HEALTH INSURANCE IN MEXICO:
FACTORS TO DRIVE ITS GROWTH

Prepared by:
Act. Eduardo Lara di Lauro

Reviewed by:

Milliman México Salud
Mexico, City, MEXICO
November, 2005.
Health Insurance in Mexico: Factors to Drive its Growth
by Act. Eduardo Lara di Lauro

INTRODUCTION

Health is a topic where the phrase “the only constant is change”, is thoroughly accomplished. In each one of its areas, it is by nature, changing, dynamic, and innovative, so continuous updating of analysis and reports on healthcare and its financing related topics are essential for its understanding and development.

This paper intends to make a review of the current situation of health insurance in Mexico, covering the following points.

I. BACKGROUND AND CURRENT SITUATION
II. EVOLUTION
III. PARTICIPANT OPINIONS ABOUT FACTORS AND STRATEGIES FOR URGING GROWTH
IV. PENDING ISSUES

To better understand the current situation of the health insurance in Mexico, we consider convenient to take its Backgrounds, starting with some reflections about “Health Insurance” as a broad concept that considers comprehensive medical as well as major and minor medical, dental and other coverage related with health attention. We follow with some relevant aspects to its origins, mentioning as well the way in which our healthcare system and the current National Healthcare Program influence in private health insurance, identifying and recognizing who are the actors and constituents in our health system, too. We conclude this section giving some relevant statistics related to the current situation of this kind of insurance.

Later we mention in a schematic way which has been the Evolution of health insurance in Mexico, from the point of view of different stages and ways of manage healthcare financing and delivery.

After reviewing the current situation and with the purpose of not skewing the paper by only presenting personal opinions, we gave ourselves to the task of obtaining Participant’s Opinion related to the challenges and opportunities that they visualize in the health insurance market. Such opinions were obtained at informal chats with colleagues and friends at the trade insurance industry association, at the ISES, and from regulators, from policyholders, providers, insurance agents and of course major medical insurers. These interesting opinions and points of view were the basis for summarizing, ordering and stating the Strategies and Factors for Urging Growth. As the core part of the report, Section III presents in 8 main points, a summary of the Participant’s Opinions for Urging the Growth of Health Insurance.

Finally we reiterate the Pending Issues we consider the industry constituents have to work together in order to put in place the basis for a solid and strong growth.
I. BACKGROUND

Health Insurance as a Concept
As we can see in international literature, when they refer to “health insurance”, they talk about a broad and including concept of the different insurance related to the attention of the different needs of medical services that insured have, which can be divided in different categories and modalities, being this, by the way in which the given benefits are paid, by the form of its provider network, by the kind of coverage they give, etc. In function to the coverage they give, “health insurance” includes comprehensive health, major medical, minor medical, dental services, hospital services, and any other combination of health coverage. By this, we consider that is mistaken that in Mexico, we separate major medical products from “health products”, since the first is a subset of the second. So the proper way to name what we call “health products” is “comprehensive health products”.

Origins
So, the origin of health insurance in Mexico can be divided with the emergence of major medical insurance (MM) and the comprehensive health insurance (CH) and other variations.

The major medical insurance have already a large tradition in the Mexican market, initially introduced as 100% indemnity products, this is, reimbursement of the incurred medicals, found since the late 1970’s, focusing on cover the effectively major medical in which the beneficiaries incurred due to accident or illness.

On its side, comprehensive health insurance emerged due to the need of regulating a dynamic but heterogeneous and anarchic market that started in the early 90’s, outside the insurance sector, throughout the so called health service administrators or Third Party Administrators (TPA) exercising actions of “pre-paid medicine”, fundamentally for medical services for bank employees, industry which have a “fees reversion scheme with subrogation of services”\(^1\) by the Mexican Institute of Social Security (IMSS), as well as other non-centralized public entities at federal and local levels.

The insurance sector had diverse incentives and pressures for being interested on participating in this opportunity. A determining incentive was the possibility discussed in the late 90’s of widening or

---
\(^{1}\) Through these agreements the IMSS reimburse to entities such as Banks part of the premiums paid for its Maternity and Illness Social Security Insurance, in order to provide private health services to employees.
extending the aforementioned agreements of “fees reversion and subrogation of services” with the IMSS to any company that filled out the established “requirements” by the IMSS – which by the way, have never been “defined”-. From here, it can be understood why the strong regulatory framework the Specialized Health Insurance Institutions (ISES) has – and its acceptance by a part of the industry. Another incentive was the important health expenses that Mexicans do as “out-of-pocket”, which goes up to a 3% of the Gross Domestic Product, around US$20,000 million.

When it comes to pressures the sector had, we can mention the continuous demand by the insured, employers, and the sales force of having novel products, with more options and more complete to the ones offered by the sector at that time. Also, the suffered costs spiral in the traditional indemnity products pushed the insurance companies to implement diverse cost control actions and coverage sophistication.

The Healthcare System
A determining factor at health insurance development is, without a doubt, the public healthcare system that each country has, in function to the kind of healthcare model is that private participants organize and determine the public and private participation mix. Under this criterion we are able to classify the healthcare systems in 3 great groups:

Public Coverage Substitutes, where the private players participation is “High”, as its name indicates, this coverage substitutes or provides services on behalf the State.

The Supplementary, where private players can complement the public coverage, which can be non comprehensive or they could offer access to different provider options. This system allows a “Median” participation of the private insurance sector.

And we have the Double Coverage Systems, in which the State theoretically provides universal coverage, but some beneficiaries do not have access to such coverage or are not willing to use it and then they acquire private coverage, reason by which the same services are being paid twice. Clearly, this system generates “Low” participation of private insurance.

This is the system we have here in Mexico, where we are able to even talk about a triple payment when for example, in a home, the man works for a private employer and has IMSS benefits, and the woman works for a public employer having ISSSTE coverage, but neither use such coverage and they buy a private medical insurance o pay out-of-pocket private medical services.

Actors and Constituents
Actors that take part in health insurance must be identified and recognized:

Who Finances – Insurance Companies / Contracting Employers / Employees (in contributions plans).
Who Articulates.- Insurance Companies with Provider Networks / Third Parties Administrators.
Who Distribute or Sells.- Insurance Agents / Brokers
Who Provides the Services.– Medical Services Providers: Hospitals / Physicians / Etc.
Who Buys.– Contractors: Employers / Individuals
Who Uses.– Insured / Beneficiaries
Thus, we can say we have 3 great groups or populations, Social Security, Assisting Services (including the new Popular Health Insurance – PHS) and the private sector. In a schematic way we have:

**Mexican Healthcare System Constituents**

<table>
<thead>
<tr>
<th>System</th>
<th>Social Security</th>
<th>Assistance</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organization</td>
<td>IMSS 44.5 Millions</td>
<td>SSA 39 Millions</td>
<td>Self Ins 1.5 Millions</td>
</tr>
<tr>
<td></td>
<td>ISSSTE 7.5 Millions</td>
<td>SPS 7.5 Millions</td>
<td>Insured 3.5 Millions</td>
</tr>
<tr>
<td></td>
<td>SSFAM 1 Million</td>
<td>No Acc. 1.5 Millions</td>
<td>Total 5 Millions</td>
</tr>
<tr>
<td></td>
<td>Pemex/CFE 1 Million</td>
<td>TOTAL 54 Millions</td>
<td>(Double Payment 2 Millions)</td>
</tr>
<tr>
<td>Provision</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Users</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In terms of membership or user population we have:

**Mexican Healthcare System Constituents**

*Includes IMSS, ISSSTE, PEMEX, SEDOHE, SSFAM.
**Includes SSA, IMSS-Etated.
National Health Program
One of the Objectives of the National Health Program of the current administration is “to close” the so-called “open population”, -the population assisted by the Ministry of Health throughout its assisting services-, enrolling it to the System of Social Protection in Health (Seguro Popular) and to take the public health system, in a second phase, to a Universal Health System. Currently, we are on Phase 1, where every system finances and attends its population, -segregation system by social groups-, Phase II, intents to broaden up the services to all users of public systems. No matter to which system a beneficiary pays or prorates, could be assisted at any public service infrastructure, being this:

Phase I: Close Open Population
Phase II: Universal Health System

Independent to the healthy repercussions that this transition is generating for the less protected population of the country and the healthy competence that this generates, this new model opens a great opportunity for the private insurance sector to the point in which it is prepared to be an active actor and not a passive one, of this Mexican Healthcare System Reform. Milliman’s proposal is a Phase III to participate at the “Broadened” Universal Health System, this is, that the private insurance sector be recognized as a financing entity and that private health services been valid providers, inside the model.

Phase III: Broaden Universal Health System *

(*) Milliman Mexico Proposal
Industry Statistics

Specifically up to October 2005, the insurance companies that report movements at premiums in major medical insurance are:

1. G.N.P.
2. ING Comercial América
3. Metlife México
4. Monterrey New York Life
5. Inbursa
6. Atlas
7. Mapfre Tepeyac
8. Banorte Generali
9. Allianz México
10. Interacciones
11. AIG México Vida
12. ACE Seguros
13. Plan Seguro
14. Royal & Sunalliance
15. Metropolitana
16. La Latinoamericana
17. Zurich Mexico
18. Banamex
19. La Peninsular
20. Salud Preventis
21. Amedex
22. Seguros Centauro
23. HSBC Seguros
24. Santander Serfin

To the same date, the Specialized Health Insurance Institutions (ISES) that report revenues movement on comprehensive health and other health insurance variations are:

1. Plan Seguro, (Alliance between Chilean and Mexican groups)
2. Médica Integral GNP, (from GNP)
3. Salud Comercial América (from Seguros ING – Comercial América)
4. General de Salud, (from General de Seguros)
5. Seguros Sanatorio Durango (from Hospital Sanatorio Durango)
6. Preventis, (from Seguros BBVA Bancomer)
7. Seguros Centauro, (from Centauro Dental Group)
8. Salud Inbursa, (from Seguros Inbursa)
9. Servicios Integrales de Salud Nova (from Dinámica-Clinica Nova Monterrey Group)
10. Novamedic Seguros de Salud, (from Intermedic Medical Group)
11. SaludCoop Mexico (from Colombian EPS - SaludCoop)
12. Vitamédica, (from Seguros Banamex)

Additionally, we have knowledge that a North American HMO is under registration process.

About TPAs we can mention:

- Consulmed
- Corporación de Protección Médica
- Dimensión Salud
- Intermedic (*)
- Imagen Médica
- Medi Access
- Meximed (*)
- Medical Group
- Red Médica de Salud Administrada (*)

- Red Master
- SIARMED
- Salud Interactiva
- Sinergia Médica
- Telemedic
- Tiempos de Salud (*)
- Tu Salud
- Zeusalud (*)

(*) TPA owned by an ISES or MM insurance company.
Health Insurance in Mexico: Factors to Drive its Growth

by Act. Eduardo Lara di Lauro

When talking about the activity in which health insurance companies have had, we show some charts as follows:

As we mentioned, given the current health system of “Double Payment” in Mexico, the participation of the private health insurance companies is not important; to December 2004, is slightly under 0.23% of the GDP. No matter, its growth dynamic has been good, even in times where the sector and the country’s economy have grown.

The following graphics reveal some strategies and trends that ISES and major medical insurance companies are taking on curse.
Health Insurance in Mexico: Factors to Drive its Growth
by Act. Eduardo Lara di Lauro

What is happening with the ISES must be explained in function to the problematic and challenges that each one is living and experimenting, in general we can comment that meanwhile traditional major medical insurance companies try to maintain their business profitable and giving the “service of major medical” to life customers and to their sales force; some ISES are trying to compete at the major medical market and the majority are changing their comprehensive health business with taking risk for Administrative Service Only (ASO) or renting their operation infrastructure to companies with self-insurance schemes. That is why the great deeming on “health insurance” premiums (let’s remember that in Mexico, health insurance is understood as comprehensive health and its variants). On the other hand, growth is at the administration business or services rent without risk taking, which until now has no record of its activity.

Nevertheless the small participation of the health insurance companies regarding to the GDP and the premium decrease, we should not forget the fact that Mexicans spend 3% of the GDP (US$20,000 million) in private health services and that only 4.5% of this number corresponds to private insurance, the remaining 95.5% equivalent to US$19,500 million, is out-of-pocket expense.

This is why we should consider the insurance market as of significance, because there is still much to take care of. The volume of “officially registered” premiums does not consider all the activity the industry is having.

Only to give some segments of the non registered markets we have:

- Enterprises with opt-out agreements from the Social Security such as the banking system, the mining industry and some northern corporations. (Grupo Alfa, Femsa, etc.)
- Government-run companies such as the National Lotto, the National Commission of Banks, the National Fund for Tourism Promotion, the National Commission of Insurance, the Mexico City Subway, and others
- Federal and State Governments, Public Universities
- Private companies with health benefits financed by self-insured schemes
Health Insurance in Mexico: Factors to Drive its Growth
by Act. Eduardo Lara di Lauro

II. EVOLUTION

Analyzing the health insurance evolution in Mexico in a schematic way, from the point of view in which they have been financed and how the delivery of services has been, could help us understand where we are, how we compare to other countries, and what could be the trend of these insurance products.

We have grouped the financing and delivery of services stages in 9 categories. ²

<table>
<thead>
<tr>
<th>Stage</th>
<th>Contributions</th>
<th>Kind of Coverage</th>
<th>Kind of Instrument</th>
<th>Risk Taking</th>
<th>Provider Election</th>
<th>Provider's Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Cash Patient</td>
<td>All Medical Services</td>
<td>Direct Services</td>
<td>Patient</td>
<td>Free Election</td>
<td>Independent Providers (IP)</td>
</tr>
<tr>
<td>2</td>
<td>Cash Patient</td>
<td>All Medical Services</td>
<td>Direct Services</td>
<td>Patient</td>
<td>Provider’s List with Discounts</td>
<td>IP, Simple Provider Network (Network)</td>
</tr>
<tr>
<td>3</td>
<td>Employer and Employee</td>
<td>Major Medical, Minor Medical, Dental Insurance</td>
<td>Rent of Provider Networks, TPA's, Trusts</td>
<td>Employer and Employee</td>
<td>Provider’s List with Discounts</td>
<td>IP, Network and Preferred Provider Network (PPO)</td>
</tr>
<tr>
<td>4</td>
<td>Employer, Employee and Insured</td>
<td>Major Medical and Hospital Expenses</td>
<td>Indemnity Insurance</td>
<td>Insurance Company, Re-insurance, Insured</td>
<td>Free Election</td>
<td>IP, Network and PPO.</td>
</tr>
<tr>
<td>5</td>
<td>Employer, Employee and Insured</td>
<td>Major Medical and Hospital Expenses</td>
<td>Insurance with Preferred Provider Network</td>
<td>Insurance Company, Re-insurance, Insured</td>
<td>Free Election and Preferred Provider List</td>
<td>IP &amp; PPO.</td>
</tr>
<tr>
<td>6</td>
<td>Employer, Employee and Insured</td>
<td>Major Medical and Hospital Expenses</td>
<td>Insurance with Exclusive Provider Network</td>
<td>Insurance Company, Re-insurance, Insured</td>
<td>Exclusive Provider List</td>
<td>Exclusive Provider Network (EPO)</td>
</tr>
<tr>
<td>7</td>
<td>Employer, Employee and Insured</td>
<td>Comprehensive health, Major or Minor Medical, Dental, Vision, Maternity, etc</td>
<td>Health Insurance</td>
<td>ISES, Re-insurance and Insured</td>
<td>Exclusive Provider List</td>
<td>EPO</td>
</tr>
<tr>
<td>8</td>
<td>Employer, Employee and Insured</td>
<td>Comprehensive health, Major and Minor Medical, Dental, Vision, Maternity, etc</td>
<td>Health Insurance</td>
<td>ISES, Re-insurance and Insured</td>
<td>Free Election and Preferred Provider List</td>
<td>IP &amp; PPO.</td>
</tr>
<tr>
<td>9</td>
<td>Employer, Employee and Insured</td>
<td>Comprehensive Health</td>
<td>Integrated Health System (IHS)</td>
<td>IHS, Insurance company and Insured</td>
<td>Integrated Health System (IHS)</td>
<td>Employees</td>
</tr>
</tbody>
</table>

² Pablo Schneider, Conference on Managed Care at the ITAM, 2000.
Summarizing each stage, we have the following Kinds of Health Insurance:

<table>
<thead>
<tr>
<th>Stage</th>
<th>Contributions</th>
<th>Kind of Coverage</th>
<th>Kind of Instrument</th>
<th>Risk Taking</th>
<th>Provider Election</th>
<th>Provider’s Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>Out-of-Pocket / Independent Providers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Out-of-Pocket / Discount Provider Network</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>Cash Flow Management / Discount Provider Network</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>Indemnity Insurance / Open Provider Network</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>Major Medical Insurance / Preferred Provider Network</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td>Major Medical Insurance / Closed Provider Network</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td>Health Insurance / Closed Provider Network</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td>Health Insurance / Open Provider Network</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td>Integrated Delivery Systems</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

From here we can say that product trends head toward hybrid products, i.e. combination of minor and major medical, comprehensive health or stand alone dental or vision coverage. Consumers will recognize the benefits of the comprehensive health programs and closed provider networks, large employers will rather take a risk through self-insurance, and a great opportunity for supplementary insurance coverage to the Seguro Popular is opening. Following the international trends attention will be given to Long Term Care and Critical Illness Insurances.

From the medical cost, quality and effectiveness’ attention point of view, the following chart gives us an idea towards which model the increases move:
III. PARTICIPANT’S OPINION ABOUT FACTORS AND STRATEGIES FOR DRIVE GROWTH

As we previously said, with the intention of not make a bias opinion about which are the factors to overcome to propitiate the growth of health insurance in Mexico, we talked to some various sector’s constituents, asking them to provide their points of view to this concern.

All the obtained comments have been grouped in the following 8 great challenges:

1. To Conciliate Sector’s Points of View with the Ones of the Authority. - Health insurance and its growth is a topic that occupies and concerns to the sector, which is working together with the authorities to foment its development, even though it is necessary to homologue and/or conciliate the authority’s points of view and the ones from the sector concerning where these insurance are wanted to be taken to. Particularly, the ISES sector suffers when accomplishing with an additional regulation to that general for insurance companies, with more statistical reports and more requirements as the medical comptroller. The expressed banning that major medical insurance companies cannot manage maintenance and preventive actions is harmful; for us any product that foments prevention actions and health maintenance for its beneficiaries should be encouraged.

2. To Develop Knowledge about Health Insurance. - Understanding health insurance as a broad concept, without making a separation of major medical from comprehensive health and its variants apart, which will allow to work over common problems such as development and encouragement of a statistical system; development of performance indicators, uniform codifying and formats development; medical guidelines and protocols development; good provider relation encouragement; synergy at provider networks creation. To land concepts such as prevention and health maintenance, cost control strategies and quality assurance programs. To change the paradigm that comprehensive health products only can be given at closed provider networks. To avoid the creation of a double infrastructure and to avoid confusing strategies for the sales force.

3. To Promote Training Among Every Player. - Authorities, insurance companies, sales force, contractors, and insured and beneficiaries. The knowledge level about health insurance (comprehensive, major, minor medical or their variants) is very uneven among sector’s participants. To the extent in which insurance companies create professional agents, confusions or misunderstandings between contractors and beneficiaries will be avoided. Diffusion must be given to
Health Insurance in Mexico: Factors to Drive its Growth
by Act. Eduardo Lara di Lauro

Knowledge of successful experiences in a national and international level. Lack of experience from some of the participants has resulted in serious problems and even in revocation of operations as an insurance company; this is being corrected.

4. To Create “ad-hoc” and Specific Marketing Strategies for Developing Health Insurance Line of Business.- To overcome major medical insurance companies and ISESs internal problems; to recognize that the different modalities of health insurance could give access to any economic level consumer, either low, mid or high; depending on the product and the market niche, the strategy on closed or open provider networks will be established; to change the “it is expensive” paradigm; to avoid confrontation between major medical and comprehensive health. To promote the quality of contracted providers among policyholders and beneficiaries and the advantages of having a preferred provider network; to develop new “not canned” and flexible products. To recognize and control the cash flow and administrative service only (ASO) businesses. New foreign players are exploring new non covered opportunities.

5. To Develop Effective Cost Containment Strategies.- Because it was a consistently mentioned topic due to the concern it generates it was considered as a challenge and independent strategy. Due to the high costs in health services such strategies have to be known and adapted or developed to make health insurance accessible for broaden population as well as a profitable operation. Drugs issue is, specially, the main challenge consuming over 30% of the total expenses.

6. To Create Insurance Culture and Change Paradigms.- Habits of those who have sold and acquired medical insurance influence in a great deal to acquire or not new products, as those of comprehensive health and its variants, which are mainly offered through provider networks called “closed”, this is, only providers previously agreed by the insurance company can be reached, while traditional major medical products have “open provider networks”, where providers from inside or outside the previously agreed ones can be reached. This led us to the challenge of changing the attention paradigm, because each kind of medical insurance accomplishes a specific function and attend specific needs. Being major medical the most “accepted” and known product by the beneficiaries as well as by the distribution channels, now a days exist a very wide variety of health insurance coverage available, being these comprehensive health, minor medical, dental insurance, vision coverage services, those that cover only hospitalization and maternity, and every other medical service combination. To explain in an appropriate manner to health insurance consumers and users the advantages and disadvantages of open and closed provider networks, of comprehensive or partial coverage, to explain the balance relation that should exist among: Accessibility, Benefits, and Premium Cost.

7. To Align Participant’s Incentives.- To change the antagonism in the relation with providers and focused in costs, for one that centered in incentives from quality attention. To modify the “one looses – the other wins” feeling or relation, to develop quality medical service infrastructure to a national level; to recognize the underlying costs of current provider structure, based on individual providers basis. To analyze advantages of grouping providers.
Health Insurance in Mexico: Factors to Drive its Growth
by Act. Eduardo Lara di Lauro

8. To improve the Product’s Image. - Throughout broaden promoting campaigns among constituents letting them know the achievements in the effective development of the aforementioned issues.

By summarizing the written above in only one phrase, we would say:

“Developing Players and Constituents of the Health Sector To Develop the Health Insurance Market in Mexico”

IV. PENDING ISSUES

Following we mention some of the topics that the industry should work and discuss together and with a wide participation.

➢ “To reach an Integrated, Profitable and User Focused Private Health System”. - AMIS.

➢ To retake the meetings of all actors, with the goal of having the possibility of “reviewing” the current regulation and to discuss eventual changes and adaptations.

➢ As we have seen from the most important challenges is to recognize and attack the fact that public in general, and even most of the distribution channels, do not know in their right mind, the benefits and services that health insurance provide to their members.

➢ Is urgent the development of own, reliable, timely, and sufficient industry statistics, being these regional as well as nationals, and having at reach clear indicators of health progress of the insured population, relying on the use of uniform codifications and at information systems.

➢ To design or adapt protocols and care guidelines of medical practice, which take the best practices available, under the premise that “the best diagnosis produces the best treatment, which generates the appropriate cost.”

➢ To implement the “Unique Claim Format” for physicians, design and reach consensus for a “Uniform Billing System” for Hospitals, as well as developing and regulating the use of the “Unified Clinical File”.

➢ To develop quality medical infrastructure to a national level, recognizing the fundamental role that service providers play at this sector.

➢ To this day, what we have seen in the market are “simple” and “canned” products, we must sophisticate and give flexibility to health products’ design.
Health Insurance in Mexico: Factors to Drive its Growth
by Act. Eduardo Lara di Lauro

- We must promote the study and analysis of experiences and knowledge about health systems and managed care in other countries, which gives us the valuable opportunity of learning and be able to adapt them to the conditions and culture of the Mexican market.

- Defining criterion for eventual transference or risks sharing with providers, will lead us towards the establishment of basis for a real capitation and the management of risk pools, and by this, to avoid, from the beginning, poor practices at these important topics of managed care.

- To develop evaluation, medical underwriting, cost containment, and quality improvement tools, as well as performance indicators that give an incentive to the best practices.

- Of course, we have to find innovative alternatives for including the so called special populations, elderly people, people with chronic diseases, those who require catastrophically financial treatments, and population with low incomes.

- Should not be left out, at mid-term, the private participation at public insurance, that could be induced in an important way by the development and sophistication that health insurance companies reach, so we cannot waste the opportunity to consolidate the sector as “the Alternative” in Mexico, for financing and articulating private health services.

- At last but not least, is the development of human resources specialists in health insurance, people who know how health systems work and are familiar with managed care techniques.

This report was presented at the XXII National Congress of Actuaries, celebrated at the City of Veracruz, on September 2005.

Author

The author is the Director of Milliman’s Healthcare Consulting Practice in Mexico, with over 10 year of expertise in health insurance, managed care and healthcare financing systems. For further information, please contact Eduardo at (55) 5615 8066 ext. 102 or via e-mail at eduardo.lara@milliman.com.