

## **The Experience of Switzerland and the Netherlands with Individual Health Insurance Mandates: A Model for the United States?**

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One of the most common and trenchant criticisms of the American health care system is that it performs very poorly when compared to the systems of other countries. The United States has the most expensive health care system in the world by any measure, yet while health insurance coverage is universal in most developed countries, between 45 and 50 million Americans remain uninsured and many more underinsured. Americans have long believed that they at least have the “best health care in the world,” but increasing comparative evidence demonstrates that American health care is in fact no better than that received in other countries that spend far less and have universal coverage.

American pro-market advocacy and insurer and provider lobbying groups however, have nonetheless rejected the possibility of learning from the experience of other countries, claiming that other countries have “socialized medicine,” and are plagued by rationing, including long queues for services and lack of access to the latest health care innovations.<sup>1</sup> Americans could not, they claim, tolerate the privations suffered by patients in other countries to keep costs low and access high.

Recently, however, these advocates and interest groups have finally discovered an international model that they like, one that, they contend presents a viable approach to health care reform for the United States. In Switzerland since 1996 and in the Netherlands since 2006, universal coverage has been achieved, they claim, by requiring all residents to purchase private health insurance. Private health insurers compete for the business of consumers, thus market forces are harnessed to hold down health care costs. In Switzerland, moreover, consumer cost-sharing is high by international levels and high deductible policies are available, thus achieving the “consumer-driven health care” dream of some policy advocates, in which consumers themselves respond to health care prices to bring down health care costs. Here is a model, advocates claim, that could be transplanted to the United States, achieving universal coverage while preserving a dominant role for private insurers, protecting providers from government price controls, and defending the central place of markets in our health care system.

These advocates, however, misunderstand or misrepresent the actual nature of the Swiss and Dutch health care systems. Moreover, when one examines the Swiss and

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<sup>1</sup> These claims are in fact a gross oversimplification of a very complex picture, and are largely wrong. It is true that some other countries (including England and Canada, the countries to which Americans are most likely to look for comparative evidence) do have waiting lists for some services, but other countries do not. Also, medical technologies that are available in the United States are generally available in other developed countries as well, although some other countries are more careful in limiting coverage for ineffective technologies. See Timothy Stoltzfus Jost, *Health Care at Risk* (Durham, N.C.: Duke University Press, 2007), 166-188.

Dutch systems more carefully, it becomes apparent that they are not the best models for the reform of our own health care system. We can, however, learn from their experience, in particular about the inadequacy of regulation as a means to stopping insurers from competing with each other by cherry picking the best risks.

*Switzerland and the Netherlands: Private Market Competition?*

It is true that in both the Swiss and Dutch systems individuals are legally required to purchase health insurance in a competitive market. But, these countries do not require their residents to purchase American-style private insurance. Health insurance in Switzerland is provided through a social insurance, not private insurance, program, just as it is in Germany, France, Belgium or Austria. Basic health insurance can only be sold by social insurers or by private insurers who agree to function as social insurers.<sup>2</sup> Health insurance, that is to say, is considered to be a social service, like Social Security or Medicare in the United States, not a commodity. Basic health insurance cannot be sold by for profit companies.

In the Netherlands, for-profit insurers are allowed to sell basic health insurance alongside nonprofit insurers, but the health insurance program is still officially considered to be a social insurance program. As in Switzerland, health insurers are understood to be providing a basic social service, not selling a product. If health insurance were considered to be a private insurance program, European Union market-entry and competition rules would govern, just as they do for other insurance markets such as property or casualty. This would severely limit the ability of the government to regulate health insurance and make it difficult for the Netherlands to accomplish the goal of achieving universal, affordable, health insurance coverage.<sup>3</sup> The alternative of a private insurance competition program, therefore, is not the route the Dutch have chosen.

This understanding of the nature of health insurance is not merely conceptual, but is reflected in the approach that Switzerland and the Netherlands take to financing and regulating health insurance. In both countries public funding is extensive. In the Netherlands, half of the premium for health insurance is paid for by social insurance taxes set at about 7.2 percent of the first 31,200 Euros of income in 2008, essentially payroll taxes.<sup>4</sup> Individuals are only responsible for paying the other half of the premium themselves. Moreover, between 40 and 60 percent of the population (reports vary) receives public subsidies to make insurance affordable, which for some covers most of the remaining cost of insurance.<sup>5</sup> Insurance for children is wholly covered by the

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<sup>2</sup> See SR 832.10, arts. 1a., 11; Uwe Reinhardt, *The Swiss Health Care System*, JAMA 292(10): 1227, 1228 (2004).

<sup>3</sup> Kieke G.H. Okma, *Recent Changes in Dutch Health Insurance: Individual Mandate or Social Insurance?* (Washington, National Academy of Social Insurance: 2009), 3-5.

<sup>4</sup> *Ibid.* at 1; Wynand P.M.M. van de Ven & Frederik T. Schut, *Universal Mandatory Health Insurance in the Netherlands: A Model for the United States*, Health Aff., 27(3): 771, 774 (2008); Robert E. Leu, et al., *The Swiss and Dutch Health Insurance Systems: Universal Coverage and Regulated Competitive Insurance Markets* (Washington, Commonwealth Fund, 2009), 3.

<sup>5</sup> van de Ven & Schut, at 774, (two-thirds); Leu, et al., at 3 (40 percent)

government.<sup>6</sup> And certain high cost services, including long-term care and mental health care are completely covered by a separate program.

Similarly in Switzerland, about a third of the population receives public subsidies, which are distributed by the cantons and vary in their generosity from canton to canton.<sup>7</sup> Most hospitals, moreover, are public or publicly-supported hospitals, and their costs are covered in part by the cantonal government payments.<sup>8</sup> Under recently adopted changes, private hospitals will receive public subsidies as well.

In both countries insurers are heavily regulated by the government. Insurers are not allowed to compete by limiting the benefits they cover. The basic benefit package that insurers must cover is defined by law and is quite generous.<sup>9</sup> In both countries, insurers are subject to community rating and open enrollment requirements.<sup>10</sup> The ability of insurers to lower premiums by shifting risk to consumers through cost sharing is also limited. In the Netherlands, coverage is subject to a 150 euro deductible.<sup>11</sup> In Switzerland, insurers must impose a minimum deductible of 300 CHF and offer a range of higher deductibles, with premiums adjusted accordingly. The maximum deductible is 2500 CHF, quite low by American standards.<sup>12</sup> Most insureds choose lower deductible policies and few the highest level of deductible.<sup>13</sup> Coinsurance is not generally permitted in the Netherlands, and 10% coinsurance is capped at a 700 CHF out-of-pocket maximum in Switzerland.<sup>14</sup> In Switzerland, premiums are subject to government regulation and are rejected if considered to be excessive. In both countries, a risk adjustment scheme redistributes premiums among insurers based on the risk profile of their insureds.

Insurers are also limited in their ability to bargain with providers. In Switzerland doctor's fees are set through a national fee schedule, with monetary point values set at the cantonal level.<sup>15</sup> Hospital fees and maximum allowable drug prices are regulated as well. In the Netherlands provider fees are also regulated, although health insurers are gradually being given more freedom to negotiate fees with providers (currently about one third of hospital charges are subject to negotiation).<sup>16</sup> Gate-keeping has long been common in the Netherlands, capitation for doctors is possible in Switzerland and for primary care doctors in the Netherlands, and both countries allow selective contracting.<sup>17</sup> Managed

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<sup>6</sup> van de Ven & Schut, at 774.

<sup>7</sup> Leu, et al., at 4;

<sup>8</sup> Reinhardt at 1229; European Observatory, *Health Care Systems in Transition: Switzerland* (London, European Observatory; 2000), 51.

<sup>9</sup> Leu, et al., at 5, 6.

<sup>10</sup> *Ibid.*, at 2, 3. Swiss insurers can vary premium by age group (0-19, 19-25, 26 and older, and by geography).

<sup>11</sup> *Ibid.*, at 7. Adults have the option to choose higher deductibles but few do.

<sup>12</sup> *Ibid.*, at 6-7

<sup>13</sup> Reinhardt, at 1229.

<sup>14</sup> Leu et al., at 7.

<sup>15</sup> Reinhardt, at 1229.

<sup>16</sup> Pauline V. Rosenau & Christiaan J. Lako, An Experiment with Regulated Competition and Individual Mandates for Universal Health Care: The New Dutch Health Insurance System, 33 *J. Health Pol., Pol'y & L.* 1031, 1043 (2008).

<sup>17</sup> Leu, et al, at 16-17.

care, however, remains uncommon in both countries. Competition among insurers to hold down provider costs is still far from the norm.

In sum, insurers in the Netherlands and Switzerland are not as a matter of public policy conceived of as private businesses and in important respects they are not allowed to function as private businesses. The Dutch and Swiss models--built on a uniform mandated benefit package, a limited menu of cost sharing, and provider rate regulation--are not the models that private insurers in the United States are in fact advocating, but rather represent a quite different tradition based on social solidarity and not on market competition.

### *Have the Swiss and Dutch Models Succeeded?*

Not only are the Swiss and Dutch health care systems not the models of consumer-driven health care or managed competition that they have been presented as being, it is also questionable whether they are responsive to our needs.

First, although it would seem that a universal mandate requiring the purchase of health insurance should achieve universal coverage, neither country adopted their current models as a response to a problem of widespread lack of insurance. In the Netherlands over 99% of the population was covered in 2006 when the current approach was established, while in Switzerland 96-98% of the population was insured when their current system was adopted in 1996. Both countries are now, however, facing the problem of how to handle those individuals who fail to comply with the mandate and pay their premiums.<sup>18</sup> In both countries, these persons are mostly indigent and often recent immigrants. In the Netherlands, the number of these persons is about the same as the number of the number of those who were uninsured under the old system. Paradoxically, however, while the uninsured under the prior system tended to be wealthy people who chose not to purchase insurance, the people most at risk now are poorer people who cannot afford it, but who were covered under the old system. Merely imposing an individual mandate does not ensure that people will actually become insured, especially when they cannot afford insurance.

Second, neither system has proved adept at controlling costs. Switzerland is second only to the United States among OECD countries in percent of GDP spent on health care.<sup>19</sup> Switzerland is also second only to the United States in excess annual health care spending growth per capita since 1985.<sup>20</sup> The Netherlands only instituted changes in its health care system two years ago, so comparative data as to spending growth are not yet available. Health insurance premiums and health care costs, however, have continued to rise dramatically in the Netherlands since the new program was instituted, with

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<sup>18</sup> Ibid, at 4-5; Okma, at 16-17.

<sup>19</sup> Gerard Anderson and Bianca K. Frogner, Health Spending in OECD Countries: Obtaining Value Per Dollar, 27(6) Health Affairs 27(6): 1718, 1720.

<sup>20</sup> Chapin White, Health Care Spending Growth: How Different is the United States from the Rest of the OECD, Health Affairs 26(1), 154, 159 (2007).

premiums rising 10 percent in the first year.<sup>21</sup> As we can see with our own experience with the Massachusetts health care reforms and with Medicare Advantage, competition between insurers has not proved an effective approach to cost control.

This is not to say, however, that we cannot learn from the Swiss and Dutch experience. It has long been known that, given the opportunity, insurers will compete for business by selecting risk rather than by holding down costs. In any given year, one percent of the population accounts for nearly a quarter of health care costs, ten percent account for over half, while half of the population spends virtually nothing on health care.<sup>22</sup> It is much easier for an insurer to profit by avoiding high cost insureds than by becoming more efficient or holding down provider costs. This is particularly true if premiums are community rated.

Even through insurers in Switzerland and the Netherlands are supposed to provide a public service rather than operate as private businesses, they do in fact try to maximize their “margin,” just as “nonprofit” hospitals and insurers do in the United States. Swiss insurers have become exquisitely adept at risk selection, even though it is technically illegal and to some extent disincentivized by a risk pooling program.<sup>23</sup> Insurers, for example, offer multiple policies and steer high cost insureds to higher cost policies and low cost insureds to lower-cost policies. Insurers commonly offer attractive deals on supplemental health coverage, life insurance, or other forms of insurance which they can risk underwrite to attract lower risk insureds. Insurers use high deductible policies and policies for which no-claims rebates are available to woo low risk insureds. There are reports of insurers closing offices in high-claims areas and of using software to identify unprofitable insureds or applicants so that they can ignore inquiries and contacts from them. There is considerable evidence that virtually all of the competition among Swiss health insurers to date has been based on risk selection. Premiums in the Switzerland vary dramatically from one policy to another, yet switching of insurers is relatively uncommon, often because insureds have other forms of insurance with insurers and are reluctant to switch.<sup>24</sup>

Risk selection to date seems to be less of an issue in the Netherlands, which does not have as much of a tradition of risk selection among insurers, and which has a much better approach to redistributing risk among insurers. Dutch insurers, however, can offer discounts for employment or association-based group policies, and most of the switching among insurers to date has involved insureds moving from individual to group policies.<sup>25</sup> There is ample opportunity for insurers to use this approach for attracting low-risk groups like sports clubs, and some evidence that this is happening. Other than movement of

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<sup>21</sup> Okma at 24.

<sup>22</sup> Marc L. Berk & Alan C. Monheit, *The Concentration of Health Care Expenditures Revisited*, *Health Affairs* 20(2):9, 12 (2001).

<sup>23</sup> Wynand P.M. M. van de Ven, *Risk Adjustment and Risk Selection in Europe: 6 Years Later*, *Health Policy* 83: 162 (2007); Wynand P.M.M. van de Ven, et al., *Risk Adjustment and Risk Selection on the Sickness Fund Insurance of Five European Countries*, *Health Policy* 65:75 (2003).

<sup>24</sup> Francesca Colombo, *Towards More Choice in Social Protection? Individual Choice of Insurer in Basic Mandatory Health Insurance in Switzerland* (Paris: OECD, 2001).

<sup>25</sup> Okma, at 15; van de Ven et al (2007), at 169-170.

individuals to group policies, there has been little switching among health plans in the Netherlands based on plan competition.<sup>26</sup>

In sum, the Swiss and Dutch models are not in fact the exemplars of managed competition or consumer-driven health care claimed by advocates of these approaches to health care reform. They have not, moreover, been successful in holding down costs or expanding access to insurance. Finally, their experience demonstrates again the tendency of insurers—even nonprofit insurers--to compete based on risk selection rather than cost, and the difficulty posed by trying to control this tendency through legal regulation.

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<sup>26</sup> Okma,, at 15; Leu, et al. at 14.