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Failure to pay for social health insurance premiums: Acts of protest or desperation?

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ABSTRACT

Background. In Switzerland, basic health insurance is mandatory for all inhabitants, but a rising number of insured have arrears in premium payments, potentially leading to coverage suspension. We aimed at characterizing insured with debt enforcement proceedings with respect to socio-demographic and health utilization aspects.

Methods. Cross-sectional analysis of 508.000 insured with basic health insurance contracts in 2013, of whom 14,000 (2.8%) with debt enforcement proceedings, from 11 Swiss cantons. Groups were characterized using logistic regression and latent class analysis.

Results. Insured with debt enforcement proceedings were more likely to be young, male and without dependents (partner, kids). Having no supplementary insurance and receiving partial premium subsidies was associated with an increased debt enforcement proceedings risk.

Within the debt enforcement proceedings group, three subgroups were identified: 60% were young and seemingly healthy, with a below-average fraction of premium subsidy recipients (18%) and low out-of-pocket payments in prior year (median Swiss Francs 0).

Two groups consisted of relatively ill elderly persons (22%, 99% of whom with chronic illnesses) or families (18%), many of whom (29% and 51%) were recipients of premium subsidies. Median out-of-pocket payments in the prior year were high (Swiss Francs 625 and 688, respectively).

Conclusions. Sixty percent of premium arrears derive from young insured without apparent financial problems; 40% are owed by elderly and families, which are potentially hurt by coverage loss.

Introduction

For statuary health insurance, Switzerland has opted for a social insurance system (Enthoven, 1978), which is characterized by mandatory enrollment into health plans, fixed and comprehensive coverage of drugs and treatments, and community-rated insurance premiums (Thomson et al., 2013). Furthermore, income-dependent premium subsidies are available for individuals in need. Those subsidies should ensure universal access to care, which, according to the latest OECD country assessment, has been widely achieved in Switzerland (Organisation for Economic Co-operation and Development, 2011).

Some authors have pointed out that access to care may not entirely be universal in Switzerland, however. Around 40% of all health care expenditures of CHF 65 billion in 2012 are carried by households, thereby leaving Swiss insured with the highest out-of-pocket payments for health care of all OECD countries (OECD Health Data, 2013). It is well known that high deductibles and co-payments can be a hindrance for access to care, and surveys have shown that foregoing medical care for economic reasons is quite prevalent in Switzerland (Guessous et al., 2012; Wolff et al., 2011) and elsewhere (Wharam et al., 2007; Galbraith et al., 2012). For example, the long-running Commonwealth Foundation survey queries randomly selected inhabitants from 11 resource-rich countries (including Switzerland) on various aspects of health care financing and access to care (Schoen et al., 2010). In this survey, 10% of Swiss respondents reported not having sought a doctor or not having refilled a drug prescription for financial reasons. This percentage was somewhat higher than in The Netherlands (6%) – with a comparable health care system – and the UK (5%), but lower than, for example, in Germany (25%) and the USA (33%). Surveys from the Swiss canton of Geneva yielded a similar prevalence of foregone health care (14%), which predominantly concerned dental care (75%), but also specialist care (33%) and general practitioner appointments (15%) (Guessous et al., 2012; Wolff et al., 2011). The Geneva study further revealed that foregoing health care was – at least partially – driven by

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disposable income, with more frequent reports of foregone health care utilization in low-income strata. Furthermore, the Commonwealth Fund survey discovered that individuals suffering from chronic conditions (asthma or chronic lung problems, cancer, diabetes, or heart disease) were also more frequently experiencing financial barriers to care than healthy respondents in Switzerland (18% of chronically ill vs. 13% of healthy individuals) (Schoen et al., 2013). This finding is particularly disconcerting because delayed or foregone health care can exacerbate chronic illnesses (Heisler et al., 2004).

Failure to pay for mandatory health insurance premiums can also lead to limitations in access to care (c.f. (Crivelli, 2005; Crivelli, 2010)). In 2006, the Swiss parliament responded to a rising volume of outstanding social health insurance premium bills with a legislation change that allowed health insurers to suspend insurance coverage (except for emergency treatment) until payment of all premium debts. Subsequently, the number of individuals with coverage suspension rose sharply from 89,000 in 2006 to almost 147,000 insured in 2010, which corresponds to 1.9% of all Swiss inhabitants (Bundesamt für Gesundheit, 2013). An additional 363,000 to 421,000 insured were faced with at least one debt enforcement request for outstanding insurance premiums, which is the initial step towards insolvency and asset seizure. The sanctions for late premium payments were intended to deter free-riding, especially by young and healthy individuals with sufficient income, but it soon turned out that they also hurt many insured with financial problems. For example, of all insured with coverage suspension during spring 2009 in the canton of Ticino, 30% had limited financial means and received premium subsidies (Crivelli, 2010). Those and other observations triggered the parliament to revise the law in 2009. Effective since January 2012, health insurers are no longer allowed to suspend coverage autonomously. Instead, they must report late premium payers to cantonal authorities, and after initiation of debt collection proceedings insurers are reimbursed 85% of the outstanding debt by the cantons in return for maintaining health coverage. Coverage suspension is still possible, but it must be initiated by cantons after due consideration of an insured's circumstances of living (for instance, insurance coverage cannot be suspended for children or persons on welfare). As of 2014, 9 cantons have established “black lists” of insured with suspended coverage (which are accessible by health care providers), but the effectiveness of this measure is debated.

Little is known about the reasons for non-payment of health insurance premiums in Switzerland. Given the possible implications of insurance coverage suspension – particularly for ill individuals – this knowledge gap is quite astounding. This cross-sectional study aimed at characterizing the population of insured with debt enforcement proceedings due to outstanding health insurance premium bills. Secondly, we performed an ecological analysis in which we explored how the risk for missed premium payments is linked with household premium burden and age (after adjustment for family status).

Methods

Setting

Purchase of a basic insurance with standardized, comprehensive coverage is required for all persons living in Switzerland. A minimum deductible of CHF 300 (1 CHF = 1 USD or 0.833 EUR; EUR 245) and co-payments of 10% up to a ceiling of CHF 700 (EUR 573) are mandatory for all for insured >18 years, whereas children have no deductible and co-payments are capped at half of the amount for adults.

Health insurance premiums are community-rated, but premium reductions can be granted to children (mandatory), young adults (at insurer's discretion) and for higher voluntary deductibles (ranging from CHF 500 [EUR 409] to CHF 2500 [EUR 2045] annually) or limitation of physician/provider choice (voluntary gatekeeping and/or managed care).

Premium subsidies are available to individuals in need based on taxable income. Each canton has implemented its own subsidy system with different eligibility criteria. Currently, 30% of all insured benefit from subsidies, with higher fractions among young insured aged 25 or less and individuals aged 86 and above (Bundesamt für Gesundheit, 2013). Assessments of the subsidy system have attested to its effectiveness to keep the premium burden below a pre-specified level, but these reports also criticized that the growth of subsidy funds has not kept pace with insurance premium increases (Kägi et al., 2012). Furthermore, several cantons are discussing or have implemented additional restrictions to subsidy access for economic reasons.

Debt enforcement proceedings for health insurance premiums are governed by the Swiss Health Insurance Act. In case of missed premium payments, after at least one warning letter insurers can start debt enforcement proceedings with cantonal authorities. If the bills remain unpaid, the insurer can initiate asset seizure. If the liquidation of assets does not generate enough funds to cover the unpaid bills, the insurer will receive 85% of the outstanding debt from the canton in return for maintenance of full insurance coverage for the indebted insured. However, cantons are allowed to sanction those debtors by limiting their coverage to emergency treatment (i.e., by placing them on “black lists”, which can be viewed by health care providers).

Data

Anonymized data was provided by CSS insurance, which is the largest social health insurer in Switzerland with a market share of 16%. This insurer's population of enrollees tends to be somewhat older and more ill than the average Swiss population, but is otherwise very representative. Our study included insured with a mandatory health insurance contract for the year 2013 (one year after the change in law forbidding autonomous coverage suspension by insurers).

We only considered insured from eleven cantons in which premium subsidies were handled by insurers (as opposed to direct subsidy payment to insured), and hence for which subsidy data were available from the insurer. As a limitation for generalization, while all language regions and both urban and rural cantons were represented in this sample, the regions of Central and Eastern Switzerland could not be included. Only one of these eleven cantons (Ticino) had implemented a “black list” by 2013.

The insurer data contained information on socio-demographic factors (age, sex, family status, place of living, eligibility for premium subsidies), chosen insurance coverage (deductible level, supplementary insurance coverage), medical information (presence of chronic illnesses as defined by pharmaceutical cost groups (Lamers and van Vliet, 2004), amount of reimbursed and out-of-pocket medical expenditures in past year, hospitalizations in past year), and timing of debt enforcement proceedings. Data on household income distributions were obtained from the Swiss Household Budget Survey 2006–2009 (Haushaltsbudgeterhebung (HABE)). Analyses were performed at the level of “payers” for insurance premiums (e.g., parents paying for children).

Statistical analysis

Payers of social insurance premiums were grouped into those with and those without debt enforcement proceedings (control group) in 2013. Those groups were compared with respect to socio-demographic, economic, and medical characteristics (see above) using univariable and multivariable logistic regression. The multivariable model was constructed by adding all variables with a likelihood ratio p-value <0.2 in the univariable regression to the multivariable regression (one variable at a time). Confounding, effect modifications, and co-linearity of variables were assessed case-by-case on the basis of effect-size changes. The final model was restricted to variables with a p-value <0.05 by