



## Going Dutch — Managed-Competition Health Insurance in the Netherlands

Alain C. Enthoven, Ph.D., and Wynand P.M.M. van de Ven, Ph.D.

Twenty-five years ago, the health care system of the Netherlands was operating under top-down cost-containment policies, such as regulation of doctors' fees and hospital budgets, that were widely

criticized for lacking incentives for efficiency and innovation. In 1986, the Dekker Committee, an independent group appointed by the Dutch government to seek a solution, recommended market-oriented reform within the context of a national health insurance system. But before the concept could be implemented, a host of adequate systems had to be developed — systems of risk equalization, of product classification and medical pricing to give providers appropriate incentives for efficiency, of outcome and quality measurement to permit the development of fully specified contracts between insurers and

providers and to prevent competition focused only on price, and of information sharing with consumers about the prices and quality of insurers and providers. Moreover, successful implementation required an adequate governance structure and an effective competition policy. For the next 20 years, successive governments consistently worked to realize the preconditions for managed competition.

Finally, on January 1, 2006, the Dutch government enacted the Health Insurance Act (HIA), under which every person who legally lives or works in the Netherlands is obliged to buy, from a

private insurance company, individual health insurance whose benefits are specified by law (see box). Penalties for failure to enroll include back payments for premiums that would have been charged had enrollment occurred on time. To date, about 98.5% of eligible Dutch people have enrolled.

The law covers care by general practitioners and specialists, as well as pharmaceuticals and hospital care (for up to 1 year). In addition, the Exceptional Medical Expenses Act provides everyone with coverage for potential needs such as long-term care and hospitalization beyond 1 year. The HIA describes the standardized basic benefits package in terms of “functions of care,” rather than “providers of care” — for instance, “rehabilitation care,” rather than care delivered by rehabilitation institutions.

**Key Elements of the Dutch Health Care System.**

Mandatory basic health insurance for everyone, purchased through private insurance companies
Annual consumer choice of insurer and insurance products
Open enrollment and community rating
Premium subsidies for elderly people and those at high risk of disease, through a risk-equalization system
Voluntary deductible up to €500 per person per year
Insurers allowed to sell other types of insurance (e.g., supplementary insurance)
Insurers intended to be the prudent buyers of care on behalf of their members
General practitioners to serve as gatekeepers
Insurers permitted to contract selectively with doctors and hospitals
Health maintenance organizations and preferred provider arrangements allowed
In transition toward managed competition

About 15 competing insurers, some for-profit and others not-for-profit, are intended to be prudent buyers of care. They compete on the basis of premiums, service, and the quality of care offered by their contracted providers, as well as on the premiums and benefits of any supplementary health insurance they provide. The insurers may contract, through various types of arrangements, with independent doctors and hospitals, or they may provide care directly, through their own facilities and staff.

Although the insurers and providers are predominantly private businesses, they are heavily regulated. But the government intends to relax regulatory constraints gradually and to turn more and more of the care over to the competitive market.

Inpatient services provided by hospitals and physicians are paid for mostly on the basis of Diagnostic Treatment Combinations (DTCs), for which prospectively fixed amounts are charged per episode of care. For 20% of the 35,000 DTCs, insurers and hos-

pitals are allowed to negotiate prices freely and to contract selectively. The government intends to increase this proportion to 70% if certain preconditions are fulfilled — for example, if the predictive accuracy of the risk-equalization model is improved. The government reinsures and shares financial risk with insurers, but it intends to shift more risk to the insurers over time, as risk equalization is improved.

All individuals must pay an income-related contribution (6.5% of the first €30,000 in annual income) to the Risk Equalization Fund. Employers are obliged to compensate their employees for these contributions, but this is then taxable income for employees. In addition, all adults must pay a community-rated premium (i.e., the same price for the same benefits, regardless of their own level of health) to the insurer of their choice. Insurers set their own prices. Households receive a care allowance if the average community-rated premium exceeds a certain proportion of their income (4%, for single adults). Two thirds

of all households currently receive a care allowance. Because they must pay for whatever portion is not covered by such an allowance, adult consumers must pay the full difference if they choose a higher-priced plan. The government pays for all costs incurred by children.

For each “basic insurance product,” insurers are obliged to accept every applicant. People may choose to buy supplemental insurance covering care that is not included in the mandatory basic insurance — for instance, dental care, physical therapy, eyeglasses, and cosmetic surgery. For supplementary health insurance, however, there are no restrictions on premium rates and no requirement that insurers accept all applicants. Since 93% of insured people in the Netherlands have chosen to buy supplemental insurance, insurers have a substantial opportunity to select risks.

Risk equalization is an essential part of this system. The expected expense associated with each enrollee is estimated on the basis of predictive modeling, and the Risk Equalization Fund pays appropriately more to insurers whose enrollees' care is predicted to cost more than average, while insurers whose enrollees' care is expected to cost less than average must pay the fund. Thus, insurers' incentives for risk selection are substantially reduced but not entirely removed.

Insurers are meant to be customer-driven organizers of care for the people they insure, similar to American health maintenance organizations. To improve care management, insurers are increasingly using many techniques, including protocols, provider selection, incentive contracting, and

standardized approaches to disease management.

The Dutch system is still a work in progress, and substantial problems remain. First, the risk-equalization model requires further improvement and continuing adjustment. Second, since the Dutch combine income-related subsidies for health insurance with similar payments for housing, child care, and scholarships, a high percentage of each extra euro earned reduces the earner's subsidy, leaving people with little incentive to earn more money. Third, the existence of supplemental insurance with risk rating and without open enrollment may leave too large an opportunity for insurers to profit from risk selection. Finally, the current focus is on insurers, but the promise of this model lies in competition among delivery systems — which the insurers are now creating.

The “Dutch model” was actually first designed and proposed for the United States,<sup>1</sup> and similar proposals are alive today.<sup>2</sup> There are already some good U.S. models of responsible consumer choice and competition that have worked well for decades; these include the Federal Employees Health Benefits Program, the Wisconsin Employee Trust Fund, the California Public Employees' Retirement System, and the employee benefit programs of Wells Fargo Bank, the University of California, and Stanford University, among others. Experience in these systems shows that people migrate to what they see as the best value for their money, and they are satisfied with their choices. The implementation of a Dutch model in the United States

could extend its best practices to the whole population.

There are many U.S. physician organizations — more than 460 with 100 or more physicians apiece — that are capable of owning and operating their own health plans.<sup>3</sup> This kind of model would be well suited to U.S. cultural preferences for individual choice, multiple competing approaches, local control, and pluralism. It is compatible with the proposal put forward by the American Medical Association in 2004, which involved offering tax credits for the purchase of portable, individually owned health insurance.<sup>4</sup>

A U.S. version of the Dutch model would provide an opportunity for U.S. physician organizations to form their own health plans and present themselves directly to the consumer market, freeing them from control by large, remote, third-party insurance carriers and from the maddening complexity of having to deal with 15 to 30 different insurance companies and self-insured employers, each with its own payment criteria and plan designs. Medical groups could build their own customer base and loyalties. They could design their own coverage criteria, incentive schemes, utilization management, and other features. Surveys show that Kaiser Permanente physicians, for instance, are the most satisfied doctors in California<sup>5</sup> — doubtless in substantial part because they deal with a single insurance plan that is answerable to the medical group and generally defines a covered service as one performed or prescribed by a Permanente doctor.

A U.S. Dutch model would also represent an opportunity for consumers to have the physician organization of their choice and stay with it for generations, whatever their job status, as long as they did not move away from the service area. Such a system would offer many benefits: the availability of complete longitudinal medical records, built-in incentives for the physician organization to make long-term investments in members' health, and an opportunity for consumers to save money by joining a less costly, more efficient delivery system. Now that health care reform has once again climbed toward the top of the national agenda, we believe that such an approach would be the best choice for the United States.

Dr. Enthoven is a professor of management at the Stanford University Graduate School of Business, Stanford, CA. Dr. van de Ven is a professor of health insurance in the Department of Health Policy and Management, Erasmus University, Rotterdam, the Netherlands.

1. Enthoven AC. Consumer-choice health plan. *N Engl J Med* 1978;298:650-8, 709-20.
2. Quality, affordable health care for all: moving beyond the employer-based health-insurance system. Washington, DC: Committee for Economic Development, October 15, 2007.
3. Shortell SM, Schmittiel J. Prepaid groups and organized delivery systems: promise, performance, and potential. In: Enthoven AC, Tollen LA, eds. *Toward a 21st century health system: the contributions and promise of prepaid group practice*. San Francisco: Jossey-Bass, 2004.
4. Palmisano DJ, Emmons DW, Wozniak GD. Expanding insurance coverage through tax credits, consumer choice, and market enhancements: the American Medical Association proposal for health insurance reform. *JAMA* 2004;291:2237-42.
5. Rittenhouse DR, Grumbach K, O'Neil EH, Dower C, Bindman A. Physician organization and care management in California: from cottage to Kaiser. *Health Aff (Millwood)* 2004;23(6):51-62.

Copyright © 2007 Massachusetts Medical Society.