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How Private Insurance Plans Can Meet the Demographic Challenge—Insights from the 10th Health and Ageing Conference

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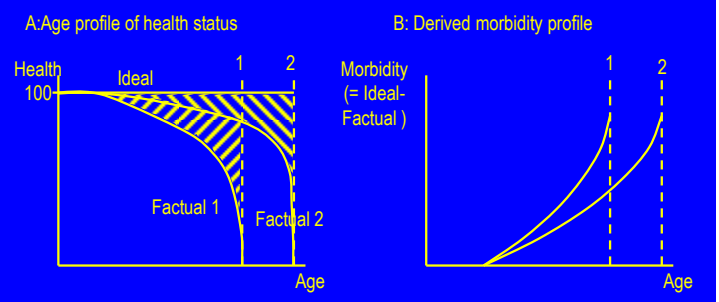
On 18–19 November 2013, The Geneva Association organised its 10th Health and Ageing Conference on the theme of "Insuring the Health of an Ageing Population". About 60 participants from Asia, Europe, and the United States enjoyed the exquisite hospitality of SwissRe at its Center for Global Dialogue in Rüschlikon near Zurich.

Carol Jagger (Institute for Ageing and Health, Newcastle University, U.K.) opened the conference with an introduction to the epidemiology of ageing. Over the past 50 years, there has been a *rectangularisation* of health status as a function of age (see the shift from "Factual 1" to "Factual 2" in Panel A of Figure 1). This shift indicates that people live longer, remaining (almost) perfectly healthy up to a higher age; their health status deteriorates only very shortly before their death (where it is zero by definition). The lower hatched triangle shows the number of healthy life years gained over time. This author complemented the picture by the hypothesis that the ideal of (Western) man is *perfect rectangularisation*: "Be 100 percent healthy, then drop dead when the time has come." Since the gap between "ideal" and "factual" then reflects morbidity, the healthy life years still lost are represented by the hatched upper triangular area. The historic development of this gap is shown as the morbidity curve in Panel B of Figure 1. For an economist, the prediction follows that individuals will seek to minimise this gap in their attempt to approach the ideal of *perfect rectangularisation*. The consequence is that health-care services are increasingly employed to bridge the gap especially at higher ages. Because it is maximum just before death, another prediction follows, viz. that health-care expenditure (HCE) is highest just before death. Comparing "Factual 1" and ,Factual 2" in Panel B of Figure 1, one also sees that the concentration of HCE during the last few years or even months of life will become even more marked in future.

Fig. 1. **Ideal health profile and the derived morbidity profile**



1 = Factual profile of the past; 2 = Predicted factual profile if current trends continue into the future

Since HCE of this type often does not amount to sensible "investments in health", insurers both private and social are confronted with the challenge of creating incentives for old individuals to save on HCE. Through its Medical Savings Accounts, Singapore has achieved just that, as argued by Kelvin Bryan Tan (Singapore Ministry of Health). Citizens pay between 7 and 9.5 per cent of their labour income for mandatory health insurance. However, those who do not present a claim obtain a personal bonus, which they can bequeath to their children. This is in contra-distinction with the United States, where medical savings accounts can only be used for financing HCE, creating a strong moral hazard effect just prior to death (where it is least wanted).

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New solutions by private insurance

Laure de Montesqieu (SCOR, Paris) opened the second part of the conference, which was devoted to new solutions developed by private insurance. She underscored the poverty risk confronting elderly people who are in need of costly long-term care (LTC). Yet, in the United States, LTC insurance covers a mere 7 million (of 314 million) individuals. By way of contrast, LTC insurance in France saw rates of growth between 15 and 20 per cent until 2006, resulting in an enrolment of 7 million (of 66 million) consumers. While the reasons for this recent stagnation remain unclear, the early success of LTC insurance seems to be due to a combination of life and LTC coverage. Put somewhat bluntly, a person who dies prematurely causes a loss under the title "life", while a person who dies "too late" causes a loss under the title "LTC". Since everyone dies just once, the two lines of insurance are uncorrelated or even negatively correlated, permitting the insurer to calculate a reduced premium for a combined policy. This effect can even be strengthened thanks to improved risk information. This was illustrated by Peter Banthrope (RGA, London), using colon cancer as the example. This type of cancer results in a modified survival curve, similar to "Factual 2" rather than "Factual 1" in Panel A of Figure 1. The shortening of remaining life expectancy means that the pension insurer has to come up with fewer payments. This allows RGA to increase the annual pension, creating welcome support to patients who have acute financial needs. However, for this innovation labelled" "impaired life annuities", three challenges had to be met. First, the conditional survival curve hat to be calculated; second, it had to be extrapolated into the future, taking account of technological change in medicine; and third, multimorbidity risk had to be estimated. RGA evidently was capable of meeting these challenges. For smaller private pension insurers, it might be advisable to seek the cooperation of (social) health insurers who can furnish multimorbidity data. In a similar vein, John Schoonbee (SwissRe) presented a possibility of offering older consumers premiums they can afford. It consists in writing indemnity coverage of heroic interventions that typically occur shortly before death. HCE exceeding the indemnity limit then falls on the insured, who (along with service providers) may be led to ponder the meaningfulness of these interventions.

Successful private health insurers in the United States

The concept of *managed care* originated in the United States but met with strong backlash by providers and consumers in the 1990s. As explained by Diana Dennett (America's Health Insurance Plans, Washington DC), it has been reinvigorated as *coordinated care*. Through limiting provider choice to physicians and hospitals with a "reasonable" practice style, private health insurers have been able to successfully take part in Medicare Advantage (also known as Medicare Part C) which complements Medicare, the public health insurance scheme for the over 65-year old. Competing for members, private insurers have increased their market share from 12 per cent in 2003 to 28 per cent at present. They are legally obliged to cover Part A (hospital services) and Part B (ambulatory care) at least as generously as public Medicare itself. In return, they obtain a contribution from federal government which depends on risk characteristics such as age and sex but also 171 pre-existing health conditions. The idea of this risk adjustment is to neutralise the incentive of competitive insurers to skim the cream.

In conclusion, this conference featured valuable contributions from around the world. One would hope that not only private insurers in other countries but also their social counterparts (who usually obtain most of the funds in terms of contributions) will be inspired by the innovations presented. Even though *rectangularisation* and improvement of health status are likely to continue, the number of people in need of LTC is certain to increase. Insurers as well as policy makers would be well advised to prepare for this future already today.