Medical Care Research and Review
2015, Vol. 72(4) 496–509

DOI: 10.1177/1077558715579867
mcr.sagepub.com
SAGE

Enforcing Enrollment in Health Insurance Exchanges: Evidence From the Netherlands, Switzerland, and Germany

Ewout van Ginneken[1] and Thomas Rice[2]

Abstract

Experience from the Netherlands, Switzerland, and Germany suggests that there may be a looming problem concerning uninsured individuals and defaulters that could derail coverage projection numbers in the United States under the Affordable Care Act. In those countries, the young, people with migrant backgrounds, and those with lower incomes—precisely the groups the Affordable Care Act is seeking to cover—are overrepresented in the numbers of the uninsured and defaulters, frequently because of difficulty in paying for their premiums. In these three countries, penalties or suspension of coverage alone has not led everyone to purchase coverage or prevented some from defaulting. Help in addressing the vulnerable position of the uninsured may be needed. Examples include using a multifaceted approach in which public authorities help with debt restructuring, freeing some funds in the exchanges to help vulnerable groups, and compensating insurers for their outstanding payments if they follow an agreed protocol instead of canceling coverage.

Keywords

health insurance, European countries, Affordable Care Act

This article, submitted to *Medical Care Research and Review* on December 10, 2014, was revised and accepted for publication on March 8, 2015.

[1]Berlin University of Technology, Berlin, Germany
[2]University of California, Los Angeles, CA, USA

Corresponding Author:
Thomas Rice, Department of Health Policy and Management, Fielding School of Public Health, University of California, Los Angeles, 650 Charles Young Drive, Los Angeles, CA 90095-1772, USA.
Email: triceucla@gmail.com

Introduction

The Affordable Care Act (ACA) aims to increase insurance coverage while improving quality and containing costs in the United States. This goal is being pursued in large measure through the development of health insurance exchanges, which started operating in October 2013. Despite the rocky start due to severe problems with the enrollment websites in the federal exchange and in some state exchanges, the Congressional Budget Office (CBO) enrollment projection of 7 million during 2014 was met. Yet the debate about the law's success in covering more people continues.

The CBO (2014) predicts that exchange enrollment will triple, to 24 million, by 2016. Whether it does will depend on many factors. A first set relates to the attractiveness of the insurance policies, including premium levels, cost sharing, breadth of provider network, and available tax subsidies. This will be directly affected by the Supreme Court's upcoming decision on the Constitutionality of the premium subsidies in states that use the federal exchange. A second set of factors concerns how enrollment is facilitated and which technical solutions are chosen, including websites, navigators, and telephone lines. How choice and available subsidies are presented is a key issue. A final set of factors focuses on how enrollment is enforced. This includes not only enforcement of the individual mandate to purchase insurance, but also how to deal with those who default on their premium. As will be shown, the enforcement levers in the United States are considerably weaker than in the other countries.

This article will focus on this final set of factors and review relevant experience with enforcing enrollment in the Dutch, German, and Swiss private insurance markets. In all three countries, mandating that people purchase private insurance, rather than providing coverage through an automatic mechanism, has led to increased numbers of the uninsured, although these effects have sometimes been temporary. A related issue currently receiving much attention is not whether people enroll in exchange policies, per se, but whether those who enroll actually pay their premiums. At the end of April 2014, when the first annual open enrollment period had ended, Republicans in the House of Representatives claimed that only two thirds of enrollees had paid premiums for their first month of coverage. Supporters of the legislation strongly disagreed, pointing out that the two thirds figure included many people whose premium payments were not yet due. Reports from Wellpoint, the Blue Cross and Blue Shield Association, and America's Health Insurance Plans (a trade association of commercial insurers) indicate that 80% to 90% of prospective enrollees had paid their premiums, while California had reported payment levels of 85% in mid-April (Jost, 2014). The issue is a critical one, because if a large percentage of those signing up on the exchanges ultimately do not pay their premiums, the overall effectiveness of the reform could be threatened—particularly if those who are delinquent are younger and healthier than the average person obtaining coverage through the exchange. A crucial question is how an exchange can enforce enrollment and prevent rising numbers of defaulters on private insurance policies in a market that is private in nature. Will private insurers simply cancel the policies of defaulters?

This article reviews the Dutch, German, and Swiss solutions to some of these problems. First, we examine how those countries responded to increasing numbers of the uninsured because of nonenrollment. Second, we review public policies for those who default on their premiums. Third, we discuss the available evidence on the backgrounds of uninsured individuals and defaulters. We finish with important lessons for government and insurers.

New Contribution

Up till now, health insurance coverage was voluntary in the United States. The ACA changed this in 2014, with the first penalties due with income taxes on April 15, 2015. The size of the penalty is small initially, but rises substantially over a 2-year period. Because the United States has no experience with such a system, it is important to examine countries that have such experience. The Netherlands and Switzerland fully rely on private insurance to cover their populations, while around 11% of the German population relies on private insurance. This article is the first to systematically examine the experience of these countries as they have tried to enforce their health insurance mandates. We focus on how their mandates are enforced as well as how each of the countries deal with defaulters.

Overview of the Three Countries

Since comprehensive health reform was enacted in Switzerland (1996) and the Netherlands (2006), it is mandated that all residents purchase their own (private) health insurance plan and be responsible for paying their monthly premium—similar to arrangements under the American exchanges (van Ginneken, Swartz, & Van der Wees, 2013). Having community-rated premiums in place also necessitated a system of tax subsidies to offset the regressive effect of premiums and to make the premiums affordable. These systems are quite generous when compared with those in the U.S. exchanges, where about 8 million people received subsides on the exchange. (Far more, of course, receive subsidies through their employers or Medicaid.) In 2014, in the Netherlands, 57% of all households received a tax subsidy (*zorgtoeslag*) in 2013 (Statistics Netherlands, 2014b), which corresponds to about 32% of all residents, while in Switzerland 29% of all insured individuals received a tax subsidy (*Prämienverbilligung*) in 2012 (Bundesamtes für Gesundheit [BAG: The Federal Office of Public Health] 2014). In the Netherlands, income should not exceed $35,580 (€30,939) per year for singles or $48,804 (€42,438) per year for households to be eligible for tax subsidies, while in Switzerland the amounts and their calculation varies by canton. Generally speaking, in both countries those receiving tax subsidies are the lower incomes, youth, and the elderly.

Prior to the reform, contributions were mostly automatically deducted as a percentage from earnings, that is, predominantly as an earmarked payroll tax in the Netherlands, whereas the Swiss system was voluntary (but also provided near-universal coverage). In 2009, Germany introduced a mandate for all residents,

including those qualifying for the substitutive private insurance scheme, who previously could opt out of insurance. The substitutive private insurance scheme (*Private Krankenversicherung* or PKV) covers 9.0 million people (11% of the population) for primary coverage and consists of people above an income threshold (roughly $5,000, or €4,350, per month in 2014), certain categories of the self-employed, and public employees (Busse & Blumel, 2014). As the system predominantly covers the well-off and the market is not regulated to the same extent as the Dutch or Swiss health insurance market, tax subsidies are not available. Collectively, these reforms led to temporary increases in the numbers of the uninsured (Netherlands, Switzerland) and also rising numbers of people defaulting on their premiums (Netherlands, Switzerland, and Germany).

Another important issue involves undocumented migrants (UDMs), who are explicitly excluded from coverage in the U.S. exchange (van Ginneken & Gray, 2013). In the Netherlands, UDMs cannot purchase coverage, but a separate regulation exists stipulating that health care providers can reclaim the costs of treating UDMs for all types of care if they cannot reclaim them from the UDMs themselves. In Switzerland, however, UDMs must purchase cover in the system. In Germany, in practice, UDMs receive only emergency care (Gray & van Ginneken, 2012).

The next sections describe policies to enforce the mandate and policies to deal with defaulters. Table 1 provides an overview.

Policies to Enforce the Mandate

In the Netherlands, the number of the uninsured has recently been on the decline after years of gradual growth. Although there has been some methodology-based debate about the actual numbers, the latest figures show that the uninsured (i.e., those not registered with a health plan) declined from 290,000 in 2010 (1.8% of the population) to 28,740 in 2012 (0.2%; RIVM, 2014). As part of its efforts to reduce the number of the uninsured, since 2011, the government has actively been tracking them down, which required setting up a new database that links various registries. The system involves several government bodies, uses a strict and detailed protocol with warnings, fines, and may end in forced enrollment and garnishing of wages (see Box 1 for more details). The only exemption made to the mandate is granted to what the Dutch call "conscientious objectors" (*gewetensbezwaarden*). These are persons who refuse to insure themselves on grounds of religious or other beliefs. Although they do not have to purchase health insurance, they have to pay a general income tax equal to the (income related) employer contribution. These contributions are then saved in personal accounts (i.e., there is no pooling), which are managed by the National Health Care Institute (NHCI).[1] Any incurred health expenditures will be reimbursed from these individuals' personal account. If this does not suffice, the rest will be due out-of-pocket. Exemptions should be requested at the *Sociale Verzekeringsbank* (SVB; Schäfer et al., 2010).

Table 1. Policies to Enforce the Mandate and Policies to Deal With Defaulters in the Netherlands, Switzerland, and Germany.

		Netherlands	Switzerland	Germany	Effective for achieving coverage or prevention of nonpaying?
Policies to enforce the mandate	Fines for nonenrollment	✓	✓	✓	Mixed, also deters people from enrolling
	Forced enrollment	✓	✓	×	Yes, but does not solve vulnerable position of insured
Policies to deal with defaulters	Suspending/ canceling coverage	No longer allowed	No longer allowed	×	No, also affects many vulnerable groups
	Benefit reduction	×	✓	✓	No, leads to less equality
	Garnishing wages	✓	×	×	Yes, but legally difficult
	Body assuming responsibility for defaulters	✓	✓	×	Yes, but requires policy capacity and funding
	Compensating insurers	✓	✓	×	Yes, but may be costly

Source. Authors' own compilation.

Box 1. The Dutch protocol for enforcing the mandate.

Every month, the National Health Care Institute, or *Zorginstituut*, receives a report from the *Sociale Verzekeringsbank* (SVB), a body responsible for registering national insurance schemes. If the NHCI finds that an individual has not purchased coverage, it will send a letter requesting that he or she do so. Failure to purchase insurance within 3 months then results in a fine of $371 (€332.25). It will be followed by another $382(€332.25) fine after another 3 months if coverage is not purchased. After a further 6 weeks of nonpayment, a reminder is sent. If this reminder is not followed by payment within 2 weeks, a bailiff from the *Centraal Justitieel Incassobureau* (CJIB), a government agency tasked with collecting different kinds of fines, will be alerted and will collect the fines. Bailiffs' costs are at least $46 (€40) and are payable by the uninsured.

There are special regulations for those with large debts, who have the option to pay in installments. If a person still does not select an insurer, the NHCI purchases a plan on behalf of the uninsured, and the premium is automatically deducted from the insured's income for the next 12 months. Those who are self-employed or without

(continued)

Box 1. (continued)

income have to pay via an invoice issued by the CJIB. The NHCI purchases plans from all available insurers according to their market share. This monthly "standard" premium (€110.75, or $127) is higher than those purchased personally (average premiums are €100, or about $115, but cheaper policies are available). Lastly, if the individual has not yet paid the fines, those are still due as well. After 12 months, the insured receives a letter stating that premiums will no longer be automatically deducted (or invoiced by the CJIB), and the insurer lowers the administrative premium to its current community-rated premium. Starting at the beginning of a new year, the insured can switch insurer again. The NHCI also informs the employer that it is required by law to deduct the uninsured employee's premium and pay it directly to the NHCI. If the employer fails to take it out of the employee's paycheck, it is still required to pay the premium for the employee.

In Switzerland, the mandate enforcement is the responsibility of the 26 cantons, which are required to establish a mechanism for those who do not voluntarily obtain coverage within 3 months of being born in, or moving to, Switzerland. These mechanisms show some variation, but generally operate as follows: Cantonal authorities, for example, municipalities, compare the data of health insurers with regional population registries, and if there are discrepancies they notify those without insurance to purchase a health plan or face a fine (Okma & Crivelli, 2013). Cantons may impose penalties of 30% to 50% above the premium on those who remain uninsured. Misrepresenting health insurance coverage is punishable by fines and prison terms (Glied, Hartz, & Giorgi, 2007). If individuals fail to purchase insurance within 3 months, the responsible authorities choose a health plan from the plans available in the canton. As a result, the newly enrolled individual can no longer make an individual choice. The rising numbers of the uninsured were mostly the result of cancellation of policies of people who were defaulting on their premiums.

Uninsurance in Germany, which, according to official statistics, represented 137,000 people (0.17% of the population) in 2011, is not as big an issue as it has been in the Netherlands and Switzerland. However, there is some debate about the accuracy of the number, as these are self-reported microcensus data and can be assumed to be underreported (Busse & Blumel, 2014). Data on uninsurance for the private substitutive insurance market are not gathered, perhaps because many of the individuals in question are eligible for the statutory system, too. The perceived low numbers of the uninsured perhaps explain why there is no explicit policy to track down this group, but some substantial fines for uninsurance do apply. As of January 2014, the uninsured may be faced with retroactive claims for the time they have spent without insurance since January 2009, when the insurance mandate was extended to all people. Fines are based on the length of time without insurance and may reach nearly $10,100.

In August 2013, to encourage people to enroll, and realizing that the high fines could deter people from doing so, the government canceled debt for those who would

enroll before the end of 2013, either by joining the statutory system or, if eligible, by purchasing substitutive private insurance. The regulation did not deliver the expected results. Reportedly, only 10,000 people enrolled, with critics lamenting that the regulation was not publicized enough (1A Verbraucherportal, 2014).

Policies to Deal With Defaulters

In the Netherlands, the number of defaulters—people who have not paid premiums in 6 months—rose to 316,378 in 2012 (2.0% of the population), an increase of 50,000 over the number in 2010 (RIVM, 2014). The government has tried to resolve the situation by no longer allowing insurers to suspend defaulters, and at the same time automatically deducting premiums from those people's salaries. The current regulation, which was agreed between the Ministry of Health and the umbrella organization of health insurers (*Zorgverzekeraars Nederland* or ZN), stipulates that if a person has not paid premiums for 6 months, he or she will be reported by the insurer to the NHCI and registered as a defaulter. After this, another strict protocol is followed in some ways similar to that for the uninsured, in which the NHCI takes over financial responsibility for the defaulter who nevertheless stays insured with his or her insurer while his or her wages are garnished (see Box 2 for the detailed protocol). An evaluation of this policy showed that, although it was successful in terms of keeping people covered and reclaiming outstanding debt, the numbers of people falling into this category by defaulting on their premiums is still increasing. This trend indicates that the regulation does not address the underlying issues that cause people to default, which mostly relate to the high debt and financial problems these individuals already have. The Ministry of Health has acknowledged that this is a complex problem. It has therefore been piloting projects with a multifaceted approach involving insurers, municipalities, and debt-restructuring organizations, focusing more on the root of the problem and its prevention (Ministry of Health Welfare and Sports, 2013).

Box 2. The Dutch protocol for defaulters.

After not paying premiums for 6 months, the NHCI registers an individual as a defaulter. From this moment, the defaulter will have to pay the higher administrative premium of €144 ([about $166] or 130% of the standard premium) directly to the NHCI, but will remain insured with his or her insurer. Any outstanding debt will still have to be settled with the insurer directly. Employers or social security agencies are notified and have to deduct the premium from monthly income and transfer it to the NHCI. Those without income receive monthly invoices from the CJIB. If a person paying through invoices is eligible for tax subsidies (which in the Netherlands normally are paid out to individuals directly), the CJIB withholds the tax subsidy from the tax agency, uses it to pay the insurer, and notifies the defaulter that it has done so. The insured needs to pay only the difference per invoice. After

(continued)

Box 2. (continued)

6 weeks of nonpayment, a reminder is sent out. If it remains unanswered within 2 weeks, a bailiff from the CJIB will collect the premium. During the procedure, the defaulter cannot switch to another insurer.

Only the insurer can free a defaulter from defaulter status and will do so only if the insured has cleared all remaining debt, has agreed on a debt-restructuring plan, or has entered a government program for debt clearance. If outstanding debt remains, the insurer can receive some compensation from the national health insurance fund (which pools all employer contributions for health insurance before risk-adjusted allocation to insurers) on the condition that the above protocol has been followed. If the employer fails to deduct the premium from the employee's salary, it is nevertheless obliged to pay the administrative premium for the employee.

In Switzerland, the problem of uninsurance was mostly the temporary result of a reform of the Federal Health Insurance Act in 2006, which allowed insurers to suspend coverage for defaulters, a rising issue at the time. Contrary to expectations, the reform did not lead to lower numbers of defaulters, but instead to higher numbers of the uninsured among people who could not afford their premiums. Indeed, the numbers of the uninsured as a result of defaulting continued to grow, by as much as 4.3% of the population in some cantons (Crivelli, 2010). More than 366,000 people (almost 5% of the country's population) were sued by insurers for unpaid premiums in 2009, and insurance reimbursements were withheld for 93,000 of them (Office Fédéral de la Santé Publique, 2011). After it became clear that allowing insurers to suspend coverage led to rising numbers of uninsured individuals, the parliament revised the law in 2010.

Similar to those in the Netherlands, Swiss authorities now mediate between the defaulter and the insurer. As of January 2012, a new regulation stipulates that, if insurers fail to reclaim outstanding premiums and debt, cantons have to pay 85% of unpaid premiums and other debts to health insurers on behalf of people experiencing serious financial problems. In addition, although wages are not garnished, tax subsidies, which normally are paid out to eligible individuals by the cantonal authorities, are directly transferred to the insurers. The defaulters must pay insurers as soon as they can, but their coverage will no longer be suspended or limited (Organisation for Economic Co-operation and Development [OECD], 2011). However, this regulation has imposed a financial burden on the cantons, and some of them (e.g., Luzern, Solothurn, & Thurgau) have reacted by establishing "black lists," with those on the lists eligible only for emergency care. This was also allowed under the new regulation and should give cantons the means to motivate people to pay their debts. The unpublished lists comprise those who have failed to pay their premiums but usually exclude some vulnerable groups (children, social security recipients). The lists are politically controversial and have been criticized as ineffective because they may pose a larger administrative burden and do not change the payment obligation of the canton (Aschwanden & Gerny, 2013).

Although the German PKV has historically been an insurance scheme for the well-to-do, many policyholders are experiencing increasing difficulty in paying their premiums for various reasons. The cost of the premiums has reportedly increased on average twice as fast as in the statutory system, and they are not community rated—that is, they may vary according to risk and could therefore become unaffordable for some more vulnerable groups. The federal government has sought to counter this development by installing a so-called basic premium (*Basistarif*; €600 per month or about $690), which is based on the maximum contribution and benefit package in the statutory system. However, switching to this policy is not permissible until the age of 55 years, and therefore many lower income self-employed individuals may be stuck with an expensive risk-rated premium. The result has been that, at the end of 2011, almost 2% of the approximately 9 million privately insured had outstanding insurance-related debt, which together amounted to more than $575 million (€500 million). Those who do pay their premiums therefore indirectly pay for these defaulters, as their policies cannot be canceled and they still are eligible for emergency care (Gesellensetter, 2013).

The substitutive private insurance companies have adopted a five-step policy to grapple with defaulting. First, if an insurer finds that a policyholder has not paid a premium for 2 months, a reminder is sent that if the debt is not settled within 2 weeks, coverage will be limited to emergency care. Second, if the outstanding premium has not been paid after those 2 weeks, the insurer sends a notice to the policyholder with a 3-day deadline to pay; otherwise, a late fee will apply. Third, although the policyholder can receive only emergency care (a benefit reduction), they owe the full amount in premiums for every month that has not been paid. Debt will add up because of interest of 1% per month on all outstanding payments. Fourth, if the policyholder still has outstanding premiums, late fees, and interest 1 year after benefit reduction, he or she will automatically have to pay the basic premium. This premium may be higher than what was charged before. The policyholder continues to receive only emergency care. Finally, the reduction of benefits will end only if the insured pays off all debt. The PKV's insurers cannot garnish wages as it remains a private insurance market.

Clearly, the policy so far is not working well. Reportedly, the federal government, together with industry, has been working on a special "defaulter premium." This is a much lower premium (there is talk of about €100 per month, or about $115) for which the insurer only reimburses emergency care. This would prevent defaulters from rapidly accumulating debt, but the proposal is very controversial politically as it implies less equality in the health system, with the emergence of a vulnerable underclass covered only for the bare minimum.

Who Are the Uninsured and Defaulters?

The organization Statistics Netherlands actively monitors the numbers and characteristics of the uninsured and defaulters. Of the relatively small group of uninsured in 2012, 63% were men, while those below the age of 35 years, those with migrant backgrounds (at least one parent born abroad), and those living in urban areas were

overrepresented (Ministry of Health Welfare and Sports, 2013). The Ministry of Health has therefore focused its information campaigns on these groups.

Among the larger group of defaulters in the Netherlands, young people, migrants, and those with lower incomes were overrepresented. In 2011, 44% of defaulters were younger than 35 years, compared with 24% who were between 35 and 44 years, 20% who were from 45 to 54 years, and 12% who were older 55 years. In the same year, 45% had a migrant background, (Ministry of Health Welfare and Sports, 2012), although individuals with migrant backgrounds make up only about 20% of the total population (Statistics Netherlands, 2014a). Fifty-seven percent earn less than €2,300 per month ($2,645), and 60% are eligible for tax subsidies, that is, most belong to lower income groups. Furthermore, about 24% (mainly the unemployed and those with disabilities) receive social security.

While precise information on the characteristics of the uninsured and defaulters on a national level is absent because of the fragmented (by canton and insurer) data collection systems in Switzerland, it seems likely that the uninsured and defaulters are coming from similar segments of the population as they do in the Netherlands. Recent cross-sectional analysis of about half a million Swiss insured largely confirms this (von Wyl & Beck, 2015). In Germany, anecdotal evidence and media reporting suggest that, in the PKV, the defaulters consist mostly of poorer-retired people and lower income self-employed. Although the elderly are eligible for the cheaper basic premium (set at the maximum contribution in statutory insurance), it may nevertheless pose a difficult financial burden. Furthermore, in Switzerland, UDM are obliged, within 3 months of arriving in the country, to purchase coverage like everyone else. In practice, the high premiums and cost-sharing requirements, as well as complex administrative procedures and fear of the authorities, may seriously hamper their ability to purchase insurance. Therefore, this group will often rely on the emergency care provided by cantons (as required by law), so it can safely be assumed that there are many UDM among the uninsured (van Ginneken & Gray, 2015).

Policy Implications for U.S. Exchanges

The first lesson coming out of the Netherlands, Switzerland, and Germany is that there may be a looming problem with the uninsured and defaulters that could derail projections of coverage numbers under the ACA. People overrepresented in the numbers of the uninsured and defaulters in the Netherlands (and likely in Switzerland) are the young, people with migrant backgrounds, and those with lower incomes. These are precisely the groups with high uninsurance rates in the United States, for which the ACA is seeking to increase coverage (Rice et al., 2013). This will be a major challenge. Already, we know that enrollment of young persons on the exchanges is lower than originally projected; that Latinos are less likely to enroll than other racial and ethnic groups; and that poor and near-poor persons remain vulnerable because half of the states did not choose to expand Medicaid coverage (Levitt, Claxton, & Damico, 2013; Lovett, 2014). As these groups tend to have lower incomes than others—and because, particularly among young people, many do not believe they need

coverage—the defaulter problem in the United States could become much larger than in the European exchanges. Therefore, exchanges should set up a database and install effective policies for monitoring the uninsured and defaulters.

Second, penalties alone have not led everyone to purchase insurance, and even perhaps have deterred people from purchasing it and from making themselves known to authorities, as seen in Germany. In European countries, individuals must both pay penalties and still enroll in insurance, and if necessary, it is purchased on behalf of them. These mechanisms are not available in the United States, where the government cannot file criminal charges against someone who refuses to pay the penalty, and the wages cannot be withheld (Blue Cross and Blue Shield of Rhode Island, 2010). Under the ACA, it is legal to stay uninsured as long as one pays a penalty. Penalties are relatively low for 2014 and 2015, but by 2016 they will rise to about $700 per person ($2,100 per family) or 2.5% of income, whichever is higher. Many exemptions exist, however. According to CBO, at least 23 of the 30 million that are expected to be uninsured in 2016 could qualify for an exemption (CBO, 2014). These include not only undocumented individuals, but those who experience financial hardship (e.g., have filed for bankruptcy or incurred major financial debt due to medical expenses recently, have incomes so low that they do not have to file tax returns, or have low incomes and live in states that did not expand Medicaid.) This, in turn, raises serious concerns regarding the long-term effectiveness of the exchanges in meeting the projected enrollment projections.

Third, exchanges should put special emphasis on monitoring the continued affordability of premiums given the size of available tax subsidies. As seen in the European exchanges, rising premium levels played a catalyzing role in the increasing numbers of uninsured and defaulters. However, there is no program (beyond the subsidies available to everyone below 400% of the poverty level) to subsidize those who have trouble paying their premiums. Nor is such a program possible without further Congressional action. It is possible that future data on affordability could influence the development of such legislation.

Moreover, a defaulter problem will certainly have an effect on premium levels in the exchanges, as insurance companies will try to recover those losses from others enrolled. But more could be done to freeing some funds in the exchanges to help vulnerable groups.

The fourth lesson is simply suspending and canceling coverage, expecting that individuals will then pay off remaining debt, will not work. It has led to some dramatic results in Switzerland and Germany, putting people in deeper financial trouble and resulting in increases in the underinsured and uninsured. In spite of this, the suspension and cancellation of coverage due to default is included in a new provision from the Centers for Medicare & Medicaid Services (Center for Consumer Information and Insurance Oversight, 2014). An alternative way to get people to pay premiums is to garnish wages and even have bailiffs sent to collect unpaid premiums. It seems unlikely that such mechanisms will become available in the United States.

Finally, making a third party—for example, a new federal, new state agencies, or the exchange itself—financially responsible for the defaulters and involving

relevant stakeholders could take the burden away from the insurers and assist defaulters with clearing their debt. Helping defaulters with debt restructuring, or compensating insurers for their outstanding payments if they follow an agreed protocol instead of immediately canceling coverage, as seen in the Netherlands and Switzerland, are solutions that U.S. exchanges could explore without having to rely on penalties or regulations.

Without appropriate and timely action, the coverage numbers of the ACA could fall behind expectations and many already vulnerable people could be further put into financial trouble due to defaulting and accumulating debt. We should not wait, as the Dutch, Swiss, and Germans did, until the numbers of uninsured and defaulters are rising.

Authors' Note

An earlier version of this article was prepared for the Commonwealth Fund Harkness Alumni Health Policy Forum in Washington, D.C. The views expressed in this article are those of the authors and do not necessarily reflect those of the Commonwealth Fund or its directors, officers, or staff.

Acknowledgments

The authors thank Bradford H. Gray (Urban Institute) and David Squires (Commonwealth Fund), neither of whom is responsible for any errors or misinterpretations that may remain—for helpful comments and excellent editorial suggestions on earlier versions of the article.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

Note

1. As of 2014, the National Health Care Institute (NHCI), or Z*orginstituut*, is the successor of the Health Care Insurance Board, known in Dutch as the *College voor Zorgverzekeringen*, or CVZ.

References

1A Verbraucherportal [1A Consumer Portal]. (2014). *Nichtversicherte: Wege zurück in die Krankenversicherung* [The uninsured: Ways back into health insurance]. Retrieved from http://www.1a.net/versicherung/krankenversicherung/nichtversicherte

Aschwanden, E., & Gerny, D. (2013, June 11). Kassenlisten mit begrenzter Wirkung [Insurer black lists with limited impact]. *Neue Zürcher Zeitung*. Retrieved from http://www.nzz.ch/aktuell/schweiz/schwarze-kassenlisten-mit-begrenzter-wirkung-1.18096683

Bundesamtes für Gesundheit [BAG: The Federal Office of Public Health]. (2014, September 25). *Faktenblatt Prämienverbilligung* [Fact sheet premium reductions]. Retrieved from http://www.bag.admin.ch/themen/krankenversicherung/00261/index.html?lang=de

Blue Cross and Blue Shield of Rhode Island. (2010). *Patient Protection and Affordable Care Act: Individual mandate & subsidy*. Retrieved from https://www.bcbsri.com/BCBSRIWeb/pdf/Individual_Mandate_Fact_Sheet.pdf

Busse, R., & Blumel, M. (2014). Germany: Health system review. *Health Systems in Transition*, *16*(2), 1-296.

Center for Consumer Information and Insurance Oversight. (2014, July 16). Affordable exchanges guidance subject: Enrollment bulletin. *Centers for Medicare & Medicaid Services*. Retrieved from https://www.regtap.info/reg_librarye.php?i=449

Congressional Budget Office. (2014, April). *Updated estimates of the effects of the insurance coverage provisions of the Affordable Care Act*. Retrieved from http://www.cbo.gov/sites/default/files/cbofiles/attachments/45231-ACA_Estimates.pdf

Crivelli, L. (2010, April). Swiss are back to (quasi-) universal coverage. *Health Policy Monitor*. Retrieved from http://hpm.org/en/Surveys/USI_-_Switzerland/15/Swiss_are_back_to_(quasi-)_universal_coverage.html

Gesellensetter, C. (2013). *Wenn PKV-Versicherte nicht zahlen* [Do not pay if the PHI insured]. Retrieved from http://www.handelsblatt.com/finanzen/recht-steuern/streitfall-des-tages/streitfall-des-tages-wenn-pkv-versicherte-nicht-zahlen/7945728.html

Glied, S. A., Hartz, J., & Giorgi, G. (2007). Consider it done? The likely efficacy of mandates for health insurance. *Health Affairs*, *16*, 12-21.

Gray, B. H., & Van Ginneken, E. (2012, December). *Health care for undocumented migrants: European approaches* (Issue Brief). Retrieved from http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2012/Dec/1650_Gray_hlt_care_undocumented_migrants_intl_brief.pdf

Jost, T. (2014, May 1). Implementing health reform: A summary health insurance marketplace enrollment report. *Health Affairs*. Retrieved from http://healthaffairs.org/blog/2014/05/01/implementing-health-reform-a-summary-health-insurance-marketplace-enrollment-report/

Levitt, L., Claxton, G., & Damico, A. (2013, December 17). *The numbers behind young invincibles and the Affordable Care Act*. Menlo Park, CA: Kaiser Family Foundation. Retrieved from http://kff.org/health-reform/perspective/the-numbers-behind-young-invincibles-and-the-affordable-care-act/

Lovett, I. (2014, February 19). California health insurance enrollments rise, but Hispanics still lag. *New York Times*. Retrieved from http://www.nytimes.com/2014/02/20/us/california-health-insurance-enrollments-rise-but-hispanics-still-lag.html?_r=2

Ministry of Health Welfare and Sports. (2012). *Verzekerdenmonitor* [Insurance monitor 2012]. The Hague, Netherlands. Retrieved from http://www.rijksoverheid.nl/documenten-en-publicaties/rapporten/2012/10/01/vws-verzekerdenmonitor-2012.html

Ministry of Health Welfare and Sports. (2013). *Verzekerdenmonitor 2013* [Insurance monitor 2013]. The Hague, Netherlands. Retrieved from http://www.rijksoverheid.nl/documenten-en-publicaties/rapporten/2013/11/19/verzekerdenmonitor-2013.html

Office Fédéral de la Santé Publique. (2011). *Statistiques de l'assurance maladie 2009* [Statistics from the 2009 Health Insurance]. Bern, Switzerland: Author.

Okma, K. G., & Crivelli, L. (2013). Swiss and Dutch consumer-driven health care: Ideal model or reality? *Health Policy*, *109*, 105-112.

Organisation for Economic Cooperation and Development. (2011). *World Health Organisation: OECD reviews of health systems: Switzerland*. Paris, France: Author.

Rice, T., Rosenau, P., Unruh, L. Y., Barnes, A. J., Saltman, R. B., & Van Ginneken, E. (2013). United States of America: Health system review. *Health Systems in Transition*, *15*(3), 1-431.

RIVM. (2014). *Zorgbalans. De prestaties van de Nederlandse gezondheidszorg* [DHCPR. The performance of Dutch health care]. Bilthoven, Netherlands: Author. Retrieved from http://www.gezondheidszorgbalans.nl/dsresource?type=pdf&disposition=inline&objectid=rivmp:259835&versionid=&subobjectname=

Schäfer, W., Kroneman, M., Boerma, W., van den Berg, M., Westert, G., Devillé, W., & van Ginneken, E. (2010). The Netherlands: Health system review. *Health Systems in Transition*, *12*(1), v-xxvii, 1-228.

Statistics Netherlands. (2014a). *Statline. Bevolking; generatie, geslacht, leeftijd en herkomstgroepering* [Population, generation, gender, age, and background]. The Hague, Netherlands: Author. Retrieved from http://statline.cbs.nl/StatWeb/publication/default.aspx?VW=T&DM=SLNL&PA=37325&D1=0&D2=a&D3=0&D4=0&D5=0-4&D6=l&HD=110629-1412&HDR=G5%2cT%2cG3%2cG2%2cG4&STB=G1

Statistics Netherlands. (2014b). *Zorgtoeslag en huurtoeslag nemen verder toe, kinderopvangtoeslag daalt opnieuw* [Healthcare and rent subsidies increase further, childcare subsidies decrease]. The Hague, Netherlands: Author. Retrieved from http://www.cbs.nl/nl-NL/menu/themas/inkomen-bestedingen/publicaties/artikelen/archief/2014/2014-4138-wm.htm

van Ginneken, E., & Gray, B. H. (2013). Coverage for undocumented migrants becomes more urgent. *Annals of Internal Medicine*, *158*(5 Pt. 1), 347-348.

van Ginneken, E., & Gray, B. H. (2015). European policies on healthcare for undocumented migrants. In E. Kuhlmann, R. H. Blank, I. L. Bourgeault, & C. Wendt (Eds.), *The Palgrave handbook of international healthcare policy and governance* (pp. 631—648). London, England: Palgrave Macmillan.

van Ginneken, E., Swartz, K., & Van der Wees, P. (2013). Health insurance exchanges in Switzerland and the Netherlands offer five key lessons for the operations of US exchanges. *Health Affairs*, *32*, 744-752.

von Wyl, V., & Beck, K. (2015). Failure to pay for social health insurance premiums: Acts of protest or desperation? *Preventive Medicine Reports*, *2*, 127–133.