미국 개인의료보험의 리스크관리

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Individual Medical Insurance : USA

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Health Insurance is a wide terminology, involving four major areas Long-Term Care, Critical Illness, Disability Income, and Medical Expense with either Fixed Benefit plan or Reimbursement plan. Out of those areas, this paper reviews the Medical Expense Insurance with Reimbursement plan, as is prevailed in USA. The US Medical Insurance could be characterized into the various aspects, but this paper focuses on Trend and Risk Management, which could influence, most essentially, the Underwriting Cycle of Insurers.

Universally, Private Medical Insurance is subject to the followings.

- Information asymmetry — Insureds have more information about their health than Insurers do.
- Higher volatility in claims experience than typical life risks — This is due to higher "adverse selection" and "moral hazard".
- Higher social risks — This product will probably have more complaints than the other insurance products from the consumers. Over a period of time, my guess is that the Private Medical Insurance will be viewed as the most important among all insurance products by the consumers.
- Higher political risks — Because over a period of time, when the country grows wealthier, this product will be viewed as a "need" by the consumers, they tend to have a tendency to be compared to Social Medical Insurance (although it's wrong to do so in principle). This product will be subject to more regulations i.e. disclosure, fairness in premiums, discrimination between sex and "disadvantaged" consumers, increase in premium regulations etc.

The 4 major points specified above are the particular characteristics for the Medical Expense Insurance and should be considered crucially in Product Design, Pricing, U/W and Claim Risk Management, Marketing, Trending, and Reserving.

Unlike any other OECD countries, the Private Health Insurance is dominant in the US. In opposite, Government plan prevails for Korea's Health plans, and Private plans are fairly limited just as a Supplemental role. Government policy is so oriented to prevent expansion of Private Health plans. Then, Individual Medical products in Korea should be developed to reflect such particular market situation, otherwise would face unfavorable results.

In terms of Public and Private Health plans, there are a number of models for the mixed types, which can be mainly distinguished by intensity of public coverage. Compared to other OECD countries, Korea is in a fairly low level of public coverage roughly as 51.5%. The major Health Care funding is from mandatory premiums that Nationals pay by their level of income, and no risk adjustment is considered. Also, the dependant criteria are too generous, which results in higher claim costs from seniors.

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As for the consumption of public funding, the cost curve is so skewed that the major portion (about 70% of total cost) is spent just to cover minor coverage, depleting funding for catastrophic illnesses. This takes away the essential needs of people in Health coverage, which has been a severe problem for people and significant social issue for decades. In this context, the role of Private Health plans is emerging, expecting to resolve this issue.

Moreover, Health Care costs keep rising rapidly and also in its size. No wonder this type of Government funding mechanism causes a severe Health Care budget deficit, and in Korea, extra funding has been raised by levying higher taxes, increasing financial burdens of people. Effective use of funding and resource allocation is desperate.

Secondly, it is so important to identify various types of risk involved in developing new Medical product. Especially, in Korea, not only Insurers' networks with providers are not permitted by law, but also Insurer's intervention over providers' billings and services is fairly restricted except for extreme cases. The severe concerns for Insurers are invoked given the characteristics of medical market more exposed to moral hazard issues, anti-selections, and medical service abuse tendency.

Unlike US, Medical management like utilization review, pre-certification, case management, and etc. can not be performed under the current law. This is a major risk Korean medical community is facing and contemplating for resolution. Therefore, Insurers should assume the supply side risks given the market situation and accept them unwillingly if they want to be in the business. Otherwise, they should seek the other way to control the cost by demand side for better risk management.

In the plan design perspective, Co-pays, Deductibles, Coinsurance, Life time max, OOP max, and stop loss level are appropriately determined to hedge the major underwriting risk. It should be emphasized that these plan design elements mainly server marketing purposes, not for utilization control easily misunderstood. But this concerns marketing and sales. If the design is too tight, it may lead to low sales and falling short of goals. So, the optimal design should be made to meet the needs of both risk management and sales. Underwriting applications should also be well designed to avoid anti-selections, and physician statements should be attached.

This applies to the pricing in the same way. Medical consumption keeps rising extremely fast, raising medical cost level significantly. Especially, the medical technology advancement is one of major drivers for the rising cost. This factor should be quantified and embedded in the pricing.

The following table shows the list of driving factors and their weights used for this project.

Trend Factors — Medical Trend	Weight (%) of Increase 100%
General Inflation (CPI)	17%
Drugs, Medical Devices & Advances	17%
Rising Provider Expenses	14%
Government Mandates & Regulation	18%
Increased Consumer Demand	14%
Litigation & Risk Management	10%
Others – Fraud, Abuse, Misc	10%

More weights are given to the risk management, fraud, and abuse, considering the particular medical environment of Korean market.

In both design and pricing, the US adopted "Consumer Driven Health Care" system in 2003 to control the skyrocketing health cost. This system itself may not directly fit into Korea, but the concepts are highly useful in mitigating supply side risks prevailing in Korea.

This concept is applied to produce the medical savings type of product. The fixed amount of money is flexibly determined by the insured, and he/she pays this amount as level gross premiums throughout the terms (usually less than 5 years). By payment cycle, the risk premiums are deducted from the level gross premiums, and the rest is deposited to the savings accounts managed by the Insurers. The savings grow by the fixed interest rate, usually above the market rate and provide protection against future catastrophic illnesses.

Finally, marketing is a crucial part of process. As learned from the US experience, an appropriate marketing channel for this product is selected. For this medical product, the most appropriate channel is selected, that is "face-to-face" agent channel. The compliance risk is high for this product, since this is to sell medical products involving complicated medical terms. Unless customers understand fully the terms and provisions, Insurers may be confronted with legal issues. Also, to minimize moral hazard issues, we should segment markets by targeting prospects above a certain level of income.

In conclusion, Trend and Risk management play the significant roles in keeping Insurers being solvent. The sound financial management comes from a solid understanding of the Medical Insurance peculiarities, and those are addressed as major points in this paper.

The medical trend factor is based on evaluating the historical claim trend levels and then projecting changes into the future. Risks to this trend assumption include unit cost increase (contract changes) greater than expected, higher utilization than expected, and unexpected technology changes that increase unit costs.

Therefore, the profits are very sensitive to this trend miss. The following initiatives are usually taken to keep the profits to the expected level.

■ Expense reduction initiatives — Originally assume % of premium to cover SG& A expenses. While many of the sales expenses (such as producer or broker commissions) are fixed, there may be ways to control administrative expenses to offset the medical cost increase.

■ Contracting initiatives — While some contracting initiatives may come in unfavorable to original expectations, it may be possible to establish a targeted strategy with the remaining providers and/or facilities yet to be contracted to mitigate the emerging medical cost. This may be more of a forward-looking initiative, however, as many times contracts signed in a given year do not go into effect for a couple of months.

■ Medical Management Initiatives — Any higher-than-expected utilization should be analyzed to determine if there are possible actions that can be implemented to control utilization.

The Medical Management refers to a broad array of practices used to improve quality and reduce cost. It usually involves the following components.

- **Prevention**
  Programs directed at preventing disease or its consequences through early detection and management. Primary, secondary, and tertiary prevention are identified.

- **Utilization Management**
  Programs directed at monitoring services for necessity, appropriateness, and efficiency to reduce cost by decreasing unnecessary or inappropriate services.

- **Patient Advocacy**
  Programs to coordinate, monitor, and evaluate services for members with high-cost Medical conditions to improve continuity, quality of care, and lower cost.

- **Disease Management**
  Programs focused on managing a defined set of diseases or conditions across all settings of care with emphasis on prevention and maintenance.

- **Reporting**
  Programs focused on reporting financial, utilization, or clinical data for monitoring, managing, and improving quality and efficiency of care, while decreasing practice variations. e.g. provider profiling report cards, pay for performance.

- **Coding**
  Programs focused on evaluating and managing provider billing practices to identify miscoding, upcoding, unbundling, and other inappropriate or fraudulent activities with the intent of recovering funds and educating providers on accepted coding standards.