8TH SEMINAR ON CURRENT ISSUES IN HEALTHCARE INSURANCE

Organized by: Advisory Group in Healthcare Insurance • Venue: The Orchid, Mumbai • Date: 11th and 12th July'13

Session 1: Introductory Note by Biresh Giri, Chairman Healthcare Advisory Group

In his address he gave brief journey of the Healthcare Insurance Seminar, which was earlier conducted in collaboration with Milliman. He mentioned that currently Advisory Group Healthcare conducts two seminars the other being "Capacity Building in Healthcare". He highlighted that Healthcare industry is growing in at health pace and the growth is across all sectors viz: Retail, Group, RSBY, Govt. Scheme etc. He emphasized the need of regular meeting at industry level to address emerging challenges and issues faced by the industry. The key note address set the tone for the seminar which covered wide range of topic related to Indian and International Healthcare Insurance industry, which were presented by distinguished speaker in the sessions that followed.

Biresh Giri

Dr. Shreeraj Deshpande, Alam Singh, Jagbir Sodhi, Kenneth Cunningham, Segar Sampath, Dr. Nayan Shah

Session 2: Panel Discussion on Fraud Management initiative at the industry level, outcomes, challenges, way forward. Panelist: Dr. Shreeraj Deshpande, Alam Singh, Dr. Nayan Shah, , Kenneth Cunningham, and Segar Sampath. Chaired by Jagbir Sodhi

The discussion focused on various common frauds prevalent in Healthcare insurance industry and how they can be mitigated. It was discussed that "Abuse" rather "Fraud" is more prevalent in Indian context. The Fraud Detection mechanism is not robust at industry or company level in India. Kenneth Cunningham (VP, LexisNexis Risk Solution) gave perspective of fraud control mechanism at international level and compared the same with India. The discussion also highlighted that unethical behavior by provider or doctors increase the fraud, this was supported by specific examples and industry level studies. Another point was shared that large pharmaceutical companies tie up with provider and provide discounts on implants and drugs, benefit of which are not passed to patient or insurance company. The initiative to reduce abuse can be: effective network management, healthcare management or clinical guidelines, considering of co-morbidities by the industry, medical education to insurance industry etc. Discussion also emphasized that periodic analytics with well defined action can support fraud detection at various levels viz: provider, geographical area, underwriting, TPA, insurance company employee etc, so that right message goes to the person involved in fraud. To achieve good results from analytics improvement data quality, close interaction at industry level, resolution to take strict actions against the culprit and create deterrent for the potential fraudster are required. Alam Singh (Independent Advisor) mentioned about Working Paper on Health Insurance Fraud by FICCI. He mentioned that the paper cover topics like, process improvements or modifications, industry collaboration/ intervention, government or regulatory interventions and Indian Penal Court System and Indian Contract Act can be a good starting point for insurance companies and industry. The session was concluding by panelist agreeing that fraud impact the honest customer and onus is on insurance company or industry to fight against the fraud.

About the Author

Irvinder.Kohli@maxbupa.com

Irvinder is a member of IAI with over 8 years of experience in General Insurance and currently working in Max Bupa as Chief Manager.

Session 3: Presentation on Micro Insurance by Dr. Nishant Jain and Dr. Siddarth Kachroo. Chaired by Sanjay Dutta.

Dr. Siddarth (Head-Health Business Development, Munich Re India Services) presented a holistic overview on Health

Dr. Siddarth Kachroo

Micro Insurance in India. He started by comparing the health expenditure as compared to GDP for various countries, which ranged from 4.1% for India to 17.9% for USA. He presented Micro Insurance Models prevalent in India viz: Partner Agent Model, Community Based Model, In-house or Full Service Model and Provider Model. A comparison of various schemes run by government and other entities on the scale of subsidy and profitability was presented which concluded that a scheme can be successful, if it premium have some proportion towards profit and is supported by subsidy to make it affordable. Statistics related to RSBY Scheme at pan Indian level was presented along with role of various stakeholders in the scheme and benefit structure of the coverage offered to beneficiary. An overview of an end to end enrollment process and challenges faced by stakeholder insurance companies in implementation of the scheme and run it profitably was also presented.

Second presentation on the same subject was done by **Dr. Nishant** (Deputy Program Director, GIZ). He presented an overview of availability of RSBY data and experience of the RSBY scheme. The RSBY process is electronically controlled

Dr. Nishant Jain

which provides quality and detailed data which is available with government and related agencies. A trend in experience of RSBY scheme by comparing data from 2008 to 2012 was presented, which concluded that average premium is decreasing over year, which can be due to improved experience or increased confidence by insurance companies or competition. The enrollment ratio and average family size had been consistent over year, while hospitalization ratio has increased over years and is currently over 5% for districts in their third year, which is alarming given the low average premium. Average claim size is in same range over years, with over 60% of claims are of less than 5000 and 60% of patient have length of stay 2 days or less. Profits are reducing for insurance companies which are in third renewal due to low premium charged and high utilization rate. Average family size is less than 5 for majority (83%) of enrolled families and female as a head of family is increasing over years. Over 60% claims are for age less than 40 with General Ward hospitalization account for 30% of claims followed by Cataract (26.4%) and Hydrocele (5.3%). 80% of Cataract are for age-band 51 - 80 and 14% for age-band 41 – 50, which indicates that most of the claim are genuine. He also presented various statistics about insurance companies operating in RSBY scheme viz. proportion of RSBY share and number of districts held by each insurance company, average premium, conversion ratio, average family size, burnout ratio. He presented way forward on RSBY emphasizing that deeper analysis of data is being done now and dashboards are being developed to help government analyze data. The presentation was concluded by mentioning the impact RSBY scheme has made to India, hospitals are setup by private players in remote areas, public hospitals competing with private hospital which is improving service standard, regular updation of BPL list by government, increased utilization by women, awareness of Health Insurance has increased and the issue is long term sustainability of the model and profitability of insurance companies.

Session 4: Presentation on Group Health Insurance Experience – Recent Trends by Raunak Jha and Pawanjit Dhingra. Chaired by Segar Sampath, GM NIC.

This session had two presentations giving the different perspective to the topic. It was an interactive session with active participation from audience.

Raunak Jha

Raunak (Sr. Consultant, Tower Watson) started the presentation by defining stakeholders for a Group Insurance Product viz: Insurance Company, Employer, Employees, Healthcare Providers and TPA's, discussing the challenges faces by each stakeholder and expected future trends. Insurance Companies face challenges related to change in disease pattern, medical inflation, increased diversification of insured profile, new product features etc and to sustain they should reduce cross subsidies across line of business, increase premiums to outpace medical inflation etc. Employers have to balance between cost of coverage and attractiveness of coverage, focus on wellness and associated cost, redefining CTC of employee etc. In future Employers may increase flexibility in choosing the benefits to attract talent. Employees have increased demand for quality of care, flexibility of coverage, increased awareness etc and in future employees will expect coverage post retirement or active employment. Healthcare Providers are coping up with development in medical technology, increase focus on luxury care rather healthcare which is adding to cost. In future provider have to increase capacity due to increase awareness of healthcare and have to be competitive on prices and service due to increased competition. TPA are required to provide efficient processes and analyze data by employer,

provide wellness services, increased hospitality to certain employees. In future insurance companies may incentivize them for profitability and it might be required to provide rate of each procedure instead of package rates. A possible scenario based on self retention model was presented, in which employer retains the risk and provides flexibility of benefits, insurance company provide coverage only for unusual risk and TPA helps employer in managing the scheme.

Pawanjit, Dhingra (CEO, Prudent) presented market dynamics stating that group insurance market is although broker driven, but large accounts are

Pawanjit Dhingra

still directly handled by insurance companies, while poor underwriting is leading to under pricing which is resulting in all stakeholders are losing money although the product has potential. There is opportunity due to low penetration, mandatory coverage for Non-ESI employees and withdrawal of government from self-managing health schemes. The main challenges faced are lack of quality data, lack of standardization of medical coding, wage policy terms and conditions. The solution is to enhance sharing of data between companies, remove reward for internal fraud and correct pricing for each account.

Session 5: Presentation on Moratorium Underwriting or Reduced Underwriting – Why, When and How? by Detloff Rump, Chief Underwriter, Swiss Re

Moratorium or Reduced Underwriting (RU) was defined as underwriting process which has less number of questions, reduced or no risk assessment is based on substitute risk factors and is not straight through processing. Benefits of RU are less hassle for customer/sales person and saving of time. Detloff

Detloff Rump

Rump shared result of two surveys done in China, Japan, Singapore, Hong Kong and Korea. First survey tested if customer is willing to share its health related details and to which channel and the results showed that over 60% of people are willing to share their health related details and most preferred channel is Insurance Agent. Second survey tested how much proportion of additional premium customer are willing to pay in case medical questions are not asked and the results showed that customer are willing to pay more than 20% of additional premium across countries. It was concluded that customer understands the importance of underwriting and is willing to pay additional premium in case there is no underwriting or reduced underwriting. He added that underwriting does not change the mortality/morbidity of an individual but reduces uncertainty and improves experience of the portfolio. He further added that cost of reduced underwriting is less but it will be compensated with increased cost of mortality, hence it is important to have a balance at portfolio level, so that benefits of reduced underwriting can result in increased sales. He also emphasized that other risk mitigators such as pre-existing clause, age limits, and sum insured limits can also help in mitigate the risk due to reduced underwriting risk. Conclusion was drawn that reduced underwriting is in demand which can be offered if it is used cleverly keeping benefits it offer to customers in mind.

Session 6: Presentation on International Health Insurance Market by Richard Kipp and Gayle Adams.

Richard (Principal Consulting Actuary, Milliman) presented overview healthcare reforms in US which has come through Affordable Care Act (ACA). ACA allows coverage to section of society it is most required, protects consumer interest, allows choice of insurer and helps in reducing cost and improved

Richard Kipp

quality of healthcare. ACA has many key features which are helpful to customers apart from empowering them against the insurance companies and protecting their interest. Some of the features which protects customers interest are allowing insurance coverage in case of pre-existing disease or denied insurance coverage, does not allowing denial of coverage to a child with pre-existing disease, stops retrospective cancellation of the insurance policy, allowing evaluation by expert in case of significant increase in insurance premium in any state etc. It also provide framework to Consumer Operated and Oriented Plan (CO-OPs), which can run as a mutual company operated by customers. It also provide framework for Health Exchange, which eases the process of buying and comparing health cover for consumer. Under ACA insurance companies are required to essentially spend 80% to 85% on medical care else provide rebate to customer and allows State to seek waivers on certain conditions to help people obtain health insurance. ACA has helped in creating first central database for health coverage options covering over 8000 private insurance company products, giving option to customer to choose option as per specific need. ACA has also introduces new taxes and fees resulting in additional revenue for the government. It was concluded that ACA will change the insurance sector in US and India can learn from it.

Gayle Adams (Consulting and Appointed Actuary, Raheja QBE) presented a comparison on various aspect of Health Insurance for Asian Countries

Gayle Adams

(India, UAE, Saudi Arabia, Thailand, Australia, Singapore and New Zealand). Comparison was done on aspects related to regulation, impact of providers on insurance and technical aspects of the insurance. It was concluded that Indian regulation is different on portability and guarantee renewability as compared to other countries, while fixed premium for 3 year is not applicable in any country. In India insurance companies are funding private hospitals growth similar to Australia and New Zealand and in most of the countries (including India) insurer does not have major control on quality of providers. Except Indian other countries have standalone or multi-line private insurance with majority of business. Aging population is not concern for India currently the way it is for developed countries like Australia, New Zealand and Singapore. Escalation of claim cost is a concern for all the countries and availability of statistical data is improving in India, while it is of high quality in Australia, New Zealand and Singapore. The session was concluded with observations that solutions and learning of Asian countries can be transferred to India after considering regulation, diversity of population, underwriting considerations, prevalent product designs etc.

Session 7: Presentation on Flexibility in Product Design – Learning from International Market by Krishna Singla, chaired by Vishwanath Mahendra, Appointed Actuary, Apollo Munich Insurance Company.

Krishna (Manager Actuarial Services, AXA Business Services) presented an overview on the product designs which are prevalent in International Market and features which can be applicable to Indian Markets, by comparing the health system of Germany, UK, Mexico and Singapore. He commenced by defining healthcare needs by state of economy of any country and life stage of insured. Four type of Private Healthcare Insurance (PHI) were defined as Primary PHI, Duplicate PHI, Complementary PHI and Supplementary PHI, with reference to the

Krishna Singla

coverage provided by government/social schemes. The countries discussed in the presentation had a mix of government/social/universal coverage and private/individual coverage, but the difference is in the proportion of population covered under each category. Germany has a Private Health Insurance System (PKV), which supplements Government Health Insurance System (GKV). GKV system provides wide range of coverage such as Sick Pay Insurance, Travel Insurance and Evacuation Benefits, Dental Care, Pharmacies and Long Term Care (LTC) provides limited coverage, additional coverage are purchased through PKV. UK has a strong government system (NHS) while PHI (11% population covered) mostly duplicates or supplements NHS. Products offered under PHI in UK are 60+ Cash Cover, Cash-back Entry, Retirement Essentials, Dental and Corporate Health Plans. Mexico has structure in which have Government Organization (50% population covered), Social Security (47% population covered) and PHI (3% population covered). Social

Vishwanath Mahendra

Security provides wide range of coverage without exclusions, waiting period and copayments. Products offered by PHI are Hospital Cash (for admission only due to accidents), Critical Illness (available as a rider only) and Medical Evacuation (available as a rider only). Singapore has a unique multilayered Universal Coverage with government providing coverage to primary, acute and rehabilitative (through Medisave) and catastrophic coverage (through MediShield). An Endowment fund has been set up by government to help insured in case payment from Medisave and MediShield are inadequate. Also an ElderShield plan is offered providing LTC to elder citizens. As per the trends in International Market future health product will emphasis on Health rather treatment, measure value of service rather volume, will have care cycles instead of discrete interventions, will consider co-occurring conditions instead of individual disease and will provide integrated care. The session was concluded by proposing product ideas which are relevant to Indian market such as LTC, Outpatient/Drug Coverage, Preventive/Wellness Services and High-Net Worth Products, challenges in implementation of these product and countries from whom model from these products can be considered.

Session 8: Presentation on Issue related to health insurance products sold by life companies by Rajesh S.

S. Rajesh

Rajesh (Product Actuary, Swiss Re Services (I) Pvt Limited) gave the overview of Healthcare Insurance Market between life and non-life insurance companies stating that although Healthcare Insurance sector is growing at healthy pace of 15% but life insurance companies have a share

of only 500 Cr as compared to 15000 Cr for non-life companies. Life and non-life companies have different approach towards design of product, distribution of policy, underwriting constraint, claims management, analytics of data/ experience and customer experience, which are possible reasons for difference in business volume. Life companies are late entrant into the market with limited or no data to support pricing. The commission structure for life product is different from health product which leads to reluctance of sale by channels. Lack of understanding on medical underwriting, challenges faced in managing the claims, difficulty in handling TPA's, limited indemnity products being offered and yet to explore the potential of fixed benefit products are the other possible reason for low volume of business. Possible solutions to these challenges/issues were differentiation in product from non-life companies, explore potential of fixed benefit products, automated underwriting engines and predictive underwriting tools.

Session 9: Discussion on Improving health of Health Insurance Industry by Krishanan Ramachandran, COO Apollo Munich Health Insurance chaired by Suresh Sugathan, Head - Health Administration Team, Bajaj Allianz General Insurance

The session deliberated on the key problems and potential solutions, to improve the health of the healthcare insurance industry. Problems included lack of profitability and relatively poor stakeholder experience / relationships. Solutions were discussed based on proposed action which four key stakeholders (Insurer, Provider, Regulator and Intermediary) can take to improve the status. Insurer needs to rationalize underwriting and premium, take firm action to improve conduct stakeholder in the market and improve customer experience. Providers have to adopt treatment protocol, have self regulation, curb abuse/frauds, standardize data capturing and requirement of an independent regulator. Regulator need to collaborate with other regulator such as SEBI, TRAI etc and enable various stakeholders to increase penetration of healthcare insurance by encouraging stakeholder to develop innovative products and services catering to various segments of society. Emphasis was made on streamlining of product approval process, effective grievance resolution mechanisms, publish study based on data collected through IIB, help industry in reducing fraud and claim cost leakages and help establishing standards of quality in the health sector through accreditation/ grading of hospitals, licensing, and introducing treatment protocols by regulator. Intermediary are required to offer innovative marketing process which increase customer awareness with low cost, reduce dissemination of information to the customer and stakeholders, help build trust with other stakeholders and regularly train and update themselves towards new challenges and concerns faced by the industry and help solve them through active participation. Audience commented on concept of renegotiating of contract with hospital if fraud is proved, is PIL a way to reduce abuse and direct authorities to take action. It was decided to approach IRDA from IAI with the specific recommendations which regulator may consider in order improving the health of Health Insurance Industry.

Krishanan Ramachandran, Suresh Sugathan

8TH SEMINAR ON CURRENT ISSUES IN HEALTHCARE INSURANCE PHOTO COLLAGE