Basic Health Insurance Plan

REVIEW OF IMPLEMENTATION BY SOCIALE INSURANCE BANK 2013-2016

CCNHFI

October 2016

Topics

- Prior to 2013
- Objectives BHIP
- Core Data 2013 => 2016
- Evaluation Objectives & Points of Attention
- Future Developments 2017-2018

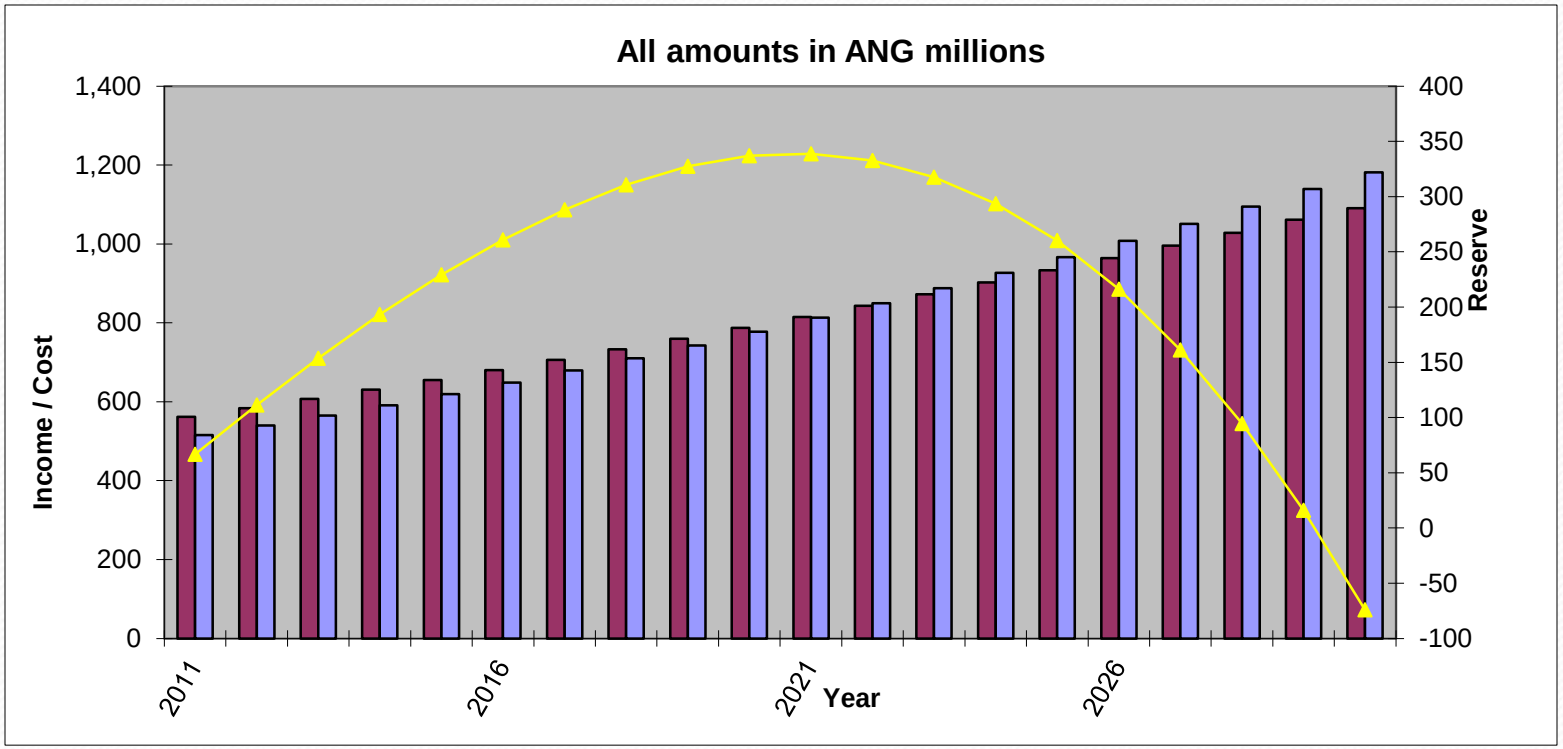
Prior to 2013

'Patchwork'

Total N = 128'000	Pensioners (Semi-Gov.)	Low Income Grp (< USD 7'000)	Civil Servants (< USD 20'000)	Civil Servants (> USD 20'000)	Pensioners (Government)	Private Sector (< USD 30'000)
	1'500	29'000	1'000	14'500	12'000	70'000
Employer	n.a.	0%	8 à 9%	7.75 à 7.95%	0.72%	8.3%
Employee	12.5%	0%	2 à 3%	3.05 à 3.25%	3.75 à 10%	2.1%
Government	deficits	100% expenses	employer	employer	deficits	2.1%
Total premium	**12.5%**	**0%**	**10 à 12%**	**10.8 à 11.2%**	**4.5 à 10.7%**	**12.5%**
Package	**++**	**++**	**+++**	**+++**	**++**	**+**
Hospital Class	3	3	3	1 or 2	2 or 3	3
Own risk / contribution				10% expenses	10% expenses	

Prior to 2013

Unchanged Policy: 'No-Go'



Objectives

Introduction: Feb 2013

- Main Objectives BHIP:

• Raise accessibility	=> Legislation: ‘Landsbesluit Verzekerdenkring’
• Uniform package	=> Legislation: ‘Landsbesluit Verstrekkingen’
• Uniform premium (% of income)	=> Legislation: ‘Landsbesluit Premieheffing’
• Improve financial sustainability	=> Government and Executive Body (SVB)
• Raise level & quality	=> Idem, incl. Health Care Providers

Core Data (2013 => 2016)

- Raise Accessibility

  - Feb 2013: Insured 128’000 of 153’000 population CUR
  - Oct 2016: Insured 151’000 of 159’000 population CUR
  - Insurance Coverage Rate: 84% => 95%
  - Insured (n): + 18%

  - 2014 ‘Repair Legislation’: (New) Immigrants not longer automatically admitted
    Adaptation premiums

  - 2015 ‘Repair Legislation’: Inclusion Civil Servants (& Empl. Government Entities)

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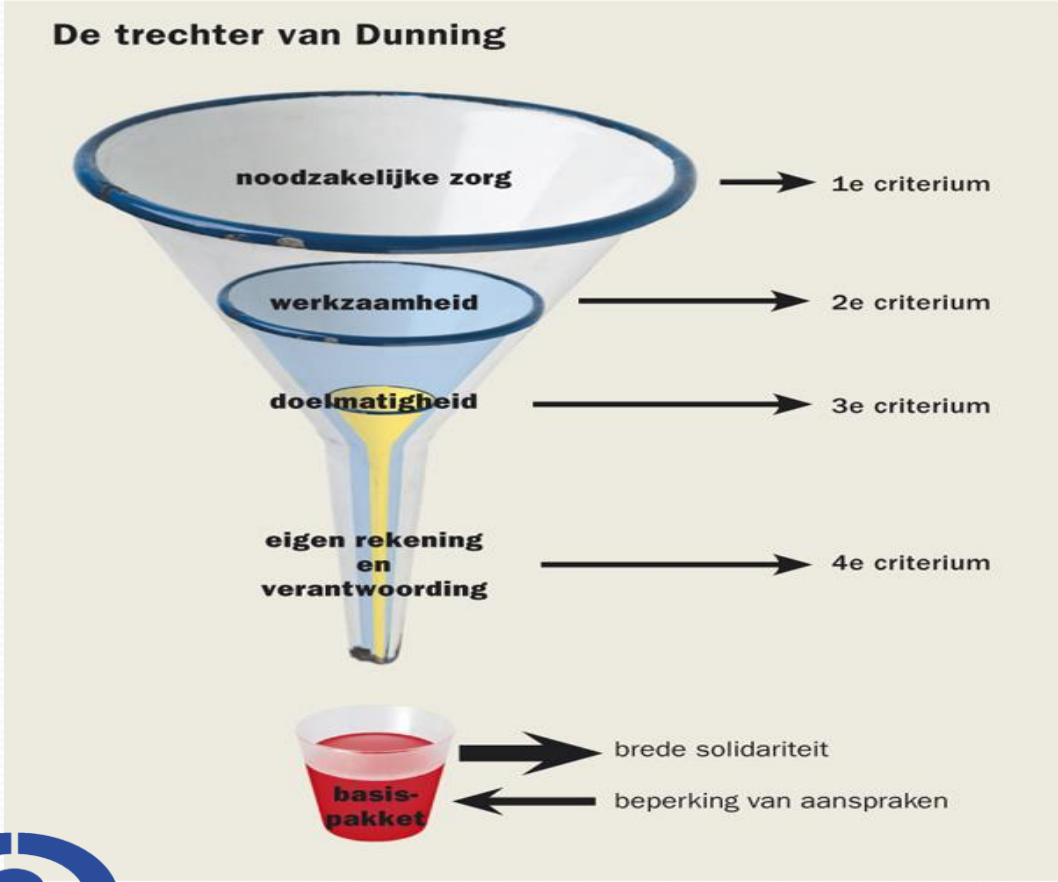
- Uniform Package: ‘Prof. Dunning’s Funnel’ (criteria):



CRITERIA (TOP -> DOWN):

1. NECESSARY CARE?

2. EFFECTIVE CARE?

3. EFFICIENT CARE?

4. PUBLIC RESPONSIBILITY?

Core Data (2013 => 2016)

- Uniform Package:

  - Feb 2013: Prevention, GP, Dentist (<18 yr), Paramedics, Maternity, Mental Health, Hospital (3rd class) & Medical Specialists, Medical Referrals Abroad, Lab, Pharmacies, Glasses (-18 yr), Medical Aids & Devices, Revalidation, Nursing & Home Care and Medical Transport.

  - 2014 'Repair Legislation': Dentist & Glasses for 60+ yr & low inc group (< $ 600 / mth); Expansion non-urgent Medical Transport

  - 2015 'Repair Legislation': Inclusion of Civil servants, BHIP+ limited supplementary coverage separately financed by Government (a.o. hospital class, glasses, dental care)
    'Inevitable / unforeseen' medical expenses abroad

Core Data (2013 => 2016)

- Uniform Premium

  - Feb 2013: Employer: 9.0% of gross income
    Employee: 3.0% of gross income
    nominal fee USD 46 / yr
    Pensioners: 10.0%
    Premium free income: $ 6'700 year (0% premium)
    Premium-income ceiling: $ 56'000

  - 2015 'Repair Legislation':
    Employer: 9.3% of gross income ↑
    Employee: 4.3% of gross income ↑
    no nominal fee ↓
    Pensioners: 6.5% ↓
    Premium-income ceiling: $ 84'000 ↑

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Core Data (2013 => 2016)

- Improve Financial Sustainability

• 2013:	Expenses:	$ 255M
	Premium income:	$ 124M (43%)
	Government contribution:	$ 163M (57%)
	Expenses per capita:	$ 1’798
• 2016:	Expenses:	$ 274M
	Premium income:	$ 149M (50%)
	Government contribution:	$ 149M (50%)
	Net result (after overhead):	+ $ 15M
	Expenses per capita:	$ 1’806 (trend +0.2% per yr)

Core Data (2013 => 2016)

- Improve Financial Sustainability, Expenses per Sector ($ M):

	2016 (p)	2013	δ
Hospitals	85	86	*- 1*
Pharmacies	58	57	*+ 1*
Specialists	38	32	*+ 6*
GP / Dentists	21	18	*+ 3*
Labs	21	18	*+ 3*
Medical Referrals Abroad	20	20	*+ 0*
Paramedics	8	6	*+ 2*
Mental Health	7	5	*+ 2*
Miscellaneous	17	13	*+ 4*
TOTAL	**274**	**255**	***+ 19 (+ 7%, trend 2.4%)***
Per capita ($)	***1'806***	***1'798***	***+ 25 (+ 1%, trend 0.2%)***

Core Data (2013 => 2016)

- Improve Financial Sustainability

  - Low trend growth expenses per cap. 0.2% / yr, through containment measures, a.o.:
    - all establishing medical specialists on payroll Hospital and office in Policlinic
      2013: 5
      2016: 36 (of 100 specialists).
    - budgetting Hospitals
    - pharma: generics only
    - pharma: nominal profit margin pharmacies instead of mark up percentage
    - prevention: screening breast & cervix, dental buses, bariatric surgery, cardio-revalidation, use of gluco(se) meters

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Core Data (2013 => 2016)

- Raise Level & Quality of Care

  - Quality: - quality & production protocols health care providers
    - o accreditated refreshment courses (GPs)
    - o 5 major treatment protocols (paramed.)
    - o standardized minimal/maximum production levels
  - implementation policy docs and vision papers health care providers
  - patients inscription with 1 GP and dentist (of choice)

  - Level: - expansion of investment in local care, substituting medical referrals
    - o catheterization laboratory: referrals cardio 293 (‘13) => 44 (‘15)
    - o expansion dialysis units
    - o expansion quantity of medical specialists

Evaluation Objectives & Points of Attention

- Accessibility:
  - Raised till 95% of population
- Points of Attention:
  - Next step: General National Health Insurance (?)
  - Undocumented Population

Evaluation Objectives & Points of Attention

- Package:
  - Relatively Broad (compared to private insurers)

- Points of Attention:
  - Medical costs abroad (without referral)
  - No complete equality (<18 yr, >60 yr and low income group: glasses & dental care)
  - Some elements seem in conflict with criteria of 'Dunning's Funnel' (e.g. non-urgent medical transport, psychological school observation)
  - Lack of care in certain areas (e.g. forms of paramedic care @ home)

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Evaluation Objectives & Points of Attention

- Premium:

  - Relatively Low for employees (compared to private insurers)
  - No increase in 2016/2017

- Points of Attention:

  - No complete equality (employees 4.3%, pensioners 6.5%, low income groups 0%)
  - Relatively High for employers with high-end incomes employees (max USD 9'700 / yr) compared to private insurers

Evaluation Objectives & Points of Attention

Financial Sustainability:

- Low growth in expenses per capita (0.2% per year)
- Less government contribution (from 57% down to 50% of expenses)
- More premium income

Points of Attention:

- Side-effects of containment measures:
  - three pharmacies stopped services (of 32)
  - budgetted institutions in some financial distress
  - budgetted institutions incline to diminish production
  - budgetted institutions have less incentive to invest, innovate & diversify
  - medical specialist on payroll incline to work less hours than billing specialists
  - waiting lists elective care for some groups of specialists

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Future Developments 2017/2018

- Patients registration with one pharmacy (of choice)
- Review ‘rigid’ budgets institutions
- More quality convenants with more groups of caregivers
- Implement minimal (50% standard) / maximum (150% standard) production levels
- Implement (more) mandatory accreditated training and refreshment courses
- Expand prevention programs (prostate, eye diagnostic buses)
- Implement multidisciplinary care groups in ‘1½ line’ (GP+paramed+med spec)
- ‘Billing Legislation’ for Medical Specialists (centralized, by Hospital)
- ‘Integration Legislation’ Medical Specialists (on payroll, Poli in Hospital)
- Set up Neurosurgery Unit
- Develop ‘Functional Differentation’ between Hospital & Clinic
- New Central Hospital Transition Process (2018): 300 beds

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https://youtu.be/yd7W3Z3f8ps