

Health plan competition – comprehensive health care reform

Comments to Ven de van and Schut article

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Open enrollment, freedom to set premiums and specified health benefits – are three principals which are mentioned in ven de Van and Schut's article to preserve a competitive health insurance market. However, these elements, which create incentives for efficiency, cause problems of affordability (access).

How to make health insurance premiums affordable for high risks population – is the main issue in the article. The authors' conclusion is that a premium subsidy is the best way to solve the access problem and that the preferred form of subsidy are risk – adjusted premium subsidies.

Should people with medical or high risk problems pay more?

Those who support the ideology that health care is a right and not just a privilege will argue that a high risk population should not pay any part of the premium according to their own risk.

I agree with the authors that a risk – adjusted premium should be the way to subsidize insurers, however I believe that this should be the sole way to allocate public resources between competing health plans.(and not just a **subsidy** that will be added to the premium rate that are set by each health plan.)

There is no perfect risk – adjusted equalization. There are unpredictable cost variations that no formula can predict in advance, therefore if we want to prevent (a better word – to decrease) risk selection , part of the basic elements of the competitive market have to be changed the most crucial element being to allow

health plans to set their own premiums. There are many ways that health plans can practice risk selection but the easiest way is by setting the premium. Premium rate restriction, such as community rates or rate banding is not enough to prevent cream skimming.

Among the problems in the U.S. health care system today are efficiency and access. The dilemmas which the policy makers need to address is not how much efficiency they are willing to sacrifice for affordability, or the trade off between affordability and efficiency, rather the trade off between a competitive market (with this market failure in the health system) and the level of state intervention in the market (both to improve access and to fix the market failures).

Israel's experience with the national health insurance law (NHIL) provides an important real-world test case of for countries like the United States that are seeking to reform their health care systems.

The passing of the NHIL in 1995 was one of the most important social revolutions since the establishment of the state of Israel (1948). According to the law the entire population of Israel is insured, and there is an extensive benefit package that is backed by legislation. The incentives for screening insurees have declined, and the insurees have complete freedom of choice of health plans. All these greatly contributed to improving accessibility of health services, and to a clear enhancement of the system's efficiency without inflating public spending on health as a percentage of GDP, or inflating national expenditure on health.

The evolution of the Israeli health system after the law's passage illustrated an interesting dynamic between private sector competition and state involvement. Israel has experienced an interesting phenomenon where although the government has

provided universal access to a uniform basic basket of health services, it has encouraged competition between the different health plans (Sick Funds). A government mandated coverage plan along with legislated freedom of choice (without limitation) between health plans has created a healthy degree of competition among the Israeli Sick Funds that has led to an increase in the quality of patient services as a tool for attracting new members and retaining an existing base. It has also led to a level playing field where the phenomena of “cream skimming”, (a problem among health insurers in the United States) has decreased. These developments are particularly instructive for the United States where the fear of government intervention and health mandates has led to the belief that an active public sector will “strangle” private competition. The Israel case has shown the opposite effect.

Additionally, in cases where the basic basket of services is felt to be restrictive, supplementary insurance plans have been established that provide additional coverage. Again the private sector has adapted to the new model and market forces are working to fill any gaps (real or perceived).

Finally, and perhaps most importantly from the US perspective, the Israeli experience has shown that a government mandated universal health care system with central fair and efficient collection of revenues, and central resource allocation mechanism, does not necessarily lead to greater overall health spending.

In regard to its implications for the US where more than 1000 insurance companies are seeking contracts with millions of employers, perhaps one could suggest that the reduction of duplicative bureaucracies dedicated to the collection of fees, and monitoring the overall cost of the health plans through a nation wide standard of calculate resource allocation formulae (based on adjusted age, gender, region and

institutional status) - has the ability to reduce a large proportion of the enormous “overhead” that currently plagues the US health care market. The savings may be able to cover the costs of bringing all the uninsured into a national health insurance plan.¹

¹Plan in which every American will be required to register (not to purchase) in one of recognized health plans . Health plan has to insure everybody with no exclusion per existing condision.