HEALTH INSURANCE POLICIES AND THE ROLE OF THE INSURANCE INDUSTRY IN HEALTH CARE MANAGEMENT

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ABSTRACT

This paper provides a broad overview of how insurance companies can be involved in the Health Care market. The paper places particular emphasis on the form of Health Insurance products that an insurance company can write and the role of Health Care Management in making a success of Health Insurance products. The aim of the paper is to highlight Health Insurance products that can be written by an insurance company to produce profits for the shareholders of the insurance company. The paper also looks at ways of ensuring that the profit-flow from the Health Insurance products remains positive (in particular via Health Care Management).

1. INTRODUCTION

Insurance is defined by the Oxford English Dictionary as follows:

"the act of securing the payment of a sum of money in the event of loss or damage to (property, life, etc.) by payment of (a) premium(s)."

In the early days of insurance, this would often involve rich individuals taking a relatively small payment ("the premium") from other individuals with the promise of making a significantly larger payment on the occurrence of certain events (e.g. death of the individual).

Over the years, insurance has evolved from covering the more traditional insurance risks such as:

- Payments in the event of death;
- Payments in the event of survival of a life;
- Payments in the event of theft;
- Payments in the event of accidental damage to property;
- Etc.

Such that modern day insurance covers a whole host of other so-called insurable risks, including:

- Weather (e.g. hurricanes or cyclones) interrupting a family holiday;
- Hole in One at a golf course;
- Contracting a dread disease;
- Disability; and,
- Sickness (loss of income, or loss of manpower).

The last three examples above have been deliberately chosen in that they are some examples of so-called Health Insurance, which is the main subject matter of this paper.

This paper outlines what insurance is and where Health Insurance fits into the insurance model (Section 3). It also outlines some of the basic Health Insurance products (Section 4) and focuses on Health Care Management – this is essentially a non-core activity of an insurance company (Section 5) which is vital to the success of many Health Insurance products.

Section 6 of this paper discusses briefly some of the other items which an insurer writing Health Insurance business needs to consider including:

- The Legislative Environment;
- Socio-Economic Environment;
- IT Systems;
- Investment strategies;
- Risk Management;
- AIDS;
● Post Retirement benefits; and,
● Cross Subsidies.

Finally, Section 7 takes a brief look at some revolutionary Health Care products and concepts that have been launched successfully in South Africa over recent years.

2. HEALTH INSURANCE MARKET

It is useful to come up with a definition of Health Insurance which I will use for purposes of this paper. However, before doing this, it is worth looking at some definitions of Short Term Insurance and Long Term Insurance. The legislation in many countries requires Short-Term (or General) Insurance to be treated differently from Long-Term (or Life) Insurance. In essence, Long Term Insurance usually pertains to events relating to the life of an individual whereas Short-Term Insurance usually relates to risks which do not pertain to a life and tend to have a relative high probability of occurrence in the short term. The following definitions of Long and Short Term Insurance have been extracted from the insurance legislation in South Africa:

LONG TERM INSURANCE

Long Term Insurance policies cover insurance on the occurrence of a life event or a health event.

A LIFE EVENT IS DEFINED AS :

"...the event of the life of a person or an unborn -
 a) having begun;
b) continuing;
c) having continued for a period; or,
d) having ended."

A health event is defined as :

"...an event relating to the health of the mind or body of a person or an unborn."

SHORT TERM INSURANCE

Short Term Insurance products cover the risk of financial loss or provide insurance cover on the occurrence of a risk event (e.g. theft of a vehicle) other than health or life events.

Defining and categorizing Health Insurance can be rather difficult. Indeed, many would argue that it is a Long Term Business with Short Term characteristics. Irrespective of legislation, consumers want cover of some sort throughout their lives, for events that (often) occur with a high level of frequency. For purposes of this paper, I will use the following definition of Health Insurance:

Insurance that provides single or multiple payments on the occurrence of certain health related events. These events can (in some cases) occur more than once.

I have considered Health Insurance as being a sub-set of Long Term Insurance; however, I am probably biased by the fact that my experience has mainly been in the Long Term Insurance arena. The concepts discussed in this paper are not materially impacted by how one classifies Health Insurance.

Given the rather broad definition of Health Insurance above, insurance companies have come up with products to deal with various health problems, these have included:

- Capital Disability Policies;
- Permanent Health Insurance Policies;
- Dread Disease (or Critical Illness) Policies;
- Long Term Care Policies.

As insurance companies have moved into new areas (e.g. Health Insurance and Medical Scheme Administration), they have also become involved in numerous non-core activities in order to enhance (and market) their core business, namely the selling of insurance products. In the case of Health Insurance, this has meant that insurance companies have become involved in, amongst other things, the following:

- Medical research;
- Putting together hospital and doctor networks;
- Providing administrative support to Medical Aids;
- Setting and approving medical tariff scales; and,
- Managing patients to assist them in returning to work (in the case of disabled or partially disabled individuals).

I have considered the last bullet point in more detail in Section 5. While the above activities are not core to the insurance business of a company, they can be of great importance to the long-term profitability of the insurance business. For instance, in many
countries, the insurance industry has set a scale of medical tariffs upon which insured benefit payments are based. This reduces the risk of abuse by Doctors charging too much for their services and knowing that this will be passed straight from the patient to the insurance company.

In many of the more developed markets (e.g. the United States of America, much of Europe and South Africa), many of the above products have been around for a couple of decades. However, in most of the developing markets (including much of Africa, Asia and South America) these policies are relatively new or do not yet exist. For those of us who come from the emerging markets, this can be seen as an advantage as we have the ability to learn from the mistakes made in other countries so as to ensure that our insurance companies can come up with profitable health insurance products. Of course, in order to do this, it is important to learn from both the successes and mistakes of others who have pioneered the ground ahead of us.

3. HEALTH CARE PRODUCTS

The following are brief descriptions of some of the major health care products available in world markets today

a) Capital Disability Policies

Disability benefits cover the financial risk to the insured of his/her becoming disabled and are expressed either as occupational disability (“own or similar” occupation) or the inability to pursue any activity for a living (“any” occupation). Benefits are payable in the form of a lump sum or as an income (see Permanent Health Insurance policies below). A lump sum benefit can be in addition to any life cover offered by the insurer, or be an accelerated benefit. If the full sum assured is accelerated on disablement, the life cover also ceases.

b) Permanent Health Insurance Policies

Disability income benefits pay a regular income should the insured experience a loss of income upon becoming fully or partially unable to follow their own (or similar) occupation. The benefit usually pays an income either until the insured has recovered sufficiently from the temporary disability to return to work, or has died, or until normal retirement age. A waiting period is usually imposed prior to the commencement of the benefit payment.

c) Dread Disease (or Critical Illness) Policies

A Dread disease benefit offers a payment (sometimes an accelerated death payment) on a confirmed diagnosis of a dread disease. This benefit is usually valid in the case of a limited number of listed diseases, which often include:

- Heart attack
- Stroke
- Coronary artery disease requiring surgery
- Cancer
- Kidney failure
- Surgery for a disease of the aorta
- Replacement of a heart valve
- Organ transplant
- Coma

Other diseases can also be included and the percentage of the sum assured paid for each disease may be related to the severity of the disease.

d) Long Term Care Policies

This policy provides financial security against the risk of needing either home or nursing-home care as an elderly person. Premiums will be paid regularly and will cease either when benefit payments commence or earlier (e.g. at a given age).

A group version of this product would enable an employer to provide long term care to retiring employees and their spouses.

e) Hospital Cash Policies

Hospital Cash polices usually provide the insured with a daily cash amount for the duration of an insured’s stay in the hospital. Further benefits are often added in order to cover the additional costs associated with any visit to the hospital. These would often be in the form of a major medical expense policy (see below).

f) Major Medical Expense Policies

Major Medical Expenses policies often complement a hospital cash policy. The policy would cover the costs associated with specified medical procedures. These would include the cost of any surgery or follow-up visits to a Doctor. The actual benefit would normally be based on a pre-determined fee scale for various different procedures.

g) Ongoing Medical Expense Policies

Policies of this nature are usually written for groups of individuals often referred to as Medical Schemes or Medical Aids. In many countries, such a product has to take the form of a “trust” or some other “non-profit vehicle”. The insurer usually monitors experience, recommends changes to rates and makes money via an
administration fee as opposed to through underwriting profits. Of course, in some legislative environments, additional sources of profit will also appear on these products.

4. COST SHARING OPTIONS AND MANAGED HEALTH CARE

Three main principles of profitable insurance are:

- The quantum of a claim must be large in relation to the insured's income or wealth;
- The frequency of claims should be relatively low; and,
- Administration costs need to be consistently low in relation to claims costs;

Hence, Health Insurance for frequent, low-cost events is often not commercially viable and insurance companies should either avoid such business, or, if it is inevitable as an add-on to other business, they should try to minimize this form of business. Many Medical Expense policies fall into this category, and as a result, can be either unprofitable or poor value for money to a policyholder.

Nonetheless, high frequency, low reimbursement Health Insurance business will be a part of many Health Insurer's ambit. So, how does the Health Insurer do this profitably? The answer lies in using Medical Savings Accounts (see Section 6), Managed Care (see below), co-payments etc., to encourage suppliers and consumers to self-select their behaviour patterns and thus mimic "proper" insurance business.

There are essentially two ways of maintaining the profit-flow on medical expense policies, namely:

- Cost sharing options;
- Managed Health Care.

a) Cost Sharing Options

In order to maintain profits on Health Insurance Policies, and, in particular, Medical Expense Policies, it is necessary to ensure that premiums exceed claims plus costs plus reserving requirements. The primary way of ensuring this is to keep claims as low as possible. This can be done by convincing the insured not to claim unnecessarily.

Some means of reducing claims from the insured include:

- Indemnity cover;
- The use of deductibles;
- Limits on amounts paid; and,
- Co-payments.

b) Managed Health Care

Health Care Management can, for purposes of this paper, be defined as the active participation of the provider (usually the insurer) in the prevention, recovery and general well-being of the policyholder. Health Care Management usually applies to disability (income) products and Medical Expense products as outlined in section 4 above.

A question that one should pose is: "why would an insurance company be involved in Health Care Management?". If one considers the nature of the products, one can see that, in the case of a Medical Expense policy, the more an individual makes use of his doctor, medical facilities, or prescription medicines, the higher the costs are going to be for the insurance company. Clearly, it is in the insurance company's best interests to minimize the insured's medical expenditure. Within limits, this is also in the insured's best interests as individuals do not (or should not), want to be making excess use of medical facilities.

Similarly, in the case of Permanent Health Insurance, it is in the insurance company's best interests to see the disabled individual returns to a state where he (or she) can return to work.

In the balance of this section, I have considered Health Care Management as it applies to medical expense policies. The following are the main forms of Health Care Management that can be used for such policies (or Medical Schemes):

- Utilization of health maintenance organizations;
- Pharmacy benefit managers;
- Setting up and utilizing preferred provider organizations;
- Requiring pre-treatment clearance;
- Utilization of diagnostic related groups; and
- Linking short term cover to "wellness" products.

One indirect form of Managed Health Care is the instance of an insurance company (or Medical Scheme) offering different plans where some plans are tightly managed (in other words, the policyholder - or member - is only allowed to claim after being thoroughly examined by the doctors and other experts of the insurance company) and other plans being much looser in their management style, but having high excesses, or using Medical Savings Accounts etc.

The sicker individual is likely to opt for the former plan as they will then get all the treatment they need, but will not be given any excess treatments. They will be charged a higher premium for this. The healthier individual would normally opt for the latter plan as he can then choose how he uses his medical savings (in the case of Medical Savings Account) or, he can...
choose to use as little as possible on medical facilities where excesses are used.

Premiums for the former would normally be higher than for the latter and this would create some form of self-selection.

5. FURTHER ISSUES RELATING TO HEALTH INSURANCE POLICIES AND HEALTH CARE MANAGEMENT

There are many other important aspects to Health Insurance Policies and Health Care Management. A single paper cannot cover all of these; however, I have tried to outline some of the major issues that need to be considered by any Health Insurer who is aiming to make profits and sell reasonable policies to his clients.

a) The Legislative Environment

A fine balance between government imposed regulation (legislation) and self regulation by the industry needs to be found. If a particular industry is “over” regulated it stifles innovation and development. On the other hand “under” regulation can result in unwanted practices and “fly by night” operators.

By way of example, in South Africa, insurers, short or long term, are constrained by Law to providing cover for “defined events” only. In other words, they can reimburse a promised sum against an event such as a defined disability, or defined occurrence such as a hospital stay, or a given illness. They are prohibited (by the Medical Schemes Act) from reimbursing the actual invoiced costs incurred by a patient if he succumbs to illness. The indemnity they are allowed to provide may thus exceed or be below actual costs.

Cost reimbursement cover (Major Medical Policies and the ongoing Medical Expense Policies outlined in Section 4), whether they be with or without co-payments, co-reinsurance, deductibles or limits, are restricted to “non profit” mutual organizations known as Medical Schemes.

The South African legislative environment has posed a problem for insurance companies and also provides a good example of how innovation can allow insurance companies to continue to make profits even in a relatively tough legislative environment. In South Africa, Medical Schemes (the non-profit organizations referred to above) are often employer-linked and therefore limited in scale. These mutual employer-linked funds have sought out specialist “for profit” administrators who manage a basket of schemes. The administrators range from the more traditional “cash shuffler” to sophisticated insurers who bring their insurance and risk management expertise to the schemes.

A prime example of such an insurer in South Africa is Discovery whose schemes cover more than 1 million lives. Insurers such as these structure the cost and reimbursement offerings of the Medical Scheme on normal insurance principles. The insurers make their profits out of fixed administration fee, and at the same time keep the risks down (as a consequence of legislation) as they are not underwriting the policy risk per sé.

b) Socio-Economic Environment

The socio-economic environment has a significant impact on the type of Health Insurance policy that consumers will look to buy. It will also have an impact on the claims pattern of consumers. For instance, in a relatively poor society, product demand will be for products that cover day-to-day basic medical care. This will tend to be products which have high frequency of claims where the average claim sizes are relatively low. As mentioned earlier in this paper, it tends to be more difficult to make profits from such products. Thus, it is important for every insurance company to identify its target market and design products that will satisfy that market and where the market is a problem, provide dis-incentives to over-utilization of the benefits under the product.

c) IT Systems

The measurement and manipulation of data is of essential importance in operating an effective health care management system. There is a vast quantity of data that must be stored and manipulated for the various aspects of health care management. In addition this data should be readily available and easily updateable. In short the system should be robust!

It should be noted that the Health Insurance industry is significantly more complicated than many other forms of insurance in terms of what must be stored and monitored. In particular, Health Insurance can often involve more than one claim (in fact, in the case of low cost, high frequency claims, there are often numerous claims in every year). This means that significantly more information needs to be maintained, monitored and analyzed for Health Insurance than for many traditional forms of insurance (e.g. Life Insurance).

d) Investment Strategies

Due to the frequency and level of
the contributions received for most Health Insurance products, providers have large amounts of funds that need to be invested in appropriate vehicles. Certain countries (e.g. South Africa) have also introduced reserving requirements, which will result in significant reserves building-up over time for Health Insurance products (in particular Medical Schemes business). This has introduced the additional complication of matching assets and liabilities. This is an area where actuarial judgment is essential.

e) Risk Management

The success of any Health Insurance Policy is crucially dependent on appropriate management of the underlying risks. Risk management in Health Insurance products can best be attained by:

- setting of appropriate premiums;
- effective underwriting;
- effective claims control;
- measurement and control of expenses;
- appropriate reserving;
- appropriate use of reinsurance;
- avoidance of anti-selection;
- internal operational control; and,
- investment strategy and subsequent measurement.

The mitigation of risks is an important part of the risk management. This involves the implementation of appropriate tools (or systems), which effectively remove the risk from the insurer or reduce any risk to an acceptable level.

An example of a tool used to reduce the risk faced by the insurer is the use of risk rated contribution tables. This results in members posing higher risks paying higher contributions relative to members who pose lower risk to the provider.

f) AIDS

AIDS is a problem which is impacting on the entire insurance industry and business in general. AIDS is a problem in most developing markets and is becoming a more real problem in first world countries as well. One of the challenges that faces Health Insurers is how to deal with AIDS claims, and what products can be designed that meet the needs of AIDS sufferers. This is a challenge that has not, in any market, to my knowledge, been fully addressed.

In some Southern African countries, insurance companies are offering certain anti-retroviral treatments in order to extend the expected life span of their policyholders. This is one area where Health Care Management can be used to delay the payment of insured benefits (normally Life Insurance) and also add to the expected life of the insured, thus benefitting all parties concerned.

POST RETIREMENT BENEFITS

Another challenge for the insurance industry is how to deal with post retirement medical benefits. One possible way of dealing with these is to use some form of endowment product (where premiums are paid during the working life of the insured) to provide a lump sum at retirement date which can be used to pre-fund medical expenses (or a future Medical Expense Policy).

CROSS SUBSIDIES

The issue of cross-subsidies is another item which needs to be carefully considered by any insurer. There often tends to be cross-subsidies in Health Insurance Polices and in particular in Medical Expense Policies. In some countries, such as South Africa, it is not possible to rate a Medical Expense Policy (actually a Medical Scheme contribution) using age or other statistics which actuaries would tend to believe have a material impact on the level of premium (or contribution) to be charged.

Even when legislation does not force cross-subsidies, it is quite common for there to be cross-subsidies in Health Insurance products. The insurance company needs to examine the level of the cross-subsidies and ensure that the style of their products is such that anti-selection will not result in abuse of these cross-subsidies.

6. REVOLUTIONARY HEALTH INSURANCE TECHNIQUES (MEDICAL COST POLICIES)

Health care products throughout the world have followed similar patterns of development. The main difference is in the level of development of the market in which the health care providers are operating. The United States of America and Europe have a highly developed health care system which links into insurance companies in many instances. In contrast, other markets have a less developed health care market and related insurance products can be expected to follow a similar path of development to that experienced in the United States of America and Europe, simply a decade or two later.

The general trend in the Health Insurance market has been away from the traditionally based Medical Schemes under which members pay a fee to the Health Care provider in return for coverage of all medical benefits (with limits applying to certain services). Under this fee-for-service arrangement, the health care provider is not linked to any of the
service providers (i.e. Doctors, hospitals, etc.). The Health Care provider merely receives an invoice from the various Health Care providers and will settle that invoice on behalf of the member (up to any relevant limits).

The more developed markets have moved to various forms of “managed care” products. Here the providers have set up specific service provider networks in which pre-agreed fees (and/or capitation arrangements) have been set up and members are channelled to relevant providers who are closely monitored in terms of service levels offered, utilization and prices charged.

b) Capitated Arrangements

A further innovation in some progressive markets, including the South African market is the use of a capitation arrangement for Medical Expense Policies (actually Medical Schemes in the South African environment). A capitation arrangement involves identifying certain service providers (usually doctors) who will provide given services to their patients (the policyholder of the insurer or the member of the Medical Scheme). The services provided are usually doctors consultations (and sometimes prescribed medicines). The doctor (or doctor network) is paid a fixed fee per policyholder (or scheme member) under its care. The doctor is then responsible for providing whatever care is necessary to that patient (be that one visit in a year, or twenty). By linking up a provider network through a capitation arrangement the risk of over servicing and hence higher costs is placed in the hands of the doctors (in that they will receive a fixed fee regardless of how often they service members). It will then be up to the doctor to ensure that members receive appropriate service and thus do not return for frequent visits (which costs the doctor – not the insurer – more).

7. CONCLUSION

The paper has given a brief overview of some of the products that can be sold in the Health Insurance environment and how Health Care Management can be utilized to enhance the bottom line of an insurance company writing Health Care products. It is clear to me that there is significant scope for growth in market share of Health Insurance products in many of the emerging markets over the next decade or two. The challenge is to put together the right product for the right market and ensure that:

- The product is correctly priced;
- Claims are monitored underwritten and kept to a minimum (without in any way impinging on the rights of the policyholder); and,
- All the right systems and procedures are put in place.

This is a challenge which, I believe, should be eagerly taken up by all of the insurance companies involved in the Insurance Congress of Developing Countries.