



The Social Health Insurance Competition Strengthening Act in Germany Can there be Competition without Risk Selection?

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This article was published in the Health and Ageing Newsletter No. 22, April 2010

Introduction

The statutory public health insurance system in Germany is a compulsory social insurance system. Premiums are not risk-based but depend on an individual's annual labour income. Children and spouses without labour income are insured without surcharge. Premiums are shared equally between the insured and his or her employer. Public health insurers are required to set a uniform premium for all their policy-holders. The public system entails risk pooling. As Pauly (1984) pointed out, community rating provides insurers with incentives for "cream-skimming", i.e. to attract low risk types and to deter high risk types. The German public health insurance system is also characterised by open enrollment, that is, health insurers are required to accept any individual who applies. This is to ensure coverage for all risk types. Yet, open enrollment may not be sufficient to prevent insurers from cream-skimming.

In contrast to the social system, the private health insurance system in Germany is restricted to an upper income group as well as to self-employed people and civil servants. Employees are only allowed to purchase private health insurance if their annual labour income exceeds a certain threshold. If their income is below this social security ceiling, they must remain within the community-rated public health insurance system. In the private system, long-term insurance contracts are calculated using a funding principle. Policy-holders accumulate funding capital to compensate for higher expected health expenditures in the future. Therefore, as health expenditures increase with age, premiums necessarily exceed expected cost in early years and fall below expected cost in older years. German law requires, however, that private health insurers calculate their premiums in such a way that they are constant over the insured's life-time. The precautionary savings element used to equalize premiums over time is the "ageing reserve".

Since January 2009, the Social Health Insurance Competition Strengthening Act (SHICSA) obliges German private health insurers to offer a new sort of health insurance contract, the so called "Basistarif" or basic benefit package. Although it is called the *Social* Health Insurance Competition Strengthening Act, it has serious implications for *private* health insurers. Compared to the existing compulsory social and income-restricted private health insurance systems in Germany, the new basic benefit package incorporates features of both systems: medical services are similar in quality level compared to Germany's public health insurance system. Since the quality levels of medical services follow the public system's service levels, the basic benefit package somehow depends on politically determined service agreements. If service levels in the public system are reduced, the basic benefit package will cover less health care services, as well. In this way, the basic benefit package is similar to the public system. However, premiums in the public system are income-dependent and thus higher income is associated with higher premiums. Premiums for policy-holders insured in a basic benefit package plan, however, are not income-dependent but—similar to the private system—depend on services covered by the underlying insurance contract as well as on age and sex of the policy-holder.

Characteristics of the basic benefit package

Insurance contracts within the basic benefit package are not allowed to exhibit individual premiums which reflect underlying risk types. Therefore, the SHICSA implies risk pooling to a certain extent. The only risk characteristics insurers can use in order to differentiate between policy-holders are age and sex. Hence, imposing a premium loading due to inferior health status is not possible. This is associated with serious consequences for insurers and policy-holders.

Being aware that no premium loadings reflecting previous illnesses of a policy-holder are allowed in a basic benefit contract, private health insurers assumed that only high risk policy-holders would enroll in such a health insurance plan. This makes basic benefit contracts relatively expensive.¹ Yet the SHICSA limits the maximum basic benefit premium to the maximum premium that is currently paid in the social system (around US\$800 per month in 2009). Only people especially in need are allowed to pay half of the maximum amount. All missing premiums have to be financed by the community of all people holding private health insurance in Germany. At the end of the day, all insureds in a basic benefit contract pay the maximum premium. Of course, it seems unprofitable to switch into a contract that offers the same health services as the social health insurance system does, but that costs the maximum premium in that system. Therefore, basic benefit contracts may not be very attractive. Indeed, in June 2009 only 9,800 policy-holders were enrolled in a basic benefit plan.²

One important special feature of the basic benefit package is that all services that are offered by insurers—and thus in particular the calculation of ageing reserves—must follow a prespecified standard. All German insurers are obliged to follow the same actuarial basis. This makes ageing reserves easily transferable between insurers if policy-holders switch from one private health insurer to another.³ The new SHICSA instructs insurers to transfer ageing reserves of switching policy-holders. At first sight, this seems a solution to the problem of lacking competition in German private health insurance. It is, however, often overlooked that the proper problem is not how to make ageing reserves transferable between insurers, but rather how to organise the private health insurance market in such a way that there is competition without risk selection.

Implications and economic analysis

The objective of the SHICSA is to increase competition and efficiency in the German health insurance market. We argue that the basic benefit package cannot reach this objective for two main reasons: on the one hand, using prespecified actuarial basis is crucial since it deprives private health insurers from making use of the most important competition parameters, that is, price and range of services. On the other hand, the law obliges insurers to transfer a sort of virtual ageing reserve for those policy-holders who are currently insured in an ordinary private health insurance contract. These virtual ageing reserves are calculated in the same way as if these policy-holders were enrolled in a basic benefit contract. Since the transfer payment does not depend on individual health status, switching into a standard package is not without disadvantages for high risk policy-holders. This is because the new insurer commonly undertakes medical risk assessments and may impose a premium loading reflecting the policy-holder's higher risk. As a consequence, undesirable risk selection is likely to occur.

Private health insurers in Germany argue that the new basic benefit package may force them to increase their premiums. This is because mid-term cancellation profits from switching policy-holders are lowered. Of course, a part of the ageing reserves—that part referring to the basic benefit contracts—has become transferable between insurers. Before the basic benefit package was introduced in January 2009, ageing reserves of switching policy-holders were kept by the insurer and thus constituted cancellation profits.

For ordinary private health insurance contracts, the basis for actuarial calculation differs between insurers because it is founded on calculated health expenditures for a collective of policy-holders. In contrast, in the basic benefit package, the health expenditures per risk curve and insurance premiums are the same for all insurance companies. Therefore, from the view of an individual policy-holder, it does not make any difference which insurer he chooses for a basic benefit package contract since all

¹ See *Private Health Insurance Statement of Accounts* (2008), p. 145.

² See *Private Health Insurance Report* (2009), p. 23.

³ This is in contrast with the conventional private health insurance system in Germany. Note that for a classical private health insurance contract, each insurance company uses some individual actuarial basis such that company-specific ageing reserves are produced.

contracts are priced alike. The transfer of ageing reserves has become simple due to uniform premium calculation. However, there is no room for competition within this new system. Generally, the ageing reserve does not include any information on individual health status, making it attractive for adverse selection processes. The reason is that ageing reserves are objectively “too high” for low risks and “too low” for high risks.

The major objective of the basic benefit package—to increase competition and efficiency in the German health insurance market—cannot be achieved by the act. The Act may, in contrast, contribute to a significant distortion of incentives leading eventually to adverse selection processes in the German private health insurance market. In particular, some kind of “watergate effect” seems to be likely: some policy-holders would first switch into the new basic benefit package of a different insurer and then, using this contract, switch again into some more valuable contract with this insurer. However, doing so is rational for policy-holders in good health (low risks) only. This is because in more valuable private health insurance contracts (including superior medical services for policy-holders) premiums are still risk-based. As a consequence, a classical adverse selection process is likely to occur. This is indeed a straightforward conclusion, and so many German private health insurers have taken the potential adverse selection effects into account by offering “options” in contracts that allowed policy-holders in the first half of 2009 to switch from the basic benefit package into an appropriate other contract. The subsequently introduced law that makes it obligatory for insureds to stay within the basic benefit package for at least 18 month has, however, contributed to make those adverse effects less attractive.

Concluding remarks

The basic benefit package is creating a sort of third health insurance system in Germany. In view of premiums and quality of health care services, the new system is somewhere between the private and the public health insurance system. The basic benefit package includes parts of the social system—for instance, the obligation of insurers to enter into a contract, risk pooling, and uniform premiums. The major purpose of introducing the basic benefit package was to enlarge policy-holders' contract choices and to facilitate switching between health insurance providers in order to increase competition in the private health insurance market in Germany.

Although the new system makes ageing reserves transferable between insurers, existing inconsistencies in the German private health insurance system will possibly remain or might even be worsened. In particular, the most important problems—lacking competition and risk selection—cannot satisfyingly be solved. The unique actuarial basis is crucial since it deprives private health insurers from making use of the most important competition parameters: price and range of services. Since these parameters are equivalent for each basic benefit contract and there is also a pooling mechanism, insurers have no incentive to improve efficiency and to offer other services like managed care or disease management programmes to their policy-holders.

It is difficult to predict how much adverse selection induced migration between insurers might be triggered by the new system and what exact consequences for the stability of the German private (and possibly public) health insurance system arise. Yet, we can state that the new law initiates migration between insurers and adverse selection processes that have significant potential to endanger the German health insurance system's stability in the long run. Fortunately, in order to prevent such a situation, the German Federal Constitutional Court has obliged legislators to observe the development of private health insurance markets and to interfere in case the private health insurance system runs the risk of becoming instable.

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*This article was published by The International Association for the Study of Insurance Economics (**The Geneva Association**). Articles, documents and recent publications of the Association can be found on its website, at www.genevaassociation.org*