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THE KEY TO SUCCESS IN THE LATIN AMERICAN AND CARIBBEAN HEALTH INSURANCE MARKETS: MULTI-LAYERED, VALUE-ADDED REINSURANCE SUPPORT

by Edmund Santiago

In the last 10 to 15 years, new health insurance programs have proliferated in the Latin American and Caribbean regions. The reason for this boom has been, basically, the need for insurance companies to identify and implement new or additional lines of insurance business in order to match or exceed the increased numbers of competitors now working in these markets. This is combined with the stronger reinsurance capacity that these insurance companies had access to, which can be attributed to the need for increased reinsurance protection that arose a number of years ago, when many insurance and reinsurance companies were seeking larger volumes of businesses based on the expected growth potential of the region.

This growing trend has been mitigated more recently by mergers and acquisitions of many existing insurance companies, as well as by a significant reduction in reinsurance capacity. Negative factors, such as political uncertainty and more restrictive local legislations, have also influenced this downward trend resulting in many foreign insurers leaving the market once they realize that it is impossible to meet their initial expectations. On the reinsurance side, many new players and even those that initially expanded into the health reinsurance field, finally realize the need for a higher level of technical expertise in order to deal with the complexities of the region.

Today, only a handful of the old players remain in existence, although once in a while a new competitor arrives. This seem to indicate that there is now a better appreciation of the real potential of this market, as well as a positive awareness of the complexities of the region and of the level of technical expertise that is required in order to be successful in it.

Even though one would think that under these circumstances the market should be much more stable, the truth is that a threat is always present, especially when new competitors arrive, since for them the main objective has always been to obtain the biggest possible piece of the pie. Frequently, this has led to very aggressive pricing and marketing techniques which in turn may result in obtaining an insufficient level of business required to cover expenses and claims.

Since the basis for establishing successful health reinsurance programs in Latin America and the Caribbean seems to be directly linked to the ability of the reinsurers to provide effective, solid technical support, along with other individualized, value-added services to the insurance companies, to achieve this goal it is necessary, in our opinion, to briefly analyze the typical health insurance plans marketed today in this region, as well as to define what value-added services and support are required to launch and maintain successful reinsurance partnerships with those insurance companies.

A look at the typical underlying health insurance plan seen today in this region reminds us of the health insurance plans that were marketed in the United States 20 or 25 years ago. With few exceptions, some of the typical features found in these plans could be considered of a negative and anti-selective nature, such as weak or ambiguous policy language, poor or inexistent coordination of benefits provisions, ineffective exclusions and limitations, etc., although some of them have successfully

incorporated some modern features seen today in the U.S. health insurance market.

These plans typically have lifetime or annual maximum benefits between $1 and $2 million, although some of them could be as low as $500,000 dollars and as high as $5 million maximum benefits. The territorial scope is usually worldwide with deductibles and co-payments differing by local country versus the United States, in order to steer coverage to the local countries.

It is very common for these policies to include internal limits for certain conditions, as well as precertification requirements with a range of penalties if services are done either outside of the PPO network or without precertification. Managed care and cost containment features incorporated in these insurance plans are based mainly on the use of PPO networks in the United States as well as in some other specific countries. The most common types of negotiations with medical providers in many of these countries are based on a discount of billed charges. There are some countries where "per diems" as well as "wrap-around packages" are frequently used today. It is also common to use medical staff to review and audit medical bills as well as to monitor utilization.

Since a significant amount of the claim benefits are spent in the United States, pricing of these programs is usually done by blending U.S. medical utilization and cost factors with those of the specific country where the product is being sold.

Adjustment factors are developed and implemented for pricing models using historical data to reflect the differences in costs and medical utilization of the different countries with regard to the United States. These factors are also used to reflect differences in existing medical trends by countries, as well as to anticipate the effects of the underwriting cycles.

While there are many limitations, the reserving methodologies of the various insurance companies in this region have evolved over time and vary by company. The availability of more timely data, as well as technical expertise, allows companies to develop reserves based on completion factors generated from triangulations of claim data. Lately, more accurate experience studies have been made available to assist in the development of reserving models.

The need for reinsurance for these health insurance plans is generated by the high level of maximum benefit amounts included in these policies, as well as by the inability of some companies to write large volumes of business. Many insurance companies are seeking technical expertise and value-added services, such as assistance with the development of policy wording or sophisticated cost containment techniques to help them in establishing a successful portfolio of health insurance products. The level of support that should be available from the reinsurance company or its reinsurance manager, if applicable, usually includes actuarial services to assist in the development of pricing and reserves, underwriting training and manuals, assistance in quoting large cases, large claims management and cost containment, plan benefit designs, as well as assistance in the development of reinsurance reports and access to managed care services.

THE MOST COMMON TYPES OF NEGOTIATIONS WITH THE MEDICAL PROVIDERS IN MANY OF THESE COUNTRIES ARE BASED ON A DISCOUNT OF BILLED CHANGES.

As the level of support needed varies by insurance company; it is key for a successful outcome that the needs are identified and support is provided early on to avoid the erosion of profits. The ability of a reinsurance company or manager to effectively provide this support tends to protect its financial interest in the program. It also enhances and assists in the development of long-term relationships with the insurance companies.

The financial needs of the insurance company is a significant factor in determining the type of reinsurance coverage provided. It is very common for start-up programs to obtain a quota share arrangement up to amounts in the neighborhood of $50,000 or $100,000—combined with a risk-attaching specific excess of loss up to the maximum limit of the underlying policy. Companies with higher financial needs or more risk averse philosophies may request aggregate excess of loss to protect their exposure on the quota share side of the agreement, or they may seek arrangements with minimum and maximum premiums as two-tier aggregate reinsurance coverage.

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Companies with more mature programs tend to focus on maximizing their returns while protecting themselves from large deviations. These companies typically seek specific excess of loss coverage on a risk or non-risk-attaching basis with deductible levels starting at $50,000 up to $250,000. Higher and lower levels may be requested depending on the specific needs of each company.

THE AVAILABILITY OF HISTORICAL AND PRESENT DATA IS KEY FOR THE REINSURANCE PREMIUM RATE DEVELOPMENT OF THESE PROGRAMS.

Reinsurance companies that can offer all these coverage alternatives are in a stronger position to establish solid health reinsurance programs on a long-term basis. The availability of historical and present data is key for the reinsurance premium rate development of these programs. New reinsurance players may face different challenges as they grow. They must realize early on the need to develop comprehensive databases and technical expertise while their blocks of business develop and surpass the necessary thresholds in order to sustain expenses and claim costs. These challenges may force them to impose certain limitations to the reinsurance arrangements that they offer. Some of these limited schemes are: minimum and maximum reinsurance premium rates with significantly wide ranges, non-risk-attaching specific excess of loss coverage only, aggregate maximum of claims payable on the specific excess of loss coverage and no quota share arrangements being offered.

While utilizing these practices may provide added protection to the reinsurance risks, these measures may not be sufficient to satisfy the scope of protection that the insurance companies seek and expect from their reinsurers.

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To conclude, some of the key success factors tha contribute to the establishment of profitable health reinsurance programs in Latin America and the Caribbean include:

- The ability to adequately price the reinsurance programs;
- The ability to assist the insurance companies in the implementation of new programs or in the modification of existing ones;
- The ability to effectively monitor the existing programs and make corrections promptly when needed. ✹