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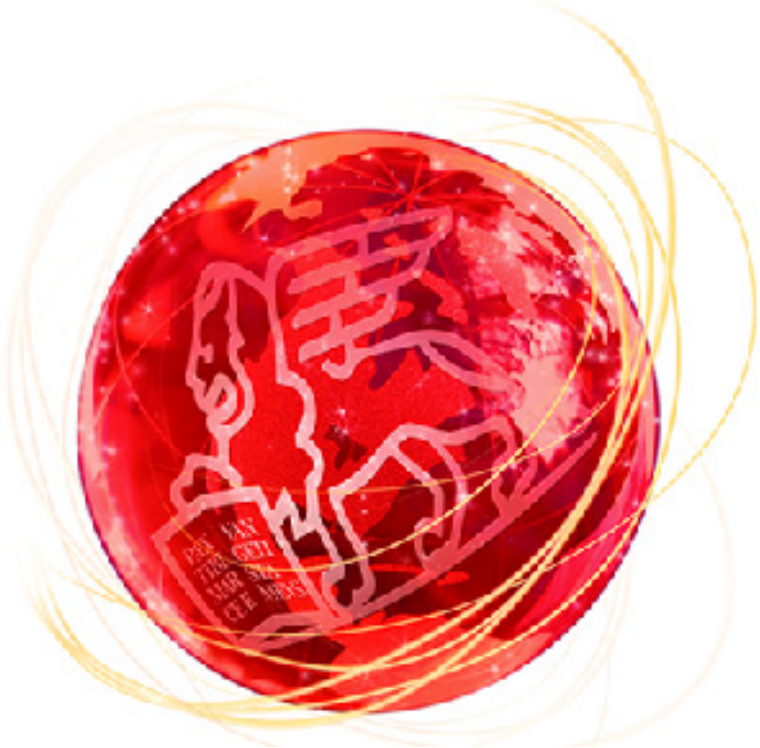
GEB News

October 2013



Special Edition - Healthcare

Generali Employee Benefits

Local protection, global connection

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Employee Benefits Network - GEB

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Editorial

Dear Clients, Partners and Colleagues,

We are pleased to release our second special edition of GEB News.

After our first special issue on captives*, we wanted to dedicate our second special edition to what is probably the most important driver shaping the entire Employee Benefits industry today: healthcare.

Globally, funding and delivering healthcare benefits have become critical challenges for employers, benefits providers and insurers: from highly sophisticated, established economies to fast-growing developing markets, healthcare costs and premiums rise every year.

- In most countries, state benefits are decreasing, shifting the burden of healthcare costs to individuals and their employers, thus widening the scope and importance of private medical insurance.
- Sophistication in medicine and new technologies are increasing the costs year by year for the industry, translating into premiums increase for both companies and their employees.
- Globalisation means that an ever growing number of corporations are entering new or "emerging" markets. Likewise, insurers are following this trend, enlarging their global footprints and increasing their penetration in each of these markets. In most of these countries, healthcare is the main customary benefit and accounts for over 80% of total employee benefits packages.
- Globalisation also means an increasingly mobile workforce, seconded to short or long-term assignments. These global employees have different – and demanding – needs in terms of benefit design and network solutions.

Healthcare currently makes up nearly 40% of the total premiums in our portfolio, and we foresee an increase of up to 50% in the coming years. GEB established its dedicated Health Centre of Excellence three years ago to help the local carriers better understand the particularities of the business. We are proud to dedicate our resources to our clients to support them in managing trends and cost drivers within their global health portfolios more efficiently.

*The special edition on Captives is available on our website at www.geb.com.

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Our new healthcare dashboard (a unique global reporting solution within the market) is one of the tangible assets of our strategy to deliver a state-of-the-art range of benefits solutions, along with competence and dedication to our customers. I would like to take this opportunity to thank the long-term clients who helped us design and continuously improve our medical reports.

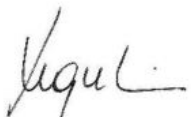
From the first article written by Generali Group's Head of Strategy and Business Development, you will see that – following the experience of GEB – the Generali Group decided to invest in this growing sector with the aim to become the preferred provider of health insurance.

This special edition will touch on some of the key components and the latest trends in healthcare: sales, underwriting, servicing and reporting for both local and mobile employees with a final complementary view on assistance services.

We hope that our special edition on the evolving issue of healthcare will provide you with insight on some of the medical trends across the globe and the tools and products available to reduce the burden of healthcare costs and make smarter decisions about corporate healthcare and wellbeing.

As usual, you can count on us!

Best regards,



Mauro Dugulin
CEO, Generali Employee Benefits

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Generali Group: committed to Healthcare

New Generali group strategy

On January 14 this year, the Group officially announced its new strategy to the financial community. While Generali was successful in the past with a decentralised organization, the goal of the new strategy is to turn Generali into a global insurance group which operates successfully in international markets and provides best-in-class products and services to its customers. Key to this strategy is the focus on Generali's core insurance business and client centricity. Its execution started at an impressively fast pace in late 2012 with several key Group decisions: the introduction of the new international management structure in October, the decision in December to reinforce the Group's Italian operations, the full takeover of the shares in the Czech Generali PPF Holding at the beginning of January and the recent operation to take full equity control of Generali Deutschland Holding. Key strategic pillars have been taking shape and are leading the Group along a substantial three-year transformational journey, built on 16 important Group strategic projects with clear governance, scope and aspirational targets.

Global Accident & Health (A&H) insurance as one of the strategic projects is a highly important focus area for the future of Generali. While we already have a sizeable portfolio in many countries, in the past we may not have brought the full global weight of the Generali Group into this business. This is changing, with a substantial management focus and increasing support of our Global Accident & Health ambitions. This includes not only putting Generali on the global map as a health insurer, but also building up substantial expertise and people in this specific area. We are also making more of our extensive expertise in mature markets to support our global ambitions by facilitating a know-how transfer and devising better ways to use synergies. With this approach we will enable our clients, especially in the corporate sector, to better understand their risks and to more efficiently manage their covers. With our regional and local specialists and investment in IT platforms, we will be able to provide expert support to our clients in this highly specialised area that is so important for the well-being of their employees.

As part of our strategy in A&H, we also are expanding our geographical presence in order to service and provide our international clients with the same high standards on all continents. For example, we have created a strong dedicated regional hub for A&H in Asia which will feature actuarial and technical functions necessary to support the local operations with a high level of expertise. This bold investment of Generali is testament to the Group's commitment to deliver its global ambitions in A&H. Similar efforts will also apply to CEE and Latin America. We also initiated steps to expand the number of countries in which Generali actively has a presence in health insurance, as many of our clients and their brokers request these services from us as a known leading insurer in Europe.

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Accident & Health: the growth driver of this century

A&H is one of the true growth drivers of this century: rising standards of living and an ageing population result in a strong demand for health insurance in all of its variations, from Accident and Medical insurance to Long-term care. Governments will not be able to provide sufficient, quality cover to satisfy the demand, leaving a huge, albeit country-specific demand for the insurance industry to address.

Trends

What trends are we seeing worldwide? Generally, the quality of health services is getting more public scrutiny. The acceptance of perceived sub-standard health service is clearly declining, alongside a public that has greater access to information than ever before. Public health services in particular are struggling with this new type of informed and demanding "customer". While private health insurers can generally provide the coverage to achieve a much better service experience for the customer, special care has to be taken to balance health insurance products between providing the best service possible and providing the medical treatment actually necessary. The fine line between medical efficiency and negative perception of service requires not only medical expertise of the insurer but also sensible network management and a high degree of transparency.

We also see covers in private insurance systems expanding in some regions and countries, but as stated above often not at the quality level that customers expect. In other regions and countries, austerity (especially in Europe) and the decline of commodity prices (emerging markets) means lower public spending power available for health.

Some of the most dramatic changes over the last year have involved technology. These changes extend beyond the known advances in medical technology, which have been large cost drivers and which generally have not delivered much impact on cost savings so far. Rather the more notable change is the technology available to consumers. For a reasonably small cost, applications for smartphones have enabled consumers to take a more active role in managing their health. As this technology becomes more sophisticated, a stronger integration with health insurance will bring rewards to all participants. For example, Generali Germany developed a smartphone application for individuals with diabetes that allows customers to monitor blood glucose levels and provides them with a personal coach to actively manage their health.

There is also a notable demand for wellness offers. Although, it remains to be seen if this is a genuine, large-scale trend or just an additional benefit in the war for talents.

Risks and benefits for companies

Providing health insurance for employees is going to become both a challenge and a benefit: a challenge, as medical trend drives costs and employee expectations higher. Companies will need a professional partner with expertise who can provide transparency on claims and support to actively manage these costs. Since medical trend is generally double normal consumer price inflation, this will be a central issue shaping the industry.

For companies, healthcare is also a benefit that positively impacts staff loyalty and productivity, especially as medical covers evolve and the company can follow a tailored approach to better manage the health of their employees.

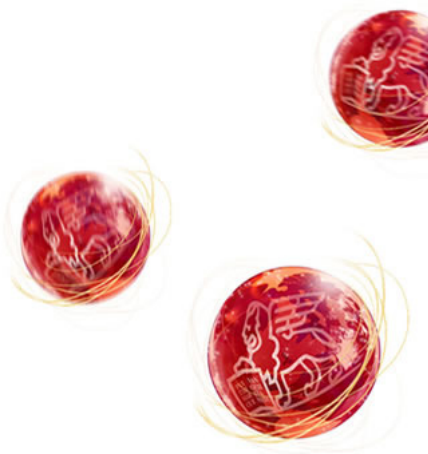
Besides the big drivers, what is currently missing is the element of prevention in public health systems, despite this being one of the areas of highest relevance for employers. Often, small changes can ensure that the workforce keeps the level of productivity and has lower absenteeism. Having measurable and short-term outcomes like this is key to a strong industry-wide implementation of prevention initiatives.

Takeaway

Generali's strategic ambition in group health is to be the preferred provider of health insurance by supplying our partners in HR and CFO departments with superior service, expertise and transparency to help them meet their needs. Generali is committed to this ambitious goal and will continue to dedicate its resources to this growing sector.

Giovanni Giuliani, Head of Group Strategy & Business Development at Assicurazioni Generali S.p.A.

Christos Stavrianidis, Ph.D., Group Strategy & Business Development at Assicurazioni Generali S.p.A.



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Complexities of Global Medical Risk – Looking for Cost Drivers

We all know that multinational companies are experiencing rising costs associated with Private Medical Insurance (PMI) across the globe. These increased expenditures are only partially due to the effects of readily understood components of Medical Trend: inflation, new medical technologies, an aging population and an increasingly sedentary lifestyle, to name a few. But the issues are actually more complicated than that. While vigilant employee benefits managers may be aware that rising costs are also due to the increasing scope of private cover purchased on behalf of employees and their dependents, not everyone fully understands this trend, nor are they arming themselves with the kind of data to help them consider the most effective initiatives for mitigating underlying cost drivers.

Many consultants and advisors are promoting simplistic, plug-and-play "wellness programs" that seem sensible from board rooms in North America or Europe, but the savviest of managers know that cost drivers in PMI can vary dramatically from country to country. This is partly based on demographics and local / regional burdens of illness, but largely based on how the local interplay of Public and Private Health Systems are changing.

"Supporting the overall well-being of our employees is of utmost importance to us at Coca-Cola. Having partners who can provide us with sophisticated analytics for growing trends specific to geographies around the globe, as well as, our own workforce in aggregate, managed in a completely confidential manner, is invaluable. It allows us to understand and tailor programs to meet the needs of our global population in a more efficient and effective manner than we would be able to do otherwise. Given the growing cost of health care and the aging population across many parts of the world, we find tremendous value in this type of strategic thinking from our global providers."

Stacy Apter

Director, Global Benefits Financing & Asset Management

The Coca-Cola Company

What PMI Products actually cover in any given country depends a lot on how the local Public Health System is structured and administered, as well as real and perceived notions of quality in that Public System.

Some countries effectively have what are known as staff-model Public Health Systems, where all care is provided in state-owned and operated hospitals and medical centres. In such countries, budgetary constraints in the past several years have often led to increased waiting times and a deterioration in the general upkeep of these facilities. Private facilities spring up in such markets to offer an alternative to the Public System, at least for certain services, to those who can afford it. Initially these facilities typically offer faster appointments with specialists, diagnostic tests and certain scheduled procedures. Over time they expand to provide increasingly complex treatments as the population capable of paying for such services grows more significant. It is not a surprise that to help pay for these evolving services in such countries, PMI usually starts out with very limited cover and expands as the private medical market also expands.

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In contrast, other countries have Public Health Systems that primarily arrange for payment for services provided at public or private medical facilities around the country. In those markets, where there is ample supply of Private Facilities, it is no surprise that PMI usually is more comprehensive, even if only covering for out-of-pocket expenses or treatments not covered by the public health system.

The scope of PMI cover in any one country, then, depends on the **Supply** and **Demand** for private treatment in that country. Some employee benefit managers mistakenly assume that PMI is similar in most or all markets. Perhaps it is human nature to assume that markets elsewhere will be similar to the market one knows at home, but this assumption can lead benefit managers to make poor decisions on benefit cover and wellness programs.

The differences between countries can be considerable.

It may be useful to remember that PMI provides reimbursement for the *treatment* of illnesses and diseases over a given time period, not for the illnesses and diseases *themselves*. As such, an employee benefits manager should recall that there is a very wide spectrum of possible treatments and services within healthcare, from the very basic and routine (e.g. inoculation's and routine diagnostic tests), to the least frequent but most expensive (e.g. organ transplants). This can be expressed visually by a Treatment Continuum:

Treatment Continuum						
Routine Care	**Urgent Care**	**Pharmacy**	**Scheduled Surgeries**	**Acute Inpatient Care**	**Trauma**	**Organ Transplants**

Based on the supply and demand for private healthcare in any given country, PMI will cover parts or components of the continuum above. The variations are many, but let's focus on five basic types:

1. **Multiple Partial/Comprehensive Systems.** In these countries there is no national Public System except for certain populations (e.g. veterans, the poor or the elderly). Everyone else is expected to buy PMI or pay out-of-pocket for all healthcare. In these markets PMI is typically comprehensive, covering the entire Treatment Continuum shown above. This structure is rare, and the best example is easily the USA.
2. **Single Comprehensive Public Systems.** In these countries healthcare is obtained entirely through the Public System and private insurance is largely unavailable (or even illegal) except to pay for services not covered by the Public System. In these markets PMI is typically very limited, covering little on the Treatment Continuum except for focused services such as Dental or Vision care, or upgrades not allowed in the Public System. This structure is also rare, and the best example is Canada.
3. **Public Opt-Out Systems.** In these countries individuals (or groups of individuals) can opt-out of the Public System (taking their contributions with them) and purchase alternative private cover. In these markets PMI is - by definition - fully comprehensive for everything on the Treatment Continuum. The best example for this structure is Germany.
4. **Supplementary Coverage Systems.** In these countries the Public System is overwhelmingly the primary payer and PMI is purchased only to fund the out-of-pocket terms (co-pays, coinsurance, deductibles, limits) of the social insurance contract. In these markets PMI may be comprehensive, providing some reimbursement for nearly all services on the Continuum, but only for a very thin portion of the costs, as the government program pays for the majority. The largest share of PMI claims in such markets is most typically for any services not included in the Public Health cover, such as Dental or Vision. A classic example of this structure is France.
5. **Dual Complementary Systems.** In these countries the Public System is fully comprehensive and available to all citizens (or residents) and PMI is effectively duplicative, paying for any treatments that insureds seek from private providers instead of from public providers. In these markets PMI may actually be structured as comprehensive, and cover could be for all services on the Treatment Continuum, but utilisation of the PMI cover may actually be focused on certain types of care, based on real and perceived notions of quality and accessibility on the public side. In Brazil if you have PMI you tend to use it completely, avoiding the Public System except for very rare and expensive services (e.g. organ transplants). In the UK, by contrast, if you have PMI you may still seek certain services from the National Healthcare System (NHS). Most typically, however, the scope of PMI in countries with this structure is quite limited, with numerous exclusions, sub-limits and other restrictions, so that only a few services on the Treatment Continuum actually end up being paid for by PMI. This structure is by far the most common in the world, and can be seen to varying degrees in countries as diverse as China, Greece, Hong Kong, India, the Philippines, Portugal and Sweden.

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Naturally, the underlying PMI cost drivers faced by global employee benefit managers will depend heavily on the countries where they have employee populations and the structure of the Public and Private healthcare systems. The socio-economic, genetic and lifestyle profiles of a company's employees are actually less important, though they will influence the intensity of services utilised within each of those structures.

It is important to remember that none of the above structures are fixed and that Supply and Demand for private care typically evolves year over year, creating a tremendous impact on utilisation of private health services and thus premiums for PMI. It is also important to remember that because of the differences in what services are covered along the Treatment Continuum, PMI cost drivers in a given country may not mirror the underlying public health concerns of that country, nor might they relate to short/long term disability or even absenteeism concerns of the HR Departments in the companies where the employees work.

> "As medical costs globally continue in an upward spiral, few healthcare delivery systems will be spared from its financial clutches. In order to manage these costs, Multinational companies will need to combine a highly effective risk financing approach with a risk prevention and mitigation strategy. Generali Employee Benefits is one of the few global insurance networks that offer numerous financing solutions with a sophisticated data platform allowing employers to surgically target primary cost drivers by country with tailored healthcare initiatives; resulting in the reduction of both short and long-term healthcare and absenteeism costs."
>
> **Bill Fitzpatrick**
>
> Vice President – Corporate Risk Benefits
>
> Deutsche Post DHL

For this reason, employee benefit managers want **comparative** and **trend reports** to easily identify PMI issues around the globe. Until recently global PMI data has been frustratingly difficult to collect and analyse due to country differences in areas such as the following:

- **Provider Invoicing.** Not all countries have providers that submit invoices with all details needed for accurate reporting (e.g. diagnosis codes).
- **IT and Claim Processing.** As PMI is a relatively new product in many countries, not all carriers have a specialised IT system to manage it. Some systems in use are old (originally designed to pay P&C / Life claims), missing fields optimal for producing accurate reports (e.g. discharge date). Claim processing rules can also be an issue (e.g. claim bundling & default codes).
- **Coverage / Benefit Design.** The definitions for types of cover may differ drastically from country to country. For some Maternity is a separate rider. For others, just the delivery itself is part of the rider. Others never cover maternity at all.

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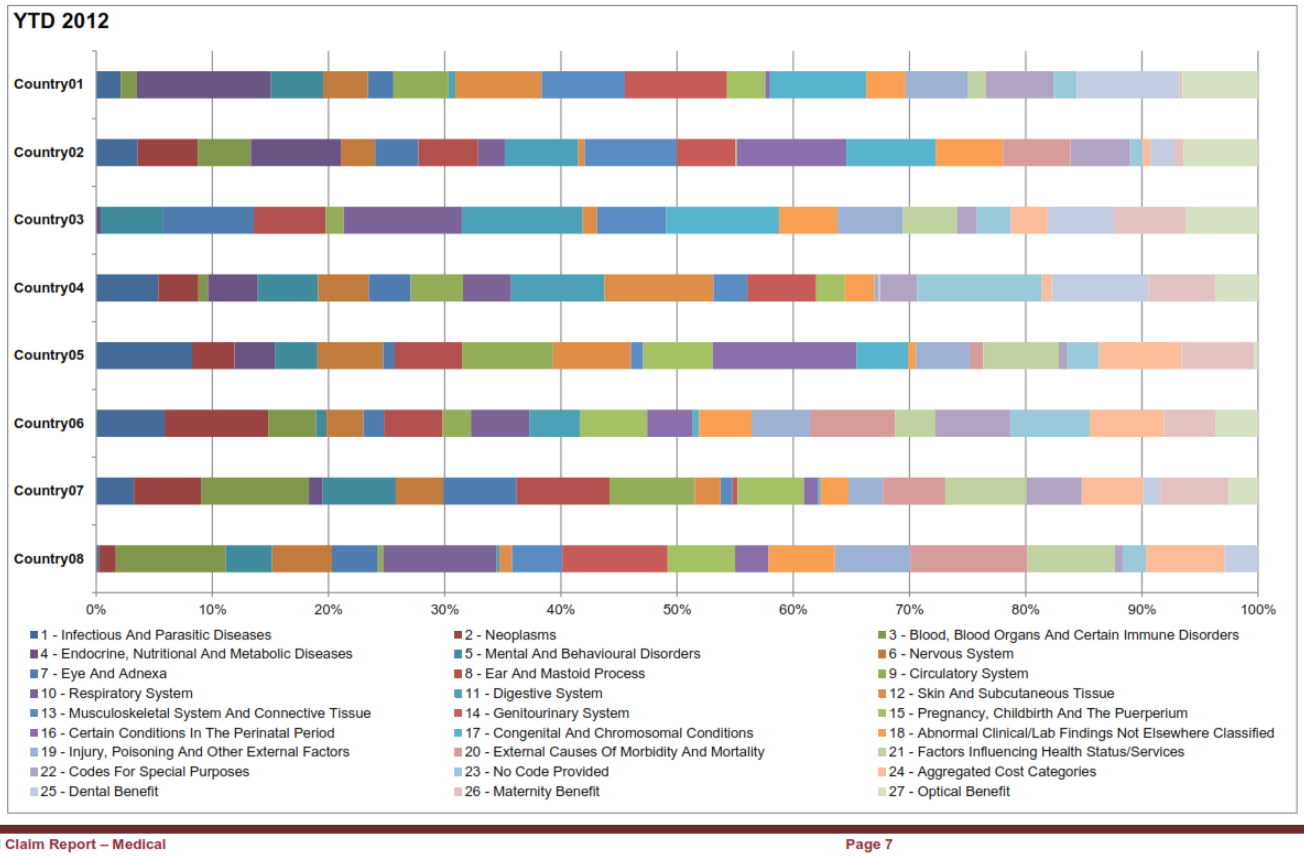
In its on-going commitment to provide its clients with the tools they need to manage their worldwide employee benefit programs, Generali Employee Benefits introduced last year a new dashboard report for clients with medical benefits administered by GEB's global Network. This report was the result of a country-by-country review of available data fields and an assessment of definitions, processing rules and data quality.

3.1/ Comparative Distribution of Paid Amounts by Diagnostic Category



Paid Claim Report – Medical Page 7

The first global medical report of its kind in the industry, GEB's *Paid Claim Report – Medical* provides a twice-yearly summary of the distribution of medical claims paid over a rolling 12-month period, sorted primarily by major Benefit Class and primary Diagnostic Categories, though additional metrics are also provided to monitor network usage and a drill-down on the largest cost categories.

As the name suggests, these reports reflect paid amounts, irrespective of incurred date, meaning they do not include an estimation for necessary Claim Reserves, but they are more immediate than Incurred Claim reports and the results can still offer insight into where important cost drivers lie.

Many clients have already been able to use these reports to make decisions in certain countries and regions about benefit design, workplace conditions and wellness programs. An example of this is a large multinational that noticed upwards of 80% of their total claim costs being spent for Outpatient benefits, and over 30% being spent on Respiratory illnesses. A drill-down study revealed that the claims were not for illnesses such as Chronic Obstructive Pulmonary Disease (COPD), Asthma and other serious issues, but rather over 60% of the Respiratory claims were for more routine Upper Respiratory Tract Infections and Flus. The results prompted the client to consider some of the following changes:

- **Ensure a Healthy Work Environment**
  Check and regularly change air filters in the factory
  Ensure soap and clean towels / driers are available in all bathrooms
  Install hand sanitizers in key common areas
  Require cleaning crews to wipe publicly used equipment (e.g. doors, handles, phones)
- **Promote Healthy Living**
  Support educational campaigns to wash hands thoroughly and frequently in Cold season
  Sponsor an annual Flu Shot program
- **Reconsider HR Policies**
  Revisit their policy of requiring a doctor's note even for a single day's absence

None of the initiatives required a change in benefit cover, or negotiation with unions. And because of the availability of GEB's *Paid Claim Report – Medical*, the client could target its initiatives to the very illnesses that were driving an extremely large portion of their claim costs. While these ideas were not directed at the classic wellness program targets, they were nonetheless far more appropriate and impactful to the reality in the local country.

Our efforts at providing useful PMI dashboard reports do not end here. GEB is very pleased to announce that we are further expanding our range of reporting tools by producing an annual *Incurred Claim Report - Medical*, which will be available by the end of 2013. This report will be much more usable for statistically-based conclusions as it will incorporate demographic counts to provide insight into Incidence and Utilization, Average Claim Costs and Total Incurred Claim Costs per Member Year (PMPY) for each Benefit Class and Diagnostic Category. From this report, GEB clients will be able to more easily identify principal cost drivers and year-over-year trends using normalised data.

Rather than implementing standard wellness programs in hopes of reducing claims and PMI expenses, companies can use GEB's *Paid and Incurred Medical Claim Reports* to target wellness initiatives to the fluctuating cost drivers across their worldwide operations. The reports actively underline components of Medical Trend and equip employee benefits managers with the necessary data to understand the expenses that drive up their companies' premiums and to focus on the health issues within a given population.

Our *Paid and Incurred Medical Claim Reports* allow our clients to move forward by having a clearer picture of the recent past and arm employee benefits and risk managers with the kind of data necessary to implement the most effective initiatives for mitigating underlying cost drivers in their EB portfolios.

Eric Butler, Global Director of Health Insurance at Generali Employee Benefits

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Anticipating claim volume:
implementing risk adjustment into your renewal strategy

"What volume of claims will a group or individual produce in the upcoming year?" This fundamental question is considered by insurers facing any health insurance renewal. A variety of methods exist to help answer this question, most of which are based on some combination of policy-specific experience and the carrier's overall market experience. Risk adjustment is a cutting edge tool that can enhance the predictive capacity of most any existing methodology.

The term "risk adjustment" refers to the two-step process of (a) using demographic and healthcare claims data to measure the medical risk associated with an individual; and (b) subsequently using that information to adjust revenue or estimated expenses. Risk adjustment has various applications in the health insurance industry, including renewal rating of individuals and groups, provider capitation, identifying potential high-cost individuals for intervention, and allocation of risk-based payments under government programs. This article focuses on the practical considerations and benefits associated with incorporating a risk adjustment component into an existing renewal rating methodology.

The common characteristic of all risk adjustment methodologies is their evaluation of the relative morbidity of individuals. This evaluation methodology generally considers characteristics including age, gender, and medical conditions, to determine an individual's relative risk. Risk adjustment tools use this information to assign each individual into age, gender, and disease categories. Each category is then assigned a risk weight based on historical cost relationships observed between individuals in the various categories.

Risk adjustment falls into two major categories: concurrent and prospective. Concurrent models use historical data, generally collected during a twelve month period, to estimate population morbidity during that same historical period. Prospective models use historical data to estimate future population morbidity (e.g. 2012 data to estimate 2013 morbidity). As a result, prospective risk adjustment methodologies do not evaluate conditions that are historical in nature and that are not expected to produce additional future costs (i.e., a broken bone). Prospective risk adjustment is more useful to incorporate as a component of a renewal rating methodology, as it can help provide insight into the expected future costs of an individual or group.

The following steps are needed to incorporate risk adjustment into a renewal rating methodology:

1. Determine which risk adjustment methodology will be employed.
2. Review the data and confirm that available elements are sufficient for the chosen methodology.
3. Determine whether risk weights should be customised for the population to be evaluated.
4. Determine the minimum exposure period for scoring or if a durational adjustment will be made.
5. Determine how the risk adjustment results will be incorporated into the renewal process (credibility weighting, incorporation with other rating variables, etc.).

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The explanation of these steps and an illustrative case study follow.

Step 1: Determine which risk adjustment methodology will be employed.

There are numerous risk adjustment tools available in today's marketplace. Various criteria should be considered before selecting a model, including the following:

- Ease of implementation and use
- Accuracy of method
- Cost
- Availability of data elements required for the model
- Ability of model to operate with imperfect data
- Applicability of the model to the population being scored
- Ability to customise the model for the population being scored (discussed further in Step 3)

Step 2: Review the data and confirm that available elements are sufficient for chosen methodology.

Data quality can have a significant impact on the results produced by risk adjustment models. As a result, it is important to perform careful data validation and testing before implementing any risk adjustment methodology. This should include a review of the completeness of diagnostic coding. Poor tracking of diagnostic information can result in less risk score differentiation if conditions are not captured through diagnostic coding.

Generally speaking, the following data elements are needed for accurate risk adjustment:

- Enrolment data that contains each individual's age, gender, and dates of enrolment
- Diagnostic information from claims data
  - This includes diagnostic information from inpatient, outpatient, and physician data
- Pharmacy data

Various risk adjustment models may use only medical claims data, only pharmacy data, or both. The availability of appropriate data may be a significant consideration in selection of a risk adjustment model.

Step 3: Determine whether risk weights should be customised for the population in question.

Risk adjustment models contain condition-based risk weights that were developed using historical cost relationships observed among members in the various categories. The population underlying these risk weights may differ from the population where the weights will be applied. For example, weights developed from a commercial population in one country may or may not be appropriate to apply to a commercial population in another country. The applicability of a risk adjustment model's risk weights may be impacted to the extent that varying social programs and/or utilisation patterns in different countries impact the relative costs of different medical conditions. Development of customised market-specific risk weights may be considered if sufficient historical data is available.

Step 4: Determine the minimum exposure period for scoring or if a durational adjustment will be made.

Risk adjustment models can be sensitive to the average historical exposure of members. In general, calculated risk scores will decrease as an individual's historical exposure period is reduced from twelve months. Ideally, a group's membership would all be enrolled for the full twelve months of the historical period. In reality, members are added and subtracted from the population for a variety of reasons. More robust risk adjustment models can adjust for variation in historical exposure periods. However, it may still be advisable to limit enrolment to a certain minimum number of months, with individuals failing to meet that standard being assigned a demographic score.

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Step 5: Determine how the risk adjustment results will be incorporated into the renewal process.

Rating methodologies may vary by country, and also by coverage type (i.e., individual, small group, large group). Determining how risk adjustment might be incorporated into an existing renewal methodology should consider regulatory limitations, market acceptance, and complexity of implementation.

Sample Case Study: Comparison of Two Small Groups

The following sample case study helps illustrate the potential impact of incorporating risk adjustment into an existing renewal methodology. In this scenario, there are two groups of five employees with identical demographics and base period claim dollars. During the base period, group A had two individuals diagnosed with significant health conditions: EE #1 with diabetes, and EE #3 with cancer. These diagnoses have not yet resulted in excessively large claims, but both carry very high prospective risk scores. The majority of the base period claims incurred by Group B resulted from a recently completed pregnancy. Because this pregnancy is completed, it is not expected to materially impact the group's expected claims for the upcoming year.

Despite having the same claim levels during the base period, each group has materially different on-going conditions. Prospective risk adjustment methodologies, unlike historical policy-specific or market-wide experience techniques, identify these on-going conditions and their disparate projected costs for the upcoming year.

The risk weights illustrated in the following example are normalised scores from Wakely Consulting Group's Risk Assessment Model. For purposes of this illustration, all individuals are assumed to have been enrolled for the full twelve month base period.

Table 1 – Comparison of Two Small Groups

	EE #1	EE #2	EE #3	EE #4	EE #5	Group Average
Group A	Male, age 25	Female, age 61	Male, age 55	Male, age 39	Female, age 28	
Base Period Claims	$700	$6,700	$8,300	$175	$200	$3,215
Demographic Baseline	0.1221	0.5675	0.6329	0.1308	0.4199	
Conditions Identified During Base Period	Diabetes with Renal or Other Specified Manifestation	Congestive Heart Failure	Metastatic Cancer and Acute Leukaemia	None	None	
Prospective Condition Score	0.8079	1.7717	3.1827	0.0000	0.0000	
Final Risk Score	0.9300	2.3392	3.8155	0.1308	0.4199	**1.5271**
	EE #1	**EE #2**	**EE #3**	**EE #4**	**EE #5**	**Group Average**
Group B	Male, age 25	Female, age 61	Male, age 55	Male, age 39	Female, age 28	
Base Period Claims	$180	$650	$445	$2,300	$12,500	$3,215
Demographic Baseline	0.1221	0.5675	0.6329	0.1308	0.4199	
Conditions Identified During Base Period	None	None	None	Drug/Alcohol Psychosis or Dependence	Pregnancy (Completed)	
Prospective Condition Score	0.0000	0.0000	0.0000	0.4914	0.0000	
Final Risk Score	0.1221	0.5675	0.6329	0.6223	0.4199	**0.4729**

In this scenario, Group A has a composite prospective risk score that is 223% higher than Group B. Given the significantly higher prospective risk score, it is very likely that Group A will produce more aggregate claims in the upcoming year than Group B. Carriers using any blend of policy-specific and market-wide experience rating will produce the same level of rate increase for both group A and B. Carriers incorporating a risk adjustment component into their renewal methodology will produce a lower rate of increase for Group B and a higher rate of increase for Group A. This will likely result in a higher rate of persistency for groups with more favourable prospective risk profiles - in this case, Group B - and ultimately better financial performance for the carrier.

Taylor Pruisner, FSA, MAAA, Senior Consulting Actuary at Wakely Consulting Group

Claim reserves in private medical insurance

An important component of understanding where health insurance costs are and where they are going is the estimation of the costs for services that have been provided but not yet paid. This is done through the Claim Reserve. The Claim Reserving approach determines adequate liabilities for the accounting balance sheet that can fairly translate to Incurred Claim amounts on the income statement. There are a variety of accepted methods which may be reasonably used for this process. The reserving methodology applied by Network carriers is in compliance with local regulatory requirements or generally accepted local market practice.

Despite the growing importance of PMI products around the world, there is not a global standard upon which all insurance carriers agree for estimating Claim Reserves for an insurer's entire PMI portfolio. There is even less agreement on how to estimate (or allocate) Claim Reserves for a single corporate group or client.

In some markets there are local regulatory requirements or market norms that differ from what may be considered Best Practice, and carriers in the Network are always encouraged to routinely test for Reserve Adequacy and make adjustments where necessary. GEB is active in working with carriers where Claim Reserves appear to be chronically under- or overestimated.

Composition of Claim Reserves: OCR and IBNR

We should be reminded that Claim Reserves effectively estimate those Incurred Claims which an insurer has not yet *paid*, but what has not yet been paid can include claims an insurer actually already knows about (Outstanding or In Course of Settlement Claims – OCR) as well as claims that the insurer knows nothing about but that history has taught them to expect (Incurred But Not Reported claims, or IBNR). Unfortunately many of us in the insurance business often just use the term IBNR when what we really mean to use is the more accurate "Claim Reserves". Both OCR and IBNR are really different *components* of total Claim Reserves.

Common Inaccuracies in OCR Estimations

OCR data is often included in total Claim Reserve estimations for some insurance covers (e.g., auto insurance) since it is (by definition) based on something an insurer *knows*. For PMI it is our experience that OCR amounts are frequently inaccurate and often cause distorted (overstated) Reserves. The reasons for this relate to how OCR values are collected, usually including one or both of the following:

Claims in Process represent the value of all claims that have been received by the insurer and which have been data entered, but which have not yet had a final adjudication (either awaiting additional information, or simply a supplemental or higher level review).

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These values usually reflect amounts prior to final adjudication, so the insurer may not be liable for the full amounts noted in the end. Such claims are often merely recognised as having been received, as they are. Even if all provider discounts, deductibles, co-pays and coinsurance are applied at data-entry (usually not the case), these claims have not had a final determination on payment eligibility and may still be partially or fully denied due to benefit limitations or exclusions.

Prior-Authorised Claims are typically the value of inpatient or high-cost services that have been prior-authorised, but the claims for which have not yet been received. These are claims which the insurer is expecting to receive as a result of the authorisation process, and often for which liability term letters or some other payment guarantee have been issued. Such claim values are often overstated for three reasons:

1. **Conservative Estimates.** In the prior authorisation process, the insurer estimates the cost of the surgery or procedure in order to issue a payment guarantee. These estimates may be overvalued to protect the Member. The conservative amounts estimated for the liability term letters are then loaded into the OCR file. Actual claims, however, often come in below the amounts reserved in this process.
2. **Future Period Claims.** Most prior-authorisation processes involve approving services in advance. As such, the OCR report can include claims for time periods not related to the risk period (exposure) for which we need to hold Reserves. The definition of a Medical Loss Ratio is Incurred Claims / Earned Premiums. So, if the claims are for the future, an insurer might not include them in the current Claim Reserves (unless policy contract provisions require it). Rather, they should go against future period premiums.
3. **Prior Period Claims.** A number of prior-authorised services are ultimately never provided to the member, yet reserves associated with them are not removed in a regular or timely manner. As such, OCR files may include reserves for services that the insurer authorised in the past but that never actually took place. Insurers should review these files regularly, but often do not do so with optimal frequency. Clearly we should not reserve for services that never occurred.

Common Inaccuracies in Simplified IBNR Estimations

Many insurers in less mature markets use simplified approaches to estimating IBNR. That is to say, IBNR amounts are estimated by using a ratio of Premium (e.g. an amount equivalent to X months' premium) or a ratio of Claims (e.g. an amount equivalent to XX months of Paid Claims or to a fixed percentage of Paid or Incurred Claims). Although such simplified approaches may have originally been based on actuarial studies, if they are applied in a manner different from the way they were calculated they can materially misestimate necessary IBNR amounts.

Using a Different Time Period. If an actuary calculates that 20% of a past calendar year's Incurred Claims were paid after the close of the year, the percentage would be useful in estimating current necessary IBNR amounts, but only if the 20% is multiplied against 12 months of claims data. Because of the Claims Lag Effect, if the 20% is used against a shorter time period the resulting IBNR estimates can be materially understated. For example, should someone apply the 20% against 9 or 10 months of claims, the resulting IBNR estimate would be much lower than what it should be. Due to the Claims Lag Effect, the proper percentage to multiply against 9 or 10 months of claims data will always be higher than the percentage used for 12 months. For shorter time periods there will be more months under study which will have had far less time to complete.

Using a Different Claim Type. The same actuarial study above indicating that 20% of a past calendar year's Incurred Claims were paid after the close of the period, would also only be useful in estimating current necessary IBNR amounts if the 20% is multiplied against Incurred Claims as was done in the original study (i.e. claims with service dates during the 12 month period) rather than Paid Claims (i.e. claims with paid dates during the 12 month period). Should someone query 12 months of Paid Claims and multiply the result by 20%, the resulting IBNR estimate would be much higher than what it should be.

Lacking Judgement. The actuarial study indicating the simplified IBNR estimate of 20% of 12 months' Incurred Claims would only be accurate in estimating current necessary IBNR amounts if the administrative environment is similar to the one existing at the time of the original study. If changes have occurred which altered the speed of claim submissions or the turn-around-time once claims are received by the insurer, the historic 20% experience may no longer reflect the new environmental reality. For example, if claims are now arriving faster since the insurer implemented a new electronic invoicing arrangements with large hospitals, or if claims are being processed quicker in-house since the insurer launched a new IT System with auto-adjudication capabilities, then the resulting IBNR from the simplified 20% metric would be much higher than what it should be. The blind application of formulae without any understanding or consideration of environmental changes is always discouraged; judgement should always be an important part of an actuary's toolbox.

Best Practice Approach

GEB always recommends Best Practice methodologies for Claim Reserves calculated from a lag analysis approach which estimates total monthly Incurred Claims from paid-to-date information for each month, historical experience, enrolment and trends.

In this methodology, incurred claim estimates are developed for each experience month by applying claims Completion Factors to the paid-to-date Incurred Claims. These Completion Factors are derived from historical experience in an iterative process. Beginning with the first month, statistics are calculated comparing the amount paid after each completion month to the total amount eventually incurred. These factors are averaged to develop the completion factor for the incomplete months.

An example of the resulting calculations is shown in the illustration table below. In this example, experience was available for paid months through June 2013, split by incurred month through the same date. The data is then re-accumulated to derive the total paid through June for each incurred month. Completion factors are derived, and the ultimate amount incurred is calculated for each incurred month. The Claim Reserve is then the difference between the estimate of the ultimate Incurred Claims and the amount paid to date.

Incurred Claim estimates for the closest two months of the analysis should always be examined for reasonableness if the Completion Factors used to derive the estimate are less than 60%. In deciding upon the override values, the Incurred Claims Per Member Per Month for the prior two years (trended to the applicable override month) should be considered. In the illustration below, the completion factor for April 2013 is 60%, but for the most recent months is less. Therefore, the incurred claim estimates for May and June 2013 were derived from past incurred claim estimates.

In markets where Claim Reserves need to be split between Outstanding Claims (OCR) or Claims In Course of Settlement (ICOS) and Incurred But Not Reported (IBNR), most carriers will subtract any relevant OCR / ICOS amounts from the Total Claim Reserve, recording the difference as “IBNR”.

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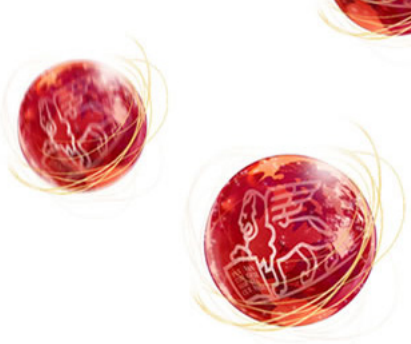
[A] Month	[B] Paid to date claims	[C] Enrolees	[D] Completion Factor[2]	[E] Incurred Claims [B] / [D]	[F] Incurred Claims per Enrolee [E]/[C]	[G] Claim Reserve [E] - [B]
Jan-11	1,349,600	6,787	1.0000	1,349,600	198.85	-
Feb-11	1,175,747	6,942	1.0000	1,175,747	169.37	-
Mar-11	1,395,360	7,097	1.0000	1,395,360	196.61	-
Apr-11	1,186,160	7,252	1.0000	1,186,160	163.56	-
May-11	1,564,495	7,407	1.0000	1,564,495	211.22	-
Jun-11	1,957,762	7,562	1.0000	1,957,762	258.89	-
Jul-11	1,444,098	7,717	1.0000	1,444,098	187.13	-
Aug-11	1,498,933	7,872	1.0000	1,498,933	190.41	-
Sep-11	1,375,747	8,027	1.0000	1,375,747	171.39	-
Oct-11	1,634,086	8,182	1.0000	1,634,086	199.72	-
Nov-11	1,243,527	8,337	1.0000	1,243,527	149.16	-
Dec-11	1,127,825	8,492	1.0000	1,127,825	132.81	-
Jan-12	1,675,144	8,649	1.0000	1,675,144	193.68	-
Feb-12	1,304,580	8,804	1.0000	1,304,580	148.18	-
Mar-12	1,831,271	8,959	1.0000	1,831,271	204.41	-
Apr-12	1,507,530	9,114	0.9989	1,509,185	165.59	1,655
May-12	1,502,146	9,269	0.9968	1,506,895	162.57	4,749
Jun-12	1,933,785	9,424	0.9982	1,937,249	205.57	3,464
Jul-12	1,270,239	9,579	0.9866	1,287,441	134.40	17,202
Aug-12	1,208,220	9,734	0.9753	1,238,761	127.26	30,541
Sep-12	1,224,424	9,889	0.9549	1,282,300	129.67	57,876
Oct-12	1,300,943	10,044	0.9356	1,390,558	138.45	89,615
Nov-12	1,441,312	10,199	0.9299	1,550,032	151.98	108,720
Dec-12	1,170,450	10,354	0.9162	1,277,513	123.38	107,063
Jan-13	1,600,730	10,509	0.8808	1,817,448	172.94	216,718
Feb-13	1,169,992	10,664	0.8377	1,396,599	130.96	226,607
Mar-13	1,012,292	10,819	0.7813	1,295,721	119.76	283,429
Apr-13	906,741	10,974	0.6000	1,511,307	137.72	604,566
May-13	531,691	11,129	0.2783	1,910,179	171.64[1]	1,378,488
Jun-13	99,125	11,284	0.0512	1,936,783	171.64[1]	1,837,658
Total	39,643,954			39,643,954		4,968,353

[1] Incurred claims set based on past incurred claim estimates since the completion factor was too low to be credible. 171.64 equals the average 2012 Incurred Claim per enrolee times 1.1 to reflect trending to the current period.

[2] Note: Completion factors will vary widely by company, country, coverage and administrative practices. The factors shown are for illustration only.

The table above shows only one of several Best Practice methodologies and we recognise that there are a number of other acceptable methods (e.g. Bornheutter-Ferguson method).



Benefits of Best Practice Methodologies Over Simplified Ones

In our opinion, this preferred approach has the following advantages over a simplified method:

- *It facilitates an easier comparison of past reserve estimates to actual experience.* This approach calculates the remaining reserve for each month. In this way the prior best estimates of the Unpaid Claim Liabilities can be examined in light of claim run out and the adequacy of the prior estimates can be determined. This process is a required part of the actuarial standards of practice in some countries (e.g. the United States).
- *It provides a ready method for cross checking reserve data.* The claim lag payment triangles can be summarised to paid amounts per month and tied to financial claims data. It is our experience that the amounts rarely tie exactly because of miscellaneous accounting entries; however, the amounts can be verified for reasonableness.
- *It is more objective and auditable.* The proposed method does recommend judgment in determining the most recent incurred claim amounts but there is a systematic approach that can be used that relies on historical Incurred Claims and objective statistics.

Application of Methodology on Individual Groups

Although some carriers apply their Claim Reserve approach to the individual claim experience of extremely large group clients, these methodologies are most credible when performed on a portfolio level. As such, for the purposes of reinsurance and retrocession reporting, most carriers will apply a secondary and usually simple methodology to *allocate* a portion of the portfolio-based Total Claim Reserves to individual group clients.

In certain markets, however, only OCR amounts associated with the individual group clients are submitted with reinsurance or retrocession reporting. This usually occurs in countries where the PMI market is less mature and local regulators only require OCR, similar to what may be required for other insurance lines. Group clients should be aware of this, as the Claim Reserves may likely be understated in such markets.

When assessing Claim Reserves it is always a good idea to understand what is included and how the methodologies are applied.

Eric Butler, Global Director of Health Insurance at Generali Employee Benefits

Challenges for expatriates

In today's globalised economy, multinational companies employ a growing number of cross-border employees, and as companies have become increasingly global, multinational workforces are critical and competitive assets. But expatriate employees often represent a larger challenge for employers than locally hired staff because of the many aspects that HR managers must consider when recruiting these employees. Providing adequate benefits for mobile employees can be challenging for companies, but it is a crucial component in retaining valuable staff and expertise. In this article we will talk about employee benefits for mobile employees with specific focus on healthcare.

Definitions

Figure 1

Expatriate, Third Country National (TCN), Assignee, Off-shore Worker and Global Nomad are just some of the names used to classify the broader category of mobile employees (Figure 1). Mobile employees are skilled professionals who, often accompanied by their families, are employed outside their home country. From an employer's perspective, mobile employees are classified based on their similar needs in terms of both benefit levels and geographical scope. They have a common need for global coverage and benefits that are often unavailable through their home country plans or through host country plans. A global international plan allows similar cross-border benefit design, equality of treatment, centralised administration and also financial synergies.

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Expatriate Destinations

Figure 2

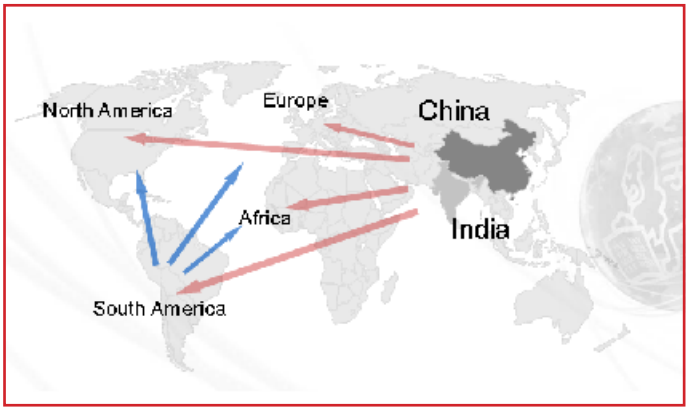

Figure 3

Traditionally, expatriate employees followed predictable patterns coming from countries like the United States, the United Kingdom and Germany (Figure 2). Today however, expatriates are increasingly going to new destinations and coming from different home countries. Asia is the most important developing destination for multinational companies to send expatriates.

Many Asian and Latin American companies are also beginning to send more expatriate employees to other regions of the world. In fact China, India and Brazil have emerged as countries with a fast growing number of assignees abroad (Figure 3). The main reason for this new phenomenon is that these economies have been growing at rates well above the levels in Europe and North America. Such growth has increased foreign investment in these countries bringing with it a greater number of skilled talents.

The shift in geographical trends among mobile employees has also impacted expatriate healthcare practice. For example, India has emerged as a country with some of the most significant increases in outbound expatriates. The Indian domestic market is over-focused on pricing, and healthcare benefit levels are rather limited when compared to other regions like Europe and North America. Indian employers tend to replicate the domestic practice of limited benefits and lowest prices at international level as well. In some cases Indian expatriates do not receive more than an extended travel plan when they go on a secondment abroad. The practice presents a challenge for both expatriate and employer because while "Indian" benefit levels might work well in India[1], in most of cases they are inadequate in Europe or the United States. It is not uncommon for Indian employees to seek medical service in the United States only to find out that they cannot receive service because of their limited coverage and the expected cost in the facility they try to access[2].

In Latin America, Brazil is another emerging "origin" market from which employees are dispatched abroad by Brazilian multinationals. More specifically, many Brazilian multinationals fall into the so-called category of "multi-latinas" – Latin American multinationals with their main footprint in Latin America. Multi-latinas are generating an entirely new market for employee benefits, including expatriates.

Healthcare practices and costs differ significantly from one country to another. If we consider per capita expenditure, there are countries that spend USD $100 and others that spend well above USD $6,000, according to the World Health Organization (WHO). Per capita expenditure and percentage of GDP spent on healthcare highlights the fact that medical technologies, service and benefit standards differ greatly from country to country. The different international standards mean that some expatriates' benefits from their home countries may not be suitable on an international assignment, since host country domestic practice cannot always be replicated at international level (Figure 4). Also, with expatriates there is an additional level of complexity. In fact, the typical expatriate group is composed of different nationalities with a variety of destinations. Differences among systems render "domestic" benefit design unsuitable at an international level because, in many cases, benefits must incorporate a certain degree of flexibility to factor the needs of expatriates in different regions.

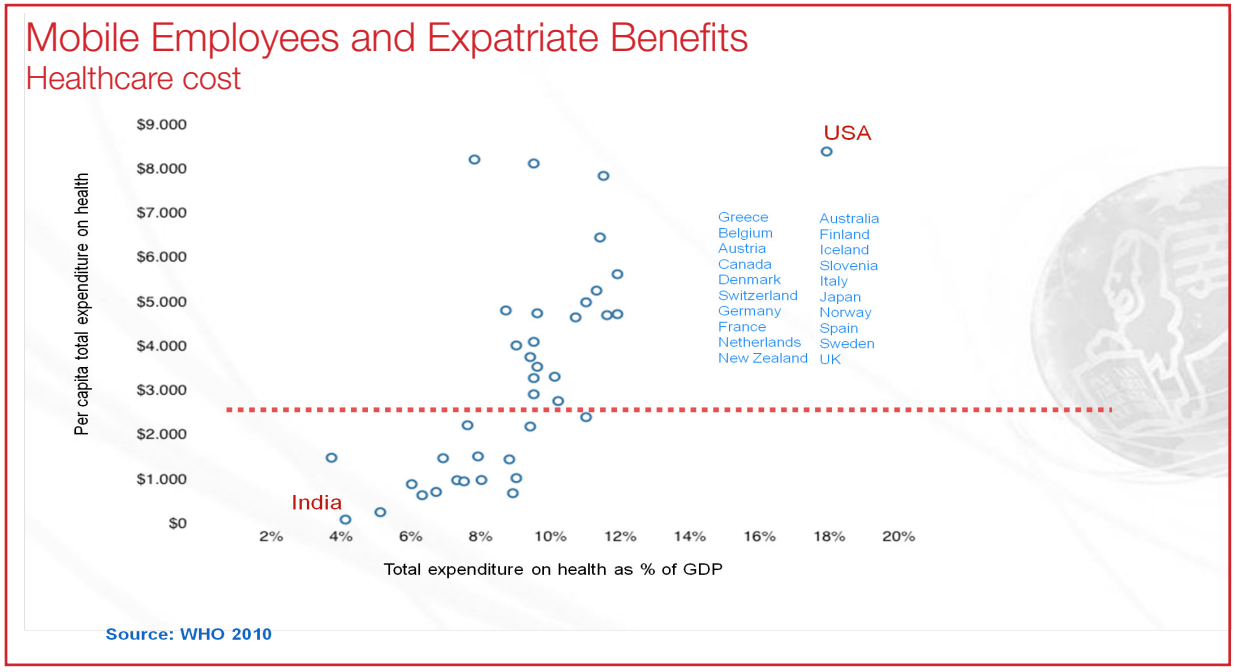

Figure 4

The most suitable solution for expatriates is a "worldwide plan" that provides for different levels of benefits depending where they are located.

[1] Healthcare in India is universally available however employees who earn above a certain level of income generally opt for private medical coverage.
[2] A member seconded in US with maternity limit of USD 10,000 was not accepted by the medical provider because the level of cover was not considered adequate. There were no complications expected. Eventually the member went back to India for the delivery.

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Main Challenges

An expatriate secondment is an investment for employers and an important challenge for employee and employer. Typical benefits required for expatriates are:

- Life
- Disability: Income Protection and/or lump sum benefit in case of Total and Permanent Disability
- Accidental Death and Dismemberment
- Critical Illness
- Pension
- Healthcare and ancillary benefits (dental, vision, maternity)
- Emergency and Evacuation
- Business Travel Insurance

Among these benefits, healthcare coverage is a critical element that could be the difference between failure and success.

Besides mobility, all mobile employees face similar challenges when it comes to employee benefits. As mentioned, medical systems differ in cost and quality. In more developed countries, state social security systems offer at least some level of healthcare benefits. However, publically funded systems have become increasingly less generous due to constrained government budgets. Consequently, expatriates need to integrate local or social security benefits with a private medical plan.

In less developed countries, the quality of public healthcare is often not adequate for the needs of expatriate employees and their families. In many cases, mobile employees may not meet the requirements to enrol in the host country plan, and due to their secondment, they are no longer eligible for their corporate home plan. In both cases, regulatory aspects and benefit practices leave employees in “no man’s land”. Usually membership in home plans is only allowed for a limited period of time because of regulatory reasons or technical impediments, and expatriate healthcare benefits often cannot be managed or serviced by a domestic provider . A host country plan, on the other hand, may not be adequate to meet the needs of an expatriate employee. With global medical practices that vary from country to country, employers struggle to replicate benefit structures that are the same level in all countries where they have expatriates. The struggle is further compounded when an expatriate seconded in country A starts a new secondment in country B.

Some local laws require a local domestic plan as a legal condition to apply for a working visa. In this case, the local qualified plan might be not adequate in terms of benefits provided and often cover is limited to country of assignment only. It does not meet the standard global benefit level – a typical requirement for expatriate groups. Consequently, an international plan is still necessary to meet an expatriate’s expected level of benefits when local compulsory covers do not.

Figure 5

As a general rule, employers consider expatriates' assignment length in order to determine whether a Home, Host or International plan is the most suitable solution (Figure 5). For a short assignment, the most practical solution is to keep the assignee on the home country plan. If instead an employee will be a long-term expatriate in one country, a good solution is to seek membership in the host country plan, if possible. The international plan comes into play almost as the only viable solution, when an employer is employing so-called "global nomads". These are expatriates that leave their home country for a long assignment that is not limited to one country.

More than 50% of mobile employees are followed by their families, a fact that requires, first and foremost, secure adequate healthcare coverage for employees' dependants as well. Family satisfaction, quality of living and adaptation to local culture are all sources of concern for expatriate employees, but Life and Healthcare benefits are key elements that can determine the success of the secondment.

Turning to benefit design, plans must consider the following features/characteristics:

- Portability: a health plan for expatriates is a global plan. Cover must be available irrespective of country of secondment and also it must follow the insured member within the elective geographical area in which the plan operates.
- Level of benefits: a healthcare plan for expatriates must offer a comprehensive level of benefits including Medical inpatient and outpatient services, Dental, Vision and Emergency and Assistance.
- Flexibility of provision: as mentioned above, among the challenges there is the necessity of different levels of benefits depending on the area or country of secondment. Flexibility of provision also includes cost management tools like deductibles, coinsurance, co-pays, etc. (Figure 6).

In-patient care	Alternative therapies, chronic conditions, oncology, AIDS & HIV, psychiatric care & counselling, hospice & palliative, accidental dental
Out-patient care	Alternative therapies, chronic conditions, oncology, speech therapy, durable medical equipment, psychiatric care & counselling, hospice & palliative
Routine health management	Routine health checks, hearing checks, cancer screening, Pap smear tests, well-child examinations & vaccinations all as standard
Maternity benefits	C-sections (emergency & elective) are covered, congenital conditions all as standard
Dental (optional)	Routine dental, basic & major restorative, preventative, orthodontics
Vision (optional)	Eye exam, prescribed glasses and prescribed contact lenses
Cost management	Deductible variations & co-pay options

Figure 6

When deciding on the level of healthcare benefits, the ideal scenario is to give employers access to the most exhaustive level of benefits and allow them to tailor the package according to budget constraints. Flexible benefit design is even more important nowadays with employers seeking to offer competitive packages while maintaining a close eye on cost-effective solutions.

Generali Offer

Generali has developed capabilities specifically for international private medical insurance (IPMI) that offer healthcare solutions for expatriates with the highest levels of benefits and a wide range of options. Generali Mobile Health Plan (GMHP) allows employers to tailor healthcare packages for their expatriates according to their needs while efficiently managing costs. Employers with 50 expatriate employees or more can benefit of fully bespoke plans.

The key elements of our healthcare product include portable global coverage, comprehensive benefits for members and flexible plan design and continued support for clients. Portability and flexibility in benefits design are key factors that meet expatriates need.

In addition to the high level GMHP, Generali has developed a specific product designed to suit the needs of clients in cost sensitive markets, or where a comprehensive plan may not be required.

Generali Mobile Essentials Plan (GMEP) is aimed at giving employers the flexibility to choose a cover that is both practical and flexible, but at a premium that fits all budgets. The modular approach of the plan gives members the ability to enhance their core product with Dental, Wellness, Vision, Maternity and cost management additions to make their chosen plan more comprehensive and suit their budgetary requirements.

Flexible plan design is a key need of a health expat plan, but the most important component is certainly the “servicing”.

Expatriates members of our GMHP and GMEP, have access to assistance from our global and/or regional customer service centres 24 hours a day, 7 days per week for plan enquiries, international claims and reimbursement. Our customer service centres offer multilingual assistance for pre-authorisation, claims and benefit queries, dedicated claims and clinical staff, centralised and international claims processing and direct billing. Members are able to submit their claims online, by email or with more traditional means like fax and post. When the case is not managed on direct billing basis, claims can be reimbursed by cheque or wire transfer.

Our medical management team works closely with Generali’s own emergency services company, Europ Assistance, to coordinate care and transport in the event of an urgent medical situation. Working closely with our sister company, we ensure that members receive the right emergency care at the right time from the most appropriate facility.

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Also, with our GMHP and GMEP members have access to an online portal where they can submit and follow claims, search for the most suitable medical provider for their needs, access all information and forms about their plan and seek information or ask questions about the plan.

Generali maintains relationships with a large number of healthcare providers worldwide. This includes solid capabilities in the United States and numerous relationships with clinics, pharmacies and hospitals around the world. Additionally, Generali is able to offer contracted direct pay and/or pricing agreements with the majority of its international providers.

We work very closely with clients to offer the most appropriate insurance solutions for their mobile employees and extend continued support with employee/employer education sessions and a dedicated account manager.

Pasquale Gorrasi, Head of Global Lines at Generali Employee Benefits

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Underwriting international medical insurance:
claims data and the challenge of pricing international plans

The underwriting of a portfolio of international medical insurance (or healthcare) presents a number of challenges.

By definition, the beneficiaries under the policy are living around the world, wherever they may be, and thus the provision of services (medical assistance, hospital admissions, emergencies, call centres, etc.) must operate around the clock, irrespective of time zones, locations, etc.

It is not just about the service to the clients – working in different corners of the world means also dealing with different legal, regulatory and customary practices. Some countries require local insurance certificates not as a matter of insurance law but rather to provide working visas (e.g. Abu Dhabi).

Consequently, it goes without saying that an international programme is rather complex from an insurance and logistical perspective. This article will tackle some of the key issues that underwriters face at the time of pricing the business. In what follows we will refer almost exclusively to "group business" as opposed to individual policies although most of the issues covered are common to both types of insurance.

When faced with a new prospect or proposal, the underwriter meets his first challenge: the quality of data. Pricing international healthcare schemes would be relatively simple if there were an agreed format for the provision of data. However, such an agreed format does not exist and often detail is vague at best. Ideally, the data should reflect the past experience of the "population" at risk through a fairly detailed analysis of the claims. It is important to establish whether there are recurring or chronic diseases, serious or critical illnesses requiring extensive treatments such as chemotherapy or other notable factors among the persons insured.

Regrettably, although international healthcare insurance is nothing new in many territories, these policies are still in their infancy, which further compounds the inconsistency in the availability and quality of data provided for quotation purposes. Different currencies and different classification of expenses (e.g. total hospital bills as opposed to separate fees for the surgeon, the theatre, nursing services, accommodation, etc.) are additional challenges that underwriters face. However, in practice, underwriters are often presented with existing large corporate clients that have had international healthcare coverage for a prolonged period of time and lack any strong provision of historic performance.

It is immediately understood that if a scheme is to be underwritten on an MHD (medical history disregarded) basis - whereby the whole group is taken on board with full coverage irrespective of their current health status/ pending claims – the claims history is crucial if a reasonable price is to be provided.

Other forms of insurance would require a different approach, but they are very seldom requested or used. We refer to "moratorium" and "full medical" underwriting. In the former, existing non-chronic medical conditions are declared upfront and not covered for a "moratorium" period but eligible for compensation if the conditions return after the end of the period. The latter form requires each individual in the group to submit a full medical questionnaire and consequently each person is rated on the basis of the risk he or she represents.

The provision of data required at inception is not just about claims and claims history. In fact, underwriters look beneath the statistics and to the profile of the scheme to ascertain exactly who they will be covering. Locations, nationalities, occupations, age profile, male-to-female split, number of dependant lives, benefits structure and company operations all help to build a picture of the proposed risk. Anecdotal knowledge also helps underwriters understand that there are some significant cultural differences that determine how medical insurance is regarded and utilised by the eligible population. More often than not, insurers are also given a composite mix within a scheme's demographic profile which further complicates perceptions. For example, the number of "families" is typically quoted but not their actual composition. In these circumstances, one works around an assumed average of 3.5 or 3.8 (parents plus one or two children on average) members per family, but it is only once the policy becomes effective that the actual number of children is known (as they have to be made part of the "eligibility" records). In this example, the problem is not just about "guesstimating" the right number of children; in fact, the number and types of claims can vary considerably depending on the age of the children, their sex etc. hence a price differential would be granted.

In order to put together a comprehensive proposition, insurers have grown accustomed to using alternative methods with the little information they receive. Such approaches are not ideal since claims performance ultimately provides the best representation of the risk and leads to more attractive and competitive pricing rationales. Whilst a price can be derived without this data, there is always a risk of differing views and opinions from the market, which can lead to perceivably inconsistent pricing proposals and ultimately disadvantage the client, who may renew with their incumbent by default.

In any event, given a set of data, the underwriting goes through some key steps in "normalising" the data to allow for changes in population and inflationary increases in costs.

The latter is a typical feature of healthcare to the extent that medical claims are affected by "normal" inflation but also by what is generally referred to as "medical trend" related to the increase in costs due to new drugs, new operating techniques, increased age of population (survival rates), etc. Clearly, all groups are also subject to changes in population with new entrants to and exits from the group; in international insurance such movements are sometime linked also to changes of location or country.

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A group may, for example, have 75% of its population in Europe and 25% in the United States; if the Employer (policyholder) decides to grow in the United States the population mix may change considerably, which may have a profound effect on costs.

The "risk premium" obtained (i.e. the expected costs of claims for the policy) is often refined by the introduction of a "credibility factor" which is meant to reflect the reliability of the data provided; if the data received are incomplete or appear "suspicious", then a multiplier (generally between 1.05 and 1.25) is applied to allow for the uncertainty.

Last but not least, the price is affected by the costs of providing the service that must be added to the "risk premium". These costs range from the policy production (including maintenance of eligibility records, transmission of documentation to each individual member – "fulfilment") and administration (the cost of call centres, medical claims handling services, commission/brokerage) to the insurer's general expenses which normally include a "risk margin" that is designed to also cover the cost of capital employed.

Many companies ask how the price of such a complex – and relatively expensive - product can be contained. Both the insured and the insurer have some room to manoeuvre. The insured (the Employer, in our case) can maintain strict control of expenditures by reducing the quantity or level of benefits and imposing a (small) deductible on its employees. From the insurer perspective, the answer lies in keeping a fast and efficient claims handling system or organisation and maintaining a good hospital and medical facilities network that provides attractive discounts on their fees.

Once again, as is the case for any other class of insurance, the secret of success for a good healthcare policy is in the relationship between insurers and insured.

Giorgio Daboni, Chief Executive Officer of Generali Worldwide

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The Generali solution for a global medical network

Europ Assistance - Global Corporate Solutions (GCS) is the Europ Assistance Group's division dedicated to International Corporations, Institutions and Global Organisations, Insurers and Health Carriers. The development of "Care Services" by the Europ Assistance Group - the union of "health, innovation and proximity" - embodies the meaning behind the Group's business lines. This involves a strong sense of being there, acting effectively when needed for customers in everyday life, and exceptional circumstances as well.

Generali's global medical network

Like local employees, expatriate staff require routine medical services with general practitioners, ophthalmologists, gynaecologists and paediatricians in exam centres where they are treated in confidence and admitted thanks to their membership in an international health programme. However when these expatriate employees are seconded in very remote or unsafe areas where international medical standards are not practiced, they need assurance that they can be stabilised or treated safely prior to an evacuation in the event of an emergency.

For expatriate employees, a global health plan that provides services ranging from a basic check-up to more urgent procedures is essential. Europ Assistance, a fully owned Generali subsidiary, developed a dedicated, global third-party administrator to provide expatriates with such services.

CMN™
Corporate Medical Network™

The Corporate Medical Network™ (CMN™) by Europ Assistance is a flexible, innovative and on-going initiative designed to meet the needs of corporate clients. Continually expanding, the Corporate Medical Network™ signs new contracts on a daily basis and the network includes industry leading hospitals, doctors, specialists, dentists and other medical providers in over 130 countries.

Members need more than just hospitals for their daily healthcare needs: the main contributing factor to any successful expatriate plan is access to all services. Some TPAs will boast about their hospital count when in reality a member will most likely seek services from a lab, pharmacy or general practitioner's office; GCS focuses on all areas of the medical field when it comes to contracting.

Just as network size is important, so too is the quality of the providers selected. The CMN™ worldwide network includes:

- 10,000 Acute care facilities
- Over 600,000 physicians across 130 countries
- Over 5,000 international facilities with cashless service

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The CMN™ team of dedicated Provider Relations Network Specialists is actively contracting with healthcare suppliers around the globe to ensure Europ Assistance is consistently working with the best providers at the best price.

Global Network of Audited Facilities

In order to ensure the quality of the CMN™, medical facilities are audited in countries that are 'under-served' medically or where quality of medical infrastructure fluctuates. The audits monitor facilities in these countries more closely to ensure quick decision making in the course of medical assistance cases while maintaining access to quality care.

Every audit contains at least one hundred control points that address a variety of fields in the hospital, including:

- General and administrative information (location and accessibility, languages spoken by staff, currencies accepted, number of beds, number of intensive care unit beds, number of ventilated beds, number of admissions per year, number of emergency department visits per year, etc.)
- Possibility of direct payment by Generali
- Quality of medical care, sterilisation standards, nurse/patient ratio, qualifications of staff, number and origin of equipment, technology and maintenance of instruments, etc.

The following services are analysed with the greatest attention:

- Intensive/critical care (ICU/CCU)
- Resuscitation services
- Surgery
- Obstetrics/gynaecology

Testing (Labs, X-rays, etc.)

All the information gathered through these audits is entered into the CMN™ database, which is accessible by all operations and medical teams throughout the world. The database enables Europ Assistance medical experts to make quick and educated decisions on treatment options and allows customers to access a worldwide preferred and audited medical provider network with peace of mind.

CMN™ is yet another example of the Generali Group's commitment to providing quality healthcare solutions worldwide. Europ Assistance - GCS has invested in both people and resources to build the network and ensure service for its corporate customers.
Emmanuel Légeron, Chief Executive Officer of Europ Assistance - Global Corporate Solutions (GCS)

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Providing travel assistance for expatriates: Europ Assistance – Global Corporate Solutions (GCS)

In a global environment, companies must multiply their efforts to reach out to overseas markets with higher risks and threats. Specifically, ensuring employees' physical, psychological and social wellbeing requires access to local health, safety and security services that meet international standards.

As global organisations become increasingly risk aware, international HR management for business travellers and employees living abroad has undergone a noticeable change for both expatriate employees and local hires. The perception of occupational health is also moving towards improved health and security prevention management. These views now tend to fall under global Corporate Social Responsibility (CSR) strategies.

Global organisations increasingly aim for **better prevention, less reaction.** This is the motto driving employers' **Duty of Care** towards their employees, which includes companies' financial, legal and moral responsibilities. Employers favour undertaking a preventive approach for an identified and estimable risk rather than inflict themselves with a liability that has potentially increasing legal sanctions. Those employers hoping to avoid their Duty of Care obligations must pay attention to a legal framework that increasingly disadvantages them.

Generali in cooperation with Europ Assistance - Global Corporate Solutions (GCS) assists corporations, insurance companies, health carriers and their insured members to both successfully navigate the increasingly complex global healthcare system and overcome challenging business environments with economic ease.

Added value healthcare and security services need to bring protection and satisfaction both to the employer and its employees and contractors by:

- Fulfilling Duty of Care obligations
- Reducing risk
- Improving life quality
- Improving patient education and awareness
- Raising health outcomes
- Reducing absence
- Optimizing healthcare spending
- Improving the wellbeing and happiness of the workforce

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Emmanuel Légeron, Chief Executive Officer at Europ Assistance - GCS, tells us more about GCS' capabilities and strong added value behind its local healthcare management programs.

Today, the Generali Group is further developing its Health activities for expatriates. As one of the Generali Group's companies, how does Europ Assistance contribute to this effort?

Europ Assistance's health activities represent 16% of its annual turnover and more than €230 million. By adding Europ Assistance's yearly medical expenditures link to travel & US Cost Containment on top, a total of €800 million contributes to the development of Generali's health activities.

Medical Assistance and medical evacuations especially, remain a mystery for people unfamiliar with this industry. How would you describe this part of your health services?

Our core activity is Human-related; each evacuation is a challenge. Each person for which the decision to evacuate must be taken is a unique case, both from a medical and logistical standpoint. All this makes the decision even more difficult to make. It is not only a question of requesting an aircraft, a pilot and a medical doctor to go get the patient and fly him/her to a safe destination. **Volumes, technology, expertise and people with knowledge, know-how and experience** are key elements to Europ Assistance's success in organizing medical evacuations.

Does Europ Assistance - GCS have its own aircraft fleet for air ambulance transportation?

Many people often ask where Europ Assistance's Air Ambulance fleet is located. Admittedly, our fleet spans some of the most improbable places on earth. The strategic locations of our Air Ambulance fleet were implemented after a 2004 study by internal experts of the more than 1,000 international Air Ambulance flights that we have organised every year since 1963 (3 per day out of the primary evacuations, totalling 6,250 flight hours).

In 2006, the Europ Assistance Group decided to review its global strategy for managing air ambulances for medical evacuations. Our International Medical Committee strongly recommended improving Europ Assistance's position with regard to time and reactivity, global network, standard processes and monitored expenses for air ambulance services. A dedicated team of experts proposed a very innovative approach that remains unrivalled today: the development of a unique seamless medical assistance booking system, **3AT**, Europ Assistance's proprietary "Air Ambulance Auction Tool".

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The principles of 3AT are:

- Prior audit of providers' capacity and organisation
- Providers' compliance with regulations (licenses and proper insurance for the company, the aircrafts, the pilot, the medical escorts, among others)
- Written contracts with approved providers, acceptance of the business rules
- Negotiated rates
- Large and multiple technical / cost effective choices per air ambulance request
- Unbeatable cost reduction.

With one message sent to the entire network the moment Europ Assistance uploads a request for an air ambulance, each provider responds within 45 minutes with a price, quote and availability. Europ Assistance can then choose the most suitable provider to carry out the service. 3AT frees up valuable staff time and allows our teams to focus even more on members, since previously medical staff had to fax each supplier and track down a response.

3AT Main Benefits

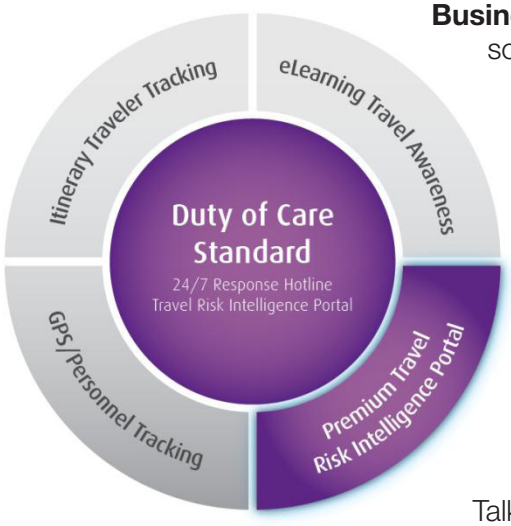
- Allow air ambulance providers to instantly provide a standardised and comprehensive offer upon receiving a request for a quote.
- Allow each Europ Assistance office to benefit from having the choice of the best price for the best quality among several providers around the world
- Contract with more than 40 air ambulance providers including a standardisation of the accreditation and audit process as well as improve commitment and special rates

Along with the Corporate Medical Network, how does Europ Assistance - GCS answer its clients' specific healthcare management needs around the world?

Europ Assistance - GCS holds a worldwide leader position and is the only international assistance company able to provide a full range of solutions for organisations with an international presence. Along with Generali's international TPA services, we provide Remote Medical & Security Services and Business Travel Risk Management.

Remote Medical & Security Services

Since 2009, Europ Assistance - GCS and its security partner, Drum Cussac (Poole, UK), have successfully worked together to offer combined medical and security solutions for remote site services and selected corporate customers. Drum Cussac has developed a proprietary traveller tracking tool that can be connected to Travel Management Companies systems or also to our clients' internal security system (badging, video-surveillance). Thanks to this tool, key assets can also be controlled 24/7. Risks and Security managers can access this tool for information and risks monitoring of their employees and assets.



Business Travel Risk Management includes prevention and intervention solutions for the health and security of mobile personnel across the globe.

Corporations increasingly have overseas operations, for which they must cover not only their own employees, but also contractors or guests from the company's country of origin or other countries with different health coverage systems, benefits packages and needs. Companies then face a host of complex situations whilst being morally and legally responsible to meet their Duty of Care obligations.

Europ Assistance - GCS operates all around the World. Which capabilities allow you to provide best-in-class services in emerging countries?

Talking about cost containment in Africa for example may seem like a challenge: to consider a real cost containment approach, there would be a need for the local healthcare offering to be sufficient in order to discuss pricing conditions beyond the quality of care.

Companies however increasingly commit to providing their employees with healthcare insurance that covers occasional heavy treatments through Travel for Treatment programs, but also daily healthcare needs: outpatient, day-care, and in-patient.

In emerging countries, local insurance companies cover more and more hospitalisation and treatment fees incurred abroad; however consultations by general practitioners and specialists as well as preventive medicine are rarely covered.

When controlled, these consultations are nevertheless the key to implementing a quality care and cost-effective healthcare program.

Experience & Success

With more than 300 million covered members, Europ Assistance has been implicated in all major events since its creation in 1963. Our clients' feedback on our interventions – professionalism, reactivity and responsibility – is a testament to the quality of the choices made by the men and women working with us and the logistical means that support their decision to evacuate or provide on-site care.

Experience with Mass Casualty Events

During the **Japan earthquake of 2011**, the Europ Assistance Group managed over 500 cases during this crisis, evacuating customers from affected zones to safer locations within Japan.

Similarly, during the **earthquake in Haiti 2010**, Europ Assistance deployed a response team, including logistics and medical personnel to the Dominican Republic to provide on-site support. The logistics team coordinated evacuations, ground and air transportation and provided communications assistance to impacted customers. Several dozen customers including a student group and a team of missionaries were evacuated.

During the **South Asia tsunami in 2004**, the Group organised the safe return of several hundred people by commercial air. In the end, more than 1,000 clients were assisted and repatriated.

Experience with security interventions

In **Tunisia**, Europ Assistance conducted a successful air evacuation of 66 employees and their dependents for an energy customer from Tunis to Central Europe.

During the Libya uprising in 2011, a successful ground and air evacuation was conducted on behalf of an energy customer for three of their employees located in a southern oil field. Our in-country network was used to effectively locate and escort the Group across the Algerian border for onward air travel.

In Nigeria, Europ Assistance carried out the successful evacuation of six employees from one city to another because of the threat to employees. We were able to fly one of their consultants from Lagos to the evacuation site to coordinate with the customer directly.

Generali Employee Benefits is proud to partner with Europ Assistance - GCS to offer its clients a full range of assistance services on top of customised Employee Benefits packages. For more information on Europ Assistance – GCS, visit their website at www.gcs.europ-assistance.com or ask your GEB Account Executive for more information on how to integrate assistance services with your company's existing benefit offerings.

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Key facts about Generali

present in **more than 60 countries** in the world

65 million customers

80,000 employees

nearly **€500 billion** in **assets under management**

€70 billion of premiums in 2012, **€4.5 billion** in health premium

one of the world's **50 largest** companies

Key facts about Generali Employee Benefits (GEB)

strategic unit within the Generali Group

established in 1966

focus on **employee benefits** solutions for **multinationals**

400+ international coordinated programmes

13 regional offices worldwide with over 120 local insurance partners

number 1 employee benefits network by premiums & geography

Key facts about Europ Assistance

208 covered countries

300 million customers & 62 million calls handled per year

12 million interventions per year

400 medical professionals and 8,000 employees

425,000 providers worldwide

established in 1963 and 100% owned by Generali Group

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