Dutch health insurers and their opinion of the Dutch risk equalization system

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PREFACE

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Summary

Objective
The objective of this thesis is to study the Dutch health insurers' opinion of the Dutch risk equalization system, and their suggestions for improvements. The central question is:
'What do Dutch health insurers think of the 2007 Dutch risk equalization system, and – in their opinion- which changes should be made to it?'

Methods
The central question has been answered by means of semi-structured interviews with 12 employees of various insurance companies.

Results
All insurers support the risk equalization system. One respondent thinks that a distinction should be made between S-type and N-type risk factors and that individuals can be held responsible for costs not related to health. The other respondents think that open enrolment and a ban on premium differentiation are essential elements, and that variation in premiums can lead to inequalities in access to health care.

All respondents answer that predictable costs are compensated for a large part, but there are also predictably profitable and unprofitable risk categories. Especially the chronically ill with high costs, people living in a large city, and individuals with a low income are predictably unprofitable. There is also no complete fair distribution of subsidies among insurers. While in theory predictable profits and losses can lead to cream skimming activities, only one insurer thinks that it is an issue in 2007. Some insurers think that cream skimming can become an issue in the future. Reasons not to cream skim are the social function of health insurers and the fear for negative publicity. Tools that can be used to cream skim are supplementary insurance, target group marketing and collective insurance schemes.

It seems that the goal that insurers should be rewarded for efficiency is not obtained yet. For a large part, this is due to the ex-post correction mechanisms that cream-off part of the saved costs. Over the past two years, insurers mainly focused on controlling overhead costs. Saving costs of the care itself, such as negotiating on the price, selective contracting, transferring care from inpatient to outpatient care, and prevention did not really come about yet. In future years most insurers will probably focus on these aspects. Since the benefits of investments to reduce future costs are insecure, however, insurers are somewhat reserved in making them. Remarkably two insurers do not believe that price negotiations will save any costs at all, because it will not lead providers to act more efficiently. Most insurers do not think that policies with

only a few selected preferred providers are desired. Since particularly healthy people will choose such a cheaper policy, they undermine the solidarity principle.

The most important shortcoming of the risk equalization system is a lack of transparency. This includes the availability of the risk-adjusters for insurers, the information used for the determination of the subsidies, and the allocation of the subsidies. Additional weaknesses are timeliness, errors, and a lack of supervision. These affect the reliability of the provided information and lead to more insecurity about financial results. The government also phases out ex-post mechanisms without really demonstrating that the ex-ante model has improved objectively. Some insurers are of the opinion that the ex-post correction mechanisms should be phased out only if the ex-ante model has improved objectively, while others think that the efficiency aspect should also play a role. However, not all insurers do believe that increasing the financial risks of insurers will give them more incentives for efficiency.

All respondents think that in the future the Dutch health insurance market will be characterized by a further concentration of insurers. Increases in scale are related to three factors, namely overhead costs, volatility of results, and higher future solvability demands. Not all insurers are sure whether in a concentrated market the original goals of the Health Insurance Act will be realized. Suggestions for improvements to the system are extending the model with new factors or categories, such as physiotherapy, medical devices, high-risk equalization, and multi-year high costs. Several respondents mention that it is important, however, to make a trade-off between improving the predictive power and feasibility. The system needs improvements when it comes to transparency, reliability, and timeliness.

Developing an adequate risk equalization model for the short-term mental care seems to be very difficult, or maybe impossible. For the long-term entitlements, currently covered by the Exceptional Medical Expenses Act, it is nearly impossible. Costs are highly skewed among individuals and insurers, while the group of users is very small. Most respondents think that short-term mental care can be executed in a competitive market, for the long-term care not everyone is sure whether it fits the Health Insurance Act.

Conclusion

While Dutch insurers support the Dutch risk equalization system, it needs especially improvements when it comes to predictive power, transparency, reliability, and the decision-making around the ex-post correction mechanisms. The government should also be more explicit about the meaning of the level playing field, and the desirability of a further concentration of health insurers. With regard to the transferring of current AWBZ entitlements to the ZVW, the government should take into account that an adequate risk equalization model is of high importance, and whether all types of long-term care fit in the organizational structure of the Health Insurance Act.

I INTRODUCTION

In 2006 the Health Insurance Act was introduced in the Netherlands. This is a statutory insurance regime that covers all residents of the Netherlands for the necessary short-term health care. It is a private health insurance with social conditions. Under this Act, competition among health insurers is used to provide them incentives for efficiency and to act as customer-oriented driven organizers of care.

A main characteristic of an unregulated competitive insurance market is that insurers will ask a premium that reflects the risks associated with the client. As a result, chronically ill, for instance, pay a higher premium for a specific benefit package than healthy individuals. Since premium differences can be rather extreme, these can lead to a lack of financial access to health insurance for unhealthy individuals.

Since it is understood that in modern society universal access to health care must be guaranteed, however, the Dutch government decided to regulate the health insurance market. Insurers are legally bound to accept anyone who applies for cover, and they are not allowed to differentiate the premium according to personal characteristics like age, gender or medical situation. The disadvantage of these measurements, however, is that they will lead to insurers making predictable profits on healthy individuals, while making predictable losses on the unhealthy. Insurers with a relatively high proportion of unhealthy clients would be at a disadvantage compared to competitors with a relatively healthy portfolio, because they are forced to ask a higher premium to compensate the losses on the unhealthy individuals in their portfolio. Therefore, insurers will try to seek for ways to attract healthy individuals, while trying to refuse the unhealthy ones.

So, financial transfers are needed to compensate for differences in risk characteristics. The best way to organize these transfers, is to set up a system of risk equalization. This system makes use of risk-adjusted premium subsidies, where low-risk individuals pay mandatory contributions to subsidize the high-risk individuals for their premium. In the Netherlands the payments are organized by means of statutory income-related premiums, which are paid to the Risk Equalization Fund. From this fund risk-adjusted subsidies, based on the risk characteristics of the portfolio, are made to the insurers. Predictable profits and losses are mitigated, and a ‘level playing field’ for insurers is created.

Ideally, the result should be a market where insurers have an incentive to compete for clients on the way they organize the care, the level of the premium and service. At the same time, consumers are given choice of insurers, while everyone is able to receive good quality care for a reasonable premium. Ultimately, this must provide a good balance between a solid social basis and the dynamics of a competitive market.

Insurers are one of the key actors in the Health Insurance Act. Their role is not only to pay for the costs of provided care, they must ensure that they provide their clients the care they are entitled to. The crucial point for them is an adequate risk equalization system, which really compensates the predictable costs of their clients and enables them to compete on the way they execute the provisions of the Health Insurance Act.

The Dutch government frequently reports on the developments in and improvements of the Dutch risk equalization system. Moreover, several studies have been published on this issue. As far as the opinion of health insurers is concerned, however, limited information can be found.

Since health insurers are an important success factor when it comes to the risk equalization system and only limited information can be found about their opinion, it would be interesting to find out about their opinion. Interesting questions in this respect are what they think of the Dutch risk equalization system, whether they think risks are compensates adequately, whether the system suffices their needs, or whether the system needs to be improved.

For that reason, this thesis has been written. The goal is to discuss the Dutch health insurers' opinion of the 2007 risk equalization system, and their suggestions for future improvements.

The central question that is answered is:
'What do Dutch health insurers think of the 2007 Dutch risk equalization system, and – in their opinion- which changes should be made to it?'

To come to an answer to the central question, the following research questions are addressed:

1) What is the rationale of risk equalization?
2) What are the criteria for an 'ideal' risk equalization system?
3) Which risk-adjusters can be used to predict future health care costs?
4) If the system is imperfect, which tools can be used to create the desired cross-subsidies?
5) What are the goals and characteristics of the Dutch risk equalization system?
6) Which future developments concerning the Dutch risk equalization system can be expected?
7) What is the opinion of Dutch health insurers of the current system?
8) Which suggestions are made by insurers to change the current system?
9) When it comes to the opinion on the Dutch risk equalization system, are there any commonalities or differences among insurers?

In chapter two, the theory about risk equalization is given. The rationale and the goals are discussed, and an overview is given of potential risk factors that can be used for the subsidies. Also, possible problems and solutions are discussed in case the risk equalization model does not predict all health care costs adequately. Chapter 3 describes the Dutch health insurance market and risk equalization system in detail. In chapter four research methods, the way the data was collected, and methodological issues related to this study are described.

The opinion of Dutch health insurers has been studied by means of one hour semi-structured in-depth interviews with employees of various insurance companies. They are all familiar with risk equalization. Chapter 5 presents the results of the interviews. Finally, in chapter six, the results are discussed in more detail, and an answer is given to the central question. Also, several recommendations are provided.

II CONCEPTUAL FRAMEWORK OF RISK EQUALIZATION

2.1 The goal of risk equalization in social health insurance

In modern society, everyone should have access to proper health care. Arranging this is a core task of the government. According to this idea, health insurance is normally understood as social insurance that must assure universal financial access to health care (Enthoven 1988). The essential element of social health insurance is cross-subsidies. To make health insurance affordable for everyone, unhealthy (high-risk) individuals receive subsidies from healthy (low-risk) individuals.

In the past, many countries used to have their health care system organized by means of central planning. The disadvantage of this system, however, is that it is inflexible and provides little incentives for providing efficient, consumer-oriented care. Therefore, many countries decided to reform their health insurance system and turn it into a competitive market. The main goals of these reforms were increasing efficiency and client satisfaction in combination with solidarity and effective control of aggregate spending (Van de Ven et al. 2003). In this market, health insurers should act as prudent purchasers of health care for their clients.

In an unregulated competitive health insurance market cross-subsidies cannot be sustained since a break-even point, in expectation, has to be reached on each insurance contract. This is called the equivalence principle. Insurers therefore risk-rate their premium according to the risk profile of individuals. In such a market, healthy individuals pay a lower premium than unhealthy ones. The difference between the highest and lowest premium can go up to a factor of 100 or more (Van de Ven and Ellis 2000), and results in a situation where individuals with a poor health status cannot afford their high premium and have no access to a proper level of health insurance coverage. So, an unregulated competitive health insurance market is incompatible with the principle of social health insurance.

The most effective way of enforcing cross-subsidies in a competitive health insurance market is setting up a regulatory system of risk equalization. This system makes use of risk-adjusted premium subsidies to compensate high-risk individuals for their health insurance costs (Van de Ven and Ellis 2000). In other words, low-risk individuals pay mandatory solidarity contributions to subsidize high-risk individuals. By doing this, the net payments of high-risk individuals to the system are reduced and affordability is improved.

The flow of payments can be organized in different ways (see, for instance, Van de Ven and Ellis 2000:766-67). Mostly, however, consumers pay a (income-related) solidarity premium to a solidarity fund. This fund is used to pay subsidies to insurers based on the risk characteristics of their clients. Since insurers receive subsidies for

predictable costs of high-risk individuals, they do not need – or at least to a lower extent- to ask for a risk-rated premium.

In sum, the goal of risk equalization is removing premium differences in a competitive health insurance market, by means of compensating consumers for their risk characteristics. Risk equalization allows a combination of solidarity and a competitive health insurance market.

2.2 The 'perfect' risk equalization model

To distribute the risk-adjusted premium subsidies, a risk equalization model is set up. Factors that are used for the risk equalization model are called risk-adjusters. Many risk factors can be used to predict future health care costs. In order to become a suitable risk-adjuster, however, a factor should ideally meet several criteria. These criteria can be clustered into three categories (see, for instance, Newhouse 1986; Epstein & Cummella 1988; Van de Ven & Van Vliet 1992; Lamers 1997): fairness, appropriateness of incentives, and feasibility. These criteria will be discussed in this section.

2.2.1 Fairness

It should first be decided for which risk factors cross-subsidies should be set. Society can decide not to subsidize all premium rate variation observed. For this purpose, a distinction can be made between S(solidarity)-type and N(no-solidarity)-type risk factors. Subsidies are desirable for premium differences relating to S-type factors, whereas no solidarity is desirable for N-type factors.

There is universal agreement about the reflection in subsidies of certain risk factors, such as gender, age, and health status. However, for others this is less clear. In general, it can be said that there should be subsidies for costs relating to risk factors that cannot be influenced by insurers or consumers. Hence, no subsidies are desirable for factors that can indeed be influenced. Whether or not a risk factor should be subsidized is a matter of value judgment which differs from country to country and from individual to individual. Society should somehow make an explicit decision to what extent it desires solidarity (Van de Ven & Ellis 2000). It can be said, for instance, that health care costs that are entirely related to a certain lifestyle do not call for compensation. On the other hand, it can be considered unfair not to treat people with serious diseases resulting from a certain lifestyle. Another factor for discussion is region. Differences in costs between regions can result from differences in health status, but also from practice style of providers, input price, taste, or accessibility. It can be decided to compensate cost differences relating to health only, for example.

The level of acceptable costs should also be determined. Acceptable costs refer to those costs of services that follow from a quality, intensity of treatment and price level that the government has decided that it is acceptable to subsidize. They could, for

instance, only involve costs for necessary and cost-effective care (Van de Ven & Ellis 2000).

A second feature of fairness is a predictive value. A risk equalization model should compensate the various risk-categories and it should not - systematically – underestimate or overestimate expenditure of identifiable sub-populations. For this purpose, it should define a system with relatively homogeneous cells with regard to health care needs.

2.2.2 Appropriateness of incentives

Risk-adjusters should give incentives for health-improving activities instead of reducing incentives for efficient production of health care. Moreover, they should compensate the costs with regard to necessity and quality of care. Furthermore, they should be easy to monitor and it should be difficult to manipulate them by parties that have an incentive for doing this.

2.2.3 Feasibility

It should be possible to collect the needed data without undue spending of time and money by all parties involved. For this purpose, risk-adjusters need to be collected routinely, they need to be standardized, and it should be possible to compare them between different insurers. Factors that can easily be validated are more feasible than those that cannot (Van de Ven & Ellis 2000). Moreover, risk-adjusters are only feasible if they are accepted by all parties involved. Risk-adjusters should not conflict with the right to privacy of clients and health care providers. The risk factors race and ethnic background, for instance, may be rejected because those are not considered ethical to be used as risk-adjusters.

2.3 Risk-adjusters in the literature

In order to find the right risk-adjusters to implement in the risk equalization model, several have been studied. This section gives an overview of the various risk-adjusters that can be found in the literature. For each factor, it is discussed to what extent the criteria of section 2.2 are met.

2.3.1 Demographic factors

Demographic factors such as age, sex and socio-economic status are used most as risk-adjusters. The rationale for using demographic factors is that they can adequately predict differences in health care expenditure, data about these factors are easy to collect, the factors are hard to manipulate, and they do not create inappropriate incentives (Lamers 1997).

A major weakness of demographic factors is, however, that they create categories that are too heterogeneous (ibid.). They do not take into account individual illness and therefore underestimate the costs of chronically ill people. Consequentially, demographic factors can be used as a basis for a risk equalization model. In order to

remove further unacceptable premium differences, however, other risk-adjusters need to be added.

2.3.2 Prior utilization

In a prior utilization model, subsidies relate to the prior use of health care. The main reason for using this factor is the fact that it is the best single predictor of future health care costs (Van de Ven and Van Vliet 1992, Thomas & Lichtenstein 1986, Beebe et al. 1985).

The main disadvantage of using this factor is the fact that insurers are paid according to prior use without regard of the appropriateness of the care, while differences in prior use can also be the result of discretionary practice patterns. Insurers that provide a relatively high number of services with a relatively low degree of efficiency, receive more subsidies than insurers that are more efficient. This might stimulate insurers to continue operating in an inefficient way (Lamers & Van Vliet 1996). Insurers can even 'pay off' losses resulting from excessive care in the base year by profits resulting from the increased clients' risk status in subsequent years (Epstein & Cumella 1988, Howland et al 1987). Second, in a prior use model no distinction is made between chronically ill people and those suffering from acute conditions (Lamers & Van Vliet 1996). Since health care utilization resulting from an acute condition leads to very different future costs than health care use resulting from an acute condition, however, this is undesirable. Finally, prior utilization does not take into account individuals who suffer from a medical condition but do not seek care (Stam 2007).

2.3.3 Self-reported health status

Self-reported health status consists of perceived health status, functional health status, and self-reported chronic conditions. Self-reported health status is the method most appropriate to measure perceived well-being, the extent of impairment, and attitudes towards health and medical care. It can be a good indicator of the severity of diseases and future costs of health care (Thomas and Lichtenstein 1986, Hornbrook and Goodman 1996).

Some advantages of using self-reported health status as a risk-adjuster are the fact that in order to get information it is not necessary that a health care provider has been contacted, the information provided is not influenced by practice style, and no prior history of claims or enrolment is needed (Hornbrook & Goodman 1996).

There are also several disadvantages of self-reported health status. First, it is relatively costly to conduct surveys in order to collect the needed data. Second, the response rate of these surveys is often low and can be correlated with health status. As a result, there are hardly any large samples to base a reliable prediction model on (Hornbrook & Goodman 1996). Third, some individuals might need assistance with completion of the survey. Fourth, it can be questioned whether it is ethical to detect and assess the health status of vulnerable population groups (Lamers et al. 2003). Fifth, incentives

for gaming are also created. Health insurers can encourage clients to deflate their health status score in order to make them look less healthy than they really are, and receive higher subsidies. Gaming can be counteracted by outcomes assessment, which provides an incentive for insurers to inflate health status scores and appear to have a healthier client base and better outcomes than competitors.

2.3.4 Physiological factors

McClure (1984) has introduced the approach of using physiological measures as a risk-adjuster. These measurers, such as blood sugar, blood pressure, respiratory function, and behavioural measures, are good predictors of the future development of diseases.

A major advantage of using physiological factors is that they reflect the risk of getting a chronic disease, while they can also predict acute episodes of several chronic diseases. Second, physiological risk factors can be measured and verified objectively, and it is difficult to 'game' them (Schauffler et al. 1992). Third, risk factors can be measured in the present and can identify previously unrecognized diseases that are not associated with prior utilization (Howland et al. 1987).

The main disadvantage is that in case that treatment alters the physiological measure and unhealthy people utilize more resources, the data do not necessarily reflect the relationship between an increase in expenditure and relatively unhealthy values (Newhouse et al. 1989). For example, a person with high blood pressure receives treatment that leads to a measured value below the one of a healthy person. While the person who receives medication generates more health care costs, a lower value leads to lower subsidy. Another disadvantage of using physiological risk factors is the fact that it brings along a lot of administration costs related to the collection and periodical assessment of the risk factors. Finally, it is worth considering whether it is ethical to require risk assessment without ensuring the follow-up of high-risk individuals (Schauffler et al 1992).

2.3.5 Diagnosis-based model

The idea behind a diagnosis-based model is that certain diagnoses can predict future health care utilization, and that clinical homogeneous diseases entail homogeneity in treatment, and therefore, in associated costs (Stam 2007). In a diagnosis-based model, more than 15,000 valid International Classification of Diseases (ICD-9) codes are grouped into more aggregated groups. Subsidies are based on these groups.

The major advantage of this model is that it can reduce inappropriate incentives related to prior utilization. This is because insurers are not paid for what they do, but receive subsidies based on diagnoses. Therefore, contrary to a prior use model, a diagnosis-based model does not penalize insurers that avoid unnecessary hospitalization and substitute it for cheaper outpatient care (Ellis et al 1996).

The main disadvantage of a diagnosis-based model is that of perverse incentives. In order to obtain higher payments in the future, there can be manipulation by means of inflating diagnoses and moving patients towards better paid categories. This manipulation of diagnoses can be counteracted by monitoring, putting similar diagnoses in the same diagnostic group and avoiding vague diagnoses (Lamers & Van Vliet 1996). One should look at the decreasing predictive accuracy of a model with relatively heterogeneous groups and the costs of monitoring, however, in relation to the benefits.

2.3.6 Information from prescribed drugs

The rationale for using information from prescribed drugs is the fact that they can be used as an indicator of treatment of chronic diseases (Von Korff et al 1992, Lamers 1999). There are several advantages to using information from them (Johnson et al 1994). First, dispensing signals that a health problem was serious enough to warrant intervention. Second, product selection, dosage and duration of prescribed drugs can reveal the severity of a certain condition. Third, prescription drugs are consistently coded.

There are also certain disadvantages to using a model based on prescribed drugs. First, dispensing patterns are influenced by the person prescribing them and can relate to unnecessary utilization of health care. Second, health status can vary substantially among patients who receive identical treatment, while it would be unfair to grant the same amount of subsidy for both a chronic disease and a minor temporary health problem (Van de Ven et al 2004). Third, people who do not seek care and do not have their prescriptions dispensed are not detected. This can result in underreporting bias. Fourth, there is the potential problem of inappropriate incentives. If additional subsidy for a classified individual exceeds the costs of the prescribed drugs that the subsidy is based on, providers might alter their prescription behaviour to maximize payment (Clark et al 1995, Lamers 1999). If assigning individuals to a certain category depends on the number of prescriptions, for instance, consumers could be given several small prescriptions instead of one for a longer period. As a result, the consumer ends up in a higher category resulting in a higher subsidy.

There are various ways of counteracting inappropriate incentives (Lamers and Van Vliet 2003). Instead of the number of prescriptions, the number of the daily doses prescribed could be used, for instance, or – in order to become eligible for subsidy- a threshold could be set. Other solutions could be establishing fewer categories, intensive monitoring, and excluding conditions that lead to a relatively small increase in subsidies. Again, just like the diagnosis-based model, one should look into the decreasing predictive accuracy of the model in case of relatively heterogeneous groups, and the costs of monitoring, in relation to the benefits.

2.4 Solutions to an insufficient system

The review of various potential risk-adjusters in the previous section reveals that it is quite a challenge to find risk-adjusters that meet all three criteria of fairness, appropriateness of incentives and feasibility. Because of feasibility problems, it is not always possible to implement adequate measures of health status. Therefore, incomplete or imperfect measures are used instead (Stam 2007). As a result, some unacceptable premium differences might stay whereas they should be reduced.

The best solution to improve an inadequate model is trying to extend it by new risk-adjusters. Factors that are not feasible yet, for various reasons, might become available in the future. Development of new risk-adjusters can be accelerated by means of insurers exchanging information about individuals and risk factors. If it is not feasible to improve the model, additional restrictions can be introduced in order to increase accessibility for high-risk individuals. These restrictions will be discussed in this section.

2.4.1 Market code

Insurers can voluntarily agree on a market code that only allows risk rating of premiums for N-type factors. The main disadvantage of a market code, however, is that it is hard to monitor whether all insurers stick to it. Moreover, European competition rules probably prohibit such an arrangement. It therefore seems unfeasible.

2.4.2 Premium rate restrictions and open enrolment

In order to increase access, the government can establish obligatory measurements. Premium rate restrictions allow insurers to vary their premiums only within certain boundaries, and rely on so called implicit cross-subsidies from low-risk to high-risk individuals. The idea behind it is that insurers set their premiums at a level that allows for predictable losses on high-risk individuals to be compensated by predictable profits on low-risk individuals.

Although premium rate restrictions intend to increase affordability for high-risk individuals, at the same time they create incentives for selection. Selection can be described as actions, undertaken by consumers and insurers, to exploit unprized risk heterogeneity and break pooling arrangements (Newhouse 1996). Two types of selection can be distinguished. First, adverse selection involves that low-risk individuals will feel that their marginal costs of buying a generous coverage will overweight the expected benefits of it. Therefore, they will try to distinguish themselves by buying new, more moderate, benefit packages designed especially for them, in exchange for a lower premium (Van de Ven and Ellis 2000). Hence, high-risk individuals are inclined to buy more coverage than low-risk individuals within the same premium risk group.

Second, cream skimming is selection that results from the fact that premium rate restrictions lead to predictable losses and profits. Having a portfolio with a relatively high degree of unprofitable individuals is a disadvantage, because then an insurer is forced to set a higher premium compared to others to compensate the relatively high proportion of predictable losses, and clients will try to find an insurer with a lower premium for the same benefit package. So, insurers prefer low-risk individuals to high-risk individuals within the same premium risk group (ibid.). If they have additional information about the risk equalization model (if they know which groups are profitable and which are not), they may try to contract only predictably profitable consumers (Ellis 1998). Insurers can 'cream skim' by simply refusing (the renewal of) a contract with unprofitable individuals (bad risks), while accepting predictably profitable individuals (good risks).

As a result, premium rate restrictions can result in a segmented market with insurers each serving a specific risk category. High-risk individuals pay a high premium for generous health insurance coverage at one insurer, while low-risk individuals pay a low premium for a moderate benefit package at another insurer. Some high-risk individuals will not be able to buy proper coverage at all.

In addition to premium rate restrictions, a sponsor can prevent cream skimming by imposing open enrolment. Under this regulation, each insurer is obliged to accept any applicant, whether profitable or unprofitable. Since predictable profits and losses are not mitigated, however, there are still incentives for selection. Although explicit selection is forbidden by law, some forms of hidden, implicit risk selection activities can be successful (Van de Ven et al. 2000). Examples of implicit cream skimming activities are not purchasing the best available care for the chronically ill, or selective advertising.

The adverse result is that the quality, affordability and efficiency of health care can be threatened (Van de Ven et al 2004). First, insurers that offer the best care arrangements to unprofitable individuals can expect a large inflow of those individuals. Thus, insurers that behave in a way that is socially desirable -contracting the best care available- might be forced to set a relatively high premium and lose market share. Thus, insurers have a disincentive to respond to the preferences of bad risks. Consequently, chronically ill people, for instance, do not have access to the best care available. Second, in the short run risk selection can be more profitable than investing in efficient care. An efficient insurer with a relatively large proportion of bad risks, can be off worse than an inefficient insurer with a relatively large part of good risks in its portfolio. Therefore, efficient managing of insurance does not determine the insurer's premium and financial result, but the composition of the portfolio does. If profits of cream skimming are high, insurers may prefer this to offering the best care available. While individual insurers might benefit from this type of activity, it means a welfare loss for society (Van de Ven & Ellis 2000, 776).

Third, cream skimming can lead to market segmentation where bad risks pay a high premium to one insurer, while good risks pay a low premium to another. This is a threat to solidarity.

So, it can be concluded that even in case of premium rate restrictions and open enrolment, an adequate risk equalization model is always of great importance.

2.4.3 Risk sharing

Risk sharing implies that insurers are reimbursed retrospectively for part of their costs caused by some of their members (Van de Ven and Ellis 2000). It can be used to complement the strategies of premium rate restrictions and open enrolment, or serve as an independent strategy. In an unregulated market, risk-rated premiums are adjusted to the level of the expected costs. So, if an insurer is compensated retrospectively for part of its costs, it can set a lower premium for its high-risk individuals. This way, affordability for this type of individuals is increased. To complement the strategies of open enrolment and premium rate restrictions, part of the predictable losses or profits are 'creamed off' and thus reduced. Consequentially, incentives for selection are also reduced, and accessibility for unprofitable individuals rises.

A disadvantage of risk sharing is that it reduces incentives for efficiency. Since part of the costs is reimbursed retrospectively, insurers might feel less of an incentive to operate efficiently.
In sum, in order to define which additional regulations should be established, affordability problems caused by an insufficient model, selection caused by premium rate restrictions and open enrolment, and a loss of efficiency caused by risk sharing should all be taken into account.

2.5 Conclusion

Risk equalization should ensure affordable health insurance for everyone by means of explicit cross-subsidies from low-risk to high-risk individuals. Ideally, these subsidies are adequate and only compensate health care costs, for which society thinks solidarity is desired. A review of various potential risk-adjusters supports the idea that in practice, however, it is hard to build an adequate risk equalization model that suffices all three criteria of fairness, appropriateness of incentives and feasibility. Consequentially, costs related to S-type risk factors are often predicted inadequately.

In order to increase affordability of health insurance for high-risk individuals in case of an insufficient model, premium rate restrictions, open enrolment and/or risk sharing can be used. A drawback, however, is that the first two create selection incentives, while risk sharing reduces efficiency incentives. In practice, therefore, risk equalization always involves some trade-off between affordability, selection and efficiency.

III THE DUTCH SYSTEM

3.1 Organization of the Dutch health insurance system

The Dutch health insurance system consists of three compartments. Each compartment has its own organization structure and covers a certain type of care. In this section, the organization of these three compartments is described.

3.1.1 The Exceptional Medical Expenses Act

The first compartment is the Exceptional Medical Expenses Act (AWBZ). This compulsory national health insurance scheme provides coverage for costs of non-insurable long-term care. Only a small part of the population depends on this type of care. Those who do, however, often cannot afford the costs.

In a free market, there will no proper insurance being established for this type of care. There are two reasons for this. First, adverse selection leads especially those people in bad health buying insurance. Since the care offered in this compartment is usually long-term, financial consequences of insuring individuals in bad health can be enormous, and it is not always possible for insurers to find out which people are in bad health, insurers are reserved when it comes to setting up insurance for this type of care. Second, for some individuals it is 100 percent clear that they need long-term care, while insurance only deals with unpredictable future events. These individuals would just be forced to pay a premium reflecting the costs of their care.

Therefore, to ensure financial access to long-term care, the AWBZ has been introduced. For this purpose, each individual is assigned to the same insurer it has chosen to cover the costs of short-term care. Health insurers are responsible for purchasing care for their clients, but they have handed over this responsibility to so-called care offices. A care office is part of an insurer, often the largest in a particular area, which purchases the care for all individuals in that particular region.

Individuals who want to apply for care have to make a request with a public service organization, which will decide on the type of care the person in question is entitled to. Moreover, the content of the care and the size of the claim are determined. If an individual is eligible for care, he or she can turn to a contracted care provider. One can also choose to receive a budget to organize his or her personal care.

3.1.2 The Health Insurance Act

The second compartment involves insurance for regular short-term care. Before 2006, this compartment used to have different schemes for different income categories. People with an income below a certain threshold were insured by means of a sickness fund. This scheme could be considered social health insurance. It was regulated by risk equalization, along with open enrolment and a ban on premium differentiation. Individuals who had an income above the threshold, could choose to have private

health insurance. This scheme worked in an unregulated competitive market with risk-rated premiums. Certain groups of civil servants were covered by a special compulsory private insurance scheme.

The major weakness of this system was that there were too many different schemes, which resulted in unacceptable premium and income effects (MoHWS 2005a). On 1 January 2006, therefore, a new single statutory insurance regime was introduced; the Health Insurance Act (ZVW). This act is a national insurance scheme under which all residents of the Netherlands have a legal obligation to take out insurance to cover a basic benefit package.

Under the ZVW, private insurers are responsible for providing health insurance within specific public conditions specified by the government. In order to guarantee universal access, all insurers are obliged to accept every applicant. Insurers are allowed to set their own premium, but are obliged to community-rate it per product. They are only allowed to differentiate the premium from province to province, collective insurance schemes offering a discount up to 10% can also be concluded.

In order to compensate the financial disadvantage of the obligation to accept any applicant – including the ones with predictable losses- a risk equalization model has been set up. The goal of this system is to create a 'level playing field' for insurers, to mitigate selection incentives, and to ensure universal access to health insurance (MoHWS 2005). This goal differs from the one mentioned in chapter two, which involved the removal of unacceptable premium differences.

The costs of the ZVW are covered by income-related contributions, premiums and public funds. Income-related contributions are levied by means of tax and deposited in the Health Insurance Fund. From this fund insurers are paid risk-equalizing subsidies. The subsidies are equal to the predicted costs, minus a fixed amount per capita. This fixed amount is determined by the government and can be interpreted as the premium an average insurer is expected to charge in order to make ends meet (Stam 2007).

The premium that insurers have to ask, should provide an incentive for efficiency in two ways (MoHWS 2005a). First, insurers can distinguish from others by means of the level of the premium. Insurers that manage to run their business and organize health care efficiently can offer quality care at an attractive premium. Second, it should make individuals more conscious of the costs of providing care.

Ultimately, the organizational structure of the ZVW should lead to a competitive health insurance market, where private insurers act as customer-driven organizers of efficient care. They distinguish themselves by means of price, product, and service. Affordability, accessibility and quality of health care are ensured (MoHWS 2005, 21).

3.1.3 Supplementary Insurance

The third compartment involves voluntary supplementary insurance for expenses that can be easily afforded by individuals and health care of a 'luxury' type. This type of insurance has no relationship with the other two compartments, is of a private nature and is operated in an unregulated competitive market. Insurers offering supplementary insurance can define their own benefit package, are allowed to refuse any applicant, and may set risk-rated premiums.

3.2 The current risk equalization model: goals and organization

The Dutch risk equalization model consists of two parts. The ex-ante part focuses on predicting health care costs as adequately as possible. Several risk-sharing mechanisms, called the ex-post correction mechanisms, should counteract possible undesired outcomes of an insufficient ex-ante part of the model.

According to the Ministry of Health, Welfare and Sports (hereafter: the government), the goal of the Dutch ex-ante risk equalization model is twofold (PWC 2006, MoHWS 2005). As far as the distribution of funds (distribution aspect) is concerned, insurers should be compensated for predictable losses or profits relating to the factors age, sex and health status of their clients. This should result in a level playing field for health insurers.

As far as the incentive for efficiency is concerned (efficiency aspect), the financial result should be influenced by the way the insurance company is managed instead of the composition of the portfolio. Since the insurer in question can influence expenses relating to operating the insurance system, no compensation is desired for them. Insurers that run their business relatively efficiently can gain a competitive advantage from setting a lower premium than competitors, or offer better quality for the same premium.

3.2.1 The ex-ante model

In 2007, the ex-ante subsidy was based on the factors age, gender, pharmacy cost groups, diagnosis-based cost groups, source of income, and region. The factors age and sex are the basis of the model, with amounts added and detracted on the information of the other factors. The Pharmacy Cost Group (PCG) is an outpatient morbidity measure based on the use of prescribed drugs. It compensates future high costs of chronically ill clients resulting from taking medicine in the past. Individuals can be classified into multiple PCGs, allowing for co morbidity.
The factor Diagnosis Based Cost group (DCG) is a variant of the diagnosis-based model. It compensates costs of chronically ill clients resulting from past hospitalization. Only DCGs that indicate current chronic diseases are used. Incidental diagnoses are excluded.
The factor source of income involves health differences between socio-economical groups, for example various types of social security or self-employment.

The factor region compensates socio-economical factors and factors related to supply that are connected with housing and cannot be influenced by health insurers on the short term. Factors that are taken into account are the degree of urbanization, the percentage of foreigners, death rates, and the number and types of regional suppliers of care. Subsidies are assigned based on ten clusters of postal codes.

3.2.2 Ex-post correction mechanism

The 2007 ex-ante model does not compensate all health differences adequately, however. There are two reasons for this. The first one relates to the fact that former private insurers did not need to record characteristics of their clients. Therefore, information about people who formerly had private insurance is missing. Consequently, it is not possible to guarantee the quality of the correlation between the characteristics of these individuals and their costs. Second, the allocation of the costs of health care providers is subject to change (MoHWS 2005). One change is the introduction of Diagnosis Treatment Combinations (DBCs). As a result, the costs among different types of treatment and clients have shifted. Since the direction and magnitude of the shifts is not clear, however, subsidies possibly do not compensate all hospital costs adequately.

While the predictive power of the model is insufficient, insurers can use several tools for cream skimming (Stam & Van de Ven 2006). First, they have freedom in the purchase of health care, can contract providers selectively and can provide financial incentives for providers. Moreover, they can include specific conditions in their policy trying to attract good risks and avoid bad risks. An example of such a condition is reimbursement of the costs of generic drugs only, while insurers know this is unpopular with unprofitable groups. Second, former sickness funds have a long tradition of social responsibility but – under the new ZVW-, new commercial insurers with experience in risk selection and premium differentiation are also allowed to offer health insurance. If one insurer engages in risk selection, others might follow. Third, insurers can decide to offer collective contracts only to profitable groups while ignoring groups with predictable losses. Fourth, insurers that offer basic insurance are also allowed to offer supplementary insurance contracts. For the latter, insurers can ask proof of good health. Applicants who are expected to make a loss in the basic benefit package, can be rejected for the supplementary insurance. Since most individuals prefer to have both basic insurance and supplementary insurance with the same insurer, this can be an effective way to avoid bad risks for the basic benefit package.

Therefore, in 2007 several ex-post correction mechanisms were used to reduce differences between subsidies and actual costs and to mitigate potential selection incentives. These mechanisms are discussed in the following sections.

3.2.2.1 Retrospective correction for client numbers

If an insurer acquires many clients, based on its reputation for instance, it should not have to wait until the next year to receive a contribution for the costs of providing care for these new clients. This is why, ex-post, a correction is made to the subsidies paid to insurers up for the difference between the estimated and the actual number of clients.

3.2.2.2 Macro-economic ex-post equalization

Each year, a certain amount of money is made available to cover total health care costs. If total health care costs rise, insurers with a relatively healthy client base have an advantage over the ones that have a less healthy client base, because the first group has fewer uncompensated costs than the second group. Since the difference between forecast and actual health care costs cannot be controlled by individual insurers, macro-economic ex-post equalization compensates these differences.

3.2.2.3 High-cost compensation

The goal of high-cost compensation is that it compensates for an unequal distribution of extremely high claims among insurers. In 2007, 90 percent of all costs over 12,500 Euros were compensated.

3.2.2.4 Generic equalization

Generic equalization is used to correct possible shortfalls in the distributive effect of the equalization model. It involves adjusting subsidies, based on the difference between the costs and the compensation of a certain insurer compared to others. Between insurers, mutual compensation takes place. A disadvantage of this type of ex-post equalization is that the result of one insurer depends on the results of others. With the development of a better ex-ante equalization model, it is desirable to phase out this type of ex-post compensation.

3.2.2.5 Retrospective calculation

Retrospective calculation involves adjusting subsidies based on the difference between the costs and the subsidy of the insurer in question, after a correction for high cost and generic ex-post equalization. The size of the financial risk is linked to the tools insurers have to influence the actual costs. Retrospective calculation is used to compensate a lack of power to influence health care costs.

3.2.2.6 Bandwidth measures

If average costs per client are 17.50 Euros above or under national average costs, insurers get a compensation of 90 percent of the costs outside this bandwidth. As a result, potential losses and profits are limited. This bandwidth measure is mainly used to compensate possible subsidy shortfalls a result of the DBCs. It will be phased out in the future.

3.2.2.7 Distinction of cost categories

When it comes to the equalization system, a distinction is made between three categories of service: variable costs of hospital care, fixed costs of hospital care, and costs of other services. The financial risk of these categories is linked to the degree to which insurers can influence health care costs. This degree differs among these three categories.

When it comes to fixed hospital costs, a retrospective calculation percentage of 100 percent applies because insurers cannot influence them (yet). Several ex-post correction mechanisms apply to variable hospital care, namely high-cost compensation, a retrospective calculation percentage of 35 percent, a generic compensation percentage of 30 percent, and the bandwidth measure. Insurers run a 100 percent financial risk for costs of other services, except for high cost compensation, which applies to this category.

3.3 Future developments and points of interest

Because the factors source of income and region do not correct sufficiently for differences in social-economic status (SES) between former sickness fund clients and those who had private insurance, in 2008 the factor SES will be added to the model (MoHWS 2007). The introduction of this new factor, which is based on the average income per address, should compensate these differences (MoHWS 2007a).

The government is of the opinion that, due to the introduction of the factor SES, the predictive power of the model will be improved in 2008. Insurers will also become better at influencing hospital costs. Therefore, some ex-post correction mechanisms will be phased out in 2008. First, generic ex-post equalization will disappear and the retrospective calculation rate will increase to 50 percent. Second, the high-risk equalization threshold will, due to inflation, be raised to 20,000 Euros. The bandwidth measure will be enlarged to 40 Euros. Overall, this will lead to a ten percent increase of financial risk on variable hospital costs (MoHWS 2007a).

The rationale for striving to phase out ex-post correction mechanisms is that some do not only compensate imperfections of the model, but also differences in efficiency between insurers. As mentioned in section 3.2, subsidizing inefficiencies is not desirable and reduces incentives for efficiency. According to the government, by using ex-post correction mechanisms one should strive for a balance between a level playing field and the prevention of risk selection on the one side, and incentives for efficiency on the other side (MoHWS 2006). Ex-post correction mechanisms that not only correct for an insufficient model but also for inefficiency should be phased out as soon as possible. The phasing out in 2008 is according to the time-path that the government has set up for the phasing out of these ex-post correction mechanisms.

However, an evaluation of the 2007 risk equalization system (Stam and Van de Ven 2007) shows that there are still substantial identifiable profitable and unprofitable subgroups. Phasing out the ex-post correction mechanisms without improving the model, therefore, will lead to an unequal 'playing field'. Since risk equalization is of high importance for an adequate functioning of the health insurance market, it is not sure whether the targeted effects of the ZVW, the improvement of quality and efficiency in health care, will indeed be realized then. A revision of the point of view of the government, that a quick phasing out the ex-post correction mechanisms is desired, thus seems to be justified. Instead of that, improving the risk equalization system needs full attention.

Another important point of interest is the decision-making process involved in the risk equalization system. An evaluation of this process shows that, on several points, the system is not transparent (PWC 2006). First, the determination of the risk-adjusters and the ex-post correction mechanisms are not transparent. Second, the decision-making involved in ex-post correction mechanisms has not been based on objective research. Third, there is a lack of clear criteria for the decision-making process. Fourth, there is no formal and traceable quality monitoring of the reliability, accuracy and objectivity of the research to the normative costs. Fifth, there is no formal and traceable monitoring on, and no possibility to adjust data and errors. Sixth, there is not enough monitoring to control the risk of receiving incorrect data from various parties.

3.4 Future model improvements

For a justified future phasing out of the ex-post correction mechanisms, the model thus needs to be improved. Remarkable in this respect is that predictably unprofitable individuals are mainly those, covering about eight percent of the population, who belong to the top 25 percent with the highest costs in the past five years. When evaluating the model, leaving them out considerably reduces predictable profits and losses (Stam and Van de Ven 2007).

High costs are often related to rare diseases. Since it is hard to predict costs of individuals who have such a disease and the groups are very small, constructing a separate subgroup for each illness would only unnecessarily complicate the model. Therefore, the current model does not include a factor for most of these illnesses. Currently, high-cost compensation is used to compensate the high costs related to some rare diseases. Since it is mainly the individuals with rare diseases that are predictably unprofitable, it is this group for which the model is to be improved. There are several alternatives for doing this. First, there is adding new categories to the PCG or DCG groups, or add a new risk-adjuster to the model. There is a limitation for this, however, because treatment of most rare diseases is based on the symptoms rather than the disease itself. Therefore, not all rare diseases have a unique treatment pattern. Since individuals suffering from a rare diseases often also use medical devices or

physiotherapy, one could also add a factor based on the use of these. A drawback is, however, that the data needed is not always available.

A second alternative, considering the fact that it is a small group that generates high costs in successive years, is adding a factor 'multi-year high costs' to the model (Stam and Van de Ven 2006). Third, ex-post correction mechanisms can be differentiated (Stam and Van de Ven 2007). The rationale is that, currently, the model works reasonably well for 92 percent of the population, leaving high predictable losses for the remaining 8 percent. Since these losses can be identified easily based on information of insurers, it means that the financial risk for 92 percent of the population can be raised while it can be lowered for the remaining group that represents most costs. This results in an increase in efficiency incentives for 92 percent of the clients, while selection incentives concerning the remaining 8 percent are reduced.

A fourth solution involves high-risk compensation (MoHWS 2007b). At the beginning of each year, insurers can decide on a certain percentage of individuals who are placed in a high-risk pool. At the end of the year, each insurer is reimbursed for part of the costs or the total costs of these individuals. Since costs of the clients placed in the high-risk pool are reimbursed retrospectively, but the insurer has to place them at the beginning of the year in the pool, high-risk equalization contains both an ex-ante and an ex-post element.

3.5 The Exceptional Medical Expenses Act and risk equalization

The care currently covered by the AWBZ is often connected to other public domains such as the ZVW, education, welfare, and housing. For continuity of and efficiency in AWBZ care, it is important that there is integration between these various domains. With the partitions between the AWBZ and the ZVW, however, parties involved often are not provided incentives to organize efficient, integrated and customer-oriented care. The reason is that insurers run a financial risk when it comes to their operations for the ZVW, while the care offices that execute the AWBZ do not. Moreover, it is not clear who is responsible for the provision of the care, while the distinction between different domains is often rather vague. This leads to various parties shifting costs to the best available domain for them.

The way the AWBZ is currently organized, therefore, does not seem to be future proof. Therefore, the government is considering how the AWBZ entitlements can be carried out as effectively as possible in the longer term. One of the alternatives is to transfer them to the ZVW. The rationale for doing this, is that the removal of the financial partitions will provide strong incentives for integration of the two domains. Moreover, competition should result in efficient and consumer-oriented care (IBO 2005).

Therefore, it is decided to transfer the short-term mental health care from the AWBZ to the ZVW in 2008. A separate risk equalization model has been developed for these entitlements, which comprises the factors age/sex, source of income, socio-economic status, a region criterion for mental care, PCGs for mental illnesses, and single address. Since this model is not expected to compensate cost differences adequately, however, insurers will be reimbursed for 100 percent of the costs in 2008 (MoHWS 2007a). In the future a more advanced model is to be developed.

In the future, significant amendments are also expected to the rest of the entitlements of the AWBZ. With the transferring of AWBZ entitlement to the ZVW, however, two different aspects must be taken into account. First, especially for the long-term care, the question needs to be addressed whether the care can be executed in a competitive market. In order for a well functioning competitive market, insurers should have a choice of providers for sufficient bargaining power on the content and the price of the care. It should also be possible for clients to make a judgement based on price and quality of the care offered, and the 'critical mass' should be large enough to get the insurer to purchase good quality care at a reasonable price. If the individuals involved cannot make a firm choice based on quality and price of care, or if the user group is too small, insurers have the incentive to skimp on quality.

Second, what complicates the development of an adequate risk equalization model is the extremely skewed distribution of costs, both among individuals and among insurers (WOR 2005). For the long-term entitlements the costs are possibly even more skewed than for the short-term mental care. Without an adequate risk equalization model, insurers that happen to have a relatively large percentage of AWBZ clients in their portfolio would probably have a large disadvantage (Van de Ven 2005).
A difficulty is that so far, there has been no reliable data to base cost estimates on. A relevant question is therefore what information subsidies should be based on, to develop an adequate model. It seems infeasible to develop an adequate model based on the information of only objective health indicators, like for the ZVW model. An alternative could be to base the model on assigning individuals to certain categories of care. Based on the assignment, the insurer in question then receives a lump sum to organize the care.

3.6 Conclusion

The Dutch health insurance system is based on a competitive market with a ban on premium differentiation and open enrolment. Risk equalization should decrease predictable profits and losses, mitigate selection incentives and create a ‘ level playing field’ for insurers.

Although the Dutch risk equalization model seems to compensate health differences for the greater part of the population, there are still predictable profits and losses. Moreover, the system needs more transparency.

Several risk-sharing mechanisms are used to avoid undesirable outcomes from an inadequate model. Since some of these mechanisms reduce incentives for efficiency, the government strives to phase them out. If ex-post correction mechanisms are phased out without improving the risk equalization model, however, the increased financial risk of insurers leads to an unequal ‘playing field’ and an increase in incentives for cream skimming. Then, realization of the original goals of the Dutch Health Insurance Act - improvement of quality and efficiency - cannot be guaranteed.

In this respect, the transferring of the short-term mental health care, and possibly also long-term entitlements, seems to be a big challenge. For these types of care, it will even be more difficult to compensate adequately and realize a level playing field.

So, although the current Dutch risk equalization model works reasonably well for the greater part of the population, it is very important that the government keeps paying attention to further improvements. Only then, all objectives of the Health Insurance Act can be realized.

IV METHODOLOGY

4.1 Research methods

The method of qualitative research addresses specific situations or people, and is emphasized on words rather than numbers. Qualitative studies not only include physical events and behaviour, but also the way this is experienced and influenced (Maxwell 1996).

In order to collect information for this thesis, two methods could be used: self-administered questionnaires or interviewing the study object. Self-administered questionnaires are filled in by the study object itself. The advantages of this method are efficiency in the collection of data, a minimum of socially desirable answers, and avoidance of interviewer bias.

The second method, interviewing, involves collecting data by talking to respondents and recording their responses (Bowling 2002). The advantages of this method are that any ambiguities can be clarified, the interviewer can probe for responses, complicated and detailed questions can be asked, and the data gives rich and quotable material which enlivens research reports. Response rates are usually also higher than with postal questionnaires (ibid.).

Three types of interviews can be distinguished (Bowling 2002:258). Structured interviews involve the use of fixed questions that are presented in the same way to all respondents. There is no variation as to how the questions are asked and response is mainly given by means of pre-coded choices. An advantage of this type of interview is the possibility to collect answers that are easy to count. Moreover, it is relatively economical to carry out. A restriction is that it only suits topics that are relatively well known among the public. If respondents cannot find the right answer among the pre-coded choices and need to choose the one that is closest to their opinion, the results can be distorted (ibid.). So, if possible response categories are unknown or too complex, it is essential to use open-ended questions.

Semi-structured interviews mainly include fixed questions, which have no or only few response codes. They usually allow the interviewer in question to probe and enable the respondent in question to raise other relevant issues that are not covered by the interview scheme. Three types of questions can be distinguished (Rubin & Rubin 1995). First, the main questions are worked out in advance, to make sure that all interest fields are covered. Second, probing questions aim for the interviewer to request extension, or different techniques to suggest that more information is needed can be used. Third, follow-up questions result in more information due to the interviewer asking the interviewee in-depth questions about topics introduced by the latter. The strength of a semi-structured interview is that it has an element of discovery, while the structure allows an analysis in terms of commonalities (Gillham

2005). Some disadvantages are the fact that open questions require more thinking with respondents, answers can be distorted by the coding process, processing of interviews can be time-consuming, and analyzing the results can be complicated (Bowling 2002).

In an unstructured interview, the respondent in question speaks freely and the conversation is not manipulated by the interviewer. This type of interview especially suits the exploring of a certain topic.

The goal of this thesis is to study the opinion of health insurers of the Dutch risk equalization system and their suggestions for improvements to it. In order to answer the central question, in-depth information is needed. Since relatively little information is known about the opinion of insurers, however, it seems best to combine a qualitative study and in-depth semi-structured interviews.

4.2 Population and response

The study population consists of 14 independent health insurers that operate under approximately 55 labels. Zorgverzekeraars Nederland, which is the branch organization for Dutch health insurers, provided a list of sixteen persons who work with these insurance companies, including their email addresses. These persons are controller, actuary, or manager at the financial department. They participate in several work groups on risk equalization, are familiar with developments in this field, and are able to express the opinion of the respective insurance company. Since there was room for sixteen interviews, they were all asked to participate in the study by email. Six persons responded to the first email; five were willing to participate, and one was not. The reason for this was that the portfolio of the insurer in question had been transferred to a different one in 2006. Therefore, the person in question was not regarded as a non-respondent. The ten non-respondents were sent another email requesting them to participate. Five were willing to participate. The remaining five were asked a third time. As a result, two more decided to participate and one refused. The reason for this was a lack of time. The other two individuals did not respond at all. This resulted in a response rate of 80 percent.

4.3 The questionnaire, interviews and analysis

The questionnaire consisted of five central questions. For each question, a short explanation about its purpose and the topics covered was given. The order of questions of the interview was not fixed. Moreover, respondents could raise relevant topics not covered by the questionnaire. In order to check whether all topics were covered during the interview, a checklist was used. After each interview, evaluation of the interview and the checklist took place. During the process of interviewing, it gradually became clear which topics were most important and which answers were to be expected. Therefore, the interview got more structure along the way. After the fifth interview, it was decided to add sub-questions to the questionnaire. This allowed the

respondents to better prepare for the interview and made it easier to check whether all topics were covered. The final questionnaire can be found in appendix I.

The interviews were recorded and written out verbatim. Then, they were split into various fragments. Each fragment gave information about one or two topics. The fragments were labelled according to a codebook. Fragments from the first three interviews with the same labels were grouped together in order to see whether there was a certain pattern when it comes to answering questions. Moreover, it aimed to determine how complete, useful and necessary the labels were. After that, a first division of the sections in the result chapter was formed. The analysis was made by adding interview results one by one to the relevant sections.

4.4 Methodological issues

Factors that influence trustworthiness of qualitative research are objectivity (conformability), internal and external validity (credibility and transferability), and internal and external reliability (dependability) (Maso & Smaling 1998). In this section, a description is given of these factors, and the way they were taken into account.

Objectivity

Objectivity refers to the fact that justice should be rendered to the study object. Objectivity of the results is improved if the object can tell his or her own story and statements are not distorted. Objectivity of the study in question is guaranteed by working out the interviews verbatim and giving respondents the opportunity to have a look at the results of their participation. This way, they can indicate whether their answers were understood correctly.

Validity

Internal validity refers to the quality of data collected and the argumentation. It assesses whether a certain instrument measures what it should measure. Higher internal validity can be expected for qualitative research than quantitative research, since changes can be made to the measuring tool during the process of research. Moreover, new insights can be added. The main concern related to internal validity is that respondents might give socially desirable answers, and by doing that, present themselves or the company they work for in a way that is in fact less positive. To counteract socially desirable answers, results were processed anonymously.

External validity refers to the possibility of generalizing the research findings to a wider population of interest. External validity can be violated if respondents have different characteristics than people who did not respond. Consequently, true population values can be under- or overestimated. ‘Total non-response’ refers to the objects that do not respond at all, while ‘item non-response’ refers to questions that are not answered by all respondents. In an attempt to increase total response, the

questionnaire was accompanied by a covering letter. This letter explained the goal of the thesis, the importance of response, the fact that confidentiality of the results was guaranteed, and the way results would be used. Non-respondents received a second and a third email. As an incentive to participate, it was mentioned that all participants would receive a copy of this thesis.

Although there is no standard when it comes to an acceptable response rate, it is generally accepted that 75 percent and up is good (Bowling 2002:264). In order to prevent bias from non-response, however, one should try to collect as much information about these non-respondents as possible. This way, differences between respondents and non-respondents can be analyzed (Bowling 2002). The final response rate of 80 percent seems to be sufficient. To find out whether non-respondents differ from respondents, health insurers have been distinguished on two characteristics. First, a distinction was be made between regionally oriented insurers, countrywide operating health insurers, and concern insurers. The reason for this distinction is that, relying on the interview results, regionally oriented insurers often have different opinions than the other two types. Second, a distinction can be made between former private insurers and former sickness funds[1]. The reason for this is that the characteristics of the portfolio's can differ between the two categories. Moreover, former private insurers have less experience with risk equalization. In table 4.1, the distribution of respondents and non-respondents, as well as a specification of the various categories of insurers is given.

	Regional	Country	Concern	sickness fund	private	Total
Population	6	4	5	13	2	15
Respondents	5	3	4	11	1	12
non-respondents	1	1	1	2	1	3
response rate	83%	75%	80%	85%	50%	80%

Table 4.1 Response rates for various types of insurers

This table shows that regional, countrywide and concern insurers roughly have the same response rate. The response rate of former private insurers is different from that of former sickness funds. This is mainly because there are only two 'private insurers'. In order to find out whether this could distort the results, the statements of the former private insurer that responded were taken into account. This insurer's opinion did not differ from the one of the former sickness funds. Moreover, no remarkable information could be taken from the interview in question. The only difference was that the respondent in question had indeed less knowledge of risk equalization

[1] Former private insurers offered only private insurance up to 2006. Former sickness funds used to operate as sickness funds, or both as sickness fund and under private label.

compared to the former sickness funds. Overall, the results seem not to be distorted by total non-response.

Item non-response can influence the validity if non-respondents are, for instance, not willing or not able to answer certain questions. In this study, item non-response is related to the fact that it is hardly impossible to cover all topics entirely in a one-hour interview. Since interviewees were given enough time to tell their story and divide time over the various questions, item non-response is a result of the factor time and the fact that respondents thought that some subjects needed more attention than others did. Moreover, it was checked and made sure that all essential questions were answered. Item non-response has been taken into account by giving numbers with topics that some or all respondents clearly reflected their opinion on, while no numbers have been given for items where it was unclear as to how many respondents agreed or disagreed with a certain statement.

Reliability

Internal reliability refers to consistency and the homogeneity of the instrument, and the degree to which it is free from random error (Bowling 2002:147). The acquired results should not be influenced by the researcher in question, the period and/or the measuring tool. This means that the results of a certain respondent should always be the same, irrespective of time, place, et cetera. Internal reliability is an important concern for qualitative research. The reason for this is that perception, interpretation and the way of reporting play an important role. External reliability refers to the repeatability of a study. Since the reports of the interviews in question are confidential, the analysis cannot be repeated.

V RESULTS

In this chapter, an overview is given of the opinions of the respondents. Although most topics overlap others to some degree, an effort has been made to make a distinction between the various themes. Furthermore, the structure of the questionnaire has been used as much as possible.
In section 5.1, the goals of the Dutch risk equalization system are discussed. Moreover, the opinion of the respondents is given on the presence of cream skimming. Section 5.2 discusses what the goal of risk equalization should be, and to what degree solidarity is desirable. It is also discussed whether respondents believe that risk equalization system is the best way to organize the health insurance market. Section 5.3 discusses the current risk-adjusters and the degree two which these meet the criteria of fairness, appropriateness of incentives and feasibility. Moreover, the ex-post correction mechanisms are discussed. Section 5.4 describes what the health insurance market and risk equalization system should look like in the future. Finally, section 5.5 goes into the question whether AWBZ entitlements can be transferred to the ZVW. A selection of statements made by respondents can be found in appendix 2.

5.1 The goals of the Dutch risk equalization system

5.1.1 The distribution aspect

All respondents answer that predictable costs are compensated for a large part of the population, but there are also predictable profitable and unprofitable risk categories.

The respondents indicate that the sum of predictable profits and losses is not zero for every insurer. Some insurers make a profit while others make a loss on the composition of their portfolio. So, there is no fair distribution of subsidies among insurers. Answers to the question to what extent a level playing field is created varied from “there is no level playing field” to “for a large part there is a level playing field”.

It seems that large insurers, which cover around 75 percent of the market, receive a fair part of the budget. The reason is that the distribution of risks in their portfolio reflect that of the distribution of risks countrywide (from now on, such a portfolio is called an average portfolio). Most of the small insurers, however, serve specific target groups or regions, which have different characteristics. Consequently, small insurers might make a profit or a loss based on their portfolio. Some respondents replied that they did not receive sufficient subsidy.

Two respondents mentioned that at the time the ZVW was introduced, some insurers were richer than others. Rich insurers can use financial resources gained in the past to reduce premiums, which increases their competitive position. It is a matter of debate, whether this is fair practice.

5.1.2 The efficiency aspect

Efficiency can be expressed in several ways. In this section, the following are discussed: overhead costs, negotiating the price of health care, selective contracting, transferring care from inpatient to outpatient care, prevention, and influencing of health care costs. It is also discussed to what extent the efficiency aspect, that saved costs should come back to the insurer in question, is realized at the moment.

Overhead costs

All respondents answer that insurers mainly focus on controlling overhead costs. The lower the overhead costs, the lower the overhead costs per client, and the lower the premium that covers these costs.

While the scope is still limited, insurers also try to organize the care market as efficient as possible. Various instruments to influence costs were mentioned, which will be discussed in subsequent sections.

Negotiating the price and content of health care

All respondents answer that insurers negotiate the price and content of the offered care, but some are not sure whether it is possible to purchase health care structurally at a lower price than others do. Three reasons are mentioned. First, if one insurer can agree on a good price with a health care provider, so can its competitors. Second, most rates are currently fixed. Third, large parts of the profits are creamed off due to ex-post correction mechanisms.

Two respondents believe that negotiating with providers does not increase efficiency of health care. If an insurer and a provider agree on a lower rate, this does not mean the provider will start to work more efficiently. The provider in question always tries to secure its income, however. Consequently, the lower rate has to be compensated. Therefore, it will set a higher price for other insurers that have less bargaining power in the region. It can also decide to raise its rate the following year. Price bargaining therefore does not lead to an increase of efficiency in health care, but only to cost shifting.

Selective contracting

Insurers are allowed to offer policies with a limited number of contracted providers, and only reimburse clients for all their health care costs if they visit a contracted provider. If an individual wishes to receive care from a provider that is not contracted, he or she might pay part of the costs itself. In this way, insurers can try to ‘steer’ clients towards certain preferred providers; the ones that have agreed on lower rates. The lower rates are expressed in a lower premium.

Most respondents indicate that the goal of the insurance company is to guarantee sufficient coverage and choice in each region, and therefore they contracted nearly all providers in 2007. As a result, clients could turn to practically any provider without

having to pay part of the costs. Also in the future, most do not expect their insurance company to offer a policy with only a few preferred providers. Several respondents also mention that it is hard to steer clients towards certain providers, because most prefer to turn to the one close by, and are probably willing to pay extra for this.

Two respondents are of the opinion that policies with a limited number of contracted providers could be a good way to control costs, and that variation in policies is desired in the future. Individuals who are willing to turn only to contracted providers can save costs by paying a lower premium. One of the respondents in question mentions that, however, the transparency of the quality of care offered needs to be raised first. According to this respondent, the risk of policies with a limited number of contracted providers is that providers with the lowest rates are contracted, without paying attention to quality. However, quality among providers can differ substantially. Only if the quality is made transparent, individuals can make a well-based decision as to which policy they should choose.

Other respondents think that such policies are not desirable, because they undermine the solidarity principle. The reason for this is the fact that agreed rates are based on expected patient costs. Since it is generally known that younger patients recover faster than older ones and therefore are cheaper, and the young and healthy individuals are expected to choose such policies more than others because they are not interested in the choice of providers contracted, insurers can negotiate lower rates and translate them into a lower premium. Since there will be more healthy people than unhealthy ones having such a policy, the healthy ones will pay a lower premium than the unhealthy ones. Part of the premium discount is therefore based on the health status, which is undesirable.

Transferring health care from hospitals to outpatient care

Efficiency can also be raised by transferring hospital care to an outpatient setting. Several respondents mention that in order to control costs, they invest in health centres and care programmes, for instance for diabetics. Most respondents state, however, that there are no real incentives provided for doing this. The first reason is that such initiatives require investment first, while future benefits are insecure and hard to quantify. The second reason is that insurers run a higher risk on the costs of outpatient care than on hospital care. Consequently, insurers should save more costs before it becomes profitable for them to transfer care to an outpatient setting.

The main reason for insurers to invest in transferring of care is that they are of the opinion that it is their job to contain the costs and provide consumer-oriented care. Second, it is good for their reputation. Third, since ex-post mechanisms will be phased out in the future, it might be wise to start now.

Prevention

Nearly all respondents answer that there are no incentives for prevention. The reason for this is that it is difficult to quantify future benefits of prevention programmes, while it is not clear whether clients will have the same insurer in the future, due to consumer-mobility. So, if an insurer develops a prevention programme and makes costs to save future costs, it might not benefit from this if the client switches insurer. Another reason is the fact that insurers are compensated for the health status of their clients. If an insurer manages to improve the health status of a certain individual, the subsidy is lowered. Most insurers unfold prevention programs because they think they have a public merit and it serves their reputation.

One respondent thinks, however, that there are indeed incentives for prevention. Imagine an insurer receives subsidy for a diabetic patient. If it manages to save costs, due to a prevention programme, it can make a profit. Second, every company runs a risk when it comes to investments. Insurers can build up a positive reputation by communicating to its clients that it aims to improve their health. This reputation, on its turn, can attract new individuals while current customers stay on.

Possibility to influence costs

Two respondents think that when it comes to efficiency, too much responsibility has been put on insurers. Savings to supply-related costs, for instance, can only be made by changing supply by means of reducing the number of providers. Insurers cannot do this and therefore cannot influence all supply-related costs. If the government does not do anything about the situation of oversupply, this should be reflected in the subsidies. Other respondents think that insurers can reduce oversupply, but it requires them to step up and do it. Another respondent mentions that every region has its own historical supply-related costs, which can hardly be influenced by the insurer in question. The respondent is of the opinion that insurers should be rewarded more for their bargaining results. Subsidies should be based on average price, but they should also take into account the supply in a certain region.

5.1.3 Selection

Every respondent but one thinks that in 2007 insurers did not try to attract good risks and avoid bad risks. Some insurers think that selection could become an issue in the future, others are not sure, and finally some think it will never become an issue.

The main reason for insurers not wanting to engage in selection activities is that they think they have a social function and should provide access to health insurance for everyone. Furthermore, no insurance company wants to get negative publicity when it comes to selection.

Several respondents mention that currently it is also quite difficult to cream skim. Insurers have a feeling about profitable and unprofitable categories, but it is difficult to identify them. The reasons are that insurers do not have all information about the

risk factors of their clients and the received subsidies are not split out per individual. As a result, they know the costs of an individual, but they do not know the exact subsidy they receive for it. Therefore, it is hard to find out whether an individual or a group is profitable or unprofitable. With the development of the model, it can also be unwise to cream skim, because certain unprofitable groups could become profitable in the future. So, a selection strategy can be financially attractive on the short term while this could be different on the long term.

Some respondents think that it is indeed possible for insurers to cream skim if they want. Several studies show which groups are profitable and which ones are not. Insurers can attract or avoid these individuals without harming their reputation. Some believe that cream skimming may become an issue in the future. The tools for cream skimming that were mentioned are supplementary insurance, target group marketing, and collective insurance schemes. Two respondents mention that one new entrant, that has nothing to lose, can start cream skimming. Other insurers must follow.

One respondent mentions that the government does not pay enough attention to the risks for selection. Another respondent thinks that there are insurers that cream skim, even in 2007, by offering only collective contracts to healthy groups or omitting certain entitlements in the supplementary insurance. So, unprofitable individuals are avoided by not reimbursing some care in the supplementary insurance for which it is known that people that use that kind of care are those who are unprofitable for the basic benefit package. The respondent in question emphasizes the fact that cream skimming is not the main goal of these insurers, but that they know very well that they attract profitable groups and avoid the unprofitable.

5.2 The goal of risk equalization

Every respondent but one is of the opinion that a ban on premium differentiation and open enrolment are essential elements of a health insurance system. Respondents raise the question whether a distinction between S-type and N-type factors can be made. Even if a distinction could be made, it can be questioned whether this should lead to premium differences. Two examples of potential N-type factors were discussed in the interviews: region and lifestyle.

In some regions, prices of land and wages are relatively high. If these factors are reflected in the premium, this leads to people living in those areas paying a higher premium for health care nearby than others. It is considered undesirable for people having to pay higher premiums, simply because they live in a certain area. Respondents question whether individuals can be held responsible for costs relating to a bad life style, such as smoking, or diabetics in case of overweight. They think that it is a joint responsibility of the government and insurers to provide information and stimulate individuals to have a healthy lifestyle. The ones who do not have a healthy

lifestyle should not be punished. It is also difficult to monitor the lifestyle of an individual.

Some respondents also think that the resulting premium variation, resulting from N-type factors, could become unacceptably large or will lead to inequalities in access to health care. Weaker groups in society, people who are not good at arranging their things, will be at a disadvantage. In case of premium variation for region, individuals who can afford a higher premium will choose a relatively expensive policy so they can turn to a provider nearby. Individuals who cannot afford a higher premium, however, will be forced to travel to receive health care. Since health care is considered a primary need, this can be best expressed in a countrywide premium for every insurer. Then, everyone is able to get health care nearby at a reasonable price.

One respondent thinks that a distinction should be made between S-type and N-type factors. The respondent thinks that it is not fair for individuals who take responsibility by choosing the most efficient care, and who are willing to travel for it, should compensate individuals who are only interested in getting health care nearby that is relatively inefficient. His opinion is that costs not related to health should be reflected in the premium, so that individuals can make a choice based on the information of price and quality of the services provided. Individuals can be held responsible for making a well-considered choice of policy. The respondent emphasizes, however, that this is only possible with a model that compensates health differences adequately and where quality of care is transparent.

All insurers are of the opinion that a competitive market with risk equalization is the best way to organize the health insurance market. They think it is the best way to control health care costs while at the same time solidarity is guaranteed.

5.3 The Dutch risk equalization system

5.3.1 The criteria for the model

Predictive power

As mentioned in section 5.1.1, the Dutch risk equalization model does not compensate all risk factors adequately. Most respondents refer to the studies published which subgroups are concerned.

One respondent emphasizes that because of transferring formerly private insured to the risk equalization system, heterogeneity in the living areas has increased. This seems to apply especially to some living areas in large cities. The factors region and source of income do not compensate this heterogeneity adequately. Two respondents feel that the financial results on hospital care in The Hague are structurally negative. It was mentioned in section 5.1.2 that this is related to oversupply, which cannot be influenced by insurers on the short term. According to them, when it comes to the model, this fact should be taken into account more.

Transparency and availability

All insurers criticize the model when it comes to transparency. The data used for defining subgroups and the way subsidies are calculated are not transparent. Nor is the allocation of the subsidies. Insurers receive a sum of money according to the risk characteristics of their clients. As mentioned in section 5.1.3, however, insurers do not know how much subsidy they receive for every individual. Because they do not know the characteristics of their clients for the factors source of income and - to a lesser extent - the factor DCG, insurers cannot calculate the subsidy they are entitled to. As a result, they also cannot monitor whether the received subsidies are correct. One respondent, however, states that transparency is not the single goal of a risk equalization model. The goal is to compensate adequately, sometimes a trade-off has to be made between predictive power and transparency. To some extent one should be able to trust that the subsidies are correct.

The problem is, however, that in the past several errors have been made by CVZ[2], while the information provided is not always reliable. Because there is also a lack of supervision on the determination and assigning of subsidies, most respondents do not trust the subsidies to be correct and reliable.

Timeliness of the budget

Another point of interest is the timeliness of the budget. Timeliness depends on various parties, the outcomes of the DBCs and the ex-post correction mechanisms. According to the respondents, the period between the closing of the book year and the assignment of the final budget is too long. Without the final budget, only an estimation of the financial results can be made. These results are needed for the determination of the premium in the following years and for other decision-making processes, however, so insurers would like to know the financial results as early as possible. According to the respondents, the final budget can differ substantially from the ex-ante budget, it is hard to estimate it, and the information provided on the height of the budget is not always reliable. Insurers might receive a letter with a certain budget one week, and find out the budget has changed substantially the week after.

5.3.2 Ex-post correction mechanisms

All respondents admit that the government phases out ex-post mechanisms without demonstrating that the ex-ante model has improved objectively. Eight respondents are of the opinion that the ex-post correction mechanisms should only be phased out if the ex-ante model has improved objectively. So, they think that currently ex-post correction mechanisms are phased out too quickly. Four respondents say that the efficiency aspect should also play a role in the decision-making around the phasing out.

[2] CVZ is an organization that calculates how much funds each insurer receives from the Health Insurance Fund.

There are also different opinions when it comes to the question whether ex-post correction mechanisms reduce incentives for efficiency. Some respondents think that an increase in financial risk will indeed provide more incentives for efficiency. The reason is that the ex-post correction mechanisms do not only correct the inadequacy of the model, but also cream off part of the profits earned by an efficient organizing of care. If insurers are allowed to keep all profits, incentives for efficiency are larger. Other respondents think that phasing out ex-post correction mechanisms will not lead to more efficiency. The reason is that currently there is also an incentive for efficiency because insurers run some risk on the costs of care. It can be questioned whether an increase of the financial risk will also increase the incentives for efficiency.

Some respondents mention the value of macro-economic ex-post equalization. This mechanism rewards insurers that make efforts for efficiency and punishes insurers that refuse to organize care efficiently. An insurer that is more efficient in organizing care than its competitors can gain a competitive advantage. The insurer makes fewer costs, and because of this, the total budget is adjusted downwards (or with a total rise of the costs it is adjusted upwards to a lesser extent). Consequently, the budget of the other insurers is also adjusted. It also reduces the financial risk of insurers. In case of a total rise of costs, the total budget available is adjusted upwards. An insurer that tries to organize care as efficiently as possible but is confronted with higher costs than estimated can also expect total health care costs to be higher than estimated. The budget will be corrected upwards, so that insurers run no risk on the total development of the costs. Consequently, the risk premium and solvability demands are also lower. This in turn leads to lower premiums.

5.4 The future

5.4.1 The future health insurance market

All respondents think that in the future the Dutch health insurance market will consist of four to six large insurance companies and maybe some small regional players. An increase in scale is related to three factors. The first is overhead costs. It is believed that large insurers have an advantage over small insurers because they can allocate the fixed costs relating to housing, computer systems and legal demands on reporting to more clients. In practice, however, there is hardly any evidence that large insurers are more efficient than small insurers. Furthermore, small insurers usually score better at service and have a stronger connection with the region. These also seem to be important factors.

The second factor is connected with the fact that large insurers run less financial risk on their portfolio than small insurers. Large insurers have clients spread over the country and do not have an overrepresentation of specific risks in their portfolio, while small insurers often focus on a certain region and depend on fewer providers. If there is a group that, for some reason, becomes unprofitable in a certain year, an insurer with a countrywide portfolio can expect macro-economic ex-post equalization

to correct differences between expected and actual costs. Insurers that focus on a specific region or on specific risk categories, however, run the risk that their costs rise more than total health care costs. For them, macro-economic ex-post equalization does not correct for all differences between expected and actual costs. Therefore, they run more financial risk than large insurers.

A third factor, that may play a role in the future, is the fact that with the phasing out of the ex-post mechanisms and the transferring of AWBZ entitlements, there will be an increase in the financial risk of insurers. Consequently, there will also be an increase in legal solvability demands. Insurers that cannot raise their solvability to the required level without a substantial raise of their premium, there are probably some insurers that cannot, will not be able to survive as an independent health insurer.

There are different answers to the question whether further concentration is desirable. Six respondents think that a market with only a few large nationwide insurers is not desirable, because then there is not enough competition. Various reasons are mentioned. First, on the organization and purchasing of care, insurers cannot distinguish themselves from others anymore. What a specific insurer does one day might be copied by a competitor the day after. Second, a market with only four insurers can result in an oligopoly, a concentration of providers, less efficiency, and a lack of client perspective. Therefore, small insurers are needed to keep the large insurers focused on good quality at a reasonable price.

The other six respondents think that there is still enough competition in a more concentrated market. Large insurers are able to operate efficiently because they have more bargaining power to negotiate with providers and operate more efficiently when it comes to overhead costs. This will result in a lower premium for clients. Some mention that due to large insurers having an average portfolio, the risk equalization model could be simplified and the ex-post correction mechanisms could be phased out without influencing the playing field.

5.4.2 Improving the model

Suggestions for improvements to the model are mainly based on the studies discussed in section 3.3.2. Factors that were mentioned are physiotherapy, medical devices, high-risk equalization, and multi-year high costs. Seven respondents mention that it is important to raise the question whether adding new factors will lead to a significant improvement of the model. According to them, it is necessary to make a trade-off between improving the predictive power and feasibility.

Two insurers mention that attention should be paid to the predictive power for large cities. As mentioned in section 5.3.1, the factors region and source of income do not compensate sufficiently the heterogeneity in some living areas. According to them, the predictive power of the model for large cities can improve significantly if the model is extended by the factor education, for instance.

5.4.3 Improving the system

Suggestions are in line with the results from section 5.3.1. All insurers answer that the system needs improvements when it comes to transparency, reliability, and timeliness. If transparency is improved, it can be defined better whether subsidies are correct and it can be determined better which groups are structurally unprofitable. This information can be used to stimulate research and improve the predictive power of the risk equalization model. To improve the reliability of the provided data, attention needs to be paid to the supervision on all parties, especially the CVZ.

Two respondents mention that if transparency of the risk equalization model and the quality of the care improves, competition between providers will be stimulated. Insurers will have more bargaining power, because they know the characteristics of their clients and can judge their health status. With this information, the efficiency of the providers can also be judged. Given the risk profile of the patients in a specific hospital, for instance, insurers can communicate to that hospital why they think they provide better care than other hospitals. Differences between them can be communicated to the clients and expressed in the policy and the premium. The clients in turn can make a well-considered choice of policy.

One respondent emphasizes that the government addresses that a level playing field is important, but fails to describe what the ideal playing field should like. Is it one that offers the same chances for every insurer or does it only allow a few large insurers, because that is the only way a risk equalization system can work adequately? According to the respondent in question, the government should make more of a statement when it comes to this matter.

5.5 The Exceptional Medical Expenses Act and risk equalization

Most respondents find it difficult to answer questions about the AWBZ, because their knowledge is sometimes limited. However, all respondents tried to base their opinion on their general knowledge of risk equalization and the AWBZ.

5.5.1 Short-term mental health care

All respondents answer that with the data currently available it seems impossible to develop an adequate model for short-term mental health care. In the future, it could be possible to develop a model that distributes funds fairly, but no respondent is sure this will indeed happen. Two respondents state that it is impossible to develop a model for short-term mental care.

The reason that it is very difficult or even impossible to develop an adequate model is that the group of users is very small and costs are highly skewed among individuals and insurers. It should highly depend on information from diagnoses and prescribed drugs, while currently there is a lack of uniformity of diagnoses and treatments for short-term mental health care. Because the costs are skewed among insurers and predictable profits and losses are also relatively large, most respondents emphasize

that an inadequate model will possibly lead to a market in which insurers make profits or losses on the composition of their portfolio, not on efficiency.

Most respondents think that, in principle, short-term mental care can be executed in a competitive market. First, the care is aimed at curing people. Second, there is a possibility to bargain the rates and content of care. There are enough providers for selective contracting and, to a certain degree, clients can be steered. Since partitions are taken away between the AWBZ and ZVW, a better connection between the two compartments will be established. One respondent mentions that price competition may be impossible, but that insurers can compete on the quality of care.

5.5.2 Long-term care

According to most of the respondents, it is nearly impossible to develop an adequate risk equalization model for these entitlements. The costs are even more skewed compared to short-term mental care, while the group of users is smaller. The respondents do not know what information the ex-ante subsidies should be based on.

Most of the respondents are also not sure whether it should be transferred to the ZVW, even if there would be an adequate risk equalization model. There are several reasons for this. First, the question is whether long-term care fits in the organizational structure of the ZVW. While the current entitlements under the ZVW can be considered insurable short-term care, this is non-insurable long-term care. Second, it could be questioned whether competition will lead to more efficiency. Respondents question whether there is sufficient choice among providers, and whether it would be possible and desirable to steer clients. Third, an increase in the financial risk of insurers can lead to an increase of the risk premium and solvability demands. This will result in higher premiums.

Two respondents are more positive about transferring to the ZVW. One insurer mentions that it will probably take years to develop an adequate risk equalization model, but that one cannot state beforehand that it is impossible. According to this respondent, the main reason for transferring is that the entire health care system should be organized as one organizational structure. This will lead to a better integration of the various domains. The other respondent admits that it will be very difficult or even impossible to develop an adequate risk equalization model, but that attention needs to be paid to the transparency of the quality and costs of the AWBZ care. Transferring care to the ZVW can lead to an increase in transparency.

VI DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

In chapter 5 an overview of the results, gathered during the interviews, was given. In section 6.1 the results will be discussed and compared to the theoretical framework provided in chapters two and three. In section 6.2, a short conclusion is given, as well as an answer to the central question of this thesis. Finally, in section 6.3, several recommendations are made.

6.1 Discussion

6.1.1 The goal of risk equalization and premium differentiation

In chapter two, it was explained that a competitive health insurance market with risk equalization is the best way to ensure both affordability and efficiency in health care. All insurers agree with this finding, which can be considered to be a remarkable result. The Health Insurance Act, namely, came into force after a discussion centred on the question whether it should be an insurance scheme under private law with public law features, or under public law with private features (MoHWS 2005a). Some feared that insurance under private law would ultimately develop into purely private insurance, loosing the central characteristic of social health insurance, namely that of solidarity.

All but one insurers are of the opinion, however, that the public conditions of open enrolment and a ban on premium differentiation are essential elements of the ZVW. Without these conditions, part of the population will probably have no access to a proper level of health insurance coverage. According to law, however, subsidies should only compensate for the factors sex, age and health (MoHWS 2005). So, implicitly it is said that for costs related to other factors no compensation is desired. Currently, the ban on premium differentiation makes it impossible for insurers to express cost differences related to other factors - such as oversupply, taste, or price differences - in the premium (Stam & Van de Ven 2006). Most insurers, however, thus mention explicitly that compensation is desirable for all costs, also those not related to health.

While the government has not expressed explicitly whether it is desirable to allow premium differences for N-type factors, it has recently provided an explicit answer on the question of selective contracting. The opinion is that it fits in the development of the health care market, because it increases efficiency, quality, and freedom of choice for consumers. It gives clients an opportunity to choose a certain price-quality ratio, while insurers can distinguish themselves from their competitors by means of their choice of providers (MoHWS 2007c). The opinion of the government that differentiation of policies is desirable, is opposite to that of most insurers, which mention that policies with only a few contracted providers for a relatively low premium are not desirable. Such policies, namely, will especially attract healthy individuals while the unhealthy will choose a relative expensive policy with more choice of providers. According to these insurers, this will result in market

segmentation and undermine the solidarity principle, because unhealthy people pay a higher premium than the healthy.

It can be questioned, however, whether this will indeed undermine the solidarity principle, since unhealthy individuals can also choose a cheaper policy. It could also be argued that it is not desirable that individuals, who are willing to trade-off the higher costs of care nearby against a lower premium, subsidize individuals who are not willing to make this trade-off.

A point of interest is, however, that the quality of care is not transparent at the moment. This leads to the risk that insurers will mainly compete on price instead on quality. Then, differentiation of policies can indeed lead to a market where the healthy buy a policy with only a few contracted 'cheap' providers, while the unhealthy will be 'forced' to pay a higher premium for care that meet their standards. Then, differentiation of policies can indeed undermine the solidarity principle. So, if the government wants consumers to make a well-considered decision, information on the price-quality ratio needs to be more transparent.

6.1.2 The Dutch risk equalization system

Several publications show that the predictive power of the Dutch risk equalization model is not sufficient and leads to predictable profits and losses. Insurers agree with this finding and add that the funds are also not distributed fairly among insurers. So, the goal of the Dutch risk equalization system that funds should be distributed fairly among individuals and among insurers, is not obtained. It is difficult to establish, however, the extent to which it really results in an 'unlevel playing field'.

A remarkable result is that while theory says that predictable profits and losses can lead to cream skimming activities, most insurers believe it will never become an important issue. After all, insurers have a social merit and a reputation to lose. Some insurers seem to have the opinion that the level playing field is basically more important than mitigating predictable losses and profits. They even pretend that if all insurers would have an average portfolio, the risk equalization model could be simplified. If there is enough supervision, insurers will not cream skim.

However, some remarks can be made in this respect. Without adequate risk equalization, a stable level playing field seems to be infeasible. Insurers will probably never admit that they engage in cream skimming activities and might have given socially desirable answers. Predictable profits and losses, however, will always lead to a continuous incentive for engaging in it. If there is one insurer that decides to cream skim, other insurers are forced to follow if they want to maintain their competitive position. Only if all insurers have an average portfolio and not any insurer would cream skim, a stable level playing field could be the result. In such a market, however, insurers cannot not distinguish themselves anymore by organizing the care as good as possible for specific risk categories, and by doing that attracting them, since the level

playing field should be maintained. This situation is also undesirable, since the goal of a competitive health insurance market is that insurers are provided incentives to compete for all kinds of clients, and provide the best care and service available.

So, to prevent insurers from cream skimming and to provide them incentives to provide the best care available for all groups in society, an adequate risk equalization model will always be of high importance.

According to the government, insurers should be rewarded for efficiency. Equivalent to the opinion of the government insurers indicate that they are not rewarded for all efforts for efficiency. For overhead costs, all costs saved come back to the insurer in question. Due to ex-post correction mechanisms, however, for saving costs in health care this is not the case.

Since some ex-post correction mechanisms not only correct for an insufficient model, but also for inefficiency and therefore in theory reduce incentives for efficiency, it is desirable to phase them out. The decision on phasing out should, according to the government, be based on maintaining a balance between the level playing field and prevention of risk selection on one side, and incentives for efficiency on the other side. All insurers question, however, what this trade-off means. Since objective information on the improvement of the model is lacking for 2007 and 2008, the phasing out cannot be justified. This finding is also supported by a 2006 report on the transparency of the system (PWC 2006). So, it seems that the government should provide more objective information to show on which grounds it thinks it can justify the phasing out. It should also take into account that, as was mentioned before, predictable profits and losses will lead to a continuous incentive for cream skimming.

Some insurers do not believe that increasing their financial risk will lead to more incentives for efficiency. The reason is that, currently, insurers already run a financial risk and therefore have an incentive for efficiency. Increasing the risk will not lead to more incentives. Moreover, it should always be the goal of an insurer to organize the care as efficient as possible, this should not only depend on the profitability of it. Some insurers indeed indicate that they do set up initiatives that reduce costs, while they are not sure whether it is really profitable.
It can also be argued, however, why phasing out ex-post correction mechanisms will lead to more efficiency. It is important for insurers to offer a low premium. Therefore, decision-making around investments will depend on whether the benefits outweigh the costs. Because ex-post correction mechanisms cream off part of the saved costs, the benefits are lower. So, insurers will be less inclined to invest in efforts for more efficiency, if the benefits for them are too low. The fact that insurers run less financial risk on hospital care than outpatient care, for instance, discourages transferring care from hospital to outpatient care facilities. Some insurers also indicate that they have their reservations when it comes to transferring care.

So, while probably not all investment decisions will depend on profitability, it is not unimaginable that for some investments, prevention programs, or the decision to transfer, insurers will be somewhat reserved because they lose money by doing it. The ex-post correction mechanisms thus seem to decrease efficiency to a certain extent. A final point that has to be made is that it is remarkable that two insurers do not really believe that price negotiations can save costs, because it will not lead providers to act more efficiently. Time will tell whether, and in what direction efficiency gains can be made.

According to the literature, risk-adjusters should be available for all parties involved. Insurers indicate that availability and a lack of transparency, however, are the main weaknesses of the Dutch system. This is related to the information used for the determination of the subsidies, the availability of the risk-adjusters for the insurers, and the distribution of the budget. Consequently, insurers cannot verify whether the subsidies assigned and received are indeed correct. An additional problem is the reliability of the information about the available budget. Since frequently incorrect information about the height of the subsidies is provided and sufficient supervision on involved parties is lacking, insurers cannot always trust the information on its correctness. These results correspond to the results of a 2006 report on the transparency of the system (PWC 2006). So, while the government seems mainly focusing on the question whether the risks are compensated adequately, it seems that it should pay more attention to the aspect of transparency.

An argument for not providing all information to insurers is that it will provide them more opportunities for cream skimming, or that available information can be used for other purposes. However, the government should look more carefully to the trade-off between the possibility of these drawbacks and the fact that if insurers have more information of their clients, they can also contribute in improving the model. As was mentioned in the interviews, insurers can also use the extra information to strengthen their position in the bargaining process.

6.1.3 Future points of interest

Besides suggestions for improvements based on current weaknesses of the system, such as predictive power and transparency, there are two other future points of interest. The first is transferring care from the AWBZ to the ZVW. In chapter three is was discussed that developing an adequate model for AWBZ entitlements seems to be very difficult, while inadequacies can lead to high predictable profits and losses, and an unlevel playing field. Moreover, it must be looked carefully whether the nature of long-term care fits the ZVW. All insurers mention that it will indeed be very difficult or impossible to develop an adequate model for short-term mental care, and even more for long-term entitlements. Since risks are probably distributed highly skewed among insurers, most are also afraid that an unlevel playing field will be the result. Considering the nature of long-term care, insurers are also not sure whether transferring care to a competitive market leads to increases in efficiency. So, the

government should take into account that transferring AWBZ entitlements and developing an adequate model is a big challenge.

Another point of interest is the level playing field. While the government pretends that the risk equalization system should create a level playing field, it seems that large insurers have a competitive advantage over the small ones. This seems partly due to an inadequate risk equalization model and the fact that macro ex-post equalization only corrects for country-wide differences between forecasted and actual costs. Therefore, financial results of small insurers are more volatile. Moreover, and this is not related to the quality of the risk equalization model, some mention that large insurers have more bargaining power to negotiate with providers and operate more efficiently when it comes to overhead costs.

It is difficult to judge to what extent there is an unlevel playing field. At the moment, however, the market is characterized by a further concentration of insurers. It can be questioned, whether this is desirable. On the one hand, a market with four to six parties can be considered a competitive one. If economies of scale are expressed in the policies, it can come at the advantage of the insured. Not everyone is sure, however, whether in such a concentrated market efficiency gains are really realized, and whether there is still enough consumer-perspective. The government currently holds aloof of the question whether further concentration is desirable. It should therefore take more a position what it thinks the level playing field means, and whether the goals of the Health Insurance Act, the improvement of quality and efficiency in health care, can also be realized in a more concentrated market.

6.2 Conclusion

The central question of this thesis was:
'What do Dutch health insurers think of the 2007 Dutch risk equalization system, and – in their opinion- which changes should be made to it?'

Dutch health insurers support the Dutch risk equalization system. The current system has some shortcomings, however. The main points of interest are a lack of transparency and that the information provided is not always reliable. Other shortcomings are that the model does not compensate all risks adequately, the level playing field, and that the phasing out of ex-post correction mechanisms is not based on objective information. These shortcomings need to be improved in the future. Two other future points of interest were mentioned. First, with transferring of AWBZ entitlements to the ZVW it should be taken into account that developing an adequate risk equalization model and creating a level playing field is a big challenge. Second, the current concentration of insurers seems to indicate that there is no complete level playing field. Therefore, the government should be more explicit in their opinion of what a playing fields means, and how the ideal health insurance market should look like.

On some topics opinions differ among the insurers. First, not all insurers agree on the way a competitive advantage can be gained and whether selective contracting is desirable. Second, not all insurers agree on the speed of phasing out of ex-post correction mechanisms. Some think that the decision should only be based on objective improvements to the model, while others think that increasing the financial risk of insurers is also important. A third difference is that some insurers are of the opinion that a more concentrated health insurance market can be considered a competitive market, while others feel Dutch citizens would not benefit from this. Insurers also do not agree fully on transferring of entitlements from the AWBZ to the ZVW. Some think they can be transferred in the future, while others think that they should not.

6.3 Recommendations

The results of this thesis show that attention needs to be paid to some aspects of the Dutch risk equalization model. Therefore, several recommendations are given.

- The Dutch risk equalization system is not transparent to insurers. They cannot verify whether the subsidies assigned and received are correct. Moreover, there is not enough supervision on the correctness of the subsidies. This affects the reliability and credibility of the model. The transparency and supervision need to be improved substantially.
- The government should take into account that selective contracting and differentiation of policies will only lead to more efficiency, quality and consumer choice, if the price-quality ratio of care is transparent. Currently, insurers and clients do not have enough information about the quality of care. Consequentially, the risk of policies with a limited number of contracted providers is that providers with the lowest rates are contracted, without paying attention to quality. If the quality of the care is transparent, however, insurers are able to express both price and quality of care in their policies. Only then, consumers can make a well-based decision when it comes to a price-quality ratio. Therefore, the recommendation is to make the quality of care more transparent.
- The Dutch risk equalization system should reduce predictable profits and losses, resulting in a level playing field for insurers. It is not clear, however, what the government considers being a level playing field. The phasing out of ex-post correction mechanisms cannot be justified by an objective improvement of the model. If the phasing out will continue without substantial improvements to the predictive power of the model, it can result in increasing predictable losses and profits, and as a consequence, an unlevel playing field. It is therefore recommended to base the phasing out on objective grounds, communicate why it can be justified, and always try to mitigate predictable profits and losses as much as necessary. Only then, the objectives of the Health Insurance Act – the improvement of efficiency and quality in health care - can be realized.

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APPENDIX 1: QUESTIONNAIRE

Questionnaire:
The Dutch health insurers and their opinion of the Dutch risk equalization system

Introduction
The goal of the interview is to study the opinion of the Dutch health insurers of the risk equalization system under the Health Insurance Act. This questionnaire consists of five central questions. Each question covers a number of topics, which are formulated in the sub questions beneath the main questions. The interview has a semi-structured character. This means that the questions in the questionnaire will be followed as much as possible, but that it is also possible to raise relevant topics not covered by the questionnaire.

Question 1: Are the goals of the Dutch risk equalization system realized at the moment?
To guarantee universal access in the competitive Dutch health Insurance market, this market has been bound to two conditions: an annual open enrolment period and a ban on premium differentiation. In order to compensate predictable losses or profits, resulting from these two conditions, a risk equalization system has been set up. This should result in a 'level playing field' for insurers, incentives for efficiency and universal access to health insurance. The question is whether, at the moment, these objectives are realized.

Level playing field (distribution aspect):

1) Are the different risks compensated adequately?
2) Are there identifiable predictably profitable or unprofitable subgroups in your portfolio?
3) Is there a 'level playing field' at the moment?
4) Is there risk selection in the market? (by means of collective contracts or supplementary Insurance, for instance)

Efficiency aspect:

5) Which incentives for efficiency are provided at the moment?
6) Is it possible to gain a competitive advantage with the purchasing of the care? How?
7) Is 'steering of clients' to preferred providers profitable? Why?
8) Are there incentives for prevention?
9) What will the future playing field look like?

Question 2: The objective of the Dutch risk equalization system concerned, is this the same as the insurer thinks the objective of a risk equalization system should be?

The starting point of the Dutch system are the conditions mentioned in question 1. Risk equalization should create a 'level playing field' for the insurers. An alternative is to take an unregulated market as the starting point, where insurers are free to risk-rate their premium. A risk equalization system is set up to compensate for those risk factors, for which solidarity is desired. In case of an inadequate risk equalization system, additional mechanisms can be used to create more solidarity. In the alternative system, the objective of risk equalization is to minimize premium differences among the various risks.

1) What should be the goal of risk equalization?
2) What is your opinion of open enrolment and the ban on premium differentiation?
3) To what extent is solidarity desired? For which factors?

Question 3: Are the current risk-adjusters appropriate to use for a risk equalization model?

<u>Ex-ante risk-adjusters</u>

In 2007 the following risk-adjusters are used: age, sex, source of income, region, FKGs and DKGs. The most important criteria risk-adjusters should meet, according to the literature, are:

Fairness: a risk equalization model should only compensate for those factors for which solidarity is desired, it should create homogeneous risk categories and it must be reliable.

Appropriateness of incentives: the data cannot be manipulated and should be objectively measurable.

Feasibility: it must be able to collect the data without undue expenditure of time and money, the risk-adjusters should be accepted by all parties involved, and the system should be transparent.

1) Do the current risk-adjusters meet these three criteria?
2) Are there other criteria risk-adjusters should meet?
3) To what extent are the current risk-adjusters transparent?

Ex-post correction mechanisms

The ex-post correction mechanisms are used to correct for an insufficient distribution of funds by the ex-ante model. in order to increase the financial risk of the insurers and providing them more incentives for efficiency, the goal is to phase out these mechanisms as soon as possible.

1) To what extent can the ex-post correction mechanisms be phased out?
2) Do you agree with the policy of the ministry of Health, Welfare and Sports?
3) To what extent do the ex-post correction mechanisms reduce incentives for efficiency?

Question 4: In which ways can the current system be improved in the future?

1) What does the perfect health insurance system look like?
2) I which ways can the risk equalization model be improved?
3) What should the playing field look like in the future?
4) Does the model improve significantly if new risk-adjusters (such as SES, medical devices, physiotherapy) will be added?

Question 5: Are the current AWBZ-entitlements suitable for a risk equalization model?

The current organizational structure of the AWBZ is, under discussion for a substantial time, yet. The provided care would not be consumer-oriented, while incentives for efficiency are lacking. An alternative is to transfer entitlements to the Health Insurance Act, like the short-term mental health care. For this purpose, a distinction can be made among four categories of patients: elderly and the chronically ill, individuals with early acquired or hereditary diseases, chronically psychiatric patients and potential sicknesses and disorders.

1) What is your opinion of transferring the short-term mental health care?
2) Is it possible to transfer the other entitlements to a competitive market?
3) Is it possible to develop an adequate risk equalization model for these entitlements?
4) Which information should the model be based on? (risk factors, an assignment, other information)?

APPENDIX 2: STATEMENTS FROM THE INTERVIEWS

Distribution aspect / level playing field

"But actually, if you look at whether a level playing field has been introduced, which is also one of the goals of the equalization system, we could ask ourselves whether there has. The entire equalization system has been based on the basis of average scores. (…) It works adequately if an insurer's population is distributed like the Dutch population. In other words: if 10 percent of the insured has been classified to region 6, they should, for instance not all live in a specific region 6 in The Hague. They should be distributed country wide among all regions 6. (…) Once an insurer is a little bit smaller, more concentrated in one region, or is a niche player, it runs the risk that the model doesn't compensate for its risks adequately."

"Basically, each insurer has the same chance. However, from the past one insurer is richer than the other insurer. In that respect, the richer insurer can perhaps utilize more financial resources than other insurers can. That particular insurer can decide to use part of its financial capacity to reduce its premium. (…) It could be questioned whether, with the introduction of the new Health Insurance Act, this was intended."

Efficiency

"If you, as an insurer, are doing your best and making very good agreements with providers on the price of the care, you will make a profit. Because of the ex-post corrections, however, that profit is currently creamed-off for a large part."

"Currently, insurers don't run a financial risk on most of the hospital care costs. (…) We indeed experience those incentives, certainly for projects such as transferring hospital care to outpatient care. While transferring is desired in terms of efficiency, we are provided incentives not to transfer care. So, we are not provided appropriate incentives, because an insurer runs much more risk on outpatient care than on hospital care. So, you will have to save much more costs before it will really become a profitable approach. I think this is a very important, very important point of interest."

"The starting point should be that, in the future, the distinction between hospital care and outpatient care will not be made anymore."

"Efficiency is especially focused on internal processes. These processes can be influenced directly by the insurer and are a 100 percent gain."

"That hospital will not produce any cheaper because we suddenly carry in 5000 clients more. I's an interaction with total costs. More like: I pick something away here and I give it away over there."

"You can try to squeeze out a provider, but not anything will be achieved by doing that. If you squeeze a provider on one side, on the other side it will present its costs to you. A provider will always have to guarantee its income."

"For the rest, initiatives are unfolded to improve the quality of health care. We integrate the care for diabetics. How do you call that, group practices for GPs, physiotherapists, and that kind of professions. Health centers. (…) Well, whether an insurer is rewarded or punished for unfolding that kind of programs. Let's say that you need to know when you are going to invest and when not. For that, you need to have a feeling."

Prevention

"The returns on investments are received in the future. Since long before this, your clients can have changed from insurer, it is difficult to really quantify those returns. Prevention is a broad concept, too. You are talking about, for instance, young people with an I-pod, the volume much too loud. Not until 20 years later they will need a hearing. You can decide to invest in them now, but it is hard too see a direct relationship with future benefits. From our mission, however, we believe that we have a certain responsibility in these kind of questions. So, we actively sponsor several sport activities. (…) Just nice activities for the youth, like basketball clinics and that kind of things."

"We are not in a market where the government reimburses all the costs. (…) We are in a private market, and then you will have to take the risk to invest and believe that you can make a substantial contribution to improving the health of those patients. You must believe that by doing that investment, and by communicating to the clients that you aim to improve their health, you will succeed in binding those patients, and that they stay insured at your company. If all clients leave I really think you are doing something wrong. (…) I would almost say that almost every self-employed entrepreneur has to take risks. But indeed, the benefits will come later."

Selective contracting

"Really selecting hospitals on the cheapest DBCs is still in its infancy. We are working on it, but it is still a scanty measure."

"The question is, however, to what extent insured can be steered. Until now, this has not been discussed at all. But we are working on it. Other insurance companies will also need to go working on it seriously, if they would like to distinguish themselves in the market. And, of course, expressing this mainly in the level of the premium."

"But actually, that is only since recently. The last year that it's a little bit underway. (…) That it is really tried to steer clients. And by doing that, you hope to reduce a number of things. (…) Because you are living in that area, you are only allowed to visit that hospital. If you would like to go to another, that's fine. Then, however, you

will have to pay an extra charge on the premium. (…) For the daily treatments in the B-segment, you should absolutely try to steer clients. That makes definitely sense. Not all clients can be steered, but that's not necessary. Those clients will pay an extra charge on the premium. Those clients that are willing to let themselves steer, then you should think of subgroups that think they will never have to visit a hospital, or don't care about it. Those are more likely to say: well, I take the cheaper product. If I need to go to the hospital, I visit to the contracted hospital, I don't care anyway. It's that group that you must try to catch, that group can be steered. That will also give a financial result."

"But it is mainly the fact that with those hospitals lower rates are arranged, demonstrably lower rates. (…) That the insurer wants to agree on lower rates. Since we also bargain with the same hospitals, we have to pay a higher rate, because we negotiate for an average population. By doing that you will undermine the solidarity principle. We think that's not fair."

Cream skimming

"It's socially seen quite tricky I think, because you can't really sell that you try to select. (…) I think that if you are the only one doing that, apart from the question whether you would like to do it anyway, I think that the market will let you pay for that."

"We are not able to analyze all data ourselves. By that I'm aiming at the fact that we cannot calculate for every client: that one costs us so much on the basis of those and those parameters. As a result, selecting groups is also very difficult."

"Because of changes in the system it is not possible to identify exactly who are predictably profitable or unprofitable. It is very difficult to put one's finger exactly on the spot which target group is good or bad for you, this year or next year. Retrospectively, it may be possible to say something about it. But, surely for the future, it isn't possible to say anything about it. This is because the model and normative amounts change each year."

"But I don't have the impression that other insurance companies engage in selection activities. If they would like, however, they know exactly how to do it."

"So, I think that some insurers will come back on the fact that they simply have accepted everyone. At the moment they will move that direction, then they will frankly, and it will not be visible on the surface, but they are going to look for ways to select. I don't know whether they will call it selection themselves, but they will take care that unprofitable groups will become less unprofitable. And that can be practiced by the way collectivities are concluded, or by target marketing (…) I think that Klink trivializes the risk of selection. (…) I think it's too simple to think that it's sure to

come right, because insurers will harm their reputation by doing that. So, I think there is a risk below the surface. And that's being underestimated."

"I would like to know what will happen if there is one insurer that is really going to target the healthy ones. Whether the large insurers are proof against that, or whether they will join the battle."

"It will not be their policy to engage in risk selection. It is possible, however, to control it to a certain extent. Definitely. If there is medical selection for the supplementary insurance, you are sure that a hemophilia patient not even dares to switch from insurer. Even though it has nothing to do with his illness. Even if there is only medical selection on his teeth and general condition, physiotherapy and that kind of things. You are sure that you scare them off. If they consume and there is selection for the supplementary insurance, and individuals are ill at the time, then they will not switch from insurer. That's the reason that they will not switch. They are just afraid that they will not be accepted elsewhere, while for the basic benefit package it is obligatory to accept everyone. And then, as colleague insurers, it can be said that selection is not practiced. But it is, absolutely."

Goal of risk equalization / premium differentiation

"What I think is that, I do absolutely believe in the system of risk equalization. I think it's also an essential system"

"So, it is a very differentiated model, and a lot of progress has been made since the introduction in '92. So, I'm in favor of holding on to the crown jewels of open enrolment and a ban on premium differentiation. And, despite the fact that a factor like region costs us money, because in general people are healthier over here, I think it's highly acceptable to maintain this factor. (…) Only because one square meter of land is more expensive over there than over here. Charges on fixed assets, I think that's a valid reason for compensation."

"I think that it's impossible to set up a system where insurers are free to set a risk-rated premium. This will lead to gigantic high premiums for certain groups"

"Well, everyone is working on diabetics, right? They are offered to exercise a little bit more in order to stay off the needle for a longer period. Well, if individuals are not willing to join such a program, then what should we do? Should they be punished? That's the question. In fact they should, but sometimes people just have no choice. The waif, did he choose to be homeless? That's the question. (…) Why is he actually homeless? I think you should look at that question rather than purely expressions. So, you should look at a level higher. Is it possible to hold that person responsible for his behavior. (…) We have the intention to be a social insurer. Let others paying attention to certain things, but you also need to help people, we also like to be a guide for them."

"That scenario, if health is compensated adequately, the bill can be laid down where it belongs. (…) The fact I mention about the self-employed entrepreneurs. It appears that they, given their health status, visit less often the hospital and physician. (…) I mean, there is not any reason that they should subsidize people that go more often than necessarily to the hospital."

To what extent the Dutch risk equalization system meets the criteria of fairness, appropriateness of incentives and feasibility

"If you look at the differentiation of those risk factors. It just depends on the way groups are clustered. Sex, male, female looks to be obvious. But take the factor region, for instance. Currently there are 10 classes for the factor region. But, for instance, in The Hague there is a living area falling in category six, there is also a region six in Tilburg, and maybe one in Amsterdam. (…) The region six in Tilburg could be much less expensive than that region six in Amsterdam. Consequentially, an insurer that is concentrated in Amsterdam and has a lot of clients in that region six, that insurer doesn't receive enough budget."

"What I think is annoying, by the way, about the factors, and that applies to both source of income and the factor SES, is that they are determined on the background. Insurers have no information on these factors. They are not transparent. It is not possible to test their reliability. I have some concerns about that. In fact, it's one black box."

"The two main problems are that we are not able to check the calculations, and calculate: A) the amount we are entitled to, and B) the amount we ultimately receive. (…) The entire time path should also be a bit shorter, in order to calculate the financial result earlier. Because at the moment, we have to wait two years before the financial result can be calculated."

"No, it's not transparent. It's one black box. And it will stay a black box if you receive a provisional settlement 2006, while one week later a new letter is receive in which it is told that you receive two hundred thousand Euro's extra. The flag can be hoisted. Which one is correct, however. (…) And where are the errors being made. It's difficult to put one's finger on the spot. I think that's a little bit annoying and a weakness. The fact that it is said here is a few million and good luck with it. That's it, done."

"Sometimes a trade-off has to be made between transparency and improving the model. Take the factor SES, for instance. The insurers don't have the information to calculate their budget themselves. So, it's not transparent. It is, however, an improvement to the model, as a replacement for the factor former sickness fund and former privately insured. In this specific situation, the improvement of the model

outweighs the fact that insurers don't have all the underlying information. To some extent, one should be able to trust that the subsidies are correct."

"CVZ is making errors, right. The model has been made so complicated, the data is not up to date last years. (…) That will lead to delays. It could be that some funds, retrospectively, if they receive a settlement about 2001, 2002, or 2003, that they are bankrupt. That's possible. From CVZ, we sometimes receive four letters in a row, again and again containing errors. (…) We also agitate against it, towards CVZ and VWS. We are obliged to accompany everything with an audit certificate. And that's fine, but then, they should also accompany the letters, they send to us, with an audit certificate."

Ex-post correction mechanisms

"What's the R^2 of the risk equalization model, 22? That's not very high, is it? If that SES factor suffices, then they must also prove that it does. That SES doesn't, however. They can't prove that it does, so then... (…) Consequentially, they can't be phased out yet."

"Has it really been improved? Well, in my view it hasn't. The data used is highly dubious. So, it has not improved objectively, that they can be phased out. (…) If you are not even sure about 2005, how is it possible to shout that they can be phased out? (…) No, this is really, all kinds of expectations and things are shouted, that don't correspond to the truth. In my point of view. The ex-post correction mechanisms can only be phased out if the ex-ante model really functions adequately and if it has been proven that it functions adequately. That last criterion has not been met, in our point of view."

"Well, what I just pointed out. We think that the ex-post correction mechanisms should be phased out as soon as possible. That's clear I suppose. But it's only possible to phase them out if the ex-ante part functions adequately. But I need to say, those ex-post correction mechanisms, I don't care a lot about them."

"Of course, we're doing our best and we will continue doing our best. Only, if there would be more competition, if we were allowed to keep that profit, then the incentive would also be larger. That goes without saying. At the moment, we are doing our best. Imagine, however, that if we would be able to make a profit, we have to return half of it. If the ex-post correction mechanisms are phased out, we can make a profit and can keep those profits. It's that simple."

"While they don't even exactly know why, but the idea is that it hampers purchasing of care. I think it doesn't at all. I think that insurers absolutely try to purchase as effective as possibly."

Macro-economic ex-post equalization

"That comes down to the fact that if I have less costs, the rest will be hit by that. First, I have less costs. Second, the budget of the other insurers will decrease. Then there is an incentive anyway, isn't there?"

"If it appears that our costs are much higher than the budget, then I assume that we are large and, by that, also representative for the market. So, total costs will also be higher than budgeted."

Future health Insurance market

"But anyway, mergers do not automatically lead to short term efficiency gains."

"By one push on the button, yard-stick competition for instance, particularly we are sensitive if it will manifest itself in one of the five hospitals, if something strange is going on there. (…) So, we are a bit more vulnerable."

"Exactly, there are just the regular premiums, but also the level of service. If there are about five or six large insurers left, and all of them are evenly able to purchase care well, while their level of service is the same, then we are not just talking about Euro's anymore. Then we are talking about whether the phone is answered in time, whether the bills are reimbursed in time, whether mediation is provided, that kind of things. Those aspects will become really important then. I think the customer will benefit by that, because they can require even more quality. Otherwise, they will switch to the competitor. So, I think it's a good development."

"It will not become any cheaper, not at all, I'm convinced about that. For large insurers it will also be very difficult to really gain a competitive advantage by the purchasing of care. The trick an insurer is doing one day, will be copied by the competitor the day after. It could be questioned then, to what extent there is really competition on that element. I think that's a tricky one. In a system with small insurers, however, that are able to organize the care well in the region, and we think we are able to do that, and are able to gain an advantage by doing that. Those insurers will keep the large ones keen, and then there is a mutual incentive. And the large insurers may be a little more efficient in their overhead costs."

"It will result in an oligopoly. And what's the drawback of an oligopoly? Right, the price will increase like this. (…) If there are four left, then the price will increase while the quality will decrease. Concentration of centers will the outcome, because that's cheaper than to spread them all over the country. This will come at the cost of the insured. That's the only thing that counts. They will strive for efficiency in such a way, that, for the insured, there isn't a hospital nearby anymore, the physician or dentist, etcetera are not accessible anymore. They will all be moved to centers. Then, cost advantages and economies of scale can be gained. The question is, however, whether the insured will really benefit by this."

Improving the Dutch risk equalization system

"I think, and I will mention it again, that attention should be paid to the large cities, since they are characterized by very volatile results. Except for The Hague, where the results are structurally negative."

"What we're also thinking about is that, actually, you should be compensated for bargaining results. So, the better you bargain the better the risk equalization system works out for you. (…) Currently, that's done indirectly. The idea is that, by a good bargaining result, the costs will decrease. The volume of the care will stay, however, and this volume also relates to health differences. I think that attention should also be paid to that aspect."

"That's also one of the main points that has been laid down by CVZ. That they should provide more information about their assumptions, which steps have been taken, which data has been used, the reliability of the data. (…) And I'm also concerned about the reliability of the data provided by our colleagues."

"In order to stimulate research, it should also be possible to identify unprofitable or profitable groups yourself. Then, you can show for which groups the model is inadequate, and should be modified. Currently, you can't. I think that's a major problem."

"We are beyond the stage of good faith, however, with all the errors taken into the mind. That's also the reason that we advocate an audit certificate, or another warranty to guarantee that the provided information is correct. That, when we receive a letter about the budget from the CVZ, that we reasonably can be confident that it's correct. Since it's the basis for the decision about the height of the premium, it's the least we can require from them."

"When you are bargaining with a provider, you should be able to indicate why you think one provider is better than another. And the first thing you will hear is: my population is so ill, while the other provider only gets the healthy ones. It should be better possible to measure that. And if it's not measurable, it's not possible to bargain, and it's not possible to benchmark."

"We are funding an oversupply of hospitals for years now, while VWS is saying that they are not going to intervene in that question. They are the only party, however, that can decide to close a hospital. They hold aloof of that discussion. (…) Something structural as a hospital, I think that the government should also take its responsibility in that matter. Whether it matches the cost structure in a particular region."

"Actually, VWS should express what the minimum size of an insurer ought to be, to be able to function well in a risk equalization."

Transferring short-term mental care to the Health Insurance Act

"It's possible to transfer the short term GGZ, I think. This is because clients can be steered in that segment. So, obviously a surplus value can be gained then. So steering, that can come down to competing providers, and it will be possible to switch insured to another provider."

"Look, a large insurer may be able to compensate its losses with its profits. The question is, however, whether large cities for instance, where there is a lot more care of addicts, and where exactly the GGZ is concentrated. So, I really expect some problems in those cities. I think, if you look at transferring the care, from the perspective of short term care, that could indeed fit in the Health Insurance Act. You should look very carefully at the equalization model, however, how you are going to do it."

Transferring AWBZ entitlements to the Health Insurance Act

"So, in the current organizational structure of the Health Insurance Act, it doesn't fit at all, since it simply isn't short term care. (…) And I doubt whether advantages in the purchasing of care can be obtained in that sector, I don't think so. Consequentially, not much efficiency gains can be obtained there. The second part of the question is whether an adequate risk equalization model can be developed. (…) That has anything to do with the highly skewed costs of the short term GGZ. I think that if you look at the rest of the AWBZ entitlements, the long term care, that's probably even more skewed. Consequentially, it's not possible at all, to develop an adequate risk equalization model for those entitlements."

"All the care will be integrated then. That the entire health care will be executed by one insurer, one office. That's what we are aiming for."

"It may be difficult to develop a risk equalization model, it's very difficult to capture all the risks with it. I know that there are also plenty who are saying that it isn't possible at all, and that it's also not possible for the short term GGZ. (…) I think it's indeed possible to develop an adequate risk equalization model for those entitlements. And I think that for the entitlements falling under the Health Insurance Act it will sooner succeed. I'm convinced about that. But to say, by definition, that it's not possible to develop an adequate model for the AWBZ. No, I'm not sure about that."