Evaluation of the Health Insurance Act

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Summary and Recommendations

On 1 January 2006, the Health Insurance Act (Zvw) and the Health Care Allowance Act (Wzt) came into effect. By virtue of the Zvw, in principle everyone who is legally living or working in the Netherlands is obliged to take out health insurance. The Wzt allows for households with a household income below a certain level to receive compensation for the insurance premium in the form of a health care allowance.

The aim of this first evaluation of the Zvw/Wzt is to obtain information about the way in which the laws have been introduced and are implemented in practice; about any bottlenecks or problems that have become manifest; and about the efficacy and (side-) effects of the legislation. In view of its relatively brief period of effect, it is not yet possible to definitively answer the question as to whether all the legislation's goals have been reached. Therefore this preliminary evaluation focuses on the initial effects, and relates in principle to the years 2006 through 2008 (and on occasion up to June 2009). The other laws that jointly determine the rules and outcomes of regulated competition are outside the scope of this evaluation. It must therefore be emphasised that this evaluation is *not* an assessment of the health care system or the changes to the system as a whole. It only refers to the Zvw/Wzt.

The **central question addressed in this evaluation** is: *How is the legislation contained in the Zvw/Wzt implemented in practice, and have any problems or bottlenecks become manifest? In the light of the aims of the Zvw/Wzt, do the findings give reason for the legislation or policy to be amended?*

Box 1 – On balance positive

On the whole, the findings of our evaluation of the Zvw/Wzt may be summarised as 'on balance positive', despite the discovery of a number of serious bottlenecks and problems. It is important to bear in mind that the evaluation by necessity chiefly focuses on the problems identified. This rather one-sided approach follows directly from the above-stated essential evaluation question. Furthermore, the problems identified should be seen against the background of the relatively short period of effect of the legislation.

Positive effects and developments

Important goals of the Zvw/Wzt are to promote appropriateness and financial accessibility of care. The positive effects of the Zvw/Wzt are:

1. The removal of the distinction between private and public health insurance has made the health insurance system more equitable. The same standard package is available to everyone, without any premium differentiation based on health.
2. Everyone is free to change their health insurer or insurance policy yearly.
3. The health insurance market is highly competitive.
4. Increasingly, information is becoming available about the price and quality of health insurers and health care providers (see for example www.kiesbeter.nl).
5. Health insurers are developing more activities in the area of purchasing health care.
6. Thanks to the Zvw, quality of care is now on the agenda.

Comparison with EU regulations

Analysed in relation to EU regulations, our evaluation of the Zvw leads to the following two important conclusions:

1. There is a considerable risk that the ban on premium differentiation (section 17.2 Zvw) is in conflict with EU regulations because:

   a. there is a strong possibility that the ban on premium differentiation is not compatible with article 29 of the third non-life insurance Directive; and

   b. there is a strong possibility that the ban on premium differentiation does not comply with the exclusion clause contained in article 54 of the third non-life insurance Directive, because the ban is not based on any explicit principle in that Directive, since the ban compels insurers to accept groups of insurees at a predictable loss. Furthermore, the ban is not necessary and is disproportionate.[1]

2. For the health care purchasing policy of health insurers, it is of great importance to know to what extent the insurers are autonomous in fixing reimbursement for care provided by non-contracted health care providers. The conclusion appears justified, that – in contrast to what is often thought to be the case – a health insurer is fully autonomous under EU law to determine the amount of the reimbursement for care provided by non-

[1] A alternative possible solution is put forward below under the heading "Ex-ante risk equalisation has not yet been properly regulated."

contracted health care providers, as long as the insurer operates within the parameters of national and European competition law and does not discriminate on the basis of the health care provider's nationality.

Since the European Court of Justice has not made any explicit judgement regarding compliance with EU legislation there can be no absolute certainty in this respect.

Health care purchasing by health insurers is slow to take off

In the model of regulated competition, health insurers have the important role as circumspect purchasers of health care on behalf of their clients to promote appropriateness of care. Currently a gradual shift is taking place from centrally driven health care provision to health care purchasing by health insurers. On the one hand, health insurers are increasingly developing health care purchasing activities, particular in extramural care, but on the other hand, a large proportion of health care delivery, particularly intramural care (A-segment) and curative mental health care (GGZ), is still centrally driven.

Health insurers appear cautious about selective contracting because they expect that restricting access to non-contracted care will be unpopular among their clients and may impact negatively on their reputation, as long as it cannot be proved on the basis of objective performance indicators that the selected health care providers are of good quality. Nonetheless, where there is scope for negotiation, health insurers appear to be gradually making more effective use of the possibilities available by means of contractual agreements for influencing the appropriateness of health care. Nonetheless, the following areas have been indentified that constitute bottlenecks to effective health care contracting:

- dysfunctional cost payment system of hospitals;
- lack of sound performance indicators;
- deficient supply of health care providers (in numbers and variety);
- the problem of 'free riding' in health care purchasing;
- practical problems with the steering instrument 'differentiated excess';
- substantial ex-post reimbursement for hospital care (A-segment)

With the exception of the last item, addressing these problems is beyond the scope of the Zvw. The functioning of the health care purchase market depends greatly on a sound package of legal instruments that are complementary to the Zvw, including in particular the Health Care Market Regulation Act (Wmg).

Possible solutions

One clear direction towards finding a solution (from the perspective of the Zvw) to the problems besetting health care purchasing is to increase the financial risk for the health

insurers by reducing the current uniform ex-post reimbursement to the health insurers. However, raising the financial risk for health insurers means increasing their financial incentive for risk selection (see below). It is a question of weighing up appropriateness of care against discouraging risk selection. In view of the ban on premium differentiation, improved risk equalisation offers the only possibility of escaping from this dilemma.

A second possible solution may be found in replacing the current uniform ex-post reimbursement with differentiated ex-post reimbursement (and/or a high level of risk equalisation). The finding that a certain 'hard core' of predictable loss-making clients exists may be reason to employ the current ex-post reimbursement which applies uniformly to all clients in a more differentiated way, i.e. exclusively to the group of 'hard core' predictably loss-making clients (say 8% of all insured). In this way the financial incentive for appropriate care can be made greater without any real increase in the incentive for risk selection.

A third possible scenario is to reduce the ex-post reimbursement to health insurers in combination with less stringent premium regulations. Thus financial accessibility will also be factored into the equation. This possible solution is discussed below.

Ex-ante risk equalisation has not yet been properly regulated

A major bottleneck consists in the fact that the financial heart of the Zvw, i.e. the ex-ante risk equalisation has not yet been properly regulated. Risk equalisation means that insurers receive subsidies prospectively for high-risk clients on the basis of their projected health care costs in so far as these are related to their health status (including age and sex). However, this financial compensation falls substantially short in the case of various (sizeable) groups of high-risk insured. With imperfect ex-ante risk equalisation and insufficient ex-post cost compensation (see tables 5.1 and 5.2), the ban on premium differentiation leads to predictable losses where an average premium rate is applied to specific groups of high-risk clients (often chronically ill; see table 5.1). This has the following negative consequences.

1 No level playing field for health insurers;

2 Market segmentation and unintended premium differentiation, undermining the ban on premium differentiation;

3 Unenvisaged cross subsidies;

4 Incentives for risk selection. Risk selection may have a number of negative effects. These include reduced access for the chronically ill to good quality care, reduced appropriateness of care and undermining of the ban on premium differentiation.

These effects point to a potentially serious problem.

Possible solutions

The best way to avoid predictable losses (and to reduce ex-post reimbursement in a responsible way) is to improve the ex-ante equalisation system.

A second solution scenario is as follows: ‘Replace the ban on premium differentiation with a premium band-width (for example, the maximum premium per health insurer per model policy may not exceed twice or three times the minimum premium), in combination with care subsidies for high-risk insured, which will act as a security net, guaranteeing that nobody will have to spend more than an acceptable amount of their income on health insurance; and compel health insurers to state the risk factors applied and the accompanying premium table in their model contracts.’

It is doubtful whether the former of these two possible solutions could alleviate the situation sufficiently within a few years. In view of the likelihood that the problems will become more serious in the coming years, because health insurers will have increasingly better insight into which clients are likely to be loss or profit making within the prevailing equalisation system, the question therefore arises whether the second possible solution might not be worth considering. While a ban on premium differentiation may guarantee financial accessibility in the short term, it also has the disadvantages outlined above. Furthermore, we may ask to what extent the regulation of insurance premiums can be effective in the long term in adequately guaranteeing financial accessibility. This leads one to question whether the advantages of the ban of premium differentiation still outweigh its disadvantages, or whether we should consider a relaxation of the ban (for example, by permitting a premium band-width) in combination with health care subsidies as an alternative.

The advantages of this compared to a ban on premium differentiation are:

1. Less (incentive for) risk selection, and therefore fewer negative effects of selection. For example, chronically ill clients will be less likely to be branded ‘predictably loss-making’ and health insurers will consequently be motivated to set up more disease management programmes for the chronically ill and to advertise these to target groups.
2. It will be possible to reduce ex-post reimbursement payments, thus increasing the financial incentive for the health insurers to provide appropriate care.
3. Fewer if any unenvisaged cross subsidies.
4. Health insurers will be able to use premium differentiation to provide information about risk factors, which can be used a few years later in the equalisation model and will then no longer be used for premium differentiation.
5. A stronger legal basis. As was concluded above, the risk is substantial that the ban on premium differentiation is in conflict with EU legislation. It cannot be ruled out that legal action against the Dutch government could be initiated by health insurers (see Appendix 6), patients/patient associations (see Box 6.4) or health care providers (see Box 6.3) who believe they are disadvantaged by the ban on premium differentiation combined with imperfect risk equalisation. Making the premium regulations less restrictive and therefore less disproportionate would give a firmer legal foundation to the health insurance system.

Against these advantages, the following disadvantages should also be considered:

1. Less transparency in the insurance premium structure could make it more difficult for the consumer to compare the various policies.
2. Explicit subsidies such as health care subsidies are accompanied by transaction costs.

Duty of care has not yet been fully clarified.

Because the duty of care (section 11.1 Zvw) in the case of health insurance reimbursement policies only obliges the health insurers to make an effort to, if requested, mediate for the provision of care, the duty of care provides those holding a reimbursement policy insufficient guarantee that they will in fact receive the required care. Since policy holders are insufficiently aware and inadequately informed of the crucial difference in claims between direct cover insurance (entitlement to care) and cost reimbursement insurance (entitlement to reimbursement of insured care), it may be attractive for health insurers to offer only reimbursement policies. Furthermore, it is unclear what services are covered in the case of direct cover policies, and what the insurers are responsible for in practice.

Possible solutions

A first possible step is for the government to provide sound information about the crucial difference between direct cover and reimbursement insurance policies (see Box 5.8), and for the health insurer to provide sound information about the precise claims attached to the various policies offered.

A second possible solution is to tighten the regulations on duty of care as much as possible for reimbursement policies, taking account of the restrictions imposed by EU legislation.

A third scenario involves creating a clearer definition of individual health insurers' obligation to deliver care for direct cover clients in relation to guaranteeing the availability and accessibility of essential care functions. It should be clear to health insurers in advance what their obligations are if, for example, a hospital should go bankrupt (see Box 5.9).

A fourth direction is to step up the supervision of duty of care (obligation to deliver care for direct cover policies; care mediation for reimbursement policies). In order to protect the consumer, health insurers could be compelled to furnish the Dutch Health Care Authority (NZa) with an 'emergency scenario' if requested. For direct cover policies, for example, this could mean that health insurers have made contingency plans in the case of a hospital's bankruptcy, to ensure that an emergency hospital is functional within an acceptable period of time.

The imposition of supplemental premiums makes it difficult for the chronically ill and the elderly to change health insurers

Selling policies of basic health insurance with tied-in supplemental plans reduces the mobility of the chronically ill and the elderly in the health insurance market. This practice lowers the incentive for insurers to focus on the preferences of those very groups who need a lot of care. This is a serious limitation to effective competition on the health insurance market.

The source of this problem is the so-called non-cancellation clause which many health insurers include on a voluntary basis in supplemental insurance plans. This clause means that after the insurance period has expired, the health insurer will accept the client again for supplemental insurance at the standard terms and (provided the policy has not been cancelled) at the standard premium. The chronically ill and the elderly will not be accepted by other insurers on such favourable conditions and are therefore more or less stuck with their existing insurer.

The legal stipulation against selling tied-in policies (section 120 Zvw) does not constitute an effective solution, because if the policyholder cancels the policy, the insurer may increase the premium for the supplemental insurance. Intervening in supplemental insurance is at odds with EU insurance regulations.

Possible solutions

An effective solution may be sought in limiting the importance of supplemental insurance. This will reduce the need of the consumer for supplemental insurance, and may mean that supplemental insurance may be offered without a non-cancellation clause.

An effective way to reduce the importance of supplemental insurance is to subject the current supplemental package to a critical review combined with policy on discouraging any paring down of the standard package. A second avenue would involve providing sound information about the value and necessity of supplemental insurance.

Defaulters, uninsured people and the price of the fixed premium

Following the introduction of the Zvw, the issue of defaulters and the uninsured became a frequently recurring topic in the political forum. In order to find a lasting solution to the problem of the growing number of non paid-up citizens (see paragraph 5.1.10) the Dutch parliament in 2009 passed a proposal to amend the Zvw. It remains to be seen whether this will reduce the problems of non-payers.

Possible solutions

A more effective approach than addressing the consequences could well be to remove the causes of the problem. A main reason for the rise in the number of non-payees appears to be found in the tripling of the fixed insurance premium by comparison with the former public health insurance system. Prior to 2006 (and the introduction of the Act), the issues of defaulters and non-insurees was not high on the political agenda. Although we are unaware of any specific research on the background to this discrepancy, it would appear logical that the tripling of the standard premium (from an average of €350 to €1,050) in

2006 is the main reason behind the increase in the problems relating to payment defaulters and non-insurees. This being the case, a reduction of the fixed premium should reduce the problems considerable. This would kill two birds with the one stone, since not only would there be a reduction in payment arrears per defaulter (as the debt rises less rapidly with a lower premium), but there would be fewer defaulters and uninsured people.

A premium of on average some €350 annually has the following advantages over a premium of around €1050:

- Less loss of premium per defaulter and fewer defaulters and non-insurees.
- Greater premium sensitivity in the insured due to an increase in the relative premium differences (see Box 5.6).
- The health care allowance currently received by two-thirds of households can be done away with (as in 2005).
- The legislation and regulations will be simplified; the Wzt can be abolished.
- Considerable reduction in work burden for the tax service.
- Reduced administrative burden for the government (59 million euro – 2006 price level) and for millions of citizens (checking whether you are eligible for a health care allowance, applying for the allowance, keeping track of whether you receive the allowance, and sending a claim if this is not the case, etc.)
- No risk that citizens won't spend their health care allowance on health insurance.
- No risk of fraud with the health care allowance.

It may be possible to limit the effects on the redistribution of income if the increase in the means-tested contribution is equal to the reduction in the fixed premium (in absolute figures), minus the lost health care allowance. Employers' contributions can remain unchanged when section 46.1 of the Zvw stipulates that the employer's contribution relates to the 'existing means-tested contribution'.

We are unaware of any drawbacks to reducing the fixed premium, other than the one-off administration costs.

The current system of out-of-pocket-payments has little effectiveness

An important aim of the system of out-of-pocket payments is to promote cost awareness in health care use, (as a deterrent) is falling well short of its mark because (1) the notion of a deterrent cannot really apply to the chronically ill and the elderly and (2) very few people (5%) avail of a voluntary out-of-pocket payment option.

Possible solutions

A simple measure that could be used to motivate the chronically ill and the elderly to become more cost aware is to apply the out-of-pocket payment to amounts from for example 1000 euro, instead of from 0 euro. This shift of the parameters would result in

fewer excess payments for both these groups and would also be a greater deterrent than out-of-pocket payment that starts at 0. This adjusted voluntary out-of-pocket paymentoption would be more attractive to the chronically ill and the elderly than the current option. Because these groups would then be liable for fewer out-of-pocket payments, they would no longer require complicated reimbursement arrangements.

The introduction of an adjusted system for out-of-pocket payments may, for practical reasons, be seen as a first step towards an age-dependent basis for calculating deductibles, for example:

- 18 – 49 years: 300 euros per annum;
- 50 – 64 years: 600 euros per annum;
- 65 – 74 years: 1,200 euros per annum;
- 75 years and older: 1,800 euro per annum.

Thus a 59 year old, for instance, would be liable to out-of-pocket payments from 600 euro.

Group insurance schemes may undermine the ban on premium differentiation

Because of the absence of an obligation for group insurance schemes to accept clients, a group insurer can opt to insure only low-risk clients (risk selection). Furthermore, section 18 of the Zvw which stipulates that the maximum premium reduction for groups is 10 percent, is not effective because greater discount is de facto offered through reductions on other insurance products. In this way, group schemes can undermine the ban on premium differentiation.

Possible solution

One way of addressing this problem effectively is to introduce sound ex-ante risk equalisation. Then market segmentation via group insurance schemes will no longer result in predictable gains per group scheme, and there will no longer be any actuarial basis for excessive group discounts (viz., ‘total discount amounting to more than 10% of the premium’, such as are currently being offered, for example via other insurance products).

Insufficient consumer information for choosing the right policy

In many cases, contracts between health insurers and health care providers do not take effect until after 1 January (the starting date of the new health insurance). One of the reasons for this is that the Dutch government only announces changes to legislation and regulations at a late stage. This means that at the time when insurees can switch to a different insurer, there is often insufficient information available about the contracted health care and healthcare providers. This hampers mobility among clients based on informed comparisons of price and quality and is detrimental to proper functioning of the health insurance market.

Possible solution

The government should ensure timely availability of information concerning changes in legislation and regulations. According to the NZa, any such changes should ideally be made public at least half a year in advance. A task of the NZa is to ensure that at the point when insurees are able to switch insurers, sufficient information is available about the health care (providers) contracted by the health insurers.

Lack of clarity about the political acceptability of vertical integration

The prevailing lack of clarity about the political acceptability of vertical integration hampers the effective use of this instrument.

Possible solution

Achieving political certainty as soon as possible about the permissibility of vertical integration between health insurers and health care providers will facilitate more effective use of this instrument.

Policyholders can switch to a different insurer every day

The ZEKUR policy allows insurees the possibility of cancelling their policy every day. A client might opt for this policy if he or she makes little or no use of health care, and then when care is needed, a different insurer is chosen. The health care costs are then borne by the last insurer. This can lead to risk selection which cannot be prevented, even with the most sophisticated risk equalisation.

Possible solution

Establish in law that all health insurances have 31 December as end date.

Insufficient coordination of the standard insurance package and diagnosis-treatment combinations (DBCs)

In the case of a number of DBCs, costs are charged to the health insurer that do not come under the Zvw. This problem will increase when the number of DBCs is reduced from 30,000 to some 3,000.

Possible solutions

1 Adapt the DBCs to the activities that are covered by the Zvw;

2 Adapt the activities covered by the Zvw to the DBCs;

3 Require a personal contribution per DBC for health care not covered by the Zvw.

Scant influence by insurees on the policies of health insurers

In theory, clients have various means of exerting influence on the policies of a health insurer; yet in practice, little is seen of this influence. Many insured are not sufficiently aware of the instruments available to them to have an impact.

Possible solutions

One possibility is, in addition to providing information about regulations, to publish the performance history of health insurance companies. Another possibility is to strengthen the position of patient organisations by increasing the knowledge that exists among patient associations and by improving ex-ante risk equalisation (see Box 6.4).