

Reform Pathways for Healthcare Financing in India

A Dvara Research and IndiaSpend Webinar Series

Session 2

Commercial health insurance: Why not pay for outcomes?

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PROCEEDINGS

Dr. Ghosh: Good evening everyone. Welcome to the second of a four-part webinar series that Dvara Research and IndiaSpend are co-organizing. I am Indradeep Ghosh, Executive Director of Dvara Research and I will be moderating the discussion today. The objective of these webinars is to throw a spotlight on the key policy challenges in the financing of healthcare in India and to learn from the rich experience of practitioners in this domain.

In the first webinar which happened on September 14, the panellists reviewed the overall state of healthcare financing in India and identified the need to dive deeper into three of the four major healthcare risk pools in India. So, to that end, today's session is devoted to thinking about the first of those three pools namely the commercial health risk pool or the commercial health insurance space.

We have a very distinguished panel of speakers with us today and each of them will have about 15 minutes to make their remarks following which I will moderate a short discussion. Commercial health insurance is a vast area of research and practice and we will surely not be able to do justice to all of its complexities in a one-hour webinar. But I have requested the panellists to touch on some key themes that are particularly relevant for India and that they can draw upon their respective experiences to speak about. So, without much further ado, I will introduce our first panellist. After she has finished, I will then introduce the second panellist and so on.

So, our first panellist is Ms. Malti Jaswal. She is a senior consultant with the World Bank and working for Ayushman Bharat Pradhan Mantri Jan Arogya Yojana [AB-PMJAY]¹. She is a post-graduate from Delhi University and has worked with [the] general insurance industry since 1986 and with [the] health insurance industry since 2008 in various leadership roles. She is an active member of industry multi-stakeholder working groups and committees on health insurance, has published many papers, and has developed a certification course on health insurance for the Insurance Institute of India. She is a member of the IRDAI [Insurance Regulatory and Development Authority of India] Health Forum and also has led the IRDAI NHA [National Health Authority] Joint Subgroup on Fraud and Abuse Control. So Malti, over to you. You have about 15 minutes and once you are finished then I will turn to the next panellist.

Ms. Jaswal: Thanks, Indradeep. Thank you for inviting me -- also for participating in this very prestigious webinar and I must also compliment the music before was very nice. It was really relaxing and peaceful, very nice music. So, I have come from the commercial health insurance background

¹ Text in [text] format indicate editor's notes/insertions.

myself. I have been an insurer all my life and accidentally walked into the government side a couple of years back. So, I think, if you look at the journey of health insurance, it was not even there some three decades ago. Insurance itself is a very small industry in India and health insurance has grown a bit by bit. Major catapult happened in 2000 when the sector opened up. Now, what is it that, I'm glad, the way that this webinar is constructed to have three different perspectives and three people from various angles.

So, the health insurance [industry] presently has some nuances, some limitations, some advantages, some enablers, and whatever you call them. Let's look at each of these. Why the industry hasn't grown? -- when we have almost a fertile ground if you ask me, where the high out-of-pocket expense is there. So why would people not buy health insurance, isn't it? That would be -- why we are just covering around 120 million lives compared to the whole of Indian population and it's not that most of the population, in the poor segment of the population is already being taken care [of] by the public health schemes like Ayushman Bharat [AB-PMJAY].

Some of the issues that have impacted the growth of health insurance -- I'll come to market imperfections a little later. There are couple of very well-known facts -- [one] that we have a very small formal sector. Health insurance goes hand in hand with the formal sector. [We have] a huge formal [the panellist meant informal] sector in the economy. Then [second] we have huge income disparities, the rich to poor and the ratios are very, very skewed. Then we have urban-rural divide, then we have the presence of hospitals, across the tiers, across the smaller tiers, tier towns. So if I have access to a private hospital where things are expensive, I look for solutions. "How do I get covered for these expenses?" Unfortunately, -- it's one of the positive fallout of I would say, Covid19, health insurance, has been fast-forwarded in people's mind. That has been one occasion when this industry has had -- rest of the industry [industries] suffered downturn and attrition and what not. This industry actually had lot of pickup in the business because of Covid19 and so in a way that has catapulted the health insurance market in India.

Now coming to the imperfections of the market, some of those are mentioned in your paper also. I think the crux of the matter, as a practitioner I can share with you that, is more or less the issue of unregulated health care. There are a lot of market imperfections. So, what insurers have tried to [do is to] ring-fence them against those provider issues -- is to have clauses, is to have co-pays, is to have limits. So that to ring-fence their own profitability and then in the process, the products have become complex. In the process, the products have [also] become expensive. So, it's a death spiral. You have an expensive product; less people join. Less people join, the risk pool is not big enough, the risk pool is not varied enough. So, it's kind of a vicious circle that has been the part of the health insurance ecosystem as such.

Now for the last 5-10 years, FICCI [Federation of Indian Chambers of Commerce & Industry], CII [Confederation of Indian Industry], IRDAI, the Health [Insurance] Forum, and all those people are coming together and discussing these issues bit by bit. For example, there is a committee by IRDAI now, recently on senior citizen's health insurance premium, which are really skyrocketing. Poor guys, they are on retirement funds and have to pay very huge insurance premium. Which is all right from the actual [insurance] perspective, there is nothing wrong. But if you look at it from the societal perspective, from the affordability perspective, they drop off from the insurance. So, there are complex issues involved here. You got to solve the issue of more people joining the pool, the products being simple, products being able to be —there has to be a distribution network which is not expensive to use.

Where you have in your paper shown that Tier-I and Tier-II cities -- Tier-II particularly and the metros have the maximum share of claims as well as the insured population. I may offer you a little bit insight on that. Some of this data is actually dependent on the pin code in the policy, right? So, it may not be exactly -- or sometimes, earlier times it happened that it was the policy issuing office's pin code which was being tracked. Now that has been corrected. So, it's a pin code, so there may be -- but still, the skewness definitely exists. It is majorly skewed towards cities, metro cities where more people of organized sectors stay.

Now expanding the coverage to the next tier, the third-tier [cities] and the other tiers, I -- in my personal view, schemes like Ayushman Bharat [AB-PMJAY] would have a role to play there in the ecosystem because if you have 40-45% of population coming under one umbrella, one ambit, so it's too big a player not to make an impact. So, the impact will be multi-fold in my view. It definitely has increased the awareness about insurance. Health insurance as such is known at the village level that, "Okay, I am covered under this card. I am covered under this scheme. I don't have to pay". So, if I [they] don't have to pay, so then the other people who are there in the village are also looking, "Okay, is there a possibility [that] I [can] join the scheme? If I can't join the scheme, how I can do this?" So, there is an awareness that it increased.

The hospital network has increased, there is IT system, which is enabled. It's like a healthcare exchange platform created by NHA where multiple transactions in a second are happening all over the country. So, it's a public infrastructure created on which the insurance companies can ride. There is a package concept, there is a hospital empanelment [that] has been rationalized. Package prices have been a little bit of a negative publicity in the media but nonetheless, there is a standardization. So, the ecosystem, the risk pool efficiencies definitely depend on these enablers. So, I think Ayushman Bharat [AB-PMJAY] has kind of created these enablers parallel to the private industry, parallel to the private insurance industry.

We are in touch -- NHA is also addressing the issue of this “missing middle”, so to say. Poor are being covered, upper-middle [classes] have purchased insurance and the very rich don't need insurance. So, this “missing middle” which is the population which is not looked after by anyone. So, recently, NHA launched this project called insurance pilots whereby insurance companies can piggy ride on the [AB]PMJAY Infrastructure. Everything from the IT [information technology] side to hospitals to empanelment to claim processing on this net -- on this infrastructure and they can offer a very affordable insurance to the “missing middle” population. So, we've just started this. 21 insurance companies have been shortlisted. Almost all of them applied to participate. So, that was very good, I mean, feedback from the industry, feeler from the industry that they want to ride on this, on the scheme to reach out to the people who they were not able to reach out earlier for various causes.

Should I rest here? Have I expanded my 15 minutes?

Dr. Ghosh: No no, please keep going, I think.

Ms. Jaswal: I have a few more minutes?

Dr. Ghosh: Yes, you do.

Ms. Jaswal: Perfect. So, then I think some of the issues which have impacted the insurance industry are also relating to not being able to manage the consumer expectation. It is the sales philosophy which kind of led the customers to believe -- because insurance is after all pooling money and paying for -- collecting from all and paying for few. So, this concept of insurance-- when we were young, we only knew LIC [Life Insurance Corporation] and LIC means you invest and you get returns. Term insurance in India is not very popular. It was always investment-linked policies. So, people did not view health insurance as a part of risk protection. They thought it was part of investment. So, they are wanting returns on that investment. They are wanting “Why my policy doesn't pay for everything? Why my policy doesn't [give] returns?” So, you have some states in India, you would not believe, where the agent sells the policy to a policyholder and say, “This is your [Rs] 10,000 spend and I promise you, you will get [Rs] 15,000 in one way or the other”. So that way, people are still not in that mindset of protecting their vulnerabilities, financial shocks and things like this.

Now you add to the complexity of these, the onset of NCDs, the chronic diseases where our products traditionally covered only hospitalization, the OPD [outpatient department], outpatient expenses were not covered, wellness wasn't covered, preventive care wasn't covered. So, the complexity of -- you got to manage chronic care because if you do not manage chronic diseases your claims are going to shoot up. If the health of the patient, health of the policyholder is going for a toss then your claims are going for a toss. So, industry is now forced to look at chronic care management. Now Covid again has helped the industry in looking at telemedicine as a gatekeeper, as a referral or

as a chronic care management tool. So, these changes would definitely help the industry to broaden the product base.

Now the health -- As far as the regulator [IRDAI] is concerned. So, the regulator has been a little, I would say, cautious. I mean we have had a regulator who's very cautious, not very aggressive either in regulating or in development. If I can use that. They have been very cautious and very conservative regulator that we have. Within that kind of a philosophy, they have now understood that few things are very necessary for the development of this market. They have understood that there has to be standardization of products, standardization of things because you have around 500 plus products to choose [from] and every bit of frill and bell and whistle is changed and it's a new product. The customer is totally confused. For the customer's sake, so they have come up with the concept of standard -- not only product but standard definition of terms [like] what is pre-existing [pre-existing diseases exclusions]. So that customers are not taken for a ride.

You have mentioned in your paper that the grievances in this area are huge because this dissatisfaction of the customers is [that] there are multiple issues. There is a touchpoint between the healthcare provider -- The policy pays but the services are provided by the health care provider. Now, these two do not meet anywhere. There is so much of distrust, there is so much of tug-of-war between the payer and provider. If you will happen to attend any one of the meetings of payer and provider, you would have some idea of how deep-rooted the distrust is. So in between the customer is "hanging fire" [editor's emphasis]. So, when policyholder lands at your hospital with some health issue the payer side is looking, "Okay, let me look at it whether what is covered, what is not covered". Hospital is looking, "How do I treat this patient in a most comprehensive manner". I'm not talking of the commercial aspect but the treating doctor's prerogative. Between these two, the insureds are just paying out-of-pocket [while] having a policy as well. So that defeats the purpose of having a policy and then still paying some part of the money.

So now the regulator was not earlier open to a tiered network attached to a policy. Their philosophy was that entire network should be open to any policyholder, to every policy order. Very recently, I think last week this discussion during our meeting on the senior citizen committee, they have at least [become] open to the idea that if I need to go for a cataract surgery, I should not be going to a tertiary care hospital because that is not required. Tertiary care should be used for tertiary care. So, I think that progressive ideas, that progression to acceptability, that policyholders' interest is also served in a way -- not to open everything because if you open everything then that policyholder's interest is not served. Policyholder is paying through the nose for increase in the premium. So, there is a bit of a realization on the insurer -- on the regulator's part also.

They have come up with sandbox so you can experiment. So, this experiment on insurance pilots is going to happen in the sandbox so people don't have to file the product, wait for long time for the approvals to come. These are some of the -- I've tried to give you a kind of a view of the marketplace or view of the policyholder, provider and the payers and the regulator in summary. I'll be happy to take further questions as well.

Dr. Ghosh: Yeah sure. Thank you, Malti. We'll come back and take some questions from the audience -- as well as perhaps I'll ask you to respond to some of the things that the other panellists also say.

So, our second panellist today is Mr Sandeep Kumar. He is an associate partner in the New Delhi office of McKinsey and Company. His undergraduate degree is in mathematics, he has an MBA [Master's in Business Administration], both from Delhi University. After a brief career in financial services, he joined McKinsey and he currently co-leads the India Insurance and the Asia Health Insurance practices at McKinsey. He has advised clients and senior executives on insurance and healthcare topics across Asia and particularly in India and APAC [Asia-Pacific]. So, Sandeep over to you.

Mr. Kumar: Thank you, Indradeep and thank you, everyone, my co-panellists and everyone joining the discussion today. It's a great, great privilege to join this discussion. I think Malti touched upon some of the points very rightly and kind of like really really quite deep in terms of when she was explaining about the private health insurance in India or commercial health insurance, whatever word we use. I think -- see the way -- I would try to kind of provide a slightly different perspective. What we really need to see is that private health insurance or commercial health insurance cannot be seen in isolation. There are three stakeholders. The provider, the payer and the customers. Okay. And if you look at this whole ecosystem there are multiple challenges all these three stakeholders actually face. We did a lot of research and analysis and there are more than 15 major challenges like the access, affordability, information availability, quality of care, the efficiency, the latent need of the customers, the technical capabilities. So, there are multiple challenges across various aspects that these providers, payers and the customers are kind of really facing in this market.

When we look at the commercial health insurance in India right now, there are some interesting things. On the one hand we see there are a lot of challenges but [on] the other hand we also see that the industry has all said and done, has achieved a lot in the last maybe 15-20 years. I won't get into the data. It's all publicly available and some of those are there in the research report that you have published. Today we are talking about this industry covering more than 3 to 4 crore of individual customers which may not be very big in comparison to what we really need in this country. But if we see from where we started it's a phenomenal achievement. The another thing Malti talked about it and very rightly so, which is around the huge distrust among these stakeholders whether it is

the payers, providers or the customers. I mean none of them basically trust each other. The one thing that I have sort of personally experienced is -- while talking to many of these stakeholders at different points of time there is no lack of intent. Nobody is trying to be a villain, nobody is trying to screw you up, right. I mean the, the whole construct has emerged in such a way and some of these points kind of Malti touched upon why so, is the construct has become such a way that they have got into this business where they are forced not to trust each other because there is a conflict of interest. Just a few days back I was having a discussion if people remain healthy, providers don't earn more money. And if people go to hospitals, then payers pay more. If suppose you come up with a proposition which is around keeping healthy people healthy and you want to work together with a provider now, it's a, it's a classic question - How do the providers make money?

So, what I really mean is that the industry at this point of time, we have grown with whatever like copy-pasting best practices from somewhere here and there we could have done and we could continue growing with this. You will talk to quite a few people in this industry and they will say "Oh there is a huge opportunity like you just need to focus on essentially your execution and you keep growing at 20-25%". Yes, true. But my sense is and I am not shying away from saying this fact that many of this growth is sitting on a time bomb. I mean if you go deeper into the book and take the new book out of the old book, you will see that basically the book is a time bomb. It will burst at some point of time, let's see when.

So, what really is needed is actually concerted efforts across these three entities. What we really require is a different kind of imagination. What we really require is a boldness in the thinking around - What is our coverage? What is the product that we are offering? How do we bring all different types of customer segments into this whole private insurance umbrella? And this needs a different kind of thinking. What I mean is a different kind of thinking -- every time we have a conversation, this is about what one player is doing, what another player is doing in the private health insurance. The learning, unfortunately, and this is my personal view, the learning will be limited if we keep learning from one insurance company to another insurance company, may it be health insurance, may it be life insurance.

The learning now and the customers, who are used to interact[ing] with now Amazon and the Uber and the Netflix of the world is expecting the similar kind of behaviours and the choice architecture. And I'm using the word "choice architecture" very carefully because we believe that, I personally believe, that is the central point -- centre of what will really drive the adoption, no matter what kind of good products you can come up with. Malti talked about more than whatever 400-500 products in this industry. You come up with more products and you confuse customers more. So how do we create a choice architecture that drives the adoption so much better among the, the customers?

So, we require a different kind of approach. We need learnings from the different other industries. We need to look outside in not just inside out. The industry has to be open to contributions.

The another point that I briefly want to touch upon this whole point around, we have the regulatory challenges, you know the regulator is not very open, we cannot do risk-based pricing, we cannot do individual pricing, yeah I mean everything is there. And personally speaking, I have served with clients more than probably 15 countries across the world. Every market is different. It's a nice thing to say and to say yes, I mean India is very different, Malaysia is very different, Australia is very different. You go to any market and, and you will hear that this market is very different. Yes, I mean the two families living next to each other are very different. What's so great about it? But if -- the starting point cannot be that because we are so different, so we cannot look outside in. The point is, we are different and that is why we have to look outside in because everybody is different. So that's the another thing that I would say that industry mindset really needs to change dramatically -- that it's not just about the regulation -- it's not just about India is a different market and so there are only as much that we can do.

Okay, the next point that I want to touch upon is this whole thing around the focus of the industry, the focus of the private health insurance players. If you look at, if you go and have a conversation with the India's insurance players and this is by the way not just in India [but] in many markets, many markets across the world. One thing they would say "Oh we have reduced the claims, like experience. Now we settle claims in 5 minutes. We have 80% straight-through process." There is a very simple question there - Are we solving for our customers or are we solving for transactions? When you settle a claim you solve a transaction. A transaction becomes faster but a customer pain point is not that 5-minute transaction. A customer pain point is admission process and discharge process. You -- an insurer might cover and settle a claim in 2 minutes but if the doctor who is supposed to write that discharge summary will not come for the 3 hours or 4 hours until 4 o'clock even if I have to just get discharged at 10 am in the morning, I have to wait in the hospital till 4 am. So how does that really matter if you settle my claims in 2 minutes or 5 minutes?

Now, this is what I mean that a concerted effort across the stakeholders has to come in. Neither payer nor provider can solve this in isolation. There is a win-win and there could be a win-win. There is a win-win for payers, providers, customers. There is an immense amount of opportunity. In India, we are at a tipping point and there is no dearth of customers willing to buy. But we really need to re-imagine our industry and what business we are in. There is one point and this is personally very close to my heart and like in the health insurance topic, I'm very personally passionate about is [that] this industry is a consumer-centric industry.

Private health insurance, commercial private health insurance has to be a consumer business and the customer service has to be at the core of it, while it's an actuarial model at the back end and all of that is there, but because it's a very different business. It's not a motor insurance. It's not that when my car gets hit and the garage guys gets paid. It's you touch, you feel, you are in a hospital -- when you go to a doctor and the doctor tells you that what you have to go through this kind of operation. It touches the emotions in a way that, that no other insurance line of business can really touch you. Unfortunately, in life [insurance], the claim comes when the person is not there. In this case, that's not the case. So, this whole mindset -- now if you look at how the industry evolved in India, most of these players that we have in India -- and this is not a criticism, this is basically the reality of life.

We were doing P&C business, [i.e.,] Property [&] Casualty business, then we started doing health insurance business. So, our mindset get carried [over] from the P&C. So, most of the architecture, you look at the people at the back end, look at the talent factory of the industry at the back end. Most of that is tuned in the mindset of P&C or life insurance because that's what provided the pool for talent. Industry needs to reimagine its talent strategy. Industry needs to reimagine its sense like the inspiration, the sources of inspiration and industry needs to really rethink about what business they are in. They are in a consumer business. They are not in an actuarial business. Till the time we come out of this actuarial mindset, -- and I'm sorry to say, I have a lot of actuarial friends, lot of respect for them, I studied mathematics, so I mean I have a lot of respect for them. But if we want India to be like really covered and we want to support the large population who need help and the Covid has kind of brought it to life for so many of us, we have to reimagine the whole industry in terms of what we are offering, how we are reaching out to these customers.

I will talk about maybe later when if we have a chance, why this whole distribution aspect of this industry has to change dramatically. We have to create a non-linear cost model. The linear cost model will just allow us to keep growing at 20-25% for another few years and after that things will just taper down. And we will get into a market share game and kind of extracting people from one another.

And the last point is around how do we really re-imagine and don't -- kind of come out of this mindset that we are very different and there are a lot of regulatory constraints that really don't allow. I mean, that's where innovations happen. Like the crisis creates the innovation and I think we are at a time, the Covid has given us that time to really rethink, reimagine ourselves and I personally feel we are at the right time to create an innovation and make the difference in this country.

Dr. Ghosh: Thank you, Sandeep. Very interesting points and I have noted some questions also which I will come back to later but first I want to turn to our third panellist. So, our third panellist is Ms. Neelam Sekhri Feachem. Neelam has over 35 years of experience in health policy financing and

management of healthcare systems. She is an associate professor in the Institute for Global Health Sciences at the University of California, San Francisco. She is joining us from San Francisco very early in the morning for her, which shows how passionate she is about this topic. She has her research and teaching focus on international health systems and financing policy. From 2003 to 2007, Neelam was senior health financing and policy advisor at the World Health Organization. Prior to that, she spent 14 years with Kaiser Permanente where she held executive positions in managed care delivery and finance -- and as Founder and CEO of the healthcare redesign group since 1994, Neelam has advised governments and international organizations on health reform financing and policy. I will ask Neelam to speak a little bit about something that she is an expert in, which is the managed care model. Neelam over to you.

Ms. Feachem: Thank you very much and thank you so much for that very long introduction. I appreciate it. So, I've been fascinated to hear what Malti and Sandeep have been saying because managed care may be just the reimagining of the insurance industry in India that is needed. And there are a number of areas that Malti talked about and Sandeep talked about that really gave rise to more sophisticated managed care in the United States. And so, I think that they have some relevance for where India is right now. First of all, this whole issue of managing chronic conditions, managed care is really set up to do that and it's also set up to create aligned incentives between the providers of care and the insurer. So, you don't have that distrust and really different incentives from each of the two providers. So, let me tell you a little bit about how it does that.

I'm going to confine my remarks to three areas. First of all, let me just describe what managed care is and what makes it better than a traditional indemnity insurance model. Then [second] I'll present about three models of managed care and then [lastly] briefly talk about opportunities in India for managed care.

So, first of all, I think all of us know this, that under the typical indemnity insurance model, a patient who's enrolled in a commercial plan visits his or her physician and might be admitted to a hospital. But the insurer doesn't know about the treatment until the care is delivered and the insurer gets the bill. So, the insurer is completely passive and bears all of the financial risk and when that happens the insurer prices its product with a considerable risk premium. So even when they empanel, when an insurer empanels providers, they're paid on a fee-for-service basis which is actually the reverse incentives of what you want providers to be paid, which is to create more tests and spend more. So, the main way the insurer then tries to manage its risk is to raise prices or deny care after the fact. And the raising prices, of course, creates completely unaffordable care and denying care after the fact makes patients extremely unhappy and we've been hearing about this very non-patient-centric care model.

I think it was very interesting to read the paper that you circulated Indradeep, saying that in - for stand-alone health insurers only 60% of the premiums are actually going to provide care and I think that underscores the point that insurers are afraid of that risk because they really don't know what's going to happen and they need to better align that risk and share that risk and the rewards that come from managing care with the providers. So, in managed care, the insurer is often referred to as a health plan and it receives obviously premiums from employers and it uses a variety of techniques to align its incentives with the provider through different payment mechanisms, to improve the quality of the care. So, very much focussed on patient outcomes and reduce the cost of the care, [i.e.] efficiency and affordability.

There are many, many different kinds of managed care arrangements, but the common features of managed care are first and foremost, inherently you must have a benefits package that covers prevention, primary care, hospital care and post-hospital care. So, it has to be the entire continuum of care, not just this hospital care model that is much more prevalent in India.

Secondly, the health plan needs to be able to contract selectively with providers based on quality and value. So, the empanelled providers include primary care physicians, specialists, hospitals, pharmacies, you name it, but they are responsible as a group for managing the health of the population.

Third common thread in all of managed care is that the health plan aligns the incentives for cost, quality and efficiency with the empanelled providers. So how does it do that? Well, it shares risk with the empanelled providers through different payment mechanisms. Capitation is the most powerful of these which is basically going to the providers and saying, "Look I'm going to pay you one set amount for each member per month to take care of all the health care needs of that member". So basically, you're [the provider] responsible for keeping that person healthy. You don't get paid when that person is sick. Just for the services, you get paid to keep that person healthy. And it's very cost-effective for chronic diseases for many, many different things, but where health care is now, it's a very good model.

And finally, if you're an effective managed care organization, you monitor the performance of the providers on cost and quality and efficiency and you provide regular report cards to the providers with the focus being on patient satisfaction and patient outcomes. So, what Sandeep mentioned about service and about outcomes. So, the whole purpose of the managed care model is to improve the health of members in a way that's cost-effective for the insurer and provides continuity and quality for the members.

So, let me turn a little bit now to some of the models of managed care. There are many, many different models as I said but I'm going to just show you three models and if you bear with me, I'm

going to share my screen. I have a couple of slides to show you. I'm having some trouble here pulling up these slides. Sorry, they were all up and now they're -- okay, here we go. So, can you see this?

Dr. Ghosh: Yes, we can.

Ms. Feachem: Okay, so most people when they think of managed care think of this particular model this is a vertically integrated health system and it's the Kaiser model which I, of course, worked in for many many years.

Dr. Ghosh: Neelam, now we are only able to see the title the first slide, which is the title slide.

Ms. Feachem: Oh you can't -- You're not seeing the vertically [integrated] model?

Dr. Ghosh: No, not yet.

Ms. Feachem: That's very strange. Okay.

Mr. Kumar: You may want to hide the notes part probably.

Ms. Feachem: Yeah, I am, I'm on slideshow right now. Can you see it now?

Dr. Ghosh: Yes yes.

Ms. Feachem: Okay, all right. Okay, good. So, this is what is the -- basically represented by the Kaiser model. It's a vertically integrated system. So, at the top here you have this insurer which is the health plan. And the insurer then, in this case, like a Kaiser model, owns all the hospitals, the physicians, pharmacies, home health agencies. So, when I was at Kaiser, as an administrator I was managing all, all of those functions. And it manages it in an integrated manner, in the sense that the health plan entity contracts with the government for a capitation fee and then agrees to provide all of the services for those health plan members basically cater cradle to grave for those members. And those services, the whole plan then -- the organization can choose, where is the best place to provide that service, where's the most efficient cost-effective place, where is the place that's best for the member or the patient. So, it provides telemedicine services, preventive care, primary care, rehab services. Basically, the motto is to provide the right care at the right time at the right place because the system is not paid for more care, the system is paid to keep people healthy. Now the criticism of the system is because you're paid not for care, are you then providing not enough care? So, there are ways though that the health plan needs to present its outcomes and monitor its performance for providing sufficient care and not skimping on care, and this is very important because in the United States if Kaiser skimps on care, for example, then the patient can just move to another health plan. So, you can change plans. So, the very purpose of managing the care of the patient allows this system to grow and to be successful and sustainable.

The second model is what's called a horizontally or virtually integrated model and this is really the most common model in the United States. In this model what happens is that a health plan empanels hospitals, physicians, pharmacies through some kind of an arrangement, an administrative

arrangement. Usually, a group of physicians and here they're called an IPA [[Independent Physician Associations](#)], but it's really a medical group loosely affiliated, they come together with hospitals but not in the same integrated way that Kaiser has. What they do is they come together to contract with health plans. So, they can provide the full array of services because these providers are not under one umbrella that can just manage all the care, health plans then get quite involved in other kinds of interventions that will help to manage care. For example, they have a primary care gatekeeper, meaning you have to go to your GP [[general physician](#)] who can then refer you to other places. They have to have like pre-authorization which means that when an expensive procedure is going to be done or when an admission to a hospital is going to be done unless it's an emergency admission, it needs to be pre-authorized by the insurer. And they have guidelines for utilization review which means if you have this particular disease, you can only stay in the hospital for this period of time.

Now, this is the model where initially in the United States there was a lot of criticism because you're getting the health plan, or the insurer involved in decisions that are really medical and clinical decisions. And that's quite an issue when you start to implement this kind of model is to make sure that there's a lot of trust between the health plan and this physician group and that they're working together to manage the care of the patient.

And then finally the newest model in the United States is what's called an accountable care organization. And these came into play during -- for ObamaCare and Medicare and they were introduced by Medicare which is the largest payer in the United States, and it covers all of the elderly and many disabled patients. So, what Medicare said is, "We need some accountability from health care providers, we can't just be a passive payer. So, we're inviting hospitals and clinics to come together to create their own network of providers." So, it's like the virtual organization that I talked about before, but it's run by the providers. And because it's run by the providers, they can then either contract directly with Medicare or they can set up their own insurance company and that insurance company then can provide care to members that are not part of Medicare.

Now I have belonged to all three of these models at various times in my life and right now I belong to an accountable care organization. It's run by my employer UCSF [[University of California San Francisco](#)] which has hospitals and clinics. They've created a conglomerate of -- a network of hospitals and clinics that are accountable for outcomes. And if I go and see one of the physicians in the network, I pay just a very small co-payment like 20 bucks, but otherwise, my care is completely covered. I also have the option of going outside of my network and if I do that, I have to pay a very large deductible and then I have to pay about 20% of my care, so lots of incentive for me as an individual patient to go within the network. And because this network is owned by the insurer, I have confidence that there's

not a separate corporate entity that is making decisions about my health and coming between me and my doctor.

So, just to end my remarks, opportunities in India that I see for managed care -- I think there are lots and lots of opportunities in India for managed care. In fact, at the turn of the century, I came to India with Kaiser Permanente International, and we conducted interviews and focus groups with doctors, employers, government officials and there was a big appetite for managed care models in India. But at that time because of the regulations and the market was so new and it was a nascent market, they didn't have the regulatory framework to allow insurers to come in and create managed care plans. I don't know if that's changed. I hope it has. But clearly, India's market has matured in the last 20 years. And so, I think there's real opportunity. One of the areas Indradeep, just before I end, I should say that the biggest opportunity is with ESI [[Employees' State Insurance](#)] or Malti, your real potential for an accountable care organization -- there's just lots of opportunities in the public sector and I know you're going to talk about those but also in the commercial sector. So, with that, I would end.

Dr. Ghosh: Thank you very much, Neelam. Very interesting points and given us a lot to think about. Let me just pick up some of the questions that have come in from our attendees first. There was a question for Malti from somebody who asks, "Why is there only one model of insurance? Why not mutual cooperative insurance?" So Malti, would you like to address that question?

Ms. Jaswal: Yeah, I think, it's as Neelam said it's much to do with the regulations because regulations here are, you know, do not allow cooperative, do not allow -- and the capital requirement is so much. I mean it's not that they do not allow cooperatives, but their capital requirement is so huge. It's [[Rs](#)] 100 crores. So, you cannot actually have mutuals and cooperatives having that kind of capital access. So, there is a barrier to that, not necessarily -- not allowing, but then there is a virtual barrier or hurdle. Coming to the managed care, managed care also is in that regulatory bias where the regulator has not yet gone to that extent and I would also add here I think to Sandeep and to Neelam both, like when a couple of hospitals here in India, hospital chains in India set up their insurance company like Apollo set up that, Max set up that, those are health insurance companies and the market thought that maybe now they would come up with plans which are a clone of a managed care but sold through in this insurance entity. Unfortunately, they did not. They also just, just followed the herd and just did whatever the other insurance companies were doing. I think with the sandbox provisions and some of the new players, new kids on the block like Acko, Digit, Toffee [[insurance companies](#)] these are all digital players. Like what Sandeep has been saying, they're reimagining the products, reimagining the customer experience, reimagining lot of things for the customer engagement and provider engagement. So, I hope that there would be some accountable care

organizations or managed care models. Just one last quick point, even the hospitals I think should be now looking at with Covid background that how to keep people healthy and earn money. The medical education has been so focused on making money out of curing people. So, I think somewhere that that mindset has to change. It hasn't [been] done. I hope it does in my lifetime I guess right. Just not sounding so pessimistic, but realistic I would say. Yes, please.

Dr. Ghosh: Sure, Malti. Sandeep, Bindu had a question for you which is that we have many health insurers in the country -- this was to your point about the health insurance industry needing to become customer-centric. So, "We have many health insurers in the country, why are we not getting better customer servicing or customer-centricity as a competitive response?"

Mr. Kumar: Yeah, yeah. I think that's a -- that's a very good question and a question that comes time and [time] again. There are two levels to answer this question. One, which is a slightly more philosophical and larger like level which is around "Does competition always create better customer service?" in or like you know, "If the market forces alone really creates something which is the best for everybody?" right? I mean -- but I won't go to that point because that's something that's out of scope, right? But then there is like this whole thing around -- if you look at this market. What is the objective or the lens that players are taking, are kind of short-term. Let me be little bit direct about this and forgive me for being a little bit direct and blunt about this, okay. It's a little bit short-term. If you are solving for a 3 to 5 year of a growth, there is so much of under-penetration in the market that just by adding few more agents, by adding one more bank distributor, you can grow by another 25% for another five years. So, if the purpose is just growth and that in my view is probably the biggest, single biggest objective is the growth, you can actually do little bit of things that it's not that they are not customer-centric at all, it's not that they are not thinking about the consumers at all. I am talking about a very different kind of consumer centricity than where it is. You can afford [to] kind of ignore that and can still grow. If you see the players in the last five years, the industry has been growing almost at a 25% on year over year. And with such an under penetration in the market, you can continue growing for a certain time period. That's why probably its not -- the market competition is not resulting into that because you can kind of grow driven by the distribution channel focus.

But last point I'll say on this one is that -- this also brings to a point -- this is not only true for health insurance by the way in India, this is true for almost all insurance lines of businesses. We are a distribution-oriented industry. Every conversation you get into at some point of time will result into - how do we solve for better distribution? So, competition is also getting into the distribution-centric kind of a model than actually a consumer-centric model and I hope some of the disruptions, probably will come and we have seen some of that happening in markets like China where Pyongyang practically made a very different model altogether. It's way more advanced than probably anywhere in the world

whether it is US or Europe or anywhere. So yes, if somebody could take that view, could take that perspective, we could see that happening. But with the current short-term growth focus of three to five years and distribution being the anchor of that growth, the focus on customer-centricity is relatively less.

Dr. Ghosh: Thank you, Sandeep. So, a couple more questions. One is coming in for Sandeep and Malti. But before I ask that let me ask a question that has come in for Neelam because it's a question about managed care. "Neelam, among the three managed care models that you presented to us which do you think has a good chance of succeeding in a country like India?"

Ms. Feachem: I actually think all three can succeed in a country like India and -- because India is so large, there's an opportunity for -- to try many many different models. The easiest model to get into is actually the middle virtually integrated model because the insurance company, if the regulations were -- allowed it, the commercial insurance company could actually start empanelling physicians and hospitals, developing benefit packages that are from cradle to grave, so primary care, prevention -- really focused on the health of the patient and customer service rather than simply paying hospital care at the, the end of the line. So, I think that would be very easy for insurers to get into.

I also think that -- as Malti mentioned, if Apollo for example has already set up their insurance company, why aren't they acting like a Kaiser? Why aren't they rethinking and reimagining how they're providing this insurance product? So, I think easily that kind of a system which is really like a Kaiser system could develop. And then accountable care organizations, there are enough large providers in India where they could come together and form networks and either -- and one of the opportunities that they could have is to start to contract with some of the public insurers in India which would really become a huge opportunity in the market to change health care and health outcomes.

Dr. Ghosh: Yeah, great point and in fact, this is the point that we want to return to in a future webinar which is what role can the public sector play in creating the right kind of systemic shift in the health care system. We will come back to this I think in the third and fourth webinars. There's a question about TPAs [[Third Party Administrators](#)]. "It seems that TPAs have not really delivered on their promise and is it time now to rethink this model?" Sandeep, Malti, if either of you want to jump in and take this question.

Mr. Kumar: Yeah, I mean I can -- Malti would be a bigger veteran I think. She has lived her part of her life on this one, but I'll share kind of one perspective around, not directly around at the TPA but part of it. See, when we are talking about the customer, Indradeep, out of 100 customers how many people file a claim in a year? There are 10 to 15% of the unique customers who really file in a year. So,

when we are like, you know, saying that TPAs have not been able to fulfil their promises and things like that. Yes, I mean may be true, may not be true. I'm not like the deepest experts on the TPAs. But what I believe is that we are actually narrowing the definition of customers to such an extent that we are losing the battle at that point itself. If I have 1 crore customer, 10 million customer for example, and only 10 lakh customers are filing, 90 lakh customers are not filing claims. What are we doing with those 90 lakh customers? How are we increasing our interaction with them? They have multiple needs.

There is dental care, there is an eye care, there is aged care, there is a home care, there is a nursing care, there is a long-term care, short-term care. There are so many things that the standard indemnity does not cover and TPAs do not even figure there. So, I mean, passing -- just saying that -- I mean yes, the TPAs have their challenges and I would let Malti respond to that. But I would say there is a bigger challenge around -- around this that even for TPAs to step up the game, what have they done really to expand their offerings and just administrating claims and maybe do things what the TPAs are doing probably in Singapore where they have expanded their scope of offerings and their services to the full end-to-end spectrum of a customer health journey rather than just paying and assessing a claim when you go to a hospital in a stage for more than 24 hours?

Dr. Ghosh: Thank you, Sandeep. Malti, would you like to say something about this?

Ms. Jaswal: Yeah, I think I agree with Sandeep with what he has said about the customer engagement part, beyond the TPA's role. I think regarding the focus point on this -- the TPAs' legacy issues are because of the very small fee percentage. Indian market, whether it's the customer or the insurance company, very price sensitive. So, I think the insurance companies are themselves to be blamed in a way for the poor service by the TPA market by paying very less and focusing on the low-cost TPAs, number one. Number two, I think the entry barriers to TPA has been so low that capital requirement is so low, you cannot have this very robust business on that. You get very less revenue, your very capital basis very low and then the regulator also has not increased entry barrier to that extent. So, these are some of the legacy issues. And plus, that then no skin in the game for the TPA to do a better job. If they keep the people healthy, if they reduce something or there is no skin in the game for the TPA.

So, these are the some of the issues that has played the TPA industry and in my personal view, I think a correction and the consolidation in TPA market is overdue and I think it should be happening sometime in the near future, in my view.

Dr. Ghosh: Thank you, thank you Malti. So, we [are] almost out of time but I want to pose one question to all the panellists and, and that is that -- I want to really think about what Sandeep has urged us to think about, which is, how do we -- how do we create this mindset shift in the Indian insurance industry? And I suppose part of this mindset shift has to be that the insurance companies

have to themselves think about the healthcare system in which they are participating, rather than just profitability. How do we do that? I know that Sandeep also said we shouldn't blame the regulator, can the regulator play a role in creating this shift. How do we create this shift?

Mr. Kumar: Yeah, I mean, I can go first and then would be great to hear views from the Malti and Neelam. I mean you were right, Indradeep. I think the future -- as I say the market is at a tipping point. And when I say we should not blame the regulator, the idea is that it's like -- just for a sake of an example, if someone is like physically differently abled, should we just take that as a kind of a condition and say that "Oh let's now like rest at home and not do anything". I mean, regulator -- and I'm not saying regulator is like that, I'm just saying that there will be always be certain given constraints in life and we have to capitalize on those constraints. So that was that was my point. Now regulator I think will definitely have to play a role there. Regulator has to definitely enable and create a platform that allows innovation in the industry. And there are three parties in my sense have to come together. Regulator, industry bodies like whether it is the GI council or CII or FICCI, I don't know I mean whichever organizations they have. They have to come together along with the healthcare ecosystem stakeholders. They all have to -- so that there has to be a provider regulator. Right now, IRDA[1] is not regulating providers. So IRDA[1] could come up with something phenomenal innovation. But when it comes to hospitals, hospitals will say okay tata bye-bye, somebody else is wrong[fully] regulating us okay. So how do we solve that problem at that level? That is point one. How do we bring the multiple regulators together and then I'm not suggesting we should have one or we should have many but coherence and a coordination across regulations so that there is a transparency and there is an agreement and alignment in what we are trying to achieve.

Second, all the players in the industry need to come together and think through what are they really trying to solve? How do they really create an industry which provides an offerings and a proposition to people [for] what they really need? I come from a poor district in Bihar. If I come from Madhubani, I mean if a person from Madhubani is not going to come for the treatment in maybe Max or some hospitals in Delhi or somewhere -- my program has to be designed differently. And it's not that somebody will tell me that "Here is your 10 programs and please go and choose". I, as an average customer, I struggle. I mean, I understand insurance probably better than an average person because I have been in this industry for many years. But even I struggle to select a plan, which one should I buy? What is top-up versus the base plan? So, what I am talking about is that the industry needs massive simplification. Regulator or anybody did not ask these companies to come up with such a complicated choice architecture that it prohibits people to entering into it. We have to blame ourselves. Industry has also to blame itself. We have created the most complicated choice architecture and that's why we are pushing people away rather than inviting people to come and join and be the

large of the pool. So, I have a very different view and perspectives because I think the future is very very, very bright if we have the leaders in the industry who could really reimagine and could really rethink and think on the lines of how Uber and the Netflix and the like the Amazons of the worlds have really thought through. And even in India like what we have seen what Reliance Jio did in the last five years, I mean we had telecom for so many years. I mean, what happened in few years it could really change the game. But it, it needs to come out of this insurance mindset where we are dealing with transactions and underwriting risks rather than humans.

Dr. Ghosh: Thank you, Sandeep.

Ms. Jaswal: Yeah, I think Sandeep has already made most of the points. To that [point on] re-imagination, I'll add three parts to it, like, whatever he has said in three manner. We have to go totally digital. I think digital is a way for us to go for re-imagination to happen. Second, we have to kind of unbundle and have small packages like a very simplified, small, [easily] understood products at an affordable price. I always maintain that we are a mass market, we are not a class market. So, I think the health insurance should not remain like a class product, it is for a mass product. The moment we come to think of [it like] that we would be making profit as well as sustainability for everyone. And the third piece is that stitching the three together - the regulator, [the provider] and the role of energy like organizations to create ecosystem enablers. I think these would be three enablers I would add to what Sandeep has already said, yeah, thank you.

Dr. Ghosh: Thank you, Malti. And Neelam, looking from outside in what are your thoughts.

Ms. Feachem: I think actually the regulator -- one of the problems with insurance regulation is that it's a regulator for financial products and then all of a sudden they have to regulate healthcare. What we have, I'll give you an example in California, is a separate regulator for health managed care products and that regulator actually understands the medical side, the health side of health insurance as well. So, the focus is not selling products or financial transactions. The focus is improving the health of the population. And so, I think one thing India could do is of course open up [through] the current regulator and allow more innovation and different kinds of arrangements. But also, I think you should consider having a separate regulator for health insurance products that is really looking at this as improving the health of the population, not just selling a financial tool to people.

Dr. Ghosh: Thank you Neelam, thank you. So, I just want to again thank all the panellists for taking time out of their busy schedules to share their thoughts with us. This is just the beginning of conversation that Dvara Research and IndiaSpend want to have around health care financing. There's a long road ahead of us. Our next webinar will be on ESI's risk pool. So, we look forward to having all our attendees back for that one. But for today, let us close here. I want to thank all of the attendees

also for making this a successful session and once again thank you Malti, thank you Neelam, thank you Sandeep. Thank you, everyone, bye.

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Transcript edited by Anjali Nambiar.