Health Insurance Reform in the Netherlands

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At the beginning of 2006 the Dutch government introduced a fundamental reform of the health insurance system. The aim of this reform was to improve quality and efficiency of the health care system by introducing a uniform health insurance system and intensifying managed competition between health insurers . In this paper we give an overview of the key features of the reform. Moreover, we analyze the short-term effects of the reform with regard to financial consequences and consumer mobility. Finally, we discuss the long-term consequences of the reform and its implications for cross-country policy learning.

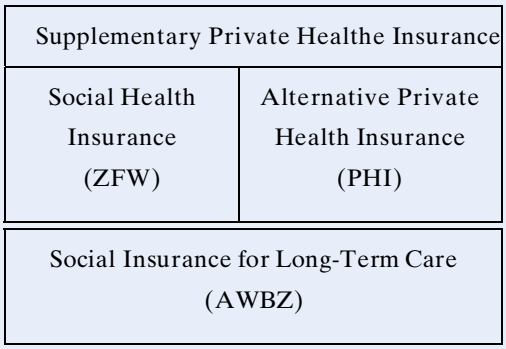
Health insurance in the Netherlands: before and after the reform

Before the 2006 health insurance reform in the Netherlands, the health insurance system was composed of four parts (see Figure 1). Two of these parts – long term care insurance and supplementary private health insurance – remained more or less unchanged . However, the former social health insurance scheme (Dutch abbreviation: ZFW) und the former alternative private health insurance scheme (PHI) ceased to exist. As a consequence of the reform a new universal "private" social health insurance scheme (ZVW) was established (see Figure 2 and Table 1).

Although the new health insurance scheme is executed by private firms, regulation of the new universal health insurance system is essentially social . All health insurers are obliged to accept all applicants;

Figure 1

Health Insurance in the Netherlands before the reform



premium rate restrictions do not allow risk-rated premiums. For different risks, insurers are compensated for by a health-based risk adjustment system.

The new health insurance scheme is compulsory for all inhabitants of the Netherlands although there is no control mechanism to seek out individuals who fail to take out health insurance. All health insurers offer a standardized basket of services. The Ministry of Health determines an income-dependent premium, which is the same for all health insurers (6.5 percent up to an income ceiling of 30,015 euros p.a.). This income-dependent premium is intended to cover 50 percent of all expenditures of health insurers. Employers pay employment-based, income-dependent premiums into a central fund. Tax authorities determine income-dependent premiums for all other income categories (capital, self-employment, etc.), which are also paid into the central fund. Individual health insurers receive risk-adjusted capitation payments from the central fund.

Another 50 percent of expenditures are financed by community-rated premiums. Community-rated premiums differ among health insurers. Premium differ-

Figure 2

Health Insurance in the Netherlands after the reform

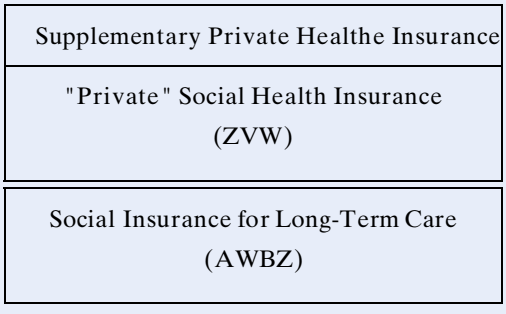


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Table 1

Key elements of the Dutch health insurance reform

	Old system		New system
	Social health insurance	Private health insurance	"Private" social health insurance
Clients	Employees und self-employed under income ceiling (mandatory) 70% of the population	Employees und self-employed above income ceiling (voluntary) 30% of the population	All inhabitants (mandatory)
Premium calculation	Income dependent (85%) Community rating (15%) No risk rating	Risk rating	Income dependent (50%) Community rating (50%) No risk rating
Benefits	Standardized	Individual	Standardized
Benefits in kind or benefits in cash	Benefits in kind	Benefits in cash	Both
Voluntary deductibles	No	Yes	Yes
Group contracts	No	Yes	Yes

Source: Greß et al. 2006.

ences are supposed to indicate differences in efficiency between health insurers to consumers. The average community-rated premium was 1,060 euros per year in 2006. Low-income individuals receive premium subsidies. These premium subsidies are based on individual need and are paid for by tax money. The state also pays for the community-rated premiums of children (up to 18 years).

Consumers are able to choose from a variety of different options. First they can choose between benefits in cash (formerly provided only by private health insurers) and benefits in kind (formerly provided only by social health insurers). Moreover, consumers are able to choose voluntary deductibles (up to 500 euros per year) and receive premium discounts in return. Before the reform, this option was only available with private health insurance. Furthermore, health insurers are allowed to offer group contracts and grant a premium discount in return in the new health insurance system. They may also offer preferred provider arrangements.

Consequences of the reform

The new universal health insurance system was implemented in January 2006. A number of short-term effects became obvious one year after the start of the reform. First, we review the financial consequences for private and public households as well as for employers. Second, we analyze the rather dramatic consequences of the reform for consumer mobility and the insurance market.

Financial consequences

Since the reform changed the premium calculation of health insurers – for the former social health insurance as well as the former private health insurance – the impact of the reform on the purchasing power of private households depends on the former insurance status of individuals. Individuals who used to be covered by social health insurance now pay a higher community-rated premium and a lower income-dependent premium. This effect is attenuated by the tax-financed subsidies for low-income groups. The financial consequences for individuals who used to be covered by private health insurance primarily depend on the age of the individual concerned. Young individuals used to pay low premiums while the elderly used to pay high premiums. Moreover, the Dutch government very carefully tried to minimize negative financial consequences for private households – e.g. by raising old-age pensions and by increasing allowances for families with children.

The government's strategy to minimize negative financial consequences of the reform has been mostly successful. According to a study by the Centraal Planbureau (CPB), average purchasing power of private households has increased by 1.5 percent in 2006. This increase is attributed largely to the direct (changes in premium calculation and premium subsidies for low-income households) and indirect (compensation measures such as the increase of allowances for households with children) financial consequences of the health insurance reform.

According to the CPB, 80 percent of households have more purchasing power after the reform while about 20 percent of households lost some purchasing power after the reform (CPB – Centraal Planbureau 2006).

The consent of employers was crucial for the success of the health insurance reform. The reform requires employers to pay income-dependent premiums for employees who used to be insured privately – which resulted in an increase in the financial burden of employers. However, the government tried to avoid increasing the financial burden of employers as a result of the reform. Thus, the income-dependent premium and corporate taxes were slightly lowered. As a consequence, the financial effect of the reform on employers was neutralized (CPB – Centraal Planbureau 2005).

The direct, short-term financial effects of the reform for public households so far has been negligible. Before the reform, the national government paid 3.6 billion euros into the central fund of social health insurers. Since the reform, the government has paid about the same amount for premium subsidies of low-income households and for financing the community-rated premiums of children (CPB – Centraal Planbureau 2005). However, this calculation does not include additional expenditures for compensation measures for private households and employers (see above). Moreover, in the long run expenditures will increase if health care expenditures go up, and community-rated premiums will increase. In that case, expenditures for premium subsidies for low-income households will also go up.

Price competition, market concentration and consumer mobility

As a result of the reform, the health insurance market in the Netherlands changed dramatically. Price competition between health insurers became very fierce, about one of five consumers changed health insurers and the consolidation of the health insurance market continued.

According to the calculation of the government, the average community-rated premium in 2006 was expected to be about 1,100 euros per year. Several independent analysts and health insurers predicted an average of between 1,250 euros and 1,300 euros (Douven and Schut 2006a). However, the average community-rated premium was 1,060 euros in 2006. If premium discounts for group contracts are taken into account, the average community-rated premium was only 1,030 euros per year. This low rate was due to two reasons. First, the Ministry of Health set a rate for the income-dependent premium that was too high. As a consequence, more than 50 percent of the expenditures of health insurers are financed by income-dependent premiums. Second, health insurers were aware of the fact that consumer mobility in health insurance markets – in the Netherlands and elsewhere – is driven primarily by price (Laske-Aldershof et al. 2004). As a consequence, health insurers tried to offer attractive community-rated premiums in order to attract as many consumers as possible. They did so primarily by designing low-priced group contracts with employers. Most of them priced their policies below costs. Resulting deficits had to be financed by financial reserves (Douven and Schut 2006b). In 2007 the rate for the income-dependent premium stayed constant while the average community-rated premium increased by about 100 euros per year.

One of the most dramatic consequences of the health insurance reform was a one-time increase of consumer mobility. Before the reform, consumer mobility and price sensitivity in the Dutch social health insurance system was rather low (Greß et al. 2003; Schut et al. 2003). According to a NIVEL (Netherlands Institute for Health Services Research) study, about 21 percent of all consumers changed to another health insurer in 2006.[1] Fourteen percent of consumers stayed with the same health insurer but chose to take out another policy. It is remarkable that the switching rates of persons who were chronically ill was only slightly lower. The dynamics of consumer mobility are driven primarily by low-priced group contracts. Seventy-eight percent of all group contracts are concluded by employers, 8 percent by unions and 2 percent by patient organizations (De Jong et al. 2006a).

While consumer mobility was extremely high in 2006, consumers were reluctant to use the full extent of new options to choose from. Seven percent of all consumers chose a voluntary deductible – 93 percent refrained from doing so. This number is rather low. Thirty percent of consumers had a deductible before the reform (De Jong et al. 2006b).

Although consumers may choose between 41 individual health insurers, market concentration has

[1] It is expected that consumer mobility will decrease to between 3 and 5 percent in 2007.

increased considerably since the implementation of the reform. The health insurance market is now dominated by four conglomerates of health insurers (VGZ-Groep, TRIAS-Groep, CZ/OZ and Achmea-Groep). Formally these conglomerates consisted of individual health insurers – both private and public insurers. In fact, however, these individual insurers are only labels of the consolidated conglomerate. The four conglomerates amalgamate 22 individual health insurers and have a joint market share of 80 to 90 percent. So far, the Dutch Competition Authority has not intervened.

Conclusion

The introduction of a single health insurance system in the Netherlands has provided more transparency for consumers. The rather arbitrary separation between social health insurance and private health insurance of the past has been abolished. This is a major achievement, since policy makers in the Netherlands had tried to introduce an universal health insurance system since the early 1990s (Schut and Van de Ven 2005). The distinction between public health insurers and private health insures has disappeared. As a consequence, all consumers are able to choose between all insurance companies on the market – both the former public and the former private health insurers – and from a variety of other options. So far, group contracts of health insurers and employers seem to be the key driver of price competition and consumer mobility. Probably the most important short-term effect of the reform is the dramatic one-time increase of consumer mobility. While consumer mobility was dormant before the reform, consumers started actively comparing prices and options after the introduction of the reform. This is an important prerequisite for successful managed competition (Greß 2006b).

While the short-term effects of the reform seem to be in line with the intentions of policy makers, it remains to be seen whether the same is true for the long-term consequences of the reform. One key aim of reform was that the new system should lead to a more efficient provision of health care services. Health insurers are able to contract selectively with health care providers in outpatient as well as in inpatient care in order to negotiate a favourable relationship between quality and price for their consumers. The system of health-based risk-adjustment provides incentives for health insurers to attract consumers with chronic conditions. However, so far competition between health insurers is based on price only – group contracts of patient groups with insurers are an important exception. As a consequence, the quality of health care services is not yet an important tool for health insurers to attract consumers.

From a comparative perspective, the health insurance reform in the Netherlands is a rather fascinating example of cross-country policy learning. Some key features of the Dutch reform such as the introduction of a universal health insurance system, mandatory coverage for the entire population, tax-financed premium subsidies for low-income consumers and voluntary deductibles can also be found in the Swiss health insurance system. What is more, shortly after the introduction of the reform in the Netherlands, policy makers in Germany became very interested in the design of the new Dutch system. There was a steady flow of Dutch experts – including the Minister of Health – coming to Germany in the first half of 2006 in order to explain the reform. As a result, some key features of the health care reform 2007 in Germany look strikingly similar to the Dutch system: the introduction of a central fund to allocate resources to health insurers, mandatory coverage for the entire population, more options for consumers to choose from (including voluntary deductibles), a uniform income- dependent premium, a community-rated premium determined by health insurers, health-based risk adjustment and more instruments for health insurers to contract selectively (Greß 2006a). However, one very important difference between Germany on the one hand and the Netherlands and Switzerland on the other hand remains: the rather arbitrary separation of social and private health insurance in Germany.

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