

HEALTHCARE FINANCING AND REIMBURSEMENT: A GLOBAL REVIEW OF MAJOR TOPICS AND TRENDS

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LAWS AND REGULATIONS ON HEALTHCARE FINANCING AND REIMBURSEMENT

- 1. Please provide a bird's-eye view on the healthcare economy, indicating, in general terms, the role of the government (public healthcare) and private actors (private healthcare).**

The National Health Insurance Law, 5754–1994 ('the Law'), determines the eligibility of every resident to national health services through one of the health funds. The Law defines, among other things, the basic principles and conditions of eligibility to receive health services, which health services are included in public medicine, the entities responsible for providing the various health services, the sources of funding for the healthcare system, and more. The main players in the healthcare system include regulators, insurers, and service providers, and in some cases the players are active on several levels, as detailed below. The Ministry of Health (MOH) serves both as a regulator, as an insurer in various areas defined in the Law (ie, in the third appendix to the Law) and as a provider of some of the health services (eg, government hospitals, public health services, preventive medicine, etc). The MOH, together with the Ministry of Finance, is responsible for setting the rates for the various health services, the accounting arrangements between the Health Maintenance Organisations (HMO/s) and the public hospitals, updating the components included in the basket of health services to which the policyholders are entitled, and providing the budgetary framework required to finance the healthcare system. The main insurers are the four HMOs that are responsible for providing their respective policyholders with the various health services defined in the second appendix to the Law. All residents of Israel are insured by one of the HMOs of their choice. The consumption of health services varies according to numerous factors and different characteristics amongst the population, and budgets are allocated to the HMOs according to a standardised populous index achieved by a capitation formula.

The compulsory insurance system is funded primarily through a national income tax and an income-related health tax. Most citizens also purchase non-compulsory additional health insurance for medications not covered by the publicly funded basket of health services and for faster access and greater provider choice. Almost all governmental health functions are organised by the MOH, which has regional and district health offices throughout the country.

- 2. Please provide a high-level overview of the legal framework regarding healthcare financing and reimbursement.**

Since 1995, the Law has ensured universal coverage for citizens and permanent residents. The Law states, 'Health insurance... shall be based on principles of justice, equality and mutual assistance'. Under this commitment, every resident is entitled to healthcare services.

Israeli residents may supplement their health insurance coverage beyond what is provided by the publicly funded basket of health services in two main ways: supplemental insurance offered by HMOs, and private health insurance coverage provided by commercial insurance companies.

Residents are free to choose one of four competing HMOs that must cover anyone who applies. Every resident has a right to receive all health services included in the publicly funded basket of health services which is mandated by the government, subject to medical discretion. Residents also have the right to receive health services at a reasonable quality level, within a reasonable period of time, and at a reasonable distance from their home. It should be noted that no formal definition of 'reasonable' exists, and there is no penalty for health plans that fail to comply.

Some populations are excluded from care under the HMOs described above: soldiers, who receive healthcare directly from the Israeli Defence Forces (IDF); inmates, who receive care from the Israel Prison Service; documented and undocumented foreign workers, whom employers are required to enrol in private insurance programmes; and undocumented migrants, temporary residents, and tourists.

The national government, through the MOH, is responsible for population health and the overall functioning of the healthcare system. It supervises and works with the National Health Insurance (NHI) health plans and owns and operates a large network of mother and child health centres, about half of the nation's acute care bed capacity, and about 80 per cent of its psychiatric bed capacity. In addition to financing insurance, the national government funds public health services and is directly responsible for the provision and funding of certain other health services, including prenatal and preventive care, infant developmental tests, communicable disease surveillance, screenings, and institutional long-term care.

3. What are the key regulators and supervisory bodies regarding healthcare financing and reimbursement?

The MOH is the key regulator of the national healthcare system in Israel and operates alongside with the Ministry of Finance.

The courts usually avoid interfering with the discretion of governmental institutes. The general tendency is consistent with the rule adopted in the legal system, that as long as the authority's discretion is lawful, the authority's decision will stand even if the court believes that it is not the best decision. The courts usually refrain from examining the wisdom or effectiveness of a decision of a governmental authority and limit themselves to examining its legality, according to the grounds formulated in the framework of administrative law. Standard practice is that the court will check whether the governmental authority holder acted in accordance with the laws of administrative law. With respect to court intervention regarding administrative directives provided by a governmental authority, the court's intervention is limited to whether there were defects, such as extraneous considerations that are not relevant, arbitrary determinations, lack of good faith, extreme unreasonableness that goes to the root of the matter, and the like. In cases where defects were found in the administrative authority's considerations of a matter, the court returned such matter to the

authority, with instructions regarding how to remediate the defect in the previous considerations.
4. Has there been a change with healthcare financing and reimbursement as a consequence of the Covid-19 pandemic?
<p>The Covid-19 pandemic has led to a sharp rise in healthcare expenditure indicators in Israel. The government, through an amendment to the Basic Law, The State Economy (1975), was entitled to increase expenditure beyond the limit of the ongoing budget for the purpose of financing the expenses necessary to deal with the crisis and for this purpose only.</p> <p>As the pandemic continued to spread throughout the population, an additional amendment was issued, allowing for financial acceleration and assistance to additional populations. Due to restrictions in the employment market and the national quarantines implemented by the government throughout the pandemic, Israel's GNP was decreased, income taxes were affected and the annual budget was in deficit.</p>
5. Who has access to the healthcare system as a patient on the one side and as a medical service provider/supplier of medical goods on the other side? What are the conditions of admission?
<p>All residents of the State of Israel are entitled to health services according to the Law. All policyholders are entitled to receive, through the HMO of which they are members, the full range of services set out in the health basket.</p> <p>Stateless foreigners without medical insurance can receive emergency medical treatment in hospitals, and pregnant women and children can go to well-baby clinics called 'Tipat Halav' for medical follow-up. These well-baby clinics are administered by district health offices and are staffed mainly by public health nurses. The MOH operates a designated clinic for stateless people at the Central Bus Station in Tel Aviv, and certain services are provided at the Levinsky Clinic for Sexually Transmitted Diseases and AIDS.</p> <p>Hospitals are obligated to provide emergency treatment to every person requesting or in need of treatment, including stateless people who do not have insurance. The costs of treating this population are estimated at tens of millions of new Israeli shekels (NIS) each year, and the hospitals bear most of such costs because there is no indemnity mechanism provided by the MOH. The aforesaid costs result from the direct charges imposed on such patients who receive treatment, but who are usually unable to pay (bad debts), the process of adapting to such a population (which may require translators and translations, staff training, and additional laboratory services), and the resulting decrease in the number of paying Israeli patients able to visit the hospital, because resources are being used by such non-paying population.</p> <p>Medical services for residents travelling abroad are made available for purchase by the HMOs, as well as by private insurance policies which may be purchased by the patient, at its discretion.</p>
HEALTH INSURANCE FINANCING AND COVERAGE
6. How are health insurance carriers financed? How are premiums determined?

Under the Law, national health insurance is mandatory.

In addition, health insurance is available from one of the four HMOs in the country.

Each healthcare plan is budgeted by the MOH in direct proportion to the number of its policyholders, with the budget for each insured changing according to age, gender and geographical location (distance from healthcare services).

In addition to the above, private health insurance is also available for purchase to all residents.

Payment of health insurance premiums is mandatory. The National Insurance Institute charges health insurance premiums from:

- *Salaried employee*: the employer deducts payment from the employee's salary.
- *Self-employed individuals*: payment of health insurance premiums to National Insurance is paid by the individual directly to the National Insurance Institute.

Payment of a health insurance premium is proportionate to one's income.

Children under the age of 18 and housewives do not pay a national health insurance premium.

People receiving pensions or other benefits from the National Insurance Institute (such as senior citizens and Holocaust survivors, early pension recipients, etc.) will pay health insurance premiums in accordance with the Law.

7. How is coverage of medical services by health insurance carriers regulated? Are there differences in coverage for in-person medical appointments and telemedicine appointments?

The basic coverage – the 'health basket' – is determined by the MOH in accordance with the Law. The 'health basket' includes different medications, determined by a public committee, and changes annually. The health services and medications under the health basket undergo periodic updates. The inclusion of new medications and medical technologies in the basket is based on a review and examination conducted by a committee. These additions require the approval of the Minister of Health and the parliament (the Knesset). It is important to note that a service or medication cannot be removed from the health basket without the approval of the Knesset's Labor and Welfare Committee.

Coverage beyond the basic service determined by the state and made available as part of the health basket is supplementary coverage, which is offered by the HMOs (for a charge). On top of that, external and additional coverage is offered (for a charge) by private insurance companies and/or extensions of the HMOs themselves.

HMOs are responsible for providing the health basket to its insured members which includes a variety of medical services as well as a list of prescription drugs.

The health basket includes the following:

- medical diagnosis and treatment in HMO clinics, hospitals, facilities, laboratories, and outpatient clinics;
- medical counsel, diagnosis and treatment;
- hospitalisation in public medical centres;

- listed prescription drugs; and
- medical devices and equipment

Telemedicine is a service provided by HMOs (and not by the government). Telemedicine has been incorporated into standard healthcare services provided by HMOs to insured members.

Orphan drugs which are not included in the 'health basket' are not covered by the state.

To request provision of health services outside the scope of the health basket, a petition to a special committee of the respective HMO must be submitted and its decision may be appealed to a regional labour court. Notably, in certain cases, these treatments may already be included in supplementary insurance packages offered by HMOs (at an additional charge), which the majority of insured member purchase and hold.

Certain patients are entirely or partially exempt from co-payments, such as chronic patients who are exempt from paying above a certain limit for pharmaceuticals included in the health basket.

HOSPITAL SECTOR

8. How are services provided by hospitals in the stationary (inpatient) and ambulatory (outpatient) settings financed and reimbursed?

The hospitals' customers are mainly the HMOs, which purchase from the hospitals: hospitalisation services – medical activity that includes accommodation, the price of which is determined according to the rate of a day of hospitalisation; differential activities – medical procedures for which a fixed price has been set by the MOH; ambulatory services – outpatient hospital services that include medical treatments that do not include accommodation; and emergency medical services – emergency room services – for this service, an emergency room fee is paid, which is charged only in cases where the patient does not require hospitalisation.

Additional clients are: the National Insurance Institute – where it is responsible for various matters concerning childbirth and premature babies, maternity hospitalisation and treatment of victims of hostile acts; the Ministry of Defence – responsible for financing treatments performed on employees of the defence establishment, disabled IDF veterans, the Ministry of Defence and IDF soldiers; the MOH – services that are not the responsibility of the HMOs in the field of mental health; insurance companies – provide services within the framework of insurance arrangements for tourists, foreign workers or private patients; and private clients – patients without a letter of referral for hospital treatment from the HMO, foreign workers, tourists and Palestinians.

There is a price list issued by the MOH for various treatments – ambulatory services and hospitalisation services, in accordance with the international classification of CPT (Current Procedural Terminology).

9. How are the prices of such services determined? How is economic efficiency controlled?

The MOH serves both as a regulator, as an insurer in various areas defined in the Law and as a provider of some of the health services (government hospitals, public health services, preventive medicine, etc.). The MOH, together with the Ministry of Finance, is responsible

for setting the rates for the various services, making accounting arrangements between the HMOs and public hospitals, updating the components included in the health basket services to which HMO insured members are entitled, and providing the budgetary framework required to finance the healthcare system. According to the Foundations of Budget Law, 5745-1985, hospitals are defined as business enterprises. In other words, a hospital's budget is a closed and balanced budget consisting of income and expenses.

A hospital in which the total income exceeds the total expenses, transfers the surplus to the MOH, and vice versa, in a situation where the total expenses exceed the total income, the hospital will receive the difference as subsidy by the MOH.

HEALTHCARE PROVIDERS IN PRIVATE PRACTICE

10. How are services provided by physicians, therapists, laboratories and other service providers financed and reimbursed?

The four HMOs offer their members the option of purchasing supplemental insurance plans which provide coverage for services not included in the health basket of services or provide coverage at an increased level. These supplemental plans are usually offered in two or three coverage tiers and include or provide discounts on services and products such as: second opinions from medical specialists, surgeries and other medical procedures by private physicians and in private or semi-private facilities in Israel and abroad, dental and orthodontic coverage for adults, discounts on drugs not included in the public health basket, expanded maternity care, additional vaccinations and medical tests, alternative medicine, and more.

HMOs are prohibited by law from denying any member participation in a supplementary health insurance plan and may not charge different premiums due to pre-existing conditions, although they typically impose an initial waiting period before supplemental coverage takes effect (which may be waived if the member transferred from another fund and was already covered under the former fund's supplemental plan).

Private insurance plans offer reimbursement or partial reimbursement for visits to specialists, diagnostic tests, and a battery of other medical tests and services that either are outside the scope of the health basket or for which services a patient does not want to wait a long time.

Due to budgetary considerations, there may be a long wait to get approval for certain diagnostic services and tests and other medical tests from the HMOs, even if such services and tests are part of the health basket and the wait time can be months. Private insurance allows patients to bypass health fund approval and request the services and/or medical tests directly from physicians and/or health service providers at full price, which may be later reimbursed (either in full or partially depending on the private insurance coverage) by the private health insurance provider. The amount of reimbursement and the type of services varies depending on the terms of the applicable policy and scope of coverage.

11. How are the prices of such services determined? How is economic efficiency controlled?

In 2018, a Supervision Order on Prices of Goods and Services (Application of the Law to Privately Funded Surgeries and Determination of the Level of Supervision), 5778-2018 was issued following discussions held by the Pricing Committee at the Ministry of Finance.

The Order sets forth the obligations of health facilities to report on elective operations performed under private financing, for the purpose of determining whether to regulate pricing of operations in the private sector. The Order was in effect for two years, but as of today we are unaware of any regulations of pricing of operations in the private sector.

The Capital Market, Insurance and Savings Authority at the Ministry of Finance supervises the insurance companies. The Authority's duties are to protect and safeguard the interests of policyholders and savers, to ensure the stability of institutional investors so that they can meet their obligations to their customers, to promote [competition](#) and to encourage technological innovation.

PHARMACEUTICALS AND MEDICAL DEVICES

12. How are pharmaceuticals and medical devices financed and reimbursed?

As mentioned above, the basic coverage – the 'health basket' – is determined by the MOH in accordance with the Law. The 'health basket' includes different medications, determined by a public committee, and changes annually. The health services and medications under the health basket undergo periodic updates. The inclusion of new medications and medical technologies in the basket is based on a review and examination conducted by a committee. These additions require the approval of the Minister of Health and the Parliament. It is important to note that a service or medication cannot be removed from the basket without the approval of the Knesset's Labor and Welfare Committee.

Coverage beyond the basic service determined by the state and made available as part of the health basket is supplementary coverage, which is offered by the HMOs (for a charge), and on top of that, there is external and additional coverage is offered (for a charge) by private insurance companies and/or extensions of the HMOs themselves.

The health care basket that HMOs are responsible for includes providing the health basket to its insured members which includes a variety of medical services as well as a list of prescription drugs that the HMO must provide to all insured members. The basket includes the following:

- medical diagnosis and treatment in HMO clinics, hospitals, facilities, laboratories, and outpatient clinics;
- medical counsel, diagnosis, and treatment;
- hospitalisation in public medical centres;
- listed prescription drugs; and
- medical devices and equipment

All major Israeli commercial insurance companies offer health insurance plans for citizens interested in additional health services. They may be purchased directly from an insurance company as a private policy or under a group policy if offered as a benefit by an employer. These plans provide coverage for additional options for treatments beyond what is provided by the public health basket. For example, in the area of elective surgery, a participant in a private insurance plan may choose the surgeon, anaesthetist and hospital anywhere in Israel or around the world (depending on the terms and coverage of the applicable policy). In the area of transplants, funding is available under private insurance to ensure a donor is found

and the procedure is done without the need for government approval. Additional coverage may be provided for specific diseases such as cancer.

In the area of medications for serious illnesses, private insurance companies provide access to a wider range of medications than the official 'basket of medications', since the Israeli government is not financially capable of covering all medications. In comparison with health insurance in other countries, private health insurance plans in Israel are considered comparatively inexpensive, but premiums are based on age, gender, and unlike the supplemental coverage offered by the HMOs, are subject to medical underwriting, ie, pre-existing conditions and previous medical history.

HMOs are not obligated to fund medical treatment that is not included in the health basket. In cases where a patient requires treatment that is not included in the health basket, such patient has the option of contacting the exceptions committee of the HMO of which such patient is a member. The exceptions committee is obligated to discuss the patient's case but is not obligated to approve their request. The exceptions committee is affiliated with the HMO and has a number of members, some of whom are doctors. The committee's role is to discuss requests for assistance to its insured members for whom the medical treatment they need is not included in the health basket. During the hearing of the application, the committee will make decisions without any discrimination between those who apply to it and will conduct a systematic and relevant examination based on all the relevant data in the case. The decision of the exceptions committee must include its reasoning and grounds for such decision, and all the committee's documents will be transparent to the patient.

Orphan drugs are generally not included in the health basket and can be financed through private insurance, depending on the policy terms.

Medication insurance is insurance coverage within the framework of private health insurance intended to finance medications that are not included in the health basket. Coverage may also be provided for medications that are included in the health basket but are not intended for the insured's specific medical condition (off-label use). In most cases, the insurance coverage will not include experimental drugs that have not yet been proven to be medically effective.

13. How are the prices of pharmaceuticals and medical devices determined? How is economic efficiency controlled?

The prices of prescriptions only medications (POMs) are determined under the 1996 Law of Supervision of Prices of Consumer Goods and Services and the 2001 Order for Supervision of Prices of Consumers Goods and Services (Maximum Prices for POMs), as amended periodically, as well as the 2001 Order for Supervision of Prices of Consumer Goods and Services (Application of Law on Preparations).

The monitoring and pricing system of POMs is based on market prices prevailing in certain corresponding countries, from which a normative price is derived to reflect the retailer costs of the drug in these corresponding countries. Currently, as amended in 2018, the maximum price will be calculated as an average of the three lowest prices from seven corresponding countries (Belgium, Hungary, Spain, France, the United Kingdom, Germany and the Netherlands), or if there is no corresponding price in three countries, an average of the relevant one or two countries, as the case may be.

Generic drugs and original drugs that have a registered generic drug (ie, they have competition) are supervised at a lower level, while their price is in fact frozen and will increase only in the event that the registration holder submits a special request to the Supervisor of Prices at the MOH. Over-the-counter (OTC) medications are also regulated in the same way.

As a rule, the actual prices are usually lower than the maximum prices set by the MOH, except in cases where there is indeed no competition at all, in which case the drug will be sold at the list price or very close to this price. The patient's deductible for the drug is derived from the maximum listed price.

The Division for Senior Planning, Budgeting and Pricing at the MOH is responsible for setting the maximum prices for prescription and OTC drugs. The regulation of prescription drugs is similar to the practice in Europe using the price quotation method – for each preparation, the official price is quoted in seven countries, and it is set on the average of the three lowest of the seven. The seven countries are Belgium, England, France, Germany, Hungary, the Netherlands and Spain. The Prescription Drug Supervision Model was updated in 2019 and brought with it two main changes – a change the method employed, which led to a significant drop in prices compared to the previous method; and easing of the supervision of generic drugs. For OTC drugs, there is a different model, where their price is determined when the drug begins to be marketed, and is updated only in the event that the OTC drug company has requested an increase of the price and provided such request has been approved by the competent authorities.

In recent years, the medical cannabis market in Israel has developed in an unprecedented way, with the number of patients increasing every year by thousands of patients licensed to consume medical cannabis, and the number of people involved in this market in the entire value chain (growers, manufacturers, trading houses) is increasing and becoming more established. In light of this, the need arose to examine whether it is necessary to supervise cannabis prices in order to protect the consumer from excessive payments for a product for which it is mandatory.

In 2023, the MOH and the Ministry of Finance issued an order requiring medical cannabis companies to report to the government on a monthly basis on the sales, prices and profitability of cannabis products, raw materials for cannabis products, and services related to cannabis. The declared purpose of the order is to examine whether there is a need to set ceiling prices for each product and service. In other words, at this stage, there is still no price control, but only an order to submit data.

LITIGATION INVOLVING HEALTHCARE FINANCING AND REIMBURSEMENT

14. Please provide a high-level overview of major litigation topics and landmark cases regarding healthcare financing and reimbursement.

Most case law in this area in Israel deals with medications excluded from the basic health basket (mostly medications for cancer patients). The tendency of the courts is not to interfere with the discretion of the MOH, which is in accordance with the principles of administrative law.

In 2021 the High Court of Justice rejected a petition issued by one of the biggest HMOs in Israel, demanding that the HMO should be entitled to stop funding ‘orphan medicines’ for patients with rare diseases as part of its supplementary insurance, on the grounds that their cost is too high.

Justice Stein, who wrote the ruling, ruled: ‘The HMO has accumulated a significant financial reserve’ and that it can bear these costs.

RECENT DEVELOPMENTS AND TRENDS

15. What are the recent developments and trends for the next few years? Please outline any unresolved issues, proposed changes, or trends for healthcare financing and reimbursement and briefly indicate how these may foreseeably affect the medical sector in the near future.

In light of the current war in Israel, we can expect to witness a growth in mental healthcare and services, rehabilitation services and other medical services of that kind.

The primary work plan of the MOH for 2025 includes the following:

- increase in medical manpower in the health system;
- improvement in child development services, in light of increase in diagnosis of children on the autistic spectrum; and
- strengthening the mental health system.

As a result of the war in Israel and its financial implications, we may also witness an increase in the costs of medical care.