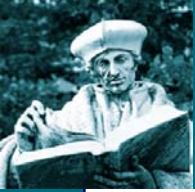


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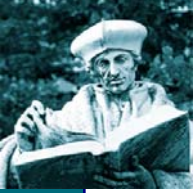
A comparison of the Risk Equalization systems and the policy context of 5 European countries

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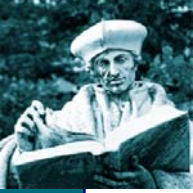
Agenda

1. Risk Equalization: what & why?
(incl. selection: causes & effects);
2. Risk Equalization in 5 European countries;
3. Policy context of Risk Equalization in 5 European countries;
4. Conclusions.



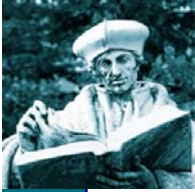
Competitive health insurance market

Australia, Belgium, Chile,
Colombia, Czech Republic,
Germany, Ireland, Israel,
Netherlands, Russia, Slovakia,
South Africa, Switzerland,
United States of America,...



Risk rating and risk selection

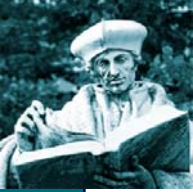
- In a free competitive insurance market insurers have to break even, in expectation, on each contract either by adjusting the premium to the consumer's risk (*risk-adjusted premiums*) or by adjusting the accepted risk to the premium (*risk selection*).
- The premium differences can easily go up to a factor 100.



Free competitive insurance market

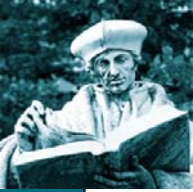
Without any external intervention individual health insurance may be unaffordable for the (low-income) high risks in a competitive insurance market.

Solution: premium subsidies.



Explicit premium subsidies

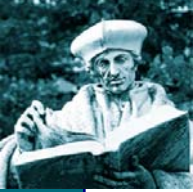
- Insurers are free to set their premiums;
- A subsidy system is organized by a sponsor (e.g. government) such that high-risk persons with unaffordable premiums receive a subsidy from a Fund that is filled by mandatory contributions.
- High risks pay their premium partly with the subsidy and partly out of pocket.



Premium-adjusted subsidies

Premium-adjusted subsidies are not optimal:

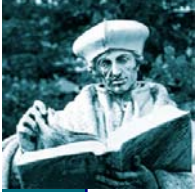
1. they reduce the incentive for high-risk consumers to shop around for the lowest premium;
2. they induce over-insurance resulting in additional moral hazard;
3. they create a misallocation of subsidies.



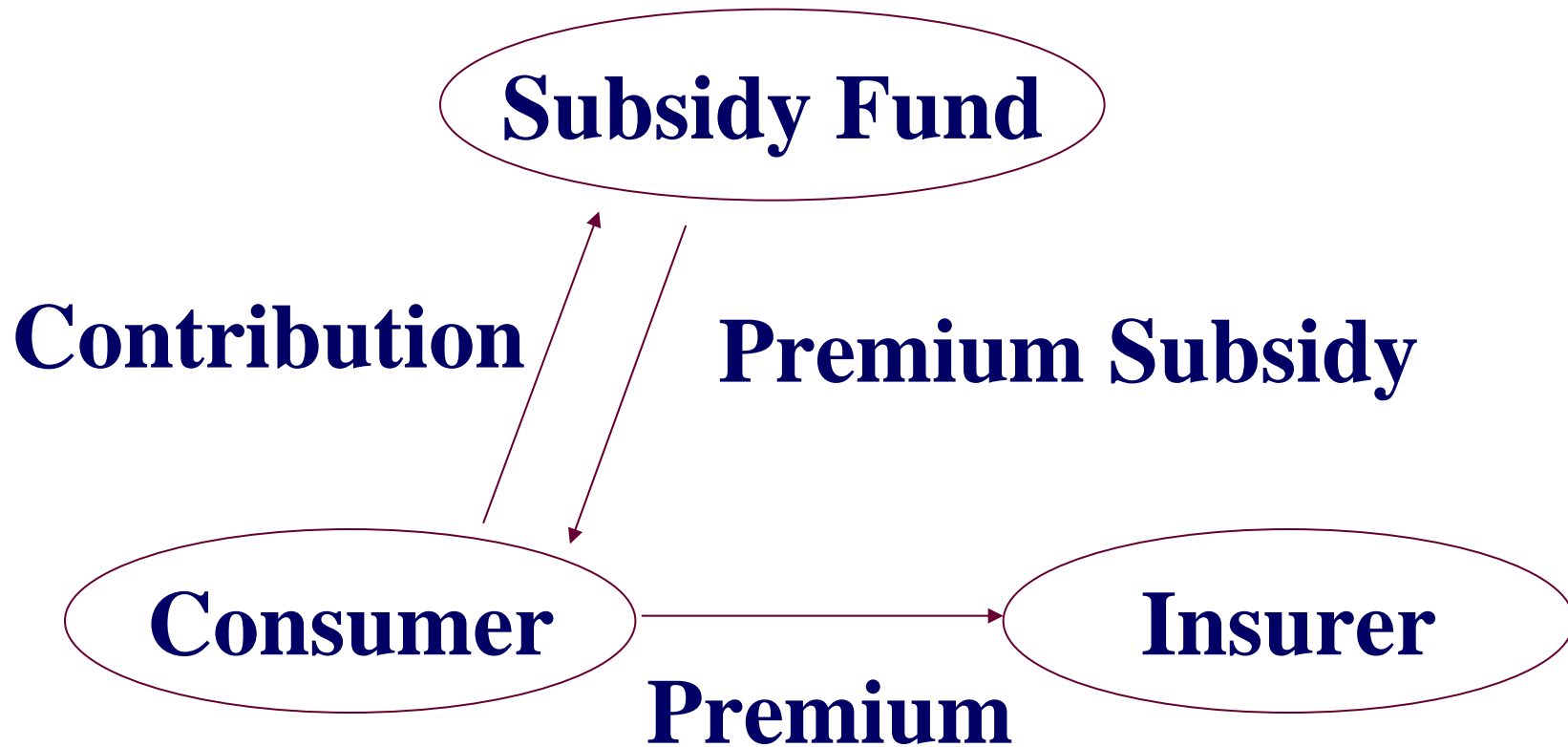
Risk-adjusted subsidies

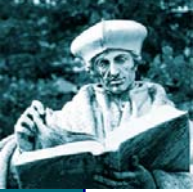
An effective way to deal with these problems is to have *risk-adjusted* subsidies rather than premium-adjusted subsidies.

Risk-adjusted premium subsidies are based on the risk factors that insurers use, such as age and health status, and do not distort competition.



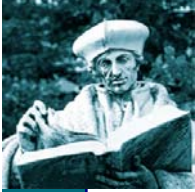
Premium subsidies





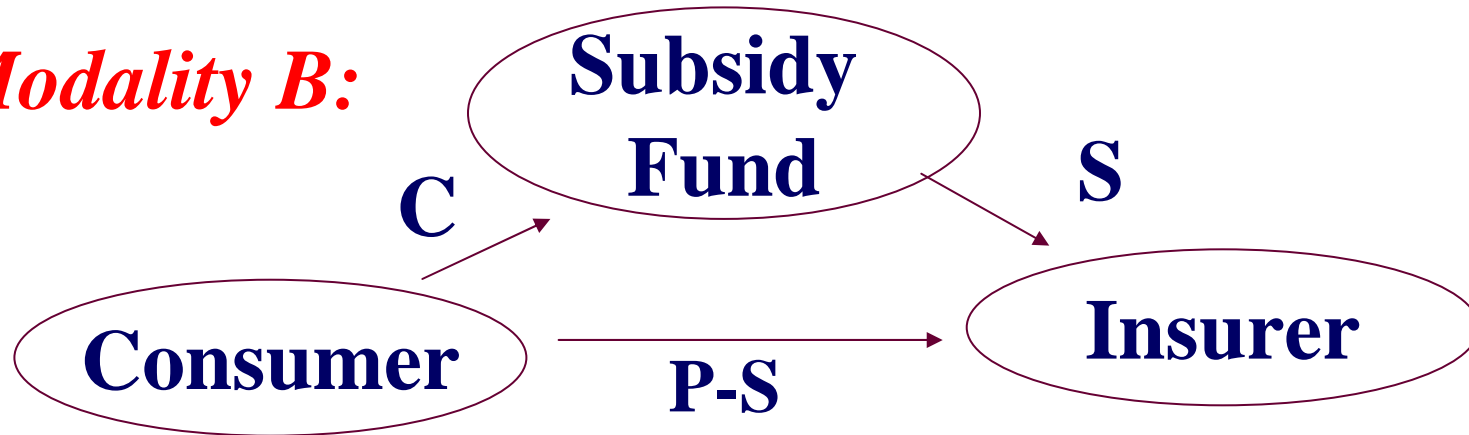
Risk Equalization

In practice all countries that apply *risk-adjusted* premium subsidies do it in the form of risk equalization among insurers, i.e. the risk-adjusted subsidies are given to the insurers who deduct the subsidies from the premium.

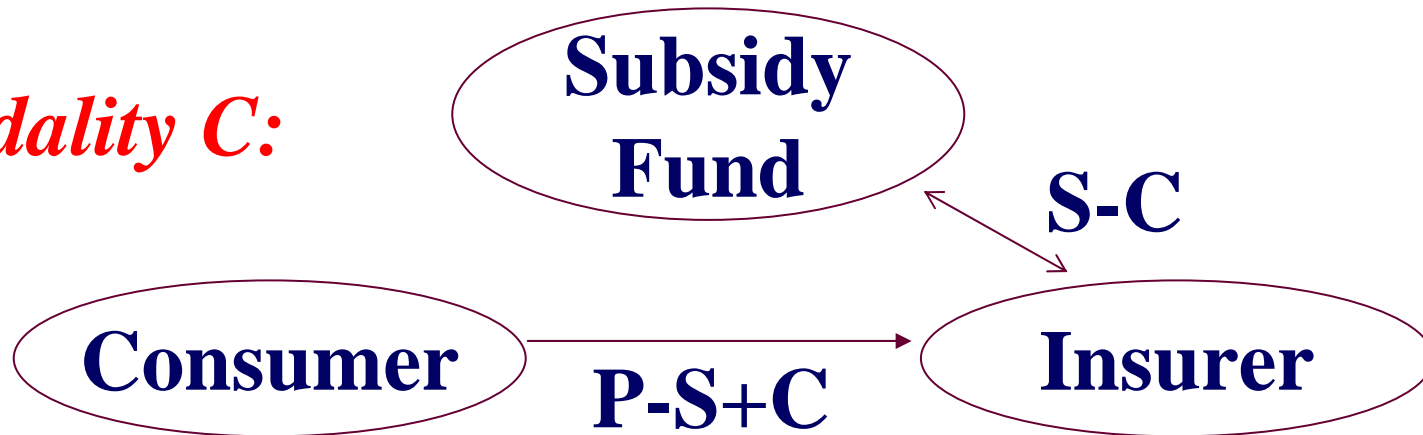


Modalities of risk equalization

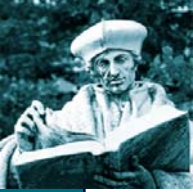
Modality B:



Modality C:



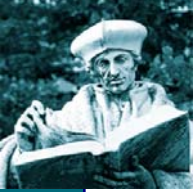
C=Contribution; S=Subsidy; P=Premium



Additional subsidies

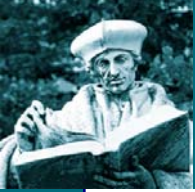
To the extent that some high-risk consumers are insufficiently subsidized, the risk-adjusted premium subsidies can be complemented by premium-based subsidies or by excess loss compensations (= compensations to the insurers by the sponsor for some or all expenses above a certain threshold for each individual).

→ tradeoff affordability - efficiency.



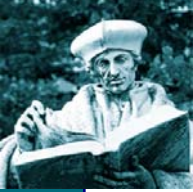
Implicit cross-subsidies

- An alternative is implicit cross-subsidies enforced by premium rate restrictions (and open enrollment) for a specified insurance coverage.
- Examples of premium rate restrictions:
 - Community rating;
 - A ban on certain rating factors;
 - Rate-banding.



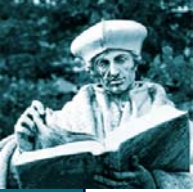
Premium rate restrictions

- Goal:
 - to create implicit cross-subsidies from the low-risks to the high-risks.
- Effect:
 - such pooling of people with different risks creates substantial predictable profits and losses for subgroups;
 - and thereby create incentives for risk selection.



Effects of selection

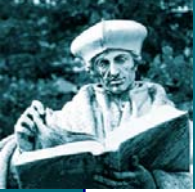
- Disincentive for insurers to be responsive to the high-risk consumers and to contract the best quality care for them;
- Disincentive for providers to acquire the best reputation for treating chronic diseases;
- Selection more profitable than efficiency;
- High premiums for high-risk patients;
- Instability in the insurance market.



Conclusion

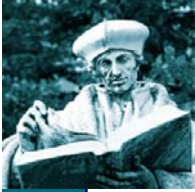
Given insufficient risk equalization we are confronted with a trade-off between:

- affordability,
- efficiency,
- and the potential effects of selection, notably low quality care for the chronically ill.



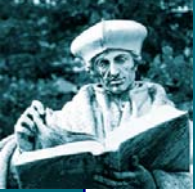
The preferred strategy

- Risk-adjusted premium subsidies or risk equalization is the preferred strategy.
- Because: the better the risk equalization is, the less severe is the resulting tradeoff.
- In the (theoretical) case of perfect risk equalization there is no need for any other strategy and the tradeoff no longer exists.
- Each of the other strategies alone inevitably confronts policymakers with a tradeoff.

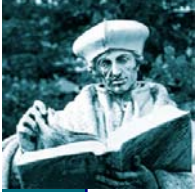


The only effective escape

Good risk equalization offers the only effective escape from the tradeoff between affordability, efficiency and selection.

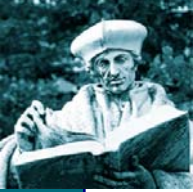


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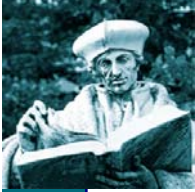
Competitive health insurance market

From the mid-1990s citizens in Belgium, Germany, Israel, the Netherlands and Switzerland have a guaranteed periodic choice among risk-bearing social health insurers, which are responsible for purchasing their care or providing them with medical care.



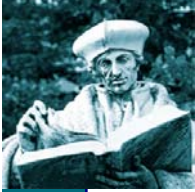
Rationale

The rationale for a competitive health insurance market is to stimulate the social health insurers to improve efficiency in health care production and to respond to consumers' preferences.



Risk Equalization in 2006

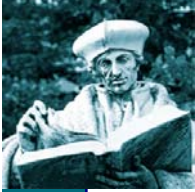
	Belgium	Germany	Israel	Netherlands	Switzerland
Risk adjusters	Age/gender, Disability, Invalidity, Chronic illness, Mortality, Employment status, Social status, Income, Urbanization.	Age/gender, Disability, Registration in a certified Disease Management Programme, Entitlement for sick leave payments, Income.	Age.	Age/gender, Disability, Pharmacy-based Cost Groups, Diagnostic Cost Groups, Self-employed, Urbanization.	Age/gender, Region.
Quality of Risk Equalization	Moderate / fair	Moderate	Low	Fair / good	Low



Premium rate restrictions

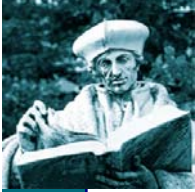
To make health insurance affordable government in each of the 5 countries imposed restrictions on the variation of the premium contributions, together with open enrolment requirement.

Given insufficient risk equalization these restrictions create incentives for selection.



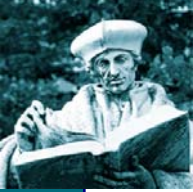
Is selection a problem? (2006)

	Belgium	Germany	Israel	Netherlands	Switzerland
Quality of Risk Equalization	Moderate / fair	Moderate	Low	Fair / good	Low
Financial risk insurers	7.5%	96%	94%	53%	100%
Number of health insurers	6	275	4	33	93
Is selection a problem?	increasing	YES	increasing	increasing	YES



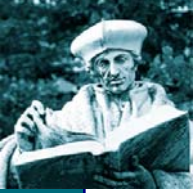
Selection activities

- selective contracting;
- limited provider plans (HMOs/PPOs);
- other managed care techniques;
- design of benefits package;
- supplementary health insurance;
- virtual (internet) health insurer;
- (employer-related) group contracts;
- software to distinguish high- and low-risk applicants during phone-calls;
- Bonusses for risk-selecting insurance agents;
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Contradictory trends?

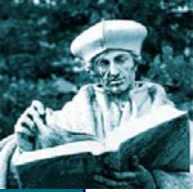
- On the one hand the risk equalization systems have been improved, and on the other hand in all 5 countries there is evidence of increasing risk selection which increasingly becomes a problem, in particular in Germany and Switzerland.
- Some potential explanations can be given for these seemingly contradictory observations.



Potential explanations

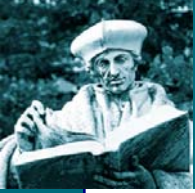
In the early stage:

- unfamiliarity with the rules of the game;
- small differences among insurers;
- social health insurers driven by social motives;
- selection no problem because of medical ethics.



How can we prevent selection?

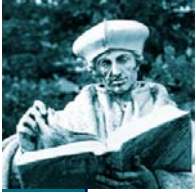
- Risk equalization;
- Less severe premium rate restrictions:
→ tradeoff selection - affordability;
- Excess loss compensations to insurers
(‘risk sharing between the sponsor and the insurers’):
→ tradeoff selection - efficiency.



Complex tradeoff

Given insufficient risk equalization we are confronted with a trade-off between:

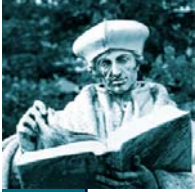
- affordability,
- efficiency,
- and the potential effects of selection, notably low quality care for the chronically ill.



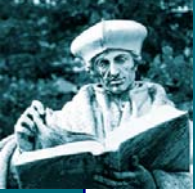
RE: complex in practice

Risk equalization appears to be complex in practice. Typical problems are:

- a lack of reliable data at the individual level;
- a lack of (agreement about) good health adjusters that fulfill all relevant criteria;
- opposition by insurers with a good risk profile;
- political opposition.

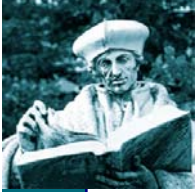


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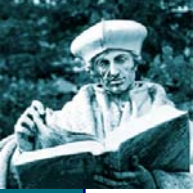
Rationale for consumer choice

In the literature ‘consumer choice of health insurer’ is associated with the model that government allows *individual* insurers to be a prudent buyer of care, or to ‘manage the care’, i.e. Enthoven’s model of ‘Managed Competition’.



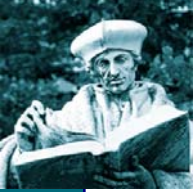
Managed Competition

A competitive market in which the allocation and price-setting are determined in principle by the market, but where government implements a regulatory framework to achieve affordable health insurance and an efficient functioning of the market.



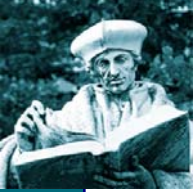
Preconditions Managed Competition

- Good risk equalization;
- Adequate competition policy;
- Consumer information (price, quality);
- Transparency (e.g. insurance products);
- Supervision of quality of care;
- Sufficient contracting freedom (price, quality, selective contracting);
- Prices must reflect costs;
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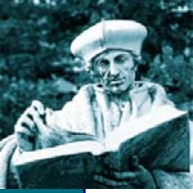
Managed care by individual insurer

- Belgium: no;
- Germany:
 - Options for GP-gatekeeper models and HMO-models;
 - Increasing discussion about selective contracting;
- Israel: some innovative forms of managed care contracts;



Managed care by individual insurer

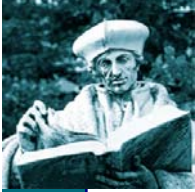
- Netherlands:
 - Insurers and hospitals are allowed to set up new pharmacies (from 2002);
 - Insurers are allowed to set up outpatient primary care centres (from 2003);
 - Prices for physiotherapy and partly (10%) for hospitals are free (from 2005).
- Switzerland: Options for GP-gatekeeper models and HMO-models.



Managed care by individual insurer

Dilemma in all 5 countries:

- Each tool for managing the care (e.g. selective contracting) is a tool for risk selection;
- Risk selection is more profitable than managing the care as long as the risk equalization system is insufficient.

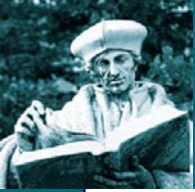


Explicit choice by politicians

Who is the third-party purchaser of care:

1. Government, or a cartel of insurers;
2. *Individual* risk-bearing insurers.

In the first option it is hard to think of any rational argument for giving consumers a periodic choice among risk-bearing social health insurers.



4. Conclusions

1. Risk equalization is the preferred strategy to make health insurance affordable in a competitive insurance market;
2. Risk equalization appears to be complex in practice.
3. Without good risk equalization the disadvantages of a competitive market may outweigh its advantages.
4. Managed competition: many technical complexities.