Healthy choices:

The changing role of the health insurer*

October 2006

Contents

01 Foreword

Health insurance is pivotal to healthcare financing. In most parts of the world, governments are looking to enlarge, or at least to encourage, the contribution of private sources of funding to the delivery of healthcare. If these efforts are to succeed in the mass market, the role of health insurers must increase.

The pressures on existing healthcare financing systems are multi-layered. In Europe, pay-as-you-go social insurance schemes are creaking under the weight of demographic change; in the US, the costs of corporate retiree healthcare commitments are increasingly challenging large employers. Demand for and expectations of healthcare services and the cost of meeting them are rising all the time and across most territories.

Reform is on the agenda and, to varying degrees, systems are undergoing change. Very similar pressures can be recognised around the world but the health insurance industry – the focus of this report – has a more national orientation than most businesses, an inevitable consequence of the close links that exist between social policy and the role of health insurance. Policymakers in each country will make their own choices and the great variety of financing systems in different countries suggests that the choices available are wide.

Health insurers are not just interested observers of national debates over healthcare financing. The changes politicians choose to make will alter the dynamics of the health insurance market in their country and have a fundamental impact on insurers' business models. The industry wants to be an active participant in policy making but what changes should health insurers be seeking? What really works?

In Autumn 2005, PricewaterhouseCoopers HealthCast 2020 report concluded: 'Determine what care or benefits are basic to public health and structure an insurance system for the rest'.[1] This report looks at existing systems in several major territories and discusses what a 'good' system should provide; how best to structure it and what some of the implications for health insurers might be.

Ian Dilks
Chairman, Global Insurance Leadership Team

[1] 'HealthCast 2020: Creating a Sustainable Future', October 2005 (http://healthcare.pwc.com)

02 Executive summary

PricewaterhouseCoopers HealthCast 2020 report identified factors that are critical to creating sustainable healthcare systems, one of which was the ‘quest for common ground’ between the different parts of the health industry, an area where the pivotal role of health insurance was highlighted.[2]

This report takes that quest forward by examining the existing health insurance systems in various parts of the world, their similarities and differences and the lessons that might be drawn from them. Clearly other territories will also be interesting, but we hope the selection here gives a flavour of the wide variation that exists. This is important because, globally, working tax-paying populations have been losing faith in the ability of governments to provide adequate healthcare for them when they most need it – in old age. Changes are expected and the choices available to policymakers appear to be wide.

Pressures for expansion in the role of health insurers

Around the world the share of GDP taken by health costs is set to continue rising. Publicly funded healthcare puts enormous pressure on the sustainability of fiscal policies. In the context of government spending limits, it will become necessary in many countries for the role of private health insurers to expand. Health insurers will, in this way, become part of the solution to what are perhaps artificial limits on health spending which flow from routing that spending through government.

Substitution works

The model of a high level of public healthcare provision, combined with a duplicate system of healthcare funding sourced from private health insurance, will be under increasing pressure to change. Measures to manage and reduce the government-funded share of healthcare activity will most likely involve a move away from purely 'duplicate' health insurance towards some form of 'substitutive' health insurance, in which defined segments of the healthcare industry are normally funded by insurers. Similarly, the substitutive role of health insurance may be expanded in parts of the world where such a role already exists.

Big is better

Larger health insurers are better placed to act as a counterweight, in bargaining terms, to the scale of care providers in the healthcare value chain, and thereby to obtain cost advantages for consumers and better quality of care. This has long been a part of the health insurers' role in some territories. Insurers need to emphasise, not only to consumers, but also to government policymakers that, as competitive entities, they can be more efficient buyers of healthcare than either individuals or the state. Individuals have no bargaining power and little market knowledge. The state is a 'has-to-buy' customer with weak incentives for efficiency. Even if health insurers serve only a limited population segment they can be a catalyst for economically efficient behaviour. Recognition of the importance of the efficient buyer role is likely to bring with it pressure for consolidation in the health insurance industry.

A risk is worth sharing

Carefully designed risk sharing with policyholders is likely to be a part of any health insurance system that funds a significant part of healthcare costs. The risks for policyholders may be tempered by a degree of community rating, which generally excludes risk rating for age, sex or health status, and charges a flat-rate premium. Policymakers' goals usually include high participation in the market, as this brings with it wide access to healthcare, and community rating is usually associated with territories where participation is high. Community rating has been an important factor in the growth of health insurance in several territories including, historically, the US. The main challenge for community-rated markets is to attract and keep policyholders who are good health risks. If health insurance is to grow, insurers will probably, in our view, have to find strategies for operating with some degree of community rating in place. Risk equalisation mechanisms are often attached to these systems. They are inevitably complex and can undermine the incentive for insurers to manage claims costs efficiently, unless sufficient care is given to the detail of design.

Be prepared

The health insurance industry has a more national orientation than most businesses. This has probably been inevitable in view of the close links that exist between the role of insurers and state social policy. The number of health insurers with experience of the different dynamics of systems in place in different parts of the world is limited. Yet pressures for reform are likely to mean that most will meet some of these unfamiliar dynamics in their business in the future. New winners are likely to emerge from the better prepared players. One of the major challenges facing the industry in building a sustainable business is the inherent difficulty of designing any framework based on 12-month health insurance contracts which properly encourages, in a systemic way, the preventative care that is essential to managing costs over the longer term. Pay-as-you-go state-funded systems face a very similar underlying challenge. In principle, the way to incentivise preventative care systemically is to move towards appropriately regulated funded level premium health insurance. Clearly such a system has its own challenges, in particular concerning policyholder mobility between insurers. However, in this way, the health insurance industry would become an important factor in promoting the required behavioural change.

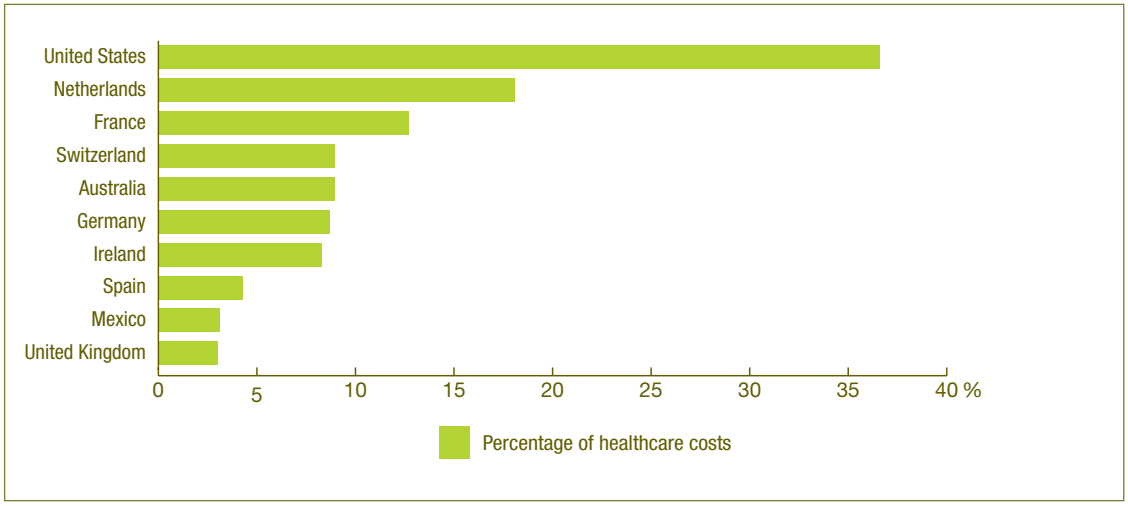
[2] 'Healthcast 2020: Creating a Sustainable Future', October 2005 (http://healthcare.pwc.com)

03 Introduction

1.1 The global pressure for change

‘Determine what care or benefits are basic to public health and structure an insurance system for the rest.’[3] This was the conclusion from PricewaterhouseCoopers HealthCast 2020 report published in 2005.

Figure 1: Percentage of healthcare costs paid by private insurance (2003)



Source: OECD Health Data 2005, Association of British Insurers (ABI), Laing and Buisson, UK Office for National Statistics (ONS), Australian Department of Health and Ageing and the Ireland Department for Health and Children.

It is certainly easier said than done but a well-structured system of private health insurance is likely, in our view, to have a crucial role in any system delivering sustainable mass-market health services.

Around the world, people say they do not expect healthcare provision by the state to improve over time. In 2005, a poll of 30- to 60-year-olds in ten different territories across the Americas, Europe and Asia Pacific, revealed their profound misgivings.[4] It showed that this age group were losing their trust in government to look after their health as they aged. They were even less confident in the ability of governments to provide better healthcare benefits for future retirees compared with the present ones.

This poll was conducted by AARP, the US-based retiree advocacy group which is the largest of its kind in the world. Respondents were asked to rate their trust in government healthcare provision for retirement-age people on a scale of one to ten (zero meaning no trust). The average score regarding current retirees was 4.5, falling to just 3.8 in the case of future retirees. The score for future retirees was lower than the score for current retirees in every one of the ten territories polled. Such a low opinion of the sustainability of state-funded healthcare, given the pressures it faces, highlights the need for governments around the world to widen their search for sources of healthcare funding.

The contribution of private health insurance to total healthcare costs is uniquely large in the US. However, within the insured population there are the same cost, demographic and sustainability pressures that are visible elsewhere. At the same time, there is considerably more limited public provision than elsewhere and access to healthcare is a major issue. Figure 1 above shows the percentage of healthcare costs paid by private insurance by territory, for 2003.

There are global pressures for change in health insurance and they will create winners and losers. The variety of systems in place around the world means that there are very few health insurers with comprehensive knowledge and experience of the range of product possibilities and the market dynamics.

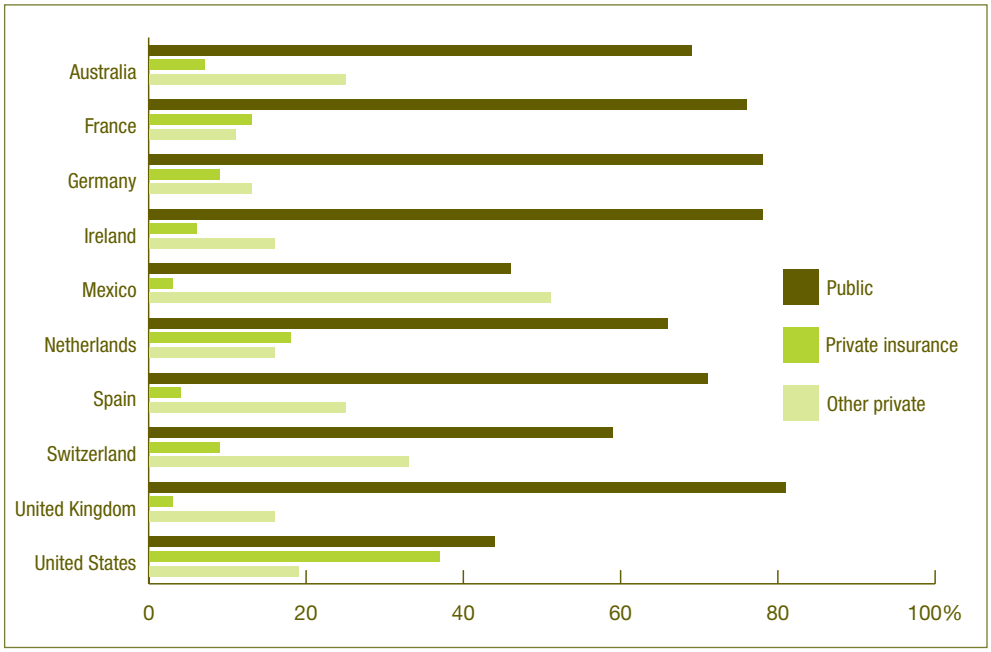
'DKV (Munich Re's health insurance brand name) believes there are only five worldwide leaders (including DKV and Allianz Kranken in Germany) with the tools to benefit significantly from health insurance reform and demographics.'[5]

The scale of the industry varies considerably by territory. In the US, the Netherlands, France and Germany, it plays an important role in financing healthcare, whereas this is very much less the case in, for example, the UK. The importance of health insurance within private funding

[3] 'HealthCast 2020: Creating a Sustainable Future', October 2005 (http://healthcare.pwc.com)
[4] 'International Retirement Security Survey', AARP, July 2005
[5] 'Potential Reform Risks', UBS, November 2005

03 Introduction

Figure 2: Split of healthcare funding 2003



Source: OECD Health Data 2005, Association of British Insurers (ABI), Laing and Buisson, UK Office for National Statistics (ONS).

for healthcare also varies greatly. Out-of-pocket and other private health funding options (particularly employer-provided retiree healthcare in the US) are also important funding sources.

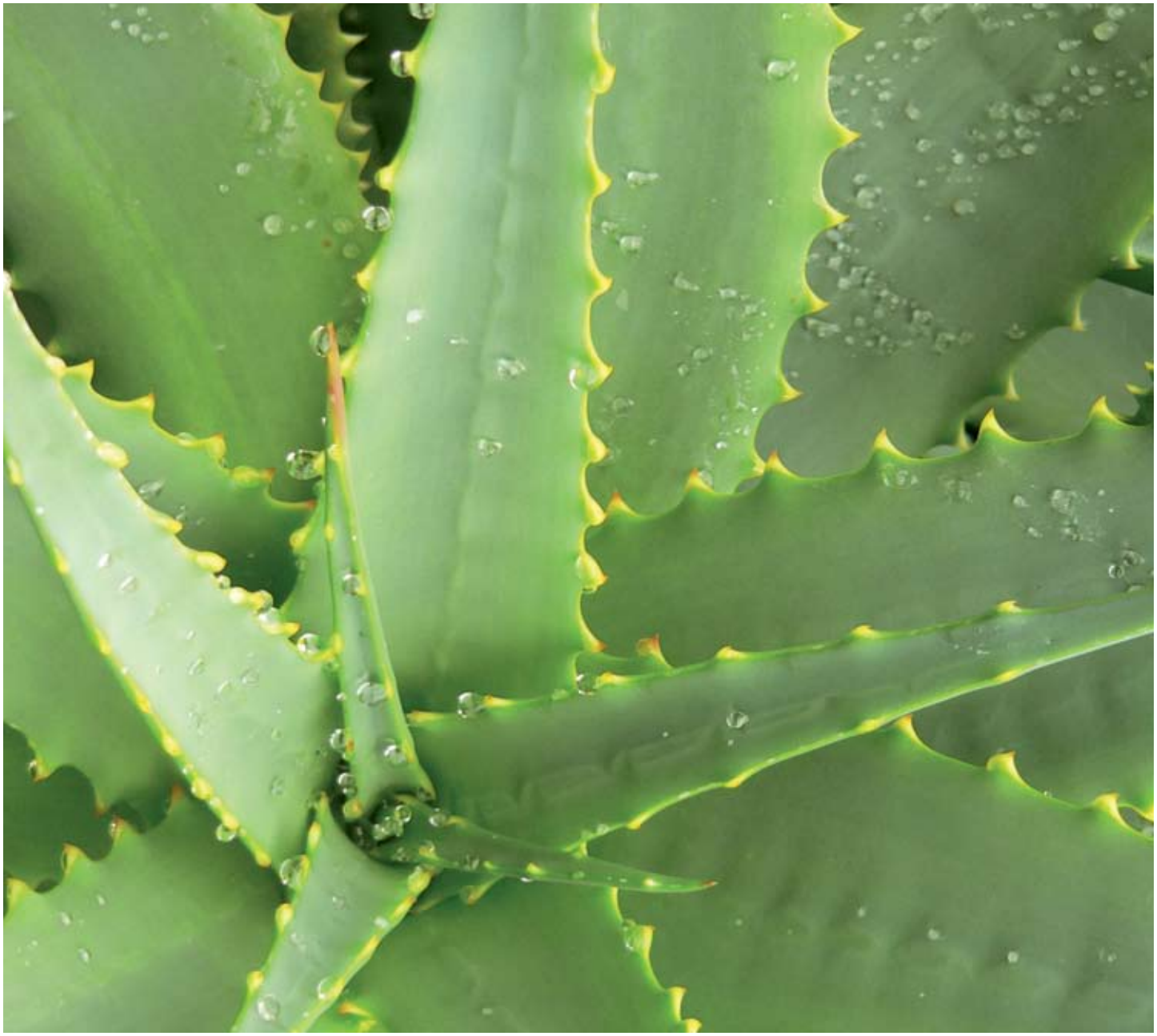
A well-designed expansion of the health insurance market has to be at least part of the way forwards for healthcare funding. But what are the essential features of an attractive health insurance system?

This paper takes a global view of the health insurance industry and:

- Considers how the drivers of success differ in different systems;
- Compares the roles played by private health insurance in different territories and identifies key features of the healthcare funding systems in place around the world; and
- Discusses how these systems shape health insurers' business activity, the drivers of profitability and the positioning of health insurers in the healthcare value chain.

04 What is good health insurance?

Health insurers' success will ultimately depend on their impact on the basic outcomes of healthcare delivery, such as the degree of access for all the people who need it and the overall cost.



How much importance is attached to these various outcomes – the results of health insurance – is a matter of social policy. However, a sound working assumption is that, to be sustainable and significantly profitable, a health insurance industry will need to have a positive impact on the various outcomes of healthcare delivery. The table summarises the relative attractiveness of some key features of health insurance models by looking directionally at their impacts on the delivery of healthcare.

Results of health insurance – healthcare outcomes

	Equity	Administrative cost	Care cost	Care quality	Incentivise prevention
Features of health insurance					
Rating/benefit regulation	✓	X	–	–	X
Scale	–	✓	✓	✓	–
Substitutive	✓	–	–	✓	–
Duplicate	X	–	X	–	–
Risk sharing	–	–	✓	✓	X
Community rating	✓	–	X	–	–
Risk equalisation	✓	X	X	X	X
Ageing reserves/ level premium	✓	–	✓	–	✓
✓ Good		– Neutral		X Negative	

Source: PricewaterhouseCoopers research

2.1 Rating regulation

One of the defining characteristics of the environment in which health insurers operate is governments' interest in maintaining good access to healthcare. This lies behind much of the regulation of premium rates. For example, rating regulation in the form of maximum premium levels, clearly will increase access to insurance and, thereby, to healthcare. But, as with any regulation, there is a cost involved in complying with the regulations and obtaining the necessary approvals. The costs of the regulatory function itself also need to be accounted for.

Regulators must give some consideration to the impact on profitability of regulatory regimes. Certainly, if there is a wider objective to expand the private health insurance industry in an efficient way, then incentives will need to be sufficient to attract the required resources.

Preventative care is discussed in more detail in section 2.10. However, the general point to make here is that experience in countries such as Australia, France and Ireland shows how regulated premium rates tend to raise the priority management gives to marketing strategies aimed at influencing health status on entry to an insurance contract. This is natural enough when the insurer is restricted in its ability to rate for that health status. Avoiding 'adverse selection' can become vital to health insurers' commercial strategy in these circumstances. In contrast, preventative care requires that health status several years after contract inception should be the focus.

2.2 Scale advantage

Scale is an advantage in efficiently operating the complex administration processes of health insurance. It is also important to insurers' bargaining position with healthcare providers. A good example is the progress made in managing medical costs by Health Maintenance Organisations (HMOs) in the US. These organisations provide a complete medical service from participating providers in return for a premium as a way of providing a more integrated insurance and care provision product, but their success has required the advantages of scale. For example, in the large-group health insurance business in the US, scale economies have driven consolidation to the point where there are now only four companies that can truly serve self-insured, national employers, and these companies have been able to negotiate improved discounts from their network providers. In Germany, the historical development of health insurance funds was closely associated with the deliberate use of their scale to improve the terms obtained from organisations that bargained on behalf of medical practitioners.

Current reforms in the Netherlands are largely aimed at enhancing the bargaining position of health insurers as buyers of healthcare. There, the statutory and private health insurance sectors are being merged to create health insurers that will, among other things, have the market presence to be more effective buyers. At the same time, insurers are being released from their previous obligation to contract with all providers.

2.3 Duplicates and substitutes

These words are often used to describe the relationship between private health insurance and state, or statutory, provision. The boundary between 'substitutive' and 'duplicate' is not always clear-cut, but substitutive health insurance refers to private health insurance that replaces, or is a substitute for, publicly funded

healthcare. A substitutive system means that the policyholder is not entitled to public funding for the relevant care. The policyholder would therefore not normally pay the fiscal dues charged for publicly funded healthcare.

For convenience, we also include in this category insurance to cover co-payments required for treatment in a publicly funded system, and cover for treatment that is not provided by the state at all, although this is sometimes called 'supplementary' health insurance.

In contrast, duplicate health insurance provides quicker access to, or better facilities for, healthcare to policyholders who remain entitled to full state-funded care for the relevant treatment. The nature of the relationship between publicly funded and privately funded healthcare, as defined by the duplicate/substitutive boundary, can differ fundamentally, and consequently the role that private health insurers fulfil varies equally fundamentally.

Substitutive health insurance can provide policyholders with a genuine alternative to state provision and it can offer care providers a genuine alternative to the state. It is really because the substitutive model can enable effective competition to state provision for a meaningful segment of the market that we have put a tick in the care quality column of our table (see page 12). Furthermore, geographical or other variations in state provision, which may not be corrected in the absence of competition, are more likely to be exposed if there is an effective alternative, so there is, on these perhaps somewhat marginal grounds, a tick in the equity column as well rather than a neutral dash. German private health insurance is a good example of a substitutive system.

2.4 Minimal integration

It is harder to argue that a system such as the UK's, in which private health insurance duplicates and sits alongside and separate from a high level of state provision, widens access and contributes to equity. It is only the high level of public provision that enables the state to afford a minimal integration 'hands off' approach to private health insurance (PHI), while, at the same time, keeping wide access to healthcare. The net effect on equity of some additional funding being drawn into healthcare and the bidding up of resource and personnel costs, is hard to gauge. However, what is apparent is the relatively small scale of the health insurance industry in the UK – even compared with other European countries where social solidarity is highly valued – and the consequent reliance in the UK on public funding.

There is considerable doubt about the sustainability of ever-increasing state funding of healthcare. PricewaterhouseCoopers Healthcast 2020 report projects that healthcare spending will reach 21% of Gross Domestic Product (GDP) in the US by 2020 and a median of 16% in other OECD countries.[6] The report also notes the argument of economists that such a projection may only be natural and even inevitable. As people throughout most of the developed and developing world get wealthier, they have – and can exercise – more choice over where they spend their extra money. Goods such as healthcare move steadily higher up the shopping list.

There must be a level of GDP spend on state-funded healthcare beyond which most governments around the world would not want to go. Eventually, state healthcare spending must conflict with overriding policy goals for overall state spending as a share of GDP. At this stage some integration of private and public funding of healthcare becomes almost inevitable. One option is to identify discrete services that may be funded through health insurance. Generally, this sort of change would involve a shift away from 'duplicate' provision towards a more 'substitutive' health insurance system and an expansion of the substitutive role where it exists already.

Government policymakers may be satisfied that, with a limited level of state provision, health insurers in a regulated market will succeed in funding healthcare provision equitably enough. Broadly, this has been the position in the US, although even there the proportion of healthcare spending that is state funded has been rising.

Generally, the US and UK have duplicate health insurance systems. The US combines duplicate health insurance with a low level of state provision comprising a patchwork of differently targeted programmes. Most European territories outside the UK have some form of substitutive health insurance system. Australia and Ireland are harder to categorise because, while policyholders are entitled to state-funded healthcare, government involvement in the way private health insurance operates produces a financial effect similar to that of a substitutive system.

2.5 Risk sharing and policyholders

Risk sharing helps influence behaviour and removes low-level claims. In principle, risk sharing can be implemented with care providers as well as with the policyholder. Focusing first on the policyholder, risk sharing clearly shifts some of the care cost back to policyholders and removes administration costs associated with low-level claims. However, countering the 'moral hazard' that attaches to

[6] 'HealthCast 2020: Creating a Sustainable Future', October 2005 (http://healthcare.pwc.com)

health insurance (that is, the way the existence of insurance increases people's propensity to consume healthcare resources) can be at least as important a driver of insurers' use of risk sharing as a form of cost control.

The effect of moral hazard is limited in circumstances such as the pre-2006 system in the Netherlands, where people without private insurance received similar cover in the state system, but the effect is very marked in the French system. In France, private health insurance primarily provides funds to meet the patient co-payments required by the state-funded providers. A recent study found that adults with private insurance were 86% more likely to visit a doctor than those without.[7] The public system pays for roughly two thirds of the cost of these visits, so it is the public system that bears most of the cost of the additional use.

A degree of risk sharing is likely to be a part of any insurance-based contribution to healthcare demand management. The challenge is to distinguish properly between the elective demand for care and the non-elective, that is, where policyholders have no choice but to claim on their policy, so making risk sharing both unpopular and mostly unnecessary. For example, significant co-payments for basic maternity treatment will diminish the attractiveness of a PHI product. The scale of co-payments was an issue that has, in the past, inhibited the expansion of health insurance in Australia.

A drawback to risk sharing is that, unless there are special allowances for certain treatments, it is likely to discourage policyholders from buying non-urgent healthcare, particularly when the health pay-off is longer term.

2.6 Risk sharing and the provider

Provider behaviour has received enormous attention in the US. Clearly, any system that pays providers on a per-procedure basis risks encouraging inappropriate procedures. The challenge is to find a way to share with the care provider the financial gains made by the insurer from more efficient care. Closer integration of insurers and healthcare providers is one way to align interests to promote efficient care. It is primarily this challenge that, in our view, has been responsible for the rise of Health Maintenance Organisations (HMO) and Preferred Provider Organisations (PPO) in the US, as highlighted in Figure 3.

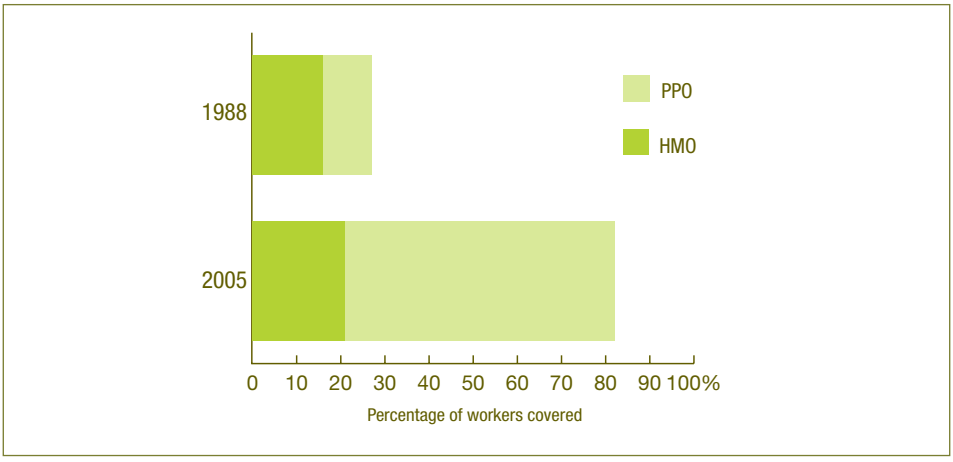
But managing efficiency at the point where care is required can only go so far in managing demand. PricewaterhouseCoopers HealthCast 2020 document quoted Dick Pettingill, CEO of US-based health provider Allina Health System, saying 'All the financial systems are set up to reward things that happen in an episodic acute-care environment, and there is no reward to go upstream to try to do early prevention and early diagnosis.'[8]

The US spends more per capita than any other OECD country, but ranks only 22nd in terms of life expectancy. Increased emphasis on prevention is, surely, a part of the way to achieve more efficient use of resources (see section 2.10).

The ever-closer management of care costs at the point of delivery which has been implemented by HMO and PPO health plans has, in addition to moderating cost increases, created conflicts and consumer dissatisfaction. One reaction has been the recent growth of Consumer Directed Health Plans (CDHP) by which the policyholder is free to seek the best cover and treatment within coverage limits. The plans often comprise high-deductible health insurance and a savings account that, in effect, acts as a source of funds to help cover the high deductible.

Outside the US, the considerably lower proportion of healthcare expenditure paid by health insurers

Figure 3: Healthplan enrolment of covered workers in US



Source: The Kaiser Foundation and Health Research and Educational Trust (HRET) Employer Health Benefits: Annual Survey, 2005.

[7] OECD Health Working Papers, 'Private Health Insurance in France', 2004

[8] 'HealthCast 2020: Creating a Sustainable Future', October 2005 (http://healthcare.pwc.com)

means that their influence on the behaviour of care providers is also considerably less. However, the intention of reforms in the Netherlands is that insurers will have a much greater influence on healthcare providers.

2.7 Community rating

Community rating requires health insurers to charge a flat premium rate to all policyholders regardless of age, sex or health status and to:

- Guarantee acceptance of all proposals;
- Guarantee renewal for all existing policyholders; and
- Guarantee not to impose any exclusion in policies.

Some relaxation of these conditions would usually still attract the community rating or 'adjusted community rating' label. The primary motivation for community rating is 'equity' or equal access. The social aim is to have wide popular participation in the health insurance market and therefore wide access to healthcare. It is normally successful, in that markets where community rating is imposed usually also have high participation rates.

Community rating might also be thought to keep down administrative costs because there is no need for the process of underwriting at individual policyholder level. However, the removal of risk rating has led to other activities aimed at attracting desirable policyholders. Australia is one of the most developed examples of this process. There, benefits are tailored to attract particular segments of the market and there has been a proliferation of such products, each with its own 'community-rated' flat rate. Sophisticated efforts to generate and track the performance of highly targeted policy types considerably diminish arguments about reduced underwriting expenses.

2.8 Impact on care costs

The impact of community rating on care costs is tied up with the nature of the community rating and any risk equalisation mechanism attached to it. Insurers remain keen to minimise care costs but the ability to show a profit from care-cost management is diminished. For example, the possibility of covering diabetics profitably on an appropriate premium rate is harder to see in a pure community-rated environment. The loss of the direct link between risk groups and premium rates means that there can be no rating for a disease on the basis of efficient treatment. The focus then moves towards discouraging applicants at risk from a disease. Management feedback on profitability is less specific and, therefore, it is probably a less powerful motivator of care cost management.

Community rating is often linked to risk equalisation payments. The exact form of the risk equalisation payments can also diminish incentives to efficient care cost management (see section 2.9).

Community rating is a significant feature of the health insurance market, particularly in Australia, Ireland and certain parts of the US. Most of the US market was community rated in the early years of mass-market health insurance in the 1930s and 1940s. Blue Cross and Blue Shield (commonly referred to as 'the Blues') were originally established by not-for-profit hospitals (Blue Cross) and medical societies (Blue Shield) in the 1930s as not-for-profit organisations dedicated to widening financial access to healthcare. They therefore followed a community rating model. At the time, they had very little competition and it was only following the substantial growth of for-profit health insurers in the US market in the 1950s that 'the Blues', in the absence of any risk equalisation mechanism, had to move away from community rating.

The guaranteed renewal feature of community rating does provide some incentive for insurers to promote preventative care, but bearing the cost of preventative care claims up-front, perhaps many years before the benefits might appear, will remain unattractive. Ageing reserves, as in the German model, can, on the other hand, help to align incentives in favour of efficient preventative care, at least in principle.

2.9 Risk equalisation

Risk equalisation is a mechanism by which health insurers may be compensated for accepting high-risk policyholders in a market with regulated rates or community rating. Funding for the mechanism would normally come from contributions made by insurers with a lower risk, maybe younger, policyholder profile.

Risk equalisation mechanisms are helpful in ensuring that insurers in a community-rated environment do not become too preoccupied with avoiding riskier customers.

The mechanisms are part of promoting solidarity in a community-rated health insurance system, helping to ensure coverage remains accessible to all and maintaining a healthy market by trying to avoid the so-called 'premium death spiral'. This is where a higher-than-average number of riskier or older policyholders leads to an increased community-rated premium for all policyholders. The insurer is then likely to lose healthier policyholders, leading

to a further turn of the premium death spiral. The process could, in theory, lead to the collapse of the insurer and its fortuitous incidence would heavily discourage other insurers from participating in the market.

Risk equalisation is operated in Australia, the Netherlands, the state-managed sector in Germany, and is part of the new system in Ireland. There are many ways to implement risk equalisation, but the market would normally be segmented by age, sex and perhaps health status. Then, the claims costs per policy in each segment or 'cell' would be identified, and finally contributions would be collected from insurers with a high exposure to low-cost cells and 'equalisation payments' made to insurers with a high exposure to high-cost cells.

The trouble is that if such a system leaves each insurer with the same market-average claims cost per policyholder whatever the insurer's actual claims cost, this will cut any incentive to manage actual care costs or any other costs carried in the risk equalisation mechanism. The Australian system has been criticised on this score. Similarly, risk equalisation can impair the return on any individual insurer's preventative care efforts.

The system being implemented for the first time this year in Ireland appears attractive, in that it should be less likely to reduce incentives to manage care costs. Equalisation payments are based on an insurer's own costs in each age/sex cell. On the other hand, the system may, in our opinion, encourage insurers to seek advantage by managing aspects of the health profile of their policyholders on entry. The overall effects of risk equalisation mechanisms are complex and outcomes depend on the details of the calculations involved.

2.10 Ageing reserves should support preventative care

Funded level premium private health insurance is unique, in our view, across private and state funding mechanisms in appearing to financially incentivise preventative care. It should therefore be a valuable option for policy-makers. Ageing reserves are the funds that are built up naturally from long-term level premium contracts. The possibility of profits or losses arising on the ageing reserves that build up in the system should, in principle, incentivise preventative care efforts. Germany provides the main example of this type of funding.

It is the long-term nature of the contract, for example in Germany, which sets it apart. It is hard to design any framework built on the 12-month contract used elsewhere that is genuinely effective in incentivising preventative care. Public sector pay-as-you-go systems face similar underlying problems in encouraging preventative care, although political decisions can be made in favour of particular programmes if funds are available.

Individual policyholders may be attracted enough by the health pay-off to initiate and pay for preventative care. Similarly, some companies that pay the health insurance costs of employees may take a long enough view of such costs to promote preventative care and favour the insurers or HMOs committed to it. But these forces look frail alongside the relentless pressures of shorter-term goals and the sheer scale of the challenge posed by the need for preventative care, if overall costs are to be managed sustainably. Also, staff turnover may diminish incentives where health insurance is provided by employers. One employer may incur the costs while a subsequent employer receives the benefits.

The major objection to funded level premium health insurance is the restricted mobility of policyholders between insurers, which results from the build-up of ageing reserves with the current insurer. Recent reported proposals in Germany for the introduction of 'transfer values' between health insurers appears to help resolve the mobility issue and promote competition. However, the system in Germany is highly regulated and this may also be seen as a drawback.

2.11 Some additional advantages of ageing reserves

Funded level premium health insurance on a substitutive basis also, unusually, extends private health insurance coverage into the post-retirement years for the mass market. This contrasts with the UK, for example, where rising insurance costs for older people can quickly make cover an unrealistic proposition. It also contrasts with the situation in the US, where cost pressures threaten the sustainability of corporate retiree healthcare provision.

The system has the following advantages:

- Individual policyholders are not dependent on a pay-as-you-go system in retirement;
- Costs are more predictable for both employee and employer as future costs do not depend on renewal terms of a 12-month contract; and
- Costs are not influenced by the demographic drivers of the pay-as-you-go system.

Predictability is, though, diminished by the scope for tariff-wide premium adjustments.

04 What is good health insurance?

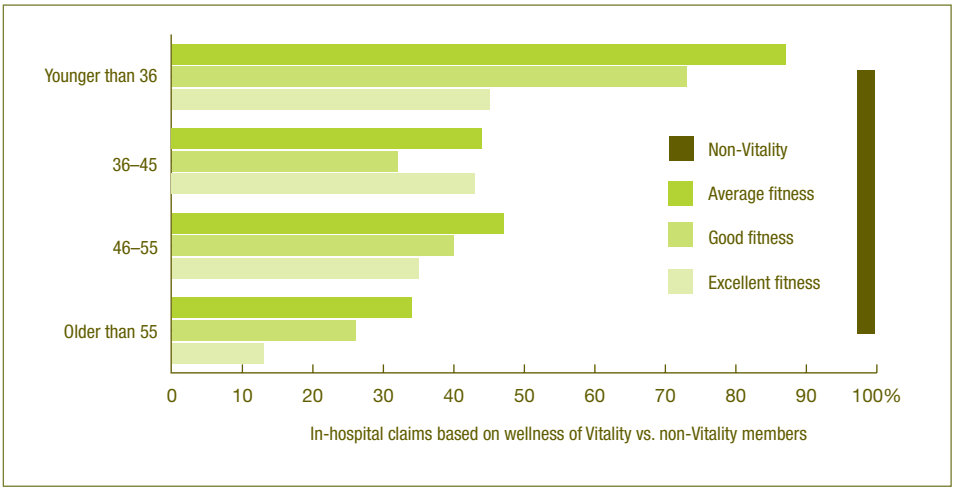
Australia has introduced an age-at-entry rating component to the country's community-rated private health insurance system. There may be proposals for a similar system in Ireland, and recently there have been proposals to expand Health Savings Accounts in the US to provide more effectively for funded post-retirement healthcare. These all look like steps towards coping with pressures more completely, catered for in a level premium funded system. Ironically, but perhaps inevitably, the German system is itself under scrutiny and some recent proposals involve moving in the opposite direction, away from a funded system.

There are other imaginative ways to encourage preventative care. Discovery Health, a South Africa-based health insurer, substantially bases its business model around preventative care. The South African market is community rated but has no risk equalisation mechanism. Discovery responded to this by creating a product designed to offer value to low-risk policyholders. Travel, leisure and other benefits are offered to policyholders who progress through the 'Vitality' programme to a healthier lifestyle by, for example, giving up smoking, attaining the correct weight and improving fitness.

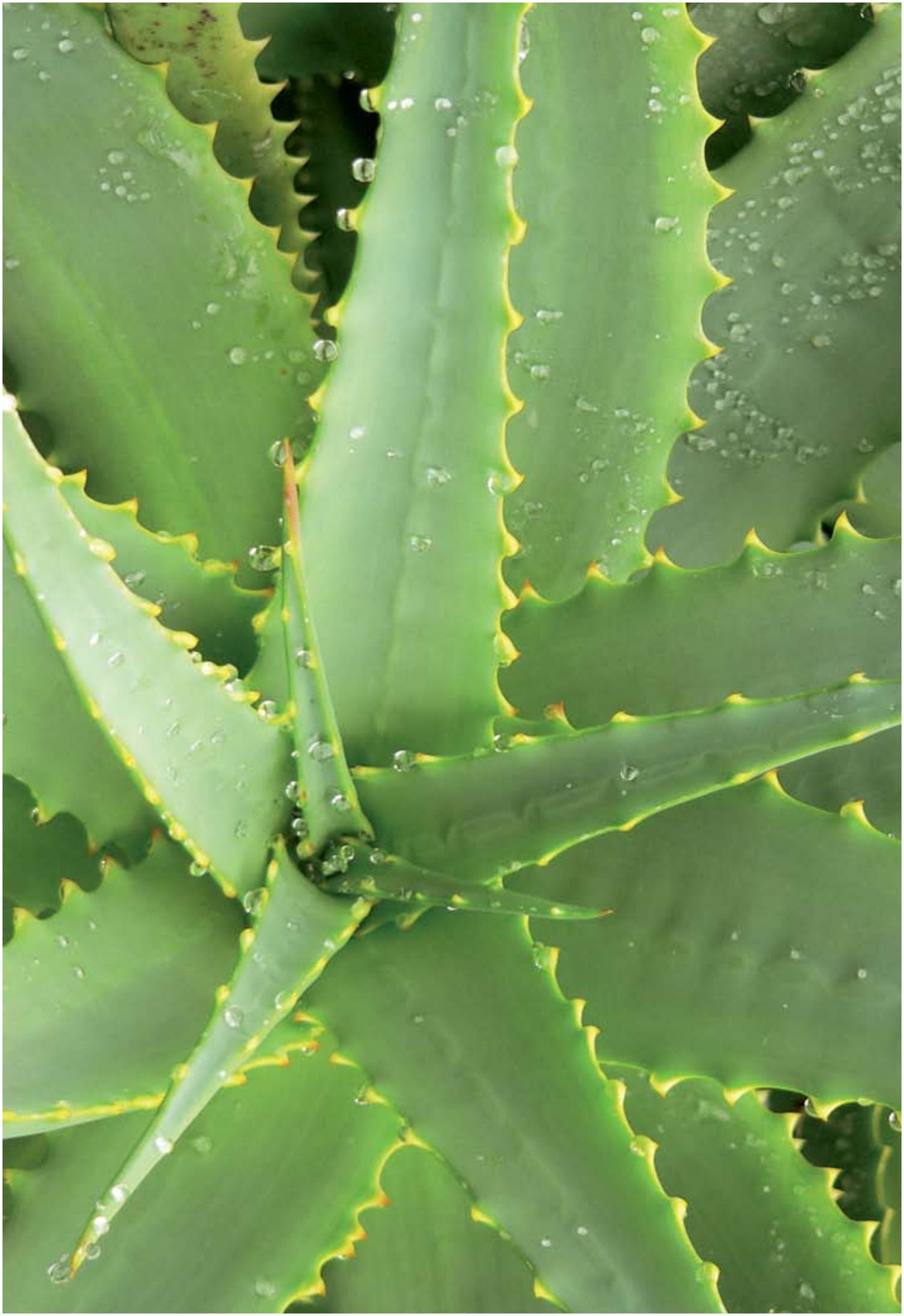
In the UK, Discovery operates through a joint venture with Prudential. The UK market is not community rated so the joint venture (PruHealth) is able to offer premium reductions to Vitality policyholders. The Vitality programme is associated with enormous improvements in claims experience (see Figure 4).

It is hard, though, to identify cause and effect. For example, the promotion of the Vitality product is itself likely to have a selection impact on the health status of policyholders at entry. The reasons for the higher claims for the 'excellent fitness' group in the 36–45 age range than for the 'good fitness' group are not obvious, although sports-related injuries would be one candidate. We have also met the suggestion that Discovery's model may reduce the claims cost of 'primary' or major health-threatening events, but would have much less effect on the secondary health issues that constitute most of the private healthcare claims costs in duplicate health insurance markets. Nevertheless, the bigger picture of improved claims experience and, no doubt, competitive premium rates, is clear.

Figure 4: Impact of Discovery's Vitality Wellness Programme on healthcare spending



Source: Institute of Actuaries Life Convention 2005, PruHealth presentation and Discovery data.



05 Country comment

Australia
China
France
Germany
Ireland
Netherlands
Switzerland
United Kingdom
United States

Private funding is too useful to ignore as populations age. The Australian government stepped in successfully to break a particularly vicious cycle of price hikes and consumer resistance in the 1990s.

Australia's government has long been committed to supporting the existence of a large and vibrant private health insurance sector. According to the country's Department of Health and Ageing: 'The Commonwealth is committed to ensuring that Australians have choice in their healthcare through the maintenance of a viable private health industry operating alongside a high-quality public system with universal access.'[9]

It is not surprising, then, that there is a high penetration of health insurance in the Australian population, despite a sharp decline in the 1980s and 1990s, now partly reversed by market reforms in 1999 and 2000 (see Figure 5).

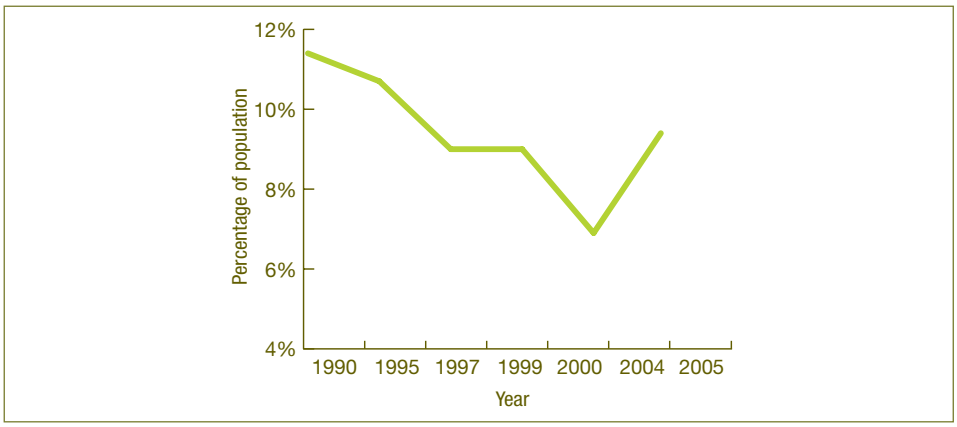
Private health insurance pays a significant percentage of total healthcare expenditure and it is likely that government support for the sector is motivated by the recognition that private funding will be useful as the population ages (see Figure 6).

Private health insurance in Australia is regulated to operate on a community rating basis. Uniform premiums are charged regardless of age, sex and health status.

Health insurance primarily pays for private patient hospital care. There are two components of this. Firstly, the hospital charges for accommodation and theatre fees which are paid, subject to co-payments and deductibles, by the insurer. Secondly, there are doctor/medical fees and, of these, 75% of the scale of charges paid by the state system (Medicare) is paid from public funds while the private insurers must pay the remaining 25% of the Medicare scale, and may pay some or all of any amount by which private medical charges exceed the Medicare scale. Policyholders remain entitled to state funded care.

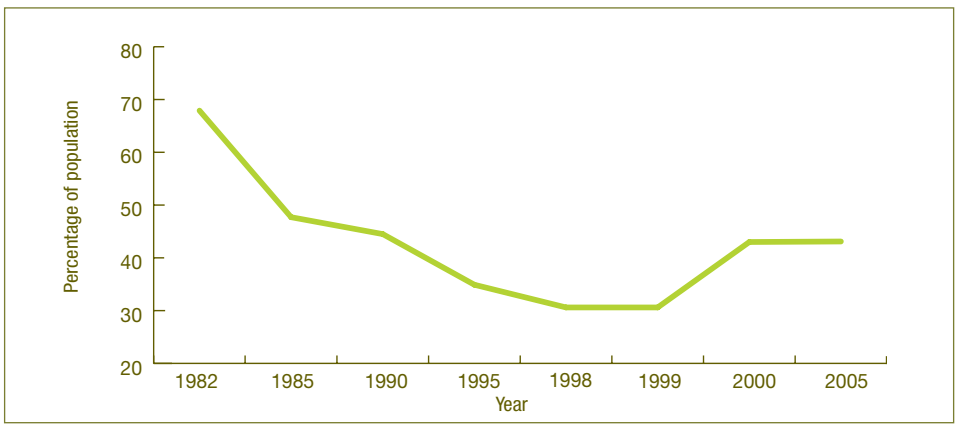
So there is a significant state contribution (in the form of 75% of the Medicare scale fees) to private patient care. The financial effect of this is similar to a substitutive system in that the resulting lower premiums should be closely equivalent to reimbursing policyholders for this element of their Medicare-related taxes.

Figure 6: Percentage of healthcare expenditure paid by private insurance



Source: Department of Health & Ageing, Private Health Insurance Administration Council, OECD.

Figure 5: Private health insurance penetration of the Australian population



Source: Private Health Insurance Administration Council (PHIAC).

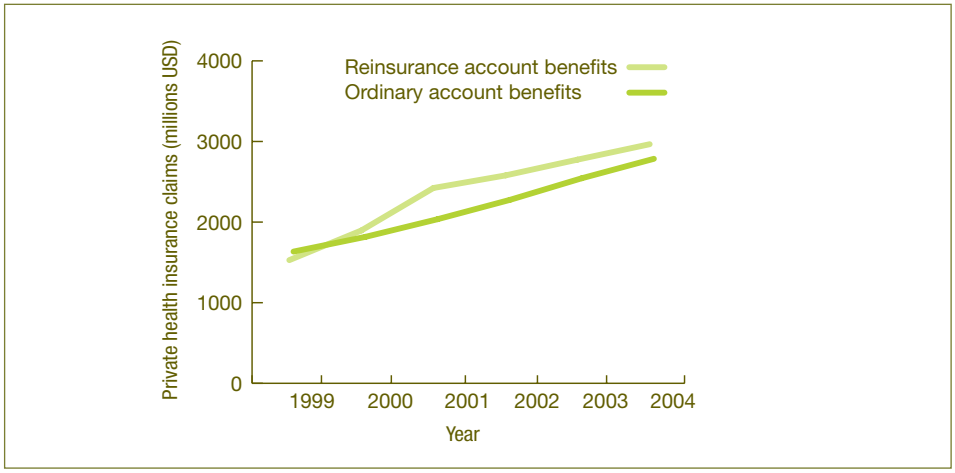
Community rating and risk

The community rating system allows different premium rates for singles, couples and families but not for age or health status. Although community rating is enforced by law, the risk equalisation mechanism currently in place is rudimentary and has been subject to occasional review. Most of the costs (79%) for policyholders who are aged over 65 or who have more

[9] Australian Department for Health and Ageing (www.health.gov.au)

06 Australia

Figure 7: Private health insurance claims in Australia



Source: Private Health Insurance Administration Council.

than 35 days in hospital each year, are equalised so that pre-equalisation costs for a fund are replaced by the cost of its share of total market claims (the share being based on the fund's share of 'Single Equivalent Units' (SEU)). The mechanism is referred to as a 'reinsurance' arrangement, although funds do not generally pay according to their risk.

Claims that fall into the reinsurance account are significant and appear to amount to around half of the claims paid (see Figure 7).

The risk equalisation mechanism still leaves insurers exposed to, among other factors, variations in claims experience due to age for those under 65 and the prevalence of large families within the policyholder base. Insurers have attempted to manage their exposures by varying the benefits offered in different products to attract specific profiles of policyholder. Products offering different benefits can have different premium rates within the community rating system. There are therefore products aimed at younger people that emphasise, for example, sports and pregnancy-related benefits, and products aimed at older age groups which may emphasise, for example, ancillary back pain treatments.

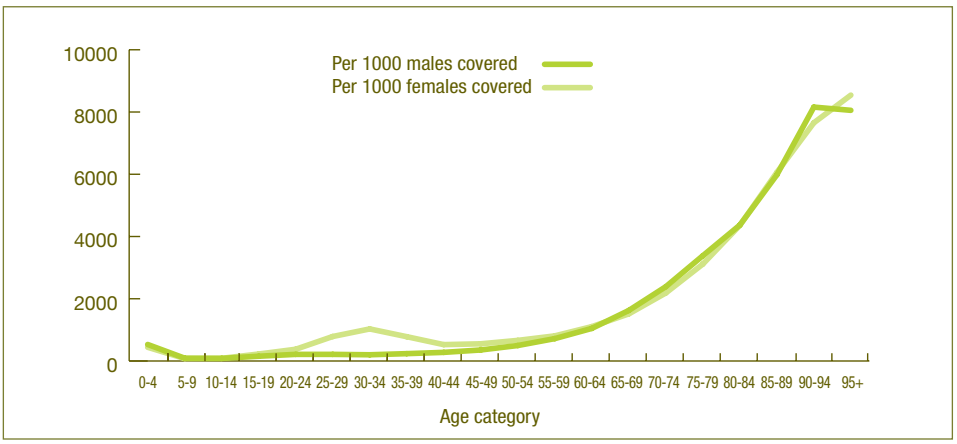
These products have different rates and, in general, each product would clearly look unsuitable for policyholders outside the targeted segment. By this means there is a degree of informal age rating. Low minimum benefits for private health insurance are one factor that has helped to encourage the current market behaviour.

Adverse selection

The dramatic fall in the number of private health insurance subscribers in the 1980s and 1990s resulted at least partly from rising premiums and the reluctance of younger and healthier people to buy. This set up a vicious cycle of further price increases provoking further adverse selection as the product became progressively more unattractive to healthier segments of the population.

The cycle was broken by two measures in particular, which were introduced in 1999 and 2000. These were a 30% rebate on private health insurance premiums and so-called 'lifetime health cover'. The 30% rebate, by which government pays 30% of premiums, appeared to stabilise the market at a little over 30% population coverage. But it was the announcement of lifetime cover in September 1999, and its implementation in July 2000, which appeared to trigger a sharp recovery. PHI coverage leaped from 32.2% in March 2000 to 43.0% in July 2000 and reached 45.7% in September of that year. At the same time, coverage in the 30–34 age group, which was just 26.9% in March 2000, had grown to 45.9% in September 2000.

Figure 8: Hospital days per 1,000 persons covered 2004 – 2005



Source: Private Health Insurance Administration Council.

Lifetime cover provides that insurers can vary premiums by age at entry to private health insurance cover. It allows for premiums to increase by 2% for each year after age 30 that cover is initiated. Once a policyholder joins, the premium rate cannot subsequently vary by age, sex or health status.

For males at least, Figure 8 suggests that the allowed increase in premium by age is probably less than required to fully reflect the increase in cost. Nevertheless, it is a considerable departure from the pure community rating and has some commonality with the German funded age-at-entry system for private health insurance. The Australian system, though, remains a pay-as-you-go arrangement.

Medical gaps

One of the biggest hurdles to further expansion of the sector has been the level of co-payments required by the policyholder. These are referred to as hospital or medical gaps according to whether it is hospital or doctors' fees which cause the out-of-pocket expenditure. Until 1995, there were restrictions that limited health insurers' ability to cover these gaps but, since 1995, insurers have been able to contract directly with hospitals to ensure coverage would leave no gaps to be paid by policyholders. Recent statistics indicate that over 80% of hospital work is conducted with no gaps, although the amount of these gaps varies widely by procedure.

A challenge for insurers in a community rating environment with universal public sector coverage has been 'hit and run' policyholders: those who buy cover when they know they are most likely to need it and then discontinue cover after treatment. There is some ability to exclude pre-existing conditions for a limited period of time and this helps insurers to deal with the phenomenon.

The 30% rebate has probably encouraged a wide definition of ancillary benefits. While, in principle, ancillary benefits are treatments that would not be covered by Medicare, they have become a way of targeting segments of the market by providing products and services (or contributions to their cost) that may be only very loosely related to straightforward medical expenditure.

07 China

Healthcare coverage in China has been patchy and expensive. However, consumer needs and government policies have aligned to create a significant PHI market to the benefit of the nation's health – and the economy.

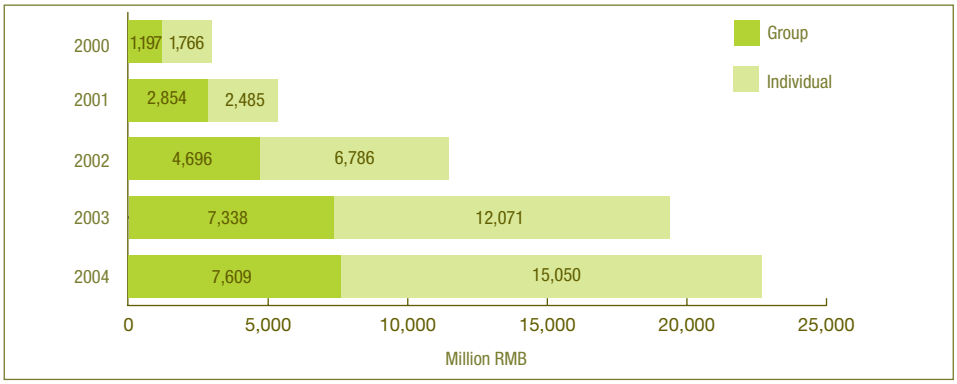
China, one of the world's newest entrants to the global market economy, has a relatively new Social Insurance System (SIB) introduced in 1998, which leaves plenty of space in which a private health insurance market can thrive. Total commercial health insurance premiums were around 22 billion RMB at year end 2004 and the growth rate of health premiums is faster than in the life market as a whole (see Figure 9). Individual health currently dominates the market and critical illness cover is the most popular category in China.

The new state-funded system, SIB, is based on two accounts: a pooled fund and an individual fund, both operated at provincial level. Employers pay about 6% of total payroll and individuals about 2% of wages. The percentage varies between cities depending on their economic situation. Usually, the more developed cities require higher contributions from both parties.

Individual accounts can only be used to pay for expenses incurred on minor illnesses; the pooled funds meet treatment costs which fall between 10% and 400% of the workers' annual average wage in the relevant locality. But individuals also have to pay a proportion of those costs eligible for reimbursement by the pooled funds. The proportion varies by province and also by quality of hospital used.

Some regions have set up funds to provide insurance for medical expenses due to critical illness. Some employers buy private insurance cover in addition.

Figure 9: Chinese health insurance premiums – group and individual



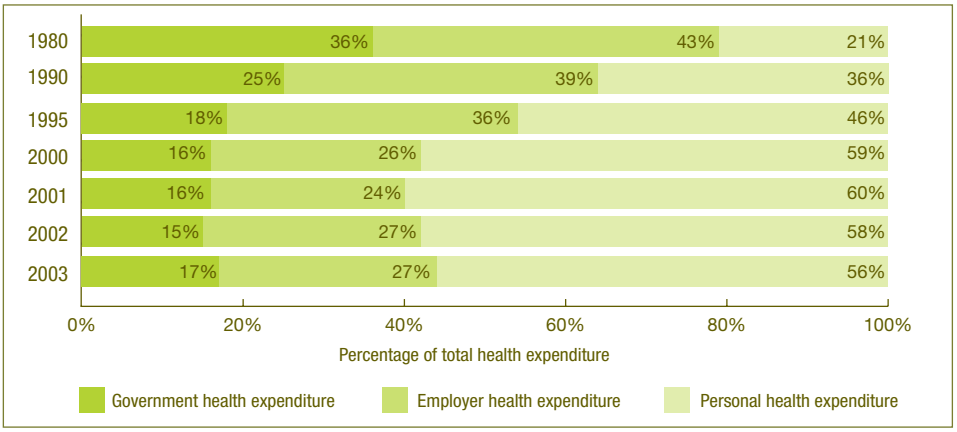
Source: China Insurance Yearbook (2001–2004).

SIB replaces a fully state-funded system, but one which never offered comprehensive universal coverage. Until 1998, China provided free medical care to civil servants and employees of state-owned enterprises. Their families also benefited from reduced fees. All costs of medical treatment, medicines and hospitalisation for civil servants were covered by government budgetary allocation. State-owned enterprises bore all costs for their employees. Rural residents usually had access to subsidised healthcare through the 'barefoot doctor' network. Like similar systems in other countries, this system came under increasing pressure from a number of directions.

There was no effective mechanism to contain patient or hospital expenditure, causing rapid increases in medical costs and high wastage. Medical benefits in less-developed areas, or from enterprises whose performance was poor, found it difficult to provide workers with adequate benefits. Coverage was narrow in scope. Booming foreign-funded and private sector enterprises were not covered by the pre-1999 system. Finances were increasingly squeezed between the state-owned enterprises' declining cash flows and a rapidly ageing population.

However, non-governmental expenditure makes up a relatively high proportion of China's overall health spending. Given the low levels of medical coverage, personal health expenditure is more than 50% of the total and the proportion paid by Government has fallen (see Figure 10).

Figure 10: Trend of China health expenditure breakdowns



Source: Ministry of Health, People's Republic of China.

Slow reform

Market research indicates that treatment costs are one of the top concerns of Chinese consumers and one of the drivers of the country's exceptionally high savings ratio. In order to absorb displaced rural and rust belt labour, however, the Chinese economy needs to keep growing and therefore needs consumers to keep spending. So reform of healthcare and reducing the need for individuals to hold large amounts of savings against uncertainty is crucial to China's economic health.

Reform has been slow. Ministry of Health statistics show that, by 2005, only around 10% of the total population were covered by the national scheme. This means that around 1000 million people rely on their savings or borrowing to pay for medical treatment. A recent OECD study shows that nearly 50% of the urban population and 80% of rural people lack medical cost coverage.

The limitations of the reformed system, both in terms of the people covered and the amount that the pooled fund element of the system can pay should mean that commercial health insurance has immense potential. The result will be two distinct markets for private insurance:

- Enterprise coverage related to and integrated with the SIB; and
- Stand-alone health insurance purchased on both a group and individual basis.

Rapidly growing

Pension savings and sickness coverage are most in demand, both by existing policyholders and for intending buyers. Medical expenses insurance is the most popular health plan but, except for critical illness cover, market penetration data suggests that purchasing behaviour does not match stated needs even though appropriate products are available to some extent.

Chinese policyholders dislike the concept of risk-related insurance and are reluctant to buy pure risk coverage. It is this that makes critical illness products, which may also provide a savings or death benefit, a compromise purchase.

The claims performance of medical expenses business has often been poor (see Figure 11). Claims ratios for some hospital insurance have been over 100%, some even as high as 200%. This is primarily due to the absence of claims controls and good risk management procedures. Some companies regard group health insurance as a loss leader.

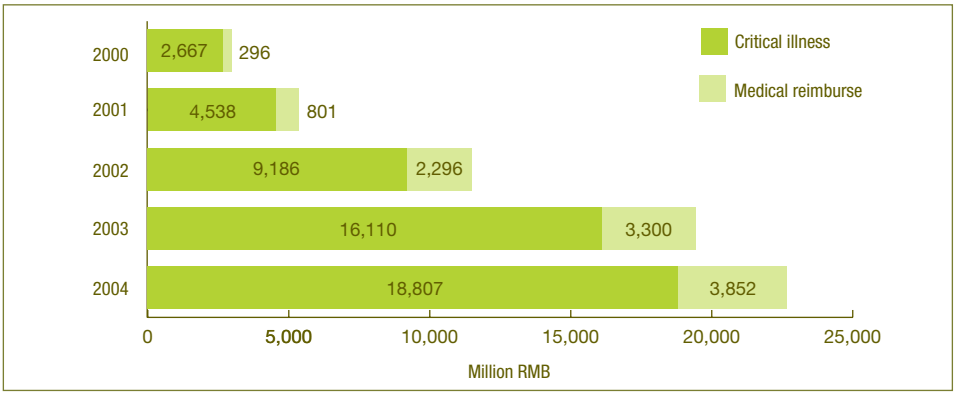
Owing to infrastructure constraints, insurers have only limited success in negotiating cost-saving discounts or superior access arrangements for their policyholders, so current medical insurance services are not necessarily attractive. The China Insurance Regulatory Commission (CIRC) has encouraged specialised underwriting of the health insurance business. In 2004, there were five specialised health insurers approved by CIRC. Major health products sold through both individual and group channels can be divided into three basic categories:

- Critical illness/disease-specific plans providing fixed payment, usually on diagnosis of specified diseases, whether or not medical costs are incurred;
- Medical expenses plans reimbursing a proportion of outpatient and hospital treatment expenses and covering payments beyond SIB coverage if held. Payments are usually capped by reference to the sum assured; and
- Defined health benefit plans providing a fixed payment based on the number of days' hospitalisation or the specific type of medical or surgical procedure. The payment cap is usually a defined number of days' hospitalisation or the cost of the procedure.

Needs and policy aligned

Consumer needs and government policy have aligned to create a significant health insurance market. Insurance will act as a supplement to the new state system. Realising the opportunity will be a tough challenge, requiring specific healthcare skills and an innovative and flexible approach to product design to meet the particular preferences of the Chinese consumer, as well as a rigorous approach to claims management.

Figure 11: Health insurance premiums – critical illness and medical expense reimbursement



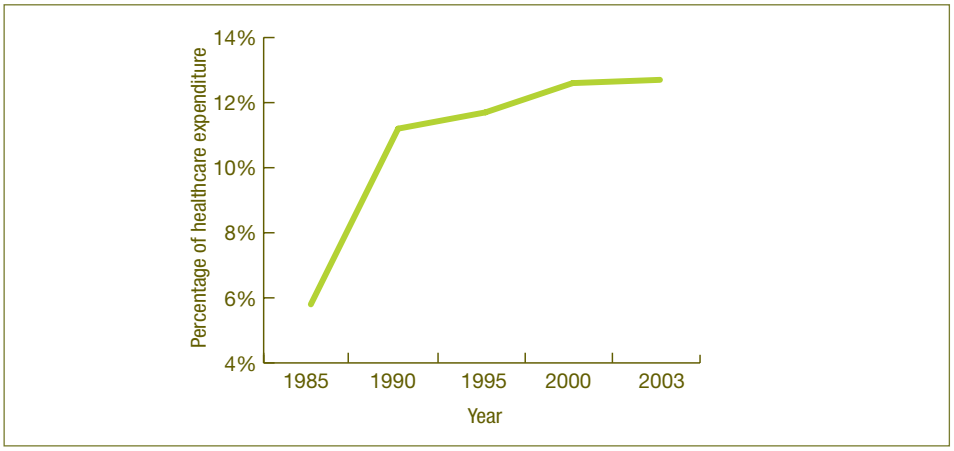
Source: China Insurance Yearbook (2001–2004).

08 France

When France's insurers forced the government to make changes to taxes on health insurance by appealing to the European Court of Justice, there could have been a sizeable shock to the health insurance system. In the event, though, all has gone relatively smoothly.

Statutory health insurance in France covers the whole working population but not necessarily for all their requirements. Demand for private health insurance arises from the need – that has been actively built into the system – to 'top up' provision. Figure 12 shows the percentage of healthcare expenditure paid by private insurance in France.

Figure 12: Percentage of healthcare expenditure paid by private insurance in France



Source: World Health Organisation, Voluntary health insurance in the European Union, 2004.
OECD Health Data 2005.

Statutory co-payments are required by the public system and private insurance may be required to help pay for the 'balance billing', where a physician charges more than the conventional tariff. About 11% of GP visits and 33% of specialist visits lead to balance billing. The statutory co-payment, called the '*ticket moderateur*', is designed to encourage cautious use of health resources and reduce the moral hazard seen to stem from making healthcare entirely free at the point of delivery. According to OECD statistics, private insurance and 'out-of-pocket' payments contribute similar amounts to costs not covered by the statutory system.

Private health insurance works to reduce the impact of the *ticket moderateur* on the take up of available services and how intensively they are used. A recent study found that adults with private insurance were 86% more likely to visit a physician within one month than those without insurance.

But private health insurance has also grown with the gradual erosion of the proportion of healthcare costs paid by the statutory system. PHI covered 33% of the population in 1960; 50% in 1970 and 86% by 2000. In 2000, legislation created free 'private' insurance coverage for the lowest earners which pushed the coverage rate for private insurance up to 92%. High penetration is therefore a feature of the French health insurance market.

The *ticket moderateur* is waived for certain categories of patient, such as those suffering from diabetes, cancer and AIDS, and this has been estimated to total roughly 7% of the population.

Particular treatments and reasons for treatment (such as accidents at work) are also exempt from co-payments. So, while the formal reimbursement rate for visits to a doctor is 70%, exemptions raise this to 81% of standard charges. Balance billing and conditions or treatments not covered at all by the public system reduce the final percentage of total expenditure paid for by the statutory system to 75%. The table details the percentages for other components of healthcare expenditure.

	Theoretical reimbursement rate	Reimbursement rate after exemptions	Reimbursement rate after exemptions, balance billing etc
	%	%	%
Visits to a doctor	70.0	81.0	75.0
Dental care	70.0	73.0	34.9
Medical auxiliaries	60.0	92.0	79.0
Laboratories	60.0	77.0	73.3
Pharmaceuticals	65.0	73.0	61.5
Hospital care	80.0	n/a	90.2

Source: World Health Organisation, Healthcare Systems in Transition.

The development of PHI in France has been heavily influenced by the preferential tax treatment given to the country's long established mutual organisations, ('mutuelles') that operate in the sector. Until recently, the mutuals, which operate a community rating system, were the only segment of the market to be exempted from a 7% premium tax on insurance contracts. Legislation imposed in 2002, however, following a complaint by the French Federation of Insurers to the European Court of Justice, extended that exemption to any insurer operating in a similar way to the mutuals. To obtain tax relief under this legislation, an insurer had to follow 'solidarity' principles and not use health status as a rating factor, although rating by age and sex remained acceptable.

Interesting dynamics

At this point the French health insurance market faced some interesting dynamics with the entry of commercial insurers. The mutuals had exposed themselves to some risk of adverse selection (that is attracting the less healthy policyholders) by not basing premiums on health status, but were protected by their tax status. In practice, most commercial insurers have now, given the choice, opted to abandon rating by health status and gain the associated tax benefits.

As well as not discriminating by health status, however, the mutuals typically have not rated by age either and have often defined contributions according to income. In the individual market, competitive pressures have led mutuals mostly to adopt an age-rated premium structure, although usually with more widely defined age bands than those used by the commercial insurers.

The group market has been less affected, though. Larger groups have often continued to be insured on a similar basis to the 'solidarity' principles of the mutuals. Different groups have had different benefit structures and earnings levels, so premiums, defined as a percentage of earnings, would always vary in any event. To what extent these variations also allowed for the health status and age structure of the group was not always clear but the mutuals probably absorbed some of the underlying variation between groups. Nevertheless, a more closely age-related premium structure has not proved attractive for larger groups and the entry of private insurers has not, so far, become a major challenge to the way in which health insurance is offered in this market.

The relatively smooth way in which the market has coped with these changes, given the risks that mutuals faced from operating community rating in a more open market, has probably been significantly helped by the less concentrated distribution of those healthcare costs covered by private insurance than is the case, for example, in the US. This is primarily due to the waiving of the *ticket moderateur* for 7% of the population, which will comprise much of the most costly population segment, and the other exemptions.

09 Germany

Private health insurance has a long history in Germany and has grown under a system of level premium funded insurance and lifetime cover which has worked well for policyholders and which builds in some incentives for preventative care. However, there is political pressure to change the basis on which private insurance operates as part of amalgamating the private and state systems, and prolonged debate over reform threatens to undermine the industry's sense of direction.

Private or semi-private health insurance provision in Germany has a long history: long enough for the German industry to claim pioneer status as a provider of mass-market health insurance. Legislation in 1883 made provision of health insurance mandatory for certain workers and health insurance had been mandatory for miners in Prussia since 1849. Early health insurance entities developed into both the statutory and private systems.

The German private health insurance system is 'substitutive' in that it provides an alternative to the state system and subscribers to private health insurance do not have to pay the state health insurance contributions. It must be noted, however, that private health insurance can only be purchased by people with income above a defined level.

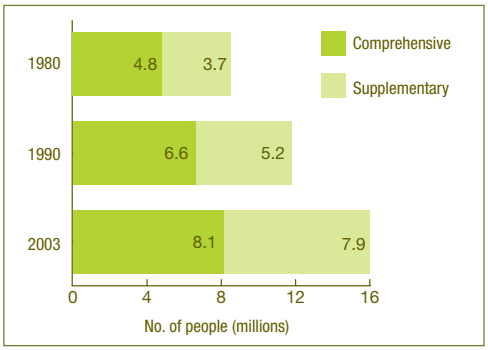
Private health insurance is, in principle, based on a level premium over the working life of a policyholder. Health status is an underwriting factor at entry, but subsequent changes in health do not affect the underlying premium level. German insurers can build in an element of automatic premium changes in the tariff, perhaps in the form of a no-claims bonus, to give policyholders an incentive not to claim. Further, the experience of policyholders as a group on a particular tariff will affect the change in overall premium levels that can be applied to allow for medical cost inflation. The policy is, though, a long-term contract and it cannot be re-underwritten. Underwriting criteria are therefore restricted to status at entry only for health, age and any other rating factor. There are currently no market-wide risk-sharing arrangements in operation for the private health insurance sector.

Ageing reserves

The level premium market practice, which is supported by a legal requirement to set aside funds for use when the policyholder is older, means that significant 'ageing reserves' are held. The level of the reserves is subject to regulation. The use of the profits and losses arising from experience is also regulated. Under current regulations, there is a corridor around initially projected claims experience, so that if actual experience is worse than this, premium increases can be implemented. The premium increase would normally be an overall premium rate change across a tariff, regardless of current attained age, sex or health status.

Figure 13 uses illustrative figures to indicate how the fund (policy reserve) builds up, peaking in value at an age in the mid-60s and then declining as the funds are used to pay benefits.

Figure 14: Private health insurance membership 1980, 1990 and 2003

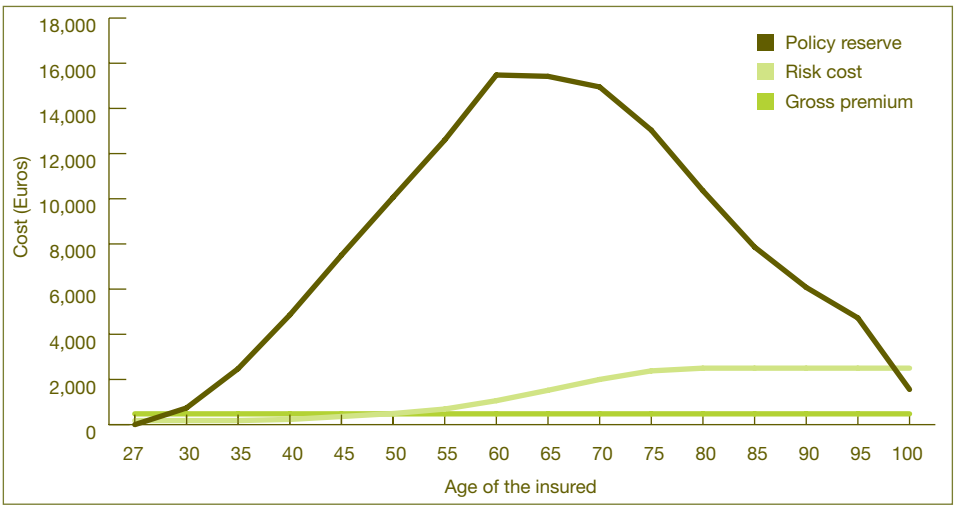


Source: UBS, Potential Reform Risks, November 2005.

Private health insurance has expanded in recent years, although most recently the expansion has been in providing supplementary insurance to members of the statutory system. Figure 14 highlights the growth in German private health membership.

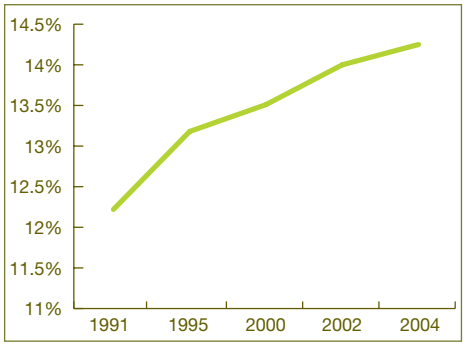
Younger, healthier, higher income people with smaller families have been more likely to choose private health insurance (a process sometimes referred to as 'cream skimming') and this is seen as pushing up the cost of the statutory scheme. However, this has to be seen in context. Medical cost inflation and the effect of the increasingly skewed age distribution of the overall population are likely to have been the major drivers of increasing statutory scheme costs.

Figure 13: Development of fund/policy reserve for a stationary tariff



Source: PricewaterhouseCoopers research

Figure 15: Statutory health insurance contribution as a percentage of relevant income



Source: The European Commission and The World Health Organisation, Healthcare Systems in Transition, 2004.

There are several statutory health insurance funds. On 1 January 2004, the rates for the different funds varied from just under 14% (the BKK fund) to 14.5% (AOK and EAK ANG funds). A risk equalisation mechanism introduced in 1994 has ensured that contribution rates to the funds have converged. Estimates have been published projecting the statutory contribution to continue increasing and even to reach at least 22% by 2029. We would note that in the context of this scale of increase, 'cream skimming' by the private sector can only be a very minor contributing factor.

The state health insurance system is financed on a pay-as-you-go basis. Private health insurance has therefore appeared to be a financially attractive choice for those who qualify for the option. Some of the reasons for this, outside of health-based selection drivers, are:

- Private insurance policyholders essentially pay a premium which is appropriate for their cohort over time;
- The state pay-as-you-go system suffers from the increasingly skewed age structure of the German population due to the ageing population; and
- The private system benefits from any positive real interest rates.

The first factor could, as a purely financial matter, be diminished by requiring private system subscribers to continue paying some portion of the state contributions which arise from the skewed age distribution. The system in the Netherlands, for example, has had a similar feature since the Medefinanciering Oververtegenwoordiging Oudere Ziekenfondsverzekerden (MOOZ) scheme was implemented. According to the OECD, the German government has statutory authority to require private insurers to participate in a risk equalisation scheme to help finance statutory cover for the elderly, although this power has not been used.

Cost pressure

The statutory sector is then suffering cost pressure but, on the other hand, the German private health insurance system has avoided some of the problems seen elsewhere. For example, there are no obvious counterparts to the adverse selection phenomenon in Australia, or the stagnant and low penetration levels in the UK.

Further, the ageing reserves under the current funded private system are an incentive to health insurers to manage the longer-term health of their policyholder base, both because of the possibility of profits or losses arising on the reserves and because of the competitive pricing that would result from successful preventative care efforts. The alignment of the current German funded private health insurance system with the policy objective of enhancing preventative care is an unusual and attractive feature. Perhaps the primary challenge for the German system as a whole is the cost projections for the statutory sector.

The largest private insurers partly blame protracted debate over possible changes and reforms to the system for a recent slowdown in the growth of comprehensive private health insurance, at least compared with the strong growth in supplementary cover.

Reform proposals have generally involved integrating the private and statutory segments into a single system and have usually included a move to pay-as-you-go. Typically, proposals are differentiated by the distribution of the funding sources. For example, the 'Citizens insurance' (Buergerversicherung) favoured by Social Democrats and Greens would raise funds by means of income-related contributions. In some proposals, income would be defined widely to include interest and rents. Proposals by the Christian Democratic Union (CDU) have been for a flat-rate contribution system, handled by the private insurance sector, which would look more like a community rated insurance premium. The latter proposals would, in particular, seek to limit employer contributions. The CDU proposals have at times been opposed by its Bavarian sister party (the Christian Social Union, or CSU).

Direction unclear

The direction of reform is unclear and new proposals may appear. At the time of writing, an agreement has been reached at the political level for a reform package which would introduce a degree of tax funding into the statutory system, oblige private insurers to have available at least one tariff on which they would accept all proposals and impose a uniform price across all insurers (statutory and private) for medical procedures. The impact of these proposals will depend on how, and indeed whether, they are implemented. There is also a proposal to introduce 'transfer values' between private health insurers. This would increase the mobility of policyholders between private health insurers and so promote increased competition in an age-at-entry premium rating system. In tackling the mobility issue, the proposal would remove one of the major objections to the current German funded private health insurance model.

10 Ireland

EU legislation has remodelled the landscape for private health insurers but the principles of public policy remain the same.

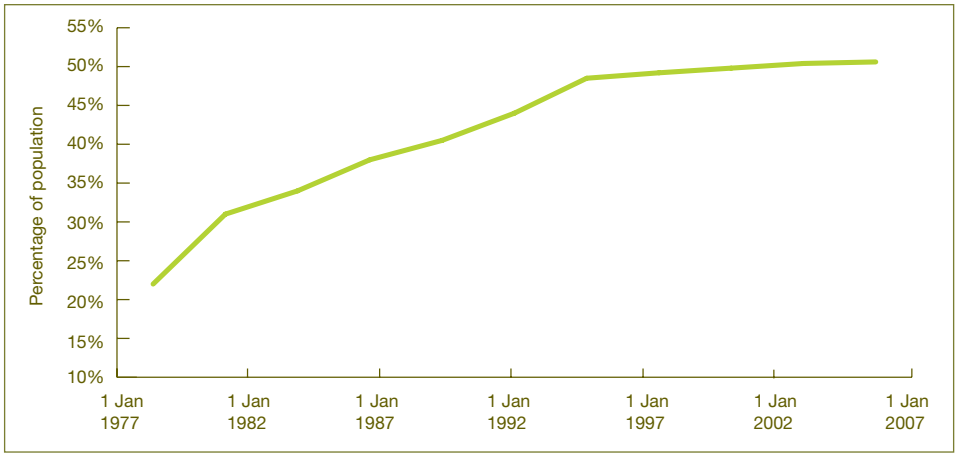
Government policy supports a prominent role for private health insurance. In Ireland, policymakers take the view that PHI plays an important social role in promoting the efficient use of resources and providing an enhanced income stream to hospitals. Most importantly, a strong PHI sector is thought to reinforce the idea of individual responsibility for the cost of care and therefore to help control costs. The Irish product, then, has a long history characterised by a generally high penetration of the population. The percentage of the Irish population insured and the year-to-year increase in the population insured is highlighted in Figure 16.

In view of the policy objectives, access has been the primary focus of a highly regulated industry. Ireland enforces a strict form of community rating, although it appears possible to charge separate rates for the individual and group markets.

There is now universal eligibility for publicly funded hospital accommodation but around 70% of the population are 'Category II' or non-medical-card holders who have to pay for GP services, some drugs charges and a daily contribution to public bed hospital charges. Apart from the 'per diem' charge (set in 2004 at €45 with a maximum of €450 total in any 12 months), Category II patients remain entitled to free hospital care on public wards. Nevertheless, private health insurance in Ireland mainly pays for the expenses of private hospitalisation rather than other costs (OECD 2004). An individual subscribing to private health insurance receives tax relief at the basic rate on the premium.

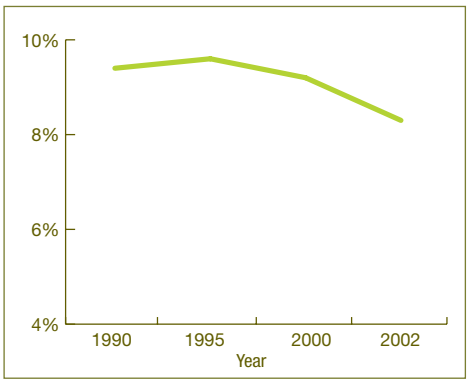
Although enrolment has continued to increase and current estimates of population coverage are in the region of 51%, a surge in public spending on health in recent years has led to a fall in the proportion of total non-capital healthcare spending paid for by private health insurance. One factor has been the increasing subsidy of private beds in public hospitals, as charges for these have not kept pace with increasing costs. Most recently, however, this subsidy has diminished as charges have been increased in a move towards charging the full economic cost rather than just a contribution. This should lead to some reversal of the trend, shown in Figure 17, of a decreasing proportion of total expenditure being paid for by private health insurance.

Figure 16: Percentage of population covered by private health insurance



Source: Department of Health and Children, Health Insurance Authority

Figure 17: Private insurance share of non-capital healthcare expenditure



Source: PricewaterhouseCoopers research.

Virtual monopoly

Ireland's approach to healthcare funding was established when the government set up the Voluntary Health Insurance board (VHI) in 1957. VHI offered private health insurance to people whose income was too high to make them eligible for any state help towards treatment in public hospitals. VHI is a non-profit entity which has operated a community rating approach since inception. Until the mid-1990s, the Board was virtually a monopoly but, following changes imposed by EU legislation, BUPA entered the market in 1997. VHI still has around 80% of the market.

BUPA also operates within a community rating framework but has been able to attract significantly younger policyholders with carefully targeted plans. The age profile of the policyholder base has become a central focus of attention in the Irish market. The issue is closely associated with risk equalisation mechanisms and the Irish risk equalisation mechanism is itself subject to legal challenge. Figure 18 overleaf highlights figures for age and health status in 2001, when VHI held around 85% of the market and BUPA held 8%.

Figure 18: Age and health status composition of policyholder base

	VHI	BUPA Ireland	Other
Age			
Under 30	30%	49%	35%
30–49	38%	42%	31%
49–64	23%	6%	27%
over 65	9%	4%	8%
Health status			
No health problem	91%	96%	95%
Health problem	9%	4%	5%

Source: OECD, Private Health Insurance in Ireland, 2004.

Although BUPA's policyholders are significantly younger than VHI's and the proportion of policyholders with a health problem is less than half that of VHI, BUPA's premium rates for groups were only around 15% less than VHI's for a comparable group policy in 2004. The lower BUPA price probably reinforces the insurer's attractiveness to its target customers which, in a community-rated market, could provoke the so-called 'death premium spiral' of ever-increasing premium rates and deteriorating policyholder risk profile. BUPA's rates for individual policyholders are close to those of VHI. One effect of this must be to deter individuals who are not in BUPA's targeted groups from approaching BUPA on an individual basis.

Risk equalisation

The possible entry of a new insurer was contemplated when the Irish market was opened up in the 1990s. For this reason provision was made for a risk equalisation mechanism as far back as 1994 to ensure that, in the community-rated environment, all sectors of the market would continue to be catered for and that insurers did not just become wholly preoccupied with attracting as young a policyholder base as possible.

It is, though, all but inevitable that any new entrant to the market will attract a younger than average policyholder base. This is because of a combination of the greater conservatism and inertia of older people combined with the first-time policyholder effect. This 'effect' is that even if an insurer's share of switchers and first-time buyers is the same, because less than 100% of the existing policyholder base switch and first time buyers are younger buyers, a younger-than-average age profile will likely result. The arrangements currently in force for risk equalisation provide, in broad terms, that:

1. Insurers' claims costs are recalculated on the basis of a market weighting of policyholders in each age/sex 'cell' and that their own healthcare utilisation costs apply to each cell;
2. The difference between the recalculated claims costs and the actual claims costs for each insurer are calculated;
3. If this difference is significant enough the government will institute risk equalisation payments; and
4. Payments are made from insurers whose market-weighted recalculated costs are less than actual claims to those where the recalculated claims cost is greater than actual claims.

Zero sum adjustment

A consequence of using the insurer's own claims costs (rather than market average costs) in each age/sex cell for the recalculation (stage 1) is that the amounts calculated in (2) will not add up to zero and the mechanism would not, therefore, be self-financing. For this reason, the Irish system applies a uniform 'Zero Sum Adjustment' (ZSA) factor to the amounts calculated in 1 so that, after applying the ZSA uniformly across the market, the 'market-weighted' claims costs then add up to the total actual claims.

An advantage of using 'own' costs (subject to the ZSA) is that insurers have to absorb the financial consequences of higher or lower than market utilisation, which creates a degree of incentive to manage efficiently the health of the policyholder base.

The process for implementing risk equalisation payments was set in motion by the state authorities for the first time with effect from 1 January 2006, although this is subject to legal challenge. Health status within each 'cell' will not be included in the risk equalisation mechanism this time. Certain organisations (Restricted Membership Organisations) can opt out of risk equalisation and in the first year payments are made under the mechanism they are at half the full rate. The latter feature still leaves at least a temporary incentive to recruit younger members.

Strategy and public policy

There are, inevitably, many strategies for operating alongside the risk equalisation mechanism and these will depend on the details of the calculation. For example, if, while complying with regulatory minimum benefit levels, an insurer was successful in attracting younger and generally healthier members, then it is still probably possible for this to be done in a way that would minimise payouts to the risk equalisation mechanism to the advantage of the insurer.

One regulatory development which most likely lies ahead is the introduction of so-called 'late entry premium loadings'. While the details of how this would work in Ireland are not yet finalised, the principle is that people who start health insurance after a certain age would pay more.

11 Netherlands

While around the world policymakers continue to debate how best to provide flexible, affordable healthcare systems, the Netherlands has gone ahead with major reform.

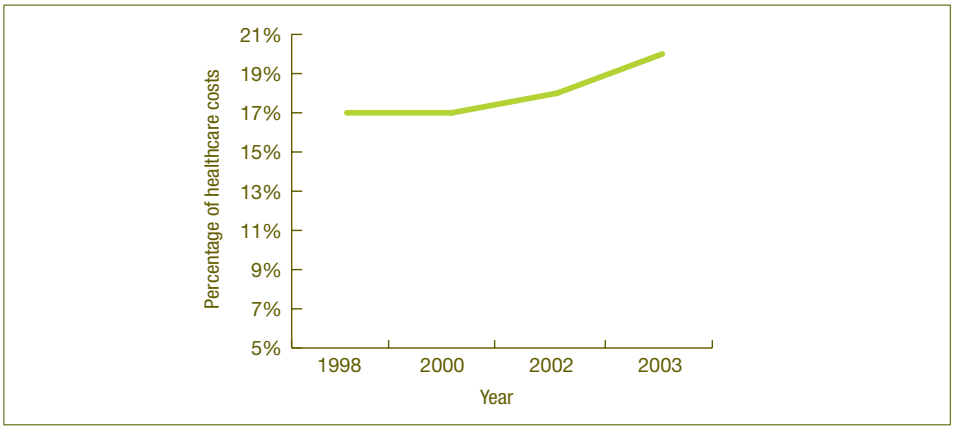
Private health insurers have played an unusually central role in healthcare funding in the Netherlands, simply because citizens earning an income above a threshold figure had no option but to subscribe to private health insurance or be uninsured. Figure 19 shows the percentage of healthcare costs paid by private medical insurance between 1997 and 2004.

The historical background and development of the country's system is similar to Germany's, in that private health insurers provided an alternative to the state system to which private policyholders did not have to subscribe. As in the German system, 'ageing reserves' were accumulated for policyholders to pay, for example, for benefits in retirement, when reduced premiums would be charged.

There was relatively light regulation of policy terms and conditions at entry. The major requirements were that private health insurers could not terminate policies or raise premiums on the basis of an individual's healthcare consumption and had to provide a minimum level of benefits. There has been a long tradition in the Netherlands of mutual health-funding organisations dating back to the 17th century.

In 1996, the MOOZ scheme was introduced to help compensate the statutory sector for its more costly age profile than the private sector's by collecting contributions from private policyholders. In January this year, the Netherlands introduced a completely new system in which the public and private sectors are amalgamated (see Figure 20).

Figure 19: Percentage of healthcare costs paid by private medical insurance 1997–2004



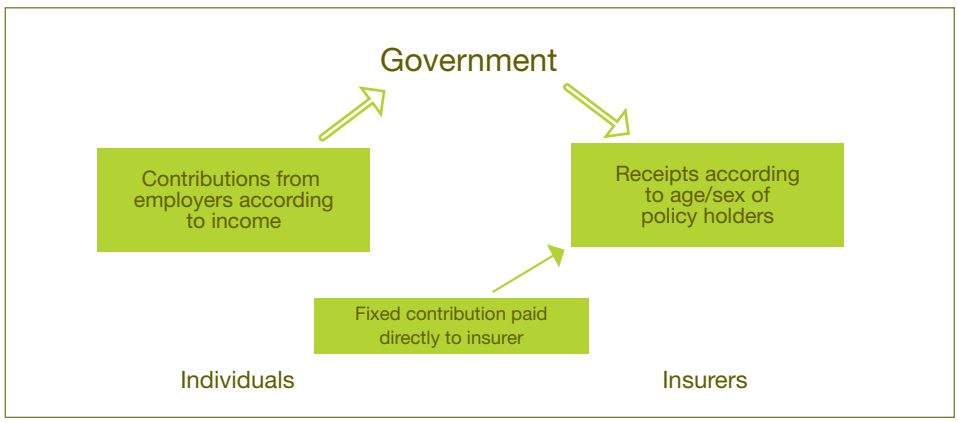
Source: OECD Health Data, 2005.

Single system

The system is intermediated by the government and there is now a single system rather than a split state/private system. The new system retains some of the features of the old statutory health insurance system. A state authority will determine what each insurer receives based on age, sex and certain measurers of health status.

Payments to insurers by the government will be set based on a forward-looking ('ex-ante') assessment of market-wide costs. The actual cost incurred by a particular insurer may well differ and, at least in the early years of the system, an after-the-event ('ex-post') investigation of costs will be undertaken each year to determine further appropriate payments and levies to equalise risk between insurers. Each insurer will also obtain revenue by charging a flat rate fee to all policyholders. This flat fee was expected to be in the region of €1,300 per annum but competition to establish market share meant that some of fees were in the region of €1,000.

Figure 20: The new Dutch healthcare system



Source: PricewaterhouseCoopers research

A primary objective is to encourage greater competition in the efficient buying of healthcare provision. Each insurer will contract directly with care providers. The scale of the (semi-) private buyers should ensure they have bargaining power.

The payments to insurers will be reassessed each year. This is a pay-as-you-go system, which implies that health insurers will not hold any significant ageing reserves under the new system.

Broadly, the new system is intended to provide only a basic level of healthcare. Health insurers will therefore still be able to serve an important market for much more lightly regulated supplementary health insurance. The ageing reserves held under the old system may, at least in part, be used to enable competitively priced supplementary insurance to be offered to pre-existing private health insurance policyholders. In principle it is possible that some supplementary private health insurance might continue to be priced on a funded age-at-entry basis for new policyholders, but it is hard to envisage such a system arising without regulatory encouragement.

Primary gains

The profitability of the new system to insurers is largely in the hands of the government. Ex-post risk equalisation may come close, at least in the early years, to cost reimbursement by the state. Equally, there is a risk that efficiencies gained in competitive purchasing of care will be reflected, at least on an industry-wide basis, in reductions to the standard allowance paid by government to the health insurers in subsequent years.

A primary gain from the new system is that it has achieved the fusion of the private and public insurance sectors, which was a public policy objective. Perhaps most importantly, efficiency gains in the delivery of care and closer co-ordination of demand and supply are the hoped-for consequences of competitive purchasing of care by insurers. For the first time, insurers are not compelled simply to contract with all providers on a country-wide basis.

Historically, the private health insurers were often established alongside not-for-profit sister organisations which operated in the statutory sector. These organisations are likely to merge and achieve the advantages of scale, both in internal efficiencies and in external bargaining power.

Mobility between insurers should also improve under the new system. One drawback of the old system was the limited mobility of older policyholders in the private sector and this was seen to limit effective competition. Accumulated health problems could have made a policyholder too unattractive to alternative insurers. An alternative insurer of last resort existed in the form of the 'WTZ' pool for high risks but WTZ was an expensive option, even though it was subsidised by the regular market. It constituted about 12% of the privately insured population. The new system should make it easier for policyholders to move insurer.

Different incentives

The advantage of the new system is primarily that it encourages efficiency in the delivery of care. It could be argued, though, that the new system also reduces incentives for insurers to manage the health of their policyholder base beyond the 12-month term of the policies under the new system. Under the old system preventative healthcare and the promotion of healthier lifestyles were important to private health insurers because of their relevance to competitive pricing and the emergence of profits or losses on the ageing reserves. The guaranteed renewal of basic insurance clearly should create some incentive for insurers to manage longer-term health, but profitability is expected to be concentrated on the supplementary segment. Here, renewal will not be guaranteed.

As ever, management is therefore likely to focus more on the underwriting process and on recruiting the healthy as policyholders. Offering health insurance is also likely to continue to be attractive to insurers as a relationship builder which helps create opportunities for cross-selling.

12 Switzerland

A compulsory health insurance system that is fairly comprehensive is well regarded – as long as the costs do not rise too far, too fast.

Swiss healthcare is funded partly through competing not-for-profit health insurance funds offering a basic level of healthcare, and partly through a supplementary private health insurance market. The basic level of care provided by the not-for-profit funds is comprehensive and, as buying it is compulsory for Swiss citizens, it is usually referred to as 'compulsory health insurance'.

Supplementary insurance is used primarily in a 'substitutive' way for care that is not provided in the compulsory system, such as some dental care, and also in a 'duplicate' role for people seeking to buy better accommodation or choice of doctor. The degree of cover in the supplementary market can vary between policies.

The compulsory system is community rated. Community rating applies per adult, with some reductions for children. The result is that the compulsory insurance can be costly for younger families. To counter this, a system of subsidy has been put in place since the start of the current system in 1996 with the aim of smoothing the costs between family units and reducing the costs for lower income policyholders. A risk equalisation system also operates in order to support the guaranteed coverage aspect of community rating. The Swiss system of healthcare funding is generally well regarded.

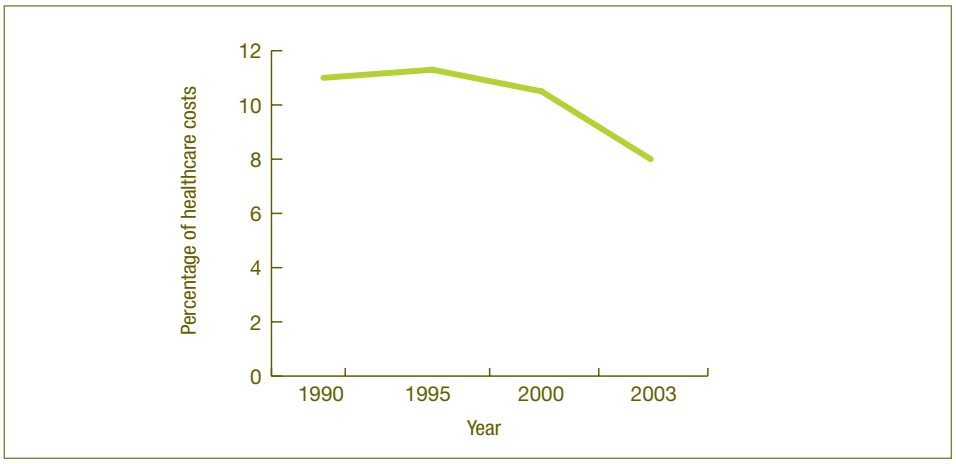
Rising costs

Around two-thirds of funding for the subsidy is derived from the state and one-third from the Cantons. However, distribution of the subsidy is largely in the hands of the individual Cantons. There has been great variation between Cantons in operating the subsidy, from a flat-rate reduction in premium on the one hand, to a subsidy linked primarily to low income and large family size on the other.

Further, the funding of the subsidy has generally not kept pace with rising health insurance costs, so compulsory health insurance has steadily become a high cost and a major issue for younger families on average incomes in some Cantons. Federal legislation, which came into force on 1 January 2006, increased the subsidy and gave some limited directions on its use, but the Cantons still retain most of their discretion over how the subsidy is distributed.

The increasing pressure felt by many Swiss from the cost of compulsory health insurance premiums has resulted in lower penetration levels of supplementary insurance. The decline in the percentage of healthcare expenditure paid by the private (supplementary) health insurance illustrates this development. A further reason for this decline is that cost increases for private health insurance have been more moderate than those for the compulsory basic insurance.

Figure 21: Percentage of healthcare costs paid by private medical insurance



Source: OECD Health Data, 2005.

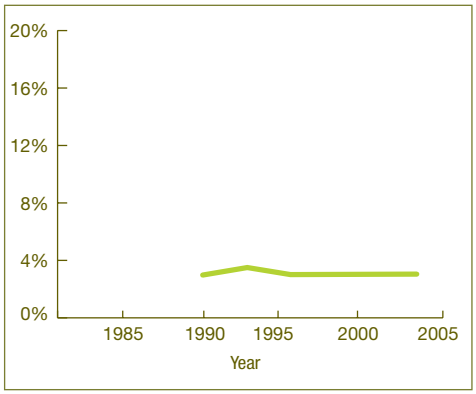
United Kingdom 13

The UK offers a poor environment in which to build a scale operation, even for innovative health insurers. The market could become mostly a corporate group market, primarily for the wealthy.

The British market for private medical insurance is small and stagnant compared with markets elsewhere in the world. The percentage of total health expenditure met by private medical insurance has remained at the exceptionally low level compared to other developed economies of 3% – 3.5% (see Figure 22).

The most obvious reason for this is the full coverage provided by the UK National Health Service, which sets out to cover all conditions for all of the population.

Figure 22: Private medical insurance as a percentage of total health expenditure



Source: PricewaterhouseCoopers research

But there are other peculiarities, such as the fact that there is no equivalent to the many methods used by regulators elsewhere to widen access to health insurance. There is, for example:

- No equivalent of the rating bands used by different US states in the small groups market;
- No encouragement through the tax system for community rating as in France;
- No equivalent of the community rating system as in Australia; and
- No regulated level premium system as in Germany.

UK health insurers have unusually wide freedom to rate individual policyholders according to the near-term risk for a 12-month contract. One result is that UK rates typically increase steeply at older ages to become unrealistic for many people (see Figure 23). Another result is that an individual who changes jobs risks accumulating very significant exclusions. Private health insurance, therefore, has come to look like a marginal component of the healthcare funding system.

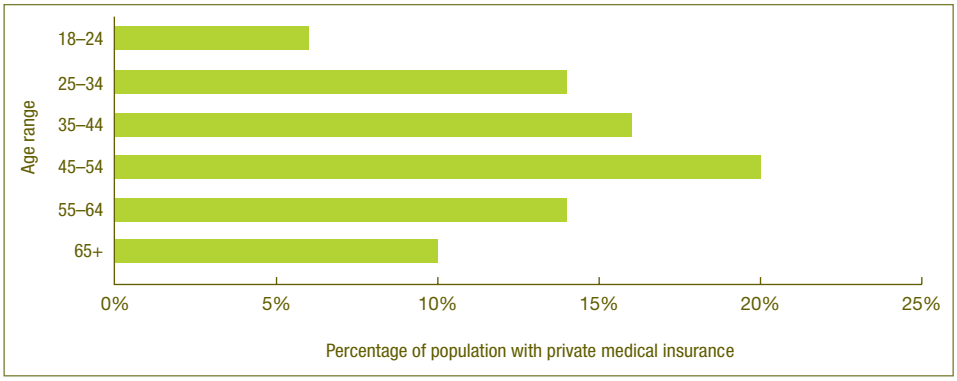
At present, UK private health insurance operates so as to 'duplicate' state provision. The policyholder remains entitled to the complete state service and continues to pay for it in taxation. This model of UK health insurance as a duplicate insurance market, however, is under pressure in areas such as dentistry, where the restricted supply of NHS provision means that it is becoming hard to justify the proposition that complete state provision is on offer. This is leading to a market that looks more like the substitutive system in operation in other countries.

In essence, the UK private health insurance industry is subject to very little specific regulation, although market practice is normally not to impose exclusions on continuing policyholders. Even then, continuing policyholders can, of course, face exhaustion of their cover for particular conditions. It may easily be argued that, overall, health insurance in the UK provides a considerably lower level of risk sharing to policyholders than in most other developed economies.

Attempts to innovate

Nevertheless, providers are making attempts to innovate in the market, mostly aimed at reducing the cost in return for reduced cover. Examples of reduced cover include increased excesses, percentage co-payments up to a limit and cover for specified conditions only. A different approach has been taken by PruHealth (a joint venture between Prudential and Discovery) which offers policyholders significant discounts for adopting healthy lifestyle choices. These innovations are usually aimed at attracting healthier and, probably, younger policyholders, often in the individual market rather than in the group market. As a whole, though, this market is dominated by older, wealthier policyholders in the pre-retirement age group.

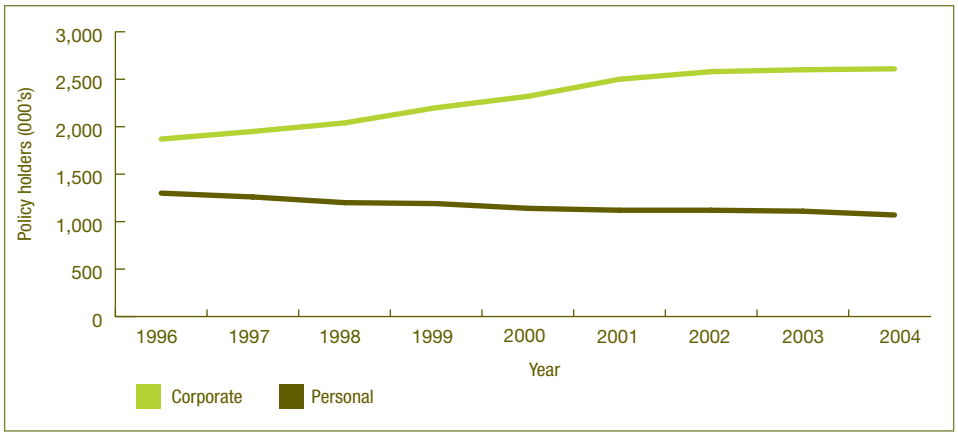
Figure 23: Percentage of population with private medical insurance by age range



Source: Ipsos Mori Jan – June 2005.

13 United Kingdom

Figure 24: Policyholder numbers (000's) 1996–2004



Source: Association of British Insurers

In fact, despite the innovations, the number of individual policyholders has continued to decline, a decline commonly attributed to premium rate increases (see Figure 24).

In addition to continuing efforts to revive the individual market on a lower cost basis for younger and healthier policyholders, at least one UK insurer bases its business model on level lifetime premiums and cover, increasing premiums only in line with overall healthcare claims inflation. This insurer is a mutual. The light regulatory framework for the product (compared, for example, to that in Germany) means that the insurer retains a high level of discretion over the premium increases. It seems to us that careful thought would be needed to create a sufficiently transparent product that would be appropriate for proprietary insurers in the mainstream of the market. However, the existence of this product is another example of the lively product environment in the UK – despite the handicaps the market faces.

More positive

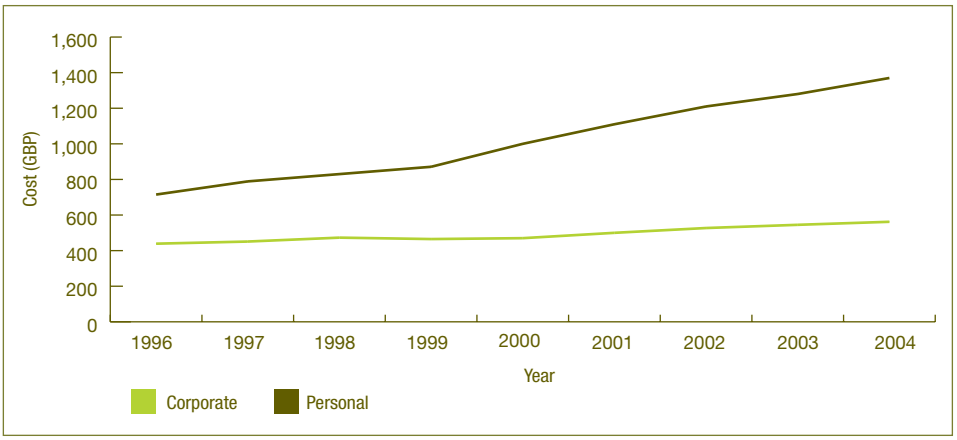
The UK corporate market is a group market which, within the group, usually operates on a quasi-community-rated basis, that is, although there may be exclusions relating to conditions diagnosed before employment with the current employer, everyone pays the same, usually regardless of age or sex. The underwriting environment for group policies is considerably more positive than that for the individual market. Changes of employer provide an opportunity to revisit exclusions and relatively well-paid employed status is a strong positive selection factor. Further, the inclination of younger employees to join corporate plans strongly supports the community rating feature.

Because, in contrast to, say, Australia, there is no legally enforced guarantee that cover will always be given, providers are less exposed to so-called 'hit and run' policyholders who only buy insurance when a claim is envisaged. Nevertheless there is some evidence that the individual market attracts older policyholders who have a higher expectation of making a claim.

The result of all these factors is that the average premium in the corporate market is considerably lower than that in the individual market (see Figure 25).

Broadly, the UK market risks becoming largely a corporate group market that provides cover during working years only and then only for conditions that arise in the course of an employee's current employment. It is also becoming increasingly only the more affluent who use the market. But the industry has shown a great capacity for innovative thinking. In a more helpful environment we would expect UK health insurers to be capable of responding strongly to any genuine opportunity to expand the market.

Figure 25: Average private medical insurance premium costs (GBP per annum) 1996–2004



Source: Association of British Insurers

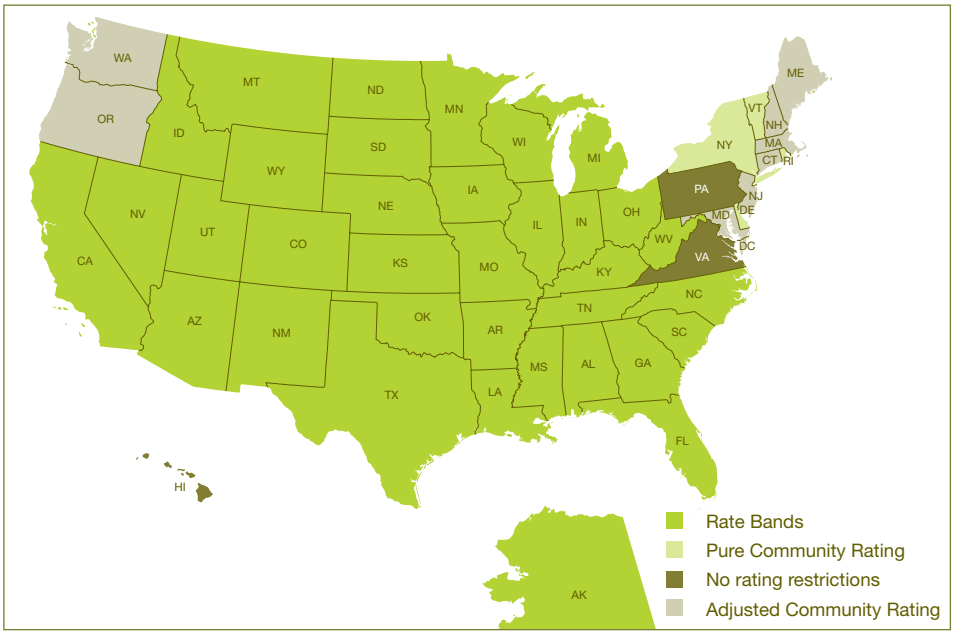
The US market has given great attention to the role of insurers in managing the cost of delivering healthcare. Nevertheless costs have risen ahead of general prices and wages. Access to healthcare is a longstanding challenge. Regulation varies between states, reflecting the different social priorities. Preventative healthcare is receiving more attention but the incentives to focus on this activity can look weak.

Private medical insurance is more important in the US than in any other major territory. However, this does not mean a uniformly free-market approach. On the contrary, the overall picture is one of a complex relationship between a free market in healthcare and the demands of social policy, usually reflected in state-level regulation.

The market forms three segments: the individual, the small group (2–50 members) and the large group market. The large group market may itself be regarded as split between the insured segment and the self-insured segment. Self-insured employer-sponsored health plans usually have over 1,000 members and are separately regulated under the federal ERISA laws. The plans themselves will then often contract with Health Maintenance Organisations (HMOs) or Preferred Provider Organisations (PPOs). Around 90% of Americans of pre-retirement age who have private health insurance obtain it through their employer and are therefore in the group market.

Individual states have powers that allow for widely varying systems – and the variation in the regulatory environment across states is indeed considerable. This can be seen, particularly, in the individual and small group markets – where insurance (as opposed to self-insurance) is dominant. For example, most states have rating restrictions of some description in the small group market. A common regulatory mechanism is to define bandings of health status and then to impose limits on the extent to which the premiums charged in each health band can vary. The definitions of the bands and limits on premium variations vary between states (see Figure 26).

Figure 26: Rating restrictions for small group market (2–50)



Source: The Kaiser Foundation.

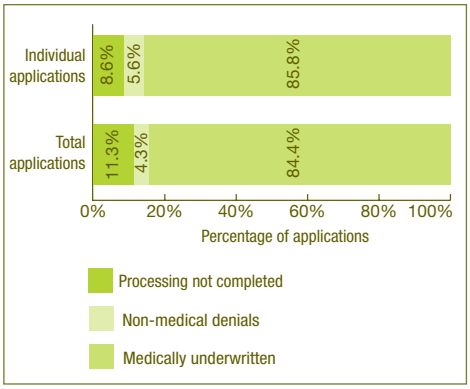
Health banding regulation is mostly a result of social policy. It is usually aimed at making the product offering of private health insurers more accessible, and aligned with the broader social policies of a particular state. Other regulatory measures may include, for example, minimum loss ratios and we are aware of nine states that have such regulations in the individual market.

Denials

In the individual market, however, a significant proportion of proposals for health insurance are declined. According to America's Health Insurance Plans (AHIP), around 25% of individual market health insurance proposals, one way or another, do not result in an offer of coverage. Proposals may not reach the stage of medical underwriting (see Figure 27).

The rating characteristics of the 'processing not completed' and 'non-medical denials' categories are unclear. Once the proposal reaches the medical underwriting stage denials are, on average, in the 10%–15% range but, inevitably, denials increase with age and AHIP figures indicate that 30% of proposals from the 60–64 age group are denied on medical grounds (see Figure 28 overleaf).

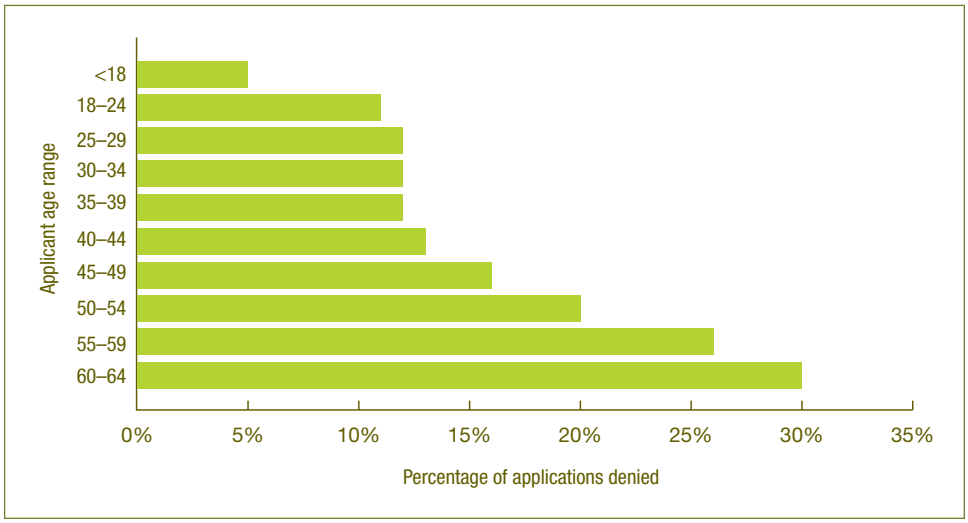
Figure 27: Percentage of applications proceeding to medical underwriting 2004



Source: America's Health Insurance Plans, Individual Health Insurance: A comprehensive survey of affordability, access and benefits, August 2005.

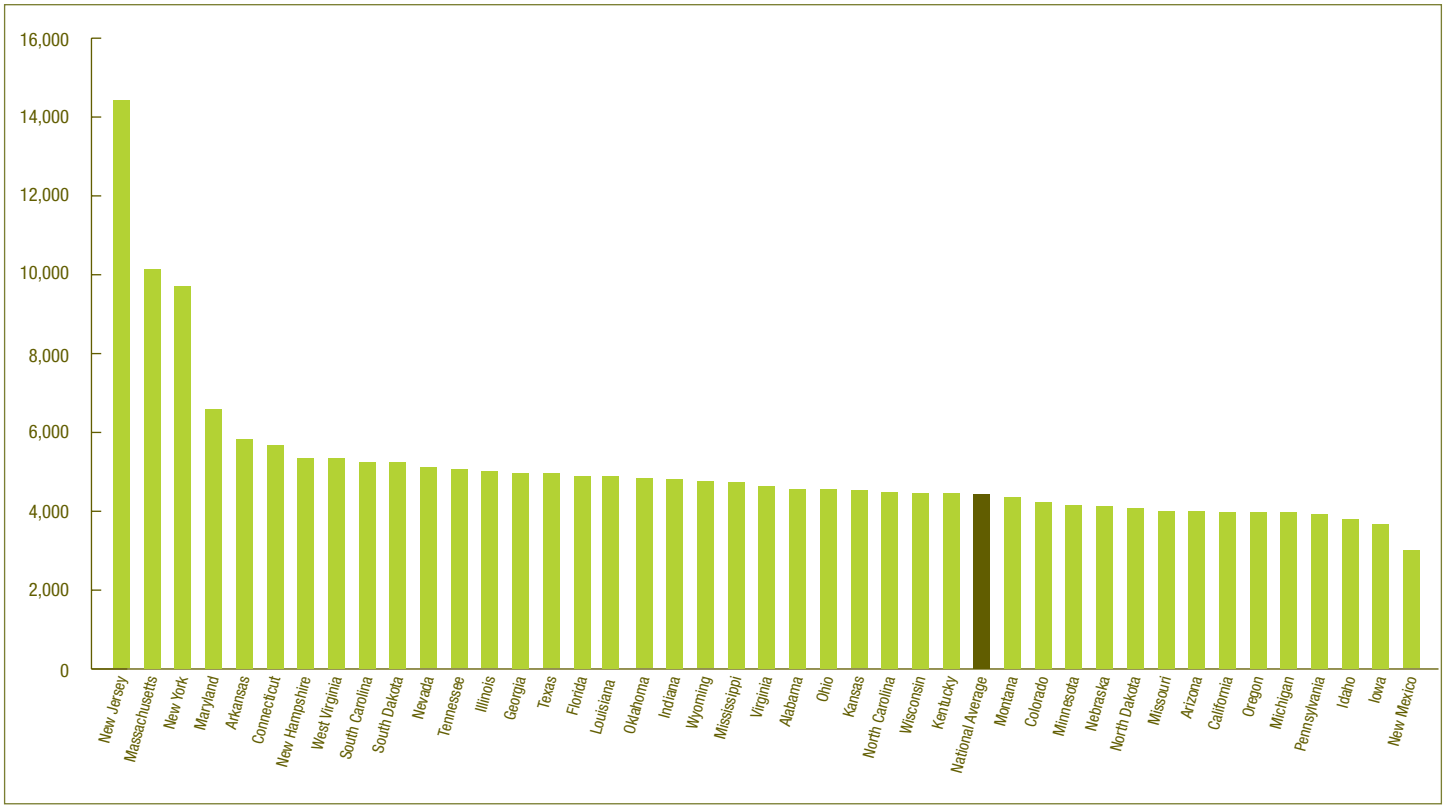
14 United States

Figure 28: Analysis of denial rates 2004 – individual applicants



Source: America's Health Insurance Plans, Individual Health Insurance: A comprehensive survey of affordability, access and benefits, August 2005.

Figure 29: Average annual premium, individual market and family coverage 2004 (USD)



Source: America's Health Insurance Plans, Individual Health Insurance: A comprehensive survey of affordability, access and benefits, August 2005.

There are some large variations between states in the average premium charged for health insurance in the individual market, at least partly because of the varying systems in place. Figure 29 shows the average annual premium, individual market and family coverage for each US state in 2004.

In three states, the average premium charged is considerably higher than for the others. The New Jersey, New York and Massachusetts health insurance markets operate under state legislation that imposes some form of 'community rating'. Generally, community rating in the US, as elsewhere, involves requirements to:

- Charge the same premium to all applicants regardless of medical status;
- To guarantee coverage, i.e. coverage cannot be declined; and
- Guaranteed renewal, i.e. existing policyholders cannot be refused coverage on renewal.

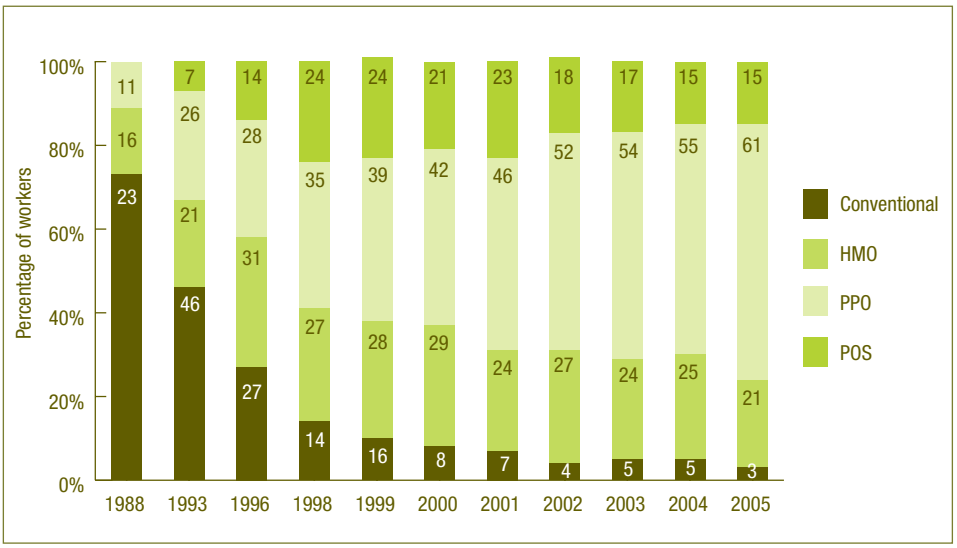
Average premium looks high under community rating

Community rating meets the challenge of coverage denial and coverage denial may be seen as contrary to social priorities. However, the inclusion of risks that would otherwise be denied coverage on health grounds clearly is one reason why the average premium will be high. High premiums and the guarantee of coverage, regardless of health status, act to discourage younger and healthier people from purchasing coverage and this will further push up community-rated premium rates.

Community rating has been an important feature of the US market and is closely associated with the emergence of mass-market health insurance. When 'The Blues' – Blue Cross and Blue Shield – were formed in the 1930s, they pioneered mass-market health insurance in the US generally as not-for-profit organisations on a community-rated basis. They were helped by tax and regulatory privileges. Employer-sponsored group health insurance expanded during World War II when companies used employer-provided health benefits to compete for workers that were in short supply, thereby circumventing wage controls in place at the time. Favourable tax treatment for companies and workers of employer-sponsored premiums also supported the trend. When commercial insurers operating on a risk rated model became a more significant part of the market in the 1950s, the Blues were forced to abandon community rating, beginning with parts of the group market in the 1950s and, later on, extending to the individual market as well.

The group rating type of approach still applies in the large group market, although rates typically vary based on the employment group's own experience. So, employees in any one plan usually all pay the same, or similar, regardless of age, sex or health status. Also, though there are some notable exceptions, contributions do not normally vary with income. However, larger employers may well have more than one plan with varying benefit and contribution tables. The advantages of group health insurance mean that high percentages of both good and bad risks usually subscribe to the plan so that, particularly for larger groups, a form of 'internal' community rating within the group can be effectively implemented. This form of health insurance dominates the way in which health insurance is obtained by US citizens.

Figure 30: Health plan enrolment by plan type 1998 – 2005



Source: The Kaiser Foundation/Health Research Educational Trust, Survey of Employer Sponsored Health benefits, 2005

Healthcare costs

In the market as a whole and in the group market in particular, there is great focus on health insurance structures which help to manage healthcare delivery costs, such as HMOs and PPOs (PPOs provide for out-of-network care, though usually at reduced benefit levels) and CDHC structures.

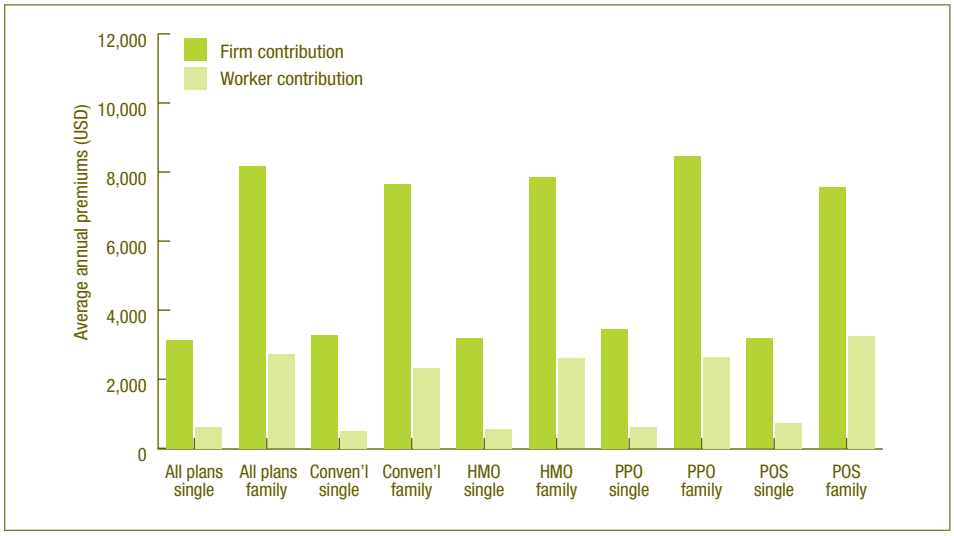
14 United States

In general, HMOs and PPOs have displaced traditional indemnity insurance in the group market.

It is hard to see, though, that the different structures have resulted in any fundamental differences in healthcare costs. Figure 31 relates to coverage for a family of four purchased through a worker's employment. We note that Point of Service (POS) plans (a definition which usually refers to a hybrid of HMO and PPO where special authorisation is required for out-of-network care) seem to have larger worker contributions.

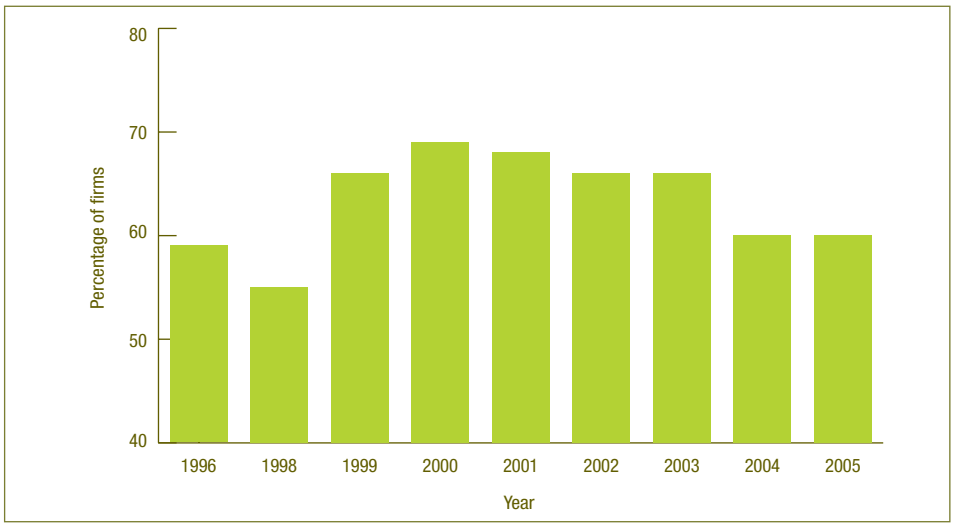
Despite all the ingenuity applied to managing cost at the point of delivery, growth in healthcare spending has substantially exceeded movements in price and wage indices and is now a heavy burden for US employers. The result has been pressure on health insurance provision. Estimates of the uninsured population in the US vary in the 40m+ range and have grown in recent years.

Figure 31: Average annual premiums by plan type 2005 (USD)



Source: The Kaiser Foundation/Health Research Educational Trust, Survey of Employer Sponsored Health benefits, 2005

Figure 32: Percentage of firms offering health benefits



Source: The Kaiser Foundation/Health Research Educational Trust, Survey of Employer Sponsored Health Benefits, 2005

Efficient purchasing

US health insurers are focused on efficient healthcare purchasing; intelligent underwriting within regulatory constraints and demand management, particularly at the stage where a potential requirement for healthcare arises. It is difficult, however, to see what incentives there are for managing the longer-term health of the policyholder base. Fundamentally, if a group becomes healthier then, at least in principle, the group's attractiveness to alternative health insurers is enhanced just as much as it is to the existing insurer. It is far from clear that the existing insurer would necessarily reap the rewards of such health improvements.

Even so, effort clearly is directed at particular preventative measures. Indeed, disease management and wellness programmes have been achieving increasing market penetration. At the leading edge are plans that attempt to encourage healthy outcomes by risk sharing and financial incentives directed at the individual plan member or policyholder. In the absence of the potential for gains and losses on 'ageing reserves', as in the German model, we see the incentive as largely one of avoiding unwelcome rises in premium rates that may provoke the employer to re-broke the contract earlier than otherwise. In a competitive market, though, a health insurance contract may still be re-broked and the insurer changed at any time.

Contents

15 Glossary

Ageing reserves: Reserves held by an insurer which are built up from income in respect of younger policyholders and are used to pay the (higher) benefits received by older policyholders. They arise when there is some form of level premium paid by policyholders for a long-term health insurance contract.

Community rating: A restrictive form of premium regulation which, in its pure form, would require health insurers to charge a flat premium rate to all policyholders regardless of age, sex or health status and would require health insurers to guarantee acceptance of all proposals, to guarantee renewal for all existing policyholders and not to impose any exclusions in policies. Some relaxation of these conditions would usually still attract the community rating label.

Duplicate model of health insurance: A health insurance framework in which the purchase of health insurance has no impact on the policyholder's tax-type payments or entitlement to state-funded healthcare.

Rating regulation: Government restrictions on the absolute level of premium rates or the extent to which rates vary between policyholders.

Risk equalisation: A mechanism to reimburse health insurers for accepting high-risk policyholders at regulated rates. The funding for the mechanism would be obtained by contributions from insurers with a lower risk (for example younger) policyholder profile.

Risk sharing: An arrangement whereby the policyholder shares with the insurer some of the expenses of healthcare.

Substitutive model of health insurance: Framework where health insurance, to at least some degree, provides a substitute for state funding of healthcare. The policyholder may obtain a reduction or rebate of relevant taxes, or may receive a contribution to public sector healthcare co-payments as a benefit of the policy. The 'substitutive' label related to the funding of the provision and may be used whether ownership of the care facilities is public or private.

Table of figures 16

17 Contacts

If you would like to discuss any of the issues raised in this report, please speak to your usual contact at PricewaterhouseCoopers. This report was prepared by:

Tony Silverman
Senior Insurance Analyst, Global Equity Research Group
tel: 44 20 7804 5057
anthony.silverman@uk.pwc.com

Global leadership teams

Healthcare

Global Health Industries Leader
Jim Henry
tel: 1 678 419 2328
jim.henry@us.pwc.com

EMEA Healthcare Network Leader
Wim Oosterom
tel: 31 30 219 1528
wim.oosterom@nl.pwc.com

Health Insurance

Global Insurance Leader
Ian Dilks
tel: 44 20 7212 4658
ian.e.dilks@uk.pwc.com

Healthcare local contacts

Australia
Anne-Marie Feyer
tel: 61 2 8266 3925
anne-marie.feyer@au.pwc.com

China
Nova Chan
tel: 86 21 6123 2501
nova.chan@cn.pwc.com

France
Jean-Louis Rouvet
tel: 33 1 56 57 85 78
jean-louis.rouvet@fr.pwc.com

Germany
Harald Schmidt
tel: 49 699 585 1702
harald.schmidt@de.pwc.com

Ireland
Paul Monahan
tel: 353 1 662 6241
paul.monahan@ie.pwc.com

Netherlands
Andre Loogman
tel: 31 30 21 91 539
andre.loogman@nl.pwc.com

Switzerland
Hans-Peter Muenger
tel: 41 58 792 7970
hans-peter.muenger@ch.pwc.com

UK
Simon Leary
tel: 44 20 7804 9969
simon.m.leary@uk.pwc.com

USA
Michael Thompson
tel: 1 646 471 0720
michael.thompson@us.pwc.com

Health insurance local contacts

Australia
Kim Smith
tel: 61 2 8266 1100
k.smith@au.pwc.com

China
David Campbell
tel: 86 21 6123 3228
david.campbell@cn.pwc.com

France
Michel Laforce
tel: 33 1 5657 1069
michel.laforce@fr.pwc.com

Germany
Alfons Koch
tel: 49 211 981 2377
alfons.koch@de.pwc.com

Ireland
Garvan O'Neill
tel: 353 1 662 6218
garvan.o'neill@ie.pwc.com

Netherlands
Godert van der Poel
tel: 31 20 56 84 107
godert.van.der.poel@nl.pwc.com

Switzerland
Armin Bantli
tel: 41 58 792 2130
armin.bantli@ch.pwc.com

UK
Paul Clarke
tel: 44 20 7804 4469
paul.e.clarke@uk.pwc.com

USA
Paul Veronneau
tel: 1 860 241 7568
paul.veronneau@us.pwc.com

For further copies, please contact Alpa Patel at alpa.patel@uk.pwc.com

www.pwc.com