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COMMENT

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Health insurance premium in Colombia for 2025: a strictly political-ideological decision without technical-scientific arguments?

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Abstract

The Colombian Ministry of Health's decision to increase the health insurance premium (Capitation Payment Unit) by 5.36% for 2025, close to the inflation rate, has sparked controversy. This adjustment disregards factors that contribute to rising healthcare costs, leading to concerns over the guarantee the right to health for Colombians and financial sustainability of the health system. The insufficient increase raises the likelihood of surpassing premium coverage, as evidenced by recent actuarial studies. This decision could affect the quality of services and jeopardize the health of 50 million inhabitants in the Colombian territory. The paper calls for a more robust, technical approach to ensure the financial stability and quality of care in the Colombian health system.

Keywords Colombian health system, Capitation payment unit, Financial sustainability, Health risk

The announcement on December 31, 2024 by the Colombian Ministry of Health and Social Protection (MHSP) to increase the health insurance premium (Capitation Payment Unit, CPU) by only 5.36%, a value very close to inflation rate (5.2%), ignoring other factors that increase patients' healthcare costs year after year, has caused controversy [20, 22]. Different stakeholders of the health sector in the country have raised their voices in protest, among them, multiple patient associations, scientific medical societies, civil society, academia, hospital centers and think tanks [23]. The insufficient increase in the CPU increases the probability of having a systematic risk materialization while deepening the financial unsustainability of the Colombian healthcare system (recent actuarial studies have already demonstrated this [9–13]). This is already generating some repercussions such as the announcement of hospital closures and the suspension or closure of essential medical services, such as obstetric wards [5, 20].

The current health care system in Colombia (CHS), created by Law 100 of 1993, is based on the so-called structural pluralism. This concept, developed by Frenk and Londoño, considers essential the synergy between articulation, financing, modulation and provision of services in health systems, under a "fair measure" [14]. The CHS includes private or public health insurers (called Health Promoting Entities—HPE, who should manage the population's health risk), together with the participation of public, private and mixed health service providers.

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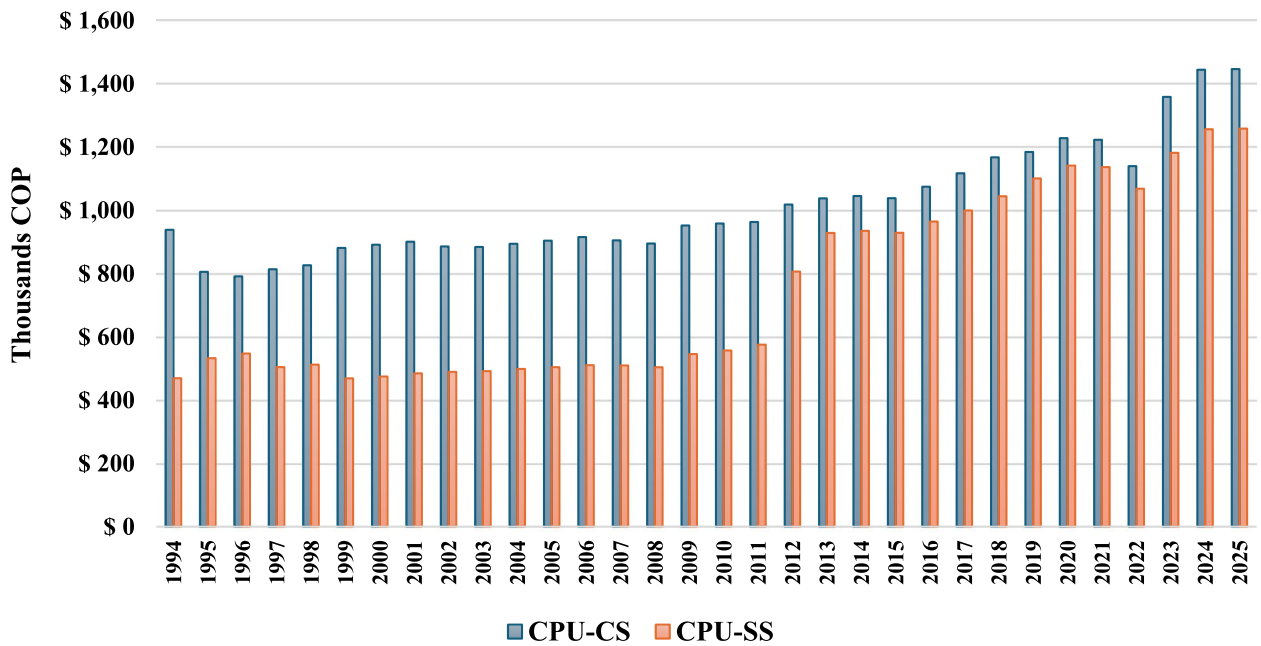

Fig. 1 Capitation Payment Unit (CPU) for contributory (CS) and subsidized schemes (SS), 1994 – 2025, constant 2024 prices. Source: technical studies with information extracted from the official website of the MHSP [16].

It offers three types of insurance plans: the contributory scheme (CS) (for workers and their beneficiaries), the subsidized scheme (SS) (for socioeconomically vulnerable people, supported by the State) and the special/exception scheme (for few people, based on agreements with some unions associated with the government, such as the military, employees of the state oil company, among others). The CHS stands out for its financial protection capacity (low out-of-pocket expenses) and high enrollment coverage [18].

The Ministry of Health and Social Protection (MHSP), as the regulatory entity of the CHS, defines the annual CPU using an actuarial approach. The CPU are in the end, the resources that the HPE will receive for the operation, guarantee and provision of health services to the insured population in the CS and SS. Especially, under two mechanisms, the first and most important, called CPU (health premium), and the second, entitled Ceiling Budgets. The CPU is an ex-ante risk adjustment mechanism that allows the HPE to operate under rational principles of microeconomics so-called managed competition [8]. The CPU represents more than 90% of the resources transferred from the government to the HPEs to guarantee the health care of the population, that is, a national value close to 20 billion dollars by 2024.

The purpose of this letter is to express our deep concern as researchers in economics, actuarial and health systems about the decision of the MHSP to increase the CPU by 5.36% for both schemes (which in practical terms translates into no real growth). We consider this to be a policy decision with no technical basis, which will directly affect the provision and quality of health services for approximately 50 million people.[1] Below, we set out our arguments under four headings.

Actuarial sufficiency (financial sustainability)

The so-called 'sufficiency study' conducted by the MHSP, in which actuarial calculations are made for the definition of the CPU by 56 risk categories (segmented by sex, age groups and geographical areas), since 2010 presents an actuarial perspective in its statistical estimation assuming that the CPU is a risk premium (see Fig. 1) [3, 24]. The MHSP estimates the increase in the CPU for year $t+1$, with information from year $t-1$. This adjustment is calculated using the loss ratio method, which is the quotient between expected health insurance costs, adjusted for trends, and HPE revenues.

Adjustments for trends allow projecting future conditions for the application of the new health insurance premium (CPU), considering factors such as inflation, claims frequency, the inclusion of new health technologies in the health benefit plan, incurred but not reported claims (IBNR), among other aspects of actuarial interest.

[1] We clarify that there are also some stakeholder groups that support the decision to not increase the CPU, however, they do not have technical documents that can be cited, mostly expressing their opinions on social media.

Likewise, the insured population exposed by pending compensation payments and the population growth expected for the following year is adjusted. The objective is to ensure that the CPU covers the expected costs of the health benefit plan, the expenses and the profit of the HPE. The required change in the CPU is obtained by calculating the loss ratio and comparing it with the allowable loss ratio established by Law 1438 of 2011, with a value of 0.9 for CS and 0.92 for SS [3].

However, under the current context and with expenditure growth pressured by technological innovations in drugs and medical procedures, the accelerated aging of the population, the millions of migrants, among other factors, the MHSP decided only to increase the value of the CPU by a value close to inflation, ignoring all other adjustments for trends. This implies a serious problem of financial sustainability, given that per capita claims will probably continue to exceed the value of the premium, as has already been demonstrated in recent years in the CHS [9–13].

When analyzing which health conditions could be affected by the null real growth of the CPU, the recent study on health spending led by researchers from the Universidad Nacional de Colombia and the London School of Economics shows that the treatments with the greatest growth in spending are neoplasms, blood diseases, circulatory system, pregnancy, puerperium and the perinatal period [9, 11, 12]. Likewise, according to this research and given the demographic change in Colombia, the groups of people aged 60 years and over would probably also be negatively affected by the provision of health services Especially for people with multimorbidity, given that 1 in 2 people present this phenomenon with frequencies, costs and UPC significantly higher than the average assigned by age, sex and geographic area [2].

Validation of information

The data used in the sufficiency studies correspond to: i) reports on the provision of health services per member issued by the HPEs authorized to administer the CS and SS; ii) databases of members, CR compensation and RS settlements; iii) financial statements reported by the HPEs to the National Superintendence of Health; iv) studies and information from the National Administrative Department of Statistics on the national population, and v) tariff manuals of health technologies financed by the CPU, among others [3].

Over the years, the MHSP has improved the processes for verifying the quality of information. Among other aspects, it reviews the verification of: the structure of the data, the consistency of epidemiological information, the insured population, health care per user and uniqueness over time, the maximum dispensing dose of drugs, the identification of outliers in frequency and values reported per member, the correspondence between diagnosis and health technology reported per member, among other technical aspects [15]. Historically for the CS, even when it has not been possible to have 100% correct information, the MHSP has always managed this administrative process with the HPEs and has managed to have the minimum standards of information coverage to estimate the increase in the CPU. For the SS scheme, it has never been possible to gather quality information (only in 2022).

Now, for the actuarial calculations that would support the increase in the CPU for year 2025, surprisingly the MHSP announced, for the first time in many years, that the information reported by the HPEs of the CS was not of adequate quality [1]. This is a bit paradoxical, given that more than half of the people are insured to HPEs that are currently intervened by the national government itself (the information used to estimate the CPU in 2025 should be that of 2023, and although at that time the government was not in charge of the management of several HPEs, in 2024 it had the opportunity to review the financial data of the intervened entities). Furthermore, it should be added that these intervened HPEs have seen a significant increase in patient complaints and claims with respect to previous years [19].

Premeditated decision to exert political pressure?

In the year 2023, the current national government presented a health reform that restructured the functioning of the CHS (i.e. the role of the HPEs), however, no reference was ever made to a serious study of the financial sustainability of the proposal. This bill failed in Congress. For 2024, the national government insisted again, and a reform proposal that is not very different from the previous one is currently in Congress. In addition, it still does not have the endorsement of the Ministry of Finance and Public Credit regarding the fiscal impact of the possible reform.

The current health reform proposal lacks technical soundness and several experts in the field have already expressed their disagreement, since it would not solve the fundamental problems contemplated by the CHS (e.g. quality of health services in rural areas, formalization of human talent in health, strengthening of the public network of health service providers, etc.). We wonder if this increase in the CPU has to do with pressures for Congress to approve the health reform that is under

evaluation.[2] In any case, the progress of a health system that has shown important advances in the last 30 years is being negatively impacted.[3]

Minimum wage slippage

Public hospitals and their patients will be the most affected by this measure given that they will have to adjust the salaries of the human talent in healthcare indexed to the increase in the current legal monthly minimum wage, which rose by 9.54%. There are no specific data from Colombia but since salaries in most health systems in Europe represent between 30 and 60% of health expenditures, it is reasonable to assume that in a country like Colombia, that value is located around the upper bound of the distribution [25]. This will inevitably affect the payroll and possibly destroy jobs, given that now in real terms public hospitals will have fewer monetary resources to hire their personnel. According to administrative records, 87.4% of the healthcare workers in Colombia recorded in the payroll taxes system report an income of one to two minimum wages.[4] Otherwise, they will have less budget available to provide health services to their patients.

Several recent technical studies have proposed concrete measures to improve the CPU actuarial calculations, such as the use of more years of history for statistical modeling, the inclusion of new risk categories (e.g., health conditions), the redefinition of risk categories, the use of Bayesian and deep learning methodologies, among others [4, 7, 9–13]. However, to date the MHSP has not considered these opportunities for improvement.

At this point it must also be said that the HPEs have not fully complied with the constitution of technical reserves and their management will have to improve. Therefore, the work of the National Superintendence of Health will be fundamental to fully enforce the financial conditions of the Colombian health insurance sector. It is also important to bear in mind that health spending should be optimized by investing in cost-effective health technologies, conducting studies on technological obsolescence, developing evaluations of the impact on health outcomes of the expenditure invested by the HPEs, refining the health benefit plan, and implementing primary health care strategies, among other aspects. Controlling health spending requires intelligent strategies that take advantage of existing information systems in order to promote the financial sustainability of the Colombian health system (while ensuring fiscal responsibility) [9, 11, 12]. There is an urgent need to return to an explicit benefit packages where new technologies entering the health system are evaluated by the Institute for Health Technology Assessment.

Final considerations

Recently, from the legal field, on January 23, 2025, the Colombian Constitutional Court declared general noncompliance in relation to the financial sufficiency component of the CPU in both health schemes and ordered the MHSP to establish the guidelines or criteria on the basis of which ex post adjustments may be made, indicating the percentages and maximum payment dates [6].

Finally, we hope that the Advisory Commission on Benefits, Costs, Rates and Operating Conditions of Health Insurance (the social body that formulates recommendations for the value of the CPU and the guidelines for determining the methodology for calculating the premium), which also includes the Ministry of Finance and Public Credit, the Presidency of the Republic, the Institute for Health Technology Assessment and the National Planning Department, will reconsider its decision based on the arguments presented here and will be able to calculate the CPU for approximately 50 million patients in Colombia in a technical-scientific manner. The health of the health system in Colombia may be at risk.

[2] According to Decree 2562 of 2012, if by December 31 of each year the MHSP has not approved an increase in the value of the CPU, such value will be automatically increased by the inflation caused. And although the CHS Resource Administrator (ADRES for its acronym in Spanish) conducted a study to contrast information for the year 2023, it does not present a degree of detail or actuarial rigor as the reports made in previous years by the MSHP (Ministerio de Salud y Protección Social [15], Ministerio de Hacienda y Crédito Público, and Administradora de los Recursos del Sistema de General de Seguridad Social en Salud 2024 [17]; Administradora de los Recursos del Sistema de General de Seguridad Social en Salud 2024 [1]; Ministerio de Salud y Protección Social 2025 [16]).

[3] In 2023–2024 Colombia fell more than 45 positions compared to 2021 in Ceoworld's ranking of healthcare systems, settling in 81st place out of 110 countries analyzed [21].

[4] Own calculations using the ReTHUS information system (consulted Jan 5, 2025) that includes information for healthcare workers (defined by their tertiary education degree) from the payroll taxes for every employee or independent contractor in the country (PILA). In 2024, 888,486 out of 1,015,715 healthcare workers reported incomes of exactly 1 to 2 minimum wages.

Authors' contributions
OE: conception and design of the work, data collection, data analysis and interpretation, drafting the article, critical revision of the article, final approval of the version to be submitted. PRL, SP, MB, JMB, AVO: drafting the article, critical revision of the article, final approval of the version to be submitted.

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Not applicable.

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