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Competition and Regulation in the Healthcare Sector – Note by Mexico

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1. Introduction[1]

1. The health sector is a central component of the population's well-being. Its proper functioning directly affects timely access to, and the quality and cost of medical services, medications, and supplies necessary for health care.

2. In Mexico healthcare is delivered through a fragmented system composed of multiple subsystems. These include multiple insurers with their own staff and facilities to serve the population, and enrollment in one or the other generally depends on the employer. The largest of these is the Mexican Social Security Institute (IMSS) which provides health insurance and medical care services (as well as pensions and other benefits), primarily for the population employed in the private (formal) sector. The Institute for Social Security and Services for Federal Government Employees (ISSSTE) provides social security (SS) coverage to federal government employees. Other key institutions include the government-funded State Health Services (SESA) network, which serves those without employer-sponsored insurance.[2]

3. In 2024, 63.8 million people reported having health insurance coverage, primarily through the IMSS and ISSSTE. However, the number of people without coverage under the public health system doubled, reaching 47.7 million in the same year.[3]

4. Total health expenditure in Mexico increased from 5.2% to 6.2% of Gross Domestic Product (GDP) between 2018 and 2024. This rise has been mainly driven by the persistence of private spending, particularly out-of-pocket expenses.[4][5]

5. In 2024, average annual household health expenditure reached $6,421 Mexican pesos (approximately 370 USD); however, this amount is higher in lower-income families.[6] At the same time, demand for health services remains high: in 2022, 24.6% of the population required medical care. Nearly 56% of these patients relied on private health facilities, highlighting the urgent need for accessible and efficient markets.

[1] Contribution by the Mexican National Antitrust Commission

[2] OECD. (2016). OECD Reviews of Health Systems: Mexico 2016. OECD Publishing, p.19, available in Spanish at https://www.oecd.org/content/dam/oecd/es/publications/reports/2016/01/oecd-reviews-of-health-systems-mexico-2016_g1g51357/9789264265523-es.pdf

[3] Méndez Méndez, J. S., & Lugo Porras, C. I. (2026, April 7). Cobertura Universal en salud. Avances en acceso, retos en afiliación y financiamiento. Centro de Investigación Económica y Presupuestaria (CIEP), p. 2, available in Spanish at https://ciep.mx/wp-content/uploads/2026/04/BOLETIN-CIEP-CUS.pdf

[4] Out-of-pocket health expenditure refers to the direct payments made by individuals when receiving any type of service (preventive, curative, rehabilitative, palliative, or long-term care) provided by any provider. These direct payments exclude any reimbursement from a third party, such as the government, a health insurance fund, or a private insurance company.

[5] Ibid, p. 4.

[6] Centro de Investigación Económica y Presupuestaria. (2025). Gasto de bolsillo en salud: resultados de la ENIGH 2024 available in Spanish at https://ciep.mx/gasto-de-bolsillo-en-salud-resultados-de-la-enigh-2024/

6. When healthcare markets do not function properly, whether because certain companies engage in anti-competitive practices or because barriers to competition exist, price increases and access restrictions may arise, disproportionately affecting lower-income households.

7. The National Antitrust Commission (Antitrust Commission or Commission) has actively addressed the healthcare sector through bid-rigging sanctions, market studies, and advocacy aimed at protecting vulnerable populations. This contribution details the Competition Authority's latest market study into medical expense insurance.

2. Competition and Free Market Access Study in Medical Expense Insurance[7]

8. Insurance policies are financial instruments that allow the distribution of risks and potential financial losses among a group of people through the payment of premiums. Under these contracts, insurance companies manage these resources to compensate those who experience a loss according to the agreed terms. Among the most significant insurance products available in the market is the Major Medical Expenses Insurance (SGM, by its Spanish acronym).

9. SGM insurance policies are a form of private health coverage specifically designed to protect households against catastrophic medical costs. They provide financial security by covering expenses related to hospitalization and certain high-cost diagnoses, thereby reducing the risk of severe economic impact on family finances. Coverage typically applies to a defined limit, ensuring that policyholders are shielded from the most burdensome medical events.

10. Insurance companies offer both individual health insurance and group health insurance. Individual policies cover one person and their family members, while collective plans (typically hired by employers) extend coverage to employees. In most cases, employees can enhance their benefits or include additional relatives by paying an extra premium.

11. SGM policies generally involve a deductible, which may be reduced or even waived if policyholders choose to receive care within a network of providers (such as hospitals and physicians) that have contractual agreements with the insurer. Additionally, premiums or insurance policy prices often vary based on factors like age and gender of the insured. For group insurance plans, insurers also take into account the health history of the covered employees.

12. Private healthcare services serve a significant portion of the population in Mexico: in 2020, they accounted for 12% of outpatient visits (over 12 million) and recorded 1.9 million hospital discharges, surpassing those of the IMSS. Spending on medications at private pharmacies reached 44.5 billion Mexican pesos (approximately USD 2.6 billion or 36% of the market). Demand for private services comes both from people without access to public institutions (26% of the population in 2020) and from families who, despite being enrolled in public systems, choose to supplement their care with private services (10% in 2018).[8]

[7] Cofece (2022). Competition and Free Market Access Study in Medical Expense Insurance available in Spanish at https://www.cofece.mx/wp-content/uploads/2022/12/Estudio-Seguro-de-Gastos-Medicos.pdf

[8] Cofece (2022), p. 19.

13. Additionally, approximately 13 million people are currently covered by SGM insurance. This market generates premiums of approximately 92 billion Mexican pesos annually (5.4 billion USD). [9]

2.1. Overview of the SGM Market

14. The Commission's analysis shows that SGM market is highly concentrated, with the four largest insurers accounting for 75% of SGM premiums. This concentration among a small number of competitors is observed in both individual policies and collective insurance plans.

15. Holding a SGM policy grant users access to the insurer's network of healthcare services and professionals, eliminating the need to negotiate directly with providers. Insurers establish service agreements with hospitals to guarantee care for insured individuals, while healthcare professionals treating these patients can use hospital facilities and supplies under these contractual arrangements.[10]

16. Insurance companies seek to include the most prestigious hospital chains in their network, along with other less well-known hospitals, provided the latter meet minimum quality standards in their level of care. Accordingly, insurance companies require private hospitals to be certified by the General Health Council (CSG) to make direct payments.

17. Hospitals have incentives to establish commercial agreements with insurers, as these partnerships can significantly increase their patient base. However, such agreements are contingent upon meeting CSG certification requirements, which serve as a quality benchmark. To maintain eligibility and strengthen their reputation, hospitals are motivated to attract well-regarded healthcare professionals and service providers, ensuring high standards of care.

18. The relationship among users, insurers, hospitals, and healthcare professionals is key in shaping both the characteristics and the pricing of SGM policies. By fostering greater competition in the insurance and hospital sectors, out-of-pocket expenses for policyholders can be minimized, while premiums become more affordable, ultimately improving access to quality healthcare services.

2.2. Problems identified and recommendations issued by the Antitrust Commission regarding the SGM market

2.2.1. High market concentration

19. The SGM market is highly concentrated; just four insurers account for 75% of total premiums and care for insured individuals is concentrated in eight hospital groups that handle 52% of the claims covered by SGM, which reduces competitive pressure.

- The private hospital system is composed of a large number of small facilities and a limited number of chains operating larger hospitals: 65% of private hospitals have fewer than ten beds, 32% fall within the range of ten to 49 beds, and only 3% have at least 50 beds.
- The 40% of census beds are concentrated in four federal entities where the major metropolitan areas are located: Mexico City (13%), State of Mexico (12%), Jalisco

[9] *Ibid.,* p. 19.

[10] For a visual representation of the private health sector, see Cofece (2022), p. 33.

(9%), and Nuevo León (6%). 57% of hospitals with 50 beds or more are located in these same federal entities.

- Hospital service prices are notably higher in the four aforementioned entities. In principle, this would be justified by the presence of large hospitals, which can treat complex diseases and offer higher quality services. However, rates are significantly higher even for similar ailments, the care for which should be standardized. This may also suggest that these hospitals exert bargaining power to increase their revenues.

20. To increase competitive pressure in the market, the Commission recommended that the Federal Consumer Protection Agency (Profeco by its acronym in Spanish) develop and publicly disseminate indicators measuring the price–quality ratio of hospital services, drawing on existing initiatives that assess quality of care, such as the "Best Private Hospitals in Mexico" ranking as well as the IMSS Integrated System for Measuring User Satisfaction. This measure will help empower both consumers and insurance companies, as policyholders would have more information to choose hospital services based on the price-quality ratio rather than the hospital's brand name.

2.2.2. Bargaining power of hospitals

21. Market concentration leads to the exercise of market power. To analyze this dynamic, the Commission developed two econometric models examining the relationship between premiums paid by policyholders and the market structure of providers.

22. In Model 1, insurance premiums are estimated as a function of the presence of large hospitals, the level of concentration in the insurance market, and various socioeconomic characteristics. In this model, the hypothesis was that the presence of large hospitals within the federal entity leads to higher insurance premiums. The results indicated that:

- The presence of hospitals with more than 100 beds increases the premiums of individual insurance policies by 12%.
- Premiums also rise when the insured individual is female, older, or purchases a policy with a higher coverage amount.
- Premiums are higher in federal entities with greater GDP per capita, which is where the largest hospital infrastructure is concentrated.

23. Model 2 posits that the price of hospital services paid by insurers depends on the presence of large hospitals, the number and type of policyholders, as well as the levels of concentration in both the insurance and hospital markets. The results showed that:

- A 1% increase in the Herfindahl–Hirschman Index (HHI) of insurers reduces hospitalization costs by 0.4%, while an equivalent 1% increase in the HHI for hospitals raises these costs by 0.3%.
- The prices of hospital services paid by insurers are 34% higher in markets where hospitals with more than 100 beds are present.

24. According to the Commission's findings, the previously mentioned recommendation to Profeco to publish indicators measuring price-quality ratio of hospital services is also relevant to this problem, as it aims to simultaneously limit the bargaining power of the major hospital chains vis-à-vis insurance companies.

2.2.3. Asymmetric information

25. Unexplained variations in treatment prices for the same medical condition restrict consumers' ability to compare alternatives and make informed decisions. This situation may be due to the presence of asymmetric information; patients lack knowledge about the true quality and cost of hospitals for identical treatments, and therefore often assume that renowned hospitals offer higher quality services. This dynamic creates a moral hazard problem, as consumers tend to select insurance plans that grant access to large hospitals, which in turn drives up their premiums.

26. To address this issue, and as a complement to the previously mentioned recommendation, the Commission recommended the Ministry of Health to require private hospitals to adopt the Clinical Practice Guidelines (CPG) developed and published in its Master Catalog of CPGs for the treatment of the most common ailments or diseases.

2.2.4. Existence of switching costs

27. Consumer mobility is significantly constrained by high switching costs. Changing to another insurance provider often results in the loss of accumulated seniority, which is critical for coverage of certain medical conditions. Waiting periods are freely set by insurers, further reinforcing lock-in effects and discouraging consumers from switching plans. To mitigate these barriers, the Commission issued four recommendations aimed at improving portability across insurance providers.

28. To the Ministry of Finance:

- Mandatory recognition of prior coverage: Require insurers to recognize the duration of coverage under a previous policy. Portability would apply only when the insured does not request an increase in the coverage amount compared to the prior policy, thereby mitigating potential opportunistic behavior.
- Standardized rules on exclusions: Establish uniform regulations governing the type and duration of exclusions that insurers may include in policy provisions.
- Independent risk bureau: Amend the legal framework to create a *risk bureau* operated by an entity independent of insurance companies, or alternatively, one in which any insurer entering the market may participate as a board member. This would guarantee non-discriminatory access to consumers' claims history for all market participants.

29. To the National Commission for the Protection and Defense of Financial Services Users (Condusef by its acronym in Spanish):

- Establish the possibility for consumers to cancel their insurance policies early at any time without penalties, requiring insurers to refund the full amount of the unearned premium (excluding issuance costs). This obligation should also apply in cases where the insurer revokes the policy, ensuring equitable treatment of consumers in all scenarios.

2.2.5. Proliferation of poorly differentiated SGM plans or products (decision architecture)[11]

30. SGMs are complex products, and consumers find it difficult to accurately assess their value for money. This difficulty is compounded by the large number of plans offered often with minimal differences which hinder meaningful comparison. On average, each insurer offers seven different individual SGM plans.[12]

31. The theory suggests that insurers have an incentive to flood the market with excessive plan options, thereby dominating the digital shelf space. The objective is to raise consumers' search costs to the point where they abandon exhaustive evaluation of complex product options, allowing insurers to exploit consumers' bounded rationality.

32. This situation prevents markets from functioning properly, as insurers lack sufficient incentives to design and offer products that deliver genuine value for money.

33. The Antitrust Commission recommended that the Ministry of Finance assess the consequences of limiting the number of health insurance plans offered by insurers to only those with perceptibly distinct characteristics. If necessary, the Ministry of Finance should request that Congress enact the corresponding reforms.

2.2.6. Sales agent compensation scheme.

34. Eight out of ten individual or group insurance policies are sold through agents. These agents typically offer products from multiple insurers, but their incentives are closely linked to commissions and bonuses, which may lead them to prioritize the sale of products that provide higher remuneration, biasing their advice toward insurers that pay higher commissions.

35. The Commission recommended that the Ministry of Finance and the National Insurance and Securities Commission (CNSF by its acronym in Spanish) establish, in the *Circular Única*,[13] an obligation for insurance agents to disclose the commissions and bonuses they receive from each insurer whose products they promote. This disclosure must occur at the time advisory services are provided and before consumers decide, regardless of whether the insured party requests the information.

36. Additionally, the Commission recommended prohibiting bonuses, incentives, or contingent commissions that are linked to meeting specific sales targets for the same plan or the same company. Such practices may induce agents to push particular products to the detriment of other plans that could be more suitable for policyholders.

37. These recommendations aim to ensure that consumers are fully aware of potential conflicts of interest among agents.

2.2.7. Regulatory uncertainty

38. Innovation is a key indicator of the intensity of competition in a market. In particular, *Insurtech* technologies have the potential to generate efficiencies in the market

[11] Thaler y Sunstein (2008) point out that consumers' purchasing decisions depend on how the alternatives are presented to them.

[12] Cofece (2022), p. 67.

[13] It is a regulatory body of provisions derived from the LISF, which give operational effect to its precepts and systematize their integration by standardizing the terminology used. Available at: https://www.gob.mx/cnsf/documentos/circular-unica-de-seguros-y-fianzas

analyzing information. This enables insurers to offer personalized products based on individual health status and habits, with the potential of reducing premiums for population segments that currently cannot afford insurance.[14]

39. In Mexico, *Insurtech* companies are not subject to specific regulations, but the Law to Regulate Financial Technology Institutions (LITF) and LISF apply to them depending on their business model.

40. In addition, data exchange through APIs can facilitate the adoption of data-driven innovation in the insurance sector, the creation of innovative products for consumers, and increased efficiency and interaction with third parties. It would also encourage greater competition within the value chain, as new players and business models emerge, potentially reducing costs.

41. The LITF establishes the obligation for the CNSF to issue general rules applicable to the insurance sector, in particular, the regulation of innovative models and the establishment of APIs that enable connectivity and access to other interfaces developed or managed by their supervised entities, as well as the publication of authorizations for innovative models in a public registry, which will be broadcast on its website. However, the general provisions applicable to insurance, as referred to in the LITF, have not yet been issued by the CNSF. This could discourage the entry of companies engaged in data intermediation, as well as new competitors that require interconnection to access user data, since the absence of such guidelines may create uncertainty among entrepreneurs.

42. Therefore, the Commission recommended that the CNSF issue the general provisions referred to in Article 76 of the LITF regarding the interconnection and sharing of transactional data, subject to prior authorization from users, which will facilitate the entry of innovative models.

2.2.8. Insufficient regulatory standards for consumer information comparison

43. Current Mexican regulation does not impose criteria or conditions requiring insurers to improve their websites to facilitate consumer choice, nor does it mandate the presentation of standardized information that eases comparison and understanding. In particular:

- The market features scarce information for comparing insurance plans.
- Insurers appear to be committed to a face-to-face insurance sales business model; therefore, their websites are not adequately designed to improve information directed at consumers.
- Two out of three insurers' websites do not allow consumers to obtain an online policy quote, given that after requesting the interested party's personal information, they are informed that an agent will contact them to provide assistance.

44. As a result, insurers can present information on their websites in a way that steers consumers toward specific plans, undermining their ability to assess all available options.

45. Condusef provides a simulator that allows consumers to compare products from eight insurers offering SGM. However, this comparison tool does not allow users to adjust key variables such as the insured amount, additional coverage, co-insurance, or federal entity; therefore, users must still seek information directly from insurers.

[14] See Cofece (2022), p. 116.

46. In this context, the Commission recommended:

- To the Ministry of Finance and the CNSF to promote the establishment in the Law for the Protection and Defense of Financial Services Users (LPDUSF by its acronym in Spanish) of minimum standards that insurers and comparators' websites must meet, drawing on international best practices.
- To the CNSF to amend the *Circular Única* to establish clear rules governing the promotion and provision of insurance intermediation services offered by comparators and other intermediaries marketing SGM through digital channels.

3. Final remarks

- The Mexican SGM market is highly concentrated, dominated by a small number of large participants. This market structure contributes to price dispersion and prevents the market from functioning efficiently.
- Competition policy plays a key role in ensuring that markets for medicines, medical supplies, and healthcare services operate under competitive conditions. Strengthening competition in these sectors helps prevent practices that drive up drug prices, restrict supply, or limit access to quality care. These efforts primarily benefit the most vulnerable households, advancing a healthcare system that is more accessible, equitable, and focused on the population's well-being.