

Private Health Insurance in the Netherlands

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1. Introduction

After a period of more than 15 years of political debate, the new Health Insurance Act (*Zorgverzekeringswet*) came into force by the first of January in 2006. HIA introduced a mandatory health insurance scheme covering all residents of the Netherlands and put an end to the old dividing line between the Sickness Fund Scheme, covering about 63 percent of the population, and private health insurance¹, covering the remaining 37 percent of the population (Maarse & Okma, 2004).

After the introduction of HIA, health insurance in the Netherlands consists of the following three compartments (see table 1)

Table 1: Structure of health insurance in the Netherlands, 2007

Compartment	Name of law	status	coverage	package	Net fraction in health care financing (x 1 million)
First	Exceptional Medical Expenses Act (AWBZ)	Public	Mandatory covering all legal residents	Mainly long-term care	€22.972 42 %
second	Health Insurance Act	Quasi-private	Mandatory, covering all legal residents	Ambulatory and hospital care. outpatient pharmaceuticals, maternity care, and so on	€26.266 52 %
Third	Complementary health insurance (no specific law)	Private	Voluntary, about 92% of the population	Complementary services, not covered by HIA or AWBZ	€3.584 6 %

* Vektis (2008). Direct patient payments and tax-funded health care are excluded.

¹ Note that private health insurance was in fact a heterogeneous category. It not only included strictly private health insurance schemes, but also schemes for public servants and, since 1986, a heavily regulated scheme to guarantee specific categories of persons who did not qualify for the Sickness Fund Scheme access to health insurance.

The overview in this report is restricted to health insurance in the second and third compartment.

2. The basic structure of HIA

The adoption of HIA was a major step to the introduction of *regulated competition* in Dutch health care. Regulated competition has never been intended as a goal in itself, but as a policy instrument to transform Dutch health care from a mainly supply-driven system into a demand-driven system. In addition, the current reform aims to improve the quality, efficiency and affordability of health care, while preserving the values of solidarity and universal access. In policy documents on Dutch health care reform these values are often referred to as the ‘public constraints to competition’.

Why HIA?

For a long period of time the division of health insurance in a social (public) and private part had been considered as a relict from the past. Already in the early 1970s there were voices to integrate both parts into a single and integrated health insurance scheme covering the entire population. Political arguments to do so were, among others, the wish to strengthen the solidarity in health insurance and to reduce administrative and political complexities due to the dual structure of health insurance. Furthermore, the dividing line between social and private health insurance was seen as a source of inequities in paying for health insurance. There were many examples of what was considered to be an unfair distribution of the financial burden.² Despite these arguments, there was no political majority to reform health insurance. Political resistance was particularly strong among private health insurers who feared to lose their business by a reform.

The Dekker Commission which published its report *Willingness to Change* in 1987 repeated these arguments and added another important one. The integration of the Sickness Fund Scheme and private health insurance was also considered a prerequisite for the introduction of regulated competition in health care. The Commission even went a step further by its proposal to integrate both insurance arrangements with the Exceptional Medical Expenses Scheme. The latter was a universal mandatory scheme that had been put in place since 1966. It mainly covered long-term care.

It is important to note that HIA is designed as a more modest insurance reform. It only integrates the Sickness Fund Scheme with private health insurance arrangements. To avoid political opposition and other complexities it does not integrate HIA with the Exceptional Medical Expenses Scheme. Nevertheless, various services (for example ambulatory mental health and some forms of community nursing) which were once covered by this scheme have been shifted to the benefit

² For instance, millionaires with a part-time job and a salary under the earnings ceiling were covered by the Sickness Fund Scheme and only paid a low (income-related) contribution for their health insurance.

package of HIA, because they are not really long-term care services and better fit in the benefit package of HIA. This operation is also assumed to advance the integrated delivery of health care. Whether the remaining parts of the Exceptional Medical Expenses Act will be integrated with HIA in future is uncertain yet.

Arrangement under private law

HIA is construed as an arrangement under private law. The relationship between subscriber and insurer is shaped as a one-year contract which the subscriber can renew each year, but also terminate and replace with a contract with another insurer. Any person who fails to purchase a basic health insurance policy (hereafter health plan) is uninsured. This is an important difference with the former Sickness Fund Scheme which automatically covered each person for whom the scheme was intended.

With its choice for an arrangement under private law, the government explicitly followed another route than outlined in all earlier government reports on regulated competition in health insurance. These reports had opted for an arrangement under public law to express the social nature of health insurance and continue the tradition of social health insurance in Dutch health care. The choice for an arrangement under private law was both for ideological and political reasons. It underscored the revised role and responsibilities of the government and the private sector in health care. Furthermore, the arrangement was necessary to overcome the opposition of the private health insurers. One of their fears was that an arrangement under public law would lead to greater state involvement in health insurance. In their view, competition required ‘by definition’ a private model.

Consumer choice

A cornerstone of health care reform is to increase *consumer choice*. To stimulate competition between health insurers, consumers must be free to choose their own health insurer and health plan that best fit their preferences. HIA gives all subscribers the legal right to terminate the plan by the end of each year and to switch to another insurer (the so-called exit option). HIA forbids health insurers to terminate the contract. However, HIA contains various restrictions to consumer choice in order to find a proper balance with solidarity (Maarse & Ter Meulen, 2006). The most important restriction is the obligation in HIA that each legal resident³ of the Netherlands must purchase a *basic* health plan (note that the purchase of a *complementary* plan is voluntary!). There is no opt-out provision. In addition, there are restrictions as regards the benefit package of the basic health plan.

Regulated competition

To stimulate competition, HIA gives insurers the freedom to set their nominal or flat-rate premium rates. As will be discussed later, this policy measure has elicited fierce competition on the health insurance market. Furthermore, HIA offers insurers some freedom to shape their basic health plans. For instance, they can offer benefit-in-kind plans, reimbursement-plans or a mixture of both types. Furthermore, they are permitted to offer plans with preferred providers or plans with a

³ Persons staying illegally in the Netherlands do not have access to HIA.

voluntary deductible on top of the obligatory deductible (see below). Yet, the discretionary power of health insurers as regards the package of the basic health plan they offer should not be overstated. This is because of the fact that the government decides upon the benefit package of HIA. What this means, can be illustrated by a simple example. Because GP care, maternity care and dental care for the youth are in the benefit package of HIA, health insurers must cover these services in their plans. This provision implies that consumers cannot take out a basic plan not covering these services. The objectives of the central (government) regulation of the benefit package are to preserve solidarity and avoid that consumers make 'wrong choices'. Below, we will see that freedom of choice for both insurers and consumers is much larger in complementary health insurance.

Solidarity and universal access

To achieve that market competition does not violate the principles of solidarity in and universal access to health care, HIA contains many regulations:

- To preserve *risk solidarity*, health insurers must accept each applicant. HIA contains a formal ban on risk selection. In addition, HIA obligates health insurers to apply community rating for calculating their nominal premium. They are forbidden to use risk rating or experience rating. Note, however, that premiums may vary for the type of health plan. For instance, a plan with a preferred provider or a high deductible will have a lower premium than a plan without preferred providers or a voluntary deductible.
- To preserve *income solidarity*, the government pays an income-related health insurance allowance to the lower incomes to compensate them for the steep rise of the nominal premium rate in 2006 because of the introduction of HIA. For instance, whereas in 2004 nominal premiums⁴ ranged from 239 euro to 455 euro, they averaged at 1028 euro in 2006 (NZA, 2007).
- Other regulations to preserve solidarity include the introduction of a single mandatory scheme, the obligation for each resident to purchase a basic health plan and the central regulation of the benefit package discussed above. The end to the traditional dividing line between the Sickness Fund Scheme and private health insurance in fact *reinforced* solidarity in health insurance!
- Health insurers are also obligated to guarantee their subscribers good access to health care. They must contract sufficient care of high quality for their subscribers.

These regulations to protect the 'social good' contrast the new health insurance scheme with 'strict' private arrangements that, generally speaking, feature a high degree of voluntary action, differentiated benefit packages, application of risk-related premium setting, absence of income-related premium rates, utilisation of medical underwriting and limited state intervention. One may therefore consider HIA to be a hybrid arrangement combining a public function with a private structure (Maarse & Bartholomé, 2007). For this reason, we see HIA as a 'quasi-private' or 'private social health insurance scheme'. Though this may seem an academic or semantic discussion, it is not from the perspective of EU regulation.

⁴ Sickness Fund subscribers have been paying a nominal rate since 1989 on top of their income-related contribution. The nominal rates have gradually increased since then and were different for each sickness fund.

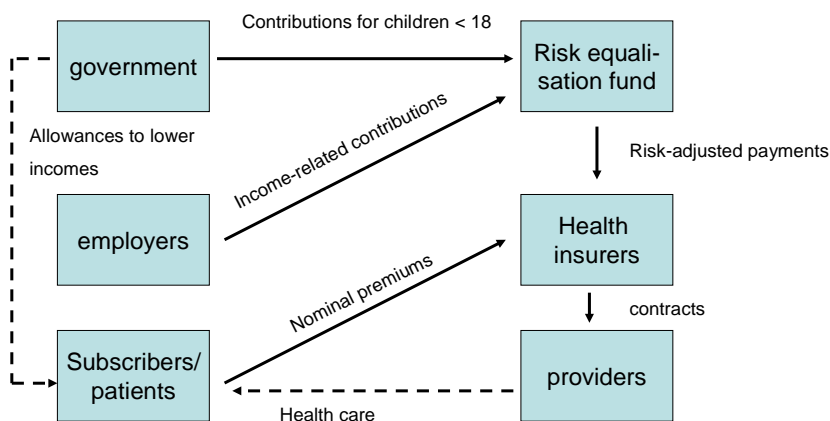
The key question is whether HIA can be considered *Europroof*. This question will be addressed later.

Premium setting

Each person has to pay a nominal or flat-rate premium for health insurance plus an income-related premium. As said earlier, health insurers are free to set their nominal premium rate. In addition, employers have to pay for each employee a income-related contribution. The contribution rate is set by government. The present contribution rate is 7,2 percent. The contribution is levied up to an earnings ceiling of 31.231 euro. Self-employed persons pay 5.1 percent of their earnings with a maximum ceiling of 1592 euro.⁵ The government pays the premium for children until 18 years.

Figure 1 gives a stylized overview of the financial flows in HIA. As can be seen, the nominal premiums directly flow as premium revenues to the insurers. The contributions paid by the employers, the self-employed and the government flow into a risk-equalisation fund. The fund pays insurers by means of risk-adjusted capitation payments. The underlying idea of the fund is that differences in the nominal premium rates of insurers only reflect differences in efficiency instead of differences in the risk structure of their subscriber population. The current risk adjusters are: age, sex, socio-economic status, region, social security recipients, farmaco-related cost groups and diagnosis-related cost groups. The latter two categories point to the inclusion of morbidity-related adjusters in risk equalisation. The list of adjusters illustrates the highly sophisticated system for risk equalisation in the Netherlands.

Figure 1: The structure of Dutch health insurance since the 2006 reform



Direct patient payments

To encourage cost consciousness, HIA initially contained a no-claim arrangement.

⁵ These percentages and maximum rates may change every year.

Under this arrangement, each subscriber had to pay a government-set premium of 255 euro on top of the insurer-set nominal premium. This extra charge was re-funded one year later to subscribers proportionate to their medical consumption in the previous year. The maximum refund was 255 euro. The costs of a visit to a GP or maternity care were excluded from the arrangement.

The no-claim arrangement – in fact nothing else than a prepaid co-payment – has always been criticised. Because of the time lag between medical consumption and refunding, it was considered an ineffective instrument to encourage cost consciousness. Patients with chronic disease saw it as an unfair instrument because they could not benefit from it. Finally, the arrangement was seen as inefficient because of its high administrative complexity.

For these reasons the no-claim arrangement has been replaced in 2008 with a mandatory deductible of 155 euro. GP care and maternity care have been excluded again. To compensate patients with chronic disease, the deductible is set at 103 euro. Note that subscribers can opt for a health plan with a higher deductible (HIA limits the maximum voluntary deductible to 500 euro).

For the rest, direct patient payments are very low for health care covered by HIA. Patients visiting a provider not contracted by their insurer must pay in principle the difference between the price charged by the hospital for the treatment and the average price of that treatment the insurer has negotiated with its hospitals contracted. So far, this has mainly been a theoretical possibility, because insurers have contracted all hospitals.⁶ Direct private payments also exist in outpatient pharmaceutical care, if a patient uses a medicine with a price higher than the reference price. Interestingly, health insurers are currently developing a new type of reference-pricing to save costs. For certain categories of medicines with an identical chemical substance, they reimburse only the lowest-priced medicine in that category (for instance cholesterol-lowering medicines). Patients using a more expensive drug must pay the difference, unless their insurer has authorised them to do so.

The structure of the private health insurance market

HIA has made the traditional dividing line between sickness funds and private insurers obsolete. It is operated by private health insurers which are permitted to work for-profit. However, the health insurance market is dominated by mutual companies operating on a not-for-profit basis. Some insurers are part of a multi-branch insurance concern. Table 2 gives an overview of the present structure of the health insurance market. It illustrates the highly concentrated structure of the health insurance market. The four largest insurance concerns ('the four bigs') are Achmea, Uvit, Menzis and CZ.

⁶ Insurers did not contract all Independent Treatment Centres delivering routine care to patients (e.g. cataracts, hip replacements or some kinds of cardiac care).

Table 2 Structure of health insurance market in 2007

Number of subscribers	Number of insurers (N=32)
>1.000.000	5
500.000 – 1.000.000	3
400.000 – 500.000	4
300.000 – 400.000	5
200.000 – 300.000	0
100.000 – 200.000	7
50.000 – 100.000	5
< 50.000	3

Source: Vektis, 2008.

Another important characteristic of the health insurance market concerns the role of collective or group contracts. In the pre-2006 period many employers negotiated a group contract, in particular to obtain a premium discount for their employees and/or to make an agreement on specific services. In the Sickness Fund Scheme group contracts did not play a significant role. HIA permits groups to negotiate group contracts, but it limits the maximum discount for the basic health plan to 10 percent. HIA does not set a maximum discount in complementary health insurance.

There are two types of group contracts. Employer-based contracts are the most important category: two-thirds of all group contracts are employer-based. The second category consists of open-group contracts. This is a heterogeneous category. For instance, there are now contracts for social minima (signed by local governments), the elderly, union members and general consumer organisations. Interesting, some patient organisations also managed to sign a group contract for their members (Bartholomé & Maarse, 2007). A patient group contract may cover some health services in the complementary plan specifically geared to the needs of their members (e.g. podotherapy for patients with diabetes).

Governance of HIA

Apart from the government, in particular the Minister of Health, the following agencies play a significant role in the governance of HIA:

- The Dutch Health Care Authority (NZA) is, among others, in charge of the supervision of the market behaviour of insurers. It also monitors the developments on the health insurance market.
- The Health Insurance Board (CVZ) is, among others, in charge of advising the government on the benefit package of HIA. It also administers the risk equalisation fund and advises the government on various health insurance topics.
- The Dutch Competition Authority (NMa) is, among others, in charge of the approval of consolidations between insurers.
- The Nederlandse Bank (DNB) is, among others, in charge of the financial supervision of insurers (solvency)

This brief overview (there are many more agencies involved) illustrates the significant role of so-called Independent Regulatory Agencies in health insurance

governance. The delegation of various administrative tasks to IRAs is intended to increase the credibility and expertise of administration. As a consequence, the Minister of Health may lack effective instruments to intervene in specific cases (for instance, he could not forbid a NMA approved consolidation between provider organisations heavily criticised in the Parliament). On the other hand, the position of the minister should not be underestimated either, because of his legal competence to issue general policy instructions to IRAs.

The wider context of HIA

HIA can be considered as the most visible part of the reform so far. It implied a significant alteration of the structure of the health insurance market and had far-reaching implications for insurers and subscribers. Yet, it is important to note that HIA is only one part of the reform. The current market reform is not only intended to introduce regulated competition in health insurance, but also in the provision of care. As said earlier, its ultimate objective is to make health care more customer-driven and to improve its quality, innovative power, efficiency and affordability. Insurers have been accorded a significant role in this respect. They are expected to negotiate contracts with providers on the quality and price of health care on behalf of their subscribers. This is the so-called purchasing or agency role of insurers.

To stimulate market competition in health care, the following market-making policy decisions were taken or are scheduled to be taken:

- Health insurers and hospitals can negotiate the prices for hospital care. In 2005 the room for price negotiations was set at 10 percent of the total hospital budget. In 2007 this percentage was elevated to 20 percent and in 2009 to about 33 percent.
- To facilitate price negotiations the system of fixed hospital budgets is stepwise being abolished and replaced with a new funding model based upon case-based payments, termed Diagnosis Treatment Combinations (DBC's). Presently, there are about 30.000 DBC's. Price negotiations regard the price of DBC's. The government is currently working on a large simplification of the system.
- Hospitals (and other provider organisations) are given much more discretionary power in planning decisions and capital investments. Because central planning is considered to be at odds with market competition, it has largely been abolished (except for some specific top-clinical services). Hospitals are paid a mark-up price on each DBC to finance their capital investments. The underlying assumption is that this new capital funding model will discipline them in planning and capital investments.
- Another market-making plan scheduled for the near future regards the lifting of the ban on for-profit hospital care. Until now, for-profit hospital care has always been forbidden in health care legislation, but there is a strong lobby for lifting the ban because it is considered to be at odds with competition. It is unclear how the government will decide on this topic. There are signs that it will opt for a social enterprise model which accords providers to make a profit, but obligates them to reinvest this profit into their own organisation.

These developments indicate the unfolding character of market competition in Dutch health care. To avoid disruptive effects upon the delivery of health care and to learn from experience, the government follows a cautious strategy of gradually staging in market reforms (Maarse & Bartholomé 2008).

The European dimension of HIA

Earlier we have seen that HIA is shaped as a privately-operated scheme under private law. In order to preserve the social good, in particular with respect to solidarity and universal access, it contains many regulations constraining the freedom of choice of both health insurers and subscribers. Therefore, we called it a 'quasi-private' or 'private social scheme'. This design of HIA raises questions about its compatibility with the regulations of the European Union. EU regulation gives the member states great discretionary power in shaping their social health insurance scheme. However, private arrangements are subjected to Community law, in particular the Third Directive on Non-Life insurance.

This is not the place for a detailed discussion on how HIA fits into Community law (Thomson & Mossialos, 2009). The Dutch government has always declared the applicability of the Third Directive because of its choice for an arrangement under private law. This directive forbids member states to regulate prices and conditions of insurance products, because such interventions would distort market competition and free trade. However, it does not fully abolish the regulatory competence of the member states. Public regulations can still be justified if private arrangements conflict with the social good. The Dutch government has taken the position that its extensive regulation of health insurance is both necessary and proportional to protect the social good. In response to letters to the Dutch government, Dutch Commissioners have accepted this position. Yet, it remains uncertain whether the European Court of Justice as the ultimate arbiter will accept the Dutch position in its rulings. There is also uncertainty on the compatibility of the risk equalisation model with the Third Directive, because risk equalisation may be interpreted as a kind of state support to economic undertakings (health insurers).

3. Complementary health insurance

Complementary health insurance constitutes the third compartment of health care financing in the Netherlands. This type of health insurance covers health services that are beyond the scope of the benefit package of HIA or AWBZ. In fact, HIA does not contain regulations on complementary health insurance with only one exception. To counteract conditional sale insurers are forbidden to terminate a complementary health plan if a subscriber switches to another insurer.

The purchase of a complementary health plan is voluntary. Nevertheless, about 92 percent of the subscribers have purchased a complementary plan in addition to their basic plan. Health insurers are free to develop the benefit package of their complementary plans. HIA does not regulate their 'package decisions'. Usually each health insurer offers their subscribers several complementary plans ranging from plans which provide only limited coverage ('simple plans') to plans provid-

ing extensive coverage ('golden plans'). As a consequence, subscribers have many options to select a complementary plan. Some subscribers make the choice of the health insurer dependent upon the benefit package of the complementary plan.

Table 3 gives a global impression of the health services covered by complementary plans. Note that these plans may include specific conditions. The maximum reimbursement is usually capped. Plans may also require prior authorisation for specific treatments. The type of health services covered plus conditions and maximum reimbursement rate depend on the type of complementary plan.

Table 3 Types of health services covered by complementary plans

Acne therapy	Alternative medicines	Asthma center Davos
Glasses	Alternative therapies	First-line mental care
Vaccinations for traveling to foreign country	Cross-border care	Physiotherapy
Aftercare for cancer patients	Circumcision on religious ground	Various physical exercise programs for persons with chronic disease
Lifestyle training programs	Treatment of patients with serious overweight	Various forms of cosmetic surgery
Vasectomy	Podotherapy	Physical
Various forms of dental care	Various preventive courses	Patient transport
Specific treatment programs of psoriasis	Various preventive screening programs	Diet advice
Single room	Stuttering therapy	Holiday camps for children and disabled

Health insurers are also free to set the nominal premium rate of their complementary plans. Premiums vary with the coverage of the plan. Some health insurers also link the premium to the age of the subscribers. Furthermore, health insurers may apply risk selection.

4. Effects of HIA

This section presents a brief overview of some of the most important effects of HIA known so far. They give an impression of what has been achieved. In our view, however, it is too early yet to draw conclusions on the ultimate impact of HIA. There are several reasons for being cautious in drawing conclusions. Firstly, it often takes some time before the real impact can be assessed and interpreted. Secondly, it is important to note that the impact of HIA also depends on other reforms programs. To illustrate, we simply refer to the fact that the capability of insurers to negotiate prices for hospital services heavily depends upon the scope of price competition which, in turn, depends on the market making decisions to be taken by the government. Another relevant factor in this respect is the further development of the new hospital funding model by means of case-based payments. Finally, we must emphasise the unfolding character of the current reform of Dutch health care. The introduction of HIA in 2006 is only an important element of the

reform. Various *market-making decisions* are yet to be taken (Maarse & Bartholomée, 2008). This implies that there is still uncertainty on the eventual design of market competition and, by implication, on its (ultimate) effects.

Effects on consumer behaviour

Table 4 summarises information on consumer behaviour during the last year before the reform and the first three years after the reform

Table 4 Consumer behaviour before and after the introduction of HIA

	2005	2006	2007	2008
Voluntary deductible				
- yes	--	93,9	94,7	94,8
- no	--	6,2	5,3	5,2
Complementary health insurance <i>before</i> HIA				
- sickness fund subscribers	91,9	--	--	--
- private insurance subscribers	98,4	--	--	--
Complementary health insurance <i>after</i> reform	--	92,6	92,9	92,0
Group health plan <i>before</i> HIA				
- sickness fund subscribers	16,3	--	--	--
- private insurance subscribers	52,0	--	--	--
- average (own calculation)	23,3	--	--	--
Group health plan <i>after</i> HIA	--	53,0	57,3	59,2
Consumer mobility <i>before</i> HIA				
- sickness fund subscribers	7,5	--	--	--
- private insurance subscribers	15,4	--	--	--
Consumer mobility <i>after</i> HIA	--	18	4,4	3,5

Sources: Health Monitors of Vektis; Health Insurance Monitors of NZa

Voluntary deductible

The percentages of subscribers opting for a voluntary deductible are consistently very low. They probably illustrate the high degree of risk aversion among Dutch subscribers. A further explanation may be that subscribers consider the premium reduction in exchange for a voluntary deductible to be relatively low.

Complementary health plans

These plans are very popular. The coverage of extra dental care is frequently mentioned as an important reason to purchase a complementary plan. Patients with chronic illness tend to scrutinise complementary plans from the specific perspective of their illness ('what is in for me?').

Group health plans

The figures on group health plans illustrate their popularity. The market share of group plans negotiated by patient associations has always remained quite small (about 1 percent). The interest for these plans of subscribers and health insurers does not generally seem particular strong (with the exception of one insurer). Much also depends upon whether the risk equalisation scheme includes the rele-

vant morbidity parameter. If not, the insurer is not likely to be interested in a patient group contract because of predictable loss.

Consumer mobility

The figures on consumer mobility suggest a shock effect of HIA. Contrary to what most insiders had expected, in 2006 almost one-fifth of all subscribers switched to another insurer. Switching rates were relatively high among young subscribers, subscribers with high education and subscribers with high self-reported health. After 2006, however, mobility turned out to be only a one-off effect, despite significant differences in the premium rates of health insurers. It is not easy to interpret this decline of mobility. Does it indicate a high level of satisfaction or high transaction costs? Are subscribers concerned not to be accepted for complementary health insurance (see section on complementary health insurance).

Uninsured and defaulters

Another effect concerns the number of uninsured. Any resident who fails to purchase a basic health plan is automatically uninsured. Statistics Netherland estimated the number of uninsured in 2007 at about 1.4 percent (CBS, 2008). The government has developed a monitoring program to track the uninsured as soon as possible. It also uses administrative penalties to keep the number of uninsured as low as possible. Uninsured persons must be distinguished from defaulters, defined as subscribers who failed to pay their premium for a period of at least six months. The estimated number of defaulters increased to an estimated 1,9 percent in 2007 (CBS, 2008). The government agreed with health insurers on a monitoring program to track defaulters as soon as possible. Several instruments are used to compel them to pay their premium. However, insurers cannot dispel defaulters from their list. They agreed with the government that they will bear the financial risk over the first six months of defaulting after which period the government takes over this risk.

Consumer satisfaction

Consumer satisfaction on health insurance is high. On a scale from 0 to 10, the CQ index varied from 7,4 for the insurer with the lowest score to 8,7 for the insurer with the highest score. Only 8,9 percent of the respondents said to be dissatisfied.

4.2 Effects on insurer behaviour

Consolidations

HIA made the traditional dividing line between sickness funds and private health insurers obsolete. Hence, it came as no surprise that in 2006 the number of insurers fell from 57 to 33 because of consolidations between sickness funds and private insurers. Note, however, that the number of health insurers had already been fallen over a much longer period of time (58 percent over the period 1985-2005). Important reasons to consolidate in the pre-HIA period were the need for greater administrative efficiency and effective risk pooling and the strive of each insurer to reinforce its market position.

Consolidations have led to significant market concentration. Presently, the total market share of the four biggest insurance concerns is about 89 percent! Not surprisingly, there is some concern (not shared by NZa) that this concentration may undermine competition and consumer choice, in particular in those areas where the HHI-index is more than 1800.

Risk selection

HIA contains a formal ban on risk selection for basic health insurance. Therefore, it is no surprise that insurers do not engage in explicit risk selection. However, there may be some subtle forms of risk selection. We discuss three alternatives.

First, insurers may deny a group contract to what they see as groups with a predictable loss. There is no evidence for this practice because, so far, efforts of insurers were directed at protecting and extending market share. However, group contracts may evolve as an instrument for risk selection in future.

Second, one insurer launched a new health plan by the end of 2007. Subscribers accept to visit only eleven hospitals for non-acute care which have been contracted by the insurer as preferred provider. In exchange for their restricted choice they pay a lower premium. This plan is only attractive to young people reporting their health as very good. It is not an attractive plan for a young couple with children. Importantly, the plan also contains the provision that a subscriber in case of an illness requiring frequent medical consumption may immediately terminate the plan and switch to a 'normal' health plan. In other words, it may elicit opportunistic behaviour.

Third, there is some concern that health insurers may use complementary health insurance as an indirect tool for risk selection. As said before, HIA does not include a formal ban on risk selection for these plans. In 2006 and 2007, insurers announced that they would apply open enrolment except for their most inclusive and expensive plans. They did so because of their strategy of protecting and extending market share. However, in 2008 the percentage of insurers asking applicants to fill in a medical questionnaire more than doubled from 12 to 25 insurers after it had declined from almost 50 percent in 2004 to 10 percent in 2006 (Roos & Schut, 2008). There is also some evidence that subscribers do not switch to another insurer for their basic health plan because they fear not to be accepted for complementary plan by the new insurer (Bartholomée et al, 2009). In other words, complementary health insurance may restrict consumer choice.

Purchasing

An important effect of HIA concerns the development of purchasing. A cornerstone of the current market reform regards the reconfiguration of the role of health insurers. In the market model, they not only function as an agent to guarantee access to health care and cover the costs of medical care, but are also expected to play an active role in purchasing health care on behalf of their subscribers. This is the so-called agency role of insurers. By contracting with provider agents insurers

are expected to improve the quality and efficiency of health care rendered. To empower them, insurers are in principle no longer obligated to contract each provider agent. Selective contracting has become a formal option.

Experience so far indicates that purchasing is still in its infancy. As yet, selective contracting hardly exists. The explanation of this state of affairs is complicated and falls beyond the scope of this report. We mention a few important factors. First, insurers still miss good information on the quality of health care, despite significant progress in measuring the quality of care. Recently, some insurers started to use this information to contract preferred providers for some specific forms of care. A second factor concerns the (quasi-) monopolistic position of hospitals in some regions. Not contracting these hospitals has been a totally unrealistic option so far. Third, insurers have abstained from selective contracting because of their concern that it could damage their market reputation. Fourth, insurers consider it extremely difficult to steer their subscribers in need of medical care. They believe that only positive incentives work. For that reason, some insurers are now letting off patients the mandatory deductible if they go to a preferred provider.

Premium setting

HIA has elicited fierce competition in both basic and complementary health insurance. The strategy of insurers to protect and extend market share forced them to calculate competitive premium rates. Because of the very competitive structure of the market for group contracts, they granted substantial premium discounts. For instance, the average discount for employer-based group contracts grew from 7 percent in 2006 to 8 percent in 2008 and some employers managed to negotiate a 10 percent. The discount for open-group contracts averaged at 6.2 percent in 2007. Not surprisingly, patient organisations were less successful in negotiating discount (4.2 percent in 2007) (NZA, 2007). Discounts were also sizeable in complementary health insurance.

In fact, many premiums generated a net loss. In its role as oversight agency DNB found that the aggregate technical result of the basic health insurance scheme amounted to 563 millions of euro in 2006 and 507 millions in 2007 (DNB, 2008). DNB also reported for 2006 a loss of 23 millions of euro in complementary health insurance in 2006, which was in fact quite remarkable given the high profitability of complementary health insurance in the pre-reform period. The loss in 2006 was followed by a positive result of 93 millions in 2007 due to the strategy of insurers to raise premiums and, if necessary, to restrict the consumption of complementary services.

Unfortunately, it is difficult to compare the nominal premium rates for basic health insurance over a longer period of time. This is mainly due to the replacement of the no-claim arrangement with a mandatory deductible. Other changes including the extension of the benefit package of HIA also complicate such a comparison.

Administrative efficiency

Table 5 clearly indicates that HIA has improved administrative efficiency. Administrative costs taken as a percentage of total costs did significantly drop. Note that the administrative costs of complementary health insurance, though falling, are relatively high compared with the costs of the basic health insurance scheme. There is also evidence that insurers have significantly lowered their the marketing costs.

Table 5 Administrative costs of insurers as percentage of total costs

	2003	2004	2006	2007
Before HIA				
Sickness funds	4,0	4,01	--	--
Complementary plans sickness funds	22,8	18,3	--	--
Private insurers	12,1	12,3	--	--
After HIA				
Basic health insurance	--	--	4,8	4,6
Complementary health insurance	--	--	15,7	14,6

Based upon the Health Care Monitors of Vektis (own calculations).

4.3 Other effects

Freedom of choice and transparency

HIA is intended to increase the consumer freedom of choice on the health insurance market. The extent of freedom is affected by many factors including the range of choices available to consumers. So far, the range of choices in basic health insurance has remained limited. The differences between the health plans offered tend to be marginal which is of course due to a great extent to the extensive public regulation of these plans. The choice options in complementary health insurance are much bigger, but the conditional sale arrangements of insurers may reduce the choice options. A further complication concerns the lack of transparency. Many consumers complain about the great difficulties in understanding and comparing their options. To support them, website have been constructed which provide systematic comparative information on health plans (e.g. www.independ.nl).

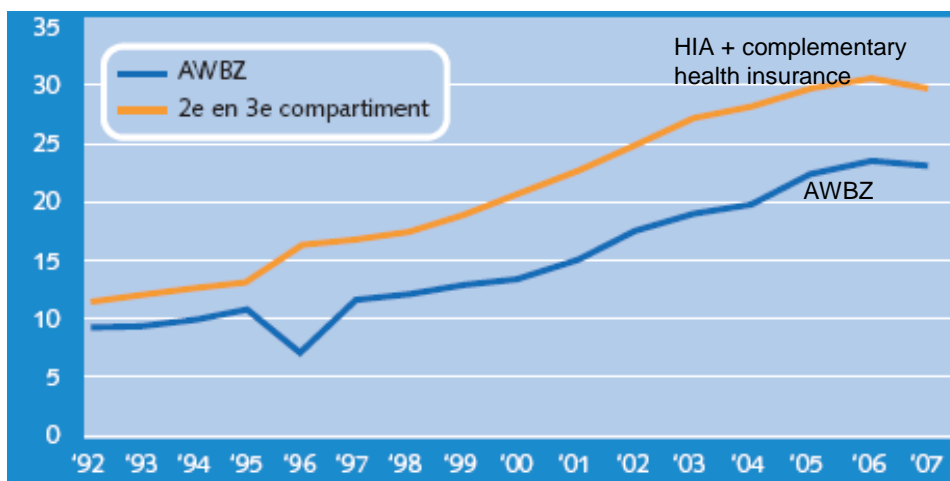
Redistributive effects

Earlier we stated that HIA is also intended to achieve to a more equitable distribution of the financial burden in health care financing. The dual structure of the Sickness Fund Scheme and private schemes had created inequitable anomalies in the distribution of the costs of health insurance. Unfortunately, we have no insight in the redistributive effect of HIA. Group plans are an important source of complexity in this respect because of the variation in discounts insurers offer for groups to sign a group contract. However, it is reasonable to assume that individual subscribers ‘pay the bill’ because they do not benefit from a discount.

Impact on health care expenditures

Figure 2 gives a bird eye’s overview of the evolution of health care spending in the first, second and third compartment. The figure demonstrates that the growth of health care expenditures has flattened since 2006 and even fell in 2007. This is a remarkable result because of the fact that the coverage of some health services was shifted from the AWBZ to HIA. The pattern is similar for AWBZ-related expenditures. However, the growth curve is somewhat misleading for 2006 and 2007, not only because of the shift of services from AWBZ to HIA but also because of the fact that the coverage of family help was removed in 2007 from the benefit package of AWBZ and shifted to local government.⁷

Figure 2 The growth of health care expenditures in the three compartments of health care



Source: Vektis, 2008

To disentangle the effect of HIA upon health care expenditures is quite complicated because of the impact of many confounding factors such as the ageing of the population, decisions on the benefit package of HIA and the advance of medical technology. Nevertheless, there are some signs of a positive effect on the prices of hospital care. The Health Care Authority reported in 2008 that the negotiating power of health insurers in contracting health care had reinforced (NZa, 2008). It found that the real prices of hospital care that have been subject to price competition since 2005 declined in 2007. The price increase of hospital services for which price competition has been possible since 2008 appeared to be moderate. Not surprisingly, insurers with a big regional market share are capable to negotiate lower prices than insurers with only a small market share. Contracting so-called Independent Treatment Centres presumably plays an important role in this respect. The number of these centres increased from 31 centres in 2000 to about 160 centres in 2006. They usually deliver high volume routine care including cataracts, hip and knee replacement, diagnostic and many other services (Maarse & Normand, 2009).

⁷ This shift formed part of the adoption of the Law on Social Support (WMO).

Unfortunately, we do not know whether these price effects will remain a lasting effect of competition and whether there is any form of cost shifting occurring. Furthermore, it is important to stress that competition may have (or is already having) an upward effect upon the volume of care. Will insurers be strong enough to effectively counteract the potential danger of supply-induced demand propelled by market competition and the interests of private investors to expand the market for health care.⁸

Vertical integration

Recently, a regionally-operating insurer announced to take a 40 percent participation in a consortium being formed to overtake a hospital in its region that is financial trouble. This participation was heavily criticised in the Parliament because of its damaging effect on patient choice and the 'double role' of the insurer. Nevertheless, the Minister of Health declared to consider vertical integration (integration of the insurance function with the delivery function) to be an interesting innovation in Dutch health care. An example of a more light form of vertical integration concerns an insurer which started to invest in centres for primary care.

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⁸ The interest of private investors for health care is increasing, because they see as a growth sector. Even though the ban on for-profit hospital care has not been lifted yet and it is still unclear what the government will decide on this issue, two hospitals in financial trouble have been taken over by private investment companies.

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