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LifeTrends

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Health Insurance: What SA can learn from the US

State of the SA market

National Treasury has confirmed its commitment to amend regulations on the demarcation between health insurance and medical schemes towards the end of 2014 [1] [2]. This includes a revised definition for the "business of a medical scheme" that will provide conditions under which certain health insurance policies will be excluded from the definition.

The conditions will include

- prohibiting health insurance policies from discriminating against any person on the grounds of age, gender and other criteria;
- enhanced product disclosure/marketing requirements;
- alignment of broker commission between health insurance and medical scheme products;
- enhanced regulatory reporting and monitoring;
- product standards which limit policy benefits; and
- limitations on bundled type health insurance products which replicate medical schemes. [2]

The Medical Schemes Act No. 131 of 1998 currently defines the "business of a medical scheme" as the business of undertaking liability in return for a premium or contribution

- to make provision for the obtaining of any relevant health service;
- to grant assistance in defraying expenditure incurred in connection with the rendering of any health service; and
- where applicable, to render a relevant health service, either by the medical scheme itself, or by any supplier or group of suppliers of a relevant health service or by any person, in association with or in terms of an agreement with a medical scheme. [3]

National Treasury has reiterated the importance that health insurance products must operate within a framework whereby they complement and support the principle of social solidarity that embodies medical schemes. In light of these developments, we expect to see new opportunities in the South African health insurance market. Appropriately designed and marketed health insurance products can play a role in meeting the needs of providing additional protection to health-related events. We take a closer look at the United States, which enjoys a well-developed health insurance market.

Changes are expected in the design of South African health insurance products in the future

1 National Treasury. 2013. Process for the Release of the Envisioned Revised Draft Regulations on the Demarcation between Health Insurance Policies and Medical Schemes. Available at: http://www.treasury.gov.za/comm_media/press/2013/2013101501%20-%20Demarcation%20media%20statement.pdf [Accessed:26 June 2014].

2 National Treasure. 2013. Release of the Second Draft Regulations on the Demarcation between Health Insurance and Medical Schemes. Available at: http://www.treasury.gov.za/comm_media/press/2014/2014043001%20-%20Demarcation%20press%20statement.pdf [Accessed: 26 June 2014]

3 Republic of South Africa. Medical Schemes Act (Act 131 of 1998). Available at: http://www.doh.gov.za/docs/legislation/acts/1998/act98-131.html [Accessed:26 June 2014].

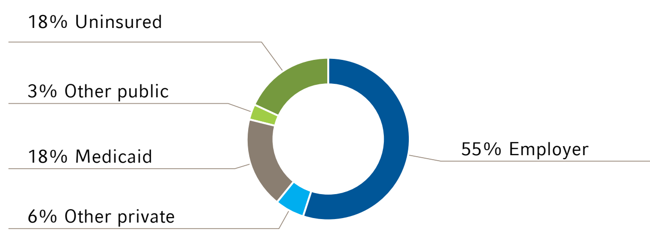
State of the US Health Market

The USA spends more on healthcare than any other country in the world. The annual health expenditure is in excess of $2.5 trillion. About $500 billion of that is spent on health insurance premiums [4]. In addition, it is estimated that the market will grow by more than 5% per year. At present the market is still made up of two basic payers, namely government programmes and commercial providers:

Public Government programmes	Private Commercial providers
• Medicare - A federal programme that covers individuals over age 65 and some disabled individuals. • Medicaid - This programme is designed for low-income and disabled individuals only.	• Employer-sponsored insurance • Private non-group (individual market) • Medicare Supplement for individuals over age 65

Private commercial providers dominate government sponsored programmes as shown in the figure [5] below:

US Health Insurance Coverage of the Non Elderly (Ages 0 - 64 years) in %



Most of the population under 65 are insured by their employer or a family member's employer (55%), 6% purchased insurance on the private non-group (individual) market, 21% were enrolled in public insurance programs like Medicaid, and 18% were uninsured. Elderly individuals (aged 65 and over) are almost uniformly enrolled in Medicare.

4 Nussbaum and Kaufman. 2013. US Group Health Market - HLR America Products

5 Kaiser Family Foundation. 2013. Health insurance coverage of non-elderly 20-64. Available at: http://kff.org/other/state-indicator/nonelderly-0-64/ [Accessed:26 June 2014].

The USA spends more on healthcare than any other country in the world

Government programmes for health insurance

With the advent of President Obama's second term, the frequently discussed new healthcare reform, officially called 'the Affordable Care Act' (nicknamed Obamacare), has been introduced. Its aims are to reform the healthcare system by giving more Americans access to quality health insurance that is affordable, and helping to curb the growth of healthcare spending in the US. Under the Affordable Care Act, there are public and private insurance platforms available, whereby insurance companies offer benefits under three tiered plans: Bronze, Silver and Gold. Premiums increase as the benefits increase. The plans can be rated by age, but the highest rates (for older people) cannot be greater than 300% of the lowest rate (for younger people). Similarly, for tobacco users, a maximum increase of 150% applies. An area can affect the premium as medical costs can depend on the State in which the individual resides. California has much higher medical costs than Alabama, for example, and therefore has higher premiums than Alabama. In addition medical insurance premiums are billed as either 'single' or 'family'. The size of the family is not a factor.

This wide-reaching reform impacts everything from practices of insurance companies to methods used to ensure better quality healthcare for all Americans. Significant reforms took effect on 1 January 2014, of which the most notable are [6]

- guaranteed issue (known as open enrolment in South Africa) for individuals, even with pre-existing conditions;
- partial community rating offering the same premium price to all applicants of the same age and region;
- the establishment of minimum standards for health insurance policies;
- that all individuals not covered by an employer-sponsored health plan, Medicaid or Medicare must purchase approved private-insurance or pay a taxation penalty;
- that the Federal poverty line has been increased to expand coverage of government-sponsored programmes, namely Medicare and Medicaid; and
- that all plans must offer unlimited benefits, whereas previously, benefit maximums of $1 million or $5 million were typically offered.

6 Obamacare. 2013. Affordable Care Act Summary. Available at: http://obamacarefacts.com/affordablecareact-summary.php [Accessed:26 June 2014].

- **Guaranteed issue:** requires insurance companies to issue a health plan to any applicant - an individual or a group - regardless of the applicant's health status or other factors.
- **Open enrolment:** Open medical schemes have to accept anyone who wants to become a member at standard rates. This protects those who are less healthy, as medical schemes are not allowed to deny access to them. It also prescribes events or times of the year when member movements into and out of the scheme or between benefit options are permitted without penalisation. This is a protective mechanism against anti-selective member movements.
- **Community rating:** Medical schemes must charge everyone the same standard rate, regardless of age, gender or state of health. This prevents price discrimination against older or less healthy members, who, in an ordinary insurance market, could be subjected to much higher risk-rated premiums.

Employer-sponsored health insurance

Employers provide health insurance as part of their benefits package for employees. This has been the most popular option in the US market. One of the key reasons that employer-sponsored plans have been so popular to date, is because health insurance coverage could not be denied under a group arrangement. However, individuals could have been denied coverage on the basis of their health status, before the implementation of the Affordable Care Act.

The basic product features of employer-sponsored plans are outlined below:

- **Administration**: Insurance plans are generally administered by insurance companies or third party administrators. These are almost all for-profit.
- **Financing**: Employer-sponsored insurance is financed both through employers (who usually pay the majority of the premium) and employees (who pay the remainder of the premium).
- **Benefits**: Benefits vary according to the specific health insurance product. The next section gives a more detailed overview of the types of health insurance products available in the US market.

A closer look at health insurance products

The US health insurance environment permits products that indemnify medical expenses. Almost all medical plans provide some form of prescription drug benefits. This is another new requirement by the Affordable Care Act. The degree of cost-sharing (including co-payments, coinsurance and deductibles) also varies considerably. Payment limits may also apply, but will depend on the specific product.

- Deductibles, co-payments and coinsurance represent the portion of the medical bill that the insured will need to cover out-of-pocket. A deductible is usually a fixed amount that the insured will have to pay out-of-pocket before the insurance will cover the remaining eligible expenses.
- A co-payments is similar to a deductible, in that it is usually a fixed amount that the insured pays. Unlike deductibles, co-payments tend to be smaller amounts and are applied on a per visit basis so that that you would have to pay it each visit. Co-payments are also used for prescription drugs, i.e. a co-payment for each drug script. They can also vary by the type of formulary, for instance, a lower co-pay may be required for generics.
- Coinsurance is usually expressed as a percentage. This percentage represents that cost that the insurance company and insured will need to pay towards the medical expenses, respectively. For example, 80/20 coinsurance means that the insurance company will cover 80% of the medical costs and the insured will pay for 20% of the medical costs. There is typically a maximum out-of-pocket limit payable by the insured towards coinsurance. Once reached, there are no other coinsurance payments required. As an example, there may be an 80/20 coinsurance up to $5 000 out-of-pocket expenses. Once the insured has paid $5 000 the coinsurance will end and costs will be met by the insurance company.

Major Medical Plans

Major Medical insurance covers large and expensive medical procedures. It is designed to cover accidents, unexpected health concerns and long hospital stays.

After the insured party has met his or her deductible and coinsurance responsibility, the insurance company will cover the remaining claim amount in full. Under the Affordable Care Act, this product is required to provide unlimited benefits.

Hospital Cash Plans

Similar to the product offered in South Africa, Hospital Cash Plans pay a cash amount to an individual based on the number of days of hospitalisation, following an accident or an illness. The benefit is a fixed cash sum, unrelated to the medical costs incurred as a result of hospitalisation. Benefits can amount to $100 to $1 000 per day. Some very extensive plans can offer as much as $2 000 per day, but allow for fewer maximum days.

Limited Medical & Accident Medical

Limited Medical is similar to a Hospital Cash Plan, but provides broader coverage. It pays scheduled benefits based on the type of service and usually includes a maximum benefit per service. The range of benefits covers preventative care, visits to a doctor's office, surgical and anaesthetics benefits, ambulance and emergency room cover and hospital benefits.

Examples of the benefit structure of Limited Medical

Benefit description	Benefit amount and number of visits or days of cover
Doctor's office visits	$50 - $75 per visit 3 to 4 visits per year
Surgical benefit	$3 000 - $20 000
Anaesthesia benefit	25% of surgical benefit
Ambulance benefit	$100 - $1 000 per visit 1 - 5 visits per year
Hospital confinement benefit	$100 - $1 000 per day Maximum of 30-360 days

Accidental Medical pays a benefit for injuries or losses incurred due to a qualified accident. It is typically offered as 24-hour coverage to cover emergency-related medical expenses. It usually covers ambulance and emergency room expenses, x-rays, hospital room and board, surgery and related medications.

Student Accident Products

Accident Medical is generally provided to various segments, including: college students, learners from preschool through to Grade 12 and sports players.

The product provides cover for medical expenses for accidental injuries that occur on school property or during supervised school activities. Student Accident Medical can be offered to students whose families do not have insurance coverage. These plans may also be available to foreign students. Otherwise, the student may be covered through the family's health plan (by virtue of their parents belonging to the group insurance scheme).

Critical Illness

Similar to the South African product, Critical Illness provides a lump sum benefit when an individual is diagnosed with a covered illness or condition. Cancer, heart attack and stroke make up approximately 75% of claims, although a comprehensive list of illnesses are covered. There is a movement towards guaranteed issue in the US. In these cases, much smaller benefit amounts are offered due to anti-selection risk.

Carve-out products

Carve-out product options cover specific categories of healthcare services required and include Dental Plans and Vision Care. Prescription drug plans are no longer offered as a carve-out, due to the Affordable Care Act. The plans usually offer tiered options, ranging from preventative to comprehensive benefits.

Typical benefits available within tiered dental plans

Preventative	Basic	Major	Orthodontics
Oral evaluations, routine cleanings and Fluoride treatment	Fillings, extractions, periodontics and root canals	Crowns, dentures, fixed bridges, space maintainers and surgery	Subject to annual limits

Coinsurance will vary by the type of Dental Plan chosen. This is typically 100% for Preventative, 80% for Basic and 50% for Major and Orthodontics.

Vision care is often sold in conjunction with a dental plan. It would normally cover an eye exam, lenses and frames or contact lenses. The benefit can be used once per year.

Employer Medical Stop Loss

This product covers self-insured group health plans where the employer assumes a portion of the financial risk of providing medical benefits to its employees. Therefore, it is designed to protect employers with self-funded health plans when their group medical costs are higher than anticipated, or when employees or their dependants experience catastrophic illness or accidents. The providers are normally the same as for all other types of insurance. The only difference is that the employer retains some of the risk.

Summary

Given that South Africa may see an environment more conducive to health insurance products towards the end of 2014, the United States acts as a good example of a well-developed market and could provide us with a few innovative product ideas.

In South Africa, the regulator's challenge will lie in balancing the various stakeholder interests and striking a good balance between creating a more hospitable environment for health insurance products, whilst at the same time preserving the integrity of the medical scheme environment. In light of these developments, we may see more entrants into the South African health insurance market in the near future.

We, at Hannover Re, have consolidated our healthcare product knowledge throughout the global Group via a dedicated network of healthcare product experts from all of the regions in which we are active. In this regard we are well-placed to lead the change in designing new and innovative products that meet the needs of the South African market. For more information please contact your Hannover Re representative.

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Farewell and welcome

Farewell Gerd Obertopp

It is with a heavy heart that we bid farewell to Gerd Obertopp who will now be focussing on his role as Managing Director of Hannover Re Life & Health Asia. Gerd has been with Hannover Re for 20 years and was no stranger to the South African market, having occupied the Managing Director role from 2003 to 2008 and stepping in again during 2012. During both periods of time, Gerd's presence was key to growing and developing our portfolio and steering Hannover Life Re Africa to become the leading individual life and health reinsurer in South Africa. It was also during his tenure that Hannover Life Re Africa exceeded the significant R2 billion premium income mark over 2013.

We wish Gerd success in the Asian markets and do hope that his travels bring him by the South African office in the future.

Welcome Wesley Clay

We are delighted to announce that Wesley Clay has taken over the position of Managing Director of Hannover Life Re Africa from March 2014. Wesley has been with the Hannover Re Group since 2002, primarily in the marketing and business development areas of our South African life team. He also established and ran the Hannover Re service office in India over 2009/10.

When he returned to the South African office in mid-2010 he retained the Head of Business Development role and was the driving force in growing key client relationships.

We wish Wesley luck and success in his new role and have full confidence that he will continue to position Hannover Life Re as the leading Life Reinsurer in Southern Africa.

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