Taxing times

The storm brewing at Westminster

IN THIS ISSUE // IPT and salary sacrifice changes // Cost containment // Health engagement // Scheme stability
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New year, same landscape?

Will the political upheaval impact the health insurance and protection market?

A new political landscape. That is for sure. President Donald Trump in the White House and Brexit in full gear.

But what impact UK health and protection? Impossible to tell of course. Positive or negative? Who knows?

Well, aside from broader matters over the Atlantic and in Brussels – an insurance premium tax hike to 12% in June 2017? That’s sure to have an impact.

And not just that – changes to salary sacrifice arrangements around health & wellbeing benefits are causing confusion for employers across the country, while there remains uncertainty around group income protection benefits.

There may be sound reasons for that – but we’re yet to hear them.

In this issue, you’ll see a round-up of industry news and appointments, as well as articles from commentators who share their views on latest healthcare funding models.

There are also articles on cost containment, health engagement and healthcare trusts – an increasing area of importance for companies across the UK.

There is also a recap on the Health Insurance Awards – and look out for news about this year’s event in the weeks to come.

And as ever, please email any thoughts or feedback to healthinsurance@informa.com.

David Sawers
Editor | Health Insurance Daily

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PMI and healthcare trust excellence take centre stage at the Health Insurance Awards

Competition as fierce as ever

Excellence across the provider and intermediary communities was recognised at the 2016 Health Insurance Awards – and competition and camaraderie was in abundance at the industry’s annual black tie gala celebration.

Around 900 guests gathered at the Grosvenor House Hotel on London’s Park Lane, where they enjoyed entertainment from celebrity host Stephen Mulhern, as well as first class dining.

Once again, the private medical insurance (PMI) and healthcare trust categories were fiercely contested, highlighting just how competitive these areas of the sector have become in recent years.

Intermediary firms large and small went head-to-head with each other, supplying case studies highlighting how they have gone the extra mile for a client over the past year.

London-based advisory firm Orb Employee Benefits came out top in the Best Group PMI Intermediary category for entering a case study which the judging panel said “delivered clear results thanks to an excellent solution”. ADVO Group and Willis PMI Group received high commendations in this hotly-contested category.

Anglia Healthcare won the Best Healthcare Trust Intermediary award for a case study which the judging panel said demonstrated “an exceptionally high level of service and care when it came to meeting the client’s healthcare needs”, while Punter Southall Health & Protection received a high commendation for a case study which also caught the eye of the judging panel.

Meanwhile, intermediary voters helped Aviva UK Health to scoop the Best Individual PMI Provider and Best Group PMI categories, while brokers also gave the nod to Healix Health Services which celebrated another victory in the Best Healthcare Trust Provider category.

The efforts of a stalwart of the PMI industry were also recognised on the evening, as Punter Southall Health & Protection’s Stuart Scullion, chairman of the Association of Medical Insurers & Intermediaries, received the Outstanding Contribution Award for his work on behalf of the sector throughout his career.

The overall Health Insurance Provider of the Year Award was won by Aviva UK Health, while Willis PMI Group was named Health Insurance Intermediary of the Year.

The Health Insurance Awards 2017 takes place on 19th of October, once again at the Grosvenor House Hotel on London’s Park Lane. Email healthinsurance@informa.com for more details.
Cost of UK company medical plans rising by 6.4%, Mercer Marsh Benefits analysis shows

Lifestyle choices such as poor diet are the main driver of claims

The cost of company-provided employee healthcare plans in the UK is set to increase by 6.4% against an inflation rate of 0.8%, according to research by Mercer Marsh Benefits.

The costs are largely driven by claims-related to employee lifestyle choices, such as smoking, a lack of exercise and a poor diet.

The research, Medical Trends Around the World, is based on a survey of 171 insurers across 49 countries (outside of the US).

Across 40 countries, the average per person increase in healthcare costs is almost triple the rate of inflation.

In 2015 there was an average 9.9% increase in medical costs globally and it is expected to be 9.8% in 2016.

Cost increases are being driven by non-communicable diseases; those that cannot be caught from other people but are frequently caused by the lifestyle choices of individuals.

The average overall price inflation reduced from 3.9% to 3.5% over the same period.

Jacques Goulet, Mercer’s president of retirement, health and benefits, said the results underscore the importance employers can play in controlling healthcare costs.

“The window of opportunity is now for employer-led healthcare transformation – in the US but also in other geographies where employers have not played a direct traditional role but where having a cost-effective and high quality healthcare system is an enabler for business success,” he said.

Graham Pearce, partner at Mercer, said that if employers want to become more serious about healthcare it will require some initial investment, strong executive support and rigorous analysis of what is, and is not, working for specific workforce populations.

“Wellness programmes, education of the impact of lifestyle choices and the redesign of medical insurance plans have all had an important role to play in better controlling long-term medical plan cost trends,” he said.

The report found that Europe was the region with the lowest levels of forecast medical inflation, running at 7.8% in 2016 against a regional average rate of inflation of 2.5%.

Russia, Lithuania and Ukraine are forecasting the highest expected increases in medical costs of 17.8%, 17.3% and 15% respectively. The lowest levels of forecast medical inflation are France (1.8%), Netherlands (2.5%) and Italy (2.9%).

In Europe, the top claims in 2015 by cost were cancer (53%), osteomuscular diseases (43%), and diseases of the circulatory system (41%).

Gastro-intestinal diseases were among some of the most frequent claims reported.

The report found that stress-related health concerns are growing in Europe.

In Asia, medical costs are expected to increase by 11.5% in 2016 against an average regional inflation rate of 2.1%. The highest cost increases are expected in Vietnam (19.3%), Malaysia (17.3%) and Indonesia (11.8%).

Costs in Canada are expected to increase by 6% in 2016 against a background inflation rate of 1.3%.

Across Latin America, medical inflation averages 12.8% compared to an average inflation rate of 8%.
AMII Summit: Insurers gain full voting rights as trade body modernises constitution

Corporate members to have a greater say – in spite of some broker opposition

The Association of Medical Insurers & Intermediaries (AMII) modernised its constitution at its most recent annual summit in London – but the move to give full voting rights to insurer members ran into some opposition.

The AMII committee seemed to have expected its proposals – including one to remove a prescriptive clause forcing it to use a specific bank – to go through without debate.

But a move to give corporate members – the 15 insurance companies which have joined AMII ever since it ceased being intermediary-only some four years ago – full voting rights instead of their current status as associate members without a franchise was opposed by some members.

AMII chairman Stuart Scullion – who received the Outstanding Contribution accolade at the 2016 Health Insurance Awards – told members that his personal belief in “one man, one vote” led him and the committee to propose that each member had equal ballot rights. He pointed out that the 15 corporates could always be outvoted almost ten to one by the intermediaries.

Scullion also proposed that the corporates could put themselves forward as honorary officers – but again they would only have a small proportion of the overall votes so would be easy to oppose. And as some have pointed out, the corporates would be unlikely to agree among themselves on a common candidate for the chair or other post.

AMII finances have been transformed for the very much better ever since it accepted corporate members.

But there were two strong interventions from the floor – seemingly unforeseen by Scullion who made the point that neither had bothered to contact him beforehand.

Trevor Hunter from Halycon Health Care in Leeds pointed out that insurers blow hot and cold in their relationships with brokers, and that the function of insurers and intermediaries is not similar.

Hunter said: “We provide advice on which we stand or fall. They provide information. We are facing a period of great change with the Financial Conduct Authority telling people to shop around at renewal. This is a great opportunity. Our AMII mission statement is ‘impartial and independent advice’ so how can insurers with their tied agents provide this?”

Accepting that AMII needs the financial boost from insurers, Hunter suggested that there was nothing wrong with associate membership – he was an associate member of another organisation.

Scullion responded with a “I believe in one man, one vote” and that “without corporate support, AMII is unsustainable.” He also added that his term of office ceases in March 2017 and if no one can be found for the time consuming job, it might be better to pay someone on a part time basis (the jist of another resolution).

AMII founding member Zig Malendewicz of Hampshire-based NIMIS added his voice to that of Hunter.

He said: “If we give full rights to insurers, we could have conflicts of interest. How will we resolve intermediary vs insurer disputes? What would then become of our role as mediator? This is a retrograde step and I shall vote against.”

Scullion responded: “It’s all about change, not them and us. We give sound advice and will always try to help intermediaries in their dialogue with insurers.”

“Motion passed: AMII members OK changes to constitution”

Q. Should corporate members have full voting rights?

YES: 31
No: 10

Q. Should corporate members serve as officers?

YES: 30
No: 11

AMII chairman Stuart Scullion

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AMII Summit: UK private healthcare sector 'could learn' from Australian model

Hospital group boss says insurance can’t be only funding model

The private hospital sector has to rethink its model if it is to increase in relevance in the UK, according to Mark Page, chief executive officer of Ramsay Health Care UK.

Page (pictured), an Australian, came here two years ago to head up the 36-site Ramsay operation in the UK, an offshoot of the parent operation in Australia, where it is a major provider, and one of the world’s biggest hospital groups.

He told those attending this year’s Association of Medical Insurers & Intermediaries Summit, held in London recently, that the NHS is “fantastic” while the often much-lauded Australian system has “a heap of problems”. But there was still a lot to learn from his native land.

Ramsay’s UK hospitals are dependent on the NHS for some 75% of admissions. It has no sites in Central London.

He said: “It’s almost entirely elective for us here with a vast amount as day cases. In the UK we do low to medium acuity and we don’t have the demand or the volume to stretch further into acute cases as we do in Australia.”

Given the UK background, he asked: “Why would anyone want full price insurance?” He cited “the cost of private medical insurance, insurance premium tax, the propensity of churn rather than new business, extra charges billed after a hospital stay that was thought to be covered by a policy, and the presence of the NHS” as reasons against buying cover.

He said: “People don’t care who looks after them as long as it’s good, convenient and has acceptable outcomes.”

Australia “is not the definitive answer but its model provides food for thought,” he said.

It has a balanced healthcare system where 44% buy at least basic cover.

“It’s basic but real,” said Page. “And there is strong government support for this. Around 40% of all admissions are private, rising to 60% for cancer and elective surgery. But unlike the UK, private hospitals have emergency departments, and tackle teaching, training and research with a broad scope of acute services.

“We have government control of premiums and policies, backed by a carrot and stick approach. The carrot is tax relief on premiums – the level depends on your earnings and age. But the stick is if you don’t have private cover, you pay an income tax surcharge.”

An Australian recipe for success?

Ramsay Health Care UK’s Mark Page’s suggestions for Britain’s private healthcare sector

- Insurers have to move to a model that is less reliant on switch/churn business and concentrates more on new business
- The private sector has to build in more patient choice
- We need a joined up approach instead of the piecemeal system now operated
- Policies to draw on private medical insurance to help alleviate pressure on the NHS
- Talk ourselves up – private health is part of the solution, not the problem. We are part of the overall economy both nationally and locally
Healthcare trusts drive market growth as corporate sector rebounds

Private medical cover shows first – albeit small – rise since 2008

Demand for UK private medical cover increased in 2015, reversing the declining trend seen in recent years.

Figures from healthcare market consultancy LaingBuisson show the number of private medical cover subscriber policies grew by 2.1% to four million, following flat demand from 2012 to 2014 and shrinking demand from 2008 to 2011.

Private medical cover includes private medical insurance (PMI) and healthcare trusts.

The findings offer good news for a sector which has seen the volume of subscriber policies reduce by 8% since the end of 2008.

Reflecting the extension of a few very large corporate schemes, growth was driven largely by a solid 8% increase in the number of subscribers to self-insured schemes. PMI subscribers moved up by 0.4%.

Company-paid subscriber policies accounted for just over three-quarters (76.3%) of total market volume demand, representing 3,070,000 subscribers at the end of 2015 as the number of subscribers (insured and self-insured) increased by 3.4%.

The number of non-corporate individual subscribers continued to decline, falling by 1.7% to 952,000. This meant the overall penetration of the UK population by private medical cover edged up to 10.6% at the end of 2015.

Claims paid to private medical cover subscribers in 2015 were valued at £3.6bn, including £2.9bn paid to insured claimants and £688m paid to claimants covered by self-insured schemes.

Overall claims paid increased by 2.1% over the year, while claims on self-insured policies were up by 7% and insurance claims overall were up 1%.

Call for private top-up insurance to help NHS

Private top-up insurance could help prevent the declining healthcare standards in the NHS, according to Christopher Smallwood, economist and former chair of Kingston Hospital NHS Foundation Trust and St George’s University Hospitals NHS Foundation Trust. Writing in The BMJ, Smallwood highlighted the long waiting times and staff shortages prevalent across the NHS and the 85% of hospital trusts who are in deficit. He said the principal cause of this is the under-financing of the system. Smallwood said lessons could be learnt from other European countries such as France, where mainstream healthcare is mainly financed from public funds but a proportion of treatment costs covered varies depending on the service provided. Treatment for “catastrophic events” could be paid for by the state, with more minor treatments requiring a contribution from individuals. But David Wrigley, a GP and deputy chair of British Medical Association Council, said private top-up insurance schemes help those with the ability to pay to receive high standard care, while those who cannot afford extra payments receive lower quality care.

Healthcare trusts and corporate PMI schemes

The good news

- Overall subscriber numbers grew by 2.1% in 2015 to 4 million
- Rise follows flat demand from 2012-14 and shrinking demand from 2008-11
- Total spending on UK private medical cover grew by 2.8% in 2015 to reach £4.7bn
- Overall penetration of the UK population by private medical cover edged up to 10.6% at the end of 2015

The bad news

- Non-corporate individual subscribers continued to decline, falling by 1.7% to 952,000
- Overall volumes are yet to bounce back to pre-2008 levels when subscriber demand stood at 4.35 million (compared to 4 million now)
- Pre-2008, market penetration stood at 12.4% of the UK population (compared to 10.6% now)


Bupa now Australia’s No1 private health fund

Bupa has become Australia’s largest private health fund with 3.7 million members. The insurer has overtaken Medibank, which lost 96,661 members in the year to June and now has 3.6 million members. Medibank still has more policies – 1.8 million versus Bupa’s 1.76 million – but Bupa covers more Australians, according to the Australian Prudential Regulation Authority. Bupa gained 78,315 new members in the year to June. Health funds as a whole generated a surplus of over $1.2bn last financial year after raising premiums by more than three times the inflation rate in April 2016. This led to the proportion of the population in a health fund falling for the first time in 15 years.

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“Affordability and innovation are crucial in attracting more people to health insurance. We need to be bolder as industry in talking about our contribution to the UK healthcare system”

Alex Perry, general manager of UK insurance, Bupa UK

Total spending on UK private medical cover (insured and self-insured healthcare trusts) grew by 2.8% in 2015 to reach £4.7bn.

Within this, premium income generated from sales of insured policies grew by 2.1%, leading to a rise in insurance gross margins to 26.7% in comparison to 25.9% in 2014.

However, volumes are yet to bounce back to pre-2008 levels when subscriber demand stood at 4,350,000 – representing market penetration of 12.4% of the UK population.

In addition, the report warned that the medical cover sector faces further headwinds from recent and forthcoming rises in insurance premium tax (IPT) and uncertainty from the UK’s impending exit from the European Union.

Report author Philip Blackburn said the sharp increase in IPT has loaded significant additional cost for all medical insurance customers.

“A further hike to 12% in June 2017 will tighten this ‘taxation straightjacket’, and in an industry where affordability has been identified as the primary reason for a lack of growth in demand, this hefty additional burden is likely to mean demand for PMI is vulnerable going forward, but this may be balanced by a shift to healthcare trusts,” he said.

Blackburn added that there has been a clear rise in interest in private healthcare recently as more and more people are dissatisfied with higher waiting on the NHS and increased restrictions on NHS treatment.

“Private medical cover will benefit from this, and there is a wide choice of policy options at different prices to attract customers,” he said.

Alex Perry, general manager of UK insurance at Bupa UK, said an uncertain economic environment and a punishing IPT increase means the insurer is continuing to focus on affordability and quality.

“Affordability and innovation are crucial in attracting more people to health insurance. We need to be bolder as industry in talking about our contribution to the UK healthcare system,” he added.

Spire Healthcare revenues up 4.5% in 2016

Independent hospital group Spire Healthcare Group expects revenues to increase by 4.5% to approximately £925m for the financial year ended 31 December 2016. The group said it was adversely impacted by trading performance at St Anthony’s hospital, but its performance excluding St Anthony’s is expected to be towards the top end of guidance for 2016, which was revenue growth of between 3% and 5%. St Anthony’s is currently undergoing a redevelopment and reconfiguration process which is expected to take longer than initially anticipated by management.

Mercer to acquire Thomsons Online Benefits

Employee benefits consultancy Mercer is to acquire Thomsons Online Benefits, the software business behind the Darwin employee benefits platform. It follows the agreement of a formal partnership in April 2016, which was designed to expand the companies’ respective offerings to multinationals looking to manage their global benefits programmes. The two companies have been collaborating over the past decade. Terms of the deal were not disclosed.

AXA PPP to provide services for Canada Life

AXA PPP healthcare is to provide employee support services to Canada Life’s 2.7 million insured employees in 23,500 employer-funded schemes. The arrangement, providing free and confidential access to all employees, takes effect from January 2017. AXA PPP will provide the employee assistance programme EmployeeCare; bereavement counselling; a probate helpline; a health risk assessment via its Health Gateway platform and app; and employment law service BusinessCare.

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Conduent appoints head of UK sales for HR Services

New role for former Mercer exec

Conduent, the diversified business process services provider that was spun off from Xerox, has appointed Steve Mathews as head of UK sales for HR Services. Mathews (pictured) joins the business with 26 years of experience in UK employee benefits consulting and outsourcing. In this new role, he will be responsible for new business growth across the spectrum of Conduent’s employee benefits consulting, outsourcing and technology services. Mathews joins Conduent from Mercer, where he held the role of senior business development consultant.

VitalityHealth appoints director of corporate business

New role for former head of underwriting Pippa Andrews

VitalityHealth, the private medical insurance (PMI) and healthcare provider, has appointed Pippa Andrews as director of corporate business. Andrews (pictured) will lead the organisation’s corporate strategy along with the sales, underwriting and retention teams for corporate business. Prior to her new role, Andrews spent two years as head of underwriting at VitalityHealth. Before that she held a number of roles at Aviva and Zurich. Her career in the group risk and corporate PMI space spans more than 20 years. Greg Levine, director of sales and distribution at VitalityHealth, said: “Strengthening our corporate team is a key component to driving business growth and expanding our corporate book. Pippa brings a wealth of experience and is highly respected in the industry.”

Spire Healthcare confirms senior management changes

COO and CEO appointed

Spire Healthcare Group, the UK independent sector hospital group, has appointed Catherine Mason, the former CEO of Allied Healthcare, as chief operating officer. The move comes as current chief operating officer, Andrew White, takes some time away from the business to undergo a period of medical treatment after which he will assume the role of CEO. Spire said that while White will need some periods out of the business over the next several months, he will remain engaged in the company’s activities and he will continue as an executive director on Spire’s board. Mason’s other previous roles have included a spells as managing director at NATS and chief executive of Translink in Northern Ireland. Her appointment will be effective from 12 December 2016. Garry Watts, Spire Healthcare’s executive chairman, said: “The Board has been extremely impressed with Andrew’s vision and drive since he joined the group a year ago, and we are therefore pleased to confirm our intention to appoint Andrew as Spire’s new chief executive officer once he has made his recovery. In the meantime we welcome Catherine to Spire and believe that her extensive operational experience will make her an important addition to the leadership team. We expect a smooth transition over the coming weeks and I will continue to be actively involved in the day-to-day running of the business.”

Industry appointments People on the move
Mike Tyler appointed head of Lockton International Benefits

New chair of Global Benefits Leadership Group too

Mike Tyler has been appointed as head of Lockton International Benefits. Tyler (pictured) is also to become chair of the broker’s Global Benefits Leadership Group, which will oversee expansion of its benefits capabilities around the globe. Lockton’s Benefits practice represents 30% of its global revenues. In a statement, Lockton said it is investing additional resource in the Benefits business, with an initial focus on the UK and Asia. Tyler joined Lockton in October 2012 and built the UK business from scratch, as well as reorganising the benefits business in Asia. Neil Nimmo, CEO of Lockton LLP, said: “We have committed to further investment in the Benefits businesses internationally and we are delighted that Mike will be providing strategic direction and oversight to these investments and global leadership to all of our Benefits business.” Tyler said: “We have made terrific progress in the four years I’ve been with Lockton, and this next phase promises to be even more exciting as we expand the Lockton capability internationally and build on our relationships with Lockton Global Partners.”

Towergate Health+ announces six new hires

Former Jelf, Mercer and Simplyhealth execs join team

Towergate Health+ has announced six new appointments at its team in Winnersh, Berkshire. Carla Young has been appointed new business international private medical insurance consultant. She has previously worked at The Health Insurance Group, Aviva International and Ageas. Terry Fromant has joined as group risk & protection consultant, having previously worked at Unum. Other new faces joining the existing team of 44 include Paul Bridges who returns to Towergate as client relationship director (North), after a period at Mercer. Darren Perkins joins as client relationship director (South) after spells at Jelf and Simplyhealth. Daniel Beament joins as business development executive, having previously worked at Vitality, Ageas and Health-on-line. Sean Gummer joins as healthcare consultant, following roles at The Health Insurance Group and Vitality.

London Bridge Hospital appoints CEO

Former Portland Hospital boss takes reins at fellow HCA hospital

Private hospital group HCA Healthcare UK has appointed Janene Madden as the new CEO of London Bridge Hospital. Madden will join London Bridge Hospital after a seven year tenure as chief executive of The Portland Hospital, also part of HCA Healthcare UK. She succeeds Andrew Gore who was chief executive of London Bridge Hospital on an interim basis. Under Madden’s leadership, The Portland has developed plans to double the size of its children’s facility, already the largest in the UK. In February 2015 planning permission was granted for a £20m expansion. Aida Yousefi will be taking on the role of interim CEO of The Portland Hospital alongside her role as CEO of The Harley Street Clinic. Yousefi has been CEO of The Harley Street Clinic since 2014.

Aviva medical director Dr Doug Wright appointed Healthcode chairman

Former GP succeeds AXA PPP’s Dave Clarke in role at online services provider

Healthcode, the specialists in online services for the private healthcare sector, has appointed Dr Doug Wright as the new chairman of its board. Dr Wright (pictured), medical director of Aviva UK Health, will work with Healthcode managing director Peter Connor with the aim of promoting the more effective use of technology across the sector. A member of the Healthcode Board since November 2014, Dr Wright succeeds Dave Clarke, the operations director of AXA PPP healthcare who retires after six years in the chairman’s role. Connor said: “Dave was a member of our board since 2004 and I want to thank him for his commitment and expertise. In that time, Healthcode has made huge progress, from our beginnings as a medical billing company to offering a range of practice management, clinical coding and secure messaging services. Our ability to move forward and develop as a company is largely attributable to his leadership. As we continue to develop our online services, we are very fortunate to be gaining Dr Doug Wright as our new chairman. Doug has huge industry experience and it’s a great advantage for Healthcode to have someone of his knowledge and stature.” A former GP, Dr Wright joined Aviva (then Norwich Union Healthcare) 18 years ago from full-time practice. He has held various roles within the company, focused on claims management and clinical pathways before becoming medical director in 2012. In that role he also led Aviva’s recent response to the Competition and Market Authority’s review of the private healthcare and medical insurance industries. Dr Wright was originally appointed as a non-executive director of Healthcode in November 2014.

Optum International appoints VP of sales for EMEA region

Optum International has appointed Lisa Rowe as its new vice president of sales for the EMEA region. Rowe joins the organisation’s global healthcare team with more than 20 years of experience working in the international healthcare market. Her expertise focuses specifically on the relationship between healthcare benefits, employee wellness and corporate performance. Lynette Oat, chief growth officer, multinational employer and payer, Optum International, said: “We are thrilled to have Lisa Rowe on our team and know that she is the right person for the job.” Optum International offers a full suite of corporate health & wellbeing services including employee assistance programmes, wellness coaching, health assessments and digital engagement globally.
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• Business-critical information you can’t get anywhere else

GO TO HEALTHINSURANCEDAILY.COM/REGISTER
The changing face of medical benefits
Challenges to employers

The world of healthcare benefits is evolving. The introduction of new and often expensive treatments presents a growing challenge to employers who want to provide modern healthcare benefits to their staff but in an affordable and compliant way.

Healthcare has moved on. Medical and technological advances mean that we’re living for longer but many more of us will live with chronic conditions than ever before. And as a result, increasing numbers of employers are reporting demands for treatments beyond those traditionally included within their corporate medical schemes.

A good example here is what is often referred to as the ‘Angelina Jolie effect’. When the Hollywood star revealed that she had undergone a Prophylactic mastectomy to reduce her risk of developing Breast Cancer, genetic testing facilities revealed that demand for BRCA1/2 testing had almost doubled and there were also many more enquiries for the risk reducing mastectomy. But should it fall to the employer to cover the cost of such treatment?

And what about gender dysphoria? Once a taboo subject, recent high profile transgender figures have increased public awareness of gender identity issues. Diversity & inclusion teams within businesses are having to consider such areas.

Modern medicine provides us with greater choice and the ability to take control over our healthcare. For many organisations, providing corporate medical schemes is an essential part of their overall benefits and remuneration strategy and is critical to keeping their workforce fit and active. But what happens when an employee wants access to treatments that aren’t covered in their policies? In many cases, the insurer will refuse to cover them.

I believe that insurers need to offer a wider solution than simply just saying ‘no’. There will always be treatments – be they preventative, provided in extremely expensive facilities or excluded from the policy – that members will want to have access to. I feel insurers should look at these situations more creatively rather than saying they are ‘excluded’. Instead they need to help members with advice on possible care pathways. Insurers should also be able to offer a self-pay facility if the benefit is not covered by insurance.

In a world where we are increasingly able to push the boundaries of medical care maybe we should see a three pillar healthcare solution (see box).

With organisations increasingly moving towards a health trust solution and able to amend the rules of policies to include benefits not historically insured – chronic care and preventative surgery as examples – insurers and administrators should look at the self-pay sector as an increasingly important area where they can really support those with complex health needs.

A three pillar healthcare solution

1. An NHS facility paid for through taxation and available to all – subject to NHS guidelines

2. A private sector providing access to acute illness and injury care to help you get better at a private facility and consultant of your choice

3. A personal pay sector where care not funded by the NHS or medical insurance policies is easily accessible, regulated and outcomes are measured

Soraya Chamberlain is director of corporate healthcare & wellbeing at Punter Southall Health & Protection
Analysis

Taxing times
The storm brewing at Westminster

After the Chancellor’s double body-blow to the world of health & protection – what next?

The way salary sacrifice schemes are taxed is changing – and IPT keeps rising too. Regular HI Daily contributor Emily Perryman assesses which benefits will be most affected and asks the experts how businesses should prepare
Changes to the way salary sacrifice schemes are taxed could lead to employers phasing out health-related benefits.

The measures, announced by the Chancellor in November’s Autumn Statement, will result in the tax and National Insurance (NI) advantages of salary sacrifice schemes being removed from April 2017, except for arrangements relating to pensions, childcare, Cycle to Work and ultra-low emission cars.

For other benefits paid for through salary sacrifice, including health screens, gym membership and certain group protection products, employees will face the same tax bill as those who buy them out of their post-tax income. Employers will also lose their 13.8% NI saving.

Health screens

The changes are expected to have a big impact in the health screening space. Emma Roberts, principal at Mercer Marsh Benefits, says health screens have become an increasingly popular benefit in recent years as people take greater interest in their health.

A comprehensive health screen can cost around £500. Under a current salary sacrifice arrangement, a higher-rate taxpayer could save in the region of £200 so taxing it as a benefit-in-kind will result in a significant saving being lost.

Roberts argues that the legislation goes against the government’s aim of levelling the playing field for the lowest-paid workers who can’t afford to take advantage of salary sacrifice.

“Employers often pay for health screens for their top executives and then offer them out to other employees to buy. These employees will now face a bigger bill after the taxation changes,” she says.

Likewise, Debi O’Donovan, director at the Reward & Employee Benefits Association (REBA), argues it will be the “just about managing” employees who will be most affected by no longer having access to health and wellbeing benefits.

“The salary sacrifice arrangements have made many employee benefits affordable for lower-paid employees in recent years,” O’Donovan says. “This change will have little impact on the higher-paid who will probably continue to afford to select the benefits they want, or receive them as an employer-paid benefit.

“While REBA agrees that the government did need to clamp down on the increasing misuse of salary sacrifice for more ‘luxury’ perks, we are disappointed that so many essential employee benefits have been caught up in this change.”

Roberts say it is unlikely that employers will stop offering health screens in the short term because they are so popular with employees. Instead, she thinks employers will transition to the new rules and then evaluate whether employees are still buying the benefits.

“It could drive employers to look at more cost-effective ways of offering benefits,” Roberts says. “Traditional health screens are very expensive because as well as offering standard blood tests they provide face-to-face time with a GP. Some companies do blood tests but they don’t offer the expensive face-to-face time – this could lead to a higher take-up. The changes offer an opportunity for employers to look at their benefits package and move to one that really targets want people want.”

Group income protection

A big question mark remains over the future taxation of group income protection (GIP), which was not included in the Autumn Statement’s list of exempted benefits. When the announcement was originally made, Mercer said it would be seeking clarity over whether GIP forms part of the clampdown.

Mercer’s Roberts says it isn’t rational to tax GIP provided through salary sacrifice because once an employee makes a claim, the claim payments are taxed.

“‘There is no sense in subjecting claimants to double tax,” she argues.

GIP has become more popular as a salary sacrifice benefit where the employer enables employees to “flex up”. For example, a company might cover 50% of salary and the employee could top this up to 75%. Alternatively, the company might pay for a limited term policy and enable employees to increase it to retirement age.

Roberts estimates that of the employers who offer flexible benefits, between a third and a half might include income protection.

Ron Wheatcroft, technical manager at reinsurer Swiss Re, believes the lack of a GIP exemption sends mixed messages. Only two months ago a government
The changes announced by Chancellor Philip Hammond mean that the tax and employer National Insurance (NI) advantages of salary sacrifice schemes will be removed from April 2017, except for arrangements relating to pensions, childcare, Cycle to Work and ultra-low emission cars.

It means that some employees who swap salary for certain benefits, such as health checks and gym membership, will pay the same tax as the vast majority of individuals who buy them out of their post-tax income.

While there remains some confusion about the impact the move will have on group income protection (GIP), Aviva has since stated that its tax team has advised it that the changes will mean that where an employee assists with the funding of GIP by entering into a salary sacrifice, the amount sacrificed will be taxable on the employee as a benefit-in-kind.

Aviva says that HMRC has also confirmed that any payments made following a claim through GIP will also be taxable – something that the insurer has described as “at odds” with government’s desire to increase uptake of GIP as a means of reducing the cost of state welfare.

The Chancellor delivered a double-whammy to the health and protection industry in his Autumn Statement, confirming that insurance premium tax (IPT) is rising, hitting those who choose to buy private medical insurance. The increase, which was expected, will see IPT rise from 10% to 12% from 1 June 2017.

Wheatcroft says the easy option for employers will be to simply remove the ability for employees to top up cover. Otherwise, a situation could arise where part of the claim is taxed and the other is not: the proportion paid for by the employer will be taxed, whereas the proportion paid for by the employee won’t because they will already have paid tax on the premium.

Katharine Moxham, spokesperson for trade body GRiD (Group Risk Development), says this will add complexity for providers and scheme members.

“It will add a further burden on businesses which might otherwise have included a facility to allow their employees to build on a basic level of employer-provided cover,” she states.

Wheatcroft says the change could increase the attractiveness of individual income protection, although he says it would be very complicated for individuals to calculate the level of cover needed if an employer pays, say, 50% of income.

“They will need to go to an adviser,” he adds.

Since November’s announcement, Aviva has stated that its tax team has been told by HMRC that there will be implications for GIP (see box on opposite page).

Group critical illness

Group critical illness (CI) has not been spared from the clampdown. Johnny Timpson, protection specialist at Scottish Widows, says group CI sales have increased significantly in recent years on the back of workplace distribution. He estimates that half of these sales are part of flexible benefit arrangements.

Timpson says if the tax incentive on group CI is removed, it is “highly unlikely” that people in lower income bands will buy an individual product.

“Given the protection gap in the UK this is a retrograde step,” he says.

Life insurance

There is also a lack of clarity over how life assurance schemes under flexible benefit arrangements will be affected. Roberts says it is common for employees to be able to “flex down” cover in exchange for cash or alternative benefits as well as purchase additional life assurance. There could be a taxable impact on monies released where members do flex down, although Roberts says the full ramifications won’t be known until further details are released.
Gyms and PMI

Employees who receive discounted gym membership through salary sacrifice schemes will only see a small impact from the changes. Gym membership is currently treated as a benefit-in-kind, so while the employee doesn’t have to pay NI they do have to pay income tax.

However, Roberts says the impact will be noticeable for companies providing on-site gym membership, which is currently free from NI and income tax. Under the new rules, on-site gym membership paid for through salary sacrifice will lose these tax exemptions.

Private medical insurance (PMI) has not been excluded from the changes but this is unlikely to have a far-reaching impact. Iain Laws, managing director – UK healthcare and group risk at Jelf Employee Benefits, says it is very unusual for PMI to be bought via salary sacrifice. This is because PMI is treated as a benefit-in-kind so there is no tax advantage to the employer for offering it under salary sacrifice. In addition, insurers do not allow selective membership for company policies so offering membership on a self-pay basis is not possible.

PMI policies will be more impacted by the increase in insurance premium tax (IPT) from 10% to 12% from 1 June 2017.

Roberts expects there to be a significant increase in large employers looking at alternative funding options, such as healthcare trusts. IPT is only due on any stop-loss insurance, so the tax is much lower than on an insured scheme.

“For smaller employers healthcare trusts can be risky. They might have to bite the bullet and look at managing their claims more effectively instead,” Roberts adds.

Next steps

The next few months are likely to be a major headache for employers. The changes are due to come into force from April 2017, although new schemes in force before that date have been granted an exemption for another year.

Jeff Fox, principal at Aon Employee Benefits, says the short timescale for communications and payroll will present challenges and it will be harder for businesses to offer a compelling and competitive benefit package.

Steve Herbert, head of benefits strategy at Jelf Employee Benefits, says it is extremely important for employers to communicate with employees about which benefits are changing and how they will be taxed.

Employers should also consider whether benefits of the same quality will be affordable and look at some alternatives.

“Businesses need to look these factors sooner rather than later,” Herbert states.

Joanne Neary, employee benefits consultant at Sanlam, says employers should consider what employees actually value and then communicate their benefits effectively.

“Employees won’t want to suffer the tax consequences on a benefit they don’t want or don’t understand,” she says.

Kevin Gude, director at law firm Gowling WLG, says details as to how the changes will be implemented will not be made clear until legislation is produced, however this will not cover the way individual arrangements need to be revised.

Gude points out that HMRC can dictate the effect of operating salary sacrifice, but the arrangements themselves are governed by the terms of the employment contract negotiated between employer and employer.
PMI THAT’S AFFORDABLE TODAY... AND IN THE FUTURE

We don’t operate individual ‘claims related’ pricing, so your customers will never be penalised for claiming.

WHAT’S COVERED?

Access to 38 Spire hospitals and clinics
In-patient, day-patient and out-patient benefits
Comprehensive cancer benefits
Available on an individual and SME basis

“ That’s a fair and transparent approach to PMI and helps keep premiums affordable. ”

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Changing the image of insurance.
Speak to most brokers about the challenges they face when selling private medical insurance (PMI) to clients and high on the list of hurdles to overcome for all of them will be the ever-increasing cost of PMI and the challenges of demonstrating value for money. Sarah Buck, CEO of APRIL UK, explains how her organisation is tackling the issue.
Health insurance providers will always face a far harder challenge than many other industry sectors when it comes to maintaining efficiencies and limiting expenses. The nature of the industry is such that new drugs are costly to research, test and bring to the market and new surgical techniques, whilst more efficient and effective, are often very expensive to buy, especially in the early years, before the new technology becomes embedded and higher production levels of new equipment eventually brings prices down.

It has long been known in the industry that medical cost inflation far outstrips domestic price or retail price inflation rates. Consumers are used to hearing about RPI or CPI running at levels at around or below 2%, so it will surprise many to learn that medical cost inflation regularly still reaches levels three or four times higher.

**Medical inflation**

In a recent piece of research carried out by Aon Hewitt entitled the Global Medical Trend Rate Survey, medical inflation rates in the UK were said to average nearly 7% in 2014 and just under 6% in 2015, at a time when RPI ran at an annual average rate of 2.4% in 2014, according to the Office for National Statistics and 1% in 2015. CPI, the government’s preferred index ran at still lower rates. Overseas, the figures can be double that, as was shown by a recent Bureau of Labor survey in the USA, where medical price inflation is reckoned to be running at 1.9% per month, which equates to around 24% per annum.

For brokers, this kind of price inflation makes the insurer’s product hard to sell, so the insurers have had to find ever more innovative ways of containing not only medical costs, but also their own operational costs, both of which impact directly upon the premium the client will be asked to pay.

**A new entrant, a new approach**

New entrants to the UK market for PMI policies are rare at times like this, as broker inertia allied to a tough selling environment where margins are thin do not usually add up to an attractive new market opportunity. For us, the starting point was to understand how we could drive medical costs down, as these are a major component of policy costs, while maintaining high service levels.

APRIL UK is an example of one provider which believes it is bucking the trend – a newcomer to the market around four years ago, sales have risen strongly for several years now and the award winning company has just been shortlisted for yet more awards in the prestigious Provider category run as part of the 2016 Health Insurance Awards.

APRIL has had to face up to this upward price pressure and give brokers a compelling reason for selling its products over and above those of the competition.

Clients did not necessarily want an almost unlimited choice of medical establishment and in fact most members of the public have no way of knowing how good their local hospital is, as they are not expert in this area. This opened up an obvious avenue for us to exploit – by focusing on one hospital group, we were able to offer that group the prospect of buying for a much larger number of clients and so help their reputation with a new category of client. This was a win win for both parties, as a significant buyer, we were guaranteed better rates and we could be sure clients would receive the highest service.
service standards. For the medical provider, they had a reliable and substantial source of business.

For the client, they have lower premium rates and APRIL fulfilling the role of quality control monitor, ensuring the highest service delivery at the point of use in the hospital.

Linking up with the Spire Healthcare, which operates 38 hospitals across the country, APRIL’s inSpire product represents one way of delivering cost containment. Research carried out by APRIL themselves shows that across 14 areas in the UK, when comparing policy premiums against an equivalent plans from a market leader across three age segments, APRIL’s inSpire policy was cheaper in 38 out of 42 cases. In over half the cases, the prices were at least 30% to 40% cheaper and in a small number of cases, inSpire was over 100% cheaper.

InSpire is not a one size fits all solution, and we offer other modular plans giving access to other hospitals where clients request this, but APRIL is, it is fair to say, focused on delivering an efficient product portfolio.

The broader balance sheet

On the other side of the balance sheet, there is much the providers themselves can do to contain their own managerial, staffing and operational costs, which in turn means premium levels can be held in check. According to work carried out by consultants McKinsey, in an article entitled “What drives insurance operating costs?” the biggest driver of cost differences is management. The McKinsey work identifies four areas where management can make the difference:

First on their list is business complexity. Companies with complex distribution channels and complex portfolios are likely to be higher cost operations. Secondly, the operational model adopted by management can be critical – lower-cost operations bring together similar parts of the group to consolidate operations and limit back office costs.

A fragmented IT system can often be another source of operational inefficiencies, as it is usually neither cheap to run and maintain nor flexible. Finally, performance management processes need to be embedded in the company to ensure business are constantly monitoring how well they work and asking the question, “Can we do this any better?”

For us, there were some easy wins. By bringing together some of the key business support units and management team for the APRIL Group’s subsidiaries in the UK, we have created a leaner, more efficient operational base, with the costs shared across the group. At our Head Office in Bristol, we have embedded a strong culture of care and accuracy. There is a rigorous focus on getting things right the first time, so we do not waste resources fixing mistakes, which can be draining. Employees are constantly encouraged to challenge processes and find better ways to do things: This is reflected in our IT systems which are designed to a specification created by front-line users and deliver exactly what we need without compromise. But cost savings and efficiency gains count for nothing, if the customer experience suffers, so it is important that we maintain high levels of customer service. Being nominated for “Best Customer Service” at the Health Insurance Awards for the last two years running shows me we have got this area right.

Many clients do not necessarily want an almost unlimited choice of medical establishment and in fact most members of the public have no way of knowing how good their local hospital is.”

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Medical inflation: Outstripping domestic price and retail inflation rates

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<tr>
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<th>2014</th>
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<td>RPI</td>
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<td>Medical Inflation</td>
<td>7%</td>
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Source: Aon Hewitt, Office for National Statistics
With rising costs from medical price inflation and an increasing Insurance Premium Tax burden, your clients may wish to consider other Aviva healthcare funding options to control costs.

Aviva can offer:

- A range of healthcare funding solutions to suit your clients’ needs
- A dedicated account management team with 60 years’ combined experience
- Bespoke management information tailored to your clients’ requirements

To find our more about our Private Medical Trusts, contact us:

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Now could be a good time for your clients to consider a Private Medical Trust

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Escalating PMI costs

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Tackling rising healthcare costs

Why the spotlight is firmly on cost containment

Rising costs triggered by medical price inflation and insurance premium tax (IPT) rate increases represent one of the biggest challenges facing the private medical insurance (PMI) schemes of large corporates today, says Nick Reynolds, Sales Director, Aviva UK Health. But cost containment pressures also present a valuable opportunity to make lower-cost healthcare available to employees who might otherwise have lost out...
On 1 November 2015, former Chancellor George Osborne announced a new revenue-raising strategy: a hike in the standard rate of IPT – which includes all traditional corporate PMI policies – from 6% to 9.5%. And with a further increase to 10% scheduled for 1 October 2016, IPT is poised to pile yet more pressure on the affordability and sustainability of healthcare schemes for the UK’s backbone of large corporates.

With the insurance industry itself unable to absorb the impact of the increases, there are fears that the second increase in IPT will hamper insurers’ ability to manage costs. This in turn could hold back market growth and drive corporate membership out of the marketplace.

While the number of full-time employees in the UK has risen, the number of company-paid policies has not kept pace, opening up a clear – and unsustainable – gap in the market. This has wider macroeconomic impacts as the NHS struggles to meet its own finance targets. Accordingly, forward-thinking insurers are looking head on at the cost containment challenges as a valuable opportunity to develop innovative, affordable solutions that can help fill the void created by this increasingly complex legislative and changing economic environment and the general state of the nation’s health.

**Trusts help to tackle the cost burden head on**

When it comes to managing costs, there is an alternative to traditional PMI contracts.

For corporate clients with more than 500 employees, private medical trusts can help to control creeping costs by reducing the IPT charged by the insurer.

So what exactly is a private medical trust? In a nutshell, it’s a long-standing and HMRC-recognised commercial construct that allows corporates to fund agreed healthcare benefits delivered to members through a trust specifically set up for that purpose. The employer makes contributions into the trust, building up a pot of money which it dips into to fund both the medical expenses as they arise and the associated administrative costs.

It’s important to understand that under the conditions of setting up the trust, the employer cannot revoke the contributions at any time and the trust must be able to meet all of the costs for treatment committed to its members. So how can trusts help control increasing costs? IPT only applies to insurance contracts. And because trusts are not insurance products, they are exempt from IPT. In comparison with a standard PMI policy, the IPT-exempt status of trusts represents a cost-efficiency advantage for larger corporate employers, enabling them to introduce a package of benefits that may cost both them and their employees proportionately less in the future.

For clients, the private medical trust also presents a clear advantage right from the start: it gives them closer control and greater flexibility when it comes to the types of benefits provided. That’s because the scheme rules can be tailored to the specific employer and/or industry.

What is more, the benefits that a trust can offer aren’t dictated by an insurance policy. As you would expect, an experienced provider like Aviva will guide clients carefully through the types and levels of benefits being offered, as well as advising them on the most effective ways to get the best from them. And in the case of our own trusts, there is no need to worry about the day-to-day operation of the trust, or training for in-house staff or trustees on its administration.

We provide our corporate clients with full support with enrolment and advice on
promoting the benefits of the trust across the business, to assessing claims, making payments and providing clear feedback on the value of the benefits they are using – or not. And alongside our trusts and where appropriate, we also support clients with two robust Corporate Excess solutions which are also IPT efficient: Fully Insured Corporate Excess and Cost Plus Corporate Excess.

At Aviva, our largest trust covers over 20,000 employees, and the client has been with us for over 18 years. Along with our 22-year experience in this field, we are experts at setting up, transferring and managing trusts. Crucially, this experience means we are also skilled enough to help businesses understand both when a trust may not be the right solution for their needs and advising on the risks and how to mitigate them.

Health Essentials: an intuitive extension of our healthcare range

Trusts are not the only way for big corporates to look at reducing rising costs. With our extensive healthcare experience, we saw an opportunity in the market and, for us, it was an intuitive step to launch two of our Health Essentials products to our large corporate clients in 2016. Health Essentials is a range of simple, top-up health insurances focused on specific conditions. It is specially designed to allow corporate employers to give access to low-cost health insurance products to their employees who might not traditionally have qualified for private medical insurance.

An average of 33% of all costs incurred by corporate schemes are accounted for by musculoskeletal conditions
(Source: Aviva UK Health)

Sitting alongside our traditional healthcare products, Health Essentials complements and supplements the care that our customers receive through NHS health services, providing cover for employees across all budgets and life stages. We have built the range around two key elements – Cancer Essentials and Physio Essentials – in recognition of the fact that an average of 33%^ of all costs incurred by corporate schemes are accounted for by musculoskeletal (MSK) conditions, while 1 in 2* people born after 1960 in the UK are at risk of being diagnosed with cancer in their lifetime.

For employees, this type of flexible funding solution can represent precious peace of mind if the worst happens, as well as vital financial, medical and emotional support for them and their families. And because Health Essentials insurances are managed digitally right from purchase through to servicing, claims and renewal, employees and corporates alike benefit from reduced costs, streamlined processes and fewer bottlenecks in the treatment process.

Crystal-clear cost-containment opportunities

Back in 2015, when the government announced the initial increase in IPT, the reaction from the insurance industry ranged from disappointment to outright dismay. Many saw it as a backward step in terms of employee engagement, fearing it could disincentivise both employers and employees from protecting their health and wellbeing at a time when the NHS was already struggling under unprecedented pressure. Others worried that higher IPT would drive up the costs of PMI, putting it beyond the reach of many people.

So with IPT poised for a further hike on 1 October, large corporates are steeling themselves for another increase in the cost of their healthcare schemes – and yet more pressure on their profits. But for insurers with the vision to recognise the opportunity represented by rising costs, the ever-sharper focus on cost containment is about more than a blanket policy of cutbacks and higher policy excesses. Instead, it is about seizing the chance to look for more cost and IPT-efficient alternatives for today’s large corporates through trusts, or by developing low-cost, top-up health insurances. Most importantly of all, though, it is about making sure that corporate clients still have the power to help their employees access the treatment they need, when they need it, at a price they can afford.

Sources:
^ Figure taken from Aviva Large Corporate portfolio average 2016.

“Private medical trusts can give employers closer control and greater flexibility when it comes to the types of benefits provided”
Health engagement

The key to a happy, healthy and productive workforce

Employee sickness and absence remains a major problem for companies across the UK, but recent innovations around self-referral and health engagement mean problems can be tackled earlier than ever before, as Cigna’s Michelle Rae explains.
In today's world, employers are encouraged to engage their employees with health and well-being more than ever. This means providing support, advice and motivation with a focus on the prevention of illness. Unfortunately, as many as 1 in 3 people will face a long-standing health problem at some point in their lives.

Social issues such as age, family status and income contribute to health risk factors. Likewise, lifestyle challenges such as smoking, alcohol misuse or poor diet and activity levels can cause the onset of a variety of illnesses. In many cases, these problems lead to absence and productivity challenges in the workplace. Whether it's physical aches and pains or mental health issues, poor health has an impact on employee attendance and performance. And accessing NHS care quickly may be a further complicating factor.

Cigna's recent UK consumer health engagement research found that three-quarters of people are not able to get an appointment on the day they call their General Practitioner (GP). In some regions, almost a quarter of people wait more than seven days for an appointment, and one in four GP practices now have a two-week wait for an appointment.

This of course has a huge impact on the bottom line of a business, and on the UK economy as a whole. The estimated cost of sickness absence to the UK economy is a staggering £29 billion each year. An average of 6.9 days per year per employee is lost due to sickness absence. This in turn results in a cost to the employer of around £554 per employee.

Sickness absence creates both direct and indirect costs for an organisation. Over and above the costs of statutory sick pay, there can be a reduction in productivity and low morale due to fewer staff and rising workloads. There may even be the added burden of having to find, train and pay for temporary cover. There's also the possibility that this can ultimately lead to reduced customer satisfaction. So it's vital that employers do everything possible to keep their staff engaged and motivated with their health.

Innovating to meet customer needs

The good news is that providers in the private healthcare market are constantly innovating to meet the needs of the employer and their employees. Preventing illness and promoting a healthy workforce is crucial. There is a growing range of support tools now available to help employers encourage their people to make good lifestyle choices. For example, health and wellbeing portals are a great tool for engaging employees and sharing information. Employers can provide healthy living tips and information on how to live with various health conditions. These tools can help employers manage their employees' health in a cost-efficient way.

Healthcare providers may also be able to support organisations with health and well-being events. Or offer financial incentives towards services such as on-site health checks, ergonomic assessments and fitness centre passes.

As the appetite for digital technology continues to increase, online tools and apps are becoming an increasingly popular and convenient way to keep employees engaged with their health. Many healthcare providers often have their own online solutions, which can provide a wealth of insight and meaningful data to support healthcare spend.

Employees can have direct access to care, removing the need to see a GP for a referral. Many providers now allow their members to refer themselves to a range of diagnostics, treatments and therapies, including early cancer diagnosis, physiotherapy, or cognitive behavioural therapy.

These self-referral routes benefit the employer by reducing unnecessary consultations and time away from work, resulting in cost savings for their business. More importantly, they provide employees with a faster route to recovery. For many health conditions, early detection or intervention is best. Fast access to diagnostics and treatment via self-referral helps to aid patient recovery, improves survival rates, provides reassurance and also ensures the condition is treated effectively.

To manage workplace health effectively, it's important that employers understand the particular health challenges of their employee population and join forces with their healthcare provider to implement workable solutions.

Focusing on musculoskeletal problems

Rather worryingly, up to 100 million EU citizens suffer from musculoskeletal (MSK) pain. In the UK alone, an estimated 1.2 million people suffer from work-related MSK disorders. Problems such as back,
Health engagement

neck and muscle pain are the most common cause of workplace absence, accounting for 30 million lost work days.

These problems can be caused by a number of factors including manual handling, uncomfortable working positions and working too long without breaks. And whilst not all back pain can be prevented, tackling a number of health risk factors can help alleviate MSK conditions.

When an ache or pain becomes troublesome, accessing expert medical advice and treatment quickly is essential. There are several benefits of early intervention for MSK problems. These include quicker treatment which can stabilise or control symptoms. There’s also a lower risk of developing additional conditions and a greater chance of recovery and return to work.

If an employee experiences pain in their bones, muscles or joints, it’s hugely beneficial to offer them the option to bypass their GP and self-refer to appropriate treatment. Cigna customers for example, can simply call a nursing team who’ll provide support, advice and, where appropriate, fast track access to physiotherapy, osteopathy and chiropractic treatments.

However, there are many different MSK problems and some can affect people in ways that go far beyond the obvious aches and pains. In some instances, because of the debilitating nature of a chronic MSK problem, it’s not uncommon for an individual to develop mood disorders or mental health problems. Notably, up to 30% of people with an MSK disorder also have depression, which makes it even more difficult to stay in or return to work. It’s important that healthcare providers look out for the signs and are able to recognise the symptoms. If an issue is identified, further treatment should be recommended to help the individual make a full recovery.

Understanding the nature of MSK disorders - and ensuring employees receive appropriate treatment for any additional conditions - is essential to achieving the best possible outcome.

Supporting your employees’ mental health

There’s a range of mental health conditions that will affect many people at some time in their lives. Right now, 1 in 6 of the UK population deals with a mental health problem such as anxiety, depression or stress. With employees working longer hours than ever, mental health issues among the workforce are prevalent. This understandably proves a major issue for UK employers and one that costs approximately £70bn every year in lost productivity, benefit payments and healthcare expenditure.

It’s important to recognise that mental health problems can also stem from the demands of a physical condition. Research shows that workers who take time off work as a result of MSK disorders are also at risk of developing symptoms of depression in the first year after their injury.

But it’s not just healthcare providers who have a responsibility to look out for the early warning signs. Sadly, many employers believe they don’t have the skills or knowledge to identify when an employee is suffering from mental health issues. According to a recent study, 56% of HR professionals say that their management doesn’t offer any training or advice in techniques to reduce workplace stress. Although many employers understand the benefits of a healthy workforce, it’s clear that more needs to be done to create awareness of mental health. This is where healthcare providers can offer support.

There are a number of solutions available that can help support employees. Cognitive behavioural therapy (CBT) is a talking therapy that helps people to manage their problems by changing the way they think and behave. CBT is most effective for conditions where anxiety or depression is the main problem. Some healthcare providers now allow their members to

“There is a growing range of support tools now available to help employers encourage their people to make good lifestyle choices”
New research shows 25% of all cancer sufferers see their GP three times before being referred for further tests

Many employers now also recognise the benefits of online self-help tools that are based on CBT techniques. These tools are suitable for those with mild to moderate stress, anxiety and depression. For employees struggling with an addiction to alcohol or drugs, some providers may also offer a home detox service, available via self-referral. These programmes can offer the individual specialist support day and night in the comfort and security of the home environment. Other employee resources can include employee assistance programmes and helplines.

Mental health problems are much more likely to recur or persist if they’re not addressed promptly. That’s why ensuring fast and appropriate treatment is essential. Cigna for example supports the cause for better workplace mental health and its self-referral option for CBT helps members to access treatment quickly.

Stepping up the corporate fight against cancer

Worryingly, Cancer Research UK predicts half the UK population will be diagnosed with cancer at some point in their lives. Of the 325,000 people diagnosed with cancer each year, more than 100,000 are of working age, and estimates suggest that more than 750,000 people of working age are now living with a diagnosis.

With increasing cancer incidence in the workplace, it’s vital that employers can support any employee who’s diagnosed with cancer.

However, it can be difficult for employers to find the right balance between offering cancer cover to employees and managing the costs involved. When an employee is diagnosed with cancer, they often have special requirements that need to be met and many questions that need to be answered. But a focus on awareness and early detection can help catch a significant number of cases at an early stage.

As mentioned, GP waiting times can often be an issue for many people. New research shows 25% of all cancer sufferers see their GP three times before being referred for further tests and so the introduction of self-referral for cancer diagnostics within the private healthcare market is a huge step forward.

These self-referral routes provide customers with fast access to local cancer specialists for a range of cancers including, breast and skin. With many appointments arranged within five working days and a diagnosis given within 10-25 days, employees can start the treatment they need quickly.

When cancer is detected early, this results in better treatment outcomes, higher cure rates, and improved survival for patients. For employers, this means employees return to work more quickly. Providing support for employees also pays dividends to an employer’s recruitment and retention efforts and helps them to maintain an engaged and dedicated workforce.

Cancer in the workplace is and will remain a pressing challenge for employers and healthcare providers for years to come. Providing quick and easy access to confidential, supportive and high quality resources goes a long way towards protecting and caring for employees and their families.

The benefits of self-referral

The introduction of self-referral routes to a range of diagnostics, treatments and therapies provides a wealth of benefits for both the employer and the employee.

The most obvious of benefits is that in comparison to GP referral, employees enjoy faster access to care. This improves their overall experience and they can start their treatment quickly. This also reduces the amount of time they need to take off work and helps prevent their condition from worsening. In many cases, the cost of treatment is also reduced and potentially it can help avoid long term chronic conditions from developing.

For employers, early intervention and direct access to treatment promotes cost savings. It also helps to reduce employee absence and maintain a healthy and engaged workforce. Promoting health engagement and supporting employees through illness will also work wonders for an employer’s recruitment and retention efforts.

Driving a healthy business

Promoting health engagement is becoming more commonplace across organisations. By helping employees to make the best lifestyle choices, employers can help maintain a healthy workforce in a cost-efficient way.

But if illness does occur there are many self-referral routes that healthcare members can take advantage of. As the NHS is still under strain and GP waiting times continue to prove problematic, the private healthcare market will continue to innovate and we can expect to see more self-referral routes made available over the coming years. Early intervention can prevent health issues getting worse, reduce the cost of treatment and help employees return to work quickly. Healthier people drive a healthier business, so supporting and engaging employees with their health and well-being is essential.
Cut 10% off one of your clients’ major operating costs

Without compromising employee care

A Healix Healthcare Trust gives you the same level of care and the capped annual costs of a PMI scheme, but lowers those costs by an average of 10%. Not only that, your clients will have greater control over what is covered and it couldn’t be simpler to set up.

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Healthcare trusts

Stability in a time of uncertainty

While no one has a crystal ball, a healthcare trust can provide long-term stability and future proofing of spend. There is no better time than now for employers to take control of their future healthcare spend, says Bruce Eaton, managing director, Healix Health Services
The 23rd of June 2016 [UK votes in favour of ‘Brexit’] will remain an indelible date for many UK citizens. Despite much speculation and opinion, nobody really knows what lies ahead and only time will tell.

In a similar vein, feelings of the unknown are often felt by HR managers, finance directors, benefit consultants and other decision makers just after the annual review of their corporate private medical insurance (PMI).

The annual journey to the next renewal can for some be a rollercoaster with one eye on employee care and the other on the business purse. If luck is on their side, the anniversary date will run smoothly with just an inflationary increase. If not, the main purpose of the plan has come into force [providing medical care for their employees] but the costs have spiralled and the simple renewal of last year becomes a distant memory as a sudden focus is imposed and inflationary costs are compounded by future medical cost adjustments in order to keep employees in care and the need to do the right thing.

For many, actual costs have been masked with insurers willing to ‘take a chance’ and reduce the increase so that employers can breathe a sigh of relief for another year, cross their fingers and hope for the best. Where there was access to circa 12 insurers in the market a decade ago, there is now an ever-reducing number with only five really offering the traditional model. In that same period, the country has been through a recession and now the unknown quantum of Brexit is upon us.

“So what”, many cynics may cry, “the market has always looked after us and I can always find the right price on the day”. Add in the fact that by 2020 (arguably two years post-Brexit outcome) the latest statistics indicate that over 50% of the UK’s working population will be over 50 years of age. Once again, “so what!” they may say. Well, part of the reason PMI premiums have been increasing year on year for many is down to the fact that corporate groups are ageing and higher cost medical claims incidence is on the up. In short, in terms of corporate PMI schemes, Brexit will only be part of your future focus.

"Aside from the continuing landscape of innovation in medicine and the associated increasing costs, is it possible to gain control of spend? The simple answer is yes!"

Why has it come to this?

Originally bought as an absence management tool, PMI has now become an employee benefit and the market obsession for market share has now burdened decision makers with a cost that is both unknown and arguably unsustainable. The medical profession has not stood still; breakthroughs in care and drug availability are hugely impressive and a privilege of the modern world – but costs are understandably higher than they were.

Over time, the pricing of a plan has been [to many] a mystery and while intermediaries go to great lengths to demystify this annual event, the reality is that insurers limit the distribution of data and are naturally in the pricing cycle to retain clients at any cost regardless of the scheme performance. In short, the client has no idea what their true performance is and what ‘shocks’ are being stored up for the future. Hence pricing volatility is rife and clients are in the dark in most cases.

While scaremongering is not always appropriate, take a look at the average PMI scheme to date. Twenty years ago, a high cost claim was probably just a routine surgery with a few issues and the final bill would have been no more than £15,000. Ten years ago, the advent of monoclonal and biological therapies in the treatment of cancer pushed the high cost claim bill to well above £15,000 and in some cases bills of £100,000+ are not uncommon. Twenty years ago, high cost claims came and went, you may have expected one or two every couple of years. From ten years ago, incidence means that the average scheme is now looking at more than two a year and the really high cost cancer claims every four years. With an ageing working population it is anyone’s guess how frequent a bill of £100,000 may be in future but the stark reality is it will be more frequently than every four years.

Take a moment to reflect on this. Your average group PMI plan may never have experienced a high claim but in the past couple of decades, the trend has been to purchase insurance that provides for the unexpected. (A general move from an acute absence management tool for speedy diagnosis and an aid to jump the NHS queue for routine surgery, to a fully charged cancer management programme that will treat your employee until death if necessary). Based on the facts presented already, it is sadly going to become the few that remain free of high claims and the norm will be additional costs on a much larger scale.

What does this mean to the average group PMI plan?

While the standard PMI carrier market has dramatically shrunk to circa five players, the ‘fringe market’ has been very busy over the last decade at least. The boom in the cash Plan cannot be ignored and the recent diversification of such products into selective surgeries cannot
be overlooked. Large group schemes have had little choice but to downsize and increasing pressure on employers to provide for all means that budgets have been thinly spread but at least everyone has access to something.

For the HR manager, finance director and the like, access to an ever confusing landscape coupled with the prospect of higher costs is no enviable positon to be in.

What is the solution?

With health premiums likely to be the largest single employee cost for a business outside of salaries and pensions, certainty and stability are likely to be key drivers in future decision making. Aside from the continuing landscape of innovation in medicine and the associated increasing costs, is it possible to gain control of spend? The simple answer is yes!

Regardless of how much your client is spending on claims, gaining insight of future spend and being in a position to control it has to be key to moving forward. There are four simple steps that can be adopted to achieve this:

1. Review the funding model. Take control of funding by being part of the process from the outset. Interrogate the current spend and as many years back as possible. Does your client have any trends unique to them? Are they spending money on claims unnecessarily? Can spend be brought in from other cost centres to achieve an integrated approach to health funding? Would a Healthcare Trust be more appropriate?

2. Review the benefits on offer. As alluded to above, the breadth of benefit promise can be a major contributor to the unknown conundrum. Are the benefits still appropriate for the here and now and the next five to ten years? Is too much being made available over and above what was originally intended way back when the plan was put in place? Has the plan inadvertently become a replacement for the NHS rather than a top-up? Are some benefits duplicated with other services that your client purchases?

3. Assess tolerance of risk. A regular measure adopted with defined benefit pension schemes, yet clients are rarely asked what they can actually afford and what measure of uncertainty they are willing to adopt. By simply asking your client where their budget will stretch will help you assess the breadth of development required.

4. Who can make this happen? With the thumbnail assessment of what your client actually wants, now is the time to find a service provider that can meet the client’s objectives. What should you be looking for:

   a. Independence – choose a provider that has an independent remit with the capability to fully bespoke networks to exactly meet your client’s demographic and budgetary requirements. From identifying commercial advantage to strategic network planning; identification of the most appropriate clinical facilities to meet budget by client office location; to introducing key partner strategies to integrate all aspects of the client health objectives.

   b. Flexibility – ensure the provider can keep pace with your client’s requirements today and also into the future. A key consideration is the technology platform that the service provider operates from, one that is not restricted to insurance policy administration but totally flexible to accommodate ‘out of the ordinary’ requirements and the ability to integrate other health pathways, GP, occupational health, physio, group risk, travel and international.

   c. Consultative – work with the service provider to leverage best in class and continuous consultative advice for your clients current and future health strategy.

An independent service provider differs from an insurance based service offering in that the focus is on the client’s exacting requirements rather than a primary focus on insurance product delivery. The resulting benefit for the client is a clear strategic focus on meeting their individual requirements for the immediate and future path. In short, providing support to your client to tear up the current PMI rule book and carve a sustainable health budget that puts the client in control of their own destiny rather than being a small fish in a large pond.

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**UK PMI – a slowing market**

The number of private medical policies in the UK stood at **3.94 million** at the start of 2015, down marginally from 3.97 million a year earlier

Medical cover policy numbers in 2015 were **9%** below a peak of **4.32 million** at the start of 2008

Overall penetration of the UK population by private medical cover (people covered) fell to an estimated **10.5%** at the start of 2015 compared to **12.3%** six years earlier
