Health Policy Institute

Assessment of Potential Risks of Hungarian Health Insurance Reform

(Final version: 19. 12. 2007)

Health Policy Institute

December 2007

Stredoeurópsky inštitút pre zdravotnú politiku - Health Policy Institute, Hviezdoslavovo nám. 14, 811 02 Bratislava, Slovak Republic | www.hpi.sk

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Contents

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List of abbreviations

HCP – healthcare provider
HIT – health insurance treasury
HF – healthcare fund
NZa – Nederlandse Zorgautoriteit
HCSA – Healthcare Surveillance Authority
EBF – Egészségugyi Biztosítási Felugyelet
TAJ – healthcare identifier in Hungary
HC - healthcare
HI – health insurance
ICD – international classification of diseases
HBCS – homogén beteg csoport – Hungarian version of DRG
OENO – catalogue of examinations and procedures
HPI – Health Policy Institute
MHC SR – Ministry of Healthcare of the Slovak Republic
EMS – emergency medical service
RH – the Republic of Hungary
PHI – public health insurance
CETE– common examination and treatment elements
FPAC– forensic and pathology and anatomy centres

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Introduction

Hungary is implementing significant transformation of the health insurance system from the monopoly of a sole healthcare insurance company to a plural model with multiple purchasing agents of healthcare. Such health insurance organization model is far more complex with respect to surveillance and regulation and therefore this field clearly calls for adequate attention.

The present study aims at providing EBF with a proposal of a risk assessment model inclusive of risk identification, using which EBF will be able to effectively monitor efficiency of the health insurance system in Hungary.

The study is composed of four parts:

- the first part summarizes the basic prerequisites of the health insurance reform in Hungary and also provides an overview of the draft act on health insurance companies (government version submitted to the parliament not reflecting the changes made in parliament)
- the second part focuses on experience in health insurance surveillance from the Netherlands and Slovakia
- the third part presents a risk assessment model example (based on the NZa pattern)
- the fourth part identifies potential risks in the health insurance market in Hungary based on the experience from the Netherlands and Slovakia while incorporating specifics of the draft Hungarian legislation

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Part One: Prerequisites of the Act on Health Insurance Companies

Health insurance (HI) will be provided by health insurance treasuries (HIT). A member of a HIT is an insured person in favor of whom the respective HIT is obliged to provide health insurance based on a contractual relationship.

Health insurance is mandatory for each individual (physical entity) residing in the territory of the RH.

The extent of coverage of healthcare (HC) from the public health insurance is regulated by decrees issued pursuant to the said act concerning HC settlement and examination and therapeutic regulations.

Health insurance preconditions are uniform with respect to each insured person.

The patient's contribution rate and the amount of fees a patient is charged is set out in a decree issued under the said act.

Each insured person of a HIT has equal rights.

The principle of openness of HC guarantees the option of changing for another HIT on the part of a patient within the limitations set under the act.

Following the closed economy principle, HIT business is restricted exclusively to activities set out by the act.

1.1 Operations of a health insurance company

Public HI can be provided by a HIT incorporated pursuant to provisions of the act and holding a valid permit. The principal activity of a HIT is provision of public health insurance.

HIT takes the legal status of a joint-stock company (j.s.c.), the incorporator and majority stakeholder is the Republic of Hungary. Control of the state owned assets is exercised by the respective minister. 51 % shares with voting rights constitute **non-marketable property** of the Republic of Hungary, the remaining shares form at the time of HIT incorporation **commercial property** of the RH. Incorporation and operations of a HIT are governed by the laws of the RH (e.g. Commercial Code).

Minimum share capital at the HIT incorporation is HUF 20 mil., which can take the form of a financial contribution exclusively. Marketable shares can be solely ordinary shares. The draft act specifies which entities may not be holders of a HIT – such as a pharmaceutical company, healthcare provider (HCP), public institution, officer of another HIT, person with shares or other interests in another HIT and other persons set out in the act.

Permit to conduct activities of a HIT is issued by EBF. EBF shall turn down a request in case

1. the requesting party fails to comply with requirements set out in the act
2. is not in a position to credibly demonstrate compliance with such requirements
3. the requesting party provided false information.

HIT can commence its activities in case it has, 30 days prior to issuance of the permit, at least 500 thousand of insured persons and at most 2 millions of insured persons.

Conditions related to HIT operations:

- HIT is obliged to operate a barrier-free branch open at least 8 hours a day, at least once per week till 18,00 hours in the following locations:
    1. in county towns, in residence of its members
    2. in towns with more than 25 thousand members
- HIT shall publish on its website data such as:
    1. company name and registered office
    2. ownership structure, share capital, annual financial statements
    3. number of members
    4. information concerning contracted providers
    5. conditions pertaining to a changeover from another HIT
    6. use of resources from redistribution
    7. resources from redistribution (monthly)
    8. supplementary insurance
    9. key economic indicators etc.

Over the entire period of its operation, a HIT is obliged to fulfill criteria related to minimum levels of shareholders´ equity and solvency criteria. In case the respective values drop below the mandatory level set by law, a HIT is obliged to follow the procedure in Figure 1.

Figure 1: Creation of share capital and reserve funds, solvency indicators

Indicator	Value	Proposed procedure in case of incompliance
Minimum level of shareholders equity (minimum equity)	HUF 3 bn in the year of incorporation Subsequently, 5 % of income from redistribution	Obligation to develop a recovery plan within 30 days
Contingency equity	80 % (from minimum equity)	Obligation to increase equity
Reserves	90 % (from contingency equity)	

Note: Creation of reserves – totaling at 30 % of profit

Source: Health Policy Institute, based on the analysis of the act, 2007

HIT is obliged to invest an amount corresponding to the value of shareholders equity and reserve into:

1. securities with maturity within 3 months guaranteed by central banks of EU or OECD countries (the volume in such securities shall be at least 95 % of the value of fixed reserves)
2. other property values

Rules of financial operations:

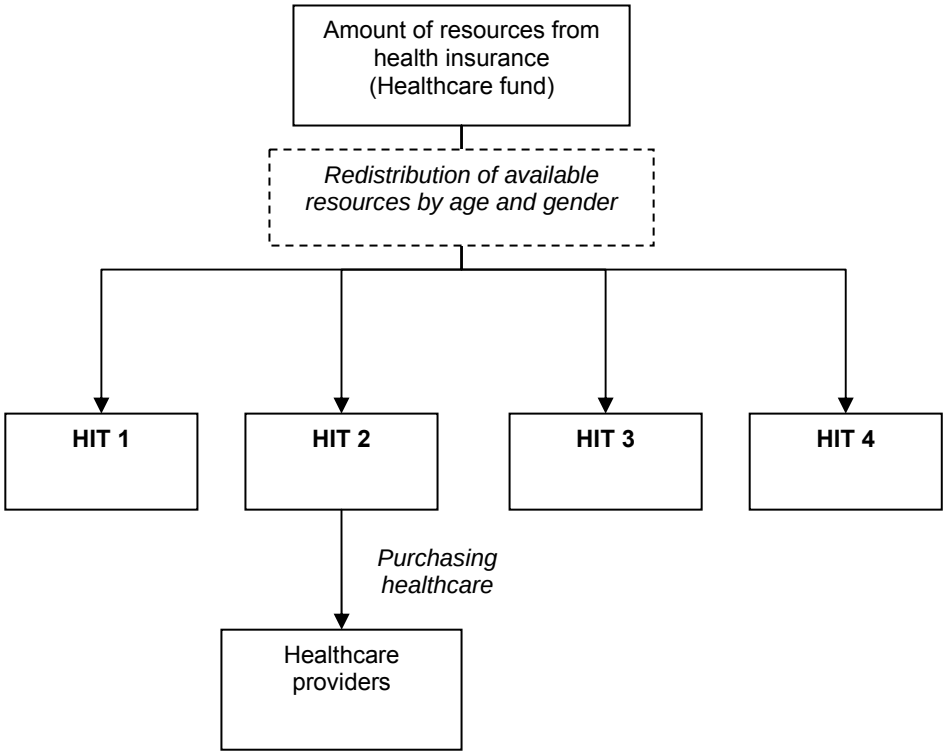
- operating income comprises:

1. income from redistribution
2. other income from health insurance
3. income from broker activities
4. other income

- operating expenses comprise:
  1. healthcare-related expenses
  2. operating expenses up to 3.5 % of annual income from redistribution
  3. expenses on broker activities – may not exceed income from broker activities
  4. other expenses

In case income from redistribution exceed expenses, dividend are paid with respect to Section 9 of the act (three-year restriction of dividend out payment in the beginning of operations of HIT) and Section 60 of the Act (HC in excess of the minimum scope financed from the balance (retained earnings) from the preceding year) in the maximum amount of 2 % of the annual income from redistribution provided necessary profit after taxation is available.

Figure 2: Health insurance system organization



Note 1: calculation of income and expenses is virtual; HIT purchases healthcare, actual cash payments are conducted by a legal successor of the present monopoly

Note 2: detailed administration concerning redistribution as well as resources from redistribution is maintained by each HIT separately on its own HIT account

Source: Health Policy Institute, based on the analysis of the act, 2007

1.2 Membership-related legal relationships

Origination of an insurance-based relationship

- An insurance-based relationship is established:
  1. upon registering of an insured person according to his/her residence
  2. by changeover from another HIT
- Upon origination of an insurance-based relation, an insured person becomes a person insured with a particular HIT with respect to his/her residence. Upon elapse of 30 days following establishment of such insurance-based relationship, a person may change for an insurance company based on his/her preferences.
- A newborn becomes an insured person of his/her mother's HIT; a legal representative may upon elapse of 30 day period opt for another HIT.

HIT is obliged to send without undue delay to each insured person so-called notice of membership. Such notice shall contain the following:

1. insured person's name and TAJ (identification number)
2. HIT availability – the location of the nearest client centre and complaint filing procedure information
3. services covered paid from public health insurance
4. scope of paid services

HIT shall issue a HIT membership notice containing the following:

1. identification personal data of an insured person
2. insured person's TAJ
3. name of HIT

Rules of acquisition campaign:

- With respect to acquisition, HIT may cooperate with individuals (physical entities), corporate bodies, and commercial companies without legal status on the basis of a concluded contract.
- HIT may inform in person, via mail or other publicised notices about services and conditions pertaining to application by making available application forms containing name and surname of an insured person, residence and number of an insured person, which, however, shall not contain any other personal or health condition data.
- An acquisition campaign cooperation agreement shall set out the amount of consideration for acquisition, conditions regulating acquisition and liability for damages caused by acquisition.
- A healthcare provider may not cooperate in acquisition.

Changeover to another HIT

- possible twice a year from 15 April to 15 May and from 15 October to 15 November
- an insured person may, upon changing his/her residence, change for another HC upon elapse of 30 days from such change.
- an insurance-based relationship shall cease on 1 July or 1 January following delivery of an application form.

An insured person may only be an insured person of a single HIT; each insured person has equal rights and obligations.

1.3 Health insurance financing organization

Healthcare fund (HF) is administered by a central authority designated by the government. Maintenance of central administration – register is one of the principal tasks of the fund, the act sets out principal data about insured persons in the register.

The pricing committee proposes:

1. the scope of HC from public health insurance
2. prices for HC (the decision shall receive 4/5 support)
3. manner of reporting of HC
4. definition of indication groups (the decision shall receive 4/5 support)
5. inclusion of technologies in the public healthcare system (the decision shall receive 4/5 support)
6. financing

Composition of the pricing committee:

1. 1 member (concurrently the Chairman) – proposed by the Minister for healthcare
2. 1 member – proposed by the Minister for finance
3. 1 member – proposed by the Prime Minister
4. 2 members – proposed by HIT
5. advisory member nominated by the surveillance authority

The redistribution committee is an advisory body of the Minister in the area of redistribution of resources for health insurance.

Composition of the redistribution committee

1. 1 member (concurrently the Chairman) – proposed by the Minister for healthcare
2. 1 member – proposed by the Minister for finance
3. 1 member – proposed by the Prime Minister
4. 2 members – proposed by HIT
5. advisory member nominated by the surveillance authority

1.4 Rules applicable to healthcare utilization

When utilizing healthcare services, an insured person shall present his/her insurance ID card, whereas the provider shall be obliged to verify whether such insured person is included in the list of members administered by the healthcare fund.

Primary healthcare is provided on the basis of:

1. a doctor selected by an insured person
2. a doctor within whose medical district an insured person is located

Specialized healthcare is provided on the basis of:

1. recommendation
2. in specific cases and in urgent cases without recommendation

Inpatient care is provided on the basis of:

1. recommendation
2. in urgent cases without recommendation

HIT is obliged to maintain waiting lists. A provider is obliged to maintain a register of orders and to inform all contracted HITs in this respect accordingly. HIT informs a provider that it registered an insured person in a waiting list of the respective health insurance company and also informs an insured person thereof.

Types of waiting lists:

1. central
2. transplant-related (e.g. stem cells)
3. administered directly by HIT

A waiting list (maintained by a HIT) comprises personal data of registered insured persons and the sequence of requests for provision of healthcare. An order (maintained by a provider) comprises personal data of registered insured persons and anticipated time of provision of healthcare.

In case an insured person registered in a waiting list of a HIT changes for another HIT, then his/her position in the receiving HIT corresponds to the date of his/her registration with the transferring HIT, while he/she may not overtake insured persons received at the same time by the receiving HIT.

In case a contractual provider of a HIT, other than that with whom the insured person has an order placed, is capable of providing healthcare within a significantly shorter time then the insured person can use services of such provider.

An insured person shall be excluded from a waiting list of a respective HIT in case:

1. the insurance-based relationship with the respective HIT ceased
2. health condition of the insured person (based on statement of the examining doctor) does not indicate the need of healthcare activity on the basis of a waiting list
3. such exclusion is requested by the insured person

An insured person shall be excluded from the order placed with the provider in case:

1. the insurance-based relationship with the respective HIT ceased
2. health condition of the insured person (based on statement of the examining doctor) does not indicate the need of healthcare activity on the basis of a waiting list
3. such exclusion is requested by the insured person
4. in case another provider takes such insured person over to its register

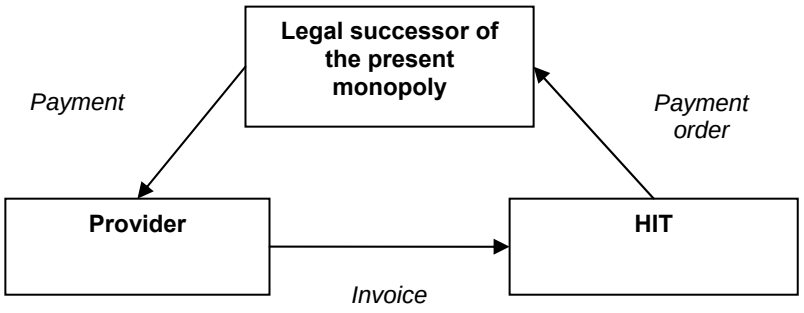
1.5 Contracts on provision and settlement of HC

Pursuant to the act, three contracts will be made, namely:

1. between the legal successor of the present monopoly and a HIT (serving the purpose of transaction clearing)
2. between a HIT and a provider (can take up also the character of a preferred contract in case of a preferred provider)
3. between a provider and a legal successor of the present monopoly (administering all resources in the system)

The provider shall issue an invoice to a HIT for healthcare provided to its insured persons. Upon release from the hospital, an insured person shall sign the bill. HIT shall review the bill and make an order to the legal successor of the present monopoly concerning settlement of the healthcare provided. A provider collects the money from the legal successor of the present monopoly (Figure 3).

Figure 3: Settlement system within the health insurance system



Source: Health Policy Institute, based on the analysis of the draft act, 2007

Upon releasing an insured person from inpatient care and/or after outpatient treatment a provider shall be obliged to issue a financial settlement document with the following information:

1. provided healthcare (based on the prescribed codes – ICD, HBCS or OENO)
2. the extent of the highest possible settlement concerning healthcare
3. the number of days in inpatient care and the amount to be settled with respect to inpatient care charges and/or amount of charges for outpatient care
4. other charges

Giving his/her signature, an insured person authorizes the financial settlement document (made in two copies) confirming the respective examinations and procedures were provided. One copy is retained by an insured person and the second is included in his/her medical documentation by the provider. In case a HIT identifies that a provider failed, owing to its own negligence, to present the financial settlement document to an insured person for signing it is entitled only to 90 % of the justified amount for examinations and procedures.

A provider is obliged to collect by itself the charge for inpatient or outpatient treatment.

1.6 Rules applicable to sale of marketable shares

The Republic of Hungary shall incorporate, within 30 days from effectiveness of the act, 22 HITs, from which

- 18 shall be assigned to counties
- 4 shall be assigned to Budapest and the county Pest

Rules applicable to sale of marketable shares:

- Upon elapse of a 15 day period following entry in the commercial register, the asset administrator in cooperation with the Ministry of Healthcare of the Republic of Hungary shall initiate a tender concerning sale of the shares.
- Initially, shares concerning the 4 areas in Budapest will be subject to sale.
  1. A single bidder can acquire shares of up to 2 neighboring counties.
  2. A single bidder can acquire shares of HITs assigned to territories with up to 2 millions of inhabitants with permanent residence in the given area
  3. A single bidder can acquire solely one territory from among the area Budapest and the county of Pest
- Unsold shares can be subject to an auction for those who previously submitted valid bids concerning other shares.
- In case any marketable share is not sold in 3 rounds such shares will be acquired by a bidder who acquired in acquisition the highest number of insured persons within the respective area in which such marketable shares of a HIT were not sold – provided the bidder pays the price calculated pursuant to Annex No 2 to the act.
- Sale of marketable shares shall be conducted on the basis of conditional futures purchase contracts. In such futures contracts, the parties will undertake that in case a HIT has as at the date of termination of acquisition 500 thousand insured persons, the purchaser shall purchase and the seller shall sell shares at the price set in advance in the contract.
- The validity date of such futures contract (effectiveness of the purchase contract) shall be the day after servicing of the official document of a health insurance authority to the HIT regarding the number of to-be insured persons.
- Detailed rules of the tender are specified in a separate legal regulation.

Participation in the tender is subject to payment of a security. From the day of entering into the futures contract, the purchaser can acquire further insured persons until 31 July 2008.

In case a priority owner of shares of any HIT fails to acquire the total of 500,000 insured persons following the effective date of the contract, then its marketable shares shall be offered by the RH for sale to minority owners of other HITs.

Consequently, 2 or more HITs owned by one minority owner shall merge pursuant to the act within 2 months.

In case sale of marketable shares offered by the Republic of Hungary is not effectuated within 2 months after termination of the futures contracts then subsequently within one month the respective HIT shall merge with another, however solely with such HIT which is neighboring.

Part Two: Experience with Surveillance over Health Insurance in the Netherlands and Slovakia

2.1 The Netherlands

The Health Market Regulation Act established the Healthcare Surveillance Authority in the Netherlands (Nederlandse Zorgautoriteit, NZa) and regulates its relations to the Ministry of Healthcare, Social Affairs and Sport as well as other regulatory and surveillance authorities along with conditions and rules pertaining to execution of surveillance over health insurance companies.

Healthcare Surveillance Authority organization

The Healthcare Surveillance Authority is an independent administrative authority with its own legal status.
It is financed from the budget of the Ministry of Healthcare, Social Affairs and Sport. Its administrative board comprises three members. Upon its incorporation, also the Health Insurance Surveillance Council (College Toezicht Zorgverzekeringen, CTZ) and the National Institute for Healthcare Contributions (College tarieven gezondheidszorg, CTG) became a part of NZa.

Tasks of the Healthcare Surveillance Authority

- regulation of the market regarding provision, insurance and purchasing of healthcare. This task also includes creation and monitoring of markets as well as their regulation. The Authority regulates healthcare prices. It also facilitates market transparency and availability of information concerning selection of HI available to clients
- surveillance over compliance with the Health Insurance Act by health insurance companies including the obligation to provide for healthcare and the obligation to accept any requesting party along with prohibition of differentiation in case of nominal insurance policy
- surveillance over compliance with the Act on Extraordinary Expenses on Healthcare by health insurance companies, regional and central branches.

Competences of Healthcare Surveillance Authority

The principal responsibility of NZa is to introduce specific obligations for players with market dominance. The power was vested in the Authority in order to improve the market of purchase of healthcare in areas with free pricing. Furthermore, the Authority has the power to set general conditions for healthcare providers and health insurance companies in order to increase market transparency for clients. The Authority can publish information concerning transparency in case such information is not published by healthcare providers and health insurance companies.

Relationship between he Ministry for Healthcare, Social Affairs and Sport and the Healthcare Surveillance Authority

Minister for healthcare, social affairs and sport sets basic rules and adopts political decision concerning healthcare. NZa implements and facilitates implementation of acts. Among other things, minister also determines which parts of the market are subject to free negotiations. Subsequently, the Authority imposes obligations, as the case may be, to players with market dominance. Minister also determines the form of price regulation in selected parts of the market, as he/she deems appropriate. The Authority elaborates on details and supervises compliance with the rules.

Minister nominates the Authority's administrative board, approves its financial budget, operational programme, financial statements, rules of procedure of the administrative board and the budget. Minister has the power to determine how the Authority should operate and conduct its activities. Such power relates also to contents of rules and general regulations issued. Minister can recommend to the monarch to annul Authority's decisions of general nature. Minister also can take action in case the Authority fails to meet its obligations.

Relationship between the Healthcare Surveillance Authority and other regulatory institutions

NZa has the obligation to exchange information with other regulators such as the Antimonopoly Office of the Netherlands, the Central Bank of the Netherlands, The Financial Market Authority and Healthcare Inspectorate with the view to harmonizing and exercising its duties. The institutions develop protocols on mutual cooperation.

The Healthcare Surveillance Authority determines rates in healthcare unless excluded from regulation (as in case of free market or excluded rates).

The Authority is also expected to reinforce market transparency in favor of clients. For this purpose, a system for handling client objections has been developed. Anyone can contact the Authority regarding a bill from a healthcare provider conflicting with rates set by NZa.

Actions breaching the Healthcare Market Regulation Act include mainly the following:

- With respect to healthcare providers
  1. Insufficient publishing of prices
  2. Declaring of a price not corresponding to the rate set by NZa
  3. Declaring conduct of an examination or procedure other than actually conducted
  4. Utilization of inappropriate description of an examination or procedure
- With respect to a health insurance company:
  1. Providing unclear, incomplete or incorrect information
  2. Unfair competition
  3. Payment by a health insurance company not in line with the legislative title
  4. Limited choice of health insurance
  5. Insurance plan not in line with requirements set in Health Insurance Act
  6. Unlawful cancellation of health insurance
  7. Supplementary insurance can only be concluded in relation to basic health insurance in the same health insurance company
  8. Incorrect calculation of the initial contribution and bonus allocated for unconsumed healthcare allowance
  9. An insured person is provided with a smaller extent of healthcare or compensation than his/her title is
  10. Healthcare quality is guaranteed insufficiently
  11. Failure to comply with protection/misuse of personal data of an insured person

Market dominance

The Healthcare Surveillance Authority monitors the public interest in the area of healthcare as follows: healthcare needs to retain a quality level and to remain physically available and financially affordable for clients. The most important tool for this purpose is introduction of market forces into healthcare in order to facilitate competition between providers and health insurance companies for a client. In case market forces fail owing to dominance in the market of providers or health insurance companies, NZa can impose measures on parties concerned with such market dominance to protect the interests of clients.

Under the Health Market Regulation Act, such measures can comprise:

- measures concerning **offer**: transparency of offer, no discrimination, cancellation of bundling of offers, publishing of offers, changes in an offer
- measures concerning the **obligation to provide**: obligation to incorporate any reasonable requirement in the contract
- measures concerning **accounting and cost allocation**: keeping separate accounts and compliance with defined principles pertaining to resource allocation,
- measures concerning **shortages**: impossibility to reserve non-conforming capacities,
- measures concerning **price regulation**: obligation to set price in line with methods determined by NZa.

If necessary, several measures can be used simultaneously. Measures applied must be balanced – they must represent the least possible intervention sufficient for resolving (anticipated) problems.

Enforcing compliance with the law

NZa can enforce compliance with measures by an administrative action, fine and by issuing a penalty payment order. In urgent cases NZa can impose temporary measures to resolve principal problems until an ultimate measure is developed.

Complaints and reports can be used as a signal from clients, healthcare providers or health insurance companies. NZa reviews whether a notion is legitimate, addressing which is within the competence of NZa and starts negotiations, if necessary. The concerned party is provided with an opportunity to make its position to the notion. Based on the findings, NZa issues its decision and, as the case may be, imposes specific measures. Parties concerned can raise objections with NZa and potentially appeal to the Trade and Industry Appeal Tribunal (College voor Beroep van het Bedrijfsleven, CBB).

Business Competition Act (Mededingingswet, Mw)

Healthcare is also subject to the Business Competition Act conformity to which is monitored by the Antimonopoly Office of the Netherlands. However, NZa enjoys priority position in cases which can be resolved within the competence of NZa on the basis of the Health Market Regulation Act. NZa and the Antimonopoly Office have agreements in place concerning mutual exchange of information and joint procedure when resolving specific cases. This means that it is sufficient to raise an objection or make a notice only with one of the two institutions.

2.2 Slovakia[1]

Healthcare Surveillance Authority (HCSA) was established under Act No 581/2004 Coll. on Health Insurance Companies, Surveillance over Healthcare and on Change and Supplementing of Certain Acts as a body corporate onto which is vested execution of surveillance over provision of healthcare and public health insurance in the area of public administration. The Authority is not listed in the commercial register and has its registered office in Bratislava.

The Authority submits to the Government of the Slovak Republic:

- A report on activities of the Authority over the period of the preceding calendar year annually by 30 June
- A report on financial operations for first half of the calendar year within three months from the calendar half year end
- An annual report on financial operations within three months from the calendar year end
- A report on conduct of public health insurance over the period of the preceding calendar year annually by 30 June
- A budget of the Authority subsequently approved by the National Council of the Slovak Republic

The Authority has the following bodies:

- Chairman
- Administrative board (composed of 7 members)
- Supervisory board (composed of 5 members)
- Chairman of the Authority is the statutory and executive body of the Authority.

From 01/04/2005 to 24/01/2007, the Chairman of the Authority was **MUDr. Ján Gajdoš**.
From 25/01/2007, the Chairman of the Authority is **MUDr. Richard Demovič, PhD.**

Basic structure of the **head office of the Authority** broken down to organization units:

- Health insurance surveillance section
- Healthcare provision surveillance section
- Healthcare purchase surveillance section
- Financial and internal administration section
- Internal audit department
- Legal department
- Analyses and research department
- Data service and application software department

Branches of the Authority totalling at 8 with offices in Bratislava, Trnava, Trenčín, Martin, Banská Bystrica, Nové Zámky, Košice and Prešov.

Forensic and pathology and anatomy centres of the Authority totalling at 13 with offices in Bratislava, Trnava, Trenčín, Nitra, Nové Zámky, Žilina, Martin, Prešov, Poprad, Banská Bystrica, Lučenec a Košice.

[1] Based on Report on activities of the Healthcare Surveillance Authority in 2006

Surveillance over provision of healthcare and over public health insurance can be executed solely by employees with a university degree in fields set out in the respective act. With respect to professions, the Authority employs the highest number of experts - doctors, followed by engineers with economic background and lawyers.

Table 1: Personnel educational structure of the surveillance authority

	Head office		Branches		FPAC centers		Total	
Education	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
University	70	60.87	91	63.19	97	40.93	258	52.02
Secondary school	42	36.52	53	36.81	96	40.51	191	38.51
Apprentice school, elementary school	3	2.61			44	18.56	47	9.47
Total	**115**	**100.00**	**144**	**100**	**237**	**100**	**496**	**100**

Source: Report on activities of the Healthcare Surveillance Authority in 2006

2.2.1 Surveillance over health insurance companies

The Authority conducts surveillance over public health insurance by overseeing compliance with provisions of Act No 581/2004 Coll. and a separate regulation – Act No 580/2004 Coll. The Authority conducts the following types of surveillance over health insurance companies:

a) **remote surveillance**. Remote surveillance in 2006 focused on:
   1. handling notions of insured persons regarding their illegitimate changeover for another insurance company
   2. monitoring of compliance with reporting obligations with respect to regular sending of reports
   3. inspections over financial operations of health insurance companies
   4. solvency

b) **onsite surveillance**. Onsite surveillance in 2006 focused on:
   1. compliance with provisions in Section 6 of Act No 580/2004 Coll. regulating submission of health insurance applications
   2. fulfillment of obligations of a health insurance company set in the permit and compliance with provisions in 6 of Act No 581/2004 Coll. regulating operations of health insurance companies
   3. fulfillment of measures adopted in the recovery plan of health insurance company Spoločná ZP, a.s.,
   4. correctness of calculation of contribution to activities of the Authority for 2007,
   5. correctness of reporting of solvency on the part of health insurance companies

In 2006, onsite surveillance over health insurance companies was conducted on the basis of:

- the surveillance plan,
- notions filed by insured persons and other health insurance companies,
- information acquired in the curse of activities of the Authority from health insurance companies.

Table 2: Conducted onsite surveillance inspections in various health insurance companies by category and identified shortcoming in 2006

Health insurance company	Scope of surveillance	Identified shortcomings	Sanction imposed
Všeobecná zdravotná poisťovňa, a.s.	compliance with Section 6 of Act No 580/2004 Coll. regulating submission of health insurance applications	failure to meet deadlines by HI in notifying the Authority of a HI change failure to meet deadlines related to submission of HI reports breach of reporting obligation related to a HI office change	penalty of SKK 100,000; obligation to report a health insurance company office change in order to enable the Authority to amend the permit
	fulfillment of adopted measures in the field of documentation administration, meetings due dates of payments and correct reporting of solvency	repeated shortcomings related to administration of documentation of paid and pending payments incorrectly reported solvency for December 2005	penalty of SKK 200,000
Spoločná zdravotná poisťovňa, a. s.	In its decision of 30/9/2005, the Authority imposed on Spoločná ZP, a. s., the obligation to develop a recovery plan based on which HI will be able to settle its liabilities within due periods. The highest priority within the recovery plan was financial stabilization of the insurance company. Fulfillment of measures adopted within the recovery plan of the insurance company aimed at liquidation of liabilities after the due period proceeding of 2005, timely settlement of liabilities and revisiting relevancy of reasons behind pending liabilities within the set period.	the health insurance company implemented measures adopted in the recovery plan by liquidating liabilities after the due period preceding of 2005 and with respect to pending liabilities with justified reasons for such non-payment were documented. Failure to meet due periods for healthcare provided in 2006 Shortcomings in accounting administration of the HI	Adopt measures aimed at removal of identified shortcomings.
	Implementation of measures in the recovery plan and correctness of reporting solvency levels.	Breach of Section 14 Subsection 2 and 7 of Act No 581/2004 Coll. incorrectly reported solvency levels in May and June 2006	Penalty of SKK 100,000

Table 2 - continuation

Health insurance company	Scope of surveillance	Identified shortcomings	Sanction imposed
APOLLO zdravotná poisťovňa, a.s.	Compliance with provisions in Section 6 of Act No 580/2004 Coll.	Failure to meet the deadline in reporting the reception of an application with respect to concluding a public health insurance contract and an insurance company changeover	Penalty of SKK 50,000
DÔVERA zdravotná poisťovňa, a.s.	Compliance with provisions in Section 6 of Act No 581/2004 Coll. and conditions set in the permit	Breach of provisions in Section 6 Subsection 10 of Act No 580/2004 Coll., failure to meet reporting obligations upon the reception, acknowledgement of an application and delivery of an insurance ID card, failure to meet the due period for healthcare provision, incorrect administration of documentation related to the list of pending payments	Penalty of SKK 10,000 for breach of provisions in Act No 580/2004 Coll., penalty of SKK 200 thousand for breach of obligations of a health insurance company under Act No 581/2007 Coll.
	Reception of public health insurance applications	No shortcomings	No sanction
SIDERIA zdravotná poisťovňa, a.s.	Overall financial operations of the insurance company and meeting reporting criteria	Failure to meet due periods, incorrect reporting of solvency level of the insurance company, breach of the measure issued by the Ministry of Finance of the Slovak Republic on accounting procedures	Penalty of SKK 300,000
Európska zdravotná poisťovňa, a.s.	Compliance with provisions in Section 6 through 8 of Act No 580/2004 Coll.	No shortcomings	No sanction
UNION ZP a.s.	Compliance with provision in Section 6 Subsection 16 of Act No 581/2004 Coll.	Breach of Section 6 Subsection 16 of Act No 581/2004 Coll. due to the fact that the health insurance company offered benefits provision of which was not guaranteed	Penalty of SKK 3,000,000
	Reception of public health insurance applications	Not identified	No sanction
	Correct reporting of solvency level	Incorrectly reported solvency for May 2006	Penalty of SKK 100,000

Source: Report on activities of the Healthcare Surveillance Authority for 2006

Imposing penalties in insured persons and insurance payers

In the course of 2006, the Authority issued under Act No 581/2004 Coll. the total of **7,839** decisions on imposing a penalty to insured persons and insurance payers due to incompliance with or breach of obligations set in respective legal regulations mostly Act No 580/2004 Coll. reported by health insurance companies.

Resolving notions and complaints

In 2006, the Authority reported 1,405 filings related to wrongful changeover of insurance policy of insured persons. The filings concerned 2,606 insured persons as the Authority was delivered also multiple filings on behalf of several insured persons. From the total number of insured persons, 2,236 were related to insured persons of Union, further 370 insured persons mainly to Európska zdravotná poisťovňa and Dôvera.

The Authority filed a notion related to unauthorized use of personal data of insured persons and filed a motion with the Personal Data Protection Authority.

2.2.2 Healthcare provision

In 2006, the Authority received within the healthcare surveillance **1,321** filings out of which 1,168 (i.e. 88.4 %) were closed in 2006 and 153 (i.e. 11.6 %) were pending. The structure of notions and complaints by their scope:

- dissatisfaction with the course of treatment (48.5 %)
- in relation to death (20.7 %)
- inconsistence in the amount of collected payments for services (5.0 %)
- non-ethical approach of healthcare personnel towards the patient (4.8 %)

Safety and protection of patients´ rights

The authority fulfilled task in the area of advisory and consultancy provided to patients, monitored awareness of the public concerning observation of patients´ rights. Within the advisory and consultancy activities of the Department for safety and protection of patients´ rights, the Authority in 2006 effectuated:

- **3,126** telephone calls
- **45** written filings
- **632** electronic filings

The queries raised by the public most frequently concerned questions related to:

- collection of fees (mainly for issuance of various confirmations and priority booking of patients),
- extracts and handover of medical documentation,
- extent of preventive examinations covered by health insurance (mainly gynaecology, hazardous employment),
- social affairs (granting disability pensions, special nursery care)
- possibilities of changing for a different doctor,
- issues related to changeover for a different health insurance company,
- title to spa treatment,
- dissatisfaction with approach and behaviour of healthcare personnel,
- refusal of a proposal for concluding a healthcare provision contract on the part of the provider (mainly stomatology)
- possibility of health damage compensation.

2.2.3 Healthcare purchasing

In the course of 2006, the Authority conducted in the area of purchase of healthcare surveillance over compliance with legislative conditions related to contractual relations between healthcare providers and health insurance companies as well as providing public heath insurance with respect to payment for healthcare which healthcare providers provide for within the extent covered from public health insurance. The Authority supervised healthcare quality in selected areas of healthcare provision.

Supervision in the field of purchase was conducted by the Authority in collaboration with the Ministry of Healthcare of the Slovak Republic, professional associations, health insurance companies and other institutions.

With respect to scope/character of filings, also in 2006 clearly the issue of charges for healthcare provided dominated. More than one fourth of all filings – the total of 125 which stands for 26 % - related to charges. Majority of that number were raised with respect to the possibility of subsequent refund of charges for healthcare provided; a smaller number was related to questioning correctness of calculation of charges. Most frequent scope of filings:

- charges 125 filings (26.0 %)
- payment for healthcare examinations and procedures 86 filings (17.8 %)
- other (EMS, licenses, HCP lease contracts, rights of insured persons, compliance with the law) 60 filings (12.4 %)
- prescription of medicine, medical accessory 43 filings (8.9 %)

Key areas of onsite and remote surveillance (based on filings and also based on the Authority's own initiative):

- review of provided healthcare quality, compliance with the legislation and effective use of financial resources at dialysis centers in the Slovak Republic (the most extensive onsite surveillance inspections in 2005-2006). Based on the findings from 2005, the Authority conducted in 2006 onsite surveillance inspections with respect to alleged breach of diagnostic and therapeutic procedures related to treatment of renal anemia owing to failure to present necessary documentation and verification of findings acquired via remote surveillance inspection. **Based on the initiative of the Authority**, **outcomes of the surveillance checks were incorporated in the decree of the Ministry of healthcare of the Slovak Republic No 428/2006 Coll.** on minimum requirements concerning personnel and material-technical facilities of certain medical centers in the part addressing dialysis centre amending the legal regulation to correspond to the necessary quality level of healthcare provided in extracorporeal elimination treatment centers. The Authority actively participated, by rising remarks based on surveillance findings, in drafting the new Specialized directive concerning execution of treatment substituting functionality of kidneys and for execution of extracorporeal elimination treatment,
- draft contracts of the healthcare providers striving to ensure continuity of contractual relations of HC and HCP,
- preparedness of health insurance companies to provide for public health insurance and ensuring healthcare provision to insured persons,
- integrity and functionality, structure and safety of information systems of health insurance companies,
- quality of healthcare provided in the field of geriatrics,

- compliance with Section 9 of Act No 581/2004 Coll. (auditing activities) at sites of emergency medical service with respect to providing HC, compliance with Section 7 of Act No 581/2004 Coll. (concluding contracts) with respect to concluding contracts on healthcare provision with EMC providers,
- conduct of health insurance companies in relation to compliance with binding legal regulations with respect to administration of lists of insured persons waiting for provision of planned healthcare,
- specialized outpatient treatment (SOT) in the fields of medical genetics, rheumatology, nephrology,
- provision of healthcare in cardiothoracic and vascular disease institutes nationwide in relation to contractual process for terminated inpatient treatment,
- inpatient healthcare treatment in the field of children's oncology
- compliance with binding legal regulations with respect to provision of healthcare in extracorporeal elimination treatment centers (nationwide),
- collaboration in preparatory phase for implementation of Slovak chairmanship of V4 – area of cross border medical cooperation.

Table 3: Unification of procedures in the purchasing process

Participants	Issue addressed
Ministry of healthcare of Slovakia **Health insurance companies - GR** **Emergency and transport medical service Bratislava**	1. Unification of procedure related to annual reconciliation of prepayments for providers of EMS in the period from 01/07/2005 to 31/10/2005 in Slovakia 2. Defining vehicle category under RLP and RZP 3. Conflict between permits to conduct activities of former and new providers of EMS, providing for continuity in provision of EMS
Principal expert at the Ministry of healthcare in the field of pneumology **Representative of prof. business** **Health insurance companies – GR**	1. Insufficient utilization of the settlement method for BCG- vaccination and tuberculin 2. Settlement method for BCG- vaccination and tuberculin in the future 3. Effective information dissemination concerning the outcome of the agreement and instructing branches of HI and HCP
Ministry of healthcare of Slovakia **Health insurance companies – GR**	Resolving the issue of prepayments for providers of EMS
Health insurance companies – GR	1. Presentation of rations of insured persons of individual health insurance companies as at 1/1/2006 2. Current problems of EMS
Ministry of healthcare of Slovakia	1. The problem of equality "specialization" and "certificate" in medical fields, with respect to which university curricula changed 2. Problem of authorization to designate shape, size, contents or other parameter of a medical stamp
Všeobecná ZP – GR	Status of concluding contracts between health insurance company Všeobecná ZP, a.s., and providers of general and specialized outpatient healthcare

Health insurance companies – GR	Annual reconciliation of health insurance prepayments
Health insurance companies – GR	1. ID numbers for foreigners 2. Sending of allowances from the Social Insurance Company – data interface 3. Conduct of the Authority in case of a change for another HI
Health insurance companies – GR **Slovak Medical Chamber** **Association of Slovak Hospitals** **Association of private doctors in Slovakia**	Acquiring a license for healthcare profession
Health insurance companies – GR	Settlement of provided HC by the emergency health service, initiation of remote supervision check concerning effective use of financial resources of VZP for activities of EMS
Health insurance companies – GR **Slovak Chamber of Dentists**	1. Auditing activities 2. Charges and settlement of healthcare provided 3. Settlement of urgent healthcare
Health insurance companies – GR	1. Status of submitting proposals for issuance of payment assessments and coordination of actions of the Authority and health insurance companies 2. Unification of conduct of HI concerning servicing of insurance ID cards of insured persons 3. Evaluation of the situation in HI in the field of annual reconciliation 4. Evaluation of compliance with the reporting obligations of HI 5. Conduct of HI when resolving the issue of license renewal 6. Annual redistribution of insurance premium – providing direction to HI
Health insurance companies – GR	1. Settlement of examinations and procedures (recipes of non-contacted doctors) 2. Creation of a list of contracted HCPs on the internet
Health insurance companies – GR	1. Settlement of medicaments issued in pharmacy 2. Settlement of executed CETE examinations prescribed by non-contracted HCP
Health insurance companies – GR	1. Procedure applicable to enforcement of the right of an insured person in case of a change of the HI without his/her consent 2. Procedure related to submission of information and cancelled applications 3. Information about the preparedness of the Authority for the change of HCP codes and status of submission of payment assessments on the part of HI

Source: Report on activities of the Healthcare Surveillance Authority for 2006

Part Three: Risk assessment model (based on the NZa pattern)[2]

3.1 Risk analysis model background

The surveillance authority (NZa) has the ambition to be prudent when conducting surveillance checks. From the perspective viewpoint, the Authority formulated several starting points (background) for the Risk analysis model:

- The model is based primarily on the regulated market as a controlling mechanism for the new healthcare system.
- Also the fact that predominantly health insurance companies and healthcare providers are responsible for health insurance implementation and for provision of healthcare including guaranteed quality is a principal point of the Risk analysis model. This is reflected in the use of controls and assessments as factors decreasing risks.
- Also important aspect in the model is achieving the desired reduction of administration activities and cost of surveillance. By means of planned systemic decisions, the Authority strives to provide necessary information and *ad hoc* information (i.e. efforts aimed at decreasing administrative cost) also striving to exercise focused surveillance (decrease in surveillance cost). Regardless of the above, the Risk analysis model needs to guarantee proper functioning of the market and fulfillment of obligations on the part of the health insurance company as set by law and in directives.
- Another starting point is ensuring that risk control and exercise of surveillance is transparent, predictable and reproducible. In this manner, it is possible to adequately determine areas that the focus of the Authority should be aimed on. Although the Authority does not focus on other areas actively; it always monitors them based on relevant signals from the society
- Besides, the Authority needs to be able to fulfill, using the Risk analysis model, expectations of interest groups while responsibly fulfilling its tasks.

Required prudence of the Authority is reflected in the Risk analysis model in three aspects:

- The Authority requires from health insurance companies (regular or *ad hoc*) (accountable) information solely in case there is a reason. Such reason materializes based on estimation of increased likelihood and/or increased rate of negative consequences if a risk occurs. Requested (accountable) information sometimes comprises one-off measurement (zero level) but more frequently a smaller number of indicators, which are relevant with regards to risks. The Authority imposes additional workload upon health insurance companies in least extent possible. Measurements are conducted using resources already available – such as information from other entitled authorities, consumer organizations and associations – as well as using information from brochures and websites of health insurance companies. In case of risks designated as low, the Authority in the beginning does not require from health insurance companies any structured accountable information. In this manner, the Authority meets one of its objectives, i.e. reduction of administrative cost on the part of health insurance companies.
- The Authority conducts more in-depth investigation solely in case that provided examinations and procedures, market development or other signal imply such action is necessary. As such investigation is in

[2] The whole part three is based on a translation of the publication “Notes: Risk Analysis Model, Health Insurance Act 2007”, original: “Toelichting: RisikoAnalyseModel, Zorkverzekeringswet 2007“, Nederlandse Zorgautoriteit 2007

the first stance aimed at identification whether the risk identified is already known and managed, it therefore remains narrowly focused. In case it is found that the risk identified is not known and managed or potentially that it is not known and managed in full, further investigations follow.

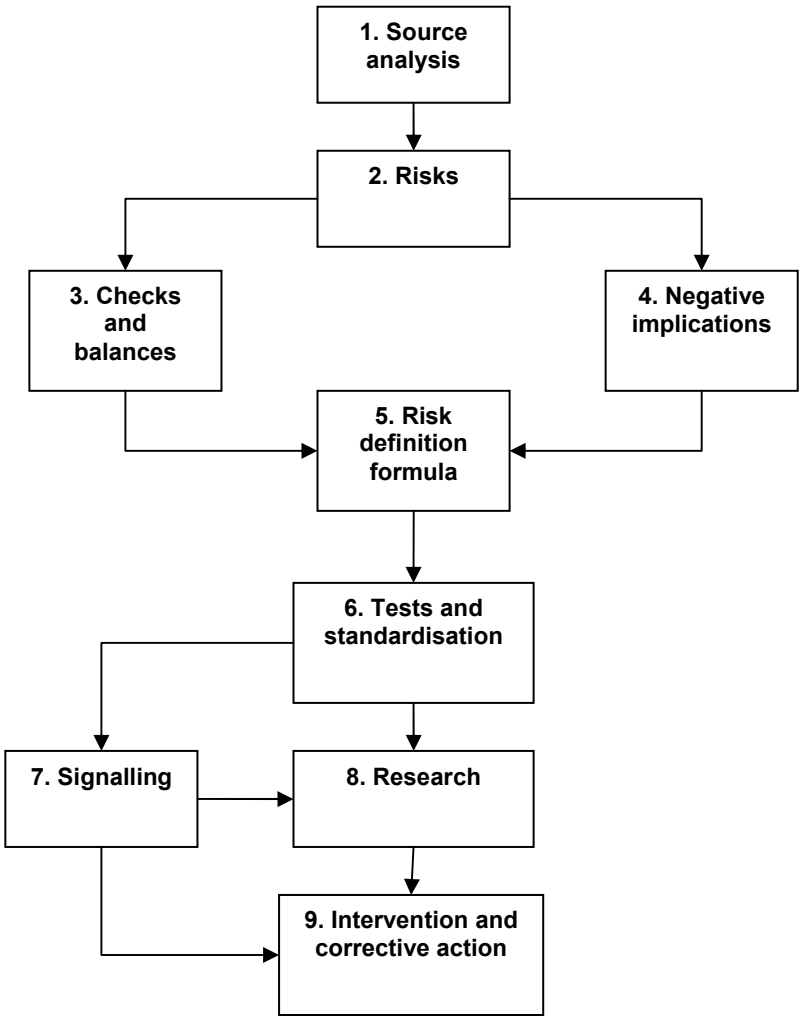
- Risks ranked as low are scrutinized only if a respective impulse is raised within the society.

The said aspects sufficiently illustrate that the Risk analysis model of the Authority is more than a mere risk analysis instrument. The model describes also further steps based on outputs from risk analysis.

Risk analysis model utilization

The Authority runs the Risk analysis model every year to identify which risks materialized and how existing risks develop. Based on primary experience with the Health Insurance Act of 2006, also risks subject to analysis were adjusted in 2007 accordingly. The Authority determines its working procedure based on outputs from risk analysis. Also, the Risk analysis model (Figure 1) is subject to annual review. Based on such review the model is adjusted and improved.

Figure 4: Structure of Risk analysis model 2007



Source: NZa, 2006

Notes to Risk analysis model

The Risk analysis model describes risk identification process, analyses risks and selects most substantial risks for the Authority. Chapters below provide detailed description of each step of the Risk analysis model structure.

Step 1: Source analysis

The first step concerns analysis of sources of risks and information. These can include among other also acts, explanatory notes, extraordinary regulations, agreements, relevant literature, scientific studies and related processes and experience of other entitled authorities.

Step 2: Identification of risks, their description and definition

Based on the analysis of sources of risks and information, the Authority needs to identify, describe and define risks. In this respect, a risk is defined as a *condition or status, which may have negative impact on persons, organizations and/or institutions, which are in relevant relation to the Health Insurance Act, General Act on Extraordinary Health Expenditures and Act on Healthcare Market Structure.*

Risks are divided into so-called risk groups. Risk groups are identical with tasks of the Authority. From the perspective of the above acts and their implications to health insurance companies it is necessary to distinguish the following risk groups:

- health insurance market (market risks);
- transparency and information (behavioral risks);
- obligations set by law as set out in the Health Insurance Act.

Step 3: Checks and balances

The next step in the Risk analysis model is examination of effects reducing control mechanism-related risks within the framework of the legislation and directives all in line with risks defined. The mechanisms are called checks and balances. In case of risk groups' health insurance market, transparency and information and mandatory obligations pursuant to the Act, similar forms or checks and balances prevail; these are, among other, derived from the Health Insurance Act. Examples: an insured person has a direct interest and can directly or by means of a third party enforce his/her rights, or an insured person has a direct interest and can change for another health insurance company.

With respect to each risk, the Authority determines whether all checks and balances create preconditions reducing risks and if this is the case, which in particular. Implications of checks and balances on risk levels are as follows:

- not reducing risks (=high residual risk, or the probability of risk occurrence still remains high),
- moderately reducing risks (=average residual risk or the probability of risk occurrence is average), or
- significantly reducing risks (=low residual risk, or the probability of risk occurrence is low).
- the most frequent outcomes of – pre-selected – most significant checks and balances make up the final decision.

Step 4. Negative implications

With respect to each risk, the Authority determines whether there is any negative implication and if so, what impact it may have upon the respective risk. Overall average assessment of all negative implications result in the ultimate decision. Some – pre-selected – negative implications have more substantial status. Negative implications can be formulated as *high, medium* or *low. High* means that the Authority expects that in case of occurrence of the specific risk, negative implications will be severe. *Low* means that negative implications will be restricted. Examples of negative implications with respect to risk groups are as follows:

- actual access of insured persons to insurance is jeopardized
- actual access of insured persons to healthcare is jeopardized, too.

Step 5: Risk definition formula

The risk definition formula is composed of a diagram, in which risk implication is assigned a color code. The color and position of a risk defined accordingly in the formula is derived using a combination of the ultimate decision in the matter of check and balance and the ultimate decision in the matter of negative implications of the respective risk (Figure 5).

Figure 5: Risk definition formula

Negative implications (Y)			
High			
Medium			
Low			
	Low	*Medium*	*High*
			Checks and balances (X)

Source: NZa, 2006

Note: Axis X determines to what extent check and balances impact on probability of a risk occurrence. Axis Y determines to what extent negative implications may arise in case of occurrence of a specific risk.

Risk definition formula colors bear the following meaning:

- ***Green**:* the risk has been, based on checks and balances, minimized and negative implications are so low that the risk is very limited or not present at all. The Authority can, however, react to signals (step 7 *passive signal research*).
- ***Orange:*** the risk has been, based on checks and balances, limited and negative implications imply the risk would increase. Risk implications can also be increased as the risk itself is not reduced following the checks and balances, however, actual negative implications are low. Therefore, it is very important that the risk is scrutinized in more depth. This means assessing information related to the current status with respect to the risk (e.g. using an indicator) or it is necessary to conduct a so-called zero measurement.
- ***Red**:* the risk has not been, based on checks and balances, minimized and negative implications range from medium to high; this means that risk implications are high. Therefore, it is very important that the risk is scrutinized in more depth. This means assessing information related to the current status with respect to the risk (indicator) but the Authority will also run (potentially also on regular basis) an in-depth research.

Step 6: Test and standardization

The formula implies the nature of the risk after the analysis of checks and balances and also negative implications. Based on the above formula, the Authority decides about the "path the risk will develop further". Green risks all fall into the *passive signal research* (step 7).

Health Insurance Companies Act required integral review of operations (performance) of each health insurance company separately. Compared to the application of the Health Insurance Act, health insurance companies were required to provide relatively vast quantity of information. Health Insurance Act no longer requires and integral review and due to this reason, surveillance based on risk control and proportionality was chosen.

Such new approach includes, among other, also the fact that the Authority identifies in advance which information is needed to assess risk probability. The thing is whether it is possible to determine using restricted information (indicator) whether a certain risk is actually materializing and whether the surveillance authority needs to initiate a surveillance activity. In this respect, the Authority uses as the information source, among other things, also annual forms summarizing Health Insurance Act implications. This means annual reports and the annual report regarding professionalism of health insurance companies´ organizations or annual report of medical centers. Using a wide array of information sources, the Authority managed to reduce the volume of information required from health insurance companies.

Regarding the Health Insurance Act, the Authority presumes that health insurance is provided in line with the regulations unless a position is made that a part thereof no longer is provided in line with regulations. As no integral review is required the indicator may not necessarily provide the full picture of operations of a health insurance company. Only conclusions related to risk management are relevant.

Using indicators and other above information sources, the Authority transformed risks into the form of tests. With respect to each risk, a different form of testing will be applied with minimum and/or relative set of standards (standardization). Minimum standards relate to requirements necessary under the legislation and respective regulations; relative standards reflect development of operations (performance) with regards to a certain risk within a

defined timeframe. Relevance of relative standardization is comparable to the functionality of a dashboard in a car: if almost all fuel is spent, red light turns on.

All collected information has a certain information value with respect to performance of a health insurance company in relation to risk and also with respect to potential requirements necessary for managing of such risk. Also by means of signals such as a defined number of (justified) complaints of customers, the Authority obtains information about performance to which the respective risk relates. The rate of risk occurrence as implied by standardization significantly determines necessary level of in-depth examination on the part of the Authority.

With regard to certain *orange* risks the Authority does want to merely wait for signals; rather it wants to act in a timely manner, if appropriate. The common denominator of risks is that the have multiple aspects. Monitoring of such risks using specific indicators annually measured e.g. in annual reports of companies or by market monitoring is not effective. Therefore the Authority takes as a starting point the fact that with respect to the said risks it conducts with health insurance companies the basic test as the zero measurement (step 7).

Regarding market risks, performance is frequently not easy to interpret unambiguously using one risk only. The development of the health insurance market is always complex. The Authority in this respect applies a limited number of indicators, frequently concurrently to various risks. Such indicators jointly indicate possible undesirable situations and development. After reviewing various indicators (reviewing indicators *individually*), the Authority commences more detailed investigation or intervenes. Such approach and intervention strategy will be implemented based on casuistry. Depending on individual cases, the Authority always needs to establish whether a certain intervention is necessary or possible.

Steps 7 and 8: Signaling and research

Based on the formula for definition of risks and specific testing methods, the Authority adopts a decision concerning next steps. There are three options:

- research of signals (passive, active and internal signals);
- zero measurement;
- research aimed at the question whether the occurring risk is identified and managed or whether specific market development will make it necessary for the Authority to step in.

Signal research

With respect to research of signals the Authority requires, collects and reviews information about health insurance companies and the market they operate in as well as about the service provider market. The Authority watches external signals and based on them determines whether more in-depth surveillance is needed. Based on external signals the Authority can also identify new risks.

Research of signals comprises passive or active research. In case of *green risks* the Authority expects signals – this represents passive research of signals. These comprise signals from patients/insured persons forming the “eyes and ears” of the surveillance authority, signals from health insurance companies, healthcare providers or other entitled authorities; written statements of health insurance companies; verdicts of the court or of various commissions, signals from the media; signals/questions from politics.

Active signal research relates to *orange* and *red* risks. Active signal research is a form of examination in which the Authority does not expect signals from its contact points but takes the initiative and monitors signals over various information channels. These can comprise various forms of advertising, brochures and websites of health insurance companies as well as model agreements. With respect to orange and red risks the Authority actively follows signals from interest associations of insured persons, patients or healthcare providers indicating insufficient risk management. The Authority can also derive signals from complaints filed by insured persons with their health insurance companies, medical centre or dispute resolution commission. This is the reason why the Authority requires that health insurance companies include information about the above topics in their annual reports.

Besides external signals the Authority takes into account with respect to conducting surveillance also *internal* signals. Internal signals can be derived from monitors and other publications of the Authority. At the same time, signals can be provided by the Authority's personnel who are insured persons themselves.

Zero measurement

In case of multiple complex most frequently *orange* risks the Authority uses the so-called zero measurement tool. If possible, the Authority relies on information already available to the National Bank of the Netherlands and the organization monitoring the health insurance market. If necessary, the Authority conducts zero measurement using a questionnaire in the form of a survey or self-reviews. More in-depth examination is conducted solely if there are serious signals that a health insurance company fails to comply with its obligations as it should or if this can be indicated by zero measurement outcomes.

Research

Using a more detailed research, the Authority determines with respect to each risk individually whether a health insurance company identifies the risk and to what extent already identified risks are managed. The Authority runs a research to confirm findings and their application using tests and standards.

A more detailed research can comprise an array of activities ranging from desk research *(low-level)* to research executed directly in the health insurance company i.e. in case of identified risks and measures aimed at managing of such risks on the part of the health insurance company *(high-level).* In case of crisis situation the Authority initiates intensive investigation. This comprises monitoring of identified shortcomings and increased volume of information identical to the case of in-depth surveillance.

In case market risks occur in combination with other undesired development this will constitute, due to their complexity, a cause for the Authority to initiate an in-depth thematic inspection. Based on findings from such inspection, the Authority will develop further forms of testing (scenarios) and, if appropriate, also intervention strategies.

Step 9: Intervention and enforcement

Based on researches, the Authority can apply intervention or enforcement. In some instances, research, intervention and enforcement are so close that the transition from one form to another is very smooth. In this case, the Authority needs to be highly resolute.

There are various intervention tools for the Authority to use:

- initiating thematic researches related to certain risk aspects;
- signals sent to the Minister. Such signals can include advices regarding measures adopted to remove market barriers;
- talks with a health insurance company on the management level and/or executive level to determine potential conflict points and solutions with respect to specific risks;
- intervention in case the market transparency may be jeopardized between health insurance companies. In such case, the Authority can publish information about features of products and services offered by health insurance companies such as insurance, wording of model contracts and the manner of provision of services to insured persons.

Apart from that, the Authority can use several other options: Based on the outcomes from research, the Authority will determine on the basis of decision-making modules whether and, if appropriate, which instruments of enforcement are to be used. Among other, the Authority can also issue recommendation, impose a mandatory charge or penalty. Also in case of imbalanced market position, the Authority can apply various measures and monitor their implementation.

3.2 Risks in the Dutch Health Insurance Act according to the NZa report

The following tables provide an overview of risks within the risk groups (1) *health insurance market*; (2) *obligations set out in the Health Insurance Act*, and (3) *transparency and information*. Risks arising from the risk group General Act on Extraordinary Health Expenditures and *regulation of tariffs and examinations and procedures* are being developed and the Authority will publish them later. The risks and risks estimates relate to the condition known as at 1 October 2006.

Table 4: Health insurance market risks

RISK GROUP HEALTH INSURANCE MARKET	***C&B***	***NI***	***Total***
Too high concentration will eliminate competition stimuli owing to which insured persons will face the possibility of less choice and also the risk of too high prices.	L	H	M
Due to existence of too broad benefits related to health insurance offering, the health insurance market entry barrier for new health insurance companies is too high and (effective) benefits of market existence are not apparent.	M	M	M
Payments an insured person receives when selecting healthcare not subject to the contract do not comply with payments set in model contracts.	L	L	L
Due to existence of individual benefits related to health insurance offering, the health insurance market entry barrier for new health insurance companies is too high and (effective) benefits of market existence are not apparent.	M	L	L
Using product differentiation, each health insurance company strives to get a unique position on the health insurance market due to which the choice for insured persons is reduced.	L	M	L
Too high costs related to acquisition of insured persons result in increased costs related to changeover ("retention cost") due to which (effective) benefits of market existence are not apparent.	L	H	M
Owing to counter conditions which a health insurance company sets with respect to health insurance termination, changeover cost (“retention cost”) would be too high due to which (effective) benefits of market existence are not apparent.	M	M	M
Insured persons are not sufficiently responsive to low price sensitivity due to which (effective) benefits of market existence are not apparent.	M	H	H

Source: NZa, 2006

Table 5: Risks related to obligations set by law

RISK GROUP OBLIGATIONS SET BY LAW	C&B	NI	Total
A. Healthcare availability			
Insurance offered on the market does not correspond to conditions set in the Health Insurance Act.	L	H	M
Equal access of insured persons to various offered versions of health insurance set by law is not possible.	M	M	M
Health insurance company wrongfully terminated health insurance of an insured person.	L	M	L
B. Access to healthcare or healthcare payments			
Health insurance company sets unjustified requirements with respect to access to healthcare or payments for healthcare.	L	H	M
Insured person receives less healthcare or lower payments for healthcare than he/she is entitled to under the law.	L	H	M
Incorrect calculation of own risk/renouncement of title	L	L	L
Insured person does not receive necessary healthcare on time (healthcare and its provision).	L	M	L
Insured person received payments in insufficient amounts when selecting healthcare not subject to the contract.	L	M	L
Quality of healthcare subject to the contract or mediated healthcare is not sufficiently guaranteed.	M	M	M
C. Affordability of the insurance system			
In case health insurance provides higher extent than determined in the offer under the law.	M	M	M
Health insurance company receives incorrect payment within redistribution as a consequence of incorrect redistribution data.	M	H	H
D. Other obligations of health insurance companies arising from the Health Insurance Act			
Health insurance company fails to comply with administrative obligations	L	M	L
Health insurance company insufficiently meets obligations pursuant to directives on statutory penalties	L	M	L
Health insurance company insufficiently meets obligations arising from ministerial regulation and partial decrees.	Not applicable in this particular case		
Health insurance company breaches privacy of insured persons or misuses their personal data.	Not applicable in this particular case		

Source: NZa, 2006

Table 6: Consumer behavior risks

RISK GROUP BEHAVIOUR	*C&B*	*NI*	*Total*
Person obliged to conclude an insurance contract is motivated on the part of health insurance company by incomplete or incorrect general information in order to conclude health insurance contract with such company.	M	M	M
Person obliged to conclude an insurance contract does not have at his/her disposal all options and therefore has limited choice.	M	M	M
Incomplete, incorrect or incomprehensible information immediately prior to concluding health insurance contract.	M	H	H
Incomplete, incorrect or incomprehensible information in the course of health insurance contract validity.	M	M	M
Person obliged to conclude an insurance contract is not in a position to sufficiently assess the difference between various health insurance companies.	L	M	L
Person obliged to conclude an insurance contract is not able to exercise his/her rights (insufficient enforceability).	M	H	H
Person obliged to conclude insurance contract cannot, due to insufficient information, incomplete information about his/her rights and/or unwillingness of health insurance companies to terminate concluded contract remotely.	M	M	M

Source: NZa, 2006

Part Four: Potential Risks on the Health Insurance Market in Hungary

This section aims at identification of potential risks in the first years of the new health insurance system in operation based on the Dutch and Slovak experience. Clearly, the list of risks is not and cannot be exhaustive. It is a task for EBF to monitor health insurance market developments, identify new risks, find solutions enabling their elimination or stimulate health policy makers to cooperate on elimination of such risks. Also, it is very important to review potential risks defined today and to reclassify them appropriately.

Identification of risk is based on the following assumptions:

- the primary goal of the new system is consumer protection and ensuring higher quality and availability of healthcare
- the goal of the new system is to introduce competitiveness in the new system stimulating competition between health insurance companies to attract insured persons by means of efficient purchase of healthcare

Table 7: Health insurance market risks

Risk	C & B	NI	Total
County auction system will in future disable market entry for new health insurance companies which restricts competition – after the auction completion the act does not make entering the market possible otherwise than by acquisition of a minority share in an already existing HIT			
Majority stake of the state in all HITs does not enable standard corporate governance – the Republic of Hungary is a 51 % owner and the stake is non-marketable			
Risk of misuse of information about competition – there is a high risk of data compromising – the legislation does not regulate data protection on the part of the majority shareholder			
Risk related to risk selection of insured persons – redistribution is derived solely from age and gender which are insufficient predictors – regional monopolization, however, mildly reduces this risk			
Incorrect calculation of payment for the HIT from the healthcare fund in the risk adjustment system			
Creation of local health insurance monopolies - risk of abuse of dominant position on the relevant market (which is constituted by the county) – absence of competition will not result in desired outcomes			
HIT fails to meet reporting obligations towards the authority			
HIT fails to comply with the condition of preliminary consent from the authority			
Implementation-related problems: The “triangle“ problem, invoice – clearing – cash			
Failure to meet solvency criteria - while the state in the position of a 51 % shareholder can always step in and increase solvency. Although this state intervention has negative impact on competitive environment (state aid problem)			

Failure to meet reporting obligations in the process of registration of an insured person in case of a HIT changeover – the implication is very negative if a HIT fails to deliver necessary documentation on time and the insured person is refused to be provided with healthcare			
Procedure related to exceeding upper limit of the number of members of a HIT (more than 2 million). Which members will be excluded from a HIT and to which HIT they will be assigned?			
Risk of inappropriate valuation of asset value corresponding to the amount of minimum shareholders equity			
Risk that a HIT will not conclude contracts with the sufficient number of providers (geographical accessibility in minutes) and in an adequate volume (capacity throughput) which may jeopardize access to healthcare			
Risk that a HIT will not contract the scope of healthcare set by law (risk of under-treatment of an insured person)			
Risk that pricing will be not transparent and will be centrally managed (without the option of local liberalization on the level of counties). Expectations related to increased efficiency of healthcare purchasing may not be fulfilled			

Source: Health Policy Institute, 2007

Notes:

CH and B (checks and balances): How the respective risk is addressed by the legislation

NI (negative implication) regarding the consumer

Table 8: Consumer protection risks

Risk	C & B	NI	Total
Incorrect application – an insured person can encounter problems in delivery of the ID card and can be temporarily refused medical treatment from his/her provider			
False application – an insured person is subject to forcible and fraudulent insurance change			
Fictitious application – an insured person does not exist i.e. no negative effect is implied with respect to any party concerned			
Offering benefits which cannot be saturated or which are conflicting with the law – misleading advertising			
A consumer is not provided with an insurance ID card – he/she has a temporary problem with availability concerning healthcare providers			
Consumer is not provided by a HIT with correct information required under the law			
Not accepted, correct application filed on time, which a HIT did not manage to administer and deliver on time to the regulator			
Consumer will encounter barriers when leaving a HIT			
HIT fails to meet reporting obligations toward insured persons			
Risks related to waiting lists			
Conflict "residence" – "workplace" when determining a HIT			
Misuse of an insurance ID card			
Refusal to provide healthcare to a HIT member despite the fact that a HIT and a HCP have a valid contract in place			

Source: Health Policy Institute, 2007

Notes:

C and B (checks and balances): How the respective risk is addressed by the legislation

NI (negative implication) regarding the consumer

Table 9: Categorization of applications according to correctness of data and signature

		Signature	
		Correct	**False**
Data	**Correct**	Correct application	False application
	Incorrect	Incorrect application	Fictitious application

Source: Health Policy Institute, 2007

Literature

1) Draft Health Insurance Companies Act of Hungary (version submitted to the Parliament)
2) Notes: Risk Analysis Model, Health Insurance Act 2007, original: “Toelichting: RisikoAnalyseModel, Zorkverzekeringswet 2007“, Nederlandse Zorgautoriteit 2007
3) Report on activities of the Healthcare Surveillance Authority in 2006, Healthcare Surveillance Authority, 2007