



Health savings account in India



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Forewords

FICCI

It is becoming imperative to design innovative financing models to provide quality healthcare for all. The ageing population and the shift in disease burden from communicable to lifestyle diseases have been pushing up healthcare costs beyond affordability. The insurance sector can play a pivotal role in developing viable and self-sustaining mechanisms to bridge the gap between rising healthcare costs and affordability. Traditional health insurance schemes have been able to provide financing options for in-patient care. There is a need to develop layers on top of the traditional schemes to finance the unmet needs and high out of pocket expenses.

The Federation of Indian Chambers of Commerce and Industry (FICCI) has set up a Task Force with key representatives from the insurance industry to deep-dive into the possible solution through a Health Savings Account (HSA). The Task Force has been entrusted to assess the requirements, look at global best practices and suggest a way forward for developing a viable HSA model for India.

This paper will pave the way for stakeholders, policy makers, insurers and regulators to take initiatives to build on the need for savings-linked health insurance schemes. This paper contains recommendations for developing a holistic framework for insurability and service scope to aide funded layering to cover expenses that are beyond the current confines of health insurance.

We are thankful for the support of the Insurance Regulatory and Development Authority of India (IRDAI) and the insurance and healthcare providers for the development of the report. Going forward, FICCI would like to work closely with IRDAI health insurance and healthcare industry to make action plans for achieving the reforms. We would also like to thank the FICCI Health Insurance Committee and FICCI Task Force on Health Savings Account for their contributions and untiring efforts.

We hope you would find this report engaging and valuable.



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Chairman – FICCI Health Insurance Committee

Chairman and MD – The New India Assurance



Mr Girish Rao

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KPMG in India

The Indian healthcare landscape is evolving rapidly. The government of India launched the National Health Policy, 2017 to build on the progress made in the past 15 years. The overarching aim of the revamped National Health Policy is to provide healthcare to all in an assured manner, and would require a holistic view of the entire Indian healthcare landscape.

A crucial factor for enabling social security for the population is to refocus on accessibility of healthcare for all. While the government's aim to increase expenditure on healthcare is admirable, more effort would be required from the private sector to ensure a sustainable model of healthcare security for all. A flourishing health insurance industry would be pivotal in providing access to better quality healthcare to the masses.

Healthcare expenditure in India is primarily driven through 'Out of Pocket' spending which accounts for ~62 per cent of the total spend on healthcare. In contrast, spends through pre-financed instruments such as insurance accounts for only 8 per cent of the total healthcare spend¹. Combined with the high medical inflation prevalent in the country, this leads a large section of the population susceptible to healthcare shock. Catastrophic healthcare shock, such as death or a chronic medical condition, is also a major reason for impoverishment in India. The health insurance industry operates through retail, group and government schemes. While these have made considerable progress in the past few years, more than 70 per cent of our population still remains uninsured². In comparison, more than 89 per cent of the population of USA is covered under some form of health insurance³.

The current health insurance offerings in India largely cater to expenses for institutional treatment. This leaves a wide chasm in demand and supply for coverage of outpatient expenses such as medicines, consultation fees and diagnostics. A comprehensive view is required to bridge the current gap between the needs of customers and the industry offerings. A comprehensive health insurance plan coupled with a Health Savings Account can be a viable option for addressing these gaps.

The concept of a Health Savings Account has been tested in other markets and the experiences from these markets have been largely positive both in terms of expanding insurance coverage and containing medical inflation. In the Indian context, as the disease profile shifts from communicable to longer term lifestyle conditions, an ecosystem-driven offering funded through a health savings account could lead the way in improving access to healthcare for all.



Shashwat Sharma

Partner and Head – Insurance
KPMG in India

1. World Bank Data, 2014

2. Annual Report, Insurance Regulatory and Development Authority of India, 2016

3. Health Insurance Coverage in United States, US Census Bureau, September 2015





Foreword by FICCI Task Force Leader

India's spending on healthcare as a percentage of GDP has remained low when compared to similar economies. This coupled with medical inflation pegged at 12-15% and 62% of the spending being "Out of Pocket", poses a significant burden on the individuals.

The traditional health insurance schemes have provided limited options to cover out of pocket expenses like OPD, diagnostics and pharmacy bills. The insurance sector has faced challenges in providing these covers in the absence of a healthcare ecosystem for management these expenses.

Rising healthcare expenditure and lack of adequate coverage in current offerings have created a pressing need to design mechanisms for taking care of the long term needs of individuals. A long term corpus built through disciplined savings is needed to have the required means for medical requirements.

With this aim, FICCI Health Insurance Committee constituted a taskforce with industry experts, to come up with a recommendation paper on "Health Savings Account", with a focus on financial security in the wake of growing healthcare expenses. This paper takes learnings from Health Savings Accounts models that have been used successfully

in international markets like USA, Singapore and South Africa and aims to put forward the voice of the health insurance industry to the government, regulators and industry bodies to encourage policy reforms suitable for establishing a Health Savings Account in the Indian context. The paper aims to detail out the recommendations from product, distribution, fund administration, solvency requirements and tax treatments standpoint.

We hope this paper accomplishes the scope of introducing HSA based coverage in India providing more control of healthcare expenses in the hands of the insured.



Mr Ashish Mehrotra

**Managing Director and Chief
Executive Officer**
Max Bupa Health Insurance



Executive Summary

The healthcare sector in India is largely underpenetrated with government expenditure around 1.4 per cent of the GDP¹. The 'Out of Pocket' expenditure for the country accounts for a staggering 62 per cent of the total healthcare spend against a world average of 18 per cent. This gap can be reduced by increasing the share of pre-financed expenditure in healthcare, which currently stands at a meagre 8 per cent for India.

Health insurance in India has been largely focussed on catering to the institutional or in patient expenses related to healthcare. But in the share of 'Out of Pocket' expenses, non-institutional expenses account for almost twice as much as institutional expenses. This leaves a large gap between healthcare financing needs for individuals and what is available in current Health insurance offerings.

A key way to increase health insurance penetration is to address the gaps in current offerings versus the demands of health care coverage. A key gap in the existing insurance offerings is limited coverage of outpatient expenses coupled with the absence of a comprehensive ecosystem for managing lifestyle conditions. This paper discusses the suitability of a holistic healthcare coverage plan utilising a Health Savings Account programme as running in some of the other geographies.

We analysed the Health Savings account programme in USA, Singapore and South Africa in order to understand the feasibility of a similar product offering in the Indian context. Some of the key learnings from these markets are:

- Introduction of Health Savings Account (HSA) along with a catastrophic High Deductible Health insurance plan can lead to an increase in insurance penetration while also reducing instances of healthcare shock for covered individuals
- Transferring the usage of health funds in the hands of the end consumer through HSA can lead to a reduction in overall healthcare inflation
- Favourable tax treatment by the authorities can lead to a much faster and wider adoption of the HSA and will thus enable households to manage their healthcare costs independently

The success of global models provides encouraging evidence for implementation of a similar approach towards healthcare management in India. We have also analysed the structure and characteristics of a HSA oriented product in India.

Key points on structure of comprehensive health savings product in India -

- While fund collection for HSA shall be done by insurers, fund administration could be done by a centralised government body, similar in outlook to the Employment Provident Fund Organisation
- Separate tax benefits for contribution to HSA need to be identified to encourage usage of this option for creation of a long term health fund
- Boundary limits on both fund utilisation and tax treatments are required to promote judicious usage of the health savings product and reduce leakages from the system
- Withdrawals to be restricted for approved usage only. Any withdrawals for non-medical reasons, while allowed in case of exigencies, could attract tax or withdrawal penalties
- Insurance companies to partner with providers for creating a healthcare ecosystem consisting of wellness chains, OPD clinics, pharmacies and diagnostic centres providing discounted services for HSA members.

1. World Bank Data, 2014

Health insurance in India

The Indian health insurance landscape has evolved rapidly over the past decade with changing consumer behaviour regarding healthcare. While higher consumer awareness about the need of health insurance has driven retail sales, healthcare itself is evolving with newer healthcare centres being opened in tier II cities and changing disease profile shifting focus from communicable diseases to non-communicable diseases.

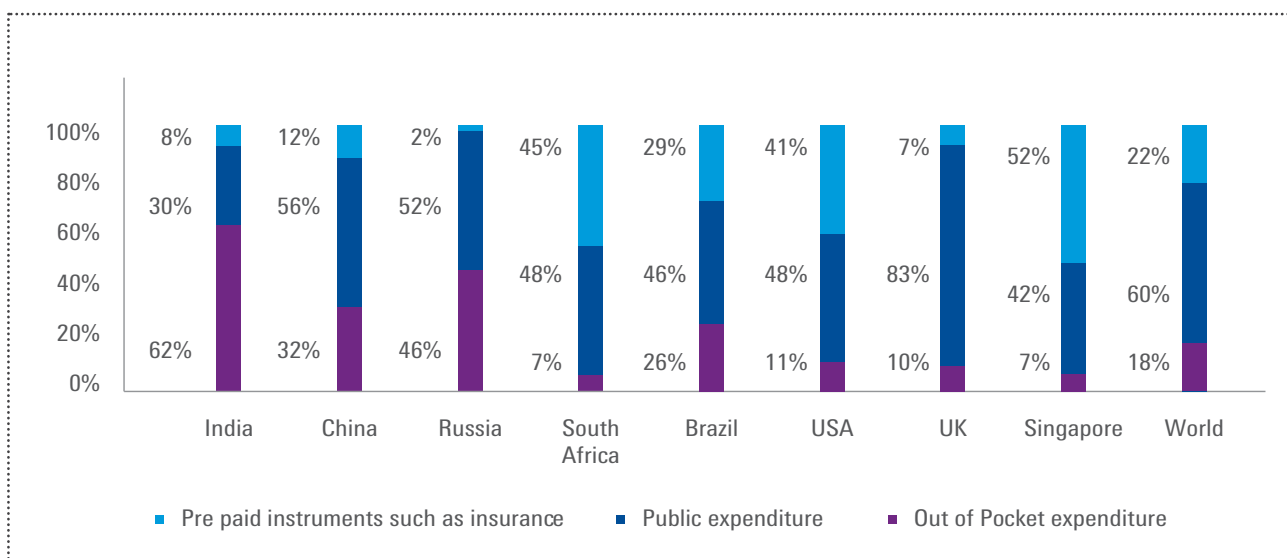
Current modes of healthcare financing in India

India has relatively lower levels of healthcare spending than comparable economies, with government spending on healthcare remaining in close to 1.4 per cent of GDP for the past few years¹. The ambitious National Health Policy - 2017 aims to increase government spending on healthcare to 2.5 per cent of GDP in a time-bound manner and ensure access of healthcare services to all citizens. However, currently most of the healthcare spending happens through 'Out of Pocket' (OOP) spending with limited spends through pre-financed instruments such as health insurance or self-funded schemes

Table 1: Public spending on healthcare as a percentage of GDP¹

Country	Public spending as % of GDP (2014)
India	1.4%
Brazil	3.8%
Russia	3.7%
China	3.1%
South Africa	4.2%
USA	8.3%
UK	7.6%
Singapore	2.1%
World average	5.9%

Figure 1: Sources of healthcare financing - 2014¹



Source: World Bank Data Bank, 2014

* Singapore data for 2009: Singapore's healthcare financing: Some challenges; Abeyasinghe, Himani, Lim

1. World Bank Data, 2014

2. National Health Policy, Ministry of Health and Family Welfare, March 2017

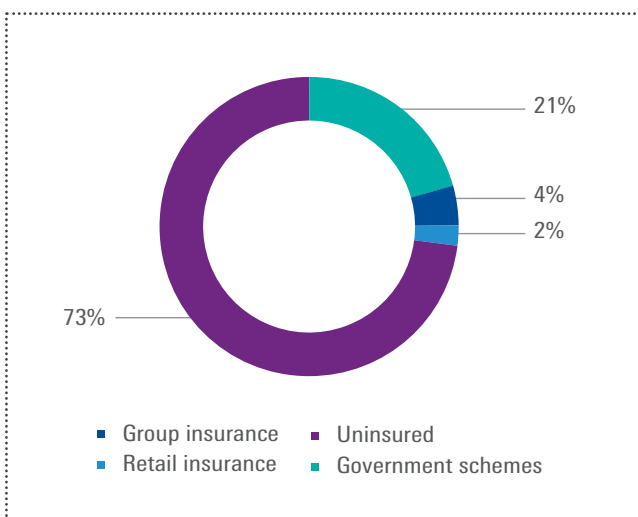
As can be seen from Figure 1, India has a relatively larger share of OOP spending on healthcare compared to other large developing economies as well as the world average.

Insurance coverage in India

Health insurance coverage in India is driven through three possible mechanisms, namely:

- Retail health insurance policies bought by individuals
- Group health insurance cover: This includes employee-employer relationships as well as affinity groups
- Government sponsored health insurance schemes

Figure 2: Health insurance coverage for population of India (2016)

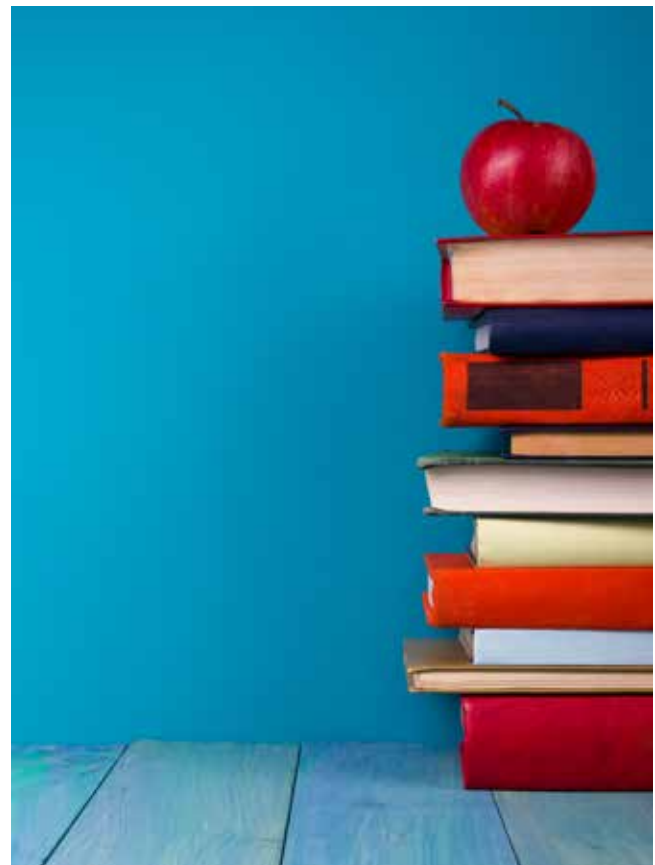


Source: IRDAI annual report, 2016,
United Nations, Department of Economic and Social Affairs, World Population Prospects

There is a significant section of the population, which is not covered under any of the current health insurance schemes, either through retail options or through government sponsored schemes. This leaves a major section of the population vulnerable to health shocks, especially from critical conditions, which may require heavy expenditure on healthcare expenses.

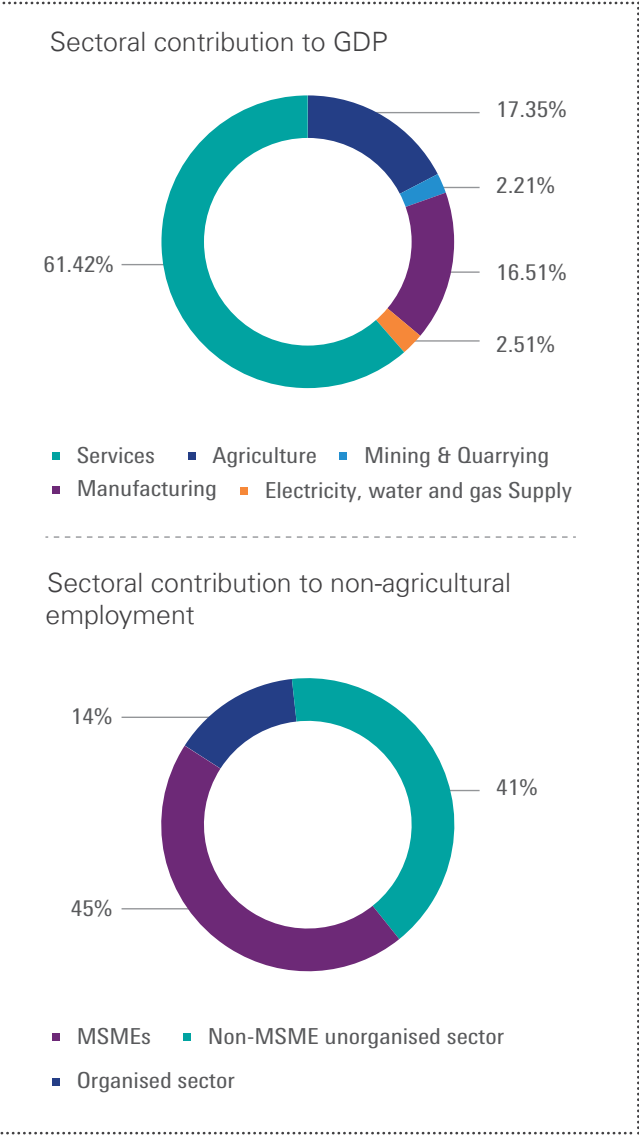
Among the three possible mechanisms of providing health insurance coverage, each has its own set of limitations, which restricts further adoption of health insurance:

- Government schemes: These have been designed to provide basic indemnity coverage for economically disadvantaged sections of the population. Given the competing demands on government finances in a growing economy, it may not be the most efficient mechanism to enhance coverage for the population, which can afford to pay for purchasing their own health insurance plans
- Group insurance: Group insurance plans are largely driven by coverage through employer groups, primarily restricted to the organised sector workforce. However, organised sector formal workforce covers only ~2.6 per cent of India's overall population, thus restricting mass coverage through corporate group insurance schemes³.
- Retail health insurance: A significant part of the workforce works in the unorganised sector with the rest of the population being underage for employment or not seeking active employment and is dependent on the active workforce. Given the limitations on public spending and the largely unorganised nature of labour force, retail health insurance is a potential option for providing financed medical coverage to a large section of the country's population.



3. Ministry of Labour, Government of India

Figure 3: Sectorial contribution to economy and employment



Gaps in current health insurance offerings

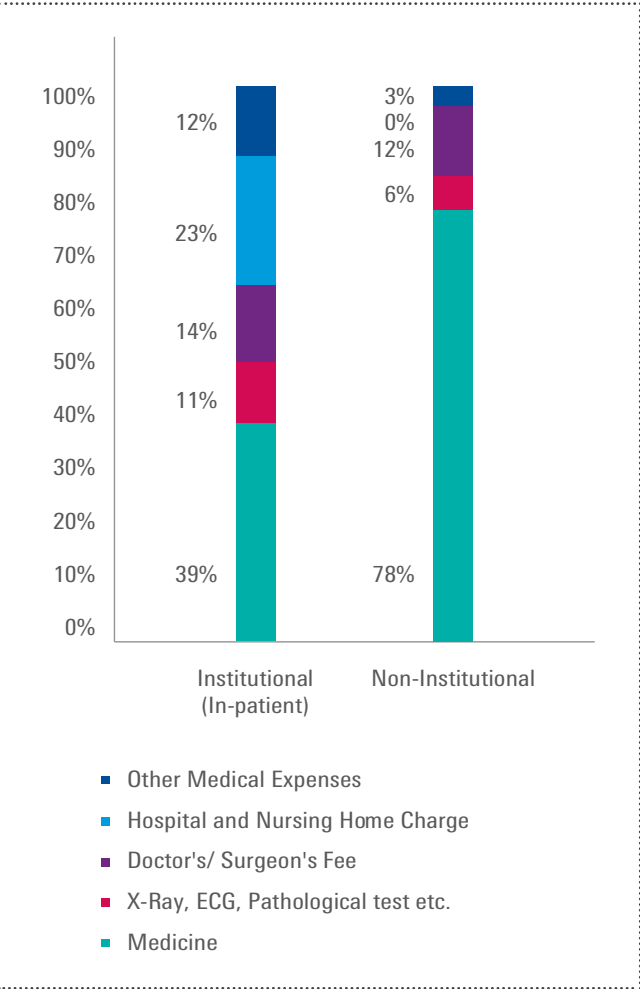
A majority of health insurance sales in India across the three segments, viz. government schemes, group schemes and retail health insurance plans are geared towards indemnity schemes providing coverage for hospitalisation expenses.

There are limited options available for coverage of expenses such as Out Patient Department,

diagnostics, medicine fee outside hospitalisation, etc. Even in the current options which are available, most of these schemes work on reimbursement basis in the absence of a defined healthcare ecosystem to take care of end-to-end expenditure.

However, as we look at the actual out of pocket healthcare expenditure incurred in India, it is skewed towards outpatient care with almost 66 per cent of out of pocket expenditure occurring in outpatient areas, including pharmacy, consulting, diagnostic spends, etc. Inpatient care accounts for 34 per cent of the total out of pocket healthcare spending in India⁴.

Figure 4: Out of Pocket (Healthcare expenses) - 2014



4. Health Data – Round 71, National Sample Survey Organization, June 2014

There are significant gaps in the current offerings of retail health insurance, which have led to a lack of penetration that the product should have given to the vast uninsured population:

- Limited coverage offered through health insurance being restricted to hospitalisation claims only. Significant components such as diagnostic tests, OPD consultation fee, medicines amongst others have limited coverage in current health insurance offerings
- Perceived high premium with no benefits in case there is no hospitalisation in a given policy year
- Lack of an ecosystem-based offering for managing diseases.

Need for long term savings

There is a significant gap between the coverage offered by current products and the need for a comprehensive ecosystem of financed healthcare. In India as well as globally, medical inflation has been higher than the overall inflation for the country by a few percentage points. India has seen healthcare expenses for individuals increase by 12 per cent – 15 per cent⁵ across different segments of healthcare over the past few years. Growth in healthcare expenditure is being driven by a few key factors, which are expected to continue in the medium term:

- Adoption of new technology: Advancement of technology is leading to development of newer methods of treatment, most of which are more expensive than existing methods, at least in the initial years of adoption
- Change in disease profile: As the disease profile has shifted from communicable to non-communicable or lifestyle conditions, the cost of treatment has gone up due to frequent interventions required in terms of medicines, diagnostic tests amongst others.
- Move to objective diagnostic protocols: As more accurate diagnostic tools have become available, there is an increase in the number of diagnostic tests, which are carried out today as compared to a decade back when there was more subjective evaluation of a medical condition with a limited number of diagnostic options.

Most of the above trends are expected to continue leading to a substantial increase in healthcare

expenses for individuals over the medium to long term.

Given the potential increase in healthcare expenditure over the next decade, and the low coverage in current product offerings, it is imperative to look at options for building a corpus which can be utilised by individuals for their healthcare needs. A disciplined savings option needs to be provided to individuals who have the required means to save for medical needs as well as emergencies.

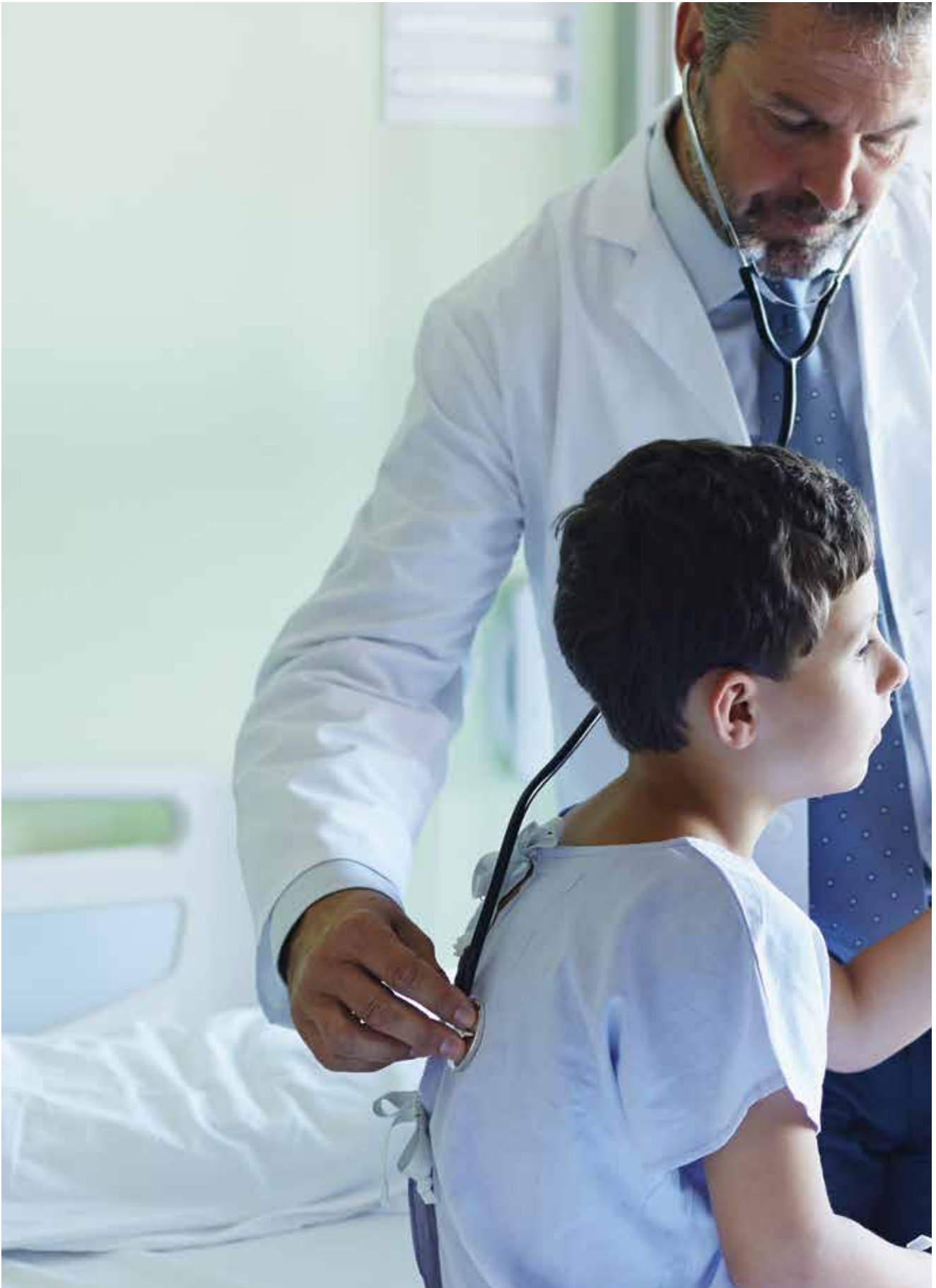
To evaluate potential methods of providing sustainable long term options for a comprehensive healthcare ecosystem, we have looked at three geographies having some of the largest share of financed healthcare spending⁶:

- USA (41%)
- South Africa (45%)
- Singapore (52%)

Figure in brackets represents share of pre-financed healthcare in overall healthcare

5. Global Medical Trends Survey Report , Willis Towers Watson, 2017

6. World Bank Data, 2014



Financed healthcare in international markets



USA

USA has one of the largest networks of private sector run healthcare services globally. Even when healthcare is financed through public resources, the delivery of healthcare is done through private healthcare networks.

USA also has a high coverage of commercial insurance policies with 89.6 per cent of the population being covered under some form of an insurance scheme¹. One of the primary drivers for high insurance coverage is the cost of medical care, which is relatively higher as compared to rest of the world, especially given the absence of public healthcare networks. Another reason driving up healthcare expenses is the prevalence of chronic conditions. Almost 32 per cent of the overall healthcare expenditure has gone into healthcare costs in the last two years of a person suffering from a chronic condition².

Given the high cost of health insurance premiums, an alternative option was introduced after the Medicare Prescription Drug Improvement and Modernization Act, 2003 was passed and the Health Saving Account (HSA) was introduced in 2004.

How HSA works:

An HSA can be funded through both an individual's contribution or through a payroll deduction. Both of the options are considered tax free. The HSA funds can be utilised for any medical expenditure and do not require prior approval from the insurance provider. Any unutilised funds are rolled over in the next year. HSA funds are paired with a high deductible catastrophic insurance plan, which kicks in for high value hospitalisation cases. Since there is a high amount of deductible, the base premium for such plans is significantly lower than a comprehensive insurance plan. The key benefit of introducing HSA based coverage was to provide more control of healthcare expenses in the hands of the insured.

To enforce utilisation of funds for medical uses, any withdrawal for non-medical uses is considered as income in the year of withdrawal. In addition to the income tax, an additional penalty of 10 per cent is levied on the withdrawal. This penalty is waived off post the age of 65 years.

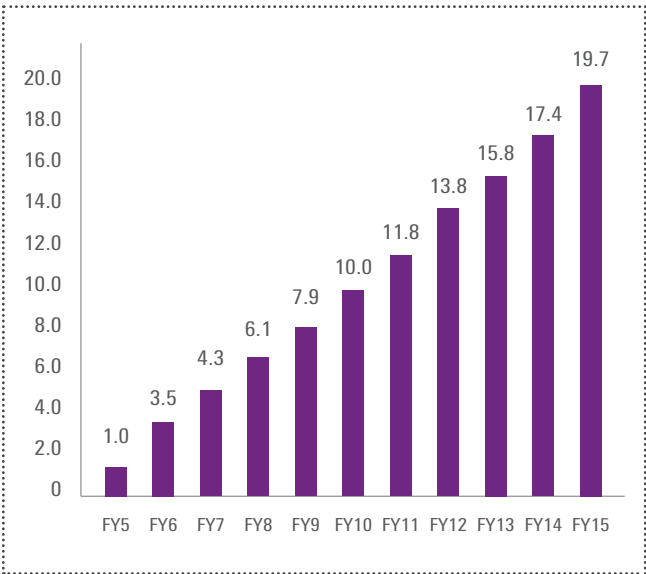
While it is preliminary to judge the long term impact of HSA on overall healthcare expenditure, a preliminary study by Sasso, Shah and Frogner suggests that consumers using HSA funds spend

5 per cent -7 per cent lower than non-HSA users on an overall basis and around 10 per cent lower on pharmacy spending³.

HSA accounts have also grown at a constant pace over the last decade with more and more new insurance seekers preferring HSA linked insurance plan than a comprehensive insurance offering⁴.

While there has been significant growth in HSA enrolments, it has been observed that most of the new members belong to a younger age group⁵. This is largely because elders prefer getting an upfront coverage while the younger population has enough time to build the HSA corpus while saving on the premiums being paid on the health insurance plan.

Figure 5: Members enrolled in HSA (In Mn)



Source: Ministry of Health, Government of India

Key learnings from USA:

- Introduction of HSA accounts paired with a high deductible catastrophic insurance policy enables reduction of overall healthcare expenditure by 5 per cent to 7 per cent
- HSA funds with lower premium payment options provide an attractive option to new members for enrolling with an insurance service provider
- HSA-based plans have a higher acceptance rate amongst the younger population and enable bringing them under the health insurance net

1. Health Insurance Coverage in United States, US Census Bureau ,September 2015
2. Dartmouth Atlas of Healthcare
3. Health Savings Account and Health Care Spending, Sasso AT, Shah M, Frogner BK, May 2010

4. Survey of Health Savings Account , Americas' Health Insurance Plans, 2016
5. Survey of Health Savings Account , Americas' Health Insurance Plans, 2016

South Africa

While a large part of the population depends on government-run hospitals for healthcare, citizens wishing to avail private sector healthcare facilities opt for a combination of a medical scheme and a top up insurance cover.

The medical scheme runs a Medical Savings Account (MSA) wherein contributions are fixed for a given year based on the benefits being provided. Each scheme also comes with prescribed minimum benefits for managing catastrophic care expenses.

South Africa also supported payroll deduction in MSA under which two-thirds of any employee MSA deposit could be made with pre-tax funds and two-thirds of any employer MSA contribution was excluded from the employee's taxable income. This tax treatment was later replaced with a low tax credit for all schemes irrespective of the MSAs and the ability to recover taxes when the 'Out of Pocket' expenditure exceeded a specified percentage of income.

How medical schemes work:

Medical schemes use various levers such as network access, partnership with OPD clinics and pharmacy networks to manage overall expenses for the scheme. Since the medical schemes control the spending for a large category of members, they are able to get better discounted rates for their members from the network providers than what is available to the general public. This helps in keeping the overall expenses lower.

In addition, most procedures have a co-pay and deductible clause, which leads to rational usage of facilities by the members and reduces risk of frauds and frivolous claims on behalf of the members.

The key success of medical schemes has been in providing a comprehensive healthcare ecosystem to their members with hospitalisation spends constituting only 37.4 per cent of their overall spending on member benefits with the rest being spent on medicines, healthcare consultation fee, etc.⁶

Key learnings from South Africa:

- Wider coverage through schemes including day-to-day medical expenses and medicine expenses helps in encouraging wider adoption of pre-paid coverage

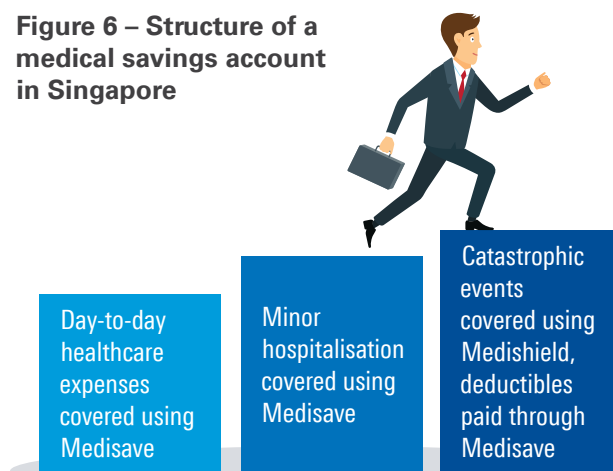
- Group negotiation done by medical scheme administrators and the limits imposed on usage of network type and medicine type, help in keeping overall expenses lower, and thus reduces the overall expenses required for scheme membership.

Singapore

Singapore has one of the most robust mechanisms of providing healthcare to its citizens. It was ranked 6th overall by the WHO in terms of performance of healthcare systems based on parameters, including responsiveness and fairness in financial parameters. The healthcare system in Singapore is largely characterised by three Ms:

- Medisave:** Compulsory contribution from annual wages to a Medisave fund, which ranges from 8 per cent to 10.5 per cent for private sector and public sector non pensionable employees and between 6 per cent to 7.87 per cent for public sector pensionable employees⁷. This fund is managed by the government, and can be utilised only for making payments against approved medical expenses
- Medishield:** It is a low cost, high deductible medical insurance plan, which provides cover against catastrophic conditions. Premium payments can be made using Medisave funds, though individuals are also allowed to opt for privately run insurance schemes offering similar levels of coverage
- Medifund:** It is a sovereign fund established for economically weaker sections of the society who cannot afford Medisave or Medishield

Figure 6 – Structure of a medical savings account in Singapore



6. Annual report 2016/17, Council for Medical Schemes, South Africa, 2017

7. CPF contribution and allocation rates, Central Provident Fund Board, Jan 2016

What makes Medisave work:

The primary objective of routing medical expenses through Medisave has been to make healthcare spending driven by consumers and hence keeping overall expenses lower. Additional enabling mechanisms have been introduced by the government to keep overall expenditure lower to ensure that the Medisave corpus can meet most medical requirements:

- Payroll deduction on Medisave: Medisave contributions are linked to payroll, and hence ensure tax benefits are available on these contributions. Even non-payroll contributions can be made to the Medisave fund
- Restrictions on medical options available under Medisave: Medisave funds can be used only for approved medical expenses. Even for medicines, individual manufacturers and brands are approved based on the overall cost at which the medicine is being sold to ensure that overall cost remains low. In order to qualify under Medisave, brands are also forced to keep their price competitive
- Since day-to-day events are covered by Medisave, the health insurance policy is required only for catastrophic events, thus keeping the premiums low and encouraging purchase. This ensures that Medisave is not exhausted in case of catastrophic medical events
- Government subsidy: Government subsidy is available in case medical treatment is taken in a lower room category, thus further reducing the expenditure from Medisave fund for those who may avail this option.

Key learnings from Singapore:

- Pre-tax contributions to enable higher contributions, which can be used to pay for day-to-day healthcare expenditure
- Centralised fund management enables easy access and portability across providers
- Boundary conditions of healthcare fund usage are determined by the fund administrator. The fund administrator approves a limited set of brands based on cost competitiveness to ensure lower price options are used wherever available
- Healthcare fund is linked to a high deductible catastrophic insurance cover to ensure that the fund is not exhausted in case of medical emergencies.



Building a financed healthcare ecosystem in India



Learning from global markets:

Going by the experience of some of the key geographies, which have a high ratio of pre-finance private sector healthcare expenditure, some of the key learnings which need to be considered while building a financed healthcare ecosystem in India are enumerated below:

- Comprehensive health insurance plans tend to get expensive over a period of time due to rising medical inflation and higher usage of benefits. Transferring the usage of day-to-day benefits into the hands of the consumers through a dedicated savings account helps reduce overall usage and keeps the healthcare expenditure under control
- Healthcare savings accounts paired with a high deductible catastrophic insurance plan to ensure the health saving account funds are not exhausted in case of a health emergency
- Having centralised fund management could enable easy management and transfer of funds.
- Payroll deductions and tax benefits play a vital role in driving adoption of pre-financed healthcare schemes for individuals. In addition, controls put in by the scheme administrators to control spend from the scheme are vital to ensure reduction in overall medical expenditure.

HSA in Indian context

An HSA is used along with supporting mechanisms to build a complete ecosystem for moving healthcare expenditure from Out of Pocket to financed means. Given the healthcare spending patterns and the current gaps in healthcare offerings in India, HSA could be adopted in India with the following characteristics:

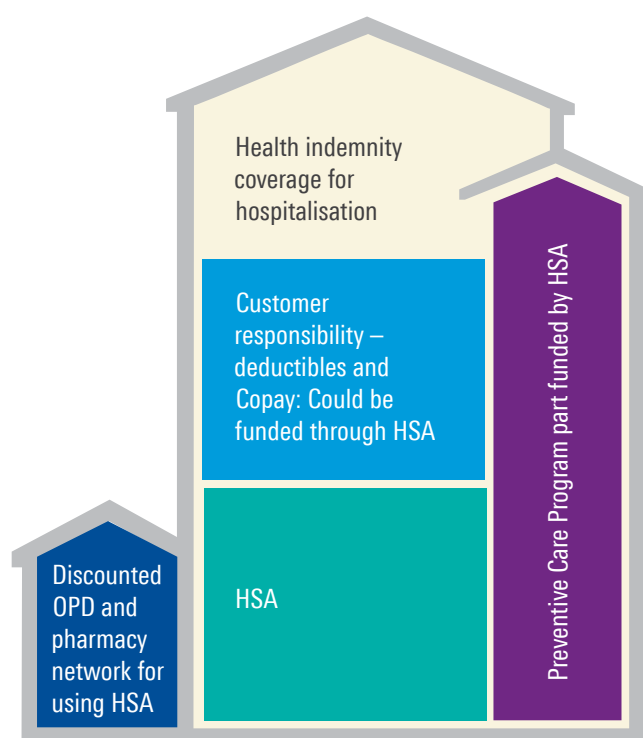
- Fund administration for the health savings accounts could be done by a centralised government nominated body
- The fund collection and usage can be managed by insurers while fund administration would rest with the centralised fund management body
- The boundary conditions on fund usage could be defined by the centralised body in terms of usage of medicine categories, approved healthcare options amongst others and contributions to the centralised fund to be tax exempt with an option of payroll deduction
- Withdrawals to be restricted for approved usage only. Non-approved usage could be considered

as taxable income in the year of withdrawal along with a penalty for withdrawal to discourage non-essential withdrawal of funds

- Insurance companies should partner with providers for creating a healthcare ecosystem consisting of wellness chains, OPD clinics, pharmacies and diagnostic centres providing services at discounted rates on payments made through HSA funds
- Insurance companies could also partner with existing healthcare aggregators to provide some of the services, which would require access through the HSA fund
- Usage of the centralised funds for purchasing health insurance plans
- Transparent and independent management of the centralised HSA funds, which could be rolled over to subsequent years.

The illustration below captures how an HSA can work in conjunction with other tools to provide a complete ecosystem for the policyholder.

Figure 7: Illustrative health insurance ecosystem using HSA



While HSA can be an enabler for managing payments in the healthcare ecosystem, the entire ecosystem needs to be created to encourage adoption of this offering with visible benefits for consumers in terms of discounted rates, easy network access and cashless payments, among others.

Potential benefits of HSA in overall health claims ecosystem

As the usage of HSA fund would primarily be driven by discretionary decisions of the insured, it is expected that incidents of fraud and abuse would come down leading to long term benefits in terms of lower loss ratios for the overall ecosystem.

In addition, HSA linked health insurance plans are also expected to provide the following benefits:

- Help in reducing the funding gap for non-institutional healthcare spends, which currently have limited coverage, by offering a funding mechanism
- Introduction of a high deductible / co-pay product, which can be used to reduce the overall premium rates and increase insurance penetration by attracting younger, first-time buyers who are looking to cover themselves against catastrophic events
- Reduce administrative expenses through direct payments using pre-paid instruments
- Provide an option for accumulation of savings for old age when healthcare needs increase while sources of income dwindle
- Help in developing an organised ecosystem for healthcare management.





Regulatory requirements for enabling health saving products



To enable the launch of an HSA enabled product, regulatory changes would be required in multiple areas, including product design, distribution, commission structures and administration of such a product.

- **Product design**

The centralised agency managing the funds would have to create a base product with boundary conditions determining the usage of the fund. Health insurance products could be designed to run on top of the base product with additional features for indemnity / wellness benefits.

While the fund would operate independently and work on the group as well as retail product platform, its ownership with respect to discretionary spending of the amount as well as utilisation could be given completely in the hands of the policyholder within the defined boundary conditions

- **Distribution**

Distribution of the HSA product could be done by insurance companies through their existing channels. To encourage distribution, a base commission may be provided to insurance companies based on the money being deposited by the policyholder every year.

- **Fund administration**

The fund administration would be managed independently by the centralised agency managing the HSA fund. A separate policyholder account would have to be kept by the centralised agency with details being shared with the policyholder every year on usage as well as returns being generated on the funds. This could run on the same model as Employee Provident Fund Organisation being managed currently.

- **Solvency requirements**

The indemnity and savings fund would be separate components being managed independently by the insurance company and the centralised fund management agency respectively. As the HSA fund would not have a risk cover linked to it, the amount of funds available in HSA should be kept out of solvency computation. Solvency computation should be linked to the risk cover being provided through the indemnity component of the product.

- **Tax treatment and withdrawal of funds**

The HSA fund requires sufficient tax incentives to be taken up by individuals. This would require creation of a separate limit for contribution to the HSA fund. A separate provision of pre-tax payroll contribution should also be provided to encourage enrolment at a younger age through corporate programmes.

Since ESIC is already available as an option to certain industries, there can be a differential rate of tax benefits available for employees who opt for ESIC vis-à-vis employees who prefer to forego the benefits of ESIC while leveraging HSA as an option for their healthcare financing needs.

All healthcare expenses being incurred through the HSA fund as well as returns earned on the fund should be considered tax free for the policyholder.

The withdrawal for non-healthcare needs can be triggered by the account holder at any point of time, given that the withdrawal from the fund would be considered as taxable income in the year of withdrawal. In addition, withdrawals for non-healthcare purposes should also invoke a penalty on the funds being withdrawn to discourage non-essential withdrawal.





Way forward

This discussion note outlines the need for establishing an organised ecosystem for meeting the overall healthcare needs and reducing dependence on Out of Pocket expenditure for healthcare.

Introduction of Health Savings Account (HSA) linked to a high deductible health insurance cover has been a successful method for providing end-to-end coverage of healthcare needs globally, and could be the impetus required to bring a major part of the population under the ambit of health insurance.

The key suggestions for different stakeholders for considering the way forward are highlighted as below:

- **Government**

- Create a centralised agency for HSA fund management as well as define regulatory ownership of the agency
- Enable tax breaks for payroll-based as well as individual contributions to the HSA fund to be used exclusively for meeting healthcare expenditure. The same can be considered as taxable income in case of withdrawal for non-healthcare requirements. There could

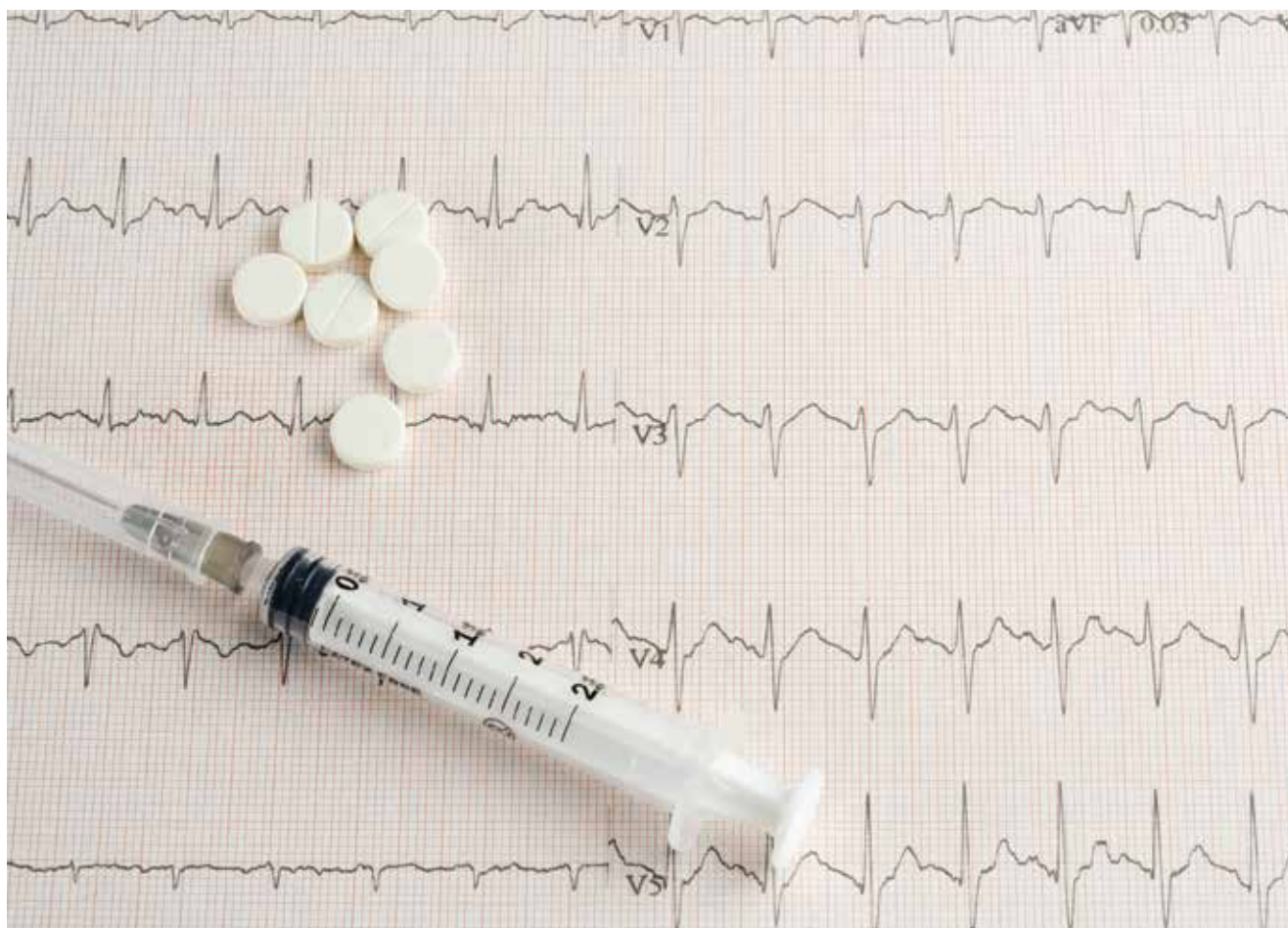
be differential limits on tax breaks based on whether the contributor is benefiting from other schemes such as ESIC

- **Regulator**

- Build enabling regulations for management of the HSA fund, including guidelines on fund management, investment and withdrawal
- Build enabling provisions for launch of Health Savings Account linked insurance products. A comprehensive coverage and seamless spending by the policyholder would be key to widespread adoption of an HSA linked product.

- **Industry**

- Create a suitable ecosystem for usage of HSA funds. This would include but not be limited to wellness chains, pharmacy chains, diagnostic clinics and OPD centres.
- To encourage usage of HSA, the industry will also have to create complementary product structures to make full utilisation of the ecosystem which would be created.





Glossary

Chronic condition: A human health condition or disease that is persistent or otherwise long-lasting in its effects or a disease that comes with time

Communicable diseases: An infectious disease transmissible by direct contact with an affected individual or the individual's discharges or by indirect means

Co-pay clause: A co-payment is a cost-sharing requirement under a health insurance policy that mandates the policyholder/insured to bear a specified percentage of the admissible costs. A co-payment does not reduce the sum insured.

Employer groups: Multiple employees covered under a single policy, generally bought by employers as part of their employee welfare programme

Financed healthcare ecosystem: Where there is a thriving ecosystem of healthcare providers and financiers/payers wherein the consumer of healthcare does not have to pay from pocket at the time of utilization

Government sponsored schemes: Insurance schemes sponsored by the government, generally targeted towards the underprivileged sections as part of the healthcare programme

Group health insurance policy: An insurance plan that provides healthcare coverage to a select group of people

Group scheme: Refers to group health insurance policy

Healthcare spending: Spending on healthcare and allied activities

Health shock: Refers to the event of death or disease, which can result in significantly adverse economic outcomes for an individual or a household

High deductible catastrophic insurance: Insurance plans that are designed to cover catastrophic medical events through a mechanism of high initial deductibles, leading to lower premiums in general than comprehensive coverage

Hospitalisation claims: Insurance claims arising out of inpatient treatment

Indemnity: Compensation for damage or loss where the insurer agrees to compensate the insured to the exact material amount of damage/loss

Lifestyle diseases: Diseases associated or arising out of the way of life of an individual or a group of persons

Loss ratio: Difference between the ratios of premiums paid to an insurance company and claims settled by the company

Medical inflation: Inflation specific to the medical industry including but not limited to healthcare costs and insurance premiums

Organised sector formal workforce: The part of the organised workforce under a full time employment contract

Out of Pocket: Refers to the expenses borne by the consumer through personal savings and borrowings

OPD: Outpatient department handling treatment of patients not admitted to the medical facility

Payroll deduction: Direct deduction of funds for a specified instrument by the employer at the time of payroll generation

Pre financed expenditure: Health expenditure financed through formal instruments prior to occurrence of the event

Prescribed minimum benefits: A set of defined benefits to ensure that all medical scheme members have access to certain minimum health services, regardless of the benefit option they have selected

Pre-tax payroll contribution: Contribution to a pre-defined instrument by either the employer or the employee at the stage of payroll generation in order to avail tax benefits

Private healthcare network: Hospitals or healthcare providers owned by non-government entities providing medical services to the public

Self-funded scheme: Healthcare schemes financed by means other than insurance. For example Central Government Healthcare scheme

Tier II cities: Developing and emerging cities with population between 50,000 and 99,999

Top up insurance: It is an insurance policy providing additional coverage for customers already having an insurance plan. The top up plan kicks in only after the initial plan limits are exhausted

Unorganised workforce: Where the terms of employment are not fixed and regular, and the entities generating employment are not registered with the government



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