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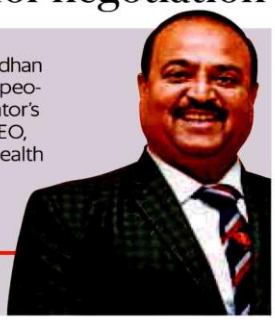
Retail health plans insure only about 10% of hospitalisation, so little room for negotiation

Health insurance has become a buzz word, thanks to the Pradhan Mantri Jan Arogya Yojana that promises to insure 500 million people from the lower economic strata, and the insurance regulator's renewed focus on it. Tapan Singhel, managing director and CEO, Bajaj Allianz General Insurance Co. Ltd, talks about how the health insurance landscape is expected to evolve



MONEYGURU

TAPAN SINGHEL
Managing director and CEO, Bajaj Allianz General Insurance Co. Ltd

In July this year, the Insurance Regulatory Authority of India (Irdai) set up a working group to look into standardising exclusions in health insurance policies. What can we expect from it? Given that health insurance comes with many caveats, the work of the committee will mark the next wave of reform in health insurance.

First let's look at the way health insurance has evolved in India. It was launched in 1986 and till about 2006, there was hardly any development. But in the last decade, health insurance has grown substantially and the products have seen important innovations. This is driven largely by consumer interest—people have realised that they need quality healthcare and insurance plays an important role in making that affordable. Even elsewhere in the world, health insurance has developed in the recent past and is monitored closely. For instance, in the US, there is a cap on how much profit you can make from health insurance.

Health insurance is crucial for quality healthcare which in turn is crucial to increase life expectancy. Hence, there needs to be a constant endeavour to improve this space. Also, health insurance is highly customer sensitive because the experience is very personal. Unlike a motor insurance claim, where you may be a little dispassionate, health claims are personal and, therefore, we need to constantly work towards making that experience smooth for customers. This is what one can expect from the working group—that it will identify the areas of confusion and standardise it. But we need to be mindful—we can't standardise everything because that stifles innovation.

The committee will also look at ways of including new medical procedures as a result of technological advancements. There are some policies that exclude latest lines of treatment. For instance, some policies exclude certain cancer treatment drugs. Why?

I feel that health insurance should be more comprehensive and leeway should be given to hospitals to include newer ways of treatment. This, of course, impacts pricing, but we shouldn't cut corners even if we are not the cheapest in the industry. But I also feel that customers need to approach their health insurance needs more holistically. A regular health policy is just the basic cover that everyone must have, but over and above that, one should go for a top-up plan that increases the cover in the most cost-effective manner, and over that, one should have a critical illness policy that pays a lump sum on the diagnosis of a critical illness.

Defined benefit plans like critical illness plans are beneficial because they give a lump sum that can be used to supplement income and seek better medical care. Because we are able to control claims, critical illness plans are cheap. When a person is insured then she gets hospitalised for ailments like diarrhoea and fever, which she wouldn't do otherwise. This impacts the claims ratio, but this is taken care of in critical illness plans because we pay a lump sum against named ailments after a survival period of 30 days.

Even with the list of exclusions, if you have a combination of indemnity and critical illness plans, your insurance will pay for your bills.

OFF TRACK

What is your favourite book

Autobiography of a Yogi by Paramhansa Yogananda

Do you bring work home

No, because I travel a lot. When I am at home, I give my 100% to my family

What would you do if you were 21 again

I would think about the society and my contribution towards making a difference to life much earlier than I did

What is your money mantra

It will give you the best returns today, spend it, enjoy life, and save whatever remains

You will be providing the Pradhan Mantri Jan Arogya Yojana (PMJAY) coverage in Jammu and Kashmir and Mizoram. The cover under PMJAY is comprehensive with very little exclusions. It also covers pre-existing ailments. Also, in all the empanelled hospitals, treatments rates are predecided. Why haven't insurers been able to replicate the model for retail health?

This is possible because of the sheer size of PMJAY. It insures 500 million people so there is no risk of adverse selection. If you look at some of the group health covers, you will realise they are as comprehensive as PMJAY. That's because when you insure a pool of people, you reduce the risk of adverse selection and so the cover is wider. A retail policy, however, runs the risk of adverse selection. Imagine if we do away with the waiting period on pre-existing ailments, then everyone with a pre-existing ailment will line up and that will impact our claims ratio. As it is, the combined ratio (claims ratio or the ratio of claims incurred to premium collected plus expense ratio) for retail health insurance is upwards of 100%, which means we are not making any money. Now about packaged rates. PMJAY is implemented on a national scale and for 500 million people; the sheer size gives the scheme the muscle to enter into package rates with hospitals. In retail, only about 10% of hospitalisation is insured, so where is the muscle to negotiate rates? But with PMJAY, I am sure even retail will experience a cascading effect.

You said the combined ratio is upwards of 100% but if we look at the claims ratio, it's about 76% for retail health insurance and in the case of standalone health insurers it's about 58% for standalone companies. Does this indicate an overcharge?

Such low claims ratio is problematic if the insurer reports it year-on-year, but what you are looking at is the aggregate claims ratio and not year-on-year claims ratio. Health insurance, in the initial years of purchase, will show a lower claims ratio. That's because the waiting period on pre-existing ailments can limit the claims. So younger insurers or even insurers that are writing a huge chunk of new business every year will show a much lower claims ratio. When you look at claims ratio year-on-year, typically by the fourth year, the claims ratio will be well over 90%.

What is available in the public domain is the aggregate claims ratio, but to get an honest picture, you have to look at the year-on-year claims ratio of the same pool of business.

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