Risk equalisation in voluntary health insurance markets: a three country comparison

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Outline:

1. Editorial: '*Risk equalisation in voluntary health insurance markets*' (Armstrong, Paolucci, van de Ven);
2. '*Risk equalisation and voluntary health insurance markets: The case of Australia*' (Connelly, Paolucci, Butler, Collins);
3. '*Risk equalisation and voluntary health insurance in Ireland*' (Armstrong);
4. '*Risk equalisation in the South African voluntary health insurance market*' (McLeod, Grobler);

5. **Risk equalisation in voluntary health insurance markets: a three country comparison.**

Agenda

1. Overview of *health financing* in the 3-countries;
2. Voluntary private health insurance (*VPHI*) and risk-equalisation (*RE*) in the 3-countries;
3. Conclusions and discussion.

Part 1.

Overview of health financing in the 3-countries

Australia (1)

- ***Mix of public-private financing & delivery*** of health services:
  - Public health insurance (Medicare, 1984). (68% of THE).
  - Out-of-pocket payments. (24% of THE).
  - Competitive **VPHI**. (8% of THE).

Australia (2)

- Medicare (1984):
  - Tax funded universal mandatory coverage;
  - 'Free' treatment as a public patient in a public hospital;
  - Subsidies for private medical services (Medicare Benefits Schedule) and pharmaceuticals (Pharmaceutical Benefits Scheme).

Australia (3)

- Competitive **VPHI**:
  - *Supplementary* coverage for (parts of) the costs of services not covered by Medicare (e.g. hospital charges levied by private hospitals);
  - *Duplicate* coverage for the costs of services (partly) covered by Medicare;
  - *Non*-substitutive;
  - Individual-based insurance;
- Out-of-pocket payments:
  - VPHI-Deductibles, POS-copayments.

Ireland (1)

- ***Public/private mix of funding & delivery*** of healthcare (almost identical to Australia):

  - Tax-funded public health insurance scheme;

  - VPHI market;

  - Out of pocket expenditures.

Ireland (2)

- ***VPHI market*** commenced in 1957 with establishment of *Vhi Healthcare* & provides:
  - *Duplicative* coverage to universal entitlement of public hospitals*;
  - *Substitutive* GP-care coverage for non- Medical Card holders;
  - *Supplementary* coverage.
  - Employer based schemes (60%) or directly by individuals.

South Africa (1)

- Public/private financing & delivery of healthcare:

Public sector (40% of THE)	***Private sector (60% of THE)***
Universal tax-funded with allocated budgets for public healthcare facilities.	VPHI market (1889) known as 'medical schemes' since 1967 covering on a voluntary basis 15% of the population (i.e. high-income groups)
64% of the population depends on it for all conventional healthcare services	A further 21% of the population use private GP and pharmacies on OOP-basis and for the rest relies on the public scheme
Salaried staff	FFS
Care is virtually 'free' at the point of service for unemployed and low-income people (e.g. user charges with exemption policies)	Deductibles and copayments

South Africa (2)

- ***VPHI features:***

  - *Substitutive* coverage & delivery via private healthcare providers, predominantly fee-for-service.

  - Not for-profit MS, owned by their members.

  - Brokers are paid commissions for taking members to open schemes – *9,742* individual health brokers while there are only *7,000* GPs.

  - Fiercely competitive market (i.e. high switching rates).

Part 2.

VPHI & RE in the 3-countries

Outline of VPHI markets

	Australia	Ireland	South Africa
% population covered by VPHI	47%	52%	**15%**
People covered by VPHI	10.9 million	2.2 million	7.8 million
VPHI expenses as % of total national hc expenses	8 %	12%	**55%**
Do consumers have free choice of insurer to enroll within?	Yes, 93% are in open schemes	Yes, 95% are in open schemes	Yes, 67% enrolees in open schemes
Financial responsibility of individual insurance entities	**Very low.** Costs >AU$50,000 are shared.	100%	100%

Market structure for VPHI

	Australia	Ireland	South Africa
Number of open undertakings	25	3	41
Market share largest insurer	30%	**66%**	25%
Market share largest 4 insurers	70%	100%	**44%**
Premium subsidies and/or tax-credits for PHI purchase?	Yes (Rebate and Medicare Levy Surcharge)	Yes	**Yes (but no subsidies for people earning below tax-threshold**
Premium restrictions?	**Community-rated premiums**	**Community-rated premiums**	**Community-rated premiums**
Flexibility for benefit package design	**Very high**	**Very high**	**Very high**

Common elements VPHI-markets

- Flexibility for benefit package design is an effective tool for market segmentation and thereby ***undermines community rating***: indirect premium differentiation via product differentiation.

- **Adverse and risk selection are significant problems!**

Risk selection: tools

	Australia	Ireland	South Africa
Preferred risk selection by insurers	▪ Selective advertising; ▪ Premium differentiation via Product differentiation; ▪ Voluntary deductibles.	▪ Selective marketing; ▪ Restricted product enhancement; ▪ Voluntary deductibles.	▪ Selective marketing; ▪ Benefits above the presribed minimum benefits.

Subsidising VPHI: HOW?

- Competitive VPHI markets require the enforcement of *regulations/ subsidies* to achieve affordability, efficiency and prevent selection.
- The current forms of subsidies for VPHI in the 3 countries:
    a. Premium-adjusted subsidies;
    b. Community rating per insurer per product;
    c. Risk-adjusted subsidies (e.g. risk-equalisation)?

a. Premium-adjusted subsidies

- Effective in achieving affordability.
- But, not optimal:
  - They reduce the consumers' and insurers' incentives for efficiency:
    - » Less effective price-competition and risk of *premium inflation*;
    - » A welfare loss because of the *moral hazard* due to over-insurance.
  - They create a *misallocation* of subsidies.

→ tradeoff affordability - efficiency

b. Community rating

- *Goal*: to create implicit cross-subsidies from the low-risks to the high-risks.

- *Effect*: Such pooling of people with different risks creates substantial predictable profits and losses for subgroups → and thereby create incentives for *risk-selection*.

→ tradeoff affordability - selection

c. Risk-equalisation

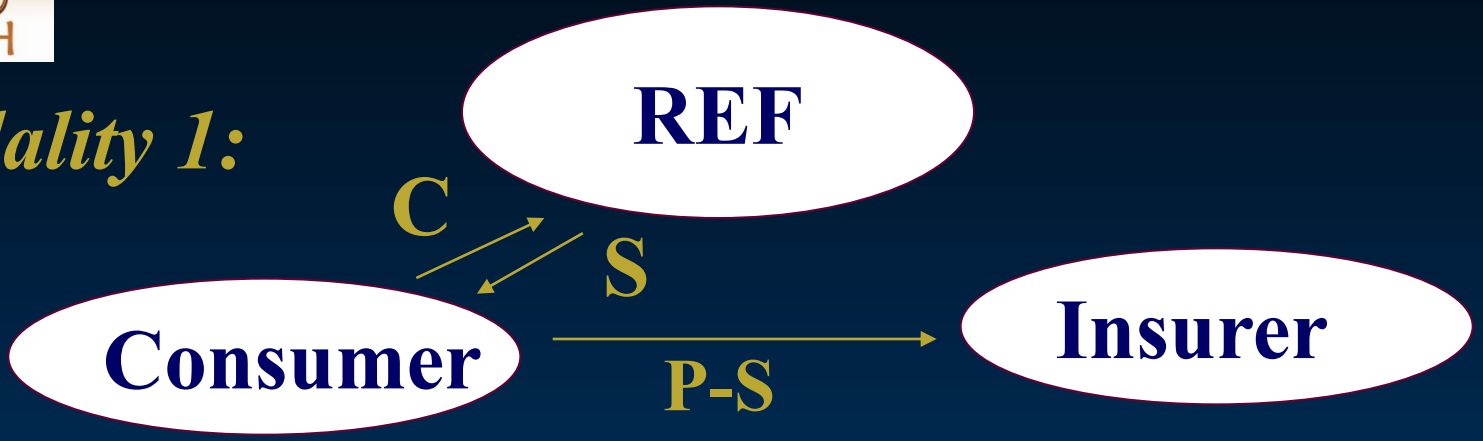
- A usual definition of risk equalisation:

  'A mechanism to equalise the risk profiles among insurers with the objective that the *ex-ante* risk profiles of each insurer become identical.'

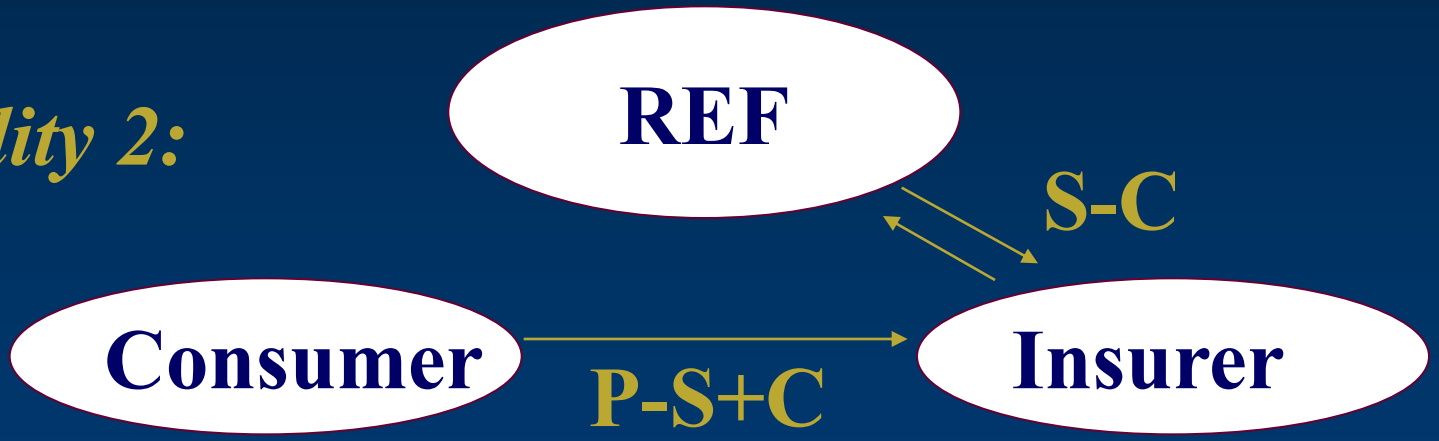
- This is done by calculating premium subsidies based on risk-adjusted predicted individual health expenses. These subsidies are given to the insurer who deducts it from the premium of the relevant consumer.

Modalities of risk equalisation

Modality 1:



Modality 2:



C=Contribution; S=Subsidy; P=Premium.

Effects of RE

- Eliminate incentives for risk-selection;
- No distortions of premium competition (efficiency);
- Achieve affordability in competitive PHI markets.

Australia: is it RE?

- Although in Australia it is called 'risk equalisation', it is a *claims cost equalisation (CE)*:

  'A mechanism to equalise the claims-costs among insurers with the objective that the *ex-post* costs per person of each insurer become identical.'

- This is done by enforcing ex-post costs-based compensations between insurers.

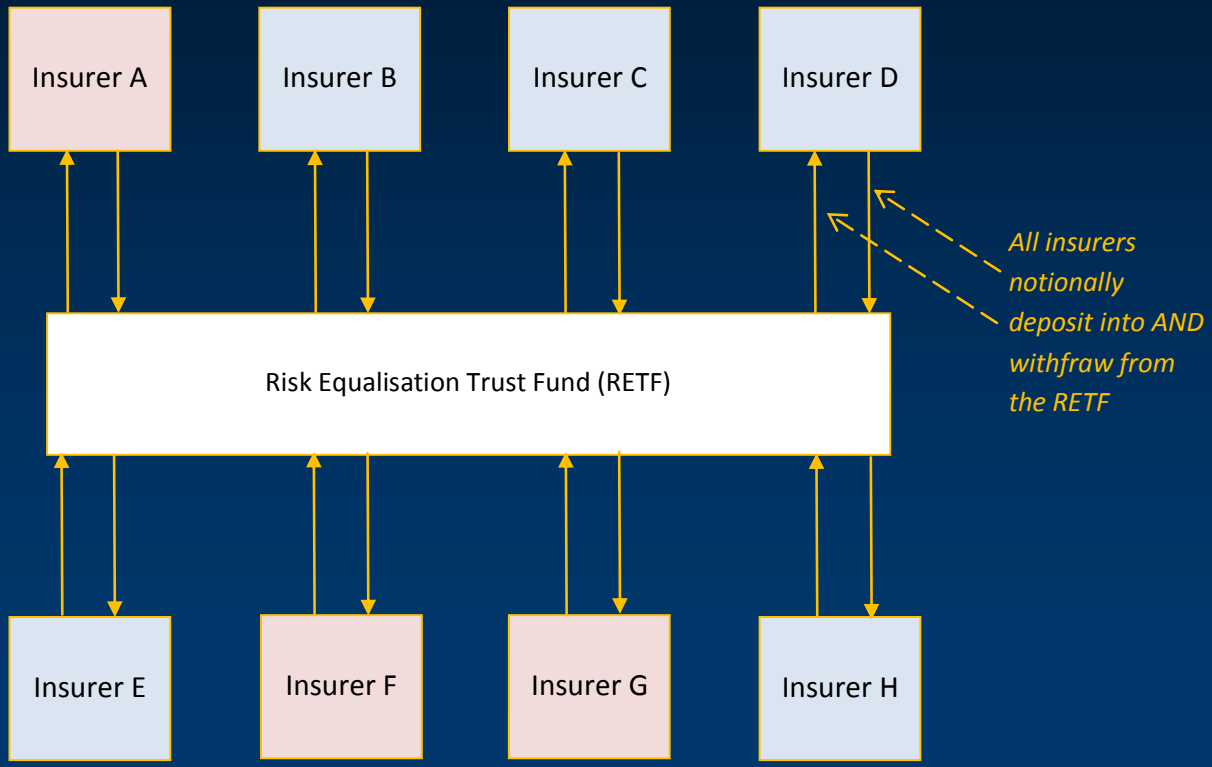
Benefits/Services

- Services covered under the Australian scheme (figures in parentheses are the proportion of the total benefits being equalised):
  - Hospital benefits (97.6%)
  - Hospital substitute benefits (0.05%)
  - Chronic Disease Management Program benefits (0.07%)
  - High Cost Claimant benefits (2.28%)

Flows

Sum of payments into the RETF = Sum of payments out of the RTF (zero sum game)

Individual insurers make or receive a net transfer, depending on claims experience



‘Risk’ vs. ‘Claims cost’

- Risk equalisation:
  A mechanism to equalise the risk profiles among insurers with the objective that the *ex-ante* risk profiles of each insurer become identical.

- Claims cost equalisation:
  A mechanism to equalise the claims cost among insurers with the objective that the *ex-post* costs per person of each insurer become identical.

Effects of CE

- Highly imperfect matching with the 'true' risk structure of insurers' population resulting in over/under compensations (i.e. misallocation of subsidies).
- Strong incentives for selection (historically a constant threat to the stability of PHI market in Australia).
- Lack of incentives for efficiency.

The preferred strategy

- *Effects of 'PAS' and 'CE'*: reduction of incentives for efficiency;
- *Effects of 'CRP'*: risk selection; and premium differentiation via product differentiation.

- Risk equalisation (*RE*) first-best strategy to escape from the tradeoffs between affordability, efficiency and selection (van de Ven & Schut 2008-7; Paolucci et al. 2006):
  - In the case of perfect risk equalisation there is no need for any other strategy and no tradeoff exists.
  - Each of the other strategies inevitably confronts policymakers with a tradeoff.

‘Risk Equalisation’

	Australia	Ireland	South Africa
‘RE’: year of implementation	2007	No transfers (most recent regulations 2003)	planned for 2010, but legislation still not passed
Policy rationale for ‘RE’	▪To support CRP (risk-solidarity) ▪To increase industry stability i.e. prevent selection	▪To support CRP (risk-solidarity) ▪To increase industry stability	▪To support CRP (risk-solidarity) ▪To facilitate the introduction of Social Health Insurance
Risk factors	▪ age ▪ health status proxy, i.e. a cap on the maximum insurer’s costs per person over a rolling 12-month period.	▪ age, gender; ▪ reserve power for health status proxy, i.e. private bed nights.	▪ age; ▪ numbers with 25 defined chronic diseases, with HIV and with multiple chronic diseases; ▪maternity events.

Part 3.

Conclusions and discussion

Similarities between A, I & SA

Similarities:

- Universal basic *public* system;
- Voluntary private health insurance (*VPHI*) market with consumer choice of 'level' of coverage and competition among 'risk-bearing' insurers;
- Regulation & *subsidies* in VPHI markets:
  - Restrictions on the ability of insurers to charge risk-related premiums (i.e. community rating);
  - Other incentives and subsidies in place for particular policy objectives.
  - ***Risk equalisation***.

Differences between A, I & SA

Differences:

- history;
- relative level of wealth;
- the role of VPHI in the overall health system;
- ……
- Definition of ***'Risk Equalisation'!***

Conclusions and discussion

- *Risk selection* is a signifcant problem;
- In case of voluntary health insurance: *adverse selection* is an additional problem;
- Risk equalisation is very complex, both technically and politically; and also the *legal* issues;

- Community rating: goal or tool?
- Rationale for (subsidising) VPHI?
- From VPHI towards NHI?

Community rating: goal or tool?

- As a ***Goal***: Each person in the community pays more or less the same premium.
- As a ***Tool***: Regulation that creates predictable profits/losses, and thereby incentives for selection that undermines the ***goal*** of community rating;
- Are there more effective ***tools*** to achieve the ***goal***?

Rationale for (subsidising) VPHI?

1. What is the rationale for buying voluntary private health insurance (VPHI), given a universal basic public system? *Answer*: to pass the queue and reduce ***waiting times*** and to receive care with better (perceived) ***quality***.

2. What then is the rationale for subsidising (tax penalties, premium subsidies 30-40%, 'risk equalisation'), and regulating (open enrolment, community rating) VPHI? *Answer*: reduce pressure on ***public system*** (& finance) and increase ***choice.***

From VPHI to SHI?

All 3-countries have been considering the introduction of ***Social Health Insurance (NHI)*** in the sense of universal mandatory insurance with consumer choice of (competing) health funds:

- Australia: National Health & Hospitals Reforms Commission (NHHRC) – "***Medicare Select***";
- Ireland: Fine Gael's "***FairCare***";
- South Africa:
  - '***Social Health Insurance***' proposed since 1994;
  - New elected Government in 2009: "within 5 years" National Health Insurance.

From VPHI to NHI: Preconditions

- Good ***risk equalisation***;
- Effective competition policy;
- Consumer information (price, quality);
- Transparency (e.g. insurance products);
- Product classification system;
- Supervision of quality of care;
- Sufficient contracting freedom (price, quality, selective contracting);
- Political support (bi-partisan) for sequential implementation;
- ….., …., …..

Risk equalisation is critical

- Good risk equalisation is an essential (but not the only) precondition to efficient competitive health insurance/provision markets (with open enrollment & community rating).
- Without good risk equalisation the disadvantages of competition might outweight advantages of a competitive market.
- Risk equalisation should not only be based on age/gender, but also on health status.

US reforms?

- The Patient Protection and Affordable Care Act (ACA) establishes various tiers of health insurance coverage for three *primary purposes*:
  - To set the universal mandatory coverage for a minimum standardised package of services (or pay a federal tax penalty beginning in 2014).
  - Premium and cost-sharing subsidies provided to lower and middle income people buying their own insurance in Exchanges.

ACA (I)

- Four actuarial value levels: 60% (a bronze plan), 70% (a sliver plan), 80% (a gold plan), and 90% (a platinum plan).
- The ACA also requires that plans cap the maximum out-of-pocket costs for enrollees, based on the out-of-pocket limits in high-deductible plans that are eligible to be paired with a Health Savings Account.
- Most people will be required to have insurance that is at least at the bronze level (a 60% actuarial value) or pay a federal tax penalty.

ACA (II)

- People who buy coverage on their own through an Exchange and have family income up to four times the poverty level ($89,400 for a family of four and $43,560 for a single individual in 2011) may be eligible for premium and cost-sharing subsidies:
  - The premium subsidies are based on family income and the premium (adjusted for age) of the second lowest cost silver plan (70% actuarial value) in an Exchange.
  - Low and modest income people buying insurance in Exchanges may be eligible for coverage with a higher actuarial value and lower out-of-pocket maximum.

Subsidies

a. Premium-related subsidies;
b. Cost-sharing subsidies;
c. Community rating per product.

- Effects of a and b: reduction of incentives for efficiency (e.g. premium inflation, moral hazard…);
- Effects of c: risk selection; and premium differentiation via product differentiation.

Why not risk-adjusted subsidies?

Universal Mandatory Coverage

- Many OECD countries have introduced *universal* mandatory coverage for a *uniform* benefits or services package (BP).

- Policy-makers see **universal/uniform mandatory coverage** as a *tool* to achieve the *goal* of affordable access to (the coverage of) health care services to vulnerable groups (e.g. low-income or high-risks individuals).

Problem

- If the financing/insurance of uniform BP is not sustainable/affordable for certain groups of individuals it does not make sense to mandate to buy it;

- If subsidies guarantee affordable access to health care services/coverage for vulnerable groups, what is the rationale for universal/uniform mandatory coverage?

Proposition

- Proposition: the arguments that motivate a system of mandatory cross-subsidies differ substantially from those that motivate mandatory coverage.

- What are the economic rationales for governments to enforce a system of ***mandatory cross-subsidies*** and to implement ***mandatory coverage*** for a set of predefined services?

Promising directions to proceed

- Single-option scheme with voluntary income-related deductibles (i.e. the higher the income, the higher the deductible).
- Allow insurers to risk rate & replace community rating by a premium rate band;
- Replace the premium and cost-sharing subsidies by risk-adjusted subsidies.

Effects:

- Less selection, both by consumers and by insurers;
- Policy goal of affordability more likely to be achieved;
- Increase incentives for efficiency (consumers, insurers).