

Health Insurance in India: Need for Managed Care Expertise

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Health insurers in India currently face many challenges, including poor consumer awareness, strict regulations, and inefficient business practices. They operate under a combination of stifling administrative costs and high medical expense ratios which have ensured that insurers operate under steep losses. External factors (eg, onerous regulations, lack of standards, high claims payouts) and internal factors (eg, high administrative costs, dependence on indemnity models that cover inpatient treatment costs only) have forced the health insurance industry into a regressive spiral. To overcome these challenges, health insurers need to innovate in their product offerings and tighten their existing processes and cost structures. But as a long-term strategy, it is imperative that health insurers deploy managed care concepts, which will go a long way toward addressing the systemic issues in the current operational models of health plans.

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India offers a wide variety of healthcare services to its population. On one hand there are the advanced hospitals and diagnostic centers in urban areas, whereas the rural areas depend significantly on government health centers. Between these 2 extremes there are government hospitals, private hospitals, private practitioners, dispensaries, and clinics (including Indian traditional medicine systems). Despite health being a major government concern, the majority of India's health infrastructure is in the private sector and more than 70% of healthcare expenses are met by consumers and not the government (Figure 1). Given this unbalanced mix of healthcare funding and a per capita income of less than \$600, medical costs are unaffordable for a majority of India's population.

To address healthcare affordability, commercial health insurance was introduced in India by the government-owned general insurers as a standardized annual indemnity product in the mid-1980s, with a view to providing alternate financing options to members and helping them access better quality healthcare. Today, with the increased liberalization of the insurance industry, many private players have entered the health insurance market, resulting in increased awareness and growth of commercial health insurance (Figure 2). Currently, around 20% of the total population is covered under health insurance schemes, with the majority covered under either government or employer programs; regular commercial health insurance has less than 2% penetration.³⁻⁵

CHARACTERISTICS OF HEALTH INSURANCE IN INDIA

Despite the liberalized environment and increased presence of private insurers, the health insurance industry has been characterized by high government control and lack of innovation, which has stunted the overall growth. The sector has not evolved significantly enough to play a major role in the country's health policy. Some of the systemic characteristics of the industry are listed here.

Regulation

Health insurance is governed by the Insurance Regulatory Development Authority of India, which is the apex body for regulating all insurance firms

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(life, property, casualty, and health). Currently, health insurance schemes are mostly provided by life insurance and non-life insurance companies. Only 3 firms have recently started business as stand-alone health insurers. Hence most of the regulations covering health insurance flow down from the regulations for the life insurance and non-life insurance sectors, which include an approximately \$25 million capital requirement to start a health insurance business. Moreover, current industry regulations prevent stand-alone health insurers from tying up with banks as a distribution channel. In India, banks have the maximum reach in terms of branches and geographical coverage, and are the primary channel for distributing all financial and insurance products.⁶ It is hence imperative that health insurance industry regulations get calibrated to reflect the business challenges.

Plan Sponsorship

Health insurance in India is sponsored by both government and private insurers. It was first marketed by the government-owned insurers as a standardized annual indemnity product in the mid-1980s, and the premiums were largely based on the annual limit chosen and the age of the prospect. Today, more than 40 insurance firms (including life, general, and stand-alone health insurers) provide health insurance products.^{2(p7)}

No Common Standards

One of the biggest drawbacks is the lack of standard terminology and protocol in treatment and billing of common illnesses. In many instances, different hospitals across the country use different terms and follow different treatment protocols and charges for treating the same medical condi-

Take-Away Points

Managed care firms can play a key role in India's emerging health insurance sector and help strengthen the country's overall healthcare effectiveness.

- The health insurance industry in India today is loss making and does not use any managed care techniques.
- Simple and innovative managed care techniques can go a long way toward addressing many of the industry challenges.
- Because there is a need for expertise on policy formulation at the industry level, US managed care firms have the opportunity to play a key role in this emerging sector.

tion.⁷ Additionally, hospitals provide diagnosis and treatment details in their claim forms in descriptive form (due to poor awareness of medical coding standards), which further complicates the claims analysis and processing for the insurers.

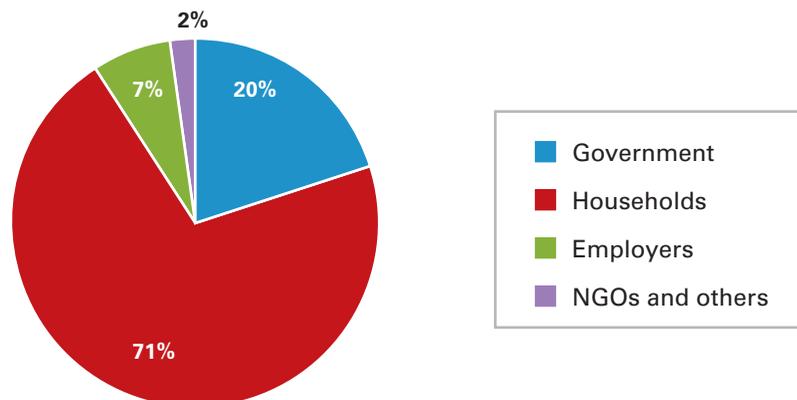
Domination of Indemnity Plans

Health plans introduced in India in the mid-1980s by the government insurers were standardized annual indemnity products covering only inpatient hospitalization. After the industry liberalization in the early 2000s, private insurance firms started to offer health insurance products. Despite the presence of many players, indemnity plans covering inpatient treatment costs continue to be the form that dominates.⁸

Presence of Third Party Administrators

Prior to the industry liberalization, health insurance products were provided only by the government insurers, and they depended on unorganized intermediaries to help sell and administer these health products. In order to regulate these intermediaries, the Insurance Regulatory and Development Authority Regulations Act (2001) formalized the role and regulations of these healthcare intermediaries and renamed them Third Party Administrators (TPAs). Although the orig-

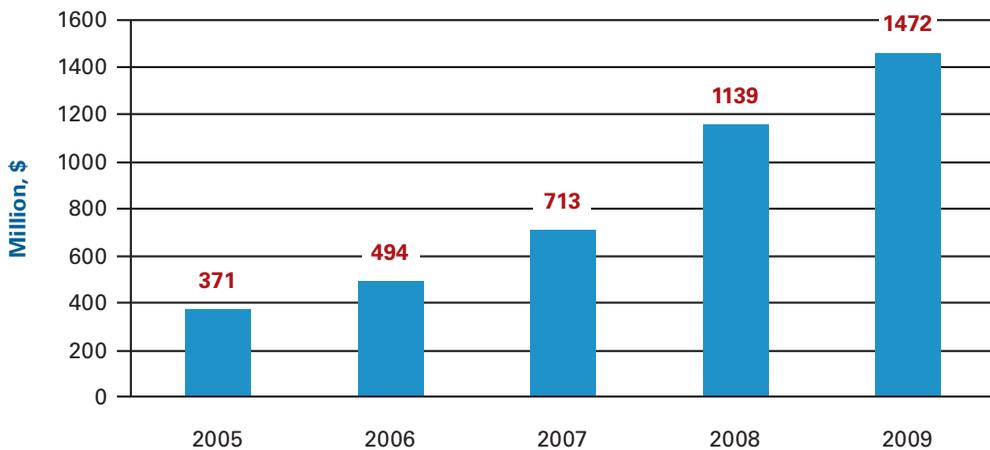
■ **Figure 1. Source of Healthcare Funding in India^a**



NGOs indicates nongovernmental organizations.

^aSource: National Health Accounts Cell.¹

■ **Figure 2.** Health Insurance Premium Growth in India (in Millions of Dollars)^a



^aSource: Insurance Regulatory and Development Authority.^{2(p32)}

inal role of a TPA was to provide the back-office administrative services to insurance companies, most TPAs today also deal with provider networks and claims payments. Currently there are more than 25 TPAs in operation, processing more than 2.4 million claims annually.^{2(p121)} For these services, the health insurers pay around 5% of the premium collected as fees to the TPAs.

High Administrative Costs

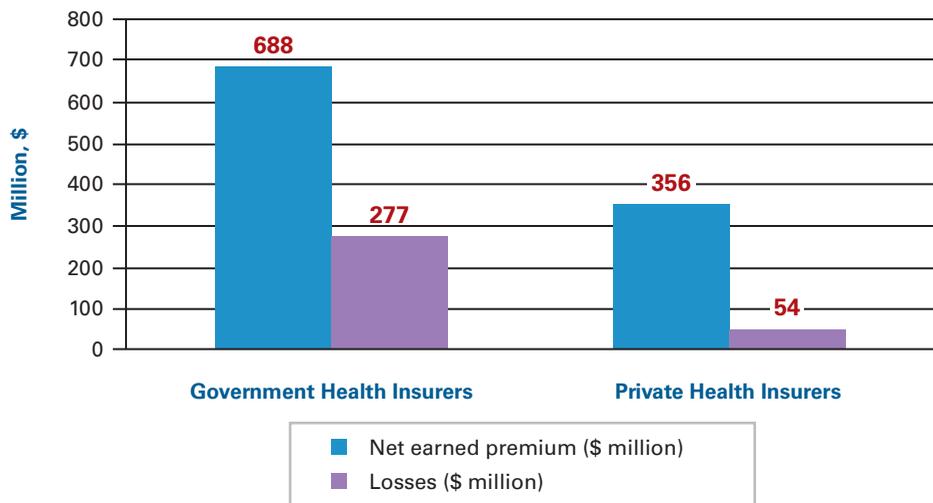
Health insurance products carry a high administrative cost component. Without in-house health expertise, the industry depends on agents and TPAs to market and administer the health business by paying high fees. Hence, admin-

istrative expenses are more than 35%, inclusive of agent fees of around 5%, TPA fees of 5%, and insurer’s operational expenses of 20%.^{9(p283)}

High Medical Expense Ratio

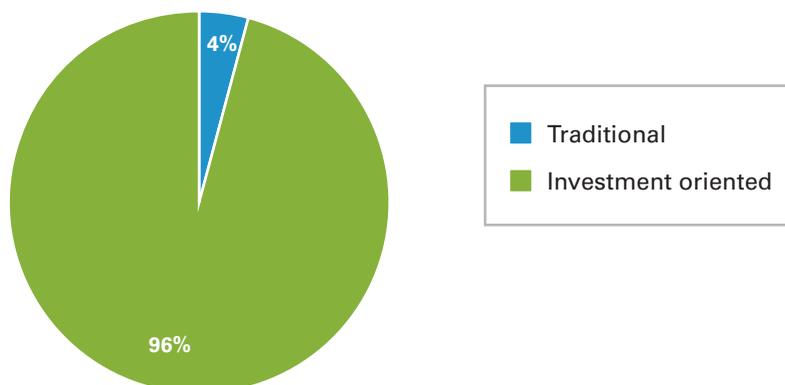
Since the parent insurance firms are focused on other sectors (such as life and property), the firms have no incentive to innovate on health products and prefer to subsidize their health products, resulting in unprofitable operations. With poor product innovation and misaligned pricing and benefit design, the medical expense ratio (also known as the incurred claims ratio) runs at more than 100% of the premium collected for most insurers.^{2(p110)}

■ **Figure 3.** Health Insurance Operations in India (2009)^a



^aSource: Insurance Regulatory and Development Authority^{2(p110)} and *Hindustan Times*.¹⁰

■ **Figure 4.** Life Insurance Policies Sold in India (2009)^a



^aSource: Life Insurance Council.¹¹

Industry Losses

Despite the robust growth in health insurance and increased awareness among consumers, the health insurance industry is not profitable. The combination of high administrative costs and high medical expense ratios has ensured that health insurers continue to have steep losses (Figure 3).

A quick analysis of the above aspects reveals that the industry operates in an environment which is not sustainable in the current form. The external factors (eg, onerous regulations, lack of standards, high claims payouts) and internal factors (eg, high administrative costs, dependence on indemnity models) have forced the health insurance industry into a regressive spiral. In the face of the above challenges, health insurers will need to change their business models to ensure ongoing and sustainable operations.

INNOVATING WITHIN THE EXISTING FRAMEWORK

The expeditious approach for health insurers would be to innovate within the existing operational framework by introducing new products and streamlining the processes to bring about more efficiency in their operations.

Widen Benefits

Currently, health products cover only inpatient treatment. Due to the nature of the benefit coverage, the insurer is brought into the care context only at the critical or inpatient treatment phase. The insurer neither has prior insight into the care pathway nor is updated on the earlier treatment stages and protocols. Health insurers have to innovate by offering benefits that cover outpatient, drug, and wellness (preventive care) programs. By expanding the benefits, insurers will get more insight and flexibility into managing the care pathways

and can focus more on preventive care and reduce avoidable hospitalization.

Widen Product Offerings

Health insurers need to reassess the indemnity-dominated model by introducing plans that incorporate better risk sharing between stakeholders. Given that consumers in India tend to pay a higher out-of-pocket component, firms have to focus on products that combine indemnity with member liability such as copays, coinsurance, and deductibles. Also, given that India is traditionally a savings-led economy, health insurers have to create products with a strong savings and investment component. For example, in the life insurance sector (Figure 4), more than 90% of the policies sold have a savings or investment objective (such as money-back, profit-sharing, equity-linked, and mutual fund investment products).

Widen Consumer Base

Health insurers also need to widen the target pool of consumers. Currently, almost all health products are targeted at the middle-class segment of the population, with typical annual premiums of around \$100 per member for an indemnity with annual maximum cover of \$10,000.¹² When compared with a mature health insurance market (such as that in the United States), the premium rates in India do not align with the overall health economics of the country (Table 1). For example, the average premium in India is twice the per capita spending on healthcare, whereas in the United States the premium is half the per capita spending on healthcare. This kind of pricing has made health insurance unaffordable for the majority of the population and has resulted in products having limited market acceptance. A more careful assessment of the market and a more realistic pricing of the product, in

■ **Table 1.** Comparison of Health Spending and Premiums

Financial Variable	India, \$	United States, \$
Per capita GDP ^a	1061	45,230
Per capita health spending ^b	43	7536
Health insurance premium ^c	111	3680 ^d

GDP indicates gross domestic product.
^aUnited Nations Statistics Division social indicators data for 2009.¹³
^bWorld Health Organization national health accounts data for 2008.¹⁴
^cAnnual premium calculated on typical indemnity plan for inpatient services only.
^dBased on Hewitt Research and Centers for Medicare & Medicaid Services National Health Expenditure Reports.^{15,16}

alignment with the acceptable price points, will ensure wider acceptance of health insurance.

Controlling Administrative Costs

The industry needs to be proactive in controlling administrative costs. Some recent developments seem to suggest that the major players in the industry have recognized this need and have identified key measures for managing administrative costs. One of the recent trends has been to bring TPA services in-house with the objective of saving the TPA fees and providing better customer service.¹⁷

The above approaches primarily impact the marketing and administration aspects of health insurance and are limited in their effectiveness in addressing the broader challenges in the industry, such as the high medical expense ratios. Hence, health insurers have to evaluate managed care techniques to help bring wider and sustainable improvements to the overall healthcare value chain.

NEED FOR APPLYING MANAGED CARE TECHNIQUES

The current indemnity products from health insurers, although easier to administer, do not promote risk sharing among payers, providers, and members, nor is there any incentive for the providers or members to curtail costs or regulate the use of medical services. By continuing to persist with indemnity models, health insurers are not using the various cost and utilization levers available to them which can ensure a more balanced approach to health services. It is imperative that health insurers in India adapt managed care techniques to effectively manage the health financing and delivery process.

Member Liability Models

In the current indemnity scenario, members do not carry any liability. Health insurers have to introduce risk-sharing models with increased member liability, including benefits such as coinsurance and deductibles. This model will ensure cost sharing with the member on all treatment expenses and

consequently regulate the utilization of acute services and inpatient services.

Utilization Controls

Indemnity plans encourage patients and hospitals to utilize specialist skills and opt for inpatient treatments. There are no checks and controls to prevent excessive utilization of medical facilities. Introduction of utilization control mechanisms (eg, assigning a gatekeeper or primary care physician, a first-level prospective utilization review) will significantly address excessive utilization.¹⁸

Tiered Networks

A typical health insurer has a provider network of around 4000 hospitals. Of these, only about 60 are in the upmarket tier-1 category, having relevant accreditations from the Joint Council International or the National Accreditation Board for Hospitals and providing international-level healthcare with high services costs.^{19,20} Due to the undifferentiated benefit coverage offered by health plans, members prefer treatment at these upmarket tier-1 hospitals, even if it means long wait periods and travel. This trend was confirmed in a recent study, where it emerged that 10% of the hospitals submit 80% of the claims.²¹ By introducing tiered networks and member incentives, members can be encouraged to utilize the other hospitals in the network, thereby ensuring balanced utilization of the provider network and resultant cost optimization.²²

Provider Contracting

In India, many hospitals have a dual price list for their services. The price list is lower for patients without health insurance than for patients with health insurance. Moreover, because only inpatient benefits are provided, hospitals encourage patients to get admitted for a day to be eligible to claim the insurance. Hence, instead of lowering the costs, the indemnity nature of health insurance has actually led to cost inflation. By negotiating provider contracts with discounted reimbursement rates, insurers can help ensure that overall medical costs are reined in. Over the long term, health insur-

■ **Table 2.** How Managed Care Techniques Can Address Current Industry Challenges

Industry Challenge	Suggested Managed Care Technique	Potential Improvement
Overdependence on inpatient-only coverage and indemnity-type plans	Create plans with various flexible benefits	Provide more choice to consumers
	Introduce simple managed care models such as HMOs and preferred provider organizations	Increased market penetration Greater control on utilization and claims payouts
Medical expense ratio of more than 100%	Optimize provider contracting	Reduced medical expense ratio
	Improve utilization control measures (including referral/authorization, gatekeeper, and prospective utilization management process)	Improved overall health effectiveness
	Introduce member liability models	
	Introduce wellness programs	
Preference for high-cost specialists and tier-1 providers for care delivery	Introduce tiered networks with variable premium depending on provider category	Provide more choice to consumers Reduced premiums Reduced medical expense ratio
	Introduce member liability models	Increased member involvement in healthcare
	Consumer-controlled plans	Reduced utilization of provider services
Members not incentivized to control utilization/costs	Wellness programs	
	Robust provider reimbursement models that standardize treatment protocols	Risk sharing with providers leading to optimized care delivery
	Capitation models	Improved medical expense ratio

ers have to evolve toward the more complex capitation and pay-for-performance models of provider reimbursement.^{23,24}

Consumer-Controlled Plans

Given the consumer propensity for savings and the industry trend of large out-of-pocket expenses, health insurers have to work creatively to launch products that leverage these 2 attributes. The model needs to be designed so that consumers have control of their healthcare funds and also have a financial incentive to control costs and increase their savings. Consequently, consumers will tend to self-regulate and become more judicious in the use of healthcare services.²⁵

Benefit Coordination

With more group coverage and family coverage plans in force, members are likely to be covered under more than 1 health plan. There is an increased need to study the coordination of benefits among the multiple carriers and ensure that insurers work with each other to achieve equitable liability management.

Wellness Programs

Despite the wide prevalence of chronic, lifestyle, and infectious diseases,²⁶ Indian health insurers have not focused on wellness and preventive care. Plans have to include benefits that provide interventions and incentives for members to undertake wellness initiatives. Even though private insurers have introduced disease-specific insurance products, the benefit coverage continues to be for inpatient hospitalization services.

DISCUSSION

Although the health insurance segment in India operates in a highly challenging business environment, several options are available to the insurance firms to address the inherent impediments. Within their current framework, the insurers need to innovate in their product offerings and tighten their existing processes and cost structures. At a more strategic level, the firms have to introduce managed care techniques, which can drive wholesale changes in the healthcare industry and help create a more sustainable insurance model.

Even as the firms evaluate the various managed care models, recent developments seem to suggest that key managed care concepts have been accepted by the industry. For example, the industry regulatory body, the Insurance and Regulatory Development Authority, has recently proposed flexible premiums to support tiered networks.²⁷ The industry has also taken the initial steps toward contracting with providers for standardized reimbursements.²⁸ These proposed changes are a positive beginning. The health insurance industry should also implement the various other managed care levers that have the potential to mitigate the wider industry challenges (Table 2).

As the industry evaluates and introduces these managed care techniques, adequate care has to be taken to avoid the pitfalls associated with managed care. In the absence of commercial-scale pilot programs and reference results, the industry also needs to be aware of the potential weaknesses in the managed care approaches. For example, excessively restricted access, inflexible utilization controls, or excessive cost shifting to consumers can undermine all the benefits that managed care promises. Therefore, it is advisable for the industry to take a regulated and nuanced approach to managed care.

CONCLUSION

Health insurance in India cannot be examined in a vacuum. The success of the industry depends on many factors such as the health services infrastructure, financial and economic ecosystems, and government regulations and support. Health insurers in India currently face many challenges, including poor awareness, low product acceptance, and uncertain business profitability. Although external factors could be partly responsible for this situation, the health insurers also need to introspect and develop innovative models to build on the existing base. In this context, it is imperative that health insurers in India deploy managed care concepts, which will go a long way toward addressing the systemic issues in the current operational models of health plans. Managed care firms, with their relevant expertise, should leverage this opportunity and extend their services to help the Indian healthcare sector be more effective.

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