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A Universal European Health System for California: The German Model

BY MICAH WEINBERG, PHD AND ALICE BISHOP

As the Affordable Care Act's future continues to hang in the balance, the idea of implementing some form of universal healthcare system in California or nationwide has become increasingly popular. Much of this discussion has focused on the desirability and feasibility of adopting a Canadian-style single-payer or "Medicare for All" system. While Canada is a worthwhile case study to examine, there are other models for a universal healthcare system that may make more sense for California and the U.S., achieve better outcomes, and have a more feasible path to implementation.

One such example is a "Universal European Health System," inspired by the Bismarck model, most clearly exemplified by Germany. This report lays out what such a model could look like if implemented in California. While this report focuses specifically on the German system, several other countries use elements of the Bismarck model, including France, Belgium, the Netherlands, Japan, and Switzerland.[1]

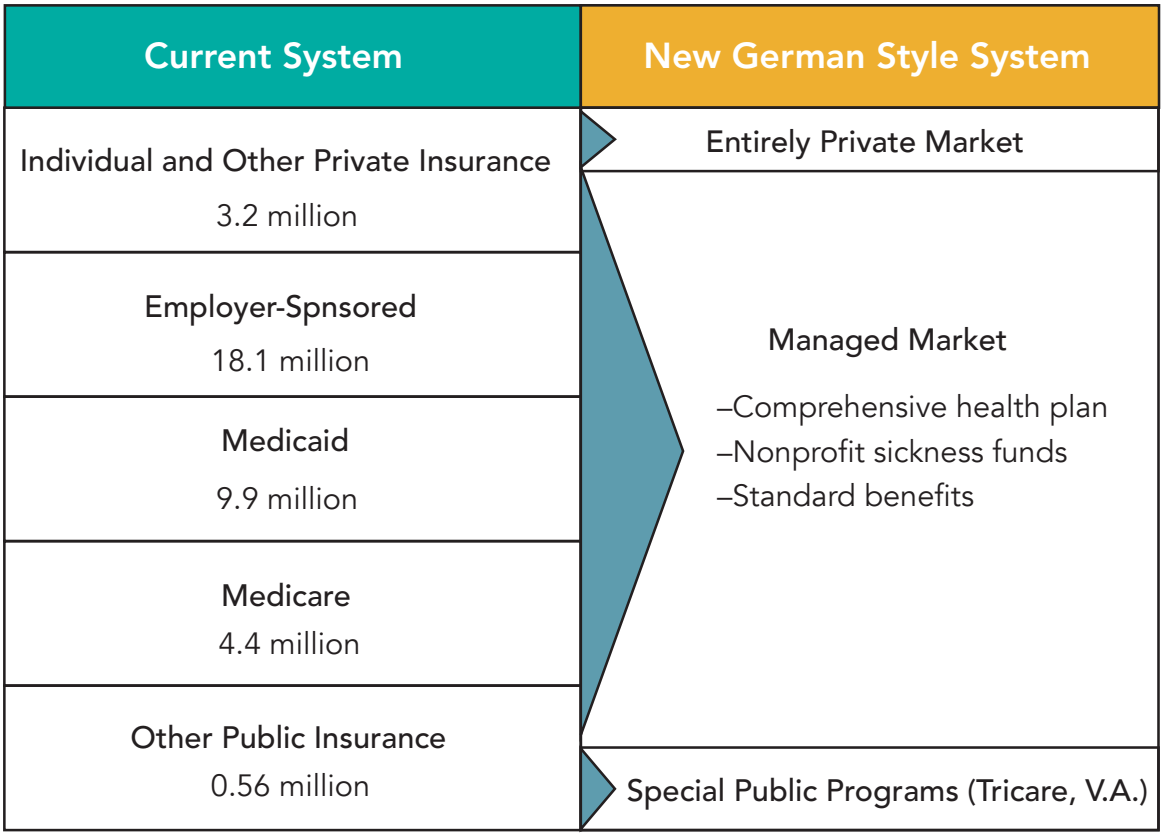
Achieving Universal Coverage and Health Equity

A System That Preserves Choice and Controls Costs

Adopting a Universal European Health System model would allow California to strike a successful balance between the competing goals of securing access, controlling cost, and improving quality. The elements of such a system include:

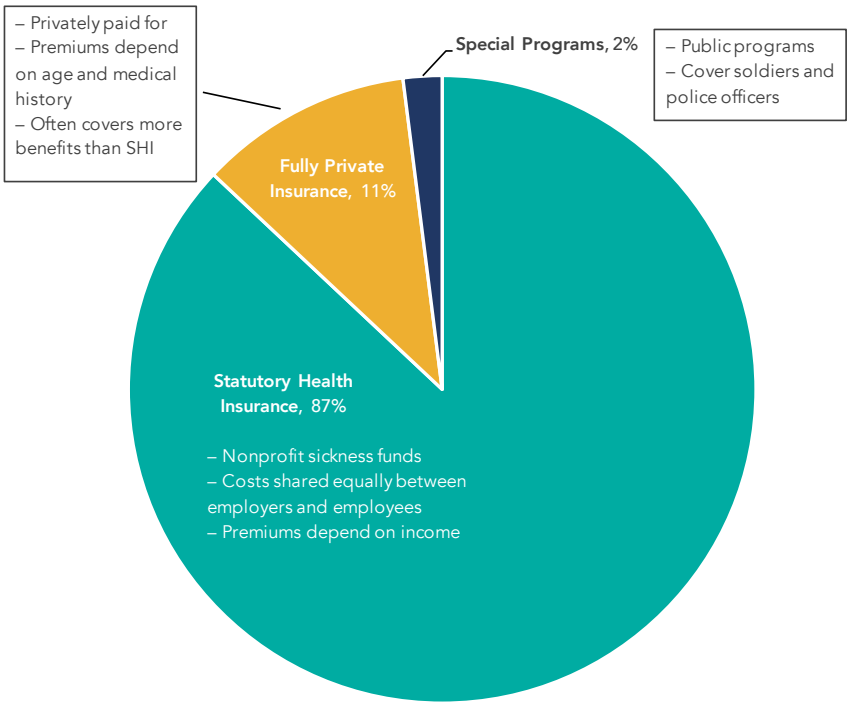
- **Not-for-Profit Health:** If enacted, such a system would have one single insurance market for most people. As in the German system, residents would obtain coverage from competing wellness funds. Unlike in California's current marketplace, however, all insurers would be nonprofit, though an external market with for-profit plans may persist.

- **Public Oversight to Ensure Equity and Value:** As in the state's Affordable Care Act (ACA) marketplace, Covered California, a public governing body would decide which plans are allowed to participate, based on quality and the range of options available to consumers. All plans would be required to cover a standardized set of essential health benefits. As a result, insurers would engage in managed competition, operating in partnership with systems and networks of care providers in order to improve quality.
- **Universal Equitable Coverage:** Plans offered by the wellness funds would be means-tested for all residents, regardless of their citizenship or immigration status. The amount that people pay for coverage would depend only on their income (and not their age); those who earn less would receive more generous subsidies. The market would offer a variety of products aimed at seniors, low-income people, and employees, but it would consist of one single risk pool and one set of options for all participants. This would spread the risk more evenly throughout the market, so the premiums of younger, healthier people would help subsidize the cost of care for people who need to utilize more health services.
- **Consumer Choice:** There would be no mandate for employers to provide insurance to their employees. The employer tax advantage, if preserved, would only be usable in the common marketplace and could not be paired with subsidies. However, employers would still be able to offer add-on services not covered by the insurance package in the general market and could offer complementary insurance without tax advantage.[2]



- **Lower Healthcare Costs:** The new system would also include a board similar to the Independent Payment Advisory Board in the Affordable Care Act that would implement cost-control measures if medical costs rose significantly above the rate of inflation. If market competition alone does not keep health care costs below this target, this independent, non-governmental consumer commission would be established to recommend maximum prices for the highest-growth components of the health industry.

Types of Health Insurance in the German System



Implementing the Plan

It would make sense for California to have a six-year transitional period to implement the new single market. Over this time period, Medicaid managed care, employer-sponsored insurance, and Medicare Advantage would slowly be rolled into the market with appropriate waivers and protections. Due to means testing, it would be possible to ensure that neither Medicaid nor Medicare recipients would pay more in the new system than they do under the current system. (In spite of beliefs to the contrary, the average combination of premiums and out of pocket costs for seniors on Medicare is over $5,000/year[3]).

Adoption in California of a health insurance model similar to that of Germany represents a politically feasible compromise that allows for a high level of individual choice while at the same time guaranteeing universal affordable coverage. It should help close the insurance gap for vulnerable populations such as undocumented residents and those who earn too much to qualify for Medicaid but too little to realistically afford plans on the exchanges. Its system of managed competition among nonprofit health plans would help drive down costs, as would its other cost-containment measures. The result would be a more streamlined system with a more stable insurance market, a greater number of Californians covered, and a higher level of quality among plans offered.

The Bismarck System in Germany

Since this proposal is modeled on the system in Germany, it is worth spending some time reviewing the aspects of this system more closely and examining how it stacks up against other international systems including those of the United States and Canada.

This paper laid out in the previous section at a very high level what the contours of such a system could be in our country. The details below would have to be adapted or replaced here.

Universal Coverage Through Competing Nonprofit Payers

The German healthcare model combines guaranteed access to healthcare with market competition between private insurers, while also containing costs and maintaining a high quality of care.[4] It provides healthcare for all, while still allowing individuals the freedom to purchase private insurance if they wish to do so. Coverage does not depend on employment, nor does it depend on age or medical history. Although nearly all German residents have to pay for health insurance in some form or another, 100% of the population is insured.[5]

Germany has a semi-private system of universal health coverage. This means that the government ensures that everyone has health insurance, but the insurance providers themselves are private organizations. Most Germans – about 87% – get their health insurance through nonprofit organizations called sickness funds, which are part of the statutory health insurance system (SHI).[6] Sickness funds are not governmental organizations; they have an independent organizational and financial structure under public law. Consumers can choose from among over 100 of these funds, which compete with one another. Everyone who makes less than a certain income threshold is required by law to be insured by a sickness fund.

Not everyone chooses to be a part of the SHI. People who make more than $67,000 a year or who are self-employed, retired, or unemployed have the option to buy private insurance outside of the SHI system. About 11% of Germans take this route, including civil servants that are required to be covered by private insurance. The remaining approximately 2% of Germans get insurance through special programs, such as those for soldiers and police officers. All health insurance plans are required to cover a standard set of comprehensive benefits. [7]

Multi-Payer Financing

Germany, like almost all systems in the world, is a "multi-payer" system. Truly "single-payer" systems are vanishingly rare. In Germany, people and employers pay yearly premiums to health funds, which distribute money to sickness funds. Premiums consist of 14.6% of the wages of every employed person they cover, up to earnings of about $58,000. Income above that is exempt from contribution. This cost is shared equally between the employee and the employer, meaning that each contributes 7.3% of the employee's wages. Short-term unemployed people pay a portion of their unemployment benefits to the health funds, and the government covers the cost for the long-term unemployed. Each individual sickness fund also charges an extra contribution fee to its members, usually around 1% of wages, but this varies by plan.[8] Through a "dual-financing" system, German hospitals' operating costs are financed by sickness funds, while their investment costs are financed by the states.

Under the German system, people's insurance premiums depend only on their income. Age and the existence of pre-existing conditions do not influence whether people can obtain insurance or how much they pay for it. Health funds distribute money to sickness funds, with the amount depending on the composition of the group insured in each sickness fund to avoid risk selection. If a sickness fund covers more high-risk individuals, it will receive more money.

In the non-SHI private insurance system, premiums are determined by age and medical history. People who purchase private insurance in Germany do not have to pay into sickness funds, but if they have a pre-existing condition, they may have to pay higher premiums. However, the government does regulate private insurance

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	U.S. Private Employer-Sponsored Insurance	Covered California	Germany
Premium variation	Dependent on age, type of plan	Dependent on age, income, type of plan	7.3% of wages, up to earnings of $58,000
Cap on out-of-pocket spending	Dependent on plan, ranges up to $7,350 for an individual (no cap for grandfathered plans)	Dependent on plan, ranges up to $7,350 for an individual	2% of annual household income
Copayments for prescription drugs	Average of $32 for preferred drugs	Average of $32 for preferred drugs, with $250 cap per prescription for silver plans	Maximum of $12

Source: Kaiser Family Foundation, "Cost Sharing for Health Care: France, Germany, and Switzerland"; California Health Care Foundation, "California Health Care Almanac"; The Commonwealth Fund, "International Profiles of Health Systems"

Analysis: Bay Area Council Economic Institute

to protect consumers from excessively burdensome premium increases as they age or if their financial situation changes.

Private insurance often covers a wider range of benefits than sickness funds do, so some people opt to purchase supplementary private insurance that covers copayments or extra amenities like private hospital rooms on top of their statutory insurance.

Germans have copayments for their health care, but by American standards they are very low. Copayments for prescription drugs are usually $5-12, and for hospital stays they are around $10 per day.[9] Regulations further protect Germans from facing excessively large medical costs. Out-of-pocket costs are capped at 2% of annual household income, and children under 18 do not have copayments.[10] This contrasts with standard limits adopted under the ACA, according to which insurers are required to provide a cap on how much a person must spend out-of-pocket. The maximum out-of-pocket limit is $7,350 for an individual plan and $14,700 for a family plan, but some plans have lower limits.[11]

Healthcare Delivery

One major distinction between the managed competition system we envision and the German system comes in the organization of the delivery system. The German government plays a minor role in the delivery of healthcare. Instead, SHI doctors form regional associations that act as intermediaries between care providers and sickness funds by negotiating contracts with individual funds. Physicians bill regional associations for the services they provide to patients, and sickness funds reimburse the regional associations. Reimbursement follows a fee-for-service model; regional associations negotiate with sickness funds to create a uniform fee schedule for all services. Hospitals are paid directly by sickness funds. This system means that those covered by SHI simply show their insurance cards at the doctor's office, and the provider is paid later. In the case of private insurance, patients pay at the point of service and are later reimbursed.[12]

In Germany, most outpatient doctors work in their own private practices, rather than in large, multispecialty clin-

ics or hospitals. Patients have free choice both of general practitioners and specialists. Most hospitals treat all patients regardless of their type of insurance, but some smaller, privately-run hospitals will only see patients with private insurance. Patients are able to see specialists without being referred by their primary care physician, unlike in systems like the government-operated system in the United Kingdom and many managed care plans in the United States.

Though neither the federal nor local governments are strongly involved in the delivery of care, the non-governmental Federal Joint Committee, an organization of health industry-related representatives, has broad power to decide which services must be covered by sickness funds. The Committee is able to negotiate prescription drug prices with pharmaceutical companies, basing its evaluation on studies of the drugs' benefits by the non-governmental Institute for Quality and Efficiency. The sixteen-state government determines hospital capacity, while ambulatory care capacity has rules set by the Federal Joint Committee.[13] This committee could be a model for the board suggested above.

Quality of Care

Germany's health care system performs very well compared to the U.S. on a variety of measures, as well as in comparison to other European countries. Out of 11 high-income countries, including the U.S., Australia, New Zealand, and several Western European countries, Germany ranked second for access to health care, which takes into account both affordability and timeliness.[14] It also ranked sixth for both administrative efficiency and equity. It scored above the 11-country average for overall health system performance. According to the World Health Organization's World Health Report 2000, Germany ranked 25th in overall health system performance out of the WHO's 191 member states, well above the U.S., which ranked 35th.[15] Germany's infant mortality rate is quite low, at 3.3 deaths per 1,000 live births, significantly lower than the overall rate of 4.6 for high-income countries.[16]

One place where there is room for improvement in Germany's healthcare system, however, is reducing health disparities between immigrants and native Germans. Although recent efforts have been made to improve health equity, studies have found that disparities persist in health outcomes and quality of care received. A 2018 analysis found that Turkish and Former Yugoslavian nationals had a 23-69% higher chance of poor treatment effectiveness than native Germans.[17]

Striking a Successful Balance Between Tradeoffs

The German healthcare system does very well at balancing the three most important goals in health reform: access, cost, and quality. First, it guarantees access to health insurance. People can choose to purchase ad-

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ditional private insurance, but everyone has access to statutory health insurance, which covers a very comprehensive set of benefits, including preventive services, dental care, mental health care, hospital care, outpatient care, and prescription drugs.

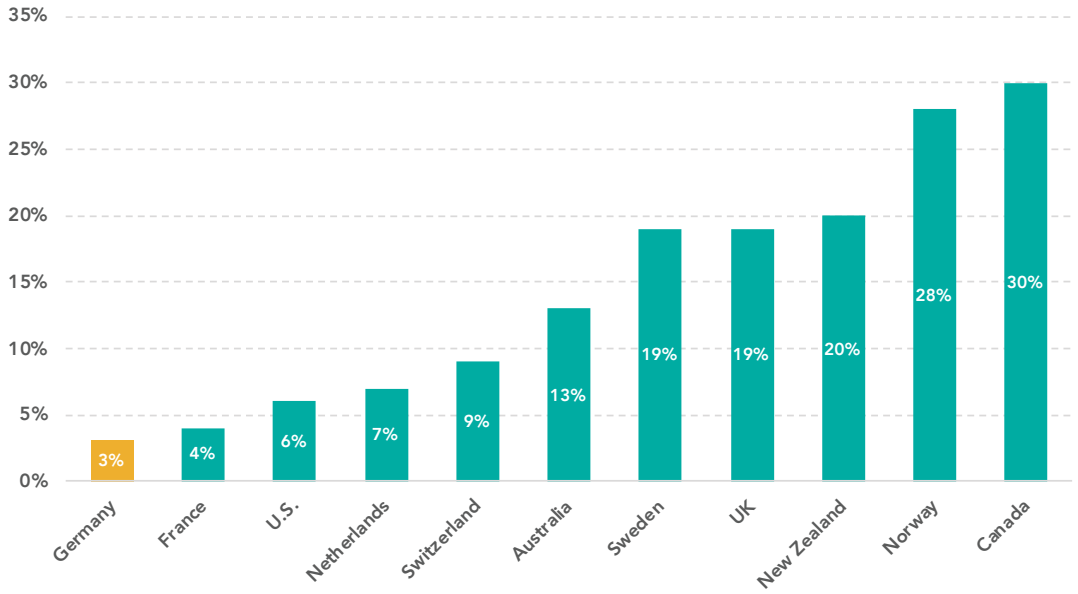
Second, the German system deals well with cost. The amount people pay for insurance varies only based on income. Copays are set at a level at which they are affordable, but because healthcare is not entirely free, people still have some incentive not to overconsume. Competition between sickness funds also keeps costs down. Additionally, because the sickness funds are nonprofit organizations, their financial incentives are tempered by their mission and organizational structure. There is some evidence that nonprofit health plans behave differently than their for-profit counterparts.[18] Although Germany has higher healthcare costs than some other European countries, it still spends a significantly smaller portion of its GDP on healthcare than the U.S. does. Where the U.S. spends about 17% of GDP on healthcare, Germany spends about 11%.[19] Per capita healthcare expenditure in Germany is about $5,000 a year, compared to $9,000 in the U.S.[20] Such a system is also easily compatible with introducing other cost-containing reforms such as value-based payment for pharmaceuticals and care services.

Third, the German model does not significantly sacrifice quality for its high level of access and relatively low costs. Out of 11 OECD countries surveyed in 2016, Germans were the least likely to experience a problem with care coordination.[21] Americans, by contrast, were the most likely. Germans also used the emergency department the least often out of the 11 countries. Only 3% of Germans who needed to see a specialist in the previous two years had waited two months or longer for a specialist appointment, compared to 30% for Canada.

This success at balancing tradeoffs suggests that implementing a Universal European Health System based on the German model would help California's healthcare system preserve choice, control costs, and achieve a high quality of care.

Goal 1: Access

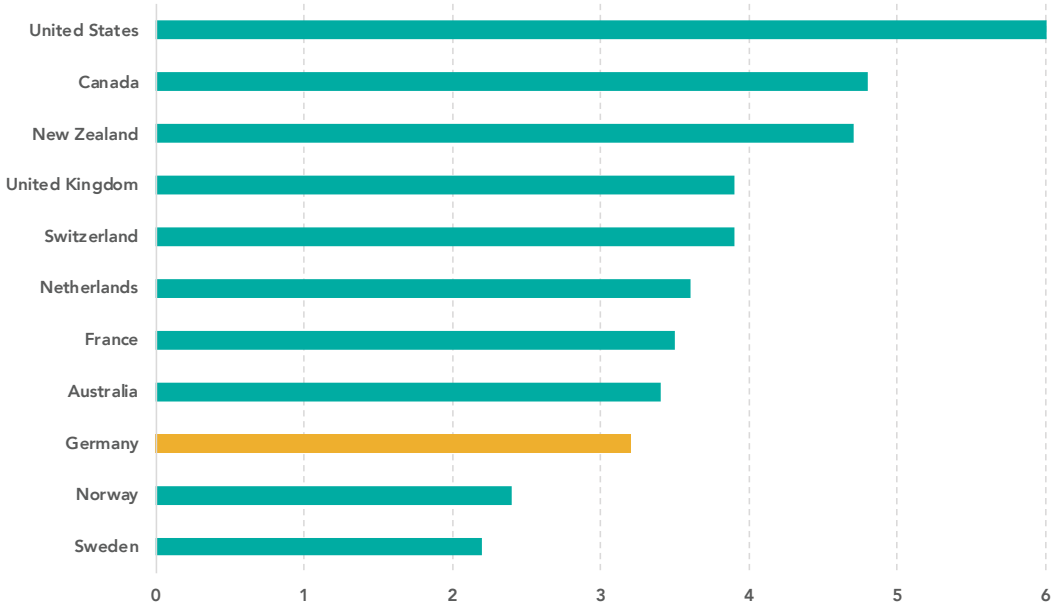
Percent Who Waited Two Months or Longer For a Specialist Appointment



Source: Commonwealth Fund 2016 International Health Policy Survey of Adults in 11 Countries
Analysis: Bay Area Council Economic Institute

Goal 2: Quality

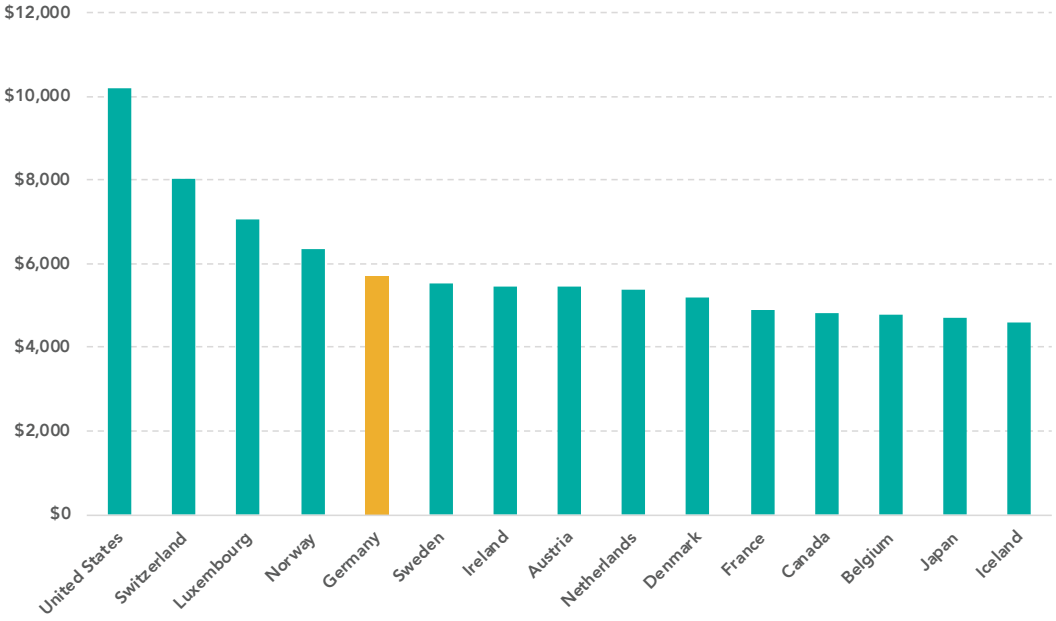
Infant Mortality (Deaths per 1,000 Live Births)



Source: "Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care," The Commonwealth Fund
Analysis: Bay Area Council Economic Institute

Goal 3: Cost

Health Spending per Capita



Source: Health Spending, OECD Data
Analysis: Bay Area Council Economic Institute

Notes

1 T.R. Reid, "The Healing of America: A Global Quest for Better, Cheaper, and Fairer Health Care," August 31, 2010.

2 One important implementation question is whether, as in Germany, to allow a separate market of plans for California residents who opt out of all government subsidies. In this market, people could either purchase comprehensive, stand-alone insurance or supplementary insurance to be combined with coverage from wellness funds. There would be some differences in regulations between this alternative market and the primary market; in particular, for-profit insurers will be allowed to participate in the alternative market, but not in the primary market.

3 Juliette Cubanski, et al. "Medicare Beneficiaries' Out-of-Pocket Health Care Spending as a Share of Income Now and Projections for the Future ," Kaiser Family Foundation, January 26, 2018.

4 Irene Papanicolas and Peter C. Smith, "Health System Performance Comparison," European Observatory on Health Systems and Policies Series, 2013.

5 Reinhard Busse, Miriam Blümel, Franz Knieps, and Till Bärnighausen, "Statutory Health Insurance in Germany: a health system shaped by 135 years of solidarity, self-governance, and competition," The Lancet, Vol. 390: 882-897, August 2017.

6 Busse et al.

7 Busse et al.

8 Busse et al.

9 "Cost Sharing for Health Care: France, Germany, and Switzerland," Kaiser Family Foundation, January 2009.

10 "International Profiles of Health Care Systems," The Commonwealth Fund, May 2017.

11 "Out-of-pocket maximum/limit," HealthCare.gov Glossary.

12 "International Profiles of Health Care Systems."

13 "International Profiles of Health Care Systems."

14 Eric C. Schneider, Dana O. Sarnak, David Squires, Arnav Shah, and Michelle M. Doty, "Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care," The Commonwealth Fund, July 2017.

15 "The World Health Report 2000– Health Systems: Improving Performance," World Health Organization, 2000.

16 "Mortality Rate, Infant," The World Bank, 2015.

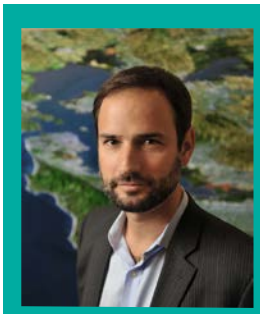
17 Patrick Brzoska, "Disparities in health care outcomes between immigrants and the majority population in Germany: A trend analysis, 2006-2014," PLOS One, January 23, 2018.

18 Leemore S. Dafny, "Does It Matter If Your Health Insurer Is For-Profit? Effects of Ownership on Premiums, Insurance Coverage, and Medical Spending," American Economic Journal: Economic Policy 11, no. 1, February 2019.

19 "Health Care Spending as a Percentage of GDP, 1980–2014," The Commonwealth Fund, July 13, 2017.

20 Melissa Etehad and Kyle Kim, "The U.S. spends more on healthcare than any other country — but not with better health outcomes," The Los Angeles Times, July 18, 2017.

21 Robin Osborn and Cathy Schoen, "2016 International Health Policy Survey in Eleven Countries," The Commonwealth Fund, November 2016.



Micah Weinberg, PhD

Micah Weinberg is currently President of the Economic Institute at the Bay Area Council. In this role, he manages a team of professional researchers who produce world class economic and policy analysis and insight. Economic opportunity, affordable housing, reliable transportation, and lifelong learning are the pillars of personal and community health. Dr. Weinberg's own research and advocacy focuses on improving these "social determinants" of health as well as on expanding access to high quality, affordable healthcare. Before coming to the Council, Micah was Senior Research Fellow at the New America Foundation. Dr. Weinberg's writing has appeared in diverse outlets from Politico to Policy Studies Journal, and he has appeared on Fox News and NPR. He holds a doctoral degree in Political Science from the University of North Carolina at Chapel Hill and graduated with honors from Princeton University with a degree in Politics.

Alice Bishop

Alice Bishop is a Senior Research Analyst at the Bay Area Council Economic Institute. In this role, she conducts data analysis and helps create reports on key economic issues facing the Bay Area and California. Her policy interest areas include housing, healthcare, and homelessness, and she has helped produce several reports and policy briefs on the future of healthcare. Alice holds a bachelor's degree in Philosophy, Politics, and Economics from Claremont McKenna College, where she completed a senior thesis on measuring health inequalities.

About the Economic Institute

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353 Sacramento Street, Suite 1000, San Francisco, CA 94111

www.bayareaeconomy.org • bacei@bayareacouncil.org

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