



Competition in Health Insurance¹

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Key messages

- A number of complex technical and institutional preconditions are necessary in order to create the right environment for multiple health insurers to compete. It may, instead, be easier for ECA countries to reform their existing single health insurance systems.
- Multiple insurance systems with competition need (i) risk-equalization across insurers if contributions are not risk-rated; (ii) competitive provider markets; (iii) well-informed consumers; (iv) investments in data collection and quality measurement; and (v) governance structures that can intervene to mitigate the negative effects of competition.
- Both single and multiple insurers can contribute to more efficient health sectors by adding competitive features like selective and performance-based contracts with providers, managed care models, and different co-payment plans for insurance members.

Hungary and Switzerland: Difficult policy-decision on single and multiple health insurance

In July 2007, the Government of Hungary decided on major insurance reforms, including shifting from a single to a multiple insurance system. Consumers would be able to choose freely from among insurers, and a risk equalization system between insurers would reduce incentives for 'risk selection' (that is, the likelihood that insurers mainly insure healthy clients). In February 2008, an insurance reform law was passed that introduced multiple insurer joint-stock companies, with each company having 49 percent private ownership. This law allowed insurers to contract selectively with providers, based on quality criteria. However, only three months later, the law was revoked, and reforms were redirected at strengthening the purchasing power of the existing single insurance fund.

In March 2007, 71 percent of the voters in Switzerland rejected a reform proposal that would have merged 87 health insurance companies into a single insurance system with income-dependent premiums.

Single or Multiple Health Insurers?

There has been much discussion about whether countries should offer the basic health benefit package through a single insurer or *multiple health insurers* (See Box). Single health insurance has been criticized for functioning like a simple disbursement agency that does not use its monopoly powers for managing costs, for example by contracting with more efficient providers. As a result, health expenditures and insurance deficits keep rising, and governments have to step in regularly to cover insurance deficits with resources from their general budgets.

This Knowledge Brief presents the key findings of a recent World Bank report on 'Health Insurance and Competition'. The report examines whether competition helps multiple insurers better manage health expenditures by, for example, contracting with more efficient providers or directing consumers towards less costly care (i.e. consumers who use generic drugs pay lower premiums or co-payments). The Netherlands, Switzerland, Slovakia, and the Czech Republic are some of the countries that already have multiple and competing insurance systems in place.

¹ This Knowledge Brief is based on the report: 'Health Insurance and Competition', May 2009, World Bank.

How Do Health Insurers Compete Against Each Other?

In an ideal multiple insurance system with competition, insurers have free market entry and exit, and they can compete against each other for healthier members and contracts with lower-cost and better-quality providers. They compete by using different insurance features, such as contribution levels, copayment levels for patients, benefit packages, different provider networks, etc. As a result, consumers can freely choose and enroll with the insurance company that best responds to their health coverage needs.

However, in reality, in most countries, competition among insurers is tightly regulated and insurance companies offer similar features to customers. In the Czech Republic and Slovakia, for instance, insurers require similar contribution levels for health insurance, such as fixed percentage of salaries. In Switzerland and The Netherlands, premiums are even subsidized by the governments based on household income levels (Table 1). Thus, households that cannot or do not pay the full ‘premiums’ have practically no incentive to enroll with insurers offering low premium levels. In most countries, benefit packages are also similar or identical across insurers and all insurers contract with all providers. In Slovakia, insurers are not allowed to charge co-payments. However, Swiss and Dutch insurers are allowed to offer plans with different co-payment levels to members who do not seek care or use less costly care. As a result of these different regulations, insurers in most countries are unable to offer features that are different from those of their competitors, making it difficult for them to compete and attract new members.

Reducing the Incentive for Risk Selection through Risk Equalization across Insurers

Given these restrictions related to insurance features, it is likely that insurers in a multiple insurance system will resort to ‘risk selection’ and compete against each other for enrolling healthier members. Healthier members are expected to have insurance expenditures that are lower than their contribution payments. Risk selection is particularly attractive for insurers when all members pay the same contributions independent of their health status.

Risk selection leads to a situation of ‘unequal risk’ across insurers; some insurers end up with mainly young and healthy members whereas others predominantly have membership pools of high-risk and poor-health individuals. This makes it difficult for insurers with higher-risk membership pools to function as financially viable entities. In several countries with multiple insurance systems, the practice of risk selection by insurers has eventually led to consolidation of the health insurance markets, leaving only a few insurers to provide health coverage to the majority of the populations. In Switzerland, for example, the number of insurers dropped from about 1,100 in 1960 to 87 in 2007--the four largest insurers cover approximately 50 percent of the population. The Netherlands has 14 insurance companies and the four largest insurers cover 90 percent of the population (Table 1).

Table 1: An Overview on Multiple Health Insurance, by Country, 2007/08

| Features | Austria | Netherlands | Slovakia | Switzerland |
|--|------------------------------------|---|------------------------------------|---|
| Number of insurers | 19 | 14 | 6 | 87 |
| Market concentration | 4 insurers cover 54 percent of pop | 4 insurers cover 90 percent of population | 1 insurer covers 56 percent of pop | 4 insurers cover 50 percent of population |
| Contributions, as percentage of gross earnings* | 7.3 to 9.1 percent | 7.2 percent on income plus community-rated average annual premium €1,105 per adult | 14 percent | Community-rated annual premium average SFr 2,596 (=€1,612) per adult (=approx 6% of average income) |
| Percentage of consumers receiving income-dependent premium subsidies | none | 68 percent of households receive “care allowance” | none | 40 percent of households |
| Percentage of population with additional private insurance | 30 percent | 90 percent | n/a | 70 percent |

* Austria: Contribution rates range from 7.3 percent of payroll for civil servants to 9.1 percent for self-employed; The Netherlands: Self-employed and retirees pay 5.1 percent; Slovakia: 14 percent of payroll is paid by formal sector employees while lower rates apply for other groups.

In European countries, risk selection is forbidden by law; multiple insurers are not allowed to exclude any individuals from enrolling in their plans². However, insurers still

² Social insurance through multiple insurers is different from voluntary and private insurers who can either reject members based on their health status or charge higher premiums for less healthy individuals (risk-based premiums).

manage to indulge in risk selection in a less visible way. For example, some insurers can refuse to contract with providers who have a reputation for treating chronic illnesses—this makes them less attractive to chronically ill individuals. An insurer can also risk-select by offering less attractive health benefits, making it less likely that people with chronic illnesses will choose to become its members.

Other risk-selection strategies include: charging higher co-payments to make health plans unattractive to less healthy consumers, and requiring patients to first pay providers for services received and then getting reimbursed from insurance (making the insurance plan unattractive to patients with regular or high-cost health care needs).

Some countries have responded to this problem by developing sophisticated ‘risk equalization transfer systems’ which reduce the incentives for multiple insurers to ‘risk select’. These systems compensate insurers for the financial risks associated with some of their high-risk members. The Netherlands has set up a risk equalization fund from which insurers receive risk-adjusted equalization payments for their high-risk members, and to which they pay equalization payments for their low-risk members.

What Are the Risk-Adjustment Parameters That Should Be Included in Risk Equalization?

Risk equalization schemes differ substantially across countries, mainly because they use different risk-adjustment parameters. Their levels of sophistication depend on the information that is available about the health-related risks of the populations. In the early 1990s, the Dutch used only age and gender parameters for risk-equalization systems (this is still the case in the Czech Republic and Slovakia). The Swiss risk-adjustment parameters include age (excluding children) and gender, calculated for each canton. The Netherlands substantially improved their equalization formula by adding pharmacy-based cost groups in 2002; two other parameters--diagnostic cost groups (DCGs) and being self-employed (yes/no)—were added in 2004.

Risk-adjustment models primarily based on demographic parameters (as in Switzerland, the Czech Republic and Slovakia) can predict only about 5 percent of the annual expenditures of the insured members. Compared with this, the more sophisticated Dutch adjustment model can predict approximately 22 percent of the expenditures. Still, the Dutch risk equalization formula does not adequately compensate insurers for high-risk members, and insurers suffer substantial and predictable financial losses when insuring the chronically ill. Thus, insurers still have the incentive to identify potentially high-cost individuals and exclude them from coverage.

The Dutch government is working on further improving its risk equalization formula by adding new risk parameters such as DCGs based on outpatient care, indicators of mental illness and of disability and functional restrictions, and multi-year DCGs instead of one-year DCGs. As of 2012, Switzerland plans to add ‘prior hospitalization’ to its risk equalization formula. These refinements should increase the

predictive powers of the formulas. As risk selection becomes less attractive to insurers, they will likely lower their costs by competing for contracts with more efficient providers.

Competing for Better-Quality and Lower-Cost Providers

Health insurers can also control their expenditures by competing for better providers and selectively contracting with providers based on their prices, services and quality of care. This could mean that some providers (for example, higher-cost providers) may not have contracts with specific insurance companies. In the Netherlands, insurers are free to selectively contract with providers and use financial incentives to motivate consumers to use those preferred providers. In addition, the Dutch have abolished price regulation for physiotherapy, and insurers and hospitals are allowed to freely negotiate prices for this service. Dutch insurers are also experimenting with giving bonuses to physicians who prescribe generic drugs instead of more expensive equivalent brand-name drugs.

In Switzerland and Slovakia, competition among insurers for providers is limited. Health insurers generally have to contract with all providers included in the network plan defined by the Ministry of Health, and prices paid to providers are regulated and defined nationally.

Insurers who want to compete for providers need to know which providers are the most effective and efficient. For this, it is necessary to have a nationwide quality framework and benchmarks against which provider performance can be compared. Substantial investment is also needed in data infrastructure at the national level, in insurance companies and in health facilities so that provider profiling can be done by insurers, and the results can be used for contracting.

Swiss and Dutch Managed Care Models Could Help Contain Costs

In Switzerland and The Netherlands, health insurers can offer their basic benefit packages through managed care plans. Dutch insurers and providers are free to choose the tools for managing care, including treatment protocols, disease and utilization management, or ways of preauthorizing care through the insurers.

Swiss insurers can offer the basic benefit package through three different managed care plans, including (i) managed care plans with lower premiums and higher co-payments, (ii) plans such as health management organizations (HMOs), preferred providers (PPs) or call centers; and (iii) a Bonus Plan rewarding members for not using care. The PP

model includes about 90 percent of primary care physicians in any specific region, and allows insurers to exclude the more costly providers based on their claims history. Call center models oblige patients with a medical problem to first contact the call center, after which the center refers them to providers if necessary. HMO staff models have achieved up to 30 percent cost-reductions compared to the basic social health insurance plans. These savings are then passed on to members in the form of lower premiums. Enrollment in these managed care plans has been increasing, mainly in HMO plans. In 2006, Swiss insurers reduced expenditures by SFr 1 billion (5 percent of total insurance expenditures) through such cost containment measures, including pre-authorization and claims management. These lower costs are passed on to consumers in the form of premium rebates.

Consumer Choice

In a multiple insurance system with competition, consumers need information about different insurance premiums, co-payment levels, the provider networks contracted, and health plans offered. Based on this information, consumers are expected to choose from among the different insurers and enroll with their preferred insurance company.

In reality, consumers often lack the necessary data on the performance of insurers and providers and cannot make informed choices. The Dutch government is trying to rectify this problem by supporting a consumer information website (www.kiesbeter.nl) where consumers can compare insurers and providers with respect to price, services, consumer satisfaction, and performance indicators.

In some countries with multiple insurance, consumers have very few choices, as insurers hardly differ from each other. Most insurers charge the same income-dependent contribution rate (payroll tax), offer the same benefits packages, contract with the same providers, and charge the same or no co-payments. In these countries, governments could facilitate consumer choice by delinking contributions from payroll to allow different premium levels. Insurers could also be allowed to charge different co-payment levels or award cash-back payments to consumers who seek care with more efficient providers.

Single or Multiple Health Insurance with Competition?

If countries have to decide between moving from a single to a multiple insurance system, or reforming their existing single insurance system to make it more efficient, the latter may be easier to implement.

Moving from single to multiple insurance with competition requires a lengthy implementation process. Also, a number of fundamental elements need to be in place for competition to have an impact on insurance expenditures. These elements include: (i) risk equalization across insurers to prevent risk selection where contribution levels are independent of individuals' health status; (ii) a competitive provider market with incentives that encourages providers to increase efficiency and improve the quality of care; (iii) investment in data collection and analysis of provider performance; (iv) knowledgeable consumers who are aware of the price and quality of health care, providers, and insurers and are freely able to choose from among them; and (v) a governance structure that includes an effective competition policy to regulate competition and avert its negative effects. A multiple insurance system with competition can be effective in an environment that includes a regulatory body with the authority to intervene and even punish insurers and providers, and well-informed and organized consumers who can help to implement reforms.

There is no evidence about which health insurance system works best. But there is some evidence on which features should be changed to make an insurance system--whether single or multiple insurance--work better. Therefore, it may be easier for countries to invest in changing some of the features in their single health insurance systems. A single insurer could charge flexible contributions and co-payment levels to guide patients towards more efficient providers, including managed care models. A single insurer could also be allowed to sign performance-based contracts with providers, with financial incentives through the provider payment system. The insurers could be allowed to charge risk-based premiums to members and, to ensure equity in health financing, governments could pay premium subsidies to lower-income individuals based on their income tax assessments. Governments would have to monitor and evaluate the effects that these changes have on efficiency, access, and financial sustainability in the health sectors of their countries.