Reviewer's report

Title: Acceptance of selective contracting: the role of trust in the health insurer

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Reviewer: Frederik Schut

Reviewer's report:

This paper addresses the interesting question whether people’s trust in health insurers affects their willingness to accept restrictions on the provider network contracted by health insurers. This topic is particularly relevant for countries in which consumers can chose among different health insurers that are allowed to selectively contract with health care providers. The analysis is sound and the paper is well organized and clearly written.

Major compulsory revisions:

1. The authors find that trust is positively related to people’s acceptance of selective contracting. As such, this finding is not very surprising. A more interesting question is whether the level of trust is too low to make selective contracting an attractive option for health insurers. The authors suggest that this is the case in the Netherlands, since health insurers apparently do not engage in selective contracting. For instance, under the heading practical implications they argue that “since no trust would be needed if there was no risk, the perceived risk about health insurers implementing selective contracting must be high.” This conclusion is puzzling, however, given that (i) on average trust does not appear to be low (4.7 on a scale of one to seven, see results/descriptives); (ii) even when trust is very high, the acceptance of selective contracting is still relatively low (see discussion); and (iii) most of the variance in acceptance of selective contracting is not explained by variation in trust (see scientific implications). Despite that selective contracting is a widespread phenomenon in the US, I doubt whether US citizens trust their health insurers more than Dutch citizens (my guess would be the opposite). So, the link between trust and the absence of selective contracting in the Netherlands seems to be weak and, as the authors remark themselves (see scientific implications), other factors may be more important. Hence, the role of trust in explaining the prevalence of selective contracting remains unclear and the authors should be more consistent in conveying this.

2. The authors implicitly assume that the role of trust and acceptance of selectively contracting by health insurers is independent of context (e.g. culture, custom, institutions). Since this is unlikely it may limit the generalizability of the results to other countries than the Netherlands. The authors should discuss the potential impact of context and the potential implications for their findings.

3. A potentially important missing variable in the model may be the individual’s level of education since this may have an impact on the level of uncertainty
(perceived risk) about the implications of selective contracting. Omitting this variable may bias the results. For instance, if younger or healthier people are better educated the effect on acceptance of selective contracting may be at least partly explained by a better understanding of the potential implications of selective contracting. I presume that the survey does not include information on people’s level of education, but the authors should at least recognize this potential bias.

Discretionary revisions:
1. It is not entirely clear what the authors mean by selective contracting. In the description of the background they state that “it means that their freedom of choice of care provider is restricted to those care providers selected by their health insurer”. Typically, a distinction is made between “exclusive” and “preferred” provider networks. In case of exclusive provider networks, people do not get any reimbursement when they visit out-of-network providers (except in emergencies). In case of a preferred provider networks, people get partially reimbursed when they visit non-preferred providers. I presume that the authors mean preferred providers networks rather than the more restrictive exclusive provider networks? Notice, however, that people’s acceptance of selective contracting may crucially depend on the level of reimbursement of care by non-contracted providers.

2. The statements in the survey as formulated in the text (see independent variables) slightly differ from those in the Appendix. My suggestion would be to use exactly the same phrasing.

3. Since the authors explicitly formulate hypotheses about expected interaction effects, it would be informative to include the estimation results in the table despite these results being not statistically significant.

4. What is the impact of leaving out the interaction effect of age*specific trust on the coefficient and SE of age?

5. The authors conclude by stating that “this study will help health insurers to implement selective contracting in a way enrollees will accept “. I do not see how this study will be of any help to health insurers, since the authors’ main finding of trust being related to the acceptance of selective contracting only seems to confirm what insurers already expect. Which helpful recommendations do the authors have in mind?

Level of interest: An article whose findings are important to those with closely related research interests

Quality of written English: Acceptable

Statistical review: No, the manuscript does not need to be seen by a statistician.

Declaration of competing interests:
I declare that I have no competing interests