MILLIMAN WHITE PAPER

Impact of Mental Healthcare Act, 2017, on the Indian healthcare insurance industry

2019

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Introduction

As per the World Health Organisation (WHO), mental health refers to a broad array of activities directly or indirectly related to mental well-being, prevention of mental disorders and treatment and rehabilitation of people affected by mental disorders.

Mental health is a major concern worldwide with approximately 14% of the global burden of disease being attributable to neuropsychiatric disorders.[1] The burden of mental disorders is likely to be underestimated due to underreporting and limited recognition of interactions between mental and other health disorders.

The enactment of the Mental Healthcare Act, 2017 (Act) grants a legally binding right to mental healthcare to all citizens of India. It is intended to set a foundation for delivering high-quality mental healthcare and protecting the rights of individuals receiving such care.

In India, mental healthcare faces challenges in terms of existing public health priorities and their influence on funding, shortage of mental health services facilities and resources, poor utilisation of the available services by patients and caretakers and issues with the recovery and reintegration processes of those who are mentally ill.

This Act aims to bring lot of changes in the healthcare sector through its provisions that place greater emphasis on the type of care, treatment and welfare of those suffering from mental illness. It also recognises the need for organising mental health services and providing appropriate training for medical professionals, including psychiatrists, psychiatric nurses, psychiatric social workers, clinical psychologists and professional caregivers.

The Act also places an obligation on insurance companies to provide health insurance for mental illness on the same basis as other physical illnesses. In response to this provision, the Insurance Regulatory and Development Authority of India (IRDAI) issued a circular dated 16 August 2018 directing insurance companies offering health insurance to cover treatment for mental illness.

1 Srivastava, K., Chatterjee, K. & Bhat, P.S. (2016). Mental health awareness: The Indian scenario. Industrial Psychiatry Journal. Retrieved 16 July 2019 from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5479084/.

In this paper, we look at the key provisions of the Act, mental illness prevalence, supply-side indicators and the current treatment gap. This paper also includes the results of an industry survey that we carried out to understand the impact of the Act on the Indian health insurance market and the mental health landscape in select international markets in order to arrive at key learnings for the Indian market.

Mental Healthcare Act, 2017: Key features

In India, the Mental Healthcare Act, 2017 (Act) was passed on 7 April 2017 and came into force on 7 July 2018. It is described as 'an act to provide for mental healthcare and services for persons with mental illness and to protect, promote and fulfill the rights of such persons during delivery of mental healthcare and services and for matters connected therewith or incidental thereto.' We describe below key features of the Act and our interpretation of potential consequences.

Definition of mental healthcare and mental illness (Chapter I and Chapter II of the Act)

- Mental healthcare includes analysis and diagnosis of a person's mental condition and treatment as well as care and rehabilitation.
- Mental illness is defined as a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgement, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life and mental conditions associated with the abuse of alcohol and drugs. It does not include mental retardation, which is a condition of arrested or incomplete development of the mind of a person, specially characterised by subnormality of intelligence.
- Mental illness shall be determined in accordance with nationally and internationally accepted medical standards as notified by the central government.

OUR VIEW

The definition of mental illness under the Act is very broad and there is no clear guidance on the mental illness definition by the IRDAI. Lack of clear definition will result in significant variation in the interpretation of mental illnesses, coverage offered and claims experience across the insurers.

Rights of people with mental illness (Chapter III and Chapter IV of the Act)

- There is a provision of the right to advance directive, which allows a person to choose the preferred way of care and appoint a nominated representative.
- A person with mental illness has the right to confidentiality with respect to mental health, mental healthcare and treatment.

OUR VIEW

Consumers' right to preferred treatment under the advanced directive offers greater choice of treatment. Insurers may need to consider appropriate claims management strategies along with the type and range of treatments to offer given their impact on the cost and ability to deliver those services.

Insurance provision (Chapter V of the Act)

- The Act requires insurers to make provisions for medical insurance for the treatment of mental illness on the same basis as is available for those with physical illnesses.

OUR VIEW

There are several considerations for insurers when offering cover for mental illness. These considerations include but are not limited to:

Product design: Given the uncertainty around definitions, a robust product design clearly defining the coverage can help limit risk arising from mental illness cover.

Pricing: In the absence of insured data, insurers will need to look at alternative data sources to price mental illness cover.

Underwriting: Given the difficulty with diagnosis of mental illness and higher prevalence of comorbidities, both physical and mental, insurers will need to revisit the underwriting guidelines for appropriate risk assessment.

Claims management: Claims assessors will need to be trained to validate and manage mental health claims.

Reserving: The greater the uncertainty around the coverage, the greater will be the need to hold higher reserves to meet the claims.

Supply provision (Chapter I, V, VII, VIII, X and XI of the Act)

- The Act mandates sufficient provision of mental health services through the establishment of:
  - Acute mental healthcare services such as outpatient and inpatient services
  - Halfway houses, sheltered accommodation and supported accommodation
  - Mental health services to support the family of the patient or home-based rehabilitation
  - Hospital and community-based rehabilitation establishments and services
  - Child and old age mental health services
- The Act requires government to integrate mental health services into general healthcare services at all levels of healthcare including primary, secondary and tertiary healthcare and in all health programmes run by the government.
- As per the Act, mental healthcare professionals include professionals having a postgraduate degree (Ayurveda) in Mano Vigyan (psychology) and Manas Roga (psychiatric diseases) or a postgraduate degree (Unani) in Moalijat (Nafasiyatt) or a postgraduate degree (Siddha) in Sirappu Maruthuvam.
- The Act offers a decentralised model, placing obligations on central and state government to put infrastructure, resources and budgets in place to bridge the deficit in mental health services and facilities. The Act also requires establishment of central and state mental health authorities.

OUR VIEW

As per the National Mental Health Survey (NMHS) 2015-2016 report, detailed evaluation of the surveyed mental health facilities showed that those facilities were suffering from shortage of staff, lack basic infrastructure and have inadequate funds. Once the Act is fully implemented, the improved supply of mental healthcare services through increased funding and greater private investment, together with increased awareness, is likely to result in higher utilisation to meet current pent-up demand. Insurers will require adequate tie-ups with mental healthcare providers to meet this increased demand. Given the current supply shortage, provider contracting will be key for insurers to manage claims costs in the long-run.

A mental health review board formed by the states will make decisions on what treatments to offer at government facilities. This may impact the type and range of treatments insurers offer under their health insurance policies at a state level.

Admissions, discharge and treatment (Chapter XII of the Act)

- For the purposes of the Act, 'independent patient or an independent admission' refers to the admission to a mental health establishment of a person with mental illness who has the capacity to make mental healthcare and treatment decisions or requires minimal support in making such decisions.
- The admission of a person with mental illness to a mental health establishment shall be limited to a period of 30 days. If the patient requires further treatment, two psychiatrists will examine the case for admission beyond 30 days. As per the law, the patient is admitted for a maximum period of 90 days and a medical officer or mental health professional has to inform the concerned board for permission. It can further be extended for 120 days at the first instance and thereafter for 180 days each time after complying with the provisions of this section of the Act.
- There is a separate provision for treatment of women with children below the age of 3 years and minors.
- An independent patient may leave the mental health establishment without the consent of the medical officer or mental health professional in charge of such establishment. A mental health professional may prevent discharge under certain circumstances for a period of 24 hours to allow for the assessment necessary for admission.
- The Act prohibits the use of electroconvulsive therapy (ECT) on minors and without the use of muscle relaxants and anesthesia for others. It also prohibits sterilisation and solitary confinement or seclusion of mentally ill people.
- The Act assures free treatment to those who are homeless or below the poverty line.

OUR VIEW

Insurers need to consider how the provisions related to admissions and discharge, especially those related to long-term institutional care, affect their claims authorisation processes and expected claims experience.

Public awareness (Chapter VI of the Act)

Government shall ensure that the provisions of this Act are given wide publicity at regular intervals through public media, including television, radio, print and online media.

OUR VIEW

Increased publicity and public awareness is likely to have an impact on the utilisation of services and hence the overall claims experience of insurers.

Offences and penalties (Chapter XV of the Act)

Unregistered mental health establishments and professionals will be penalised under the Act.

OUR VIEW

Penalties and punishments will help ensure that only registered mental health establishments and professionals offer treatment and will help maintain the quality of services offered under the insurance cover.

Miscellaneous (Chapter XVI of the Act)

A person who attempts suicide shall be presumed to be suffering from mental illness at that time and will not be punished under the Indian Penal Code.

OUR VIEW

Attempted suicide is not covered currently under a typical health insurance plan. Insurers need to consider the implications of covering attempted suicide as per this provision of the Act. As per the NMHS 2015-2016 report, the proportion of respondents having the risk of suicide in the past month was 6.0%, with high risks of suicide recognised among 0.9% of subjects. The medical costs alone for treating attempted suicide could vary from INR 10,000 to INR 100,000 per person based on the severity of the attempt.

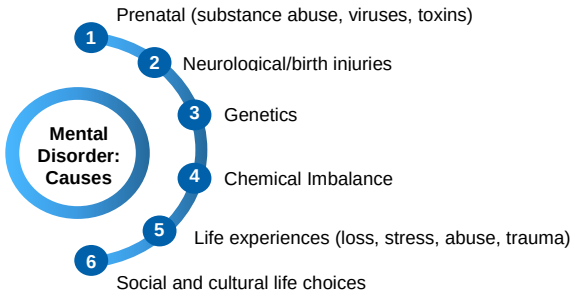
Mental health in India: Demand

For this section, we have relied on the 2015-2016 National Mental Health Survey (NMHS), undertaken by the National Institute of Mental Health and Neurosciences (NIMHANS).

Cause

Mental health illness occurs in a variety of forms and symptoms can overlap, making disorders difficult to diagnose. A variety of factors contribute to the onset of a mental illness and many of these conditions are caused by a combination of biological, psychological and environmental factors.[2]

FIGURE 1: MENTAL DISORDER CAUSES



Classification and types

Mental disorders can be divided into two broad groups:

Common mental disorder (CMD)

- CMDs represent a group of highly common disorders often misdiagnosed as physical illnesses. They include substance use disorder, depressive disorder and neurotic and stress-related disorders.
- CMDs are the causation and consequences of several noncommunicable disorders (NCDs).

Severe mental disorder (SMD)

- SMDs are predominantly a result of genetic factors. They include schizophrenia, bipolar disorders and severe depression with psychotic features.
- Life expectancy of people with SMDs is estimated to be as much as 30 years less compared to the general population.

Mental illnesses are of different types and have different degrees of severity. There are more than 300 mental disorders listed in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5). We have focused on the most prevalent ones in India.

Prevalence

- The NMHS report estimates current and lifetime prevalence rates for mental illnesses in India.
  - Current prevalence rate is the proportion of a population who has the condition at some point during a given period, and includes people who already have the condition at the start of the study period as well as those who acquire it during that period.
  - Lifetime prevalence rate is the proportion of a population who at some point in their lives (up to the time of assessment) have experienced the condition.
- As the current prevalence rates are more relevant for the purpose of this report, we have limited our findings in the subsequent sections of this report to include only the current prevalence rates.
- As per the NMHS report, the current prevalence rate for overall mental morbidity of the population was 10.6%.
- The prevalence rates listed in the report are weighted prevalence rates for adults over 18 years only, with weightings based on the sampling techniques as described in the survey report.
- Figure 2 shows the current overall prevalence rates by key risk factors, classifying the population into different risk levels that could potentially help insurers identifying substandard risks when offering mental health cover.

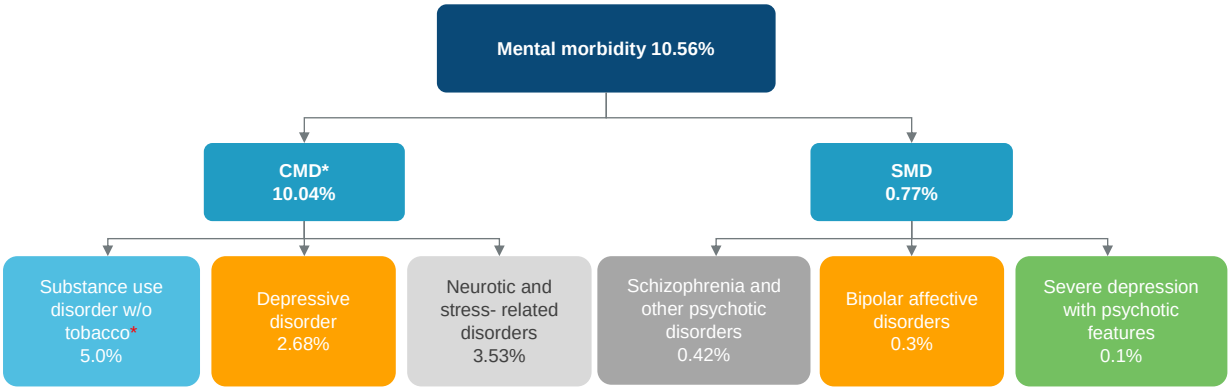
FIGURE 2: OVERALL MENTAL MORBIDITY PREVALENCE RATE BY KEY RISK FACTORS

RISK FACTORS		CURRENT PREVALENCE RATE
AGE- GROUP	18-29	7.39
	30-39	11.58
	40-49	**14.48**
	50-59	12.42
	60 and above	10.90
GENDER	**Male**	**13.86**
	Female	7.47
RESIDENCE TYPE	Rural	9.57
	Urban non-metro	9.73
	Urban metro	**14.71**
EDUCATION	Illiterate	11.81
	Primary	**13.49**
	Secondary	11.40
	High school	9.41
	Pre-university	7.61
	Graduate	6.03
	Not known	10.05
OCCUPATION	**Worker**	**13.67**
	Non-worker	7.92
	Others	14.77
MARITAL STATUS	Never married	7.66
	Married	11.16
	Widow/divorced/separated	**12.89**
	Others	8.66
INCOME	**Lowest**	**12.28**
	Second	12.14
	Middle	10.53
	Fourth	9.61
	Highest	8.76
Total		10.56

- Figures 3 to 6 show the current prevalence rates by broad classification and for the top four most prevalent types of mental illnesses in India by age band, gender and region separately.

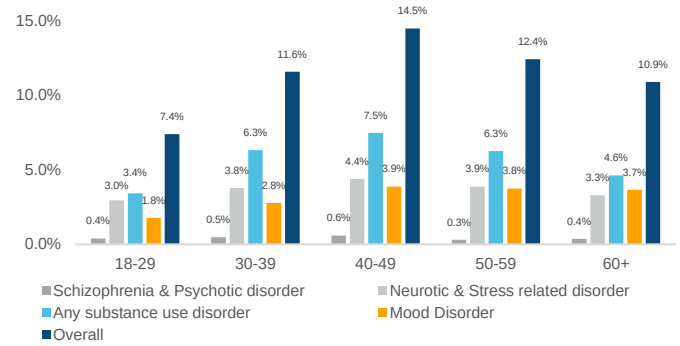
2 International Journal of MCH and AIDS (2015). Figure 1: Theories of Causation and Mental Disorders. Retrieved 16 July 2019 from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4948168/figure/F1/.

FIGURE 3: PREVALENCE RATE OF COMMON AND SEVERE MENTAL DISORDERS



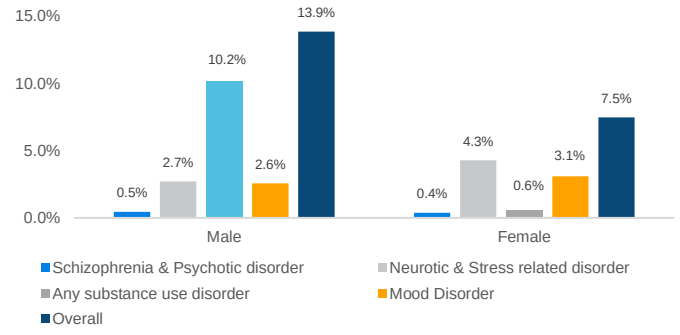
* With substance use disorder without tobacco

FIGURE 4: PREVALENCE RATE BY TYPE OF ILLNESS AND AGE BAND#



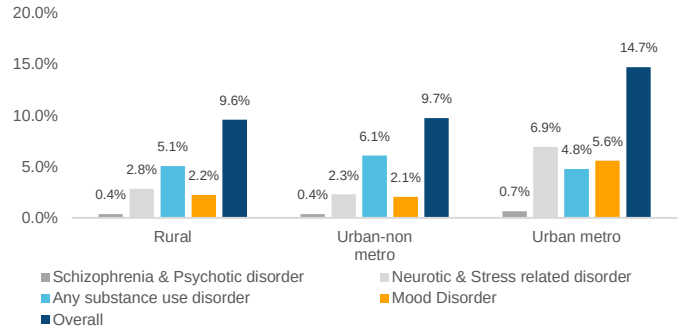
Mood disorders include depressive disorders and bipolar affective disorders.

FIGURE 5: PREVALENCE RATE BY TYPE OF ILLNESS AND GENDER#



Mood disorders include depressive disorders and bipolar affective disorders.

FIGURE 6: PREVALENCE RATE BY TYPE OF ILLNESS AND REGION#



Mood disorders include depressive disorders and bipolar affective disorders.

Comorbidity

- This section provides a brief description of comorbidity and different types of mental and physical illnesses that may coexist with the different types of mental illnesses.
- Comorbidity refers to the occurrence of more than one disorder at the same time. In the case of mental illness, it may refer to common possible co-occurring mental disorders or co-occurring mental disorders and physical conditions.
- Comorbidity results in lower adherence to medical treatment, higher disability and mortality rates and higher health costs.
- Figure 7 shows the comorbid physical illnesses with respect to the common type of mental disorders. This is based on the research from various publicly available studies.
- The likelihood of having comorbid mental illness is 16%.

FIGURE 7: PREVALENCE OF COMORBID PHYSICAL ILLNESS

MENTAL ILLNESS	Comorbid Physical Illness												
	Hypertension	Cardiovascular disease	Cerebrovascular disease	Diabetes	Obesity	Migraine	Respiratory disease	Gastrointestinal diseases	Cancer	Infectious disease	Parkinson's disease	Osteoporosis	Liver disease
Anxiety/panic disorder	X	X											
Depression		X			X			X					
Bipolar disorder		X		X	X	X							
Generalised anxiety disorder		X						X					
Schizophrenia and other psychotic disorder	X	X		X					X		X		
Neurotic and stress-related disorder	X	X		X		X							
Mood disorder		X			X			X					
Substance use disorders	X	X	X							X		X	X
Phobic anxiety disorder	X	X				X		X					
Suicide	X	X	X				X	X					

Mental health in India: Supply

Provision for mental healthcare: Infrastructure

- The provision of public mental healthcare in India is a joint responsibility of the central and state governments. The responsibility of mental health falls under the domain of the Ministry of Health and Family Welfare (MoHFW).
- Mental health services are provided mainly through psychiatric hospitals, psychiatric nursing homes, observation wards, day centres, inpatient treatment in general hospitals, ambulatory treatment facilities and other facilities such as halfway houses.
- There has also been an increasing involvement of nongovernmental organisations (NGOs) and the private sector in providing mental healthcare to the community.
- There are three centrally run mental health institutes, 40 state-run mental hospitals and 398 departments of psychiatry in various medical colleges (183 in government and 215 in private) equipped to treat patients suffering from mental illness across the country.

Provision for mental healthcare: Resources

- As per the NMHS, undertaken in 12 states across six regions, the mental healthcare human resources (per 100,000 population) are shown in Figure 8.

FIGURE 8: MENTAL HEALTH RESOURCES PER 100,000 POPULATION[3]

MENTAL HEALTH PROFESSIONAL	PER 100,000 POPULATION
Psychiatrists	4.64
Medical doctors trained in mental health	19.98
Clinical psychologists	1.56
Nurses trained in mental health	22.69
Nurses with Diploma of Nursing Practice (DNP) qualification	0.64
Psychiatric social workers	1.32
Rehabilitation workers and special education teachers	21.86
Professional and paraprofessional psychosocial counsellors	68.75

Treatment options

- Mental illnesses can vary greatly even amongst those with the same mental health diagnosis. This makes it unlikely to have a standard protocol for the treatment of mental health disorders.
- For conditions with no definite cure, treatment aims to reduce symptoms, address underlying causes, if any, and make the condition manageable.
- We have listed in Figure 9 the traditional treatment options that may be used on their own and in combination with other treatments in individual or group settings.

3 Information obtained from Indian Association of Clinical Psychologists.

FIGURE 9: TREATMENT OPTIONS [4]

TYPE OF TREATMENT	WHO MAY NEED IT?
Psychiatric hospitalisation	Those with severe mental health symptoms, hallucinations or delusions, suicidal or homicidal ideation or who have not slept or eaten for days and lost the ability to care for themselves due to mental health symptoms.
Inpatient/ residential treatment	People who require constant medical supervision as well as those with relatively severe, long-term symptoms who have not shown significant progress after outpatient mental health intervention.
Outpatient treatment	Those with mild to moderate symptoms, a solid support system and the ability to function outside of the treatment environment.
Psychotherapy	Used to treat a wide range of mental health conditions.
Medication	Used to treat a wide range of mental health conditions such as depression, generalised anxiety, social anxiety, panic attacks, insomnia, bipolar disorders, mood disorders, schizophrenia and other psychotic disorders.
Brain-stimulation treatments	Used in conjunction with traditional forms of treatment to help improve the mental health and well-being of the patient.
Complementary/ alternative treatment	Used in conjunction with traditional forms of treatment to treat a wide range of mental health conditions.

- Along with the traditional treatment options, a plethora of mental well-being applications in the market claim to improve the mental well-being of a person. In addition to this, a lot of clinical research is focused on the use of virtual reality to assess its feasibility as a potential tool for diagnosis and treatment of mental health conditions. Virtual reality can create convincingly realistic simulations of experiences that may provoke symptoms, and it can do so consistently, potentially making diagnoses more objective—or at least less subjective.[5]

Mental health in India: Demand-supply gap

- The supply-side barriers include insufficient, inequitably distributed, and inefficiently used resources for continued care and lack of counseling services and rehabilitation centres.
- The table in Figure 10 summarises the need and availability of mental healthcare professionals in the country, suggesting greater shortage at lower skill levels.

FIGURE 10: MENTAL HEALTH PROFESSIONALS IN INDIA[6]

MENTAL HEALTH PROFESSIONALS	NEED*	AVAILABILITY	AVAILABILITY/NEED
PSYCHIATRISTS	11,500	3,800	33%
CLINICAL PSYCHOLOGISTS	17,250	898	~5%
PSYCHIATRIC SOCIAL WORKERS	23,000	850	~4%
PSYCHIATRIC NURSES	3,000	1,500	50%

* Estimated using a norm of 1 psychiatrist per 100,000 population, 1.5 clinical psychologists per 100,000 population, 2 psychiatric social workers per 100,000 populations and 1 psychiatric nurse per 10 psychiatric beds.[7]

4 PsychGuides.com. Types of Mental Health Treatments. Retrieved 16 July 2019 from https://www.psychguides.com/guides/types-of-mental-health-treatments/.

5 Chandler, S. (15 January 2019). Virtual reality's latest use? Diagnosing mental illness. Wired. Retrieved 16 July 2019 from https://www.wired.com/story/virtual-realitys-latest-use-diagnosing-mental-illness/.

6 Mirza, A. & Singh, N. (4 September 2017). Mental Health Policy in India: Seven Sets of Questions and Some Answers. University of California, Santa Cruz. Retrieved 16 July 2019 from https://economics.ucsc.edu/research/downloads/mirza_singh_mental_health_04sep1.pdf.

7 Directorate General of Health Services, Ministry of Health and Family Welfare, Government of India (2002). National Survey of Mental Health Resources (May-July 2002).

- The demand-side barriers include social stigma and poor awareness about the symptoms of mental illness.
- People tend to seek expensive private care due to low-quality care and poor availability of doctors in the public sector. As per the NMHS 2015-2016 report, median out-of-pocket expenditure per month on mental healthcare was about INR 1,000 to INR 1,500. This presents a significant challenge to households with low income, where the prevalence of mental illness is much higher than the average. The table in Figure 11 shows the median monthly cost of treatment for different types of mental health disorders.

FIGURE 11: MEDIAN MONTHLY COST OF TREATMENT FOR DIFFERENT MENTAL DISORDERS

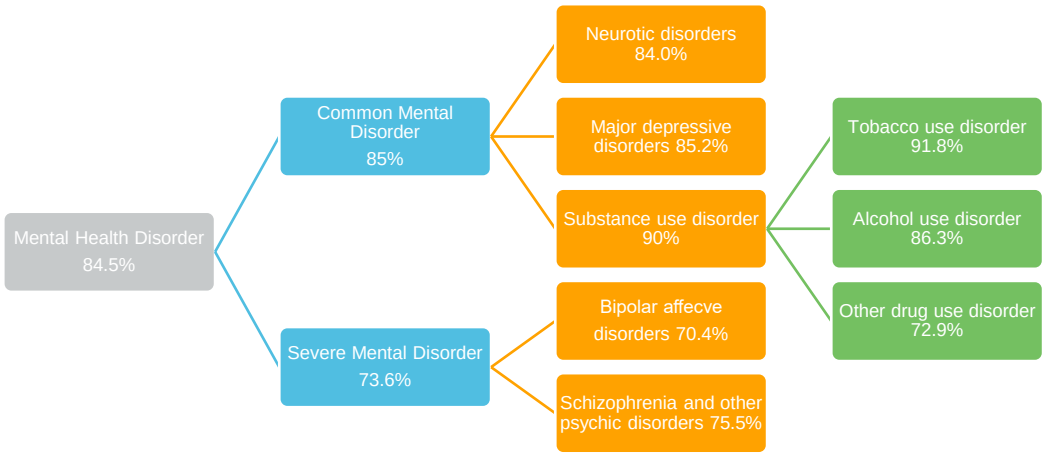
MENTAL DISORDER	MONTHLY TREATMENT COST (INR)
ALCOHOL USE DISORDER	2,250
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	1,000
BIPOLAR AFFECTIVE DISORDER	2,000
DEPRESSIVE DISORDER	1,500
NEUROSIS	1,500
EPILEPSY	1,500

- Many states have mobile mental units and de-addiction centres that provide mental health services but the existing facilities still seem inadequate, with limited care accessibility. At times, the listed essential drugs expected to be available under local primary health centres (PHCs) and community health centres (CHCs) for mental healthcare are not available continuously.[8]
- India spends less than 1% of its total health budget on mental health compared to the global average of 3%.[9] While the national and district health programmes have sought to bridge this gap by integrating mental healthcare at the primary level of the public health system, they face significant implementation challenges, resource constraints, infrastructure gaps, financial deficits and sociocultural barriers.
- According to the NMHS 2015-2016 report, nearly 85% of persons suffering from mental disorders had not received any treatment despite the presence of illness for more than 12 months. The treatment gap was more than 70% for major mental disorders and 85.2% for depressive disorders. Figure 12 provides the treatment gap by mental illnesses.
- Currently, there are no specific public insurance programmes for mental healthcare in India. The Ayushman Bharat Yojana—Pradhan Mantri Jan Arogya Yojana (AB PMJAY)—launched recently by the central government to provide comprehensive health services includes mental illnesses as one of the conditions covered under the scheme. Given the greater reach of this scheme, it may help increase health awareness and help bridge the demand-side and supply-side barriers to promote mental well-being of the people.

8 Mirza & Singh, op cit.

9 Global average spending percentage based on Mental Health Atlas survey conducted by WHO in 2014.

FIGURE 12: TREATMENT GAP OF MENTAL ILLNESS[10]



Industry survey

As a part of the research, we conducted a survey amongst Indian insurers to understand the market's interpretation of the Act and its potential impact on the industry. We shared the survey with 17 appointed actuaries and nine underwriters in the industry. Of these, three appointed actuaries and six underwriters responded to our survey. We have summarised the findings of our survey below.

Product design

Definition of mental illness:
We asked the respondents to comment on the definition of mental illness for their product constructs given the definition of mental illness in the Act.

Results

Almost 50% of the respondents expect that mental illness will be defined using a list of illnesses included and excluded under the product construct. Other responses included removal of any reference to mental illness in the policy document, defining mental illness as per the Act and with no restriction on coverage post facto except substance abuse.

OUR INSIGHT

Lists of mental illnesses to be included and excluded in the product construct may result in additional risk considerations for the insurers. They include:

- The Act requires insurers to cover mental illnesses on the same basis as physical illnesses. Disparity in the cover offered for mental illnesses may result in regulatory action against the insurer.
- Limited mental illnesses covered under the product construct may be seen as limited cover, resulting in higher lapses and lower new business growth.

Restricted lists of exclusions may expose insurers to the risk of covering mental illnesses that they do not intend to cover but failed to include in the exclusion list.

Evolution of product design:
We asked the respondents about their expectations of the evolution of product design with the inclusion of mental illnesses. Respondents had the option to select multiple options.

Results

Popular responses included indemnity cover with hospitalisation for mental illness up to a sub-limit, standalone mental illness product and outpatient covers with fixed numbers of visits and benefit amount.

OUR INSIGHT

Mental illness coverage via indemnity cover including hospitalisation for mental illness up to a sub-limit is likely to help with risk management by capping the mental illness claims, but the insurer needs to ensure that the product is compliant.

Standalone products are likely to expose insurers to a lot of risk in terms of:

- Anti-selection
- Low self-awareness about mental illness and hence nondisclosure
- Difficulty with diagnoses of mental illness and hence the underwriting loads
- Lack of insured data to accurately estimate the risk cost of the product
- Lack of providers that deliver mental health services

Outpatient Department (OPD) covers are likely to include coverage for common mental disorders that have relatively high prevalence rates. This could result in high premium rates making the product uncompetitive and difficult to sell.

10 National Mental Health Survey of India, 2015-16: Prevalence, Pattern and Outcomes. Retrieved 16 July 2019 from http://www.nimhans.ac.in/sites/default/files/u197/NMHS%20Report%20%28Prevalence%20patterns%20and%20outcomes%29%201.pdf.

Treatment options

We asked the respondents about the treatment options that are likely to be covered besides allopathy. Respondents had the option to select multiple options.

Results

Half of the responses (50%) suggested including multiple treatment options like Ayurveda, Unani and homeopathy.

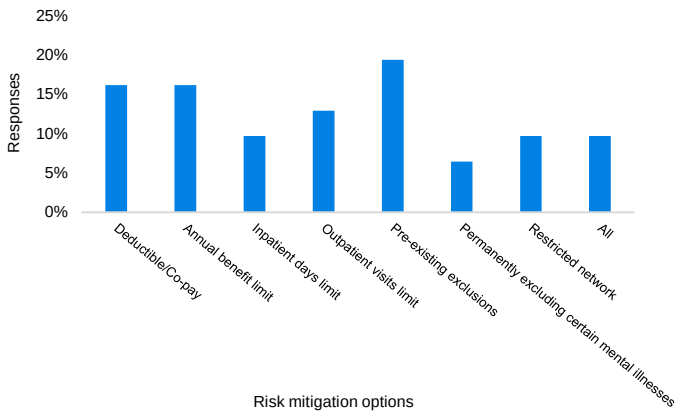
OUR INSIGHT

These responses are in line with our expectations, as most insurers already include Ayurveda, yoga and naturopathy, Unani, Siddha and homeopathy (AYUSH) in their standard indemnity covers.

Risk mitigation

We asked the respondents about the risk mitigation strategies for their product constructs to manage risk arising from covering mental illness. Respondents had the option to select multiple options, as shown in Figure 13.

FIGURE 13: RISK MITIGATION OPTIONS



Results

As per the survey response, popular risk mitigation options amongst the industry include:

- Preexisting exclusions
- Deductible/copay
- Annual benefit limit
- Outpatient visits limit

OUR INSIGHT

Preexisting exclusions may be challenging to apply given the difficulty of diagnosing mental illness, low self-awareness about mental illnesses and current levels of nondisclosure. The ability and ease of administering such risk mitigation options is another consideration for insurers to make sure that their current systems can handle it.

Underwriting

Changes to the existing underwriting process

We asked the respondents about the expected changes in the underwriting process upon inclusion of mental illness within the policy cover. Respondents had the option to select multiple options.

Results

As per the survey response, the expected underwriting changes included:

- Tele-underwriting/interview for mental health screening
- Additional questions for mental health assessment.

All the respondents that chose additional questions for mental health assessment also included tele-underwriting in their response.

OUR INSIGHT

The insurers need to carry out cost-benefit analysis when revising their underwriting processes, giving due consideration to the:

- Uncertainty in the ability to accurately diagnose mental illnesses
- Training of the underwriters for accurate risk assessment for mental illnesses
- Revision of underwriting guidelines for appropriate risk stratification to identify standard and substandard risks and their impact on premiums charged and coverage offered.

Changes in existing risk mitigation strategies for common chronic conditions

We asked the respondents about the changes in the existing strategies like underwriting, pricing etc. for chronic conditions when present in addition to mental illnesses.

Results

Most of the respondents are considering additional risk mitigation strategies for mental health disorders only.

OUR INSIGHT

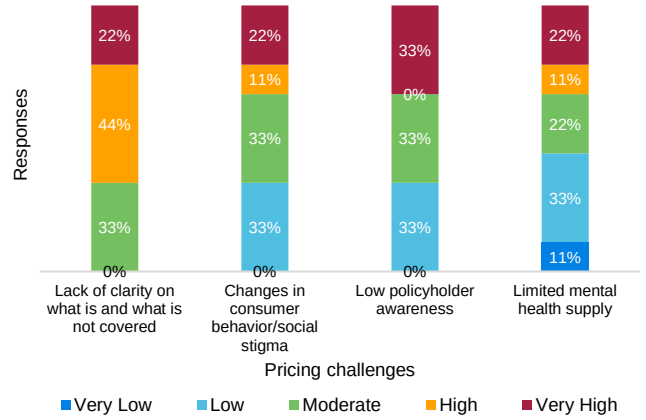
While most of the respondents are considering additional risk mitigation strategies for mental health disorders only, it is important to note that mental health disorders can be the cause of some noncommunicable diseases and this is likely to impact the existing risk mitigation framework.

Pricing

Key challenges

We asked the respondents about the key challenges for pricing mental illness into existing and new products. Respondents had to rate the listed options on a scale of 1 to 5, where 1 represented very low risk and 5 represented very high risk.

FIGURE 14: PRICING CHALLENGES: RISK LEVELS (VERY LOW TO VERY HIGH)



Results

The respondents had variable views about the level of risk with each of the listed pricing challenges, resulting in a lack of clarity on what is and what is not being covered as the biggest one.

OUR INSIGHT

Lack of clarity on what is and what is not covered was rated a high to very high risk by 67% of the respondents. We believe it is likely to be a key concern when estimating the price for mental illness cover. Lack of clarity will also result in varying interpretations of coverage and hence the premiums, making it difficult for the policyholder to choose a cover that provides adequate coverage.

Similarly, 67% of the respondents consider change in consumer behaviour or social stigma and low policyholder awareness to be low to moderate risks. Any changes in consumer behaviour or social stigma are likely to have significant impacts on the utilisation of this benefit and hence the claims experience, making it one of the high-risk challenges.

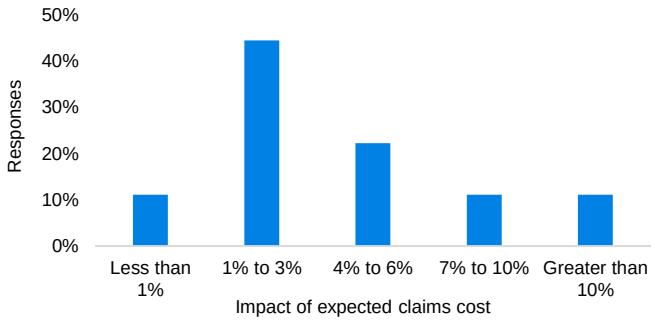
Respondents seem to have varying views on limited mental health supply as a key pricing challenge. The current supply of mental health services is very limited and may not have an impact in the short run, but increased demand due to higher levels of awareness is likely to increase the supply and utilisation of these services in the future and hence the premiums.

Other pricing challenges as commented by respondents included an expectation of the industry moving towards developing institutions such as rest and stress retreats, irrespective of the limited supply of psychiatrists. Given that mental health stays could last longer than two weeks, if the insurers end up providing cover of such stays, the cost of offering insurance will become prohibitive.

Expected claims cost

We asked the respondents about the likely impact of covering mental health disorders on the expected claims cost.

FIGURE 15: IMPACT ON EXPECTED CLAIMS COST



Results

Respondents have a very variable view on the impact of the expected claims cost, with 44% of the respondents expecting it to be between 1% and 3%.

OUR INSIGHT

With all the current pricing challenges that an insurer faces, it is very difficult to comment on the impact of the expected claims cost.

Provider network management

Network providers

We asked the respondents about the proportion of hospitals in their current networks that provide treatment for mental illness.

Results

Sixty-seven percent of the respondents said they didn't have any information on the mental health providers in their networks. Thirty-three percent of the respondents have between 1% and 30% of the hospitals in their networks that provide mental illness treatment.

OUR INSIGHT

The industry needs to first assess the current levels of supply in its networks. Once insurers have clarity on the product offering they need to ensure that they have sufficient provision of services for the benefits that they are intending to cover in their benefit designs.

International markets

As a part of this research study, we looked at several international markets to understand the mental health coverage in those countries. We sent out the survey to international consultants who are subject matter experts in health insurance in different countries. In particular, we focused on the United Kingdom (UK), United States of America (USA), Brazil, South Africa and United Arab Emirates (UAE). We have summarised the results of the survey in Figure 16.

FIGURE 16: INTERNATIONAL SURVEY RESULTS

		UK	USA	BRAZIL	SOUTH AFRICA	UAE
Legislation for private mental insurance cover.		No	Yes	Yes	Yes	No
Does private insurance cover mental illness?		Yes (covered under group and comprehensive individual plans only)	Yes (covers substance use disorder as well)	Yes (covers list of procedures approved by the regulatory body)	Yes (covered under Prescribed Minimum Benefits [PMBs], Medical Schemes Act)	Yes (covered under group and comprehensive individual plans only)
Type of cover offered		As core or add-on cover. Inpatient, daycare, outpatient and addiction treatment programme	Inpatient, outpatient, professional, emergency services, prescription drugs	Psychiatric emergencies, appointments, diagnosis, psychotherapy sessions, hospitalisations, treatments etc.	On-site psychologists, 'mental health days' and employee assistance programmes under employer group plans.	Coverage for psychiatric services with annual benefit limit
Overall mental illness prevalence rate*		17.0% (CMD** prevalence, excludes substance abuse)	18.9% (excludes substance abuse)	12% (excludes substance abuse disorders)	16.5% (includes substance abuse)	15% (not known about substance abuse)
Mental prevalence rate*	Female	20.7% (CMD prevalence, excludes substance abuse)	22.3% (excludes substance abuse)	NA	NA	NA
	Male	13.2% (CMD prevalence. excludes substance abuse)	15.1% (excludes substance abuse)	NA	NA	NA
Top five common mental illnesses with prevalence rates		CMD-NOS***, 7.8% GAD^, 5.9% Depression, 3.3% Phobias, 2.4% OCD#, 1.3%	Anxiety disorders, 18.1% Major depression, 6.9% Bipolar disorder, 2.6% Schizophrenia, 1.1%	Depressive/nourish/anxious disorders, c. 12% Substance abuse, c. 6%	Major depressive disorder, c. 5% Agoraphobia, c. 5% Alcohol abuse, c. 5%	Psychosomatic disorders Depressive disorders Anxiety disorders
Current underwriting practices		Moratorium underwriting for most individual policies. If medically underwritten based on short/long form, may result in exclusions.	No medical underwriting since Patient Protection and Affordable Care Act (ACA) except for tobacco use.	Risk selection strictly prohibited for individual plans. Underwriting allowed for group plans at portfolio level and not beneficiary level. Two-year waiting period for preexisting conditions.	Three-month waiting period or 12-month waiting period depending upon individual's prior medical scheme and whether the person voluntarily changed the scheme.	Medical underwriting (forms include questions on mental health).
Separate assessments for mental health?		No	No	No	No	No
Key challenges with offering mental illness cover		Regulation of the benefit.	NA	No underwriting, anti-selection, ageing population, revision of list of mandatory procedures every two years, restriction on premium increases for individual plans.	Issues with coding practices to get cover under PBM; suicides, self-attempted injuries are common exclusions covered under emergencies; high HIV/AIDS infection	Limited data and lack of details for pricing, limited supply, no clarity on who will bear the cost of increased coverage once Mental Health Law becomes effective.

	UK	USA	BRAZIL	SOUTH AFRICA	UAE
				rate affecting mental health prevalence.	
Risk mitigation mechanisms	Annual benefit limits, day limits, visit limits. Specialist case management programmes.	NA	Copays on mental illness treatment like psychotherapy and psychiatric hospitalisation etc.	NA	NA
Evolution of mental health cover	Level of cover offered has decreased over the years, as it is a relatively expensive benefit to cover.	Mental Health Parity and Addiction Equity Act (MHPAEA) along with the ACA prevents insurers from imposing less favourable limits on mental health/substance use disorder (MH/SUD) benefits	Mental health excluded under private insurance until 1998. In 1998, a new law mandated the cover for mental illness as defined under the covered list of procedures. Public policies are also encouraging mental health treatments.	Mental health, which may have been excluded before, is now covered with the introduction of PBMs in the early 2000s.	Shift towards integrating mental health services into primary care and allocating more resources to smaller community mental health facilities. Mental health identified as one of the top five health challenges facing the Middle East. Regulators are working towards including mental health under health insurance.

* General population prevalence rates
** CMD: Common mental disorders
*** CMD-NOS: not otherwise specified
^ GAD: Generalised anxiety disorders
# OCD: Obsessive compulsive disorders

KEY LEARNINGS

As per the Lancet Commission report on global mental health and sustainable development, mental health disorders are on the rise in every country in the world and could cost the global economy up to $16 trillion between 2010 and 2030 if a collective failure to respond is not addressed. With the rising importance of mental well-being globally, countries are putting greater emphasis on the mental health of their citizens.

The survey shows that while not all the countries may have legislation for private insurance for mental health, all countries do offer some mental health insurance cover, ranging from inpatient hospitalisation to outpatient cover and prescription drugs. Indian insurers could possibly use a combination of such covers with appropriate benefit limits to ensure risk management.

Amongst the countries surveyed, the USA has the highest prevalence rate of mental illness followed closely by the UK. Where statistics for the prevalence rate by gender were available, mental illness prevalence was found to be much higher amongst females, unlike India where the mental illness prevalence is much higher amongst males, primarily driven by higher substance use disorder prevalence.

Most of the countries have limited levers to manage risk through underwriting and there is usually no separate assessment for mental health. Insurers use benefit limits, copays and specialist case management programmes to manage the risk.

The key challenges faced in the survey countries include anti-selection due to limited underwriting, claims management, regulatory changes, issues with coding practices and limited supply. Indian insurers also face these challenges and an early grasp over these issues will help the insurers provide adequate and affordable coverage in the long run.

Coverage for mental illness has increased over the years as countries are realising the importance of mental well-being and the potential economic loss that this condition poses.

Conclusions

Mental illness cover is a fairly new concept for the insurance market in India. As insurers start offering products to comply with the Act, we have concluded the paper by listing key considerations and recommendations for the insurers.

Product design

- Definition of mental illness is a key element for designing a product. Lack of clarity in mental illness definition and hence coverage offered will result in:
  - Difficulties in designing a product that meets the needs of all the stakeholders.
  - Financial and reputational implications.
  - Significantly varying levels of 'mental illness' covers in the market, making it difficult for a policyholder to select an adequate level of cover for himself or herself.
- Insurers will also need to design appropriate offerings for mental illness cover for different products, keeping in mind the customer needs met by each product and the current and care delivery infrastructure for mental health.
- The industry and IRDAI need to work together to establish a standard definition of mental illness that the insurers are expected to cover under the plan, as seen in some of the international markets.
- IRDAI is currently working on the regulations for a standardised health insurance product and this may help in defining a level of mental illness cover that could be offered under the policies.
- Increased demand for mental health services upon inclusion of mental illness in the health insurance products may result in further evolution of the product design as the supply increases to meet the increased demand.

Pricing

- Definition of mental illness and hence coverage level is a key element of pricing.
- We believe that the uncertainty around coverage for mental illness, lack of relevant data, limited mental health supply and social stigma and changes in policyholder behaviour after the implementation of the Act make it difficult to quantify the impact on pricing.
- With the majority of the plans in the market offering hospitalisation cover only, the impact on the expected cost may not be significant in the short run. However, increased availability of comprehensive plans with all-inclusive cover, policyholder awareness and supply is likely to result in increased utilisation of services in the future.
- Given that some of the companies have already started offering cover for mental illness and others are considering offering cover in their new and existing products, companies should consider appropriate contingency margins to allow for lack of relevant data, uncertainty in claims experience, current underreporting of mental illness prevalence and changes in policyholder behaviour.

Underwriting

- As per the industry survey, insurers are considering revising their current underwriting practices to include separate assessments for mental health via additional questions and tele-underwriting. They also plan to revisit the existing risk assessment strategies for common chronic conditions when present in addition to mental illness. When doing so, insurers need to ensure that the updated practices and guidelines are in line with their underwriting philosophies and approved by their boards to ensure regulatory compliance.
- Revised guidelines will necessitate system updates and training of the underwriters to handle cases with preexisting mental illness or those with the likelihood of developing mental illness because of preexisting chronic conditions.

Sales and marketing

- Insurers will need revise their sales and marketing material to ensure it clearly states the benefits covered under the policy.
- Insurers will need to train sales staffs, agents and brokers to ensure they clearly understand the additional coverage offered by the company.

Data

- There is no insured data on mental illness and its treatment. The 2015-2016 NMHS, commissioned by the Ministry of Health & Family Welfare, is intended to provide a nationally representative mental health study on the burden and patterns of mental health problems. It may be used as the basis for pricing in the absence of any other credible data source available, with appropriate adjustments to reflect the insured population characteristics.

Claims processing and management

- Insurers will need to make policy and claims system updates to capture relevant information related to mental illness.
- Lack of experienced and skilled claims assessors capable of handling mental illness claims is likely to affect insurers' claims processes, including preauthorisation and acceptance or rejection of claims. Difficulty in diagnosing mental illness conditions and policyholders' own lack of mental health awareness will exacerbate this issue.
- While mental health conditions are recognised in the latest international classification of diseases (ICD-10), there are currently no reliable biomedical markers to indicate the presence or severity of common prevalent mental health conditions. As a result, the conditions may only be diagnosed at a later stage, making it difficult to carry out early interventions and save costs.
- Symptoms for mental illnesses may vary over time with original diagnoses no longer valid, causing changes in the course of treatment and inefficiencies in case management.

Reserving

- Insurers may need to make separate provision for the claims due to mental illnesses because of uncertainty in the claims experience and potential long lengths of stay.

Expected changes in supply

- The current supply-side statistics show a wide gap between the availability and the need for a mental health infrastructure and professionals. Implementation of the Act is expected to bridge some of this gap, through increased public and private sector investment as the demand for mental health services increases.
- Identification of effective mechanisms of resource sharing between general and mental healthcare, along with community or home-based care for prevention, cure and rehabilitation of mental illnesses, can help meet some of the supply-side challenges.
- Promotion of preventive health services in the indigenous system of medicines (AYUSH) and telemedicine to address mental illnesses could be further explored.
- Medical advancements resulting in the advent of app solutions for mental well-being and use of virtual reality to treat mental disorders are opening new avenues for diagnosis and treatment of mental health disorders.

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