

Incentives in Healthcare: The System's Broke; Let's Fix It,

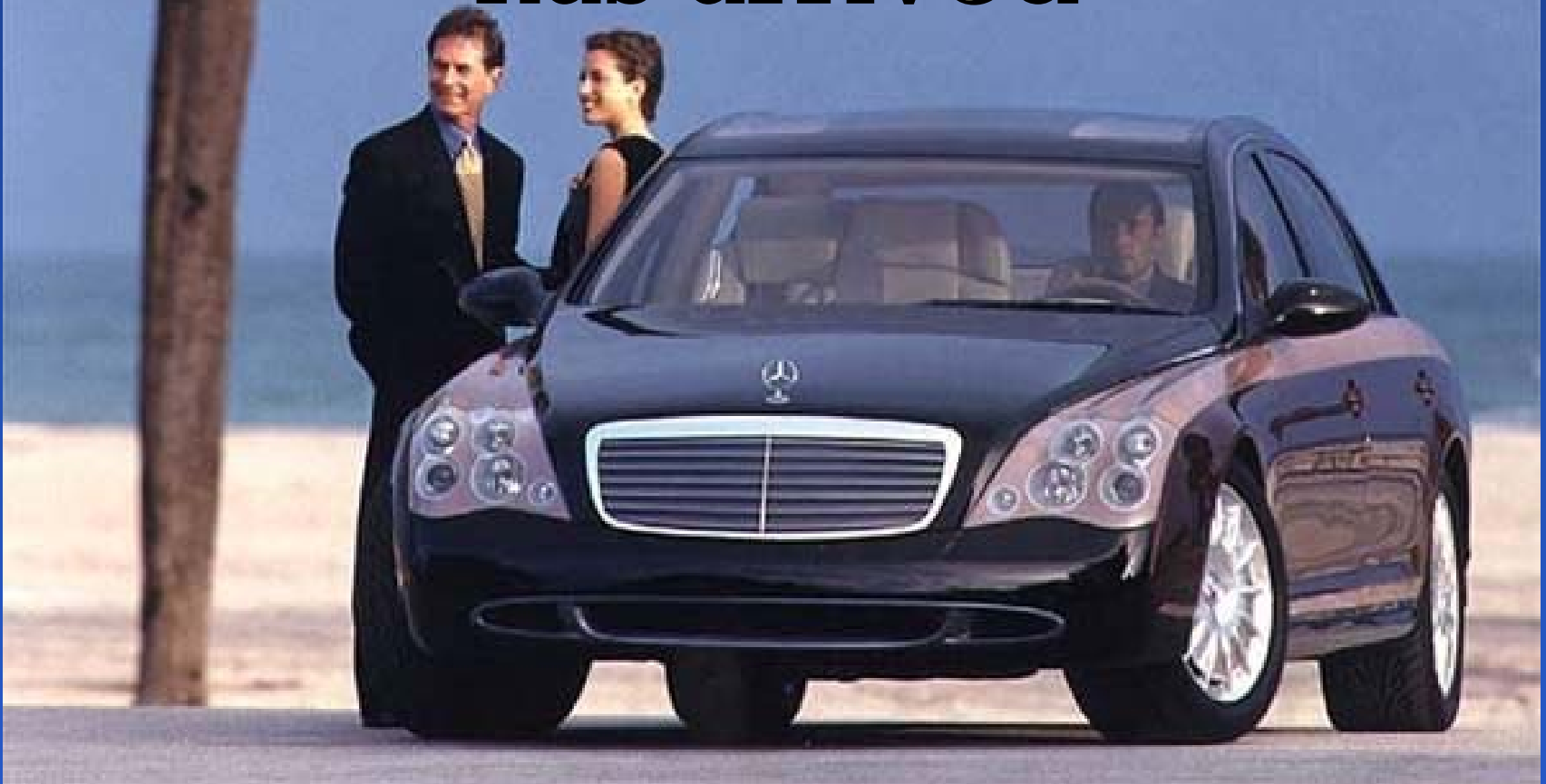
The National Healthcare Incentives Institute

October 21, 2008, Washington, D.C.

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**The Center for Health Care Policy
Research and Analysis
Merrick, NY**

Your new Healthcare System has arrived



October 21, 2008

“Developing tomorrow’s healthcare system today.”

With Great Parking...



October 21, 2008

“Developing tomorrow’s healthcare system today.”

An Office Up to Your Standards...





A Space
To
Relax ...

October 21, 2008

“Developing tomorrow’s healthcare system today.”

A Nice Meeting Room....



October 21, 2008

“Developing tomorrow’s healthcare system today.”

A Place to Exchange Ideas...



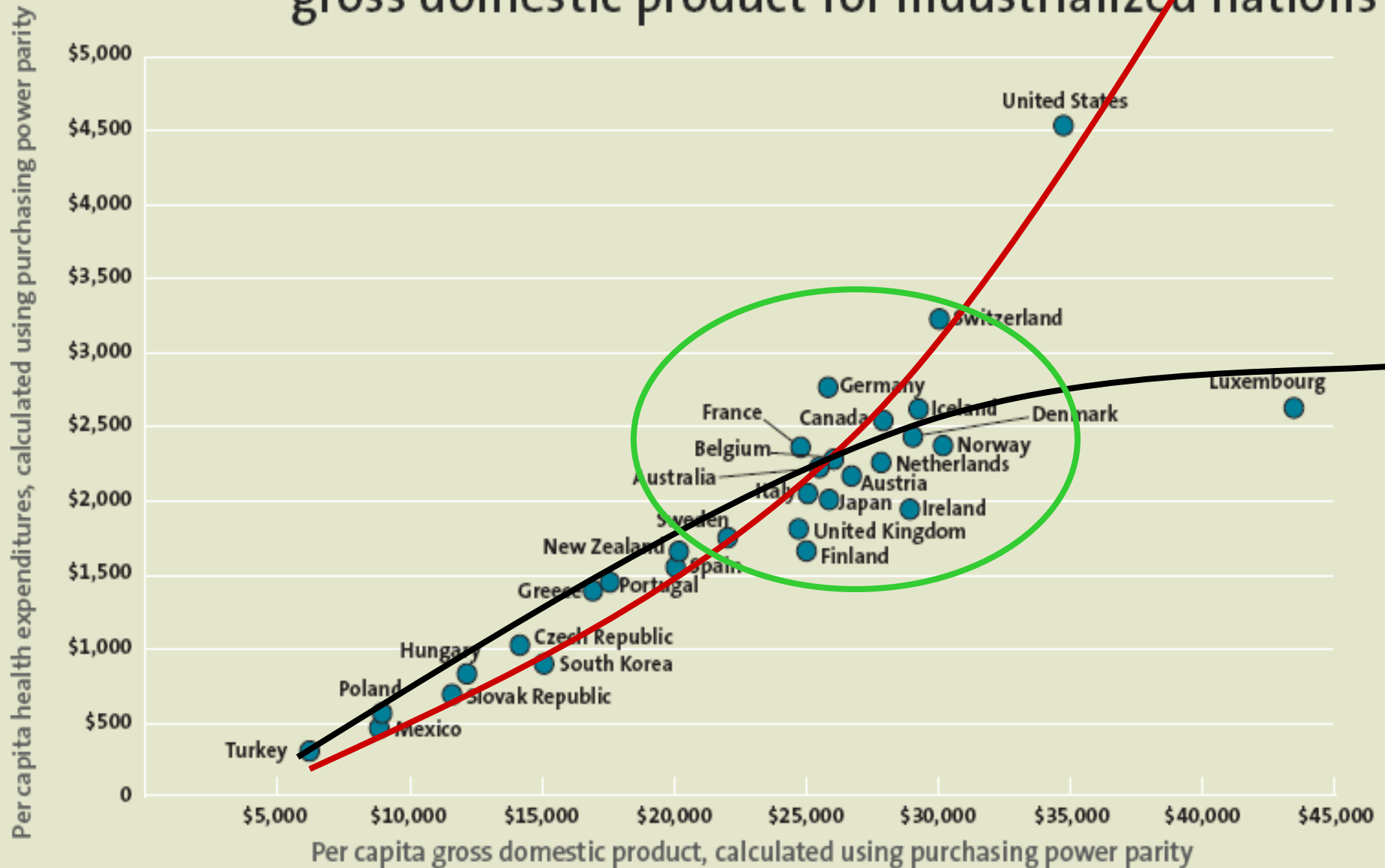
October 21, 2008

“Developing tomorrow’s healthcare system today.”



**STOP DREAMING AND GET
BACK TO WORK!!!**

Per capita health care expenditures and per capita gross domestic product for industrialized nations



Healthcare Systems in Industrialized OECD Nations

Totally Government owned and managed

Government is the Single Payor – Providers function Independently

Multi-Payor Universal Enrollment Healthcare Systems with Complementary roles for both government and private insurers

No Healthcare Policy – The United States

It is a misconception that all European healthcare systems have single-payer systems.

Most have Multi-payor Universal Enrollment Healthcare Systems

Private Health Insurance (PHI) covers at least 30% of the population in a third of OECD member nations.

PHI covers a lesser percentage of people in several more nations.

Single-Payer vs. Multi-Payer

Universal Enrollment systems (100% Access)

Percent of population with Private Health Insurance (PHI)

CANADA	11%	GERMANY	10%
– no private primary PHI (supplementary only)		NETHERLANDS	31%
		AUSTRALIA	46%
UK	3.3%	IRELAND	49%
–(duplicate or supplementary only)		JAPAN	60%
		FRANCE	86%
		SWITZERLAND	99%

- “Soft rationing”
- Waiting times; 6-12 mo
- “High-tech”
- No Waiting times



Netherlands (old system)

- About one third (31%) of the population with the highest income is required to purchase PHI
- The two thirds (64%) of the population with lower income is insured by the government health plan—assuring coverage for the poor
- Civil servants, (5%) covered by a special GHI fund
- Exceptional Medical Expenses Act covers the “uninsurable”
- By regulation, services to patients with GHI are given the same priority as services for patients with PHI, thereby avoiding a tiered system
- By regulation, PHI and GHI reimburse at same levels



Netherlands (old system)

- Government healthcare is paid for with worker and employer contributions based on income level (85%), and national consumption tax
- PHI is considered a source of additional funds for health care services
 - Generating increased capacity of healthcare services
 - Increasing market responsiveness to consumers demands
 - Allowing increased choice among services for all patients
- Until the late 1990s, the Netherlands had no observed waiting times for elective procedures



Netherlands (1990s)

- Aging population
- Economic downturn
- Inadequate public health policy
 - Tobacco use; etc.
- Supply-side controls
- Disconnect between revenue stream and payment for services



Netherlands (new system)

- Reform features of a “self regulating” system
- ## Access
- Participation in private health insurance is mandatory; 100% enrollment (not yet)
 - The distinction between services of private insurers and ‘social health’ funds is to be abolished
 - Health insurers must accept all subscribers and may not differentiate out-of-pocket premiums between the insured
(Guaranteed issue, community rating)



Netherlands (new system)

Solvency

- Every adult pays an out-of-pocket premium for a uniform, broad, basic package, with a compulsory deductible and an income-dependent employer contribution
 - (Solidarity concept mixed with fixed premium concept)
- Lower income groups are compensated by a benefit from a new health fund
- Health insurers negotiate with healthcare providers about the price and services of healthcare.
 - (Transparency)



Switzerland

- **100% basic coverage through mandatory PHI**
 - Uniform policy offered by all providers; insurers must compete on price and service
 - Supplementary insurance also available
- **Mandated community rating**
 - Insurers not allowed to compete on the basis of risk
 - Cost allowances are made for students and children
- **Guaranteed issue**
- **No GHI**
 - PHI applies for government subsidies to cover the poor
 - Re-insurance compensates for high risk patients
- **Bundling of Primary and Supplementary policies discourages switching between insurers**



Switzerland

- Several competing PHI providers
- PHI defines overall healthcare capacity
 - Provides funding mechanism
 - Promotes market responsiveness
 - Allows consumer choice, but policy “bundling” discourages switching between insurers
- No observed waiting times for elective procedures
 - Moral hazard contained with use of co-payments and deductibles
 - Money follows the patient



Ireland

- 1957 established universal Coverage for middle and lower classes, upper classes expected to buy their own health insurance from...
- Voluntary Health Insurance Board, the VHI, a not-for-profit government sponsored entity (a statutory corporation with legal status similar to the Public Broadcasting System in the U.S.) that provides the equivalent of “private” health insurance.



Ireland

- In response to a directive of the Council of European Communities, Ireland passed the Health Insurance Act of 1994 and invited other private health insurance companies into its market.
- Required universal enrollment
- Consequently, the Irish healthcare market is now divided between the public sector (about 51% of the population), the VHI (about 39%), and competitive private health insurance companies (about 10% of the population.)



Ireland

- Individuals are given a tax benefit for enrolling with either the VHI or a private health insurance company.
- Forty-nine percent of the population take advantage of this and leave the public plan favoring a private plan or its near equivalent, the VHI.



Ireland

- Open enrollment (“lifetime cover” and “open enrollment” being the equivalent of “guaranteed issue.”)
- 1996 Insurance Regulations added regulations for standard minimum benefits



Ireland

- 1996 Regulations also provided for a “risk-equalization” plan, essentially a reinsurance plan to distribute risk across the entire population.
- When The British United Provident Association (BUPA) started doing business in Ireland in 1997 the company marketed to younger healthier populations – practicing what is commonly referred to as “cherry picking.”



Ireland

- BUPA later declined to pay the fees that VHI claimed it owed under the risk-equalization plan.
- The Supreme Court decided in late 2006 that BUPA owed the fees.
- BUPA announced it would quit doing business in Ireland and sold its business in Ireland to the Quinn Group in January 2007. (BUPA is an international insurer with revenues in 2004 of over GBP 3.6 Billion.)



Ireland

- Preserved Choice
 - Public plan with default enrollment
 - Statutory not-for-profit “private” plan
 - Private plans; guaranteed issue, community ratings, uniform benefits
- Preserved the risk redistribution plan
- 2002 per capita healthcare costs \$1,900
 - vs. US costs, \$4,500.
 - (57.8% less than US)



Review: Keys to achieving access and solvency

- **Choice between insurers (Competitive markets ‘find’ the cost of production)**
 - Large numbers of competing PHI providers; often including a publicly sponsored plan
 - Absence of barriers to switching carriers
 - No restrictions based on health status
 - No age restrictions (Germany)
 - No bundling of policies (Switzerland)

Keys to achieving access and solvency

- **Mandatory or Default Enrollment**
 - No ‘Free-riders’
 - Diminishes the need for ‘Cost-shifting’
 - Diminishes the effects of ‘Adverse selection’
 - Vulnerable populations receive care

Keys to achieving access and solvency

- **Community ratings**
 - Everyone share the responsibility
 - Everyone shares the benefits
 - Distributes cost across the community
 - Distributes cost across a lifetime
 - Largest possible risk pool

Keys to achieving access and solvency

- **Guaranteed issue**
 - No restrictions based on health status
 - No restrictions based on age (Germany)
 - No restrictions based on geography (Switzerland)

Keys to achieving access and solvency

- **Uniform basic benefits**
 - Clear information regarding product and price
 - Insurers compete based on price and service
 - Assures a basic level of care for all (no under-insurance)

Keys to achieving access and solvency

- **Re-insurance**
 - Assures solvency of insurers
 - Allows some insurers to accept increased risk
 - Redistributes costs across the entire community



Switzerland

- Several competing PHI providers
- PHI defines overall healthcare capacity
 - Pro
 - Pro
 - All “bundling”
dis insurers
- No o ective
proc
 - Mo co-payments
and deductibles
 - Money follows the patient

MICGU

VS.

C-MICGU

Health insurance “Market failure” and C-MCGU

- Increasing prices
- Increasing profits
- Reduced availability

- “Patient protection” policies “normalize” health insurance markets

Policies of Market Reform

Essential Market Condition	Policy Measures Employed	Effects on Insurance Market
Uniform product		
Universal availability		
Knowledge of product and price		
Competing suppliers		
Price sensitivity		

Policies of Market Reform

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Policies of Market Reform

Essential Market Condition	Policy Measures Employed	Effects on Insurance Market
Uniform product	Uniform Benefits Package	Insurers compete on Price and Service
Universal availability	Mandatory enrollment; Guaranteed issue	Availability assured; No Adverse selection
Knowledge of product and price		
Competing suppliers		
Price sensitivity		

Policies of Market Reform

Essential Market Condition	Policy Measures Employed	Effects on Insurance Market
Uniform product	Uniform Benefits Package	Insurers compete on Price and Service
Universal availability	Mandatory enrollment Guaranteed issue	Availability assured; No Adverse selection
Knowledge of product and price	Uniform Benefits Package	Consumers shop based on Price
Competing suppliers		
Price sensitivity		

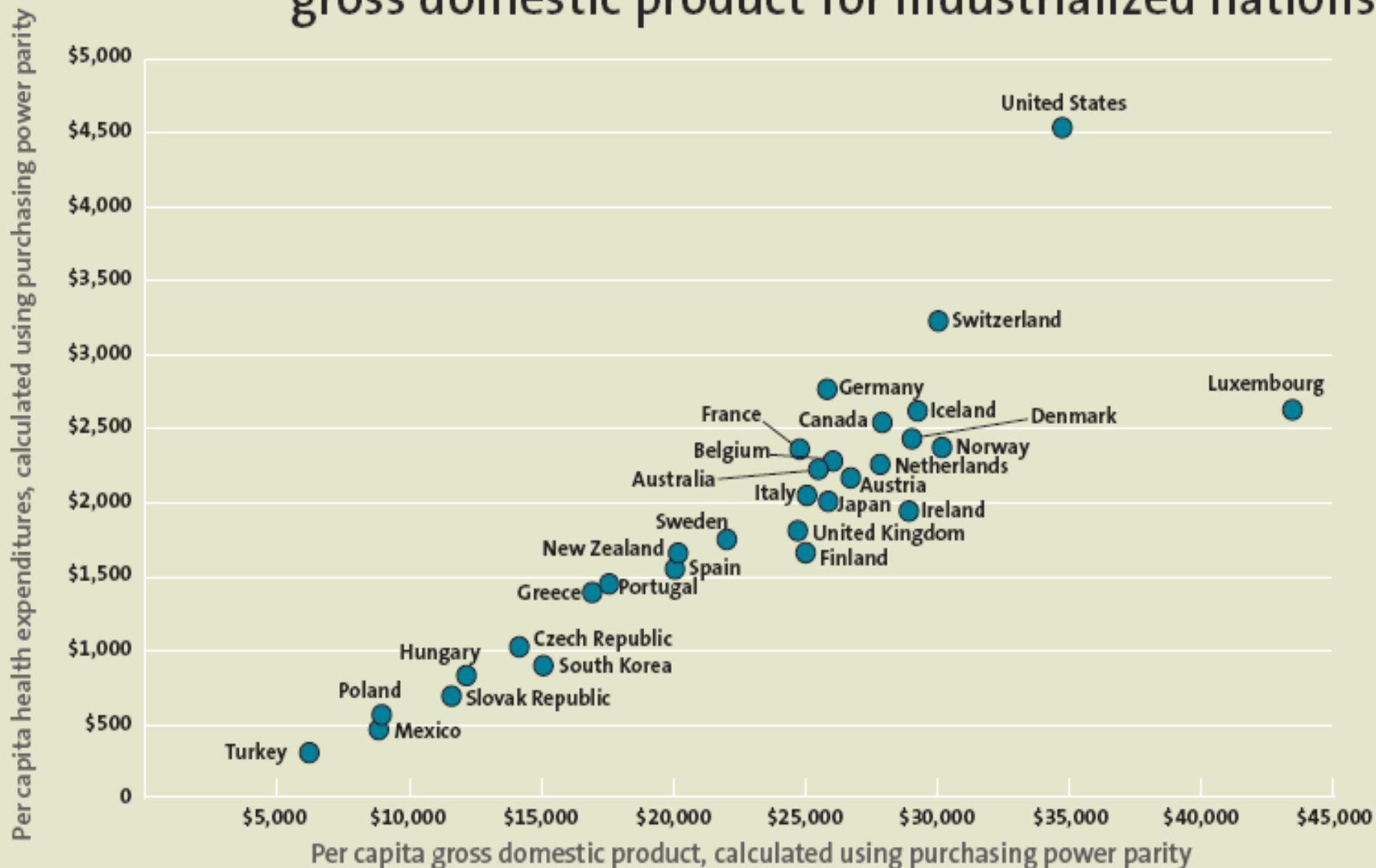
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Price sensitivity		

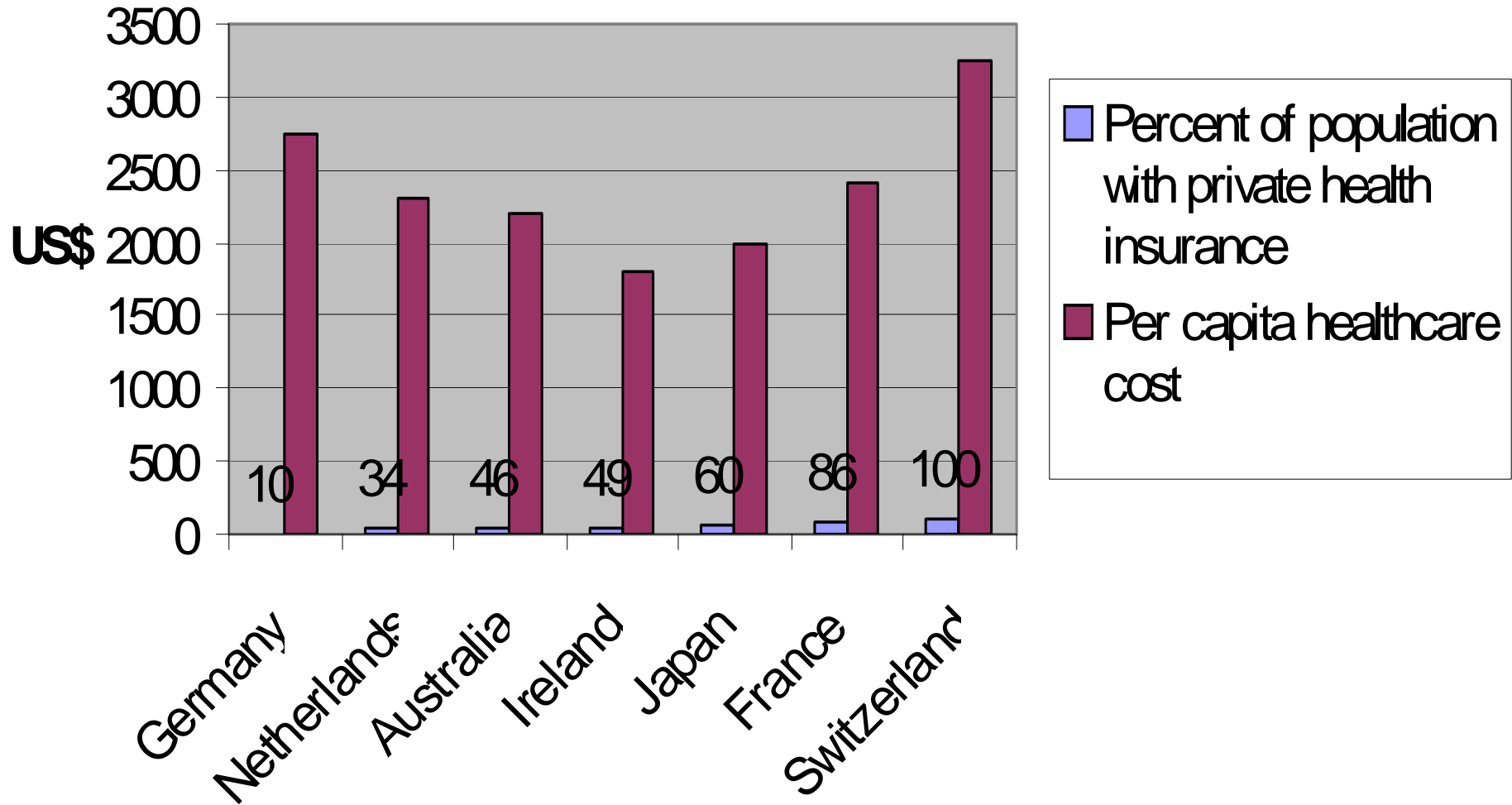
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Competing suppliers	Choice between Public and Private Insurers	Insurers compete on Price and Service
Price sensitivity	Uniform Benefits Package Community ratings	Insurance available to everyone at competitive prices

Per capita health care expenditures and per capita gross domestic product for industrialized nations



National Per Capita Healthcare Costs Relative to Percent of Population with Private Coverage



Conclusion

- The average per capita healthcare cost among industrialized nations is 50% less than the U.S.
- Even the second most expensive healthcare system on the planet has per capita healthcare costs 29% less than the U.S.
- The success of these nations is not always because they have 'socialized' their healthcare systems.

Four types of healthcare systems

- Government owned
- Single-payer
- Multi-payer universal enrollment
- U.S.A. – No healthcare policy

Access and Solvency

Access: Can the population get the care they need—including elective care?

- What is the percentage of the population with coverage/access?
- What are observed waiting times?

Solvency: Can the system meet the costs of growth in the healthcare industry?

- Of Access
- Of Quality

The Shared Policies of Successful Healthcare Systems

- C- Choice between public and private coverage.
- M- Mandatory universal enrollment
- C- Community Ratings
- G- Guaranteed issue
- U- Uniform benefits

	Single Payor	USA	Multi-payor Universal
Universal enrollment	X		X
Uniform benefits	X		X
Portability	X		X
Lower admin costs Lower <u>total</u> costs	X		X
No queues		For insured only	X
Shared access to infrastructure		X	X

Lessons in Cost Reduction from Foreign Healthcare Systems

1. Universal enrollment

- No “free riders”
- No “adverse selection”

2. “Patient protection” policies (C-MCGU) also “normalize” health insurance markets

- lower costs
- decreased waiting times

Thank you.

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