Loyens & Loeff N.V.
P.O. Box 71170
1008 BD Amsterdam
The Netherlands

The Hague, 26 October 2020

Number of enclosures:
Your reference:
Our reference: ACM/UIT/543322
Contact person :
Subject: ACM/20/039827 ACM's response to the planned agreement on the distribution of the effects of the coronavirus (COVID-19) crisis among health insurers for 2020

Dear Sir/Madam,

On behalf of ZN (Zorgverzekeraars Nederland, an umbrella organization of ten health insurers in the Netherlands), you asked the Netherlands Authority for Consumers and Markets (ACM) for a response to the planned arrangements of health insurers to '*distribute proportionally [among the participating health insurers] – after a threshold amount has been reached – the financial effects that will remain after payment of additional funds under Section 33 of the Dutch Health Care Insurance Act and after the determination of the equalization contribution by the National Health Care Institute (Zorginstituut Nederland) with the spring recalculation, and which are the direct result of the coronavirus (COVID-19) crisis [..]*' (draft memo of 2 September 2020)'.You contacted ACM with an eye to the compatibility of these proposed arrangements with competition rules.

This is our response.

<u>Background</u>

In April 2020, ZN contacted ACM on behalf of its members, which are the individual health insurers, and indicated that its members were considering setting up a 'solidarity scheme' for the year 2020. Over the past few months, health insurers deliberated what the scheme could look like, also against the backdrop of ongoing discussions with health care providers on the compensation of the additional costs resulting from the coronavirus crisis, and ongoing discussions with the National Health Care Institute (ZiNL) and the Ministry of Health, Welfare and Sport (VWS) on the effects of the coronavirus crisis on the compensations for risk equalization. In that context, health insurers included ACM in the process, kept ACM informed about the thought process regarding the implementation of the proposed agreement, and, at various times, answered questions to clarify issues. Meanwhile, ACM, during that period, also kept in touch with the Ministry of Health, Welfare and Sport and ZiNL in order to be informed of any developments regarding the risk equalization, and ACM also consulted officials of the European Commission. On 2 September, ACM received from you a new draft version of the proposed 'Agreement on the distribution of the effects of the coronavirus (COVID-19) crisis among health insurers', and, on September 9, you answered several final questions.

The draft version of the agreement that you submitted reveals that, with the proposed arrangements, health insurers seek to prevent 'the level playing field [..], on which health insurers are supposed to compete with one another, as well as the health insurance system as

such from becoming significantly affected by the coronavirus crisis,' which may have negative implications for the functioning of the health insurance market and the health care provision market.

Relevant facts and circumstances

Risk equalization in the Dutch health care system
For the basic health insurance, Dutch health insurers are statutorily required to accept all applicants, which means they cannot refuse anyone. In addition, a ban on premium differentiation is in place. Whether a person is young, old, sick or healthy, the premium charged by an individual health insurer for its basic health insurance package is the same for everyone. These obligations are some of the key foundations underpinning the solidarity of the national health care system. In order to safeguard the proper functioning of this system, health insurers receive an annual contribution from the Health Care Insurance Fund, corresponding to the risk profiles of their populations of insured individuals. In the absence of risk equalization, an insurer with a population of insured with an unfavorable risk profile would be forced to charge a higher premium than a health care insurer with a healthier population. This creates an incentive for health insurers to select favorable risks (risk selection), and undermines the level playing field on which health insurers should compete with each other. The contribution reduces that incentive for risk selection, and guarantees the accessibility of the basic health insurance for all insured. That, in turn, makes effective competition possible between health insurers, and it increases the incentive for health insurers to distinguish themselves from competitors in ways other than risk selection, such as the efficiency of health care procurement and their own costs.

The contribution from the Fund mainly consists of an ex ante component. Until 2012, ex post calculations had also existed, which were based on actual costs (including a macro subsequent calculation for macro-cost overruns). Since 2012, that ex post calculation has been gradually phased out in order to stimulate health insurers more to invest in good health care procurement, and control of health care costs.

Since 2017, health insurers have virtually borne all the risk with regard to the implementation of the Health Care Insurance Act. Ex post adjustments are only made for the correct number of insured and background characteristics of insured, and for several specific costs[1]. In addition, once all claims of a certain year are known, the effects of an overestimation or underestimation of the macro-performance amount based on population characteristics are distributed among the health insurers. With this "flanking policy", health insurers continue to bear risk on macro-cost overruns, yet insurers with a different portfolio of insured are compensated for negative (or positive) equalization outcomes as a result of macro overruns or underruns in order to ensure a level playing field[2].

Since 2015, the Catastrophe Scheme, which has been laid down in Section 33 of the Health Care Insurance Act, has also been implemented. The government did not find it desirable to have health insurers bear all the risks in the event of catastrophes such as a pandemic. If the government had done so, it (and also against the backdrop of tighter solvency requirements) would have resulted in large additional financial buffers and, in turn, in increased pressure on premiums. That is why Section 33 of the Health Care Insurance Act stipulates that, if health care costs, as a result of a catastrophe, are significantly higher than expected at the time of the award of the equalization contributions, ZiNL is to grant, at the request of a health insurer, an additional contribution in order to cover the costs that the health insurer has to bear as a result of a catastrophe, and insofar these costs exceed a certain threshold.

[1] These involve costs of several smaller providers with budget financing, and certain prescription drugs that are phased into the basic package via 'the lock'.
[2] The flanking policy distributes the effects of overestimations or underestimations of the macro performance amount on the basis of population characteristics among the risk bearers, without adjusting the macro performance amount to the realized cost level (which is what the macro subsequent calculation did).

Health insurers thus, to a significant degree, face risks regarding their expenditures (in the form of health care costs), and, in that sense, do not differ, in principle, from other undertakings. This was also explicitly intended. Health insurers are expected to respond to these risks, and to be able to deal with unpredictability. In fact, the increased risks that they bear should stimulate them to pursue a robust and efficient financial strategy over the course of a calendar year, thereby controlling their costs. In that context, the risk equalization system (including the Catastrophe Scheme) offers, in principle, the necessary public safeguards for the quality, accessibility and affordability of health care.

Uncertainty about the effects of the coronavirus crisis, and the importance of maintaining health care capacity

This spring, the coronavirus (COVID-19) outbreak put the functioning of the health care system to the test, with significant risks for the continuity and sustainability of the provision of health care, both in the short term and in the long term. On a national level *and* on a global level, governments, market participants, and people (as patients, employees or citizens) suddenly had to enter uncharted territory, while facing major medical, economic and social challenges. In the spring, everyone was dealing with unprecedented uncertainties in each of these areas, which meant that a wide variety of scenarios had to be taken into consideration with regard to the course of the crisis and its consequences. Specifically with regard to the health care sector, the coronavirus crisis has posed exceptional challenges to health care providers, carers, and health insurers when it comes to addressing the significant financial consequences (and the uncertainties thereof) of the crisis. Already at the beginning of the crisis, the risk of continuity problems of health care providers was recognized by the Dutch House of Representatives and the Minister for Medical Care and Sport. In early-April, the Minister held discussions with health insurers about in what ways, by using resources available for health care, they could provide health care providers and carers clarity and certainty as soon as possible regarding the financial consequences of the crisis. In that context, the Minister also stressed the importance of maintaining health care capacity so that health insurers would be able to fulfill their duty of care, not only during the coronavirus crisis but also after that, and to guarantee the continuity of care.

The Dutch Healthcare Authority (NZa) subsequently made it possible, following a ministerial instruction, that both 'extra costs related to the coronavirus' as well as so-called 'continuity contributions' can be claimed by health care providers, and compensated by health insurers under their statutory duty of care, so that health care providers would be able to focus on the provision of care without having to be worried about the financial consequences of the coronavirus crisis.

"Extra costs related to the coronavirus" include, for example, costs related to additional personal protective equipment and additional compensations based on the number of occupant days (days of hospitalization), but also costs associated with deliberately and actively keeping health care capacity free and available for COVID-19 patients at certain locations as part of national agreements, as well as costs associated with additional COVID-19 care capacity created at the request of organizations that have been designated for that purpose.

'Continuity contributions' include the allowances intended as compensation for covering running costs as a result of the drop in turnover, because no or less insured health care (both under the basic health insurance and the additional insurance packages) is provided as a result of the crisis and the National Institute for Public Health and the Environment's (RIVM) guidelines.

Source: NZa, https://puc.overheid.nl/nza/doc/PUC_307025_22/1/ (in Dutch)

Compensations for the extra costs and continuity contributions by health insurers

Both the 'extra costs related to the coronavirus' as well as the costs associated with the continuity contributions are costs that, under normal circumstances, are not (or not necessarily) allocated to or borne by individual health insurers or insured. This applies, in any case, to any

undercoverage of running costs as a result of a drop in demand, insofar those costs exceed the regular individual duty of care, and result from the public interest of maintaining health care capacity, now and in the future. It also applies to, at least, part of the 'extra costs related to the coronavirus', particularly insofar they are related to health care with an availability responsibility (similar to emergency care, specialized burns care, and care provided in a 'calamity hospital').

Against the backdrop of significant uncertainties and urgency, ACM understands and acknowledges that, with an eye to establish and maintain the necessary health care infrastructure and continuity of care, it was of vital importance that health insurers were able to provide health care providers the necessary financial comfort quickly and unconditionally. Health insurers also gave that comfort directly in April, and, in the period thereafter, they made arrangements with health care providers about compensation of the 'extra costs related to the coronavirus' and the continuity contributions. By doing so, health insurers have made an essential contribution to the creation of the necessary health care infrastructure to cope with the then rapidly expanding coronavirus crisis, as well as to the maintaining of the "regular" health care capacity in order to meet their duty of care, now and in the future.

Uncertainty about the effects on the equalization result and the role of mutual solidarity
In that context, health insurers did immediately express their intention to stand by each other, and to make arrangements among each other for 2020 about distributing (or the ability to do so) the financial effects (net effects) that are the direct result of the coronavirus crisis. After all, the promised financial support to health care providers resulted in a considerable increase in uncertainty over the expected equalization outcome for health insurers. This uncertainty not only concerned how total health care costs would evolve, but also the way in which the impact of the coronavirus crisis would be distributed and borne by each individual health insurer. Even though no one could predict exactly how the coronavirus crisis would affect the equalization outcomes, as a result of the highly unpredictable course of the pandemic, health insurers, officials at the Ministry of Health, Welfare and Sport and ZINL explicitly considered that the financial effects would not be felt equally by health insurers, considering the regional differences at the start and during the course of the coronavirus outbreak, as well as the regional nature of health care procurement by health insurers. It was also expected that the existing flanking measures (including the Catastrophe scheme, which assumes a generic market impact) would be able to reduce some of the differences, but not all of them.

As a result, the scenarios that had to be taken into account also include situations in which, without any distribution among each other in the form of a solidarity scheme, some health insurers would face significantly higher costs and a significantly more negative equalization outcome than other insurers. That could lead, with an eye to the solvency of health insurers, to an additional risk surcharge on premiums, as a result of which insured would have to pay more. Depending on the magnitude of the volume effects of catch-up care or deferral of care, or the extent to which a health insurer would have to pay a larger or smaller share of the "extra costs", there was also the risk that large differences in premiums would lead to such dynamics on the health insurance market that the health insurance system could come under pressure, which could have spillover effects on the general functioning of the Dutch health care system.

The planned agreement
On the basis of the received agreement (the draft version thereof) as well as the further clarifications thereof, ACM understands the core of the proposed agreement between health insurers to be the following.

- The participating health insurers wish to enter into the agreement for a pre-determined fixed term, where the duration has been limited from 1 March 2020 to 31 December 2020. The technical settlement of the agreement will take place in the subsequent years, as the effects of the equalization scheme will only become apparent later.

- The health insurers wish to distribute (or have the ability thereto) the costs that follow from three schemes for continuity contributions, settled with any revenues under the Catastrophe scheme, proportionally among themselves. These are the continuity contribution arrangements for 2020 that they have agreed on with providers of specialist medical care, mental health care, and district care (with a turnover of more than 10 million). These schemes also include the 'extra costs related to the coronavirus'.
- Should the difference between the expected equalization result without the effects of the coronavirus crisis and the actual equalization result in 2020 for individual insurers still fall outside a certain range around the national weighted average of that difference, health insurers would then wish to be able to decide to distribute those costs among themselves[3].

The third point deals with the spread of the difference between the expected and actual equalization result for 2020, and removes the largest differences between individual health insurers in terms of the financial effects of the coronavirus crisis. Within the range, each health insurer continues to bear risks on an individual basis. Beyond that, the participating health insurers collectively bear the consequences of the coronavirus crisis, after the risk equalization and any additional funds under the Catastrophe scheme.

ACM's response

Given the role of health insurers as individual risk-bearing undertakings in the national health care system, ACM considers, in general, that mutual agreements on financial equalization are not compatible with competition rules. Only in exceptional ('crisis') circumstances, ACM does not consider it inconceivable that an agreement to distribute financial effects among themselves may be necessary in order to make way for timely and sufficient measures in order to be able to withstand seriously negative effects of the challenges that have arisen as a result of the crisis, which are a potential threat to the overall functioning of the health care system. ACM therefore deems an agreement to distribute effects, in principle, only allowed in the exceptional case when substantial, unforeseen sums of money are involved, and the non-distribution thereof will lead to a serious disruption of the overall functioning of the health care system, and the effective functioning of the risk equalization. Therefore, there must be a safety net scheme (last resort), with an effective threshold, and preservation of sufficient incentives for individual health insurers to procure health care efficiently.

In this case, on the basis of the facts, the information you provided, the nature and magnitude of the abovementioned exceptional circumstances of the coronavirus crisis in 2020, as well as the large uncertainties in the spring, ACM sees no reason for a further investigation into the collaboration's compatibility with competition rules. In that context, it is relevant to note that ACM finds it sufficiently plausible that the collaboration was necessary for withstanding the coronavirus crisis's threats to the overall functioning of the health care system, and ACM finds it essential that the collaboration is temporary, has a fixed term, and the period of equalization is confined to the calendar year 2020.

More specifically, ACM considers it plausible that the planned agreement to distribute the additional costs directly caused by the coronavirus crisis was necessary in order to be able to provide health care providers financial support in a timely and effective manner in order to ensure the establishment of the necessary corona-specific care infrastructure and the maintenance of regular health care capacity for the future implementation of the duty of care of insurers. This was against the backdrop of the great uncertainties (from a medical, financial and social point of view), faced by health insurers, too, in the spring of 2020. ACM considers it highly likely that, in the absence of such mutually stated intention of equalization, the necessary expeditious clarity and certainty for health care providers would, as a result of coordination

[3] The pre-coronavirus competitive positions of health insurers are taken into account by taking the actual equalization result from 2019 as the starting point for the 'expected equalization result' (without the effects of the coronavirus crisis).

problems (because health care providers have to deal with multiple health insurers) either not have been achieved, not sufficiently achieved or with harmful delays.

In its considerations, it is also relevant for ACM that, on the basis of the intentions, the distribution is limited to the additional costs (including the continuity contributions) that are the direct result of the exceptional 'crisis' circumstances, and those that remain after any awarding of additional resources. ACM also notes and considers that, for 2020, individual health insurers have little to no latitude left to influence the additional costs (including continuity contributions) in their strategic and commercial plans, and that no opportunities appear to exist to take those costs into account in the risk equalization.

Furthermore, in this context, it is essential, in ACM's opinion, that, generally speaking, equalization only takes places insofar such is necessary for the effective functioning of the risk equalization and the functioning of the health insurance system in general. To that point, ACM wishes to emphasize the following. ACM understands that, in practice, it will not always be easy or even possible to determine precisely the additional costs (net or otherwise) (including continuity contributions) or to distinguish unequivocally between different categories of costs. ACM therefore assumes that mutual agreements on cost distribution will, in all cases, affect the effective functioning of the risk equalization, and, in turn, the health insurance system. That effect will be negative if, as a result of those agreements, costs that fall under the regular risks that insurers bear are shared by health insurers among themselves. Such sharing hinders the effective functioning of the risk equalization, reduces incentives for efficient health care procurement, and can lead to higher health care expenditures. However, in exceptional situations, that effect can also be positive if there is sufficient 'cleaning up' of costs that, in normal circumstances, would not be borne or not necessarily be borne by individual health insurers or insured.

In addition, ACM understands and considers it to be sufficiently substantiated by the health insurers that they had to take a pragmatic approach when fleshing out the continuity contribution arrangements and the solidarity scheme for 2020. Large segments of regular care have been shut down (temporarily or otherwise), and are therefore inextricably linked to coronavirus care. Therefore, in light of the exceptional and unpredictable course (certainly at the time of the basic agreement in the spring) of the year 2020, it is not sufficient to abstract completely from the regular health care costs in order to meet health care provider effectively and to bear the 'costs' thereof proportionally. It is, in practice, also not possible, which VWS and ZiNL also indicate.

Finally, ACM assumes that the collaboration meets the following conditions:

1. The arrangements do not go beyond what is necessary, which in any case, means:
    a. Within the planned collaboration, the health insurers do not make any arrangements regarding the determination of health insurance premiums, the procurement of health care or any other areas in which they compete that are not strictly necessary for the intended redistribution. In addition, they will not coordinate their conduct in these areas;
    b. Any exchange of business confidential and competition-sensitive information is limited to what is necessary for a proper distribution of the additional costs. The required information is shared by insurers only with a Thrusted Third Party (TTP). The TTP does not share business confidential or competition-sensitive information with health insurers, only aggregated information. The TTP is also responsible for calculating the amounts to be distributed;
2. Participation in the collaboration is on a voluntary basis, and is open to any health insurer that wishes to participate.

ACM also expects all exchanges of information that take place within the framework of the collaboration to be documented by the health insurers, and that this documentation is made available to ACM by the health insurers upon request.

In conclusion
On the basis of the information regarding the facts and circumstances as described by you and which ACM has in its possession, the planned collaboration, as set out above, does not give any reason for ACM to take further steps.

For the sake of completeness, ACM points out that its response only concerns the planned solidarity agreement, with the equalization confined to the year 2020. However, it is likely that the effects of the coronavirus outbreak will not be limited to 2020. In 2021, too, those effects will continue to demand enormous efforts from hospitals, and other health care providers, health insurers, and other market participants in order to create the conditions in which health care providers are able to continue to do their jobs, to safeguard the continuity of health care, and to enable health insurers to meet their duty of care vis-à-vis their insured. And ACM puts those interests first in 2021, too. That also means that, if it turns out to be necessary that, with regard to contracts, on top of regular, individual contractual agreements, health insurers must collaborate in several areas in order to safeguard the continuity of health care, they have the leeway to do so.

With regard to the possible necessity of financially equalizing among themselves the costs that follow from these contractual arrangements for 2021, ACM notes that, contrary to 2020 and to all appearances, individual health insurers have significantly more options to take into account the impact of the coronavirus crisis in their strategic and commercial plans. In addition, agreements (individual or possibly necessary joint ones) regarding the compensation of the extra costs and possible additional continuity contributions still need to be finalized with hospitals and health care providers. Furthermore, the Minister for Medical Care and Sport has decided to reduce the risks incurred by health insurers in 2021 by, among other ways, the introduction of a form of macro subsequent calculation.

In light of the above, and with an eye to the compatibility with competition rules, it will be important in assessments of any future agreements regarding equalization among health insurers for 2021 that, within the public safeguards that the risk equalization (including the Catastrophe scheme) offers for 2021, individual health insurers will continue to have sufficient incentives for efficient procurement of health care

Yours faithfully,

The Netherlands Authority for Consumers and Markets,
On its behalf,

Bart Broers
Director of ACM's Health Care Department