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**Private Insurance
and Managed Care
An International View**

Hugh Waters

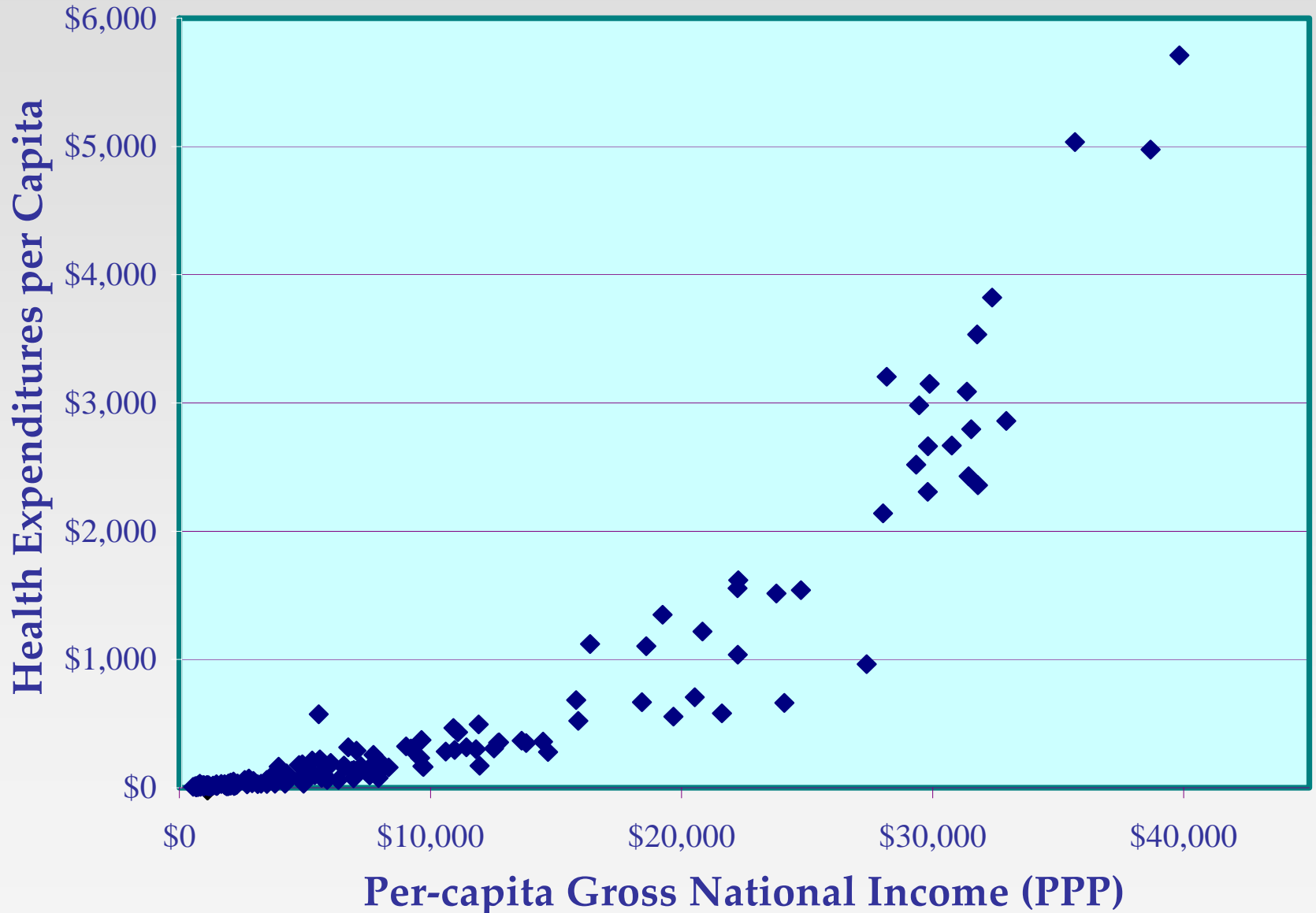
February 22, 2007

Outline of Talk

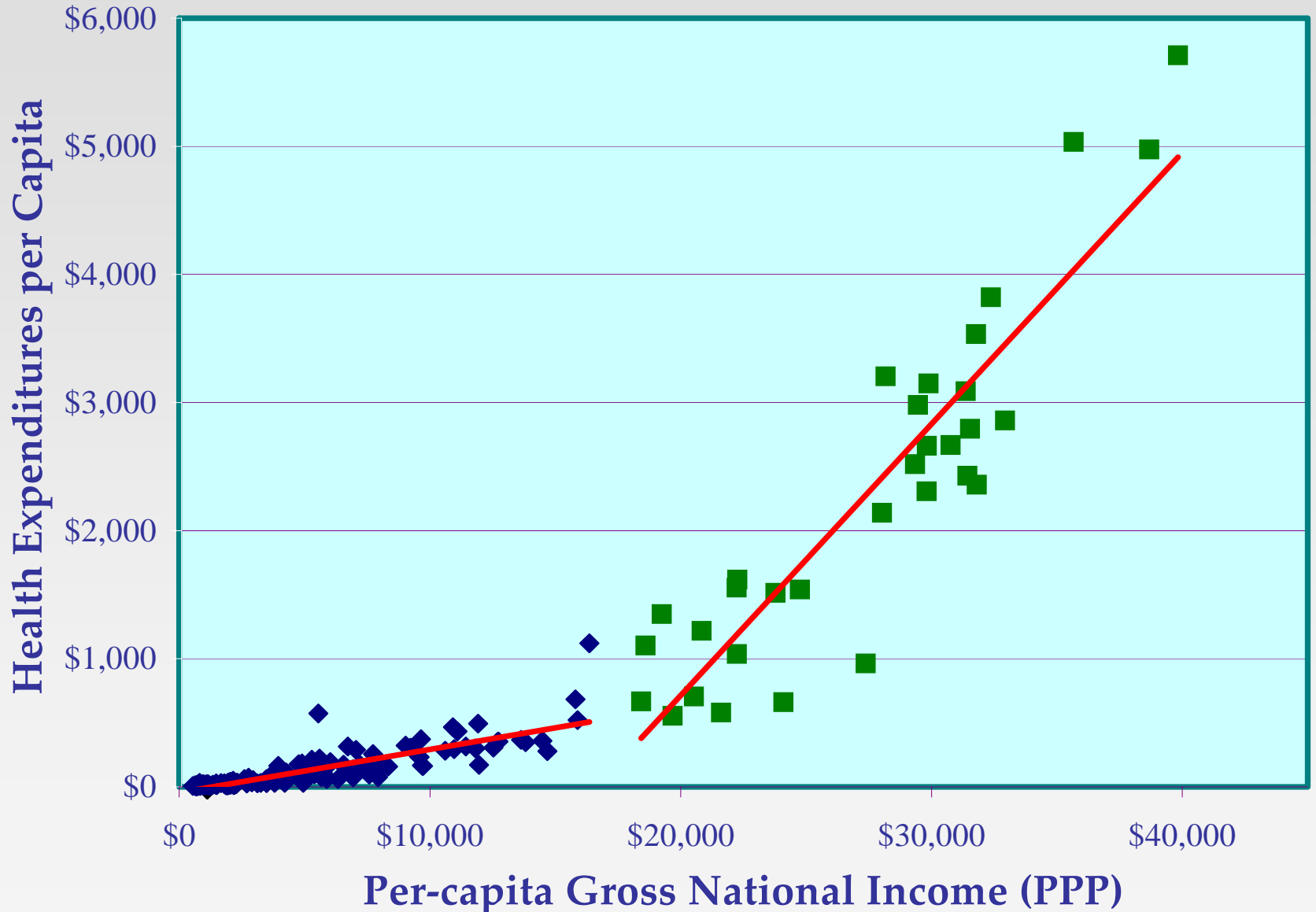
- (1) Comparison of Health Expenditures Internationally
- (2) Overview of Types of Health Insurance Internationally
- (3) Experience of U.S. Health Insurance Companies in Latin America
- (4) Example of Chile

Health Care Expenditures Internationally

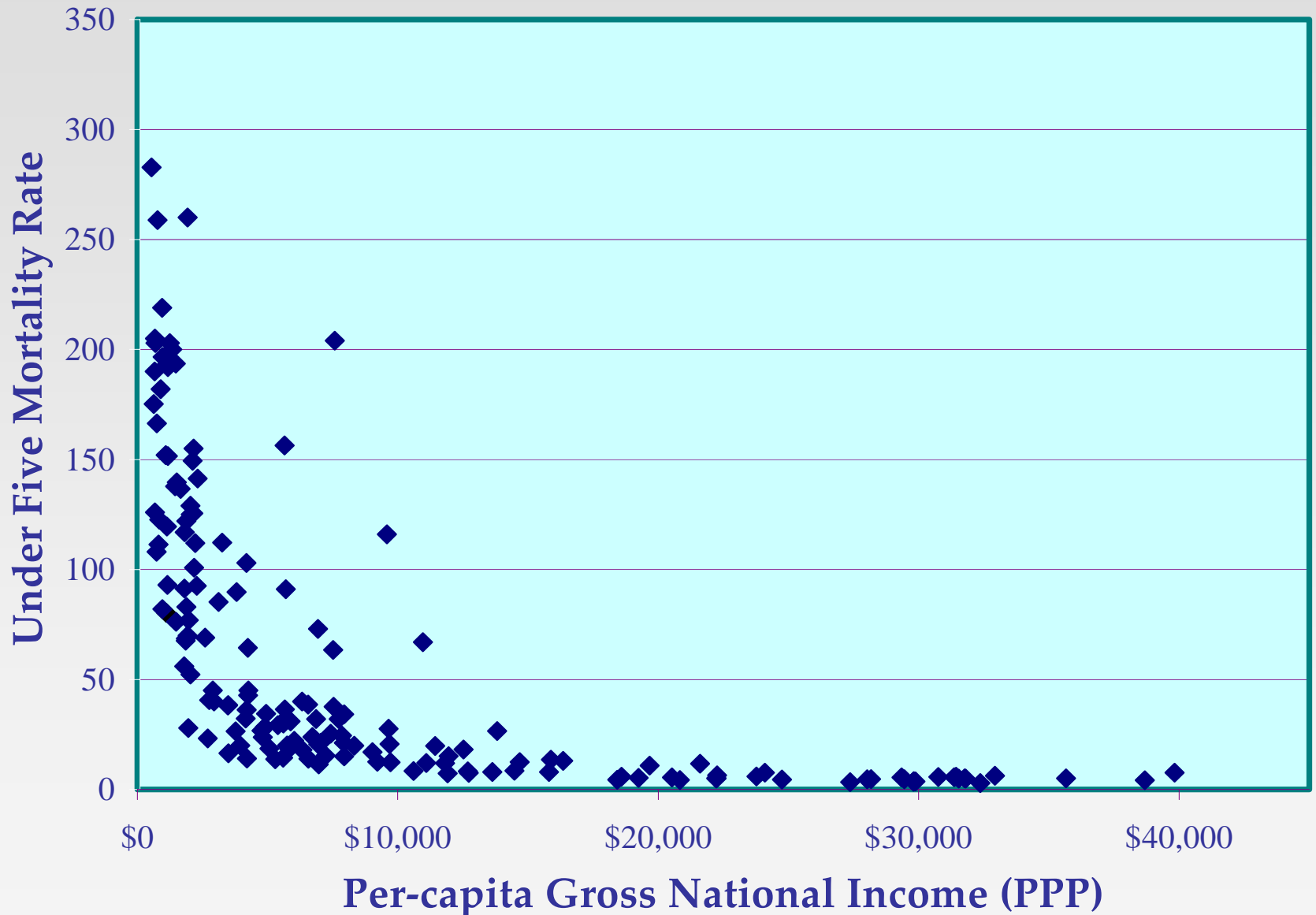
Health Spending and Income, by Country, 2004



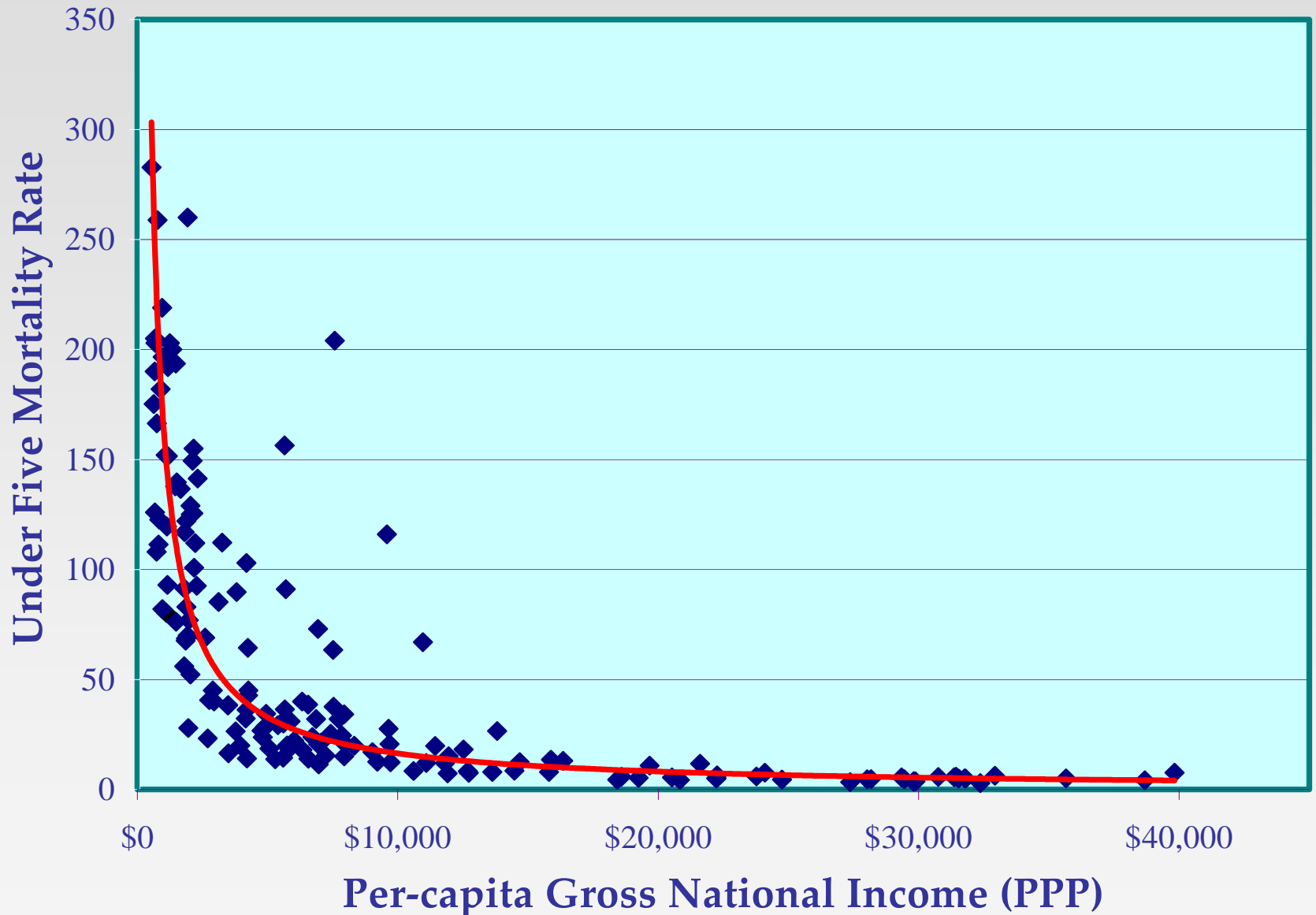
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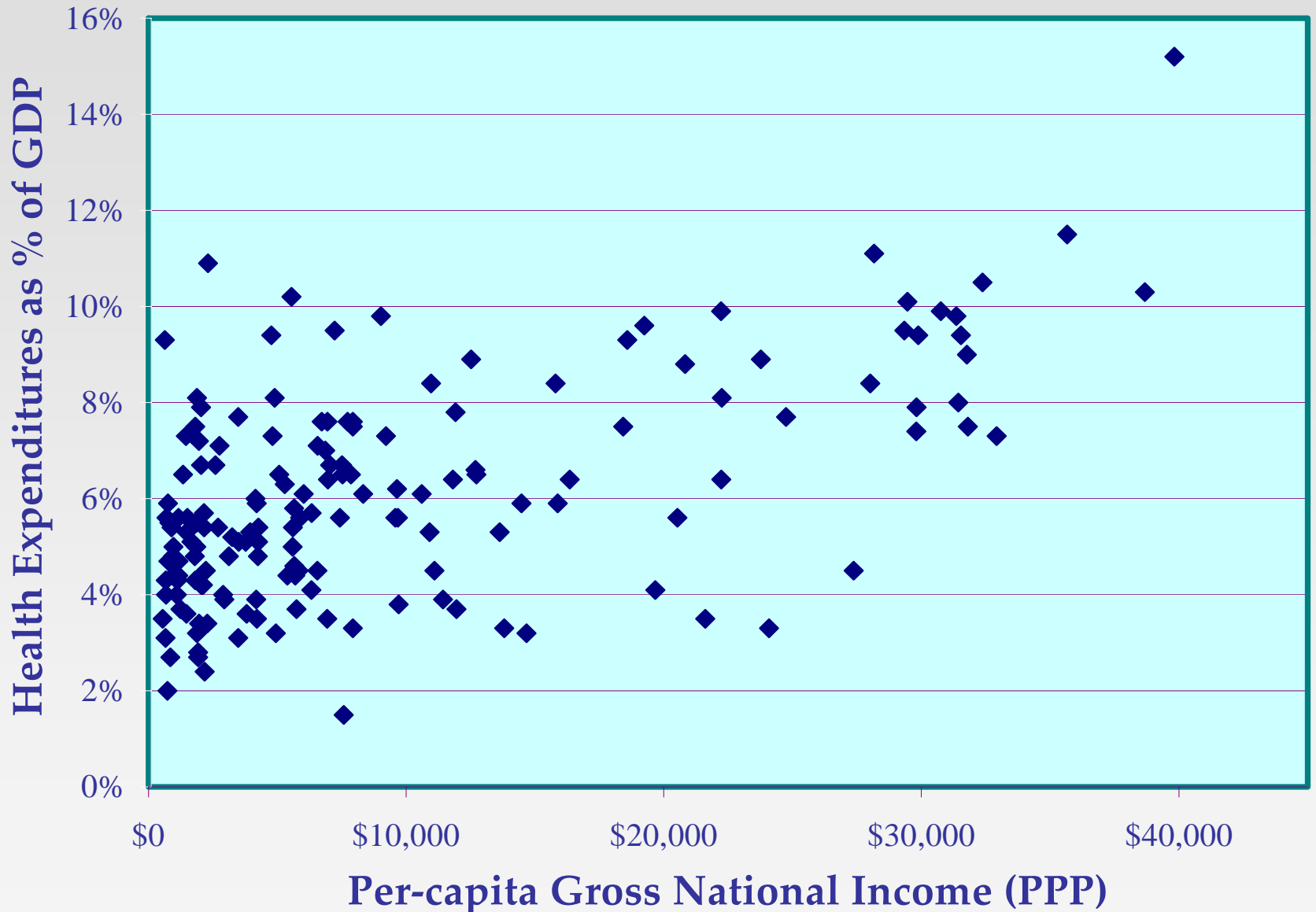
Under-Five Mortality and Income, by Country, 2004



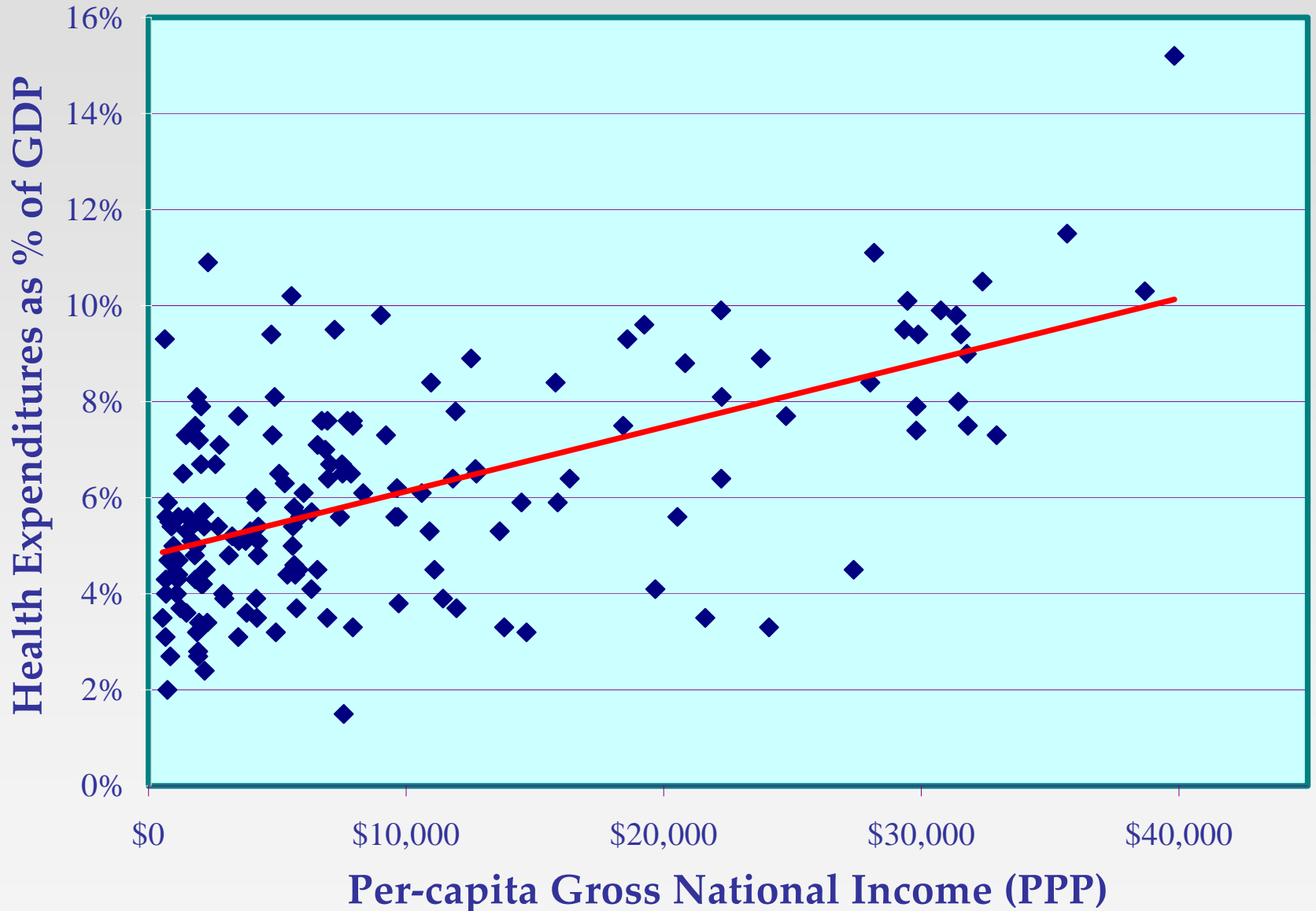
Under-Five Mortality and Income, by Country, 2004



Health Spending as % of GDP, by Country, 2004

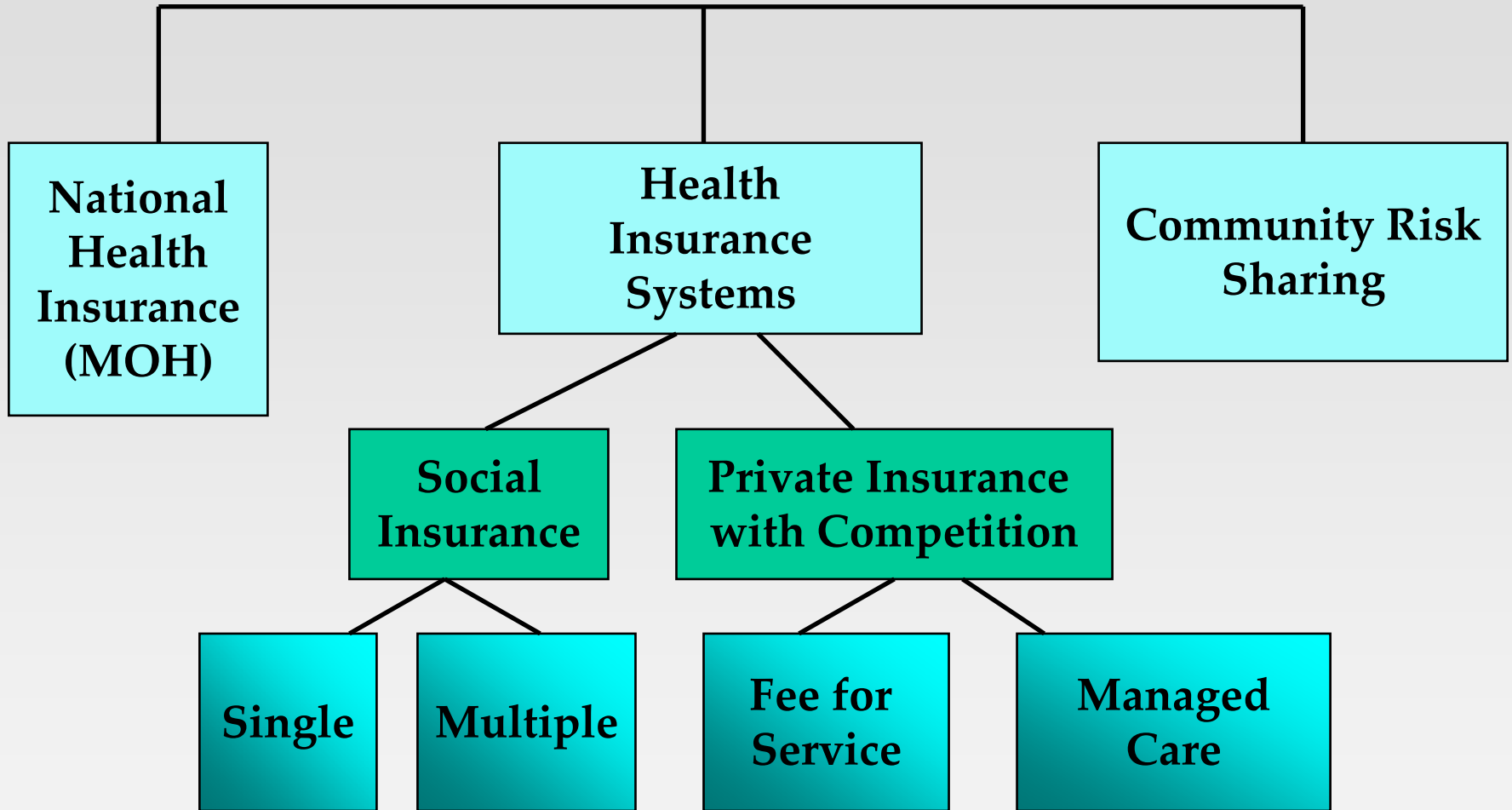


Health Spending as % of GDP, by Country, 2004



Types of Health Insurance Internationally

Types of Pooling Arrangements



Social Health Insurance

- Health insurance through payroll tax.
 - Sometimes mandatory for designated population, but eligibility requires that the enrollee has paid the premium (contribution).
 - Social insurance is not a right of every citizen. Social insurance programs are financially autonomous and have to maintain solvency.

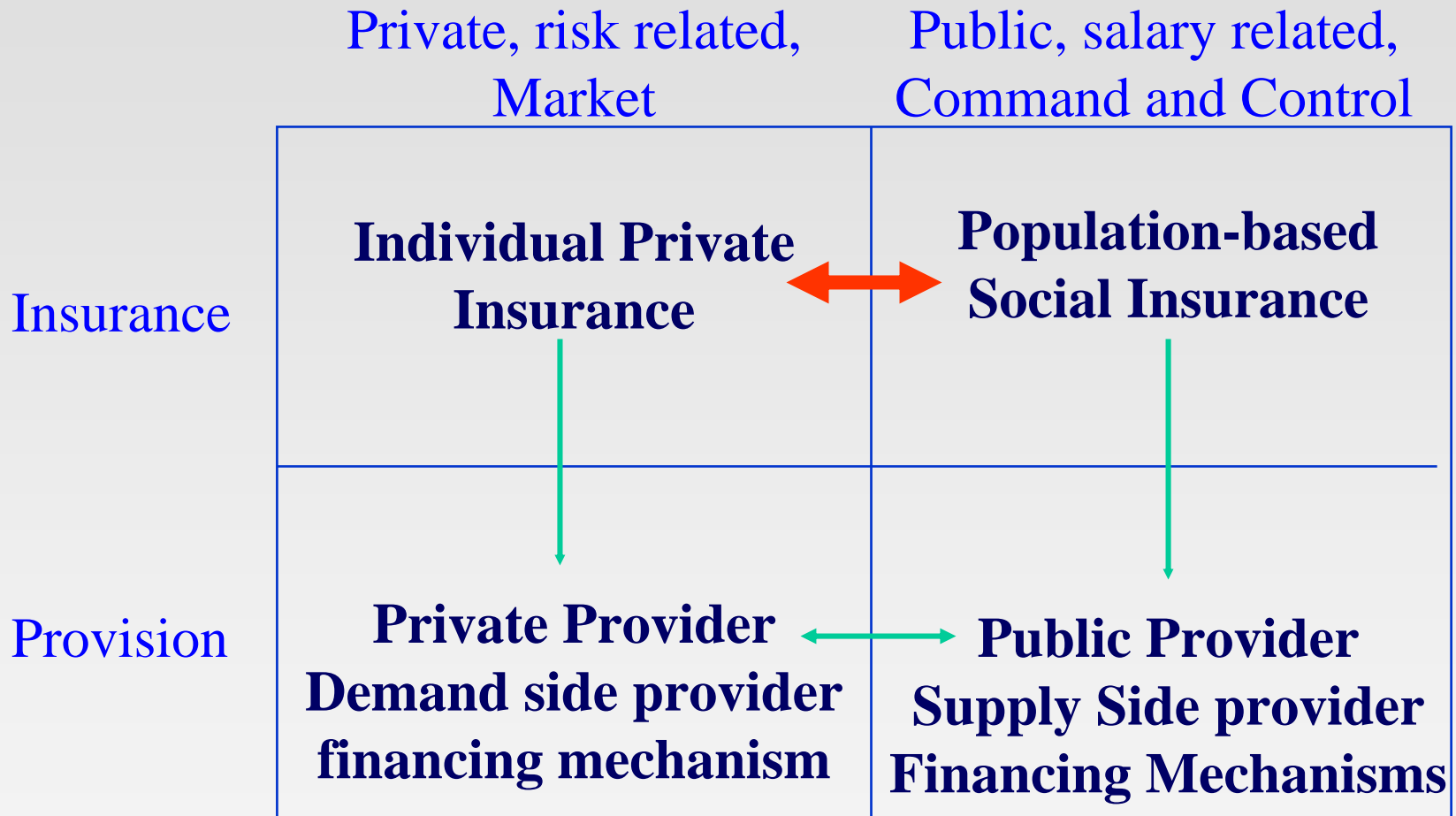
National Health Insurance

- Government collects funds and also (generally) acts as a health care provider.
- Most NHI programs are mandatory, have universal coverage, financed from general government revenues.

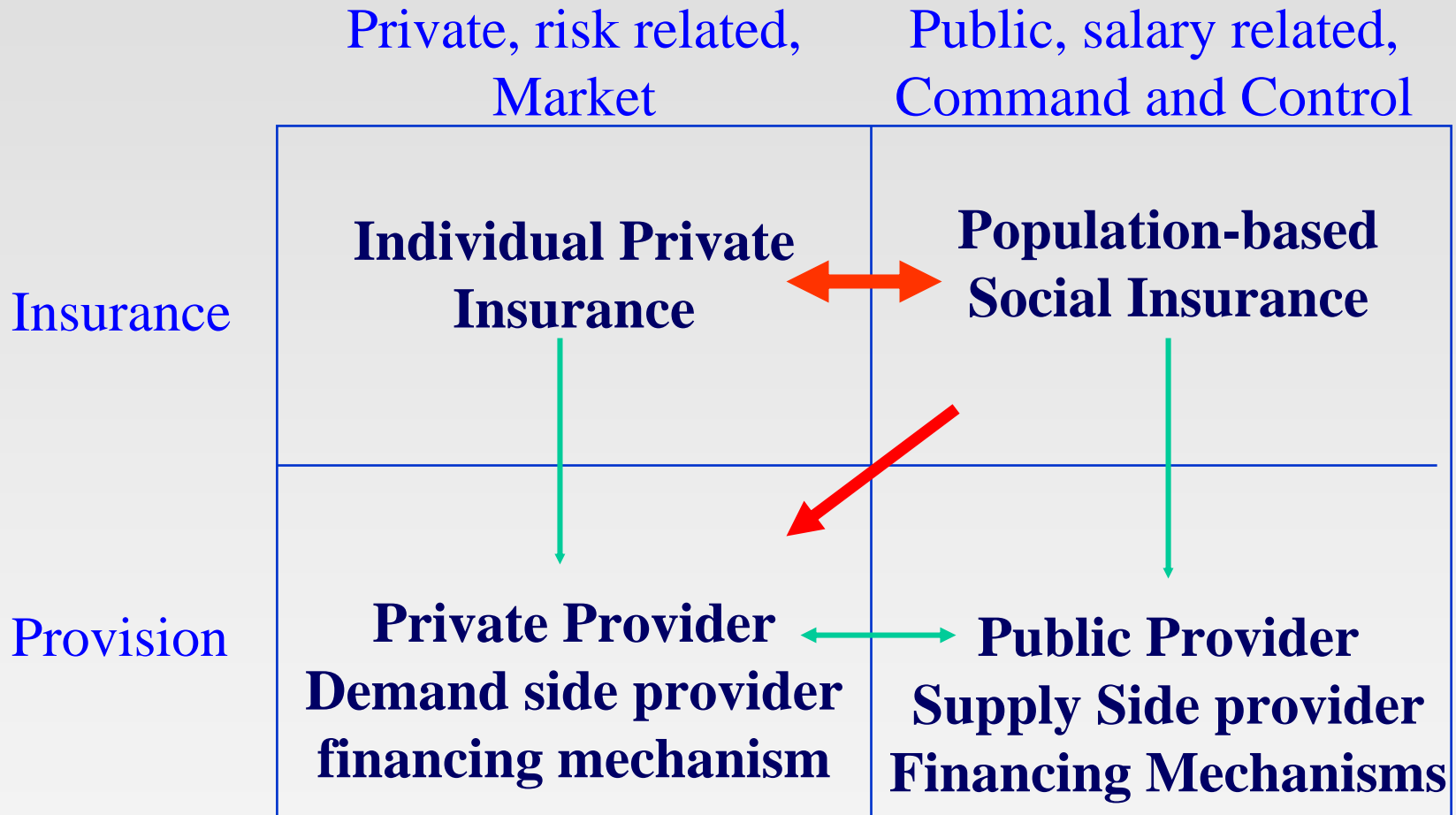
Roles for Public and Private Health Insurance

- Uninsurable risks for private sector:
 - Non-random health care risks.
 - Very low-cost services.
 - Uninsurable individuals or groups.
- Roles for private insurance:
 - Coverage for those ineligible for public insurance.
 - Supplemental coverage for services not covered by a universal public insurance program.
 - Potential for competition in the context of universal coverage.

Private – Public Integration



Private – Public Integration



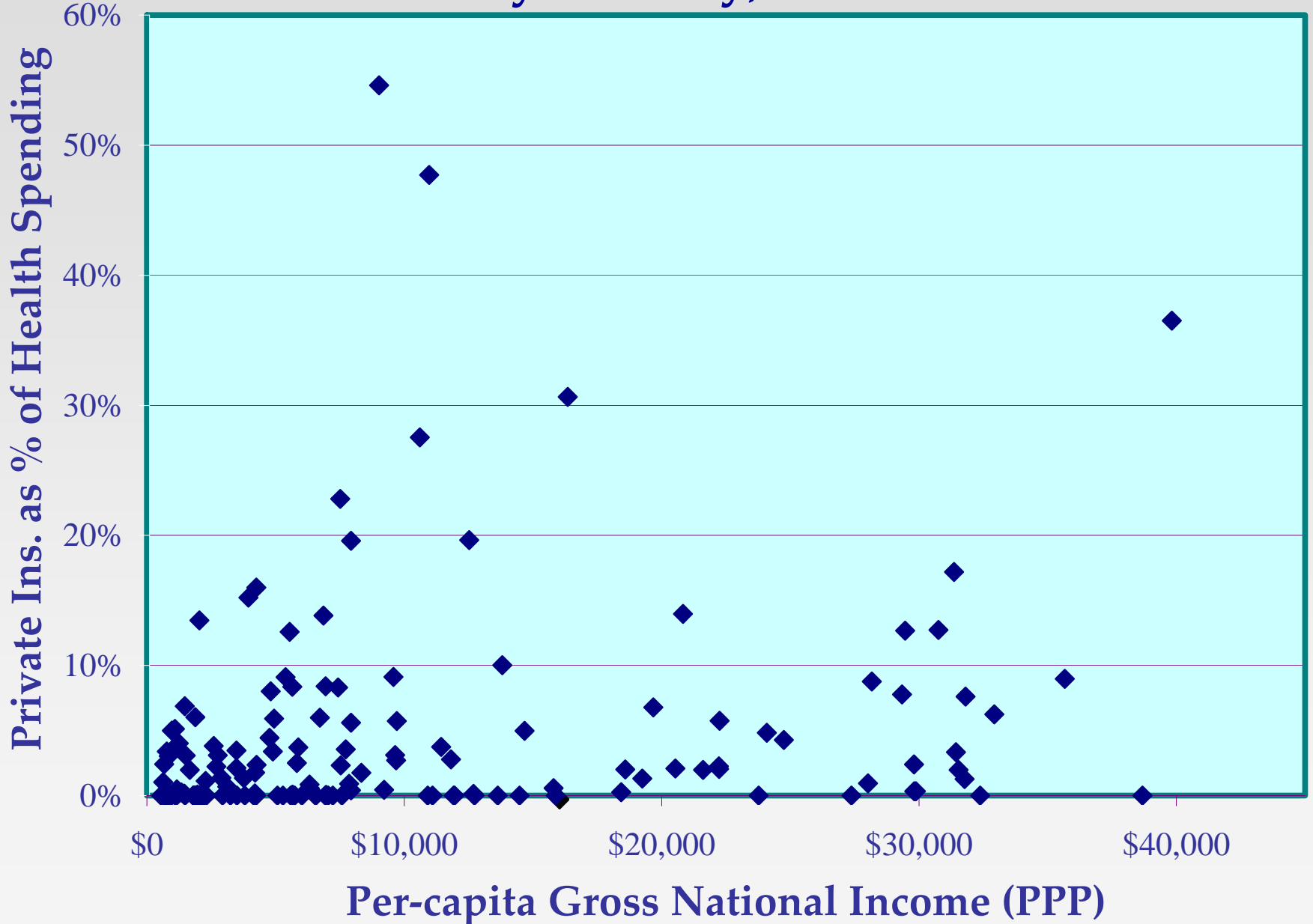
Public Sector Purchasing from the Private Sector

- Private health care often considered of higher quality than public services.
- A demonstrated willingness to pay for perceived higher quality care. Examples – Thailand, Zimbabwe.
- Examples of contracting with private sector providers – Peru, El Salvador, Guatemala, Cambodia.
- Constraints – limited competition, public financing and institutional capacity – including human resources and information systems.

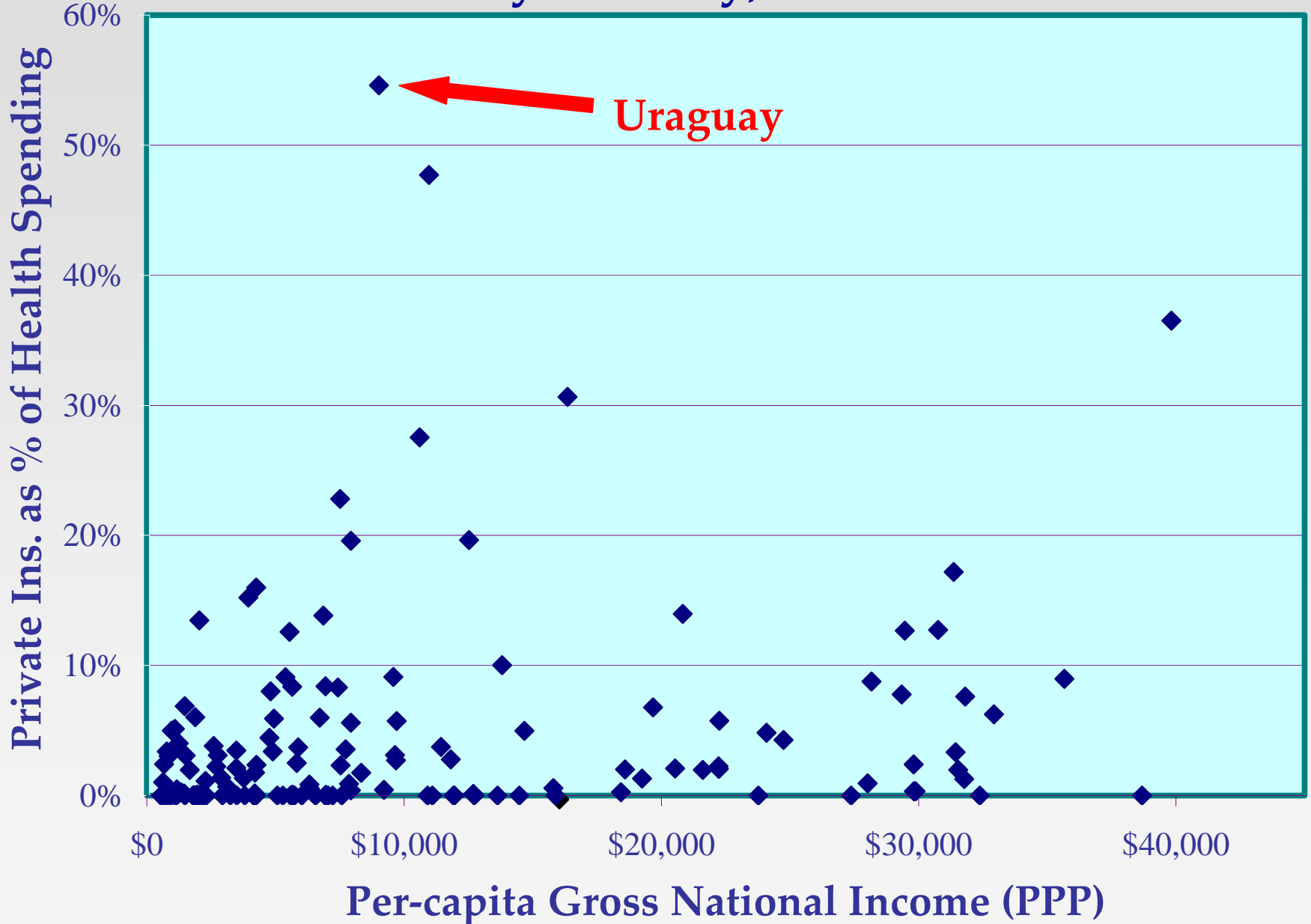
Private Insurance Companies as Purchasers

- The average contribution of formal private insurance to total health spending is just 3.3 %.
- But in some countries it is as high as 43% – and in many low and middle-income countries private insurance coverage is growing.
- In low and middle-income countries, very limited evidence of impact on quality.

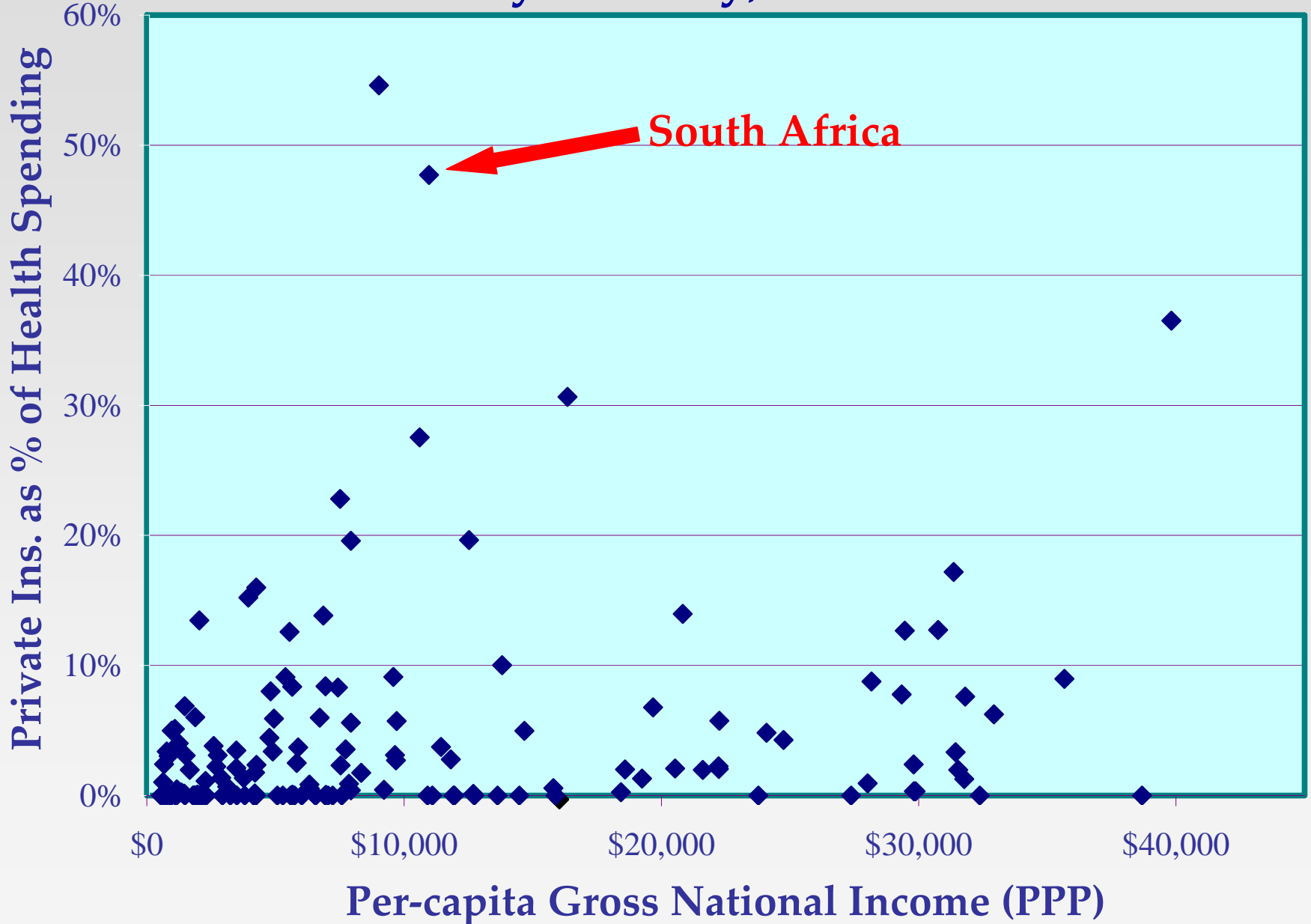
Private Insurance as % of Health Spending, by Country, 2004



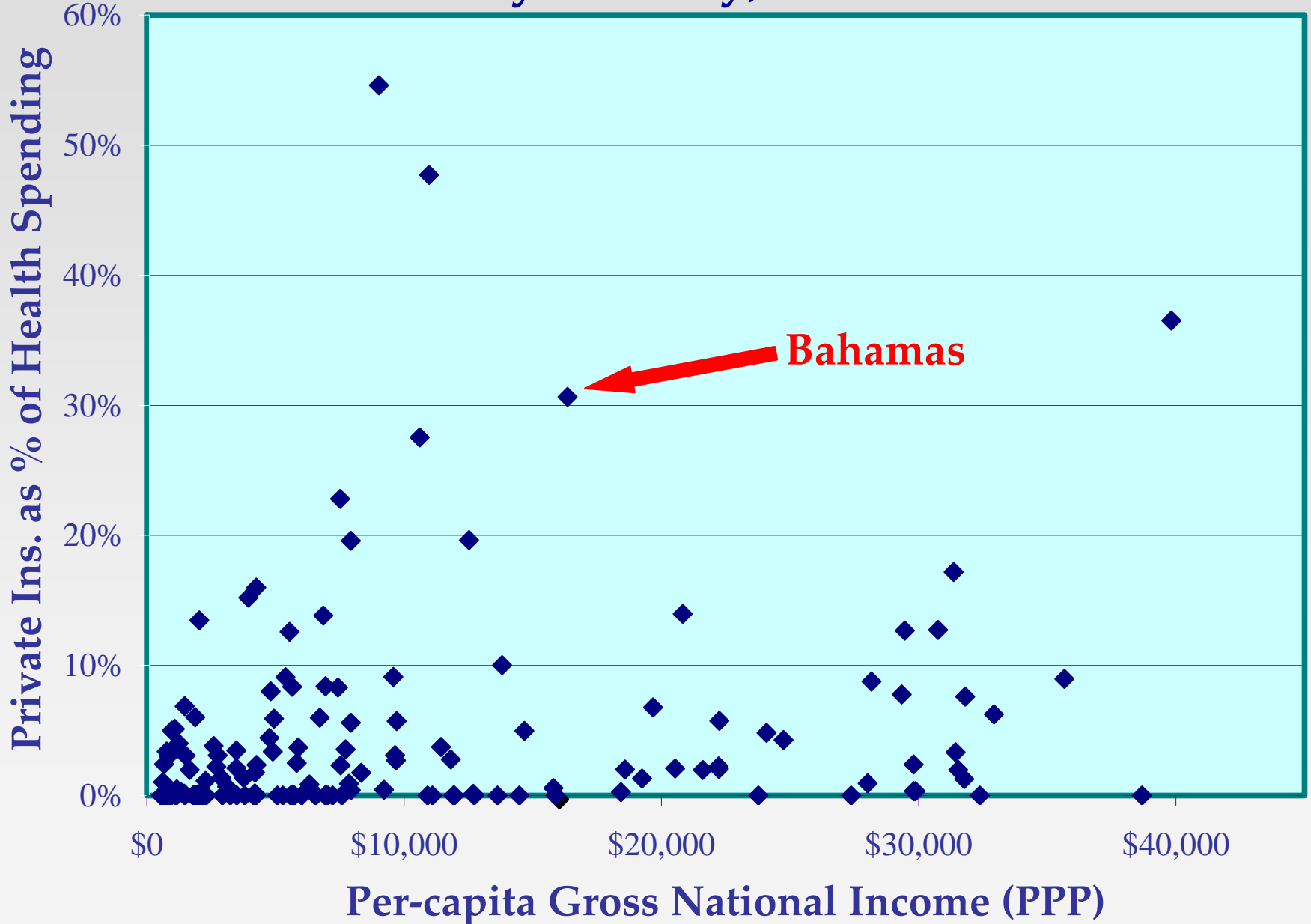
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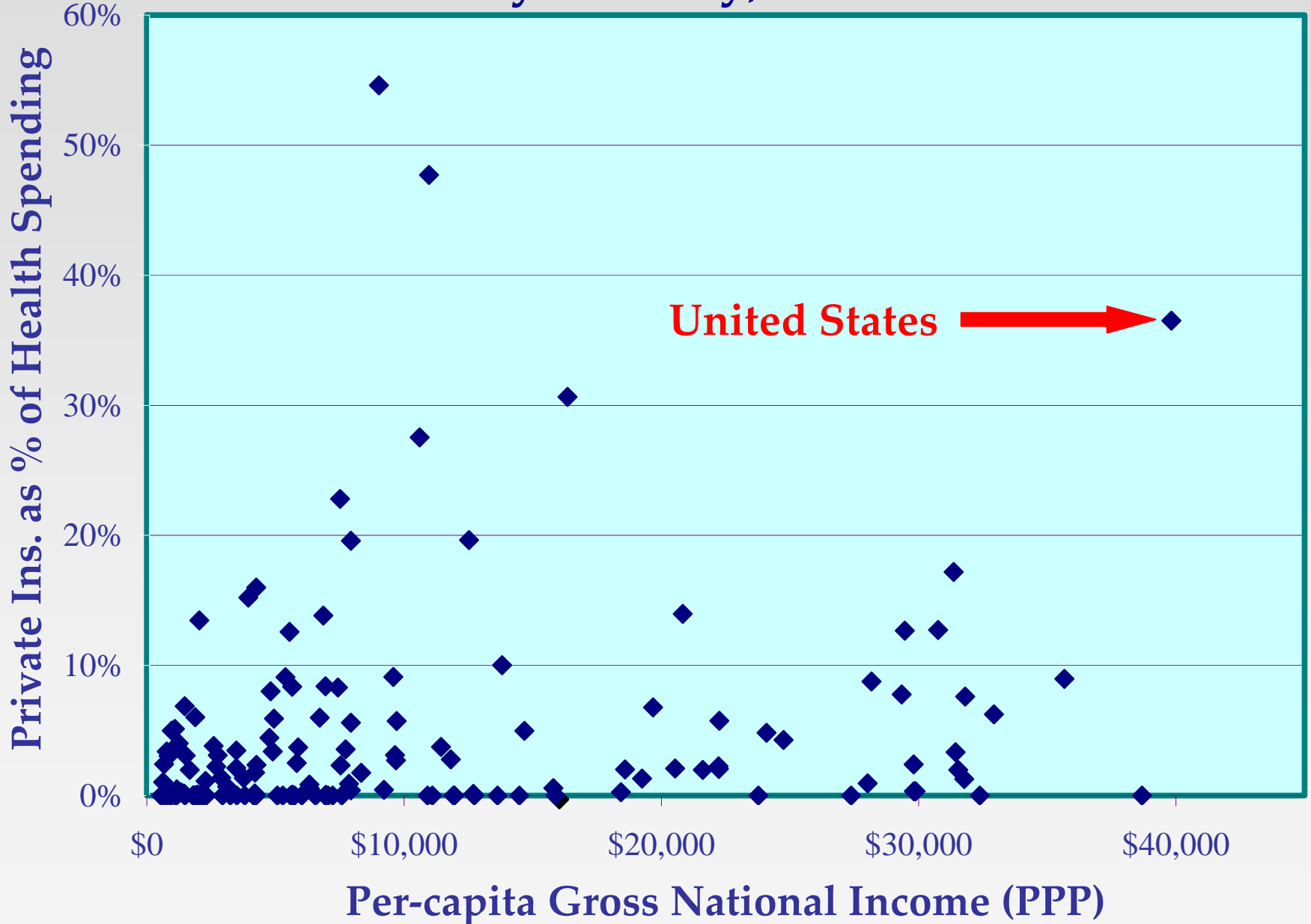
Private Insurance as % of Health Spending, by Country, 2004



Private Insurance as % of Health Spending, by Country, 2004



Private Insurance as % of Health Spending, by Country, 2004



Experience of U.S. Companies in Latin America

Characteristics of Managed Care Readiness

Country	Overall System Structure		Consumers		Providers		Clinical Service	
	Centralized Government Control	Autonomy of Health Plan	Consumer Choice of Health Plan	Consumer Choice of Provider	Provider Integration	Financial controls and Incentives	Population Orientation	UR / EBM and Care Management Tools
U.S.	-/-	+ /+++	+++ /+++	++ /+	+ /+++	+ /+++	- /+++	+ /+++
U.K.	++	+	--	-	+	+	++	+
Chile	+	+	+	+	-	+	-	-
Canada	++	--	--	+	--	-	-	-
Sweden	++	-	--	-	+	+	+	-
Germany	+	-	+	++	-	+	-	-
France	+	-	+	+	-	-	-	-

Managed Care Companies in Latin America

- Multinational insurers are active in Argentina and Chile, and have begun in Brazil.
- Three ways that multinational corporations invest finance capital in Latin American:
 - (1) Purchasing companies that sell indemnity insurance or prepaid health plans;
 - (2) Joint-ventures with other companies;
 - (3) Agreements to manage social security and public sector institutions.

Managed Care Companies in Latin America

- The main multinational companies operating are Aetna, CIGNA, the EXXEL Group, the American International Group (AIG), International Medical Group (IMG), and Prudential.
- In Chile, Aetna controls a subsidiary, *Aetna Chile Seguros Generales*, and created an ISAPRE – *Aetna Salud* – in 1993, which has 60,000 insured subscribers (5th among the ISAPREs).

Managed Care Companies in Latin America

- In Argentina, Aetna operates through investments in the EXXEL Group and bought the largest and oldest prepaid insurance plan in Argentina, *Asistencia Médica Social Argentina* (AMSA).
- CIGNA operates in Chile, Brazil and Ecuador.

Private Insurance Internationally

- Only a few countries in the world have a national health system based primarily or heavily on multiple private insurers.
- Among high-income countries, a national system based on multiple private insurers exists only in the United States
- Even in the U.S., public sources account for 45% of health expenditures nationwide.

Roles for Private Insurance Internationally

- Supplementary benefits for higher-income population groups.
- Administrating public insurance.
- Managed care in developed health systems.
- Increase investment in health; allow government to focus on lower-income groups.
- Other nations with a substantial private insurance market include Chile, South Africa, and the Philippines.

Private Insurers and Public Insurance

Currently, the most common administrators of health benefits include:

- National government
- Regional government
- Social insurance funds
- Private insurers or Managed Care Organizations (MCOs)
- Quasi-autonomous non-governmental management units (for example locally controlled “Primary Care Trusts” in the UK)

Exporting Managed Care

- In countries with a growing middle class, MCOs can play a complementary role to the public system – although others believe that such private plans can potentially undermine the public system.
- These complementary plans can be purchased either by employers or the individuals themselves.

Example – the Philippines

- Spends just 3.2 percent of its GDP on health.
- Has 35 private insurance companies.
- The primary driving force behind this process is the need for access to quality health services in the private sector.
- In principle, the government is able to reallocate its limited resources and strengthen its programs for the poor.

Managed Care in Developed Health Systems

- In high-income countries, policymakers have suggested that competing health plans could offer benefits to socialized models of care.
- Learn from the methods applied by private health insurance and MCOs.
- Can efficiency be improved through competition and introduction of internal markets?

Issues

- *Cream-skimming* – experience in Israel show that instead of focusing on improving clinical quality and efficiency, competing sickness funds emphasize in customer amenities and marketing.
- Since government funding is based on average cost, without risk adjustment funds will try to select members with the lowest risk, threatening the integrity of the system.

U.S. Companies Abroad – Advantages

- Processing
- Utilization management
- Care management
- Quality improvement
- Design and implementation of provider payment schemes.

U.S. Companies Abroad

- In the 1990's managed care companies – including Aetna, CIGNA, United, and Blue Cross Blue Shield plans – formed joint ventures in Latin America, Asia, and Africa.
- Now most U.S. MCOs have abandoned their risk-bearing insurance operations overseas.
- Why? Complexity of adapting to local conditions, provider resistance, and anti-American or anti-managed care sentiment.

Case Study – UnitedHealth in South Africa

- In the 1990's, United formed a joint venture with Southern Life, a South African insurance company, and Anglo-American Corporation, a large mining conglomerate.
- Faced several challenges including negative physician response and bad press.
- When the Anglo-American Company made an independent business decision to divest of its non-mining businesses, the joint venture was effectively abandoned.

Case Study – UnitedHealth (cont.)

Several factors contributed to the failure:

- (1) Over-commitment of resources;
- (2) Failure to recognize the importance of direct patient-pay pharmaceuticals as a source of revenue for physicians;
- (3) Failure to gain the support of employers;
and
- (4) Lack of full understanding of the complex racial situation in South Africa.

Current Situation

- United and a few other U.S. MCOs – including Kaiser Permanente and CIGNA – maintain international operations.
- Consulting and administrative services – and partnerships for healthcare provision.
- Insurance products are limited mainly to U.S. expatriates and those working for U.S. companies abroad.

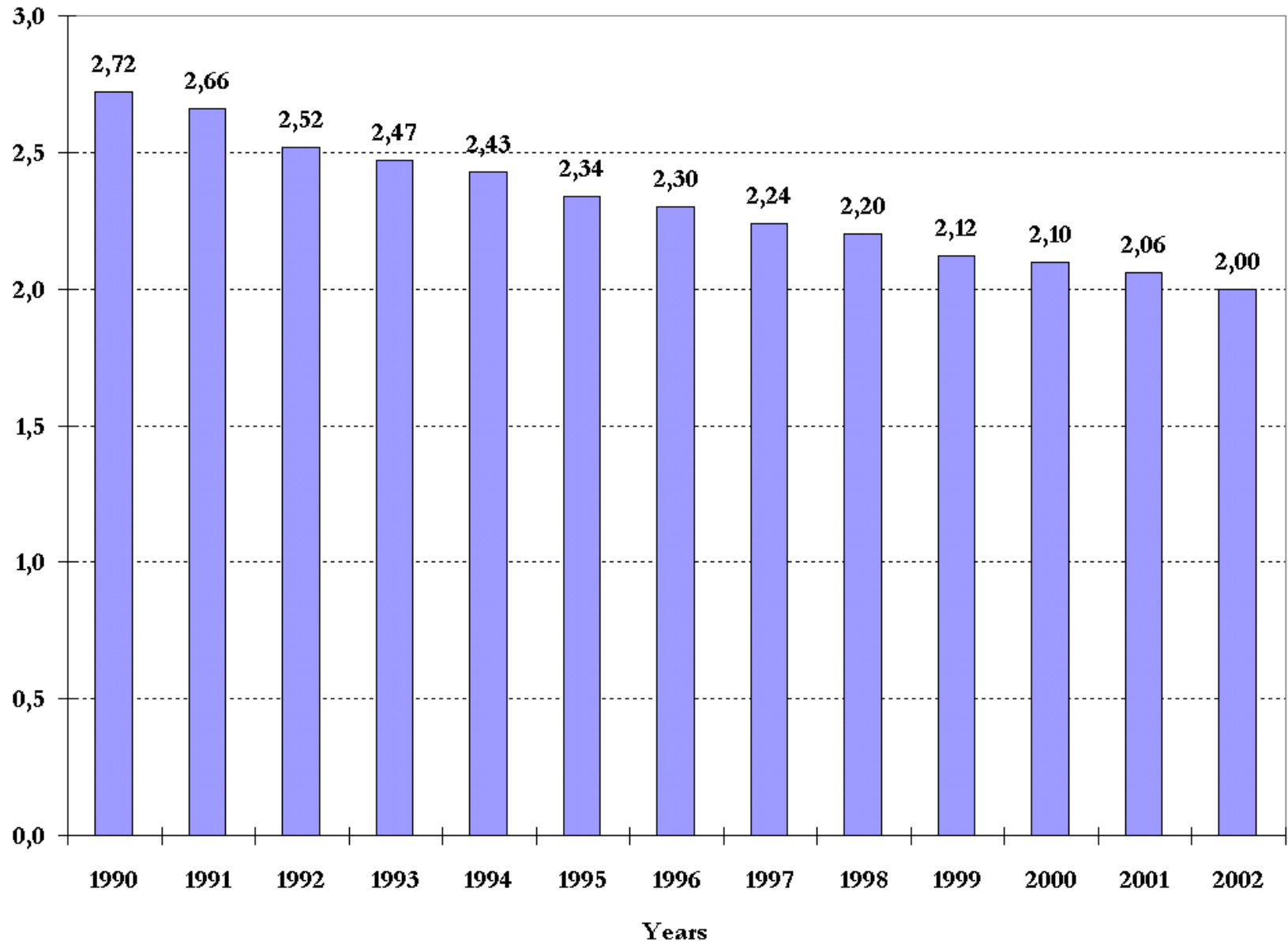
Chile – Case Study



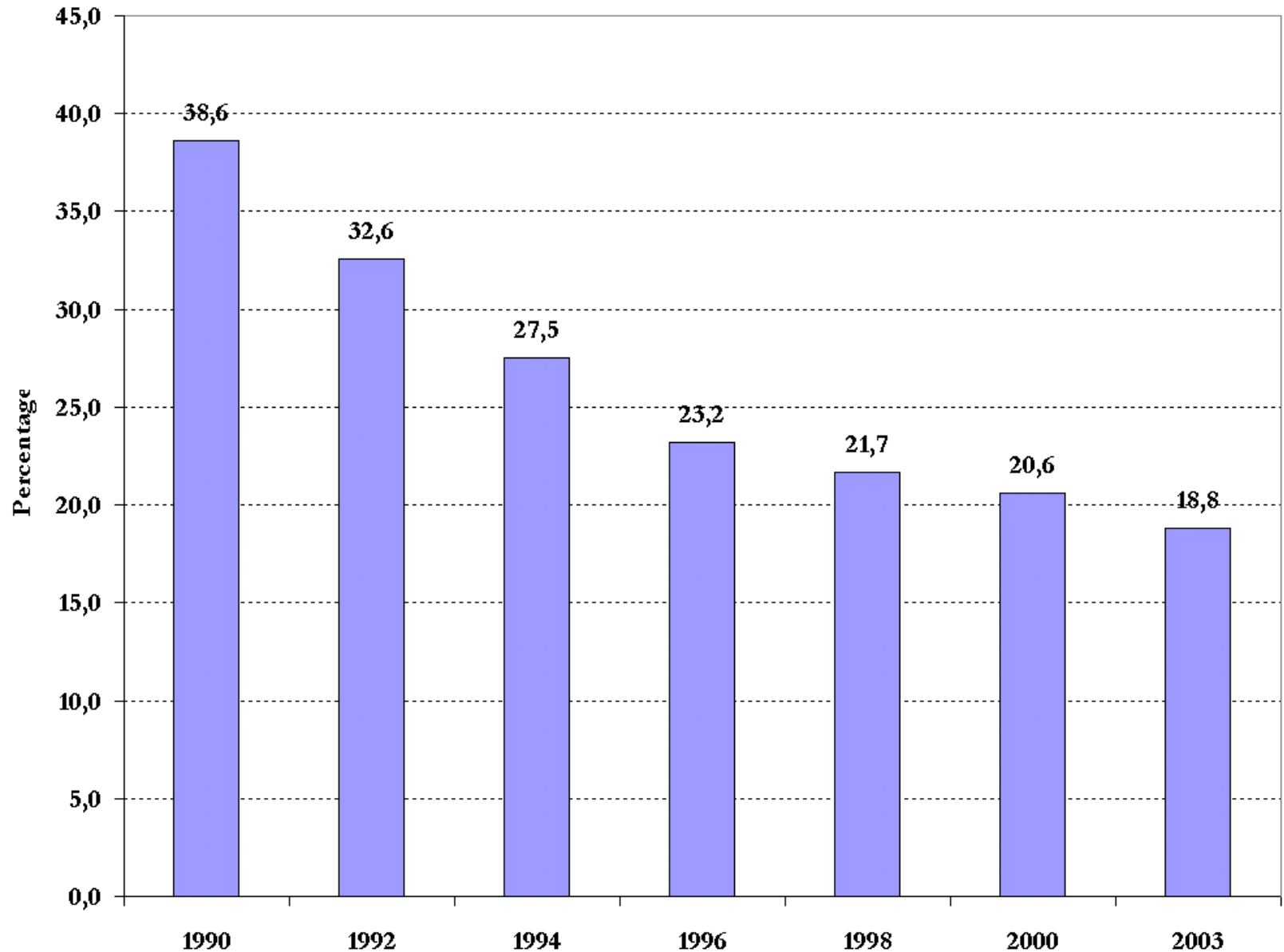
Chile

- Population – 16.1 million.
- GDP per capita (PPP) – \$10,874.
- Health expenditures \$489 per capita.
- Total Fertility Rate (TFR) – 2.0.
- Life expectancy at birth – 78.0.
- OOP as % of total health spending – 23.7%.

Chile – Declining Total Fertility Rate



Chile – Declining Poverty Rate



Chile – Health Sector Organization

	Health Sector	
	Public subsector	Private subsector
Curative and preventive health insurance	National Health Fund (FONASA): 10.3 million beneficiaries (67.5%)	18 private health insurance plans (ISAPRES): 2.8 million beneficiaries (18.5 % of population)
Public health interventions	National programs funded and managed by the Ministry of Health (i.e. free vaccination, TBC treatment, Hanta virus control, PNAC, etc.) Insurance must finance annual preventive physical examination for each beneficiary.	
Providers	28 Regional Health Services (SS) make up a complex network of 194 public hospitals, specialty centers, and (mostly municipal) primary care centers. 31.804 hospital beds	Network of providers, located mainly in major urban centers. 11.208 hospital beds (including mutual fund hospitals)
Stewardship and Regulation	Ministry of Health (both subsectors) through Regional Health Services	
		Private health insurance regulatory agency (Superintendencia de Isapres)

Health Financing

- Health expenditures \$581 per capita.
- Health care system financed through the public National Health Fund (Fondo Nacional de Salud – FONASA), and a group of private insurers (Instituciones de Salud Previsional – ISAPREs).
- Employed individuals not otherwise covered are required to contribute 7% of their income to FONASA (up to a maximum of approximately US\$135). or to purchase health insurance from an ISAPRE.

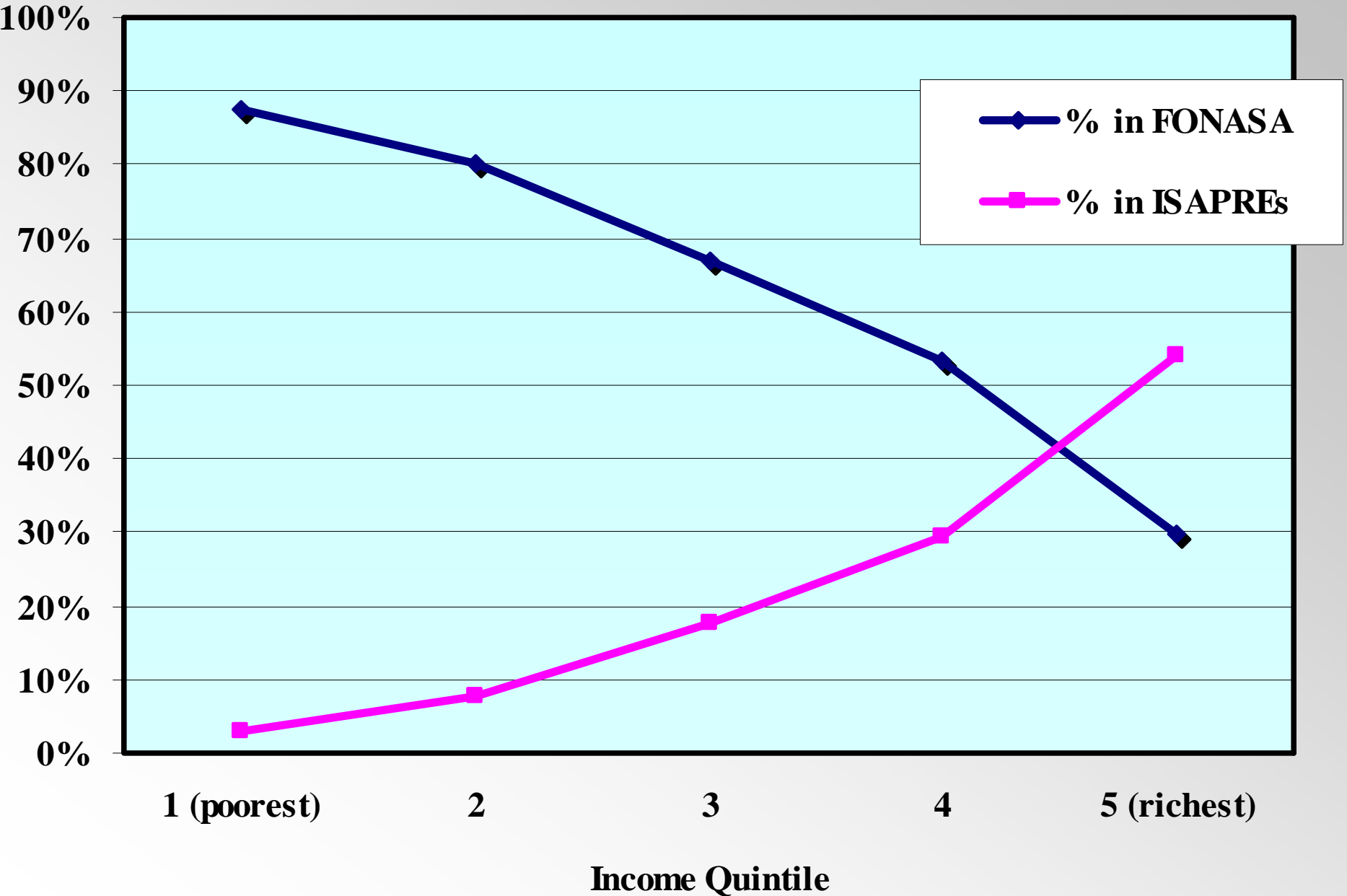
Coverage

- From 1981, possible to opt out FONASA and into ISAPREs.
- ISAPREs cover 20% of the population (from 2% in 1983) and FONASA 67%.
- There are currently 17 ISAPREs, covering 20% of the population (from 2% in 1983), vs. 67% for FONASA.

Coverage (cont.)

- The ISAPREs, by law, set premiums at community rates – by age, sex and family size.
- Other private insurance companies offer differentiated plans that vary according to the premium paid and the health risk of the insured family.
- FONASA's rates are tied *only* to income. People can buy health insurance simply by paying 7% of their income, independent of their age, number of beneficiaries, or health status.

Chile - Source of Health Insurance, 2000



Coverage (cont.)

- Wealthier Chileans went to ISAPREs – example of adverse selection.
- 9.0% of FONASA's risk pool is over 65 years of age, compared to only 2.2% of the ISAPREs' beneficiaries.
- The ISAPREs' beneficiaries have a mean monthly income of \$554 (1998 estimate) while the majority of FONASA beneficiaries have a mean monthly income of less than \$154.

FONASA's Benefit Package

- Beneficiaries have access to a network of primary care centers that are mostly managed by municipal governments.
- The primary health care centers must deliver a predefined package of health services, the Primary Care Program

ISAPRE's Risk Rating Table

<i>Age</i>		<i>Insured</i>		<i>Dependants</i>		
		<i>Male</i>	<i>Female</i>	<i>Spouse</i>	<i>Male</i>	<i>Female</i>
<i>Months</i>	<i>00 - 11</i>	2,40	2,40	2,40	3,00	3,00
	<i>12 - 23</i>	2,40	2,40	2,40	2,40	2,40
<i>Years</i>	<i>02 - 17</i>	1,10	2,30	2,50	1,10	1,10
	<i>18 - 24</i>	1,00	3,00	2,50	1,00	1,30
	<i>25 - 39</i>	1,00	4,20	3,30	1,00	3,30
	<i>40 - 49</i>	1,60	3,80	2,70	1,40	2,70
	<i>50 - 59</i>	2,10	3,90	2,80	2,00	2,80
	<i>60 - 64</i>	4,00	4,50	3,60	3,60	3,60
	<i>65 - 69</i>	5,10	5,10	4,30	5,50	4,30
	<i>70 - más</i>	5,70	5,50	5,20	6,70	5,20

Criticisms

- This mixed system of insurance has been criticized principally because of an alleged negative effect on equity.
- One specific criticism is that permitting the rich to opt out of the public health system diminishes what some call the system's "solidarity."
- Public opinion surveys show that a majority think that access to good health services is not available to all Chileans.

Current Reform Efforts

- The Standard Guaranteed Benefit Package (SHP)
- Integrating two systems:
 - Resolving problems in the current public – private interaction.
 - Identifying sources and mechanisms for ensuring cross-subsidization.