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Supplemental Health Insurance: Did Croatia Miss an Opportunity?

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Croatia continues to face a health-funding crisis. A recent supplemental health insurance law increases revenues through first increasing co-payments, then raising the payroll tax to cover those co-payments. This public finance "slight-of-hand" will not solve the system's structural issues and may worsen system performance both in terms of efficiency and equity. Should Croatia have considered private supplemental insurance as an alternative? There is a new single private supplemental health insurance market now evolving over the EU countries and into Eastern Europe. Croatians could take advantage of lowered costs due to larger risk pooling and the lower administrative overheads of mature insurance organizations. Private supplemental insurance, when designed well, can address several objectives, including a) increased revenues into the health sector; b) removal of the public burden of coverage of selected services for certain population groups; and c) encourage new management and organizational innovations into the sector. Private and multiple company insurance markets are thought to be superior in terms of consumer responsiveness; choice of benefits; adoption of new, more expensive technology; and use of private sector providers. Private sector insurers may also encourage "spillover" effects encouraging reforms with public sector insurance performance. There is already an emerging private insurance market in Croatia, but can it be expanded and properly regulated? The private insurance companies might capture as much as 30-70% of the market for certain services, such as high cost procedures, preferred providers, and hotel amenities. But the Government will need to strengthen the regulatory framework for private insurance and assure that there is adequate regulatory capacity.

Key words: *cost sharing; Croatia; delivery of health care; health care reform; insurance, health; insurance, major medical; insurance benefits; insurance selection bias*

The Challenge

It is no secret that the fundamental challenge facing Croatia's health system remains that demands for more and better health care services are virtually unlimited, but the resources available to meet those demands are severely limited. Reform initiatives undertaken since 1993 have somewhat stabilized the rapidly deteriorating situation faced by Croatia's health system in the early 1990s. But the multiple problems of high expectations on the part of the public and health providers, an inefficient and costly structure to provide health services, and limited national resources to finance those services remain the central challenge of health sector reform (1).

Indeed, the Croatian health sector has continued to find itself in a fiscal crisis. In 2000, the payroll tax was lowered from 18% to 16% (7% for employer, 9% for employee), but then the public insurance fund again found itself in debt. The existing stock of arrears stood at approximately 2.5% of gross domestic product (GDP) at the end of 2000, and by September 2001 was further increasing by about 120 million HRK per month or about 1.5 billion HRK annually – about 10% of the overall Health Insurance Institute revenues. It instituted an overall global cap for hospital care, but some observers saw this applied pressure as mis-focused, instead encouraging queues for certain high-end services, such as cardiac surgery, percutaneous transluminal coronary angioplasty, and stent. The current budget has again called for further squeezing on hospital budgets.

Longer term, health reform efforts must focus on multiple fronts. New policies are needed that can enhance the efficiency and effectiveness of the system to provide care based on high standards of medical and scientific practice. New steps must be taken to improve the understanding of both the public and health professionals regarding their roles in the evolving health system. Financial incentives should be put in place for all actors in the system – both providers of health care, including hospitals and physicians, and consumers of that care – that encourage the efficient production and use of health care services. The first steps have been taken, including new pilot programs in Koprivnica, which test a number of financing and delivery changes (2).

Recently, the Croatian Government passed a new supplemental insurance law. Some saw this as a part of the reform agenda, but others were not so sure. In this article, the new law is briefly reviewed, and is

placed in the context of multi-country experience for introducing supplemental health insurance. It is posited that supplemental insurance might be better organized and sold through a private market context, especially in light of an evolving EU-based market for this product. Probable impacts and options are assessed for the sector in light of this new legislation, and probable impacts of private insurance products discussed.

Recent Legislation

To help meet the revenue shortfalls, Croatia has passed the legislation changing its benefit package, and then stimulating the purchase of a supplemental health insurance plan, slated for implementation in 2002. Briefly, the new law enacts the following:

1) New co-payment "price schedule" for selected services in the current benefit package, with an emphasis on services in the hospital, specialist care and diagnostic tests. There are 22 diagnostic categories, which would come under higher co-pays. The proposal includes higher co-pays for pharmaceuticals.

2) Offering a supplemental health insurance package to cover these new co-pays to re-establish the level of full coverage now in place. Second, it will facilitate the purchase of brand-name drugs over generics as well as longer-term care. Third, it will cover the use of high-end services in private facilities and with private providers.

3) The supplemental health insurance can be bought through the public insurance agency – the Health Insurance Institute – but not from a private insurer, though only one currently exists. Implicitly, there is an expectation that the supplemental health insurance will act as a new tax revenue source for Health Insurance Institute. Second, there will be a tax refund for anyone or any employer that purchases the supplemental health insurance. So, there will be a negative impact on general revenues for the Government as a whole. Local government will be affected significantly: profit and personal income tax – shared taxes between state and local government – are major sources of revenues (around 46% in 1999) (3).

4) The new, higher premium can be easily purchased by those paying the payroll tax (formal economy) currently. It can be done at the individual or employer level. The premium has been estimated from HRK40 to HRK80 per month (February, 2002).

5) However, there are categories of population not currently paying contributions: children under 18 years of age; pensioners; those pregnant and under maternity benefits; farmers; unemployed; households with head over 65 years; and those on social benefits such as those who are disabled.

These groups make up somewhere between 1.7 million and 2.0 million people of a total population of about 4.5 million. Until the new law, the Health Insurance Institute covered the contribution for these groups. Under the supplemental health insurance legislation, the new supplemental health insurance premium could be partly or entirely picked up for most of these groups by the local (county) governments, and then paid to the Health Insurance Institute. This would be a second source of new revenue for Health Insurance Institute, which could pay part of the premiums for kids, pregnant women, and pensioners over 75 years.

While the regulatory details are being developed, there are issues of both equity and efficiency in the new legislation. From an equity standpoint, for example, 40% of poor citizens of Croatia live in households where the pensioner or an inactive elderly person is the breadwinner. At least 25% of the elderly do not receive pensions at all, and at least 50% receive pensions below the poverty line. Any partial coverage could further erode access to quality care for these groups.

From an efficiency standpoint, the new supplemental health insurance law is at best a public finance "sleight-of-hand" trick to generate new revenues for the Health Insurance Institute at the expense of the Treasury and local governments. It could have the effect of generating debts in other government sectors, or a call for new, higher taxes, or both. More fundamentally, it does nothing to help restructure the incentives underlying the overuse of services and drugs and the inefficient allocation of resources. It may not be enough to cover Health Insurance Institute debts even if utilization does not change over the next few years.

Are There Alternatives?

It is somewhat surprising that Croatia has not taken advantage of the new single private insurance market now evolving over the European Union (EU) countries and into Eastern Europe. Recent changes in EU regulation, culminating in the third non-life insurance directive, have led to the creation of a single market for private supplemental insurance in the EU. Such a change could mean that Croatians could take advantage of lowered costs due to larger risk pooling and the lower administrative overheads of mature insurance organizations.

Private supplemental insurance, when designed well, can address several objectives. It can encourage increased revenues into the health sector; remove public burden of coverage of selected services for certain population groups; and encourage new management and organizational innovations into the sector. The management and information systems in private insurance arrangements often use up-to-date software in claims processing and in profiling providers both on quality and cost. These innovative approaches can have spillover effects on the entire sector.

Mossialos and Thomson (4) distinguished between two types of supplemental insurance in the EU: complementary, which provides cover for excluded or not fully covered services by the State, and supplemental, which provides faster access to services, greater consumer choice of provider, and amenities, such as private rooms in the hospital. The largest markets are currently Germany, France, and the United Kingdom. As least 17 companies sell supplemental insurance in Germany alone. Currently, there is high

use of supplemental coverage in EU countries, according to the Mossialos and Thompson framework (Table 1).

Current Market in Croatia

In Croatia, there are 29 companies that sell insurance. About half (52%) of the market share is held by the Government-owned insurance company, a joint stock company, which is (according to the schedule) to be privatized by the end of 2002. Smaller companies are being more closely scrutinized by the Government to meet reasonable capital reserve standards, something that should help consumer confidence. But currently, most private health insurance is sold by one company – Addenda Insurance. Addenda Insurance sells both complete and private health insurance in Croatia. Established in the early 1990s, they sold supplemental insurance for several years, and in the last year or two have moved into the market for complete package of private insurance. Croatian law allows an "opt-out" of the public insurance system, and allows an individual with a formal (reported) income of 30,000 or higher to take the 16% payroll tax paid to the Health Insurance Institute and place it with private insurance. Unlike the German system, Croatians are free to move in and out of the public system as they choose. The number of lives covered for supple-

Table 1. Benefits provided by complementary and supplementary private health insurance in the European Union according to Mossialos and Thomson, 2002 (4)

	Health insurance	
Country	complementary	supplementary
Austria		hospital expenses accommodation and treatment costs material expenses costs of special category ward in public hospitals free choice of doctor upgraded hospital accommodation hospital daily cash payments outpatient medical expenses (only in conjunction with above policies)
Belgium	"large risks": reimbursement of actual costs or a flat sum paid per day in hospital co-payments "minor risks": cover for all outpatient treatment medicines and dental care	"large risks": upgraded hospital accommodation
Denmark	co-payments for pharmaceuticals dental care home care, eye care, medical aide	care in private hospitals
Finland		mainly covers children care in private hospitals some hospital costs in public sector
France	co-payments dental care primary care, pharmaceuticals, glasses, orthopedics	charges for private rooms flat-rate hospitalization payments the excess fees of Sector II physicians
Germany	dental care	upgraded hospital accommodation
Greece		upgraded hospital accommodation cash benefits care in private hospitals diagnostic care in the private sector
Ireland	co-payments for outpatient care	care in private hospitals consultants private beds in public hospitals some outpatient costs
Italy	hospital, convalescence, outpatient costs new law in 2000 defining essential package covered by mutual funds: co-payments private services in public facilities complementary services excluded from the benefit package funded by the NHS	upgraded hospital accommodation free choice of doctor diagnostic services/specialists visits (for higher premiums)
Luxembourg	co-payments for hospital treatments dental care	
Netherlands	dental care for adults cosmetic surgery, maternity care, medical aids, spectacles, alternative medicine	upgraded hospital accommodation
Portugal		cash benefits for hospital care total coverage of all other treatments free choice of doctor and hospital
Spain	co-payments	medical expenses upgraded hospital accommodation direct access to specialists fee choice of GP/hospital
Sweden		free care in private hospitals
United Kingdom	dental care alternative treatment	upgraded hospital accommodation cash benefits private beds in public hospitals care in private hospitals

Table 2. Regulatory issues for implementing private health insurance according to Tapay, 2001 (7)

Financial and non-financial standards for market entry and operation	Rules for reporting and exit of health insurance plans	Employer/consumer protections and mechanisms to improve fairness
Capital and surplus requirements	Regular reporting of financial and market information	Language and marketing of contracts
Common accounting and actuarial practices	Use of accounting and actuarial professions to conduct on-site examinations	Provider-plan relations
Reinsurance requirements	Notice to policyholders and financial plan for paying incurred but not reported expenses	Guaranteed issue/renewal
Approved business plan	Guaranty funds	Community rating
Citizen/residency of owners		Rate review/approval
Lawful organization forms		Mandated/standard benefits
Prohibited products		

mental insurance is over 20,000; the number of covered lives for complete packages is only around 2,000. This is the only company in Croatia that sells a complete package of services (3).

The package of supplemental insurance is sold in a couple of dozen variants and primarily marketed and sold to employer groups, such as banks and larger firms. Increasingly, they attract international firms with both domestic and international workers. The supplemental insurance mostly covers "upgrades" on physicians, facilities, and pharmaceuticals. This includes private care. It can also cover out-of-country surgery, notably in Germany and the UK.

The company has contracts with over 2,000 physicians and over 300 facilities, and these are both public and private. The company uses a gatekeeper model similar to managed care organizations in the United States of America. Consumers initially call in by telephone. On the other end of the line is a team of doctors available 24 hours a day. This gatekeeper or team, in turn, provides advice or referral to a general practitioner, clinic, specialist or even hospital.

Services are paid according to set price lists developed by the company using historic data. The company asserts that prices paid are 5 to 9 times as much as the public sector (Health Insurance Institute) reimburses per service, but that overall expenditures are less by 20%. This is due to tight administrative controls of the gatekeeper team relating to volume and appropriateness. In addition, the gatekeeper team is incentivized: while on salary, the gatekeepers are eligible for twice-annual bonuses, if volume and expenditure targets are met (Lovrić D, personal communication, 2001).

Some Croatian observers think the private insurance companies can capture between 30% and 70% of the market for supplemental health insurance. At the same time, the Government will need to strengthen the regulatory framework for private insurance and assure that there is adequate regulatory capacity (3,5).

Private and multiple company insurance markets are thought to be superior in terms of consumer responsiveness, choice of benefits, adoption of new, more expensive technology, and use of private sector providers (6). The Addenda experience is suggestive that this is already the case in Croatia. At the same time, there can be abuses in multi-payer private insurance markets, such as fee escalation, cross-subsidization through billing/claims manipulation, and risk selection by insurers of healthy individuals and groups, leaving the poor and relatively sick in danger of not finding affordable coverage. A regulatory framework and capacity, therefore, become important. Table 2 outlines briefly some of the regulatory issues in any private insurance market (7).

Further, a recent EU analysis suggests that the market for voluntary health insurance in the European Union suffers from significant information failures that seriously limit its potential for competition or efficiency and also reduce equity (8). Substantial deregulation of the EU market has created the potential for broader markets and pooling of risks. At the same time, EU-level regulation of markets for voluntary health insurance has taken away powers from national regulatory bodies to protect consumers. This re-balancing of regulatory oversight poses interesting challenges for national regulators, particularly if the market is to expand in the future (8).

Supplemental Health Insurance: Should It Cover High-Cost Medical Care?

One of the challenges facing the health system is the desire on the part of both physicians and patients to use the most up-to-date medical practices. Many of those innovations involve the use of expensive technologies and pharmaceuticals. Widespread application of high-cost medical care could place an unsupportable burden on the health financing system. The following multiple strategies could help resolve the challenge of financing high-cost care in Croatia (1).

Comprehensive priority setting. A few health programs in other countries have developed formal processes to set comprehensive and clinically-detailed priorities for the use of health system resources.

Utilization review and treatment guidelines. Utilization review procedures are common in all health insurance systems. These could be strengthened, with a special focus placed on high-cost treatments. Similarly, treatment guidelines for clinical decision-making that exist in the medical community could be more aggressively used to make treatment decisions.

Centers of excellence. Treatment could be confined to a few centers of excellence, rather than allowing the high-cost treatment to be more generally available. That could reduce overhead costs in the health system, improve patient outcomes, and improve the clinical basis for treatment decisions.

Private supplementary insurance. Unlike the other strategies, private insurance would bring some

additional resources into the health system. Beneficiaries could have greater access to high-cost treatments, but would be required to pay their own health insurance premiums for that coverage.

The least practical strategy is to develop a complex formal decision-making process. Such systems are generally difficult to develop and manage, and they may not be very effective in constraining expenditures. Many of the benefits of that approach can be obtained by stronger utilization review and more thorough application of clinical guidelines. Those steps can be implemented quickly and can be more readily adapted to the needs of the Croatian health system.

Designating hospital centers of excellence is another useful and practical strategy to managing resources and improving quality. As part of the ongoing health reform effort, plans are already underway to assess the capacity and structure of the hospital system. That assessment could lead to some restructuring to minimize duplication across facilities and to improve the flows of patients and resources within that system.

Developing private supplemental insurance to cover high-cost care is a way to bring more resources into the health system, but there are many complications to be resolved. Private insurers would try to attract the most profitable beneficiaries – healthier groups of people, or those with illnesses whose costs of treatment are very predictable. Such favorable selection of health risks could leave the most difficult and costly cases in the public insurance system. Favorable selection can be minimized, but not eliminated, through careful insurance design.

Private insurance might also impose other costs on the public system, particularly if a patient receiving high-cost treatment (covered by private insurance) needed more than the usual amount of routine care following that treatment. Some of those costs could be recaptured by requiring insurers to pay the Health Insurance Institute for the expected cost of that additional use of services.

Making high-cost treatments available to persons with private supplementary insurance creates a "two-tiered" health system. Those without private insurance would have access to care only through the public system, and high-cost treatments would not be part of that coverage. But private insurance could be a way for the health system to adopt medical advances from other countries that could eventually become available through the public insurance system. Moreover, the requirement that beneficiaries pay their own insurance premium would reinforce the economic reality that health care is not a free good (1).

Conclusion

Any private insurance initiative should be approached with particular caution. Initial project development would address the design of the program, including what should be included in the benefit package, how much to charge for premiums, and how to deal with risk selection. A marketing study to determine the likely demand for various kinds of supplemental policies (reflecting both the preferences of people for greater choice in the care they receive and their willingness to pay for those choices) would be a useful part of the design work. Indeed, to some extent, that market study has been rendered unnecessary by the entry of Croatia's only private insurance company. But probably more information is needed to look at issues, such as demand for certain services, extent of informal payments now being used to gain preferred providers and improved access, and available supply of physicians and beds to respond to consumer needs and preferences. Once the market is better understood, enabling legislation and a regulatory framework might be developed to implement some combination of incentives, such as tax deductions, one or more pilot insurance projects, or a clearer entry to the Croatian market by insurers now selling policies in the European market.

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