Managed competition reforms in the Netherlands health care

The 3rd International Evidence-based Health Care (EBHC) Symposium
“Rational basis for the reform”

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The Netherlands

Three waves of health care reforms

In many OECD-countries three consecutive waves of health care reforms can be discerned:

1. Universal coverage and equal access;
2. Controls, rationing, and expenditure caps;
3. Incentives and competition.

David Cutler, Journal of Economic Literature 2002(40) 881-906.

Role of government

1865: Act on Medical Licenses
1941: Sickness Fund Act
1968: Exceptonal Medical Expenditures Act
1971: Hospital Facilities Act
1982: Health Care Tariffs Act
1985: Health Care Facilities Act
1988: “Dekker Reforms”
2006: New Health Care Insurance Act

Key elements of reform debate

1. Who is the prudent buyer of care on behalf on the consumer?
2. Yes/No competition among:
   – Providers of care?
   – Sickness funds / insurers?
3. Which benefits package?
   Which premium structure?

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Dutch health care system

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- Health care costs 2006: 10% GDP;
- Much private initiative and private enterprise: physicians, hospitals, insurers;
- Still much (detailed) government regulation;
- GP-gatekeeper;
- Health insurance before 2006 a mixture of:
  - *mandatory* public insurance (67%),
  - voluntary *private* insurance (33%).
- From 2006: *mandatory private* insurance (100%).

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Reforms since the early 1990s

The core of the reforms is that:

- Risk-bearing insurers will be the prudent buyer of care on behalf on their members;
- Government will deregulate existing price- and capacity-controls;
- Government will “set the rules of the game” to achieve public goals.

Health Insurance Act: 01jan06

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- Mandate for everyone in the Netherlands to buy individual private health insurance from a private insurer;
- Standard benefits package;
- Broad coverage: e.g. physician services, hospital care, drugs, medical devices, rehabilitation, prevention, mental care, dental care (children);
- Mandatory deductible: €150 per person (18+) per year.

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Consumer choice

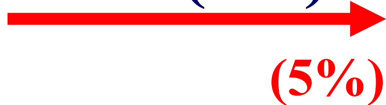
- Annual consumer choice of insurer and choice of insurance contract:
  - in kind, or reimbursement, or a combination;
  - preferred provider arrangement;
  - voluntary higher deductible: at most €650 per person (18+) per year;
  - premium rebate (<10%) for groups.
- Voluntary supplementary insurance.

Health Insurance Act: 01jan06

- Individual insurer is assumed to be(come) the prudent buyer of care;
- Much flexibility in defining the consumer's concrete insurance entitlements;
- Selective contracting insurers - providers;
- Open enrolment & 'community rating per insurer' for each type of health insurance contract;
- Income-related care allowances per household;
- Risk equalization.

Risk Equalization Fund (REF)

Gov't contribution (18-)



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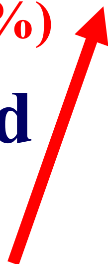
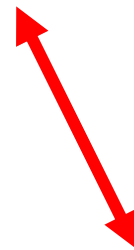


Income-related contribution



REF-payment based on risk adjusters

Insured

(45%)

Insurer

premium (18+)

Two thirds of all households receive an income-related care allowance (at most € 1,464 per household per year, in 2008)

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(annual-)premium range 2008

15 competing insurers	Deductible = €150	Deductible = €650
Minimum premium	€ 936	€ 684
Maximum premium	€ 1164 (+24%)	€ 1020 (+49%)
Average premium	€ 1105	€ 899

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Managed Competition

- Competition among ***health insurers***:

  consumers have a periodic choice among health insurers or 'health plans' ('organizations in which insurer and providers are integrated');

- Competition among ***providers of care***:

  insurers may selectively contract with providers;

- Not a free market.

Commercialisation? Privatisation?

- Avoid confusion:
  - Competition versus monopoly;
  - For-profit versus not-for-profit;
- Worst situation: monopoly & for-profit!
- Netherlands: started with competition & not-for-profit;
- IF healthy competition: not so much difference between for-profit and not-for-profit.

Insurer as purchaser of care

Insurer

Insurance policy

contract

Consumer

Provider of care

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Managed Care

- From 2002 sickness funds and hospitals are allowed to set up new pharmacies.
- From 2003 sickness fund are allowed to set up outpatient primary care centres. Some sickness funds do it.
- From 2005 prices for physiotherapy and partly (10%) for hospitals are free.

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Managed care activities

- Insurers set up primarycare centers & pharmacies.
- Insurers are experimenting with bonuses for general practitioners (risk sharing).
- Some insurers reimburse only the cheapest medicine of medicines that are therapeutically interchangeable.
- Quality of care is more an issue in the negotiations between insurers and hospitals than a few years ago, in particular for the services with liberalized prices (20% in 2008).

Preconditions Managed Competition

- Good risk equalization;
- Effective competition policy;
- Consumer information (price, quality);
- Transparency (e.g. insurance products);
- Product classification system;
- Supervision of quality of care;
- Sufficient contracting freedom (price, quality, selective contracting);
- ….., ….., …..

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Selection

- In case of insufficient risk equalization, the requirement of community rating & open enrollment provides the insurers with incentives for selection.
- Selection can be desribed as actions by consumers and insurers to exploit unpriced risk heterogeneity and break pooling arrangements.

Adverse effects of risk selection

1. A disincentive to be responsive to the preferences of high-risk consumers;
   → selection may threaten good quality care for the chronically ill;
2. Risk selection is more attractive than improving efficiency;
   → selection may threaten efficiency;
3. Market segmentation;
   → selection may threaten solidarity.

Risk equalization is critical

- Good risk equalization is an essential (but not the only) precondition for reaping the benefits of a competitive insurance market with open enrollment & community rating.
- Without good risk equalization the disadvantages of such a competitive market, due to risk selection, may outweigh the advantages of a competitive market.
- Risk equalization should not only be based on age/gender, but also on health status.

Supervisory authorities

- The ***Dutch Health Care Inspectorate*** (IGZ) supervises the quality of the care.
- The ***Dutch Competition Authority*** (NMa) (1) prevents cartels, (2) authorizes or forbid mergers, and (3) prevents the abuse of a dominant market position.
- The ***Dutch Central Bank*** (DNB) supervises the financial solvency of the insurers.
- The ***Financial Markets Authority*** (AFM) makes sure the insurers provide financial services properly.
- *The* ***Dutch Health Care Authority*** (NZa):

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Dutch Health Care Authority (> 2006)

- Responsible for managing the competition among health care providers / insurers;
- Supervises (sub)markets of health care provision (costs, prices, contract conditions);
- Supervises the health insurance market;
- Close cooperation with the Dutch Competition Authority;
- Responsible for transparancy and consumer information, see e.g.: **www.kiesbeter.nl**

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Challenges

- Are insurers capable of being a prudent buyer of care on behalf of their insured?
  - If **NOT**, what then is the rationale of a competitive insurance market with all problems of risk selection?
- Is government prepared to give up its traditional tools (i.e.: supply-side regulations) for cost containment?
- The Dutch health care reform is work-in-progress. So far, the jury is still out.

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Risk Equalization is critical

The crucial question is:
How to calculate the risk-adjusted equalization payments?

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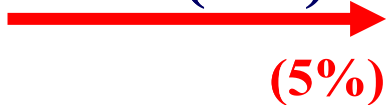

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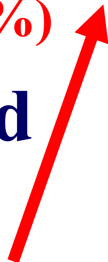

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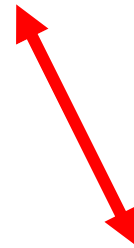

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RE in the Netherlands

In the Netherlands the equalization payment for each individual in subgroup s equals the predicted national average health expenses per capita in subgroup s (calculated according to the equalization formula), minus X euro.

X equals 45% of the predicted national average health expenses per capita over all subgroups. (Negative equalization payments imply payments from the insurer to the REF.)

Risk adjusters in the Dutch REF

Year	*New risk adjuster*
1992	Age/gender
1995	Region, yes/no employee, disability
1997	Age/disability
2002	Pharmacy-based Cost Groups (PCGs) (13 PCGs and about 7% of population)
2004	Diagnostic Cost Groups (DCGs) (about 2% of pop) yes/no self-employed
2007	Multiple PCGs allowed (co-morbidity); (20 PCGs and about 16% of population)
2008	Indicator of Socio-Economic Status

Pharmacy Costs Groups (PCGs)

- An outpatient morbidity measure based on information about chronic conditions deduced from the use of prescribed drugs.
- Extending the demographic model with PCGs substantially increased the predictive power of the model.

Additional annual REF-payment

Risk Group		Additional annual REF-payment (in €)
PCG 0	Reference group	0
1	Asthma / COPD	876
2	Epilepsy	1051
3	Rheumatism	1176
4	Heart diseases	1495
5	Crohn’s disease/ c. ulcerosa	1538
6	Stomach diseases	1932
7	Diabetes (insuline dependent)	2807
8	Parkinson	2653
9	Organ transplants	4363
10	Cancer	4796
11	Cystic fibrosis	5382
12	HIV / AIDS	11455
13	Kidney problems	18225

Diagnostic cost groups (DCGs)

The essence of DCGs lies in the allocation of people to a restricted number of groups according to the diseases diagnosed during previous hospitalizations and incorporating this information in the risk-equalization model.

Additional annual REF-payment

Risk Group		Additional annual REF-payment (in €)
DCG 0	Reference group	0
7	Brain injury	1735
9	Colon cancer	2261
11	Liver disorders	3487
12	Rectal cancer	3636
13	Congestive heart failure	3578
14	Hypertension, complicated	4491
15	Neurologic disorders	5390
16	Brain / nervous system cancers	6165
19	Chemotherapy	7591
20	Diabetes with chronic complications	7288
21	Pulmonary fibrosis and brochiectasis	8603
22	HIV / AIDS	9780
23	Renal failure / nephritis	24020

Source: Van de Ven et al., 2004

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Imperfect risk equalization…

An imperfect risk equalization system may be complemented with a system of risk sharing between the REF and the insurers.

Risk sharing implies that the insurers are retrospectively reimbursed by the sponsor for some of the acceptable costs of some of their members.

→ Tradeoff selection - efficiency.

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Risk sharing in the Netherlands

Risk sharing in the Netherlands has the form of a complex mixture of :

- Outlier risk sharing &
- Proportional risk sharing &
- …..

Financial risk Dutch health insurers

	Outpatient expenses	Inpatient expenses	Total expenses
1992	0%	0%	0%
1993	3%	3%	3%
1995	3%	3%	3%
1996	20%	9%	13%
1997	42%	15%	27%
1998	48%	15%	28%
1999	63%	16%	35%
2001	65%	20%	38%
2002	65%	24%	41%
2003	92%	23%	52%
2007	94%	25%	53%
2008	97%	34%	59%

Evaluation equalization-2007

We have evaluated the Dutch equalization formula-2007. The results indicate that it compensates the overwhelming majority (92%) of the population reasonably well for differences in health status; and that it provides insufficient compensation for a hard-core group of high-risk individuals (8% of the population).

(Results: see Hand-out Tables)

Further research

1. Focus on new risk-adjusters to compensate the hard-core of high risks.
2. Multi-year prior expenses/hospitalization are promising risk-adjusters to do so.
3. Further research should focus on the information a sponsor can routinely collect and use to reduce the hard-core group of high risks.

New (potential) risk-adjusters

The Dutch government intends to further improve the Risk Equalization system:

- Diagnostic information not only from prior hospitalization, but from all prior medical encounters (to be implemented from 2009);
- Indicators of mental illness;
- A better indicator of invalidity or functional restrictions (based on medical devices?);
- Multiyear-DCG's (rather than one-year DCGs);
- Indicators for rare diseases with high expenses.

Risk equalization

- The insurers' incentives for selection are the result of the premium-rate restrictions → Risk equalization is used as a **tool to reduce selection.**
- An alternative option: insurers are free to ask risk-adjusted premiums. → Risk equalization is used as a **tool to make health insurance affordable for the high-risk people.**

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‘Fresh way’ of thinking

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In that approach insurers will focus on efficiency rather than on risk selection, and the chronically ill will become the most preferred clients for efficient insurers, rather than non-preferred ‘predictable losses’.

This will stimulate insurers to contract with providers who have the best reputation for high-quality well-coordinated care for chronically ill people.

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Conclusion

Selection is not inherent to the "competing-insurer model", but is the result of one possible form of regulation in this model (i.e. open enrollment & community rating) .

Alternative forms of regulation result in other outcomes.

Managed Competition model

The Managed Competition model, i.e. competition among both insurers and providers, is a complex model, which requires several preconditions to be fulfiled.

Recommendation for policy makers

Yes/no switching to a competitive-insurer SHI-system?

A wise policymaker would make sure to have (advisors with) an excellent understanding of the theory and practice of Managed Competition, including the experiences in other countries with the political and technical issue of its implementation in practice.

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