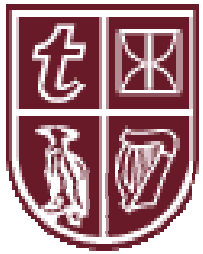


Managing costs under universal health insurance

Successes and failures in the Dutch system

Our company

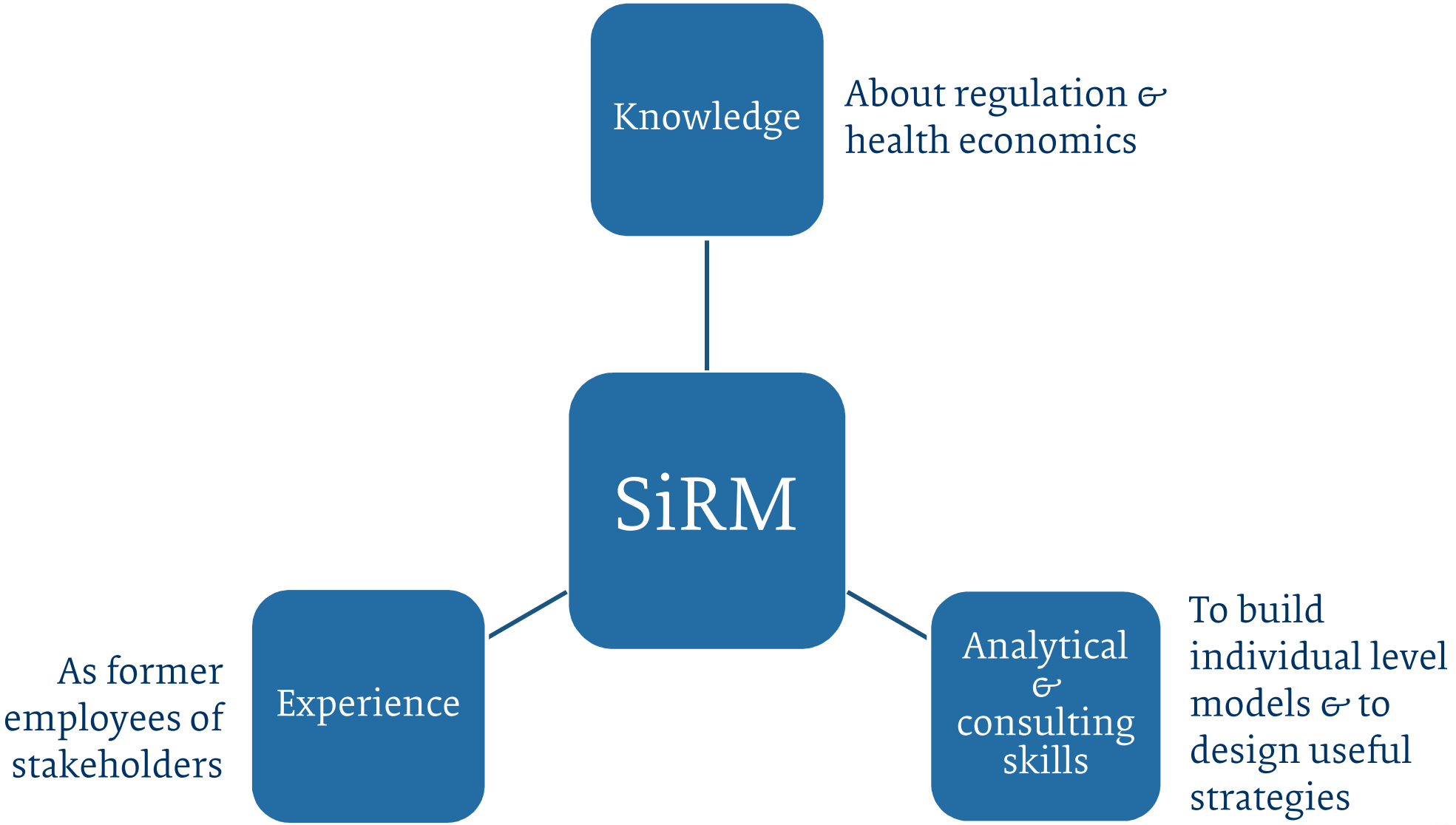
We provide strategic advice to stakeholders in markets where the government (still) has a regulatory role.

Our current priorities:

- Healthcare
- Network industries

Our advice is always based on a combination of a strong *analytical* approach and thorough *knowledge* of and *experience* with the complex dynamics of the market in which our clients operate.

Our competences



My bio

Dr. Piet Stam

(partner SiRM)

- SiRM – Strategies in Regulated Markets (founded 2008)
- VU University
- Econometrician & health economist
- PhD thesis on risk adjustment
- Insurer Agis Zorgverzekeringen (1996-2008)
- Dutch MoH Commission (1998-2008, monthly meetings)
- Risk Adjustment Network (RAN)

Contents

1. Cost development in the Netherlands
2. Health Insurance Act (Zvw)
3. Health Care Market Regulation Act (WMG)
4. What next?
5. Lessons

Societal goals in Dutch health care

Dutch government strives for

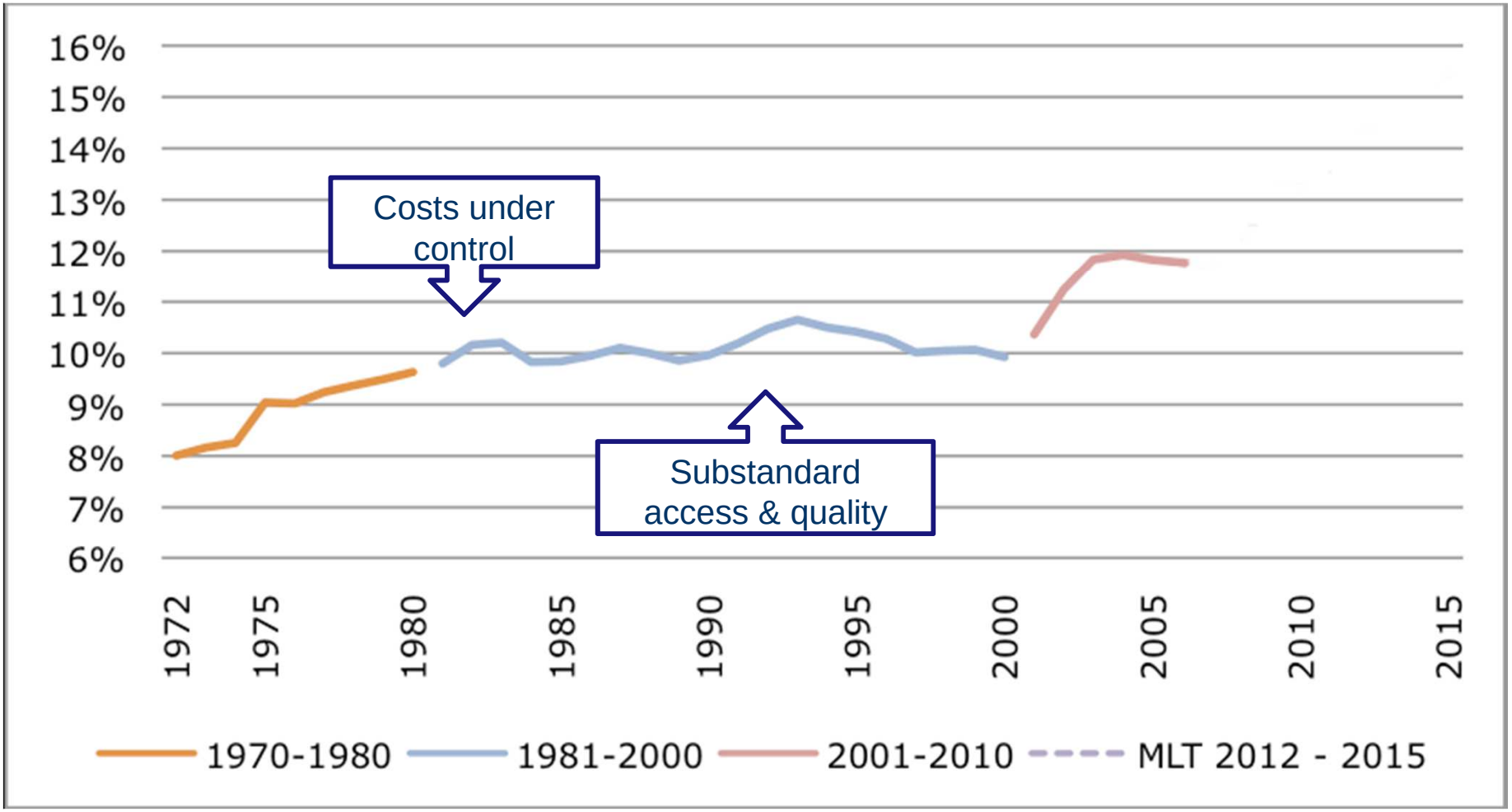
- Universal access
- Good quality of care
- Affordability

How to achieve these goals?

- Supply-side regulation (until 2006)
- Regulated competition (since 2006)

Supply-side regulation had its ups-and-downs

Total health care expenses [% of Dutch GNP, incl. LTC]



Source: Figure 1.2 in Taskforce "Naar beter betaalbare zorg", 2012

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Intended cost increase since 2001

"That's our new mission statement."

Why a change to regulated competition?

- Detailed government regulation did not avoid underperformance of the system
  - Trade-off access, quality and costs
- A profound wish to increase the (financial) incentives for each and every stakeholder in the health care system and hold them accountable for their actions
- Government regulation to prevent undesired effects of unregulated markets

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- Introduction of Health Insurance Act (HIA) in 2006

Contents

1. Cost development in the Netherlands
2. Health Insurance Act (HIA)
3. Health Care Market Act (WMG)
4. What next?
5. Lessons

Dutch Health Insurance Act 2006

- Broad coverage (incl. primary care, inpatient & outpatient hospital care, prescribed drugs)
- Mandatory private health insurance for every Dutch inhabitant
- Income subsidies for low- and middle income people
- Yearly free choice of insurer and community rating
- Risk equalization
- Standardized benefits package (functions of care, i.e. insurer chooses where & by whom)

Meet consumer preferences with respect to efficiency (i.e. cost and quality) of care

A market where efficiency of providers is transparant, such that consumer preferences can be met

Top pick?

- Top quality, ignoring price

Best buy?

- Good quality for a reasonable price

Economical choice?

- Lower quality, but price is low

What is the ultimate market outcome?

Ultimately, there are insurers who publicize ads with the following message:

"Are you in need of health care? Come to us, you are best off with our insurance policy"

However, solidarity does not exist in private markets…

Equivalence principle

- Predictable profits per contract are minimized in free competitive markets by risk rating
  - Risk selection is not an option because of yearly open enrollment

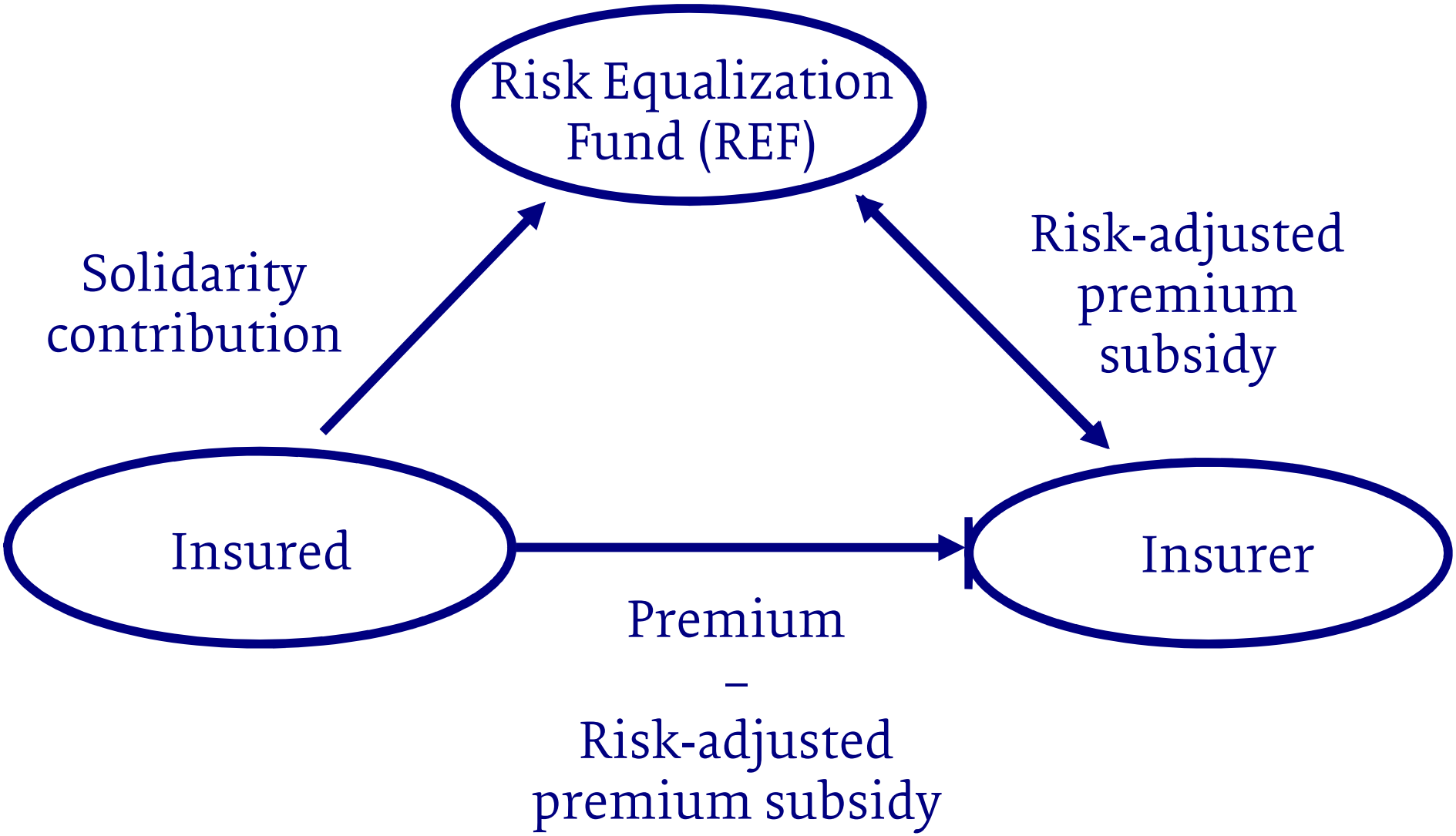
- In practice, there are a lot of rating factors
  - age, gender, family size, geographic area, occupation, length of contract period, individual/group contract, deductible level, health status at enrolment, lifestyle, prior costs,…

Affordable insurance premiums

- *Question* : How do we organize solidarity on a market of competing insurers?

- *Answer*: subsidies

Risk equalization



Solidarity for which rating factors?

Explicit Dutch policy goal:

….” The risk equalization equation should only include parameters which equalize cost differences in **health status** of an insured as a consequence of differences in **age**, **gender** and other objective **measures of health status**.”….

(*Dutch Health Insurance Act 2006, Health Insurance Decision, 389, p. 23*)

Subsidies for which premium risk factors?

Subsidies desired for:

"S(ubsidy)-type risk factors"

- Age
- Gender
- Health status

Subsidies not desired for:

"N(on subsidy)-type risk factors"

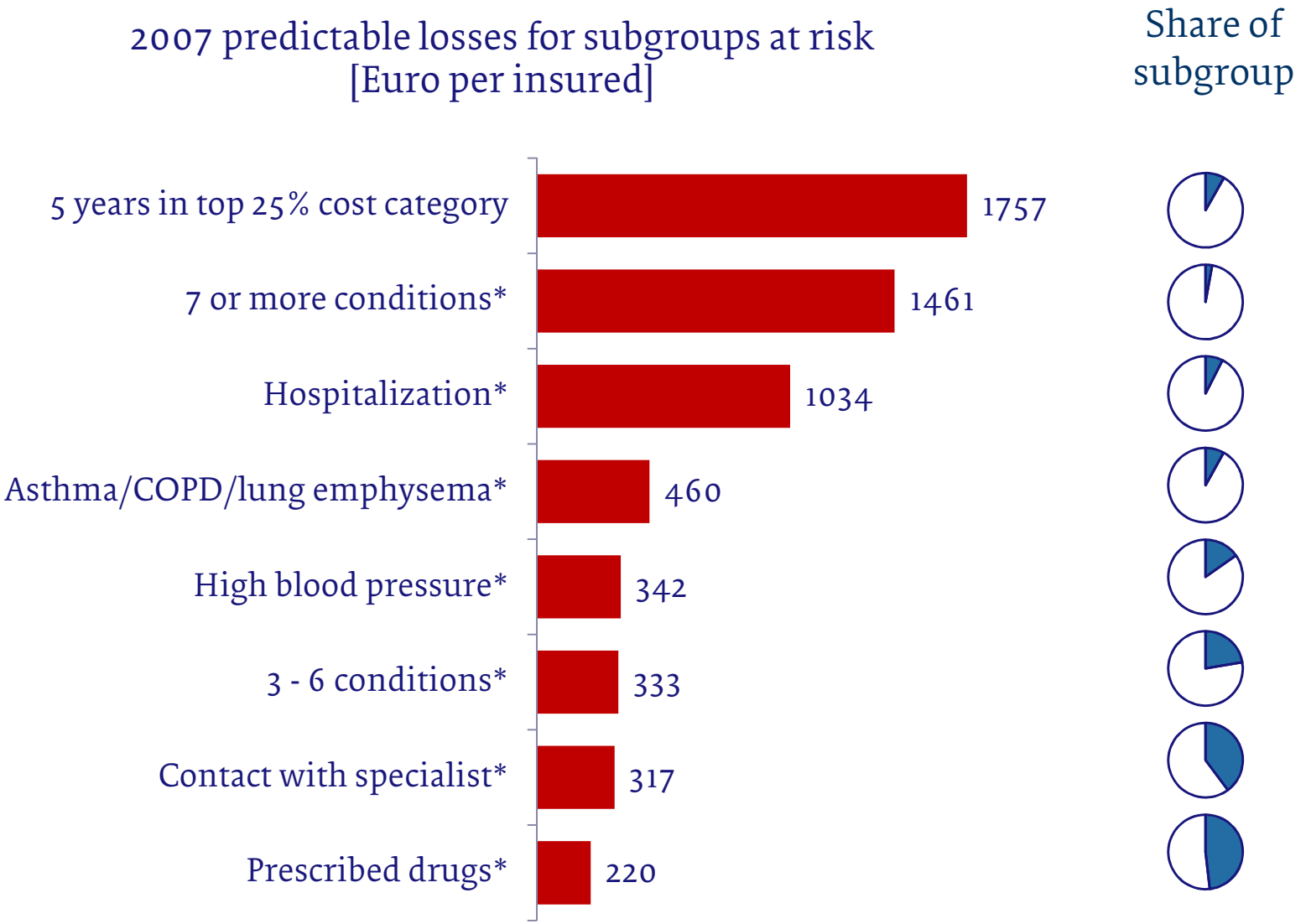
- Overcapacity
- Input prices
- Propensity for medical consumption
- Lifestyle (smoking, drinking, exercising)
- Region
- Practice style
- …
- Random chance!

Insurers have full incentives for cost containment, because subsidies do not reduce these

- The premium subsidy is
  - equal for every insurer
  - an ex-ante estimate of health care costs

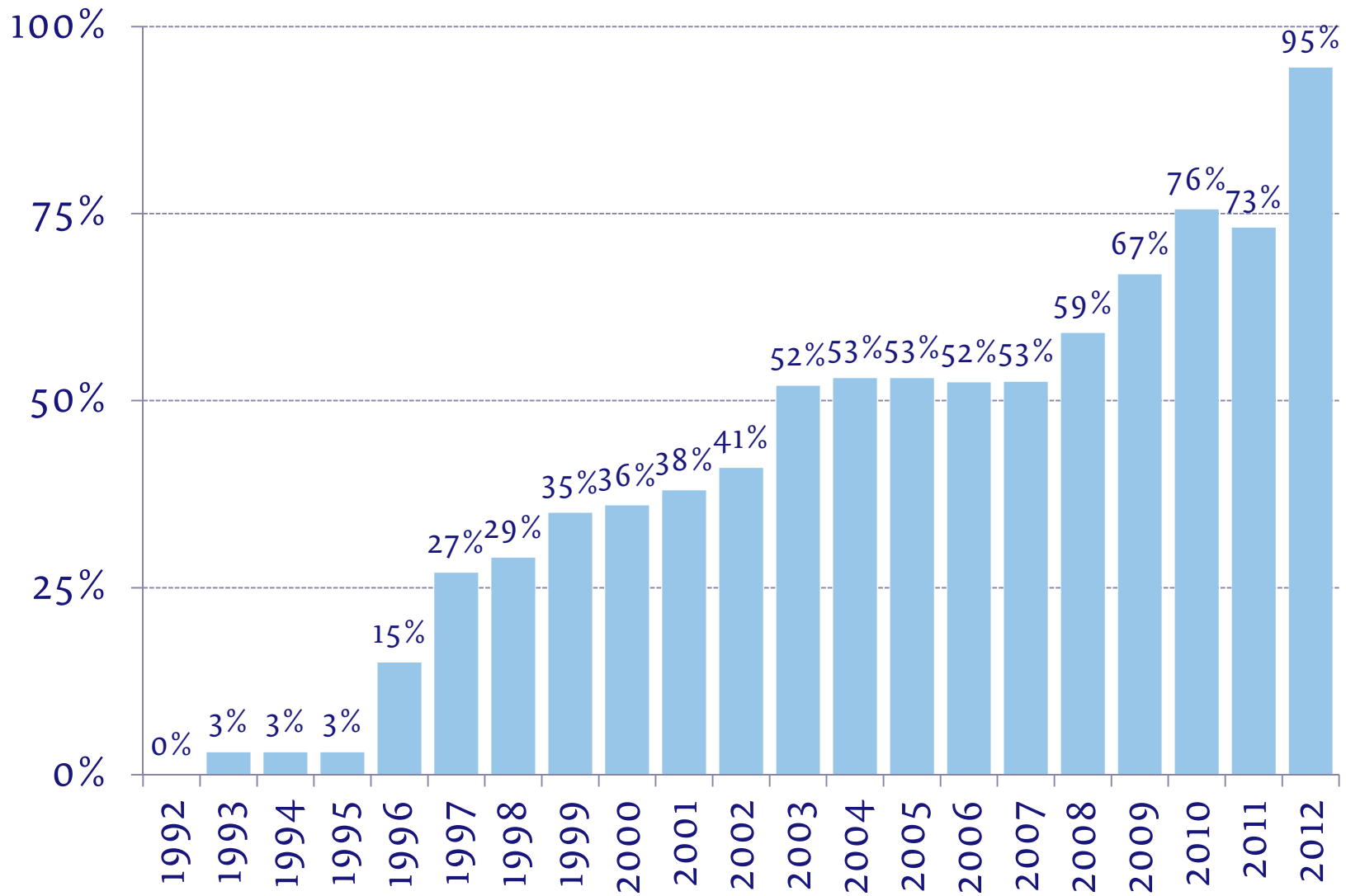
- However, health status is hard to measure
  - Age/sex
  - PCGs and DCGs
  - SES and source of income
  - Region
  - Multi-year high costs (MHC)

However, there are subgroups of patients, for which the subsidy is still not adequate



* Self-reported, based on a health survey (N= 18,617)

Ex-post compensations do reduce the incentives for efficiency, therefore reduction as model gets better



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A second reason for the gradual way of phasing-out ex-post compensations

- Health insurers are held more responsible for cost variation as product markets develop

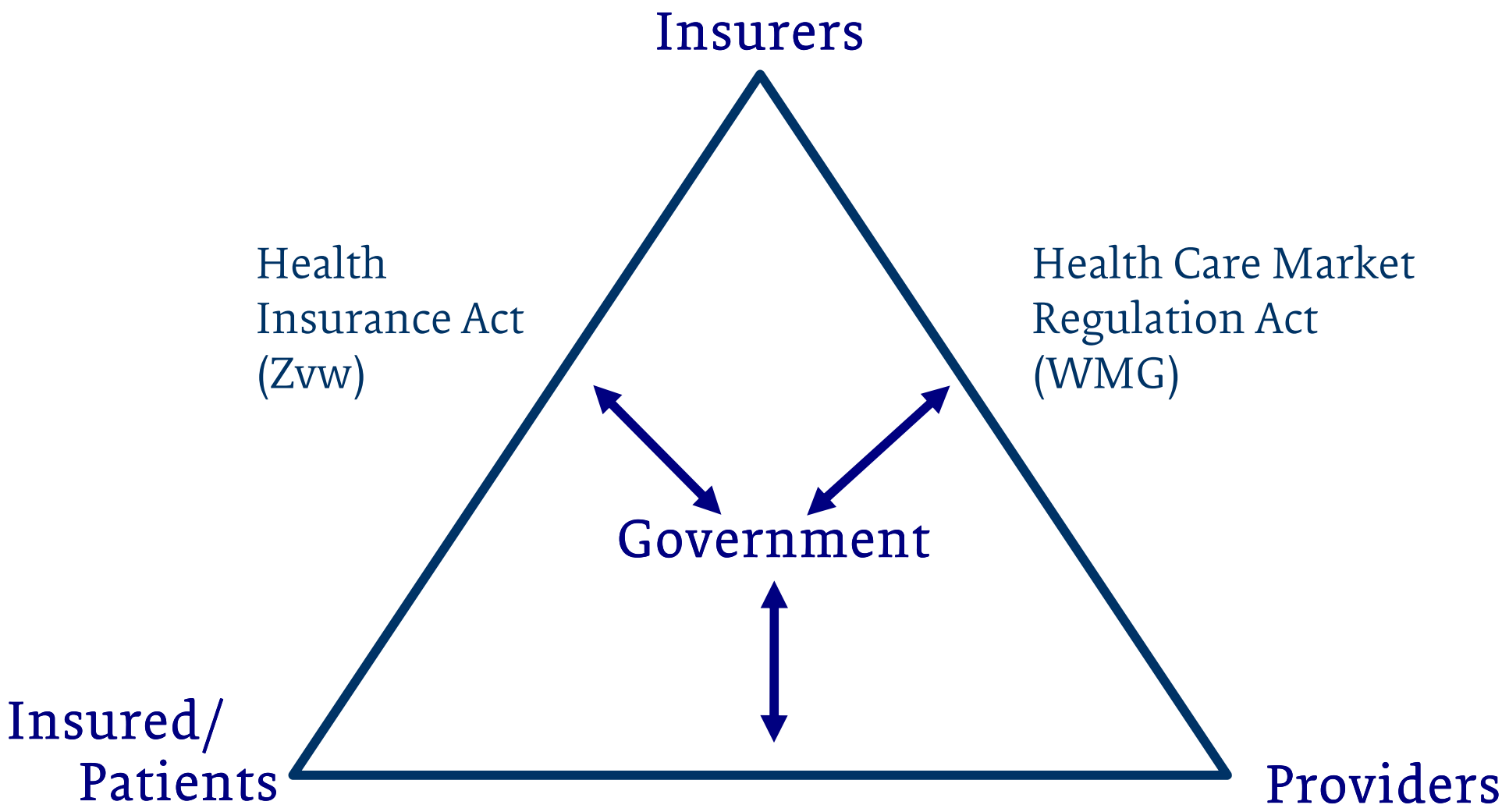
- Necessary conditions for markets to exist
  - Choice among providers
  - Transparancy of prices and quality of services
  - Prices must be freely negotiable

Health Care Market Regulation Act (WMG)

Contents

1. Cost development in the Netherlands
2. Health Insurance Act (Zvw)
3. Health Care Market Regulation Act (WMG)
4. What next?
5. Lessons

Insurers operate on 2 markets, regulated by government



The need to contain costs via the WMG

- The macro health care budget (BKZ) sets a national limit to health care expenditures, also in deregulated markets
- An incentive to increase volume exists, as long as paying providers is based on (bundles of) services instead of health outcomes
- Insurers meet ex-post preferences of consumers, which may differ from their ex-ante preferences
  - Insurance creates moral hazerd
  - Providers create supplier induced demand

WMG INSTRUMENTS

- Definition of the products (= bundle of services)
- Price regulation
- Monitoring how markets develop
- Fine stakeholders who do not act according to regulation

The application of WMG instruments in practice

Case studies

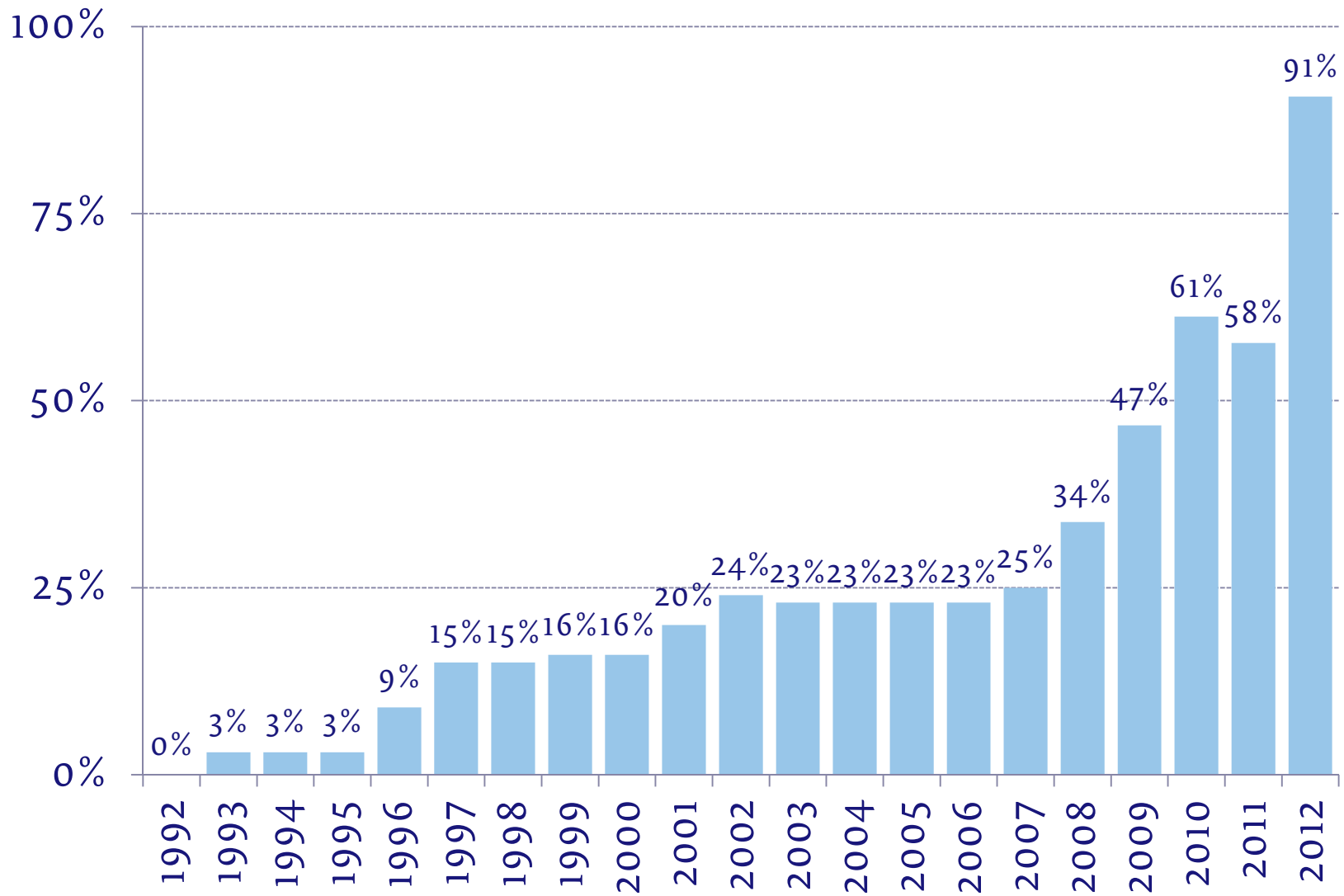
- Hospital care
- Pharmaceutical care
- Dental care

Case study: hospital care

- Until 2005, not all payment parameters were production-based
  - Capacity, production, and capital parameters
- Since 2005, the product definition gradually changes to production-based parameters alone ("B-segment")
- Therefore, gradually, prices can be freely negotiated
  - 2006: 10%
  - 2008: 20%
  - 2009: 34%
  - 2012: 70%

- Direct implication of WMG regulation on Zvw regulation
  - Each time prices are deregulated, ex-post compensations are further reduced

Size of ex-post compensations differs among health care sectors: the sector of hospital care



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Case study: hospitals

- In the period 2005-2008 price increases are smaller for the B-segment DTCs than for the other DTCs
- However, volume increases but hard to measure
  - Change product structure
  - Increase of B-segment
- For example, cost increase medical specialists (2001-2009)
  - Self-employed: 8.3% on average (2010: -/- 20% drawback)
  - Employee of hospital: 3.2%

Case study: hospitals

- Reason for cost increase: product definition causes incentives for volume
- In 2011 another national convenant about maximum expenditure growth was concluded among government, hospitals, medical specialists and insurers
- There is a severe need for a payment system that is based on health outcomes for insurers to take up their role

Case study: outpatient pharmaceutical care

Manufacturers and pharmacists

- "Voluntary"" convenant with government and insurers (2004-2009):
  - in 2004 the discount was 40% of prices of generics
  - In 2008 the discount was another 10%

Government

- Pharmaceuticals Prices Act (WGP, 1996): sets maximum (reference) prices for manufacturers
- Clawback (1998): pharmacists were obliged to share their purchasing discount

Insurers

- Selective reimbursement of multi-source generics (since 2008)
- Very successful !

Since 2006, financial risk was already above 90%

- Prices in 2012 are half of those in 1996

- Service and drug prices are freely negotiable since 2012

Case study: dental care

- Before 2012, big changes of product definition
- Experiment "free pricing" 2012-2014
- However, in Q1 2012
  - steep price increases: 6,1% excl. inflation (9,6% incl. inflation)
  - smaller number of concluded contracts than in previous years
- Potential reasons:
  - Only 2-6% switched to another dentist
  - Consumers could (almost) not visit dentists for partial treatments
- Dutch parliament enforced abolishment of the experiment

Contents

1. Cost development in the Netherlands
2. Health Insurance Act (HIA)
3. Health Care Market Act (WMG)
4. What next?
5. Lessons

So, were insurers successful since 2006?

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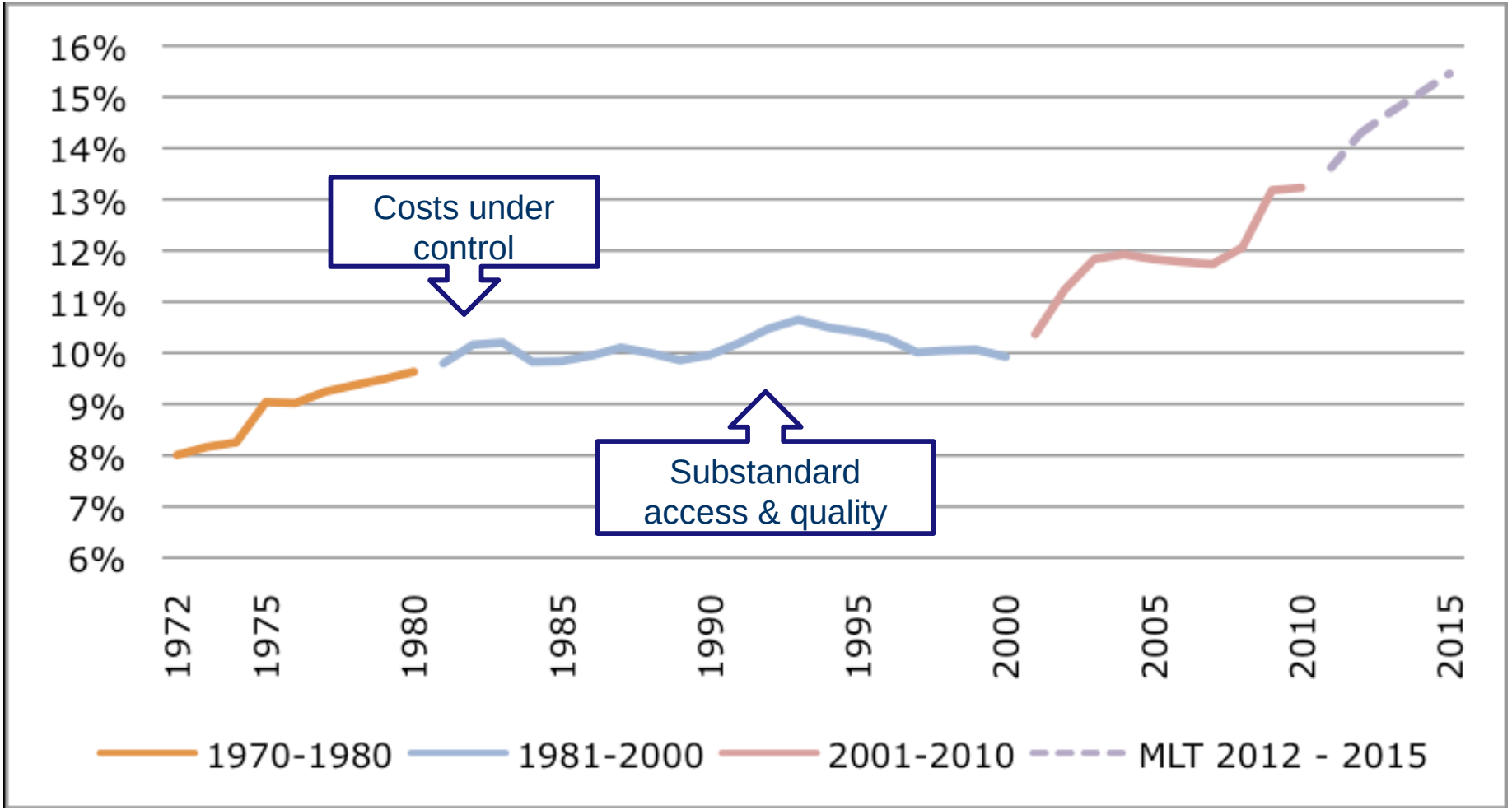

Source: Figure 1.2 in Taskforce "Naar beter betaalbare zorg", 2012

Recent report Taskforce: "no need for a system change"

Non-system specific causes:

- Increased productivity of individual providers did not lead to reduced growth of health care expenses
- Stretching the concept of 'care' (more ICD & DSM codes)
- The type of care changes: increasingly focused on less severe cases

Over the last decade, health care has become more expensive

MORE AND MORE MEDICAL INDICATIONS, ESPECIALLY FOR LESS SEVERE CASES

Reason: there does not exist enough countervailing power from

- hospitals and other institutions, nor individual professionals (maximum incentives for volume, scarce transparancy of own practice and costs)
- clients (scarce cost awareness, trusting the provider)
- insurers/purchasers (individual legal right for care, reputation)

An integral strategy to cost containment

- More out-of-pocket payments
- Restriction of the benefits package
- 'Care' must be delivered in the right place (outpatient care, self-management, reduction of capacity)
- Improvement of the financing system:
  - Removing remaining ex-post compensations
  - Removing the incentive to increase volume from the provider payment systems
  - Productivity increases are taken into account in the WMG instruments
  - Purchasers get maximum freedom to contract care

Contents

1. Cost development in the Netherlands
2. Health Insurance Act (HIA)
3. Health Care Market Act (WMG)
4. What next?
5. Lessons

A lesson: health insurance market

- Define societal goals explicitly
  - Choice of S-type and N-type risk factors
- Gradually reduce ex-post compensations as
  - The subsidies from the risk equalization model get better
  - Preconditions for markets to develop are met
- Process of model development
  - Joint work of government, health economist and experts from health insurers
  - Periodic meetings (for example, each month)
  - Organization of medical expertise (PCGs, DCGs)

In order to for the regulation and the market to work properly, look closely at the characteristics of a market:

- B-segment DTC's: a market can properly be created for regular elective hospital care, because there is enough supply and thus many choices for the patient

- Dental care: there is a specific relationship between dentist and patient for this annually recurring type of care, therefore patients do not choose other providers and a price incentive for the dentist is absent

A lesson: the direct link between both markets

- Increase risk of insurers if the preconditions of a market are fulfilled
- However, if these conditions are not fully met, a good stimulus on one side of the system may lead to a poor stimulus on the other side of the system
  - Increasing financial risk borne by insurers may lead to less solidarity
- To prevent such a situation, monitor quality, accessibility and affordability of the developing markets on a continuous basis

Another topic…

- Quality information is only sparsely established, therefore
  - much emphasis on costs of care and
  - little emphasis on the benefits of care

- Insurers should differentiate according to quality, otherwise a race to the bottom may occur due to lack of adequate quality information

- The Health Care Inspectorate (IGZ) should properly supervise minimum quality

Major lesson: No system change

- There is no health care system that performs systematically better in delivering cost-effective health care
  - In fact, the efficiency estimates vary more within country groups sharing similar institutional characteristics than between groups.
  - Both market-based and more centralised command-and-control systems show strengths and weaknesses.

- It may thus be less the type of system that matters, but rather how it is managed
  - Adopt best policy practices implemented by countries in its own group, while borrowing the most appropriate elements from other groups.

Source: OECD 2010, "Health care systems: Getting more value for money", OECD Economics Department Policy Notes, No. 2

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