



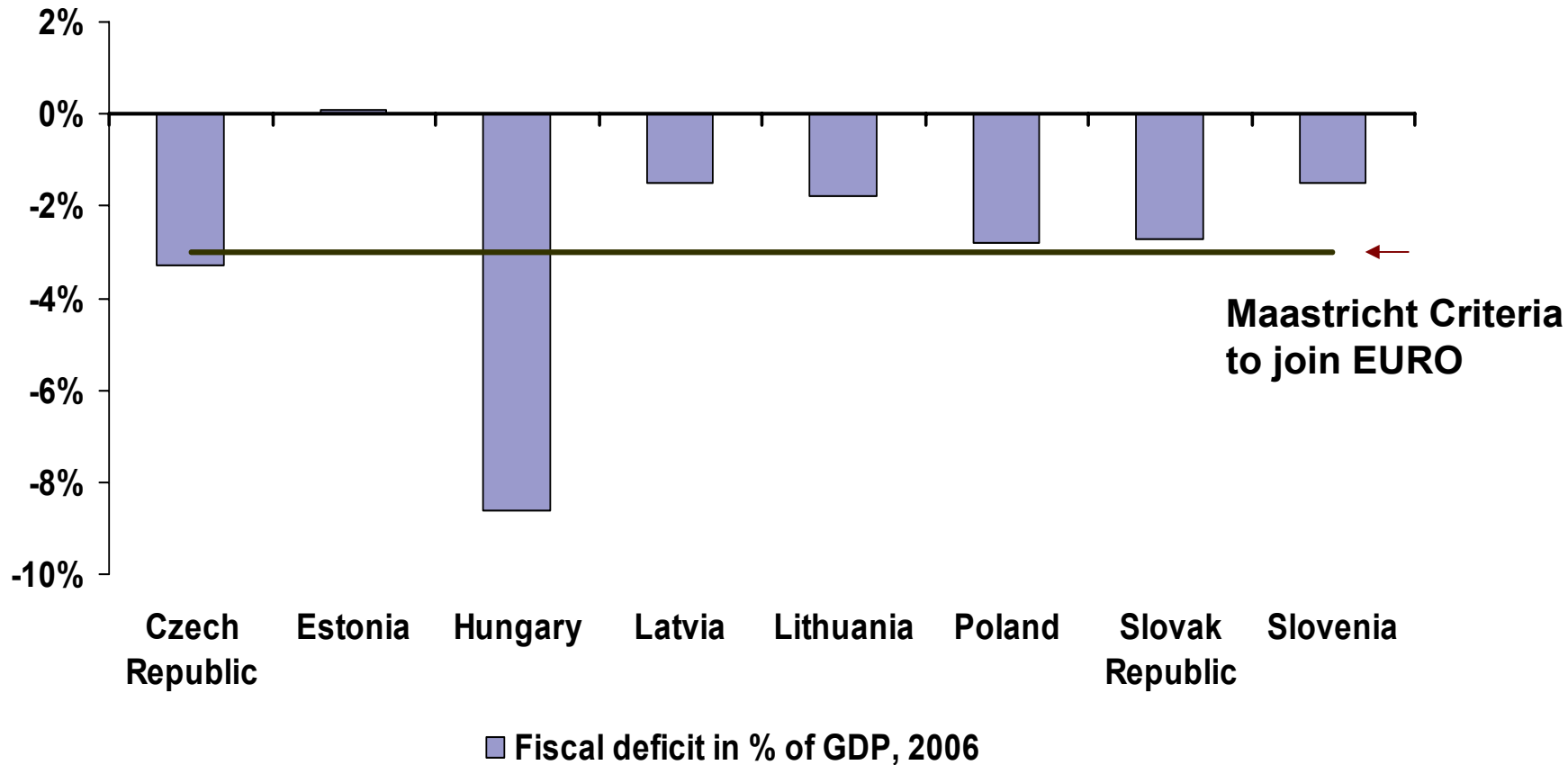
Health Insurance and Competition

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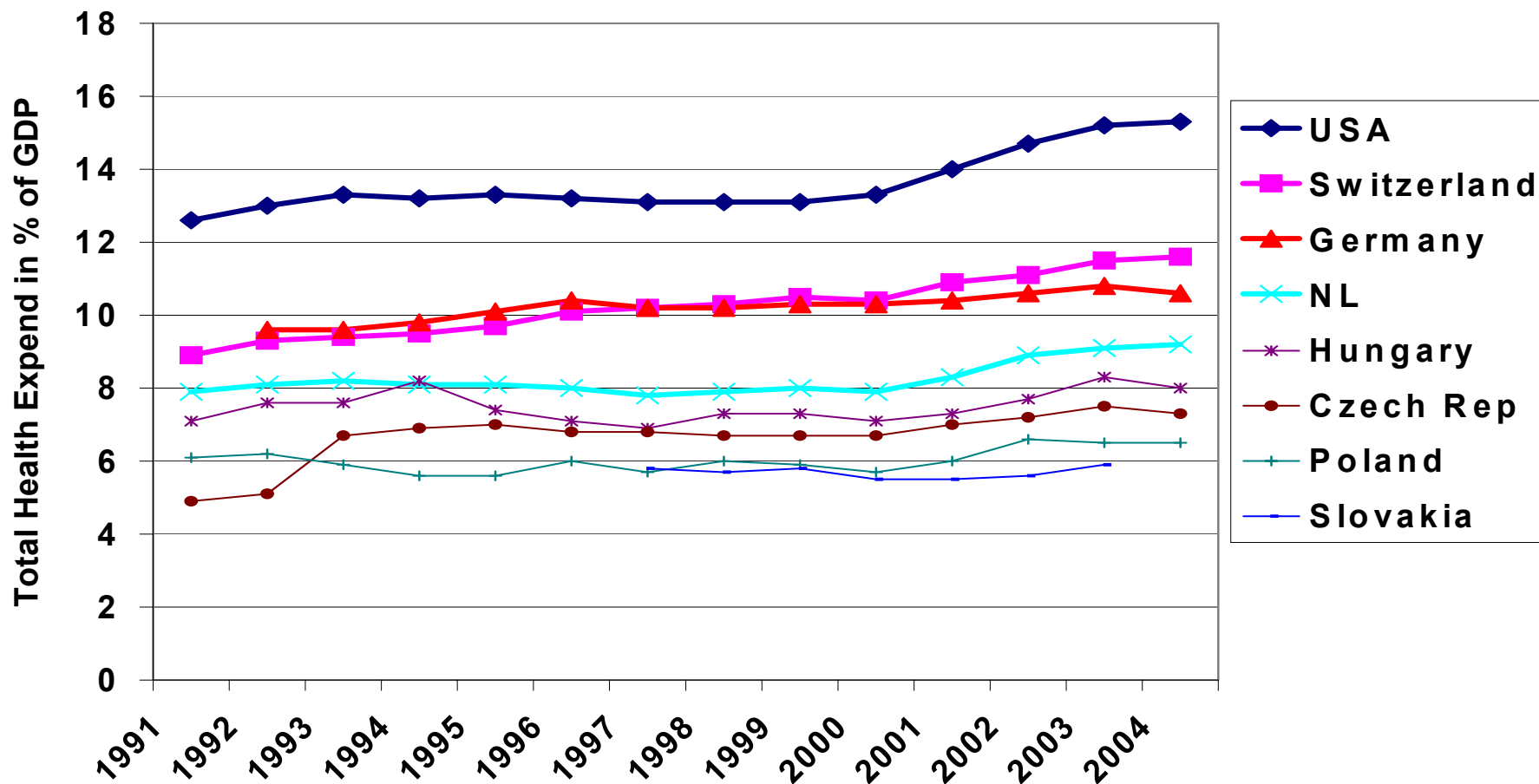
Outline

- Reasons for health financing reforms in new EU member states
- Expectations from reforms
- Some evidence
 - Risk selection
 - Instruments for care management
 - Consumer choice
- Key-lessons for strengthening competition

Health sector deficits put pressure on fiscal situation



... and growth rates for health spending continue exceeding overall economic growth



Source: OECD Health Data



Cost drivers in health are causing Governments to look for alternative health financing options

- Overcapacities in hospitals and beds
 - Financial incentives through provider payment
 - Competition between providers for selective contracting

- High utilization rates
 - Selective contracting to reduce availability of providers
 - Different co-payment levels to steer demand for care

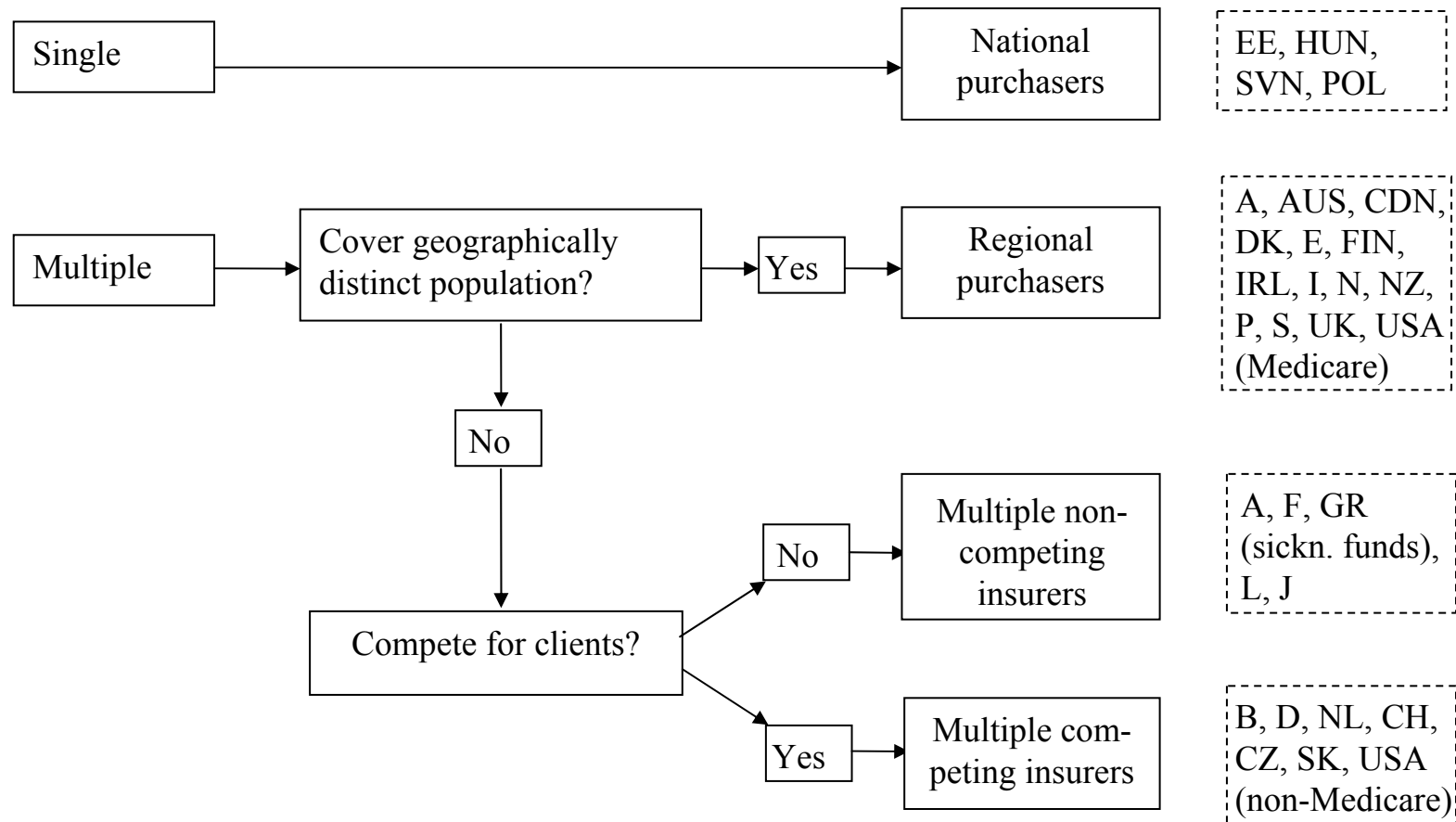
- Health sector deficits
 - Set financial incentives to providers to manage health care expenditures

What reform options do countries have?

Single or multiple purchasers
for main benefit package?

Market structure

Countries



Countries have multiple insurance system for different reasons

- **Switzerland, the Netherlands, Germany**
 - Systems evolved of decades/centuries
- **Slovakia**
 - Inter alia, to help control increasing debt in the health sector in the 90'ties
- **Czech Republic**
 - Inter alia, to help reduce overcapacities

Some countries with single insurance have been looking to multiple insurance ...

■ Hungary

- Deficit of single health insurance fund increased to about one-third of total revenues
- 2007 – first year without deficit
- In July 2007, Government decided to allow a pluralistic insurance system with free choice for consumers, and a system of risk equalization transfers between insurers
- Law was withdrawn. Reforms have been redirected to strengthen the purchasing power of the single insurance fund

... with the hope to address issues of salary reforms; though not really clear “how”

■ Poland


- Major disputes over salary reforms before 2007 elections led to a request by the Physician Trade Union for replacing the single health insurer NFZ with a pluralistic health insurance system including
 - Competition among independent insurance companies
 - All citizens could be insured by the government using funds from personal income tax (PIT) revenue

Multiple insurance with competition is expected to support cost containment

- Competitive insurers sell insurance contracts to consumers so as to maximize their profits or minimize costs

- Prerequisite
 - Consumer Choice
 - Consumers need to be able to select an insurer and provider
 - Information
 - Consumers need to know price and quality of contract
 - Insurers need to know cost of consumer risk
 - Regulatory Framework
 - Allows insurers and providers to behave competitively without threatening health policy goals

Source: Rothschild and Stiglitz, 1976



How to maximize profit/minimize cost?

Profit-maximizing multiple insurers have different strategies to reduce costs

- 1. Insurer selects “good risks” (=low-cost patients)**
- 2. Insurer uses instruments of care management (e.g. strategic purchasing) to contract with less-costly providers**
- 3. Insurer influences consumer behavior to choose less-costly health plans**

Insurance strategy #1: Risk selection

- Risk selection
 - Where uniform contributions do not reflect individual risk
 - Insure “good-risk” consumers
 - Contributions > costs

- Set incentive to consumer for self-selection
 - Results in different insurers with different risk pools, and market segmentation

Insurers tend to use risk selection as the strategy to reduce their costs

- **Aggressive commercial campaigns of “cheaper” plans to young/healthy**
 - **Health plans with high deductibles and lower premiums**
 - **Less attractive plan for higher-cost individual**
 - **Waiting times for procedures or delayed reimbursement**
- **Information about consumer health status revealed for additional insurance**
 - **used by SHI for risk selection where SHI offers basic and additional private insurance**

To limit risk-selection, risk-equalization is becoming more sophisticated

Country	Year of Implementation	Risk-adjustment parameters
Belgium	1995	-Age, sex, social insurance status, employment status, mortality, urbanization, income
	2006	-Age, sex, social insurance status, employment status, mortality, urbanization, income, diagnostic and pharmaceutical cost groups
Germany	1994/1995	-Age, sex, disability pension status
	2002	-Age, sex, disability pension status, participation in disease management programs
Netherlands	1993	-Age, sex
	1996	-Age, sex, region, disability status
	1999	-Age, sex, social security/ employment status, region of residence
	2002	-Age, sex, social security/ employment status, region of residence, diagnostic and pharmaceutical cost groups
Switzerland	1993	-Age, sex, region

Risk management requires information

Information needed

- Consumer's health status and potential use of future care
- Performance of health plans and contribution/premium
- Performance of contracted providers

Risk adjustment transfers to correct for risk selection

- From low- to high-risk pools
- Prospective risk adjustment of health expenditures based on risk adjusters resulting in risk-adjusted payment
 - Predicted health expenses – Ave health expenditures

Incomplete information results in low-quality risk adjusters

- **Incomplete risk-adjusters cause insufficient risk transfers across risk-pools**
 - Max. 30% of total expenses can be predicted when risk adjusting
 - In NL: $R^2=23\%$ - most sophisticated
 - In Switzerland and Israel: $R^2=5\%$
- **Some countries have therefore added ex-post risk equalization based on actual cost**
 - Actual health expenses – Ave health expenditures
 - Reduces incentives for cost containment and efficiency



Insurance strategy #2: Reduce costs by managing care

Strategic contracting

- Exclude higher cost providers from care through selective contracting
- Health plans with generics instead of brand name medicines
- Contract providers at discounted rates for increased patient volume

Set financial incentives to providers

- Provider payment to improve performance and contain cost, e.g. performance withhold

Pass on efficiency gains to consumers

- Reduce premiums or pay cash-backs

Insurers need information to manage care

- **Claims data from providers**
 - to evaluate utilization and cost
 - to analyze and compare performance across providers
- **Patient health data from providers**
 - to adjust providers' performance by their patients' case-mix
- **Investment in data and quality is expensive**

In reality, insurers have few instruments for managing care

- **Limited use of provider payment**
 - Insurers negotiate prices with providers within price range
 - Performance based contracting predominantly in US managed care
- **Limited selective contracting**
- **Some instruments for managing care are used to select risk**
 - Higher deductibles and reduced premium in Switzerland, Israel



Insurance strategy #3:

Offer less costly health plans to consumers

Prerequisite for consumer choice:

- Information about different health plans, quality and price differences
- Consumer has choice of different health plans, contributions
- Employers offer choice to select from all insurers
- Consumers switch plans during open enrolment
- Non-insured pay out-of-pocket at time of consumption

Factors that “neutralize” consumer choice

- Premium subsidies to improve equity in health financing in Switzerland

Consumer choice is limited and appears to be used for self-selection

Several factors limit consumer choice

- Employment based insurance
- Uniform contributions
- Relatively small price difference across insurers
- Premium subsidies in Switzerland reduce incentive for choice

Switchers are

- Younger, healthier, and better educated
- Health expenditures of switchers about 30% below average expenditures in NL

Competition does not have expected effect where not correctly implemented

- Little competitive pressure from insurers to influence:
 - Provider behavior that would result in improved efficiency
 - Major cost drivers including pharmaceuticals, modern technologies, hospital surplus, salaries and aging
- Insurers lack information to choose providers selectively based on performance results
- As long as risk adjustment is incomplete, incentive for risk selection is higher than to improve efficiency in provision of care

Few insurers negotiate prices with providers as a group ...

	Germany	Switzerland	NL
Nbr insurers	275	87	33
Market share of 4 largest insurers	63%	39%	60%

... which may lead to cartelistic situation and non-competitive agreements between insurers and providers

	Hungary	Poland	Czech Republic	Slovakia
Number of insurers	1	1	9	6
Market share of largest insurer	100%	100%	Approx 60%	56%
Risk adjuster	none	none	Age gender	Age gender

Recommendations for strengthening multiple insurance systems with competition

1. Better risk equalization is needed where uniform contributions and choice lead to risk selection
2. Selective contracting with providers to allow competition among providers
3. Information
 - For consumers on provider and insurer performance
 - For insurers on patients and providers (provider profiling)
 - Databases and data-protection measures
4. A long-term investment
 - Consumers, providers and insurers need time to adjust
 - Regulatory authorities to support effective competition (see NL)