

Health Products and Coverage in Israel - Policy and Implications

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Abstract

The health system in Israel is a highly advanced and developed, as well as complex. It includes a broad national compulsory health coverage, complemented by a voluntary collective supplemental group health coverage, and supplemented by private insurance health policies and extensive private medical services. Its development was affected by many factors, including the birth and growth of the State of Israel during the last half century; the social beliefs of Israel's founders; the constant conflict between centralized socialistic thinking and decentralized private market capitalism; the nature of Israel as a major immigration absorbing country; and the technical and scientific advances of Israel. This work presents the current history and design of the Israel health system and its governmental, public and private providers and insurance sectors, and outline the lessons to be learned from the Israeli experience.

Introduction and summary

The health system in Israel is a highly advanced and developed, as well as being a most complex one. In essence, it includes a broad national compulsory health coverage, complemented by a voluntary collective complementary group health coverage, and supplemented by private insurance health policies and extensive private medical services. The public elements of the system suffer chronic financing shortage, despite a hefty salary-based health tax and relatively high-percentage of the GNP that is devoted to health expenditure. Its development was affected by many factors, including the birth and growth of the State of Israel during the last half century; the social beliefs of Israel's founders; the constant conflict between centralized socialistic thinking and decentralized private market capitalism; the nature of Israel as a major immigration absorbing country; and the technical and scientific advances of Israel. Our intention in this work is to present the history and design of the Israel health system and its governmental, public and private providers and insurance sectors, and outline the lessons to be learned from the Israeli experience.

The Israeli health system, as well as the insurance sector, have only been developed in the last 70 years. During these years a highly developed socialized, collective health providing program that preceded the birth of Israel has been developed. Even after Israel emerged, and for more than 45 years, medical service in Israel was dominated by what is known in Israel as "sick funds" - health providing non-for-profit organizations, belonging to their members, and similar in services to a U.S. Health Maintenance Organization (HMO). Medical insurance coverage by commercial insurers existed but was relatively meager in its scope and coverage. In 1995 Israel implemented a national health law, resulting in a three tier health providing system: (1) national basic health system, covering every resident, whose services are provided by the current four sick funds; (2) complementary health coverage, based on a collective coverage, and provided on a voluntary basis by the sick funds as an extension of the basic coverage; and (3) commercial insurance, based on individual coverage and extensively using private medical providers, offered by the Israeli insurance market. Today, few years after its establishment, the national health system faces a major financial crisis, and the country is struggling with the provision of sufficient medical services at affordable price.

These transformations, from a voluntary wide-spread socialized collective health provision to a national health coverage that exists in parallel with a developed and fast-growing commercial health insurance, are the subject of this article.

Historical & economical perspective - prior to the 1995 National Health Law

Up to the mid-thirties the health system of the country included mostly private physicians, supporting medical disciplines, and few hospitals. At this time, following a pre-second world war immigration from Europe that included a substantial number of medical professionals, several health providing organizations started to emerge. The most important of these - the (Kupat Holim) Klalit - belonged to the labor unions, the major political force in the country in the pre-Israel era. The term "kupat Holim" literally means "sick fund", and denotes in Israel a health providing organization. It is similar to a U.S. Health Maintenance Organization (HMO), though in Israel it is a non-for-profit organization, which belongs to its members. Klalit considered itself as the national health provider, essentially a pre-cursor to the ministry of health of the envisioned State of Israel. Due to its labor roots, it considered equality of

health services - based on needs - to be of major importance, regardless of income. At the same time the private insurance market emerged, but its emphasis was on non-life and later life products, rather than health products.

Following the birth of Israel, and due to the ruling of the labor party in the first thirty year of its existence, Klalit remained the major health service provider in Israel. Its services were offered throughout the country, it had a vast network of hospitals and medical facilities, and it insured most of the population. Coverage was family-based, with all members of the family being covered through the membership of the bread-winner in Klalit, and monthly premiums were based on family income subject to a (relatively low) ceiling. Klalit was closely linked to the ruling labor party, and membership in Klalit was involuntary: once a person worked in a unionized work-place, s/he was automatically insured by Klalit. At the same time, part of the premiums were diverted to finance the activities of the labor unions. Klalit was heavily subsidized, as the Israeli authorities recognized its social value and its wide medical and geographical coverage regardless of costs.

At the same time, several other collective sick funds provided medical services, mostly in the large urban centers. As their members were limited to non-unionized workers, they usually catered to professionals and the upper middle-class - a segment of the population that was usually younger, better educated and more aware of health issues and preventive medicine, and economically better-off than most of the population. Naturally, these sick funds had a "better" population, medically and economically, than the Klalit sick fund. Thus, they have been able to provide better services at a lower cost. At the same time, these sick funds provided services through several central clinics and labs, relying mostly on a network of individual practitioners. Whenever more substantial facilities, such as hospitals and geriatric homes were needed, they relied on the facilities of Klalit, and later - when such facilities were made available by the Israeli ministry of health - on the state facilities. This approach saved these sick funds the costs of setting up, upgrading and maintaining costly medical infrastructure and facilities, thus adding to their profitability and ability to provide selected improved services to their constituencies.

Originally the sick funds provided a basic coverage, which covered ambulatory services, various laboratories and supporting services, and hospital coverage; each sick fund, though, had its own set of services. Eventually, due to competitive pressures and with the wish of distinguishing themselves, the sick funds started adding complementary services, such as life-saving surgeries and transplants abroad, long term care, IVF, cardiac transmitter, and some dental services. All the sick funds, except for Klalit who objected ideologically, also offered services by private physicians and selection of surgeons and specialists when needed. These complementary services were limited in scope, were constrained to lists of services and providers who had agreements with the sick funds, and were usually involuntary. Each sick fund offered a different set of complementary services.

A number of sick funds had emerged and merged in the period from the mid-thirties to the mid-fifties. By the sixties, three major sick funds dominated the market in addition to Klalit: Macabi, Meuhedet and Leumit. These sick funds, together with Klalit, form the infrastructure for the national medical health coverage. In 1995, a few months after the introduction of the national health law, Klalit had about 3.4 million insureds out of about 5.4 million Israeli insureds, Macabi had about 1 million, and Leumit and Meuhedet had each about half a million insureds.

The Israeli government was, and is, a major player in the Israeli health arena. The ministry of health maintained a network of public hospitals, which served all the population, including those not insured in any sick fund as well as members of Klalit, which had its own network of hospitals. In addition, the ministry provided geriatric, psychiatric and long-term care hospitals and service facilities - usually to lower-income groups - as well as services to young children and other target groups. The Israeli social security services supported invalids, incapacitated people, and others who required nursing care and lacked the economical capabilities needed for these services. Consequently, Israel had a wide-spread public - though diffused - medical safety net which covered most of its citizens.

In Israel, as in other countries, a major reason for the development of private insurance has been the inability of public funding sources to meet all the medical needs as perceived by the population. In addition to coverage by government agencies and sick funds, as described above (up to 1995) and below (after the introduction of the National Health Law), commercial health insurance is provided by the private sector. Commercial insurance companies had traditionally few policies, mostly as riders for dreaded diseases, several major surgeries, and incapacity to work disability coverage. One insurance company (Shiloah) specialized in health insurance, and up to 1995 controlled about 80% of the surgery, dreaded disease, and dental care commercial insurance. Since workers compensation is covered (to a large extent) by the social security system, and because a large percentage of the working force was covered by pension and invalidity and disability arrangements, there was little incentive to the commercial insurers to invest heavily in these areas, and they usually were covered by riders attached to "managers policies" which were directed at the higher echelons of the employees. Most insurers - except for Shiloah - concentrated on group policies, rather than on individual policies.

The National Health Law of 1995

In 1977 Israel passed through a political "revolution", which replaced the labor-based rule (that governed Israel since it was created as well as the pre-statehood period) with a Likud-based right-wing rule. One of the results of this revolution was a slow weaning of the labor unions, their sick fund Klalit, and other labor-related ventures, off government subsidies and (other direct and indirect) support. Consequently, these organizations began to face financial difficulties that raised questions about their long-term survival. These difficulties led to several government sponsored emergency rescue efforts, particularly of the Klalit sick fund, which was an essential national health service provider.

Throughout the existence of Israel, there were many efforts to create a national health system in Israel. These efforts were driven by the social emphasis of the Israeli society, as the lack of coverage for a section of the Israeli population on the one hand, and the different levels of medical services available to different economical segments of the society, were considered as unjust and improper in a socially-driven nation. These efforts always failed, mostly because the labor unions were not ready to relinquish their hold on Klalit, which was one of their major income sources. In late 1994, three major forces combined to change this situation and promote a national health law: the aforementioned difficulties of Klalit and the labor unions reached a critical level; a labor controlled government was ruling the nation; and the labor

unions elected a new leader, whose declared goal was to rehabilitate the unions and Klalit and resolve their financial difficulties.

In late 1994, an agreement was reached between the labor unions and the government, that led to the privatization of many union-controlled industries, and to the establishment of a national health law in Israel. According to this agreement, all the then existing sick funds - Klalit, Leumit, Macabi and Meuhedet - were semi-nationalized into service providers for the involuntary health coverage provided by the national health law for the whole population. At the same time, the government agreed to cover all of the existing deficits of the sick funds (and Klalit in particular), and to support their operations through the imposition of a salary-based "health tax", to be collected from the population and distributed to the sick funds by the Israeli social security administration.

The principles major guidelines of the Israeli national health law, which became effective January 1, 1995, were:

- As specified in the preamble to the law, the law is based "on the principles of justice and fairness, equality, and mutual support". Thus, the goal was to provide the same level of medical services and support to all the segments of the population, regardless of social, economic, or demographic standing, or geographical distribution.
- All the Israeli residents are covered (prior to the law, about 250-300,000 people were not covered, mostly the weak segments of the population, of which about 40% were children).
- Every resident is entitled to all the services of a basic health coverage. This basic "health basket" included all the services that Klalit provided to its members as of December 1994, and was very extensive. It also included many of the services that were earlier included in the complementary offerings of the sick funds. Effectively, the health basket covered the population for (almost) all medical conditions, from pre-conception to the grave. It included even very costly treatments such as dialysis, transplants (even abroad), etc.
- The contents and coverage of the health basket will be updated from time to time by the ministry of health, which is responsible for the law, as well as for the definition and updating of the basket of coverages.
- Medical services will be provided by the four existing four sick funds. Each resident may select at will his or her service provider, and procedures for changes in service providers were instituted (prior to the law, and particularly for Klalit members, participation was involuntary and was linked to the employer). The government may determine the size of each sick fund, even though this right was never implemented. The hope was that this approach will promote competition for basic medical services between the four sick funds.
- Coverage will be provided without any pre-conditions, and everyone is entitled to full coverage.
- Individual collection of fees by the sick funds, as well as discounts and special rates, will be discontinued. All the health basket related expenditures will be paid through the imposition of a salary-based health tax. The tax will be levied up to a level of four times the average employee salary, at a rate from 6.2% for people with low income and reaching up to 9.6% of salary, equally divided between the employee and the employer. The tax will be collected by the Israeli social security

administration, which already has existing “machinery” for collecting salary-based taxes, for a collection fee of 1% of the revenues. It will be distributed to the sick funds according to a weighted capitation formula which takes into account the number of members and their age (to cover different levels of medical costs at different ages). Special groups (like security forces) pay a reduced rate. The overall revenue were set at the same level as the expenditures of the sick funds at the time the law was instituted.

- The government, through the ministries of health and finance, is responsible for covering any deficits that might result from the implementation of the law.
- Payments by the sick funds to external medical providers, such as hospitals, are based on Diagnostic Related Groups whenever possible.

The principal components of the national medical basket, as provided by the law, are:

- Preventive medicine and personal education
- Examinations and diagnostics, laboratory services
- Ambulatory medical treatment, including radiology, psychiatric, at home or on an out-patient basis
- Hospitalization - general, psychiatric, psycho-geriatric, and chronic long-term
- Surgery - most surgical procedures and treatments, including transplants
- Cardio-vascular operations and treatment
- Rehabilitation - medical, psychological, physiotherapy, speech therapy, and social work
- Medications
- Medical implants and appliances
- Preventive dental treatment for children
- Emergency medical services
- Medical and mental aid to addicts (drugs and alcohol)

The law provides many treatments and consultations, but often for limited amount, e.g., for transplants or second opinion the law caps the coverage amount. These limitations present insurance companies and sick funds with marketing opportunities for various complementary services.

One of the major results of the law is the effective semi-nationalization of the sick funds, as they are required by the law to provide the services of the health basket, at levels determined by the law and the ministry of health, and their income - and coverage of future deficits - is controlled by the government. The sick funds did not receive any reimbursement for this semi-nationalization, except for Klalit that benefited from the elimination of its huge deficit. Therefore, the law provided for complementary medical benefits, to be provided by the sick funds and commercial insurers, on a “free market” competitive basis. The scope of benefits and premiums for these services may be set by each provider according to its own calculations, subjected to supervision by the government. But this supervision had a major loophole - the commercial insurers were subjected to supervision and control by the commissioner of insurance at the ministry of finance, where as the sick funds were subjected to supervision and control by the ministry of health. As each supervising authority had different guidelines and control principles, similar coverages often resulted in very different approval conditions and rates.

Indeed, almost immediately after the introduction of the national health law, each of the sick funds developed its own complementary medical benefits package. The law guaranteed that the medical services will be given to all residents, subject to medical judgement, "at an acceptable level of quality, within an acceptable time frame, and at a reasonable distance from the insureds residence". The law never provided yardsticks for "acceptable", and many people felt that the basic health basket provisions resulted in a lower quality of medical service than what was available to them prior to the law. The complementary services sought to remedy this situation, for a price, by interpreting "acceptable" as "under the insured's control" or "extended services (relative to the health basket)". For example, surgeries by a surgeon selected by the insured (from a recommended list, or even any surgeon), at a hospital selected by the insured, and within a short time frame. Since most of the ambulatory services were provided by the health basket, the complementary services emphasized surgeries, transplants, improved nursing and recuperation services, second opinion, extension of IVF services, and long term care.

While membership in the complementary coverage within any sick fund was legally independent of the selection of sick fund that would provide the basic coverage, most of the members of the complementary coverage selected the same sick fund for the basic and complementary services. This, naturally, provided for a continuity of services at both levels. The penetration of the complementary coverage, however, differed considerably between the various sick funds. While 74% of Macabi's members and nearly 60% of Meuhedet's members had complementary coverage in 1997, only 33% of Leumit's members, and only 22% of Klalit members, had complementary coverage in that year. This can be explained mostly by socio-economic factors. The concentration of groups with higher socio-economic and education levels in Macabi and Meuhedet is markedly higher than in Leumit and particularly than in Klalit.

These developments in the health arena, following the national health law, attracted commercial insureds to this market. Several insurers developed medical insurance policies, which were either a complete alternative to the sick fund coverages, or complementary to and extensions of these coverages. Other insurers started to sell individual health insurance (rather than riders to other policies), that usually combined the traditional health insurance coverages such as dreaded diseases, surgeries, transplants, second opinion, etc. Long term care policies were another attractive offering. Many of these policies were marketed on a group basis, usually to employees of large organizations. However, since many insurers lacked sufficient historical data for tariffs settings, many priced their products on the basis of re-insurance rates. This fact, together with relatively high initial commission rates and a very competitive market, resulted in premiums that many believe may be too low and insufficient for building sufficient long-term reserves. The Israeli commissioner of insurance traditionally required medical reserves equal to three years of claims; only now is the commissioner considering a more comprehensive and appropriate medical reserving system.

The 1998 regularization law

The national health law set a three year period for the settlement of various regulatory issues, including the procedures for updating the health basket and the health tax, the level and scope of complementary services to be offered by the sick funds, the status of the sick funds (as profit or not-for-profit organizations), and the creation of additional sick funds. The law also specified that the level of "acceptable services" will be determined by experts within two years of the commencement of the law. However, political concerns and government priorities resulted in little

activity to resolve these issues. It also became apparent within a short period of time that the national health law suffered from various deficiencies, including:

- Financing of health services: The law did not consider many issues that may affect the future level of costs, such as the ageing of the population, the increase in life expectancy, growth of population, immigration (usually of population segments with different health concerns and history), advances in medical technology, increase in medical salaries, and inflation. Furthermore, the law took into account the variable costs of the sick funds, but did not provide for infrastructure expenses, nor was it oriented to prevent duplicity of services and facilities. The law, while covering some very expensive procedures such as dialysis, did not provide sufficient funds for these services (e.g., it originally paid for about 60% of the actual costs of dialysis). Consequently, the sick funds accumulated considerable deficiencies, which the government did not hasten to cover (despite its obligation to do so, as specified in the law).
- The law had a very short-term perspective, with the objective of solving Klalit's (and labor unions) political and financial woes, and did not arrange for long-term planning. The approach was accounting - rather than insurance and risk-management - oriented. Further, the law did not provide for data collection that would enable long-term planning. This not only generated distortions in the provision of services, but it also led to contradictory treatment of the sick funds and the commercial insurers - even though they often provided similar services and coverages - by the supervising ministry of health and commissioner of insurance.
- Improper financial assumptions: The law assumed a 10% annual increase in tax revenues, while expenses grew, for example in Klalit, at a 13% annual rate. Since most of the sick funds' income was derived from the health tax, this deficiency became material. Furthermore, the expense structure of the sick funds is inflexible - in Klalit, for example, 60% were used for medical services, 33% for community services, and only 6 to 7% for administration; but cost-savings steps could be applied effectively mostly to the administrative services, and thus could not materially reduce the overall level of expenditures.
- The net result of these phenomena was a strong feeling by the public, that despite a steep increase in medical premiums and payments by most of the economically-established population, the level of services declined precipitously.
- Hospitalization: A major cost element for the sick funds is hospitalization. But here the Ministry of Health was caught in a catch-22 situation. A considerable percentage of hospitalization days are in public hospitals that are budgeted by the Ministry of Health. These budgets are heavily affected by the price of a hospital-day, as charged to the sick funds. Increasing this price would have decreased the deficits of the public hospitals, while increasing the costs - and thus deficits - of the sick funds, deficits and costs that the national health law decreed to be covered by the Ministries of Health and Finance. As the hospitals were under direct administrative control of the Ministry of Health, while the sick funds were independent entities, it was convenient to roll-over the hospitalization costs to the sick funds, and delay their reimbursement.

Several open issues were particularly "thorny", and a source for lengthy disputes between the sick funds and the insurance industry. These were the structure and number of sick funds; the complementary services and their coverage; and the long term (invalidity) coverage. The national health law required that the sick funds will as non-for-profit organizations, that their provision of health basket services will be completely separated (accounting and financial-wise) from their

complementary operations, and it further limited the creation of additional sick funds. A few years later one of the largest insurance conglomerates in Israel tried to establish a fifth, for-profit sick fund, with its group of insureds as the target market; this effort failed.

The arguments against complementary services to be provided by the sick funds were driven by two contradictory forces. Many argued that despite the national health law stipulation of “principles of justice and fairness, equality, and mutual support”, the complementary services effectively generated two levels of basic and preferred services, and thus obviated equality. In particular, there were arguments against alternative substitute services, such as a surgery by a private surgeon at a private hospital. The main argument was again the lack of equality, and the provision of improved services to people with higher income who can afford to pay for complementary services.

The commercial insurers argued, on the other hand, that the sick funds lack the financial stability and insurance know-how for the provision of insurance-like services; the fact that these complementary services were declared as “complementary insurance” in the national health law bolstered their argument. Further, the insurers claimed that to allow publicly-subsidized sick funds, with large captive market, to compete on the insurers’ turf is anti-competitive. Some supported the complementary services of the sick funds, as they claimed that in this way better services are provided to the population without burdening the public coffers, while others believed that indirectly the health basket monies and infrastructure support the complementary services. The sick funds argued that as the complementary services are enhancements of the basic medical services they already provide, and based on their many years of experience, they are the best equipped to provide these services at a reasonably low cost. Further, the sick funds suggested that there is no good reason why the profits from the complementary services they already provide, which they (as not-for-profit organizations) direct to improved medical services and facilities, should be used to further enrich the commercial insurers.

A particular area of contention was the long-term care, as in this coverage the element of long-term insurance - in contrast to the level of immediate medical services - is quite high. Here the arguments emphasizing the lack of insurance experience, the need for long-term reserves, and that in contrast to the short-term framework of the sick funds services, were particularly convincing.

The regularization law which became effective in January 1998, and the regulations and procedures that were specified in the following months, sought to clear these issues. The sick funds were allowed to offer complementary coverage to their members, based on the following principles:

- The complementary services to be provided by the sick funds were legally defined as “additional medical services” rather than insurance, to be supervised and controlled by the Ministry of Health. They were recognized as a separate entity from the complementary and other medical insurance coverages sold by commercial insurers, which are supervised and regulated by the commissioner of insurance at the Ministry of Finance.
- The scope and coverage of the complementary services were left to the discretion of each sick fund, as were the premiums - but all of these must be approved by the Ministry of Health. These services may not include services that are included in the basic health basket.
- Long-term care was specifically excluded from the complementary services that the sick funds could offer, and only insurance companies were allowed to market it. Sick

funds were permitted to make arrangements to provide long-term care coverage to the members of their beneficiary services, as long as it was bought from an insurance company (e.g., through a collective group policy).

- Membership in the complementary services is voluntary, and the sick funds cannot discriminate against new entrants (according to their medical status) or set rates based on underwriting considerations. The sick funds, however, were allowed to set waiting periods for the coverage (or parts thereof) to become effective.
- The coverage is through provision of services, either directly or through contracted medical providers, but does not include monetary compensation.
- Premiums are set by age group. Cross-subsidization between age groups is permitted, as long as it is part of the announced age-group rates.
- The complementary services are to be managed as a separate economical unit, that cannot transfer profits or losses to the basic health coverage or to other programs. The complementary services must be self-sufficient. Therefore, rates may change from time to time (to the whole group) with the approval of the Ministry of Health, in contrast to insurance contracts in which only increases resulting from linkage to cost-of-living or major changes in mortality and health experience are allowed.
- Sick funds may add other levels of services, as long as they are sold on similar basis. In other words, they are not limited to a single complementary program or set of services.
- Sick funds are limited in their participation in other business activities to health related endeavors, and only if they fully controlled them. Consequently, all such related activities are subjected to the same rules and controls as the sick funds.

In January 1998, immediately after the regularization law was approved, a deputy-minister was appointed with responsibility over the sick funds and all the issues related to the national health and regularization law. A set of clarifying regulations were then issued, which specified:

- Membership in complementary services is independent of membership in the basic health basket. Thus, a person can be covered for basic services in one sick fund, and for complementary services in another fund.
- There is no partial enrolment in a complementary program, i.e., a person cannot be enrolled in a selected set of services and pay only for these services.
- Full information is mandatory, and the sick funds must explain all the rights and obligations of members, including tariffs and discontinuation of service and coverages.
- All members' claims have to be settled within a pre-set time. An appeal process must be established by the sick funds.
- Members will be able to move, and transfer rights, from one sick fund to another.

In effect, these regulations changed the nature of the sick funds from (partially) commercial enterprises that set their own coverage, premiums and rules, as was the case up to 1995, to non-for-profit medical service provider, as well as some sort of a medical social security system. It also created a clear distinction between the sick funds and the commercial for-profit insurers - in terms of the type of service (medical service vs. insurance), coverage (services vs. financial compensation), enrolment and pricing (group-based without underwriting constraints vs. individual-risk acceptance and pricing), and controlling agency (ministry of health vs. commissioner of insurance in the finance ministry).

The current health insurance scene

The Israeli health system is well developed. In 1996, for example, this sector employed about 6.2% of all the workers in Israel, with 22 health workers per 1,000 people. In 1997 there were 472 physicians per 100,000 residents with average of 6.8 annual physician visits per resident, and six hospital beds per 1,000 residents with 94.7% bed-occupancy. By the end of 1996 there were in Israel 47 general hospitals, 28 psychiatric hospitals, 200 long-term care institutions, 30 day-care (excluding overnight stay) units (not associated with hospitals), 17 mental health units, 6 geriatric units, and two rehabilitation centers. Health expenditures in Israel in 1997 were 8.7% of the GDP, and they increased by 47% between 1965 and 1995 above the cost of living index. This rate of GDP expenditure is close to the rates found in the European Community, and still is low relative to the United States and Canada.

The Israeli health system is currently structured in three layers: (1) A broad national compulsory health coverage, provided by law to all the Israeli residents through four sick funds that acts as service providers, and financed through salary-based tax; (2) A voluntary collective complementary group health coverage, with age-group-based premiums but without any underwriting entry considerations, provided by the four Israeli not-for-profit sick funds, under the control of the ministry of health; and (3) Private insurance health and long-term care policies, supported by an extensive private medical services, under the control of the commissioner of insurance in the ministry of finance.

Following the introduction of the national health law in 1995, many new commercial medical insurance policies were introduced (the appendix contains descriptions of several typical coverages of commercial policies). Some competed with the complementary coverage of the sick funds, others sought to supplement it, while others issued personal or group policies for specific coverages. A significant factor of this development was a fierce competition and a price-and-terms war, while at the same time many of the agents and insurers lacked sufficient information and knowledge. This led to confusion of the potential insureds, which was increased by the lack of ability to evaluate the differences between the commercial insurers and sick funds medical coverages. At the same time, the competitive pressures by the commercial insurers forced the sick funds to broaden their offerings, often without financial or medical considerations.

Underwriting of a personal medical commercial policy is usually based on a 10-15 questions within the framework of the insurance application questionnaire. Some companies even reduce it to fewer questions at underwriting time, with more extensive checking of pre-conditions once a claim is submitted. In group policies the underwriting is very liberal, and is often limited to pre-existing conditions; not surprisingly, many millions of NIS were lost in group policies. Rates are often based on reinsurance rates, due to the lack of sufficient statistical data at the company's level. Reinsurance rates, however, are mostly based on non-Israeli experience, and thus there are many questions about the sufficiency of the resulting rates.

Reserves are generally not required of the sick funds, as they are not controlled by the commissioner of insurance and are not subjected to insurance laws and regulations. Commercial insurers are expected to maintain reserves. In the U.S., for example, reserves are established for both short and long term coverages, including medical reserves, claim-related reserves, premium-related reserves, and policy reserves that reflect the longer term liabilities associated with medical expenses, as well as to provide for the distribution of income and

expenses over the effective duration of the contract. In Israel, however, only short-term reserves that are essentially equal to three years claim experience are currently required.

The fierce competition between the insurers, the lack of experience with regulation of health and long-term insurance by the commissioner of insurance, and the lack of accumulated history, resulted in premiums of which some (at least) are too low, and setting of reserves of which some (probably) would not suffice in the long-run. During the last few years the commissioner of insurance expends considerable efforts on the regularization of the health and long-term insurance markets, including capital considerations, reserves, premium settings, reporting rules, information to be reported to insureds, etc. Particular attention is given to collective medical policies, and the interests and rights of individual participants vs. the policy owner. In the long-term care arena, the major issues are the need for long-term reserves on the one hand, the relatively little initiative to young people to get insured, and the steep increase in the annual renewable premiums for this coverage with the advance in age.

The public elements of the system continue to suffer chronic financing shortages, despite a hefty salary-based health tax that is imposed on employers and employees, and a relatively high-percentage of the GNP that is devoted to health expenditure. The government and the public are still struggling with the level and scope of coverage to be provided to all residents, the financing of this coverage, and how to balance the concept of equal medical service to all with the different economical capabilities of different public segments and the operation of a free market. Thus, the Israeli national health "experiment" is still going on, and the final word has not yet been written.

Appendix - Typical Coverages of Commercial Medical Insurance Policies

The sick funds have reimbursement-based coverage, often with co-participation payments. Some commercial policies are also reimbursement-based, while other provide a fixed monetary compensation. All reimbursement-based amounts are subjected to the price schedules of the provider, and any excess amount (if any) is to be paid by the insured. All providers have caps over the amounts covered, which are usually coverage-related (rather than a gross total amount for all coverages combined). These caps are, in most cases, annual (rather than total over the life of the coverage). A typical complementary coverage may include:

SECTION	TREATMENT	TERMS & EXPENSES BEFORE EXCESS	EXCESS LIMITS (Amounts in NIS)
Operations	Surgeon /Anesthetist	Full refund	
	Hospital, including drugs / dressing	Full refund	30 hospitalization days for each procedure
	Pathology tests	Attached to operation and second opinion	No more than 1,000 per annum
	Operating theater	Full refund	
	Private nursing in hospital	Partial refund	up to 250 per day for max of 8 days per operation
	Implant device		max 14,000

SECTION	TREATMENT	TERMS & EXPENSES BEFORE EXCESS	EXCESS LIMITS (Amounts in NIS)
	Ambulance	Emergencies, and when needed for transfer	Average 200
	Operation and transplants abroad	Operation that could not be performed in Israel	100% of covered cost of operation in Israel up to policy limits
	Physiotherapy	After operation	up to 200, max 6 visits per operation
	Craniotomy	Performed abroad	Double the cost of operation in Israel
	Hepatitis B -Aids	Infected during operation	150,000
	Fertility treatment	I.V.F.	First two births up to 8,000, but no more then 75% of the real cost
	Institutional rehabilitation	After heart disease	Up to 300 per day limited to 50% of cost for max 14 days
	Cardiology beeper	After heart transplant and heart surgery	Period: 18 months up to 120 a month, but no more of 50% of the real cost
	Rehabilitation gymnastics	After heart transplant and heart surgery	Participation of 50% in the real cost of the treatment up to 9 months at 110 a month, up to total 1,000
	Speech rehabilitation	After C.V.A. case for people over age 18.	Up to 12 treatments beyond the Health Law, up to 70 per treatment
	Consultation fees before surgical procedure	Examination before operation	Up to 2 consultations for the same operation ,but no more than 6 consultations in a calendar year, up to 450 each visit, participation 20%
	Special consultation fees	In case of dreaded diseases	Up to 2 consultations, but no more of 1,500 over a life time
	First dental aid	Dental pain relief	Up to 2,000 per calendar year
	Oncology treatment	With approval of expert	Up to 30,000 for life, participation 20%
Ambulatory	Periodical examination	From the second year	Costs up to 300

SECTION	TREATMENT	TERMS & EXPENSES BEFORE EXCESS	EXCESS LIMITS (Amounts in NIS)
	Laboratory test MRI-CT	With approval of physician With expert's approval	Max 3,000 per insured, participation 20% , min each test 100. Cost average: MRI 3,000, CT 800. Once a year.
	Consultation, diagnosis	With physician approval, from an approved list	Max 3,000 per insured or family plan. Up to 2 consultations for the same operation. Up to 450 each consultation. Participation 20%.
	Alternative Medicine: Homeopathy, Acupuncture, Chiropractic, Reflexology, Shiatzu, etc.	Approval of family's doctor	Excess 20%, up to 10 visits during a calendar year. Max cost per one treatment is 80

Another medical insurance product is a catastrophic surgery coverage, limited to 10 - 12 surgical operations. The coverage includes reimbursement of pre-surgery consultation, surgeon's fees, anesthetist's fees, hospitalization up to 30 days, operating theatre expenses, and tests and diagnostic procedures. Typical limits are:

PROCEDURE	SUM INSURED (NIS)
Brain Surgery	28,000
Cardiac Artery Bypass	60,000
One or more valve replacement	73,000
Valve Repair	35,000
Closed heart valve repair	19,000
Surgery for aortic aneurysm or rupture	70,000

As the cost of this coverage is low, transplants and special treatment abroad are often added, usually for an amount up to \$1,000,000.