Four levers of controlling health claim costs

The Indian private health insurance (PHI) industry has more than doubled in the last five years, with annual gross written premium now at INR 51,636 crore ($6.9 billion) as of March 2020. While the premium growth has been encouraging, most insures are struggling to make any underwriting profits. The ongoing pandemic (Covid-19) has made it even harder to offset the losses through investment income. Although the insurers are hoping to capitalize on increasing awareness about health insurance, adding new people to the insurance fold who will remain as customers for the medium to long term is still a daunting task. Therefore, it has become all the more important for insurers to manage their claims and expenses. In this paper we will only focus on managing claim costs.

When we think about managing claims costs, we tend to think about four "levers" that the payer (insurer) can pull.

Underwriting/ risk selection	Benefit design	Network management	Care management

We will take each of these in turn and explain a little more:

Underwriting / risk selection.

An individual's claims risk is related to various factors: genetics, environment, lifestyle, culture, access to healthcare, to name just a few. Historically, we have used age as a proxy for claims risk, but most statistical models show that it is an imperfect proxy. That is why rating models have become more sophisticated over time - to the extent that many insurers in the market are using 10 or more different rating factors to set premiums. It has been found, through detailed statistical modelling, that one (not the only one, but a major one) of the most important predictors of claims risk in future is whether you have had claims historically. This is part of the reason that factors like No Claims Bonus (NCBs - generally provided as 5% or 10% increase in sum insured on renewal for every claim free year cumulative up to 50%) have grown so dramatically, because actuaries have not been able to find better proxies for future health risk than using a combination of age, historical claims (where NCB level serves as a useful proxy), location (location reflects access to facilities and not just local cost) etc.. We can speculate that the historical claims experience is a proxy for some of those environmental and genetic factors, lifestyle and cultural factors that we cannot measure directly, but of course, we do not know this for certain.

Insurers use pricing to select risks. The more sophisticated and accurate the pricing model, the easier it is to attract good risks (as your competitors with less sophisticated rating models will tend to over-price these risks). So having a less sophisticated rating model than your competitors opens you up to significant anti-selection. This implies that if you do not have for e.g. an NCB scale, you need to find other, more accurate (predictive), factors to use in your rating model, otherwise your competitors will always be able to select preferential risks and you will be left with the poorer risks.

Medical underwriting has always been an imperfect way to limit anti-selection (i.e. the tendency of the applicant to know more about their health risk that you, the insurer can ever hope to do). However, medical underwriting struggles in the face of new advances like genetic tests and can never hope (with limited time and budget and the inevitable obstacles it creates in the sale pathway) to fully negate the information asymmetry that exists between the applicant (member) and the insurer. That is not to say that it is not useful, but we would never rely on it as our only tool to manage anti-selection risk.

Other ways to manage risk selection are to have a closed distribution channel and marketing strategy that is very tightly aimed at preferential risks. So, for example, the need to have a sophisticated rating model is lower if you have a distribution channel where you are not competing directly with other insurers in an open market because the customers will be unable to compare prices on a like for like basis.

Benefit design

The benefits you include and the limits and co-pays you put on those benefits have a significant role. Benefit design does two separate things:

(I) the types of benefits and the way the product is put together appeals to particular groups of people (we call that "risk selection" because it can be designed to target particular low risk people, i.e. by including high deductibles, you are more likely to attract healthier lives who feel they are less likely to use their insurance, but they want high level protection) and

(ii) the limits and copays/coinsurances on benefits manage moral hazard - which is the tendency of people to access services and benefits they are insured for that they would not access if they were paying themselves directly. If you do not have a

sophisticated pricing model, a leaner benefit design can manage some of the financial risks that arise, because if you have high coinsurances or strict benefit limits, you become less attractive for poorer risk lives.

In some markets (Ireland, South Africa etc.), you are not allowed to price by age, and benefit design becomes critical because you can design products that appeal to younger or older people specifically and, by designing and marketing these products to a specific target audience, you can price that pool of people more accurately.

Network management

This is simply the prices insurers pay to the providers, and whether or not the insurers can steer customers towards specific providers where you have cheaper deals. This has become much more important over time, because the gap between what the larger insurers pay and what the smaller insurers pay for the same service has become meaningfully wider in the last 10 years. This is therefore a key cost control mechanism for the larger insurers.

Care management

This is about how insurers manage the claims from pre-authorisation through to final payment and how much directing of customer treatment you do. Denying inappropriate or experimental treatment would come in this category, but also a host of other things such as:

- programmes to encourage use of established public or not-for-profit provider services for cancer etc..
- utilisation management
- care co-ordination
- musculoskeletal (MSK) triage (referring potential MSK surgical claims to a counselling service and explaining the options of conservative treatment before moving straight to surgery for example)

The larger insurers have a fair amount of sophistication around these programmes and some certainly reduce the incidence and size of large claims significantly for certain population segment.

In addition, developing capabilities to better understand market practices, benchmarks, clinical profiling of members, provider profiling, and customer segmentation provide necessary edge to insurers and enable them to use the above levers more effectively. Quality financial and clinical data is the prerequisite for all such capabilities. Some insurers understand this more than others and are investing in enabling tools for clinical codes, OCR technologies, Machine Learning (ML), and Artificial Intelligence (AI).

Conclusion

All the above are relevant for health insurers to manage the financial risk and some of these levers are just not available with every insurer or not being used in India. For example:

- Insurers don't have better data than the competition to estimate accurate prices for risks
- Insurer's benefit design and marketing/branding are not aimed at preferential risks
- Insurers don't have a closed distribution channel, but instead are competing for customers in an open market
- Smaller insurers don't have access to the hospital rates of the large competitors
- Large insurers may have some care management capabilities, but most insurers are still in early stages of exploring their potential role and building capacity in this area.

Not all of the insurers in the market use all of these levers, but most have a significant advantage in at least one. Insurers through their business strategies need to continuously strengthen their core area so that they can build capabilities to make use of these levers as much as possible. For example, an insurer may use group business to build volume to enable a stronger negotiating hand with hospitals to build economic advantages through provider discounts. This becomes self-fulfilling, as more business drives more discounts which drives more business.

Increasing pressures on new business volumes and entry of new players with disrupting pricing, making it even more important to reduce claims costs. In this scenario, existing insurers may use very tight medical management to build a competitive advantage with a focus on lower cost mass market segment and manage their claims tightly.

Written by

Rachin Aggarwal

rachin.aggarwal@milliman.com

Rachin Aggarwal is a lead consultant in the Milliman New Delhi Health and Property and Casualty Practice.

Joanne Buckle

joanne.buckle@milliman.com

Joanne Buckle is the lead consultant in the Milliman London healthcare practice.