Waiting for stronger integrated networks of care

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Current Process Stages

Idea	Pilot	Policy Paper	**Legislation**	Implementation	Evaluation	Change

1. Abstract

In order to promote the diffusion of insurance contracts with managed care characteristics among Swiss citizens the Federal Council suggests that Parliament defines networks of integrated care (with budgetary responsibility) as part of the federal law on social health insurance. At this stage Parliament is still searching for an appropriate solution.

2. Recent developments

A slowly progressing reform

Meanwhile the debate on the Federal Council's proposal still goes on in Parliament. The decision - expected for January 2006 - has been postponed for several reasons. One reason is that the political goal can be questioned. Politicians are in favor of cost containing strategies, such as HMO plans, where providers are not reimbursed by fee for service but per capita. In other words, these plans operate with fixed budgets and change the provider's incentives. While in the fee-for-service context providers earn more income by providing as many services as possible, the incentive under budgeted models is reversed. Here, whenever the providers are able to reduce the level of services below the budgeted amount, they are additionally rewarded by a profit (= budget minus level of services). If the network overruns the budget, its providers are obliged to finance the deficit out of their own pocket.

But as long as plan choice is free, the incentives of the insured matter as well. While premium rebates of between 10% and 25% give incentives to choose an HMO or PPO plan, the insured have to accept the additional gatekeeper restriction. They have to give up free access to all providers (within the same canton). While in the German part of Switzerland several people rate the benefit of lowered premiums higher than the loss of free choice, it is often the contrary for the Italian and French speaking parts of the country (see the convincing empirical evidence given by Telser et al. 2008). This corresponds to the fact that most networks are located in the German part of Switzerland (and within this part several especially in the big towns, where premiums are rather high and premium allowances also - Switzerland does not know community rating with respect to regions). The French speaking part knows only one big model in Geneva - where premium level is the highest in Switzerland - and not until recently another one in Lausanne. In the Italian speaking parts the networks have been opened and closed again.

Two obstacles to the diffusion of managed care plans

Now since the choice of a gatekeeper plan is a free choice, the assumption that too few models will be offered as long as there are no evident obstacles is questionable. In fact, two legal obstacles can be identified: mandatory contracting with every physician and the current risk adjustment formula.

One obstacle is evidently the obligation for the insurer to contract with every physician. Since access to the market is guaranteed by law for each and every physician, the willingness to accept additional risks such as an HMO budget is generally very low. Therefore, the number of networks offered to the insurer to choose from is lower than it would be in a free market. Only since fee-for-service fees for primary care physicians have become rather low, are more and more primary care physicians interested in capitation contracts looking for additional income in the form of increased efficiency improvements.

The other obstacle is a simple mathematical error in the risk adjustment scheme. Although it is out of the question that the risk adjustment scheme itself is necessary to establish solidarity in a market with more or less community rated premiums, the currently applied formula drives managed care plan premiums up and premiums in the traditional plans down. It is even possible to have specific constellations, where premiums of managed care plans turn out to be higher than the premiums of traditional plans despite significant cost containment in the managed care plans (for a discussion see van Kleef et al. 2008). This is far from being politically desired, and it doesn't need any legal changes to rectify the situation. Some simple mathematical improvements of the risk equalization scheme would be sufficient. But although the Federal Council has the competence to do so, it was only looking for measures to promote gatekeeper plans, and it never took the described shortcoming into account for reasons unknown to the author.

Do managed care contracts really need explicit promotion?

But even the assumption that managed care contracts need to be promoted can be questioned looking at the latest figures. According to santésuisse statistics for 2003, there were less than 10% of the Swiss population in managed care plans (6.6% in PPO plans and only 1.5% in capitated plans) and also growth rates in the plans with capitation budgets were negative for two consecutive years. But this picture has altered significantly meanwhile. For example, one large insurer that promoted capitation budgeting was able to increase the number of enrollees in the specific plans from 2003 till now by a factor of 5.3. In 2007 17% of the Swiss population opted for a PPO-plan while 2.5% of the insured have chosen a managed care plan with capitation (figures from December 2007). These are the figures policy makers refer to. But it is important to note that these figures are very likely to underreport the current situation. Santésuisse statistics divide the population into people choosing any form of managed care plans (19.5%) and others choosing high deductibles (35.1%) or traditional insurance (45.4%). Since people can simultaneously choose high deductibles and managed care plans - and more and more people do so - the reported figures are biased by this intersection. If we refer to the second largest fund and an adequate definition of the categories, we find higher figures: 18% (22.7%) in PPO-plans and 5.8% (6.9%) in capitation contracts [figures in brackets for March 2008]. Given this latest evidence the need to promote managed care plans must be questioned. It would be more than sufficient to eliminate the existing obstacles in legislation and in the risk adjustment scheme.

As a matter of fact, the political discussion completely neglects the specific problem with the risk adjustment scheme while the impact of mandatory contracting with every physician has remained very controversial. It is doubtful if members of Parliament are aware of the significant changes in the market shown (partially) by santésuisse statistics.

During the discussion some additional changes and new ideas have been brought up. The changes are the following:

- While the Federal Council wanted to promote only fully vertically integrated networks, where all types of services covered by basic health insurance have to be provided by the network, Parliament's current version is more liberal, including only a compulsory coordination of the patient on his way through the health care system by a member of the network. So the network could also be a net of primary care gatekeepers (the most common form applied today in Switzerland).

- On the other hand, Parliament is more restrictive with respect to preferred provider models (seen as a kind of "soft-type" managed care networks). We have seen that this form of managed care plans represents 87% of all managed care plans with 1.2 million enrollees. In these plans the insurer defines a list of preferred providers. There is no special contract between provider and insurer. For the plan to work it is sufficient that the insured defines a specific provider on the insurer's list as his personal gatekeeper. Services are only covered by that plan, as long as they are provided by the personal gatekeeper himself or a referral is given by the gatekeeper. Without referral the costs will not be reimbursed and will have to be paid out of pocket by the insured.
  Although Lehmann (2003) reports a 21% true cost reduction for a Swiss preferred provider network (that is about half the cost containment in capitated plans as reported by the same author, where the providers have an explicit budget responsibility), these plans are considered by most politicians to produce risk selection effects only. As a matter of fact, PPO plans are less effective than plans with budget responsibility. But there is

definitely more research needed to evaluate the economic effectiveness of the different Swiss managed care plan types.

- Other ideas brought up in the last few years are the promotion of lower compulsory copayments for insured in the managed care plans and forcing the insured to accept longer minimal contract periods (today all managed care plans can be left within one year).

Pursuing a strategy of combined reforms

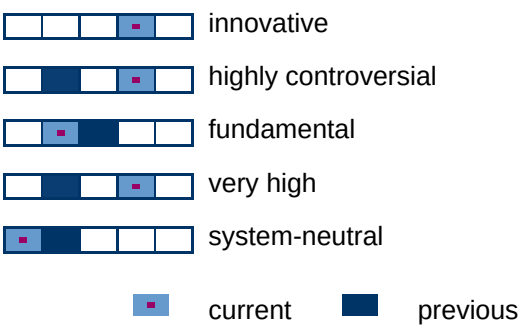
Since the promotion of managed care is politically linked with the banning of the obligation of the insurer to contract with every physician, the issue is used to create compromises with respect to this question. The latest idea is to restrict mandatory contracting to those physicians only who are organized in a network and willing to accept financial responsibility.

But what happens when there are more HMOs offered than enrollees willing to choose these plans? Since the building of networks becomes vital for all physicians, - without a network they might lose the right to work within the basic insurance scheme - it is very unlikely that networks with truly preferred providers will survive. Some networks are more efficient because they have selected the efficient subset of providers in the given region. As soon as all providers (the efficient and the inefficient) are united in a given network, efficiency gains will either disappear or be substantially reduced.

Another problem is the definition of financial responsibility. It is not possible to define it by law, therefore there's a risk of never-ending litigation. Even from the actuarial point of view it is not simple to tackle this question. It is the insurer's job to reduce the average variation of costs. This is done by enrolling as many people as possible (according to the law of large numbers). No Swiss managed care plan will ever cover a comparable large amount of members. The risk within each managed care plan will therefore be higher (because the variance reduction is weaker because of the smaller number of enrollees). Therefore, it makes no sense to transfer 100% of the risk to the managed care plan. A risk reduction is necessary. And this opens the door for endless negotiations about the amount of risk to be transferred. Since insurers have to accept the network (by law) and the network must have a contract with the insurer to gain the privilege to provide for the social insurance scheme, the preconditions that satisfactory solutions can be found are not promising.

3. Characteristics of this policy

Degree of Innovation	traditional	innovative
Degree of Controversy	consensual	highly controversial
Structural or Systemic Impact	marginal	fundamental
Public Visibility	very low	very high
Transferability	strongly system-dependent	system-neutral



4. Purpose and process analysis

Idea | Pilot | Policy Paper | **Legislation** | Implementation | Evaluation | Change

Initiators of idea/main actors

- Government
- Parliament: It is difficult to qualify the members of Parliament, since this specific issue is supported by a small subset of all the members of the commission who might not reflect the position of their party in every question.
- Providers: Those mc pioneers, who created the first HMO with budget responsibility, are lobbying very effectively for legal changes that suit their models well. The remaining network physicians are often more reluctant regarding the proposed reform.
- Payers
- Media: Nowadays managed care has a good reputation in the media compared to the early nineties.

Stakeholder positions

Among the stakeholders the most important group are the pioneer physicians. They have invested many resources and much commitment in their networks and managed care organizations. Therefore, they have a vital interest to get managed care promoted. Since markets in Switzerland are small and the overheads of a managed care organization are substantial, efficient managed care needs large numbers of enrollees. Even when the direct comparison of service levels of managed care plans and traditional plans is in favor of managed care, the question remains open if the managed care plan is able to cover its higher overhead costs.

All other stakeholders have a less vital interest in managed care. For sickness funds risk selection is still the most profitable strategy to gain market shares. The revision of the risk adjustment formula will be effective not before 1st January 2012. This reform will reduce the incentive for risk selection and improve the incentive for managed care. But since the implementation of this reform will be delayed for another 3 years, its influence will grow slowly.

An important aspect of the discussion is the possible banning of mandatory contracting with every physician. It might be assumed that traditional physicians support this managed care issue in order to let mandatory contracting survive at least within the network (at least this could explain the 180° change of their head organization, Foederatio Medicorum Helveticorum, which supports the idea of network today whereas the FMH strongly opposed managed care in the beginning).

Actors and positions

Description of actors and their positions

Government			
Ministry of Health (Federal Council)	very supportive		strongly opposed
Staff of the Ministry	very supportive		strongly opposed
Parliament			
Council of States Commission	very supportive		strongly opposed
National Council Commission	very supportive		strongly opposed
Left wing parties	very supportive		strongly opposed
Right wing parties	very supportive		strongly opposed
Providers			
Pioneers in Managed Care	very supportive		strongly opposed
Followers in Managed Care	very supportive		strongly opposed

Traditional physicians	very supportive	strongly opposed
Payers		
Sickness Funds	very supportive	strongly opposed
Media		
Newspapers, etc	very supportive	strongly opposed

Actors and influence

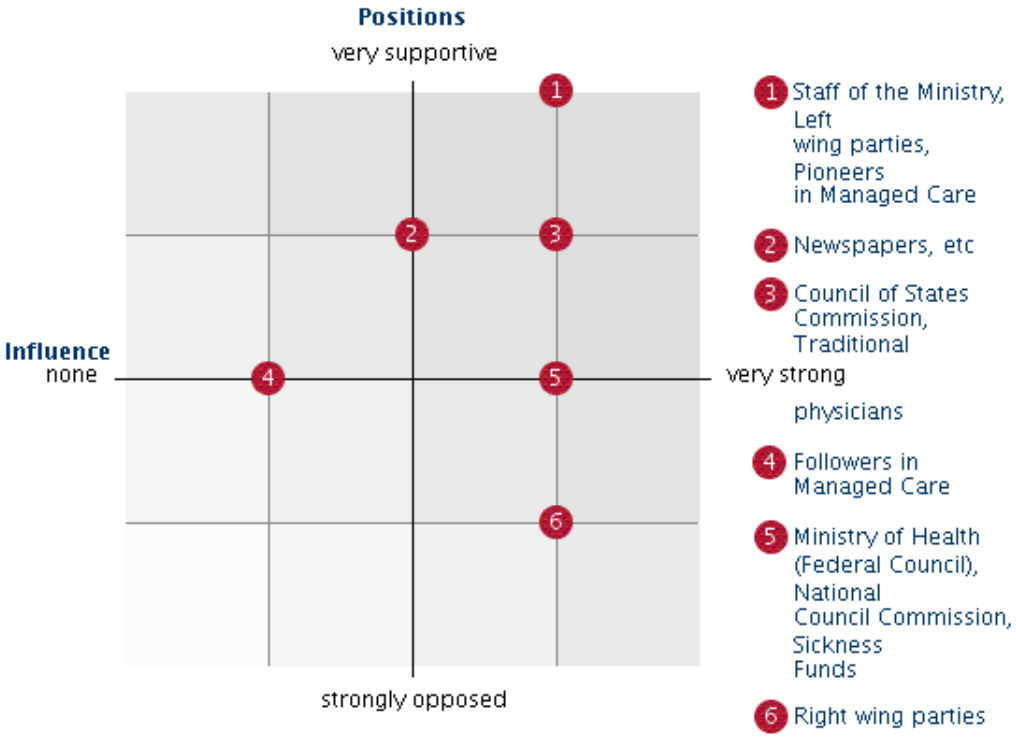
Description of actors and their influence

Government		
Ministry of Health (Federal Council)	very strong	none
Staff of the Ministry	very strong	none
Parliament		
Council of States Commission	very strong	none
National Council Commission	very strong	none
Left wing parties	very strong	none
Right wing parties	very strong	none
Providers		
Pioneers in Managed Care	very strong	none
Followers in Managed Care	very strong	none
Traditional physicians	very strong	none
Payers		
Sickness Funds	very strong	none
Media		
Newspapers, etc	very strong	none

Positions and Influences at a glance

Monitoring and evaluation

The fact that there have been too few monitoring and empirical analyses of the impact networks have on efficiency and quality cannot be over emphasized. Efficiency gains reported by Lehmann (2003) lie between 37% and 10%. But this study - the only one at this scientific level for the time being - restricts itself to people choosing the lowest level of deductible, which might bias the result, and neglects administration costs, which might outweigh efficiency gains. On the other hand, Beck and Käser's study (2008) meets both requirements but it does not control effectively enough for risk selection effects. Nevertheless they show at least persisting cost reducing effects (partially due to selection, partially to improved efficiency) over time in the range of 20% to 30%, comparing cost effects in panel data over several years. But the evident conclusion remains that more research has to be done.



5. Expected outcome

While this policy issue has not been implemented nor finally passed yet, managed care itself as an additional option in Swiss Social Health Insurance was implemented in 1990. In the past 18 years, managed care networks underwent several evolutionary stages where inefficient networks were closed again and the more efficient improved. Even provider payment has experienced at least three generations of models, and different sickness funds apply quite different models to calculate their capitation. At the beginning of this century, sickness funds started to collaborate with networks that proved to be efficient in the sense that they did not produce high losses for the insurer and became more and more attractive for the insured. This evolutionary process was a crucial condition for the current generation of models to evolve.

With the introduction of a definition of managed care by law, this process could stop. But we have no guarantee that the current model will remain the most efficient and effective for years. So this law could hamper further development toward more efficient provision of health care.

On the other hand, it is questionable if promotion of a certain type of health insurance plans makes sense in a market where people can choose and change their plans freely, with a self-selection of more or less risk rated premiums with respect to the plan chosen. If the outcome should be a law that neither solves the problem of forced cross-subsidization from the cost containing managed care plans to the (probably) less efficient traditional plans, nor the problem of a market with mandatory contracting (between physician and insurer), not much will be gained by this reform. In that case it would only counteract the effects of inappropriate regulation.

Although this policy is more in the focus of media interest than, for example, the reform of risk adjustment (passed on 21st December 2007), the impact of the latter on efficiency and solidarity is far more important while the impact of this policy remains ambiguous.

Quality of Health Care Services marginal fundamental

Level of Equity	system less equitable		system more equitable
Cost Efficiency	very low		very high

current previous

The appropriate rating depends on the specific formulation of this policy. At the moment it is still very difficult to predict the specific proposition that will evolve from the political process.

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