Comparing the U.S. Health Insurance System to Those Of Other Countries

California State Assembly, Select Committee on Health Care Delivery Systems and Universal Coverage: Informational Hearing on Healthcare Delivery Systems in California and Other Countries

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EXHIBIT 1

Introduction

- The term “single-payer” is often used to describe how countries other than the U.S. achieve universal health insurance coverage.
- But when we look abroad, there is much more variation across countries than the term implies.
- Some countries’ governments pay for health care directly while others use insurance as an intermediary between financing and health care.
- Some countries have approaches with strong parallels to California’s marketplace, Covered California.

EXHIBIT 2

Countries with universal coverage can be grouped into two broad categories

Publicly Financed Health Care:

- Canada
- Denmark
- England
- Italy
- New Zealand
- Norway
- Sweden

Publicly Financed Health Insurance:

- Australia
- China
- France
- Germany
- India
- Israel
- Japan
- Netherlands
- Singapore
- Switzerland
- Taiwan

Source: International Profiles of Health Care Systems, The Commonwealth Fund, http://international.commonwealthfund.org/?_ga=2.265972751.1601011202.1508177510-false

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EXHIBIT 3

Publicly financed health care: Two examples

	England	Canada
Participation	All citizens entitled to health care	All citizens entitled to health care
Authority	National Health Service	Provinces and Territories with Federal Standards
Financing	General taxation and payroll tax	Provincial and Federal (25%) revenues
Benefits Covered	Comprehensive but not defined	Federal floor: physician, diagnostic, hospital; provincial variation on other
Cost-sharing	Rx, dental, vision with limits by income, age, health	Federal floor: free physician, diagnostic, hospital; provincial variation on other
Private Insurance	10% of population has private insurance	Supplemental: 2/3 of population covered by for-profit insurers, employers pay 94% of premiums
Undocumented Immigrants	ER and infectious disease	Limited services

Source: International Profiles of Health Care Systems, The Commonwealth Fund, http://international.commonwealthfund.org/?_ga=2.265972751.1601011202.1508177510-false

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EXHIBIT 4

Publicly financed health insurance: Two examples

	Netherlands	Germany
Participation	Individual mandate to buy insurance from private non-profit insurers	Automatic coverage through regional insurance ("sickness") funds
Financing	National income related contribution + community rated premium set by insurer	Employer and employee tax + contribution set by sickness fund
Insurer payment	National contributions centrally collected and distributed to insurers by risk	Contributions centrally collected and distributed to funds by risk
Benefits Covered	National government sets standard	National government sets standard
Premiums & Cost-sharing	Average Premium= $125/mo.; lower income (<$33k) get subsidy Deductible of $465 + copayments	Minimal, with annual cap = 2% of income
Private Insurance	Supplemental: 84% population	Substitute: covers 9 million
Undocumented Immigrants	Cannot buy insurance; acute care, maternity, long term care	Acute care, maternity

Source: International Profiles of Health Care Systems, The Commonwealth Fund, http://international.commonwealthfund.org/?_ga=2.265972751.1601011202.1508177510-false

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EXHIBIT 5

Provider Payment in Netherlands and Germany

	Netherlands	Germany
Primary Care	GPs work in group, small, solo practices. Payment: capitation, disease management fees, pay for performance.	GPs and specialists are members of regional associations. Associations negotiate contracts with sickness funds, paid annual capitation Doctors bill associations on fee-for-service basis; uniform fee schedule.
Specialists	Hospital based. Payment: Salaried (54%), fee-for-service rates negotiated with hospitals	See above
Hospitals	Private non-profit. Payment: 4,400 case-based diagnostic and treatment combinations Rates: 70% negotiated with insurer; 30% are nationally set	Public and private non-profit. All doctors are salaried. Payment: Per admission by 1,200 DRGs.

Source: International Profiles of Health Care Systems, The Commonwealth Fund, http://international.commonwealthfund.org/?_ga=2.265972751.1601011202.1508177510-false

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EXHIBIT 6

Covered California and Netherlands

	Covered California	Netherlands
Individual Mandate	Individual mandate, but not 100% participation	Individual mandate, 100% participation
Risk Pool	Risk pool is only those who lack employer or public coverage	Risk pool is all residents
Participating Insurers	Competing private insurers	Competing non-profit insurers
Benefits & Cost-sharing	Essential benefits and AV tiers set by federal government; CC has innovated on benefit design to improve access	Benefit standard and cost-sharing set by government
Insurer Payments	Federal and individual contributions go directly to insurers	Wage tax (7%) centrally collected; premiums go to insurers
Adjusting for Risk	Lower risk insurers compensate higher risk insurers under risk adjustment	Wage tax revenues distributed to insurers according to risk

Source: M. Kroneman, et. al., Health Systems in Transition, Netherlands Health System Review. Vol. 18, No. 2 2016.

EXHIBIT 7

What Do People Pay? (2016)

	Covered California	Netherlands
Premiums	Age-rated Average silver plan, 40 year old: $309/mo. Subsidized, all ages: $50 - $380	Community-rated Average, all ages :$126/mo Subsidized, all ages :$25 – $122
Cost-Sharing	National average deductible, silver plan: $246 - $3,065 (varies by income) Copayments and coinsurance	Required deductible: $465 (does not vary by income) Copayments and coinsurance
Services Excluded from Deductible	All physician visits and outpatient visits, some Rx	Primary care visits

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Sources:

J. Gabel, H. Whitmore, A. Call, et. al., Modest Changes in 2016 Health Insurance Marketplace Premiums and Insurer Participation, The Commonwealth Fund, January 2016.

M. Kroneman, et. Al,, Health Systems in Transition, Netherlands Health System Review. Vol. 18, No. 2 2016.

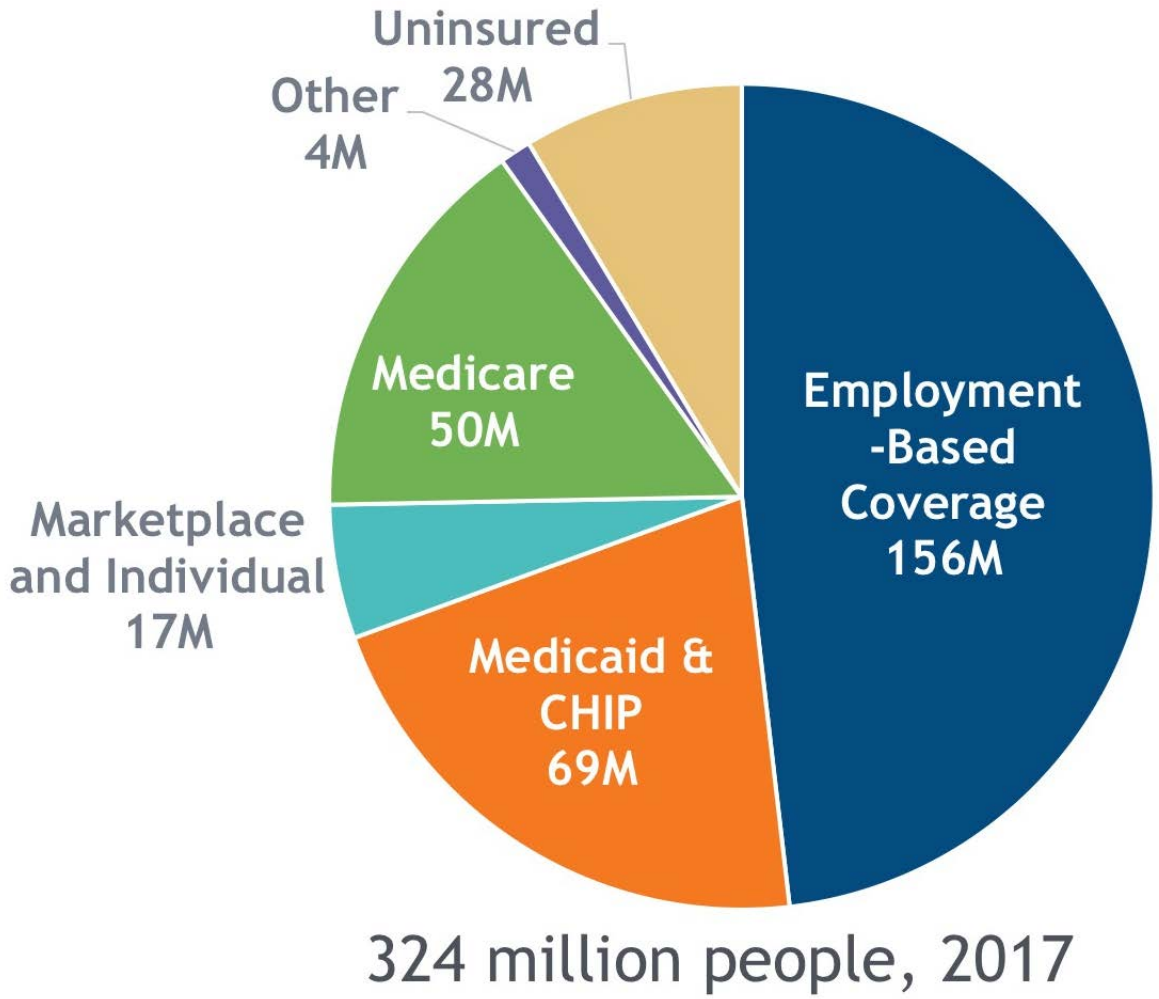
EXHIBIT 8

Key Difference: How Risk is Shared

	Covered California	Netherlands
Risk pool	Limited to individual market	Full population
Financing	Enrollee premiums and federal tax credits	7% nationwide wage tax + enrollee premiums
Risk adjustment	Limited to individual market	Wage tax revenues allow risk to be shared across the full population

EXHIBIT 9

Risk pools are highly fragmented in the U.S.



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Sources:

Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2017 to 2027. Congressional Budget Office, September 2017.

Current Population Survey data.

EXHIBIT 10

Benefits and cost-sharing vary by coverage source

	Benefits	Cost-Sharing
Medicaid	Comprehensive	Minimal with monthly or quarterly cap 5 % of income
Medicare	Comprehensive, no long-term care	High; supplemental public and private insurance
Employer-Sponsored Insurance	Comprehensive on average, but no national standard	Variable, but has increased significantly over time
Individual/ Marketplace & Small Group	Comprehensive, federal floor set by ACA	High; lower for lower income ACA marketplace enrollees

EXHIBIT 11

Federal and state revenues are a major source of financing across all coverage types

	Source of Financing
Medicaid	Federal and state general revenues
Medicare	Federal payroll taxes and enrollee premiums
Employer-Sponsored Insurance	Federal employer and employee tax exclusion; employer and employee premium contributions
Individual and Marketplace	Various federal taxes and general revenues, enrollee premiums, employer and individual mandate penalties, insurer fees

EXHIBIT 12

Looking Forward

- California's implementation of the ACA has led to historic gains in coverage and improvements in access.
- Despite uncertainty at the federal level, California will likely continue to make coverage and access gains given the commitment of state policy officials to successful ACA implementation.
- Shifting to a new system raises several critical questions:
  - What coverage sources would be combined? Are there regulatory limits?
  - What is the method of financing? What revenue streams would be redirected and how?
  - If insurance, what are premiums, benefits and cost-sharing? How would risk adjustment be achieved?
  - Would providers be reimbursed differently?