a variety of European and Asian healthcare systems.

Finally, Professor *Wei Hualin* of Wuhan University presented "Discussion on trends of health insurance development in China." Professor Wei discussed similarities and differences between the US and China with regard to the mix of social and private insurance, emphasizing that while the US development was market-led, China's has been government-led. Both systems face challenges in cost control and achieving universal coverage. One cannot blame China's system for the cost increases that are a global phenomenon. Moreover, many countries began their healthcare coverage systems with social programs to prevent illness-induced poverty, and only later began to turn over parts of the system to the market. The social insurance systems in the US focus on vulnerable groups left out from commercial insurance – the elderly and poor – whereas in China it is just the opposite; social insurance programs to date have covered the urban employed and left most of the population -- especially rural residents, urban dependents, and the poor -- without insurance. He touched upon the managed care backlash in the US and the current policy debates in China, concluding that China must forge its own path and cannot simply imitate the systems developed elsewhere.

Day II of the seminar presented views from industry, beginning with a panel discussion led by John Morrison, Commissioner from Montana, who discussed the "Insure Montana" program. This innovative state program in Montana creates a purchasing pool for previously uninsured small businesses that receive premium assistance payments for employees, indexed to income, and a fixed premium incentive payment to employers. Payments are drawn from a special revenue account funded by a tobacco tax. It also offers tax credits to other small businesses that are previously insured. Insure Montana now makes affordable health insurance available to over 10,000 Montanans after just two years in operation.

Mr. Tan Qijian of PICC Health gave a presentation entitled "The Development Characteristics and Trends in China's Commercial Health Insurance Industry." He spoke of the contrast between the structures of the US and Chinese health coverage system, where in China the official place for commercial insurance within the system remains unclear. Although some of the social insurance programs, such as the new and expanding rural New Cooperative medical Scheme (NCMS) use some commercial insurance for administration, there remains wide variation across the country in the acceptance of commercial insurance as a supplement to social insurance programs. He discussed the tax and regulatory context, including the 2002 and 2006 decisions that have laid the groundwork for commercial insurance playing a role in China's health sector. While the US market is dispersed and competitive, China's is relatively concentrated. Insurers generally do not provide comprehensive coverage because they (1) cannot control providers (manage care) and therefore spending; (2) lack expertise and experience with strategic purchasing; and (3) have a different perspective because they developed from life insurance companies. In general purchasers are weak vis-à-vis suppliers, especially large hospitals in urban China, with regional variation. Mr. Tan emphasized the problem of medical providers deriving a large share of their revenue from dispensing medicines. He also spoke about customer relation management, business strategy risks, the need for technological and human resource development, and implementation challenges.

Next, *Alfred J. Fortin, Ph.D.,* of the Blue Cross Blue Shield Association, provided an overview of the Blue Cross Blue Shield system in the United States. He noted that it is the largest health insurance system in the U.S.—covering 99 million lives and rating number one in brand recognition. Dr. Fortin then reviewed in some detail the BCBS health insurance programs for the U.S. federal and state governments such as Medicare and Medicaid. BCBS plans work closely with hospitals and doctors, and operate many consumer and quality programs across the nation. Finally, Dr. Fortin emphasized that BCBS has been a strong promoter of ethics in managed health care.

Dirk Visser, CEO of Allegiance Benefit Plan Management, Inc., next presented a talk entitled "Third Party Administration: Overview and Market Characteristics." A third party administrator (TPA) is an independent firm contracted by an employer to provide administrative services related to their employee benefit plan(s). Mr. Visser discussed TPA services, ranging from plan design and compliance to administration of enrollment and billing and network management. Types of plan services include not only health benefits (dental, vision, disability as well as medical), but also qualified reimbursement accounts, executive compensation packages, retirement plans, and workers compensation. There are approximately 3500 TPAs in the US, ranging from very small to large and/or highly specialized firms, functioning under different state licensing requirements. Mr. Visser noted that China should avoid this confusing regulatory scene in the US by having standardization of such regulation across provinces and regions.

Another voice from industry came from *Brett Grant* of AFLAC. The presentation described Aflac, which insures approximately 40 million people in the US and Japan, and their supplemental health policies designed to supplement comprehensive private or public medical insurance to cover patient out-of-pocket expenses as well as travel and lost wages. Coverage can be disease-specific or setting-specific (e.g., hospital indemnity, long term care), with benefits based on fixed amounts, not actual charges. Policies are issued to individuals, usually on a lifetime level premium basis; underwriting needs to be simple but sufficient to avoid adverse selection. He responded to a Chinese representative's question about payments: Aflac's schedule of payments is matched to the severity of the medical condition; the cash benefit is a fixed amount that the insured can use on many things, such as travel associated with receiving medical care.

Finally, *Wendy Huang* of United Family Hospitals and Clinics discussed a provider-side view of China's changing health sector. United Family Hospitals and Clinics provide services in Beijing and Shanghai, with discussion about expanding into Xiamen and Guangzhou. They obtained JCI accreditation in 2005 – the first provider in China to do so. They primarily serve the expatriate community, but with a growing segment of Chinese nationals. They provide service teams in multiple languages as part of their targeting strategy for multinationals, who are increasingly seeking high-end benefits for recruitment and retention for their executive teams, both expatriate and Chinese. Group discussion touched upon the key question in China of disease-based versus comprehensive insurance. Ms. Huang made the point that the healthcare provider is key to creating a win-win situation for commercial insurance. In a survey they conducted in

Beijing, they found that most patients listed high quality first, and price considerations later.

In the discussion period, Commissioner Holland reiterated the view of US States as "laboratories" for health policy initiatives; China is also decentralized with experimentation by province/region, so there appears to be considerable potential for learning from each other and between states and regions.

Several participants discussed the plight of rural farmers. In China, they are generally of low income, and local government resources are constrained in meeting local farmers' needs. In the US there have been diverse experiences, including state farmers' federations, programs to subsidize premiums for low income self-employed (such as farmers) in several states, and state-supported risk pools; in some cases farmers have a higher insured rate than the general population. The political economy of coverage differs.

Finally, several participants emphasized the new approach in the US and elsewhere to quality of medical care outcomes and a value-based approach. This includes building transparency about price and quality outcomes into the system, as well as empowering consumers through information to make better decisions about their health care and provider choices.

In the closing remarks, the NAIC Chairman noted the need for expanding health insurance coverage, controlling costs, promoting consumer health education, and enforcing careful regulation to "provide sanity to the market". For China, the new regulations will be key. Health insurance issues have so many facets, there is no silver bullet, and the challenge of coordination is formidable.

Director Meng of CIRC noted that although 1.5 days is short, we enjoyed broad discussions and highlighted many challenges, especially in China's initial stages of developing commercial health insurance. He expressed appreciation for the recommendations from NAIC experience, and special thanks to the representatives from industry in the US and China, as well as other participants and local hosts.

II. Recommendations

The following are recommendations from NAIC to CIRC based on U.S. experience and the discussions at Yi Chang. The NAIC appreciates the chance to participate in China's planning process. The U.S. has spent a tremendous amount of time and money studying needed changes to the health insurance and health care delivery systems in our own country, but has been unable to make many changes because of entrenched interests. China's opportunity to create a new system at this time in history is both remarkable and exciting.

China has many interesting and promising innovations occurring in health care delivery and payment schemes across the country. The suggestions below are focused on

approaches that may enhance the climate for commercial health insurance growth in China.

In addition to providing these recommendations, the NAIC has asked several commercial insurers to offer their thoughts about what steps might next be taken in China to encourage the development of a commercial insurance market. The papers these insurers prepare will be submitted when they are received by NAIC.

Presentations at the Yi Chang meeting made clear that China hopes commercial insurance can contribute to the goal of developing a "harmonious society." Health care access and financial protection from the high cost of care are certainly important to social harmony in any country. The U.S. has its own challenges in this area. It is also clear that Chinese leaders are especially concerned about providing health insurance coverage to rural residents as part of the larger effort to narrow economic differences between urban and rural areas.

Lack of health insurance not only endangers individual and public health, but also productivity and related economic progress. Because the uninsured rate is high and the economy is developing, a joint effort among public and private players will be necessary to achieve a broad expansion of coverage.

It is likely that commercial health insurers will first be drawn to areas of China that are enjoying greater prosperity. The industry will probably gain its foothold in urban areas, for several reasons. First, consumers with higher incomes will be able to pay meaningful premiums for meaningful coverage. Second, covering employees at larger workplaces is administratively easier for companies. Third, companies will likely be more comfortable with medical care delivery systems in urban areas. Once the foothold for commercial health insurance is established, companies over time will increasingly branch out into rural areas. Standardization of rural health care quality and subsidies for rural residents and businesses seeking to purchase health insurance will accelerate this growth.

The NAIC hopes that recommendations discussed in this paper will be useful to CIRC in its great effort to develop and expand commercial health insurance in all parts of China.

1. Develop Premium Assistance/Tax Subsidies/Purchasing Pools

A. Rationale. Many uninsured are able to pay some premium, but cannot afford the market price for health insurance. Premium assistance can bridge the gap, allowing an uninsured business or individual to pay as much as they can afford toward coverage, reducing the public expense of coverage accordingly. Tax subsidies serve the same purpose. Purchasing pools allow small businesses to spread risk and increase bargaining power when buying health insurance.

B. U.S. Experience. Consider the example of the Insure Montana program. This program covers thousands of small business employees and their family members using a purchasing pool and premium subsidies. Businesses with 2-9 employees are eligible. The pool will soon be community rated. Employers receive a fixed premium incentive payment and employees receive a variable premium assistance payment,

indexed to income. Insure Montana has become a prototype. Maryland is preparing Insure Maryland presently and Oklahoma recently adopted a similar program. This model has the advantage of covering more people with less cost to the state. For example, under Insure Montana, it costs the state $1350 to cover the child of an employee for a year. Under the Children's Health Insurance Program, which is an entirely state funded public program, the same coverage costs $1750 per year. Although the private insurer that underwrites the Insure Montana program has a 15-20% administrative margin, the contribution by the employer and employee make the coverage in that program cheaper for the state.

C. Chinese Application. Deputy Director Fang Li noted her interest in the premium subsidy approach and Xiamen Deputy Director Xue Jiang discussed the successful use of premium assistance in that municipality. Such subsidies can help consumers purchase comprehensive coverage, catastrophic coverage or supplemental coverage. They can be used in urban or rural areas, as they have been for the New Cooperative Medical Scheme (NCMS) in China. They have many applications. The key feature is that the consumer and the government – and in the US and China's urban employee insurance, the consumer's employer--all contribute to paying the cost of coverage. This allows commercial insurers to enter markets in which consumers could not otherwise afford their products. One significant challenge is indexing premium assistance to income when the administrative and information systems for such indexing are lacking for the rural majority in China.

2. Use Third Party Administration

A. Rationale. When public or private employers directly underwrite the health coverage for their employees, third party administrators can provide a host of cost saving services. TPAs can assemble networks of providers who provide discounted services and they can design plans, deal with regulators, enroll and bill employees, evaluate and pay claims, and review coverage and medical need issues. TPAs can also administer health savings accounts as well as retirement and workers compensations programs.

B. U.S. Experience. TPA services are performed both by health insurance companies and by independent TPAs. There are 3500 TPAs in the U.S. Over 50% of the non-federal employees receiving employee benefits in the U.S. are enrolled in self funded plans that are, to some degree, administered by TPAs. There are almost no self funded employer plans in the U.S. that do not use a TPA. Commercial insurers provide vital administrative services for Medicare and Medicaid programs.

C. Chinese Application. In some areas, commercial insurers are apparently providing TPA services to local authorities for the administration of social insurance. Perhaps the most promising area for promoting an active role of commercial insurers in China is in providing TPA services to social insurance programs in both urban and rural areas. Overall China may not wish to promote an employment-based coverage system, which reduces portability and leaves out the most vulnerable groups. However, employers should nevertheless be encouraged to offer supplementary insurance, as noted below, and many should consider expanded use of TPAs to do so.

3. Encourage Supplemental Benefits

A. Rationale. When public or employer-sponsored plans can only provide a basic

coverage, supplemental policies can allow those with sufficient means to obtain coverage for additional services or to pay deductibles and co-pays of the basic plan.

B. U.S. Experience. The U.S. has a variety of supplemental benefit products. Medicare supplemental insurance (regulated Medigap insurance) covers many of the expenses that the Medicare program does not. Medicare part D plans provide prescription drug coverage. Companies like AFLAC, which was represented at the Yi Chang meeting, supplement accident and sickness coverage with lost wages and out of pocket expense protection.

C. Chinese Application. Supplemental insurers can provide insurance coverage in markets where consumers can afford more than the basic minimum level of coverage. Supplemental coverage would be especially well suited to urban areas where the BMI coverage is not sufficient and employees have the means to purchase additional coverage. Hopefully, supplemental insurance will be available to complement NCMS, as well. Clear regulation—as in the US Medigap program or many European countries--can be used to avoid problems such as risk selection (serving only the most profitable consumers) through selective coverage in supplementary insurance.

4. Consider High Risk Health Insurance Pools

A. Rationale. In a competitive insurance market, no company can afford to shoulder more than its share of chronically ill or high risk enrollees, so it can be very difficult for high risk consumers to obtain coverage. High risk pools accept those enrollees whose health conditions make them unacceptable to any one commercial insurer, spreading the risk across the market.

B. U.S. Experience. In the U.S. there are two models for dealing with this problem. Guaranteed issue jurisdictions require companies to accept all applicants. High risk pool states allow companies to reject high risk applicants who then are placed in a state supervised pool that is funded by all health insurers in the market, based on market share. Commercial insurers generally prefer this approach.

C. Chinese application. Establishing high risk pools will not only ensure that Chinese people with chronic health conditions have a coverage option, but will also signal to commercial health insurers that no one company will be required to carry risk that is unsustainable. This may be an important option to develop, alongside risk adjustment for premium and provider payment systems, to ensure a "fair playing field" among insurers competing for any given market (e.g., regional supplementary insurance for BMI or NCMS).

5. Reduce Marketing Costs

A. Rationale. An insufficiently competitive insurance market can lead to high agent/producer commissions that inflate the cost of coverage. Lower commissions and marketing costs mean lower premiums.

B. U.S. experience. In the U.S., health insurance marketing costs can be as low as 1% of the premium, and in the small group market range from 5-12%. The highest marketing costs are in the individual market, where they can be 20-30%. Producer commissions are not directly regulated in the U.S., but competition in the mature market keeps marketing costs relatively low.

C. Chinese application. Taiping Life reported in the Yi Chang meeting that its marketing costs are 30-40% for most of its health coverage. These rates are excessive. CIRC should promote competition and may consider limiting the commissions that can be charged by producers until the market is more competitive.

4. Clarify Regulatory Authority

A. Rationale. Commercial health insurers, like all businesses, can only risk capital when they understand the legal landscape. That includes a clear picture of who regulates them and what the regulator expects of them.

B. U.S. Experience. Commercial health insurance in the U.S. is regulated by the state insurance departments. Self-funded, employer-sponsored plans are regulated by the U.S. Department of Labor. Although some fraudulent insurance schemes (discussed below) have tried to hide in the cracks between these two regulators, companies generally know who their regulators are and the rules they must follow. Insurers do complain that the multi-state system of regulation in the U.S. is confusing and inefficient and the NAIC facilitates efforts to achieve more uniformity and reciprocity among the state regulators.

C. Chinese application. Although China, like the US, benefits from the "laboratory" of experimentation across provinces/states and regions, uniformity and transparency of regulation will be increasingly important as insurers expand nationally and consumers gain greater geographic and socioeconomic mobility in China's dynamic economy. China should avoid the fragmentation of insurance regulation associated with the self-funded employer-based insurance plans in the US, focusing on consistent nationwide regulation for the basic social insurance programs and supplemental commercial insurance programs.

5. Improve Quality of Care

A. Rationale. Commercial health insurance companies assume risk for the quality and quantity of health care provided to their insureds. Health insurance companies will not participate widely in markets where there is no established system for ensuring the delivery of appropriate care. Therefore, developing and standardizing the health care delivery sytem is essential for the growth of commercial health insurance.

B. U.S. Experience. The U.S. healthcare system has its own quality problems, but generally operates according to known and accepted standards of care. This provides a level of predictibility to the risk assumed by carriers.

C. Chinese Application. The health care delivery system in China has been criticized as inefficient and lacking in quality standards. Studies of some provinces have concluded that 70% of village doctors have no education beyond high school and have received an average of 20 months of medical training. There is evidence that diagnostic tools such as MRIs and surgical procedures are widely overused because of compensation schemes that encourage such overuse. One study also concluded that less than 2% of drug prescriptions in township health centers and village clinics have a rational basis. These factors have caused health care costs to rise dramatically in the past 15 years. Standardizing delivery and reforming provider payment incentives are essential to the sustainable development of both social and commercial health insurance, especially in rural areas. Provider reimbursement reforms can remove the incentive for wasteful overuse and can be used to require adherence to established standards of care. Further

research into innovation in health service delivery and strategic purchasing will be important complements to expanding insurance coverage in China, both for social insurance program sustainability and commercial insurance viability.

6. Promote Wellness

A. Rationale. The cost of health insurance is driven by the underlying cost of medical care. Healthcare expenditures vary according to the quality of care (discussed above) as well as the underlying health needs of the population. Many researchers and policymakers have focused on the potential cost savings of increased emphasis on prevention. The logic is simple: If the population is healthier, not only will people enjoy longer, healthier lives, but health coverage costs and insurance premiums will be lower, thus allowing more people access to care.

B. U.S. Experience. Smoking and obesity are major cost drivers in the U.S. They are responsible for many types of cancer and heart disease, as well as increased rates of diabetes and other chronic illnesses. There is some suggestive evidence that employers and communities that have implemented health management programs have reduced smoking and obesity and have thereby successfully contained health insurance premium increases. Chronic disease management programs have also been shown to be cost-effective for many diseases and healthcare settings.

C. Chinese Application. The Chinese government should strongly encourage and create incentives for the development of health improvement and chronic disease management programs. Here, too, reform away from fee-for-service (FFS) payment will be important, since providers currently do not have financial incentive to develop prevention and disease management programs (and indeed may loose significant revenue from reduced need for acute services), while the purchasers lack the medical expertise to develop such programs. Payment reform can help align delivery system reforms with the social goal of wellness.

7. Tax Tobacco

A. Rationale. Public health insurance programs, as well as premium assistance and tax subsidies, cost money. As governments look to fund such programs, tobacco is a good source of revenue because tobacco use is responsible for a substantial share of health care costs. In a developed health care system that spreads risk, whether through public programs or health insurance, non-smokers (generally the majority of the population in the west, although the minority of men and majority of women in China) end up paying for most of the costs of treating smoking-related diseases. By taxing the product and using the revenue for health care programs, a government can achieve several benefits: 1) The higher price of cigarettes reduces demand, especially among children; 2) Smokers take responsibility for a larger share of the financial cost of treating the diseases related to their lifestyle choice; 3) Health insurance premiums and public taxes for health care are lower for non-smokers; 4) The tobacco tax is more popular than most other taxes; 5) Revenue is available to help more people afford health insurance.

B. U.S. Experience. The U.S. spends $50 billion per year on medical care for tobacco related diseases. Tobacco in the U.S. imposes another $50 billion per year in social costs including lost productivity. Many states have imposed taxes on tobacco to

support health care programs. For example, the Insure Montana program that provides premium assistance to small businesses to cover their employees draws the money for the tax subsidies from a special revenue account funded by the tobacco tax. Other states fund children's health insurance programs with tobacco tax revenue.

C. Chinese application. While the U.S. has about 65 million smokers, China has 320 million--67 % of male adults (but fortunately only 4% of female adults.) About 1.8 trillion cigarettes are smoked in China each year, roughly 90 billion packs. Current taxes total $31 billion, suggesting there is room for increase. Although the health costs for treating smoking-related diseases in China have been estimated at about $7 billion annually, that number is certain to rise as access to health care services improves. Raising the tobacco tax will increase revenue while decreasing health care costs. It will also curb demand for smoking which would be consistent with China's participation in the WHO's Framework Convention on Tobacco Control. Although tobacco taxation is a large fiscal issue in China, and many local governments derive substantial benefits from promoting local tobacco industry, health insurers should lend a voice to those who emphasize the health costs of tobacco industry promotion in China.

7. Control Health Care Costs

A. Rationale. Perhaps the greatest barrier to affordability of health insurance is the rapidly rising cost of health care and prescription drugs.

B. U.S. Experience. With 16% of GDP devoted to health care, the U.S. has the worst record of controlling health care costs. The causes of healthcare spending growth are complicated and multifaceted. As Joseph Newhouse and others have pointed out, the most fundamental cause appears to be the increasing capabilities of medicine. No healthcare system in the world has escaped the dilemma associated with providing equitable access to more and more expensive technologies for extending and improving life. Compared to most other OECD countries, the even higher US level of healthcare spending, if not rate of growth, has been attributed to an array of factors from rapid innovation to direct-to-consumer advertising of drugs to trade barriers; from wellness issues (discussed above) to poor information systems and distorted provider reimbursement schemes. Hospitals and doctors make three times more money than the average among OECD countries. Many unnecessary procedures are performed. Most providers are still paid more to render more care (i.e., FFS) instead of by the quality of the outcome (i.e., pay for performance). As Wennberg and colleagues have long pointed out, the amount and cost of services varies dramatically from state to state. Managed care successfully controlled costs briefly in the 1990s, but Americans rejected the limitations on use and choice of care.

C. Chinese Application. Some cost containment strategies can be integrated within reforms to addess the quality of care and wellness issues discussed above. For example, implementing case-based payment rates for hospitals, as the US has for both public and private insurers since the 1980s, can reduce costs without damaging quality if regulatory oversight and risk adjustment methods are sufficient. Such a system can also remove the strong financial incentive for over-prescription of drugs, a problem mentioned by the PICC Health representative at the Yi Chang meeting. Another way to contain rising costs is through the creation of a quality, integrated health information technology (HIT) system. A nationwide, integrated HIT system will provide an optimal platform for

monitoring the quality of health care services and effectiveness of outcomes. Electronic medical records will allow doctors to avoid duplicative care and reduce medical errors. Restricting advertising and marketing by vendors of health products and services can help to prevent artificially inflated demand and fraudulent claims about efficacy. Payment incentives and integrated service delivery systems associated with managed care can help to reduce excessive, inappropriate use of services.

8. Fight Fraud

A. Rationale. Fraud emerges in markets where people are desperate for coverage and cannot afford it. Fraudulent enterprises cheat consumers, leave them without coverage, and undermine legitimate companies.

B. U.S. Experience. Unlicensed and fake health insurance companies have sold tens of thousands of policies and left millions of dollars in medical bills unpaid. States in the U.S. have prosecuted fake insurance aggressively and conducted multi-state investigations. Discount card companies have preyed upon people desperate for health coverage, as well. They advertise "full coverage" "for the entire family" and appear tomany to be insurance, which they are not. In fact, they offer discounts for services provided by a network of providers, but many of the companies have no real discount agreements with the named providers. Some states have adopted laws giving insurance departments jurisdiction over discount cards to regulate advertising and ensure that provider networks are genuine.

C. Chinese application. Fraud has become a world wide business with the growth of electronic communication. As the Chinese people struggle to afford health coverage for themselves and their families, they will be vulnerable to those that would sell them cheaply something that looks like health insurance but is worthless. China should adopt strong laws to prohibit unlicensed health insurance companies and to regulate the medical discount card business.

9. Blend Public and Private Sectors

A. Rationale. Most countries agree that the ideal system provides access to basic health care for all. Because unlimited care for all is deemed too expensive for the public sector in many countries, private health insurance supplements the public sector. CIRC officials, including Director Meng, have indicated an interest in this blended approach.

B. U.S. Experience. The United States maintains public health care coverage for the poor, the old, the disabled, government employees, and disabled veterans. Medicaid covers those whose family income is below a percentage of the federal poverty level. (The ceiling ranges from 100-300% of poverty depending on the state.) Medicare covers those over 65 years of age and older. The State Children's Health Insurance Program covers low income children. The Veteran's Administration hospitals are available to active, disabled and some retired military personnel. Commercial health insurance for the rest of the population is mainly delivered through employers. About 9% of the market is individual coverage. Commercial insurance also supplements the public programs, paying for costs that public programs do not. Recently, the U.S. adopted a program that allows commercial insurers to sell Medicare coverage and supplemental coverage together in a "Medicare Advantage" plan. The U.S. government has also relied on private insurers to sell a special supplemental Medicare coverage for prescription

drugs. Moreover, in the US and many other countries, healthcare delivery systems feature a mixture of government-owned and private (for-profit and not-for-profit) providers.

C. Chinese Application. As CIRC representatives at the meeting repeatedly pointed out, China has a more government-led healthcare insurance and delivery system, although important development of the private sector has already begun. Unfortunately (as Professor Wei pointed out), the population left out of formal social insurance programs to date have been the vulnerable groups that social insurance programs were developed in the US to cover, such as the elderly and the poor. China's current strategy for expanding NCMS coverage in rural areas and urban employee and urban resident insurance for city-dwellers presents a promising framework for eventually reaching universal coverage through basic social insurance programs. However, fiscal constraints and the diversity of socioeconomic groups in China suggest the need for a mixture of public and private coverage to meet diverse layers of demand. Including commercial insurers as TPAs in social insurance programs would be one effective way to achieve a blend of public and private insurance for efficiency and flexibility, even without explicit competition among insurance plans. Regulation and risk adjustment methods will be important for making sure that supplemental commercial insurance does not evolve toward a "two-tier" system accessible only to the rich. China's experimentation with ownership diversification in healthcare service delivery can also play a role in developing a diverse supply of services that then also allows managed care methods and strategic purchasing to control costs while improving quality.

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