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Micro Health Insurance – The product development challenge

Roseanne da Silva
Actuarial Society of South Africa

The challenge

- Lack of access to health insurance amongst the poor in developing nations
(Griffin & Shaw, 1995; Doyle et al., 2011)
- Prefunded health insurance is preferable to alternative sources of finance
(Brown & Churchill, 2000; Binnendijk, Koren & Dror, 2012)
- BUT: MHI providers have largely failed to deliver.....

» **Why?**

» **Can we help?**

Agenda

- The need for micro health insurance
- Key challenges
- Our project plan
- Progress to date
  - Case studies
  - Work in progress

Target Market

- The goal of universal access to healthcare
- The need for prefunded, pooled care
  - Types of care
  - Levels of care
- Informal economy (irregular incomes)
- The role of the State / dependence

Insurance Core Principles

- Is an inclusive insurance market feasible for MHI?
  - Affordable
  - Sustainable
  - Convenient
  - Responsible
  - Supervised insurance providers (proportionality principle)

Structuring delivery

- Funding
  - Sources
  - Adequacy
- Pooling
  - Entity
  - Mechanism
  - Governance

- Purchasing
  - Incentives
  - Contracting
- Benefits
  - Level of care
  - Managing expectations
  - Cost sharing
- Monitoring
  - Data collection
  - Risk management
- Distribution

Specifying the problem

- Willingness to pay
- Benefit expectations
- Current utilisation (impact of insurance)
- Accessibility of service providers

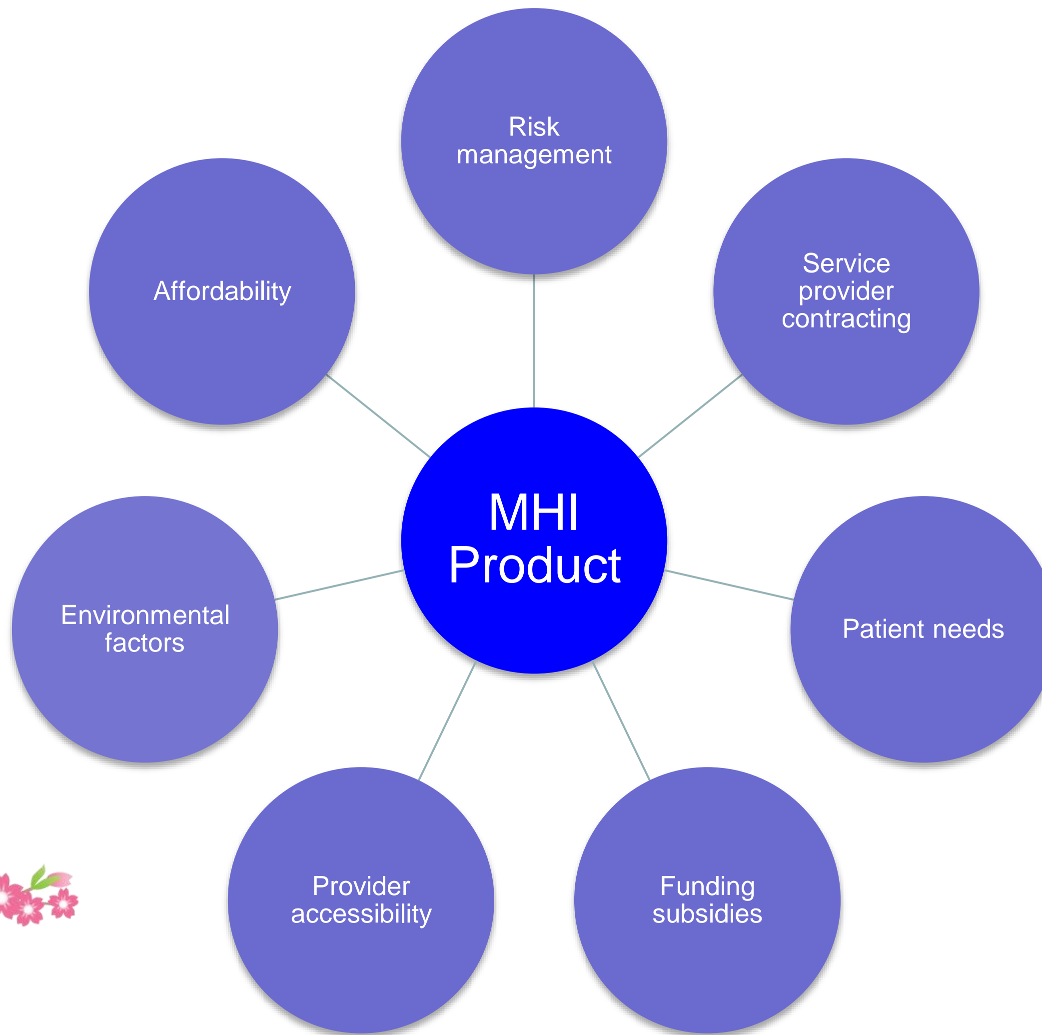
LIMS study in SA

- GP visits
- X-ray and laboratory tests ordered by the GP
- Dental consultations
- Optometry services
- Prescription medicines, subject to a primary care formulary
- Emergency transport to a public hospital

Pricing requirements

- Population
  - Identify targets
- Utilisation
  - Benefit expectations
- Infrastructure
  - Accessibility
  - Levels of care
- Price of services
  - Contracting opportunities (risk sharing)

Lots to consider…..



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Micro health insurance project

- Aims
  - Investigate practices
    - Benefits
    - Structuring
  - Framework for assessing utilisation
    - Process
      - » Data collection
      - » Best practice assessment
      - » Framework development
      - » Link to Milliman Pricing Model Project

Collaborators

- Micro Insurance Working Group of the IAA
- Finmark Trust
- Wits University
- Milliman

Sources of data per country

- International statistics (WHO…)
- National statistics
- Regional statistics
- Local (insurers and community entities)
  - Challenges
    - Specificity
    - Consistency
    - Confidentiality

Burden of disease

- Preventative vs. curative care
- Communicable vs. non-communicable
- Assessments of prevalence
  - Diagnosed
  - Latent
- Treatment protocols and levels of care

Components of claim cost

Utilisation

% claiming

Claims per patient

Cost per treatment

Type of treatment

Service provider

A model for assessing costs

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Some case studies

- Kenya
- India
- Ghana
- Columbia

Kenya case study

- 39m population
- Small formal sector
- NHIF
- Burgeoning private sector

CIC's journey in micro health insurance

Initial product
2004-2008

- Family health insurance cover piloted with KADET (MFI) and expanded cover to other MFIs and SACCOs
- Extended benefits, included private healthcare providers (more costly)
- **Low take-up and business was loss making**

Bima ya Jamii
2008-2010

- Bundled life and family health , health component underwritten by NHIF
- **Low take up and renewal rates, health component was loss making (LR 120%), challenges with the relationship with NHIF**

Afya Bora
2012

- Family health insurance cover underwritten by CIC
- International consultant for product development and pricing
  - Used national data for setting assumptions for utilisation rates
  - Developed a list of procedures and recommended rates to be negotiated with healthcare providers
- **Low claims ratio in first year, but loss making in second year, premiums may need to be adjusted**

India case study

Country overview

- Population 1.2 billion (2011) (+/- 30% BPL)
- Healthcare expenditure 4% of GDP (2008-09)
- National objective of universal health

Burden of disease

- Majority of healthcare expenditure for low income market:
  Diarrhoea, dysentery, gastritis, respiratory infections, malaria
- Main reasons for hospitalisation:
  Heart disease, kidney and urinary system disease, gynaecological disorders, accidents and injuries

Overview of RSBY

Targeted at households living BPL
Member plus 5 dependants (143m beneficiiaries in 2012)

Hospitalisation benefits: 727 listed procedures incl. maternity (secondary care), transport costs
Annual max benefit: US$555 per household (sufficient for 90% of households)

Healthcare services provided by empanelled hospitals (75% admissions at private hospitals)

Premiums 100% subsidised by government (households pay US$0.5 enrolment fee)

Underwritten by commercial insurers
Districts allocated to insurers based on lowest premium quote

Key indicators

Enrolment

38 million households, 512 districts

Utilisation and cost

Hospitalisation ratio: 2.5% (2010) (6.4% private insurance)

1.9% (round 1) → 2.2% (round 2)

Average cost of admission: US$100 (2012)

Premium and claims ratio

Average premiums: US$11.5 (2009) → US$6.8 (2013)

Claims ratio: 73% (round 1) → over 100% (round 3)

Factors affecting utilisation and cost

Age and gender

Diagnosis/ procedure

Enrolment

Out patient pilot

Risks and Risk Management

Adverse selection	Less of an issue	Subsidised premiums
Cream skimming	Less of an issue	Targeted enrolment list
Moral hazard and over utilisation	Substitution for IP for OP Increase in utilisation over time	Max annual benefits, listed procedures and packaged rates
Provider induced demand	Increase procedures higher fees Pair procedures to maximise fees (increase in hysterectomies)	Independent review of treatment Dis-empaneling providers involved in fraud

Work in progress

- Expected outcomes
  - Literature survey under way
  - Identification of best practices
    - Benefit design
    - Implementation
  - Collection of data
  - Utilisation framework

The Role of the Actuary

- Providing a framework
- Advice and support
- Monitoring and analysis

- **I**nnovation, **C**are, **E**xperience

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