

The Swiss Experience with Managed Care in a Managed Competition Setting

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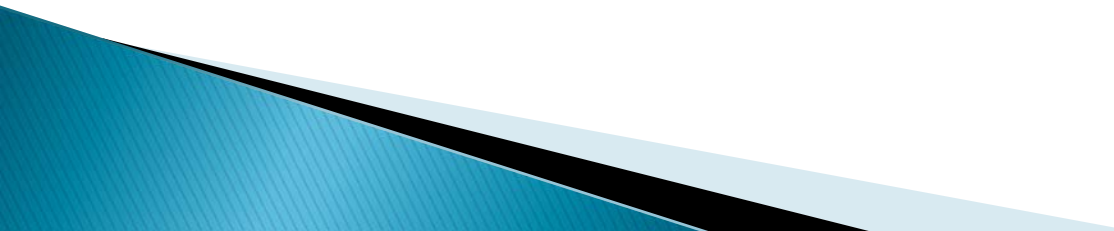
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New Directions in American Health Care Conference

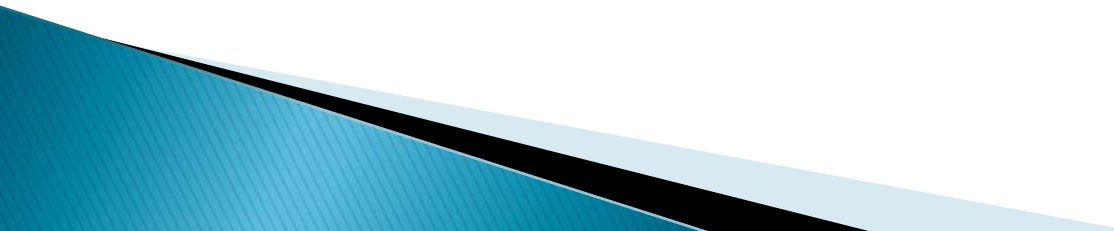
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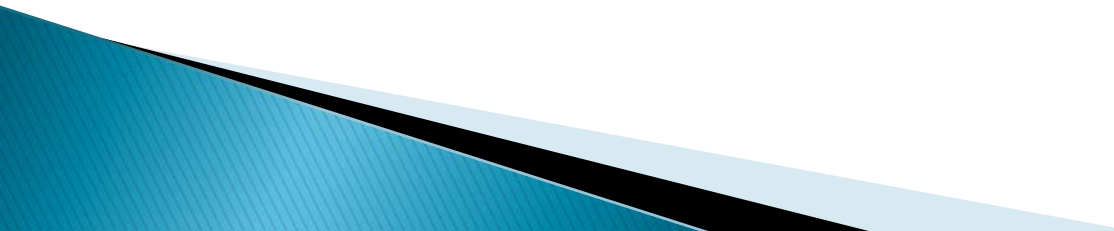
Swiss system performance

- ▶ Ties with Norway for second most expensive health care in the world, but still spends about 35 percent less than U.S. per capita.
 - ▶ Increase in health spending as percent of GDP is well above average, partly because GDP growth has been relatively low.
 - ▶ Very good health outcomes (life expectancy, infant mortality, etc.)
 - ▶ Low levels of health disparities compared with other wealthy democracies.
 - ▶ Out-of-pocket spending accounts for relatively high level of total health spending, and because of this, funding is among the more regressive.
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Managed Care

- ▶ Defining characteristic: selective contracting.
 - Health plans contract with a selected subset of health care providers.
 - Restrictions on individual's choice of provider via coverage limitations.
 - Plans use variety of payment and non-payment mechanisms to manage behavior of providers with whom they have contracts.
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Managed Competition

- ▶ Defining characteristics:
 - Individuals bear financial cost at the margin of choosing a more expensive health plan. Goal is to create price elastic demand.
 - Outside entity (government, employer, cooperative) manages market to alleviate inefficiencies and/or inequities due to information asymmetries, risk selection, and market power.
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Swiss Compulsory Basic Social Insurance (CBSI)

- ▶ System in effect since 1996.
 - Revised Health Insurance Law (LAMal) approved by referendum in 1994.
 - 2007 referendum rejected move to single payer system.
- ▶ Rather comprehensive benefit package defined by statute.
- ▶ Individual mandate to buy CBSI.
 - Employers not permitted to provide CBSI.
- ▶ Negotiated/regulated prices: providers, drugs, medical devices

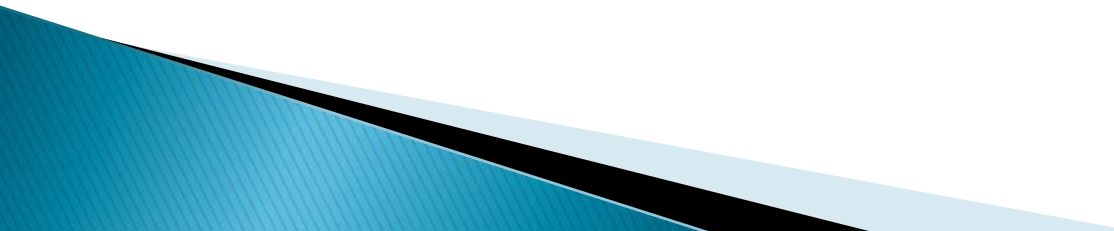
How the Market Works

- ▶ Private, registered plans compete for individual CBSI enrollees.
 - About 85 plans, down from 145 in 1996. Top 10 have 80% market share.
 - ▶ Insurers not permitted to earn profits on CBSI.
 - Insurers offering both CBSI and supplementary insurance products may be able to evade this to some extent through creative book-keeping.
 - ▶ Cantonal/federal subsidies for low income individuals.
 - Tied to cost of low-cost coverage. Subsidies limit premium costs to about 8% of income.
 - ▶ Community rating and guaranteed issue. Age/gender risk compensation among plans (prior-year hospitalization to be added in 2012).
 - ▶ Low risk individuals more mobile between plans than high risk. Substantial risk selection across plans.
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Choices: traditional model

- ▶ Limited menu of choices of deductible (lower premiums for higher deductible). “Bonus” plans, which lower premium if don’t have claims in prior year.
 - ▶ Required 10% co-insurance up to a defined out-of-pocket maximum expenditure.
 - ▶ Free choice of out-patient doctor, and of hospital, but NOT of in-patient doctor.
 - ▶ Otherwise, identical benefit packages.
 - ▶ Substantial range in premiums, largely related to biased selection of risks.
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Choices: alternative models

- ▶ HMOs
 - Not available everywhere
 - Where available, often only one or two provider organizations which may contract with many insurers
 - ▶ Family Doctor Models (assigned gatekeeper)
 - ▶ PPOs
 - not same as U.S. model with same name – coverage only for in-network
 - ▶ Telmed models
 - Only a couple of companies, one of which contracts with many insurers.
 - ▶ Substantial range in premiums
 - ▶ Limits on how steep a discount a company may offer on alternative plans relative to its traditional offerings
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Assurance / Assurance-maladie / Comparaison des primes maladie

Assurance-maladie Comparatif Potentiel d'économies Demande d'offre Confirmation/suivi

Trouvez la caisse-maladie la moins chère à l'aide de notre comparaison des primes d'assurance-maladie pour votre famille. Comparez et économisez maintenant!

Profitez gratuitement de notre comparaison des primes en ligne pour trouvez la solution la plus adaptée pour votre famille. Calculez votre prime simplement et choisissez votre nouvelle **caisse-maladie**.

Introduisez les données de base pour la comparaison.

Comparatif pour famille

Votre code postal :

1260

Rechercher le code postal

Modèle d'assurance à afficher :

[plus d'infos](#)



Traditionnel



Alternatifs (HMO, médecin de famille, Telmed, ...)



Traditionnel et alternatifs


Personne	Année de naissance	Franchise	Couverture accident	Assureur actuel
Personne 1	1958	1500	Avec	C. Vaudoise (GM)
Personne 2	1957	1500	Avec	C. Vaudoise (GM)
Personne 3	1994	500	Avec	C. Vaudoise (GM)
Personne 4	1996	500	Avec	C. Vaudoise (GM)

E-mail pour le rappel avant échéance :

Example: Family of four, Nyon

- ▶ Traditional, with CHF1500 deductibles
 - CHF 663.20 – CHF 1036.80 per month
- ▶ Alternative
 - CHF 508.40 for “Pharmed” model: doctors all in Geneva
 - CHF 624 for only HMO model with doctors available in Nyon
 - CHF 632.80 for cheapest Telmed plan
 - CHF 1002.60 for Family Doctor gatekeeper product with doctors available in Nyon

(Swiss franc worth about 92 cents)



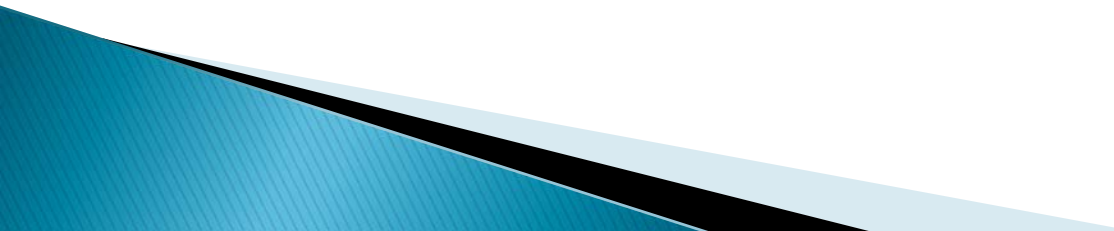
Supplementary insurance

- ▶ About a third of Swiss population buys supplementary insurance, has been trending downward.
- ▶ Supplementary insurance gives choice of doctor for in-patient care.
 - Semi-private room and treatment by senior physician
 - Private room and treatment by chief physician
- ▶ Risk-rating permitted

Low managed care market share

- ▶ About 12 percent of population has enrolled in managed care plans, and majority of those in “Family Doctor” and PPO models, rather than HMOs.
 - Chicken/egg issue: outside certain urban areas, HMO providers not geographically accessible.
- ▶ Zweifel and co-authors: respondents would require substantial discounts on premiums in return for accepting managed care restrictions on choice of provider.
 - Older respondents, wealthier respondents, and those with chronic conditions require greater compensation. Also Francophone Swiss.

Lessons from Swiss experience

- ▶ It is wrong to assume that managed competition among health plans necessarily leads to integrated provider networks/accountable care organizations. (e.g. Enthoven 2008 NYT op ed)
 - ▶ It is wrong to assume that health plan competition necessarily is the most effective way to slow the growth of health care costs.
 - ▶ In U.S., main role of managed care health plans has been to use market power to negotiate provider price discounts. Negotiated fee schedule makes this role less important.
 - ▶ Biased risk selection is a real issue in multi-payer systems of health coverage.
 - ▶ On the one hand, it is a bit of a cautionary lesson for advocates of single-payer approaches that the Swiss have such low health disparities. They set the bar for the minimum acceptable standard pretty high.
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Uncertainty and the value of keeping options open

- ▶ One explanation offered for consumer resistance to restrictions on provider choice has to do with uncertainty: individual doesn't know what future health problems may be, and so cannot evaluate ability of HMO network to meet his future needs.
 - ▶ Disease management program: integrated care network specializing in particular condition – in theory could deliver higher quality, better coordinated care (maybe even at lower cost)
 - ▶ But individuals with chronic conditions prove more resistant to restrictions on provider choice, even though they have less uncertainty about their future needs.
 - ▶ Theory is all very well, but perhaps hard experience has taught them that it is valuable to preserve the option to change providers on occasion.
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