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Impact of Deductible on Group Health Insurance in Pakistan

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CASE STUDY

Introduction

Health insurance is a type of insurance against the risk of incurring medical expenses among individuals. According to the Health Insurance Association of America, health insurance is defined as "coverage that provides for the payments of benefits as a result of sickness or injury. It includes insurance for losses from accident, medical expense, disability, or accidental death and dismemberment". Depending on the type of health insurance coverage, either the insured pays costs out-of-pocket and is then reimbursed, or the insurer makes payments directly to the provider. In health insurance terminology, the "provider" is a clinic, hospital, doctor, laboratory, health care practitioner, or pharmacy. The "insured" is the owner of the health insurance policy; the person with the health insurance coverage.

Usually, a health insurance policy is a contract between an insurance provider (e.g. an insurance company or a government) and an individual or his/her sponsor (e.g. an employer or a community organization). The contract can be renewable on annual basis in the case of private insurance, or be mandatory for all citizens in the case of national plans. The type and amount of health care costs that will be covered by the health insurance provider are specified in writing, in a member contract or "Evidence of Coverage" booklet for private insurance, or in a national health policy for public insurance. The individual insured person's obligations may take several forms as;

- Premium: The amount the policy-holder or their sponsor (e.g. an employer) pays to the health plan to purchase health coverage.
- Deductible: The amount that the insured must pay out-of-pocket before the health insurer pays its share. For example, policy-holders might have to pay a $500 deductible per year, before any of their health care is covered by the health insurer. It may take several doctor's visits or prescription refills before the insured person reaches the deductible and the insurance company starts to pay for care. Furthermore, most policies do not apply co-pays for doctor's visits or prescriptions against your deductible.
- Co-payment: The amount that the insured person must pay out of pocket before the health insurer pays for a particular visit or service. For example, an insured person might pay a $45 co-payment for a doctor's visit, or to obtain a prescription. A co-payment must be paid each time a particular service is obtained.
- Coinsurance: Instead of, or in addition to, paying a fixed amount up front (a co-payment), the co-insurance is a percentage of the total cost that insured person may also pay. For example, the member might have to pay 20% of the cost of a surgery over and above a co-payment, while the insurance company pays the other 80%. If there is an upper limit on coinsurance, the policy-holder could end up owing very little, or a great deal, depending on the actual costs of the services they obtain.
- Exclusions: Not all services are covered. The insured are generally expected to pay the full cost of non-covered services out of their own pockets.
- Coverage limits: Some health insurance policies only pay for health care up to a certain dollar amount. The insured person may be expected to pay any charges in excess of the health plan's maximum payment for a specific service. In addition, some insurance company schemes have annual or lifetime coverage maxima. In these cases, the health plan will stop payment when they reach the benefit maximum, and the policy-holder must pay all remaining costs.
- Out-of-pocket maxima: Similar to coverage limits, except that in this case, the insured person's payment obligation ends when they reach the out-of-pocket maximum, and health insurance pays all further covered costs. Out-of-pocket maxima can be limited to a specific benefit category (such as prescription drugs) or can apply to all coverage provided during a specific benefit year.
- Capitation: An amount paid by an insurer to a health care provider, for which the provider agrees to treat all members of the insurer.
- Network Provider or Panel Hospital: A health care provider on a list of providers preselected by the insurer. The insurer will offer discounted coinsurance or co-payments, or additional benefits, to a plan member to see an in-network provider. Generally, providers in network are providers who have a contract with the insurer to accept rates further discounted from the "usual and customary" charges the insurer pays to out-of-network providers.
- Prior Authorization: A certification or authorization that an insurer provides prior to medical service occurring. Obtaining an authorization means that the insurer is obligated to pay for the service, assuming it matches what was authorized. Many smaller, routine services do not require authorization.
- Explanation of Benefits: A document that may be sent by an insurer to a patient explaining what was covered for a medical service, and how payment amount and patient responsibility amount were determined.

Group Health Insurance

Group Health insurance is a type of health insurance in which the policy holders are groups (large organizations/employers of different industries) instead of individuals. Majority of health insurance available in Pakistan is provided to the groups by the insurance companies. There are a lot of pros and cons of providing the benefit on a group basis. Usually, the administration becomes easy for the insurance companies as they contact and deal only with only person or department in the company to finalize the matters of coverage, premiums, exclusions etc. Usually, the following benefits are covered in group health insurance in Pakistan;

Hospitalization Cover

The hospitalization cover in a Group Health Insurance Policy covers the following;

- Daily Room Charges
- Operation Theatre Charges
- Surgeons/ Consultant's fee
- Anesthetist fee
- Pharmacy/ Surgical Items
- Pre-admission and Post-hospitalization Benefits
- Day Care Surgeries;
- Diagnostic Tests
- Dialysis, MRI, CT Scan, Endoscopy, Thallium Scan, Angiography,
- Treatment of Fractures & Lacerated Wounds,
- Local Road Ambulance
- Dental Treatment due to Accidental injuries etc.

Maternity Cover

The coverage of maternity benefits includes the following;

- Gynecologist's fee
- Labor Room/Operation theatre charges
- Anesthetist fee
- Miscarriage, D&C
- Medicines or Drugs
- Diagnostic tests
- Baby's Nursing Care
- Circumcision of baby boy up to a specific limit

Outpatient Cover

The coverage of OPD benefits includes the following;

1. Consultation Fee paid to a Registered Medical Practitioner (General Practitioner / Specialist)
2. Prescribed Medicines
3. Prescribed Lab and Diagnostics Tests
4. Prescribed physiotherapy
5. Pre natal and post natal consultations and tests
6. Dental Treatment
7. Optical Treatment

Background Of The Case

There are a lot of factors which play an important role in the determination of loss ratio of health insurance segment of any company. The two most important are;

- Frequency OR Incidence Rate
- Severity OR Average Claim Cost

Frequency (Incidence Rate)

The incidence rate in group health insurance depends upon many factors. Most important of these are the following;

- Type of coverage (Hospitalization or maternity or OPD)
- Health Status of members
- Ages of the covered members
- Industry of the group

Usually, the frequency of claims (incidence rate) ranges from 5% to 20% in case of hospitalization while 15 to 35% in case of maternity coverage. It is important to mention that incidence rate of maternity is determined from female married employees/spouses of the group only. The pattern of OPD varies depending upon many factors.

Severity (Average Claim Cost)

The severity of loss depends upon the final bills prepared for each treatment. This loss has direct relationship with the medical inflation and changes of hospital rates on year to year basis. Better are the controls in the hospitals for effective treatments and on wastages, better will be the average claim cost. Some treatments require few days' admission while serious illnesses require more day's admission and costly treatments. Example of economical treatments are conditions like acute infections like gastrointestinal infections etc. while examples of costly treatments include of Cancers and Ischemic Heart Diseases (Angioplasties and Heart Bypass etc.).

Moral Hazard in Health Insurance

It is very important to mention that moral hazard is considered to be an important factor in health insurance all around the world. It is attributed to be responsible for 5 to 15% of the loss ratios in various countries of the world. This moral hazard works in many ways and one of these is the admission of the patient in the hospital that would be possible as on OPD basis. Therefore, the hospitals and treating doctors consider themselves sympathetic to the patients and admit those cases that would recover otherwise at homes by using appropriate medicines. These cases contribute towards bad loss ratios of the

insurance companies all around the world.

Key Parties

Alfalah Insurance has been providing group health insurance services to various groups of the country since year 2008. These groups belong to different industries and are of various sizes as far as number of employees are concerned. The insured members in these groups are sometimes employees only and at other times, the spouse, children and parents as well in addition to the employees. Some of the groups opt for hospitalization benefit only, and at other times they take the maternity cover along with the hospitalization. There are few groups who get interested to opt for the OPD benefits in addition to hospitalization and maternity benefits.

The usual mechanism of treatment works as cashless basis for hospitalization and maternity benefits while majority of the members get the reimbursement of bills in case of OPD coverage.

Implementation of Deductible in Group Health Insurance

Considering various factors that have impact on the frequency and severity of health claims, Alfalah Insurance took an initiative in year 2010. Although, deductible was not a norm in Pakistan's Health Insurance Industry, the company introduced a deductible in one of its group health insurance policy that covered more than 25,000 insured members all across Pakistan. The characteristics of the deductible were as;

1. It was introduced on hospitalization coverage only and not on maternity or OPD coverage.
2. Rs:2,000 was the share of insured member that he must have paid out-of-pocket before the company paid its share.

Impact of Deductible in Group Health Insurance

Although, it was not an easy decision to implement the deductible considering market practices, however, response of the client was encouraging. After one year, following results were obtained;

1. The incidence rate of hospital claims decreased to 8.47% in comparison to 9.98% of the previous year. This ultimately caused a decrease of around 15% number of claims expected for the same number of insured members. It was quite significant for the company as every claim incurs certain cost that in turn leads to the loss ratio.
2. The decrease of Rs:2,000 in each bill contributed towards downward trend of average claim cost. It ultimately did not rise much considering the medical inflation prevalent at that time.
3. The client got the monetary benefit of around Rs:30 Million in 3 years due to implementation of this deductible directly and indirectly. This ultimately helped the client towards reduced premiums and decrease in the trend of increase in medical insurance premiums every year.

Conclusion

Health Insurance is considered to be a segment of loss by most of the insurance companies. The acceptable loss ratio varies from 80 to 110% all over the world. There are many factors that make this segment not an attractive product for the insurance companies in Pakistan. However, there are many ways to see the picture. It may contribute towards the top line of any company. Moreover, it may open the door for other segments of insurance for the insurance company as well. In addition to considering all these factors, it is a challenge to make this product a profitable line of business for the insurance industry. It can only be possible by prudent underwriting and loss mitigation programs by the insurance company.

Prudent Underwriting

Following factors may help to any company to underwrite this class of business prudently;

1. Proper Understanding of Risk
2. Charging appropriate premium according to the risk
3. Setting terms and conditions appropriately according to size of group and risk
4. Relationship of group size on incidence rate
5. Relationship of deductible on incidence rate

Loss Mitigation

Following factors may help to any company to mitigate the health insurance losses;

1. Proper Understanding of Treatments
2. Proper Understanding of Hospital Rates
3. Careful approach in setting the hospital rates during empanelment or rate revision
4. Proper check on treatments while patients in hospitals
5. Careful scrutiny of the reimbursement bills by personal verifications
6. Competent team for processing of bills according to agreed rates or identification of doubtful bills.

References

- Wikipedia & Chartered Insurance Institute