CURRENCY EQUIVALENTS

(Exchange Rate Effective as of January 30, 2009)

Currency Unit

US$1.00  Euro 0.78

FISCAL YEAR
January 1  –  December 31

ABBREVIATIONS AND ACRONYMS

BBP  Basic Benefit Package
CPI  Consumer Price Index
DCB  Dutch Central Bank
DCG  Diagnostic Cost Group
ECA  Europe and Central Asia
FDHA  Federal Department of Home Affairs
FFS  Fee for Service
FMA  Financial Markets Authority
FOPH  Federal Office for Public Health
GP  General Practitioner
HIF  Health Insurance Fund
HMO  Health Maintenance Organization
HSA  Health Surveillance Authority
HVSV  Federation of Austrian Social Security Institutions
IPA  Independent Physician Association
MOF  Ministry of Finance
MOHI  Ministry of Health
OECD  Organization for Economic Cooperation and Development
OOP  Out-of-pocket Payments
PCG  Pharmacy-based Cost Group
P4P  Pay for Performance
PHC  Primary Health Care
PIT  Personal Income Tax
PP  Preferred Provider
REF  Risk Equalization Fund
SHI  Social Health Insurance

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# EU ACCESSION COUNTRIES
## REGIONAL HEALTH TA

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EXECUTIVE SUMMARY

Health financing systems in some Europe and Central Asia (ECA) countries are undergoing some major reforms. In parallel with the transition from central planning to developing market-based economies, countries in Central Europe have moved within a relatively short period of time from having health systems that were government-managed and funded by taxes to single health insurance systems that are payroll-funded. In the mid-1990s, the Czech Republic and Slovakia went even further and introduced multiple insurance with competition. Recently, Hungary and Poland have considered introducing similar reforms and have initiated some related legal amendments. Multiple insurance with competition can be defined as an insurance industry with many insurers with free market entry and exit. In this kind of insurance system, competition among insurers gives them incentives to contain costs, become more efficient, and provide better quality care, while the large number of insurance providers ensures universal access and financial sustainability. Countries that plan such reforms all look to the experience of Western European countries like Germany, Austria, the Netherlands, Belgium, and Switzerland where, over several decades, sophisticated multiple insurance systems have evolved. This study takes stock of recent reforms in countries with multiple insurance systems. It discusses whether they were able to create incentives for providers and consumers to improve their performance of the health sector and presents options for further reforms.

Countries that are dissatisfied with the single health insurance model have several reform options. Few single insurance systems are designed to promote “cost containment,” in other words, permanently slowing the growth in real medical care spending per capita. Rather, single insurers behave like a centralized collection and reimbursement agent and have accumulated substantial deficits. These deficits are a fiscal concern because governments frequently have to step in with additional resources from the general budget to cover those deficits. Some governments have implemented substantial debt management measures; for example, the Government of Slovakia succeeded in reducing the stock of debts in its health sector from 2 percent of GDP in 2003 to 0.4 percent in 2006. Reform options for single insurers include: (i) moving towards multiple insurance with competition as in the Netherlands, Switzerland, and Slovakia; (ii) moving towards multiple insurance without competition as in Austria; or (iii) strengthening the competitive features of their current single insurer and introducing additional factors that would encourage health care providers and consumers to behave more efficiently.

A key lesson is that governments often restrict competition among multiple insurers and regulate the design of insurance features to limit risk selection. Multiple insurers have considerably fewer ways to compete against each other if: (i) they charge fixed
contributions such as payroll tax rates or community-rated premiums; (ii) contributions are subsidized and households do not pay the full “price”; (iii) the benefit package is similar or even essentially identical across insurers; and (iv) cost-sharing with patients is limited. Consequently, competing insurers may find it difficult to control their costs, either by competing for contracts with more efficient providers or by influencing patients’ care-seeking behavior, for example by passing any such savings on to consumers in the form of lower contribution or co-payment levels. Instead, to reduce their financial risks, insurers have an incentive to opt for risk selection, in other words, to attract healthier individuals who may not need to use very much health care. In multiple insurance systems with open enrollment and risk-independent contributions, risk selection is attractive for insurers, especially when the risk-adjustment is based on incomplete information.

To limit the extent to which insurers choose risk selection, some governments have introduced risk equalization schemes across insurers. There are several different kinds of risk equalization schemes, and their level of sophistication depends on what information is available on the health and socio-demographic/economic status of the population. Policymakers define the risk equalization transfer amount for insurers based on explicit risk-adjustment parameters that have evolved over time. In the Czech Republic and Slovakia, these parameters are based on age and gender. The Swiss risk-adjustment parameters include age (excluding children) and gender, calculated separately for each canton. However, risk-adjustment models that are mainly based on demographic variables can predict only about 5 percent of the variation in individuals’ annual expenditures. The Netherlands has the most sophisticated adjustment system, which was substantially improved by adding pharmacy-based cost groups (PCGs) in 2002 and two additional parameters in 2004 - diagnostic cost groups (DCGs) and “being self-employed.” The Dutch adjustment model is able to predict about 22 percent of variation in expenditures. Inadequate risk-adjustment gives insurers an incentive to select lower-risk (healthier) individuals as members or to offer less attractive health benefits that would dissuade people with health issues from enrolment (self selection).

Insurers could also compete for contracts with more efficient health care providers to manage their costs. However, in most countries, provider markets and particularly public providers are protected by the government from competitive behavior. This means that providers have a limited exposure to competitive tools such as differential price setting, selective contracting based on providers’ quality of care results, and quality and performance-based payments. Also, managed care provider models are not very common yet in European countries. Lastly, for competition to be effective, this requires informed consumers who are free to choose among insurers and providers.

There are several preconditions that are necessary to create the appropriate incentives for consumers, health care providers, and insurers within a competitive health insurance system. The Dutch experience shows that the following five elements need to be in place in a multiple insurance system with risk-independent premiums: (i) risk equalization across insurers; (ii) a competitive provider market with incentives that

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1 van de Ven, Wynand (2008).
encourage providers to increase efficiency and improve the quality of care; (iii) outcome and quality measurement; (iv) consumers knowledgeable about the price and quality of health care, providers, and insurers, and consumers being freely able to choose among them; and (v) a governance structure that includes an effective competition policy. In practice, countries have progressed at different rates in adopting these five elements, which has also affected the extent to which competition has succeeded in increasing efficiency in the health sector. In countries where these systems are less well developed, multiple insurance may trigger risk selection.

First, risk-adjusted equalization payments provide a level playing field for health insurers. Where risk-adjustment is imperfect — which is largely the case in Switzerland, Slovakia, and the Czech Republic — it is still more profitable for insurers to attract healthier individuals than to compete for contracts with better performing providers to increase the efficiency and improve the quality of the health sector. Therefore, risk equalization should include some health parameters as this is the case in the Netherlands. Furthermore, ex-post compensation, as is used in Slovakia, gives insurers less of an incentive to compete for more efficient providers and should be reduced substantially. The experience in the Netherlands with risk-adjustment may have helpful lessons for other countries that need to reform their risk-adjustment system.

Second, in most countries, reform has not put enough emphasis on competition among providers. Competition among providers has so far only occurred in some submarkets such as managed care business. As a result, health insurance companies can only compete with each other in terms of administrative efficiency and superior customer services. In Switzerland, managed care innovations such as Health Management Organization (HMO) models have yielded cost savings, and other insurers could learn from this experience to influence their own expenditures. Reforms in contracting are needed to give insurers an incentive to compete for better quality and more efficient care. Such reforms should allow bilateral negotiations between insurers and individual providers instead of with provider associations, and selective contracting of providers (meaning negotiating with providers to select those with the best prices, services, and quality of care). Provider payments, provider profiling, and the use of results for performance-based contracts can enhance the impact of competition on the provider side. Such provider reforms would be relatively new for many Central European countries and are relevant not only in multiple insurance systems but also in single insurance systems that aim to increase the efficiency of providers.

Third, investing in quality control programs can prevent providers from reducing their costs by delivering substandard care. In most European countries, adequate quality indicators and quality assurance programs have not yet been established. What little quality control exists is limited to self-regulation by physicians. Ensuring a high quality of care throughout the health system would require policymakers to invest in collecting data on patients and providers, putting in place additional incentives for providers (for example, through a provider payment system), and regulating and supervising the quality of care. As happens in the Netherlands, insurers could use feedback on the quality of the care provided by health care providers to negotiate prices and contracts with those providers. The results of these quality assessments should also
be published in newspapers to inform consumers and enable them to access care from the better-quality providers. Providers might also feel pressure from other providers to improve the quality of their care where necessary. Such quality improvement measures are equally relevant for single health insurance systems and for competitive insurance systems.

**Fourth, information is needed to ensure good quality and consumer choice.** A lack of information on the performance of providers and insurers as well as on individuals’ risk status is a major impediment to making competition work. Consumers need to be able to consult readily accessible, standardized, and accurate information on how well or badly providers and insurers have performed. Insurers in Switzerland, Austria, and Slovakia do not have the necessary preconditions to set up provider profiling programs that is using the information given on insurance claims forms, including diagnosis and treatment information, to evaluate the performance of health care providers and using the results of this evaluation to exclude any providers whose performance has been unsatisfactory and to adjust the amount of the reimbursement paid to providers. The need for insurers to receive more information on patients and on providers’ treatment patterns to profile providers may require changes in data protection laws. Thus, regulatory agencies should intervene if competition does not lead to the desired level of transparency. These concepts are all relatively new for Central European countries and for some Western European countries such as Switzerland, and Austria, and are equally relevant for single health insurance systems and for competitive insurance systems.

**Fifth, governments should allow more competition to make multiple insurance systems more effective.** The Dutch experience shows that regulatory agencies play an important role in preventing the adverse effects of competition. In most countries in Central Europe, there is a need to relax the strong regulation of the insurance and provider market (over, for example, contracting, provider payments, co-payments, and premiums). For example, in Slovakia’s multiple insurance system, the contribution rates are nationally defined, the benefits package, co-payments and deductibles are standardized, and insurers’ contract prices to providers are mostly fixed at similar levels. Introducing some competitive elements could lead to efficiency gains and cost containment. This could be of particular interest in Central European countries, which have lagged behind other countries in reducing overcapacity in their provider markets.

**Some governments may prefer to improve the performance of their single insurance system instead of implementing major reforms to introduce multiple insurance systems.** In most Central European countries, single insurers could help to make the health sector substantially more efficient by abandoning their simple disbursement role and becoming active strategic purchasers. Policymakers could make this happen by strengthening an insurer’s purchasing and contracting function, allowing performance-based contracting, defining the benefit package based on what public resources are available, and setting explicit cost-sharing levels to guide patients towards more efficient goods and services. To increase equity in health financing, single insurers could implement similar reforms as those that have been adopted in multiple insurance systems, including charging risk-based premiums with compulsory enrollment and paying premium subsidies to lower-income individuals based on their income tax assessments.
All Central European countries with a single health insurer could consider implementing such reforms to increase efficiencies in the provision of health care.
1. INTRODUCTION

1.1 As part of their market-oriented reforms, some new EU member states have introduced or are considering introducing multiple insurance systems. Social health insurance can be offered in a country by a single health insurer or by multiple insurance companies with or without competition. Multiple insurance with competition can be defined as an insurance industry with many insurers, all of whom have free market entry and exit (Rothschild and Stiglitz, 1976). In multiple insurance systems with open enrollment and contributions defined with no reference to individuals' health risk, insurers have an incentive to resort to risk selection, in other words, to select lower-risk (healthier) individuals as members or to offer less attractive health benefits that would dissuade people with health issues from selecting their services (self selection) (Ackerlof, 1974). To prevent risk selection, some countries have developed sophisticated risk equalization systems to compensate insurers for the different health risks faced by their members. Countries like the Netherlands, Switzerland, and the US, have a long history with multiple insurance systems. Other countries, such as in the new EU states, have moved from single to multiple insurance with competition as a way to use insurers' competitive behavior to improve the performance of the health sector.

1.2 This study presents an overview of the functioning of multiple health insurance with competition in the Netherlands, Switzerland, and Slovakia, and without competition in Austria. All these countries have risk equalization schemes across insurers to partially equalize the risk distribution among insurers. Also, these countries have the market structure and sufficient insurance regulation to restrict the extent to which insurers can engage in risk selection. The study will examine several questions, including how competing insurers manage their risk distribution and health care expenditures, whether insurers choose to contract with more efficient providers (known as selective contracting), and whether savings made by reducing costs are being passed on to consumers in the form of lower premiums, thus giving consumers an incentive to choose more efficient insurers and providers. The study will further explore (i) how insurers compete for members and for providers; (ii) the factors that support or impede the performance of competing insurers; and (iii) the necessary institutional, financial, and organizational conditions that must be in place for multiple insurance with competition to work. Lessons are identified that might be useful for insurance reforms in other countries.

1.3 Central European countries have gone through major health financing reforms in recent years. Most health care systems in Eastern Europe and Central Asia (ECA) were based on the Semashko health care model – the centrally planned, National Health Service model of the former Soviet Union. Eligibility was universal for all services, which were provided free of charge and underwritten by the general state budget. All facilities were owned by the state, and health care personnel were salaried state employees. In the late 1980s and early 1990s, the governments of most Eastern
European countries introduced major health system reforms that set up single insurance models (Langenbrunner, 2005).

1.4 In several countries, single health insurance has failed in cost-containment and efficiency terms and has not yielded enough quality improvements. While total health spending in the new EU member states is not too high given their level of GDP, several factors threaten the sustainability of the public financing system in these countries and have contributed to annual deficits in health sectors. These factors include the generous coverage of health services under social health insurance (SHI) with few or no patient copayments, the fast growth in pharmaceutical expenditures and salaries, excessive hospital infrastructure, and the rising costs of new medical technology. In most newly admitted EU countries, health expenditures have now surpassed the available resources, resulting in insurers and providers becoming increasingly indebted (Chawla, 2007). Only a few countries, including Estonia and Slovenia, had the political support to embark upon the necessary reforms to reduce these underlying inefficiencies. Some countries, such as Hungary, changed the payment system to DRGs for hospitals to give providers a financial incentive to provide care more efficiently. Despite these reforms, social health insurers around the world tend to behave like a centralized collection and reimbursement agent and do not have enough purchasing power, including flexibility in contracting, to affect providers’ behavior. In some countries, these unmet expectations have led to policymakers becoming interested in multiple insurance as an alternative to SHI.

1.5 Among the new EU member states, the Czech Republic and Slovakia have already moved to a multiple insurance system that allows insurers to compete for members. In Slovakia, in the early 1990s the adoption of a multiple insurance system with public and private for-profit insurers was expected to help to control increasing debt in the health sector, while insurance competition in the Czech Republic was seen as a way to reduce over-capacity on the supply side. Over time, these systems have undergone several refinements. In October 2007, the Government of Slovakia passed the Amendment 530/2007 to the Health Insurance Act 58 1/2007 that requires the for-profit health insurance companies to reinvest their profits into the health care system rather than paying dividends to their shareholders. In addition, two petitions have been launched advocating a return to a single health insurance system. In the Czech Republic, the insurance system has undergone several changes including the introduction of co-payments in January 2008.

1.6 Poland and Hungary are considering similar insurance reforms but are facing some obstacles in the conceptual phase. Since its inception in 1992 until 2006, the Hungarian Health Insurance Fund (HIF) has reported an annual deficit reaching 1.6% of GDP in 2003 and 1.3% in 2004, which was regularly financed by the Government budget. However, in 2007, the HIF made a surplus for the first time due to mandatory transfers from the state budget to the HIF on behalf of pensioners and other non-contributing persons, coupled with formal co-payments by patients, strict expenditure controls, and a reduction in hospital beds. In July 2007, the Government of Hungary decided to allow a pluralistic insurance system that gave consumers a free choice among insurers and that included a risk equalization system between insurers. In February 2008, an insurance reform law was passed that introduced multiple insurer joint-stock
companies with 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 have been redirected to strengthen the purchasing power of the single insurance fund. Consequently, the HIF is currently consolidating its 19 county-level branches into seven regional offices responsible for selective contracting with providers based on explicit quality performance criteria. Similarly, in Poland, major disputes over salary reforms before the 2007 elections led to a request by the Physicians' Trade Union for replacing the single National Health Fund (NHF) with a pluralistic health insurance system, based on competition among independent insurance companies, whereby all citizens could be insured by the government using funds from personal income tax (PIT) revenue. The Government is currently reviewing this proposal.

1.7 The move from single to multiple insurance requires a sophisticated supporting framework for competition to work. The experience of several countries shows that competition in health care can only meet public policy goals if a number of complex technical and institutional preconditions have been met, which requires a lengthy and cautious implementation process. This entails some upfront investments that can be costly, which can make insurance reforms less attractive than other reforms, as the recent experience in Hungary shows.

1.8 The remainder of the report will be organized as follows. The next chapter (Chapter 2) describes the insurance context in Austria, the Netherlands, Slovakia, and Switzerland. Chapter 3 examines risk selection in a multiple insurance system. Risk-adjusters and equalization schemes in different countries are discussed as well as the resulting incentives for insurance companies to develop cost containment strategies. Chapter 4 discusses whether and how insurers compete for providers, including the different forms of managed care contracts that have evolved under multiple insurance and the impact of such contracts on policy goals. Chapter 5 describes consumer choice in different health financing systems and whether consumers are exercising their choice to switch insurers and plans. Chapter 6 presents an overview of the different options for insurance reforms. The final chapter will identify the main lessons drawn from the preceding chapters and will present potential policy solutions for increasing the effectiveness of insurance systems, including the necessary regulatory framework to prevent adverse effects, purchasing, improved risk pooling, and monitoring and evaluation systems.

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2. COUNTRY INSURANCE CONTEXT

2.1 This chapter presents an overview of multiple insurance systems and shows how they differ with respect to their insurance features, based on the specific examples of Austria, the Netherlands, Slovakia, and Switzerland. The insurance features that will be discussed include insurance contribution rates or premiums, risk-pooling, cost-sharing with patients, the basic benefit package covered as well as options for voluntary coverage. The ways in which insurance features are defined influences how insurers can manage their financial risks, which is particularly important in a competitive environment in which the government does not guarantee to underwrite insurers' deficits. The design of these features also influences the related risk mitigation strategies and the task of insurance supervisory authorities. Table 2.1 summarizes the characteristics of key insurance features for the countries that are reviewed in this chapter.

FEATURES OF HEALTH INSURANCE

2.2 In all countries, multiple insurance companies offering compulsory health insurance policies are heavily regulated. In Austria and Switzerland, insurers may not be for-profit, they must offer the same basic insurance package, and the central government tightly controls premiums, benefits, and the prices paid to providers. Swiss insurers are not-for-profit companies that have to meet standard business requirements in accounting, financing, and auditing as defined in Swiss law. Similar regulations apply in Slovakia and the Netherlands, with the exception that insurers may be for-profit. Since October 2007, government regulations require Slovakia's for-profit insurers to reinvest their profits into the provision of care, for example, by paying higher prices to providers instead of paying dividends to their shareholders.

2.3 In all countries reviewed, insurance enrollment is mandatory and individuals cannot be refused coverage. In Austria, individuals have to insure with their regional or professional health insurance fund (HIF), depending on their employment status or place of residence. In Slovakia, each resident enrolls with an insurer that then receives members' payroll tax contributions directly from the treasury department of the Ministry of Finance (MOF). Residents of Switzerland can enroll with any insurer in their canton, and the cantonal governments assign uninsured individuals to an insurer. In the

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3 This chapter draws heavily on the background papers prepared by Koettl (2008) on Austria, Schuetz (2008) on Switzerland, and van de Ven (2008) on the Netherlands. Information on Slovakia was collected during interviews with representatives from the health sector in January 2008.

Netherlands, since January 2006, residents have to buy individual health insurance from a private insurance company.

2.4 **In most multiple insurance systems, the majority of the population is insured by a small number of insurers.** Mergers, acquisitions, insolvencies, and liquidations have led to a substantial reduction in the number of risk pools in multiple insurance systems. In Austria, more than 100 non-competing insurers have now been reduced to 19 HIFs, which form the Federation of Austrian Social Security Institutions (HVSV). The Netherlands now has about 14 insurers; some of whom have subsidiaries operating under different titles. In Slovakia, the number of insurers has remained small and more or less stable. Currently, there are two public and four non-public insurers that are legally joint-stock companies, falling under the commercial code. The number of Swiss insurers has decreased from about 1,100 in 1960 to 86 insurers in 2006 (Table 2.1). A more recent market development is “group building”, with insurers building sub-companies or buying out competitors to follow a multi-brand strategy. As a result of this market concentration, a relatively small number of insurance companies insure the majority of the population, and this is even the case in countries such as Switzerland with many insurance companies. However, whatever operating efficiencies that market consolidation may have generated in these countries, none of them have been passed on to consumers in the form of lower contribution rates.

2.5 **Most social insurance contributions are levied as a fixed percentage of a person’s monthly paycheck.** Insurance contributions can either be risk-rated to account for individuals’ health status and for the related financial risk; or be community-rated, with all members within a group paying the same amount independent of that individual’s health risk status. These payroll rates are generally set by national legislators. In Austria and Slovakia, payroll tax rates for health insurance vary across population groups. In Austria, health insurance payroll taxes vary between 7.3 percent for civil servants to 9.1 percent of gross income for self-employed individuals and are subject to a salary ceiling. Contribution rates in Slovakia amount to 14 percent of wage income per individual, while the rate for the severely disabled is 7 percent of their gross wage. The self-employed and self-paying pay 14 percent of the minimum wage. The Slovak government pays insurance contributions on behalf of the non-working population (pensioners, the unemployed, and social assistance recipients) and contributes 4.5 percent of the average wage from two years ago (status in 2007).

2.6 **Only in Switzerland and the Netherlands do contributions vary according to which insurer and health plan is chosen.** In Switzerland, individuals pay a monthly community-rated premium directly to the health insurer of their choice. Each insurer sets its own community-rated premium. Premiums are independent of individuals’ income but

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5 Including nine regional funds for employees covering about 77 percent of the population, four national occupational funds (for civil servants, railway and mining workers, the self-employed, and farmers), and six company funds. The size of the regional HIFs varies substantially, ranging from 137,000 members in the Burgenland HIF to 1.1 million members in Vienna.

6 The average number of members per insurer increased from 3,574 in 1960 to 85,959 in 2006.

7 The minimum base is the official monthly minimum wage (SKK 7,600), and the maximum base is three times the official average wage (SKK 51,822), in January 2008.
vary widely across insurers and cantons. On average, premium payments are equal to about 6 percent of the average income (Jeitziner and Peters, 2007).

2.7 In the Netherlands, individuals pay two kinds of contributions and can benefit from group discounts. Since 2008, all Dutch residents have to pay 7.2 percent of the first €31,200 of their annual income to the tax-collector, who transfers these contributions to a Risk Equalization Fund (REF). The sum of the income-related contributions equals 50 percent of the total insurers' revenues for the mandatory basic insurance. In addition, all adults pay a premium directly to their chosen insurer. The government pays the premium for children (under the age of 18) to the REF. As in Switzerland, each Dutch insurer sets its own community-rated premium. In 2008, the average premium equaled about €1105 per adult (18+) per year, ranging from €936 to €1,164. Dutch insurers can give a group discount of up to 10 percent to insured people if they enroll as a group. In 2007, about 57 percent of the population benefited from a group discount, with an average discount of 7 percent. Group members have the same insurance benefit entitlements as those insured as individuals (van de Ven, 2008).

2.8 Competition between insurers has not led to a convergence of insurance premiums or containment of premium growth. In Switzerland, competition between insurers and the resulting consumer mobility did not trigger a convergence of premiums across insurers and within cantons, and monthly nominal premiums charged for the same benefit package continue to differ across insurers, ranging from SFr254 (€156) to SFr287 (€176) per person in Zurich, for instance (BAG, 2008a). In the Netherlands, premium differences among insurers have caused people to shop around for the best rates.

2.9 In some countries such as Switzerland and the Netherlands, governments subsidize the premiums paid by some households to increase equity in health financing. Almost 70 percent of Dutch households receive an income-related subsidy ("care allowance") from the government. The Swiss cantonal governments pay means-tested subsidies to individuals with incomes below a defined threshold based on their taxable income. The subsidies are paid if the household's premium payments exceed a specific percentage of household income – usually 8 to 10 percent. In 2006, roughly 30 percent of the population of Switzerland or 40 percent of households received means-

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8 Each insurer within a canton sets community-rated premiums for three age groups: children (0 - 18 years), young adults (19 - 25 years), and adults (26+ years). Different health care costs in cantons result in different average annual premium per adult across cantons, ranging from SFr 1,712 in Appenzell to SFr 3,664 in Geneva, and an average premium of SFr 2,596 in 2006 (BAG, 2008).

9 A group can take the form of any legal entity including firms, patient organizations, sport associations, labor unions, co-operative banks (for their clients/members), and independent entrepreneurs who organize groups (for example, via the Internet).


11 Exchange rate: 1 Swiss Franc = 0.6143 Euro on July 28, 2008.

12 For a one-person household the annual care allowance is at most €552 (in 2008). In 2006, 4.9 million households received a care allowance (CBS Webmagazine 12 March 2007). In total there are 7.2 million households in the Netherlands (CBS Webmagazine 18 April 2007). See: http://www.cbs.nl

13 Cantons are responsible for subsidy payments based on cantonal-defined criteria and receive financial contributions from the confederation. The average subsidy was SFr 1,519 per person and SFr 2,798 per household in 2007.
tested premium subsidies. Essentially this means that, in Switzerland and the Netherlands, lower-income groups receive free insurance coverage or coverage at a much reduced price.

Table 2.1: Health Insurance by Country (2007/08)

<table>
<thead>
<tr>
<th>Features</th>
<th>Austria</th>
<th>Netherlands</th>
<th>Slovakia</th>
<th>Switzerland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of insurers</td>
<td>19</td>
<td>14</td>
<td>6</td>
<td>87</td>
</tr>
<tr>
<td>Market concentration</td>
<td>4 insurers, 54% of pop</td>
<td>4 insurers, 90% of population</td>
<td>1 insurer, 56% of pop</td>
<td>4 insurers, 50% of population</td>
</tr>
<tr>
<td>Contribution as % of gross earnings*</td>
<td>7.3-9.1</td>
<td>7.2 on income plus community-rated average annual premium of €1,105 per adult</td>
<td>14</td>
<td>Community-rated annual premium average = SFr 2,596 (=€1,612) per adult (approx 6% of average income)</td>
</tr>
<tr>
<td>% of consumers receiving income-dependent premium subsidies</td>
<td>none</td>
<td>68% of households receive “care allowance”</td>
<td>none</td>
<td>40% of households</td>
</tr>
<tr>
<td>Administrative costs as % of total insurance expenditures</td>
<td>3%</td>
<td>4%</td>
<td>3%</td>
<td>5.7%</td>
</tr>
<tr>
<td>Health plans offered by social insurers</td>
<td>Basic public health package</td>
<td>Basic public and private additional health plans</td>
<td>Basic public and private additional health plans</td>
<td>Basic public and private additional health plans</td>
</tr>
<tr>
<td>% of population with additional private insurance</td>
<td>30%</td>
<td>90%</td>
<td>n/a</td>
<td>70%</td>
</tr>
</tbody>
</table>

Note: * In Austria, contribution rates range from 7.3 percent of payroll for civil servants to 9.1 percent for the self-employed. In the Netherlands, the self-employed and retirees pay 5.1 percent. In Germany, the average contribution rate is 14.3 percent but rates vary across funds. In Slovakia, 14 percent of payroll is paid by formal sector employees while lower rates apply for other groups.

2.10 In all four countries, the standardized basic benefits package (BBP) is prescribed in the health insurance law and is strongly regulated. The Dutch Health Insurance Act prescribes what entitlements must be offered (the content and extent of care) and when entitlements exist (the relevant medical conditions or events). The benefit package covers general practitioner (GP) care, specialist care, prescribed pharmaceuticals, hospitalization, maternity care, dental care for children, some paramedical care and medical devices, transportation of patients, industrial accidents, and occupational diseases. The BBP is described in terms of functions instead of providers of care, and, as a result, plans must provide specific kinds of “rehabilitation care” rather
than the more general "care delivered by rehabilitation institutions." In Switzerland, the BBP is defined by federal law and national by-laws and includes coverage for care delivered in public hospitals, private outpatient care in the canton of residence, and emergency and pre-authorized care in all cantons. In Austria and Slovakia, the benefit package is regulated at the national level and includes similar coverage as in the Netherlands and Switzerland.

2.11 Cost-sharing arrangements in the form of co-payments and deductibles enable insurers to influence patients' demand for care. In Western Europe, cost-sharing is a common practice and used by insurers to manage patients' demand for care. In the Netherlands, every adult has a deductible of €150 per year (excluding GP services and maternity care). Consumers can obtain a premium discount if they voluntarily choose a higher deductible (up to €650 per year). In 2008, the average premium for a policy with a higher deductible of €650 equaled about €899 per adult (over the age of 18) per year, ranging from €684 to €1,020. A similar variety of deductibles exist in Switzerland. Under the basic insurance plan, individuals pay a SFr 300 (€184) deductible per year plus 10 percent co-payments. Consumers can enroll in higher deductible plans of SFr. 2,500 (€1,535) to receive a premium discount of up to 50 percent (Table 4.1). In Switzerland, Article 64 of the health insurance law (KVG) forbids the introduction of voluntary insurance to cover co-payments charged by the social health insurers. In Austria, insurers can charge co-payments, but the maximum level of co-payment is capped by national law and varies slightly across HIFs. Also, regional HIFs are supposed to charge deductibles, though deductibles are not implemented consistently.

2.12 Insurers in the new EU member states have encountered resistance from politicians and the population in implementing official cost-sharing arrangements with patients. Generally, insurers in all Central European countries charge co-payments for diagnostics, pharmaceuticals, and some medical materials. Slovakia abolished very modest co-payments for health services in 2006, but patients still co-pay for pharmaceuticals. Co-payments caused the share of household income spent on health care to increase from 1.38 percent in 2000 to 2.95 percent in 2005, with the lowest income groups paying almost 5 percent of household income compared with the 2 percent spent by the richest groups. Despite these increases, the Slovak out-of-pocket spending share is still among the least regressive in Europe (Kiss et al, 2007). In Hungary, a recent effort to introduce co-payments by patients had to be abolished in April 2008 following a nationwide referendum. Multiple insurers who operate with no cost-sharing lack an important competitive element and cannot pass on efficiency gains to the insured in the form of lower deductibles or co-payments.

2.13 Administrative expenses in European multiple insurance systems are relatively low. From 1996 to 2006, administrative costs of Swiss insurers have decreased from 8.2 percent to 5.7 percent of total insurance expenditure, while total membership grew by 300,000 individuals. Administrative expenditures for Dutch insurers are about 4 percent, while Austrian non-competing insurers spend 3 percent of their total expenditures on

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14 Hospital planning includes public and private hospitals.

15 The co-payment was implemented in February 2007 but abolished in April 2008.
administrative costs including revenue collection and billing (Hofmarcher et al, 2006). In Slovakia, administrative expenditures are capped at 3 percent of total insurance expenditures. Compared with these rates, the Polish single insurance fund (NHF) has very low administrative costs, amounting to only 1 percent of its total expenditures. The statutory obligations of the NHF include price setting and contracting with selected providers; however the NHF does not need the same level of investments and expenditures that are required in a multiple insurance system.

**PRIVATE VOLUNTARY HEALTH INSURANCE**

2.14 On top of their compulsory health insurance, people often purchase private voluntary insurance for which they have to reveal additional information that insurers could use for risk selection. (Risk selection will be discussed in Chapter 3.) Private health insurance is generally financed by risk-rated premiums, and insurers are allowed to refuse applicants or exclude pre-existing conditions from coverage. In Austria, social health insurers are forbidden to sell private insurance coverage. About 30 percent of the population has voluntary health insurance offered by private insurance companies to cover better hospital accommodation and free choice among physicians. Swiss and Slovak health insurers can also sell voluntary insurance. In Slovakia, two of the social insurers also offer additional voluntary insurance that covers preventive care, fees for doctors’ appointments, better hospital rooms, and lower out-of-pocket payments. The number of people with private insurance is estimated to be small in Slovakia. In Switzerland, about 70 percent of the population has voluntary health insurance to enable them to access health care outside their canton of residence and services not covered under the BBP. All health insurers are allowed to sell basic and private health plans. In the Netherlands, health insurers are allowed to sell mandatory health insurance together with any other type of non-life insurance (for example, voluntary health insurance, sick leave insurance, and car insurance). Consequently, more than 90 percent of the population is enrolled in voluntary insurance that covers care that is excluded from mandatory basic insurance, including dental care for adults, physiotherapy, glasses, alternative medicine, and cosmetic surgery. In the Netherlands and Switzerland, most individuals buy voluntary insurance coverage from the same insurer who provides their basic compulsory coverage. When enrolling in voluntary plans, individuals are revealing health information that could be used for risk selection by social insurers.

**SUPERVISORY AUTHORITIES**

2.15 Supervisory authorities are empowered to enforce insurance legislation to ensure the effective functioning of the market, to protect consumers, and to assure the quality of care. The Netherlands has several supervisory authorities that are semi-public and function quasi-independently of the government (see Box 2.1). They have been created over time as a result of the different waves of health insurance reforms. The Swiss Federal Council is responsible for supervising the implementation of the insurance law, for consumer protection, and for the regulation and surveillance of the insurer market. The actual implementation of these functions is delegated to the Federal Department of Home Affairs (FDHA) and the Federal Office of Public Health (FOPH) who have the power to grant and revoke licenses to insurers, supervise the annual budgets
and financial results of the insurers, and approve annual premiums. Furthermore, the FDHA conducts solvency tests and audits of insurers and manages a fund that guarantees reimbursement for health services provided by an insolvent insurer. The cantonal authorities are responsible for subsidies to individuals in income groups below a defined income threshold and for enforcement of mandatory health insurance.

**Box 2.1: Supervisory Authorities for Insurers and Providers in the Netherlands**

<table>
<thead>
<tr>
<th>Authority</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dutch Health Care Inspectorate (Inspectie voor de Gezondheidszorg)</td>
<td>Supervises the quality of care provided by the health care system, focusing on patient safety and effective care and on problems that individual consumers are unable to assess or influence themselves. The Inspectorate develops and publishes performance indicators on health care providers.</td>
</tr>
<tr>
<td>Dutch Health Care Authority (Nederlandse Zorgautoriteit)</td>
<td>Established in 2006, is responsible for managing competition among health care providers and among insurers. The Authority supervises costs, prices, and contract conditions and is responsible for classifying health care products and for disseminating adequate consumer information.</td>
</tr>
<tr>
<td>Dutch Competition Authority</td>
<td>Cooperates closely with the Health Care Authority. The Competition Authority's tasks are: (i) to prevent cartels; (ii) to authorize or forbid mergers; and (iii) to prevent abuses by insurers who are in a dominant market position. So far, the Competition Authority has forbidden horizontal price-fixing and market sharing agreements, entry regulations, and collective contracting practices by general practitioners, physiotherapists, pharmacists, and other independent medical practitioners.</td>
</tr>
<tr>
<td>Dutch Central Bank (DNB)</td>
<td>Supervises the financial solvency of insurers based on regulations laid down in the Insurance Supervision Act of 1993.</td>
</tr>
<tr>
<td>Financial Markets Authority (AFM)</td>
<td>Ensures that insurers provide financial services properly, including whether an insurer informs its members about their options and about the premiums associated with the different insurance options.</td>
</tr>
</tbody>
</table>

*Source: van de Ven (2008)*

2.16 The Slovak Health Surveillance Authority (HSA) was established in November 2004 and acts independently of the government and private bodies. The HSA is responsible for: (i) supervising and registering health care providers, health insurance companies, and entities paying premiums on behalf of the insured; (ii) licensing insurers and issuing secondary legislation; (iii) cooperating with the government in preparing insurance legislation; (iv) risk equalization; and (v) sanctions and remedies for health insurance companies. In 2006, the HSA had 500 staff working in eight regional offices and was financed by fees and contributions from insurers (0.5 percent of premium revenue).

**Health Insurance Reforms**

2.17 The implementation of multiple insurance and competition in several countries is the result of several decades of major insurance reforms and has been strongly influenced by the countries’ political history. The first Swiss health insurance law dates back to 1911 and underwent substantial revisions in 1996 that resulted in the current system. Similarly, since the first unsuccessful attempt to enact a universal health

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16 See HSA's website: www.udzs.sk
insurance scheme in the Netherlands in 1904, it took more than a century to successfully implement mandatory comprehensive health insurance for all.

Box 2.2: Three Major Waves of Health Care Reforms in the Netherlands 1940-2007

<table>
<thead>
<tr>
<th>First Wave: Towards Universal Coverage (about 1940-1970). Until the 1970s, the Dutch government aimed to guarantee a minimum level of quality health care (for example, by professional licensing) and ensure universal access to basic health services. A mandatory health insurance scheme for low- and middle-income groups was introduced in 1941. In 2005 this mandatory scheme covered 68 percent of the population. People with an income above a certain threshold were excluded and were allowed to enroll voluntarily with a private insurance company. In 1968, the Exceptional Medical Expenses Act was passed, which constituted a mandatory national health insurance scheme with an income-related premium covering long-term care, care for the mentally and physically disabled, and hospitalization for longer than one year.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Second Wave: Cost Containment by the Government (about 1970-2000). By the end of the 1960s, the government became worried about rising health care expenditure and its detrimental impact on the goals of universal access to basic care as well as higher labor costs, which in turn could raise unemployment and harm the Dutch open economy that relied heavily on exports. The growing pressure to contain medical spending led to increasing supply and price regulation from the mid-1970s onwards. In 1983, the open-ended hospital reimbursement system was replaced by a budgeting system that was expanded in 1984 to all other inpatient care institutions. The Health Care Prices Act (1982) enabled the government to control physicians' fees and, later, also their total revenues. By the mid-1990s, the fee-for-service system was largely replaced by a lump-sum payment per hospital for all specialists working in that hospital. Subsequently, further steps have been taken towards encouraging partnerships between and integration of hospitals and medical specialists.</td>
</tr>
<tr>
<td>Third Wave: Efficiency through Managed Competition (from about 2000). From the early 1980s, top-down rationing policies were being increasingly criticized. The criticisms focused on the lack of incentives for efficiency and innovation within the prevailing system of health care finance and delivery. This led to broad support for incentive-based reforms and a move towards increasing the role played by competition in the health care sector. In 1987, the government-appointed Dekker Committee recommended the introduction of a market-oriented health care reform and a national health insurance system. Although during the 20 years following the Dekker plan, health care politics can be described as an ongoing process of competing policy programs (Helderman et al., 2005) in which successive governments have consistently worked towards realizing the preconditions for managed competition. The Health Insurance Act (2006) and the current regulatory regime are based on these proposals.</td>
</tr>
</tbody>
</table>

Source: van de Ven (2008)

2.18 Three major waves of Dutch health care reforms can be discerned spanning over more than six decades (see Box 2.2) (Scotton, 1991 and Cutler, 2002). Historically the Dutch health care system has been characterized by private initiatives, both in funding and in the provision of care. After decades of central price- and capacity-control by the government, the health care system is now in transition from supply-side regulation towards managed competition. The Health Insurance Act (2006) reflects a series of market-oriented reforms that were gradually implemented from the early 1990s. Annex Figure 1 presents an overview of the flow of funds in the Dutch health care system since 2006 (van de Ven, 2008).

Goals of Health Insurance Reforms

2.19 While many reforms have been implemented in multiple insurance systems with competition to reach specific policy goals, few of them have been evaluated. In Switzerland, insurance reforms aimed to achieve three health policy goals: (i) universal
insurance coverage for all residents and expansion of the compulsory basic insurance package; (ii) risk-pooling by the healthy and the sick, the rich and the poor, and men and women; and (iii) cost containment in the health sector with total health expenditures growing at the same rate as the Consumer Price Index (CPI). Although the first two goals have been achieved to a considerable degree in countries with multiple insurance systems, in Switzerland, the costs and premiums for SHI have risen considerably faster than the CPI since the revision of the insurance law in 1996 (Figure 2.1) (Schuetz, 2008).

Figure 2.1: SHI and CPI Premiums and Costs in Switzerland (1996-2005)

Cost inflation in health care remains a major issue in all European countries, regardless of their insurance system. Between 1990 and 2004, health care spending has grown faster than GDP in every OECD country except Finland. In 1990, it accounted for 7 percent of GDP on average across all OECD countries and reached 8.9 percent in 2004. Total health spending is projected to continue to increase as a share of GDP, especially now that the economy is contracting in most European countries. Reforms aimed at reducing health care costs, such as cost-sharing and managed care options, appear to have had little impact in terms of curbing the growth of health expenditures. However, it can often be difficult to establish a clear link between reforms and policy outcomes because few if any rigorous evaluations have been done of how insurance reforms have affected the performance of the health sector.

In sum, this chapter has shown that competition among insurers is restricted by government regulations and by the design of insurance features. Insurers have considerably fewer instruments to compete against each other if: (i) they charge fixed contributions such as payroll tax rates or community-based premiums; (ii) contributions are subsidized and households do not pay the full “price”; (iii) the benefit package is similar or even essentially identical across insurers; and (iv) cost-sharing with patients is limited. Consequently, competing insurers may find it difficult to reduce their expenditures and manage their costs.
2.22 The following two chapters present the two key strategies that insurers in multiple insurance systems can pursue to control their expenditure growth. Insurers can maximize their profits or reduce their costs either by: (i) insuring relatively healthy individuals who are unlikely to use health care services very often (risk selection) or (ii) designing their contracts and payments in ways that give providers an incentive to become more efficient. Chapters 3 and 4 will show how these two strategies have been applied in countries with multiple insurance and will investigate whether they had any impact on health expenditures. Chapter 5 thereafter evaluates to what extent consumers are actually free to choose less costly and more efficient providers.
3. RISK SELECTION

3.1 This chapter describes the incentives that insurers have to engage in risk selection and the potential effects of this strategy and discusses risk equalization as a tool to reduce these incentives. In multiple insurance systems with open enrollment and contributions defined independent of individuals’ health risk, insurers have an incentive to resort to risk selection. Risk selection happens when insurers choose to insure predominantly healthy individuals, in other words, those with health care expenditures that are lower than the contribution payment the insurer receives. Since risk selection can threaten insurers’ financial results, some countries have adopted a risk-adjustment system, which pays health insurers a risk-adjusted amount for each member that reflects the insured’s likely level of health expenditure. The objective of risk-adjustment is to compensate insurers for the higher financial risk associated with some of their members and prevent them from resorting to risk selection. As risk selection becomes less attractive to insurers, they are likely to have an incentive to lower their costs by contracting with more efficient providers and will be able to pass any possible savings on to their members in the form of lower premiums. This chapter examines lessons that can be learned about risk selection from the experiences of the four multiple-insurance countries and presents ways to improve the design and implementation of risk-adjustment mechanisms.

RISK SELECTION AND RISK ADJUSTMENT

3.2 Risk selection is forbidden by country’s health insurance law, but in practice, it is still possible in some multiple insurance systems with consumer choice. Active risk selection is not possible in Austria as insurers are not allowed to compete, and individuals are allocated to insurers based on their profession or place of residence. In the Netherlands, Switzerland, and Slovakia, individuals can choose among insurers and health plans. Generally, an insurer is obliged to accept each applicant for the same community-rated premium. However, insurers can still indulge in risk selection in a less visible way. For example, insurers can refuse to contract with providers who have a reputation for treating chronic illnesses, which will then make those insurers less attractive to chronically ill individuals. In addition, an insurer can use cost-sharing mechanisms such as deductibles and co-payments to make a health plan less attractive to less healthy consumers, particularly in situations where insurers require patients to pay their provider for services received and then are reimbursed from their insurance based on their receipt. Individuals who need regular or high-cost health care may then prefer to choose insurance companies that reimburse providers directly. Risk selection can involve costs for the insurer as they will have to collect information on individuals’ potential health risk. It may also damage an insurer’s reputation if its risk selection behavior becomes known to the public.
3.3 To reduce the incentives for insurers to resort to risk selection, some governments have introduced risk equalization schemes. There are several different kinds of risk equalization scheme, and their level of sophistication depends on how much information is available on the health-related risks of the population. Policymakers define the risk equalization transfer amount for insurers based on explicit risk-adjustment parameters that have evolved over time (Table 3.1). In the early 1990s, the Dutch parameters included only age and gender, as is still the case in the Czech Republic and Slovakia. The Netherlands substantially improved their equalization formula by adding pharmacy-based cost groups (PCGs) in 2002 and two more parameters in 2004 – diagnostic cost groups (DCGs) and being self-employed (yes/no) (Van de Ven et al., 2004). The Swiss risk-adjustment parameters include age (excluding children) and gender calculated for each canton. Risk-adjustment models that are mainly based on demographic variables as in Switzerland, the Czech Republic, and Slovakia can predict only about 5 percent of the variation in individuals’ annual expenditures, compared with the approximately 22 percent predicted by the more sophisticated Dutch adjustment model, which is currently the best model worldwide (van Vliet, 2006). If risk-adjustment measures are inadequate, this gives insurers an incentive to select lower-risk (healthier) individuals as members (risk selection) or to offer less attractive health benefits that would dissuade people with health issues from selecting their services (self selection).

Table 3.1: Risk-adjustment Parameters by Country

<table>
<thead>
<tr>
<th>Country</th>
<th>Year of Implementation</th>
<th>Risk-adjustment Parameters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belgium</td>
<td>1995</td>
<td>- Age, sex, social insurance status, employment status, mortality rate, urbanization, income</td>
</tr>
<tr>
<td></td>
<td>2006</td>
<td>- Age, sex, social insurance status, employment status, mortality, urbanization, income, diagnostic and pharmaceutical cost groups</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>1995</td>
<td>- Age, sex</td>
</tr>
<tr>
<td>Germany</td>
<td>1994/1995</td>
<td>- Age, sex, disability pension status</td>
</tr>
<tr>
<td></td>
<td>2002</td>
<td>- Age, sex, disability pension status, participation in disease management programs</td>
</tr>
<tr>
<td>Netherlands</td>
<td>1993</td>
<td>- Age, sex</td>
</tr>
<tr>
<td></td>
<td>1996</td>
<td>- Age, sex, region, disability status</td>
</tr>
<tr>
<td></td>
<td>1999</td>
<td>- Age, sex, social security/ employment status, region of residence</td>
</tr>
<tr>
<td></td>
<td>2002</td>
<td>- Age, sex, social security/ employment status, region of residence, diagnostic and pharmaceutical cost groups</td>
</tr>
<tr>
<td>Slovakia</td>
<td>1995</td>
<td>- Age, sex</td>
</tr>
<tr>
<td>Switzerland</td>
<td>1993</td>
<td>- Age, sex, within cantons</td>
</tr>
</tbody>
</table>

Source: van de Ven et al (2007); and country background papers.

RISK EQUALIZATION TRANSFERS

3.4 Many countries with multiple insurance and community-rated contributions have taken steps to equalize the risks faced by insurers when recruiting members.
The Netherlands has set up a risk equalization fund (REF) from which insurers receive a risk-adjusted equalization payment for their high-risk (less healthy) members, and to which they have to pay an equalization payment for their low-risk (healthier) members. Generally, the equalization payment for any given individual is calculated as the difference between the average costs of a risk group and the overall average costs of the insured. In the Dutch system, an individual’s equalization payment is equal to the predicted health expenses of that individual based on his or her risk factors that are included in the equalization formula (see Table 3.1), minus a fixed amount (about 45 percent) of the average health expenses per adult. In Slovakia, insurers transfer the equalization amounts directly between themselves based on the risk calculations made by the MOH. Premium revenues are redistributed among insurers monthly according to their members’ risk status based on their age and gender and adjusted by a health care cost index which is derived from information contained in providers’ invoices to insurers. In Switzerland, risk equalization is calculated retrospectively based on actual health insurance expenditure, which reduces insurers’ financial risk and gives them no incentive to reduce their costs by contracting with more efficient providers. Using data from Switzerland, Figure 3.1 shows the risk equalization transfers for men in contrast with average constant premiums for the year 2006. At present, insurers pay equalization transfers to other insurers for members up to the age of 51 to 55 and receive transfers for people in risk groups with costs above the average for all adults (mainly the elderly members). The sum of the contributions to the risk equalization scheme from low-risk pool insurers and payments to high-risk pool insurers are equal according to the formula, resulting in a zero balance at the end of the year (Schuetz, 2008).

Figure 3.1: Average Costs, Risk Equalization, and Premiums per Month per Male Member in Switzerland (2006)


Note: Premiums and risk equalization payment/contributions are calculated by canton.
3.5 *Ex-post transfers reduce insurers’ financial risk and give them a disincentive to contract with more efficient providers.* Because the *ex-ante* risk-adjusted equalization payments insufficiently compensated the insurers for the very high expenditures of their high-risk members, the Dutch government agreed to pay insurers some *ex-post* compensations based on their actual expenses. Because *ex-post* equalization reduces insurers’ average financial risk, thus also reducing their incentive to compete for more efficient providers, the Dutch government has improved the equalization formula and gradually increased the insurers’ financial risk from 3 percent in 1992 to 59 percent in 2008\(^\text{18}\) (van de Ven, 2008). In Slovakia, risk equalization still pays insurers *ex-post* reallocations at the end of the year based on actual expenditures from two years prior to the current reallocation year, which calls into question the need for any *ex-ante* adjustment.

3.6 *Risk equalization transfers within a given insurance company across different risk groups are larger than transfers across insurers.* Community-rated premiums combined with a simple age/gender risk equalization formula tend to result in substantial financial transfers from younger to older age groups across and within insurance risk pools. Figure 3.2 shows that, within Swiss insurance companies, there are large intergenerational transfers from the young to the elderly independent of their health status. In 2006, this intergenerational transfer amounted to approximately SFr5 billion, which is considerably more than the total risk equalization transfers between insurers of SFr1.3 billion (or 6 percent of total SHI expenditures) (Schuetz, 2008).

**Figure 3.2: Risk Equalization Transfers among Age Groups, Genders, and Insurers in Switzerland in million SFr (1996 - 2006)**

Note: Gross transfers: transfer volume between age groups and between sexes. This volume is a theoretical volume (result of the community rating principle). Net transfers: transfers between insurers; payments from net payers to net receivers in the risk equalization scheme.


\(^{18}\) Including increasing the threshold above which insurers receive a compensation of 90 percent of all expenses per insured person per year up to €20,000 (in 2008).
3.7 The Austrian risk equalization system is set up to help those insurers that are in financial difficulties. In Austria, the different risk profiles of non-competing insurers lead to different levels of use of health services and, therefore, different financial results (Hofmarcher et al., 2006). Generally, urban populations, the elderly, and groups such as miners and railroad workers use health services the most. The Austrian REF aims to compensate insurers for their financial risks; however, the risk equalization transfer is defined differently than in other countries. Risk transfers are based on an insurer's risk-pool (45 percent of the total transfer), liquidity criteria (45 percent), and financial emergencies (10 percent) (Table 3.2) and are funded from the federal government's tobacco tax revenues and 2 percent of the contribution revenues of the regional HIFs. In reality, annual payouts are subject to negotiations, and those insurers with better financial results have to lend money to the REF to support insurers with increasing deficits (Koettl, 2008).

Table 3.2: Transfers from the Austrian Risk Equalization Fund to Regional Insurers in million EUR (2006)

<table>
<thead>
<tr>
<th>Regional Health Insurance Fund (HIF)</th>
<th>Risk-based (45%)</th>
<th>Liquidity-based (45%)</th>
<th>Optional redistribution (10%)</th>
<th>Subsidy for Hanusch Hospital</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>%</td>
<td>Total</td>
<td>%</td>
<td>Total</td>
</tr>
<tr>
<td>HIF Vienna</td>
<td>10.5</td>
<td>17.2</td>
<td>19.0</td>
<td>31.1%</td>
<td>4.0</td>
</tr>
<tr>
<td>HIF Lower Austria</td>
<td>14.5</td>
<td>23.7</td>
<td>-</td>
<td>-</td>
<td>2.2</td>
</tr>
<tr>
<td>HIF Burgenland</td>
<td>5.6</td>
<td>9.1</td>
<td>9.5</td>
<td>15.3%</td>
<td>1.3</td>
</tr>
<tr>
<td>HIF Upper Austria</td>
<td>2.8</td>
<td>4.5</td>
<td>-</td>
<td>-</td>
<td>0.6</td>
</tr>
<tr>
<td>HIF Styria</td>
<td>8.8</td>
<td>14.5</td>
<td>11.8</td>
<td>19.3%</td>
<td>2.0</td>
</tr>
<tr>
<td>HIF Carinthia</td>
<td>12.6</td>
<td>20.6</td>
<td>17.8</td>
<td>29.1%</td>
<td>0.8</td>
</tr>
<tr>
<td>HIF Salzburg</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>0.3</td>
</tr>
<tr>
<td>HIF Tyrol</td>
<td>4.1</td>
<td>6.7</td>
<td>3.1</td>
<td>5.1%</td>
<td>2.1</td>
</tr>
<tr>
<td>HIF Vorarlberg</td>
<td>2.3</td>
<td>3.6</td>
<td>-</td>
<td>-</td>
<td>0.3</td>
</tr>
<tr>
<td>Grand Total</td>
<td>61.2</td>
<td>100.0</td>
<td>61.2</td>
<td>100.0</td>
<td>13.6</td>
</tr>
</tbody>
</table>

%          | 36.9% | 36.9% | 8.2%  | 18.1% | 100.0% |


3.8 The Austrian occupational funds (for defined professional groups) have more financial management autonomy and report better financial results than regional funds. Austrian regional insurers report substantial differences in average net income, with the Styria regional HIF reporting the highest deficit (Figure 3.3), which can be explained by differences in regional risk profiles and insurance financial management.

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19 In the Upper Austria HIF, women represent 50 percent of members compared with 56 percent in Vienna. The Vienna Regional HIF has a larger share of pensioners (31 percent) and unemployed individuals (8 percent) than the Salzburg Regional HIF (27 percent pensioners) and the Upper Austrian HIF (5 percent unemployed). In addition, the share of urban population in HIFs varies substantially between largely rural regions like Vorarlberg to entirely urban regions like Vienna.

20 The Constitutional Court overturned the request to increase the regional HIFs' equalization transfer to the REF from 2 to 4 percent of insurers' contribution revenues.

21 In 2006, for example, payouts included a subsidy of EUR 30 million to the Vienna Regional HIF to reduce liquidity problems in the Hanusch hospital, which is the only hospital owned by an HIF.
All occupational funds report positive results. Occupational funds operate country-wide and not just by region, and they have more autonomy than regional HIFs in defining such insurance features as contribution rates, benefit packages, co-payment levels, and contracts; which also allows them to better manage their expenditures (Koettl, 2008).

3.9 **Risk equalization provides Austrian non-competing insurers with soft budget constraints.** While equalization transfers provide Austrian insurers with some financial security, these transfers also reduce insurers’ incentives to become more efficient, which may lead to subsidizing more expensive treatment in poorly managed funds. For example, in 2008 the National Audit Court (*Rechnungshof*) compared two regional HIFs – the Upper Austrian HIF and the Viennese HIF – to quantify their cost differences (*Rechnungshof*, 2008). After adjusting for differences in risk structure, the study found that the Viennese HIF has a deficit because its costs per member are 40 percent higher for medical services and 20 percent higher for pharmaceuticals than those of the Upper Austrian HIF. This cost difference is mainly related to their respective methods of paying their providers per service provided and to the higher prices paid by the Vienna HIF. Some insurers pay a lump sum for a bundle of services, while others such as in Vienna, pay their providers on a fee-for-service (FFS) basis, which sets different financial incentives for providers and may lead to higher costs for insurers, particularly under FFS. Equalization transfers can put some peer pressure on the worse-performing HIFs when the better-performing HIFs have to cross-subsidize the worse-performing HIFs (Koettl, 2008).

3.10 **In countries with multiple insurance without competition like Austria, the current risk equalization transfer does not include any efficiency requirement.** This could be changed to a system in which insurance risk is pooled in one single risk pool for the entire country and funds are allocated to “purchasing agents” based on their members’ risk profiles and on actuarial analysis. These purchasing agents should be responsible for contracting with competing providers and offering different health plans to members.

*Figure 3.3: Net Income of Austrian HIFs as Percentage of Revenues (2006)*

VOLUNTARY HEALTH INSURANCE AND RISK SELECTION

3.11 Even when sophisticated risk equalization transfer systems exist, insurers still have an incentive to engage in risk selection, even though this behavior can be difficult to observe. Voluntary insurance can be an effective tool for insurers who want to engage in risk selection as it provides them with information on the care-seeking behavior of individuals, which can then be used to refuse coverage to higher-cost patients. Dutch insurers can sell voluntary health insurance at discounted rates to groups with any risk composition and enrollment criteria. In 2007, almost 40 patient organizations representing people with various chronic conditions had concluded group contracts with insurers (Schut and De Bruijn, 2007). Several of them also received a premium group discount for basic insurance. Dutch insurers have a collective agreement not to refuse any applicants for voluntary insurance, which may explain why there was no evidence of risk selection through voluntary insurance in the Netherlands in late 2006 and early 2007 (van de Ven, 2008). In Switzerland and Slovakia, it has not been possible to detect any risk selection through voluntary insurance because of insufficient data.

3.12 In the Netherlands, risk selection in voluntary group insurance has spurred governments to improve their risk equalization arrangements. Patient groups, who were refused a group contract for voluntary insurance at a reduced price (for example, patients with migraines or hearing problems), have protested and lobbied successfully for better risk equalization. Since 2006 and as a result of the extension of the risk equalization system for diabetes and active patient groups, several insurers have advertised special additional group insurance for diabetes patients and have started setting up disease management programs for diabetes, which is expected to improve the quality of treatment available for diabetics (van de Ven, 2008).

IMPROVING THE RISK EQUALIZATION FORMULA

3.13 Improving the risk equalization system and publishing information about insurers’ behavior both reduce any incentive that insurers may have to engage in risk selection. Some countries with multiple insurance and community-rated premiums have periodically refined and improved their risk-adjustment system as shown in Table 3.1. The Dutch government plans to further improve its risk equalization formula by adding new risk parameters such as Diagnostic Cost Groups (DCGs) based on outpatient care, indicators of mental illness and of disability and functional restrictions, and multi-year DCGs instead of one-year DCGs (Lamers and Van Vliet, 1996). In addition, the government is considering giving insurers ex-post compensation for high-expenses individuals with rare chronic diseases (Van Barneveld et al, 2001). Switzerland has just

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22 See for example De Telegraaf, January 7, 9 and 10, 2006. Insurers may not conclude a contract with unfavorable groups of chronically ill people if they are concerned about incurring significant losses on those groups. In: van de Ven, 2008.
24 Tweede kamer 2005-2006, 29689, nr. 99 (11-16); Tweede kamer 2006-2007, 29689, nr. 129 (9); Tweede kamer 2007-2008, 29689, nr. 164 (8) and nr. 165 (1-4). In: van de Ven, 2008
decided to expand its risk equalization formula to include prior hospitalization as a variable as of 2012, which is expected to make the formula more predictive.

3.14 Despite the substantial progress being made in the development of risk-adjustment, the most sophisticated risk-adjustment formula in existence – in the Netherlands - still does not effectively compensate insurers for high-cost individuals. An evaluation of the Dutch risk equalization formula found that the formula still does not adequately compensate insurers for the 8 percent of the population whose health risk is high (Annex Table 1). As a result, insurers make substantial predictable financial losses when they cover groups of the chronically ill who represent about 1 to 40 percent of the population. The average predictable loss per adult within a group can range from €541 for the 21 percent of the population who report their health status as being fair/poor to an average predictable profit of €144 per adult for the other 79 percent of the population. Similarly, within each risk group, there can be a wide variation in the predictable loss per adult. Significant predictable losses also occur among groups whose disease is included as a risk-adjuster in the equalization formula (for example, heart problems and cancer), even though there are substantial additional annual equalization payments for some selected PCG and DCG groups (Annex Table 2). Thus, while the risk formula compensates the overwhelming majority of the population reasonably well, the average predictable losses remain quite substantial per adult for high-risk groups, and therefore insurers still have an incentive to identify and exclude from coverage these potentially high-risk individuals who are likely to cause them to lose money (van de Ven, 2008).

3.15 In practice, any country aiming to expand its risk-adjustment formula will need to make substantial investments in its capacity for data collection, management, and analysis and may also need to make some changes to its legal framework. Insurers in a multiple insurance system will need to collect additional information on enrollees' demographics, health status and use of care for the purposes of risk-adjustment, which means that providers will need to ensure that their invoices to insurers contains this kind of information. In some countries, including Switzerland, personal data are strictly protected as this information can potentially be misused by insurers for risk selection. Currently, the Swiss data protection law prohibits providers from including any information on diagnoses, procedures, and risk statuses for SHI patients on their claims forms (Schuetz, 2008). Therefore, Swiss law would have to be updated to allow insurers to compete for better-performing providers and to develop some sophisticated risk-adjustment, as in the Netherlands.

3.16 This review of insurance experience suggests that multiple insurers still have an incentive to engage in risk selection, which is mainly due to the low quality and performance of most equalization schemes. In countries like Switzerland, the Czech Republic, and Slovakia, where risk-adjustment is based on age and gender (Table 2.1), insurers still have an incentive to try to attract low-risk (healthier) individuals instead of increasing efficiency by competing for better-performing providers. Along with improving the risk equalization formula, these countries should try to reduce ex-post compensation. In multiple insurance systems with competition, risk equalization should be expanded to include some health parameters to predict the financial risk for insurers more accurately while at the same time still giving insurers an incentive to keep health
care costs down by contracting with more efficient providers. This will be the focus of the next chapter.
4. COMPETITION FOR PROVIDERS

4.1 This chapter examines whether competing insurers minimize their expenditures by contracting with more efficient providers and services instead of selecting members with the lowest health risks. In theory, competing insurers are expected to be prudent buyers of care on behalf of their insured consumers and to contract selectively with providers by negotiating with them about their prices, services, and quality of care. Therefore, the provider market needs to be large enough for insurers to be able to contract selectively. As can be seen in Table 4.1, Austria, the Netherlands, Slovakia, and Switzerland all have at least the EU average number of physicians and acute care hospital beds, which suggests that, in these countries, insurers can contract selectively. However, there may be some distributional inequalities within these countries, for example, between urban and rural areas, which may result in a lack of access to insurance for rural dwellers when insurers contract selectively with providers.

<table>
<thead>
<tr>
<th>Supply-side Indicators</th>
<th>Austria</th>
<th>Netherlands</th>
<th>Slovak Republic</th>
<th>Switzerland</th>
<th>EU Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practicing physicians per 1,000 population</td>
<td>3.6</td>
<td>3.8</td>
<td>3.1*</td>
<td>3.8</td>
<td>3.2</td>
</tr>
<tr>
<td>Acute care beds per 1,000 population</td>
<td>6.1</td>
<td>3.0</td>
<td>4.9</td>
<td>3.5</td>
<td>4.1</td>
</tr>
</tbody>
</table>

Source: OECD Health Data 2008 and WHO Euro Health for All Database.
Note: * data from 2004

SELECTIVE CONTRACTING AND PROVIDER DATA

4.2 There is only limited selective contracting in Europe. Contracts between insurers and providers generally specify who provides care, where, and under what procedural conditions (for example, the requirements for obtaining permission, referrals, and prescriptions). In the Netherlands, insurers are free to selectively contract with providers and use financial incentives to motivate consumers to use those preferred providers (van de Ven, 2008). Austrian, Swiss, and Slovak insurers may only contract selectively with a few providers. Austrian HIFs negotiate annual outpatient contracts with the regional physician associations. The contracts are based on a network plan of contracted GPs and specialists in the region to control the volume of patients per physician (Koettl, 2008). In Slovakia, the MOH’s minimum network plan25 includes only state-owned hospitals, and insurers have to contract with all of them at a price dictated by the MOH, whereas non-

network hospitals can be excluded from contracts. **Swiss** cantons have to publish a list of hospitals (public and private) that are admitted to perform and contract services covered by SHI. Most contracts are signed between insurers and the Association of Providers, which further limits selective contracting (Schuetz, 2008).

4.3 **Insurers need information about the quality of care offered by providers to help them to decide how to get the most value for their money, but this kind of information is rarely available.** The Dutch national association of health insurers (Zorgverzekeraars Nederland) publishes a purchasing guide for contract negotiations between insurers and hospitals. The updated guide (DBC-inkoopgids 2008) pays special attention to the quality characteristics of hospitals,\(^{26}\) which has resulted in quality of care becoming an important factor in the negotiations between insurers and hospitals for services with deregulated prices (20 percent in 2008)\(^{27}\) (van de Ven, 2008). In **Switzerland**, providers and insurers have to agree to include measures in their contracts to improve quality and increase efficiency, measures which are monitored by the federal and cantonal authorities. However, the lack of systematic information on quality of care means that insurers are unable to engage in provider profiling (using the information given on insurance claims forms, including diagnosis and treatment information, to evaluate the performance of health care providers and using the results of this evaluation to exclude any providers whose performance has been unsatisfactory), contracting, price-setting, and defining payment mechanisms (Schuetz, 2008).

4.4 **For insurers to engage in selective contracting, they need to know which providers are the most effective and efficient.** This in turn requires the existence of a nationwide quality framework complete with benchmarks and the infrastructure to collect and analyze the relevant data. In **Switzerland**, numerous quality instruments are being implemented, though, in the absence of a nationwide framework, these programs all use different methods (OECD, 2006, p.83). Survey results (Baur and Schultz, 2006, p. 2133) highlight the need to collect more and better data on the quality of care and on patient treatment and outcomes and to increase collaboration across different levels of providers (Schuetz, 2008). The situations in **Austria** and **Slovakia** are very similar, in that there are no systematic quality improvement programs and, with the exception of peer pressure and the maintenance of professional standards, providers have no incentive to implement quality assurance measures. If quality benchmarking were adopted in these countries, if providers failed to meet their quality assurance obligations, then they would be penalized by being excluded from insurers' contracts.

**PROVIDER PAYMENT AND SUBSIDIES**

4.5 **Price-setting is still strongly regulated, which limits the extent to which insurers can compete and choose to pay higher prices for better value.** In the **Netherlands**, price regulation was abolished for physiotherapy in 2005, and insurers and hospitals are now allowed to freely negotiate prices and contract selectively for a range of

\(^{26}\) ZN-Journaal, October 25, 2007 (number 43) In: van de Ven, 2008.

products accounting for about 20 percent of hospital revenues in 2008. Further reductions in price regulation are planned, allowing insurers to negotiate with providers regarding prices (van de Ven, 2008). All Swiss insurers have to pay nationally defined prices for the services included in the basic benefit package based on a nationwide uniform price system (TARMED). In Slovakia, prices paid by insurers to network providers are based on tariffs regulated by the MOH. Price regulations do not allow insurers to compete for a lower-priced medical product that appears within a standard range of quality of care but is provided at a lower cost. In Austria, the prices paid by insurers to providers are regulated at the national level. Some insurance outpatient contracts include ceilings to pay decreasing prices to physicians with increasing patient volumes (Koettl, 2008).

4.6 **In principle, insurers should be able to reward certain providers for offering better quality care and increasing efficiency which in turn would spur competition among providers.** However, this does not yet happen in contracting. The Austrian regional HIFs set different payments for specific services, including lump sum payments and FFS payments, with or without payment ceilings, thus giving providers an incentive to increase the number of services that they offer. In Slovakia, insurers pay capitation fees to primary health care (PHC) providers, and they pay hospitals on a per-case basis. In addition, insurers reimburse specialists and providers an FFS price for each technical service that they provide and for every drug that they prescribe, which has also caused the number of cases and services to increase. In Switzerland, insurers still use FFS to pay for outpatient care, while hospitals receive per diems combined with FFS, thus giving them an incentive to prolong patients' hospital stays and to provide more services. Prices for inpatient care are based on hospitals' actual cost, which does not give them an incentive to increase productivity as those hospitals with higher costs receive higher payments\(^{28}\). Thus, even in multiple insurance systems, provider payments are not organized in such a way as to give providers an incentive to deliver better quality care or to deliver it more efficiently, which also prevents insurers from competing to contract with the best-performing providers.

**MANAGED CARE AND HIGHER COST-SHARING PLANS**

4.7 **Managed care and disease management plans give health care providers an incentive to operate more efficiently.** Managed care is a concept aimed at reducing unnecessary health care costs by, for example, giving physicians and patients incentives to select less costly forms of care, reviewing the medical necessity of specific services, increasing beneficiary cost sharing, controlling hospital inpatient admissions and lengths of stay, establishing cost-sharing incentives for outpatient surgery, selectively contracting with health care providers, and intensively managing high-cost health care cases. Disease management plans reduce health care costs by preventing or minimizing the effects of a disease, usually a chronic condition, through coordinated health care interventions and communication to the public.

4.8 **Managed care models are most advanced in the United States.** Managed care is provided by various types of organizations, including HMOs and preferred provider

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\(^{28}\) Switzerland is in the process of introducing diagnostic related groups (DRGs) as hospital payment.
organizations (PPOs). Both contract with health care providers for a lower than non-managed care business price in return for higher patient volumes. HMOs manage the health of their enrollees by using primary care physicians as gatekeepers for referring patients to specialists within the network when necessary. PPOs charge their members higher co-payments than HMOs, but they allow them to consult out-of-network providers and will reimburse them for the cost of those services. HMOs increased their market share considerably during the 1990s. By 1999, about 83 million people, 30 percent of the U.S. population, were enrolled in HMOs. The large majority (61 percent) were enrolled in for-profit HMOs. There is evidence that suggests, after various compounding factors are controlled for, that this extensive enrollment in HMOs among the privately insured, non-elderly population has reduced neither total health care spending nor total insurance payments, though it has reduced total out-of-pocket expenditure for patients (Shin and Moon, 2007).

4.9 Few managed care and disease management plans exist in Europe. In Switzerland, the Netherlands, and Slovakia, each insured person has to register with a single general practitioner (GP) who then coordinates and pre-authorizes any specialist care that the patient may need (gatekeeper). Dutch insurers are allowed to set up new primary health care centers and pharmacies using their own staff including nurses, which has helped to compensate for the shortage of GPs. Dutch insurers and providers are free to choose the tools for managing care, including protocols, disease and utilization management, or other ways of preauthorizing care (van de Ven, 2008). In Switzerland, 11 insurers with a total market share of 67 percent had case management programs in place in 2006 (Werthemann, 2006). Case and disease management by insurers was expected to strengthen cost control and quality assurance and to establish good reputations for providers. However, one study has found that case management programs, in which medical practitioners collaborate in finding high-quality ways to meet an individual's health needs in a cost-effective way are not suitable to manage the care of high-risk patients (Sommer and Biersack, 2005), and another study has shown that more and better data (including a revised data protection law) will be needed to identify patients to participate in case and disease management programs (Sommer and Engeler, 2007) (in: Schuetz, 2008).

4.10 Swiss insurers can offer three basic managed care plans. In addition to the basic BBP plan, insurers can offer: (i) health plans with higher than average deductibles and lower than average premiums, (ii) managed care plans such as health management organizations (HMOs), Independent Physician Associations (IPAs), preferred providers (PPs), or call centers that operate like a patient’s GP; and (iii) a Bonus Plan rewarding members for not using care (Table 4.2). All plans have the same benefit package. HMOs are mainly in cities and are generally operated by insurers under capitation agreements with physicians. The IPA model offers a large choice of medical gatekeepers and mainly pays providers by FFS or capitation. The PP models usually include about 90 percent of primary care physicians in any specific region of Switzerland; and allow insurers to

29 De Volkskrant, November 23, 2006. One insurer (Menzis) has responded to the shortage of GPs in Groningen by setting up a primary care centre with nurse practitioners and other assistants in addition to the existing GPs (van de Ven, 2008).
exclude the more costly providers based on their claims history. The call center model is relatively new. Patients are obliged to contact the call center in the first instance with a medical problem, after which the center will refer them to a provider if necessary (Schuetz, 2008).

Table 4.2: Overview of the Four Health Plans in the Swiss Health Insurance Act

<table>
<thead>
<tr>
<th>Benefit package</th>
<th>Basic plan</th>
<th>Special insurance plans</th>
<th>Bonus plan</th>
<th>Managed care-plan (HMO, IPA, PP, and Call Center plan)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost sharing</td>
<td>All insurers have to offer the same basic benefit package in all plans.</td>
<td>Basic deductible: CHF 300 per year. No basic deductible for children</td>
<td>Basic deductible (CHF 300)</td>
<td>Basic deductible. Insurers have the option to offer the same levels as in the plan with higher deductibles. Accumulated rebate cannot exceed 50%</td>
</tr>
<tr>
<td>- deductible</td>
<td>Five levels of deductibles (CHF): - Adults: 500; 1000; 1500; 2000; 2500 - Children: 100; 200; 300; 400; 500; 600.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- co-payment</td>
<td>10% of the health care expenditure exceeding the deductible (CHF 300 or higher). This co-payment is limited to CHF 700 annually (children and adolescents under 18: CHF 350), so adult consumers pay a maximum of CHF 1,000 in the basic plan and CHF 3,200 in the plan with the highest deductible of CHF 2,500.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Inpatient care contribution</td>
<td>In all plans patients have to pay a contribution to the costs of inpatient care in acute hospitals of CHF 10.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premiums</td>
<td>Premiums are set by each insurer for each canton and paid per person as a flat rate (community rating. The community is defined by age and region. There are three age groups 0 - 18; 19 - 25 and &gt;25 years. The premium for a higher deductible, bonus and managed care plan must be at least 50% of the premium for the basic plan.</td>
<td>Premiums are reduced to level of the deductible, but not more than 80% of the deductible.</td>
<td>Initial premium at enrollment: +10% higher than basic plan. Annual premium reduction from initial premium if no claims are made (15%/25%/35%/45%) Premium reduction of 45% after five successive years without claims.</td>
<td>Premium reduction according to cost savings through the managed care plan.</td>
</tr>
<tr>
<td>Choice of doctor/hospital</td>
<td>Choice of any doctor or hospital with a general ward in the canton of the member - providers have to be entitled for reimbursement.</td>
<td></td>
<td>Limited to the providers defined in the plan.</td>
<td></td>
</tr>
<tr>
<td>Provider contracting</td>
<td>There is no free contracting. Insurers have to enter into a contract with all providers that are allowed to render SHI services.</td>
<td></td>
<td>Insurers have freedom to contract with or to exclude specific providers from rendering services.</td>
<td></td>
</tr>
</tbody>
</table>

Source: Schuetz, 2008.

4.11 Enrollment in managed care and higher deductible plans has been increasing in Switzerland (Figure 4.1). Despite potential premium savings of up to 45 percent, few people have chosen to enroll in a bonus plan, possibly because of the 10 percent higher premium charged during the first year. Higher deductible plans tend to have lower than average health care expenditures, as their enrollees tend to be healthier individuals. However, those consumers who expect their need for care to increase in the future tend to switch from a higher deductible plan to a basic plan with lower cost-sharing rates to

Figure 4.1: Percentage of the Swiss Population Covered by a Health Plan (1996 – 2006)

4.12 Managed care plans such as HMOs tend to have lower than average costs and are often able to pass on these savings to their members in the form of lower premiums. HMO staff models and capitation IPAs achieve 20 to 30 percent higher savings than the basic plan with FFS, and these savings are passed on to members in the form of premium rebates for capitated HMOs and IPA plans. The cost savings potential of call centers, non-capitated IPAs and PP plans is probably lower, but these plans have lower operating costs than capitation models and can more easily be set up and enter the market. In 2006, Swiss insurers achieved savings of SFr 1 billion (5 percent of total insurance expenditures) through cost containment measures such as pre-authorization and claims management. Thus, while self-selection of healthier individuals reduces costs in higher deductible plans, other kinds of plans have reduced their costs through better care management (Schuetz, 2008).

4.13 Cost-sharing can be used as a way to steer patients to more efficient providers and services. Dutch insurers are experimenting with giving bonuses to those GPs who prescribe generics instead of equivalent brand-name drugs. Also, insurers will only reimburse patients for the cheapest of a range of therapeutically interchangeable drugs. Patient organizations in the Netherlands support these initiatives aimed at increasing efficiency and lowering costs (van de Ven, 2008). Findings from Switzerland show that patients will choose generic over brand-name drugs if the co-payment is lower (see Box 4.1). In 2006, the government decreed that patients would pay lower co-payments for generics than for brand-name drugs, and this caused the market share of generics to rise substantially and led the manufacturers of brand-name drugs to drop their prices.

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30 After correcting for risk selection (Schuetz, 2008)
31 Twenty-seven percent of all members in HMO models (Baur, 2004: 45)
32 Santésuisse (2006). Almost 100 percent of the population are covered by this association.
33 The bonus payment was unsuccessfully challenged in court by four major pharmaceutical companies.
34 NRC Handelsblad, April 11, 2008. If the prescribing physician argues that the brand-name drug is medically necessary, then the insurers will agree to cover it (van de Ven, 2008).
These lessons may be useful for other countries considering introducing cost-sharing for pharmaceuticals and other services. In Central European countries, this would require changing the current cost-sharing policy to allow different co-payments for different products, including health services.

**Box 4.1: Modified Cost-sharing Scheme for Drugs in Switzerland**

On January 1st 2006, the federal government of Switzerland introduced two modifications of the cost-sharing scheme:

1. The co-payment for original brand-name drugs with a generic equivalent was set at 20 percent whereas the co-payment for the generic drug remained at 10 percent.
2. Prescribers are obliged to inform patients that a generic drug is being substituted for the brand-name drug and that a higher co-payment will apply if they still choose the brand-name drug.
3. Exemptions exist for patients with medical reasons (such as side effects).

**Impact**

From 2005 to 2006, the market share of generic drugs increased from 19.6 to 32.7 percent and in revenue terms by 46 percent, while the total revenue for brand-name off-patent drugs decreased by 49 percent. This development is due to substitution effects and price reductions for brand-name drugs by pharmaceutical companies. In 2005, the average weighted price difference between brand-name drugs and their generic substitutes amounted to 51 percent compared with 28 percent by the end of 2006 (Interpharma, 2007 and IMS, 2007).

<table>
<thead>
<tr>
<th>No.</th>
<th>Name of original product</th>
<th>Price reduction 2006/2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Selipran</td>
<td>16.3 - 19.7%</td>
</tr>
<tr>
<td>9</td>
<td>Norvasc</td>
<td>28.7 - 35.6%</td>
</tr>
<tr>
<td>13</td>
<td>Torem</td>
<td>25.1 - 39.1%</td>
</tr>
<tr>
<td>19</td>
<td>Zoloft</td>
<td>25.7 - 40.2%</td>
</tr>
<tr>
<td>22</td>
<td>Zocor</td>
<td>22.9 - 27.6%</td>
</tr>
</tbody>
</table>


4.14 There is some limited evidence to suggest that risk selection is more profitable for insurers than investing in managed care contracts. One study from Switzerland indicates that Swiss insurers can achieve higher savings through risk selection (up to 57 percent) than with HMO plans (25 percent).\(^{35}\) Thus, under the current regulatory and institutional framework, Swiss insurers have a strong incentive to engage in risk selection. This highlights the need for stronger regulation with more risk equalization and supervision to prevent risk selection in multiple insurance systems (Schuetz, 2008).

4.15 In sum, insurers have few tools and insufficient information to compete for better performing providers, which means that they still find risk selection an attractive option. Only in a few sub-markets can insurers negotiate with providers about their prices, services and quality of care, as these variables are heavily regulated by

governments in network plans and national price policies. As a result, all insurance companies can do is try to attract more members by increasing their administrative efficiency and providing superior customer service, but the cost for these factors are already rather low. However, insurers in many countries do have the option to use managed care models such as HMOs to manage expenditures. Ideally, insurers should also be able to promote better-quality and more efficient health care by engaging in selective contracting with providers, giving them financial incentives through the provider payment mechanisms, and adopting innovative cost-sharing models that guide consumers towards more efficient providers and less costly products. These reforms would need to be accompanied by significant investments in collecting and analyzing data on provider performance and by regulatory changes that would make the provider-insurer relationship more flexible while at the same time still ensure access to care and protect patients from substandard care.
5. CONSUMER CHOICE

5.1 Competition between insurers and providers requires that consumers are free to choose the more efficient insurers and providers. In a competitive insurance system, well-informed consumers can be expected to enroll with lower-premium insurers that contract with better quality and more efficient providers, thus stimulating competition and increasing efficiency in the health sector. However, in practice, consumers often do not have the necessary information about the performance of insurers and providers to make informed choices or regulations may limit their choice. Also, by engaging in risk selection, insurers can encourage consumers to self-select into other health plans. This may lead healthier individuals to tend to enroll in plans with higher deductibles, while the only affordable option for the chronically ill is the more comprehensive – and more expensive – basic plan. This chapter examines whether consumers actually have a choice among insurers, how they use it, and its impact on the health insurance and provider market.

CHOICE OF INSURER AND PROVIDERS

5.2 In countries with multiple insurance and competition, individuals can choose which insurer to enroll with. In Slovakia, Switzerland, and the Netherlands, consumers can freely choose their insurer. Consumers have at least one opportunity per year – for example on January 1 – to switch to another insurer. Insurers are legally required to publish information about their premiums (when these are independent of payroll) ahead of time to enable consumers to compare different offers. In Austria, individuals cannot choose their insurer and are instead enrolled according to their place of residence or profession36 (Koettl, 2008).

5.3 In many countries, consumers have access to only limited information on the performance of providers and insurers, and cost-reductions are not passed on from insurers to consumers in the form of reduced premiums. In Slovakia and Austria, consumers know the level of their payroll contributions to insurers, but there is no systematic information on the quality of the care provided by the various providers, and those consumers who have a choice do not receive any financial incentive (in the form of a reduction in their payroll contributions) to enroll with insurers who contract with more efficient providers. To help consumers to make well-informed choices, the Dutch government set up a website where consumers can access information about insurers and providers (www.kiesbeter.nl) and compare them with respect to price, services, consumer satisfaction, and supplementary insurance (premiums and benefits). The website also rates hospitals based on different sets of performance indicators developed by the Health

36 The exception is individuals working in professions such as architects, engineers, and lawyers, who can choose between private group insurance offered by their professional association or a public HIF.
Care Inspectorate (IGZ) (van de Ven, 2008). In Switzerland, information on different insurance premiums is widely available through the media and the Internet, but there is no information on how well insurers perform, for example, how long they take to reimburse consumers or the impact of managed care on patient outcomes. There is only one private webpage on hospital performance, and no standardized information on providers from independent sources37 (Schuetz, 2008).

**CONSUMERS SWITCHING INSURERS**

5.4 **In systems where consumers are allowed to switch insurers, this put pressures on insurers to respond to the needs of consumers.** Switching rates *per se* do not reveal anything about, for example, the extent of competition between insurers, the willingness of consumers to consider other plans, or the variety of plans available for consumers to choose from. If switching rates are high, consumers are probably exercising their ability to choose and are responding to changes in contribution levels and other insurance features. Low switching rates may be an indication that switching has high transaction costs, that consumers are not well-informed about the price and the quality of different plans, or that there is only a limited amount of choice between very similar plans. It may also be that all consumers are perfectly happy with their current choice. Given that the health insurance market is characterized by asymmetric information and complex products, low switching rates are likely to be an indication of a lack of extensive competition.

5.5 **Under the current risk-adjustment process in many countries, health insurers are not making substantial profits from consumers who switch insurers.** While insurers may make some profit on young and healthy switchers, the total insurance profits from switchers are still low given the relatively small number of switchers and given the existence of risk equalization across insurers with different risk pools. As a result, insurers have no incentive to try to persuade members of other insurance companies to switch insurers.

5.6 **Consumers will switch insurers when they consider it worth their while to do so.** The number of consumers switching between insurers in Western European countries seems to be low (Figure 5.1). Switching rates are generally highest during reform years, as, for example, in Germany in 2004. In 2006, the new Dutch national health insurance scheme led to premium competition among insurers, causing an all-time high rate of switching of 18 percent of the total population. This fierce premium competition caused Dutch insurers to lose €563 million (2 percent of their total revenues) in 2006 (Douven and Schut, 2006) and €507 million in 200718 (van de Ven, 2008). However, in Slovakia, few insurance members have changed their insurance company in the past three years. A Swiss survey shows that switching rates ranged from 2.1 percent to 5.4 percent between 1997 and 2000, and the switchers were young and healthy (Colombo, 2001).

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37 [http://www.comparis.ch/krankenkassen/spitalfuehrer/patientenzufriedenheit-uebersicht.aspx](http://www.comparis.ch/krankenkassen/spitalfuehrer/patientenzufriedenheit-uebersicht.aspx) / accessed: 01/28/08. However, this may change as the Federal Office for Public Health (FOPH) plans to launch a quality indicator project for acute care hospitals and publish the results (Schuetz, 2008).

for the period 2003 to 2008 yielded similar results (2 to 4.6 percent). However, within insurance companies, an increasing share of the population is enrolling in lower-priced HMO plans, a development which is not captured in these switching rates between insurance companies (Schuetz, 2008).

Figure 5.1: Percentage of Individuals in Germany, the Netherlands (NL), and Switzerland (CH) Switching Insurers (2000-2007)

Sources: Gress, 2006; van Vliet, 2006; and van de Ven et al., 2007

5.7 In addition to reform years, switching rates are affected by consumers' age and satisfaction with their insurer as well as by potential transaction costs. Only a limited amount of information is available on why people switch insurers, and their reasons for switching are difficult to assess. A Swiss survey showed that 68 percent of insured individuals aged 56 years old had been with the same insurer for at least 21 years (BSV, 2001, p. 101). Factors such as “satisfaction with insurer performance” in terms of, for example, reimbursement time influence whether individuals switch insurers or not. Individuals with additional private insurance are less likely to switch if this would result in them being insured with two different health insurers (Schuetz, 2008). Findings from the Netherlands indicate that switchers consist predominantly of the young and healthy who are “good risks” and who report health care expenditures of around 40 percent below the average (van Vliet, 2006).

5.8 In sum, there are three key messages about consumer choice in multiple insurance markets. First, in insurance markets that are funded by payroll taxes or subsidized enrollment, and with generally high consumer satisfaction with insurers and providers, consumers will find few reasons to switch insurers. Second, consumers tend to switch insurers during reform years but then stay enrolled with the same insurer thereafter. Third, switching also tends to increase in two situations: (i) if insurers contract selectively with providers and consumers enroll with insurers based on their provider network, which puts pressure on insurers to contract with more attractive providers and

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39 Based on a questionnaire submitted to the 30 largest insurers (Schuetz, 2008).
40 BSV, 2001: 101
(ii) if insurers pass on lower costs to consumers in the form of lower contributions or cost-sharing rates. Governments can facilitate switching by providing consumers with timely and relevant information about the performance of providers and insurers to enable them to compare and by delinking contributions from payroll or allowing insurers to award cash-back payments to consumers who behave in cost-conscious ways.
6. OPTIONS FOR REFORMS

6.1 Countries that plan to reform their health insurance systems can look to other countries that have already done so for lessons to be learned about what costs and gains they can expect. While multiple insurance systems contain some incentives for providers, insurers and consumers to reduce health care costs, competitive insurance systems have had only a limited impact on health care expenditures as the factors that might spur competition among insurers and providers tend to be strongly regulated. This may be a reason why some countries are thinking carefully before moving towards adopting a multiple insurance system. Hungary for instance, is now considering ways to improve its single insurance system by strengthening the insurers’ purchasing function, which even in multiple insurance systems is only weakly developed. This chapter discusses the three main reform options based on the country-specific experiences presented in the previous four chapters. This chapter starts by summarizing some key points about multiple insurance markets.

SOME KEY POINTS

6.2 The existence of a market incentive to reduce costs makes the multiple competing insurer approach highly attractive. A competitive insurance market exists when there is a plurality of insurers, when the market operates transparently, and when there is free entry and exit. The more competitive the insurance market, the more incentive there will be for providers, insurers and consumers. Market incentives to reduce cost will be greater the more competitive is the insurance market and the smaller the share of equalization payments that are ex-post.

6.3 The selection of low-cost enrollees (or risk selection) is the predominant strategy available to insurers to reduce treatment costs. Risk selection is a concern where treatment costs cannot be reduced because all providers have to charge to insurers the same negotiated or fixed price. Risk selection is a particular concern, even if insurers can select low-cost providers: it is a way for insurers to reduce their costs. In these circumstances, those insurers who do not resort to risk selection will be undercut by those who do.

6.4 The insurer has an incentive to select low-cost individuals in preference to the high-cost individuals within a risk group. The more sophisticated the ex-ante risk equalization adjustment mechanism, the smaller the incentive insurers have to resort to risk selection. This imposes costs on enrollees in general in the form of higher premiums if insurers spend their resources on selecting low-cost individuals instead of on selecting

41 Adam Wagstaff wrote this chapter.
the best providers and on ensuring quality control. It can lead them to reduce premiums for low-risk consumers but only at the expense of high-risk individuals like the chronically sick who could see their premiums being increase, or their claims being dealt with too slowly, or the quality of health services deteriorate.

6.5 **Fixing the existing system may carry less risk and produce results sooner than moving to a completely new system.** There is no evidence on the costs of risk selection and how they are distributed across different groups, nor is there any evidence on the benefits associated with the competitive insurer model. Therefore, it may be easier and less risky for countries to focus on improving whatever type of health insurance system they already have in place, whether it is a competing insurer model, a multiple non-competing insurer model, or a single insurer model.

**Making the Competing Insurer Model Work (better)**

6.6 **In the competing insurer model, there are four likely ingredients of success,** though it needs to be emphasized that the evidence on this issue is virtually non-existent. Nonetheless, these measures seem to have improved the performance of the current health insurance systems in **Slovakia** and **Switzerland,** and have the potential to do so in **Austria** as well if the Austrian government decides to move towards a competitive system.

6.7 **First, both the insurance market and the provider market should be competitive.** Entry and exit in both markets should be unrestricted, and there should be several different players in both. This will require the creation of regulatory bodies to cover both insurers and providers, as is the case in the Netherlands (see Box 2.1).

6.8 **Second, ex-post equalization needs to be limited.** It does not need to be abolished entirely, but it should be limited or insurers will not have any incentive to contract with more efficient providers. This is particularly important for **Slovakia,** where ex-post redistribution is common and prevents competition from increasing efficiency as would otherwise be likely to happen.

6.9 **Third, the ex-ante risk-adjustment mechanism needs to be carefully designed.** Most countries including **Switzerland,** **Slovakia,** and **the Czech Republic** use a mechanism that is far too crude to reduce the incentives for insurers to engage in risk selection. The **Dutch** risk-adjustment scheme is more complex, but experts consider even this model to be inadequate.

6.10 **Fourth, there needs to be a mechanism in place to ensure that insurers that engage in risk selection are made an example of, if not punished.** This will require evidence that insurers actively sought to exclude less healthy individuals from membership and/or evidence that such groups were actually disadvantaged by this behavior by insurers. This monitoring and collecting of evidence could be done by a statutory regulatory body or by patient associations as in the **Netherlands.** In Holland, associations exist for various different diseases, and they invite their members to contact them if the members experience any discrimination from their insurers. Such consumer
organizations should be encouraged in the new EU member states, and they should be given access to the relevant information to enable them to become effective consumer advocates.

6.11 It is important to emphasize that these four ingredients are not easy to put in place. This is evident from the longtime experience of the Netherlands, which is arguably the furthest ahead with multiple insurance. There are no less than five supervisory authorities responsible for ensuring competition among insurers and among health care providers, and they all have the authority to enforce rules. Also, the Government of the Netherlands has spent many years developing its risk-adjustment formula. It has taken many years for the necessary data to be routinely collected and to be made available to the analysts developing the formula. With respect to transparency, the Netherlands has been able to make use of its strongly independent media to threaten insurers who transgress with adverse publicity. Other countries that operate the competitive insurer model including Switzerland, Slovakia, and the Czech Republic are well behind the Netherlands in most if not all of these respects.

6.12 One alternative worth considering, although untested, is to maintain risk equalization and to allow insurers to risk-rate premiums, thus abandoning the idea that insurers have to charge everyone the same premium. Risk-rated premiums could allow insurers to focus on efficiency rather than on risk selection, and the chronically ill would become preferred clients for efficient insurers. This would stimulate insurers to contract with providers who have the best reputation for providing high-quality well-coordinated care to chronically ill people. The downside is that the financing could become inequitable, in that the poor would be charged premiums that they could not afford, and, at any given level of income, different people would end up paying different premiums depending on their health risk. Therefore, to ensure the equity of health financing, the government in question would have to subsidize the premiums of certain groups, presumably those with low incomes and perhaps those with especially high premiums. This is currently the case in Switzerland.

IMPROVING THE PERFORMANCE OF SYSTEMS WITH MULTIPLE NON-COMPETING INSURERS

6.13 The main drawback of the non-competing insurer model as in Austria is that revenues and expenditures are linked to a specific enrollee profile. Insurers depend on payroll contributions for their revenues, and these contributions in turn depend on the earnings of the enrollees. Also, how much insurers spend depends on the risk profile of their enrollees and are higher for urban population groups. Insofar as the less well off pay lower contributions, are sicker and are heavier users of health services, the likelihood is that insurers with low per-member revenues are also those with high per-member outlays. Most countries in this situation have implemented some kind of equalization system that transfers resources from insurers with low risks and/or high revenues to those with the opposite. However, this equalization process is often not transparent and does not always achieve full equalization. Insofar as it does achieve full equalization, insurers have no incentive to reduce costs. Insofar as it does not, it leaves the losers with an unwarranted pressure to reduce their costs, with possibly negative effects on their benefit package. If
insurers are not able to reduce their costs sufficiently, the outcome will be a financial deficit.

6.14 An obvious way to improve the situation would be for the income of insurers to vary according to the risk profile of their members by charging a risk-adjusted premium. To encourage efficiency, the amount an insurer would receive for each risk group could take into account the performance of the most efficient insurer or the performance of the average insurer compared with its most efficient peer (known as yardstick competition). This benchmarking is not possible in the single insurer model, which is the reason why many countries may prefer the multiple non-competing insurer model to the single-insurer model. Evaluating the relative performance of insurers and the risk profile of their members requires substantial investment in data collection and analysis. Under this yardstick competition approach, inefficient insurers would run up deficits. If they did so continuously, the government would have to decide whether they should be allowed to continue operation or whether they should be forced to close, in which case either their members could be reallocated to other insurers or the government could appoint a new insurer to replace the old one.

6.15 Further incentives could be introduced by requiring insurers to compete for the right to operate in a specific region. There would still be just one insurer for each region or for each occupational group, but the current insurer would have to bid against other insurers for the right to continue to operate as a sole supplier of health insurance for that population. The winner would have the right to operate for a defined period, for example, five years. This process is often used for privatized utilities. This approach is more realistic where there are already multiple insurers operating inside the country than when there is only one, and might be a useful approach to take in Poland where the government is considering adopting a multiple region-specific insurance system. The regulator would need to be sure that the lowest bidders did not underestimate the costs of providing health care to the population. One argument against this approach might be that the insurer that wins the bid would have no incentive to provide preventive health services because it might not still be the provider for that market when the returns start accruing with healthier members seeking less health care. However, this is not a compelling argument. The same problem arises in the competitive insurer model and can be overcome by a central public health agency paying providers to provide these services as happens in the Netherlands. Alternatively, insurers could be given bonuses that reflect the investments that they make during their tenure in the region, as the UK’s pay-for-performance (P4P) program rewards general practitioners in the UK for the preventive services that they provide.

6.16 These approaches could be coupled with efforts to make insurers more accountable and to encourage competition among providers. Ways to make insurers more accountable might include establishing a regulator, requiring insurers to appoint boards of directors, and giving cash back to enrollees at the end of the year. These measures could be enhanced by giving insurers an incentive to encourage providers to reduce health care costs, for example through selective contracting with price competition, the use of prospective payments for providers, and the use of P4P to incentivize higher quality.
IMPROVING PERFORMANCE IN THE SINGLE-INSURER MODEL

6.17 Some of the ideas mentioned in the previous section also apply to single insurers. It ought to be possible for countries with a single insurer such as Hungary and Poland to exert downward pressure on health care costs in through selective contracting and price competition, applying yardstick competition among providers for contracting, making payments based on provider profiling, introducing differentiated co-payments, and promoting the use of generic drugs. It also ought to be possible to improve the governance of the single health insurer and benchmark its performance against other single insurers operating in other European countries.

WHICH STRATEGY?

6.18 Nobody knows which of the three models works best. The evidence is scanty, some elements have not been fully implemented anywhere, and, in some countries, some ideas have never even been tried. Furthermore, what works in one country may work less well elsewhere due to institutional and cultural factors. In all three systems, there are things that can be done to improve matters without completely changing the entire system.

6.19 If countries have to decide between overhauling the whole insurance system or changing some elements of the existing system to make it more efficient, the latter may provide a larger pay-off. There is no evidence about which insurance system works best. However, 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 advisable for countries to invest in changing some of its insurance features such as contribution levels, purchasing, benefit packages, and cost-sharing levels and to monitor and evaluate the effects that these changes have on efficiency, access, and financial sustainability in the health sector. A regulatory body with the authority to intervene with and even punish insurers and providers is needed, and well informed and organized consumers can help to implement the necessary reforms, as the experience from the Netherlands suggests.
7. CONCLUSIONS AND RECOMMENDATIONS

7.1 Several countries view multiple insurance with competition as a way to increase efficiency and to make insurers more responsive to the needs of consumers in the health care sector. In reality, the experience from European multiple insurance systems shows that competition between insurers is restricted by government regulations and by the design of insurance features. In particular, insurers have considerably fewer instruments to compete with if: (i) they charge fixed contributions such as payroll tax rates; (ii) contributions are subsidized; (iii) the benefit package is similar or even essentially identical across insurers; and (iv) cost-sharing with patients is limited. Consequently, competing insurers may find it difficult to reduce their expenditures and manage their costs. In this situation, insurers would have an incentive to attract healthier members who will use care moderately and to contract with selected providers that are more efficient performers.

7.2 Competition in health care can only meet public policy goals if a number of complex technical and institutional preconditions have been met. This requires a lengthy and cautious implementation process. In particular, the following five elements need to be in place for competition to have an impact, including (i) risk equalization across insurers; (ii) a competitive provider market with incentives that encourage providers to increase efficiency and improve the quality of care; (iii) outcome and quality measurement; (iv) consumers knowledgeable about the price and quality of health care, providers, and insurers and freely able to choose among them; (v) a governance structure that includes an effective competition policy to regulate competition and avert negative effects. In practice, countries have progressed at different rates in adopting these five elements, which has also affected the extent to which competition has succeeded in increasing efficiency in the health sector.

7.3 First, risk-adjusted equalization payments provide a level playing field for health insurers. Risk-adjustment aims to prevent adverse selection in situations where the health insurance system includes open enrollment, community-rated contributions, and a standard benefit package. Where risk-adjustment is imperfect – which is largely the case in Switzerland, Slovakia, and the Czech Republic – it is still more profitable for insurers to attract healthier (and thus less risky) individuals than to compete with other insurers to work with better performing providers to increase the efficiency and improve the quality of the health sector. Therefore, risk equalization should include some health parameters as this is already the case in the Netherlands. In practice this requires substantial investment in data collection, management, and analysis. Data protection laws, such as in Switzerland may need to be updated to allow more sophisticated risk-adjustment. Furthermore, ex-post compensation, as is used in Slovakia, gives insurers less of an incentive to compete for more efficient providers so the use of this tool should be reduced substantially.
7.4 Second, in most countries, health insurance reform has not put enough emphasis on competition among providers. Competition among providers has so far only occurred in some submarkets such as managed care, where insurers negotiate with health care providers about their prices, service, and quality of care. As a result, health insurance companies can only compete with each other in terms of the quality of a range of contracted non-network providers, administrative efficiency, and superior customer services. Managed care innovations such as HMO models have yielded cost savings, and single and multiple insurers might consider adopting them as a way to reduce their own expenditures. Bilateral negotiations between insurers and individual providers instead of provider associations and selective contracting of providers should be allowed to give insurers an incentive to compete for better quality and more efficient care. Setting up financial incentives for providers to improve efficiency and quality, using provider payments, provider profiling, and performance-based contracts can enhance the impact of competition on the provider side. These reforms would be relatively new for Central European countries and are as relevant for single insurance systems as for multiple insurance systems.

7.5 Third, investing in quality control programs can prevent providers from reducing costs by delivering substandard care. In most European countries, adequate quality indicators and quality assurance programs have not yet been established. What little quality control exists is limited to self-regulation by physicians. Ensuring a high quality of care throughout the health system would require policymakers to invest in collecting data on patients and providers, putting in place additional incentives for providers (for example, through the provider payment system), and regulating and supervising the quality of care. As happens in the Netherlands, insurers could use information on the quality of care provided to negotiate prices and contracts with health care providers. The results of these quality assessments should also be published in the media to inform consumers and enable them to access care from better-quality providers. Providers might also feel pressure from their peers to improve the quality of their care where necessary. Ideally, better-quality providers would be rewarded through the provider payment system, for example in the form of bonus payments. Such quality measures are equally relevant for single health insurance systems and for competitive insurance systems.

7.6 Fourth, information is needed to ensure good quality and consumer choice. A lack of information on the performance of providers and insurers as well as on individuals' risk status is a major impediment to making competition work. To make informed choices, consumers need to have access to readily available, standardized, and accurate information on how well or badly providers and insurers have performed. Insurers in Switzerland, Austria and Slovakia should be able to set up provider profiling programs to evaluate provider performance based on claims data that include diagnosis and treatment procedures; and use results to exclude providers with unsatisfactory performance from contracts. The need for more information may require changes in data protection laws in these countries. Regulatory agencies should intervene if competition does not lead to the desired level of transparency.
7.7 Fifth, to make multiple insurance systems more effective, governments should allow more regulated competition. The Dutch experience shows that regulatory agencies play an important role in preventing the adverse effects of competition. In most countries in Europe, there is a need to relax the strong regulation of the insurance and provider market (over, for example, contracting, provider payments, co-payments, and premiums). For example, in Slovakia’s multiple insurance system, the government defines contribution rates, standardizes the benefits package, prevents insurers from setting different co-payments and deductibles, and fixes insurers’ contract prices to providers, mostly at similar rates. Introducing some competitive elements supervised by regulatory agencies in multiple insurance markets, as well as in single insurance markets, could lead to efficiency gains and cost containment. This could be of particular interest in countries that have lagged behind others in reducing overcapacity in their provider markets.

7.8 Some governments may prefer to improve the performance of their single insurance system instead of implementing major reforms to introduce multiple insurance systems. In most Central European countries, single insurers could help to make the health sector substantially more efficient by abandoning their simple disbursement role and becoming active strategic purchasers. Policymakers could make this happen by strengthening insurers’ purchasing function, allowing performance-based contracting, defining the benefit package based on what public resources are available, and setting explicit cost-sharing levels to guide patients towards more efficient goods and services. To increase equity in health financing, countries with single insurance systems could implement similar reforms as those that have been adopted in multiple insurance systems, including charging risk-based premiums with compulsory enrollment and paying premium subsidies to lower-income individuals based on their income tax assessments. All Central European countries with a single health insurer could consider implementing such reforms to increase efficiencies in the provision of health care.

7.9 Countries with multiple insurance systems may wish to revisit some of their insurance features and consider making some gradual changes with respect to premium setting, risk equalization, cost-sharing, contracting, and data collection and analysis. Introducing risk-rated premiums and premium subsidies to increase equity could be one alternative financing method to community rating and payroll contributions in countries with multiple insurers. At the same time, the governments of countries with such systems should further support risk equalization mechanisms by making the necessary investments in data collection and analysis. They should also introduce a competitive element into the relationship between insurers and providers to maximize efficiency gains and quality improvements. In Central European countries, current cost-sharing restrictions would need to be revisited to allow insurers to use cost-sharing as a way to direct consumers towards more efficient health care.
REFERENCES


ANNEX 1: DUTCH HEALTH FUNDS

Annex Figure 1: Flow of Funds in the Dutch Health Care System (2006 legislation)\textsuperscript{42}

\begin{itemize}
  \item General taxation
  \item Income-related care allowances (two-thirds all households)
  \item Tax-collector (Gov’t)
  \item Earmarked income-related contributions, via tax-collector (50%)
  \item Costs of children under 18 (5%)
  \item Risk-equalization Fund (REF)
  \item Risk-adjusted equalization payment (55%)
\end{itemize}

\textit{Competing insurers}

\textit{Competing providers}

\textsuperscript{42} Source: van de Ven, 2008.
Annex Table 1: Average Predictable Losses per Adult for Selected Groups of Consumers given the Dutch Risk Equalization Formula of 2007, Community Rating and Open Enrollment and without Ex-post Compensations (N = 16,891)

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<tr>
<td></td>
<td>%</td>
<td>€</td>
<td>€</td>
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<tr>
<td><strong>Health status (2001)</strong></td>
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<td></td>
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<tr>
<td>Self-reported health status fair/poor</td>
<td>21.2</td>
<td>3,404</td>
<td>541*</td>
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<td>10% worst score physical functioning (SF-36)</td>
<td>10.0</td>
<td>4,469</td>
<td>1,140*</td>
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<td>Auditive impairment (OECD-score)</td>
<td>4.8</td>
<td>2,851</td>
<td>308</td>
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<td>Visual impairment (OECD-score)</td>
<td>7.3</td>
<td>2,920</td>
<td>222</td>
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<td>Mobility impairment (OECD-score)</td>
<td>14.9</td>
<td>3,740</td>
<td>653*</td>
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<td>10% worst score mental health (SF-36)</td>
<td>10.0</td>
<td>2,527</td>
<td>297*</td>
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<td>Stroke, brain haemorrhage / infarction</td>
<td>2.6</td>
<td>4,341</td>
<td>943*</td>
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<tr>
<td>Myocardial infarction</td>
<td>3.3</td>
<td>4,755</td>
<td>789*</td>
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<tr>
<td>Some type of malignant cancer</td>
<td>4.8</td>
<td>3,440</td>
<td>689*</td>
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<td>High blood pressure</td>
<td>15.2</td>
<td>2,961</td>
<td>342*</td>
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<td>3-6 self-reported conditions</td>
<td>22.3</td>
<td>2,848</td>
<td>333*</td>
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<td>7 or more self-reported conditions</td>
<td>2.9</td>
<td>4,833</td>
<td>1,461*</td>
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<td><strong>Prior healthcare utilization (2000-2001)</strong></td>
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<tr>
<td>Use of prescribed medicine last 14 days</td>
<td>48.2</td>
<td>2,597</td>
<td>220*</td>
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<tr>
<td>Contact with medical specialist last year</td>
<td>39.8</td>
<td>2,586</td>
<td>317*</td>
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<td>Hospitalization last year</td>
<td>7.5</td>
<td>3,611</td>
<td>1,034*</td>
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<td>Contact with physiotherapist last year</td>
<td>18.5</td>
<td>2,144</td>
<td>315*</td>
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<td>Home health care last year</td>
<td>2.2</td>
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<td><strong>Top 25% highest expenses 1997-2001</strong></td>
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<td>In none of these years</td>
<td>40.5</td>
<td>722</td>
<td>-343*</td>
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<td>1 out of 5 years</td>
<td>18.2</td>
<td>1,301</td>
<td>-153*</td>
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<td>2 out of 5 years</td>
<td>9.8</td>
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<td>3 out of 5 years</td>
<td>5.9</td>
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<td>4 out of 5 years</td>
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<td>All 5 years</td>
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</tr>
<tr>
<td><strong>Hospitalization 1997-2001</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In none of these years</td>
<td>63.8</td>
<td>1,335</td>
<td>-149*</td>
</tr>
<tr>
<td>1 out of 5 years</td>
<td>17.1</td>
<td>2,252</td>
<td>165*</td>
</tr>
<tr>
<td>2 out of 5 years</td>
<td>4.7</td>
<td>3,613</td>
<td>728*</td>
</tr>
<tr>
<td>3 out of 5 years</td>
<td>1.1</td>
<td>6,606</td>
<td>2,030*</td>
</tr>
<tr>
<td>4 out of 5 years</td>
<td>0.3</td>
<td>11,763</td>
<td>5,933*</td>
</tr>
<tr>
<td>All 5 years</td>
<td>0.1</td>
<td>14,373</td>
<td>6,453*</td>
</tr>
</tbody>
</table>

| All insured                                       | 100%          | 1,646                                                     | 0**                                                 |

St. S J van de V 2007 & 2008 Notes: * t 0.05 ** t 0.01 REF the average predicted premium herefore the average t equals zero
Annex Table 2: Additional Annual Equalization Payment (in €) for Selected PCG and DCG Groups (Dutch Risk Equalization Formula of 2004)

<table>
<thead>
<tr>
<th>Selected PCG and DCG Groups</th>
<th>Additional Annual Equalization Payment (in €)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCG 0 / DCG0 = Reference group</td>
<td>0</td>
</tr>
<tr>
<td>PCG 1 Asthma / COPD</td>
<td>876</td>
</tr>
<tr>
<td>PCG 2 Epilepsy</td>
<td>1,051</td>
</tr>
<tr>
<td>PCG 3 Rheumatism</td>
<td>1,176</td>
</tr>
<tr>
<td>PCG 4 Heart diseases</td>
<td>1,495</td>
</tr>
<tr>
<td>PCG 5 Crohn’s disease / e. ulcerosa</td>
<td>1,538</td>
</tr>
<tr>
<td>PCG 6 Stomach diseases</td>
<td>1,932</td>
</tr>
<tr>
<td>PCG 7 Diabetes (insulin-dependent)</td>
<td>2,807</td>
</tr>
<tr>
<td>PCG 8 Parkinson</td>
<td>2,653</td>
</tr>
<tr>
<td>PCG 9 Organ transplants</td>
<td>4,363</td>
</tr>
<tr>
<td>PCG 10 Cancer</td>
<td>4,796</td>
</tr>
<tr>
<td>PCG 11 Cystic fibrosis</td>
<td>5,382</td>
</tr>
<tr>
<td>PCG 12 HIV / AIDS</td>
<td>11,455</td>
</tr>
<tr>
<td>PCG 13 Kidney problems</td>
<td>18,225</td>
</tr>
<tr>
<td>DCG 7 Brain injury</td>
<td>1,735</td>
</tr>
<tr>
<td>DCG 9 Colon cancer</td>
<td>2,261</td>
</tr>
<tr>
<td>DCG 11 Liver disorders</td>
<td>3,487</td>
</tr>
<tr>
<td>DCG 12 Rectal cancer</td>
<td>3,636</td>
</tr>
<tr>
<td>DCG 13 Congestive heart failure</td>
<td>3,578</td>
</tr>
<tr>
<td>DCG 14 Hypertension, complicated</td>
<td>4,491</td>
</tr>
<tr>
<td>DCG 15 Neurologic disorders</td>
<td>5,390</td>
</tr>
<tr>
<td>DCG 16 Brain / nervous system cancers</td>
<td>6,165</td>
</tr>
<tr>
<td>DCG 19 Chemotherapy</td>
<td>7,591</td>
</tr>
<tr>
<td>DCG 20 Diabetes with chronic complications</td>
<td>7,288</td>
</tr>
<tr>
<td>DCG 21 Pulmonary fibrosis and bronchiectasis</td>
<td>8,603</td>
</tr>
<tr>
<td>DCG 22 HIV / AIDS</td>
<td>9,780</td>
</tr>
<tr>
<td>DCG 23 Renal failure / nephritis</td>
<td>24,020</td>
</tr>
</tbody>
</table>
