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Reasons why private health insurance is unlike "insurance" and the implications for sustainable health financing systems

Robin Ali

Founder and Head of Practice

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Authored by Robin Ali, Founder and Head of Practice at The Consilient Consultancy Limited, Head of Program Content of the International Health Insurance Forum and a former Health Insurance Regulator

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Why this paper?

The author of this paper has 31 years’ experience across all forms of insurance, including health insurance, in many countries. His last 10 years have been specifically focused on health system financing in developing countries in the Middle East and Africa. The author’s work has included working for a “Big 4” advisory firm, a GCC government and providing *pro bono* advice to other regulators in the Middle East and Africa. He has also provided health system financing and regulation advisory and consulting services to clients of other consulting companies.

The reason for this paper comes from the author’s observations of developments in the role of private health insurance and the increasing use of private health insurance by some governments as a health system financing tool. Together with changes to underwriting brought about by the increasing collection of behavioural data at the consumer level, competition pressures on insurance companies and the expectations of some governments that health insurance policies should offer preventive benefits, the author argues that health insurance is leaving behind some of the core insurance principles such as covering unexpected risks and risk pooling.

This paper suggests reasons to support the view that the above and other changes are leading to private health insurance creating a disenfranchised population, a three-tier system of financing health care, the marginalisation of some insurers and increasing market control concentrated in fewer market participants.

The paper also challenges existing models of health insurance and proposes alternatives, some of which are counter-intuitive in an economic environment in which some governments are “disengaging” from providing health care and in which policy makers and the private sector push for privatisation of health care financing.

Limitations on scope

This paper does not represent a full assessment of the various health financing systems around the world but focuses on private health insurance.

Importantly, this particular paper does *not* address the impact of “insurtech” in its various forms or the growing impact of “telehealth”. Nor does it deal with the role of technology in supporting efficiencies in private health insurance or its regulation. These matters will be the subject of other papers.

Disclaimer

Private health insurance as a health system financing tool is used in many different ways in different countries and its regulation also varies widely. Accordingly, this paper does not seek to be a definitive source of reference for legislation in specific countries.

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Reasons why private health insurance is unlike "insurance"

Reason 1 - Individual underwriting vs risk pooling

A core principle of insurance going back thousands of years before the rise of the London insurance market and firmly embedded within the Islamic principles of Takaful is that of providing a guarantee that help can be provided to an individual, a group of individuals or some other party with an interest such as a commercial organisation who find themselves suffering the economic or physical effects of an unexpected event whether it be crop failure, a disease affecting livestock, a personal illness, death of a key business director or a cyber-attack. We call this principle "risk pooling".

Most people reading this paper will understand this principle so it requires no further explanation. However, the principle particularly in the area of health insurance is now under attack by the increasing availability of data relating to pre-existing health conditions, medical history, consumer behaviour and lifestyles, the ability of underwriters to manipulate these data and by the increasing availability of and access to genetic information.

Whilst the author accepts that underwriting of health insurance at the individual or small group level has always relied upon the insured declaring items such as personal medical history, family history of some medical conditions (such as cancer or cardiovascular problems) and lifestyle (smoking or alcohol consumption) he argues that the degree to which technology provides underwriters with so much more granularity and specificity of data to price the individual risk is leading to the demise of risk pooling and the rise of highly targeted individual level underwriting. The effect of this is that eventually only the healthy will find private health insurance affordable. Set against a trend towards privatisation of health system financing in some countries this has significant social and economic consequences.

Reason 2 - Severity and frequency of health insurance claims

For some personal business lines such as motor or property the frequency of claims is very low relative to health insurance. The severity of health insurance claims is also somewhat different in that it includes very many small value claims (particularly for the maintenance of chronic conditions) with relatively fewer high value claims. This produces a much higher frequency of a claim under health insurance than under motor or property. The result is that premium pricing and rating adjustments are tied much more closely in terms of value and timing to actual experience. Advances in technology in relation to claims processing have strengthened this tie. In other words, the *uncertainty* of the risk and quantum of a claim in the underwriting process for motor or property insurance is replaced by much greater level of *certainty* in health insurance which makes it less of a "risk" product and more a reimbursement mechanism for claims that are widely expected. This is another reason why the author believes that private health insurance is becoming less of a risk product and more of a "transactional" product which sees the insurance company acting as a payment gateway between the patient and the provider.

Reason 3 - Policy period

There has been much discussion around introducing certainty of premium pricing by creating multi-annual policies for health insurance rather than the ubiquitous annual policy which leaves consumers uncertain as to their health insurance costs for the coming year. So why is it so rare to find such policies?

One reason is that medical technology and interventions increase at a rapid pace, generally introducing new therapies or surgical techniques that are, at least in the early years, more expensive than existing ones. This leaves underwriters unable to determine utilisation and costs of new treatments until at least two or three years after their introduction. The result is an uncertainty in the expected severity and probability of claims which in turn leads to underwriters merely adding some of these new treatments to their list of exclusions and taking a wait and see approach before pricing them into their ratings.

Another reason specific to group schemes is that underwriters are concerned that in the absence of full disclosure of medical history, they are unable to provide a price guarantee spanning several years at a

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competitive price lest they end up with a scheme which displays the onset of conditions creating catastrophic claims. However, if health insurance was a true insurance product surely this risk should be offset across the insurer's whole portfolio and not just the individual group scheme using the principle of risk pooling?

A third reason is the distribution mechanism. In markets where distribution is highly dominated by intermediaries, we see a tendency for consumers to seek, and be encouraged to seek, lower premiums at renewal. Intermediaries will compete to either snatch a client from another intermediary or attempt to retain the client. In both cases the result is that insurers are forced to provide enhanced renewal or new terms in order to retain or acquire the business. In such an environment, insurers are unwilling to lock themselves into multi-annual policies with little room for negotiation of terms on a yearly basis.

Reason 4 - Emotion

While people can often be emotionally attached to their vehicles or their homes and may "grieve" when such assets suffer a loss or damage of some sort, such assets can be repaired, or if not, replaced with the help of insurance. However, when it comes to their own health, that of their loved ones or their families, their approach to insurance is very different. People therefore have a different view about what their health insurance policy should cover (basically anything and everything) compared to what they accept that property or motor insurance should cover (replacement value, scrap value etc).

This manifests itself in the buying process. A motor policy may be partly priced on the resale value of the vehicle which will deteriorate over time. Renewal terms often reward "good" drivers or punish "bad" drivers using *bonus/malus* schemes. Consumers accept this. However, consumers tend not to accept a premium increase because their health has deteriorated through what they may see as no fault of their own.

Consumer expectations of how their health insurance policy should work are therefore very different to how they see their motor policy. There also seems to be an expectation amongst health insurance policyholders that the insured should achieve "value for money" by utilizing their cover. So we see cases of people using services such as dental, optical and primary health care physician consultations just to "receive their money back". No one would take this approach with property and casualty insurance thus. "I must crash my car to receive the value of my insurance" or "I must set my house on fire to make a claim" (arsonists excluded of course). No one will cause intentional self-harm just to make a health insurance claim but many will utilize the cover offered when maybe not strictly medically necessary. Emotion is therefore another reason that health insurance is unlike other business lines.

Reason 5 - Consumer misbehaviour

Whilst earlier it has been said that insured members will not (normally) inflict self-harm simply to make a health insurance claim but may utilize some services to extract "value for money", there is certainly greater scope for fraud and abuse in health insurance. It is accepted that, for example in motor insurance, repairers can form cartels to defraud insurance companies and consumers can directly attempt fraud or abuse, but in health, the evidence of an illness can be vague. Back pain is a classic example (although improved imaging techniques are reducing the potential of such abuse).

With health insurance, it is easy for an insured member to seek healthcare services that an uninsured person might not seek, the former knowing that the cost would be covered (in whole or in part) whilst the latter knowing that he or she would have to pay out of pocket. Thus, we do indeed see activities such as "doctor shopping" or obtaining multiple prescriptions, sometimes for onward sale. It has to be said that this is where centralized, regulator controlled electronic claims systems are a valuable tool to detect and reduce such misbehaviour.

The effect of consumer misbehaviour again makes health insurance a product unlike any other insurance product.

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Reason 6 - "Wear and tear" and prevention

There are some things that motor insurance does not cover such as replacement of worn tyres, an annual vehicle inspection and test, a paint respray or rust removal. This is a key difference to health insurance which necessarily covers "wear and tear" of the physical body and may provide for the cost of annual health checks.

The "curative" aspects found in health insurance are not found in motor insurance (other than vehicle repairs after an accident) and the "preventive" aspects found in health insurance are never found in motor insurance. Similarly, with property insurance, the repair of an old roof that has begun to leak (curative) is not covered by a buildings insurance policy (although storm damage would be covered under a buildings insurance policy or water ingress caused by a leaking roof may be covered under a home contents policy) and no insurance policy will cover the cost of the installation of a burglar alarm (preventive) although having a system in place can produce a premium discount.

Health insurance companies are increasingly adding benefits of a preventive nature, either because they believe that such preventive measures will reduce future claims or because they are instructed to do so by some government authorities. But should such benefits be part of an insurance policy? Certainly, they are not benefits which cover a "risk": they are covering a near certainty that a claim will arise once someone knows that they can avail, for example, a "free" cancer screening test.

The addition of preventive benefits does little more than add the cost of the benefit to the premium payable by the insured, a cost which the insured would have incurred and paid directly to the screening test healthcare provider if they chose to have the test. However, it is accepted that the effect of including such benefits is advantageous from a public health perspective since without the benefit, an insured member may not necessarily seek and pay for the test independently. It is also accepted that if the insurer allows such benefits to be received at specified screening centres, a discount to the retail price can be negotiated, hopefully to the benefit of the insured member. But the contention remains that these benefits are not covering risks but are covering the near certainty of a claim being made. This is not insurance.

So, health insurance provides "wear and tear" and preventive benefits that other insurances do not, again making it a form of insurance distinct from all others.

Reason 7 - Employer ties

If I change my employer, it has no effect on my personal motor insurance or my home insurance (unless, of course, the vehicle or home are owned by the employer). However, as we have seen during the major job losses in the United States throughout 2020, the loss of employment has a devastating effect on the former employee's health coverage. Unless able to secure another job which also offers health insurance, an employee is left with the option of trying to buy individually underwritten cover at open market rates (subject of course to any underwriting restrictions surrounding premium pricing) often with previous medical history factored in to the premium and with the loss of the benefits of risk pooling that group schemes typically offer. This often results in no cover because it is unaffordable to the individual. One solution would be for insurers to offer continuation of cover on the same basis but with the premium being paid by the former employee. Few insurers offer this as an option.

Reason 8 - Product design and distribution channels

For most insurance business lines, the main *channels* of distribution are direct from the insurer, through tied agents or through independent intermediaries. The *media* of distribution have of course changed over the years to a greater or lesser extent for all three channels with in-person sales being supplemented, and in some cases replaced, by telephone sales and online sales. Product design has largely been the realm of the risk carrier, be that a direct insurer or that insurer's reinsurer.

Health insurance distribution and indeed product design has developed along a slightly different track. Third party claims administrators dominate the health insurance claims administration process in some markets. But their role has expanded beyond just claims administration. Several such TPAs are owned by global

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reinsurers who provide reinsurance support to the insurance companies who ostensibly carry the risk. It is therefore no surprise that insurers who are backed by such reinsurers use the services of the TPA which is owned by the very same reinsurer. Furthermore, it is no surprise that the schedules of benefits for plans sold by different insurers look remarkably similar when you consider that they share the backing of the underlying reinsurer. But it goes further than this. Insurers have stopped designing health insurance products. Instead, with the benefits of their huge claims data banks, TPAs owned by global reinsurers are now the product designers, providing the reinsurer with an "indirect to market" route. This model abounds in the health insurance markets of the Middle East and Gulf States.

Doubtless there is nothing inherently wrong with this practice. But it can lead to aberrations where some, mainly independent TPAs, have been developing and marketing products to employers and then trying to place the business with an insurer. This marketing of insurance products by TPAs who are not licensed as insurers is illegal in several countries.

But the point is that this is another departure for health insurance from traditional insurance.

Reason 9 - Remuneration structure

The insurance intermediary business was built upon the concept of commissions. In some countries commissions have been outlawed, being replaced instead by fee-based advice. Whilst this has appeared to work and permeate many lines of corporate insurance business, it has not done so to a great extent in many personal lines of business. Specifically, in health insurance, intermediaries continue (in countries where it is not outlawed) to receive their remuneration by way of a percentage of the gross premium payable. This produces a number of inequities.

Firstly, what is the justification for an intermediary receiving the same percentage commission for placing a scheme with an annual premium of, say, 20,000 Euro compared to a scheme with an annual premium of 200,000 Euro (accepting the fact that collecting and analysing census and claims data might be more onerous for a scheme with many members but don't data processing applications take care of that these days?)

Secondly, the existence of commissions as an intermediary's basis of remuneration can result in a bidding game where employers will seek rebates of commissions to reduce premiums and intermediaries will in turn offer such rebates. Sometimes, the rebates become "unofficial" with the beneficiary not being the employer but a member of the employer's procurement department with a similar "redirection" of some of this rebate to the insurance company salesperson. This is not conjecture. There have been proven cases. The contention is not that such practices are restricted solely to group health insurance, only that it is easier.

The third inequity is that premium related commissions constitute a "leakage" from the health care financing system, particularly in countries where governments rely upon private health insurance as a health system financing tool.

Reason 10 - Profit motive

Linked to the third point above, profits made by health insurers and distributors can be argued as being detrimental to the efficient functioning of the health insurance system which is intended to provide healthcare to all those in need and not to be an opportunity for commercial organisations to profit. This is very much a moral and ethical argument into which the author will not enter here. However, some countries, such as The Netherlands allow private health insurance but disallow health insurers to make profits. In the United States, insurers' profitability (though not absolute profit) is restricted.

The point is that this is another aspect of the difference between private health insurance and other lines of insurance business.

Reason 11 - The "symbiotic" relationship between insurers and healthcare providers

To most observers, it would appear obvious that a health insurer, the ultimate payer of private health insurance claims, would aim to contain claims costs, including negotiating deep discounts with healthcare

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providers for inclusion in their network of providers. However, this appears to change where the patient or an employer is covering a significant portion of the treatment costs. It is worse in self-insured schemes where the insurer is merely managing the claims. There is evidence that in some countries, insurers seek to improve profits by authorizing higher than necessary treatment costs where the patient is paying, say, 25% of the bill, or where the employer is paying on the basis that these patient or employer shares do not diminish profits. In the United States, insurers are allowed to make no more than 20% profit, but if they allow higher treatment costs and build this into their premium pricing and higher copayments, then whilst their profitability may stay the same, their absolute profits will be higher.

Reason 12 - Loss leader, cross subsidy and cross selling

For many insurers, health insurance is barely profitable and often unprofitable. So why do insurers continue to offer it? The reason is simple: to protect their other corporate business. As an example, if an insurer decides not to offer health insurance (or to withdraw it) then it risks losing a client's other business such as fleet, buildings and many other business lines should the client decide that it wants an insurer that can meet all its needs.

So how does the insurer compensate for low or no profitability in its health portfolio? Simply by accepting that it is a loss leader to attract or retain other business and cross subsidise those losses with profits from other business lines. Of course, a monoline health insurer cannot do this.

Another reason that insurers may continue to offer health insurance is that it provides the opportunity of cross-selling.

Therefore, unlike other lines of business, health is often run at an accepted loss or minimal profit. This is even more evident in those countries which have made private health insurance compulsory.

Reason 13 - Premium pricing mechanisms

There are a number of premium pricing mechanisms available to an insurer, some of which are regulated and mandated by government regulators.

One mechanism is the banding approach whereby individuals' premiums are calculated according to age, gender, geographic location, occupation and possibly health status (although some regulators ban this criterion).

Another is to rate the individual risk and assign a premium based upon that risk.

A third approach for group schemes is experience rating, whereby the insurer will price the scheme at renewal based upon claims experience.

A fourth approach is what is known as community rating in which the same rate is charged regardless of age, gender, medical history or other factors. The idea here is that across the insured population as a whole the premiums collected will cover the claims costs although healthier lives tend to pay higher premiums and poorer lives will pay less than under an individually priced premium. Another version of this is age-related banding, where adjustments are made so that older people pay more whilst younger people pay less.

The above is a simplification. In Germany for instance, the community rated system includes a "savings element" so that in the early years of an individual's policy, a reserve is built up to cover expected higher claims in later years. In The Netherlands which also operates community rating, to protect insurers who end up with more costly portfolios, a risk adjustment mechanism consisting of over 150 factors was developed to effectively calculate repayments from the insurers with better performing portfolios to a central pool which is then used to pay rebates to the insurers with poorer performing portfolios.

Regardless, this is another reason why health insurance is unlike other business lines.

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Reason 14 - Aggressive pricing to win business (or to lose it)

Linked to Reason 12 -is the practice of underpricing health insurance to either win or retain business. This leads inevitably to more losses created by the grab for market share pushing aside prudential underwriting. On the other hand, some insurers may attempt to offload their poor performing health portfolios by making them “more attractive” to competitors. The easy way to do this is to provide intermediaries with claims records that are exaggeratedly good. The converse trick is to make the claims record look exaggeratedly bad to deter competitors from taking the business. In the absence of any regulations controlling the production and content of claims records this is very easy to do.

Reason 15 - Cynical pricing at renewal

The author has personal experience of seeing premium increases at renewal which effectively seek to reclaim the insurer’s losses on the policy in the preceding year. This practice specifically disadvantages holders of individual policies covering themselves and possibly family members. The choices open to them are to accept the premium increase, try to find alternative cover with another insurer or simply abandon cover. But this is problematic as switching insurer will normally entail individual underwriting and a prospective insurer may just decide to attach a high premium due to previous medical history anyway and in some countries, where having health insurance is mandatory, not taking cover would be illegal and carry possible consequences.

This practice should not be likened to the loss of no claims discounts as in motor insurance. No claims discount schemes are transparent and renewal premiums objectively calculated in accordance with the policy terms and conditions.

This practice is another example of where the concept of risk pooling across the insurer’s whole health portfolio is abandoned.

Reason 16 - Opportunity for fraud, waste and abuse

As mentioned in Reason 5 -Reason 5 - abuse by policyholders is easier in health insurance due to the often vague nature of an ”illness” presented by the insured member to a physician. But this also provides the physician with an opportunity.

To be clear, fraud, waste and abuse are very different things. Fraud is criminal offence and in health insurance this can range from salespeople and procurement officers manipulating premiums and commission rebates to line their own pockets to a determined and coordinated effort by unscrupulous healthcare providers to extract more revenue from insurers than they legally should.

Abuse is a step down from fraud but is still intentional, be it a patient pretending to be ill for whatever reason, making unnecessary visits to a clinic or making multiple visits to different physicians, so-called “doctor shopping”. Abuse on the part of providers can take the form of unnecessary tests, repeated tests or “upcoding” or “unbundling” of services.

Waste is perhaps the least intentional and may involve unnecessary prescriptions, medically unnecessary diagnostic tests, a physician not following clinical guidelines or simply a patient not taking prescribed medications. But in all cases the insurer is paying.

Whilst fraud can occur in almost any line of insurance business, waste and abuse are almost entirely exclusive to health insurance, again making it less like traditional “insurance”.

Reason 17 - Where the risk lies: capitation schemes and Health Management Organisation type operations

Sometimes, an insurer may say to a healthcare provider group or a Health Management Organisation that it will pay a maximum amount per capita for the expected number of patients annually. Once the aggregate cap is reached, the insurer will pay no more claims for treatment. If applied at the individual patient level this is egregious and often outlawed. At the general level it poses problems. If the provider has reached (or is close to reaching) its cap for a particular group or insurer it may start to restrict services. Once the cap is reached it may even stop providing services. The only alternative the provider has is to bear treatment costs itself.

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An argument against capitation schemes is that it transfers the *insurable* risk to an entity that is not licensed as an insurance company. However, a counter argument is that the insurer is not transferring *insurable* risk but that the healthcare provider is assuming a *business* risk.

Nevertheless, the danger is that patients will see access to care restricted and this is another reason why health insurance is unlike other lines of business and also a reason why some regulators have banned such schemes.

Reason 18 - The healthcare network provider system

Most private health insurance policies will allow an insured member to seek treatment at specific healthcare providers. Health insurers (more often their Third Party Administrators) will build networks of providers and link these networks (on the basis of their relative price for services or their geographic reach) to levels of plan benefits. Basically, a network of providers accepting lower prices for their services can be offered to members at cheaper premiums. The problem is that quite often, although not in every case, quality is determined by price with the result that those who can afford only lower premiums usually end up with access to providers where quality of care, health outcomes or both are lower.

Quality of care is not necessarily a difficult one to measure, unfortunately in the world of private healthcare, regulators are sometimes reluctant to publish data on quality of care, particularly in countries where foreign direct investment in healthcare is of key economic performance.

So, we are left with a system where, in the absence of data on quality of care, quality in the eyes of the consumer is linked to price, notwithstanding the fact that the price may include the luxurious curtains, gourmet menus or valet parking provided to patients and visitors.

So, what the network system does is to allow insurers to say to consumers, if your resources for private health insurance are limited, we will offer you limited access to healthcare facilities, possibly with lower quality.

The other problem with the network system is that consumers will want the best access, perceive the best as being linked to price and therefore demand access to networks that include the “best” hospitals. This results in consumers seeking “better” networks in their health insurance plans but being unwilling to pay the extra cost. This in turn results in pressure on insurers and TPAs, in order to retain business, to include the more expensive healthcare providers which pushes up premiums.

One final related point is the use by TPAs of “volume rebates” whereby, in return for achieving certain levels of claims approvals at a specific provider, the TPA will receive a rebate from the healthcare provider which, theoretically, should be returned to the insurance company which the TPA serves. But this is not always the case with the TPA retaining some or all of this rebate as an addition to their profit.

Reason 19 - The originator vs generic drugs debate

Apart from motor insurance where replacement parts can be chosen from either the original manufacturer, an independent manufacturer or recycled parts (not an option with pharmaceuticals), private health insurance is the only other personal business line where options exist in terms of solutions, namely, the choice for physicians to prescribe originator (branded) drugs or generic substitutes and for payers to include or exclude originator drugs by the use of “formulary” lists.

The purpose of this reason is not to discuss the efficacy of originator compared with generic drugs but to again show that private health insurance is unlike other lines of insurance business.

For example, some countries prohibit the use of formulary lists which often exclude some expensive originator drugs on the grounds of patient safety or health outcomes whilst others promote the use of formulary lists, allowing payers to effectively limit their approvals to “cheaper” generic alternatives on the grounds that they are more cost effective. Here, we must be clear that there is a great difference between “cost effectiveness” and “efficacy” of drugs.

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Health insurance claims data show that pharmaceuticals represent, as a claims cost driver, somewhere between 20% to 32% of total claims costs depending on therapeutic area (the remainder being out-patient, in-patient and emergency room costs).

Some pharmaceutical company manufacturers of originator drugs argue that payers should focus not on reducing claims costs by substituting originator drugs with generics but by encouraging patient adherence to medications, particularly those with chronic conditions, to avoid the higher, indirect costs of treating acute episodes or even emergency room visits.

Again, this is not a debate which exists outside health insurance as a business line, thereby supporting the arguments in this White Paper.

Effects on the sustainability of health financing systems

Effect 1 - Exclusion of those in need and health insurance disenfranchisement

In countries where private health insurance is used as a health system financing tool, many of the reasons cited above (although not all) do result in the exclusion of some of those in need of healthcare or, at best, the requirement for them to make considerable out of pocket payments which they can ill afford. Medical financing debt is a significant problem in the United States.

Some of the reasons such as cynical pricing at renewal also leave individuals unable to afford to renew their policy, in some cases, endangering their compliance with laws on mandatory health insurance and, if expatriate workers, their very ability to remain in their country of work.

The use of employer funded private health insurance is laudable. But as we have seen most notably in the United States with the employment losses caused by the Covid-19 pandemic, “lose your job and you lose your health cover”.

Effect 2 - A 3-tier system of access to healthcare and quality of care

Some of the reasons above result in some people having no or limited access to healthcare (for example where there is no state government safety net in terms of free or subsidised access), in some people having the ability to pay for their own health insurance premiums (usually with limited coverage) and in some people having the benefits of employer funded health insurance often providing broad benefits and coverage limits and including coverage for pre-existing conditions. This, of course, applying only while the employee retains his or her employment.

Linked to the above is the quality of care that is provided. Whilst adequate quality care can be provided in some systems “for free” (for example the UK NHS) in the world of private health insurance money generally talks. As detailed in Reason 18 - insurers will build networks of healthcare providers and link them to the pricing of their insurance plans, offering reduced quality and/or access to those whose financial means are limited.

Effect 3 - Marginalisation of smaller insurers

Health insurance is generally offered by insurance companies alongside many other lines of business such as motor, property and casualty, life insurance and others. Then there are some insurers, particularly the large health insurers in the United States who specialize only in health insurance. Elsewhere, you may also find a few locally based “monoline” health insurers who do not offer any other type of insurance other than health insurance.

The effect is that the large, health insurance focused companies tend to achieve buying power that smaller, multiline insurers cannot command. This in turn leads to pressure on pricing which eventually produces a situation seen in a number of Middle East countries where multiline insurers are forced to run their health

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business at little or no profit, ore even a loss. They do this to protect their other business lines in markets where private health insurance is mandatory and not offering it might result in the loss of other business from corporate clients. As a result, such insurers are confined to the margins of the health insurance business and become reliant upon using the services of TPAs (at a cost) to give them a little more access to provider groups that they could otherwise not access or afford.

Effect 4 - The "network system" and control by TPAs and providers with buying power

Another effect of the private health insurance system is that it drives the tendency towards oligopoly. In several countries, third party administrators that have developed large portfolios of insured members can negotiate large discounts with private healthcare providers who are desperate to be included in the TPA's network of providers as this is a key revenue source for the provider. The effect enables the TPA to be more competitive when trying to attract insurance company clients, leading to an even larger portfolio of insured members under management and so the cycle continues. On the other hand, smaller TPAs are in no position to negotiate such large discounts against provider fees leading to the opposite effect and the diminution of their portfolios.

On the provider side, the larger providers can resist such negotiating pressures from large TPAs (to an extent) and certainly the smaller TPAs have little bargaining power with large providers since the volumes of business that will result from their smaller insured member portfolios are not as important to large providers. But in order to satisfy the needs of their insurance clients, these smaller TPAs still need these providers in their network.

Accordingly, the network system drives a distorted market, in the following way. To attract clients, insurers want the broadest networks possible, these can be achieved at a better cost by the larger TPAs who thereby grow larger and even more powerful. Some would argue that driving down costs of provider services is a good thing, but this is only if the TPA passes on the reduced prices rather than retain the benefit for itself. Additionally, excessive downward pressure on provider prices produces the danger of reduced standards of service provision by the provider. Another argument in favour of this system is that the savings can be used by the TPA to improve its technology to reduce claims processing costs and also to invest in systems to detect errors, fraud, waste and abuse (EFWA). The resulting savings in overall claims costs should ultimately benefit the insurance company.

Yet the insurers have to pay a price for the services of the TPA and the more powerful TPAs will always use that power to maximize their own profits.

For employers and individuals who cannot afford to pay insurance premium rates which reflect the inclusion of the largest and most expensive hospitals, they are left with selecting plans which have restricted networks with healthcare providers who, possibly, provide lower levels of quality patient outcomes.

Therefore, it is the network system itself (see also Reason 18 -which is the driver towards oligopoly and results in those with restrictive financial resources having lesser access to healthcare facilities and possibly poorer health outcomes. This is neither sustainable nor desirable.

Effect 5 - An inefficient system with financial leakage, scope for abuse and a disincentive for insurers to invest in prevention

A well-designed private health insurance system can work very well and efficiently so long as it is well regulated which implies an effective enforcement system. Unfortunately, such regulation and enforcement are seen in very few countries (The Netherlands being a notable example of a good system, well regulated).

What we see in many countries that have adopted private health insurance as a health system financing tool is that the imperative for its adoption was to reduce the pressure on state financing of healthcare (this is particularly true in countries with large expatriate worker populations where employers pay no or little corporation tax, some of which could be used to fund expatriate workers' healthcare if companies actually paid corporation tax). This imperative ignored the potential for abuse of the system and the resources to

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enforce the regulations were often lacking. The result has often been an increase in business levels and profits for insurers and TPAs, an increase in healthcare provider revenues and passing the financing burden either to employers or to individuals. Thus created is a system where fraud, abuse and other forms of financial leakage from the health financing system are prevalent and access to quality care for some is questionable, all to the detriment of health outcomes.

Another inefficiency lies in the distribution of private health insurance products. Many sales are still highly intermediated with commissions and salaries payable to "advisers". This inefficiency is linked to a number of the reasons listed above, including the constant churning of business between insurers driven largely by intermediaries seeking to maximise commission revenues on an annual policy renewal.

A further effect of this distribution "flaw" is that insurance companies, in whose interest lies better population health, are reluctant to invest in preventive measures such as paying for screening tests or promoting behavioural lifestyle change. In their eyes, why should they invest in this if the insured member is not going to be a long term client?

These effects, which are not an exhaustive list, do not foster a sustainable healthcare financing system based upon private health insurance, the current state of which is flawed in its product design, marketing, distribution and claims management.

Recommendations for a way forward while maintaining private health insurance as a funding tool

These recommendations relate specifically to the continued use of private health insurance as a health system financing tool and how its implementation and regulation should be reviewed and revised. The subsequent "alternatives" focus more on a deeper review of insurance as a funding tool including government funded schemes, social health insurance schemes as well as private health insurance and the hybridization of some or all of them.

Recommendation 1 - Review the appropriateness of private health insurance as a health system financing tool

Policy makers who are using private health insurance should conduct a thorough review of its appropriateness as a health system financing tool. This should be conducted in relation to the populations to be served, that is, by segmenting the population by the following:

- Those individuals who have the financial ability to pay private health insurance premiums
- Those individuals who do not have the financial ability to pay private health insurance premiums
- Those individuals for whom the government has a constitutional obligation to provide healthcare
- Those individuals for whom the government does not have an obligation to provide healthcare (primarily expatriate and migrant workers)
- Other individuals of a temporary nature such as tourists and visitors (refugee populations are out of scope of this paper)

This review should also take account of the responsibility for payment of private health insurance premiums for the employed and their dependents (whether they be nationals or expatriate residents), meaning should employers be responsible in whole or in part and also to what extent in terms of dependents? It should also consider the position of the self-employed, the informal and the non-working sectors as applicable in each country.

Recommendation 2 - Review the minimum benefits to be provided in relation to their affordability

One of the primary reasons why some governments use private health insurance as a health system financing tool is to relieve themselves of the financial burden of providing open-ended healthcare benefits without limit

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by passing on some of that burden to individuals themselves or to employers. This is often the case where governments have no constitutional obligation to provide healthcare benefits free of charge to some segments of the population, typically expatriate or migrant workers and their dependents.

However, in doing so, governments often stipulate a minimum level of benefits to be provided under such private health insurance arrangements, often referred to as Minimum Benefits Plans, Basic Benefits Packages, Essential Benefits Plans or similar.

The dilemma for government is that if it sets the minimum benefit levels too high the insurance plan will be too expensive for whomever has to pay the premiums whilst if they set the minimum benefit levels too low there is a danger that some members of the population experiencing catastrophic treatment costs will need to have their treatment costs covered by the state or go without treatment.

If governments determine that minimum benefit levels should be provided within private health insurance plans, they must continually review the appropriateness of the range of illnesses covered, the benefit levels in terms of both minimum and maximum sums insured, limits and sublimits and the level of premiums necessary to support such benefits.

Recommendation 3 - Review the regulatory approach to private health insurance as a health system financing tool

Should the review in 0suggest that private health insurance is indeed appropriate as a health system financing tool for some or all of the population segments, policy makers must conduct a review of the way they approach the regulation of the system and, importantly, its enforcement. Far too often it can be seen that the private health insurance framework is logical and well-structured yet its enforcement falls short due to either a lack of political will or a lack of resources or both, both of which facilitate market practices which undermine the system, create financial leakage, discourage foreign investment and harm health outcomes.

The below is not a comprehensive list but specific aspects to be addressed should include a review of:

- Distribution and marketing of private health insurance
- The role of TPAs in capitation schemes, use of formulary lists and volume rebates from providers
- The regulator’s capacity to identify fraud, waste and abuse and the technologies employed to do so
- The extent to which the regulator has “visibility” of market transactions between market participants
- Use and mechanism of “capitation” schemes and their effect on access to quality care
- Pricing and underwriting practices including methods of premium regulation (this is a complicated topic requiring the allocation of significant resources to develop a system that is appropriate for the specific country and which will work)
- The extent and prevalence of arrangements which are outside the system such as health management organisation (HMO) type operations, employer self-funded schemes/TPA administered schemes, self-funded/self-administered schemes and direct arrangements between employers and health care providers
- Compliance with timely payment transfers between all market participants be they between insurers, TPAs or health care providers

Recommendation 4 - Reform the provider network system

As noted in Reason 18 -and in Effect 4 -for many insured members, the network system is detrimental to access to and affordability of quality care and desirable health outcomes. Inclusion of a healthcare facility should be based on quality not on price of services or “perceived” quality linked to price.

It is difficult to argue that there is *not* a linkage between price of services and quality of services. Quite often, it is the more expensive facilities which have advanced technologies and they are more expensive partly because they have invested in such equipment. However, as argued above, inclusion of a facility should be on the basis of quality care and outcomes, not on price. This can only be achieved by a grading system which can identify these variables. This is easier said than done.

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Two main problems affect the development of a reliable grading structure for healthcare facilities. The first is the availability and reliability of data, the second is applying a risk factor to take account of the fact that health outcomes may be lower at some facilities purely because of the nature of cases that they treat. A simple example of the second problem would be outcomes related to neurospinal treatment where a particular facility develops a reputation with treating more complex cases, receives more referrals but, due to the very nature of the cases being more complicated, has lower satisfactory outcomes than other facilities. This becomes even more of a problem where the specialism is dependent upon a particularly well experienced surgeon who moves from one facility to another.

Beyond *development* of a grading system, we then have a third problem of *implementation* of a quality grading structure. As noted earlier, there are both economic and commercial obstacles to publication of such a grading structure in some countries where influential shareholders' interests in a poorer performing facility may create pressure against publication or where governments are trying to encourage foreign direct investment in healthcare provision. The author's belief is that such considerations should be made subsidiary to the business of delivering quality healthcare with quality health outcomes. This action is the responsibility of government.

Current network systems based on commercial factors are not efficient in delivering equitable accessibility and affordability for many so the author argues that regulation of the system in some way will not solve the problem of insurers desperate (for marketing purposes) to have the "best" providers in their network and the problem of oligopolistic power that lies with some payers and providers. Instead, the network system should be scrapped and replaced with a system that is based upon a reliable healthcare provider grading system.

So how would this work? Given a reliable grading system, the insurer could design a benchmark policy that provides treatment at *any* provider that reaches a specific quality standard, regardless of price of services. By itself however, this would not work as insured members would probably still choose the most expensive providers because of the "price equals quality" myth. They would also simply opt for the most highly graded facilities. But these problems can be handled with careful policy design.

The first issue can be handled by insurers stipulating that they will pay for treatment at a facility that meets the specified quality standard but apply a "reasonable and customary" standard to contain the claim cost. However, this "reasonable and customary" cost must be quantified and established on a scientific basis and not left to the whim of the insurer to determine on a case by case basis.

The second issue can be covered by insurers having different levels of "quality of provider" for different policies. Basically, if an insured member or an employer wants access to higher graded facilities they must pay a higher premium. This is not the same as the current network "tiering" system as this new approach is based upon data, facts and a scientific approach to determining what facilities an insured member can access, at what level of quality and at what price. This approach will also go a long way to reversing the tendency towards oligopoly and re-educating the consumer about the "price equals quality" myth. Finally, this system would need government oversight and regulation.

Recommendation 5 - Institutionalise rewards for good behaviour and lifestyle change

If private health insurance continues to be used as a health financing tool, the system can be made more sustainable from a financial perspective if insurers, with support from health ministries, create real benefits for insured members who adopt healthy lifestyles and change their behaviour. Perhaps the best known scheme is the Vitality brand of Discovery Limited, a large South African insurer. The program is now 24 years since inception and claims over 20 million members across 24 markets. It is a subscription service starting at around 22 USD per month for an individual membership, in return for which, by undertaking exercise, eating healthily and attending screening programs, the member is awarded points which can be redeemed for a number of services at specific retailers and service providers.

However, there are other ways in which insurers can encourage and incentivize members towards a healthier lifestyle. Several insurers, particularly large international insurers, already provide educational programs and some local activities for members. Some also encourage workplace wellness programs. Yet enrolment

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remains low and the programs few and far between. The issue seems to be not *empowerment* of the member but *engagement* by the member. It is this aspect of engagement upon which private health insurance companies should focus.

This is why the term “Institutionalise” is used and can better be achieved with support from health ministries to improve levels of engagement in programs established by private insurers. But to avoid a fragmented approach, insurers and governments need to adopt a nationwide public-private partnership of publicity, promotion and rewards which can be a mix of premium discounts at renewal or discounted retail services.

Recommendation 6 - Consider not for profit private health insurance

Insurance companies and third party claims administrators have a great deal to offer in the field of health insurance in terms of product design, underwriting, distribution and claims administration with many organisations having invested heavily in technology across all of these areas. Yet the private health insurance system continues to be an inefficient funding tool for health financing with insurers making little or no profit. At the same time, financial leakage takes place in the form of errors, fraud, waste, abuse, intermediary commissions and others listed in the “Reasons” section of this paper.

On the basis that there is little or no profit in this line of business, then why not formalize it as a “not for profit” business? This would enable regulators to organise and oversee a system in which the insurers themselves could operate in a manner which would remove many of the problems highlighted above and which are created by a profit-seeking system driving the need to achieve market share at any cost.

There are, of course, obstacles. Firstly, as stated in Reason 12 -in highly competitive markets where insurers rely on corporate business, not offering health insurance could jeopardise other business lines. Therefore, a system where only some insurers participated on a not-for-profit basis would disadvantage those who did not participate. It would only work if all insurers who wanted to participate did so. This might present challenges for regulators in markets with many tens of insurers.

Secondly, a not-for-profit system would likely need some form of premium regulation which many would oppose. But with the profit motive removed, so also removed are some of the current problems of over-pricing and under-pricing described in the “Reasons” section.

Thirdly, premium regulation, particularly one involving community rating such as in The Netherlands, would require a comprehensive risk equalisation mechanism to be put in place.

However, this option should not be discounted and the success of the system in The Netherlands would be a good place to begin an assessment.

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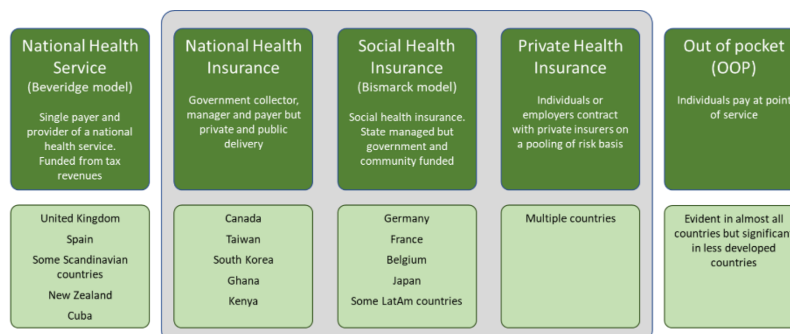
Alternative approaches to the use of "insurance"

The following points consider some alternative approaches to the use of "insurance" in health system financing including hybridization of models.

Alternative 1 - Review the options for national health insurance or for social health insurance

There are broadly 5 models (see illustration) of health system financing. However, this is an over-simplification for the purpose of this discussion. A complete list can be found at the World Health Organisation website.

National health insurance (NHI) comes in many forms but typically it is a system where funds from various sources are collected by government authorities and deployed to finance healthcare provision at no or low-cost at point of delivery. Sources of funds can be direct government expenditure, tax revenues, national health insurance scheme contributions, employer contributions and individual contributions. The system relies upon an efficient allocation of sufficient funds to where they are needed and sufficient capacity to deliver services.



Note that these are high level models. Each country mentioned has adopted hybrid systems to meet its demographic and healthcare infrastructure needs.

Social health insurance (SHI) originated in various industrial sectors in Germany under the chancellorship of Otto von Bismarck (1871-1890). It is a scheme where workers from a particular trade or industry would belong to a scheme funded by employer and employee contributions where the funds are pooled to provide healthcare services when required. Over time these schemes typically became managed by government (including some government funding) although retaining their industrial based roots.

There are several key considerations in deciding upon whether to employ NHI or SHI such as:

- How much can the government afford to contribute?
- How much can the population and employers afford to contribute?
- Does government have the resources to operate the financial aspects of the system (principally collection and distribution of funds)?
- Where will the burden of contributions fall?
- To what extent will the ability to pay be accounted for (progressive or regressive systems)?
- Should the system be designed as a safety net for the poorest and most vulnerable in society?
- In what facilities will services be accessible (public, private or both)?
- How will non-national residents be treated?

The above list is not exhaustive.

Models of NHI and SHI that are seen in some African countries are based upon the models that exist in the countries of former occupying colonial powers and are designed to reach the mass of the population. However, their success in this objective is fragmented and such systems suffer from the prevalence of non-working citizens and the informal employed sector, from whom it is difficult to extract individual contributions. However, for these populations, NHI or SHI are often the only viable solutions although microinsurance schemes have been gaining traction to serve as a PHI alternative and some countries have adopted Community Based Health Insurance (CBHI) schemes which are a local form of NHI schemes.

Also, governments often do not have the capacity to fund, raise funds for or manage such systems for the whole population which brings us to 0– a public/private hybrid system.

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Alternative 2 - Review the possibilities for a public/private hybrid system

To simplify matters for this part of the discussion, the population falls into two groups where healthcare financing is concerned: those who can afford to contribute and those who cannot. It therefore makes sense that for those who cannot afford to contribute, some form of government funded scheme will be required. This would most likely be a NHI type scheme funded and managed by the government but not requiring individual contributions nor "access fees", payments required to be made by citizens at point of service.

However, this necessitates government funding from tax revenues or revenues generated from state assets. In many developed countries this is often at an insufficient level to cover the whole population. Therefore, governments must consider raising funds from those who can afford to contribute.

This can be achieved in two ways, either contributions are levied on those who can afford to pay and directed to the government scheme or those who can afford to pay are excised from the government scheme and instead make contributions to PHI schemes. But the next question is where do people contributing to PHI schemes receive services: at state facilities, at private facilities or at both?

The scope of this paper does not include options for delivery of healthcare services, merely the financing options, but clearly the inclusion of the PHI sector can alleviate the burden on government allowing it to focus its resources on the poorest and most vulnerable. The challenge is to avoid a 3-tier system as detailed in Effect 2 -.

One of the things that the private health insurance sector can bring is an enormous capacity to manage contributions and to administer benefits be that through internal or third party claims administration systems. The amount of data generated from claims also enables operators to identify and reduce errors, fraud, waste and abuse and to control allocation of funds in service provision. It also allows for the analysis of clinical outcomes and measurement of the quality of care. However, on the contrary side, unless matters are addressed, all of the "Reasons" listed earlier in this White Paper will simply contribute to an inefficient system exhibiting financial leakage.

Nevertheless, the growth of public/private hybrid systems is prevalent in many countries as each seeks to serve the diverse needs of its population and the resources it has available. Such systems must be the way forward but efficient management of the public element and regulation of the private element are essential.

--- *Robin Ali*

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