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Canada's emerging health care system

by Shannon Patershuk

Health care in Canada is emerging as a different system from that of the early 1980s. The principles embodied in the Canada Health Act of 1984 — universality, comprehensiveness, portability, accessibility, publicly funded administration — remain intact. However, refinement of these principles such as reasonable access has occurred as budgets come under tighter control.

The system has evolved from the first provincially funded hospital system in Saskatchewan before 1950 to an interlocking set of ten provincial and two territorial health insurance schemes today. These schemes cover hospital, diagnostic, and medical services, plus provincial coverage supplemental to the Canada Health Act, such as subsidized or free drug coverage for seniors. Provinces are required to provide services defined under the Canada Health Act, and they determine the allocation of resources and services.

Actuarial input

Until recently, the change in health care has evolved at a steady pace. Recent emphasis on reducing federal and provincial deficits, however, has sparked more rapid change.

What contributions can the actuarial profession make to the changing cost and design of the public health care system? The Canadian Institute of Actuaries (CIA) has set up a task force to address relevant financing issues. Its scope includes examining current costs, projecting future trends in costs, developing options to deal with

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In the midst of transition

Reform and re-reform

by Janet M. Carstens

I recently moderated a seminar on health care reform at the Society of Actuaries meeting in San Diego. To prepare for that seminar and to complete my assignment for two task forces of the American Academy of Actuaries, I reviewed the literature on U.S. health care reform that had crossed my desk in the past few months. After two 16-hour days, I was tired, overwhelmed, and confused. I found myself wondering whether specific state proposals replaced proposals issued for the previous month or if they were additions to that state's previous month's legislation.

State reform accelerates

Despite what happens on a national level, U.S. health care reform is moving at a very rapid pace. In many instances, state reform legislation is being re-reformed. What is contributing to this flurry of state activity?

The high cost of health insurance coverage and the many uninsured individuals provided the impetus for a serious political debate on health carereform. In the past few years, the

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Reform cont'd

National Association of Insurance Commissioners (NAIC) adopted model rating and access legislation for health insurance coverage to control rating practices and address the uninsured problem. The model regulation affects the coverage of individuals and small employer groups and limits allowable rating variables, rate variations, and underwriting practices used by health insurers. The model also incorporates a reinsurance mechanism to help level the playing field for insurers who may experience a disproportionate amount of high-risk insureds due to the legislation.

State legislation varies

As states began to adopt legislation, individuals and special interest groups provided an overwhelming amount of information on their version of the causes of the health care crisis and the correct approach to reform.

States assimilated some of this information along with the model legislation. As a result, we have at least 24 states with health care reform legislation and almost as many variations. Some states chose to adopt the NAIC model with slight modifications to allowable rating limits, applicable employer group size, allowable case characteristics, or reinsurance provisions. Some states are requiring carriers to guarantee issue a minimum benefit package to all applicants.

Other states have incorporated unique provisions for coverage and funding. For example:

- New York requires community rating for all individual and small group products and, beginning in 1994, requires products to satisfy an anticipated loss ratio of 75%.
- California allows liberal initial rate variations but grades the limitation to a more restricted level by July 1996. The state also has established voluntary purchasing pools for employer groups.
- Florida recently enacted a version of managed competition that establishes Community Health Purchasing Alliances in specific geographic territories to purchase managed health care coverage for employers and individuals. The plan also establishes accountable health partnerships that are required to enroll and provide health care services to all individuals, regardless of health status.
- Minnesota established integrated service networks to provide employers with the advantage of a large pool for insurance purchasing. The reform package will be financed with a tax on the gross revenues of health care professionals, hospitals, and managed care organizations.
- Oregon enacted legislation that prioritized coverage of health care services for those eligible for Medicaid.

Too early to assess results

As states continue to devise methods to reform their health care systems, the inevitable question is, "Which method works best?" One advantage of having 50 states with 50 varying forms of reform legislation is that it allows concurrent evaluation of alternate approaches. However, state legislation often addresses state-specific circumstances and the strength of special interest groups within the state. What may work best in one state may not work as well in others.

Very few states have had health care reform legislation in place for a significant length of time. For those that have, results are not yet credible. Many states barely had one type of health care reform implemented before another proposal was on the table. It may be a long time before any reliable results can be tabulated.

Back to the basic objectives of reform

In the midst of this flurry of activity, it is worth revisiting the initial premises for reform: affordability and accessibility. Are states really implementing reform legislation that will affect health care costs and decrease the number of uninsured?

For example:

- Health purchasing cooperatives and integrated service networks have been promoted as a way for small employer groups to purchase health insurance coverage with the purchasing power of large employer groups. Since much current activity seems to be directed toward allowing or requiring these entities to continue to pay traditional brokerage commissions, will they accomplish this objective?
- Much of the current reform legislation encourages establishing new types of relationships with providers and emphasizes the importance of delivering quality care. Do we continue to train specialists when we need primary care physicians, or do we encourage the use of nurse practitioners to deliver primary care services? Should the insurance industry have a voice in addressing these societal issues?
- Most small employers who do not provide health insurance coverage to their employees cite the high cost of insurance as the reason. Proposals that restrict a carrier's ability to vary rates among small groups imply that premium rates for lower cost employer groups will have to increase to cover the cost of insurance coverage for the higher cost groups. Without an employer mandate or some type of tax subsidy, will more small employers/employees find the cost of insurance coverage unaffordable? Are we providing access at the expense of affordability?
- One of the proposals to control health care costs is to reduce administrative expenses. However, variation in state reform legislation increases the administrative expenses for carriers operating in many states. The use of reinsurance mechanisms in some states also may increase administrative expense, because carriers are encouraged to underwrite individuals to determine which risks to cede to the reinsurance pool. Reinsurance mechanisms also can result in double adjudication of claims, increasing administrative expense. Even if these increases are minor, are they consistent with the intent of reform?
- Minimum benefit plans are being promoted as a way to provide access to coverage at an affordable price. To make costs affordable, benefits must be carved out to where some may find the coverage unattractive. Some claim that if the minimum benefit plan has too many benefits carved out, it may adversely impact health. Since low option benefit plans have routinely been available, does the imposition of state-mandated standardized minimum benefit plans really address affordability issues?

Our challenge in the midst of reform is to address these and other key issues to ensure that we are developing viable financing vehicles for cost-effective health care delivery.

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