

# **Consumer Mobility in Social Health Insurance Markets: A Five-country Comparison**

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## Abstract

During the 1990s the social health insurance schemes of Germany, the Netherlands, Switzerland, Belgium and Israel were profoundly reformed by the introduction of freedom of choice (open enrolment) of health insurer alongside a system of risk-adjustment to compensate health insurers for enrollees with predictable high medical expenses. Despite the similarity in the health insurance reforms in these countries, we find that both the rationale behind these reforms and their impact on consumer choice vary widely.

In this paper we seek to explain the observed variation in switching rates by cross-country comparison of the potential determinants of health insurer choice. We conclude that differences in choice setting and in the net benefits of switching offer a plausible explanation for the large differences in consumer mobility.

Finally, we discuss the policy implications of our cross-country comparison. We argue that the optimal switching rate crucially depends on the goals of the reforms and the quality of the risk-adjustment system. In view of that, we conclude that switching rates are currently too low in the Netherlands and an active government policy to encourage consumer mobility seems warranted. In Germany and Switzerland, high switching rates urge for an improvement of the rather poor risk adjustment systems. Given low switching rates in Israel and Belgium, improving risk adjustment is less urgent, but still required in the long run.

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## 1. Introduction

During the 1990s the social health insurance schemes of Germany, the Netherlands, Switzerland, Belgium and Israel were profoundly reformed by the introduction of freedom of choice (open enrolment) of health insurer alongside a system of risk-adjustment to compensate health insurers for enrollees with predictable high medical expenses [1].

In this paper we first discuss the empirical evidence of how the introduction of freedom of choice of health insurer has affected consumer behaviour in each of five countries. Next, we compare the rationale behind the reforms, focusing on the role of consumer choice and we investigate how the observed differences in consumer switching behaviour might be explained. Finally, we will discuss the policy implications of our findings.

## 2. Effects of reforms on consumer mobility

How did the introduction of freedom of choice of health insurer affect consumer behaviour in each of the five countries? Did consumers use the opportunity to switch to another health insurer?

Several empirical studies estimated to what extent consumers were sensitive to price differences among health insurers. Because of different estimation methods and levels of aggregation, results are not readily comparable.<sup>1</sup> Nevertheless, what is clear from the available empirical evidence is that average price elasticities are the high in Germany (ranging from  $-2.5$  to  $-4.3$  at the type of sickness fund level [2]), substantially less in Switzerland (about  $-0.5$  [3]) and low in the Netherlands about  $-0.3$  but only statistically significant during the initial years after the reforms [2, 4]). In Belgium premium differences for basic insurance are negligible, except for some minor risks for the self-employed, in which segment the estimated price elasticity is about  $-0.4$  [5]. In Israel, price of basic coverage does not play a role as a determinant of sickness fund choice because sickness funds are not allowed to charge direct premiums for basic health insurance.

While studies on price elasticities only measure the impact of premium differences on consumer health plan choice, aggregate switching rates can provide an indication of overall consumer mobility.<sup>2</sup> Using Swiss survey data, Columbo [6] observes the

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<sup>1</sup> Furthermore, because the estimated price elasticities typically are calculated at the mean, the magnitude of price elasticities depends on the average market share and premium level, which widely vary between the different countries.

<sup>2</sup> Notice that usually only net switching rates per health insurer are observable. Hence, the total number of switchers is likely to be higher than reflected in the reported switching rates.

highest switching rates during the period immediately after the reform. The switching rate decreased from 5.4% in 1998 to 2.1% in 2000. However, more recent data indicate that switching increased again to about 4% in 2002. Anderson and Schwarze [7] and Schwarze and Anderson [8] show that switching rates in Germany are increasing from 4% in 1997 to 5% in 2000. There is no evidence that switching increased further after 2000. In the Netherlands switching rates are low, but increasing from less than 1% in the years before 2000 to about 2.5% in 2003. In Belgium and Israel switching rates remained steady at a low level of about 1% [9,10]. We conclude that the introduction of freedom of health insurer choice has resulted in large differences in consumer mobility among the five countries. Consumer mobility is high in Germany, substantial in Switzerland, low but slowly increasing in the Netherlands and virtually absent in Israel and Belgium. This raises the question why the impact of the introduction of freedom of health insurer choice on consumer choice is so different. A second interesting question is what the implications of the different switching rates are for the effectiveness of the reforms in each of the countries. We will address both questions in the following sections.

### **3. Rationale of health insurance reforms**

To determine the implications of consumer mobility on the effectiveness of the reform, we first have to examine the primary goals of the reforms in each of the five countries. Despite the similarities in content and timing of the reforms, the reasons behind the introduction of freedom of health insurer choice were quite different. For each country we will discuss the rationale behind the reforms, ordering the countries in terms of increasing ambition and scope of introduction of health plan choice.

#### *Belgium*

The 1995 Belgium reforms were primarily intended to improve efficiency by making sickness funds more financially responsible for the medical expenses of their enrollees [9,11]. Alongside the introduction of a risk equalization scheme the financial risk for sickness funds would be gradually raised. Contrary to the other countries, however, no formal open enrolment requirement was introduced. Prior to the reforms Belgian citizens already were free to choose among one of the five sickness fund associations (each comprising a large number of local sickness funds). Sickness funds were not obliged, however, to accept all applicants (except a sixth sickness fund “of last resort”). In practice, however, sickness funds do not deny access to any applicant. Although the incentives for risk selection have been increased since sickness funds have to bear some financial risk, selective enrolment is still permitted.

However, the scope for risk selection appears to be small, since discriminatory policies would face strong social and political opposition and would be damaging to a sickness fund's reputation [2]. Contrary to the other countries, Belgian reforms neither seem to rely on consumer choice as a means of enhancing efficiency or equity nor seem to bother too much about the risk of adverse selection due to free consumer choice.

The situation is quite different, however, in the *voluntary insurance* market for minor risks for self-employed.<sup>3</sup> As premium setting is completely free in this market segment, substantial variation in premium rates can be observed, not only between the large sickness fund associations but even within associations between different regional funds [12]. There are substantial premium differences between the regional sickness funds for the same benefits package and premiums are risk-rated according to age, gender, family composition and social status.

### *Israel*

The 1995 health insurance reforms in Israel were motivated both by efficiency and equity considerations [10]. The National Health Insurance Legislation (NHIL) replaced the unregulated competitive health insurance market by a regulated competitive market. The new insurance law introduced a mandatory standardized basic benefits package, a bi-annual open enrolment requirement, and an age-based risk compensation scheme. The open enrolment was introduced mainly to enhance competition on quality of care. Although prior to the reforms Israeli citizens were formally free to choose among one of the four sickness funds, two of the four sickness funds exercised effective risk selection [10]. Hence, most high-risk individuals enrolled in the largest socially oriented sickness fund that consequently ran into serious financial trouble.

### *Germany*

Principal reasons behind the German reforms were to equalize premiums and choice opportunities for all German citizens [2,13]. Prior to the reforms, different sickness funds charged widely varying premiums (i.e. income-related contribution rates). Sickness funds were fully at risk for all non-elderly enrollees (younger than 65) and

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<sup>3</sup> Belgium has a *compulsory* national health insurance system for a *basic package* that covers major health risks (e.g. hospitalizations) for the entire population and virtually all other minor risks for about 88% of the population. The remaining 12% is self-employed and does not have compulsory insurance for minor risks (GP, specialist, drugs, etc) but most self-employed (85%) take out voluntary cover for these minor risks. In addition, people are free to purchase supplementary cover for non-basic items (such as transport, etc).

were not allowed to risk rate their premiums. Hence, the premium level largely depended on the risk structure of the enrolled population. Most of the insured persons in Germany (mostly employees with an income below the income ceiling) could not choose their sickness fund. On average this group of enrollees had to pay much higher premiums than others for essentially the same benefits package without being able to change this situation – while others were allowed to do. This was widely considered to be unfair and therefore in 1992 a risk adjustment scheme (RSA) was enacted that redistributes revenues from sickness funds with a favourable risk structure to sickness funds with an unfavourable risk structure. Next, to create equal opportunities to choose sickness funds, in the same law sickness funds were required to have annual (since 2002 monthly) open enrolment periods during which they had to enrol any applicant in the region (state) they are active. These changes were implemented in the middle of the 1990s. A secondary reason behind the introduction of freedom of choice was to create 'socially bounded competition' among sickness funds in order to improve efficiency. The possibilities for German sickness funds to improve efficiency of health care provision are limited, however, since they jointly negotiate contracts with providers and selective contracting is prohibited (with some minor exceptions).

### *Netherlands*

In the Netherlands, the primary reason of the reform was to motivate sickness funds to improve the efficiency of health care. The absence of appropriate incentives for sickness funds was perceived as a major problem. Prior to the reforms sickness funds were completely retrospectively reimbursed for the medical expenses of their enrollees and consequently had no stake in a more efficient provision of medical care. In 1993 the retrospective reimbursement system has been replaced by a system of prospective risk-adjusted capitation payments. Parallel to a steady improvement of the risk adjustment method, the financial risk for sickness funds has been gradually raised from 3 percent in 1995 to 54 percent in 2004. In addition to appropriate financial incentives, freedom of choice and the possibility of price competition were introduced. In 1992 the legally protected regional monopolies were abolished and sickness funds were required to have biennial open enrolment periods. By the end of 1996, biennial open enrolment periods were replaced by annual periods. Furthermore, the legal entry barriers to the sickness fund market were largely removed and several new sickness funds were permitted to enter the market. Finally, to provide sickness funds with the opportunity to manage care in 1992 the

government abolished the obligation for sickness funds to contract with any willing provider, except for inpatient care institutions.

### *Switzerland*

In Switzerland the 1996 reform of the health insurance scheme was motivated by both efficiency and equity considerations [14]. Besides, an important reason driver of the reform was to reduce risk selection. According to [6] the introduction of “free choice of insurer” was intended to serve the following goals:

- Intensifying insurers’ competition in the basic mandatory health insurance market.
- Creating cost containment incentives for sickness funds.
- Strengthening individual liberty to choose a sickness fund.

Although the Swiss could choose among health insurers prior to the 1996 reforms, there was no open enrolment requirement and freedom of choice was restricted by underwriting practices by health insurers. High-risk individuals could not move freely across insurers because sickness funds could cream skim and charge premiums irrespective of previous sickness funds affiliation [6]. For most people health insurance was voluntary and insurance conditions varied greatly across sickness funds. Individual premiums were calculated on the basis of gender and the age of entry. Sickness funds with a relatively large proportion of high risks were forced to charge higher average premiums, which created an adverse selection incentive for young and healthy individuals. As a consequence, some sickness funds were caught in a deadly premium spiral and were forced to leave the market or to merge with other sickness funds to avoid bankruptcy [6].

In addition to having biannual open enrolment periods, the 1996 Federal Law on Health Insurance (KVG) required sickness funds to charge community-rated premiums by class (three age groups: 0-18, 19-25 and over 25) and by region (78 regions). A risk compensation scheme was established in 1992 in order to compensate sickness funds for the differences in costs that originate from differences in risk structures across funds on a Canton-by-Canton basis (for more details: [14]).

#### **4. Explanations for differences in consumer mobility**

How can the observed cross country differences in consumer choice of health insurers be explained? We distinguish four potential explanatory factors: the available choice options, the choice setting, the net benefits of switching, and consumers’ inclination to switch.

### **Choice options**

We distinguish three choice categories (applicable to both basic and supplementary insurance): variation in premiums, variation in benefit packages (coverage, co-payment, coinsurance, deductibles), and variation in provider choice and managed care. For each country we first will examine whether variation is allowed, irrespective from the actual presence of substantial variation. We expect that limited choice options will be associated with low switching rates.

[Table 1]

Table 1 summarized the available choice options. In four of the five countries, the *premium* for the basic insurance is allowed to vary between sickness funds. The exception is Israel, where enrolees do not pay a contribution rate. In The Netherlands variation is allowed for about 15-20% of the total premium. This part of the total premium corresponds with the community rated premium set by the sickness fund. The other part is an income related premium set by the government.

Israel is the only country where it is allowed to vary the *basic benefits package*. The German government allows for very small variations with respect to for example spa treatments or acupuncture.

In Belgium by law, *selective contracting* is not allowed. Sickness funds in Germany are obliged to contract all licensed health care providers. There are very few opportunities for selective contracting. As a consequence of the 2003 Health Reform Act, sickness funds are obliged to offer 'gatekeeping models' for their enrolees. The GPs that are participating in these models need to be contracted selectively by each sickness fund. In addition, the legislator earmarked up to one percent of overall budgets of ambulatory care and hospital care for integrated care projects. Contracts for these projects also are negotiated between individual sickness funds and individual providers. Swiss sickness funds have an obligation to contract each provider but may also offer special preferred providers contracts. In the Netherlands selective contracting is allowed for out-patient care. In Israel, sickness funds have the most opportunities for managing care as they may not only selective contract providers but also employ providers themselves.

Health insurers in each of the five countries are allowed to risk rate their premiums for *supplementary insurance* and are not restricted to offer the same supplementary insurance package. Until 2004, only private insurers offered supplementary insurance in Germany. Since then, sickness funds are allowed to act as agents for private health insurers. In the Netherlands, private health insurers with a strong link to the sickness fund offer supplementary health insurance to sickness fund members.

Comparing the five countries, we conclude from Table 1 that Belgian consumers have the fewest choice options. In Germany the choice options mainly come from the possibility to vary premiums. The Netherlands offer some options to vary premiums and some options for selective contracting. Also Switzerland offers some options for selective contracting, but does not set a limitation to the variation in premiums. The substantial choice options in Israel are related to the variation of the compulsory basic benefit package between the sickness funds and the allowance of selective contracting. Except for Germany, in each country variations in supplementary insurance may also influence consumer choice of sickness fund.

### ***Choice setting***

Given the available choice options consumer choice and switching behaviour are also likely to be affected by the market and institutional features of the health insurance choice setting. We distinguish market structure and institutional variables.

#### *Market structure*

All other things equal consumer mobility is expected to be higher, the larger the number of sickness funds and the lower the level of market concentration. The relevant geographical market is national in Belgium, Israel and the Netherlands since in these countries all sickness funds are operating nationwide. In Germany most sickness funds operate in only one or in several states, while in Switzerland choice is confined to the health insurers in the Canton of residence. Even considering the relatively small size of the country, the number of sickness funds in Belgium and Israel is much lower than in the other three countries.

The presence of entry and exit barriers may also have a positive impact on consumer choice and mobility. If the market is more contestable health insurers will be more eager to compete and entrants may come in if the incumbent insurers are not responsive to the preferences of (specific subgroups of) consumers.

Finally if collusion is easy and an effective competition (or antitrust) policy is absent, this is expected to have a negative impact on consumer mobility since colluding sickness funds are less likely to differ in premiums and other insurance conditions.

#### *Institutional features*

The institutional design of the social health insurance market is also likely to have an impact on consumer choice and switching behaviour. First, the opportunity to switch crucially depends on the presence and form of open enrolment requirements. Are consumers allowed to switch irrespective of health and other personal characteristics



and, if so, are there any restrictions on how frequent they are allowed to switch. Obviously, the less restrictions on free choice of sickness funds the higher the expected consumer mobility.

The quality of the risk adjustment scheme may also affect consumer mobility. If the risk adjustment scheme does not include adequate proxies for health status, as is the case in all countries except for the Netherlands, sickness funds are likely to be under compensated for high-risk individuals and overcompensated for low risk individuals. This provides sickness funds with incentives to attract the low risks and deter the high risks (e.g. by selective marketing, the design of the benefit package and the selection of providers). Since low-risk individuals tend to be more mobile (see below) risk selection efforts targeted on this risk group may enhance mobility. This effect is likely to be stronger, the larger the financial risk for the sickness funds. Therefore we include the level of financial risk for sickness funds as a potential determinant of switching behaviour.

Employers may also influence on consumer choice and switching behaviour. If employers have to contribute to their employees' total health insurance premium, and the contribution is positively related to the premium level, they may exert pressure on their employees to move to a less expensive sickness fund. Hence, we expect that proportional (mandatory) employer contributions are positively related to switching rates.

In all countries consumers can buy supplementary private health insurance in addition to mandatory basic insurance coverage. The proportion of population that purchase both supplementary and basic insurance coverage ranges from only 10 percent in Germany, to 50 percent in Israel, 70 percent in Switzerland and as high as 90 percent in Belgium and the Netherlands. The presence of supplementary insurance may have an effect on consumer mobility in the market for basic health insurance if it can only be purchased in combination with basic insurance coverage from the same health insurance company. In Belgium joint purchasing is mandatory, while in Israel, sickness funds offer supplementary coverage only in combination with basic coverage. Swiss sickness funds also offer both basic and supplementary coverage, but since the courts have explicitly forbidden tie-in sales, consumers are free to buy supplementary coverage from another sickness fund. In the Netherlands, sickness funds are not allowed to sell supplementary insurance but usually offer supplementary coverage through a separate entity that operates under the same brand name. Moreover, but both types of insurance are often linked by tie-in provisions in supplementary policies. A similar situation applies to Switzerland, except that tie-in practices are legally forbidden. In Germany basic and

supplementary insurance were strictly separated, but since 2004 sickness funds are allowed to co-operate with private health insurance in offering supplementary coverage. Given the typical absence of any open enrolment requirement in supplementary health insurance, a tie-in of supplementary and basic insurance may effectively reduce consumer mobility in the basic health insurance market. For despite open enrolment in basic health insurance, high-risk individuals may not be willing to switch if they are not accepted for supplementary insurance. Therefore, in addition to tying provisions another important feature is whether health insurers are permitted to selectively underwrite applicants for supplementary coverage. Finally, in several countries governments and consumer organizations provide comparative information about health insurers to facilitate switching. Information on the relative performance of health insurers, premiums, benefits packages, and switching rules, such as prior-notification requirements, contract termination dates, the length of contract periods, open enrolment seasons, may effectively reduce search costs and thus is expected to enhance consumer mobility. For each of the five countries principal market and institutional features are summarized in Table 2.

[Table 2]

Given the features of the different choice settings and the expected effects of these features on mobility, we conclude (last row of Table 2) that choice settings in Belgium and Israel are not likely to enhance consumer mobility, while the opposite seems to hold for the German situation. The Dutch and Swiss choice settings provide only moderate incentives for consumers to switch.

### ***Net benefits of switching***

Consumers' propensity to switch crucially depends on their expectation whether the benefits of switching will outweigh the costs. Hence, substantial net benefits of switching are likely to induce consumers to switch. Notice, however, that small benefits (e.g. premium variation) does not necessarily imply that consumers are not willing to switch, since the absence of substantial variation might well be the result of high (potential) mobility (e.g. in case of homogeneous goods, homogeneous tastes and well-informed consumers). For the same reason, persistently large net benefits of switching may well indicate that consumer mobility is low, unless the large variation may be sustained by the characteristics of those who switch (e.g. risk selection).

The potential benefits of switching sickness funds depend, among other things, on the extent of premium dispersion. In all countries, except Israel, sickness funds are allowed to charge different community-rated premiums for basic insurance. However, the extent of premium variation is very different between the countries. In Switzerland huge (regional) premium differences exist, so consumers could financially benefit by choosing the cheapest sickness fund in the region.<sup>4</sup> In Germany, benefits can be substantial for employees and employers, since contribution rates are income-dependent. Moreover, enrollees can realize minor savings (lower co-payments) by enrolling in a gatekeeping model or in some integrated care option. Due to the moderate premium variations in the Netherlands, the benefits for Dutch consumers are relative low compared to the potential benefits for German and Swiss consumers. Premium differences in Belgium are negligible with respect to the compulsory insurance. However, the premiums of the voluntary insurance for the self-employed exhibit much more variation.

In most countries, the government determines the basic benefits package, so consumers cannot obtain a more attractive benefits package by switching funds. In Germany and Israel, however, some marginal differences in benefits package are permitted, resulting in slightly different benefits packages per sickness fund.

Another potential benefit of switching depends on the extent of choice of providers or the extent and type of managed care offered by sickness funds. In Belgium managed care options are not allowed and German sickness funds selectively contract only in very specific cases (in case of gatekeeping models and integrated care projects). In the other three countries it is allowed to selectively contract. In the Netherlands, however, sickness funds have been very reluctant to engage in selective contracting and managed care. Only the Israeli and Swiss consumers may really benefit from switching due to variations in managed care.

Furthermore, switching may be more beneficial in countries where sickness funds offer a broad range of supplementary insurance coverage. Variation in both premium and coverage of the supplementary insurance may provide substantial potential benefits of switching. This will be particularly so if supplementary insurance accounts for a substantial part of total health care expenditure. The share of supplementary insurance varies considerably, ranging from only 2 percent in Belgium, 5 percent in the Netherlands, 7 percent in Israel to about 30 percent in Switzerland (Germany is

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<sup>4</sup> The total premium range is even larger than the existing premium differentiation for the same level coverage because sickness funds are allowed offer premium discounts if their enrollees opt for a higher deductible.

not included since until 2004 supplementary and basic insurance were effectively separated). Hence, especially in Switzerland supplementary insurance is likely to have a strong impact on sickness fund choice.

The potential benefits of switching are summarized in Table 4. Overall we conclude that in Germany and Switzerland benefits of switching are much larger than in the other three countries.

[Table 3]

Switching benefits, however, have to be weighed against switching costs. One source of switching costs are search costs. Search costs are higher when products are more differentiated. For basic insurance, Israel offers substantial variation in products, while in the other countries product variation is almost absent. For supplementary insurance the situation is reversed. Then, Israel offers only small variation in products, while the other countries offer moderate to large variations, implying larger switching costs for the consumers in these countries (again, in Germany the extent of product differentiation in supplementary insurance is not relevant, since until 2004 supplementary and basic insurance were effectively separated).

Another type of costs comes from administrative duties. A large administrative effort or complex switching procedures may withhold people from switching. In general, switching rules are straightforward and the time needed to fill in forms is for most people not considerable.

In contrast to the other countries, Israeli consumers usually need to switch providers when they switch sickness funds. An established relation with a provider may therefore hinder Israeli citizens from switching.

Because open enrolment requirements do not apply to supplementary health insurance, selective underwriting in supplementary health insurance may reduce switching rates given that in both types of insurance are typically only offered and purchased in combination (except in Germany). This seems particularly the case in the Netherlands, where premiums for supplementary health insurance are community rated rather than risk rated. In the presence of community-rated premiums it is unattractive for sickness funds to accept high-risk applicants for supplementary coverage. Hence, in the Netherlands high-risk individuals are likely to face less favourable supplementary conditions if they want to switch funds. Although, tie-in practices are forbidden in Switzerland, most people buy supplementary coverage

from the same sickness fund. Beck [3] found that having supplementary is negatively related to consumers' propensity to switch funds.

Table 4 summarizes the switching costs involved by consumers in the five countries. Switching costs are low in Belgium and Germany and somewhat higher in the other three countries.

[Table 4]

Table 5 compares the overall benefits (last row Table 3) and costs (last row Table 4) of switching. Roughly weighing these overall benefits and costs, consumers in Germany may obtain the largest net benefits from switching. Also in Switzerland switching can have substantial advantages for consumers. In the other three countries the potential benefits of switching may well not outweigh the potential costs, so for many consumers switching funds may not be attractive.

[Table 5]

### ***Consumers' inclination to switch***

In addition to objective factors differences in consumer mobility might also be explained by differences in subjective factors that determine consumers' switching behaviour. A potentially important determinant of consumers' inclination to switch is their past experience with switching sickness funds. If consumers were confronted with choice of insurers for the first time after the reforms, they are less likely to switch than those who already had some choice options. Prior to the reforms ample switching opportunities were present in Switzerland and Israel, although in practice only low-risk individuals were actually able to switch. Germany and Belgium had limited switching opportunities. In the Netherlands switching was hardly possible. Prior to the reforms, Dutch sickness fund enrolees had to register with the sickness fund that operated in the region of their residence. Only when people moved to another region they had to switch funds, so switching experience was very limited. For historical or cultural reasons, consumers in different countries may differ in the way they express discontent, by using "exit" or "voice" option [15]. The "voice" option (using one's voice without leaving) is more likely to be used in countries with, for example, powerful client counsels or labour unions. In these situations, we expect individuals to be less inclined to actually switch. In Belgium, Israel, and to a lesser extent in the Netherlands members traditionally have been involved in the board of the sickness funds. In Germany, at least in theory there is strong institutional voice, as well as increasing individual voice. Only in Switzerland the exit option has always

played a substantial role as a way of expressing consumer preferences. Also for historical, cultural or ideological reasons consumers in different countries may differ in their “loyalty” to specific (types of) sickness funds. More loyal persons are less likely to leave their sickness fund. In all countries, people are on average very loyal to their sickness fund or providers (Israel), though loyalty is declining. Dutch sickness fund members still show a very high loyalty to their original regional sickness fund. In Belgium religious and political aspects used to play a major role in the choice of health insurer and still provide an important explanation for people’s considerable loyalty to specific types of sickness funds. The membership of sickness funds in Germany still is not as heterogeneous as may be expected. The loyalty from former target groups has become smaller but still determines the basic (risk)-structure of the fund’s membership.

In sum, we conclude that consumers’ inclination to switch is highest in Switzerland and Germany, and relatively low in Belgium, Israel and the Netherlands (Table 6).

[Table 6]

### ***Overall explanation of cross country differences***

Table 7 summarizes for each of the five countries the expected effects on consumer mobility of the available choice options, the design of the choice setting, the potential net benefits of switching and of the consumers’ inclination to switch. Combining these expected effects, we roughly infer an overall expectation of the level of consumer mobility in each country (last row of Table 7).

[Table 7]

Looking at the empirical evidence on switching behaviour, the distinguished determinants of consumer mobility seem to explain the observed differences among the countries quite well.

Germany and Switzerland have a lower level of market concentration and lower barriers to entry for new health insurers than the other countries. Moreover, in Germany employers have a huge incentive to direct their employees’ choice towards the cheapest sickness funds. In a well functioning market high consumer mobility would encourage the more expensive firms to reduce their prices to the competitive level. However, due to the rather poor risk adjustment system in both Switzerland and Germany and the legal prohibition to differentiate premiums according to risk,

sickness funds with a disproportionate proportion of high-risk individuals are not able to reduce their premiums. Moreover, empirical studies in both countries show that the young, healthy and higher educated enrollees are more likely to switch [3, 7, 8, 14].<sup>5</sup> Hence, the substantial consumer mobility in Germany and Switzerland does not effectuate a reduction of the price dispersion among sickness funds [2, 23].

In contrast to Germany and Switzerland the choice setting in Israel offers very limited incentives to consumers to switch funds. Not only the number of sickness funds is very low, but price differences are absent while consumers face the possibility of having to give up their own physician in case of switching funds.

An additional explanation for higher consumer mobility in Germany and Switzerland is that consumers have more past experience with switching since limited choice options have always been present. By contrast, in Belgium and the Netherlands consumer choice of sickness funds was virtually absent and many consumers still seem to be very loyal to the largest regional sickness fund (as in the Netherlands) or to the sickness fund from a specific ideological background (as in Belgium).

## **5. Discussion and policy implications**

The conclusion from our five country comparison is that there is a large variation in consumer mobility in social health insurance markets which seems to primarily due to differences in choice setting and in the net benefits of switching. Hence, if policy makers want to increase or reduce consumer mobility in social health insurance, they should focus on redesigning the choice setting and/or increasing the benefits or reduce the costs of switching.

An important question for health policy is what the appropriate rate of switching should be. First of all, the answer to this question depends on the objectives behind the introduction of freedom of choice of health insurers. Next, it also depends on the features of the choice setting in general, and on the quality of the risk-adjustment scheme in particular.

In *Belgium*, the introduction of consumer choice was not intended to motivate sickness funds to improve their performance or to encourage them acting as a prudent buyer of health services on behalf of their enrollees. The primary motivation seems to be just to give the Belgian citizens a free choice of sickness fund. Whether or not people effectively use this opportunity is not important and in this respect the

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<sup>5</sup> That switching propensity is negatively related to age and positively related to health and education is also found by empirical studies in the US [16, 17, 18, 19], the Netherlands [20,

extent of consumer mobility does not seem to be a relevant health policy issue. If those who switch are profitable for sickness funds, however, a high level of consumer mobility could be beneficial for sickness funds that are able to attract a disproportionate share of the switchers. Given the empirical evidence that switchers tend to be relatively healthy and the absence of adequate proxies for health status in the Belgian risk adjustment scheme, a high level of consumer mobility could cause financial problems for sickness funds that experience a net outflow of enrollees to other funds. Hence, for Belgian policy makers there does not seem a reason for encouraging consumer mobility, but, at least in the long run, there is a clear rationale for improving the risk adjustment system.

In *Israel* open enrolment and risk adjustment were introduced mainly to enhance competition on quality of care and to eliminate the prevailing incentives for risk selection. The current rather crude risk adjustment system mitigates but certainly not eliminates the incentives for risk selection. In addition, the low level of consumer mobility does not seem to be sufficient in motivating sickness funds to invest in better health services. Although consumer mobility presumably is too low to effectuate competition on quality, policies targeted at enhancing consumer mobility would be risky as long as the risk adjustment system has not yet been improved. Hence, improvement of the risk adjustment methodology should get priority over stimulating consumer mobility.

In *Germany*, the primary goal of the introduction of free choice was to reduce the prevailing premium variation among sickness funds. The underlying idea was that consumer mobility would equalize differences in the risk composition of the insured population of the individual sickness funds. Despite the high consumer mobility, however, premium variation remains high. As a result of a rather poor risk adjustment system, the favourable risk of the switchers and successful risk selection strategies by often newly established sickness funds, the gap between the cheapest and the most expensive sickness funds is widening rather than narrowing. Within the context of the current risk-adjustment system, consumer mobility seems to have an adverse effect on the goal of creating a level playing field among sickness funds. A secondary goal of creating free choice of sickness funds was to encourage efficiency. Although consumer mobility may motivate sickness funds to improve administrative efficiency it is not likely to enhance a more efficient health care delivery. This is because sickness funds lack effective instruments to influence the provision of medical care. Sickness funds are still obliged to contract all licensed health care providers. As

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21], Belgium [5] and Israel [22].



explained before, there are only very few opportunities for selective contracting. Moreover, the inadequate risk-adjustment system makes risk selection far more profitable than investments in managing care more efficiently. Hence, given the policy goals the current switching rates in Germany seem to be too high and policy makers should focus on improving the risk adjustment system rather than on enhancing consumer mobility.

In the *Netherlands*, free choice of sickness fund was specifically introduced to motivate sickness funds to act as a prudent buyer of health services and to promote a more efficient provision of health care. The current level of consumer mobility, however, does not seem to offer strong enough incentives for sickness funds to display the desired behaviour. Despite the opportunity of selective contracting of health care professionals was created more than a decade ago, sickness funds hardly use it.<sup>6</sup> The substantial and increasing rather than decreasing premium variation among sickness funds provides another indication that switching rates are too low. In contrast to the other countries, the substantial premium variation is not likely to be caused by inadequate risk adjustment, since the Dutch risk adjustment system is quite good, especially after the introduction of various proxies for health status since 2002. Owing to the low consumer mobility, sickness funds have considerable latitude in setting premiums and making profits. The substantial surpluses generated by sickness funds even urged the government in 2001 to set a limit to the level of financial reserves sickness funds were allowed to have. Hence, Dutch policy makers should encourage consumer mobility by redesigning the choice setting and by increasing the net benefits of switching (e.g. by reducing search costs and facilitating the switching process).

In *Switzerland* open enrolment was introduced to improve incentives for efficiency as well as to reduce the prevailing risk selection. In contrast to Germany and the Netherlands, Swiss sickness funds increasingly engaged in managing care, although still to a rather limited extent. The poor risk-adjustment system makes investments in risk selection still much more attractive than investments in more efficient health care delivery, however, particularly if this would make the sickness fund more attractive to high-risk individuals. Hence managed care is primarily used as a tool for risk selection rather than for improving the efficiency of medical for the chronically ill. Like in Germany the poor risk adjustment system, the favourable risk profile of the switchers and the successful risk selection strategies by sickness funds, make that substantial premium variation among sickness fund even increased over time [23].

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<sup>6</sup> The absence of selectively contracting can be partly explained, however, by supply

Therefore also in Switzerland the focus of policy makers should be on improving the risk adjustment system.

What is clear from the discussion is that the optimal or socially desirable level of consumer mobility crucially depends on the primary goals of introducing consumer choice, the quality of the risk adjustment system and the available tools for health insurers to influence the provision of medical care. In four out of five countries policy makers should give priority to improving the risk adjustment scheme rather than to encouraging consumer mobility. Only in the Netherlands the quality of the risk adjustment system is sufficient, but consumer mobility is too low to discipline the behavior of sickness funds. Therefore, Dutch health policy should focus on encouraging cost and quality conscious consumer choice.

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**Table 1. Choice options in the five countries**

	<b>Belgium</b>	<b>Israel</b>	<b>Germany</b>	<b>Netherlands</b>	<b>Switzerland</b>
Can premiums basic insurance vary between SFs?	Yes, variation allowed for small part of total premium	No, no premiums paid to the SF	Yes	Yes, variation allowed for 15-20% of total premium	Yes
Can basic benefits package vary between SFs?	No	Yes	No, but there are very small variations (e.g. spa treatment, acupuncture)	No	No
Can SFs selectively contract and manage care?	No	Yes, selective contracting and employment of providers allowed	No, except in the specific case of "integrated care" and Gatekeeping models	Yes, selective contracting of outpatient care providers allowed	Partly, obligation to have a standard contract with every provider, but preferred providers special contracts allowed (e.g. HMOs)
Can premiums supplementary insurance vary between SFs?	Yes, risk-rated premiums set by SF	Yes, age-related premiums set by SF (to be approved by government)	Not relevant	Yes, community-rated premiums set by SF (risk-rating allowed but not applied)	Yes, risk-rated premiums set by SF
Can supplementary coverage vary between SFs?	Yes	Yes	Not relevant	Yes	Yes
<i>In sum: How many choice options do consumers have?</i>	Few	Substantial	Moderate	Moderate	Substantial

**Table 2. Features of the choice settings in the five countries (2000-2003)**

	Belgium	Israel	Germany	Netherlands	Switzerland
<b>Market structure</b>					
Number of sickness funds to choose from	5 (nationwide)	4 (nationwide)	70-130 per state*	21 (nationwide)	40-70 per canton
Level of market concentration	High, 90% market share for 3 largest SF	High, 58% market share for largest SF (2000)	Low, nationally 20% market share largest 3 SFs	Moderate, nationally: 35% market share for 3 largest SFs High, regionally: 50-90% market share for largest fund	Low, 13-44% maximum market share per canton. Largest SF has total market share of 14%
Contestability	None, no entry permitted	Low	High	Moderate	High
Collusion among insurers possible?	Yes, no competition policy applied	Yes, no competition policy applied	Yes, no competition policy applied	Tacit collusion only, competition policy enforced	Tacit collusion only, competition policy enforced
<b>Institutional features</b>					
Open enrolment periods required for basic insurance?	No, not formally but in practice people can switch quarterly	Yes, biannually***	Yes, monthly**	Yes, annually	Yes, biannually
Financial risk for sickness funds	Low 8-10%	High >90%	High 97-100%	Moderate 54%	High 100%
Quality of the risk-adjustment system	Moderate	Low	Moderate	High	Low
Financial incentives for employers to influence consumer choice	No, legally fixed uniform employer contribution	No, no employer contribution	Large, employers pay 50% of premium; many company-based funds	No, legally fixed uniform employer contribution	Negligible, voluntary employer contribution very unusual
Supplementary tied to basic insurance?	Yes, mandatory supplemental insurance provided by same fund	Yes, both by SFs and private insurers offering supplementary insurance	No, but co-operation with private insurers possible since 2004	Tie-in applied by most sickness funds (though by separate legal entities)	No, but most funds offer both types of insurance
Underwriting (risk selection) allowed for supplementary insurance?	Yes	No, not for SFs Yes, for private insurers	Yes	Yes	Yes
Is comparative information about health insurers easily available?	No	Information on benefits and switching rules available on internet	Comparison of premiums and benefits available on internet	Comparison of premiums and benefits available on internet	Comparison of premiums & switching rules on internet
<i>In sum: is choice setting enhancing consumer mobility?</i>	No	No	Yes	Moderate	Moderate

\* In 2001 there were 395 German sickness funds, of which 214 had open enrolment. Since most sickness funds operate in a limited number of states, the actual number of sickness funds with open enrolment per state varies between 70 and 130 (about 100 on average).

\*\* A minimum stay is required of 18 months after switching sickness funds. However, enrolees may

switch within this period if the sickness fund raises its contribution rate. Company-based funds (BKKs) and guild-based funds (IKKs) are allowed to refrain from open enrolment. Once they have chosen for an open enrolment status, however, there is no way back.

\*\*\* A minimum stay of 12 months is required before switching.

**Table 3. Potential benefits of switching sickness funds in five countries**

	Belgium	Israel	Germany	Netherlands	Switzerland
Premium variation basic benefits package	Negligible, premium varies from €2 to €15 per year (2003) Moderate, average premium varies from €480 to €620 per year for voluntary insurance for self-employed (2002)	No, not relevant	Large, varying from 12.2% to 15.7% of gross income (2004)	Moderate, community-rated premium varies from €240 to €390 per year (2003)	Large, substantial variation in total community-rated premiums. Cheapest region: €1272-€1680. Most expensive region: €2700-€4608 per year (2004)
Variation in out-of-pocket payments basic insurance	No	Practically no	No	No	Yes*
Variation in basic benefits package	No	Only marginally, (e.g. variation in number physiotherapy sessions, drugs use practice)	Extra benefits up to 5% of total costs	No	No
Variation in managed care basic insurance	No	Substantial variation in provider contracts and choice of providers	Negligible	Limited, selective contracting hardly used	Moderate, market share HMOs increased from 2% in 1996 to 7% in 2002
Premium variation supplementary insurance	Small but increasing	Small	Not relevant	Substantial	Substantial
Variation in coverage of supplementary insurance	Yes, substantial, even among local funds of same SF-association	No essential differences	Not relevant	Yes, substantial	Yes, substantial
<i>In sum: Potential benefits of switching</i>	Low	Low	High	Moderate	High

\* All Swiss sickness funds offer a choice between different legally determined levels of deductibles (1999-2003: CHF 230, 400, 600, 1200, and 1500 per year).

**Table 4. Potential costs of switching sickness funds in the five countries**

	<b>Belgium</b>	<b>Israel</b>	<b>Germany</b>	<b>Netherlands</b>	<b>Switzerland</b>
Extent of product differentiation basic insurance	No	Substantial variation in provider contracts and provider practise style/guidelines	Limited, only for extra benefits	Very limited variation in provider contracts	Different deductible levels, bonus insurance and HMOs
Extent of product differentiation supplementary insurance	Moderate	Small	Not relevant	Moderate, and increasing	Large
Administrative switching costs	Low	Moderate	Moderate	Moderate	Low
Need to switch providers	No	Usually yes	No	No	No, except when choosing for an HMO
Risk of less favourable conditions supplementary insurance	Low	Low	No	Moderate	Low
In sum: Potential costs of switching	Low	Moderate	Low	Moderate	Moderate

**Table 5. Expected net benefits of switching (summary of Table 4 and 5)**

	<b>Belgium</b>	<b>Israel</b>	<b>Germany</b>	<b>Netherlands</b>	<b>Switzerland</b>
Potential benefits of switching (Table 4)	Low	Low	High	Moderate	High
Potential costs of switching (Table 5)	Low	Moderate	Low	Moderate	Moderate
In sum: Potential net benefits of switching	Low	Low	High	Low	Substantial

**Table 6. Consumers' inclination to switch in the five countries**

	Belgium	Israel	Germany	Netherlands	Switzerland
Past experience with switching	Low, people hardly used existing freedom to choose funds	Moderate	Moderate, before reform about 60% of people had some choice of funds	Low	Substantial, primarily among low-risk individuals
Propensity to use 'exit' rather than 'voice' option	Low	Low	Moderate	Low	Substantial
Loyalty to specific (types of) sickness funds	High, Political or religious loyalty to specific SFs (declining)	High, Loyalty to providers rather than SFs	Moderate, Loyalty from original target groups: companies, guilds, blue/white collar workers (declining)	High, Regional loyalty to original regional SF (declining)	Moderate (declining)
<i>In sum: Consumers' inclination to switch</i>	Low	Low	Moderate	Low	Substantial

**Table 7: Summary of cross country differences in consumer mobility**

	Belgium	Israel	Germany	Netherlands	Switzerland
How many choice options do consumers have?	Few	Substantial	Moderate	Moderate	Substantial
Is choice setting enhancing consumer mobility?	No	No	Yes	Moderate	Moderate
Potential net benefits of switching	Low	Low	High	Low	Substantial
Consumers' inclination to switch	Low	Low	Moderate	Low	Substantial
<b>Overall effect on consumer mobility</b>	Low	Low	High	Low	Substantial