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Supplementary insurance as a switching cost for basic health insurance: Empirical results from the Netherlands

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ABSTRACT

Nearly everyone with a supplementary insurance (SI) in the Netherlands takes out the voluntary SI and the mandatory basic insurance (BI) from the same health insurer. Previous studies show that many high-risks perceive SI as a switching cost for BI. Because consumers' current insurer provides them with a guaranteed renewability, SI is a switching cost if insurers apply selective underwriting to new applicants. Several changes in the Dutch health insurance market increased insurers' incentives to counteract adverse selection for SI. Tools to do so are not only selective underwriting, but also risk rating and product differentiation. If all insurers use the latter tools without selective underwriting, SI is not a switching cost for BI. We investigated to what extent insurers used these tools in the periods 2006–2009 and 2014–2015. Only a few insurers applied selective underwriting: in 2015, 86% of insurers used open enrolment for all their SI products, and the other 14% did use open enrolment for their most common SI products. As measured by our indicators, the proportion of insurers applying risk rating or product differentiation did not increase in the periods considered. Due to the fear of reputation loss insurers may have used 'less visible' tools to counteract adverse selection that are indirect forms of risk rating and product differentiation and do not result in switching costs. So, although many high-risks perceive SI as a switching cost, most insurers apply open enrolment for SI. By providing information to high-risks about their switching opportunities, the government could increase consumer choice and thereby insurers' incentives to invest in high-quality care for high-risks.

1. Introduction

Several countries (e.g. Germany, Israel, Switzerland, the Netherlands, and the United States) have introduced a competitive market for basic health insurance (BI) to enhance efficiency, quality, and consumer responsiveness in healthcare. Health insurers in the Netherlands have the major task of purchasing care on behalf of their consumers. Consumer's choice of insurer is an essential precondition for achieving the intended results of a competitive health insurance market [1]. The government sets the rules of the game (e.g. an open enrolment period, community-rated premiums, and a risk equalization system) to facilitate consumer choice for BI.

The threat of consumers switching to a competitor must continuously stimulate insurers to be responsive to consumer preferences. In healthcare, these preferences are highly heterogeneous. For example, low-risks (i.e. young and healthy consumers) are mainly interested in price [2], while high-risks (i.e. elderly and unhealthy consumers) also value (the quality of) the composition of the provider network [3]. This implies that if groups of consumers with specific preferences are not free (or feel not free) to easily switch insurer, insurers have low incentives to be responsive to the specific preferences of these consumers.

In the Netherlands, the BI is a standardized benefit package defined by the government. Consumers can buy voluntary supplementary insurance (SI) for benefits not covered by BI. Because insurers offer BI and SI as a joint product, consumers' decision to switch insurer for BI is also influenced by their expectations regarding SI [4]. Previous studies [4,5] show that many high-risks perceive SI as a switching cost for BI. In 2012, 32% of the self-reported unhealthy consumers expected another insurer would not accept them for SI [5]. SI as a perceived switching cost by high-risks is a serious problem, because it reduces effective competition among health insurers for BI and thereby reducing insurers' incentives to be responsive to the preferences of the high-risk consumers, e.g. by reducing premiums and investing in high-quality care. Members of Parliament have frequently asked the government to regulate SI. However, the Dutch government repeatedly answered that the

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government is not allowed to regulate the SI market because of EU regulation (see e.g. [6,7]).

Dutch insurers guarantee to renew SI of their *current* enrolees. SI has become a (perceived) switching cost for BI because high-risks fear that other insurers apply selective underwriting and therefore would not accept them for SI, while the renewal of their current SI is guaranteed. Selective underwriting is one tool insurers can use to protect themselves against adverse selection for SI. Adverse selection is the tendency of high-risks to buy more insurance than low-risks because of a consumer information surplus [8,9]. Adverse selection may seriously threaten the stability of an insurance market [10]. However, besides applying selective underwriting, insurers can also counteract adverse selection by risk rating or product differentiation [9,11,12].

In the period 2006–2009, about 20% of the insurers used selective underwriting (based upon health questionnaires) in the acceptance procedure for new applicants for at least one of their SI-products [13,4]. The remaining 80% used open enrolment (i.e. they accepted all applicants without the exclusion of pre-existing conditions) for all of their SI-products. In the following years, several changes in the health insurance market increased insurers' incentives to protect themselves against adverse selection for SI. Therefore, our research question is: "Did insurers use more visible and straightforward tools to counteract adverse selection in 2014–2015 in comparison with 2006–2009?".

To answer this question, we will extensively review insurers' practices in the SI-market by evaluating the policy conditions of the SI-products offered. Our conclusions may help policymakers to design effective solutions to increase high-risk individuals' choice for BI and thereby increase insurers' incentives to reduce premiums and invest in high-quality care for them. Other countries that have introduced a competitive BI-market and allow a joint purchase of BI and SI (e.g. Switzerland) can learn from the Dutch experiences.

The article is organized as follows. Firstly, we describe the background of the problem. Secondly, we describe the insurers' tools to protect themselves against adverse selection, and indicate when SI is a switching cost for BI. Thirdly, we pay attention to the behaviour of Dutch insurers in the SI-market in the periods 2006–2009 and 2014–2015 and describe potential explanations for our observations. Fourthly, we conclude and discuss our results.

2. Background of the problem

In 2015, 84% of the Dutch population had SI [14] (see Table 1 for a description of the Dutch health insurance market). More than 99% take out BI and SI from the same insurer [22], because 1) one-stop shopping has several advantages (e.g. a good coordination of basic and supplemental benefits) [23]; 2) almost all insurers make it unattractive or impossible to take out separate SI [4]; and 3) consumers may be unaware that they are allowed to take out BI and SI from different insurers [24].

The SI market is an unregulated competitive market without risk equalization. Insurers are allowed to refuse applicants or charge risk-rated premiums for SI. For the contract-years 2006 and 2007, insurers collectively agreed – under strong societal and political pressure – to accept all applicants for the majority of their SI-products and to charge mostly community-rated premiums for SI [25,4]. Given this pressure, insurers came to this agreement in 2005 when there was a very critical discussion about the introduction of the Health Insurance Act (implemented on January 1, 2006) and the role of commercial insurers. In late 2006 they prolonged this agreement.

So, for the years 2006 and 2007 consumers had the possibility to take out their preferred SI-product with an (almost) community-rated premium. However, from late 2007 the insurers no longer made this voluntary collective agreement. As a form of self-regulation, however, each insurer continued to incorporate a guaranteed renewability (GR) clause in each SI contract [4]. GR consists of a guaranteed, automatic renewal of SI with an equal adjustment of the premium and other policy conditions for all consumers with that specific SI. Thus, all consumers with the same SI are at renewal of this SI – irrespective of changes in their health status – confronted with the same changes in the premium, coverage and other policy conditions. In addition, if insurers adjust the premium or other policy conditions for a certain SI product – e.g. by starting charging risk-adjusted premiums – they should do this equally for all of their current consumers with this SI product.

Due to the 2005 agreement among insurers and the GR in each SI contract, SI has become a perceived switching cost by in particular high-risks. In 2012, 6% of the healthy consumers expected another insurer would not accept them for SI, while 32% of the unhealthy consumers revealed this expectation [5]. SI as a perceived switching cost by high-risks has adverse consequences, because it reduces effective competition among health insurers for BI and it substantially reduces insurers' incentives to reduce premiums and to invest in high-quality care for high-risks.

2.1. Increasing incentives for insurers to counteract adverse selection for SI

Several recent changes in the Dutch health insurance market increased the insurers' incentives to protect themselves against adverse selection for SI.

First, several developments in the SI market indicate the existence of adverse selection. For example, the percentage of consumers without SI increased from 7 in 2006 to 16 in 2015 [14]. Reitsma-van Rooijen and De Jong [26] showed that the majority of the consumers without SI (i.e. 72% in 2014) did not take out SI because they do not need the care covered by SI. Another indication of adverse selection is that the consumers with SI buy on average SI-products with less comprehensive coverage, which indicates that the consumers became more selective in choosing only the coverage they need. For example, the demand for SI-products covering physiotherapy decreased from 66% in 2011 to 49% in 2012 [27]. In addition, different consumer organizations (e.g. "Consumentenbond" and www.independer.nl) and current affairs programs (e.g. "Radar") have advised low-risks to be critical and to carefully evaluate whether SI is attractive to them. These tendencies increase

Table 1
Description of the Dutch SI market.

	2006	2007	2008	2009	2014	2015
Number of insurers[a]	33	32	32	30	26	25
% of consumers taking out BI and SI from one of the four largest group of insurers	91	91	91	91	90	89
% of consumers with a SI	93	93	92	90.1	84.5	84.0
% of consumers switching to another insurer	18	4.5	3.5	3.5	6.5	6.8

Source: NZa [15,16]; Vektis [17–21,14].

[a] Dutch insurers are allowed to offer BI under different names (i.e. under different labels).