

Helping the sick through innovation in insurance

Health cover for all

A number of arguments are emerging in the health care financing environment on the new ways that medical schemes and health insurers price their products and screen the applicants who join the schemes and purchase the products.

Typically, the battle cry is one of foul play, accusing the newly emerging health insurers of “cherry-picking”, or skimming off the best risks and leaving the poorer risks for the traditional medical aids. It is claimed that this violates the principles of cross-subsidisation and further jeopardises the old and sick.

The reality is quite the opposite. The challenge in a health insurance system is to cover as many people as possible and make the cost of that cover as low as possible. In order to do this, health insurers have to ensure that they cover a mix of healthy and sick people.

Our statistics show that of the typical covered population, just 8% of those people consume more than 75% of the hospital expenses. The question is, who pays for that 8%? The only possible answer is the other 92% healthy people.

The lesson is simple, yet very powerful. For a health insurance product to sustain itself and deliver its brief, it requires a balance of protection for the old and sick, and value for money for the young and healthy people.

Helping the old and the sick

Let us examine what the emerging health insurers are doing. Typically an individual or small group, when buying a new health insurance product, is required to undergo a screening process known as underwriting. This involves the completion of a medical questionnaire (just like for life insurance) and an evaluation may result in an outright decline of cover or a loading charged on top of the standard premium.

It would be easy to jump to the conclusion that this favours young, healthy lives at the expense of the old and sick, but one needs to look a little deeper.

How insurance works

When individuals or small groups decide to purchase cover, they do so of their own choice — there is no law mandating medical scheme coverage. People can thus move in and out of the system freely.

The question then is: why do people purchase medical scheme or health insurance coverage? The answer is simple: they are concerned that if they do not do so now, they will not be able to get cover when they are sick.

Therefore, in the absence of any form of screening, healthy people would never enter the system, knowing that cover is readily available without penalty should they become ill.

Schemes would end up covering only sick people, resulting in exorbitant contribution rates and jeopardising exactly those people you are trying to help.

Underwriting therefore gives people incentives to join the system when they are healthy and provides them with an appropriate reason not to leave. This provides the necessary funding for the sick and high claimers.

Pricing risk is not “cherry-picking”

This gets to the next point — pricing of contributions more accurately. Pricing risks accurately ensures that the medical scheme, contrary to popular belief, is doing the opposite of cherry-picking.

Matching the contribution to the risk that a person presents provides value for money in a real sense, and provides protection to the medical scheme.

A system that does not take into account risk factors results in overcharging on young and healthy lives, often resulting in their taking the decision not to enter in the first place.

What most people tend to ignore when talking about the newer health insurance products is the fact that once you are in the scheme, your rates do not take into account your personal health circumstance. In other words, regardless of your state of health at any time, the rates still reflect the predetermined underlying factors that were applied when you joined the medical scheme.

This is the real principle of insurance — protecting you against unpredictable events.

Security in an uncertain world

What are the alternatives? Government is suggesting an environment which enforces “**flat community rating**”. This is where schemes charge the same rate to everyone, regardless of an individual’s risk profile. This flat rate, by necessity, is based on the average cost for the entire community, hence the name “flat community rating”.

A scheme which charges flat community rates and allows entry to only the young and healthy will therefore be charging substantially more than required to cover claims.

Faulty regulation will raise health care costs

Divorcing what members pay from the risk that they present creates opportunities for real cherry-picking.

The only way of preventing this is to remove the right to underwrite, but this, as discussed above, will result in only the sick seeking cover.

The net effect of either of these scenarios is reduced coverage and increased costs — precisely the opposite of the social ideal.

What can be done?

An environment wherein all insurers rate accurately and control access to their risk pools will maximise coverage and minimise costs with only two exceptions: today’s old and the uninsured sick.

Analysis in my company has shown that these together form a minute portion of the population which can be adequately protected by focused regulatory measures.

Further Reading

Reekie, WD (1995) *Health-care options for South Africa: Lessons from the UK and the USA*, Free Market Foundation, Johannesburg.

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