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Medical Insurance in Latin America: Lessons Learned

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Introduction

I served as chief actuary for a medical reinsurance facility active in Latin America and the Caribbean from early in 1998 to early in 2001. At its peak, the facility managed about $30 million in medical reinsurance premium. Reinsurance support for the facility was withdrawn early in 2001. To the best of my knowledge, run-off liabilities are still being settled.

This article will document the lessons learned in managing the actuarial aspects of this facility. It will contain many clichés and most of the lessons documented apply worldwide, not just in Latin America. It is said that a smart person learns from his or her own mistakes, and a brilliant person learns from the mistakes of others. I hope to help readers move toward brilliance.

Universal Truths

Those who manage insurance programs can often forget the basic universal truths of our business. Managers of medical insurance programs are particularly susceptible to this challenge. Universal truths apply worldwide, but ignoring them can be particularly dangerous in developing economies such as Latin America.

We've all heard the saying: "Work expands to fill the available time". A similar version says, "Medical care expands to consume the available resources". Once a person is injured or ill and enters most medical care systems, there is no natural limit on the money that can be spent treating that person. Only standards of medical practice or limited resources can limit the treatment. Limitations on resources generally arise from limitations in medical insurance contracts.

In the U.S., we know that utilization of medical care increases dramatically when costs are covered by insurance. Insurance increases the resources available, and medical care expands to consume the available resources. International reinsurance can increase the resources available for medical care in developing countries. The result is exactly the same from a national perspective in developing countries. Medical care expands to consume the available resources. Thus, pricing reinsurance arrangements in developing countries based on historic utilization patterns is certain to lead to losses.

We also know that physicians control utilization of medical care. If maximizing care increases a physician's income (as in fee-for-service medicine), then controlling utilization of care is nearly impossible. Medical insurance programs must be designed and managed to the benefit of physicians as well as patients in order to control utilization. Nearly all successful managed care programs recognize this universal truth. In developing countries, physicians have even more control over utilization. Potential patients are plentiful. Thus, if a physician can maximize his or her income by maximizing the treatment provided, then utilization can not be controlled.

Finally, universal participation is required to make medical insurance programs viable. Just like Robin Hood robbed from the rich and gave to the poor, healthcare programs rob from the healthy and give to the sick. If the healthy don't participate, there's not much money to give to the sick. Developing countries in Latin America recognized this truth early on, and nearly all have laws requiring mandatory participation in healthcare plans. However, most of these countries are better at writing laws than they are at enforcing them. From a theoretical perspective, social healthcare plans in Latin America look much better than the system in the U.S. However, administration of these plans leaves much to be desired, and the result is even more adverse selection than we see in the U.S.

Latin American Challenges

Some of the challenges we experienced seemed to be unique to developing countries, and were certainly present in Latin America. The biggest challenge was the concept of WIN-WIN business relationships. Most of the people in Latin America believe that the international insurance markets, and particularly U.S. insurers, control all of the money in the world. In fact, they aren't too far from being correct. However, the idea that we were doing business in Latin America in order to make money was often lost on our clients. They seemed to think that we were there to give them money. Many seemed to view international business relationships as either WIN-LOSE or LOSE-WIN situations. They always wanted to make sure they were on the winning side.

We were challenged to design reinsurance arrangements that were WIN-WIN deals, and then sell them to our clients. In retrospect, a WIN-WIN medical reinsurance arrangement in Latin America is likely to look more like a financial guarantee than a risk transfer. Such guarantees can probably be designed to meet the requirements for reinsurance written into the law in many countries and still avoid contributing resources that are likely to expand medical care.

What About the Future?

Despite the challenges documented above, I'm still looking forward to reentering the medical insurance market in Latin America. Medical systems are still being developed to treat over 400 million people. That's a real challenge. When I do start working in the market again, I'll follow these rules:

1. Don't rely on past experience as a predictor for the future.
2. Make sure that physicians are on my side of the table.
3. Never close a transaction that doesn't look like a WIN-WIN deal.