GENERAL HEALTH INSURANCE IN SINT MAARTEN - FOSTERING ACCEPTANCE

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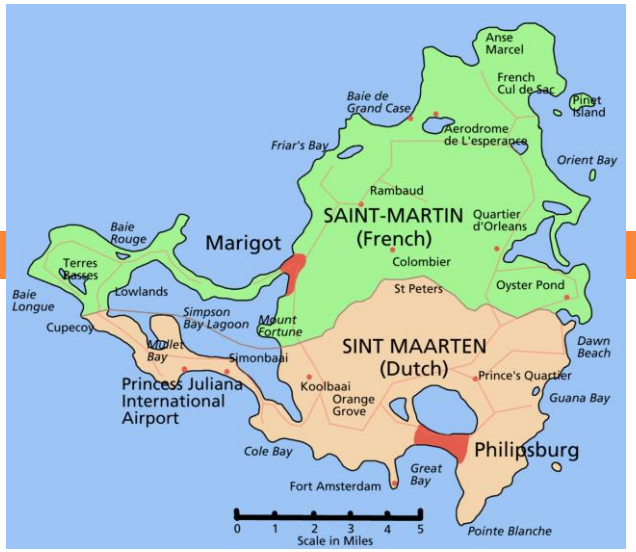
Sint Maarten



- Constituent country within the Kingdom of the Netherlands
- Approx 14 sq. mi
- Island shared with the collectivité of Saint Martin (French, 23 sq. mi)
- Approx. 50,000 residents
- Single pillar economy – tourism
- 2016 GDP US$ 1.06 billion

Patchwork health care system

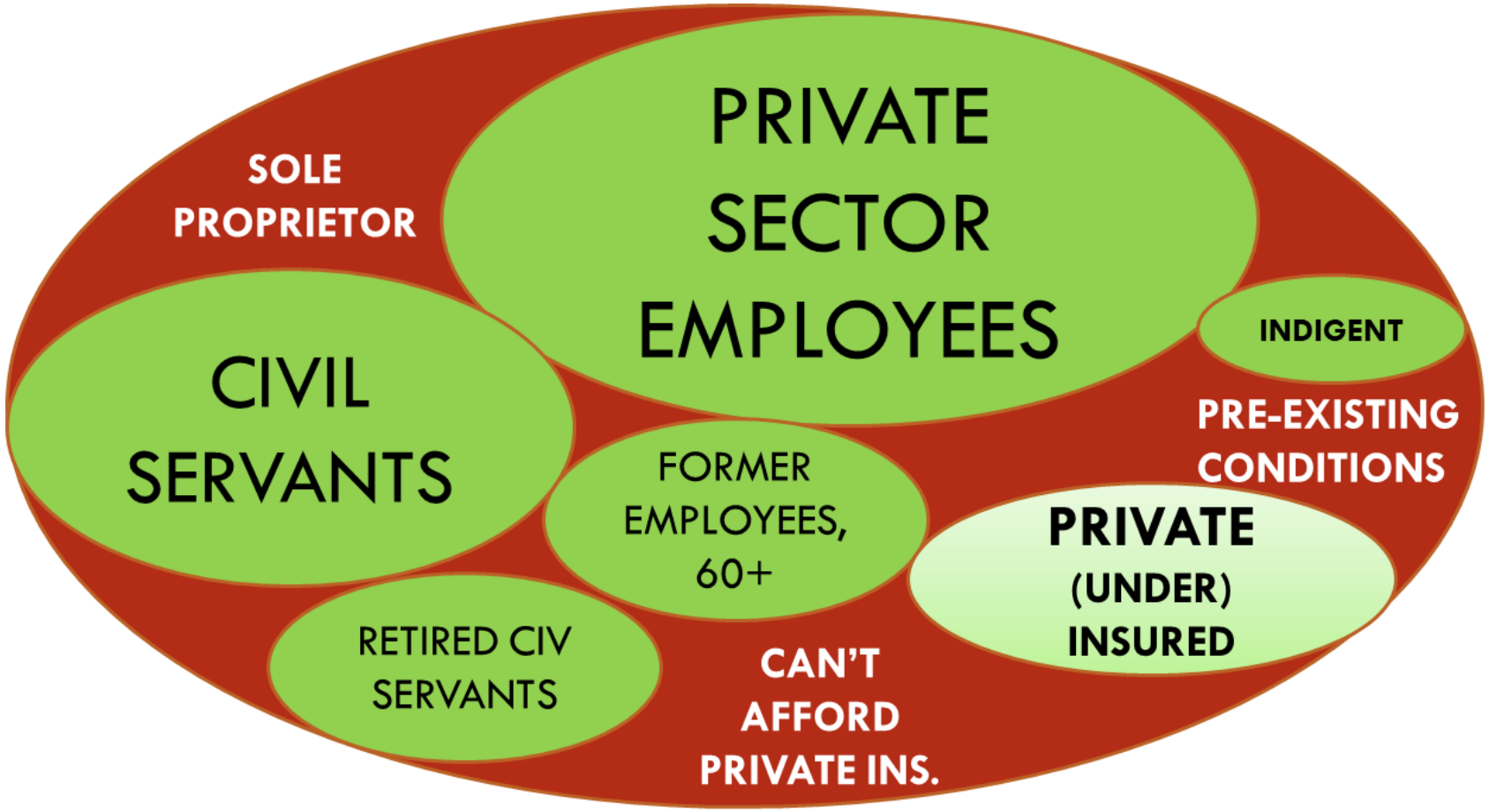
- Public funds inherited from Netherlands Antilles

1. Employee insurance scheme, extended for elderly and former employees (ZV)
2. A civil servant package (OZR)
3. A retired civil servant package (FZOG)
4. Indigent scheme (PP card)
5. Chronic and elderly care package (AVBZ)

- Private insurance
  - For those who are not eligible for public schemes
  - If they can afford the premium

Current system: gaps in coverage/access

- The present patchwork of insurances creates barriers in access, government as backstop



Current system: not financially sustainable

- Because the various funds are not sustainable, the financial burden falls on government
  - ZV covers many groups besides actual employees, without the necessary funding. 60+ & formerly employed
- Civil servants contribute 1.25% of their salary, not covering costs, 10% co-payment
- PP-card available for low income families, catch-all for everyone who has no other access
- High overhead because of different packages, premiums, criteria
- Government carries ultimate financial responsibility for all of the above

Current system: private insurance leakage

- Private insurance – not a viable alternative
  - Cherry picking
  - Premiums increase with age and poor health
  - Many companies exclude persons above certain age
  - Profits, marketing costs are health care system leakages
  - Once excluded by a private insurer, the government becomes the fall back

National Health Reform

- National Health Reform is a comprehensive plan to improve health care access, quality and cost
  - Pharmaceutical cost control (GVS)
  - Efficiency and quality control through Health Care Information systems (HIS)
  - Registry for medical professionals (BIG)
  - Focus on prevention
  - Health in all policies; government-wide
    - Seat belts & helmets
    - Septic systems
    - Dump, solid waste management
    - Education

Keystone: new hospital

- Essential to National Health Reform is the new hospital
  - Increase patient capacity, medical specialties & specialists
  - Decrease overseas referrals by 50%
  - JCI accreditation & LEED certified
  - Funding secured in 2018 & operational in 2022

General Health Insurance (GHI)

- Draft law on its way to Parliament
  - Universal coverage for:
    - all legal residents
    - all who work and pay premiums
  - One basic standard package
  - Premium:
    - 5.7% employee, 9% employer (tentative)
    - Levied on annual income up to $55,000,
  - Free co-insurance of dependents

How we developed GHI

- Studied Universal Health Care package of Kingdom partners; Netherlands, Aruba, Curaçao
- International experts' advice
- Tailored Universal Health Care package to small island community
- Some options that fit larger countries ruled out, such as a multi-payer system

Before and after

	BEFORE GHI	GHI
Coverage	Multiple diff. packages	One standard package
Premium cap	NAF 60,000	NAF 100,000
Self-employed	Not covered	Premium over non-wage income
Civil servant	Insufficient contribution	Same premium as everyone else
Premium percentage	ZV Empl'r 8.3 % Ee 4.2 % AVBZ 2% TOTAL 14.5%	Employer 9% Employee 5.7% TOTAL 14.7%
Deductible	None	Yes, different methods
Lifestyle incentives premium reduction	None	Yes, income-related
Spousal contribution	None	Yes, based on income
Total health care % GDP	6.7%	6.7%

Challenge: perception is; GHI is unaffordable

- Including more people in GHI is perceived as a risk
  - The present system of collective health care insures roughly 70% of our population.
  - GHI would extend this to 95% or more
  - Critics think, that these additional people will bring about high or unpredictable medical costs

Response: real risk is limited

- Bringing the privately insured & uninsured into GHI is not as risky as it seems
  - Most patients requiring high levels of care already covered by the present system
    - Elderly represent approx 20% of group
    - Elderly generate 90% of total cost
  - Private insurances are for profit – exclude most patients requiring high medical costs
  - This group would on average contribute positively to GHI finances
- Current system is definitely unaffordable

Challenge: no personal freedom

- GHI is *perceived* to eliminate choice
  - Single payer system seems to give the insured no choice
  - There is one standard medical package
  - Can't go to doctor of choice
  - Can't choose to accept more risk and pay less premium
  - Local treatment mandatory once available
  - When sent for overseas treatment, can't choose which country

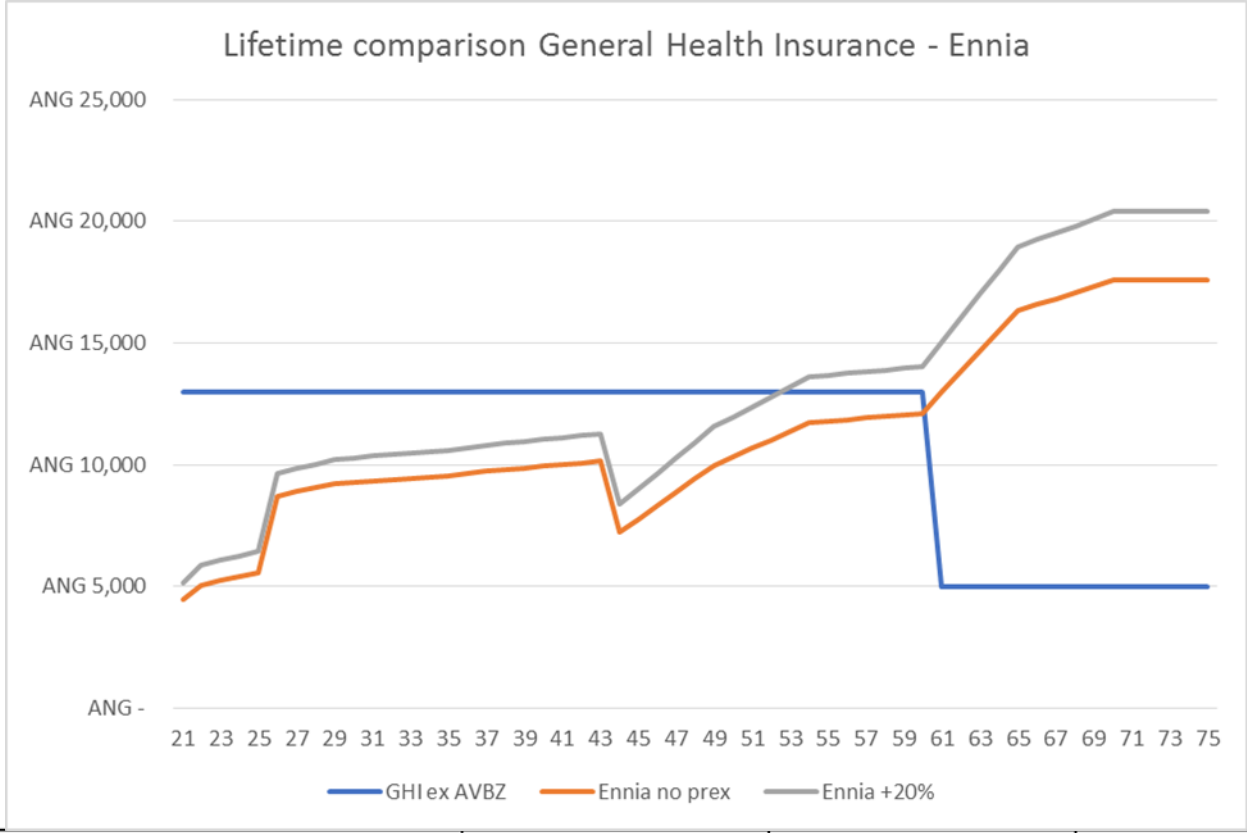
Response: GHI offers choices

- In reality, GHI will offer concrete alternative choices
  - Supplementary insurance (from private insurers):
    - extend the package of treatments covered
    - or pay for additional local or overseas choices
  - Choice for deductible in return for lower premium can be built into GHI
  - Opting out of GHI will be possible – if equivalent private insurance and with payment of a "solidarity fee"

Challenge: private insurance cheaper?

- Private insurance perceived as cheaper
  - Premium based on risk
  - Younger, healthier people pay less than under GHI
  - However, older people pay more, or are excluded
  - GHI charges premium based on lifetime cost, dependent on income

Response: GHI lifetime cost lower



	National Ordinance GHI	Ennia zero pre-existing cond.	Ennia 20% surcharge
Lifetime total 21 through 75, 1.5 children during 18 yrs	NA*f* 595,000	NA*f* 621,718	NA*f* 712,657

Challenge: distrust in executing agency

- The sole executing agency (SZV) suffers from a negative public image:
  - Multitude of schemes leads to heavy bureaucracy
  - Many rules are inherited in 2010 from the Netherlands Antilles
  - Slow service and lack of customer friendliness

Response: quality control

- SZV improves automation & professionalism
  - Replacing the 5 main insurances by one single GHI
  - Simpler system means less fraud issues
  - Accountability: 5 year evaluation with consequences
  - Option to outsource front office services to insurance brokers
  - Entirely reinventing SZV not realistic

Way forward: alleviating doubts

- Flexibility – levers & dials to respond to dynamic changes
- Reduced financial risks – everyone pays their fair share
- Less pressure on government budget

Way forward: creative solutions

- A single payer system can still use market-based incentives

  - Deductibles or co-pay in return for lower premium;
  - Introduce a deferred deductible;
  - Reward positive lifestyle choices;
  - Outsource front office services to private companies;
  - “Sin tax” to help fund GHI
  - Supplemental insurance
  - Opt-out possibility
  - New entries to system: one year waiting period

THANK YOU!

Questions?