Choice

of health insurer and healthcare provider

An analysis of regulated competition in the Dutch healthcare system

Daniëlle M.I.D. Duijmelinck

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Choice of Health Insurer and Healthcare Provider

An analysis of regulated competition in the Dutch healthcare system

Keuze van zorgverzekeraar en zorgaanbieder

Een analyse van gereguleerde concurrentie in de Nederlandse gezondheidszorg

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Chapter 3

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Chapter 4

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Chapter 6

Duijmelinck, D.M.I.D. and W.P.M.M. van de Ven. 2015. 'What can Europe learn from the managed care backlash in the United States?' *Submitted for publication.*

1

Introduction

1.1 BACKGROUND

Health policymakers around the world are confronted with the challenging task of increasing efficiency, quality, and consumer responsiveness in healthcare. Policymakers in the Netherlands (and in several other European countries; e.g. Germany and Switzerland) approached this task by taking steps towards regulated (or managed) competition in healthcare, as defined by Enthoven (1978, 1988a, 1988b). The introduction of the Health Insurance Act (HIA, *Zorgverzekeringswet*) in 2006 was an important step towards regulated competition in the Dutch basic health insurance (BI) market. For many years, the government planned the capacity and regulated the tariffs in the Dutch healthcare system. However, because this top-down strategy did not contain sufficient incentives to enhance efficiency, quality, and consumer responsiveness in healthcare, it has been replaced with regulated competition. The introduction of regulated competition has changed the role of insurers fundamentally: instead of being only the third-party 'payers of care', insurers have become also the third-party 'purchasers of care'. In this new role, insurers have to negotiate with healthcare providers on the price, quality, and quantity of care. As critical purchasers of care on behalf of their consumers, insurers are allowed to selectively contract with healthcare providers; e.g. with only the best and most efficient healthcare providers. Thus, insurers can limit consumer choice of healthcare provider to that of the selected providers.

In the regulated competition setting, the government sets, as regulator of the market, the rules of the 'regulated competition game'. These rules should contribute to the fulfillment of the following essential preconditions for achieving *efficiency*[1] in healthcare: 1) consumer choice of insurer, 2) consumer information and market transparency, 3) risk-bearing buyers and sellers, 4) contestable markets, 5) freedom to contract and integrate, 6) effective competition regulation, and 7) effective quality supervision, and to the following crucial preconditions for achieving *affordability*[2] in healthcare: 1) cross-subsidies without incentives for risk selection, 2) cross-subsidies without opportunities for free riding, 3) effective quality supervision, and 4) guaranteed access to basic care (Van de Ven et al., 2013).

The first part of this dissertation focuses on one of the crucial preconditions for achieving the intended results of regulated competition: consumer choice of insurer. We empirically examine whether consumers are free to easily switch insurer and introduce potential strategies to improve consumer choice of insurer. Most analysts (Miller and Luft, 1994; Folland et al., 2010) consider selective contracting with healthcare providers

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1 We use the same definition of *efficiency* as Van de Ven et al. (2009): ''as low as possible unit costs for a given quality of care''.

2 Van de Ven et al. (2013) have defined *affordability* as follows: ''everyone has access to affordable health insurance covering a basic care package of services of acceptable quality within reasonable travel time and without undue waiting time''.

as the main tool that insurers have to stimulate efficiency in healthcare. The credible threat for healthcare providers of having no contract with an insurer – which may result in less patients and less income for them – stimulates price- and quality competition in the healthcare provision market. However, if consumers are unwilling to give up (to some extent) their unlimited free choice of healthcare provider in return for a lower premium, they will not take out the insurance products with a limited healthcare provider choice. Because the threat of selective contracting will then be substantially reduced for healthcare providers, regulated competition will be less able to enhance efficiency in healthcare. The United States were about 20 years ago confronted with a substantial backlash against selective contracting (i.e. the ‘’managed care backlash’’). The second part of this dissertation evaluates the causes of this backlash and seeks lessons for the Netherlands.

This dissertation integrates evidence from different disciplines; such as health policy, health economics, behavioral economics, and health law. Although it focuses on the Dutch context, the conclusions and policy recommendations can also be relevant for other European countries that have taken steps towards regulated competition or countries that intend to do so (e.g. Australia, Ireland, and Russia).

1.2 CONSUMER CHOICE OF HEALTH INSURER

The threat of consumers switching to a competitor must continuously stimulate insurers to be responsive to consumer preferences.[3] The government facilitates this consumer choice of insurer by enforcing open enrollment, a standardized basic benefit package, community-rated premiums, and a risk equalization system that should eliminate predictable losses and profits in healthcare expenditures among different consumer groups. In markets with homogeneous preferences, all consumers will benefit from the critical choice of a minority, because a few critical consumers can be sufficient to spur insurers to be responsive to consumer preferences. However, in healthcare, consumer preferences are highly heterogeneous. For example, low-risks (i.e. young or healthy consumers) are mainly interested in price (Buchmueller, 2000), while high-risks (i.e. elderly or unhealthy consumers) value also (the quality of) the composition of the provider network (Beaulieu, 2002). This implies that if groups of consumers with specific preferences are not free or feel not free to easily switch insurer, insurers have lower incentives to accommodate the specific preferences of these consumers than the preferences of other consumers. This would be particularly problematic if these consumers are those with the most healthcare needs, because insurers have then most

3 The assumption is that the risk equalization model does sufficiently eliminate predictable differences in healthcare expenditures among different risk groups of consumers.

likely reduced incentives to act as quality-conscious purchasers of care for them. This led to the following **central question** of the first part of this dissertation:

Are all consumer groups with specific preferences free and do they feel free to easily switch insurer in the Dutch basic health insurance market? If not, what are potential strategies to improve consumer choice of insurer?

In order to answer this central question, we formulated 5 research questions. These research questions will be answered by both quantitative and qualitative research methods.

Research questions

The media pay a lot of attention to the total percentage of consumers switching insurer (e.g. Financieele Dagblad, 2015), while the switching rates of different groups of consumers receive less attention. However, in the context of regulated competition, what matters is that all consumer groups with specific preferences feel free to vote with their feet. Previous studies (e.g. Alterly et al., 2005; Shmueli et al., 2007; De Jong et al., 2008; Mosca and Schut-Welkzijn, 2008; Dormont et al., 2009; Reitsma-van Rooijen et al., 2011; Boonen et al., 2015) showed that young consumers are more inclined to switch insurer than elderly consumers. These studies used subjective health information (e.g. self-reported health, diseases, and healthcare utilization) to compare the switching behavior of healthy and unhealthy consumers. Our study contributes to these previous studies by using administrative data on nearly the entire Dutch population (n=15.3 million individuals) with objective health information (i.e. medically diagnosed diseases, pharmaceutical use, and healthcare expenditures) to answer the following research question:

Q1: To what extent do switching rates differ between low-risks and high-risks?

This first research question has a descriptive character. Because it remains unclear whether the differences in the switching behavior of groups of consumers are problematic, the following research questions aim at explaining these differences. Consumers will switch insurer if their perceived switching benefits outweigh their perceived switching costs (Scanlon et al., 1997; Laske-Aldershof et al., 2004). In the literature, a conceptual framework providing insight into the potential switching benefits and switching costs in a competitive health insurance market is lacking. This led to the following research question:

Q2: What are potential switching benefits and costs in the competitive health insurance market?

Low switching rates among specific groups of consumers may be explained by low perceived switching benefits due to satisfaction with the current insurer. However, substantial perceived switching costs that outweigh the perceived switching benefits may also hinder consumers from switching, even when they are dissatisfied (Schlesinger et al., 1999). Insurers will then have lower incentives to accommodate the specific preferences of the consumer groups who perceive high switching costs compared to their switching benefits than to accommodate the preferences of the other consumer groups. Therefore, it is important to have insight into the switching benefits and switching costs that influence the decision of (groups of) consumers to (not) switch insurer:

Q3: What are the main perceived switching benefits and costs in consumers' decision to (not) switch insurer?

About 85-90 percent of the Dutch population voluntarily take out supplementary insurance (SI) for benefits not covered by BI, such as alternative care, glasses, and paramedic care (Vektis 2012; Vektis, 2013; Vektis, 2014). More than 99 of them take out BI and SI from the same insurer (NZa, 2014a), because one-stop shopping has several advantages (e.g. a good coordination of basic and supplemental benefits). In addition, most insurers make it unattractive or impossible to take out separate SI (Roos and Schut, 2012). Consequently, consumers' decision to switch insurer for BI is also influenced by their perceived switching benefits and perceived switching costs regarding SI.

Because of EU regulation, the Dutch government is not allowed to regulate the SI market. This implies that insurers are permitted to refuse applicants or to charge risk-rated premiums for SI. However, in the first two years after the introduction of the HIA, insurers collectively agreed to accept all consumers for the majority of their SI products and to charge mostly community-rated premiums for these products. Thus, all consumers had the possibility to take out their preferred SI product with an (almost) community-rated premium. Although since 2008 the collective agreement did no longer exist, all insurers have incorporated a guaranteed renewability (GR) in each SI (Roos and Schut, 2012). This GR consists of a guaranteed renewal of the annual SI contract with an equal adjustment of the premium and the insurance conditions for all current consumers with that specific SI (Van de Ven and Schut, 2011). SI is therefore a switching cost for the consumers who fear that other insurers apply selective underwriting in their acceptance procedures for *new* enrollees. These consumers may fear that another insurer will not accept them for SI, while the renewal of their current SI is guaranteed. In other words, because switching to another insurer may result in the loss of the favorable

conditions of SI, SI is a potential switching cost for BI. This led to the following research questions:

Q4: To what extent is supplementary insurance a switching cost for basic health insurance?

Q5: What are potential solutions to reduce supplementary insurance as a switching cost for basic health insurance?

1.3 CONSUMER CHOICE OF HEALTHCARE PROVIDER

Selective contracting in healthcare results in a limited choice of healthcare provider for consumers. The degree to which consumers are free to choose their healthcare provider depends upon: 1) the size of the contracted provider network and 2) the reimbursement level for non-contracted providers. Selective contracting will enhance efficiency in healthcare if consumers – and in particular those with the most healthcare needs – are willing to give up (to some extent) their unlimited free choice of healthcare provider in return for a lower premium.

The HIA and jurisprudence state that the insurer's reimbursement level for non-contracted providers may not hinder consumers from visiting these providers. Because this can be considered as a legal restriction on selective contracting in healthcare, the Dutch minister of Health, Welfare and Sport proposed an amendment to the HIA allowing insurers to provide consumers no reimbursement if they visit non-contracted healthcare providers. Healthcare provider organizations, together with consumer organizations and patient organizations, signed a manifest against this proposal (VvAA, 2014), because they were hostile towards restrictions on healthcare provider choice. Eventually, the proposal was rejected by the Senate. This indicates a backlash against selective contracting in the Netherlands even before insurers do actually selectively contract with healthcare providers.

While the Netherlands has its first experiences with selective contracting only recently, selective contracting has a long history in the United States. The American experiences show that selective contracting is a powerful instrument for controlling healthcare expenditures (Harris et al., 2000; Simonet, 2007), while it does not have a negative effect on the quality of care (Miller and Luft, 1997; Miller and Luft, 2002; Dowd, 2005; Rich and Erb, 2005). Despite the positive effects, American insurers and policymakers were during the late 1990s confronted with a substantial backlash against it (i.e. ''the managed care backlash''). The Netherlands – and the other European countries that have taken steps towards regulated competition (e.g. Germany, and Switzerland) – may learn from the backlash against selective contracting in the United States.

Therefore, we evaluate the main causes of the American managed care backlash and seek lessons for the Netherlands. This led to the following **central question** of the second part of this dissertation:

What can the Netherlands learn from the managed care backlash in the United States?

1.4 STRUCTURE OF THIS DISSERTATION

This dissertation is organized as follows. **Chapter 2** addresses the first research question. By doing so, it uses individual-level information on risk characteristics and healthcare expenses to determine which groups of consumers switched insurer in 2009. In addition, it uses 3-year sample data to compare the switching behavior of low-risks and high-risks in the period 2010-2012. **Chapter 3** focuses on the second and third research question. It integrates evidence from health economics, behavioral economics, and health policy to develop the conceptual framework with potential switching benefits and switching costs. It does further use an online questionnaire to assess to what extent the different switching benefits and switching costs were consumers' main reasons for (not) switching insurer. The fourth and fifth research question are answered in **chapter 4** and **chapter 5**. Chapter 4 investigates to what extent SI is a *perceived* switching cost by consumers for BI. Chapter 5 analyzes whether SI is a *real* switching cost for BI. By doing so, it reviews insurers' practices in the SI market between 2006-2009 and 2014-2015. This review provides valuable information regarding the suitability of the proposed solutions to counteract SI as a switching cost for BI. **Chapter 6** answers the question 'What can the Netherlands learn from the managed care backlash in the United States?' by a literature review on the main causes of the American managed care backlash. **Chapter 7** concludes, discusses the findings, and presents policy recommendations. Because chapter 2-6 are written as separate articles, they could be read independently.


2

Switching rates in health insurance markets decrease with age:

empirical evidence and policy implications from the Netherlands

ABSTRACT

All consumer groups with specific preferences must feel free to easily switch insurer in order to discipline insurers to be responsive to consumers' heterogeneous preferences. This chapter provides insight into the switching behavior of low-risks (i.e. young or healthy consumers) and high-risks (i.e. elderly or unhealthy consumers) in the Netherlands in the period 2009-2012. We analyzed: 1) administrative data with objective health status information (i.e. medically diagnosed diseases and pharmaceutical use) and information on healthcare expenses of nearly the entire Dutch population (n=15.3 million individuals) and 2) 3-year sample data (n=1,152 individuals). Our findings indicate that switching rates strongly decrease with age. For example, in 2009, consumers aged 25-44 switched 10 times more than consumers aged 75 or older. Another finding is that switching rates decrease as the predicted healthcare expenses increase. Although healthy consumers switch twice as much as unhealthy consumers, this difference becomes much smaller after adjusting for age. We conclude that our findings can be explained by higher perceived switching costs by elderly consumers than by young consumers. Consequently, insurers have low incentives to act as quality-conscious purchasers of care for the elderly consumers. Therefore, strategies should be developed to increase the choice of insurer of elderly consumers.

2.1 INTRODUCTION

In competitive health insurance markets, health insurers have the major task of purchasing (or delivering) efficient and high-quality care on behalf of their consumers. They must also have the tools to do so, e.g. some freedom to define enrollees' entitlements. In such multiple choice settings, consumers must have the freedom to choose on a regular basis the insurer that best satisfies their (healthcare) needs and preferences. The possibility of consumers switching to a competitor must continuously stimulate insurers to succeed in their roles of purchasers of care. This is assumed to enhance efficiency, consumer responsiveness, and quality in healthcare.

In markets with homogeneous consumer preferences, all consumers will benefit from the critical choice of a minority, because a few critical consumers can be sufficient to spur insurers to be responsive to consumer preferences. However, in healthcare, consumer preferences are highly heterogeneous. For example, young and healthy consumers have other preferences than old and unhealthy consumers. Consequently, if specific groups of consumers do not feel free to easily switch insurer, insurers have low incentives to accommodate the specific preferences of these groups of individuals. This would be in particular problematic if these consumers are those with the most healthcare needs (i.e. the elderly and unhealthy consumers), because insurers are then no longer spurred to act as quality-conscious purchasers of care for them.[4]

In this chapter we focus on the question to what extent switching rates differ between low-risks (i.e. young or healthy consumers) and high-risks (i.e. elderly or unhealthy consumers) in the Netherlands in the period 2009-2012. Although we focus on switching rates in the Dutch context, the policy implications of our findings can also be relevant for other countries in which insurers are purchasers or suppliers of care and have some freedom to define enrollees' entitlements (e.g. Israel, the HMO market in Switzerland, and the United States).

Previous studies in different Western countries showed that young consumers are more inclined to switch insurer than elderly consumers (Atherly et al., 2005; Shmueli et al., 2007; De Jong et al., 2008; Mosca and Schut-Welkzijn, 2008; Dormont et al., 2009; Reitsma-van Rooijen et al., 2011; Boonen et al., 2015). Moreover, most of these previous studies concluded that healthy consumers do not switch more frequently than unhealthy consumers, after adjusting for the age differences between the two groups (Shmueli et al., 2007; De Jong et al., 2008; Dormont et al., 2009; Hoffmann and Icks, 2011; Reitsma-van Rooijen et al., 2011).

4 We assume that the risk equalization model and the premium rate regulation provide insurers with incentives to provide good quality care to all enrollees, including the chronically ill (see e.g. Van de Ven, 2011).

Our study is in different ways a valuable contribution to the current evidence regarding consumers' switching behavior in the health insurance market. Previous studies mainly used consumers' self-reported health, (chronic) diseases, and prior healthcare utilization as health indicators (Mosca and Schut-Welkzijn, 2008; Dormont et al., 2009; Hoffmann and Icks, 2011; Lako et al., 2011; Boonen et al., 2015). However, Hoffmann and Icks (2011) and Dormont et al. (2009) considered the use of these subjective health measures and the lack of information regarding switchers' and non-switchers' healthcare expenses as serious limitations. In addition, most previous studies on consumers' switching behavior used sample data instead of population data. Two major strengths of our study are therefore the use of: 1) information on objective health indicators (i.e. medically diagnosed diseases and pharmaceutical use) and healthcare expenses and 2) population data of about 15.3 million individuals to compare low-risks' and high-risks' switching behavior in 2009.[5] Atherly et al. (2005) and Shmueli et al. (2007) used also population data instead of sample data in their studies on consumers' switching behavior, but these studies lacked detailed information on consumers' health status. Therefore, our use of data with objective health information and information on healthcare expenses of nearly the entire population is a new approach for comparing high-risks' and low-risks' switching behavior.

Another major strength of our study is the comparison of low-risks' and high-risks' 3-year switching rate. Only a small number of consumers is willing to decide on their health insurance each switching period (Tamm et al., 2007). Therefore, we also focus on low-risks' and high-risks' switching rates over multiple years by using sample data. Dormont et al. (2009) and Hoffmann and Icks (2011) have also focused on consumers' switching behavior over multiple years. They asked consumers whether they switched insurer in the previous years. Because consumers may not remember whether they switched insurer several years ago, the use of a single question to evaluate consumers' switching behavior over multiple years may result in response bias. We asked the same individuals (n=1,152) recently after the switching period in 2010, 2011, and 2012 whether they switched insurer in that period and evaluated whether they switched insurer (yes/no) in the period 2010-2012. This research method reduces the potential response bias.

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5 De Jong et al. (2008), Hendriks et al. (2010), and Reitsma-van Rooijen et al. (2011) compared the switching behavior of a sample of 'non-institutionalized consumers with a medically diagnosed chronic illness or disability' with the switching behavior of a sample of the 'general population'. It was unclear whether consumers belonging to the 'general population' suffered from a medically diagnosed chronic illness or disability (Hendriks et al., 2010). Advantages of our study are the inclusion of: (1) information about both institutionalized consumers and non-institutionalized consumers and (2) objective health information about almost the entire Dutch population.

This chapter is organized as follows. Firstly, we describe the Dutch health insurance market. Secondly, we pay attention to the data and methods. Thirdly, we present our main results. Fourthly, we discuss potential interpretations of our results. Finally, we pay attention to some policy considerations and conclude.

2.2 THE DUTCH HEALTH INSURANCE MARKET

We focus on the switching behavior of Dutch consumers. These consumers are allowed to switch insurer on 1 January each year.[6] In the Netherlands, the introduction of the Health Insurance Act (*Zorgverzekeringswet*) in 2006 was an important step towards a nationwide competitive health insurance market. All inhabitants are legally obliged to take out basic health insurance (BI) from a private health insurer.[7] Insurers are free to offer several BI products, which may differ, for example, in the panel of contracted healthcare providers and the deductible level. Insurers must accept each applicant for BI and must charge the same premium for the same BI product to each consumer, regardless of the consumer's risk (i.e. community-rated premiums). Each insurer is free to set its own community-rated premium[8] and to specify consumers' precise entitlements (e.g. the contracted healthcare providers and pharmaceuticals) in the BI product.

Consumers can voluntarily take out supplementary insurance (SI) for benefits not covered by BI. Insurers are allowed to refuse applicants or to charge risk-rated premiums for SI. About 90 percent of all consumers take out SI. More than 99 percent of them take out BI and SI from the same insurer (Vektis, 2012), because almost all insurers make it unattractive or impossible for consumers to take out separate SI (Roos and Schut, 2012).[9] Due to this joint purchase of BI and SI, the decision to switch insurer for BI is also influenced by consumers' expectations regarding SI.

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6 Consumers who turn 18 and consumers whom insurer increases the premium or changes the policy conditions have the right to switch immediately. We left this type of switching behavior out of consideration.

7 Total number of insurers operating nationwide: 30 in 2009, 28 in 2010, 27 in 2011, and 26 in 2012 (NZa, 2009a; NZa, 2010; NZa, 2011; NZa, 2012).

8 The community-rated BI premiums equal 50 percent of the total insurers' revenues for BI. The other 50 percent consists of income-related contributions that are allocated to the insurers via a risk equalization fund (Van Kleef et al., 2013).

9 For example, insurers offer SI only in combination with BI or require premium surcharges if a consumer only applies for SI.

2.3 DATA AND METHODS

We used both administrative data and questionnaires among an Internet panel to determine to what extent low-risks' and high-risks' switching behavior differed in the Netherlands in the period 2009-2012.

2.3.1 Switching behavior in 2009

We used individual-level information on risk characteristics, healthcare expenses, and subscriptions of 95 percent of the Dutch population (n=15.3 million individuals) to determine which groups of consumers switched insurer on 1 January 2009.

Our analyses involved three steps. Firstly, we determined the switching behavior of different age groups. Secondly, we evaluated the switching behavior of healthy and unhealthy consumers by using objective health status indicators. In this respect, pharmacy-based cost groups (PCGs), diagnoses-based cost groups (DCGs), and multiple-year high costs (MHC) are used as indicators (see Van Kleef et al., 2013 for more details about these indicators). Consumers are classified into one or more PCGs if they received in 2008 at least 180 daily dosages of a specific pharmaceutical. If consumers had a specific (hospital) diagnosis in 2008, they are classified into a DCG. Consumers are classified into a MHC if their healthcare expenses were in 2006, 2007, and 2008 at least in the top 15 percent of total healthcare expenses.[10] Because the health indicators PCG, DCG, and MHC overlap with each other, we distinguished 'healthy consumers' (i.e. not classified into a PCG, DCG, and MHC) and 'non-healthy consumers' (i.e. classified into a PCG, DCG, and/or MHC). Thirdly, we determined consumers' switching behavior by their predicted healthcare expenses for 2009. These predicted expenses are based upon the risk equalization formula of 2012, which uses the following risk adjusters: age/gender, region, source of income, PCGs, DCGs, socioeconomic status, and MHC (see Van Kleef et al., 2013).

2.3.2 Switching behavior in the period 2010-2012

Because only a small number of consumers is willing to decide on their health insurance each switching period (Tamm et al., 2007), we also investigated consumers' switching behavior over a three-year period (2010-2012). An online questionnaire was distributed in February 2010, February 2011, and February 2012 among members of the CentER-panel aged 18 or older. Members of this panel complete questionnaires at home every week. An invitation to fill in the questionnaire was sent to 2,227 members in 2010, 2,665 members in 2011, and 2,419 members in 2012. In 2010, 2011, and 2012, respectively, 1,963 respondents, 1,852 respondents, and 1,939 respondents fulfilled the complete questionnaire. We merged the samples of 2010, 2011, and 2012, and evaluated which

10 For a detailed description of MHC see Van Kleef et al. (2013).

respondents completed the questionnaire in all three years. We performed our analyses solely on the 1,152 respondents who completed the questionnaire in 2010, 2011, and 2012. This sample of respondents was older than the general Dutch population. For example, the percentage of respondents aged 20-39 was in our research 15 compared to 33 in the population. Because we focus on switching rates within different consumer groups, the non-representative character of the sample may not seriously threaten the external validity of our results. Respondents have revealed whether they switched insurer in 2010, 2011, and 2012. The switching rates in these three years were, respectively, 3.6 percent, 4.5 percent, and 3.8 percent. Although switchers may be more eager to respond to a consumer questionnaire about health insurance than non-switchers (Kerssens and Groenewegen, 2005), these switching rates are lower than the switching

Table 2.1 Background characteristics consumer questionnaires 2010-2012

Available information	**Operationalization data analyses**	**Sample (n=1,152)**
Gender (n=1,152)	- Male	56.1%
	- Female	43.9%
Age in 2010, 2011, and 2012 (n=1,152)	Age in 2011	56.33 years (average)
Self-reported health in 2010, 2011, and 2012 (n=1,142)	Self-reported health in the period 2010-2012:	
- Bad - Moderate	- At least in one year bad or moderate (i.e. bad or moderate)	22.5%
- Good - Very good - Excellent	- All years good, very good, or excellent (i.e. good, very good, or excellent)	77.5%
Self-reported disease (e.g. asthma, cancer, rheumatism, diabetes, and cardiovascular disease) in 2010, 2011, and 2012 (n=1,152)	Self-reported disease in the period 2010-2012:	
	- None	32.2%
	- At most one self-reported disease in 2010, 2011, and/or 2012 (i.e. at most one)	32.6%
	- At most two self-reported diseases in 2010, 2011, and/or 2012 (i.e. at most two)	18.2%
	- At least three self-reported diseases in 2010, 2011, and/or 2012 (i.e. at least three)	17.0%
Education in 2010, 2011, and 2012 (n=1,143)	Education in 2011:	
	- Low	32.4%
	- Middle	29.6%
	- High	38.0%
Supplementary insurance in 2010, 2011, and 2012 (n=1,024)	Supplementary insurance in the period 2010-2012:	
	- In all years (i.e. yes)	84.3%
	- At least in one year no supplementary insurance (i.e. no)	15.7%

rates in the Dutch population (3.9 percent in 2010 (Vektis, 2010), 5.5 percent in 2011 (Vektis, 2011), and 6.0 percent in 2012 (Vektis, 2012)). Because the switching rates in the separate years were low, we were not able to perform reliable analyses by using the panel data approach. Therefore, we focused only on the switching rate over these three years; i.e. did consumers switch at least once in the 3-year period 2010-2012 (yes/no)?

We obtained demographic information, health information, and insurance-related information about each respondent (Table 2.1). In contrast to the objective health measures used concerning consumers' switching behavior in 2009 (see Section 2.3.1), we used self-reported health and self-reported disease(s) as health indicators for comparing the switching behavior of healthy and unhealthy consumers in the period 2010-2012.

Different previous studies concluded that high-educated consumers were more inclined to switch than low-educated consumers (De Jong et al., 2008; Mosca and Schut-Welkzijn, 2008; Lako et al., 2011; Reitsma-van Rooijen et al., 2011; Boonen et al., 2015). In addition, Dormont et al. (2009) and Boonen et al. (2015) showed that having a SI is associated with a low switching propensity. Therefore, in the data analyses, we also focused on the switching behavior of low-, middle-, and high-educated consumers, and on the switching rates of consumers with SI and of consumers without SI.

Our analyses involved two steps. Firstly, we performed Pearson's Chi square tests to determine whether the variables gender, age, self-reported health, self-reported disease(s), education, and holding a SI are correlated with switching insurer (yes/no) in the period 2010-2012. Secondly, we performed a binary logistic regression model with y_i =1 if a consumer switched insurer at least once in the 3-year period 2010-2012 and y_i =0 if a consumer stayed with his or her current insurer in that period. The switching model is derived from an underlying latent variable: $y^*_i = X'_i\beta+\varepsilon_i$, where y_i =1 if y^*_i >0 and y_i =0 otherwise. $X'_i\beta$ is a vector of the explanatory variables (i.e. gender, age, self-reported health, self-reported disease(s), education, and holding a SI). In this respect, the latent variable represents the net benefit of switching health insurer. We present the odds ratios to illustrate the differences in the switching behavior of different consumer groups. Odds ratios range between 0 and positive infinity. An odds ratio greater (smaller) than one indicates that a characteristic increases (decreases) the odds of switching compared to the reference group, ceteris paribus.

2.4 RESULTS

2.4.1 Switching rates in 2009

Our results indicate that 2.81 percent of all consumers switched insurer on 1 January 2009.[11] Bivariate analyses (Table 2.2) show that females switched slightly more frequently than males. Switching rates differ by a factor of 10 between young and elderly

Table 2.2 Percentage of consumers that switched insurer on 1 January 2009

	Size of the group as percentage of the total (n=15,279,552)	Switching rate of the group
Total	100.0	2.81
Gender		
Males	49.1	2.78
Females	50.9	2.85
Age		
Aged 0-17	21.2	3.26
Aged 18-24	8.4	4.97
Aged 25-44	27.0	3.81
Aged 45-64	27.7	2.07
Aged 65-74	8.6	0.87
Aged 75 or older	7.1	0.37
Pharmacy-based cost groups (PCGs)		
Not classified in 2009	83.5	3.08
Classified into at least one PCG in 2009[1]	16.5	1.46
Diagnoses-based cost groups (DCGs)		
Not classified in 2009	97.5	2.86
Classified into a DCG in 2009[2]	2.5	0.98
Multiple-year high costs (MHC)		
Not classified in 2009	92.7	2.93
Classified into a MHC in 2009[3]	7.3	1.30
Combination PCG, DCG, and MHC		
Not classified into a PCG, DCG, and MHC in 2009 (i.e. healthy consumers)	80.6	3.12
Classified into at least one PCG, DCG, or MHC in 2009 (i.e. unhealthy consumers)	19.4	1.54

[1] These consumers received in 2008 at least 180 daily dosages of a specific pharmaceutical.
[2] These consumers had a specific (hospital) diagnosis in 2008.
[3] These consumers' healthcare expenses were in 2006, 2007, and 2008 at least in the top 15 percent of total healthcare expenses.

11 Vektis (2009) found that 3.5 percent of the Dutch population switched insurer in 2009. The difference can be explained by a different definition of 'switcher' and differences in the research population.

consumers: the annual switching rate was 3.81 percent at age 25-44 and decreased to 0.37 percent at age 75 or older. About 5 percent of the consumers aged 18-24 switched insurer. The switching rates of children under the age of 18 follow the same pattern as the switching rates of their parents who are most likely aged 25-40 (Figure 2.1). The percentage of males switching to another insurer is highest at age 18 and 19, while the percentage of females switching to another insurer is highest at age 24 and 25. Females aged 18-30 were about 20 percent more inclined to switch insurer than males aged 18-30 (not presented in Tables and Figures).

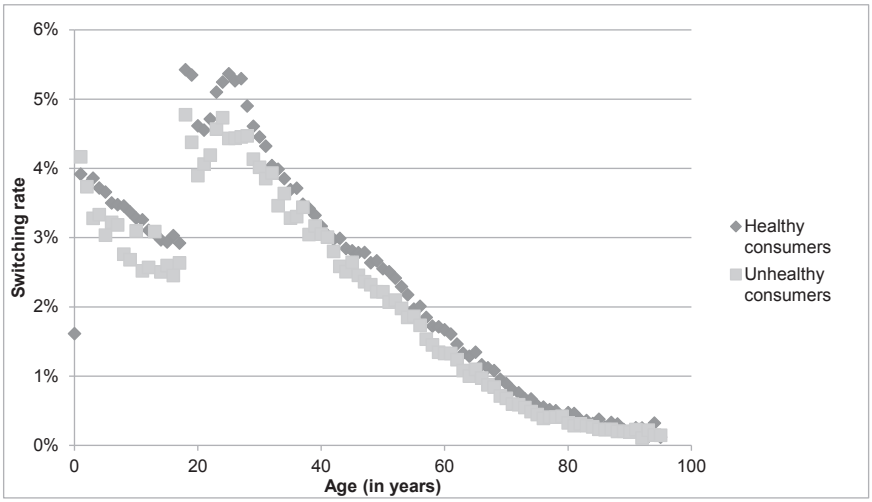

Figure 2.1 Switching rates on 1 January 2009 of healthy consumers (i.e. in 2009 not classified into a PCG, DCG, and MHC) and unhealthy consumers (i.e. in 2009 classified into at least one PCG, DCG, or MHC) by age

Although healthy consumers switch twice as much as unhealthy consumers (Table 2.2), this difference becomes much smaller after adjusting for age (Figure 2.1). This finding is consistent with previous studies (see Section 2.1). At each age, healthy consumers are 10 to 20 percent more likely to switch than unhealthy consumers. Figure 2.2 shows that switching rates strongly decrease as the predicted healthcare expenses increase. For example, 5 percent of the consumers with very low predicted healthcare expenses switched insurer in 2009, while this percentage decreased to about 0.5 for consumers with very high predicted healthcare expenses.

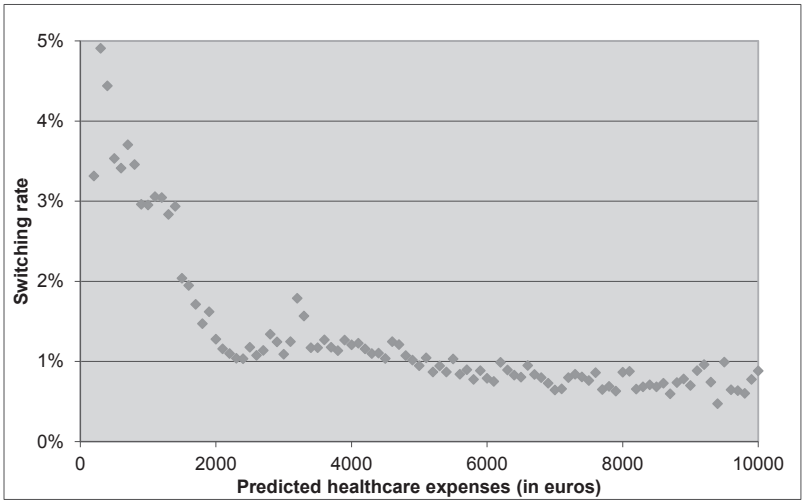

Figure 2.2 Switching rates on 1 January 2009 by predicted healthcare expenses (in euros) for 2009[1,2]
[1] Predicted expenses are based upon the risk equalization formula of 2012.
[2] About 80 percent of individuals had predicted healthcare expenses lower than 2,000 euro.

2.4.2 Switching rates in the period 2010-2012

In the period 2010-2012, 10.3 percent of all consumers switched insurer at least once: 8.85 percent switched once, 1.39 percent switched two times, and 0.09 percent switched three times. Bivariate analyses show that switching rates differ significantly among age groups (Table 2.3). For example, about 3 percent of the consumers aged 76 or older switched insurer at least once in the period 2010-2012 compared to about 15 percent of the consumers aged 31-50. Consumers without a self-reported disease were about 40 percent more likely to switch insurer than consumers with a self-reported disease. In contrast, based on consumers' 3-year switching rate and subjective health indicators, we can conclude that consumers with a good, very good, or excellent self-reported health are not more inclined to switch insurer than consumers with a bad or moderate self-reported health. This may partly be affected by the fact that respondents revealing their perceived health status take their age into account. High-educated people switched insurer about 85 percent more than low-educated people. Furthermore, consumers without a SI switched twice as much as consumers with a SI.

Multivariate analyses do also show that elderly consumers are, ceteris paribus, less inclined to switch insurer than young consumers (Table 2.4). For example, the odds of having switched in the period 2010-2012 for those aged 41-50 are 565 percent of those aged 76 or older, ceteris paribus. The difference in switching behavior of consumers with and consumer without a self-reported disease disappears after adjusting for age. The results regarding education and SI are consistent with previous studies: low-educated

consumers and consumers with SI were less likely to switch insurer than, respectively, high-educated consumers and consumers without SI, ceteris paribus. For example, keeping all other explanatory variables constant, having a SI decreases the odds by 56 percent compared to having no SI.

Table 2.3 Percentage of consumers that switched insurer (yes/no)[1,2] in the period 2010-2012

	Size of the group as percentage of the total	3-year switching rate of the group	
Total (n=1,152)	100.0	10.3	
Gender (n=1,142)			
Males	56.1	8.5	**
Females	43.9	12.6	
Age (n=1,152)			
Aged 18-30	3.6	23.8	
Aged 31-40	13.0	14.7	
Aged 41-50	16.2	15.5	
Aged 51-60	24.2	11.8	***
Aged 61-70	26.5	6.2	
Aged 71-75	7.9	3.3	
Aged 76 or older	8.5	3.1	
Self-reported health (n=1,142)			
Bad or moderate	22.5	9.7	
Good, very good, or excellent	77.5	10.4	
Self-reported disease (n=1,152)			
None	32.2	12.9	
At most one	32.6	10.9	*
At most two	18.2	6.7	
At least three	17.0	8.2	
Education (n=1,143)			
Low	32.4	7.0	
Middle	29.6	10.7	**
High	38.0	12.9	
Supplementary insurance (SI) (n=1,024)			
No	15.7	18.6	***
Yes	84.3	9.0	

*p<0.10; ** p<0.05; *** p<0.01

[1] We asked consumers whether they switched insurer. Dutch insurers are allowed to offer BI under different names. Consequently, consumers who switched to a BI that is offered under another name by their current insurer may have stated that they switched insurer while they did actually not.

[2] ''Yes'' indicates a switch on 1 January 2010, and/or 1 January 2011, and/or 1 January 2012 (i.e. ''3-year switching rate'').

Table 2.4 Logit model of consumer's decision to switch insurer (yes/no)[1,2] in the period 2010-2012 (n=1,009)

	Odds ratio	P-value
Gender		
Female	Reference	
Male	0.617	0.026 (**)
Age		
Aged 18-30	10.465	0.002 (***)
Aged 31-40	3.554	0.055 (*)
Aged 41-50	5.646	0.007 (***)
Aged 51-60	3.609	0.041 (**)
Aged 61-70	2.016	0.274
Aged 71-75	0.674	0.672
Aged 76 or older	Reference	
Self-reported health		
Bad or moderate	Reference	
Good, very good, or excellent	0.634	0.145
Self-reported disease		
None	Reference	
At most one	0.922	0.755
At most two	0.731	0.400
At least three	0.935	0.865
Education		
Low	0.559	0.039 (**)
Middle	0.840	0.485
High	Reference	
Supplementary insurance		
Yes	0.441	0.001 (***)
No	Reference	

*p<0.10; ** p<0.05; *** p<0.01

[1] ''Yes'' indicates a switch on 1 January 2010, and/or 1 January 2011, and/or 1 January 2012 (i.e. ''3-year switching rate'').

[2] McFadden R^2= 0.086.

2.5 INTERPRETATION OF OUR RESULTS

Consumers will switch insurer if their perceived switching benefits outweigh their perceived switching costs (Scanlon et al., 1997; Laske-Aldershof et al., 2004). Therefore, switching rates indicate for which proportion of consumers the switching benefits did outweigh the switching costs.[12] Our main finding is that switching rates decrease sharply

12 Next to consumers' decisions to switch insurer, switching can be influenced by exogenous changes (e.g. job changes, moves outside an insurer's area, bankruptcies, and mergers)

with age. This raises the question: did elderly consumers switch less frequently than young consumers because they: 1) face higher switching costs; 2) face lower switching benefits; or 3) face higher switching costs and lower switching benefits?

2.5.1 Switching costs

Previous studies mentioned that the differences in the switching behavior of young and elderly consumers can be attributed to differences in their switching costs (Atherly et al., 2005; Hendriks et al., 2010; Lako et al., 2011; Reitsma-van Rooijen et al., 2011; Shmueli et al., 2007[13]). The finding is supported by Nosal (2012) and Handel (2013) who found higher switching costs in the US Medicare market with relatively old consumers (65+) than in the US employer-sponsored insurance market with relatively young consumers (under the age of 65). Nosal (2012) found a switching cost of $4,163 for the median Medicare consumer and Handel (2013) showed that, due to switching costs, an average employee forgoes $2,032 each year in expected savings from an alternative option. In addition, Buchmueller (2000) and Strombom et al. (2002) found that young consumers were more price sensitive than elderly consumers and attributed this finding to lower switching costs for young consumers than for elderly consumers.

Given this background, it seems likely that differences in the perceived switching costs by young and elderly consumers are also an explanation for our results. Elderly consumers may face higher transaction costs than young consumers, because they may consider price and quality information, while young consumers may be interested in price information only (Hendriks et al., 2010). Different studies did further conclude that elderly consumers have more difficulties with processing health insurance information than young consumers (Hibbard et al., 2001; Hanoch and Rice, 2006). Moreover, the psychological switching costs for elderly consumers – which may result from habit, tradition, and sunk costs (Samuelson and Zeckhauser, 1988; Frank and Lamiraud, 2009) – may be greater than the psychological switching costs for young consumers. For example, elderly consumers may face higher sunk costs – i.e. the non-recoverable investments in terms of time, money, and effort in establishing and maintaining a relationship with the current insurer – than young consumers, because elderly consumers may be quite familiar with the rules and procedures of their current insurer (Samuelson

(Schlesinger et al., 1999; Shmueli et al., 2007; Lako et al., 2011).

13 Shmueli et al. (2007) mentioned insurers' risk selection practices as another potential explanation. Due to the Israeli incomplete age-based risk-adjustment scheme, children are profitable clients and insurers' risk selection practices to attract them may also encourage their young parents to switch insurer. Risk selection is not an explanation for our findings because in the Netherlands no age group is systematically under- or overcompensated by the risk equalization model. In addition, the Dutch risk equalization model contains much more relevant risk adjusters than only age (see Section 2.3.1).

and Zeckhauser, 1988; Zhang et al., 2012). This is consistent with the results of Beaulieu (2002) and Frank and Lamiraud (2009) who found that longer tenures of enrollment continuously reduce the likelihood of switching. In addition, previous studies showed that elderly consumers mentioned the loss of the favorable conditions of their current SI – in terms of premium and acceptance – more frequently as a switching barrier than young consumers (Duijmelinck and Van de Ven, 2014; see Chapter 4).

Consumers choosing an insurer for the first time – who are most likely the consumers aged 18-24 – may be the consumer group with the lowest switching costs (Pomp et al., 2005). For example, sunk costs and the loss of the favorable conditions of SI may be irrelevant switching costs for these consumers entering the health insurance market. Therefore, low switching costs may explain their high switching propensity.

2.5.2 Switching benefits

Potential switching benefits for consumers are: price, (financial) welcome gifts, the benefits of SI, insurers' service level, and the contracted provider network (i.e. the quality of the provider network and the freedom to choose a provider or drug) (Duijmelinck et al., 2015; see Chapter 3). During the research period, these switching benefits were quite comparable for low-risks and high-risks in the Netherlands. Firstly, insurers did mainly compete on price (Brabers et al., 2012), which is a relevant switching benefit for both elderly and young consumers. Secondly, welcome gifts were a relevant switching benefit for both consumer groups, because there were no indications that insurers provided welcome gifts to attract specific consumer groups. Thirdly, given the considerable amount of differentiated SI products in the Dutch health insurance market (e.g. in 2009, consumers had the choice among about 370 SI products (NZa, 2009a)), SI was a switching benefit for both young and elderly consumers. Because the SI coverage regarding maternity care is a relevant switching benefit for young females, young females were probably more inclined to switch insurer than young males. Fourthly, insurers' service level and their contracted provider network are in particular important switching benefits for high-risks because of their high healthcare use. However, these were quite irrelevant switching benefits during the research period (Brabers et al., 2012). For example, in the period 2009-2012, insurers contracted all hospitals (NZa, 2009a; NZa, 2010; NZa, 2011; NZa, 2012).

So far, the above mentioned arguments indicate that during our research period switching benefits were roughly similar for young consumers and elderly consumers. However, consumers' switching benefits are also influenced by their switching behavior in previous years. The switching benefits for consumers who did not switch in previous years will be relatively higher than the switching benefits for consumers who did so. For example, the latter group may have switched to lower-priced insurance products, while the former group may still have to pay a high price. In the period 2006-2008,

elderly consumers were – such as in later years – less likely to switch insurer than young consumers (Vektis, 2006; Vektis, 2007; Vektis, 2008). This implies that elderly consumers faced on average higher switching benefits in the period 2009-2012 than young consumers.[14]

The above arguments lead to the conclusion that during the research period the switching benefits for the elderly consumers were not lower than those of the young consumers. This implies that the substantial lower switching rate of the elderly consumers compared to the young consumers cannot be explained by a difference in their switching benefits. Therefore, we conclude that elderly consumers face higher switching costs than young consumers.

2.6 DISCUSSION

In general, low switching rates in the health insurance market may have some positive side-effects, such as low administrative expenditures and increased insurers' incentives to invest in preventive care (Pomp et al., 2005; Brandon et al., 2009; Lako et al., 2011). However, in the Netherlands the low switching rates are concentrated among the elderly consumers who perceive high switching costs compared to their switching benefits. Therefore, the positive effects do most likely not outweigh the potential negative effects.

Firstly, lower switching rates for elderly consumers than for young consumers may reduce insurers' incentives to act as quality-conscious purchasers of care for the elderly consumers (Pomp et al., 2005; Shmueli et al., 2007). The developments in the Dutch long-term care sector may exacerbate this problem. In 2015, insurers became responsible for the purchase of long-term outpatient care (i.e. nursing and personal care). In particular elderly consumers need this type of care (Sietsma and Groot Koerkamp, 2014). Due to the high perceived switching costs by elderly consumers compared to their switching benefits, it is questionable whether insurers are sufficiently motivated to become prudent buyers of long-term outpatient care.

Secondly, in case of an imperfect risk equalization model, cross-subsidies among risk groups may be threatened, because young consumers with low switching costs can switch to lower-priced alternatives (Atherly et al., 2005). For example, Nuscheler and Knaus (2005) found that heterogeneous switching costs resulted in the separation of low-risks from high-risks in the German public health insurance system.

Thirdly, large differences in switching rates among groups of consumers reduce effective price competition (Pomp et al., 2005; Nosal, 2012). Insurers may initially

14 It is an open question whether these *potential* switching benefits are similar to consumers' *perceived* switching benefits.

charge premiums below costs to attract consumers and subsequently increase their premiums to exploit consumers with high switching costs (Pomp et al., 2005; Farrell and Klemperer, 2007; Han et al., 2014). Simultaneously, they could introduce cheaper products to attract the consumers with low switching costs. Marzilli Ericson (2012) provided evidence for such insurers' behavior in the US Medicare Part D insurance market. Insurers who charge very low premiums to attract the consumers with low switching costs may enter the market. However, incumbent insurers can keep their premiums above the premiums of entrants, because the profits made on those consumers who do not switch may outweigh the losses associated with the consumers who switch to new entrants (Pomp et al., 2005).

To avoid the above effects, the Dutch government should develop strategies to improve the choice of insurer of elderly consumers. For example, the integration of BI and SI into one basic-plus-insurance (BPI) would be an effective solution to decrease the switching costs for the elderly consumers and the chronically ill (Duijmelinck and Van de Ven, 2014; see Chapter 4). This solution takes into account that almost all insurers currently offer BI and SI as a joint product and that one-stop shopping has several advantages for consumers (e.g. a good coordination of basic benefits and supplemental benefits). After the introduction of the BPI, open enrollment also holds for the supplemental benefits. Insurers are still allowed to apply risk rating for the supplemental benefits within the BPI. However, they must charge groups of enrollees with equal risk characteristics and the same supplemental benefits, the same premium. Consequently, consumers opting for a basic-plus-insurance would no longer face the risk that a new insurer imposes less favorable conditions for SI in the next contract period than their current insurer does. A BPI will not threaten the affordability of the basic benefits, because insurers are still bound to community-rated premiums for the basic benefits.

In addition, special attention should be paid to potential strategies to decrease the transaction costs of elderly consumers, for example by focusing on the development of standardized health insurance information that is easily to understand (Hibbard et al., 2001; Hanoch and Rice, 2006). Moreover, the regulator could launch an information campaign – for example via television and newspapers – that emphasizes the potential switching benefits for elderly consumers in the health insurance market. This campaign could encourage elderly consumers to compare the insurance products of different insurers with each other.

Furthermore, next to the exit option, consumers could express dissatisfaction with their current insurer by using the 'voice option' (Hirschman, 1970). As long as elderly consumers do not have equal opportunities as young consumers to act as well-informed and empowered buyers in the health insurance market, the voice option should be

effectively facilitated for the elderly consumers; e.g. by establishing consumer councils and consumer questionnaires.

Due to the lack of selective contracting in the Netherlands, the costs of (not) switching to another healthcare provider were irrelevant during the research period. These switching costs may be more relevant in later years, because since 2013 Dutch insurers started to selectively contract with healthcare providers more frequently. Consumers' switching benefits may have also increased, because insurers' contracted provider network may have become a relevant switching benefit in the health insurance market. For consumer choice of insurer it is crucial that the switching costs do not increase more rapidly than the switching benefits. Future research can pay attention to this subject. Moreover, future research could attempt to quantify the size of the switching benefits and the switching costs for different consumer groups.

2.7 CONCLUSIONS

In competitive health insurance markets, consumer choice of insurer disciplines the insurers to be responsive to consumer preferences. Because these preferences differ among consumer groups, all groups of consumers with specific preferences must be free (and must feel free) to easily switch insurer. We analyzed administrative data with objective health status information (i.e. medically diagnosed diseases and pharmaceutical use) and information on healthcare expenses of nearly the entire population to evaluate switching rates in the Netherlands in 2009. Our findings indicate that switching rates decrease strongly with age. For example, consumers aged 25-44 switched 10 times more than consumers aged 75 or older. The same conclusion holds when evaluating whether consumers switched in the period 2010-2012 (i.e. a 3-year switching rate). In addition, we found that switching rates strongly decrease as the predicted healthcare expenses increase. For example, 5 percent of the consumers with very low predicted healthcare expenses switched insurer in 2009, while this percentage decreased to about 0.5 for consumers with very high predicted healthcare expenses. Another finding is that although healthy consumers switch twice as much as unhealthy consumers, this difference becomes much smaller after adjusting for age.

We conclude that our findings can be explained by higher perceived switching costs by elderly consumers than by young consumers. Because an essential precondition of a competitive health insurance market – the disciplining effect of ''voting with one's feet'' – is not fulfilled for elderly consumers, insurers have low incentives to act as quality-conscious purchasers of care for them. Policymakers should develop strategies to increase the choice of insurer of elderly consumers, because a competitive health

insurance market can only succeed if all groups of consumers with specific preferences feel free to easily switch insurer.



3

Switching benefits and costs in competitive health insurance markets:

a conceptual framework and empirical evidence from the Netherlands

ABSTRACT

Competitive health insurance markets will only enhance efficiency, quality, and consumer responsiveness if all consumers feel free to easily switch insurer. Consumers will switch insurer if their perceived switching benefits outweigh their perceived switching costs. We developed a conceptual framework with potential switching benefits and costs in competitive health insurance markets. Moreover, we used a questionnaire among Dutch consumers (1,091 respondents) to empirically examine the relevance of the different switching benefits and costs in consumers' decision to (not) switch insurer. Price, insurers' service quality, insurers' contracted provider network, the benefits of supplementary insurance, and welcome gifts are potential switching benefits. Transaction costs, learning costs, 'benefit loss' costs, uncertainty costs, the costs of (not) switching healthcare provider, and sunk costs are potential switching costs. In 2013 most Dutch consumers switched insurer because of (1) price and (2) benefits of supplementary insurance. Nearly half of the non-switchers – and particularly unhealthy consumers – mentioned one of the switching costs as their main reason for not switching. Because unhealthy consumers feel not free to easily switch insurer, insurers have low incentives to invest in high-quality care for them. Therefore, policymakers should develop strategies to improve consumer choice.

3.1 INTRODUCTION

In several Western countries (e.g. Belgium, Germany, Israel, Switzerland, the Netherlands, and the United States) steps have been taken towards a competitive health insurance market. In these countries, the government sets the rules of the game (e.g. an open enrollment period, community-rated premiums, a risk equalization system, and a standardized benefit package), while health insurers have the major task of purchasing (or delivering) efficient and high-quality care on behalf of their consumers. The threat of consumers switching to a competitor must continuously stimulate insurers to successfully fulfill this task. All groups of consumers must be free (and must feel free) to easily switch insurer to spur insurers to be responsive to the heterogeneous needs and preferences of consumers. This must enhance efficiency, quality, and consumer responsiveness in healthcare.

One could be inclined to consider switching rates as an indicator of the competitiveness of a health insurance market. This may result in wrong conclusions because low switching rates can be observed in both perfectly and poorly competitive markets (Schut and Varkevisser, 2009). Instead of switching rates, consumers' reasons to (not) switch insurer provide more meaningful information regarding the functioning of the competitive health insurance market. Consumers will switch insurer if their perceived switching benefits outweigh their perceived switching costs (Scanlon et al., 1997; Laske-Aldershof et al., 2004). Low switching rates among consumers may be explained by low perceived switching benefits due to satisfaction with the current insurer (Schut and Varkevisser, 2009). However, substantial switching costs that outweigh the switching benefits may also hinder consumers from switching, even when they are dissatisfied (Schlesinger et al., 1999). This seriously threatens effective competition. New insurers may, for example, experience barriers to enter the health insurance market as it is difficult to attract consumers with high switching costs (Enthoven, 1988a; Karakaya and Stahl, 1989). In healthcare, the (healthcare) needs and preferences of consumers are highly heterogeneous. If specific groups of consumers perceive high switching costs compared to their switching benefits, insurers have low incentives to satisfy their specific preferences. This may be particularly problematic if these groups are those with the most healthcare needs (i.e. unhealthy consumers), because insurers are then no longer spurred to invest in high-quality care for them.

Previous studies solely focused on the relevance of one specific switching benefit (e.g. Beaulieu, 2002) or switching cost (e.g. Frank and Lamiraud, 2009). However, a conceptual framework with potential switching benefits and costs in a competitive health insurance market is lacking. Therefore, our first aim is to provide such a framework by integrating evidence from different disciplines; health economics, behavioral economics, and health policy. Previous studies (e.g. Mosca and Schut-Welkzijn, 2008; Hendriks

et al., 2010; see Chapter 2) showed that high-risks are less inclined to switch insurer than low-risks. However, the reasons of (groups of) consumers to (not) switch insurer are unclear. Therefore, our second aim is to empirically examine the main switching benefits and costs in consumers' decision to (not) switch insurer in the Netherlands in 2013. Other countries that have taken or intend to take steps towards a market-oriented healthcare system can learn from the Dutch experiences.

This chapter is organized as follows. Firstly, we introduce the conceptual framework with potential switching benefits and costs. Secondly, we describe the data and methods and summarize the main switching benefits and costs in the Dutch context. Finally, we pay attention to some policy considerations and present our main conclusions.

3.2 CONCEPTUAL FRAMEWORK

This section describes potential switching benefits, which are derived from the theoretical model of regulated competition as defined by Enthoven (e.g. 1978, 2012). Klemperer (1995), Jones et al. (2002), and Burnham et al. (2003) have described different switching costs. This is the first study applying these costs to health insurance markets. The switching benefits and costs are context specific and may differ across consumer groups, across countries, and over time.

3.2.1 Switching benefits

Switching benefits are consumers' perceived benefits from switching insurer. A first potential benefit is price, which plays a prominent role in the decision to switch insurer in Germany, Switzerland, and the Netherlands (Thomson et al., 2013). Consumers are – on average – sensitive to price. However, high-risks are less sensitive to price changes than low-risks (Royalty and Solomon, 1999; Buchmueller, 2000; Strombom et al., 2002; Schut et al., 2003; Van Dijk et al., 2008; Buchmueller et al., 2013).

Secondly, insurers' service quality is an important reason for switching insurer in Belgium and Germany (Thomson et al., 2013). This switching benefit encompasses the speed of payment of claims, coverage decisions, and the help from the call center (Abraham et al., 2006). Insurers' service quality may be especially an important switching benefit for high-risks. These consumers may have regular contact with their insurer because of their large healthcare use.

A third potential switching benefit is the insurers' contracted provider network. This benefit consists of the quality of the contracted providers, the freedom to choose a provider or drug, and the way an insurer organizes healthcare. The composition of the provider network, the reimbursement level for non-contracted providers, and the prescription drug reimbursement affect consumers' freedom to choose a provider or drug. Consumers can consider the quality of the contracted providers as a switching

benefit based upon negative prior experiences. Moreover, other information sources (e.g. word-of-mouth information, consumer satisfaction rates, and health outcome measures) can make consumers aware of the performance of their current insurer compared to the performance of others (Kolstad and Chernew, 2009). In Belgium, the insurers' contracted provider network is an irrelevant switching benefit, because insurers are not allowed to selectively contract with healthcare providers. In contrast, in the United States, the insurers' contracted provider network may be a considerable switching benefit due to the widespread use of preferred provider networks (Boonen et al., 2011a). Other international examples show that, for example in Germany, the design of the range of disease management programs may be a switching benefit (Greβ et al., 2006). Because of their healthcare use, insurers' contracted provider network is in particular a switching benefit for high-risks. Moreover, it may be an interesting switching benefit for consumers whom provider is no longer contracted by their current insurer.

The benefits of supplementary insurance (SI) are a fourth potential switching benefit. These benefits can provide supplemental coverage (e.g. a superior hospital stay) or complementary coverage of excluded or partially covered basic benefits. The benefits of SI are only a potential switching benefit if consumers are legally obliged to take out basic health insurance (BI) and SI from the same insurer (e.g. in Belgium), or if the separated markets for BI and SI are closely tied by a joint purchase of BI and SI (e.g. in the Netherlands and Switzerland). In the Netherlands, high-risks switched more often because of the benefits of SI than the general population (De Jong et al., 2008).

Welcome gifts are a fifth potential switching benefit. In 2013, for example, some Dutch insurers offered 75 euro cashback to new applicants. Free gifts to new applicants, such as gift cards, are another example of welcome gifts.

3.2.2 Switching costs

Switching costs are the costs consumers associate with switching insurer (Jones et al., 2002; Burnham et al., 2003). Firstly, making a switching decision involves (pre-switching) transaction costs, i.e. the time and effort it takes to make a decision and to actually switch insurer (Strombom et al., 2002). The lack of comparable information on insurers' contracted providers and reimbursement levels for non-contracted providers may increase consumers' transaction costs in some European countries (Van de Ven et al., 2013). Moreover, transaction costs could be substantial if consumers have to analyze information about a large number of (differentiated) health insurance products (Laske-Aldershof et al., 2004). In this respect, consumers can be overwhelmed by too much choice (i.e. the cognitive overload theory as defined by behavioral economists) (e.g. Iyengar and Lepper, 2000; Schwartz, 2004; Elbel, 2007; Frank and Lamiraud, 2009). Employer-sponsored health insurance, like in the United States, may decrease consumers' transaction costs by offering only a limited number of subsidized options

(Van Beusekom et al., 2004; Cunningham, 2013). Moreover, a disenrollment service (i.e. the new insurer will inform the old insurer after receiving the enrollment form) and the possibility of switching via the Internet may decrease consumers' transaction costs (Van de Ven et al., 2013). Low-risks may face lower transaction costs than high-risks, because the former group may be mainly interested in price information, while the latter may consider quality information as well (Hendriks et al., 2010).

Secondly, after switching, consumers are confronted with learning costs, i.e. the time and effort it takes to learn the rules and procedures (e.g. the administrative requirements) of a new insurer (Klemperer, 1995; Jones et al., 2002; Strombom et al., 2002; Burnham et al., 2003; Handel, 2013). High-risks may face higher learning costs than low-risks, because particularly high-risks should gain insight into their entitlements and how they should submit a claim (Schlesinger et al., 1999).

Thirdly, switching may involve 'benefit loss' costs, i.e. the benefits that are lost if the relationship with the current insurer is terminated (Klemperer, 1995; Jones et al., 2002; Burnham et al., 2003). In the United States, employees with an employer-sponsored health insurance may receive a premium contribution from their employer and subsidies in the form of tax credits. Consumers switching to a non-subsidized insurer may lose these advantages. In the Netherlands and Switzerland, the perceived loss of the favorable conditions of SI is a major switching cost for high-risks. In these countries, BI and SI are offered as a joint product and high-risks are afraid that another insurer would not accept them for SI or would charge them a high premium (Dormont et al., 2009; Roos and Schut, 2012; see Chapter 4). In Ireland, the largest provider of private health insurance closely ties its health insurance and travel insurance products (the Irish Competition Authority, 2007). Consumers switching to another insurer for health insurance lose their travel insurance or face a price increase of their travel insurance.

Fourthly, switchers may be confronted with uncertainty costs, i.e. the costs of accepting the psychological uncertainty surrounding the performance of other insurers with a potential for negative outcomes, e.g. additional costs or waiting times (Jones et al., 2002; Burnham et al., 2003). Uncertainty costs are likely to be larger for high-risks than for low-risks (Hendriks et al., 2010).

Fifthly, switching insurer may imply the costs of (not) switching to another healthcare provider. Selective contracting in healthcare increases the probability that a new insurer has not contracted consumers' current provider. If a consumer switches to another healthcare provider, it will take time and effort to initiate a relationship with this new provider (Royalty and Solomon, 1999; Jones et al., 2002; Strombom et al., 2002; Burnham et al., 2003). In contrast, if a consumer stays with the current, non-contracted, healthcare provider he or she will have to pay the healthcare costs (partially) out-of-pocket. The costs of (not) switching to another provider may be a substantial switching cost in Israel and the US. In these countries, insurers largely restrict consumers' provider

choice and reimburse non-contracted providers only to a limited extent (Van de Ven et al., 2013; Cunningham, 2013). The costs of (not) switching to another provider would be especially a switching cost for high-risks (Buchmueller and Feldstein, 1997; Schlesinger et al., 1999; Strombom et al., 2002).

Sixthly, sunk costs, i.e. consumers' perceptions of the non-recoverable investments – in terms of time, money, and effort – in establishing and maintaining a relationship with the current insurer, are a psychological switching cost (Jones et al., 2002; Patterson and Smith, 2003; Whitten and Wakefield, 2006; Chebat et al., 2011). This switching cost may result in irrational behavior, such as status quo bias (Samuelson and Zeckhauser, 1988). Consumers with an established relationship with their current insurer, e.g. elderly consumers, may face high sunk costs (Samuelson and Zeckhauser, 1988; Zhang et al., 2012). This is consistent with the results of Frank and Lamiraud (2009) who found that longer tenures of enrollment continuously reduce the likelihood of switching. Moreover, high-risks may face high sunk costs, because they may be quite familiar with the rules and procedures of their current insurer and may have expended a great deal of effort in obtaining prior authorization (Nuscheler and Knaus, 2005).

Table 3.1 summarizes the determinants of the different switching benefits and costs.

Table 3.1 Determinants of the switching benefits and costs in the health insurance market

	Determinant(s)
Switching benefit	
Price	Insurers' freedom to set its own prices
Insurers' service quality	Availability and quality of consumer information
Contracted provider network	(1) Insurers' freedom to selectively contract with healthcare providers and (2) availability and quality of consumer information
Benefits of supplementary insurance	Joint purchase of basic and supplemental benefits
(Financial) welcome gift	Insurers' freedom to provide welcome gifts
Switching cost	
(Pre-switching) transaction costs	(1) Availability and quality of consumer information; (2) number of consumers' choice options; (3) availability of a disenrollment service; and (4) possibility of switching via the Internet
(Post-switching) learning costs	Insurers' freedom to set its own rules and procedures
'Benefit loss' costs	(1) Availability of employer-sponsored health insurance; (2) joint purchase of basic and supplemental benefits; and (3) joint purchase of basic health insurance and other insurance products (e.g. car or home insurance)
Uncertainty costs	Availability and quality of consumer information
Costs of (not) switching to another healthcare provider	Insurers' freedom to selectively contract with healthcare providers
Sunk costs	Insurers' freedom to set its own rules and procedures

3.3 THE NETHERLANDS AS A CASE STUDY

We used an online questionnaire to assess to what extent the different switching benefits and costs were consumers' main reasons for (not) switching insurer in the Netherlands in the period November 2012 to January 2013 (i.e. switching insurer in 2013).

3.3.1 Description of the Dutch competitive health insurance market

The introduction of the Health Insurance Act (*Zorgverzekeringswet)* in 2006 was a major step towards a competitive health insurance market (Enthoven and Van de Ven, 2007). All inhabitants are legally obliged to take out standardized BI from a private health insurer. In 2013, 26 different insurers offered BI (Vektis, 2013). An annual open enrollment period, community-rated premiums, a risk equalization model, and a standardized basic benefit package facilitate consumer choice. Although BI is standardized, insurers are free to specify consumers' precise entitlements (e.g. the contracted providers and pharmaceuticals) in the BI contract. Consumers can voluntarily take out SI for benefits not covered by BI, e.g. dental and paramedic care. In 2013, about 85 percent of the Dutch consumers took out SI (Vektis, 2013). Due to the joint purchase of BI and SI, more than 99 percent of the consumers take out their BI and SI from the same insurer (Vektis, 2012). Consequently, the expected switching benefits and costs concerning SI influence the decision to switch insurer for BI.

Each insurer is free to set its own community-rated premium for each of its products. In 2013, the average BI-premium equals about 1,280 euro per adult per year (Vektis, 2013). BI premiums equal 50 percent of the total insurers' revenues for BI. The other 50 percent consists of income-related contributions that are allocated to the insurers via the risk equalization fund. A new phenomenon in the Dutch health insurance market is the so-called 'budget policy' that imposes restrictions upon consumers' healthcare provider choice (BS Health Consultancy, 2012). The (very) low price of the 'budget policy' may be the main reason for consumers to take out this policy.

Insurers may provide premium discounts up to 10 percent to consumers belonging to a group, such as employees. Moreover, employees or low-income consumers may receive earmarked subsidies from their employer or municipality for the purchase of insurance from listed insurers. Consumers who switch to a non-listed insurer may lose these premium discounts or subsidies. Thus, the loss of the obtained benefits provided by the employer or municipality is a potential 'benefit loss' cost in the Netherlands. The loss of the favorable conditions of SI is another 'benefit loss' cost (see Section 3.2). Finally, consumers may lose other obtained benefits if they switch insurer. For example, a Dutch insurer introduced a special saving program for consumers. In this program, consumers accumulate bonus points for obtaining discounts on the SI premium or on sport articles. Consumers switching to another insurer would lose these points.

3.3.2 Data and methods

Before the actual data collection, our constructed questionnaire was pretested amongst colleagues. Moreover, we conducted three cognitive interviews (DeMaio et al., 2002) to determine whether respondents understood the questions used. After the pretests, some minor revisions were made.

In February 2013, the questionnaire was distributed among members of the Stem-Punt-panel of Motivaction. Members of this panel complete regularly questionnaires at home. An invitation to fill in the questionnaire was sent to 3,755 members aged 18 or older. In total, 1,091 of them completed the questionnaire. Because consumers could only fill in the questionnaire on the Internet, consumers without Internet access were excluded. This may (partly) explain why the sample of respondents was not completely representative of the Dutch population (Table 3.2). We used five weighting factors (0.6 5 – 0.87 – 1.09 – 1.34 – 1.55) to avoid selection bias. All respondents are assigned to one of the weighting factors based on their age, gender, education, region, and values-and-lifestyle characteristics (i.e. Mentality model; see for more information about the Mentality model www.motivaction.nl/en/mentality). The over-represented respondents received a weight of 0.65 or 0.87, while the under-represented respondents received a weight of 1.09, 1.34, or 1.55. Section 3.4 shows the weighted results.

Table 3.2 Background characteristics of respondents

	% Population (aged 18-80)	% Sample (unweighted)	% Sample (weighted)	% Switchers per group (weighted)
Gender				
Males	49.5	54.4	49.1	9.0
Females	50.5	45.6	50.9	12.6
Age				
18-24 years	10.9	8.0	10.3	22.5
25-34 years	16.1	12.9	16.0	12.0
35-44 years	19.3	17.0	19.8	12.5
45-54 years	19.8	19.1	19.8	8.8
55-64 years	17.7	22.7	17.2	8.0
65-80 years	16.2	20.3	16.8	6.0
Self-reported health				
Bad or moderate	19.9	21.5	21.2	10.4
Good, very good, or excellent	80.1	78.5	78.8	10.8
Education				
Low	25.8	22.5	24.1	7.6
Middle	50.0	52.0	51.2	11.7
High	24.2	25.5	24.7	12.3
Total	100.0	100.0 (n=1,091)	100.0 (n=1,091)	10.8

We asked all respondents whether they switched insurer in 2013. The switching rate in our sample (i.e. 10.8 percent) is higher than the switching rate in the Dutch population (i.e. 7.2 percent) (Vektis, 2013). Dutch insurers are allowed to offer BI under different names (i.e. under different labels). The switching rate in the Dutch population refers only to the consumers switching to another insurer and does not include consumers switching to another label of their current insurer. However, most consumer information sources (e.g. websites that compare the products of different insurers) present the different labels as different insurers. Therefore, a first explanation for our high switching rate may be that respondents who switched to another label of their current insurer perceived that they switched insurer. These perceptions do not influence our conclusions, because switching to another label of the current insurer involves the same potential switching benefits and switching costs as switching to another insurer. For example, one Dutch insurer offers BI under two different labels (i.e. ''De Friesland Zorgverzekeraar'' and ''Kiemer''). In this case, consumers switching to the other label of their current insurer are confronted with the same switching benefits as consumers switching to another insurer, because the BI products and SI products offered by these labels differ (e.g. the prices, the benefits covered by SI, and the freedom to choose a provider or drug differ). Moreover, switching costs are the same because consumers are confronted with premium surcharges on their SI premium if they do not switch label for SI too. In addition, low-income consumers who receive earmarked subsidies from their municipality for the purchase of insurance from the one label will lose these subsidies if they switch to the other label. This implies that 'benefit loss' costs are – just as the other switching costs – relevant when consumers switch to another label offered by their current insurer.

Secondly, switchers may be more eager to respond to a questionnaire about health insurance than non-switchers (Kerssens and Groenewegen, 2005). Thirdly, the online questionnaire only reaches consumers with Internet access. It takes probably less time and effort for these consumers to switch insurer than for consumers without Internet access.

Respondents have revealed their main reason for (not) switching insurer in 2013. Despite the limited number of respondents who switched insurer (n=118), switchers' main reasons for choosing a new insurer may serve as an illustration of the relevance of the different switching benefits. Moreover, we asked the non-switchers which benefits they associated with switching. In addition, we investigated to what extent the non-switchers have indicated one of the switching costs as the main reason for not switching insurer (see Table 3.3). We associated satisfaction as main reason for not switching with low perceived switching benefits. Finally, we evaluated whether the reasons for not switching insurer differ across groups of consumers. These groups are based upon gender, age, self-reported health, education level, and interactions between age and self-reported health. We used Pearson's Chi square tests to determine whether two variables are correlated.

Table 3.3 Operationalization of the switching benefits and costs in the questionnaire

Switching benefits	
Switchers	Why did you choose your current insurer?
Non-switchers	What was your main expected benefit from switching insurer?
	Answer category in the questionnaire
Price	1. Price of basic health insurance
	2. Price of supplementary insurance
	3. Discount via group
Insurers' service quality	Insurers' service quality
Contracted provider network	1. Quality of the contracted providers
	2. Out-of-pocket payments for visits to non-contracted providers
	3. Composition of the provider network
Benefits of supplementary insurance	Content of supplementary insurance
(Financial) welcome gift	(Financial) welcome gift
Switching costs	
Non-switchers	What was your main reason for not switching insurer?
	Answer category in the questionnaire
(Pre-switching) transaction costs	It takes a lot of time and effort to switch insurer
(Post-switching) learning costs	It takes a lot of time and effort to learn the rules and procedures of a new insurer
'Benefit loss' costs	1. I am afraid that another insurer would not accept me for SI
	2. I expect that I have to pay a higher premium for SI than other consumers with the same SI
	3. My employer or municipality pays partly the premium of my current insurer, but not of another insurer
	4. I accumulate bonus points at my current insurer
Uncertainty costs	Switching involves feelings of uncertainty
Costs of (not) switching to another provider	I am afraid that I would no longer have access to my current healthcare provider(s)
Sunk costs	1. I take out insurance from this insurer already for many years
	2. I take out my other insurance products (e.g. car or home insurance) also from this insurer

3.4 RESULTS

In 2013, about 64 percent of all switchers changed insurer because of price and 16 percent of all switchers mentioned the benefits of SI as their main reason for switching insurer (Table 3.4). The contracted provider network was for only 4 percent of the switchers the main reason for switching, while insurers' service quality was not mentioned at all as main reason for switching. In total, 38 percent of the non-switchers reported that they did not associate any benefits with switching and 34 percent of the non-switchers did not know whether there were any benefits associated with switching. Non-switchers mentioned price (20 percent) and the benefits of SI (7 percent) also as main potential switching benefits. These consumers actually did not switch because of satisfaction with their current insurer or because of switching costs that did not outweigh the perceived switching benefits.

Table 3.4 Perceived switching benefits in the Dutch health insurance market

Main reason for switching insurer	**% of switchers (n=118)**
Price	63.8
Benefits of supplementary insurance	15.6
(Financial) welcome gift	6.9
Contracted provider network	3.8
Insurers' service quality	0.0
Other reason(s) (not specified)	*9.9*
Expected switching benefit	**% of non-switchers (n=971)**
None	38.0
I do not know	31.4
Price	19.6
Benefits of supplementary insurance	6.8
Contracted provider network	2.6
Insurers' service quality	0.7
Other benefit(s) (not specified)	*0.9*

Satisfaction was for 50 percent of the non-switchers the main reason for not switching insurer (Table 3.5). However, half of them reported one of the switching costs as another important – but not the main – reason for not switching insurer. For 55 percent of the consumers aged 55 or older satisfaction was the main reason for not switching insurer compared to 47 percent of the consumers aged 18-55. Moreover, healthy consumers mentioned satisfaction significantly more frequently as the main reason for not switching than unhealthy consumers (52 percent versus 40 percent).

For 43 percent of the non-switchers one of the switching costs – instead of satisfaction – was the main reason for not switching insurer (Table 3.5). One of the switching costs was for 55 percent of the unhealthy consumers the main reason for not switching compared to 40 percent of the healthy consumers. Moreover, 61 percent of the unhealthy consumers aged 18-55 reported one of the switching costs as their main reason for not switching insurer.

'Benefit loss' costs, sunk costs, learning costs, and transaction costs were the four most reported switching costs as main reason for not switching. These costs were for, respectively, 16 percent, 15.6 percent, 4.7 percent, and 4.3 percent of the non-switchers the main reason for not switching insurer (Table 3.6). Regarding the 'benefit loss' costs, the loss of obtained benefits provided by the employer or municipality, the loss of the favorable conditions of SI, and the loss of obtained benefits were for, respectively, 7.2 percent, 8.4 percent, and 0.4 percent of the non-switchers the main reason for not switching insurer.

'Benefit loss' costs were for 18 percent of the consumers aged 18-55 the main reason for not switching compared to 13 percent of the consumers aged 55 or older.

Table 3.5 Percentage (per group) of non-switchers (n=967) that mentioned satisfaction or one of the switching costs as the main reason for not switching insurer

	Satisfaction (%)		One of the switching costs[1] (%)	
Non-switchers (n=967)	49.6[2]		42.8[2]	
Males (n=484)	49.4		42.1	
Females (n=483)	49.9		43.5	
Aged 18-55 (n=642)	46.9	**[3]	43.9	
Aged 55 or older (n=325)	54.9		40.7	
Unhealthy consumers[4] (n=206)	39.5	***	55.1	***
Healthy consumers[5] (n=761)	52.3		39.6	
Low education (n=242)	54.1		39.9	
Middle education (n=493)	49.3		44.5	
High education (n=232)	45.3		42.5	
Age and self-reported health				
Unhealthy consumers aged 18-55 (n=108)	34.3	*	61.1	*
Unhealthy consumers aged 55 or older (n=98)	45.9		48.0	
Healthy consumers aged 18-55 (n=535)	49.5	**	40.4	
Healthy consumers aged 55 or older (n=226)	59.0		37.6	

*p<0.10; ** p<0.05; *** p<0.01

[1] Transaction costs, learning costs, 'benefit loss' costs, uncertainty costs, costs of (not) switching to another provider, or sunk costs mentioned as main reason for not switching insurer.

[2] In total, 7.6 percent (100 percent-49.6 percent-42.8 percent) of the non-switchers mentioned another main reason for not switching insurer.

[3] Thus, the Pearson's Chi square test shows that consumers aged 55 or older mentioned satisfaction significantly more frequent (at the 5%-level) as main reason for not switching insurer than consumers aged 18-55.

[4] Bad or moderate self-reported health.

[5] Good, very good, or excellent self-reported health.

However, 20 percent of the latter group mentioned sunk costs as the main reason for not switching compared to 14 percent of the former group. Sunk costs were for 21 percent of the unhealthy consumers the main reason for not switching compared to 14 percent of the healthy consumers. High-risks did not mention transaction and learning costs frequently as their main reasons for not switching insurer. Low-educated consumers frequently reported sunk costs as their main reason for not switching, while high-educated consumers mentioned 'benefit loss' costs and learning costs relatively frequent as their main reason for not switching.

Table 3.6 Top 4 most reported types of switching costs[1] by (groups of) non-switchers (n=967) as the main reason for not switching insurer

	'Benefit loss' costs (%)		Sunk costs (%)		(Post-switching) learning costs (%)		(Pre-switching) transaction costs (%)	
Non-switchers (n=967)	16.0		15.6		4.7		4.3	
Males (n=484)	17.1		13.8		3.5		5.0	
Females (n=483)	14.9		17.4		6.0	*	3.7	
Aged 18-55 (n=642)	17.8	**[2]	13.6	**	5.3		5.3	**
Aged 55 or older (n=325)	12.6		19.8		3.4		2.5	
Unhealthy consumers (n=206)[3]	19.9	*	20.9	**	4.4		4.4	
Healthy consumers (n=761)[4]	15.0		14.2		4.9		4.2	
Low education (n=242)	10.3		22.6		1.7		2.1	
Middle education (n=493)	17.1	**	14.6	***	5.3	**	5.1	
High education (n=232)	19.4		10.3		6.9		4.7	

*p<0.10; ** p<0.05; *** p<0.01

[1] Only 2 percent and 0.2 percent of the non-switchers mentioned, respectively, uncertainty costs and the costs of (not) switching to another provider as main reason for not switching insurer.

[2] Thus, the Pearson's Chi square test shows that consumers aged 18-55 mentioned 'benefit loss' costs significantly more frequent (at the 5% level) as main reason for not switching insurer than consumers aged 55 or older.

[3] Bad or moderate self-reported health.

[4] Good, very good, or excellent self-reported health.

3.5 DISCUSSION

One could be inclined to conclude that a competitive health insurance market works well if many consumers switch insurer. This may result in wrong conclusions, because the goal of a competitive health insurance market is not maximizing switching rates. A high fraction of switchers can even have negative side-effects, such as high administrative costs (De Jong et al., 2008). Moreover, some consumer inertia can prevent adverse selection in the health insurance market (Rothschild and Stiglitz, 1976; Cutler and Zeckhauser, 2000a; Handel, 2013).

The aim of a competitive health insurance market is enhancing efficiency, quality, and consumer responsiveness in healthcare. Consumers' (perceived) freedom to easily switch insurer is one of the essential preconditions for achieving this. In healthcare, consumer preferences are highly heterogeneous. To discipline insurers to be responsive to these heterogeneous preferences, all consumer groups must perceive low switching costs compared to their switching benefits. However, our results indicate that switching costs restricted in particular consumer choice of unhealthy consumers. This substantially reduces insurers' incentives to invest in high-quality care for high-risks. Therefore, strategies should be developed that aim at increasing consumer choice.

The integration of BI and SI into one basic-plus-insurance would be an effective solution to reduce the 'benefit loss' costs (Duijmelinck and Van de Ven, 2014; see Chapter

4). Due to the features of a basic-plus-insurance, consumers will no longer face the risk that another insurer imposes less favorable conditions for SI in the next contract period than their current insurer does. The introduction of a basic-plus-insurance will not threaten the affordability of BI, because insurers are still bound to open enrollment and community-rated premiums for the basic benefits. As soon as 'benefit loss' costs are no longer a (substantial) switching cost, transaction and learning costs may become more important switching costs in the health insurance market. Consumers who (consider to) switch insurer will then be confronted with the time and effort it takes to make a switching decision, to actually switch insurer, and to learn the rules and procedures of a new insurer. Therefore, policymakers should develop strategies to reduce consumers' transaction and learning costs. In this respect, policymakers should also pay attention to the question to what extent the government should facilitate the switching process in the health insurance market (see e.g. Enthoven and Schaeffer, 2011).

Our research has some limitations that may be addressed in future research. Firstly, the use of an online questionnaire reaches only consumers with Internet access. Because consumers without Internet access may face higher switching costs than those with Internet access, future research could include this former group of consumers. Secondly, we only investigated whether consumers perceived a specific switching cost in the health insurance market. Future research may also pay attention to the size – e.g. in terms of time and money – of the different switching costs. Thirdly, a lack of knowledge and misunderstandings about the right to switch may also hinder consumers from switching insurer. We did not pay attention to these aspects. This may be an interesting area for future research. Fourthly, we solely focused on switching insurer, while Dutch insurers are allowed to offer more than one BI contract. Future research may focus on the extent to which consumers switch to another BI contract offered by the same insurer and their reasons for (not) doing so. Fifthly, Hirschman (1970) described that – next to the exit option – consumers could express dissatisfaction with their current insurer by using the 'voice option'. This option involves, for example, complaining, participating in consumer councils, and completing consumer satisfaction questionnaires. Future research may examine to what extent groups of consumers make use of the voice option.

3.6 CONCLUSIONS

Consumer choice of insurer has become a key element of an increasing number of countries' healthcare system. In these countries, consumer choice must stimulate insurers to distinguish themselves from their competitors by continuously improving efficiency and quality in healthcare. Consumers will switch insurer if their perceived switching benefits outweigh their perceived switching costs. Price, insurers' service

quality, insurers' contracted provider network, the benefits of supplementary insurance, and welcome gifts are potential switching benefits, while transaction costs, learning costs, 'benefit loss' costs, uncertainty costs, the costs of (not) switching provider, and sunk costs are potential switching costs. A Dutch case study in 2013 showed that switching costs restricted in particular consumer choice of the unhealthy consumers: about 55 percent of the non-switching unhealthy consumers mentioned one of the switching costs as their main reason for not switching insurer. However, this substantially reduces insurers' incentives to invest in high-quality care for unhealthy consumers. Because an essential precondition of a competitive health insurance market – consumers' (perceived) freedom to easily switch insurer – is not yet fulfilled, policymakers should develop strategies to improve consumer choice.

4

Choice of insurer for basic health insurance restricted by supplementary insurance

ABSTRACT

Choice of insurer is an essential precondition for achieving efficiency in healthcare systems based on regulated competition. However, supplementary insurance (SI) may restrict choice of insurer for basic health insurance (BI) due to a joint purchase of BI and SI. Roos and Schut (2012) found that the belief in not being accepted by another insurer for SI was an important reason for not switching insurer for BI for about 4 percent of the non-switching Dutch population in 2006. This increased to about 7 percent in 2009. We provide evidence that in 2011 and 2012 about 10 percent of the Dutch population expected that another insurer would not accept them for SI. An additional 20 percent of the consumers expected to be accepted by another insurer, but only for a higher premium than other consumers with the same SI. About one third of the elderly (55+) consumers and more than half of the consumers with a bad or moderate self-reported health, expected their current insurer to offer them more favorable conditions for SI, in terms of acceptance and premium, than other insurers do for similar SI. However, if dissatisfied high-risk consumers, due to a joint purchase of BI and SI, do not switch insurer for BI, the disciplining effect of 'voting with one's feet' is substantially reduced. This is a serious problem that may increase in coming years. We discuss several potential solutions. Our conclusion is that the integration of BI and SI into one basic-plus-insurance is an effective solution under current EU legislation. This conclusion may also be relevant for other countries.

4.1 INTRODUCTION

The introduction of the Health Insurance Act (HIA, *Zorgverzekeringswet,* 2006*)* was an important step towards regulated competition in the Dutch healthcare system (Enthoven and Van de Ven, 2007). Insurers are assumed to be prudent buyers of care on behalf of their consumers and to increase efficiency and quality of healthcare delivery (Schut and Ven de Ven, 2005). Consumers who are dissatisfied with the premium or purchased care by their insurer must be free (and must feel free) to easily switch insurer (Enthoven, 1978). For this reason, Dutch insurers are legally obliged under the HIA to accept all applicants for mandatory basic health insurance (BI) for a community-rated premium. Consumers' decision to switch insurer depends on their expectation of whether their switching benefits (e.g. price or contracted provider network) will outweigh their switching costs (e.g. transaction costs or the costs of (not) switching healthcare provider) (Laske-Aldershof et al., 2004).

In the Netherlands, insurers are allowed to selectively contract with healthcare providers. This may increase product differentiation in the BI market. High-risks (i.e. elderly or unhealthy consumers) make an above-average use of the purchased care by their insurer. Product differentiation increases their health insurance options. Therefore, these consumers have a great interest in the possibility of switching each year. Previous studies indicated that in particular elderly consumers place value on the (quality of the) insurers' contracted provider network (Beaulieu, 2002), while young consumers seem to be mainly interested in price (Buchmueller, 2000). The probability of switching decreases with age (see Chapter 2). High switching costs may explain the low switching rates among high-risks (see Chapter 2). However, if only young individuals switch, insurers may have low incentives to invest in high-quality care for elderly consumers. In the Netherlands, voluntary supplementary insurance (SI) may restrict consumer choice of high-risks. In this chapter, we focus solely on this potential barrier to switching for BI.

Consumers can take out SI for benefits that are not covered by BI. Dutch insurers are allowed to offer both BI and SI. In 2011 and 2012, about 90 percent of the Dutch population took out SI and 99.8 percent of them took out their BI and SI from the same insurer (Vektis, 2012). In contrast to BI, SI is based on free market principles, which means that insurers are allowed to apply risk rating and selective underwriting for SI. Roos and Schut (2012) have indicated that in 2009 almost all Dutch insurers offered BI and SI as a joint product. For example, insurers offered SI only in combination with BI or they required premium surcharges if a consumer only applied for SI. This joint purchase can generate two negative spillover effects of SI on BI: (1) SI can be used as a tool for risk selection in BI and (2) SI can reduce consumer choice of insurer for BI. Improving the risk equalization scheme can counteract the first effect (Roos and Schut, 2012). In this chapter we focus on the latter effect, which is maybe harder to solve than the first effect. If high-risk consumers are 'locked' in their current SI, they would also not

switch insurer for BI. Consequently, insurers may have low incentives to be responsive to the preferences of high-risks and to invest in high-quality care for them. As a result, effective competition among insurers may decline. It is likely that in coming years, due to rising healthcare expenses, benefits will be removed from BI. Because insurers may extend their SI with the benefits that are being removed from BI, SI may become more important and the problem that SI can restrict choice of insurer for BI is likely to increase in the coming years.

Roos and Schut (2012) showed that an increasing proportion of high-risks did not (consider to) switch insurer for BI because they expected that another insurer would reject them for SI. In 2006, for about 4 percent of the non-switching Dutch population the belief in not being accepted for SI by another insurer was an important reason for not switching for BI. This percentage increased to about 7 in 2009 (Roos and Schut, 2012). In this chapter, we investigate to what extent consumers expected in 2011 and 2012 that another insurer would not accept them for SI. In addition, we pay attention to the question of whether consumers expect that another insurer would accept them, but would charge them a higher premium than other consumers with the same SI.

The aim of this chapter is fourfold: (1) to analyze the problem that SI restricts choice of insurer for BI when BI and SI are offered as a joint product; (2) to examine the extent to which SI was a barrier to switching in the Netherlands in 2011 and 2012; (3) to provide an effective solution in order to increase choice of insurer for BI; and (4) to discuss the relevance of our conclusions for countries with a healthcare system characterized by elements of regulated competition and SI that is offered in combination with BI (e.g. Belgium, Germany, Israel, and Switzerland) (Wasem et al., 2004).

4.2 ANALYSIS OF THE PROBLEM

A joint purchase of BI and SI can restrict consumer choice of insurer for BI (Roos and Schut, 2012). For example, in the period 2006-2009 in the Netherlands, the probability of switching insurer was about 20 percent lower for a consumer with SI than for a consumer without SI (Boonen et al., 2011b). By 2009, almost all Dutch insurers used at least one of the following instruments to offer BI and SI as a joint product: (1) they offered SI only in combination with BI; (2) they required premium surcharges for SI if a consumer only applied for SI; (3) they required premium surcharges for SI if a consumer switched to another insurer for BI; (4) they used stringent acceptation policies if a consumer only applied for SI or; (5) they used parent-child-tie-in provisions (Roos and Schut, 2012). Consumers may have strong preferences for a joint purchase of BI and SI because it may facilitate the coordination of basic and supplemental benefits (in particular for types of care that are partly covered by BI and partly by SI (NZa, 2009b)),

and because one-stop shopping lowers search and transaction costs (Paolucci et al., 2007).

Given the joint purchase of BI and SI, several features of SI can restrict consumer choice of insurer for BI. In this chapter we will primarily focus on the guaranteed renewability (GR) of SI. Dutch insurers have incorporated a GR in each SI without any legal duty to do this (Roos and Schut, 2012). For other types of insurance – like car insurance, burglary insurance, or fire insurance – GR is not incorporated. The GR of SI consists of a guaranteed renewal of SI each year without any discrimination in the adjustment of the premium and the policy conditions for all current consumers with this specific SI. This means that a consumer who has developed a chronic disease during the previous contract period will be offered the same premium and policy conditions for the next contract period as a consumer who has not developed a chronic disease. GR imposes an acceptance duty and premium-rate restrictions for the insurer with respect to renewing SI of their own enrollees, but this does not hold for new applicants. Consequently, high-risks can expect their current insurer to offer them more favorable conditions in terms of acceptance, premium, and waiting periods than other insurers do. In other words, because of GR, high-risks may be 'married with their insurer' (Van de Ven and Schut, 2011).

In 2006 and 2007, all Dutch insurers informally agreed not to refuse new applicants for SI (except for extensive dental coverage) (Roos and Schut, 2012). Moreover, during these years, risk rating was only applied by a few insurers and these insurers only used a few risk factors to determine the premium of SI (De Bruijn and Schut, 2006). As a result, in 2006 and 2007, all Dutch consumers had the possibility of taking out SI with an (almost) community-rated premium. However, in 2008, the informal agreement was no longer continued. Therefore, since 2008, high-risks can expect their current insurer to offer more favorable conditions in terms of acceptance, premium, and waiting periods than other insurers do for a similar SI.

4.3 CHOICE OF INSURER FOR BASIC HEALTH INSURANCE HINDERED BY GUARANTEED RENEWABILITY OF SUPPLEMENTARY INSURANCE?

The previous section has indicated that GR of SI can, in theory, restrict high-risks' choice of insurer for BI. Two methods are used to determine the extent to which GR of SI, in practice, restricted choice of insurer for BI in 2011 and 2012. Firstly, a consumer questionnaire was used to determine whether – and, if so, which – consumers expect their current insurer to impose more favorable conditions than other insurers do for similar SI next year. Table 4.1 presents the question used and the corresponding answer categories.

Table 4.1 Consumer questionnaire

Question: Suppose you want to take out similar SI from another insurer. What do you expect this other insurer would do? Choose the answer category that best applies to you.
I expect I have to pay a lower premium than other consumers with the same SI at this insurer
I expect I have to pay the same premium as other consumers with the same SI at this insurer
I expect I have to pay a higher premium than other consumers with the same SI at this insurer
I think another insurer would reject me
I do not know

Data were collected in February 2011 and February 2012 through the Internet by using the CentERpanel. In 2011, the CentERpanel consisted of 2,665 respondents aged 18 years or older who completed questionnaires at home every week. In 2012, the CentERpanel consisted of 2,419 respondents aged 18 years or older. The response rates in 2011 and 2012 were, respectively, 73.8 percent and 76.6 percent.

Background characteristics of all respondents are presented in Table 4.2. The sample of respondents was significantly older and healthier than the general Dutch population. The percentage of respondents older than 65 years, among respondents of 20 years or older, was in our research 27 compared to 21 in the general Dutch population. In addition, the percentage of respondents reporting a bad or poor health status was 16 compared to 20 in the general Dutch population.

Table 4.2 Background characteristics of respondents

	2011	**2012**
	% of total (n=1,968)	**% of total (n=1,852)**
Age		
Aged 18-55	48.6	45.3
Aged 56 or older	51.4	54.7
Self-reported health		
Bad or moderate	16.1	16.4
Good, very good, or excellent	83.9	83.6
Gender		
Female	46.5	46.0
Switched insurer		
Yes	4.6	4.7
Supplementary insurance		
Yes	84.6	83.7
No	8.8	11.5
Do not know	6.7	4.8

Secondly, in 2011, six employees of six Dutch health insurance companies were interviewed to determine whether insurers applied risk rating, selective underwriting, and product differentiation for SI and whether they expect to change their behavior in the near future. In addition, questions were asked about GR and questions were asked to determine the main motives of insurers for their current behavior (see Table 4.3). We selected these six employees because they were responsible for the design, the premium setting, and the policy conditions of the SI products offered. The interviewed employees were working, for example, as chiefs of departments for product design and development, for both large and small insurance companies.

Table 4.3 Interview topics

Risk rating[1]	Current application of risk rating
	Motives for current behavior
	Expected application of risk rating in the future
Selective underwriting[2]	Current application of selective underwriting
	Motives for current behavior
	Expected application of selective underwriting in the future
Product differentiation[3]	Various types of SI offered by the insurer
Guaranteed renewability	Motives for incorporating GR in SI

[1] Risk rating: “adjusting the premium for each product to the individual’s risk” (Van de Ven and Schut, 2011).
[2] Selective underwriting: ‘’adjusting the accepted risk to the stated premium of a given product’’ (Van de Ven and Schut, 2011).
[3] Product differentiation: ‘’adjusting the product to attract various risk groups per product and charge premiums accordingly’’ (Van de Ven and Schut, 2011).

During the interviews, it was possible to keep on asking questions in order to clarify answers. In addition, the interviewer could guarantee an unambiguous interpretation of the concepts of risk rating, selective underwriting, product differentiation, and GR by exemplifying these concepts during the interviews. Each interview was recorded, with the permission of the interviewee, and transcribed. After each interview, a summary was sent to the interviewee concerned for checking. Thus, the results are based on authorized interviews. Potential biases in the employees’ answers were counteracted by comparing their answers with consumer information on insurers’ websites and on other public information sources (e.g. http://www.kiesbeter.nl). Public information sources were further used to determine whether non-interviewed Dutch insurers apply risk rating, selective underwriting, and product differentiation for SI.

Expectations of Dutch consumers

Table 4.4 shows consumers' expectations concerning the behavior of other insurers if they decide to switch insurer for a similar SI. A Pearson's Chi square test was used to determine whether two variables were correlated. In both years, about 10 percent of all Dutch consumers aged 18 years or older expected that another insurer would reject them for SI. Roos and Schut (2012) found that in 2006 for about 4 percent of the non-switching Dutch population, the belief in not being accepted for SI by another insurer was an important reason for not switching for BI. This percentage increased to about 7 in 2009. Although the question used in the present study differs slightly from that used in the research by Roos and Schut (2012), there is a clear indication that the proportion of consumers who expected that another insurer would not accept them for SI has increased in the period 2006-2012. In addition, about 20 percent of the respondents expected that another insurer would accept them, but would charge them a higher premium than other consumers with the same SI. In 2011, about 27 percent of the respondents expected their current insurer to offer a more favorable SI than other insurers. This increased to 31.5 percent in 2012. Given the total adult Dutch population of 12 million individuals, in 2012 almost one third, i.e. 3.75 million individuals, expected their current insurer to offer a more favorable SI than other insurers.

Table 4.4 Percentage of respondents that expects that another insurer would reject them for similar SI or expects that another insurer would accept them, but would charge them a higher premium than other consumers with the same SI[1]

	1. Expect to be rejected		2 Expect higher premium		3.Expect higher premium or to be rejected	
	2011 (n=992)	2012 (n=881)	2011 (n=992)	2012 (n=881)	2011 (n=992)	2012 (n=881)
Aged 18-55	5.1% ***	5.6% ***	16.0%	22.7%	21.0% ***	28.3% **
Aged 56 or older	15.7%	14.1%	16.9%	20.3%	32.6%	34.5%
Good, very good, or excellent health	6.2% ***	5.6% ***	15.6% *	20.2% **	21.7% ***	25.8% ***
Bad or moderate health	31.9%	32.0%	21.3%	27.9%	53.1%	59.9%
Total	10.4%	10.0%	16.4%	21.5%	26.8%	31.5%

*p<0.10; ** p<0.05; *** p<0.01

[1] Individuals who indicated that they do not know whether another insurer would apply the instruments of risk rating and/or selective underwriting for SI are left out of the analyses (26.8 percent of the respondents with SI in 2011 and 22.1 percent of the respondents with SI in 2012). The remaining sample size is 992 respondents in 2011 and 881 respondents in 2012.

Table 4.4 shows that more than half of the consumers with a bad or moderate self-reported health and about a third of the consumers aged 55 years or older expected their current insurer to offer a more favorable SI than other insurers. This problem is caused by GR of each SI. Due to the joint purchase of BI and SI, these high-risks would most likely not switch insurer for BI. Because these non-switching consumers make an

above-average use of the purchased care by insurers, they have a great interest in the possibility of switching insurer each year. Therefore, if these consumers do not switch if they are dissatisfied, the disciplining effect of 'voting with one's feet' is substantially reduced. This is a serious problem that is expected to increase in coming years, if SI becomes more important. The conclusion is that currently an essential precondition for achieving efficiency in the Dutch system of regulated competition is largely unfulfilled.

Actual behavior of Dutch health insurers

Interviews with individuals working at various health insurance companies indicated that Dutch insurers substantially applied product differentiation for SI. Insurers stated that they have offered, for example, special SI products for women, young consumers, and families to respond to the various preferences of various groups of consumers. Insurers informed us that they have not applied selective underwriting and risk rating to a major extent. Supplementary dental insurance products and the most comprehensive SI products can be considered as exceptions. The same conclusions can be drawn from the extensive review of publicly available information sources. Our conclusions are consistent with those of Roos and Schut (2012). If a consumer has been refused for a high-option SI, an alternative low-option SI will be offered. Insurers referred to their social foundation, the importance of solidarity for health insurance, and the transaction costs as explanations for their limited use of selective underwriting and risk rating for SI. Moreover, due to public pressure in 2004 and 2005, insurers incorporated the GR in each SI.

Nevertheless, the previous section has shown that about 30 percent of the respondents expected that another insurer would apply risk rating or selective underwriting for SI. This implies that a discrepancy exists between the actual insurers' practices and consumers' expectations about these practices. Consumers' experiences with risk rating and selective underwriting in private health insurance before 2006 or in other insurance products may explain this discrepancy.

Expected behavior of Dutch health insurers in the future

In coming years, benefits may be excluded from the BI and included in the SI. As a consequence, the current SI would be extended and insurers' incentives to apply risk rating and selective underwriting may increase. Paolucci et al. (2009) examined the potential premium range of SI in the Netherlands in 2002 and the potential premium range if SI only covered the total expenses for certain specific types of care. Table 4.5 presents the premium range if no risk factors are used (i.e. the community-rated premium), if only demographic risk factors are used, and if health-related risk factors are also used in premium setting. The magnitude of the premium range is especially substantial for benefits like pharmaceuticals and medical devices. The potential gains from using

health-related risk factors in addition to demographic factors are quite limited for the SI as it was in 2002 (Paolucci et al., 2009).

Table 4.5 gives an indication of the potential premium range of SI in 2011 and 2012. In these years, SI consisted, among others, of benefits that were covered by SI in 2002, for example alternative care and cross-border care. From 2004, reimbursement of dental and paramedic care by BI has been reduced. Currently, dental and paramedic care are the main benefits covered by SI. In 2011, for example, expenses for dental and paramedic care formed about 75 percent of the total expenses covered by SI (Vektis, 2013). From Table 4.5 we conclude that the premium range of SI covering these benefits is relatively limited (in absolute euros) and primarily determined by demographic factors and not so much by health-related risk factors. However, from 2012, pharmaceuticals to treat gastric acid, the most used pharmaceuticals in the Netherlands (Croonen, 2009), were no longer reimbursed by BI. To the extent that these pharmaceuticals are covered by SI, the potential premium range of SI in 2012 increased and health-related factors became important as well.

Table 4.5 Potential premium range of SI in 2002 and of insurance covering total expenditures (BI and SI) on certain types of care

	Community-rated premium	Demographic risk factors	Demographic and health-related risk factors
SI in 2002	€ 75	€ 6 - € 125	€ 6 - € 138
Dental care	€ 83	€ 35 - € 143	€ 27 - € 143
Paramedic care	€ 70	€ 18 - € 176	€ 13 - € 314
Medical devices	€ 76	€ 17 - € 299	€ 12 - € 723
Pharmaceuticals	€ 309	€ 57 - € 813	€ 38 - € 2,175

Source: Paolucci et al. (2009)

If, in the future, more benefits (e.g. medical devices or pharmaceuticals) are transferred from BI to SI, insurers would have more incentives to apply risk rating and selective underwriting for SI. As soon as one insurer starts doing so, other insurers would have to follow, otherwise their low-risks would switch to the insurer that applies risk rating or selective underwriting, and they would be left with the high-risks only. During the interviews, the individuals working at various health insurance companies revealed that they indeed keep a close watch on the behavior of their competitors. They stated that if important competitors started to apply risk rating and selective underwriting more extensively, they would adjust their behavior to do the same.

4.4 SOLUTIONS

The previous section has indicated that GR of SI restricts choice of insurer for a substantial group of high-risks. Section 4.4.1 discusses potential solutions that have previously been suggested, but for several reasons are no longer promising. Section 4.4.2 describes a new effective solution under current EU legislation.

4.4.1 Potential solutions

Roos and Schut (2012) have suggested four strategies to reduce the lock-in effect for high-risks. However, for several reasons these solutions (currently) do not seem to be highly promising.

Firstly, a strict legal separation between BI and SI is not a legally feasible solution because both BI and SI are private insurances subject to the Third European Non-life Insurance Directive. Under this directive, the government is not allowed to control policy conditions or prices of insurance products. BI falls under an exemption on this prohibition (Article 54) because it replaces the social security scheme. SI does not replace the social security scheme, so the government is not allowed to regulate it. Consequently, the Dutch government is not allowed to control policy conditions of the SI that link SI and BI, or to stop an insurer that offers BI from also offering SI, and vice versa.

Secondly, limiting the role of SI by confining its role to only 'luxury' benefits has become unrealistic due to the financial crisis and the urgent need for the government to reduce the public healthcare expenses. The increasing importance of SI seems unavoidable. For the same reason, the potential solution "providing information to consumers about the unimportance of the benefits that are covered by SI" may not be very promising anymore. The Dutch government holds the view that all necessary and cost-effective care is included in the publicly financed BI and that the SI covers only those benefits for which no need for public financing exits (Ministerie van VWS, 2008). Nevertheless, the percentage of consumers with SI is very high in the Netherlands (about 90 percent). Therefore, it could be the case that consumers have insufficient knowledge of the benefits that are covered by SI or attach too great importance to SI. The question arises, however, as to whether consumers would believe an information campaign that states that taking out SI may be unnecessary if SI becomes more important in the coming years.

As a third strategy, Roos and Schut (2012) suggested monitoring insurers' underwriting practices and publishing the results to make insurers reluctant to engage in stringent underwriting practices because they don't want to lose their reputations. In the short term this solution may be effective because insurers may face the trade-off between underwriting practices and the potential loss of reputation. However, if in the coming years benefits are transferred from BI to SI, insurers' incentives to apply risk rating and selective underwriting will increase. The competitive SI market will induce

them to apply risk rating and selective underwriting for SI more extensively (see Section 4.3). Therefore, this strategy can at best postpone risk rating and selective underwriting, but not eliminate them.

A fourth solution suggested by Roos and Schut (2012) is to improve consumers' knowledge of insurers' underwriting practices. The previous section has shown that a discrepancy exists between the expectations of consumers about the insurers' practices and the actual insurers' practices for SI. Disseminating information about actual switching opportunities, particularly to high-risks, could decrease this discrepancy. However, if in the coming years benefits are transferred from BI to SI, insurers' incentives to apply risk rating and selective underwriting will increase. If some insurers start applying these instruments more frequently, the adverse selection spiral will also force other insurers to apply risk rating and selective underwriting in the coming years more often than currently. In that case, a (successful) campaign that states that high-risks would not be confronted with risk rating or selective underwriting for SI would provide incorrect information.

4.4.2 One basic-plus-insurance

Description of one basic-plus-insurance

An alternative potential solution is to integrate the current BI and SI into one insurance product: a basic-plus-insurance (BPI), as suggested for example by Enthoven (1978, 1980) and Chinitz (1994). Insurers that offer BI would then also be allowed to offer a BPI. This solution takes into account that almost all Dutch health insurers currently offer BI and SI as a joint product. The income-solidarity and risk-solidarity for BI can remain unchanged. That is: risk equalization refers only to BI and insurers should maintain a separate financial administration for basic benefits and supplemental benefits; the mandatory deductible only refers to the basic benefits; and the care allowance is based on the premium of BI only.

The current Health Insurance Act (HIA) should be adjusted in four ways:

1. Basic-plus-insurance policy: at this moment, the HIA describes a more or less fixed basic benefit package. It is an economic crime if insurers offer a BI contract that covers more than the legally defined basic benefits. The introduction of the BPI would allow insurers to offer, in addition to BI, a BPI contract covering the benefits of the current mandatory BI plus supplemental benefits.
2. Open enrollment requirement: currently, insurers must accept each applicant for BI without exclusions and waiting periods before coverage of benefits. After the introduction of the BPI, this open enrollment requirement should also hold for any BPI. To prevent adverse selection, waiting periods for supplemental benefits could

be allowed if an applicant had no coverage for these supplemental benefits in the previous contract period.

3. Risk rating: currently, each consumer has to pay a community-rated premium for BI. After the introduction of the BPI, insurers would still be obliged to charge a community-rated premium for the basic benefits. However, to prevent low-risk individuals taking out a separate SI for a low premium (see Section 4.3), risk rating for the supplemental benefits within the BPI should be allowed. Insurers have the freedom to decide which risk factors (e.g. age or health status) they use in their premium setting. However, an insurer must charge individuals with the same risk characteristics the same premium for the same BPI. Currently, due to the GR, insurers may charge their current enrollees a lower premium than new enrollees with the same risk characteristics for the same SI. After the introduction of the BPI, insurers must charge groups of enrollees with equal risk characteristics and the same supplemental benefits, the same premium.
4. Separate basic health insurance: after the introduction of the BPI, an insurer should be obliged to offer at least a separate BI without supplemental benefits. This obligation guarantees that a consumer can still choose a BI without unwanted supplements. Moreover, this obligation guarantees transparency in the market for BI. Consumers can still compare the premiums of various BI products and insurers with each other.

To sum up, the introduction of a BPI differs from the current joint products of BI and SI in several aspects. Firstly, BI and SI are two separate contracts with the insurer, while BPI integrates BI and SI into one contract. Secondly, insurers are allowed to apply selective underwriting for separate SI. However, insurers must accept each applicant for supplemental benefits within BPI and consumers would no longer face the risk that another insurer would reject them for supplemental benefits. Consumers who opt for a BPI would further have no uncertainty about waiting periods if they switch insurer for a similar BPI. Thirdly, a BPI will eliminate GR of current SI by obliging insurers to charge the same premium to all consumers (i.e. both current and new enrollees) with equal risk characteristics and the same BPI. Consequently, consumers who opt for a BPI would no longer face the risk that another insurer imposes less favorable conditions for supplemental benefits in the next contract period than their current insurer does. GR of SI would no longer be a restriction on consumer choice.

Compliance with EU legislation

According to the Dutch government, the current BI – which restricts the insurers in risk rating, selective underwriting and defining their insurance coverage – is in accordance with the EU regulations including the European Non-life Insurance Directive. These

restrictions to protect the general good must be objectively necessary and proportionate to the objective concerned. The latter condition is not fulfilled if there is an alternative that is less restrictive and offers the same protection of the general good. The proposed BPI offers the same protection of the general good, but is less restrictive than the current BI because foreign insurers that are solely interested in the possibility of offering a BPI are at present (under the BI) hindered in entering the Dutch health insurance market, while under BPI this would not be the case. Therefore, the proposed BPI is more proportionate than the current BI, which makes the proposed BPI more in accordance with the EU regulations than the current BI (which, according to the Dutch government, is in accordance with the EU regulations). So, from the perspective of EU regulations, BPI is to be preferred to BI. In addition, the introduction of the BPI is not in conflict with the European Non-life Insurance Directive because insurers are not obliged to offer BPI in addition to BI. Insurers that, for example, do not want to accept all applicants for supplemental benefits, can decide to continue offering separate SI. BPI can be considered as an extra option for insurers that offer BI.[15]

Would insurers opt for the basic-plus-insurance?

Given a voluntary option for insurers to introduce a BPI, the question arises as to why insurers would prefer a BPI to separate SI. We can imagine two reasons why insurers would offer BPI contracts. Firstly, in recent years, insurers voluntarily enforced a joint purchase of BI and SI (Roos and Schut, 2012) by using different instruments (see Section 4.2), because the combination of BI and SI has several advantages for consumers and insurers (e.g. one-stop-shopping, low transaction costs, and a good coordination of basic and supplemental benefits). After the introduction of the BPI, insurers would be legally allowed to sell BI and SI together as one combined BPI and insurers would no longer have to use these instruments. Secondly, insurers apply risk rating for SI to a limited extent. However, the consumer information surplus may result in an adverse selection spiral (Van de Ven and Van Vliet, 1995). Consequently, if insurers prefer not to lose low-risk consumers, the free market principles force them to apply risk rating or selective underwriting.[16] In a BPI, insurers are legally allowed to apply risk rating. We expect that with this explicit legal permission, insurers would not be hindered by a loss of reputation if they prefer to risk rate for the supplemental benefits within the BPI rather than applying selective underwriting for separate SI.

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15 The introduction of a BPI may further encourage competition by eliminating current features of SI that are important restrictions for high-risk consumers to switch insurer.

16 If low-risks no longer take out SI or switch to another SI or a BPI, the risk profile of the old contract will worsen (adverse selection) and insurers will have to charge high-risk consumers a high, actuarially fair premium (Roos and Schut, 2012).

Due to adverse selection, there may be no business case for a separate SI covering only the most comprehensive supplemental benefits. An exception may be the most comprehensive SI products covering high dental expenses, but the joint purchase of BI and that kind of SI do not take place frequently and these SI policies would not lead to a severe restriction on consumer choice for BI.

Potential objections to the introduction of the basic-plus-insurance

Four potential objections to the introduction of BPI can be discerned. A first objection could be that transparency in the health insurance market may decrease, because insurers can offer many different health insurance contracts. In theory, with the current more or less fixed basic benefit package, consumers can focus their attention on differences in price and quality rather than on what is covered and what is not covered (Enthoven, 1994). However, in practice this is not the case because currently insurers offer many different SI products and consumers already consider BI and SI as one product. Therefore, transparency in the health insurance market may not decrease after the introduction of BPI.

A second potential objection could be that insurers may invest in competition on supplemental benefits rather than on basic benefits. Consequently, competition in the market for BI may decline. However, given the joint purchase of BI and SI, insurers could currently also have more incentives to invest in competition on SI rather than in competition on BI.

A third potential objection could be that insurers may use the design of supplemental benefits to attract consumers for whom the risk equalization system for BI provides an overcompensation. At present, the Dutch risk equalization system is not sufficiently refined (Van de Ven et al., 2013). As a consequence, insurers are able to identify groups of consumers for whom the risk equalization system provides over- and undercompensation. However, given the joint purchase of BI and SI, the current SI offers exactly the same instrument for risk selection. Therefore, the introduction of BPI would not provide insurers with new instruments to use supplemental benefits to attract especially those consumers for whom the risk equalization system provides an overcompensation.

A fourth potential objection could be that insurers may charge consumers for whom the risk equalization system provides an undercompensation (e.g. chronically ill individuals), a higher premium for the supplemental benefits covered by BPI than consumers for whom the risk equalization system provides a sufficient compensation. Therefore, high-risks could be charged a much higher premium than low-risks. However, given the joint purchase of BI and SI, the current SI provides insurers with exactly the same instrument for risk rating.

4.5 RELEVANCE FOR OTHER COUNTRIES

In recent decades, elements of regulated competition have also been implemented in the social health insurance systems in Belgium, Germany, Israel, and Switzerland. A mandatory health insurance system, a guaranteed periodic consumer choice among health insurers, and SI are important common elements of these countries' healthcare systems (Van de Ven et al., 2003; Van de Ven et al., 2013). Below we discuss the relevance of our conclusions for these countries.

In Belgium, consumers are legally obliged to take out BI and SI from the same insurer and insurers are not allowed to refuse applicants by age or health status. Choice of insurer for BI is hardly restricted by SI in Belgium (Van de Ven et al., 2013). The BPI differs from SI in Belgium, because Dutch insurers are not obliged to offer SI in combination with BI.[17] In addition, in Belgium, consumers are obliged to take out mandatory SI while taking out SI is voluntary in the Netherlands.

In Germany, two types of SI can be distinguished: mandatory SI and voluntary SI. BI and mandatory SI are legally offered as a joint product. BI providers are allowed to offer extra benefits, e.g. spa treatments and hospice treatment, up to a maximum of 5 percent of BI expenditures, on top of BI. Open enrollment also applies to mandatory SI and insurers must charge a single contribution for BI and mandatory SI. Therefore, choice of insurer for BI is hardly restricted by mandatory SI (Van de Ven et al., 2013). In fact, mandatory SI which is legally offered as a joint product with BI, can be considered as a kind of BPI. However, this kind of SI is mandatory while in the Netherlands consumers could voluntarily opt for a BPI. Moreover, in the Netherlands, insurers should be obliged to offer at least a separate BI without supplemental benefits.

The German market for voluntary SI is unregulated. German insurers that offer BI are not allowed to offer voluntary SI. However, insurers that offer BI cooperate with insurers that offer voluntary SI. Consumers are offered premium discounts for the voluntary SI if they take out voluntary SI from the insurer that is cooperated with. A consumer will lose this premium discount if he or she switches insurer for BI (Van de Ven et al., 2013). As a consequence, the voluntary SI can restrict choice of insurer for BI. The integration of BI with voluntary SI into one BPI may be a solution for Germany as well.

In Israel, BI can be considered as a minimum benefit package and insurers are thus allowed to offer extras in BI (Van de Ven et al., 2013). Insurers are further allowed to offer SI to their own enrollees. Since 1998, the Israeli SI market has been regulated. According to the regulations, insurers are not allowed to apply selective underwriting

17 Because SI is subject to the Third European Non-life Insurance Directive (see Section 4.4.1), the Dutch government is not allowed to legally oblige consumers to take out BI and SI from the same insurer. In Belgium, the regulations concerning SI may be in conflict with the Third European Non-life Insurance Directive (Van de Ven and Van Vliet, 1995).

for SI and they can only charge risk-rated SI-premiums based on age (Gross and Brammli-Greenberg, 2004). In Israel, however, waiting periods imposed by SI restrict consumer choice for BI (Shmueli et al., 2007; Shmueli, 2011; Van de Ven et al., 2013). The introduction of a BPI may solve this problem, because insurers are then obliged to accept each applicant for supplemental benefits without waiting periods before coverage of these benefits.

The Swiss healthcare system has a similar structure to the Dutch healthcare system (Dormont et al., 2009; Roos and Schut, 2012). As in the Netherlands, insurer-established joint purchase of BI and SI can be observed (Dormont et al., 2009). Dormont et al. (2009) found that holding a SI substantially decreases the propensity to switch. The problem in Switzerland, that SI restricts choice of insurer for BI, is comparable to the problem in the Netherlands and therefore the introduction of a BPI may also be a potential solution for Switzerland.

4.6 CONCLUSIONS

The introduction of the Health Insurance Act (HIA) in 2006 was an important step towards regulated competition in the Dutch healthcare system. Choice of insurer is an essential precondition for achieving efficiency in healthcare systems based on regulated competition. In addition to a mandatory basic health insurance (BI), about 90 percent of the Dutch population voluntarily take out supplementary insurance (SI). Insurers can apply risk rating and selective underwriting for SI, but not for BI. Because almost all Dutch insurers offer BI and SI as a joint product, consumer choice of insurer for BI can be restricted by SI, e.g. by the GR in each SI contract.

The findings of our empirical research indicate that more than half of the Dutch consumers with a bad or moderate self-reported health and a third of the elderly (55+) consumers expected in 2011 and 2012 their current insurer to impose more favorable conditions than other insurers do for a similar SI. These consumers expected that another insurer would either reject them or would charge them a higher premium than other consumers with the same SI. Due to the joint purchase of BI and SI, these high-risks would most likely not switch insurer for BI. Because these non-switching consumers make an above-average use of the purchased care by insurers, they have a great interest in the possibility of switching insurer each year. Therefore, if dissatisfied consumers do not switch insurer for BI, the disciplining effect of 'voting with one's feet' is substantially reduced. This is a serious problem that may increase if SI becomes more important.

A negative effect of a restricted choice of insurer for BI for high-risks is that insurers have low incentives to be responsive to high-risks' preferences and to invest in high-quality care for them. As a result, effective competition among insurers may decline.

We discussed several potential solutions to improve consumer choice of insurer for BI. We conclude that the integration of BI and SI into one BPI is an effective solution under current EU legislation. A BPI takes into account that almost all Dutch health insurers currently offer BI and SI as a joint product and that a joint product has several advantages for consumers (e.g. one-stop-shopping, low transaction costs, and a good coordination of basic benefits and supplemental benefits). Our conclusion may also be relevant for other countries.

5

Supplementary insurance as a switching cost for basic health insurance:

theory and practice from the Netherlands

ABSTRACT

Previous studies showed that high-risks perceive supplementary insurance as a switching cost for basic health insurance. Because consumers' current insurer offers a supplementary insurance contract with a guaranteed renewability, changing supplementary insurance involves a switching cost if insurers apply selective underwriting to new enrollees. In the last years, Dutch insurers' incentives to protect themselves against the adverse selection spiral increased. Tools to do so are selective underwriting, risk rating, and product differentiation. These tools have different consequences for supplementary insurance as a switching cost for basic health insurance. We investigated to what extent insurers used these tools between 2006-2009 and 2014-2015. Only some insurers applied selective underwriting: in 2015, 86 percent of insurers used open enrollment for all their supplementary insurance products. As measured by our indicators, the proportion of insurers applying risk rating or product differentiation did not increase. We hypothesize that, due to the fear of reputation loss, insurers used 'less visible strategies' to counteract the adverse selection spiral. These strategies are forms of risk rating and product differentiation and do not result in switching costs. So, although many high-risks perceive supplementary insurance as a switching cost, most insurers apply open enrollment for supplementary insurance. Providing information to high-risks about their switching opportunities could improve consumer choice and thereby insurers' incentives to invest for high-risks in high-quality care in basic health insurance.

5.1 INTRODUCTION

Several countries (e.g. Germany, Switzerland, the Netherlands, and the United States) have introduced a competitive market for basic health insurance (BI) to enhance efficiency, quality, and consumer responsiveness in healthcare. BI is a standardized basic benefit package defined by the government. Health insurers have the major task of purchasing (and/or delivering) care on behalf of their consumers. The possibility of consumers switching to a competitor must continuously stimulate insurers to successfully fulfill this task. The government sets the rules of the game (e.g. an open enrollment period, community-rated premiums, and a risk equalization system) to facilitate consumer choice for BI.

In the Netherlands, insurers offer BI and voluntary supplementary insurance (SI) for benefits not covered by BI as a joint product (Roos and Schut, 2012). Therefore, consumers' decision to switch insurer for BI is also influenced by their expectations regarding SI. Because of EU regulation, the Dutch government is not allowed to regulate the SI market. Thus, insurers are permitted to refuse applicants or to charge risk-rated premiums for SI. Previous studies (Roos and Schut, 2012; Duijmelinck and Van de Ven, 2014; see Chapter 4) showed that many high-risks (i.e. elderly or unhealthy consumers) perceive SI as a switching cost for BI. In 2012, 32 percent of the unhealthy consumers expected another insurer will not accept them for SI (Duijmelinck and Van de Ven, 2014; see Chapter 4). SI as a perceived switching cost by high-risks is a serious problem, because it reduces insurers' incentives to invest in high-quality care for this category of consumers.

Dutch insurers guarantee to renew annual SI contracts of their *current* enrollees. SI is a (perceived) switching cost for BI because high-risks fear that other insurers apply selective underwriting in their acceptance procedures for *new* enrollees. Thus, high-risks fear that another insurer will not accept them for SI, while the renewal of their current SI is guaranteed. Insurers can apply selective underwriting to protect themselves against the adverse selection spiral. Adverse selection can be described as the tendency of high-risks to take out more insurance than low-risks (i.e. young or healthy consumers) because of a consumer information surplus (Cummins et al., 1983; Van de Ven and Van Vliet, 1995). This tendency may seriously threaten the stability of an insurance market (Cutler and Zeckhauser, 2000b). Besides applying selective underwriting, insurers can also apply risk rating or product differentiation to counteract the adverse selection spiral (Schut, 1995; Van de Ven and Van Vliet, 1995; Godfried et al., 2001). SI is hardly a switching cost if insurers use these tools without selective underwriting, because consumers' current insurer and other insurers will then charge them quite similar premiums for comparable SI products.

In the period 2006-2009, about 20 percent of the insurers used health questionnaires in the acceptance procedure for new enrollees for at least one of their SI products (Roos and Schut, 2009; Roos and Schut, 2012). The remaining 80 percent used open enrollment (i.e. they accepted all applicants without the exclusion of pre-existing conditions) for all of their SI products. In the following years, insurers' incentives to protect themselves against adverse selection increased because of the larger potential premium range of SI and the increased financial risk for the medical costs covered by BI. If this would have led to more selective underwriting, consumers' switching costs resulting from SI would have increased. Therefore, we focus on the following important question for policymakers: how did Dutch insurers protect themselves against the adverse selection spiral in recent years, by applying 'selective underwriting' and/or by applying 'risk rating and/or product differentiation'? To answer this question, we will extensively review insurers' practices in the SI market by evaluating the policy conditions of the SI products offered. Our conclusions may help policymakers to design effective solutions to increase high-risk individuals' consumer choice for BI and thereby increase insurers' incentives to invest in high-quality care for them. Other countries that have introduced a competitive BI market and allow a joint purchase of BI and SI (e.g. Switzerland) can learn from the Dutch experiences.

This chapter is organized as follows. Firstly, we describe the background of the problem. Secondly, we describe when SI is a switching cost for BI. Thirdly, we pay attention to the behavior of Dutch insurers in the SI market between 2006-2009 and 2014-2015. Fourthly, we discuss our results and conclude.

5.2 BACKGROUND OF THE PROBLEM

About 85-90 percent of the Dutch population take out SI (Vektis, 2012; Vektis, 2013; Vektis, 2014). More than 99 percent of them take out BI and SI from the same insurer (NZa, 2014a), because 1) one-stop shopping has several advantages (e.g. a good coordination of basic and supplemental benefits) (Kifmann, 2006); 2) almost all insurers make it unattractive or impossible to take out separate SI (Roos and Schut, 2012); and 3) consumers may be unaware that they are allowed to take out BI and SI from different insurers (Dormont et al., 2009).

Insurers are allowed to refuse applicants or to charge risk-rated premiums for SI. In 2006 and 2007, insurers collectively agreed – under societal pressure – to accept all applicants for the majority of their SI products and to charge mostly community-rated premiums for SI (De Bruijn and Schut, 2006; Roos and Schut, 2012). Therefore, consumers had the possibility to take out their preferred SI product with an (almost) community-rated premium. Although after 2007 this collective agreement did no longer exist, insurers had incorporated a guaranteed renewability clause (GR) in each SI con-

tract (Roos and Schut, 2012). This GR consists of a guaranteed renewal of the annual SI contract with an equal adjustment of the premium and the policy conditions for all consumers with that specific SI. Thus, all consumers with the same SI are at renewal of this SI – irrespective of changes in their health status – confronted with the same changes in the premium and policy conditions.

Due to the agreement among insurers and the GR in each SI contract, SI is a perceived switching cost by in particular high-risks. In 2012, 6 percent of the healthy consumers expected another insurer will not accept them for SI, while 32 percent of the unhealthy consumers revealed this expectation (Duijmelinck and Van de Ven, 2014; see Chapter 4). These expectations may be influenced by the close media attention to the examples of high-risks who were refused for SI. Boonen et al. (2015) showed that consumers with SI have a 10.6%-point lower switching propensity than consumers without SI, ceteris paribus. Moreover, they showed that old consumers having SI are less likely to switch insurer than young consumers having SI. SI as a perceived switching cost by high-risks has adverse consequences, because it substantially reduces insurers' incentives to invest in high-quality care for high-risks.

Thus, SI is a perceived switching cost for BI because consumers fear that insurers apply selective underwriting in the acceptance procedures for new enrollees. Insurers can apply selective underwriting to protect themselves against the adverse selection spiral for both SI and BI. This spiral is caused by low-risks leaving the SI product.

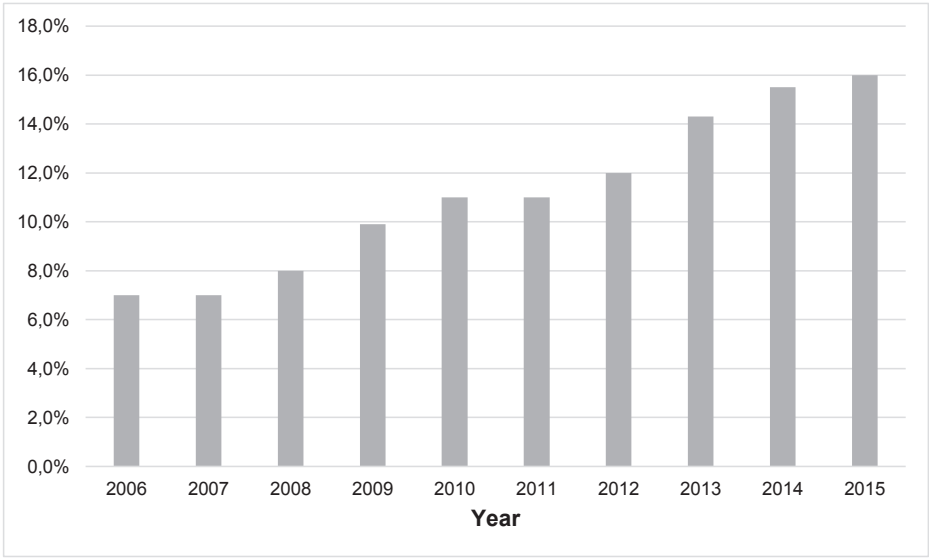

Figure 5.1 Percentage of consumers without a supplementary insurance in the period 2006-2015
Source: Vektis (2015)

Consequently, the premium of the SI product has to go up, which led to the next group of low-risks leaving the SI product. The result is a so-called 'death spiral'.
Different developments in the SI market could indicate (the existence of) adverse selection. Firstly, the percentage of consumers without a SI increased from 7 in 2006 to 16 in 2015 (Figure 5.1) (Vektis, 2015). Reitsma-van Rooijen and De Jong (2014) showed that the majority of the consumers without a SI (i.e. 72 percent in 2014) did not take out SI because they do not need the care covered by SI. Secondly, the consumers with a SI take out products with less comprehensive coverage. For example, the demand for SI products covering physiotherapy decreased from 66 percent in 2011 to 49 percent in 2012 (Gezondheidsnet, 2012). Thirdly, different consumer organizations (e.g. "Consumentenbond'' and www.independer.nl) and current affairs programs (e.g. ''Radar'') have advised low-risks to be critically and to carefully evaluate whether a SI is attractive to them. These tendencies increase insurers' incentives to protect themselves against the adverse selection spiral. Moreover, the larger the potential premium range of SI – i.e. the difference between the maximum and the minimum premium if insurers charge risk-rated premiums (Paolucci et al., 2009) – the more insurers will be inclined to protect themselves against the adverse selection spiral for SI. Paolucci et al. (2009) showed that this range is substantial for benefits like medical devices and pharmaceuticals, while it is limited for benefits like dental and paramedic care. In the last years, the potential premium range of SI increased due to the transfer of different medical devices (e.g. walking frames) and pharmaceuticals (e.g. pharmaceuticals to treat gastric acid) from BI to SI. Consequently, the total expenses for medical devices and drugs as percentage of the total expenses covered by SI increased from 8.4 in 2009 (total SI expenditures: 3.5 billion euros) to 10.5 in 2012 (total SI expenditures: 3.9 billion euros) (Vektis, 2011; Vektis, 2014).

Moreover, insurers' incentives to apply selective underwriting may have increased due to stronger incentives to protect themselves against adverse selection for BI. The BI market is characterized by community-rated premiums and open enrollment. A risk equalization system should eliminate predictable differences in healthcare expenditures among different risk groups of insured. However, risk equalization is still imperfect and insurers are undercompensated for the high-risks and overcompensated for the low-risks (Van Kleef et al., 2013). Insurers' financial risk for the medical costs covered by BI increased from about 50 percent in 2006 to 90 percent in 2012 (Van Kleef, 2012), while the risk equalization model was still imperfect. On balance, the financial incentives for selection were in 2011 a third larger than in 2007 (Van Kleef et al., 2012). Consequently, due to the joint purchase of BI and SI, insurers' incentives to use SI as a selection device for BI may have increased. The idea behind this strategy is that high-risks who are refused for SI will most likely also not take out BI (Paolucci et al., 2007; Roos and Schut, 2012).

To sum up, recent changes in the Dutch health insurance market have increased insurers' incentives to protect themselves against adverse selection spirals for BI and for SI. However, selective underwriting is not the only tool insurers can use to protect themselves against adverse selection.

5.3 INSURERS' TOOLS TO COUNTERACT THE ADVERSE SELECTION SPIRAL

Insurers can apply selective underwriting, risk rating, and product differentiation to protect themselves against the adverse selection spiral. These tools have different consequences for SI as a switching cost for BI.

5.3.1 Protecting against the adverse selection spiral

Insurers applying selective underwriting adjust the accepted risk to the stated premium of a given product (Van de Ven and Schut, 2011) (e.g. by refusing applicants, excluding pre-existing medical conditions from coverage, or requiring premium surcharges based on pre-existing medical conditions (Light, 1992; Schut, 1995; Shmueli, 1998; Van de Ven and Schut, 2011)). Insurers intending to apply selective underwriting will use mostly health questionnaires to obtain information on applicants' health status. Risk rating implies that insurers adjust the premium for each product to the individual's risk (Van de Ven and Schut, 2011). If insurers apply product differentiation, they adjust their SI products to attract different risk groups per product and charge premiums accordingly (Van de Ven and Schut, 2011). For example, they can offer SI products that are targeted at specific groups, such as women and young consumers. Because high-risks will choose SI products with comprehensive coverage (and high premiums) and low-risks will choose SI products with restricted coverage (and low premiums), product differentiation works as a self-selection mechanism that may result in market segmentation. Thus, product differentiation can be considered as (indirect) risk rating *across the market*, while (direct) risk rating results in different premiums *per product*. Due to the joint purchase of BI and SI, insurers may be inclined to use the pricing of their SI products (i.e. risk rating) that may be targeted at specific groups (i.e. product differentiation) to charge 'the consumers for whom they are undercompensated by risk equalization for BI' higher premiums for SI than 'the consumers for whom they are overcompensated by risk equalization for BI' to protect themselves against the adverse selection spiral for BI (Kifmann, 2006).

As soon as one serious competitor starts applying selective underwriting, risk rating, or product differentiation, other insurers will follow, because otherwise their low-risks would switch to this insurer and they would be left with the high-risks only.

5.3.2 Supplementary insurance as a switching cost

Due to the GR in each SI contract, SI is a switching cost for BI if insurers apply selective underwriting in their acceptance procedures for new applicants for SI. High-risks face then the risk that another insurer will not accept them for SI, while their current insurer guarantees to renew their SI.

SI is hardly a switching cost if insurers apply risk rating or product differentiation without selective underwriting. The GR offers no protection against risk rating, because it only prescribes that all current consumers must be confronted with the same changes in the premium and policy conditions (Patel and Pauly, 2002). Thus, insures are allowed to start charging *all* their current enrollees and new enrollees risk-rated premiums. For example, in 2015, one Dutch insurer that previously used community-rated premiums for SI (i.e. 'de Amersfoortse') started applying risk rating for SI for *all* their current enrollees and new enrollees. SI may be a temporary switching cost for the high-risks for whom the current insurer still charges community-rated premiums, while (some) other insurers have started charging risk-rated premiums. However, in the following year(s) (e.g. after 1 or 2 year(s)), their premium will go up. This is either the result because their insurer is forced by the market to differentiate their premium (to prevent that low-risks switch to a risk-rating premium) or because the low-risks switch to the insurers applying risk rating. Consequently, the risk profile of high-risks' current SI product will worsen and their current insurer must also charge them a high, actuarially fair premium. SI is then no longer a switching cost for these high-risks.

If insurers apply product differentiation, other insurers may offer high-risks comparable and same-priced SI products as high-risks' current insurer does. If high-risks' current insurer does not apply product differentiation while other insurers do, SI can even become a switching benefit (i.e. a reason to switch insurer). High-risks could perceive that another insurer offers a SI product that perfectly fits their preferences, while their current insurer does not.

In sum, SI is a switching cost for BI if insurers apply selective underwriting for SI; SI is hardly a switching cost for BI if insurers apply risk rating or product differentiation for SI without selective underwriting. Section 5.2 shows that insurers' incentives to protect themselves against adverse selection increased. The important question is which tools insurers increasingly used to do so: 'selective underwriting' – which results in less open enrollment for SI – and/or 'risk rating and/or product differentiation'. If the results indicate less open enrollment for SI, consumers' switching costs resulting from SI have increased in the last years.

5.4 EMPIRICAL RESULTS FROM THE NETHERLANDS

We extensively reviewed insurers' practices in the Dutch SI market to evaluate to what extent SI was a switching cost for BI between 2006-2009 and 2014-2015.

5.4.1 Data and methods

Table 5.1 presents the indicators used to review insurers' practices in the SI market. These indicators are broadly based on the information provided in previous research reports that investigated Dutch insurers' behavior in the SI market in the period 2006-2009 (De Bruijn and Schut, 2006; De Bruijn and Schut, 2007; Roos and Schut, 2008; Roos and Schut, 2009). Developing indicators based on this information was essential to compare insurers' practices in the period 2006-2009 with their practices in later years. Based on the main indicators, we measured open enrollment, risk rating, and product differentiation in the SI market. The additional indicators provided background information.

Table 5.1 Indicators for measuring open enrollment, risk rating, and product differentiation for SI

	Indicators
Open enrollment[1]	Main indicator * Percentage of insurers without health questionnaires or additional questions for new applicants for *all* of their SI products offered Additional indicator * Percentage of insurers without health questionnaires or additional questions for new applicants for *at least one* of their SI products offered
Risk rating	Main indicator * Percentage of insurers charging different premiums[2] for at least one of their SI products offered Additional indicators *Among all SI products for which insurers applied risk rating:* * Average relative difference between the highest and lowest premium charged for the same SI product (i.e. highest premium / lowest premium). * Average number of risk classes used (e.g. age classes) to determine the premium of the SI product
Product differentiation	Main indicator * Percentage of insurers targeting SI at specific groups Additional indicator * Average number of SI products targeted at specific groups among the insurers that applied product differentiation

[1] In this respect, stringent acceptance policies if a consumer only applied for SI (without BI) and selective underwriting for SI products that are targeted at specific groups are left out of consideration.
[2] Exclusive discounts (e.g. group discounts) or premium surcharges if a consumer only applied for SI.

Information on insurers' selective underwriting practices is lacking. In 2014, for example, most insurers did not know how many applicants they refused for SI (NZa, 2014b). Insurers intending to apply selective underwriting will use health questionnaires to obtain information on the health status of applicants. The use of health questionnaires does not necessarily imply that insurers indeed refuse applicants or exclude pre-existing conditions from coverage. Because we can conclude that insurers without health questionnaires for SI used open enrollment for SI, we focused on the proportion of insurers using open enrollment for SI; i.e. not using health questionnaires.

We used the results of the previous reports to describe insurers' behavior in the SI market in the period 2006-2009. If necessary, we made additional calculations, e.g. based on the provided tables in the appendices of these reports. We used the policy conditions and the provided information on insurers' websites to evaluate whether insurers used open enrollment or applied risk rating or product differentiation in 2014 and 2015. Regarding product differentiation, we focused on the names and descriptions of the SI products. For example, we concluded that the insurer offering a SI product named 'Supplementary insurance student' applied product differentiation. We drew the same conclusion for the insurer promoting one of its SI products as: 'This SI product fits the preferences of young consumers'. The previous reports (De Bruijn and Schut, 2006; De Bruijn and Schut, 2007; Roos and Schut, 2008; Roos and Schut, 2009) excluded the SI products that only provided coverage for dental care. Because our primary aim is to compare our results with the results of these previous reports, we also excluded the SI products from our analyses that only provided coverage for dental care. In total, we reviewed 159 SI products offered in 2014 by 29 different insurers, and 145 SI products offered in 2015 by 28 different insurers.

5.4.2 Results

The percentage of insurers using open enrollment for all of their SI products increased from 77 in 2008 towards 86 in 2015 (Figure 5.2). Insurers using health questionnaires for at least one of their SI products did also offer one or more SI products with open enrollment (Table 5.2). Thus, during the period considered, all insurers used open enrollment for *at least one* of their SI products. Insurers used health questionnaires especially for their most comprehensive SI products. In particular high-risks prefer these products. Therefore, the high-risks who prefer to switch to the BI of an insurer using health questionnaires for its most comprehensive SI products may be confronted with a trade-off between the price and quality of this BI and the comprehensiveness of their SI product.

Figure 5.3 shows an increasing trend towards risk rating in the period 2007-2009. However, this trend did not continue in later years: 45 percent of the insurers applied risk rating for at least one of their SI products in 2009 compared to 32 percent in 2015.

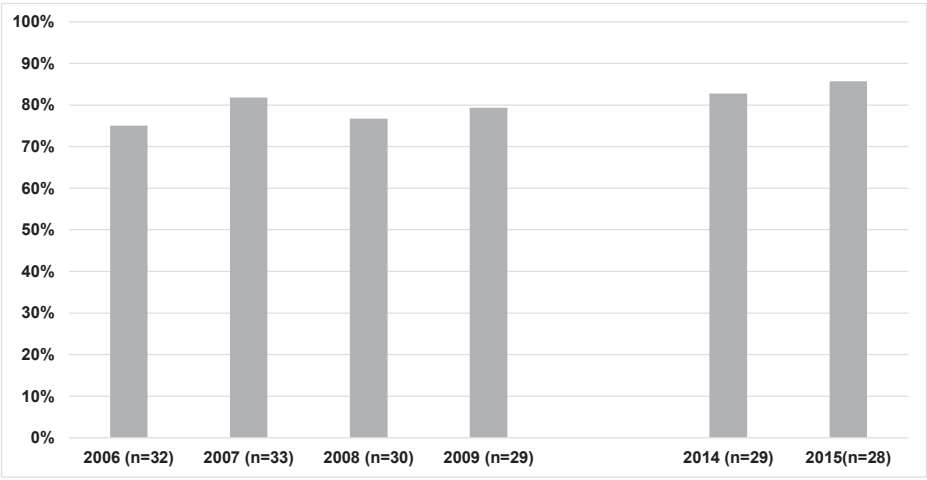

Figure 5.2 Percentage of insurers without health questionnaires or additional questions for new applicants for *all* of their SI products offered in 2006[1], 2007[1], 2008[1], 2009[1], 2014, and 2015
[1] Own estimates based on previous reports (De Bruijn and Schut, 2006; De Bruijn and Schut, 2007; Roos and Schut, 2008; Roos and Schut, 2009).

Table 5.2 Additional information regarding open enrollment, risk rating, and product differentiation for SI

	2006[1]	**2007**[1]	**2008**[1]	**2009**[1]	**2014**	**2015**
Number of insurers	32	33	30	29	29	28
Open enrollment						
Percentage of insurers without health questionnaires or additional questions for new applicants for *at least one* of their SI products offered	*Information not available*	100	100	100	100	100
Risk rating						
Average relative difference between the highest and lowest premium charged for the same SI product	1.71	1.78	1.90[2]	1.84[2]	1.87	1.89
Average number of risk classes used (i.e. age classes) to determine the SI premium	3.40	3.75	3.00	2.62	3.50	3.56
Product differentiation						
Average number of SI products targeted at specific groups among the insurers that applied product differentiation	3.4	2.4	2.7	2.1	2.3	2.2
Percentage of insurers using at least one 'tool to counteract adverse selection' (i.e. no open enrollment, risk rating, product differentiation) for at least one SI product	50.0	51.5	70.0	75.9	62.1	60.7
Percentage of insurers with open enrollment and with no risk rating and product differentiation for all of their SI products	50.0	48.5	30.0	24.1	37.9	39.3

[1] Own estimates based on previous reports (De Bruijn and Schut, 2006; De Bruijn and Schut, 2007; Roos and Schut, 2008; Roos and Schut, 2009).
[2] In 2008 and 2009, respectively, 1 SI product and 4 SI products were offered for free to consumers aged 18-22. In these calculations, these SI products are left out of consideration.

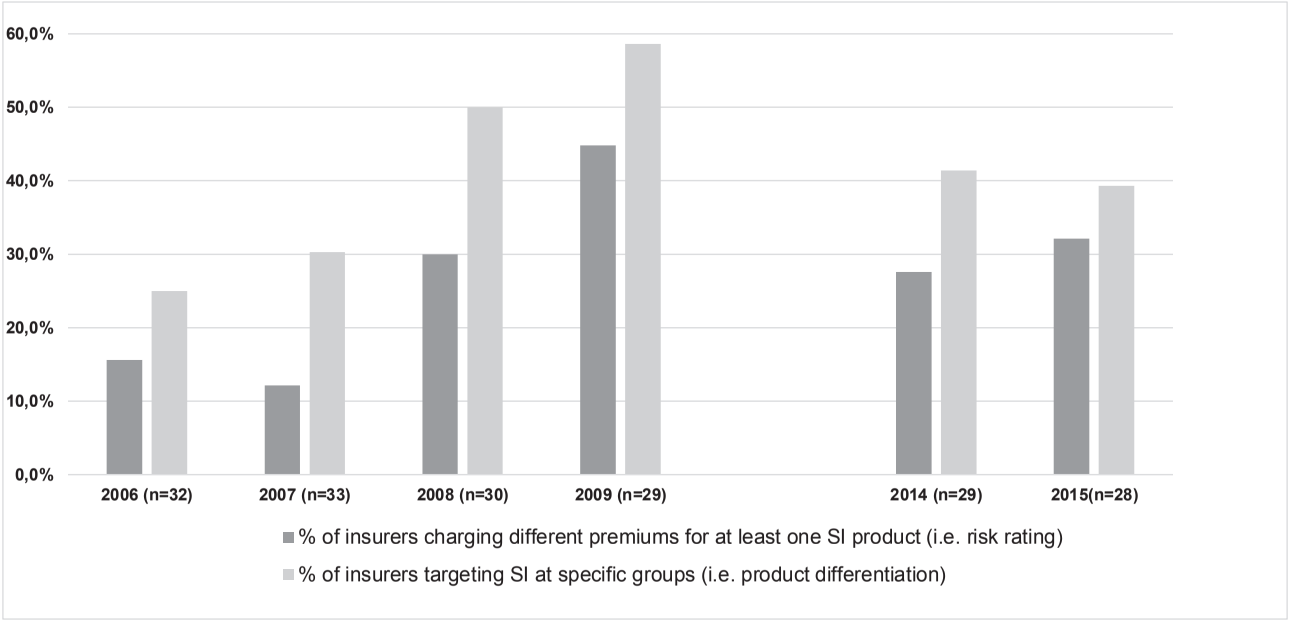

Figure 5.3 Risk rating and product differentiation for SI in 2006[1], 2007[1], 2008[1], 2009[1], 2014, and 2015

[1] Own estimates based on previous reports (De Bruijn and Schut, 2006; De Bruijn and Schut, 2007; Roos and Schut, 2008; Roos and Schut, 2009).

The insurers applying risk rating used age as risk factor. The average number of age classes was highest in 2007 (i.e. 3.75) and lowest in 2009 (i.e. 2.62) (Table 5.2). In the period considered, the relative difference between the highest and lowest premium charged for the same SI product varied between 1.7 and 1.9.

In the period 2006-2009, there was a trend of increasing product differentiation (Figure 5.3). However, this trend did not continue in later years either. In 2015, 39 percent of the insurers offered SI product(s) that were targeted at specific groups (e.g. young and elderly consumers, students, and families) compared to about 59 percent in 2009. The average number of SI products offered by an insurer targeted at specific groups remained stable in the period considered (Table 5.2).

In contrast to our expectations, the percentage of insurers using at least one tool to protect themselves against the adverse selection spiral as measured by our indicators (i.e. no open enrollment, risk rating, or product differentiation) decreased from 76 in 2009 to 61 in 2015 (Table 5.2). This is an unexpected and somehow surprising result that needs further explanation.

5.5 POTENTIAL EXPLANATIONS FOR THE UNEXPECTED FINDINGS

In the SI market, insurers face the trade-off between 1) the need to protect themselves against the adverse selection spiral and 2) the strong societal pressure to offer all consumers an affordable SI. Dutch insurers are strongly confronted with different forms of the latter. Firstly, insurers' selective underwriting practices are closely monitored by consumer organizations and the results are publicly available. Secondly, an independent commission emphasized in its report to the Minister of Health, Welfare and Sport the potential use of SI as a selection device for BI (Commissie Evaluatie Risicovereveningning Zvw, 2012). Thirdly, different groups of politicians are strong proponents of the introduction of a legal periodic open enrollment period and community-rated premiums for SI, which is currently not feasible because of EU regulation (Tweede Kamer 2012; Ministerie van VWS, 2013; Tweede Kamer 2013; Tweede Kamer 2014). Due to the fear of reputation loss, insurers may have used 'less visible strategies' to protect themselves against adverse selection than the strategies measured by our indicators. Below we discuss these 'less visible strategies' and conclude that insurers did indeed use some of these strategies.

Firstly, insurers may promote their insurance product(s) to a targeted consumer group only (i.e. selective marketing). For example, they may advertise their product(s) only on television or radio channels that focus on the target group. This strategy can be considered as a form of product differentiation, unmeasured by our indicators.

Secondly, insurers may increase premiums over time of their most comprehensive SI products intending that low-risks switch to less comprehensive and lower-priced alternatives (Herring and Pauly, 2006). Consequently, the risk profile of the most comprehensive SI products will worsen and eventually high-risks will have to pay an actuarially fair premium. This strategy has the same effect as product differentiation: low-risks take out (low-priced) SI products with restricted coverage, while high-risks prefer SI products with comprehensive coverage that are high-priced.

Thirdly, insurers may stop offering their most comprehensive SI products to new applicants, while they still renew these SI products of their current enrollees. Simultaneously, they could try to drive out low-risk enrollees from these products by, for example, introducing less comprehensive SI products that are lower-priced. If these low-risks switch to other SI products, high-risks' premium will eventually increase to actuarially fair premiums (Hall, 2002; Herring and Pauly, 2006), which has the same effect as product differentiation.

Fourthly, insurers may use group insurance to protect themselves against the adverse selection spiral. Insurers could apply risk rating by providing groups of low-risks (e.g. student organizations and high-educated consumers) with a significant premium discount for a particular SI product (Commissie Evaluatie Risicoverevening Zvw, 2012)). Recently, discounts of 25 percent or more have been observed. Insurers could also offer specific SI products to specific groups only. Because these SI products may not be available or visible for other individuals or groups, this strategy may result in product differentiation. Because information on the premium discounts and SI products offered to groups is not publicly available, these forms of risk rating and product differentiation are not included in the results presented in Figure 5.3.

Fifthly, the Dutch Healthcare Authority (2014b) has concluded that some insurers used their application processes and websites to deter specific consumer groups from taking out BI from them. For example, consumers not belonging to the target group could only take out BI in written form or by phone, while consumers belonging to the target group could easily take out BI via the Internet. Via their websites, some insurers have further steered different consumer groups – after consumers have revealed some personal characteristics such as age – to different BI products, which can be considered as a form of product differentiation for BI. Insurers may have used the same strategies for SI.

Sixthly, insurers may reduce the coverage of the SI products that in particular high-risks take out without reducing prices. There are indications that Dutch insurers used this strategy (NZa, 2014a, Heijne, 2013; Ridderbos, 2013). For example, in 2014 most insurers limited the coverage of physiotherapy in their SI products compared to previous years. Consequently, the number of insurers offering access to unlimited physiotherapy was substantially reduced. This strategy can be considered as a subtle form of selective

underwriting, because most insurers refused to accept any applicant for unlimited access to physiotherapy. Because insurers apply this subtle form of selective underwriting to both their current and new enrollees, it does not influence consumers' switching costs resulting from SI.

To sum up, the 'less visible strategies' that insurers have used to protect themselves against the adverse selection spiral – and which we did not measure by our indicators (as presented in Table 5.1) – are forms of risk rating and product differentiation. These tools to counteract adverse selection do not result in switching costs for BI (see Section 5.3.2).

5.6 CONCLUSIONS AND DISCUSSION

In several countries the possibility of consumers switching to a competitor for BI must continuously stimulate insurers to improve efficiency and quality in healthcare. In the Netherlands, most insurers offer BI and SI as a joint product. Dutch insurers guarantee to renew SI of their *current* enrollees. SI is a switching cost for BI because high-risks fear that other insurers apply selective underwriting in their acceptance procedures for *new* enrollees. SI as a perceived switching cost by high-risks is a serious problem, because it reduces insurers' incentives to act as quality-conscious purchasers of care on behalf of high-risk individuals.

Insurers can apply selective underwriting to counteract the adverse selection spiral. Risk rating and product differentiation are other tools insurers can use to protect themselves against adverse selection. SI is not a switching cost for BI if insurers use these tools for SI without selective underwriting. In the last years, insurers' incentives to protect themselves against adverse selection increased due to several changes in the Dutch health insurance market. If this would have led to more selective underwriting for SI, consumers' switching costs resulting from SI would have increased. Therefore, we focused on which tools insurers increasingly used to counteract the adverse selection spiral: 'selective underwriting' – which results in less open enrollment in the SI market – and/or 'risk rating and/or product differentiation'. An extensive review of insurers' practices in the Dutch health insurance market between 2006-2009 and 2014-2015 shows that most insurers used open enrollment for SI. In 2015, 86 percent of the insurers used open enrollment for all of their SI products and no insurer used health questionnaires in the acceptance procedure for new enrollees for all of their SI products offered. This implies that high-risks had the possibility to take out at least one SI product from another insurer without being confronted with selective underwriting practices. A lot of media attention to the rare examples of high-risks who were refused for SI may explain the high proportion of high-risks perceiving SI as a switching cost for BI.

Despite the increasing insurers' incentives to protect themselves against adverse selection, our results indicate that the proportion of insurers applying risk rating or product differentiation as measured by our indicators (see Table 5.1) did not increase either in the period considered. We therefore hypothesize that insurers have used 'less visible strategies' to protect themselves against adverse selection than the strategies we measured by our indicators. These 'less visible strategies' appeared to be forms of risk rating and product differentiation. These tools to counteract adverse selection did not result in switching costs for BI.

In conclusion, although an increasing number of high-risk consumers perceive SI as a switching cost, in reality most insurers apply open enrollment for all of their SI products. Because high-risks' perceptions regarding SI restrict their choice of insurer for BI, we recommend that the government as regulator of the BI market should disseminate information to high-risk consumers about their switching opportunities (Roos and Schut, 2012). For example, the Dutch government could launch an information campaign during the annual switching period (November to January). This campaign should underline that insurers use largely open enrollment for SI. The government can use different information sources; e.g. they can provide information to consumers on television, in newspapers, on the websites that compare the different insurance products of insurers, and on the websites of patient and consumer organizations. Such an information campaign can increase high-risks' consumer choice for BI and thereby increase insurers' incentives to invest in high-quality care for high-risks. However, our findings are based upon a situation with low switching rates among high-risks. In such a situation, insurers may not have had a strong need to apply selective underwriting (Dormont et al., 2009). So, it is still an open question how insurers will protect themselves against the adverse selection spiral if an increasing number of high-risks switch insurer. Therefore, insurers' behavior should be continuously monitored.[18]

Reflection on our results

We hypothesized that Dutch insurers relied on 'less visible strategies' instead of the straightforward tools (i.e. selective underwriting, risk rating, and product differentiation) to protect themselves against the adverse selection spiral. One example of such a strategy is to stop offering unlimited access to physiotherapy, which now appears to

18 In April 2015, Dutch insurers announced to have the opinion that all consumers should have the possibility to take out similar SI from another insurer without being confronted with selective underwriting practices (Zorgverzekeraars Nederland, 2015). Further research may examine whether this statement is in line with insurers' current behavior.

be an ‘uninsurable risk’ (Berliner, 1982). High-risks but also risk-averse low-risks are therefore no longer able to take out SI with unlimited access to physiotherapy.

An explanation for the fact that insurers do not use the straightforward tools to protect themselves against the adverse selection spiral, is that the Dutch society holds the view that there should be solidarity with respect to SI. However, in the long run, it is an unrealistic expectation that solidarity can coexist with an unregulated competitive market. In the last years, solidarity did already decrease in the SI market, because an increasing proportion of consumers – particularly young and healthy consumers – did no longer take out SI or took out SI with only restricted coverage. Insurers are confronted with the apparent incompatibility between the need to protect themselves against the adverse selection spiral and the societal pressure to maintain solidarity for SI. Due to the fear of reputation loss, insurers relied on the ‘less visible strategies’ to protect themselves against the adverse selection spiral. However, creating solidarity on a competitive SI market is the responsibility of the government and cannot be expected from competing insurers. Because of EU regulation, the Dutch government is not allowed to regulate the SI market in order to maintain solidarity. Therefore, if society desires solidarity for certain benefits that are currently covered by SI, this could be achieved by giving subsidies to the high-risk individuals or by including these benefits in the standard basic benefit package.






6

What can Europe learn from the managed care backlash in the United States?

ABSTRACT

Germany, the Netherlands, and Switzerland have taken steps towards regulated competition in healthcare to enhance efficiency and consumer responsiveness. The rationale of regulated competition is that individual insurers manage the care for their enrollees. The United States were about 20 years ago confronted with a substantial backlash against managed care. We evaluate the causes of this backlash and formulate lessons for European policymakers and insurers. First, the greatest backlash against managed care came from providers. For example, even during the managed care backlash period the proportion of consumers with a managed care insurance product increased. Second, insurers should offer consumers the choice between a standard insurance product with a standard premium and a lower-priced insurance product with a lower reimbursement for out-of-network use than the standard product. Third, American consumers held the opinion that insurers were only interested in cost containment and not in the quality of care. Therefore, insurers should provide information to consumers on the quality of their contracted providers and use input from consumers in their decisions regarding managed care. Three other lessons for Europe are: 1) provide information on the features and effects (in terms of price and quality) of managed care; 2) establish formal grievance mechanisms for consumers to contest denied care; and 3) limit the administrative costs associated with managed care. European countries with a competitive health insurance market should pay attention to these lessons, because regulated competition can only succeed if insurers (are able to) effectively manage the care.

6.1 INTRODUCTION

Several European countries (e.g. Germany, the Netherlands, and Switzerland) have introduced elements of regulated competition in their health insurance market. For many years, these countries attempted to deal with increasing healthcare expenditures by using supply-side regulation. However, because this top-down strategy did not contain sufficient incentives to enhance efficiency, quality, and consumer responsiveness, it has been replaced with regulated competition. In a regulated competition setting, individual risk-bearing insurers have to fulfill the agency function besides their insurance function (Schut and Doorslaer, 1999). This implies that insurers have to act as effective purchasers of care on behalf of their consumers. Thus, insurers are no longer only payers of care, but become also purchasers and managers of care (Van de Ven et al., 1994). The possibility of consumers switching to a competitor – which is facilitated by open enrollment, a risk equalization system, premium rate restrictions, and a standardized basic benefit package – must continuously stimulate insurers to effectively manage the care for their enrollees. Managed care is assumed to enhance efficiency, quality, and consumer responsiveness in healthcare.

Germany, the Netherlands, and Switzerland have – at least to some extent – taken steps towards managed care. While Europe had its first experiences with managed care only in recent years, managed care has a long history in the United States. Despite the great ability of the managed care tools to control the American healthcare expenditures (Harris et al., 2000; Simonet, 2007), the United States were during the late 1990s confronted with a substantial backlash[19] against managed care. Due to this backlash, insurers limited their managed care activities, which resulted in increasing healthcare expenditures (Mays et al., 2004; Lagoe et al., 2005). Against this background the goal of this chapter is to answer the question ‘’What can Europe learn from the managed care backlash in the United States?’’. In doing so, we evaluate the main causes of the managed care backlash in the United States. In this respect, our aim is to gain insight into the reasons of healthcare providers and consumers to dislike managed care. This chapter is relevant for European policymakers, because regulated competition among insurers without managed care will not enhance efficiency in healthcare.

This chapter is organized as follows. Firstly, we pay attention to the tools insurers can use to manage the care for their enrollees. Secondly, we describe which of these tools European insurers (are allowed to) use. Thirdly, we focus on managed care in the United States and present the main causes of the managed care backlash in this country. Based on these causes, we formulate lessons for Europe. Finally, we discuss our results and conclude.

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19 According to the Cambridge dictionary, we have used the following definition of *backlash*: ‘’a strong feeling among a group of people in reaction to a change or recent events in society or politics’’.

6.2 WHAT IS MANAGED CARE?

Baker (2011) defined managed care as follows:

> *''Managed care in the broadest sense, encompasses a range of activities, organization structures, and financial incentives designed to better integrate health insurance and health care delivery in order to more effectively manage the delivery of health care and achieve goals such as lower costs, increased quality, and improved efficiency."*

Three main types of tools that insurers can use to manage the care for their enrollees can be discerned. The first tool – which is considered by most analysts as the most important one (Miller and Luft, 1994; Folland et al., 2010) – encompasses selective contracting with healthcare providers. This tool provides insurers with the possibility to contract (or vertically integrate) with only those providers who deliver efficient and high-quality care. Because the contracted providers are guaranteed a patient flow, insurers are in a good position to negotiate with providers on, for example, prices, quality, and waiting times (Mays et al., 2003; McGuire, 2011). The threat of having no contract with insurers, which may result in less patients, creates competition among healthcare providers. Insurers may use differentiated reimbursement levels for contracted and non-contracted providers to steer consumers to the contracted providers (Glied, 2000).

The second tool is utilization management and includes strategies for insurers to influence healthcare utilization. Prior authorization requirements, gatekeeper arrangements, evidence-based guidelines, disease management programs (DMPs), and integrated care networks are examples of such strategies (Glied, 2000; Baker, 2011). Insurers using prior authorization requirements will only reimburse the costs of a treatment, drug, or hospital stay if they have approved it. If insurers use gatekeeper arrangements, they require consumers to obtain a referral from a gatekeeper – who can be a primary care physician or a general practitioner (GP) – before consulting a specialist (Glied, 2000; Baker, 2011). DMPs aim at improving the integration and coordination of care for patients with specific chronic diseases (Busse, 2004). The use of guidelines, patient education, and quality management systems are features of DMPs (Greβ et al., 2006). While DMPs focus on the coordination of ambulatory care, integrated care networks intend to coordinate cross-sector care (e.g. by coordinating ambulatory and hospital care) (Busse and Blümel, 2014).

The third managed care tool consists of the introduction of financial incentives for providers to improve efficiency. Insurers can, for example, share financial risk with providers by providing them a fixed periodic payment for each patient regardless of the patient's actual healthcare use; i.e. capitation (Glied, 2000; Baker, 2011). Insurers could use bundled payments (i.e. episode-based payments; a prospective fixed payment that

covers the costs of providing some or all services to a patient (Charlesworth et al., 2012)) to stimulate the development of DMPs and integrated care networks.

Potential resistance to managed care

Potential resistance to managed care may come from healthcare providers and consumers. Providers may be hostile towards all three managed care tools. Firstly, they may dislike selective contracting because this may result in price competition (and less patients for some of them), which could reduce their income. Secondly, providers may hold the opinion that insurers' utilization management strategies threaten their professional autonomy, because guidelines and prior authorization requirements influence the treatment providers (have to) provide to patients. Moreover, utilization management by insurers may increase providers' administrative costs. Thirdly, providers may be opponents of capitation, because this payment system makes them financial responsible for the care they provide. This places them in the uncomfortable position in which they should rationing care to safeguard their income. In addition, capitation creates financial uncertainty among providers since part of the risk is transferred from the insurer to the provider. If providers are risk-averse they may oppose capitation also for this reason.

Consumers may dislike selective contracting, utilization management, and capitation because these tools create barriers for them when they need healthcare. Due to selective contracting in healthcare, insurers may not (fully) reimburse the providers with whom consumers have an established relationship. In addition, due to gatekeeper arrangements and prior authorization requirements, consumers cannot directly visit a specialist or receive a treatment. Moreover, capitation may result in underprovision and waiting times. In Section 6.5 we will describe the results of our empirical analyses on the reasons why providers and consumers in the United States disliked managed care.

6.3 MANAGED CARE IN EUROPE

Germany, the Netherlands, and Switzerland have in common that they have taken steps towards a competitive health insurance market. However, the managed care tools insurers (are allowed to) use differ significantly across these countries (Table 6.1). There are indications that insurers in Germany, the Netherlands, and Switzerland are confronted with a backlash against managed care even before they actually manage the care for their enrollees.

Table 6.1 Managed care tools that insurers (are allowed to) use in Germany, the Netherlands, and Switzerland

	Germany	The Netherlands	Switzerland
Selective contracting	- Not allowed for hospital care - Selective contracting allowed for the other types of care, but the provider always has the collective contract as alternative to choose	- Used to a limited extent - Reimbursement level for non-contracted providers is about 75 percent	- Only allowed for managed care insurance products
Utilization management			*In the managed care sector:*
Tools used to a large extent	- Disease management programs - Integrated care networks	- Gatekeeper arrangements - Disease management programs	- Integrated care networks - Gatekeeper arrangements - Guidelines
Tools used to a limited extent	- Gatekeeper arrangements - Prior authorization requirements	- Guidelines - Prior authorization requirements	- Disease management programs - Prior authorization requirements
Financial incentives	- Bundled payments - Capitation	- Capitation - Prospective payments - Bundled payments	- Capitation

Sources: Shmueli et al. (2015) and sources mentioned in text

6.3.1 Insurers' tools to manage the care

Germany

Since 2004, German insurers increasingly used utilization management strategies, such as gatekeeper arrangements, DMPs, and integrated care networks (Lisac et al., 2010). This can be explained by the financial incentives insurers have to establish DMPs and integrated care networks (e.g. insurers receive additional payments from the risk adjustment model for consumers enrolled in a DMP) (Greβ et al., 2006; Busse and Blümel, 2014). In 2012, 10,385 DMPs were certified and the number of participating consumers in a DMP increased from 2.7 million in 2006 to 7.2 million in 2012 (Busse and Blümel, 2014). The programs focused on asthma, breast cancer, chronic heart failure, COPD, coronary heart disease, diabetes type I, and diabetes type II (Stock et al., 2011). Although the *individual* insurer has to sign the DMP contract, insurers negotiate mostly *collectively* with the provider associations on DMPs (Busse, 2004; Greβ et al., 2006). In 2011 and 2012, there were about 6,000 integrated care contracts with 2 million consumers participating. The total healthcare expenses on integrated care networks were 1.5 percent of the total expenses (Amelung et al., 2012; Busse and Blümel, 2014). Financial incentives for providers (e.g. bundled payments (Blümel, 2013)) and for consumers (e.g. a reduction in co-payments (Greβ et al., 2006)) have been introduced to stimulate the development and use of integrated care networks.

Individual insurers are not allowed to selectively contract with hospitals. For hospital care, representatives of insurers collectively negotiate and contract with provider associations. In contrast, insurers are allowed to selectively contract for generic drugs, gatekeeper arrangements, integrated care networks, and outpatient specialist care (Schlette et al., 2009; Van de Ven et al., 2013; Busse and Blümel, 2014; Shmueli et al., 2015). However, providers can choose whether they join contracts with individual insurers or rely on the collective contract for these types of care. Thus, selective contracting with providers is not an effective managed care tool for German insurers. A mix of reimbursement designs exists, e.g. fee-for-service, capitation, and lump sum (Shmueli et al., 2015).

The Netherlands

In the Netherlands, individual insurers are allowed to selectively contract with all types of healthcare providers and to negotiate with them on the content of the contract (Van de Ven et al., 2013). Insurers can use differentiated reimbursement levels for contracted and non-contracted providers to steer consumers to the contracted providers. However, the Health Insurance Act and jurisprudence state that the insurer's reimbursement level for non-contracted providers may not hinder consumers from visiting these providers. This implies that a minimum reimbursement level of about 75 percent is required for all of the insurance products offered by an insurer. This minimum reimbursement level is a restriction on selective contracting (Van Kleef et al., 2014). Currently, insurers are reluctant to selectively contract with healthcare providers; e.g. most insurers contract with nearly all hospitals.

GPs are the gatekeepers for specialist care. These GPs play also a central role in the DMPs. Since 2007, bundled payments promote the establishment of DMPs for patients with diabetes type II, COPD, and those at risk for a cardiovascular disease event (Tsiachritas et al., 2014). Insurers pay a single fee to a group of providers (called ''care-groups'') for the delivery of all primary care needed for the chronically ill (Bakker et al., 2012). In 2010, there were 97 care-groups (De Jong-van Til et al., 2012). Moreover, insurers use different financial incentives, such as capitation and prospective payments (Shmueli et al., 2015).

Switzerland

In Switzerland, two types of managed care insurance products can be distinguished: the family doctor model (i.e. the physician network model) and the Health Maintenance Organization (HMO). Both insurance products are integrated care networks that are characterized by gatekeeper arrangements and guidelines (Peytremann-Bridevaux et al., 2011). Selective contracting is restricted to the managed care insurance products. For the other insurance products, the price negotiations are largely conducted by associations of insurers and providers (Van de Ven et al., 2013). The percentage of

consumers enrolled in a managed care insurance product increased from below 10 until 2004 to about 37 in 2009 (Reich et al., 2012; OECD and WHO, 2011).

DMPs are scarce in Switzerland (Peytremann-Bridevaux and Burnand, 2009; Berchtold and Peytremann-Bridevaux, 2011). For example, Peytremann-Bridevaux and Burnand (2009) identified only seven DMPs for chronic diseases (i.e. diabetes, hypertension, heart failure, obesity, psychosis, and breast cancer), for which the number of participants varied between 65 and 250. In 2010, in 84 percent of the managed care insurance products healthcare providers shared financial responsibility with health insurers (OECD and WHO, 2011). Shmueli et al. (2015) described that provider networks received risk-adjusted capitation payments that should cover all care provided or prescribed.

6.3.2 A managed care backlash before managed care?

In Germany, the Netherlands and Switzerland, healthcare providers and consumers are not familiar with insurers as managers of care. Consequently, policymakers and insurers in these countries are confronted with major objections – in particular of healthcare providers – against managed care. This can be illustrated by different examples. Firstly, in Germany, the national assembly of physician associations initially boycotted the introduction of DMPs, because they feared that DMPs initiated by insurers would harm the quality of care. In addition, they were afraid that the guidelines used in DMPs would reduce their professional autonomy (Busse, 2004; Greβ et al., 2006; OECD and WHO, 2011). Secondly, in 2003, the German government intended to introduce selective contracting for all types of care except GPs. However, these plans were abandoned because of providers' resistance (Busse and Blümel, 2014). Thirdly, in order to remove the restriction on selective contracting in the Netherlands (see Section 6.3.1), the minister of Health, Welfare and Sport proposed an amendment to the Health Insurance Act allowing insurers to provide no reimbursement if a consumer visits a non-contracted provider or hospital. However, together with consumer organizations and patient organizations, healthcare provider organizations signed a manifest against this proposal (VvAA, 2014), because they were hostile towards restrictions on healthcare provider choice. Eventually, the proposal was rejected by the Senate. Fourthly, in 2014, some Dutch GPs rejected to contract with insurers because they did not accept financial incentives imposed by insurers to influence healthcare delivery (Croonen, 2014). Fifthly, in 2012, the Swiss federal government proposed legislation that aimed at expanding managed care. Providers were hostile towards this proposal, because they opposed financial responsibility for healthcare delivery (Rischatsch, 2015). During a referendum, 76 percent of the Swiss voters rejected the proposal, because they disliked restrictions on their provider choice (Amelung, 2013; Zweifel, 2013).

These examples indicate a backlash from providers and consumers against different proposals to increase insurers' managed care tools. Thus, there seems to be a managed care backlash in Germany, the Netherlands, and Switzerland even before there is actually managed care. However, for a successful implementation of regulated competition it is crucial that insurers (are allowed to) effectively manage the care. The United States have been confronted with a managed care backlash about twenty years ago. We will evaluate the causes of this backlash and seek lessons for European countries.

6.4 MANAGED CARE IN THE UNITED STATES

Managed care has a long history in the United States. Because of the managed care backlash in the late 1990s, insurers were confronted with the difficult question of how to deal with the increasing healthcare expenditures.

6.4.1 Features of managed care

Indemnity insurance has many years dominated the American health insurance market. This insurance product is characterized by consumers' free choice of healthcare provider, the absence of insurers' strategies to influence healthcare utilization, and fee-for-service payments (United States General Accounting Office, 1997). The Health Maintenance Organization Act of 1973 strongly promoted the development of managed care insurance products. For example, this act provided start-up funding and required large employers that offered their employees an indemnity insurance product to offer them also a managed care product (Kongstvedt, 2007). In later years, indemnity

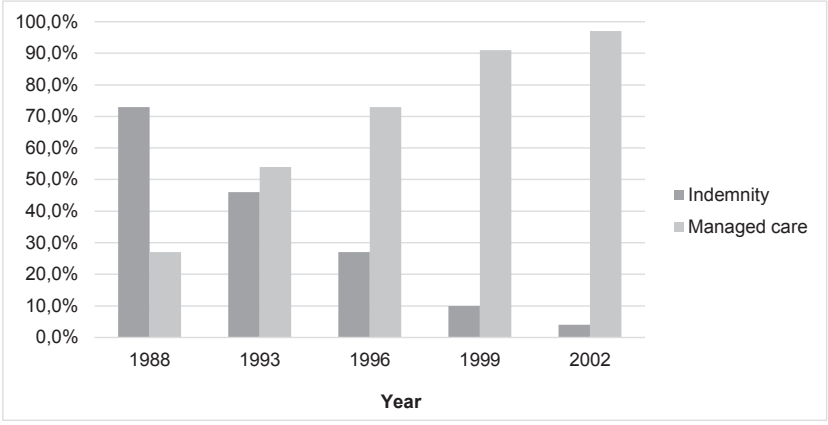

Figure 6.1 Percentage of insured consumers with an indemnity insurance product or a managed care insurance product in the period 1988-2002
Source: The Kaiser Family Foundation and Health Research & Educational Trust (2012)

insurance was largely replaced with managed care. For example, the percentage of consumers with an indemnity insurance product decreased from 73 in 1988 towards 4 in 2002 (Figure 6.1).

Three main types of managed care insurance products can be discerned: an Health Maintenance Organization (HMO), a Preferred Provider Organization (PPO), and a Point of Service Plan (POS) (Figure 6.2). Traditional HMOs do limit consumer choice of healthcare provider severely by providing no reimbursement for out-of-network use, except in the case of emergencies or when the consumer needs care far away from the service area (Kongstvedt, 2007). HMOs are further characterized by guidelines, gatekeeper arrangements, prior authorization requirements, and risk-based provider payments (i.e. capitation and prospective payments) (Bodenheimer, 1996; Glied, 2000; Mays et al., 2003; Kongstvedt, 2007; Baker, 2011). In 1987, for example, 93 percent and 88 percent of the HMOs used, respectively, gatekeeper arrangements and prior authorization requirements (Langwell, 1990).

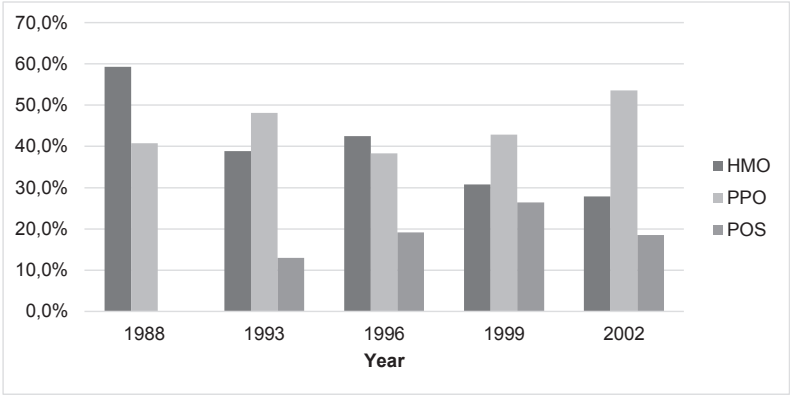

Figure 6.2 Percentage of consumers – among those with a managed care insurance product – enrolled in an HMO, PPO, and POS[1] in the period 1988-2002
[1] Information was not available for POS insurance products in 1988.
Source: The Kaiser Family Foundation and Health Research & Educational Trust (2012)

POSs can be considered as a combination of HMOs and PPOs. The main difference between POSs and PPOs is that PPOs do generally not use gatekeeper arrangements, while POSs do. In contrast to HMOs, PPOs and POSs do not restrict consumer choice of healthcare provider, but use incentives to stimulate consumers to use preferred providers (Glied, 2000). For example, consumers visiting non-contracted providers are confronted with higher out-of-pocket payments than those visiting contracted providers. Table 6.2 shows that the individual out-of-pocket payments for out-of-network use compared to the individual out-of-pocket payments for in-network use are relatively

Table 6.2 Average individual out-of-pocket payments (in dollars) for in-network and out-of-network use for PPOs and POSs and the relative difference in the period 1988-2001

	PPO in-network use	PPO out-of-network use	Relative difference	POS in-network use	POS out-of-network use	Relative difference
1988	106	177	+67%[1]	Information not available	Information not available	N.A.
1993	170	289	+70%	Information not available	Information not available	N.A.
1996	181	313	+73%	71	324	+356%[2]
1999	190	315	+66%	41	359	+775%
2000	187	361	+93%	79	367	365%
2001	201	407	+102%	84	406	+383%

[1] Calculation of relative difference: [(PPO out-of-network use / PPO in-network use) -1] x 100%
[2] Calculation of relative difference: [(POS out-of-network use / POS in-network use) -1] x 100%
Source: Gabel et al. (2001)

higher under POSs than under PPOs. PPOs do usually not use financial incentives for providers (United States General Accounting Office, 1997).

6.4.2 The managed care backlash

A great success of managed care was its ability to control healthcare expenditures (Harris et al., 2000; Jacobson, 2003; Rich and Erb, 2005; Simonet, 2007), while it did not have a negative effect on the quality of care (Miller and Luft, 1997; Miller and Luft, 2002; Dowd, 2005; Rich and Erb, 2005). Despite the positive effects, managed care was confronted with a substantial backlash from healthcare providers and consumers during the late 1990s. As a response to this backlash, most insurers changed their strategies used to manage the care for their enrollees (Draper et al., 2002; Hall, 2005). Firstly, insurers that originally offered only an HMO started offering a PPO as an alternative insurance product to their consumers (Draper et al., 2002). Secondly, insurers did expand the provider networks for their HMO products (Draper et al., 2002). Between 1990 and 2000, the average number of contracted providers in an HMO did nearly quadrupled, while the average number of contracted hospitals more than doubled (Stires, 2002). In addition, during this period, the percentage of HMOs reimbursing out-of-network use (at least to some extent) tripled and was 63 percent in 2000 (Stires, 2002). Thirdly, the percentage of HMOs without a gatekeeper arrangement increased from 13 in 1997 to 21 in 1999 (Martinez, 2001). Fourthly, insurers reduced the number and types of healthcare services that required prior authorization (Draper et al., 2002; Hall, 2005). Felt-Lisk and Mays (2002) focused on the utilization management tools used by 48 insurers and showed that between 1998 and 2000 20 of them eliminated prior authorization requirements. Fifthly, between 1998 and 2001, 38 percent of the insurers reduced the financial incentives used for providers in their HMO products. These insurers reduced,

for example, the scope of services for which they used financial incentives and the number of members covered under these risk contracts (Hurley et al., 2002). Due to these changes, the differences between HMO products and PPO products largely disappeared.

Simultaneously, many states introduced legislation placing restrictions on managed care. Hall (2005) concluded that this legislation was not responsible for the changes in the managed care market as described above. Insurers stated that before the introduction of legislation they did already change the tools used to manage the care for their enrollees.

Due to the powerful lobby of healthcare providers against selective contracting, many states introduced any willing provider (AWP) laws and freedom of healthcare provider choice (FOC) legislation (Marsteller et al., 1997; Ohsfeldt et al., 1998). AWP laws require insurers to contract with all providers who are willing to accept the terms of the contract, while FOC legislation gives patients the freedom to visit any provider (Marsteller et al., 1997). At the end of 1996, 17 of the 28 AWP laws and 25 of the 29 FOC laws focused on pharmacies only, and about 30 percent of these laws applied to all managed care products (i.e. HMOs, PPOs, and POSs) (Marsteller et al., 1997). Three types of FOC laws are possible. Firstly, most states have introduced FOC laws that permit insurers to use differentiated co-payments or deductible levels for contracted and non-contracted providers. For example, Utah has introduced this type of FOC law and allows insurers to steer their consumers to preferred providers, but requires insurers to use at least a reimbursement level of 75 percent for non-contracted providers (Marsteller et al., 1997). Secondly, weak versions of FOC laws provide consumers only a free choice of healthcare provider if a network provider is not reasonably accessible or in the case of an emergency situation. Thirdly, strong versions of FOC laws require insurers to use the same reimbursement levels for in-network and out-of-network use (Marsteller et al., 1997). Marsteller et al. (1997) showed that the strength of selective contracting restrictions in 50 states is as follows: in 10 states none, in 13 states weak, in 13 states weak to medium, in 9 states medium to strong, and in 5 states strong.[20] This implies that the selective contracting restrictions in most states are limited in scope.

Furthermore, until 2003, 41 states have passed legislation permitting consumers to have direct access to specialists without the need to obtain a referral from a gatekeeper, 40 states have enacted legislation requiring insurers to establish an external review process for denials of care, and 30 states have introduced legislation prohibiting insur-

20 Strong versions of selective contracting restrictions protect all providers and regulate all insurance products, while weak versions apply, for example, to pharmacies only (Marsteller et al., 1997).

ers to use financial incentives for healthcare providers (Rich and Erb, 2005; Pinkovskiy, 2014).

6.4.3 How did insurers deal with the increasing healthcare expenditures after the backlash?

The decrease of managed care led to increasing healthcare expenditures and premiums (Harris et al., 2000; Draper et al., 2002; Lagoe et al., 2005). To deal with these increasing expenditures, insurers introduced a wide range of new products; e.g. consumer-driven health insurance products (Mays et al., 2003; Lagoe et al., 2005; Regopoulos et al., 2006). In consumer-driven insurance products, consumers – instead of insurers – are assumed to act as well-informed buyers of care in the healthcare provider market. Consumers are stimulated to act as price-conscious buyers of care by the high deductibles they face (i.e. consumers must pay a high share of their healthcare costs out-of-pocket before the insurer takes over) (Christianson et al., 2008; Dowd, 2005). In addition, many insurers introduced DMPs to reduce the healthcare costs of consumers with chronic diseases, such as diabetes, asthma, hypertension, cardio vascular diseases, hypertension, and high-risk pregnancies (Draper et al., 2004; Mays et al., 2004; Lagoe et al., 2005).

A remarkable tendency after years was the reintroduction of some managed care tools complying with the adopted legislation. For example, Mays et al. (2004) described the re-introduction of prior authorization requirements that were less restrictive than the requirements used before the managed care backlash. These requirements were particularly added to the PPO products because of the increasing popularity and costs of these products (Felt-Lisk and Mays, 2002; see also Figure 6.2). In addition, insurers introduced insurance products that used tiered provider networks. Such products divide providers into tiers based on their costs and quality. Tiered provider networks stimulate consumers to visit the preferred providers by reducing cost-sharing for these providers (Mays et al., 2004). These networks are generally allowed under legislation, because FOC laws mostly permit insurers to use differentiated reimbursement levels for providers (see Section 6.4.2). The rationale of the reintroduction of selective contracting and utilization management was that rising premiums have made consumers willing to accept these cost containment strategies (Mays et al., 2004; Schur et al., 2004). Furthermore, insurers introduced new incentive-based payment systems that aimed at stimulating providers to deliver efficient and high-quality care, such as shared saving programs and pay-for-performance programs (Mays et al., 2003; Mays et al., 2004; Folland et al., 2010).

So, due to the backlash, American insurers limited selective contracting, utilization management, and financial incentives in the late 1990s and the beginning of the 2000s,

which resulted in increasing healthcare expenditures. After years, they fell back on managed care to deal with these increasing expenditures. Europe may learn from the causes of the managed care backlash in the United States.

6.5 LESSONS FOR EUROPE

We discuss causes of the backlash against ''managed care in general'' as well as causes of the backlash against the different managed care tools (i.e. selective contracting, utilization management, and financial incentives). Based on these causes, we formulate lessons for European countries that can contribute to a successful implementation of regulated competition. Table 6.3 summarizes these lessons.

Table 6.3 Overview of the lessons from the American managed care backlash for Europe

Lessons from the managed care backlash in general
Be aware that the greatest backlash against managed care may come from the healthcare providers
Provide information to providers and consumers on the effects of managed care (in terms of efficiency and quality)
Use input from providers and consumers regarding managed care
Lessons from the backlash against selective contracting
Offer consumers the choice between a standard insurance product with a standard premium and a lower-priced product with a lower reimbursement for out-of-network use than the standard product
Provide information to consumers on the (quality of the) contracted providers and the reimbursement levels for non-contracted providers
Lessons from the backlash against utilization management
Respect the professional autonomy of the medical profession: - Use in particular utilization management tools that are controlled by healthcare providers - Involve providers in the development of the utilization management tools
Provide information to consumers on the motives to deny care
Establish formal grievance mechanisms for consumers to contest delayed or denied care
Limit the administrative costs associated with prior authorization requirements and gatekeeper arrangements
Lessons from the backlash against financial incentives
Use a blended payment system for providers instead of a capitation-based payment system

6.5.1 The backlash against managed care in general

In the United States, particularly healthcare providers did make many negative statements about managed care. Simultaneously, the proportion of consumers with a managed care insurance product did continuously increase during the period 1988-2002 (see Figure 6.1). This implies that even during the “managed care backlash period” an increasing proportion of consumers switched from an indemnity insurance product towards a managed care insurance product. Moreover, consumer questionnaires showed that most consumers with a managed care product were quite satisfied with their health

insurer and the care they received (Davis et al., 1995; Enthoven and Singer, 1998; Mechanic, 2004). Therefore, an important lesson for Europe is that they may expect the greatest backlash against managed care to come from healthcare providers. This is in line with the results of Section 6.3.2 that show that it were mainly the providers who strongly resisted proposals to introduce managed care in Europe.

Moreover, because of consumers' great trust in healthcare providers, the considerable opposition of providers against managed care aroused worries amongst consumers about the effects of managed care (Mechanic, 2004). While healthcare providers and the media (see e.g. Brodie et al., 1998) openly expressed their aversion to managed care, American health insurers failed in showing the effects of managed care in terms of efficiency and quality. Therefore, a lesson for Europe is to provide insight into these effects.

In addition, American insurers faced a credible commitment problem and were unable to overcome this problem. Consumers held the opinion that insurers were only interested in cost containment and not in the quality of care (Zelman, 1997; Rich and Erb, 2005; Miller, 2006; Lepolstat et al., 2009). For example, Lepolstat et al. (2009) found that 61 percent of the consumers with a managed care insurance product held the opinion that insurers were more concerned with saving money than with giving patients the best treatment. European insurers could overcome such a credible commitment problem by using input from consumers in their decisions regarding managed care (i.e. the so-called 'voice option' (Hirschman, 1970)) (Raad voor de Volksgezondheid en Zorg, 2014). Insurers can use a wide range of strategies to facilitate this voice option. For example, they can establish consumer councils for (formal) advice about the tools to manage the care for their consumers.

6.5.2 The backlash against selective contracting

The lack of consumer choice of insurance product is a first cause of consumers' dissatisfaction with selective contracting in healthcare. Several studies (Davis et al., 1995; Ullman et al., 1997; Gawande et al., 1998; Enthoven et al., 2001) showed that consumers are more satisfied with their insurer if they have a choice of insurance product. Insurers should therefore offer consumers a choice among different insurance products. Enthoven et al. (2001) demonstrated that consumers who could choose between an HMO product and an indemnity insurance product or a PPO insurance product were two to four times more satisfied with their insurance product than consumers who could only take out an HMO. A lesson for Europe is therefore that insurers should offer consumers the choice between a standard insurance product with a standard premium and a lower-priced product with a lower reimbursement for out-of-network use than the standard

product.[21] A choice of insurance product will also increase consumers' trust in their insurer (Zelman, 1997; Zheng et al., 2002; Dorr Goold et al., 2006), which may therefore also reduce the credible commitment problem of insurers.

Secondly, American consumers held the opinion that their insurer only contracted with the least costly providers instead of with the best healthcare providers (Harris et al., 2000; Miller, 2006; Simonet, 2007). Because of a lack of objective and reliable information regarding the quality of the contracted healthcare providers, insurers were not able to contradict these expectations. Therefore, insurers and policymakers should provide objective, understandable (i.e. without the use of technical language), and reliable information to consumers on the quality of the contracted healthcare providers (Boonen and Schut, 2011; Bes et al., 2013). Because this quality information is lacking in Germany and Switzerland, this is in particular an important lesson for these countries (Shmueli et al., 2015). In the Netherlands, quality information is becoming increasingly publicly available. The next step for this country is to verify whether the information provided on the quality of the contracted providers is accurate and easy accessible for consumers (Schippers, 2015a).

Thirdly, consumers' hostility against selective contracting was intensified by the lack of adequate and clear information on insurers' contracted providers and the reimbursement level for non-contracted providers (Enthoven and Singer, 1998; Kyanko and Busch, 2012). The lesson for insurers is to provide consumers timely with adequate information on the contracted providers and the reimbursement levels for non-contracted providers. This is an important lesson for all European countries considered, because this information is still lacking in these countries (Van de Ven et al., 2013).

6.5.3 The backlash against utilization management

Because prior authorization requirements, guidelines, and gatekeeper arrangements are – at least to some extent – used in the three European countries considered, the lessons from the backlash against utilization management are relevant for all three European countries.

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21 A potential objection against such a choice is that low-income individuals cannot afford the products with free choice of provider and are forced to choose the insurance products with a restricted healthcare provider choice. However, this depends on the system of subsidies. If the subsidies (including the risk equalization) are such that the insurance product with free choice of provider is affordable for everyone, then everyone has a choice between an insurance product with free choice of provider and a lower-priced product with a restricted network of providers. Without the option of selective contracting, consumers would not have this choice. Even more, the lack of selective contracting in healthcare will, ceteris paribus, result in higher premiums for all consumers and particularly low-income individuals will be badly affected by these high premiums (Schut et al., 2015).

Firstly, American providers put forward that insurers' strategies to establish influence on healthcare utilization – such as guidelines and prior authorization requirements – did severely undermine their professional autonomy and authority (Mechanic, 2004). Providers did strongly feel that unqualified persons influenced clinical decision-making (Enthoven and Singer, 1998). An important lesson for European countries is to respect the professional autonomy of the medical profession. They can do this by using particularly utilization management tools that are controlled by the healthcare providers (guidelines and gatekeeper arrangements) instead of tools that are mainly controlled by insurers (e.g. prior authorization requirements) (Enthoven and Singer, 1998; Deom et al., 2010). As long as insurers use prior authorization requirements, they could gain providers' acceptance by involving them in the development of the criteria used in the review processes (Goldberg, 1998). Although guidelines reduce an individual provider's professional autonomy, they do not reduce the professional autonomy of the medical profession as long as the healthcare providers themselves develop these guidelines. Respect for the professional autonomy of the medical profession may increase the acceptance of utilization management among providers.

Secondly, consumers experienced insurers' prior authorization requirements and gatekeeper arrangements mostly in terms of barriers to access to healthcare (Bodenheimer, 1996; Robinson, 2001). Due to the poorly motivated authorization denials (Harris et al., 2000; Draper et al., 2002), consumers had the impression that insurers denied care to save money. A lesson for European insurers is therefore to provide information to consumers on the motives to deny care.

Thirdly, the absence of formal grievance mechanisms is another cause of consumers' hostility against insurers' utilization management strategies. European insurers should give consumers the right to contest delayed or denied care by establishing an independent grievance process (Jacobson, 2003).

Fourthly, providers' and consumers' dissatisfaction with gatekeeper arrangements and prior authorization requirements was intensified by the administrative costs and hassle associated with it (Felt-Lisk and Mays, 2002; Mays et al., 2003). An important lesson for Europe is to limit the administrative costs associated with managed care.

6.5.4 The backlash against financial incentives

American healthcare providers did largely complain about the capitation-based payment system. They emphasized that this payment system placed them in the impossible position of acting in the patient's best interest, while also taking cost considerations into account. Providers put forward that this trade-off created a fundamental ethical dilemma for them (Bodenheimer, 1996; Enthoven and Singer, 1998; Jacobson, 2003; Simonet, 2004). To cease providers' hostility, American insurers and policymakers have successfully introduced blended payment systems that combine elements of

fee-for-service payments with that of capitation-based payments (Robinson, 1999; Zuvekas and Cohen, 2010). These blended payments can be further combined with financial incentives for providers to deliver high-quality care (e.g. pay-for-performance). An important lesson for Europe is to implement blended payment systems instead of capitation-based payment system.

6.6 CONCLUSIONS AND DISCUSSION

Several European countries (e.g. Germany, the Netherlands, and Switzerland) have taken steps towards regulated competition in the health insurance market to enhance efficiency and consumer responsiveness. The rationale of a competitive health insurance market is that individual risk-bearing health insurers manage the care for their enrollees. Three tools to manage the care can be discerned: 1) selective contracting with healthcare providers; 2) utilization management (e.g. prior authorization requirements and gatekeeper arrangements); and 3) financial incentives. While European countries had their first experiences with managed care only in recent years, the history of managed care in the United States goes back more than 30 years ago. Despite the great ability of managed care tools to control healthcare expenditures, the United States were during the late 1990s confronted with a substantial backlash against managed care. We evaluated the causes of this backlash to answer the question: ''What can Europe learn from the managed care backlash in the United States?''

We formulated the following lessons for European insurers and policymakers: 1) be aware that the greatest backlash against managed care may come from the healthcare providers; 2) provide information on the features and effects (in terms of price and quality) of managed care; 3) use input from providers and consumers in the development of managed care tools; 4) establish formal grievance mechanisms for consumers to contest denied care; 5) offer consumers the choice between a standard insurance product with a standard premium and a lower-priced product with a lower reimbursement for out-of-network use than the standard product; 6) provide information to consumers on the (quality of the) contracted providers, the reimbursement level for non-contracted providers, and the motives to deny care; 7) respect the professional autonomy of the medical profession; 8) limit the administrative costs associated with managed care; and 9) use blended-payment systems for providers. European countries should pay careful attention to these lessons, because regulated competition will only succeed if insurers (are able to) effectively manage the care.

Besides the above lessons, we have two additional policy recommendations. Firstly, while the European countries have taken steps towards regulated competition among insurers, policymakers were reluctant to allow insurers to actually manage the care for their enrollees. For example, German and Swiss insurers can only selectively con-

tract with providers to a limited extent, and Dutch insurers are bound to a minimum reimbursement level of about 75 percent for non-contracted providers. The backlash from mainly healthcare providers against proposals to provide insurers with more managed care tools may explain policymakers' behavior. The formulated lessons may help European policymakers to overcome this backlash.

Secondly, in the regulated competition setting, a risk equalization model should eliminate predictable differences in healthcare expenditures among different risk groups of consumers. However, risk equalization is still imperfect in most European countries and insurers are undercompensated for the high-risk consumers and overcompensated for the low-risk consumers (Van de Ven et al., 2013; Van Kleef et al., 2013). Due to imperfect risk equalization, insurers will have incentives to select against high-risk consumers. Because insurers can use the described managed care tools also for risk selection (Van de Ven et al., 2003) – e.g. by not contracting with the best healthcare providers – improving the risk equalization model should be a priority for European policymakers.

7

Conclusions and discussion

7.1 ANSWERS TO THE RESEARCH QUESTIONS

The introduction of the Health Insurance Act (*Zorgverzekeringswet)* in 2006 was an important step towards regulated competition in the Dutch basic health insurance (BI) market. For many years, the government planned the capacity and regulated the tariffs in healthcare. Because this top-down strategy did not contain sufficient incentives to enhance efficiency, quality, and consumer responsiveness in healthcare, it has been replaced with regulated competition. The role of insurers has changed fundamentally: instead of being only the third-party 'payers of care', insurers have become also the third-party 'purchasers of care'. In this new role, insurers have to negotiate with healthcare providers on the price, quality, and quantity of care. As critical purchasers of care on behalf of their enrollees, they are allowed to selectively contract; e.g. with only the best and most efficient healthcare providers. During each switching period, consumers must have the opportunity to choose the insurer and the insurance product that best satisfy their preferences. In this respect, consumers could take out insurance products with (some) restrictions on their choice of healthcare provider or higher-priced insurance products with an unlimited free choice of healthcare provider.

Consumer choice of insurer must continuously stimulate insurers to be responsive to consumer preferences. As regulator of the BI market, the government facilitates this choice by enforcing open enrollment, a standardized benefit package, community-rated premiums, and a risk equalization system. In markets with homogeneous preferences, a critical choice of a minority is mostly sufficient to spur insurers to be responsive to consumer preferences. However, in healthcare, consumer preferences are highly heterogeneous. This implies that if groups of consumers with specific preferences are not free or feel not free to easily switch insurer, insurers have lower incentives to accommodate the specific preferences of these consumers than the preferences of other consumers. This would be particularly problematic if these consumers are those with the most healthcare needs (i.e. elderly or unhealthy consumers), because insurers have then most likely reduced incentives to act as quality-conscious purchasers of care for them. The central question of the first part of this dissertation is: ''Are all consumer groups with specific preferences free and do they feel free to easily switch insurer in the Dutch basic health insurance market? If not, what are potential strategies to improve consumer choice of insurer?''

If consumers feel free to switch insurer, they will be able to choose the insurer and the insurance product that best satisfy their preferences. Most analysts consider selective contracting with healthcare providers as the main tool that insurers have to stimulate efficiency in healthcare. The credible threat for healthcare providers of having no contract with an insurer – which may result in less patients and less income for them – stimulates price- and quality competition in the healthcare provision market. However, if consumers are unwilling to give up (to some extent) their unlimited free

choice of healthcare provider[22] in return for a lower premium, they will not take out the insurance products with a limited healthcare provider choice. Because the threat of selective contracting will then be substantially reduced for healthcare providers, regulated competition will be less able to enhance efficiency in healthcare. The United States were about 20 years ago confronted with a substantial backlash against selective contracting (i.e. the ''managed care backlash''). The central question of the second part of this dissertation is: ''What can the Netherlands learn from the managed care backlash in the United States?''.

7.1.1 Consumer choice of health insurer

In order to answer the first central question, we formulated 5 research questions that were answered by means of quantitative and qualitative research methods.

Switching rates, switching benefits, and switching costs

With the first research question – which has a descriptive character – we aimed at gaining insight into the switching behavior of low-risks (i.e. young or healthy consumers) and high-risks (i.e. elderly or unhealthy consumers):

Q1: To what extent do switching rates differ between low-risks and high-risks?

Chapter 2 gave insight into the switching behavior of low-risks and high-risks in 2009 by analyzing administrative data on nearly the entire Dutch population (n=15.3 million individuals) with objective health status information (i.e. medically diagnosed diseases and pharmaceutical use) and with information on healthcare expenses. Most consumers are unwilling to decide on their health insurance each switching period. Therefore, we also compared low-risks' and high-risks' switching behavior over a three-year period (2010-2012) by using sample data with subjective health status information (i.e. self-reported health and self-reported disease(s)) of 1,152 individuals.

Both the administrative data and the sample data indicated that switching rates strongly decrease with age. In 2009, for example, the annual switching rate was 3.81 percent for consumers aged 25-44 and decreased to 0.37 percent for consumers aged 75 or older. Moreover, the results showed that switching rates substantially decrease as the predicted healthcare expenses increase: about 5 percent of the consumers with very low predicted healthcare expenses switched insurer compared to about 0.5 percent of the consumers with very high predicted healthcare expenses. Another important finding

22 The degree to which consumers are free to choose their healthcare provider depends upon: 1) the size of the contracted provider network and 2) the reimbursement level for non-contracted providers.

was that although healthy consumers switched twice as much as unhealthy consumers, this difference becomes much smaller after adjusting for the age differences between these groups.

Consumers will switch insurer if their perceived switching benefits outweigh their perceived switching costs. During the research period, switching benefits were quite comparable for young and elderly consumers. For example, insurers did mainly compete on price, which is a relevant switching benefit for both young and elderly consumers. In addition, the contracted provider network – which is particularly an important switching benefit for high-risks because of their high healthcare use – was because of the lack of selective contracting an irrelevant switching benefit during the research period. However, consumers' potential switching benefits are influenced by their switching behavior in previous years: the switching benefits for the consumers who did not switch insurer in previous years will be relatively higher than the switching benefits for the consumers who switched insurer. For example, the latter group may have switched to lower-priced insurance products, while the former group may still have to pay a high price. During the period 2006-2008, elderly consumers were – just as in later years – less inclined to switch insurer than young consumers (Vektis, 2006; Vektis, 2007; Vektis, 2008). Consequently, during our research period, elderly consumers faced on average higher potential switching benefits than young consumers. This implies that the substantial lower switching rate of the elderly consumers compared to that of the young consumers cannot be explained by higher switching benefits for the young consumers. The conclusion is that elderly consumers faced higher switching costs than young consumers.

Low switching rates for elderly consumers resulting from high switching costs compared to the switching benefits can have different negative effects. Firstly, high switching costs for elderly consumers reduce insurers' incentives to act as quality-conscious purchasers of care for the elderly consumers. Because young consumers with low switching costs can switch to lower-priced alternatives, a second negative effect is that – in case of an imperfect risk equalization model – cross-subsidies among risk groups may be threatened. Because of these potential negative effects, it is important to have insight into the switching benefits and switching costs that influence the decision of (groups of) consumers to switch insurer. This led to the following research questions:

Q2: What are potential switching benefits and costs in the competitive health insurance market?

Q3: What are the main perceived switching benefits and costs in consumers' decision to (not) switch insurer?

These questions were addressed in chapter 3. We integrated evidence from different disciplines – such as behavioral economics, health economics, and health policy – to develop a conceptual framework with potential switching benefits and costs in the competitive health insurance market. In total, we identified five potential switching benefits and six potential switching costs (see Figure 7.1). We developed a consumer questionnaire to empirically examine the relevance of the different switching benefits and costs in consumers' decision to (not) switch insurer in 2013. In total, 1,091 members of an Internet panel completed the questionnaire. The results indicated that consumers mentioned particularly price (64 percent of the switchers) and the benefits of supplementary insurance (SI) (16 percent of the switchers) as the main reasons for changing insurer. For half of the non-switchers, satisfaction with the current insurer was the main reason for not switching insurer. However, about 50 percent of them reported one of the switching costs as another important reason – but not the main reason – for not changing insurer. About 43 percent of the non-switchers mentioned one of the switching costs as their main reason for not changing insurer.[23]

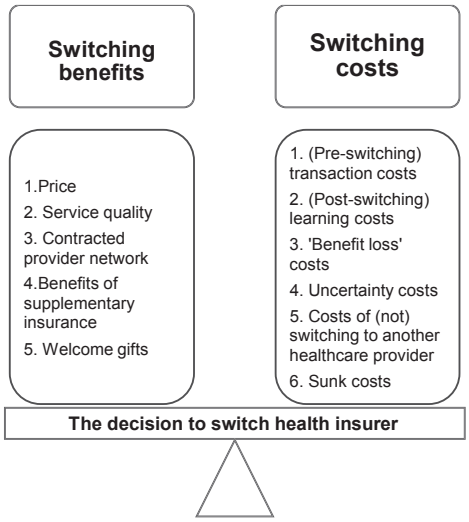

Figure 7.1 Potential switching benefits and switching costs in the competitive health insurance market

Satisfaction with the current insurer was for 55 percent of the non-switching elderly (55+) consumers the main reason for not changing insurer. Due to this satisfaction, most elderly consumers will currently not consider the high switching costs they face

23 The other 7 percent of the non-switchers mentioned another main reason for not changing insurer.

as problematic. However, as soon as insurers do no longer accommodate the specific preferences of elderly consumers, this consumer group will experience that they cannot vote with their feet. The questionnaire indicated that for 55 percent of the non-switching unhealthy consumers – i.e. those with a bad or moderate self-reported health – one of the switching costs was the main reason for not switching insurer. Thus, particularly unhealthy consumers perceived high switching costs compared to their switching benefits. The threat of healthy consumers switching to a competitor is greater for an insurer than the treat of unhealthy consumers switching. This reduces insurers' incentives to be responsive to the preferences of unhealthy consumers.

'Benefit loss' costs are the switching cost that hinder most consumers from switching insurer. In total, 16 percent of the non-switchers mentioned 'benefit loss' costs as their main reason for not switching insurer. The loss of the favorable conditions of SI is one of the 'benefit loss' costs. We aimed at getting detailed insight into this switching cost to help policymakers developing effective strategies to improve high-risks' choice of insurer.

Supplementary insurance as a switching cost for basic health insurance

About 85-90 percent of all consumers voluntarily take out SI for benefits not covered by BI. More than 99 percent of them take out BI and SI from the same insurer, because one-stop shopping has several advantages (e.g. a good coordination of care covered by both BI and SI) and most insurers make it unattractive or impossible for consumers to take out separate SI. Consequently, consumers' decision to switch insurer for BI is influenced by their perceived switching benefits and costs regarding SI.

Because of EU regulation, the government is not allowed to regulate the SI market. This implies that insurers are permitted to refuse applicants or to charge risk-rated premiums for SI. However, the first two years after the introduction of the HIA, insurers collectively agreed to accept all consumers for the majority of their SI products and to charge mostly community-rated premiums for these products. This implies that all consumers had the possibility to take out their preferred SI product with an (almost) community-rated premium. Although since 2008 the collective agreement did no longer exist, all insurers have incorporated a guaranteed renewability (GR) in each SI. This GR consists of a guaranteed renewal of the annual SI contract with an equal adjustment of the premium and the insurance conditions for all current consumers with that specific SI. Thus, GR imposes an acceptance duty and premium-rate restrictions for the insurer with respect to renewing SI of their *current* consumers, but this does not hold for *new* applicants. Because switching to another insurer may result in the loss of the favorable conditions of SI, SI is a potential switching cost for BI. This led to the fourth research question:

Q4: To what extent is supplementary insurance a switching cost for basic health insurance?

Chapter 4 and 5 addressed this question. The first step was to evaluate whether consumers *perceived* SI as a switching cost for BI. In 2006 and 2009, respectively, 4 percent and 6 percent of the non-switching consumers reported that the belief in not being accepted for SI was an important reason for not switching insurer for BI (Roos and Schut, 2012). A consumer questionnaire (n=992 in 2011; n=881 in 2012) indicated that in 2011 and 2012 about 10 percent of the consumers expected that another insurer would not accept them for SI. This clearly indicates that the proportion of consumers expecting that another insurer would not accept them for SI increased. We further found that an additional 20 percent of the consumers expected to be accepted by another insurer, but only for a higher premium than other consumers with the same SI. Particularly high-risks perceive SI as a switching cost for BI: about one third of the elderly (55+) consumers and more than half of the consumers with a bad or moderate self-reported health expected their current insurer to offer them more favorable conditions for SI than other insurers do for similar SI.

The second step was to determine whether SI was indeed a switching cost for BI. Insurers have different tools to counteract adverse selection in the health insurance market: selective underwriting, risk rating, and product differentiation. These tools have different consequences for SI as a switching cost for BI. Because of the GR of each SI, SI is a switching cost if insurers apply selective underwriting to new enrollees. High-risks face then the risk that another insurer will not accept them, while their current insurer guarantees to renew their SI. In contrast, SI is hardly a switching cost if insurers apply risk rating or product differentiation without selective underwriting, because consumers' current insurer and other insurers will then charge them quite similar premiums for comparable SI products. The GR offers no protection against risk rating, because it only prescribes that all current consumers must be confronted with the same premium adjustments. Thus, insurers are allowed to start charging all their current consumers and new enrollees risk-rated premiums.

We conducted six interviews with employees of six different insurance companies and reviewed the policy conditions of the products offered in the SI market to determine which tools insurers used to counteract adverse selection. The interviews showed that insurers were reluctant to apply selective underwriting for SI. In contrast, insurers stated that they did largely apply product differentiation for SI to be responsive to the heterogeneous preferences of consumers. The extensive review of the policy conditions of the SI products also indicated that the proportion of insurers applying selective underwriting for SI was limited. For example, in 2015, 86 percent of the insurers used open enroll-

ment for all of their SI products. The other 14 percent did use health questionnaires for their most comprehensive SI products. In particular high-risks prefer these comprehensive products. Therefore, SI is a switching cost for the high-risks who would like to switch for BI to an insurer that uses health questionnaires for its most comprehensive SI product(s). However, because the majority of insurers applies open enrollment for all their SI products, a discrepancy exists between the actual insurers' practices and consumers' expectations about these practices. This led to the conclusion that although many high-risks perceive SI as a switching cost, most insurers apply open enrollment for SI. A lot of media attention to the rare examples of high-risks who were refused for SI may explain this discrepancy. SI as a perceived switching cost by high-risks is a serious problem, because it reduces insurers' incentives to invest in high-quality care for this category of consumers. This led to the following question:

Q5: What are potential solutions to reduce supplementary insurance as a switching cost for basic health insurance?

Disseminating information to high-risks about their switching opportunities could be a solution to improve high-risks' consumer choice and thereby increase insurers' incentives to be responsive to the preferences of high-risks. The Dutch government could, for example, launch an information campaign during the annual switching period that underlines that insurers use largely open enrollment for their SI products. However, currently, insurers may not have had a strong need to apply selective underwriting for SI because of the low switching rates among high-risks. It is still an open question how insurers will protect themselves against adverse selection if an increasing number of high-risks actually switches insurer. Therefore, it is crucial to continuously monitor insurers' behavior in the SI market and to adjust the information campaign if necessary.

Recently, Dutch insurers announced that they will reduce SI as a switching cost for BI by using open enrollment for SI for the enrollees who took out a comparable SI from their old insurer (Zorgverzekeraars Nederland, 2015). Because consumers will no longer face the risk that another insurer will not accept them for a comparable SI, SI is no longer a switching cost for BI. Another long-term solution is the integration of BI and SI into one contract: the basic-plus-insurance (BPI). After the introduction of the BPI, open enrollment also holds for the supplemental benefits, while insurers are still allowed to apply risk rating for the supplemental benefits within the BPI. The introduction of the BPI will not threaten the affordability of the basic benefits, because insurers are still bound to community-rated premiums for these benefits.

7.1.2 Consumer choice of healthcare provider

Insurers can selectively contract with healthcare providers to effectively manage the care for their enrollees. However, if consumers are unwilling to give up (to some extent) their unlimited free choice of healthcare provider in return for a lower premium, insurers cannot use their most effective instrument to enhance efficiency in healthcare. While the Netherlands – and some other European countries (e.g. Germany and Switzerland) – has its first experiences with selective contracting only in recent years, selective contracting has a long history in the United States. Despite the great ability of selective contracting to deal with the increasing American healthcare expenditures, the United States were about 20 years ago confronted with a substantial backlash against it from healthcare providers and consumers (i.e. ''the managed care backlash''). Insight into the causes of this backlash may provide relevant lessons for the Netherlands. Chapter 6 addressed the question ''What can the Netherlands learn from the managed care backlash in the United States?'' by performing an in-depth analysis of the American managed care backlash. This analysis indicated that even during the ''managed care backlash period'' an increasing proportion of consumers was willing to give up their unlimited free choice of healthcare provider in return for a lower premium. In 2002, almost all American consumers (i.e. 96 percent) had (to some extent) given up their unlimited free choice of healthcare provider. However, the extent to which consumers gave up their choice of healthcare provider – in terms of the number of contracted providers and the reimbursement level for non-contracted providers – decreased. Initially, insurers offered insurance products that did limit consumer choice of healthcare provider severely (the so-called Health Maintenance Organizations (HMOs)). Consumers who did take out an HMO had only access to a limited number of contracted healthcare providers and did not receive any reimbursement if they visited non-contracted providers.[24] During the American managed care backlash period, the demand for HMOs relatively declined, while insurance products with a larger provider network and a higher reimbursement level for non-contracted providers gained in popularity. Thus, the American experience shows that consumers are willing to give up *to some extent* their free choice of healthcare provider in return for a lower premium. Some selective contracting in healthcare may be sufficient to stimulate healthcare providers to deliver efficient care.

The analysis did further show that consumers will be more satisfied with their insurer if they could choose between an insurance product with a limited healthcare provider choice and a higher-priced insurance product with a more extensive choice of healthcare provider. A lesson for the Netherlands is therefore that insurers should

24 Because of insurers' duty of care and because insurers' reimbursement level for non-contracted providers may not hinder consumers from visiting these providers, Dutch insurers will not be allowed to restrict consumer choice of healthcare provider as severely as the HMOs did.

offer consumers the choice between different insurance products. In addition, American consumers held the opinion that insurers were only interested in cost containment and not in the quality of care. Therefore, insurers should provide information to consumers on the quality of their contracted providers. Moreover, insurers could overcome their credible commitment problem by using input from consumers in their decisions regarding selective contracting.[25] Three other important lessons for the Netherlands are: 1) provide information on the features and effects (in terms of price and quality) of selective contracting; 2) establish formal grievance mechanisms for consumers to contest denied care; and 3) limit the administrative costs associated with selective contracting.

7.2 OVERALL CONCLUSION AND REFLECTION

An essential precondition for achieving efficiency and consumer responsiveness in healthcare is that all consumer groups with specific preferences are free and feel free to easily switch insurer. Due to legislation – e.g. the enforcement of open enrollment and community-rated premiums – consumers are free to switch insurer. However, the empirical results from the period 2009-2013 do indicate that Dutch high-risks do not feel free to easily switch insurer. Consequently, insurers have lower incentives to satisfy the specific preferences of this consumer group than to satisfy the preferences of other consumer groups. In the last years, the government, the Dutch Healthcare Authority (NZa), and insurers have acknowledged this problem and have proposed different solutions to reduce high-risks' switching costs.

The loss of the favorable conditions of SI is a major switching cost for high-risks. Dutch insurers announced that they will reduce SI as a switching cost for BI by using open enrollment for SI for the enrollees who took out a comparable SI from their old insurer (Zorgverzekeraars Nederland, 2015). The question arises whether this solution is equally effective as the integration of BI and SI into one basis-plus-insurance. The solution proposed by insurers is a form of self-regulation. The informal agreement among insurers of not refusing new applicants for SI in 2006 and 2007 was also a form of self-regulation. This agreement was no longer continued in later years. So, it is questionable how sustainable solutions based on self-regulation are. As soon as one insurer ignores the rules imposed by self-regulation, the other insurers may have also increased incentives to protect themselves against adverse selection. This increases the possibility that also other insurers ignore the rules imposed by self-regulation and

25 In April 2015, Dutch insurers announced that they will: 1) improve the information provided on their contracted provider network, 2) increase the input from consumers regarding (selective) contracting in healthcare, 3) reduce consumers' switching barriers and 4) improve the risk equalization model (Zorgverzekeraars Nederland, 2015).

start applying selective underwriting. In addition, self-regulation by insurers may be in conflict with the competition rules. Therefore, the introduction of a basic-plus-insurance (BPI) seems to be a more sustainable and appropriate solution to reduce SI as a switching cost for BI. However, the Dutch Health Authority (NZa) considers the purchase of BI and SI as one product as undesirable, for example, because SI can be used as an instrument for risk selection for BI[26] (NZa, 2015a). A BPI will not exacerbate this problem, because the current joint purchase of BI and SI offers insurers with exactly the same instruments to use SI as risk selection tool for BI. Moreover, it is important to realize that a strict legal separation between BI and SI is not a legally feasible solution because both BI and SI are subject to the Third European Non-life Insurance Directive. This implies that the government is not allowed to stop an insurer that offers BI from also offering SI, and vice versa. In addition, a joint purchase of BI and SI has several advantages for consumers, such as low transaction costs and a good coordination of basic and supplemental benefits. This lead to the conclusion that the introduction of a BPI seems to be the most effective long-term solution to reduce SI as a switching cost for BI.

As soon as the loss of the favorable conditions of SI is no longer a switching cost for BI, consumers may increasingly perceive transaction costs, because consumers who (consider to) switch insurer may be confronted with the time and effort it takes to make a switching decision and to actually switch insurer. Insurers and the Dutch government have formulated different strategies to decrease consumers' transaction costs. Insurers have stated, for example, that they will clearly present their BI products on their websites, will provide information to consumers about their contracted providers and the reimbursement levels for non-contracted providers, and will explicitly bring specific policy conditions to consumers' attention (Zorgverzekeraars Nederland, 2015). The Dutch minister of Health, Welfare and Sport aims at reducing the number of BI products offered by insurers to decrease consumers' transaction costs. The Dutch Healthcare Authority (NZa) will investigate whether there could be still effective price- and quality competition in a health insurance market with a limited number of BI products (Schippers, 2015b).

A reduction of high-risks' switching costs may increase their intention to switch insurer. However, in the case of imperfect risk equalization, increasing switching rates of undercompensated high-risks stimulate insurers to select against them by, for example, not contracting with the best healthcare providers. In other words, under imperfect risk equalization, a reduction of high-risks' switching costs may eventually threaten the

26 The Dutch risk equalization model does currently not adequately compensate insurers for the predictable expenses of selected groups of consumers: insurers are undercompensated for the chronically ill and overcompensated for the healthy consumers.

quality of care. Therefore, improving the risk equalization model is a necessary complement of reducing high-risks' switching costs. Recently, the minister of Health, Welfare and Sport announced that she aims at improving the risk equalization model (Schippers, 2015a). An improvement of the risk equalization model may increase high-risks' switching benefits. If high-risks become more preferred clients for insurers, insurers will have more incentives to invest in the switching benefits these consumers attach great importance to.

The improvements in the choice of insurer and the risk equalization model will increase insurers' incentives to satisfy consumer preferences. The American experiences show that consumers are willing to give up to some extent their unlimited free choice of healthcare provider in return for a lower premium. In the Netherlands, consumers did not have had the choice between an insurance product with a limited choice of healthcare provider and a higher-priced insurance product with a free choice of healthcare provider. Because Dutch consumers have to become used to this choice, it may take some time before they are willing to give up (to some extent) their unlimited free choice of healthcare provider. There are indications that they are increasingly willing to do so: the percentage of consumers with an insurance product that did limit their free choice of healthcare provider increased from 0.5 in 2010 to 4.4 in 2014. This percentage did further increase to 7.5 in 2015 (NZa, 2015b).

Besides consumer preferences, the tools insurers have to selectively contract with healthcare providers influence the extent to which selective contracting will enhance efficiency in healthcare. The Health Insurance Act and jurisprudence state that the insurer's reimbursement level for non-contracted providers may not hinder consumers from visiting these providers. However, this is a legal restriction on selective contracting in healthcare. This implies that the efficiency gains from selective contracting may be limited. In addition, it is unclear which reimbursement level for non-contracted providers will hinder consumers from visiting these providers. Therefore, policymakers should be clear about which reimbursement level is (not) allowed for non-contracted providers (Duijmelinck and Van de Ven, 2015). For effective selective contracting it is crucial that this reimbursement level for non-contracted providers discourages consumers sufficiently from visiting the non-contracted providers.

Areas for further research

The introduction of regulated competition can be considered as a gradual process. This dissertation has focused on consumer's choice of insurer, which is one essential precondition for achieving the intended results of regulated competition. However, contestable markets, effective competition regulation, and effective quality supervision are examples of other essential preconditions for achieving efficiency in healthcare.

Therefore, all preconditions for achieving the intended results of regulated competition should have the constant attention of policymakers and researchers.

We recommend seven other areas for further research. Firstly, this dissertation focused solely on switching insurer, while Dutch insurers are allowed to offer more than one BI product. Switching to another BI product offered by the current insurer involves lower switching benefits than switching insurer; e.g. insurers' service quality is then an irrelevant switching benefit. However, it involves also lower switching costs. For example, consumers switching to another BI of their current insurer will not lose their SI. Therefore, the loss of the favorable conditions of SI is an irrelevant switching cost for this type of switching behavior. Further research may evaluate to what extent different consumer groups (feel free to) switch to another BI contract offered by the current insurer.

Secondly, Hirschman (1970) described that – next to the exit option – consumers could express dissatisfaction with their current insurer by using the voice option. Insurers can further use this voice option to overcome their credible commitment problem. The voice option involves, for example, participating in consumer councils and completing consumer satisfaction questionnaires. Dutch insurers have announced that they will intensify 'the voice of consumers' in the coming years (Zorgverzekeraars Nederland, 2015). In addition, the Dutch government intend to introduce legislation that should guarantee consumers' influence on the decisions and behavior of insurers (Schippers, 2015c). Future research may examine: (1) how insurers facilitate the voice option; (2) to what extent consumers use the voice option; and (3) to what extent insurers respond to the 'voice of consumers'.

Thirdly, this dissertation only investigated whether consumers perceived switching costs in the health insurance market. Further research may also pay attention to the actual size – e.g. in terms of time and money – of the different switching costs.

Fourthly, we used an online questionnaire to evaluate the switching costs for different consumer groups. Because consumers could only fill in the questionnaire on the Internet, consumers without Internet access were excluded. However, consumers without Internet access may face higher switching costs than those with Internet access. For example, the absence of the possibility of switching via the Internet may lead to high transaction costs. Because the group of consumers without Internet access may be a specific consumer group with specific preferences, we recommend further research on the switching costs for consumers without Internet access.

Fifthly, the empirical research did take place during a period (2009-2013) in which insurers did (almost) not selectively contract with healthcare providers. Therefore, during the research period, the costs of (not) switching to another healthcare provider were irrelevant switching costs. In later years, Dutch insurers started to selectively contract with healthcare providers more frequently. The costs of (not) switching to an-

other healthcare provider may have become a more important switching cost, while the insurers' contracted provider network may have become a more relevant switching benefit in the health insurance market. For achieving the intended results of regulated competition it is important that the switching costs do not increase more rapidly than the switching benefits. Future research may pay further attention to the switching benefits and switching costs resulting from selective contracting in healthcare.

Sixthly, this research did pay only limited attention to psychological factors that may explain consumers' switching behavior. Therefore, future research may investigate the importance of specific psychological factors – such as cognitive overload, regret avoidance, and loss aversion (Samuelson and Zeckhauser, 1988) – in consumers' decision to switch insurer.

Seventhly, because selective contracting has a long history in the United States, we extensively reviewed the American insurance market to formulate lessons for the Netherlands. However, we did not pay attention to the potential cultural differences between the two countries. Therefore, some lessons based on the American experience with selective contracting may be less relevant for the Netherlands, while the Netherlands may be confronted with other difficulties regarding selective contracting that were – due to cultural reasons – not relevant in the United States. Future research may focus on Dutch consumers' opinion regarding selective contracting. In this respect, it would be interesting to perform a discrete choice experiment that evaluates Dutch consumers' trade-off between price and freedom to choose a healthcare provider.








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Summary

The introduction of the Health Insurance Act (*Zorgverzekeringswet)* in 2006 was an important step towards regulated competition in the Dutch basic health insurance (BI) market. For many years, the government planned the capacity and regulated the tariffs in healthcare. However, because this top-down strategy did not contain sufficient incentives to enhance efficiency, quality, and consumer responsiveness in healthcare, it has been replaced with regulated competition. Since the beginning of this century, risk-bearing health insurers have the important role of third-party purchasers of care. By doing so, they have to negotiate with healthcare providers on the price, quality, and quantity of care. As critical purchasers of care on behalf of their consumers, insurers are allowed to selectively contract; e.g. with only the best and most efficient healthcare providers. In the regulated competition setting, the government sets as regulator of the market the rules of the 'regulated competition game'. During each switching period, consumers must have the opportunity to choose the insurer and the insurance product that best satisfy their preferences. In this respect, consumers could take out insurance products with (some) restrictions on their choice of healthcare provider or higher-priced insurance products with an unlimited free choice of healthcare provider.

The threat of consumers switching to a competitor must continuously stimulate insurers to be responsive to consumer preferences. In healthcare, consumer preferences are highly heterogeneous. Consequently, if groups of consumers with specific preferences are not free or feel not free to easily switch insurer, insurers have lower incentives to accommodate the specific preferences of these consumers than the preferences of the other consumers. An essential precondition for achieving the intended results of regulated competition is therefore that all consumers with specific preferences must be free and must feel free to regularly switch insurer. The government enforces open enrollment, a standardized benefit package, community-rated premiums, and a risk equalization system to facilitate this choice of insurer of all consumer groups. However, it is unclear whether all groups of consumers with specific preferences feel indeed free to easily switch insurer for BI. The first aim of this dissertation is therefore (1) to evaluate whether all consumer groups with specific preferences feel free to easily switch insurer and (2) to formulate strategies to improve consumer choice of insurer. These results are presented in **chapter 2-5**.

If consumers feel free to switch insurer, they will be able to choose the insurer and the insurance product that best satisfy their preferences. Most analysts consider selective contracting with healthcare providers as the main tool that insurers have to stimulate efficiency in healthcare.[27] The credible threat for healthcare providers of having no contract with an insurer – which may result in less patients and less income for

27 We use the same definition of *efficiency* as Van de Ven et al. (2009): ''as low as possible unit costs for a given quality of care''.

them – stimulates price- and quality competition in the healthcare provision market. However, if consumers are unwilling to give up (to some extent) their unlimited free choice of healthcare provider[28] in return for a lower premium, they will not take out the insurance products with a limited healthcare provider choice. Because the threat of selective contracting will then be substantially reduced for healthcare providers, regulated competition will be less able to enhance efficiency in healthcare. While the Netherlands has its first experiences with selective contracting only in recent years, selective contracting has a long history in the United States. The United States were about 20 years ago confronted with a substantial backlash against selective contracting (i.e. the ‘’managed care backlash’’). The second part of this dissertation evaluates the causes of this backlash and seeks lessons for the Netherlands. These results are presented in **chapter 6**.

Young consumers switch ten times more than elderly consumers

Chapter 2 provides insight into the switching behavior of low-risks (i.e. young or healthy consumers) and high-risks (i.e. elderly or unhealthy consumers) in the period 2009-2012. We analyzed: 1) administrative data with objective health status information and information on healthcare expenses of nearly the entire Dutch population (n=15.3 million individuals) and 2) 3-year sample data (n=1,152 individuals). The results indicate that switching rates strongly decrease with age. For example, in 2009, consumers aged 25-44 switched 10 times more than consumers aged 75 or older. Another important finding is that the switching rates substantially decrease as the predicted healthcare expenditures increase: about 5 percent of the consumers with very low predicted healthcare expenses switched insurer compared to about 0.5 percent of the consumers with very high predicted healthcare expenses. Although healthy consumers switch twice as much as unhealthy consumers, this difference largely disappears after adjusting for the age differences between these groups.

High switching costs for high-risk consumers

The question arises why low-risks are more inclined to switch insurer than high-risks. Consumers will switch insurer if their perceived switching benefits outweigh their perceived switching costs. **Chapter 3** shows that (1) price, (2) insurers’ service quality, (3) insurers’ contracted provider network, (4) the benefits of supplementary insurance, and (5) welcome gifts are potential switching benefits, while (1) transaction costs, (2) learning costs, (3) ‘benefit loss’ costs, (4) uncertainty costs, (5) the costs of (not) switching

28 The degree to which consumers are free to choose their healthcare provider depends upon: 1) the size of the contracted provider network and 2) the reimbursement level for non-contracted providers.

provider, and (6) sunk costs are potential switching costs. During the research period, the potential switching benefits for high-risks and low-risks were quite comparable. Therefore, higher switching costs for high-risks than for low-risks can explain the substantial lower switching propensity of high-risks.

A questionnaire among Dutch consumers (1,091 respondents) indicates that about 43 percent of the non-switchers mentioned one of the switching costs – instead of satisfaction – as their main reason for not switching insurer. In particular consumers with a bad or moderate self-reported health (i.e. 55 percent) did mention one of the switching costs as their main reason for not changing insurer.

Supplementary insurance as a switching cost for basic health insurance

The results show that 16 percent of the non-switchers mentioned the 'benefit loss' costs as their main reason for not changing insurer. **Chapter 4** and **chapter 5** focus on one of the 'benefit loss' costs: the loss of the favorable conditions of supplementary insurance (SI). About 85-90 percent of all consumers voluntarily take out SI for benefits not covered by BI and more than 99 percent of them take out BI and SI from the same insurer. Consequently, consumers' decision to switch insurer for BI is influenced by their perceived switching benefits and costs regarding SI. In contrast to BI, insurers are allowed to apply selective underwriting and risk rating for SI. However, they have – without any legal duty to do this – incorporated a guaranteed renewability in each SI, which consists of a guaranteed renewal of the annual SI contract with an equal adjustment of the premium and the insurance conditions for all current consumers with that specific SI.

The first step was to examine by means of a questionnaire (n=992 in 2011 and n=881 in 2012) to what extent consumers perceive SI as a switching cost for BI. The results indicate that in 2011 and 2012 about 10 percent of the consumers expected that another insurer would not accept them for SI. An additional 20 percent expected to be accepted by another insurer, but only for a higher premium than other consumers with the same SI. Particularly high-risks perceive SI as a switching cost: about one third of the elderly (55+) consumers and more than half of the consumers with a bad or moderate self-reported health expected their current insurer to offer them more favorable conditions for SI than other insurers do for similar SI.

The second step was to determine whether SI was indeed a switching cost for BI for high-risks. Insurers can use the following tools to counteract adverse selection in the health insurance market: (1) selective underwriting, (2) risk rating, and (3) product differentiation. These tools have different consequences for SI as a switching cost for BI. Because of the guaranteed renewability of SI, SI is a switching cost for BI if insurers apply selective underwriting to new enrollees. High-risks face then the risk that another insurer will not accept them for SI, while their current insurer guarantees to renew their SI. SI is hardly a switching cost if insurers apply risk rating or product differentiation

without selective underwriting, because consumers' current insurer and other insurers will charge them then quite similar premiums for comparable SI products. To determine which tools insurers used to counteract adverse selection, we conducted six interviews with employees of six different insurance companies. Moreover, we reviewed the policy conditions of the SI products offered (i.e. 159 SI products in 2014 and 145 SI products in 2015). The results indicate that insurers are reluctant to apply selective underwriting. In 2015, for example, 86 percent of the insurers used open enrollment for all their SI products. The other 14 percent used health questionnaires for their most comprehensive SI products. In particular high-risks prefer these products. Therefore, SI is a switching cost for the high-risks who would like to switch for BI to an insurer using health questionnaires for its most comprehensive SI product(s). However, because the majority of insurers applies open enrollment for all their SI products, a discrepancy exists between the actual insurers' practices and consumers' expectations about these practices. SI as a *perceived* switching cost by high-risks is a serious problem, because it reduces insurers' incentives to respond to high-risks' preferences.

The third step was therefore to provide solutions to reduce SI as a switching cost for BI. A first solution is disseminating information to high-risks about their switching opportunities. However, in the last years, insurers may not have had a strong need to apply selective underwriting for SI because of the low switching rates among high-risks. It is unclear how insurers will protect themselves against adverse selection if an increasing number of high-risks actually switches insurer. Therefore, it is crucial to continuously monitor insurers' behavior in the SI market and to adjust the information campaign if necessary.

Recently, Dutch insurers announced that they will reduce SI as a switching cost for BI by using open enrollment for SI for the enrollees who took out a comparable SI from their old insurer. Because consumers will no longer face the risk that another insurer will not accept them for a comparable SI, SI is no longer a switching cost for BI. Another long-term solution is the integration of BI and SI into one contract: the basic-plus-insurance (BPI). After the introduction of the BPI, open enrollment also holds for the supplemental benefits, while insurers are still allowed to apply risk rating for the supplemental benefits within the BPI. The introduction of a BPI will not threaten the affordability of the basic benefits, because insurers are still bound to community-rated premiums for these benefits. Given the assumption that the risk equalization model does sufficiently eliminate predictable differences in healthcare expenditures among risk groups of consumers, insurers' incentives to satisfy consumer preferences will increase if SI is no longer a switching cost for BI.

The backlash against selective contracting

If consumers are unwilling to give up (to some extent) their unlimited free choice of healthcare provider in return for a lower premium, insurers cannot selectively contract with healthcare providers. This implies that insurers cannot use their most effective instrument to enhance efficiency in healthcare. The United States were about 20 years ago confronted with a substantial backlash against the most extreme types of selective contracting (i.e. ''the managed care backlash''). **Chapter 6** gives insight into (the causes of) this backlash and provides relevant lessons for the Netherlands. In the United States, the backlash against managed care came in particular from the healthcare providers and not from the consumers. Even during the ''managed care backlash period'' an increasing proportion of consumers was willing to give up their unlimited free choice of healthcare provider in return for a lower premium. In 2002, almost all American consumers (i.e. 96 percent) had (to some extent) given up their unlimited free choice of healthcare provider. However, the extent to which consumers gave up their choice of healthcare provider – in terms of the number of contracted providers and the reimbursement level for non-contracted providers – decreased. Initially, insurers offered insurance products that did limit consumer choice of healthcare provider severely (the so-called Health Maintenance Organizations (HMOs)). Consumers who did take out an HMO had only access to a limited number of contracted healthcare providers and did not receive any reimbursement if they visited non-contracted providers.[29] During the American managed care backlash period, the demand for HMOs relatively declined, while insurance products with a larger provider network and a higher reimbursement level for non-contracted providers gained in popularity. Thus, the American experience shows that consumers are willing to give up *to some extent* their free choice of healthcare provider in return for a lower premium. Some selective contracting in healthcare may be sufficient to stimulate healthcare providers to deliver efficient care.

The analysis does further indicate that consumers will be more satisfied with their insurer if they could choose between an insurance product with a limited healthcare provider choice and a higher-priced insurance product with a more extensive choice of healthcare provider. A lesson for the Netherlands is therefore that insurers should offer consumers the choice between different insurance products. In addition, American consumers held the opinion that insurers were only interested in cost containment and not in the quality of care. Therefore, insurers should provide information to consumers on the quality of their contracted providers. In addition, insurers could overcome their credible commitment problem by using input from consumers in their decisions regard-

29 Because of insurers' duty of care and because insurers' reimbursement level for non-contracted providers may not hinder consumers from visiting these providers, Dutch insurers will not be allowed to restrict consumer choice of healthcare provider as severely as the HMOs did.

ing selective contracting.[30] Three other important lessons for the Netherlands are: 1) provide information on the features and effects (in terms of price and quality) of selective contracting; 2) establish formal grievance mechanisms for consumers to contest denied care; and 3) limit the administrative costs associated with selective contracting.

Conclusion

The overall conclusion is that one essential precondition for achieving efficiency in healthcare – the disciplining effect of 'voting with one's feet' – is currently not fulfilled for the high-risks. This reduces insurers' incentives to be responsive to the preferences of these consumers. Insurers' initiative to use open enrollment for SI for the enrollees who took out a comparable SI from their old insurer and the integration of BI and SI into one basic-plus-insurance are effective solutions to eliminate SI as a switching cost for BI. Currently, the Dutch risk equalization model undercompensates insurers for the chronically ill and overcompensates insurers for the healthy consumers. An increasing switching intention of the high-risks may increase insurers' incentives to select against them; e.g. by not contracting with the best healthcare providers. This implies that under imperfect risk equalization a reduction of high-risks' switching costs may eventually threaten the quality of care. Therefore, improving the risk equalization model is a necessary complement of reducing high-risks' switching costs.[31]

The improvements in consumer choice of insurer and the risk equalization model will increase insurers' incentives to satisfy consumer preferences. The American experiences show that consumers are willing to give up to some extent their unlimited free choice of healthcare provider in return for a lower premium. In the Netherlands, consumers did not have had the choice between an insurance product with a limited choice of healthcare provider and a higher-priced insurance product with a free choice of healthcare provider. Because Dutch consumers have to become used to this choice, it may take some time before they are willing to give up (to some extent) their unlimited free choice of healthcare provider. As soon as the demand for insurance products with a limited choice of healthcare provider increases, insurers can use their most effective tool to enhance efficiency in healthcare (i.e. selectively contracting with healthcare providers).

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30 In April 2015, Dutch insurers announced that they will: 1) improve the information provided on their contracted provider network, 2) increase the input from consumers regarding contracting in healthcare, 3) reduce consumers' switching barriers, and 4) improve the risk equalization model (Zorgverzekeraars Nederland, 2015).

31 Recently, the Dutch minister of Health, Welfare and Sport announced that she aims at improving the risk equalization model (Schippers, 2015a).








Samenvatting[32]

32 De tekst van dit proefschrift is afgerond op 1 juli 2015.

De introductie van de Zorgverzekeringswet (Zvw) in 2006 was een belangrijke stap in de richting van gereguleerde concurrentie op de Nederlandse zorgverzekeringsmarkt. Jarenlang was het de overheid die de capaciteit en tarieven in de gezondheidszorg vaststelde. Deze top-down benadering bracht echter onvoldoende prikkels tot doelmatigheid, kwaliteit en klantgerichtheid met zich mee. Vanaf begin deze eeuw heeft de Nederlandse overheid zich geleidelijk teruggetrokken wat betreft de planning en tariefstelling in de gezondheidszorg en zijn het de individuele zorgverzekeraars die verantwoordelijk zijn voor de zorginkoop. Zorgverzekeraars dienen met zorgaanbieders te onderhandelen over de prijs, kwaliteit en kwantiteit van de zorg. Om hun rol als kritische zorginkoper waar te kunnen maken, mogen zorgverzekeraars selectief zorg inkopen. De overheid bepaalt de spelregels van gereguleerde concurrentie. Gedurende de jaarlijkse overstapperiode dienen verzekerden de verzekeraar en het verzekeringsproduct te kunnen kiezen die het beste aansluiten op hun preferenties. Verzekerden hebben hierbij de keuze tussen verzekeringsproducten met een beperkte keuzevrijheid van zorgaanbieder en duurdere verzekeringsproducten met een vrije keuze van zorgaanbieder.

De dreiging dat verzekerden overstappen naar een concurrent dient zorgverzekeraars voortdurend te stimuleren om optimaal in te spelen op de preferenties van verzekerden. Doordat in de gezondheidszorg de preferenties van groepen verzekerden uiterst heterogeen zijn, kan een beperkte keuzevrijheid van bepaalde groepen verzekerden nadelige consequenties hebben. Zorgverzekeraars zullen dan minder prikkels hebben om in te spelen op de specifieke preferenties van de groepen verzekerden die zich niet vrij voelen om over te stappen dan op de preferenties van andere groepen verzekerden. De keuzevrijheid van verzekerden is derhalve een cruciale voorwaarde voor het slagen van gereguleerde concurrentie. De acceptatieplicht en het verbod op premiedifferentiatie voor de basisverzekering (BV), het door de overheid vastgestelde basispakket en het risicovereveningssysteem dienen de keuzevrijheid van verzekerden te waarborgen. Het is onduidelijk of alle groepen verzekerden met specifieke preferenties zich ook daadwerkelijk vrij voelen om over te stappen naar een andere zorgverzekeraar. Het eerste doel van dit proefschrift is om dit na te gaan en om strategieën te formuleren die de keuzevrijheid van verzekerden kunnen vergroten. Deze resultaten worden gepresenteerd in **hoofdstuk 2 tot en met hoofdstuk 5**.

Als verzekerden zich vrij voelen om over te stappen, kunnen zij de verzekeraar en het verzekeringsproduct kiezen die het beste aansluiten op hun preferenties. Veel gezondheidseconomen beschouwen selectieve zorginkoop als het meest effectieve instrument dat zorgverzekeraars voorhanden hebben om de doelmatigheid[33] in de

33 In navolging van Van de Ven et al. (2009) is *doelmatigheid* als volgt gedefinieerd: “zo laag mogelijke eenheidskosten bij een gegeven kwaliteit”.

gezondheidszorg te bevorderen. De geloofwaardige dreiging niet gecontracteerd te worden door een zorgverzekeraar – hetgeen kan leiden tot minder patiënten en een lager inkomen – stimuleert de prijs- en kwaliteitsconcurrentie op de zorgverleningsmarkt. Als verzekerden echter niet bereid zijn hun volledige keuzevrijheid van zorgaanbieder[34] (enigszins) op te geven in ruil voor een premievoordeel, zullen zij niet kiezen voor de verzekeringsproducten met een beperkte keuze van zorgaanbieder. In dat geval zal gereguleerde concurrentie minder in staat zijn om de doelmatigheid in de gezondheidszorg te stimuleren. Terwijl Nederland pas recentelijk kennis heeft gemaakt met selectieve zorginkoop, speelt selectieve zorginkoop al jarenlang een belangrijke rol op de Amerikaanse zorgverzekeringsmarkt. Ongeveer 20 jaar geleden hebben de Verenigde Staten te maken gehad met een flinke weerstand tegen de meest extreme vormen van selectieve zorginkoop. Het tweede doel van dit proefschrift is inzicht krijgen in de oorzaken die ten grondslag lagen aan deze weerstand en het formuleren van lessen voor Nederland. Deze resultaten worden besproken in **hoofdstuk 6**.

Jongeren stappen tien keer zo vaak over als ouderen

Hoofdstuk 2 geeft inzicht in het overstapgedrag van laagrisicoverzekerden (i.e. jonge of gezonde verzekerden) en hoogrisicoverzekerden (i.e. oude of ongezonde verzekerden) in de periode 2009-2012. De overstappercentages van beide groepen verzekerden zijn bepaald op basis van: 1) gegevensbestanden met objectieve gezondheidsinformatie en de verwachte zorgkosten van vrijwel de gehele Nederlandse bevolking (n=15,3 miljoen personen) en 2) 3-jarige steekproefgegevens (n=1.152 personen). De resultaten wijzen uit dat het overstappercentage substantieel verschilt tussen leeftijdsgroepen. Zo stapten in 2009 verzekerden in de leeftijd 25-44 jaar 10 keer zo vaak over als verzekerden van 75 jaar of ouder. Naarmate de verwachte zorgkosten toenemen van een paar honderd euro tot 10.000 euro, daalt het overstappercentage van circa 5 procent tot 0,5 procent. Gezonde verzekerden stapten in 2009 twee keer zo vaak over als ongezonde verzekerden, maar dit verschil verdwijnt grotendeels als gecorrigeerd wordt voor de leeftijdsverschillen tussen beide groepen.

Hoge overstapkosten voor hoogrisicoverzekerden

De vraag is waarom laagrisicoverzekerden meer geneigd zijn om over te stappen dan hoogrisicoverzekerden. Verzekerden zullen overstappen indien de verwachte overstapbaten per saldo groter zijn dan de verwachte overstapkosten. **Hoofdstuk 3** beschrijft de volgende potentiële overstapbaten op de zorgverzekeringsmarkt: (1) premie, (2)

34 De mate waarin verzekerden vrij zijn een zorgaanbieder te kiezen wordt bepaald door: 1) het aantal gecontracteerde zorgaanbieders door een zorgverzekeraar en 2) de hoogte van de vergoeding indien een niet-gecontracteerde zorgaanbieder wordt geraadpleegd.

service van een verzekeraar, (3) zorginkoopbeleid van een verzekeraar, (4) dekking van de aanvullende verzekering (AV) en (5) welkomstacties. Mogelijke overstapkosten zijn daarentegen: (1) transactiekosten, (2) leerkosten, (3) het verlies van verworven voordelen, (4) onzekerheidskosten, (5) de kosten van het (niet) overstappen naar een andere zorgaanbieder en (6) verzonken kosten. Gedurende de onderzochte overstapperioden waren de overstapbaten van laagrisico- en hoogrisicoverzekerden min of meer gelijk. Hogere overstapkosten voor hoogrisicoverzekerden dan voor laagrisicoverzekerden vormen een verklaring voor de bevinding dat hoogrisicoverzekerden minder geneigd zijn om over te stappen dan laagrisicoverzekerden. Een vragenlijst onder 1.091 verzekerden wijst uit dat ongeveer 43 procent van de niet-overstappers één van de mogelijke overstapkosten als de belangrijke reden heeft aangedragen om niet over te stappen naar een andere zorgverzekeraar. In totaal benoemde 55 procent van de verzekerden met een slechte of matige gezondheid één van de overstapkosten als de belangrijkste reden om niet van zorgverzekeraar te veranderen.

De aanvullende verzekering als overstapkost

Voor 16 procent van de niet-overstappende verzekerden vormt het mogelijke verlies van de verworven voordelen bij de huidige zorgverzekeraar de belangrijkste reden om niet over te stappen. **Hoofdstuk 4** en **hoofdstuk 5** focussen zich op één van de mogelijke verworven voordelen die een verzekerde kan verliezen, indien hij of zij overstapt naar een andere zorgverzekeraar: het verlies van de verworven voordelen ten aanzien van de aanvullende verzekering (AV). Ongeveer 85 tot 90 procent van alle verzekerden sluit vrijwillig een AV af voor zorgvormen die niet gedekt worden door de basisverzekering (BV) en meer dan 99 procent van hen heeft de BV en AV bij dezelfde zorgverzekeraar afgesloten. De beslissing om al dan niet over te stappen voor de BV wordt daarom mede ingegeven door de verwachte overstapbaten en overstapkosten ten aanzien van de AV. Voor de AV mogen zorgverzekeraars premiedifferentiatie en risicoselectie toepassen. Wel hebben de verzekeraars, zonder dat hiervoor een wettelijke plicht bestaat, in alle aanvullende verzekeringen de clausule van stilzwijgende verlenging van de verzekering tegen de standaardpremie en standaardvoorwaarden opgenomen.

Op basis van een vragenlijst (n=992 in 2011 en n=881 in 2012) is bepaald in hoeverre verzekerden de AV als een overstapkost ervaren voor de BV. Zowel in 2011 als in 2012 verwachtte ongeveer 10 procent van de respondenten door een andere zorgverzekeraar niet geaccepteerd te worden voor de AV. Daarnaast vermoedde 20 procent van de respondenten wel geaccepteerd te worden door een andere zorgverzekeraar, maar uitsluitend tegen een hogere premie dan andere verzekerden met dezelfde AV. Voornamelijk hoogrisicoverzekerden beschouwen de AV als een overstapkost voor de BV: ongeveer een derde van de 55-plussers en meer dan de helft van de verzekerden met een slechte of matige gezondheid uitten de verwachting dat hun huidige zorgver-

zekeraar de AV tegen gunstigere voorwaarden zou afsluiten dan andere verzekeraars zullen doen voor dezelfde AV.

Vervolgens zijn we nagegaan of de AV daadwerkelijk een overstapkost vormt voor de BV. Zorgverzekeraars kunnen drie instrumenten toepassen om zichzelf te beschermen tegen antiselectie op de verzekeringsmarkt: (1) risicoselectie, (2) premiedifferentiatie en (3) productdifferentiatie. Deze instrumenten hebben uiteenlopende gevolgen voor de AV als overstapkost voor de BV. Vanwege de jaarlijkse stilzwijgende verlenging van de AV, vormt de AV een overstapkost voor de BV indien zorgverzekeraars risicoselectie toepassen voor nieuwe verzekerden. Hoogrisicoverzekerden lopen het gevaar door een andere zorgverzekeraar niet geaccepteerd te worden voor de AV, terwijl hun huidige zorgverzekeraar de AV gegarandeerd verlengt. Daarentegen vormt de AV nauwelijks een overstapkost, indien zorgverzekeraars premiedifferentiatie of productdifferentiatie toepassen en risicoselectie afwezig is op de aanvullende verzekeringsmarkt. Andere verzekeraars zullen verzekerden een vergelijkbare premie vragen voor een soortgelijke AV als hun huidige verzekeraar doet. Van zes verschillende zorgverzekeraars is een medewerker geïnterviewd om na te gaan welke instrumenten zorgverzekeraars hebben gebruikt om antiselectie tegen te gaan. Voorts zijn hiertoe de polisvoorwaarden van verschillende aanvullende verzekeringsproducten (i.e. 159 producten in 2014 en 145 producten in 2015) geanalyseerd. Naar voren komt dat verzekeraars terughoudend zijn met het toepassen van risicoselectie voor de AV. In 2015 hanteerde bijvoorbeeld 86 procent van alle zorgverzekeraars een non-selectief acceptatiebeleid voor al hun aanvullende verzekeringen. De overige 14 procent hanteerde alleen gezondheidsvragenlijsten voor hun meest uitgebreide aanvullende pakketten. Dit zijn wel de pakketten waarin voornamelijk hoogrisicoverzekerden geïnteresseerd zijn. De AV vormt daarom een overstapbelemmering voor de hoogrisicoverzekerden die voor de BV over willen stappen naar één van de verzekeraars die een selectief acceptatiebeleid hanteert voor de AV. Aangezien echter het gros van de verzekeraars een non-selectief acceptatiebeleid hanteert voor al hun aanvullende verzekeringen, kan gesteld worden dat een discrepantie bestaat tussen de verwachtingen van verzekerden en de daadwerkelijke werkwijze van de meeste verzekeraars. De AV als *gepercipieerde* overstapkost door hoogrisicoverzekerden is desalniettemin een serieus probleem, omdat verzekeraars verminderde prikkels zullen hebben om in te spelen op de preferenties van deze groep verzekerden.

Ten slotte zijn verschillende oplossingsrichtingen aangedragen om de AV als overstapkost voor de BV te verminderen. Een eerste oplossing is een informatiecampagne die hoogrisicoverzekerden wijst op hun overstapmogelijkheden. Vanwege de lage overstapgeneigdheid van hoogrisicoverzekerden hebben zorgverzekeraars echter de afgelopen jaren wellicht geen risicoselectie toe hoeven te passen voor de AV. Het is de vraag hoe verzekeraars zich zullen wapenen tegen antiselectie als de overstapge-

neigdheid van hoogrisicoverzekerden toeneemt. Het is daarom van cruciaal belang om de werkwijze van verzekeraars in de aanvullende verzekeringsmarkt voortdurend te monitoren.

Zorgverzekeraars Nederland (ZN) heeft recentelijk aangegeven de AV als overstapkost voor de BV te willen verminderen door het uitgangspunt te hanteren dat een aspirant verzekerde zonder acceptatievoorwaarden toegang heeft tot een AV, indien deze verzekerde bij de vorige zorgverzekeraar een vergelijkbare AV had. Verzekerden lopen hierdoor niet langer het risico geweigerd te worden door een andere zorgverzekeraar voor een soortgelijke AV en de AV is dus niet langer een overstapkost voor de BV. De AV vormt verder niet langer een overstapkost voor de BV, indien de BV en AV geïntegreerd worden in een basisplus-polis. Na de introductie van de basisplus-polis zullen verzekeraars namelijk ook iedereen moeten accepteren voor de aanvullende zorgvormen. Voor de basiszorg zal het verbod op premiedifferentiatie blijven bestaan, maar verzekeraars zullen wel premiedifferentiatie toe mogen passen voor de aanvullende zorgvormen. Onder de veronderstelling dat het risicovereveningsmodel voldoende corrigeert voor de verwachte kostenverschillen tussen verzekerden, zullen de prikkels van verzekeraars om in te spelen op de preferenties van hoogrisicoverzekerden toenemen als de AV niet langer een overstapkost vormt voor de BV.

Weerstand tegen selectieve zorginkoop

Als verzekerden niet bereid zijn hun volledig vrije keuze van zorgaanbieder (enigszins) op te geven in ruil voor een premiekorting, zullen verzekeraars het meest effectieve instrument dat zij hebben om de doelmatigheid in de gezondheidszorg te bevorderen – namelijk selectieve zorginkoop – niet kunnen gebruiken. **Hoofdstuk 6** geeft inzicht in de oorzaken die ten grondslag lagen aan de weerstand tegen selectieve zorginkoop in de Verenigde Staten en formuleert lessen voor Nederland. De analyse van de Amerikaanse zorgverzekeringsmarkt wijst uit dat de weerstand tegen de zorgverzekeraar als zorginkoper vooral vanuit de zorgaanbieders kwam en niet zozeer vanuit de verzekerden. Zo nam gedurende de weerstandsperiode het percentage verzekerden dat bereid was zijn volledig vrije keuze van zorgaanbieder op te geven in ruil voor een premiekorting toe. In 2002 had vrijwel iedere Amerikaan – namelijk 96 procent van alle verzekerden – gekozen voor een verzekeringsproduct met een beperkte keuzevrijheid van zorgaanbieder. De mate waarin verzekerden hun keuzevrijheid van zorgaanbieder – in termen van het aantal gecontracteerde zorgaanbieders en de hoogte van de vergoeding voor niet-gecontracteerde zorgaanbieders – opgaven in ruil voor een premiekorting nam wel af. Verzekeraars boden in eerste instantie voornamelijk verzekeringsproducten aan die de vrijheid van verzekerden om een zorgaanbieder te kiezen, vrijwel volledig beperkten (i.e. 'Health Maintenance Organizations' (HMO's)). Verzekerden die voor deze producten kozen, hadden slechts toegang tot een beperkt aantal gecontracteerde zorgaanbieders

en ontvingen geen vergoeding indien zij niet-gecontracteerde zorgaanbieders raadpleegden.[35] Tijdens de weerstandsperiode nam in Amerika de vraag naar HMO's relatief af en nam de populariteit van verzekeringsproducten met een groter gecontracteerd zorgaanbod en een hogere vergoeding voor niet-gecontracteerde zorgaanbieders toe. De Amerikaanse ervaring leert ons dat verzekerden bereid waren hun keuzevrijheid van zorgaanbieder *enigszins* op te geven in ruil voor een premiekorting. Een beperkte mate van selectieve zorginkoop door zorgverzekeraars kan echter al voldoende zijn om zorgaanbieders tot doelmatigheid te stimuleren.

De analyse wijst verder uit dat verzekerden meer tevreden met hun zorgverzekeraar zijn, indien zij de keuze hebben tussen een verzekeringsproduct met een geringe keuze van zorgaanbieder en een duurder verzekeringsproduct met een uitgebreide keuze van zorgaanbieder. Een les voor Nederland is dus dat verzekerden de keuze moeten hebben tussen verschillende verzekeringsproducten. Daarnaast bleken Amerikaanse verzekerden de perceptie te hebben dat verzekeraars bij hun zorginkoop meer geïnteresseerd zijn in de prijs dan in de kwaliteit van zorg. Het is daarom belangrijk dat verzekeraars inzicht verschaffen in de kwaliteit van de door hen gecontracteerde zorgaanbieders. Voorts zal het vertrouwen van verzekerden in hun zorgverzekeraar toenemen, indien verzekeraars bij het vaststellen van hun zorginkoopbeleid input van verzekerden gebruiken.[36] Drie andere lessen die op basis van de Amerikaanse ervaringen getrokken kunnen worden zijn: 1) informeer verzekerden over de kenmerken en de effecten van selectieve zorginkoop; 2) zorg voor effectieve klachtenprocedures voor verzekerden; en 3) beperk de administratieve lasten.

Conclusie

De conclusie is dat een essentiële voorwaarde voor het slagen van gereguleerde concurrentie – de keuzevrijheid van zorgverzekeraar – nog niet vervuld is voor hoogrisicoverzekerden. Zorgverzekeraars hebben hierdoor verminderde prikkels om in te spelen op de specifieke preferenties van hoogrisicoverzekerden. Een effectieve oplossingsrichting om de AV als overstapkost te verminderen voor de BV is het initiatief van verzekeraars om een aspirant verzekerde zonder acceptatievoorwaarden te accepteren voor de AV, indien deze verzekerde bij de vorige verzekeraar een vergelijkbare AV had. Daarnaast

35 Vanwege de zorgplicht en het hinderpaalcriterium (i.e. de vergoeding voor niet-gecontracteerde zorgaanbieders mag geen hinderpaal voor verzekerden vormen om deze zorgaanbieders te raadplegen) zullen Nederlandse verzekeraars de keuzevrijheid van zorgaanbieder momenteel niet volledig mogen beperken zoals de HMO's deden.

36 In april 2015 heeft Zorgverzekeraars Nederland (ZN) kenbaar gemaakt dat zorgverzekeraars de transparantie omtrent hun zorginkoop en de invloed van verzekerden op hun beleid willen vergroten. Daarnaast beogen zorgverzekeraars de overstapbelemmeringen voor verzekerden weg te nemen en het risicovereveningsmodel te verbeteren.

vormt de integratie van de BV en AV in een basisplus-polis een effectieve oplossingsrichting. Het huidige risicovereveningsmodel is imperfect: de financiële compensaties voor diverse groepen van hoogrisicoverzekerden schieten substantieel tekort, terwijl zorgverzekeraars overgecompenseerd worden voor diverse groepen van laagrisicoverzekerden. Een hogere overstapgeneigdheid van hoogrisicoverzekerden kan de prikkels van zorgverzekeraars om risicoselectie toe te passen voor de BV vergroten. Het niet contracteren van de beste zorgaanbieders voor hoogrisicoverzekerden is een vorm van risicoselectie die verzekeraars kunnen toepassen. De vermindering van de overstapkosten van hoogrisicoverzekerden vormt onder imperfecte risicoverevening een serieuze bedreiging voor de kwaliteit van zorg. Een verlaging van de overstapkosten van hoogrisicoverzekerden dient daarom hand in hand te gaan met een verbetering van het risicovereveningsmodel.[37]

De toename van de keuzevrijheid van verzekerden op de zorgverzekeringsmarkt en de verbetering van het risicovereveningsmodel zullen de prikkels van zorgverzekeraars om in te spelen op de preferenties van verzekerden vergroten. De ervaring in de Verenigde Staten met selectieve zorginkoop laat zien dat verzekerden bereid zijn hun keuzevrijheid van zorgaanbieder enigszins op te geven in ruil voor een premiekorting. Nederlandse verzekerden hebben echter nooit de keuze gehad tussen een verzekeringsproduct met een beperkte keuzevrijheid van zorgaanbieder en een duurder verzekeringsproduct met een volledig vrije keuze van zorgaanbieder. Aangezien verzekerden zullen moeten wennen aan deze verandering, zal het even duren voordat zij bereid zullen zijn hun volledig vrije keuze van zorgaanbieder op te geven. Zodra de vraag naar verzekeringsproducten met een beperkte keuzevrijheid van zorgaanbieder toeneemt, zullen zorgverzekeraars het meest krachtige instrument dat zij voorhanden hebben – namelijk selectieve zorginkoop – kunnen toepassen om de doelmatigheid in de gezondheidszorg te bevorderen.

37 Minister Schippers heeft onlangs kenbaar gemaakt in te zetten op een verbetering van het risicovereveningsmodel (Schippers, 2015a).








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PhD Portfolio

Name Daniëlle M.I.D. Duijmelinck
Department Institute of Health Policy and Management (iBMG)
PhD period 2011 - 2015
Promotor Prof.dr. W.P.M.M. van de Ven
Copromotor dr. I. Mosca

PhD training	Year
A successful doctoral track	2011
Academic writing in English	2011
Training in Problem-based Learning (Dutch PGO)	2012
Speaking skills for academic EUR staff exit level C1	2012
Studievaardigheden	2012
Coachings- en gesprekstechnieken	2012
Quantitative methods for applied economics	2012
Toetsing I, beoordeling en feedback	2012
Geven van onderwijs I, kleine groepen	2012
Begeleiden van schrijfopdrachten	2013
Mediatraining (Eva Kuit)	2013
Geven van onderwijs II, plenaire bijeenkomsten	2014
Scriptiebegeleiding	2014
Prince2 Foundation	2015

Seminars and conferences	Year
Policy workshop 'Quality of healthcare and the design of the basic benefit package', Den Haag (Ministry of Health, Welfare and Sport)	2012
LOLA Health Economics Study Group, Almen	2012
9th European Conference on Health Economics, Zürich	2012
Symposium 'Aanvullende verzekering', Den Haag (Ministry of Finance)	2013
LOLA Health Economics Study Group, Nunspeet	2013
10th European Conference on Health Economics, Dublin	2014

Presentations	Year
iBMG, Rotterdam	2012
Dutch Healthcare Authority (NZa), Utrecht	2012
LOLA Health Economics Study Group, Almen	2012
9th European Conference on Health Economics, Zürich	2012
iBMG, Rotterdam	2013
Dutch Healthcare Authority (NZa), Utrecht	2014
10th European Conference on Health Economics, Dublin	2014
KPMG Plexus, Amstelveen	2014

Teaching activities	Years
Statistiek (Bachelor and Pre-master), lecturer and tutor working groups	2011-2015
Statistiek en kwantitatief onderzoek (Pre-master), tutor working groups	2011-2012
Studiepractica (Bachelor), tutor working groups	2012-2013
Schrijf- en onderzoeksvaardigheden (Pre-master), supervisor	2012-2013
Mentor first year students (Bachelor)	2012-2014
Stage (Bachelor), tutor working groups	2013-2014
Bachelor thesis, supervisor	2013-2014
Algemene economie van de gezondheidszorg (Bachelor), tutor working groups	2014-2015

Dutch publications and reports	Year
Duijmelinck, D. & W. van de Ven. 'Beperking keuzevrijheid zorgpolis door aanvullende verzekering.' *ESB* 96(4621): 634-637.	2011
Duijmelinck, D.,W. van de Ven, R. van Vliet & R. van Kleef. *Overstapgedrag en risicoselectie op de zorgverzekeringsmarkt.* Rotterdam: iBMG.	2013
Duijmelinck, D., T. Laske-Aldershof, I. Mosca & W. van de Ven. *Belemmeringen voor subgroepen van verzekerden om over te stappen naar een andere zorgverzekering.* Rotterdam: iBMG.	2013
Duijmelinck, D., I. Mosca, W. van de Ven & T. Laske-Aldershof. 'Welke zorgverzekeraar? Overstapbaten en overstapkosten ontrafeld.' *Tijdschrift voor Gezondheidswetenschappen* 92(5): 193-202.	2014

Additional activities	Years
Member of the BMG Council	2013-2015
Board member of the PhD Council jBMG	2013-2015








About the author

Daniëlle Duijmelinck (1989, Roosendaal) studied Health Sciences (2007-2010) and obtained her master's degree in Health Economics, Policy and Law (2010-2011) at the Erasmus University Rotterdam. From 2011 to 2015, she worked at the institute of Health Policy and Management (iBMG) on her PhD research on regulated competition among insurers. The results of this research did she publish in (peer-reviewed scientific) journals and present at several conferences, both national and international. In addition, Daniëlle worked on two projects commissioned by the Dutch Healthcare Authority (NZa). These projects focused on consumer choice of insurer and risk selection in the Dutch health insurance market.

As a teacher, Daniëlle was involved in different courses of the bachelor and pre-master program Health Sciences at the Erasmus University Rotterdam. She gave lectures and working groups for the course 'Statistics'. Moreover, she gave working groups for the courses 'Health Economics' and 'Study skills'. Furthermore, she was a mentor for first year students and supervised a bachelor thesis.

Besides her research and teaching activities, Daniëlle was in the period 2013-2015 member of the BMG Council and board member of the PhD Council jBMG.

Daniëlle continues her work on health insurance issues as policymaker at the Ministry of Health, Welfare and Sport.

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Consumer choice of health insurer is an essential precondition for achieving efficiency and consumer responsiveness in healthcare. In healthcare, consumer preferences are highly heterogeneous. This implies that if groups of consumers with specific preferences feel not free to switch insurer, insurers have lower incentives to accommodate the specific preferences of these consumers than the preferences of other consumers. This thesis examines whether all groups of consumers with specific preferences feel free to easily switch insurer in the Netherlands and formulates strategies to improve consumer choice of insurer.

If consumers feel free to switch insurer, they will be able to choose the insurance product that best satisfies their preferences. Analysts consider selective contracting with healthcare providers as the main tool that insurers have to stimulate efficiency in healthcare. If consumers are unwilling to give up their unlimited free choice of healthcare provider in return for a lower premium, they will not take out the insurance products with a limited healthcare provider choice. Because the threat of selective contracting will then be substantially reduced for healthcare providers, regulated competition will be less able to enhance efficiency in healthcare. The United States were confronted with a substantial backlash against selective contracting. The thesis evaluates the causes of this backlash and seeks lessons for Dutch insurers and policymakers.

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