Health insurance competition: from theory to practice

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More competition in health care produces foremost more needs-based equity, better [quality], higher [efficiency], reduced costs and [less bureaucracy].

To achieve this, the idea of competition has to become stronger in all sectors of health care: among [sickness funds], among the providers of services, and between sickness funds and [providers] – physicians and hospitals.

In a healthy competition, the sickness funds compete to offer the best quality at the best possible price. The sickness funds have various possibilities to improve the quality of their offer beyond the statutory [benefit basket], e.g. in the form of [integrated (NB: selective) care contracts] or with optional tariffs (NB: e.g. no-claim bonuses, deductibles).

SOURCE: MY OWN TRANSLATION OF THE GERMAN MoH WEBSITE; NBs ADDED.
Wettbewerb (im Gesundheitswesen)

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Third-party Payer

Population

Providers
The three areas for competition

Third-party payer
= insurer (sickness fund)

1. for patients
2. for contracts
3. for insured

Population

Providers

European Observatory on Health Systems and Policies
Third-party payer
= insurer (sickness fund)

Population

Providers

for patients
- To a certain extent existing in all systems, partly only regarding GP
- Special emphasis in UK: patient must be offered 4 to 5 providers (copying from SHI-countries?)
- In SHI-countries rather trend to limiting choice for quality reasons (copying from NHS-countries?)

Population  Providers
for patients
Third-party payer
= insurer (sickness fund)

But based on what?
Price, quality, access …

Population Providers
for patients
Myth: People use health system report cards to make decisions about their healthcare.

In a culture obsessed with ranking the Top 10 everything, it seems logical patients would want their hospitals and doctors to be rated as

In addition, a large study of Wisconsin hospitals that were included in a public report card showed no change in the number of people using each hospital after the report’s release. Further, only 10 percent of people who were exposed to the report used it to recommend or choose a hospital within two years, and almost no one spoke with their doctors about it.

Finally, report cards on bypass surgery, heart attack care, and spinal surgery in New York and California
Clinton Surgery Puts Attention on Death Rate

• Clinton hospital’s death rate higher for bypass surgery *(NY Times 9/6/2004)*
• Overall CABG death rate for New York State is 2.18% *(nysdoh 2001)*
• Columbia Presbyterian Center of New York Presbyterian Hospital overall CABG death rate 3.93% - nearly double *(nysdoh 2001)*
Third-party payer
= insurer (sickness fund)

Contracts:
collective
selective

Population

Providers
1. **Does it work**, i.e. does selective contracting/application of Managed Care produce better outcomes and/or lower costs?

2. Must competition among insurers be combined with managed patients’ access (i.e. **no or limited choice of provider**)?

3. Is it **financially** successful because of **cream-skimming**?

4. Is it **quality-wise** so successful that it leads to **adverse selection** (of insurers)?
Expenditure is highly skewed: 5% of population account for >50% of expenditure (example Germany 2001)
80% of all insured have below-average expenditure (and only 14% have costs at least 150% of average)

50% cost < €1/day, another 15% < €2/day
For whom should sickness design selective contracts? For the 65% who don‘t need health care? For the 5% really ill? Or for the 15-20% chronically ill?
<table>
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Source: Bundesamt für Gesundheit der Schweiz. Bestandsaufnahme Managed Care Modelle 2004
Reducing choice in access is problematic: healthy insured want more compensation than expenditure can be saved and the very ill want access to THE provider for their condition.

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Third-party payer
= insurer (sickness fund)

for insured

Population

Providers
Third-party payer
= insurer (sickness fund)

- Ascertaining the views of citizens - **Voice**
- Enforcing purchasers' accountability – **Voice**
- Enabling choice of purchaser and/or provider - **Exit**

Population

for insured

3
Third-party payer
= insurer (sickness fund)

- (until now) not in tax-funded systems
- in CEE countries only in Czech Rep. and Slovakia
- western European SHI countries are divided: YES in Germany, Netherlands, Switzerland and – without much rhetoric – Belgium, NO in Austria, France and Luxembourg
Third-party payer = insurer (sickness fund)

But based on what? „Price“ (contribution rate, premium); benefits; contracts with providers; tariff conditions (no claim bonus etc.) ...
Gains/losses in sickness fund membership in the western part of Germany in relationship to contribution rate.
Money makes people moving, even though in Germany it’s only 3 to 4% annually – more than in the Netherlands until 2005 with its relatively small nominal premium.
Evidence on the various factors

- **Price**: only if difference is based on insurer efficiency, not different risk profiles
- **Increased benefits** -&gt; increases costs (CZ)
- **Decreased benefits** -&gt; cream skimming*
- **Selective contracts**/ disease management programmes -&gt; adverse selection** (if not compensated in risk-based allocation)
- **Tariff conditions**: usually -&gt; cream-skimming* (requires careful risk-based allocation)

* Attracts healthy; **attracts ill; both -&gt; de-mixing of risks
Dependent on risk, but independent of actual utilisation.

Contribution collector:
- Independent of risk, need and utilisation, i.e. income-related or community-rated.

Third-party payer:
- Dependent on volume, appropriateness (service = need) and quality, steered by priorities and incentives.

CRUCIAL!

Population

Providers
Expenditure is highly skewed: 5% of population account for >50% of expenditure (example France 2001)

Source: CNAMTS/EPAS
Expenditure is highly skewed: 5% of population account for >50% of expenditure (example Germany 2001)

How can we predict who these 5 or 10% are?
Even the incomplete old risk structure compensation mechanism reduced otherwise existing differences in contribution rates drastically:

Variation of income/ expenditure-covering rates with and without RSC

Upper limit: 26.3 %

Factor 8!

Upper limit: 16.2 %

Lower limit: 11.0 %

Lower limit: 3.5%

Sickness funds
Legal requirements for risk-structure compensation from 2009

• “morbidity-oriented“ with surcharges for 50 to 80 diseases,
• with average expenditure more than 50% higher than overall average per person,
• which are cost-intensive chronic or serious, and
• well-defined.
• Surcharges should be „care-neutral“, i.e. not lead to a certain treatment over another.
Questions (not only in Germany)

• What constitutes a well-defined disease?
• Which data to use? Diagnoses from hospitals only – or also from ambulatory care? Do they need to be validated, e.g. through fitting drugs (-> care-neutral?)?
• Is the expenditure overall expenditure or disease-specific additional expenditure?
• Should surcharges be really care-neutral, i.e. be paid if prevention was possible?
If the law is taken seriously (as we did in the Expert Committee):

14% of all insured above legal threshold of 1.5x average for 50 to 80 „costly chronic and serious diseases“
What constitutes a disease for the Risk Structure Compensation?

**Scientific Expert Committee**
- Diabetes mellitus 2 with severe complications
- Myocardial infarction/instable angina pectoris
- Bleeding in early pregnancy

**Final version (Federal Insurance Authority)**
- Diabetes mellitus 2
- Coronary heart disease
- Pregnancy
- Iatrogenic complications
- Hypertension
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<td>Disease?</td>
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Almost 50% are allocated based on morbidity surcharges …

- Age/sex drive 51% of the allocation, disability 2% (used to be much more important)
- If all diseases would be included (instead of 80), morbidity would drive ca. 70%

Quelle: Göpffarth (2008)
Competition -> oligopoly? 2007 market shares of health insurers in NL

Mergers until early 2009 have left de-facto 4 insurers: choice & competition?
And finally: Does competition at least lower administration costs? NO!

For comparison: administration costs in German PHI 16-17%
Shall we abandon organised structures in favour of competition?

When Treasury finally gets around to restructuring the human heart...

We consider the relationship between the left and right ventricles is far too cosy... our proposal would separate the heart into four isolated chambers located in different parts of the chest, they would then tender independently for the right to pump blood to particular parts of the body.

Competition should improve the overall cost efficiency of the blood vascular system.
Shall we abandon organised structures in favour of competition?

The proof that insurer competition (with choice) improves quality and efficiency is yet to come. The discussion about „choice/exit“ und „voice“ (= participation in payer’s decisions) continues.
Thank you for your attention

Analysing Health Systems and Policies