The Mechanism of Phased Introduction of Compulsory Health Insurance and Assessment of its Financial Burden

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Պարտադիր բժշկական ապահովագրության փուլային ներդրման մեխանիզմը և դրա ֆինանսական բեռի գնահատումը

Հակոբյան Գագիկ Մ.
Բանկային գործի և Ապահովագրության ամբիոնի ասպիրանտ, Ֆինանսական ֆակուլտետ, ՀՊՏՀ (Երևան, ՀՀ)

Ամփոփագիր. Առողջապահության ֆինանսավորման մեխանիզմներն ու ծավալները չեն համապատասխանում ոլորտի զարգացման պահանջներին: Ցանկացած պետություն, այդ թվում և ՀՀ-ն, մեծածավալ ֆինանսական ռեսուրսների կարիք ունի բնակչությանը առողջապահական ծառայություններով ապահովելու, անհրաժեշտ քանակի և որակի մասնագետներ պատրաստելու, նորագույն բժշկական սարքավորումներով հագեցած կենտրոններ ստեղծելու և որակյալ ծառայություններ մատուցելու համար: Դրա հետ մեկտեղ երկրում քրոնիկ հիվանդությունների տարածումը, բնակչության ծերացումը և տնային տնտեսությունների գրպանից դուրս կատարվող զգալի ծախսերը պահանջում են պարտադիր բժշկական ապահովագրության համակարգի ներդրում: Հետազոտության հիմնական նպատակն է սահմանել պարտադիր բժշկական ապահովագրության փուլային ներդրման մեխանիզմը և հաշվարկել այդ համակարգի յուրաքանչյուր փուլի ֆինանսական ծանրաբեռնվածությունը, ինչպես նաև ՀՀ-ում պարտադիր բժշկական ապահովագրության ներդրման դեպքում մեկ անձի համար տարեկան ապահովագրավճարի հաշվարկը:
Հանգուցաբառեր՝ պարտադիր բժշկական ապահովագրություն, իրականացման փուլեր, ֆինանսական բեռ, ապահովագրավճար, ապահովագրական ֆոնդ, հարկային բեռ

Механизм поэтапного внедрения обязательного медицинского страхования и оценка его финансового бремени

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Аннотация: Механизмы и объемы финансирования здравоохранения не соответствуют требованиям развития отрасли. Любое государство, в том числе и Армения, нуждается в масштабных финансовых ресурсах для обеспечения всеобщего охвата населения услугами здравоохранения, подготовки необходимого количества и качества специалистов, создания центров, оснащенных новейшим медицинским оборудованием, и предоставления качественных услуг. Наряду с этим распространение хронических заболеваний в стране, старение населения и значительные расходы из собственных средств требуют введения системы обязательного медицинского страхования. Основной целью исследования является определение механизма поэтапного внедрения обязательного медицинского страхования и расчет финансовой нагрузки каждого этапа этой системы, а также расчет ежегодной страховой премии на одного человека в случае введения обязательного медицинского страхования в РА.
Ключевые слова: обязательное медицинское страхование, этапы внедрения, финансовая нагрузка, страховая премия, страховой фонд, налоговая нагрузка

INTRODUCTION

In Armenia, healthcare funding is allotted according to specific programs and ranges from 1.5% to 2.2% of total state budget expenditures. Healthcare financing fails to address the sector's needs, it is based on the limited budget principle and neglects to account for the necessity of the introduction and advancement of new technologies,

the spread of diseases and other factors. According to Figure 1, there has been minimal variation in the financing of state-targeted health programs between 2012 and 2022 when compared to RA state budget expenditures, ranging from 5.3-6.3%. Meantime, the correlation between the indicators of state budget expenditures and financing of targeted programs is 0.97.

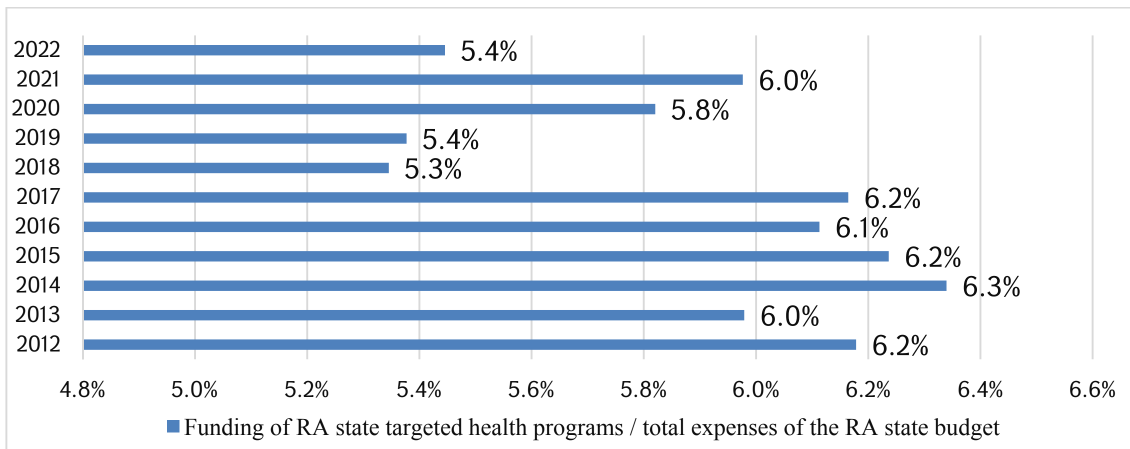

Figure 1. *The ratio of funding of the RA state health targeted programs in the total expenditures of the RA state budget in 2012-2022* [**1**]

In Armenia, healthcare spending is also highly dependent on GDP and fluctuated within the framework of 1-1.7% of the GDP during the years 2000-2022 [**2**]: making 2.36% only in 2020, while the international average was 5-7% [**4**]. However, it is important to understand the relationship between healthcare spending and GDP. For this purpose, we calculated the *Mean squared error/mean* coefficient (coefficient of variation) for the number series, which shows how much the number series deviates from their average index. Naturally, the lower this indicator is, the higher the correlation between healthcare costs and GDP in that country. In the case of Armenia, this coefficient is 18.84%, which shows, that there is an almost identical correlation between GDP and healthcare costs, moreover, the degree of this dependence is quite high. This circumstance also proves that the state financing of healthcare is highly correlated with such a macroeconomic indicator as the GDP.

If we also take into account the fact that per capita healthcare costs in RA are approximately 551 USD [**4**], of which only 7.7% is financed by the state [**3**], the circumstances of the state's underfunding and lack of social insurance mechanisms for the population become obvious. All this, in turn, has led to a periodic increase in out-of-pocket costs (Figure 2).

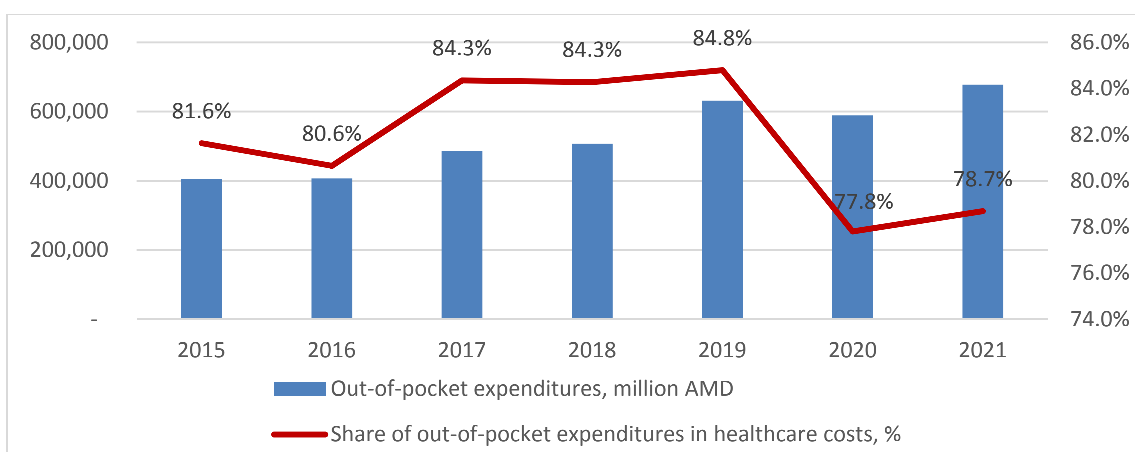

Figure 2. *Annual out-of-pocket healthcare costs (mln AMD) and its share in total healthcare costs (%)* [**5**]

In Armenia, household consumer spending on healthcare accounted for 14.2% of total spending in 2022 [**7**]. Between 2015-2021 out-of-pocket expenses accounted for an average of 87.7% of healthcare costs, while the global average ranged from 16-19% [**5**]. Meantime, the population's gender, age, and health characteristics are not taken into account when relevant budget programs and measures are being prepared, and the extent of their impact is not calculated. This leads to a situation

where some programs are consistently over-executed, and failing to account for these overfulfills transfers the risks to beneficiaries and medical institutions.

Such a financial burden on the population and the budget, which in any case does not expand universal health coverage in RA, necessarily requires either the improvement of the existing model of defining and organizing state funding, or the replacement of the medical services financing system with a completely different mechanism - mandatory medical insurance. In these conditions, the introduction of compulsory health insurance (CHI) will allow the maintenance of healthcare as a subset and will create a new social structure that combines the protection of citizens' rights, innovative methods of financing medical care, and insurance principles. But this procedure also entails the implementation of considerable financial costs, to the estimation of which is aimed this research.

LITERATURE REVIEW

CHI is a complex and multifaceted issue that has received significant attention from healthcare providers, regulatory bodies and policymakers. In recent years, there has been a growing concern about the introduction of CHI in Armenia.

The literature review highlights the critical role of the introduction health insurance system in Armenia. In this context, health insurance is the basis for creating fair and sustainable healthcare systems that will be to provide high-quality, safe, comprehensive, accessible and inexpensive medical care for all, especially for the most vulnerable sections of the population [**8**]. The World Bank study additionally prioritizes the urgent need to review services, depth of package coverage and beneficiaries in line with improvements in population health, comprehensive access to primary care and sustainable financing [**9**].

Discussions on the implementation of CHI in RA have been ongoing since 2010. In the past few years, three concepts for the implementation of the Comprehensive Health Insurance System have been put up for public discussion, the latest on January 11, 2023. This project presented the main conceptual approaches to the implementation of comprehensive insurance and the expected results of the introduction, in particular, increasing the level of financial protection of the population when receiving health services, improving financial access to health services, as a result of which it will be possible to reduce the costs incurred by the population, including catastrophic health costs, reduce morbidity, the number of deaths, increase the average life expectancy. The project also presented the phased introduction strategy of comprehensive health insurance (hereinafter referred to as CHI) in Armenia, the measures to be implemented according to the stages, and the time frame of their implementation [**10**]. According to this project, the CHI will be implemented on the principle of a single buyer/payer via the Fund established by the government (hereinafter referred to as the Fund), which should ensure the efficiency of calculating and spending the amounts necessary to cover the insured's health care expenses.

However, the critical review of the legislative draft introducing comprehensive health insurance reveals that the concept also has significant gaps in the assessment of the financial burden, the selection of mechanisms for putting insurance principles into practice, and determining population groups. The systems implementation and the establishment of a single, unified fund will require significant investments. Large sums of money will be required for the development, testing, and deployment of contemporary technical and information technologies, as well as for the hiring, training, and compensation of professional specialists to serve the whole population of RA.

The draft does not provide the basis for initial calculations, but it intends to spend no more than 2% of the insurance coverage costs overall on the periodic provision of all of this. Approximately 47% of life insurance companies and roughly 61% of non-life insurance companies have different operating costs in international practice [**11**]. Furthermore, if we take into account the six insurance companies in RA, as of 2021, administrative and operational costs accounted for nearly 29% of total expenses for all organizations [**12**]; as a result, 2% is an inaccurate cost estimate that is too small.

Apart from all this, for the introduction of the insurance mechanism, clarity is needed regarding to the project's funding sources, the participation insurance premiums and the methods and amounts of state financing or co-financing.

Before introducing any insurance mechanism, it is very important to study the precedents that exist or have been used before. The aforementioned legislative draft fails to evaluate the potential and the practice of the current voluntary health insurance system, to consider the possibility of its further improvement instead of introducing an additional tax burden. Additionally, the draft disregards the use of existing resources, the examination of the infrastructure, and the existence of health insurance companies.

The study of international experience showed that there are often examples of the phased introduction of compulsory insurance, when different groups of the population become participants in compulsory insurance in order (Japon [**13**], Kazakhstan, Azerbaijan). There are also

countries for which compulsory health insurance was a natural consequence of the country's normal development and historical changes (Great Britain [**14**]). There are also states whose system is unique and has a rather complex, combined structure and financing mechanisms (Germany [**15**]).

Although the development of CHI systems has varied greatly across countries, but aforementioned questions are discussed in different models [**16**]. To support development and scale-up of health insurance it is necessary to reveal how to increase the country's financing capacity, extend health insurance coverage to the hard-to-reach populations, expand benefits packages, and improve the performance of existing schemes [**17**].

METHODOLOGY

The research methodology includes both qualitative and quantitative analysis approaches. To access the financial burden of the CHI introduction we need to calculate several indicators. In order to understand under what approximate conditions of relative workload we will be able to finance healthcare costs for all or part of the RA population at the expense of the working population, we have conducted an analysis of the number of the working population, the average salary to calculate the volume of the salary fund in the state.

Then, we estimated the burden of monthly out-of-pocket expenses on the salary fund, which will provide a basis for calculating the percentage of deductions from the salary. It should also be noted that such calculations have certain limitations. They disregard the potential rise in the use of health services, as well as shifts in the population's size and composition, which were disregarded in the computations (they were not subject to the impact of the subsequent factor).

Based on the concepts of effective financing implementation, the financial burden of the phased introduction of CHI was estimated using the proposed gradual (phased) introduction mechanism. This implies that the financing of insurance premiums should be implemented both at the expense of RA citizens and the state budget so that there is no financial gap in the state budget and the private sector is not burdened. From this point of view, we propose to carry out the financing between the public and private sector with the following distribution:

Table 1

Funding from the state budget	Funding from the private budget
Persons aged 18 and older and included in socially disadvantaged and special groups	Working and self-employed population, independent taxpayers
Disabled people	
Pensioners (persons aged 63 years and older)	
Unemployed and job seekers	
Children (from 0 to 18 years old)	
Farmers, students	
Other population groups	

At the first stage of CHI implementation social insurance package is exempted from the financing of the state budget and these amounts are directed to financing the insurance premium of citizens working in the public sector [**20**]. During the second and subsequent stages, the financial resources of state-targeted programs are redirected to the financing of compulsory insurance.

Then, according to the sequence of inclusion of population groups, we calculated the possible financial burden on the working population and the state budget. The calculations were carried out based on the principle of full reimbursement of all healthcare costs for 2019. The population size for each group is also taken for 2019. Funding volumes have not been reduced, because, after the introduction of insurance, healthcare expenses generally tend to increase, as a result of the decrease in self-medication volumes and the reduction of cases that did not consult a doctor due to financial problems.

ANALYSIS

An insurance mechanism for comprehensive financing of health costs implies an additional financial burden on the working population. During 2015-2022, the number of the working population in RA increased along with the increase in the average salary level. In 2022 the number of working population in RA was 708,000 with an average salary of AMD 235,576.

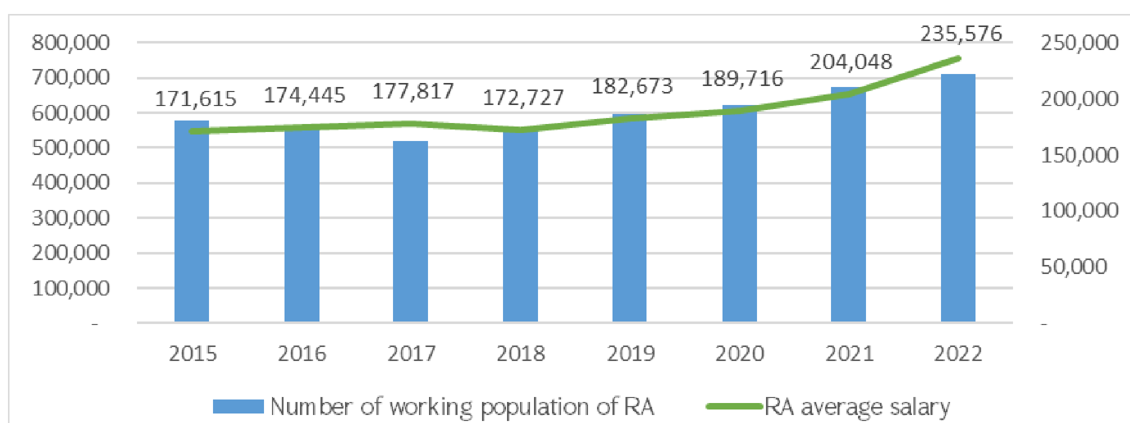

Figure 3. *RA average salary and number of working population, 2015-2022 (Source: ARMSTAT)*

Table 2 combines the total monthly salary pool, total annual and monthly healthcare expenses, annual and monthly out-of-pocket healthcare expenses, as well as the ratio of monthly out-of-pocket expenses to the salary fund. As the statistical data for total healthcare costs and out-of-pocket expenditures was missing these indicators are calculated taking into account the average rate of change and the mean square error of the indicators for the previous 7 years under study (regression method).

Table 2

Indicators	2015	2016	2017	2018	2019	2020	2021	2022
Total monthly salary in RA, mln. AMD - W	99,211	97,044	92,425	96,153	109,282	118,377	137,114	167,001
Total expenditure on healthcare in RA, mln. AMD - C	510,324	504,310	576,632	592,602	717,827	756,700	861,283	942,100
Out-of-pocket expenditures, mln. AMD - OOP	405,372	406,698	486,378	507,370	631,393	589,074	677,680	742,081
Total healthcare monthly expenditures in RA, mln. AMD – C_m	42,527	42,026	48,053	49,384	59,819	63,058	71,774	78,508
Monthly out-of-pocket expenditures, mln. AMD – OOP_m	33,781	33,892	40,531	42,281	52,616	49,090	56,473	61,840
C_m /W:	42.87%	43.31%	51.99%	51.36%	54.74%	53.27%	52.35%	47.01%
OOP_m /W	34.05%	34.92%	43.85%	43.97%	48.15%	41.47%	41.19%	37.03%

Source: based on the data from Figure 1, 2, 3.

The estimated size of the payroll indicates that the out-of-pocket healthcare expenditures can be financed by allocating 34-48% of the working population wages, and by 42-55% for covering total healthcare costs.

Calculations show that almost 55% of the working population wages need to be directed to insurance allocations in order to finance the health services for the entire population. This is a serious financial burden on the working population and means that each working person in RA will finance about 4 non-working persons. It is not feasible in this situation for the working population to bear the whole insurance burden. Therefore, we can unequivocally state that any similar project will not be implemented without significant participation of the state.

The full implementation of the CHI with state participation is also challenging and cannot be implemented at once. The full implementation of the

program will become a big financial burden for the state as well. It means that the gradual introduction of CHI will facilitate the implementation process and will allow to introduce specific regulations while scaling up the CHI.

Accordingly, in **the first phase,** it is necessary to insure the part of the population that is most aware of insurance mechanisms and can be quickly integrated into the system. The first stage is, in fact, the most important, because the further steps of system development depend on the results of the first stage. At this stage, we propose to insure RA citizens who are beneficiaries of the social package (from the state sector: 120,000 people) as well as RA citizens working in the private and public sectors (preferably already using voluntary health insurance), but not beneficiaries of the social package (around 521,802)[1]. In this way, we will build up a group of insured people working both in the private and public sectors. Therefore, the state budget will get free of financing the social package having the possibility to direct these funds to the financing of compulsory insurance premiums. Moreover, we will have such a group of insured persons who are somewhat familiar with insurance compensation mechanisms.

At the end of the first phase (after 1 year), all the collected information should be used to enter the second phase. It will be necessary to review the scope of compensable services, and compensable drugs: based on the results of the study of applications and rejected claims of insured persons. Insurance premiums and financing options should be also reviewed when a progressive rate of benefits is offered within the insurance framework. Only after making all the follow-ups and modifications, we can move to the second phase.

In the **second phase,** disabled people (191,959) and those who are 18 years of age or older and belong to socially disadvantaged and special groups (489,924) enter the insurance field. Insurance of this group is one of the most important problems of the state: the vulnerable class is currently facing a serious problem in terms of assuming the constitutional right to health. In the second phase, the part of the RA population that is most prone to health problems and is in the highest position in terms of drug consumption is insured. Thus, in the second stage, the most risky segment of the population enters the field of insurance. At the end of the second stage, we again summarize the scope and paths of compensation and change the insurance conditions, after which we move forward to the third phase.

In the **third phase,** the ranks of insured persons will be completed by pensioners (208,184 persons), children (562,399 persons) and those employed in agricultural holdings (212,800 persons). The transfer of each group of population to the field of insurance is also accompanied by the release of appropriate funds from the state budget and their subsequent transfer to the insurance budget. At this stage, the insured persons constitute a broad segment of the population, which will lead to the implementation of the final insurance regulations. After the completion of the third stage, the formation of the final picture of compulsory insurance can be expected.

In the **fourth phase**, the rest of the population will come to the insurance field: students, unemployed, job seekers and other population groups (approximately 654,932 people). Thus, after the introduction of the 4th phase of mandatory insurance, the entire population of RA will be insured. After the end of the fourth stage, RA laws and other legal regulations on CHI will take their final form.

Thus, taking into account the total health care expenses of 717.8 billion AMD, out-of-pocket expenditures of 631.4 billion AMD, and the average salary of 182,673 AMD, we will have the following picture of financing at each health stage (Table 3):

Table 3

	Stages of insurance implementation				
	1st stage	**2nd stage**	**3rd stage**	**4th stage**	*Share in GDP*
Total, of which	*155,537,724,535*	*320,788,892,683*	*559,107,181,137*	*717,826,900,000*	*10.97%*
Funding from the state budget	*32,704,503,766*	*197,955,671,913*	*410,488,416,087*	*500,886,257,592*	*7.65%*
Funding from the private sector	*122,833,220,769*	*122,833,220,769*	*148,618,765,050*	*216,940,642,408*	*3.32%*
Reduction of government costs during the insurance period	3,600,000,000	92,219,710,900	92,219,710,900	92,219,710,900	1.28%

[1] All figures for population groups are taken from the 2023 legislative draft "On Establishing the Concept of Contribution to Comprehensive Health Insurance" - https://www.e-draft.am/projects/5233 (11.11.2023).

All calculations in Table 3 are based on 2019 Census data (the data of the census corresponds to the data of the RA legislative project of CHI of January 11, 2023). The calculations were carried out based on the principle of full reimbursement of all healthcare expenses for 2019. If we take into account the fact that the target index of out-of-pocket expenses after the introduction of mandatory insurance is 25% or less (according to the objective of the CHI legislative draft of the RA of January 11, 2023), the financing volumes could be reduced. But we should also take into account the fact that after the introduction of insurance, healthcare expenses will tend to increase, as a result of the decrease in self-medication volumes and the reduction of cases that did not consult a doctor due to financial problems.

If we continue the financing calculations, we will get the following indicators for the working population (Table 4):

Table 4

Expenditures	Monthly, mln. AMD	Monthly per capita, AMD	Cost rate in average monthly salary
Total healthcare costs	59,819	20,195	11.06%
Out-of-pocket expenditures	52,616	17,764	9.72%

According to the calculations, the monthly amount of healthcare costs per capita is 20,195 AMD, of which out-of-pocket expenditures are 17,764 AMD. Also taking into account the fact that the average monthly salary in RA in 2019 was AMD 182,673, we get that the salary rate necessary to finance the working population's own health expenses is 11.06%, and for out-of-pocket expenses - 9.72%. Under our proposed approach, 50% of these rates should be paid by the employer and 50% by the employee. Thus, we can note that the effective rate of health care insurance financing is 11% of the salary of the working population, which is equivalent to an annual insurance premium of 242,345 AMD, calculated with the precondition of insuring the entire population of the Republic of Armenia.

The distribution of the insurance premium between the state and the private sector is only the primary distribution. In the private sector, the funding for the working population is also shared with the employer organizations, and the insurance premium is divided equally between the employee and the organization. We suggest also that the insurance premiums paid by the organizations must be deducted from the taxable profit base (as is currently done for voluntary health insurance benefits). This tax break will do little to discourage organizations from incurring additional fees. The principle of dividing the insurance premium between the employer and the employee will also apply to persons working in state and local self-government bodies and state structures. This assumes that the state will share the cost of insurance premiums with the population working for it.

CONCLUSION

As a result of the analysis, it was confirmed that the population of RA faces significant healthcare costs. The study showed that financing such expenses within the framework of the insurance system would require huge amounts of money, which would not be possible to finance only at the expense of the working population. Calculations of the financial burden also showed that it is necessary to distribute it between the population and the state, and in order to carry out this process without economic shocks and budget gaps, it should be carried out in a phased version, the step order of which we have presented the scope of work. A phased implementation will also help to identify the process, analyze problems arising from the use of the system, which will be easier to manage as a result of non-comprehensive inclusion, and implement corrective changes and move forward.

Thus, in order to effectively solve the health financing problems faced by the population of RA, we propose to introduce an insurance system working with the above-mentioned mechanisms, which will prevail on the basis of the existing norms of regulation and self-regulation and will be controlled by the Central Bank of RA. This system will be a powerful tool that will lead to an increase in the level of social protection of the RA population and will lead to an increase in the population's longevity and life expectancy. The implementation of the system will lead to changes in the structure and volume of private health expenses in the long term, as a result of which the out-of-pocket health expenditures of the RA population will be reduced. The freed funds will be directly invested in the economy and the volume of consumer spending will increase, which will lead to the growth of the GDP, and the taxes and duties formed from them will be directed to the state or local budget.

According to our calculations, the financing ratio of the total insurance premiums of compulsory health insurance between the state and the private sector will be 70% and 30%, respectively (Table 3).

Here it should be taken into account that the financing carried out by the state, compared to the previous volumes, will increase about 5 times, making 7.65% of the GDP compared to the previous 1.28%. This, in turn, speaks about the economic consequences of the CHI implementation, in particular, the provision of economic growth.

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