Voluntary private health insurance: challenges & opportunities in complementing State-funded healthcare

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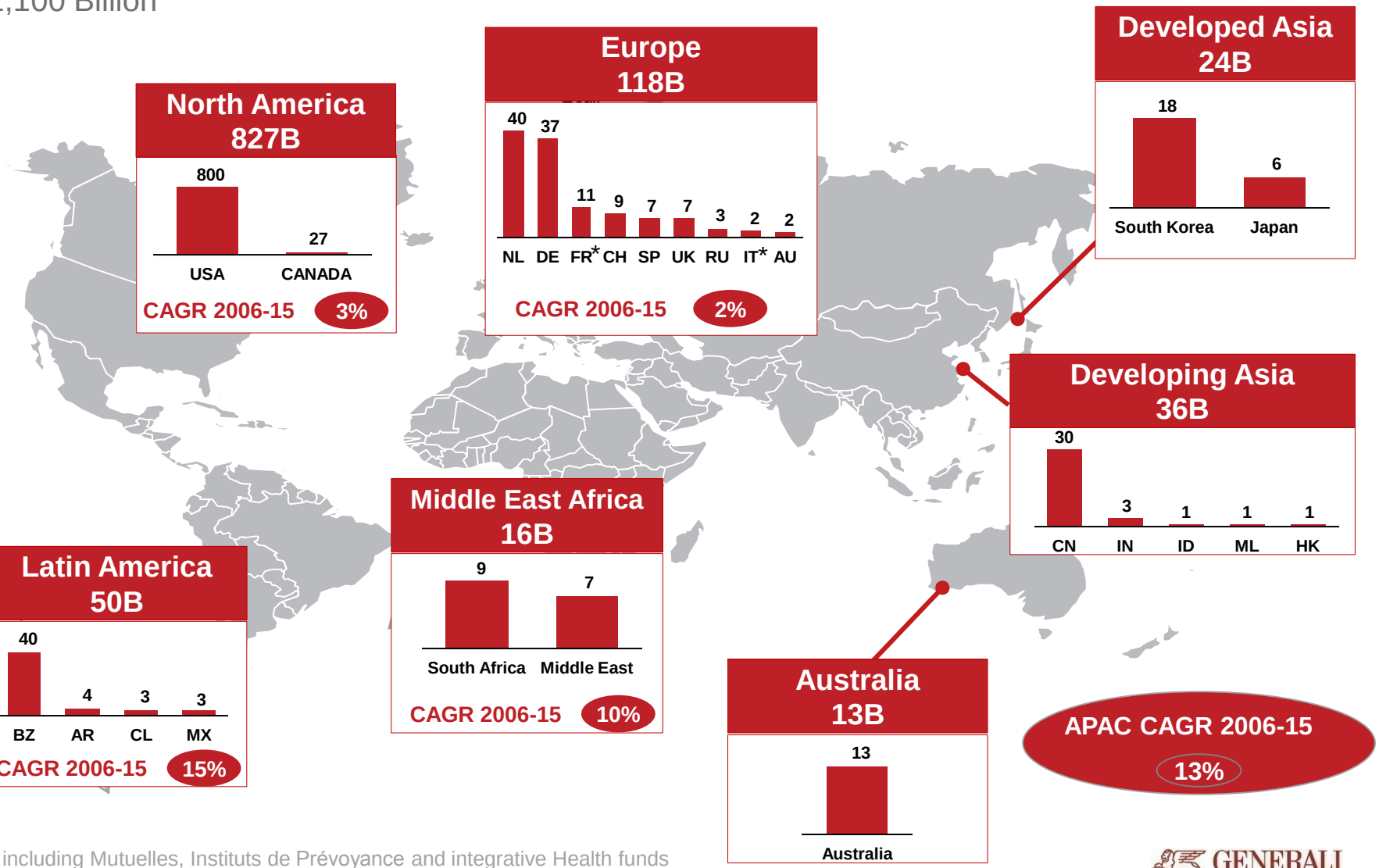
Global Health Insurance expenditure

€ 1,100 Billion



* Not including Mutuelles, Instituts de Prévoyance and integrative Health funds

(Source: WHO, Global Insight, MunichHealth, Axco)

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Health Trend vs General Inflation

	2016			2017		
	Annual General Inflation Rate (%)	Annual Medical Trend Rates		Annual General Inflation Rate (%)	Annual Medical Trend Rates	
		Gross (%)	Net (%)		Gross (%)	Net (%)
Global	**2 .9**	**8 .1**	**5 .2**	**2 .8**	**8 .2**	**5 .4**
North America	1 .5	6 .0	4 .4	1 .6	6 .3	4 .7
Latin America & Caribbean	6 .4	13 .6	7 .2	6 .0	14 .2	8 .2
Europe	1 .6	5 .9	4 .2	1 .6	5 .7	4 .1
Middle East & Africa	6 .3	11 .6	5 .3	6 .7	14 .3	7 .6
Asia	3 .2	9 .4	6 .3	2 .9	8 .9	6 .0

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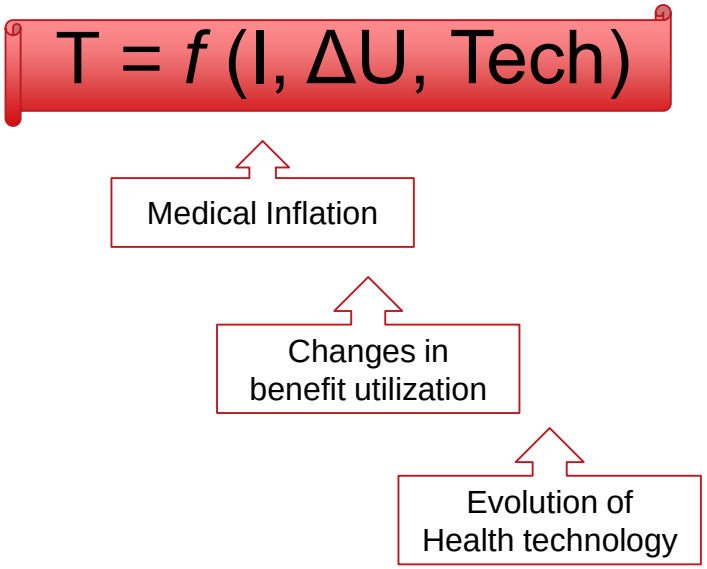
Understanding Health Trend

Local Health Trend averages are approximately 2X higher than CPI

- Understanding global health trend



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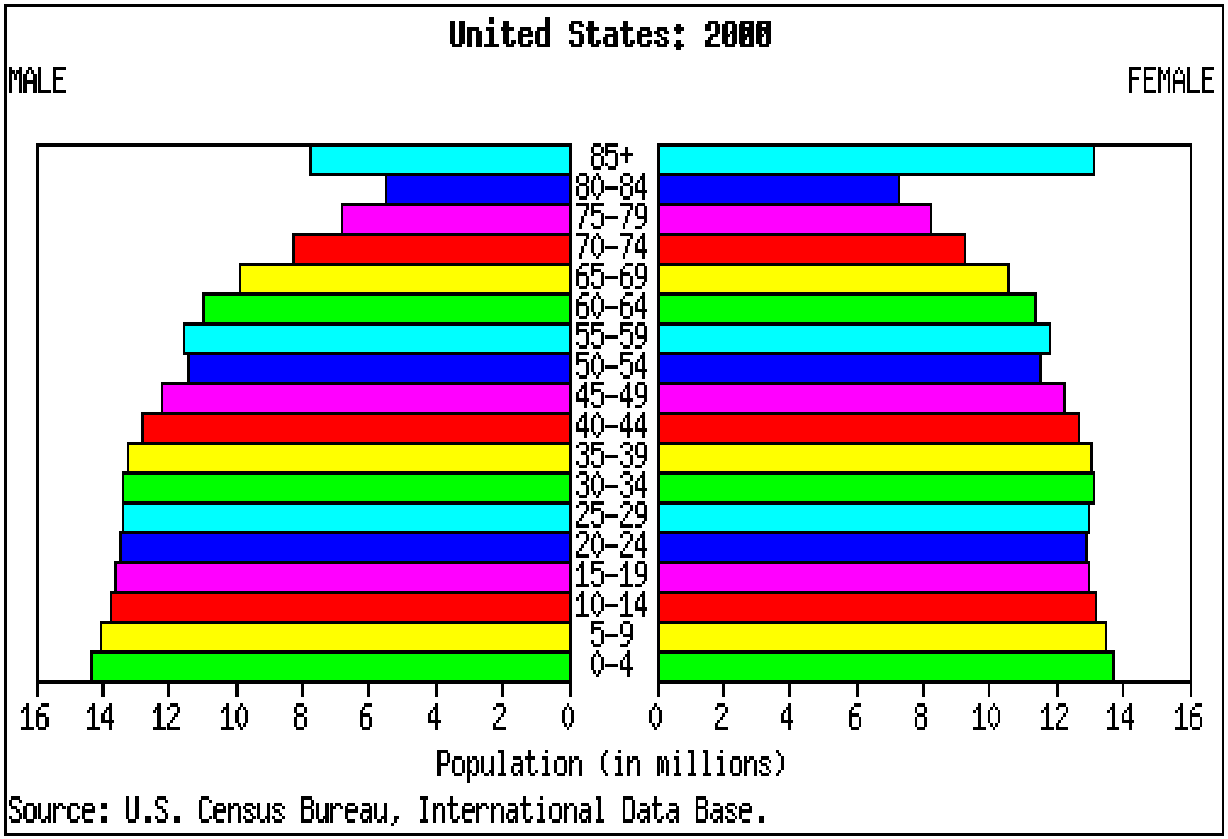
Aging population trends

Local Health Trend averages are approximately 2X higher than CPI

- Aging population



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Risk mitigation to manage rising healthcare costs

Asia Pacific		Europe		Latin America		Middle East/Africa	
Cost Sharing	**88%**	**Provider Networks**	**66%**	**Provider Networks**	**65%**	**Cost Sharing**	**73%**
Service Limits	**59%**	Plan Changes	**66%**	Cost Sharing	**60%**	Service Limits	**50%**
Provider Networks	**59%**	Cost Sharing	**52%**	Service Limits	**55%**	Provider Networks	**36%**
Plan Changes	**47%**	Service Limits	**38%**	Plan Changes	**50%**	Plan Changes	**36%**
Medical Services Pre-approval requirement				**18-30%**			

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What does Private Medical Insurance cover? Strong Differences Exist

What PMI Products cover depends on what local Public Systems are like.

*The scope of PMI cover depends on **Supply** and **Demand** for private treatment. Supply and Demand for private care can evolve year over year.*

*When working with PMI in a country, it is best **not to assume** that the local Public/Private interplay is the **same** as that in **your own country**.*

Public / Private Interplay – 5 main PMI Models

1. ***Multiple Partial/Comprehensive Systems***

   *No national public system except for certain populations (e.g. very poor or elderly). Everyone else expected to buy PMI or pay out-of-pocket (**e.g. USA**).*

2. ***Single Comprehensive Public System***

   *Health care is exclusively through Public System and private insurance is illegal except to pay for services not covered by Public System. (**e.g. Canada**).*

3. ***Public System Opt-Out***

   *Insureds may opt-out of the Public System and purchase comprehensive coverage for all health services (**e.g. Germany, Austria**).*

4. ***Supplementary Coverage to Public***

   *Public System is primary payer. PMI funds out-of-pocket requirements (copays, coinsurance, deductibles) of social insurance (**e.g. Belgium, France**).*

5. ***Dual Complementary Systems***

   *Public System is usually primary payer and provider. PMI pays for care rendered by private providers. Often comprehensive (**e.g. Brazil, UK**), it is usually limited (**e.g. Hong Kong, India, Portugal, etc.**).*

Health systems and payment mechanisms

Reimbursement model	Description	Incentives	Major risk-bearers
System payroll	▪ Clinical staff on national workforce contracts (e.g., England, Turkey)	▪ Little incentive for increased productivity	▪ Patients
Line item budgets	▪ Budgets allocated line-by-line to providers (e.g. Egypt)	▪ Little/no incentive for performance or efficiency	▪ Patients
Global budget	▪ Fixed budget linked to high-level output requirements	▪ Drives output levels to match targets/requirements	▪ Providers
Capitation	▪ Providers paid a fixed amount per year for each patient on their panel (e.g., England)	▪ Rewards limited cost of treatment, potential underutilization of necessary care	▪ Providers
Diagnostic-related groups	▪ Risk-adjusted paid for bundle of eligible care activities (e.g., Germany)	▪ Incentive to improve volume and microeconomic efficiency	▪ Payors
Fee for service	▪ Providers or practitioners paid a pre-defined price for each activity performed	▪ Incentivizes increased volume, leading to supply-induced demand	▪ Payors
Point FFS	▪ Level of reimbursement reduced as total volume increases (e.g., Germany)	▪ Incentivizes increased volume from individuals	▪ Providers

Payment mechanisms are becoming more sophisticated

	Payment characteristics	Implications for systems
Promoting access	▪ Activity-based reimbursements to increase activity (e.g., DRGs, FFS)	▪ Reduces financial pressure on payors for coverage of high-risk patients ▪ Reduces financial pressure on providers for care of high-risk patients
Increasing quality	▪ Increases awareness and improvement on quality metrics (e.g., PFP) ▪ Highlights safety expectations (nonpayment for failures or “never events”)	▪ Drives safety without intervention of regulatory body
Increasing transparency	▪ Reveals system performance (e.g., PFP) ▪ Clearly defines care activities performed (e.g., DRGs)	▪ Link to incentives increases likelihood of provider completion ▪ Allows payors to define what is part of a treatment
Improving productivity	▪ Incents increased productivity (e.g., PFP) ▪ Drives cost-effective care bundles (e.g., capitation) ▪ Incentivize greater activity while limiting risk (e.g., point FFS)	▪ Rewards top-tier providers ▪ Places onus to improve on underperforming providers
Integrating care	▪ Single payment (e.g., capitation) to cover both primary and integrated care	▪ Provides option to drive integration that is accessible to payor (contrast to restructuring provider network)

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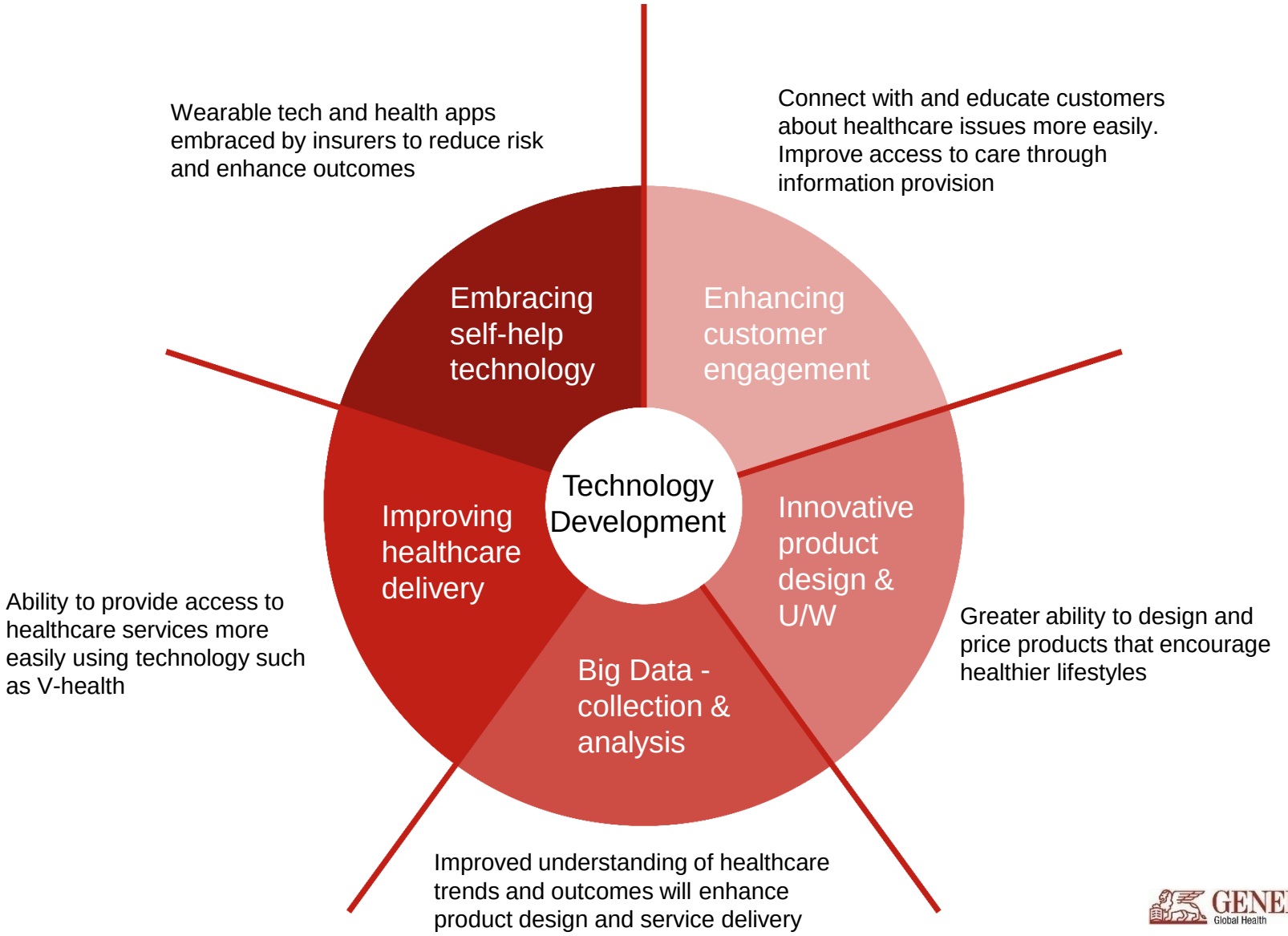
Evolving Healthcare: key topics for a new Health Insurance business model

	From	To
Product design	▪ **Mostly** (if not only) **curative** component ▪ **Hospital** care	▪ **Also preventive** component ▪ **Most effective care, e.g. home** care ▪ Steering towards **better quality providers**
Distribution	▪ Contact with client **only if claims incur**	▪ **More frequent contact with clients** irrespective of their health condition ▪ **CRM** to focus on Xsell/upsell also on the employees of collective business
Underwriting	▪ **Selecting and pricing the best risk** (where possible)	▪ **Actively working on risk pool** to improve mortality, morbidity and disability risk
Claims Management	▪ **Mostly** (if not only) **focus on admin components** of plan	▪ **Also focus on medical appropriateness,** e.g. diagnosis-treatment consistency ▪ **Simplified client experience** in terms of submission, monitoring and reporting
Network Management	▪ Main focus (in any) on **size of network** ▪ **Volumes** vs. **unit cost discounts**	▪ Selection and contracts embedding **cost/quality criteria** ▪ **Dedicated services** to medical providers
Medical management	▪ No particular focus	▪ **Strong focus on improving clients' health** through wellness, prevention and care programs, and behavioral change

From Sickness Insurance to Health Insurance



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Thank you.

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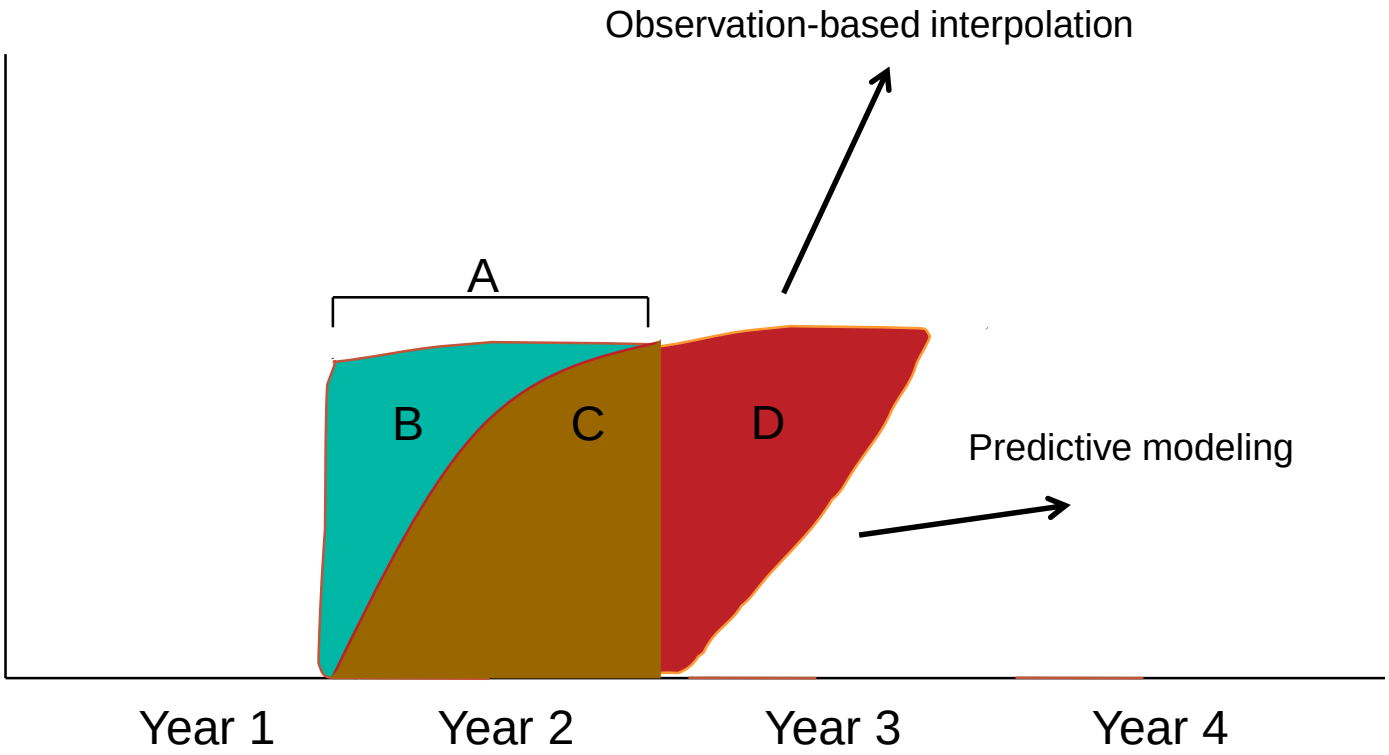
Technical reference: health claim analysis

Incurred Claims – Importance of Accurate Claim Reserves

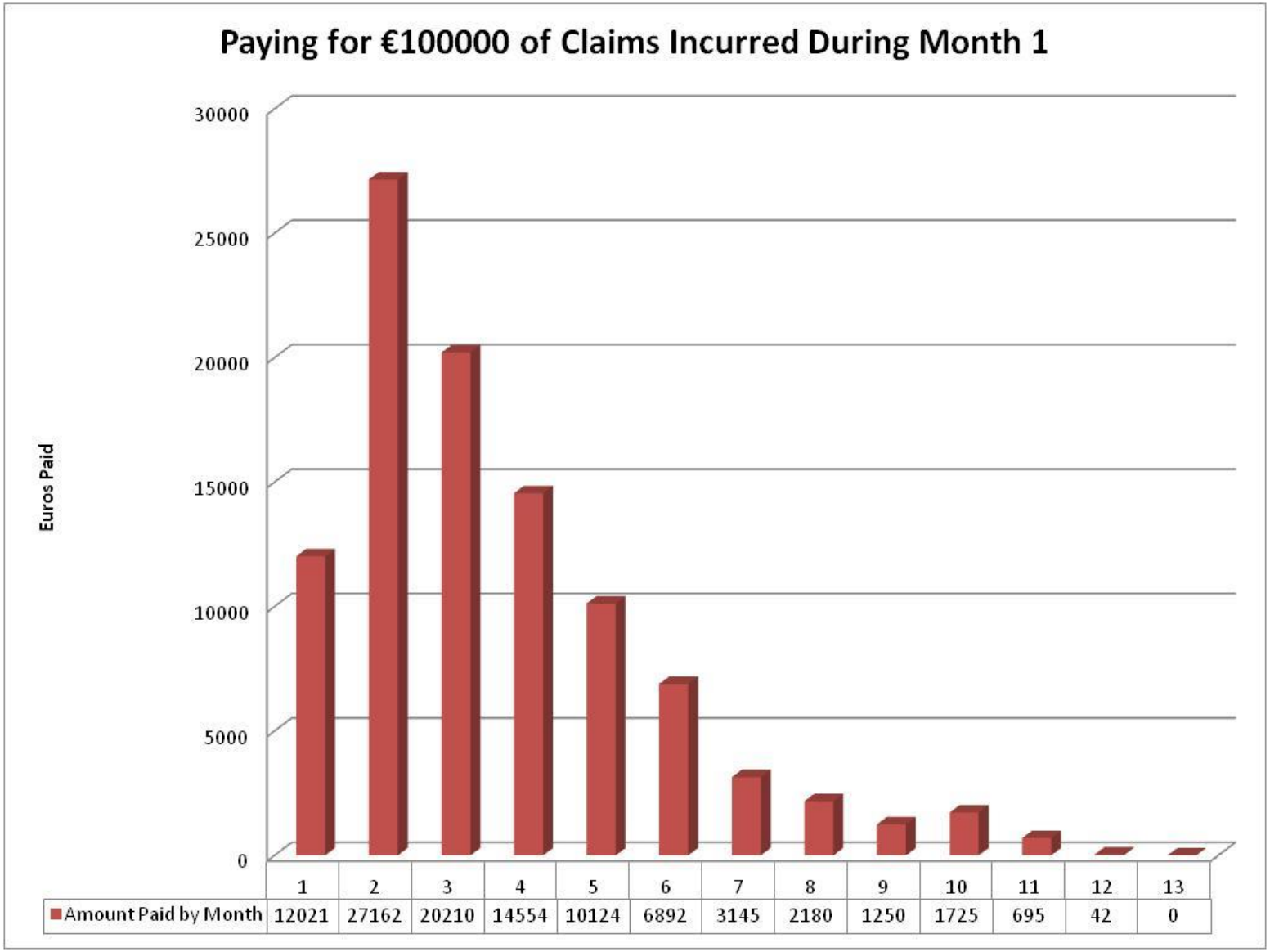


To estimate with **Paid Claim** data (irrespective of D.O.S.), we add Claims **+** Change in Reserves.
Incurred Claims = A + (Current estimates for D – Prior estimates for B)

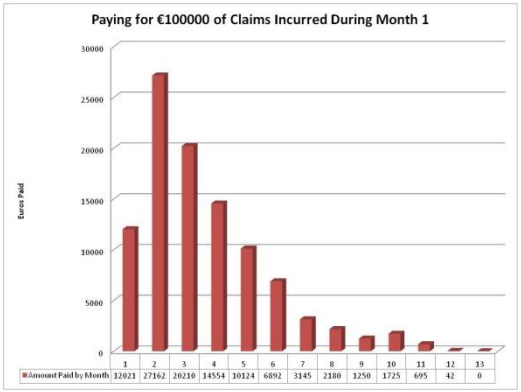
To estimate with **Incurred Claim** data (D.O.S. within the period) we add Claims + Reserves.
Incurred Claims = C + Current estimates for Dc

Understanding Claims Lag

Using Claims Lag to identify a single month's completion trend



Understanding Claims Lag



Completion Factors for Month 1 Incurred Claims

Total Euros Paid

120000
100000
80000
60000
40000
20000
0

12.0%
39.2%
59.4%
73.9%
84.1%
91.0%
94.1%
96.3%
97.5%
99.3%
99.9%
100%
100%

	1	2	3	4	5	6	7	8	9	10	11	12	13
Cumulative Amount Paid	12021	39183	59393	73947	84071	90963	94108	96288	97538	99263	99958	100000	100000