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Chairperson's Corner

by Michelle Chong Tai-Bell

The results are in … Michael Gabon, Ronald Poon-Affat, and James Toole have been elected to our Council. As you can see from the following bios, the new members of our Council have been quite active as members of the SOA and of the International Section.

- ***Mike Gabon.*** Mike is a manager with KPMG Peat Marwick in New York. His major field of professional activity is in providing financial risk and reinsurance solutions for domestic and international life client companies. He has participated in numerous SOA activities having been a Financial Reporting Section panelist in 1996, a moderator/panelist for the 1997 Annual Meeting, and International Section Program Committee representative

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The Future of the Brazilian Health Market

by Ronald L. Poon-Affat

In the first week of June 1998, the Brazilian Senate passed the long-awaited Act that radically revises the regulation of the private health insurance industry. The importance of this passage should not be underestimated; the revisions will have an impact on a $17 billion (U.S) industry encompassing 1,400 registered health carriers, 233,000 physicians, and 41 million private health clients.

This is understandably a very complex piece of legislation, which is still being hotly debated (even as this goes to press). The intention of this brief article is to give a general overview of the reforms and to highlight some of the main challenges, that now face the health industry.

The intention of the legislation is to effect the following revisions:

- To standardize the "product" that the health industry sells
- To level the "reporting requirement" playing field of the various players
- To place the industry on a stronger financial footing
- To allow health carriers to gain direct access to the capital of foreign partners
- To put into place a facility that will allow the government to receive financial compensation in the event that a person with a private plan uses the government's services.

The following develops each of these points in more detail.

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Standardized Product

In the past there was a wide range of plans, with premiums ranging from R$20 to R$800 per month. Plans at the lower end offered inexpensive but very restricted medical attendance. Common deficiencies for the bottom-basement prices included limited length of stays for "in-patient" treatment (including treatment within intensive care units), the omission of treatment for all major organ transplants, lengthy initial waiting periods, and no protection in terms of holding technical reserves.

The politicians gained kudos for the elimination of the time restrictions, which were often applied to in-patient treatment, that is, many low budget plans limited the number of days that could be spent in a private hospital. The Minister of Health was reported to have said that selling health insurance with such in-patient limitations was akin to selling property insurance that protected your home for only the first hour of a fire.

The new law introduces five types of standardized plans, which all health carriers can offer. These plans have defined benefits and limited exclusions. They are (1) a wide ranging, all-encompassing comprehensive plan (plano referencial) and four distinct plans that provide treatment only in respect to (2) out-patient (ambulatorial), (3) in-patient (hospitalar), (4) maternity (obstétrico), and (5) dental (odontológico) benefits.

The law sets out the minimum benefits that must be offered under each plan. Companies may, of course, choose to improve their product and include a wider range of benefits.

Level Playing Field

My previous article ("Brazilian Health Industry," *International Section News*, June 1998) described the differences between insurance companies' plans (seguros saúde), the HMO-type plans (Medicina de Grupo), the co-operative association-type plan (Unimed) and the self-insured sector (Autogestão). In the past only the insurance companies had supervisory control under the Ministry of Finance. The new law puts all health carriers under the watchful eye of four supervisory authorities.

First, two bodies under the Ministry of Finance existed in the past:

- The Conselho Nacional de Seguros Privado (CNSP) or the National Council for Private Insurance
- The Superintendência de Seguros Privados (SUSEP) or Superintendent of Private Insurance.

Two newly created bodies now exist under the Ministry of Health:

- Conselho Nacional Saúde (CNS) or the National Health Council
- Conselho Nacional de Saúde Suplementar (CONSU) or the National Council for Supplementary Health.

So from the statutory point of view, not only has the field been leveled, it has also become much more complicated. The Ministry of Finance will deal with technical issues and the Ministry of Health will look after the on- going quality of service. As yet, the roles of each of these bodies have not been strictly defined.

Stronger Financial Footing

In the past, only insurance companies that sold health business (21% of the market—Seguros Saúde) were obliged to set up reserves, but only for unearned premiums and reported but unsettled claims; very few companies established IBNRs. The rest of the health industry was not required to establish such reserves; and the vast majority did not. The new legislation now necessitates that all health plans establish some reserves. This will include, at the very least, unearned premiums and reported-but-unsettled claims. SUSEP, the legislative body responsible for defining reserve requirements, is presently formulating its policy on IBNRs.

Access to Foreign Capital

Allowing health carriers to gain direct access to the capital of foreign partners fits in with President Fernando Henrique Cardoso's ongoing drive to "open up the economy to foreign investors." In the past, it was difficult, but certainly not impossible, to secure a financial interest and many international companies are already well established in the local health market—Aetna, AGF, AIG, Cigna, Allianz, Generali, HSBC, ITT-Hartford, and Prudential, to name a few. However the passage of this law will now make direct investment easier and allow up to 100% foreign investment.

Compensation for the Government Health Plan (Sistema Unico de Saúde (SUS) or Single Health System)

Under the new law, if a person with a private health plan receives treatment from a government facility, the government can seek financial reimbursement from the person's private health carrier. A database will be established that will compare the names of all Brazilians who have a private health plan with the names of those who are receiving treatment from a public facility. This is a bit of double taxing, because all tax-payers contribute to SUS. There are many cynics who say that this is the raison d'être for the change of legislation.

Some of the More Interesting Clauses

- Premiums cannot be "actuarially" increased for persons over 60 who have been in a scheme for at least 10 years. In respect to individual plans, this would seem to imply that one would then have to pre-fund the cost of actuarial increases by establishing mathematical reserves that could then lead to surrender values. Building up long-term actuarial reserves will certainly be a challenge, given the inavailability of long-term assets.
- As to pre-existing conditions, a health carrier has up to two years to ascertain whether a new client had a pre-existing condition that he knew about upon entering the plan, to decline coverage for such an illness. After two years has passed, the client is eligible for treatment even if he or she knowingly sought to deceive and stated that he or she did not having a pre-existing condition at the contract's inception.
- Waiting periods have been slashed. At one time, carriers offered plans with a wide range of initial waiting periods. Terms of up to 18 months were not uncommon for the less

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expensive plans. The maximum waiting period is now 24 hours for emergency treatment, 300 days for pregnancy, and 180 days for all other treatment.

- Inclusion of treatment for AIDS, major organ transplants and mental health illnesses. These were commonly excluded in the past. The new benefits are limited to the treatment of "full blown" AIDS (this does not include treatment of pre-AIDS antiretroviral medication) and transplants of kidneys and corneas. There is presently fierce lobbying taking place in an attempt to defer the introduction of these new benefits.

These points must be implemented quickly! The initial September 1998 date set out in the legislation has recently been pushed back to November 1998. This deadline mandates that all health carriers must submit actuarial technical notes for the five new "standardized" plans by that date, and they cannot sell "old" plans to new clients after November 1998.

Other Implications

Increases in Premiums

Increases in premiums is inevitable. The industry is saying that, on average, premium increases will be between 10% and 20%, but this is still a poker game and no one is as yet willing to show their hand. While one of the noble intentions was to give the Brazilian public a better health plan, the reality of the situation is that many will not be able to afford a new health plan.

Brazil has a population of 156 million, however only 41 million presently have access to a private health plan. This is due in large part to the poverty level, which is still quite high. Statistics showed that in 1995, only 10% of Brazilians earned more than $350 (U.S.) per month (three times the minimum salary). It is inevitable that these price increases will push access to private health plans out of the reach of many, which will then undoubtedly increase the demand for the government's already over-stretched health services.

The prices of the insurance companies' (Seguros Saúde) plans will probably not increase very much because these plans were already quite comprehensive and the pricing included the capital cost of establishing some reserves. The really hefty price increases are expected to be experienced by the clients of other health carriers, that is the HMOs (Medicina de Grupo), Unimed associations (Cooperativas), and the self-administered plans (Autogestão).

TABLE 1

	Number	Premiums $U.S. (Billions)
Self-Insure Groups (Autogestão)	300	5.1
HMO-Type Plans (Medicina de Grupo)	730	4.6
Cooperatives (Unimed)	320	3.7
Total	1,350	13.4

Less Players

The reserving requirement will require a large number of health carriers to establish reserves for the very first time within a five-year time period. Those health carriers (79% of the health market) that previously did not have to establish reserves are shown in Table 1. There will be many who will not have access to the required capital and it is predicted that there will be many mergers and acquisitions accompanied by the entry of new foreign capital.

Concluding Comments

A common misinterpretation in the local press is that the law changes the structure of health carriers. This is not technically correct. The new law only changes the "product." Clearly, some of the changes introduced point to making certain changes to the corporate structure, but such changes have not been mandated by the law.

The general mood is positive with the industry largely admitting that there are many positive aspects of the new law that will benefit both the consumer and the industry as a whole. Nevertheless, much doubt exists as to the exact interpretation of many aspects of the new law and a feeling that the time-frame for the implementation of the new plans is too short to achieve a seamless transition.

If you would like to receive a complete copy of the legislation translated into English, please feel free to contact me at raffat@colognere.com.

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