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FICCI

Leapfrogging beyond Hospitalization

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Contents



1	**Preface**	4
2	**Acknowledgements**	5
3	**Leapfrogging Beyond Hospitalization: Health Insurance 2.0**	5
	3.1 Current Reality	6
	3.2 Why focus on healthcare financing structures in India now?	7
	3.3 Impact of Out of Pocket (OOP) spending on lower income segments	10
	3.4 Moving towards OPD financing structures	10
4	**Focus: Health Financing for Chronic diseases in India**	11
	4.1 Market Reality	11
	4.2 India's chronic disease profile	12
	4.3 Chronic Pandemic	13
	4.4 Why manage Chronic Ailments	14
	4.5 Health financing framework for Chronic Care	18

4.6 Compliance with disease management 20

4.7 Provider network structure for chronic care 22

5 Focus: Health financing - Senior Citizens 23

5.1 Market reality 23

5.2 Senior Citizen Health Spend 24

5.3 Key healthcare financing needs of the elderly care market 26

5.4 Insured framework for elderly care health financing 26

5.5 "Deferred" risk structures 30

5.6 Healthcare Network design principles 31

5.7 Ecosystem enablers 32

1. Preface



The current government's overarching goal of healthcare is to provide, 'Health Assurance to all Indians' and to reduce the out of pocket spending on health care' which is about 60% of the total expenditure on health. However, India faces challenge in terms of financing solutions for both chronic and primary care. The Indian health insurance sector has historically focused on selling hospitalization based insurance covers. There is, as yet, no well-defined national strategy or guidelines for the health insurance sector to create chronic care insurance or products which cover primary care.

Chronic diseases are proliferating at an alarming pace in India. The growing number of reported instances of heart and kidney diseases, diabetes, obesity and other preventable and treatable chronic diseases are taxing the already hard-pressed health care resources and health care delivery systems. These and other conditions have long been the object of concern for health care planners and professionals alike. Insurance coverage for chronic health conditions are either excluded or covered partially despite the rising prevalence of chronic health conditions as well the rising cost of care.

Similarly, primary care in India has not been given the appropriate importance that it deserves. The time is ripe for creating financing mechanisms for the lion's

share of health spend in India - i.e. primary care. Aggregation of provider capacity for primary care is now possible; and payers, including the government programs as well as commercial insurers can provide the platform to scale primary care financing across the country, by 'layering' these atop existing schemes. Structurally, this 'melting point' of aggregation and scale can move the healthcare market away from an "out of pocket" structure towards pooled health financing.

Since 2008, FICCI has striven to create a multi stakeholder group supported by the Insurance Regulatory and Development Authority (IRDA), with representatives from the World Bank, NABH, health care providers, health insurance companies and other key stakeholders for convergence of various initiatives and bringing in a synergy propelling the growth and development of the health insurance sector.

It is in this regard that the FICCI Health Insurance Advisory Group, met with Chairman, IRDA, and who called upon health insurance stakeholders to look beyond financing of healthcare and focus on overall health and wellness of the people. He emphasized on transparency in the system to ensure end-to-end smooth processes enabling customer satisfaction and streamlined businesses for insurers, providers and intermediaries. He also asked the group to recommend a framework for elderly care and chronic care through the insurance mode as well as explore ways to channelize and integrate mandatory CSR funds into the healthcare domain. We also interacted with several other key stakeholders in the health sector, who indicated to us the importance and timeliness of discussing this topic and exploring suitable options for the way ahead.

The above rationale guided the FICCI Health Insurance Advisory Group this year to put their efforts to develop a product framework for financing chronic diseases, a white paper on elderly care and a discussion note on primary care.



2. Acknowledgements



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3. Leapfrogging Beyond Hospitalization: Health Insurance 2.0



The Indian health insurance sector has historically focused on selling hospitalization based insurance covers. Market liberalization in 2001 increased the number of insurers offering health insurance capacity, and resulted in aggregating of the hospitals into networks by specialist TPAs (Third Party Administrators). The entry of specialist health insurance companies between 2007 and 2013 increased the focus on the retail market for health insurance. However, product innovation has been confined to variants of the "inpatient" indemnity product or hospitalization cover.

With the increasing spread of social insurance schemes during the same period (i.e. 2007 to 2013) , close to a third of the population now enjoys access to health financing for inpatient coverage.

The time is ripe for creating financing mechanisms for the lion's share of health spend in India - i.e. primary care. Aggregation of provider capacity for primary care is now possible; and social insurance schemes can provide the platform to scale these across the country, by 'layering' these atop existing schemes. Structurally, this 'melding point' of aggregation and scale can move the healthcare market away from an "out of pocket" structure towards institutional health financing mechanisms.

For insurers, embedding alternate financing structures such as fee for service or capitation based pay structures to cover outpatient spend, would create a new segment of 'comprehensive' covers. These products finance a greater proportion of overall health spend of consumers -so have higher relevance to consumers.

For the insurer the premium generated for the same distribution effort is significantly higher - increasing top line, and market share. In addition, these structures make insurers relevant to the diagnostics and physician communities (not just hospitals, as is the current scenario). They provide the basis of increased customer connect, greater data and analytics visibility through electronic health records and the ability to build a strong brand franchise, differentiated on service - which can aid shareholder value creation.

This paper on "Leapfrogging beyond hospitalization: Health insurance 2.0" - focusses on insurance financing structures for two key segments - for the chronic care disease and elderly care.

3.1 Current Reality

The figure below gives the structure of the Health Financing market in India currently.

Figure 1 : Population access for health financing

A large section of the India population does not have access to formal health financing mechanisms.

Population coverage (mn) by Scheme	2003-4	2009-10	2015*P
Employees' State Insurance Scheme (ESIS)	31	56	72
Central Government Health Scheme (CGHS)	4	3	3
(Min. of Labour sponsored scheme)	NA	70	300
State govt schemes	1.6	114	153
Commercial Private insurers	51.6	298	618
Uncovered population	898	752	532

BPL

Source:

Commercial health insurers cover 5% of the population. The govt focuses on the (Below Poverty Line) 'BPL' Population.

About half the population of the country does not have access to any health financing mechanism. While the social health insurance schemes such as Rashtriya Swasthiya Bima Yojana (RSBY) have had a major impact on overall health insurance coverage - they are largely restricted to inpatient coverage, and their target audience is the below poverty line consumer. Commercial private insurers cover about 9 cr (90 MN) of the population, and the government employees are covered through the ESIC and CGHS Schemes cover about 7.5 cr (75 MN) of the population. That means that about half the population (532 MN or 53 cr) does not have access to any health financing mechanism.

3.2 Why focus on healthcare financing structures in India now?

The rationale for focusing on healthcare financing structures in India is based on the following trends:

1. As India moves away from a 'low income' country, the structure of healthcare financing will migrate away from out-of-pocket spending.

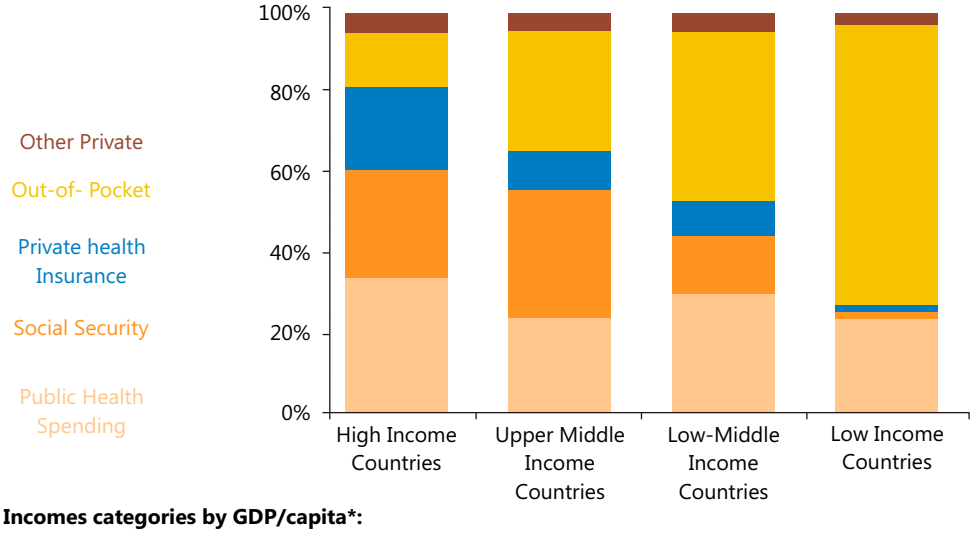
2. India's disease profile has shifted to non-communicable diseases. That impacts the pattern of spending and moves the focus towards out-patient funding. Product design by commercial health insurers have to follow this market trend - and evolve towards outpatient financing.

3. The provider market has matured and has seen success in being part of the aggregation effect that formal healthcare financing structures provide. Both the inpatient hospitalization product sold by commercial insurers, and social insurance schemes, have shown the providers the revenue stabilization effect of healthcare financing mechanisms.

3.2.1 Need to move away from OOP based healthcare financing

Figure 2 below shows changes in healthcare financing, as countries graduate up the income ladder.

Components of Health Expenditure
[measured in 2003 US dollars]



Incomes categories by GDP/capita*:

High income: US$ 10,066 or more
Upper middle income: US$ 3,256 - US$ 10,065
Low middle income: US$ 826 - US$ 3,255
Low income: US$ 825 or less

Source: national Health Accounts unit, Health System Financing, EIP, World Health Organization, www.who.int/nha
**World Development Indicators 2006, The World Bank*

India is currently classified as a "Low-Middle" income country - in terms of its global peers - with high levels of Out of Pocket spending (around 60%).

As per-capita GDP and per-capita Health spends grow, the composition of Health funding will need to change on two fronts. The first would be the creation of 'social security' nets - largely funded through government spending. However, the second force relates to how the commercial health insurance market develops. At a market level, the role of the commercial health insurer is secondary to government spending - the commercial profit motive will mean that they would not be able to sell to all segments of the income pyramid in the country.

During the period of transition from a "Low-middle" income country to a Middle income country - the question for commercial insurers also is about future market relevance. If they constrain their role either by segment (e.g. top quintile by income in terms of target consumer) or by benefit (e.g. inpatient hospitalization cover only) - they run the risk of becoming marginal players.

3.2.2 Changing disease profile and character of health spend

India faces the human and economic threat posed by Non Communicable Diseases (NCDs). Cardiovascular diseases, cancers, chronic respiratory diseases, diabetes, and other NCDs are estimated to account for 60% of all deaths in India, making them the leading cause of death - ahead of injuries and communicable, maternal, prenatal, and nutritional conditions. Furthermore, NCDs account for about 40% of all hospital stays and roughly 35% of all recorded outpatient visits[2] - and as the table below shows almost 40% of total deaths in the country. (See Table 1 : Prevalence of NCDs in India 2010 - below)

Table 1: Prevalent NCDs in India, 2010

NCD	DALYs	%of total DALYs	Deaths	% of total deaths
CVD (Including coronary heart disease and stroke/schemic heart disease)	48,793,600	9.4	2,095,930	21.1
Chronic respiratory disease (Including asthma; chronic obstructive pulmonary disease [COPD]; and occupational lung diseases, such as chronic bronchitis or emphysema)	35,880,300	7.0	1,176,740	11.8
Cancer (Including lung; lip/oral cavity and other pharynx-related cancers; and cervical, breast, and ovarian cancers)	19,094,000	3.7	663,032	6.7
Diabetes	7,968,930	1.5	223,999	2.2

Source: IHME (2013)

The change in disease profile means that consumers face a greater need for healthcare financing structures which fund outpatient (ambulatory) care. Increasing life expectancy also means that these structures will be required for the longer term. Consumers are likely to be more receptive to insurance based structures which help them save to fund future health costs - as compared to other financial instruments.

[1]*Economics of Non-Communicable Diseases in India, WEF, Harvard School of Public Health, November 2014*

Also, since NCD patients won't be 'cured', conventional health insurance product development approaches which impose waiting periods (pre-existing disease clauses) or decline cover for chronically diseased customers will result increased mistrust in commercial health insurance as a category.

With the expected structural change of India migrating to a medium income country, health financing as a whole (and health insurance in particular) needs to move towards a longitudinal approach to keeping the patient healthy.

3.3 Impact of Out of Pocket (OOP) spending on lower income segments

Healthcare expenditure is defined as catastrophic when it exceeds a threshold percentage of the household's non-food expenditure. A 2005 study[2] showed that 3.5% of the population fall below the poverty line and 5% of households suffer catastrophic health expenditures (measured as more than 40% of non-food expenditure. Medicines (72%) constitute the main share of OOP expenses - this reaches 82% in case of Outpatient care, versus 42% for inpatient care.

In a market context, where the disease profile will change the structure of spending towards outpatient care, healthcare financing needs to move people away from high out-of-pocket spend levels.

3.4 Moving towards OPD financing structures

Commercial insurers in India have traditionally cited lack of data and the disaggregated nature of the provider network to be able to create insurance structures for OPD spend. This argument has to be viewed in the context of the fact that commercial health insurance in this country was written by general insurers, and specialized health insurers have entered the market since 2007.

In the last decade, healthcare delivery has been aggregated by TPAs - there are now more than 35000 hospitals and 9000 diagnostic centers on the insured network across all TPAs - with 10974 hospitals and Diagnostic centers added in 2010 alone (Source IRDA 2010 Annual report).

[2]Insured yet vulnerable: Out of pocket payments and India's poor - Renu Shahrawat & Krishna D Rao - NIHFW, PHFI

OPD financing structures do not transfer risk in the conventional sense. However, they provide access to significant cost efficiency through better contracting and purchasing. In other words, the first step towards moving away from Out of Pocket is for the market to evolve financing structures to aggregate healthcare purchasing.

3.4.1 Structures for healthcare purchasing

Currently, the health insurance market uses a fee for services for inpatient services - i.e. a packaged rate - a simplified case rate consisting of a single fee or close-ended payment for a set of inputs and services for a predetermined medical or surgical procedure.

As schemes move towards outpatient financing, there would be a need to move to structures which integrate expected clinical quality with cost - e.g. a blended approach. For example there are capitated structures with performance based elements ('Blended Capitation') that transfer risk to providers and have been the crux of successful primary care systems in other markets notably - NHS UK, Thailand, Turkey. These structures have also been used in markets where healthcare delivery is mostly private sector - (e.g. Kaiser Permanente in the US rewards its doctors for keeping patients healthy).

In the context of the Indian market - the two areas where health insurers can evolve healthcare financing schemes which cover OPD are - for Chronic Diseases and for Elderly care. The rest of the paper focusses on these two segments.



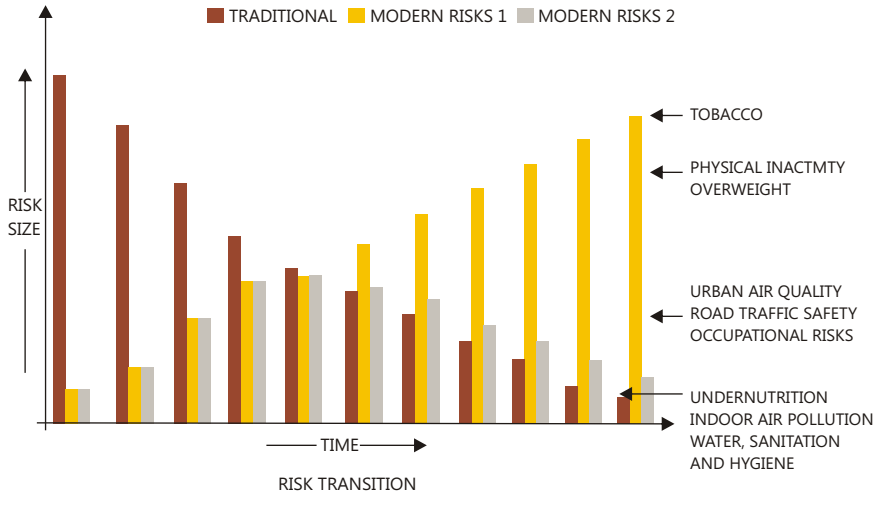
4. Focus: Health Financing for Chronic diseases in India



4.1 Market Reality

As a country develops, the type of disease that affects the population shifts from communicable diseases to non-communicable diseases. Similarly the risk that affects a community also shifts. India is increasingly facing 'modern' health risks such as physical inactivity, obesity, diet related factors, tobacco and alcohol related risks.

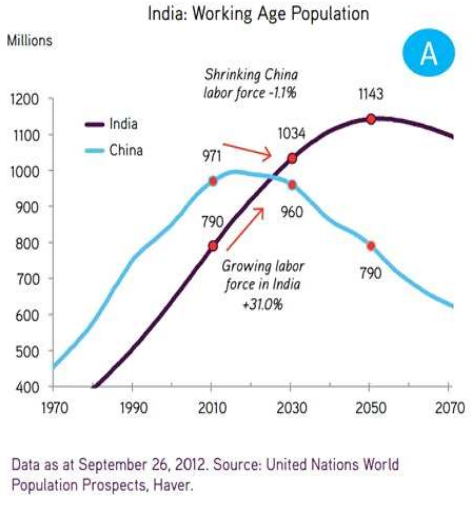
Figure 3 : Changes in risk profile - from 'traditional' to 'modern'.



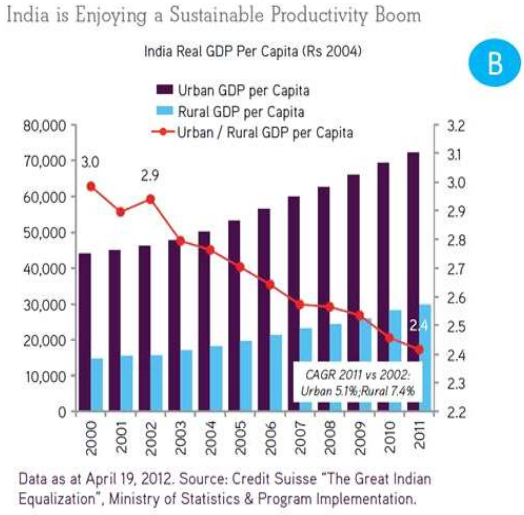
Source: WHO Global Health Risk Report 2009

4.2 India's chronic disease profile

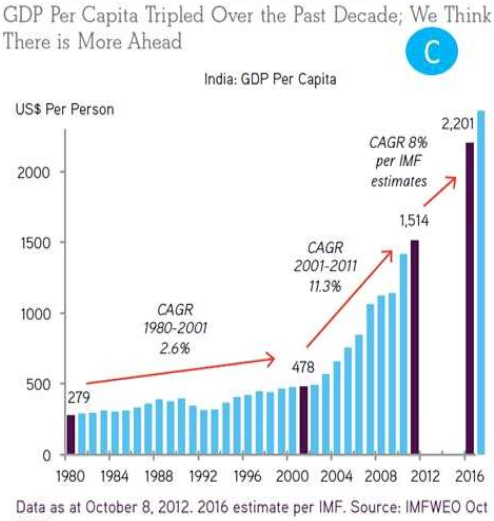
India's population size and structure has the potential to deliver a demographic dividend in terms of productivity and consumption. This has been well documented, and is one of the levers behind the country attracting international and investor interest in the last two decades. Figure 5 below shows some of the usual metrics used to describe 'the India Story' - the demographic dividend (Panel A) together with the sustained increase in Labour productivity (Panel B) which has increased Per Capita GDP threefold in the last decade (Panel C) leading to the creation of the "Great Indian Middle Class" (Panel B).



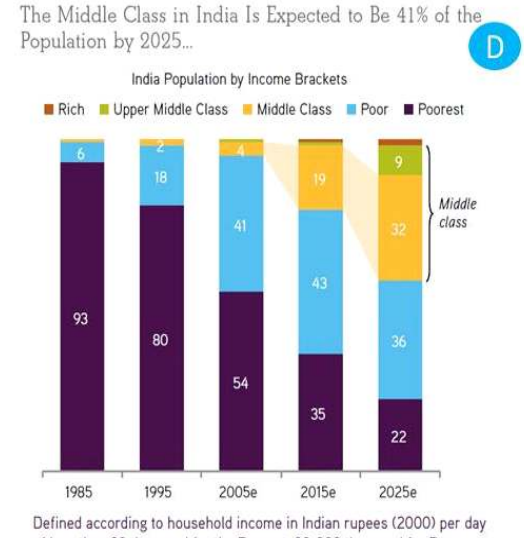
Data as at September 26, 2012. Source: United Nations World Population Prospects, Haver.



Data as at April 19, 2012. Source: Credit Suisse "The Great Indian Equalization", Ministry of Statistics & Program Implementation.



Data as at October 8, 2012. 2016 estimate per IMF. Source: IMFWEO Oct 2012.



Defined according to household income in Indian rupees (2000) per day of less than 90 thousand for the Poorest, 90-200 thousand for Poor, 200-500 thousand for Middle Class, 500-1000 thousand for Upper Middle Class, and more than 1000 thousand rupees (2000) per day for the Rich. Data as at May 30, 2007. Source: McKinsey Global Institute, "The Rise of India's Consumer Market", May 2007.

4.3 Chronic Pandemic

The three fold rise in GDP has also bought with it the following health / disease profile, as shown in the figure below.

Figure 5: Chronic Disease profile

Snapshot of India's disease profile



5-15%	Diabetes prevalence in urban populations
25%	Hypertension incidence in urban populations
45%	Women & 29% of Men in Urban areas are overweight
>20%	Population with at least one chronic disease
>10%	Population with more than one chronic disease

India is in the throes of a Chronic ailment pandemic : Diabetes, Hypertension, Dyslipidemia, Obesity

Reference : Working paper_NCD_12th 5 yr plan, Planning Commission, Government of India

4.4 Why manage Chronic Ailments

One of the main reasons for managing Chronic Ailments is the impact on GDP of the country. As the figure below shows, chronic ailments have the potential to reduce GDP growth by 1.27% PER ANNUM.

Figure 6: Impact on NCD's on Loss of GDP of various countries

(US$ billion, 1998 prices)

	Loss in 2005	Loaa in 2015	Average annual loss	Income loss as a % of GDP in 2015
Brazil	-2.7	-9.3	-5.1	0.48
China	-18.0	-13.0	-53.5	1.18
India	-8.7	-54.0	-23.0	1.27
Nigeria	-0.4	-1.5	-0.8	0.65
Pakistan	-1.2	-6.7	-3.0	1.02
Tanzania	-0.1	-0.5	-0.2	0.86
Canada	-0.5	-1.5	-0.9	0.15
Russia	-11.0	-6.6	-29.8	5.34
U.K.	-1.6	-6.4	-3.4	0.32

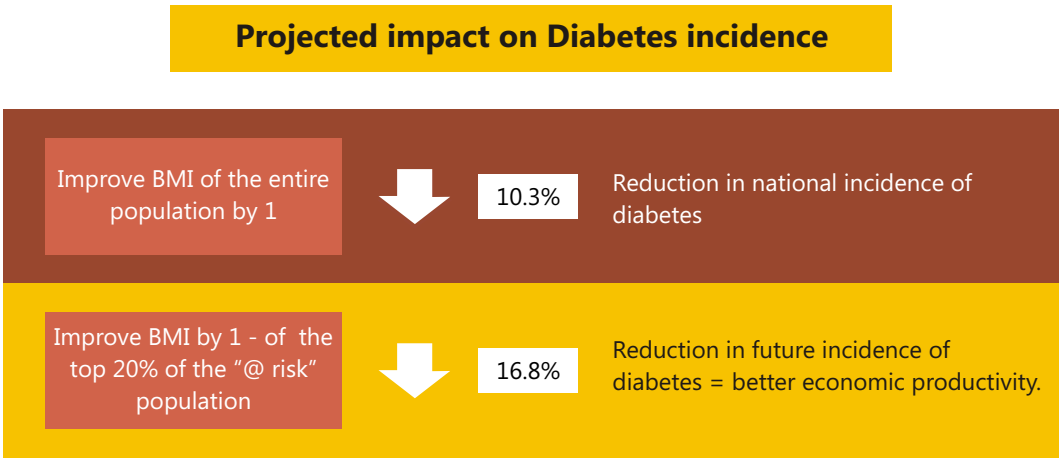
Source: Abegunde and Stanciole (2006)

By 2015, India could lose 1.27% of GDP due to chronic ailments

The second reason is that, chronic diseases also lend themselves to structured intervention - where the impact of changing outcomes at a population level is much higher than the cost of doing so - in other words, these diseases show up positively on a cost-benefit scale.

As the figure below shows, improving the BMI by 1 for a targeted population has the potential to reduce the incidence of diabetes by 10%. Similarly, an improvement of the BMI by 1 of the top 20% of the at risk population, can reduce national incidence of diabetes by almost 17%.

Figure 7: Impact of managing chronic ailments



Ref : C Lee, AJ Dobson, WJ Brown, L Bryson, J Byles, P Warner Smith, et al., et al. Cohort profile: the Australian longitudinal study on women's health.IntJ Epidemiol 2005; 34: 987-99.

Chronic disease management programs have the potential to ensure that the structural productivity improvements in the economy do translate into economic growth.

If not managed, chronic diseases exponentially increase healthcare costs (See exhibit Fig-9 below). For example, for a diabetic, renal complications cost 2.82 times the cost of hospitalization for non-diabetic patients; Podiatric complications are 1.45 times as expensive. Most diabetics have more than one complication - and as the exhibit shows, any two complications cost 1.27 times more.

Figure 8: Chronic care costs

	Diagnosed diabetic, no complications (base index = 100)	Diagnosed diabetic, renal complications	Diagnosed diabetic, Cardiovascular complications.	Diagnosed diabetic, Podiatric complications.	Diagnosed diabetic, Retinal complications.	Diagnosed diabetic, two complications
Episodic	100	282	104	145	73	127

For a diabetic (with any two complications), hospitalization is 1.27 times normal costs. Just renal complications could be 2.82 times as expensive as that of non-diabetic patients.

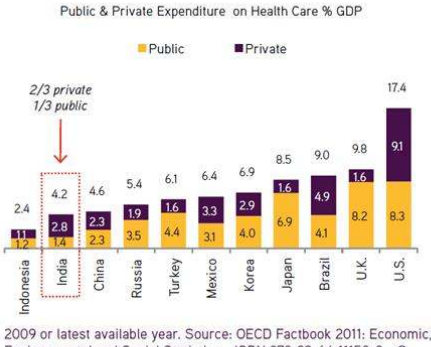
Courtesy: Colombi Asia

Source: The Costs of Treating Long Term Diabetic Complications , in a Developing Country: A Study from India Satyavani Kumpatla, Hemalatha Kothandan, Shabana Tharkar, Vijay Viswanathan, JAPi, Feb 2013

In a country, where most of the expenditure is already by the private sector, (i.e. not by the government) and paid out of pocket - this means that the lack of chronic care financing programs will have a very significant impact on medical inflation. [The figure below shows the split of total healthcare spend in India between government and public sources- and the split by source of funding].

Figure 9:

India's healthcare spending is among the lowest in Emerging Markets



2009 or latest available year. Source: OECD Factbook 2011: Economic, Environmental and Social Statistics - ISBN 978-92-64-11150-9 - © OECD 2011.

	Health expenditure					
	Total	Public	Out of pocket	External resources	Per capita	Per capita
	% of GDP	% of total	% of total	% of total	$	PPP $
	2012	2012	2012	2012	2012	2012
Brazil	9.3	46.4	31	0.1	1,056	1,109
China	5.4	56	34.3	0.1	322	480
India	4	33.1	57.6	1.2	61	157
Russian Federation	6.3	61	34.3	..	887	1,474
South Africa	8.8	47.9	7.2	1.7	645	982
World	10.2	59.8	17.9	1.2	1,030	1,121
All Low income	5.4	37.3	48.1	28.7	31	66
All Middle income Countries	5.8	52.7	35.8	0.7	262	416
All High income Countries	12.2	61.4	13.8		4,635	4,513

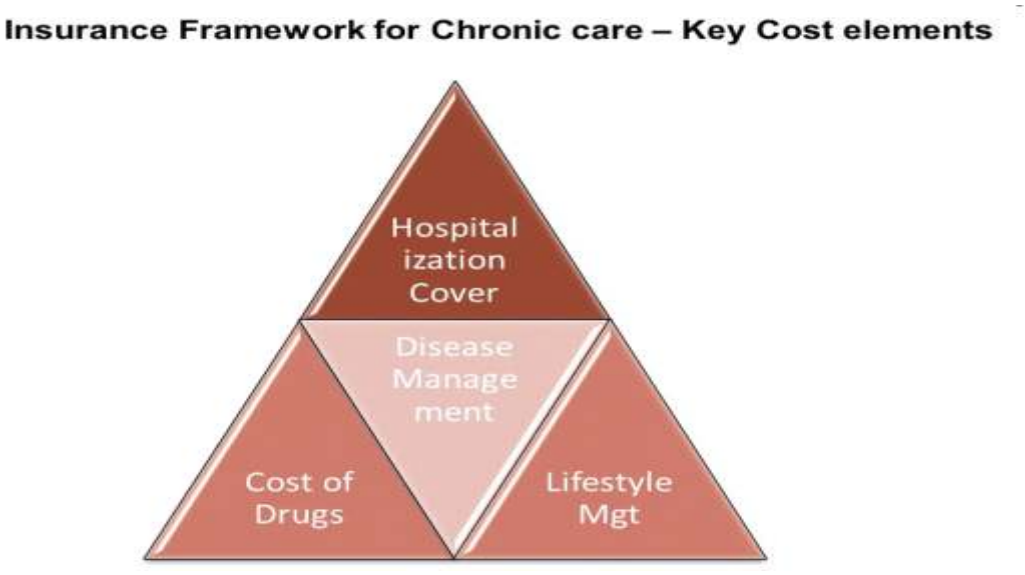
Source: World Development Indicators 2014, THE WORLD BANK; Last updated date 04/09/2014

4.5 Health financing framework for Chronic Care

For any chronic disease, the health financing framework has to fund the following costs:

- Cost of medicines and consumables (e.g. strips for glucose monitoring in case of diabetes)
- Disease management costs (regular tests, consultations with specialists)
- Hospitalization costs and finally,
- Support / Life style management costs. These could range from nutrition counselling to emotional counselling to adjust to the changes in lifestyle usually needed to manage any chronic disease.

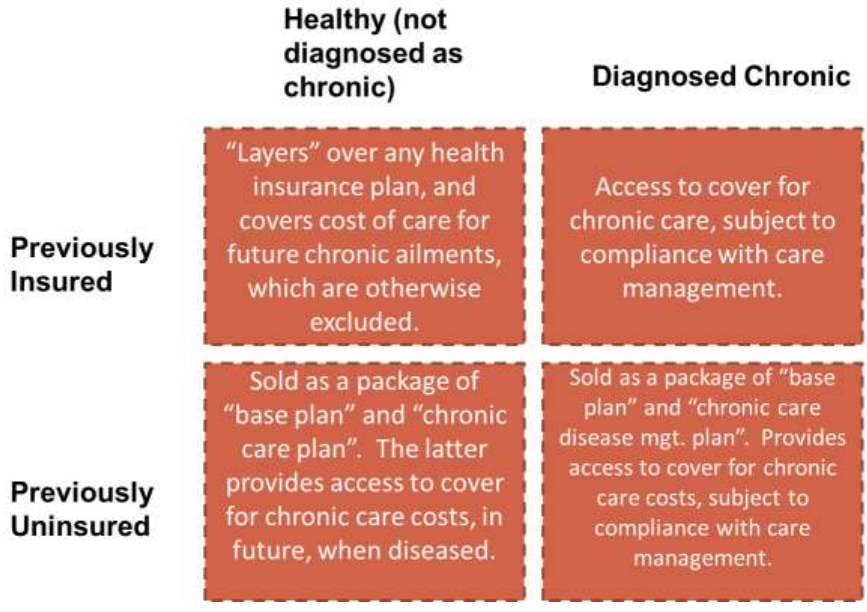
Figure 10:



Most chronic diseases onset after the age of 40 – so the typical target segment is the 40 year old, who has just begun to realize the need for health management.

Figure 11:

How Chronic Care Insurance works for various target customer segments



For commercial health insurers in India, creating chronic care insurance products also includes the need to ensure that these products are correctly positioned to the consumer in the context of existing hospitalization based insurance offerings.

Current product offerings for hospitalization exclude chronic conditions for the first four years under the pre-existing disease (PED) clause.

The following sections details out the insurance product design for chronic care. Given the current absence of chronic care covers in the market, any new products to be introduced by commercial health insurers, need to differentiate the targeted, affected population as follows:

1. Insured who did not have a chronic condition when they bought coverage (designated as healthy - i.e. not diagnosed with a chronic disease). The stress on the word 'diagnosed' is important - chronic care products usually 'layer' on existing health insurance covers and do not penalize customers who are chronically diseased but undiagnosed.
2. Uninsured who have developed a chronic condition.

This segmentation based on current disease status and current insurance status results in a two dimensional table - with the product coverage and selling approach customized to each of the four sub-segments as follows:

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2. Uninsured who have developed a chronic condition.

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4.5.1 Chronic care programs for 'healthy' i.e. non-diagnosed customers

For this segment, once they develop a chronic condition, the type & level of additional benefits have to be based on decisions they made before diagnosis, at the time of purchasing coverage (e.g. by segmenting their chronic care programs as 'gold', 'silver' or 'bronze'). This is a fundamental design principle which helps to control anti-selection and the resultant moral hazard for the insurer. Once diagnosed with a chronic condition, it is natural that any patient would want access to the most optimum care & therapies.

In other words, for healthy customers, they must decide BEFORE they are diagnosed with any chronic disease, the level of benefits they would get, should they become chronically diseased.

The above mentioned gold / silver / bronze segmentation could be to create plan variants as follows:

- Bronze: In-patient cover that includes coverage for limited annual OPD care (mainly primary care visits) in case of pre-specified chronic disease
- Gold: In-patient cover that includes coverage for richer OPD benefits (including diagnostics, physician visits and access to a limited formulary) in case of a wider range of pre-specified chronic disease

4.5.2 Uninsured customers

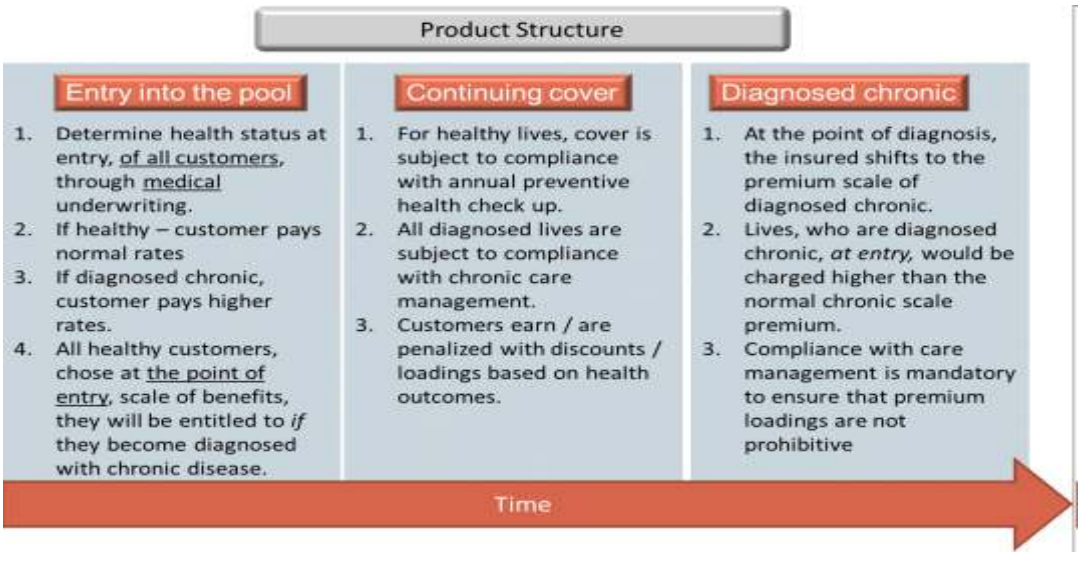
For the uninsured that develop a chronic condition an insurer can provide a disease management program. This is not pure insurance but more of an aggregation and bulk purchase program with elements of care coordination and care quality assurance built into it.

4.6 Compliance with disease management

An important design principle for any chronic care insurance program would be that the customer would be required to comply with the Disease Management Program (DMP). The DMP would lay out minimum compliance requirements, linked to the risk profile of the customer. [The risk profile is based on disease progression, control and lifestyle or clinical health outcome parameters.]

Compliance with the disease management would lead to an incentive / disincentive structure - where consumers would earn premium discounts or be penalized with loadings. In an extreme case of non-compliance the premium loading structure would be high enough and benefits would be increasingly limited - effectively, these would dissuade renewal. Note that under the current regulatory framework, health insurance covers have guaranteed life time renewability - which means Insurers are obliged to carry the risk as long as the customer is alive.

Figure 13 below shows the interplay of the DMP with the base cover, at various points of time.



Other aspects of the chronic care product:

- Retail product with option to cover spouse, parents and in-laws. Children not included (not part of the target group).
- Single Standard product across the insurance industry, with a co-insurance for all insurers to participate in.
- Could also be funded partly by user and partly by the state (e.g. 40-60 contribution ratio) - this would provide a basis to 'layer' these programs on existing inpatient, social insurance schemes such as RSBY.
- Cover for cost of care related to specific chronic ailments - the following serving as an illustrative list - Diabetes, Hypertension, Coronary Arterial Disease, Stroke, Renal Failure, Cancer (tumors), Late onset degenerative diseases like cataract, arthritis, intervertebral disc prolapse, autoimmune disorders.
- Full medical underwriting at point of sale.
- No maximum entry age.
- No waiting periods. No PED clause for chronic conditions: Since the product is medically underwritten at inception it would be possible to obtain an accurate understanding of health risk. Additionally, since chronic conditions are covered by the program - the PED clause would not be required.
- Limited exclusions (e.g. suicide, strike riots civil commotion, hazardous hobbies etc.).

4.7 Provider network structure for chronic care

A critical component of administering the disease management program is the need for establishing outcome metrics to measure disease progression and enable the patient's condition to be managed. Electronic Health Record technology exists in India but chronic care insurance structures would need to ensure that these were embedded into the doctor's office – i.e. completing the last mile connectivity.

The DMP would pay the doctor based on patient compliance with the protocol for tests and consultations; with additional 'rewards' for outcomes. Thus provider contracting would be on a blended capitation basis.

Current market gaps are around empanelling existing physicians / doctors / specialists into the delivery network for the DMP.

For this segment of the provider network, willingness to be partner with insurers is a function of two factors:

- The DMP results in existing patients regularly consulting doctors – i.e. care moves from episodic to continuous.
- The program results in additional patient traffic.

This is possible ONLY by using closed provider network designs. This is not to limit customer choice - but to create an initial, 'entry barrier' for network participants so that they are able to see visible impact of the program.

In the Indian context, mapping patient catchments is an important part of network design. Again, technology exists - which allows patients to be mapped using geo-spatial mapping (latitude / longitude). By mapping the physician (doctor) network presence with customer presence - insurers can ensure that the closed provider group network does not limit customer choice.



5. Focus: Health financing - senior citizens



The second segment where the insurance market can evolve towards outpatient care financing mechanisms is with reference to the elderly care market.

5.1 Market reality

India's demographic 'dividend' often obscures the fact that the country has a sizeable senior-citizen market. As the table below shows, by the year 2020, almost 15% of the population would be aged above 60 – a substantial market segment numbering above 17 crore (170 MN).

Figure 13: Proportion of the elderly in the population

Proportion of the Sr. Citizen, 2001-2051				
	2001	2011	2021	2031
Numbers (cr)	11.4	14.1	17.5	26.8
% to the total population	10.6	12.00	14.50	17.7

Current hospitalization insurance covers are inadequate for this segment since they do not cover for continuous chronic disease management services like ongoing medication, specialist visits, diagnostic tests, OPD procedures. While some of the health insurers (e.g. National Insurance Company) have introduced specific 'senior citizen' covers - these products focus on extending the 'age at entry' to include senior citizens. The main benefit continues to be inpatient indemnity cover; and these products do not include any significant features on preventive or primary care.

From the customer's perspective, these products do not address the underlying need for post-retirement health cover. Typically, for senior citizens 70% of total spend is on account of outpatient spend and is linked to chronic rather than episodic care. Secondly, the average after premium for customers entering the hospitalization cover pool after the age of 60 is Rs 20,000 (per lakh of cover). Urban, male life expectancy in India has touched 74 years, and the market currently 'self-insures' by earmarking savings for health expenses. Finally, most senior citizen covers exclude pre-existing diseases for the initial 2 to 4 years of cover - which most customers perceive as being restrictive. The customer's mindset works like this: "If I have to pay Rs 20,000 for 4 years before getting full hospitalization cover, which will cost me on average 1 lakh, then I might as well put the same money in an interest yielding deposit and create the same corpus".

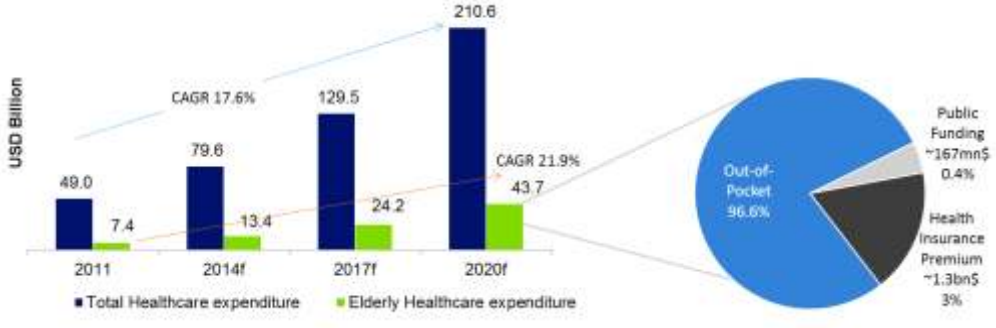
5.2 Senior Citizen Health Spend:

For the health financing market to target the senior citizen segment, the second dimension to 'marketability' is about how much of total healthcare spend is on account of senior lives.

Whereas the total healthcare expenditure has been pegged to grow at a CAGR of 17.6% till 2020[3], elderly healthcare expenditure is estimated to grow at a CAGR of 21.9% over the same period[4]. Moreover, these expenditures cover only the medicine and various clinical expenses. A considerable investment is needed for non-clinical care such as long-term care or assisted living in the case of elderly. All these expenses further multiply the quantum of actual expenditure on elderly healthcare. Consequently, in future, the expenditure on elderly will increasingly take up a larger portion of the total healthcare expenditure pie.

[3]IBEF Healthcare report Nov 2011
[4]Deloitte Analysis

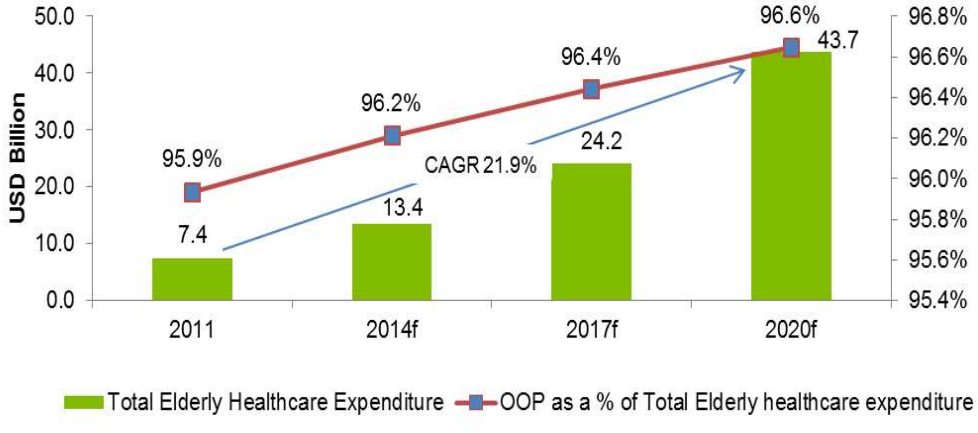
Figure 14: Total Healthcare expenditure vs Elderly Healthcare expenditure in India, 2010-2020* (USD billion[5])



While this expenditure can be financed through different routes; in India, historically the share of public funds and health insurance contribution out of total elderly healthcare expenditure has been abysmally low. In terms of a dedicated government spending, an investment of USD 28 million under National Programme for Health Care of the Elderly (NPHCE) was made by MoHFW in 2011. And, the total health insurance premium raised from elderly for the same year was close to USD 250 million14. As against these, the total elderly expenditure stood at approximately USD 7.4 billion14. Thus, most of elderly care was financed out-of-pocket.

Accounting for reasonable assumptions for growth in elderly insurance and public funding, the analysis shows that over time the out of pocket expense would reach alarming proportions and become unsustainable for majority of elderly population in India.

Figure 15: Elderly Healthcare expenditure in India, 2010-2020f (USD billion)



While the insurance premium from elderly is estimated to grow at a CAGR of 20%, translating to ~USD 1.3 billion by 2020, this amount will be only ~3% of the total expected expenditure on healthcare of elderly[6].

Based on estimates, health insurance penetration among elderly is currently as low as ~1.6% of the total elderly population14. These estimates underscore the need to expand the health insurance coverage among elderly and create health care financing structures, in order to bring down the OOP spend.

5.3 Key healthcare financing needs of the elderly care market

- Elderly care financing - three key needs
  - Financing for outpatient and inpatient care; including pharmacy
  - Chronic disease costs (including outpatient, drugs, pharmacy)
  - Long Term care ('end of life' care - i.e. financing structures for the cost of care, linked to a life stage when the patient cannot carry out the Activities of Daily living or ADL)

5.4 Insured framework for elderly care health financing

This section details a framework for commercial health insurers to create products aimed at the 'grey' market. Note - this framework is relevant to commercial health insurers, and should not be read in the context of social health insurance scheme design.

Creating senior citizen health insurance products is a retail market opportunity. This is because there are few, if any, institutional mechanisms for aggregating the senior population of the country. While banks and other deposit taking institutions do provide differential interest rates and therefore could be a natural aggregator, the insurance transaction with the customer is still on a one-to-one, individual basis. In other words, the selling effort is one-to-one and products would be underwritten and priced for individual retail risks.

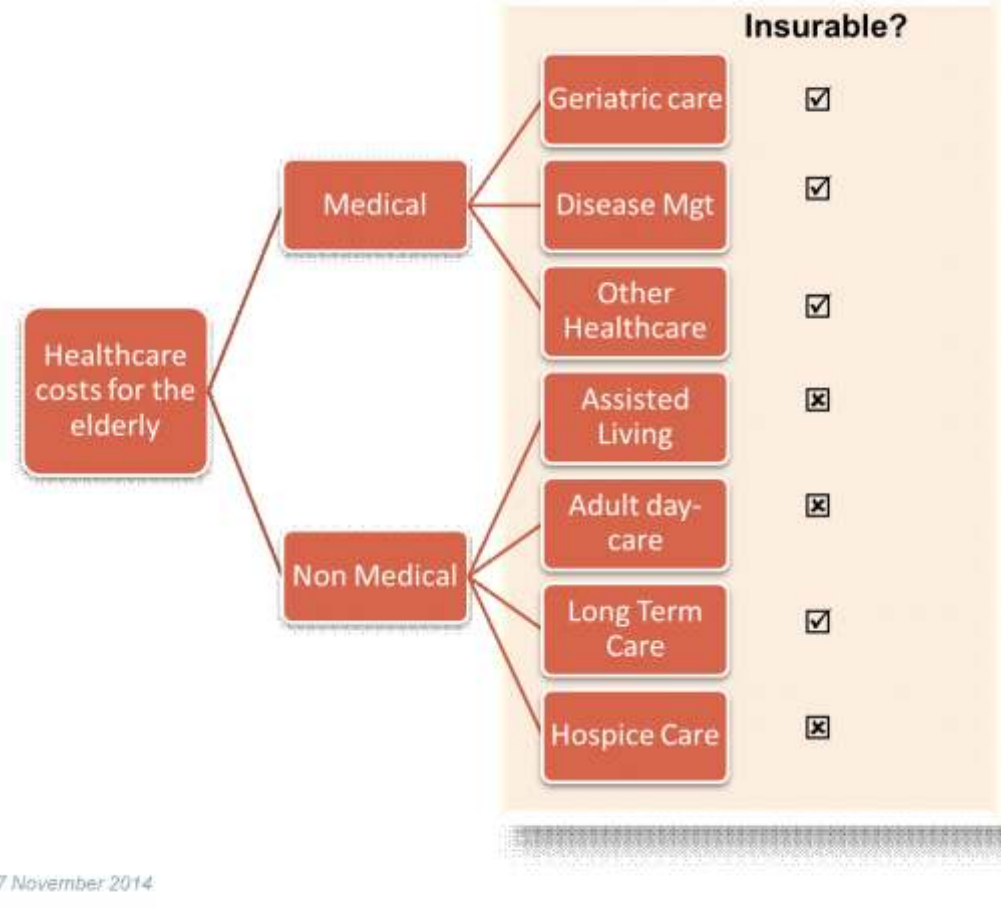
[6]Deloitte Analysis

The structure proposed below marries a long term savings component with risk cover and risk pooling. The risk cover pays for hospitalization expenses while the risk pooling allows customers to access OPD financing on preferential terms.

5.4.1 Framework for product design:

Any commercial insurance product is based on an assessment of the level and predictability of healthcare costs and the extent to which these can be pooled (i.e. the interplay with the healthcare delivery system). The costs of healthcare for the elderly are segmented below and analyzed in terms of the Indian market's maturity to include these within an insurance cover:

Figure 16: Elderly care - insurability framework



Market maturity is evaluated on the basis of:

- Capacity available (this could be healthcare delivery capacity, or administration capacity)
- Predictability of costs (this refers to availability of data to price the risk).

Table 2 : Elderly care - mapping cost elements to Indian market readiness

Element	Description	Indian market readiness
Geriatric care	Geriatric care management is the process of planning and coordinating care of the elderly and others with physical and/or mental impairments to meet their long term care needs, improve their quality of life, and maintain their independence for as long as possible. It entails working with persons of old age and their families in managing, rendering and referring various types of health and social care services. For example, they may assist families of older adults and others with chronic needs such as those suffering from Alzheimer's disease or other dementia[7].	Specialized skills on geriatric care management do not exist in the Indian market. However the component skills (e.g. psychology, human development) and the clinical skills are available in the market - and for existing health administrators - represent an extension skill set. [In markets such as the US, geriatric care managers also play a strong role in advocacy and liaising with the government - something that the Indian market has not seen]. Data on costs attached to geriatric care management is partially available - since the insured pool includes parents of working employees in India.
Disease Management	Disease management - a system of coordinated healthcare interventions and communications for any population with conditions in which patient self-care efforts are significant. For senior citizens this most usually refers to chronic care.	Healthcare capacity in the Indian market to manage chronic diseases is available. For the main chronic diseases e.g. diabetes, hypertension - the capacity to aggregate exists in the market and therefore so does the ability to create risk transfer / risk pooling structures. Costs linked to disease management are predictable - there are data structures such as prescription audits available to quantify drug cost which is usually the main component of out of pocket spend.

[7]Cress, Cathy Jo. Handbook of Geriatric Care Management. Jones & Bartlett Publishers, 2010.

Element	Description	Indian market readiness
Assisted Living Costs	An Assisted Living Facility (ALF) is a housing facility for people with disabilities.	The Indian market lacks capacity in terms of ALFs – while some cities such as Pune and Coimbatore (Vanaprastham) have seen the creation of capacity – these are niche facilities targeted at non-resident Indians to help them ensure security / safety for their dependent parents or elders. These facilities do not specialize in providing round-the-clock care for seniors with severe disabilities. This means that there is little transparency or predictability around assisted living costs.
Adult Day Care	Adult day care services are non-residential facilities that support the health, nutritional, social support, and daily living needs of seniors and adults in professionally staffed, group settings.	In the Indian market, day care for senior citizens are restricted to the efforts of charitable societies (e.g. Help Age India, Silver innings) and support groups such as Satsanghs or "laughter clubs". These may or may not be professionally staffed, but have not evolved to the point where they can be aggregated at a state level. That said, the experience with telephone based counselling services for senior citizens has been positive.
Long Term Care (LTC)	Refers to the cost of providing care for senior citizens who are no longer able to perform, "Activities of Daily living".	Capacity for delivering LTC benefits is similar to Assisted Living – and is not available within the country with any significant level of scale. Data on the prevalence of Total / Permanent disability (i.e. conditions where senior citizens are not able to fulfill the "activities of daily living" and would be entitled to cover) – is available in India. However, in the absence of delivery capacity, the insurance cover would be restricted to providing a fixed (usually limited) payout – i.e. it would finance part of the financial need without the attendant structures necessary to manage associated costs. This may not make for a sustainable LTC insurance component.

5.5 "Deferred" risk structures:

Figure 17 - the need for deferred risk structures for elderly care insurance

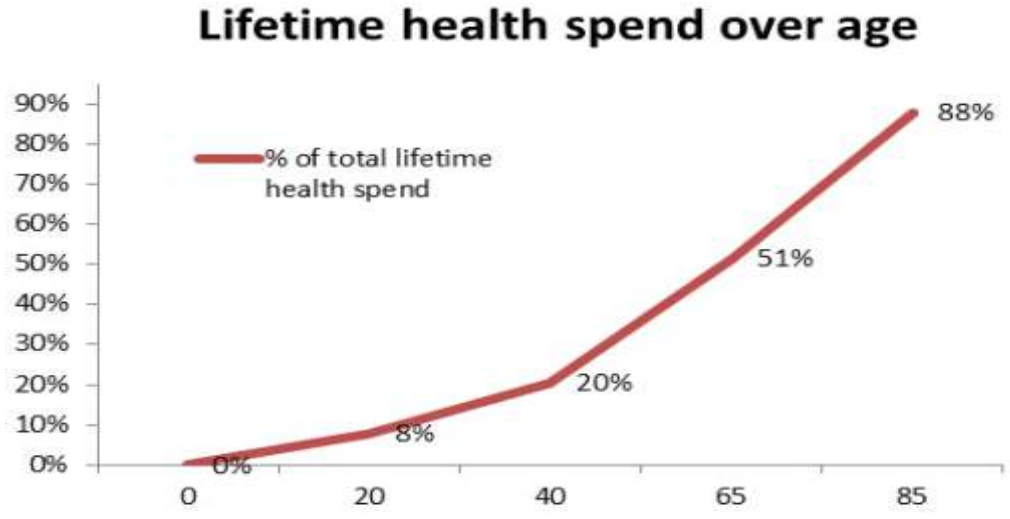


Exhibit 18 above shows a typical pattern of lifetime expenditure - in terms of Relative Life Expenditure - i.e. the %age of total, lifetime, healthcare spend at various ages. The data is from a US study, but is relevant since it compares relative expenditures at each age - i.e. market differentials on account of differentiated cost bases are eliminated. Secondly, the model used in the study uses a construct which holds all other factors (e.g. improvements in medical technology, changes in healthcare prices, medical techniques, incidence of disease and effectiveness of treatment) as constant, and quantifies relative life expenditures only by varying age.

The graph is important from the perspective of its impact on senior-citizen insurance product design.

Comprehensive healthcare financing programs rely on a combination of risk transfer and aggregation - for example - some of the structures use to finance outpatient spend are based on creating price efficiencies from aggregation.

In markets such as India - when comprehensive programs targeting customers which are 'naturally' at the high-spend slope of the curve, efficiencies from aggregation are largely offset by cost increases. Since disease prevalence also increases with age, such programs face the risk of degenerating into a cash-funding program, where every 'rupee of risk' is priced in.

To create structural shifts, the first set of comprehensive financing programs introduced need to have time to build up a 'risk fund' to buffer cost increases (in the initial stages of introduction of any new risk financing structure, the pricing structure will include buffers for such contingencies).

The exponential increase in healthcare costs over the lifetime of an individual, means that any senior citizen cover needs time to be able to build up a fund to buffer volatility due to changes in prevalence or disease profile. This means that the target customer for the senior citizen cover is around the age of 40 - the point at which the curve 'bends'.

In order to be viable, elderly care covers written by commercial health insurers would include a strong 'deferred' risk cover. This refers to a period of time, long enough to create a risk fund for future cost.

Note - that these are not traditional savings products - the financing structure needs time to build up a risk fund, to correctly serve the needs of the target consumer - i.e. the elderly segment. Therefore, it would not be correct to conclude that only life insurance companies can underwrite such programs.

The typical deferment period before cover commences would be about 5 to 7 years - in other words, if the target consumer is aged 50, then healthcare expenses after the age of 58 (or retirement age) would be covered by the scheme.

5.6 Healthcare Network design principles

In order to be sustainable, elderly care insurance structures in India would include four key healthcare delivery components - as an integrated part of program design. These include:

- Clinical Protocols - in the area of acute / emergency care as well as chronic disease management programs
- Discounted services on drugs, tests, consults and lifestyle or support counselling.
- Provider contracting structure: Since a large component of spend would be on chronic care, the network design would be a 'closed provider group' structure.
- Physician's as 'gate keepers': As with chronic care financing, the physician (or the nurse in many cases) would play a 'gatekeeper' role in terms of monitoring compliance with chronic disease management as well providing the first level of 'support' services.

5.7 Ecosystem enablers

For the elderly care financing market to grow, over the next 5 years, capacity is required around:

- Geriatric specialization - in terms of quasi-medical qualifications as well as physical infrastructure in terms of Hospice / Assisted Living Facilities / Senior Day Care facilities. This segment of the healthcare delivery market is unlikely to be viewed as a pure-play commercial opportunity. This is because, the Indian market will not find such facilities to be socially acceptable other than in cases of nuclear families where the next generation has changed citizenship and resides overseas, which is a very niche area in the context of the overall senior-citizen market.

- Risk pools created for funding high risk cases (citizens above age of 80, those with risk-based loading of 60% or beyond as an example) - these could be at an industry level or through the government. The impact of this structure is that it reduces volatility of expected cost, and therefore, over time, this helps eliminate the need for deferred risk pooling structures.

5.7.1 Tax incentives - chronic care and elderly care

- Tax incentives: Under the current Indian tax laws, health insurance premium paid under section 80D is Rs 15,000, with an additional Rs 20,000 available as a tax break for the premiums paid on the lives of dependent parents. Deferred Risk senior citizen financing structures may need to be bought into the ambit of the current tax laws.

- Incentive structure - Double Tax Credit for chronic care financing - Allow individuals and business to offset double the amount spent on health insurance or healthcare schemes - as 'allowable expenditure' / tax credit. This benefit is given for a limited period of time - e.g. 10 years. Revenue impact to the exchequer more than offset by the gain in productivity, since chronic diseases could result in a loss of 1.27% of GDP, and care management could reduce incidence by 10% at a population level.

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