Mental Healthcare Act, 2017 in India and its impact on the healthcare insurance industry

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Agenda

- Introduction.
- Key features of the Mental Healthcare Act, 2017.
- Mental illness and its types.
- Mental health: demand and supply:
  - Demand: Prevalence.
  - Supply: Facilities and resources.
  - Demand and supply gap.
- Mental health coverage in international markets.
- Industry Survey- India.
- Key considerations.

Cover

- This presentation is a part of the research study on "Mental Healthcare Act 2017" organized by Institute of Actuaries of India (IAI) to be held on 4th -6th March, 2019.
- The purpose of this presentation is to provide a brief description on the research study conducted on the Mental healthcare Act 2017 and to assess the impact of including mental illnesses on the Indian health insurance industry. This will include key features of the act along with the demand & supply side of the mental health in Indian and in International market with key considerations for the Indian Insurers.
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Introduction

Mental Healthcare Act, 2017

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.

- The new act superseded the previously existing Mental Health Act,1987 that was passed on 22 May 1987.
- Act states mental illness determined "in accordance with Nationally and Internationally accepted medical standards notified by the Central Government."
- The act recognizes mental illness as a clinical issue treated by medicines and clinical procedures.
- An attempt to protect the rights of the mentally ill and enable citizens to decide on the method of treatment.
- 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, IRDAI issued a circular dated 16 August 2018 directing insurance companies offering health insurance to cover treatment for mental illness.

Key features of Mental Healthcare Act, 2017

Key Features

In India, the Mental Healthcare Act 2017 passed on 7 April 2017 and came into force from July 7, 2018.

- **Rights of people with mental illness:**
  - Right to advance directive - preferred way of care and appoint his/her nominated representative.
  - Right to access mental health care by both public and private services.
  - Right to confidentiality w.r.t. care and treatment.
- **Insurance provision:**
  - Insurance company to provide medical insurance on the same basis as those with physical illnesses.
- **Supply provision:**
  - Integration of mental health services at all levels of healthcare - primary, secondary and tertiary.
  - Bringing professionals with a postgraduate degree in Ayurveda, Homoeopathy, Unani and Siddha.
  - Establishment of Central & State mental health authority.
  - Establishment of mental health review commissions & Mental health review boards for a district or group of districts within a state.

Key Features

In India, the Mental Healthcare Act 2017 passed on 7 April 2017 and came into force from July 7, 2018.

- **Admissions, Discharge and Treatment:**
  - Admission as independent patient in mental health establishment.
  - Admission limited to a period of thirty days.
  - Treatment beyond period of thirty days or discharged, then two psychiatrists independently will examine for admission.
  - Provisions for not separating woman & child below 3 years of age unless approved by the authority.
- **Public awareness:**
  - Wide publicity through public media, including television, radio, print and online media at regular intervals by government.
- **Offences and penalties:**
  - Unregistered establishments or health professional liable for penalty.

Mental Illness and its types

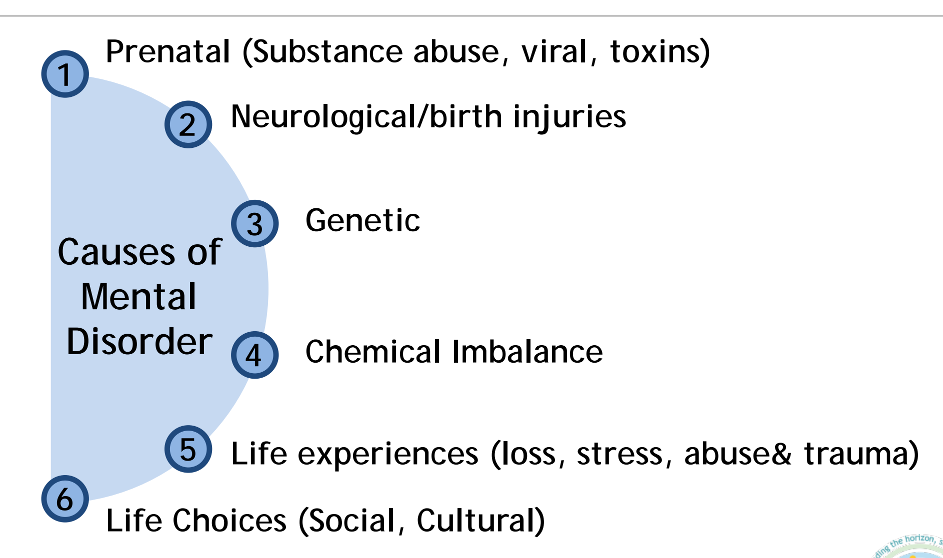
Definition of Mental Illness

Definition - as per the act

"Mental illness is defined as a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterized by sub normality of intelligence."

General statistics

- The incidence of mental illness increased more rapidly in India than in other countries over the last decade.
- As per the WHO report on depression, 7.5% of Indians suffer from major or minor mental disorder requiring expert intervention.
- About 1 in 10 people with mental health disorders are seen to get professional treatment.
- India accounted for 15 per cent of the global mental, neurological and drug abuse disorders.



Classification of mental illnesses*

The classification of mental illnesses is been considered from the NMHS survey report 2015-16.

- Mental morbidity 10.56%
  - CMD with SUDs 10.04%
    - Any substance use disorder w/o tobacco 5.0%
    - Depressive disorder 2.68%
    - Neurotic and Stress related disorders 3.53%
  - SMD 0.77%
    - Schizophrenia and other Psychotic disorders 0.42%
    - Bipolar Affective Disorders 0.3%
    - Severe depression with psychotic features 0.1%

Common mental disorder with SUDs

- Prevalence will vary depending on psychological and social atmosphere.
- Prevalence peaks in people aged 40-49.
- Common mental disorders identified more among women.
- Urban metro has the highest Prevalence rate.

Severe Mental disorder(SMD)

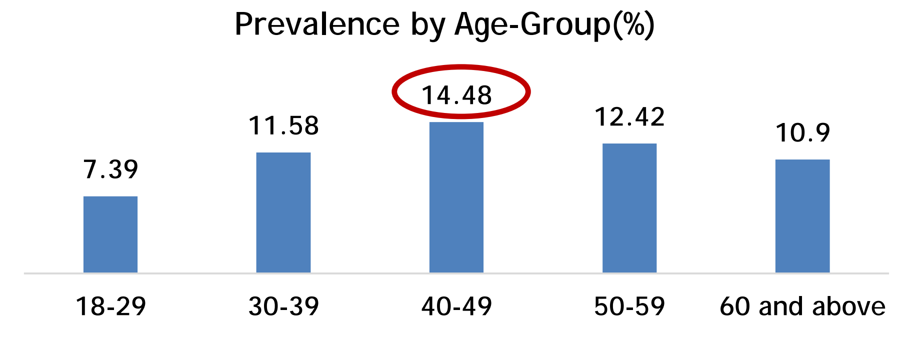
- Life expectancy estimated as much as 30 years less compared to general population.
- Severe mental disorders identified more among men.
- Prevalence peaks in people aged 40-49.

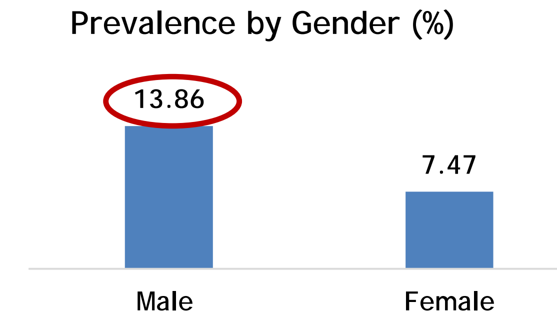
*NMHS survey report 2015-2016 - Weighted prevalence rates

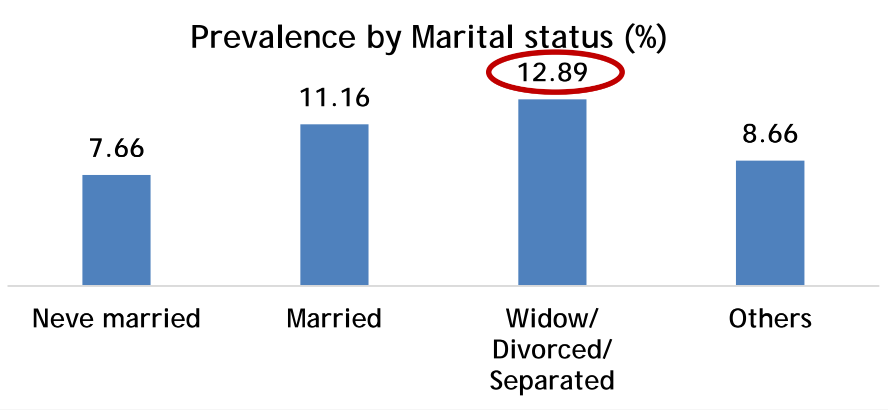
Mental health: demand and supply

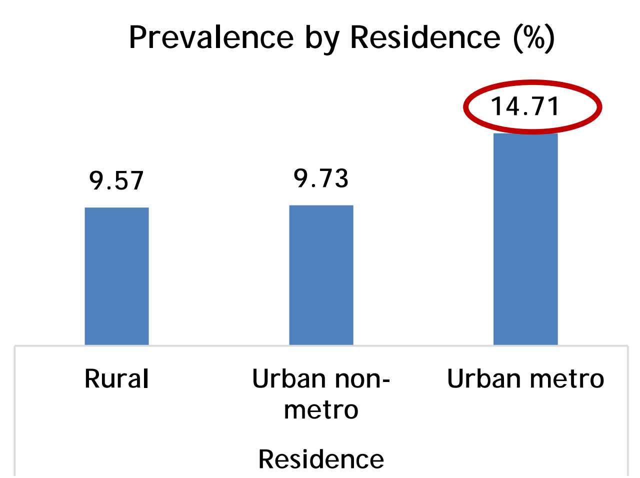
Demand: prevalence rates (%) by socio-economic characteristics

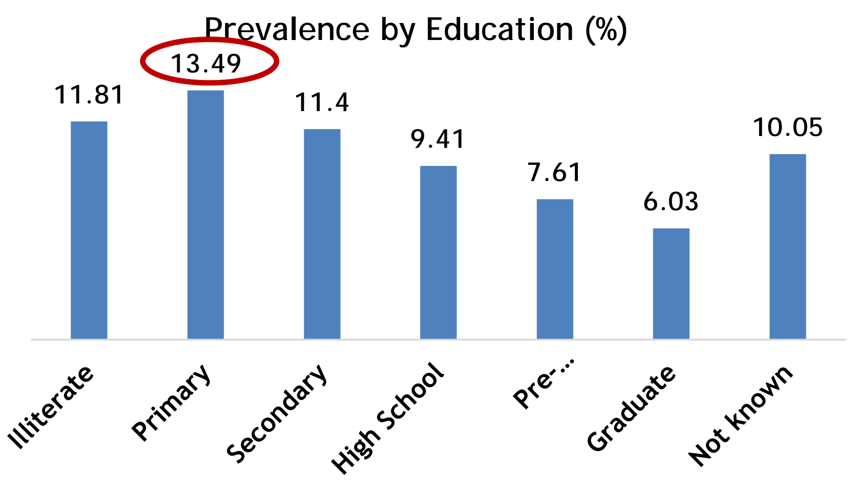
The distribution of current weighted prevalence rate by age, gender, marital status , residence, education and income from the NMHS Survey report 2015-16

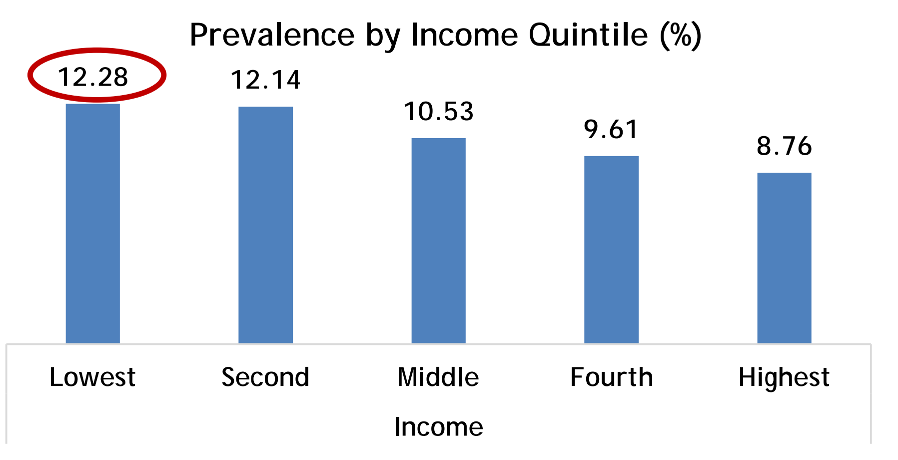






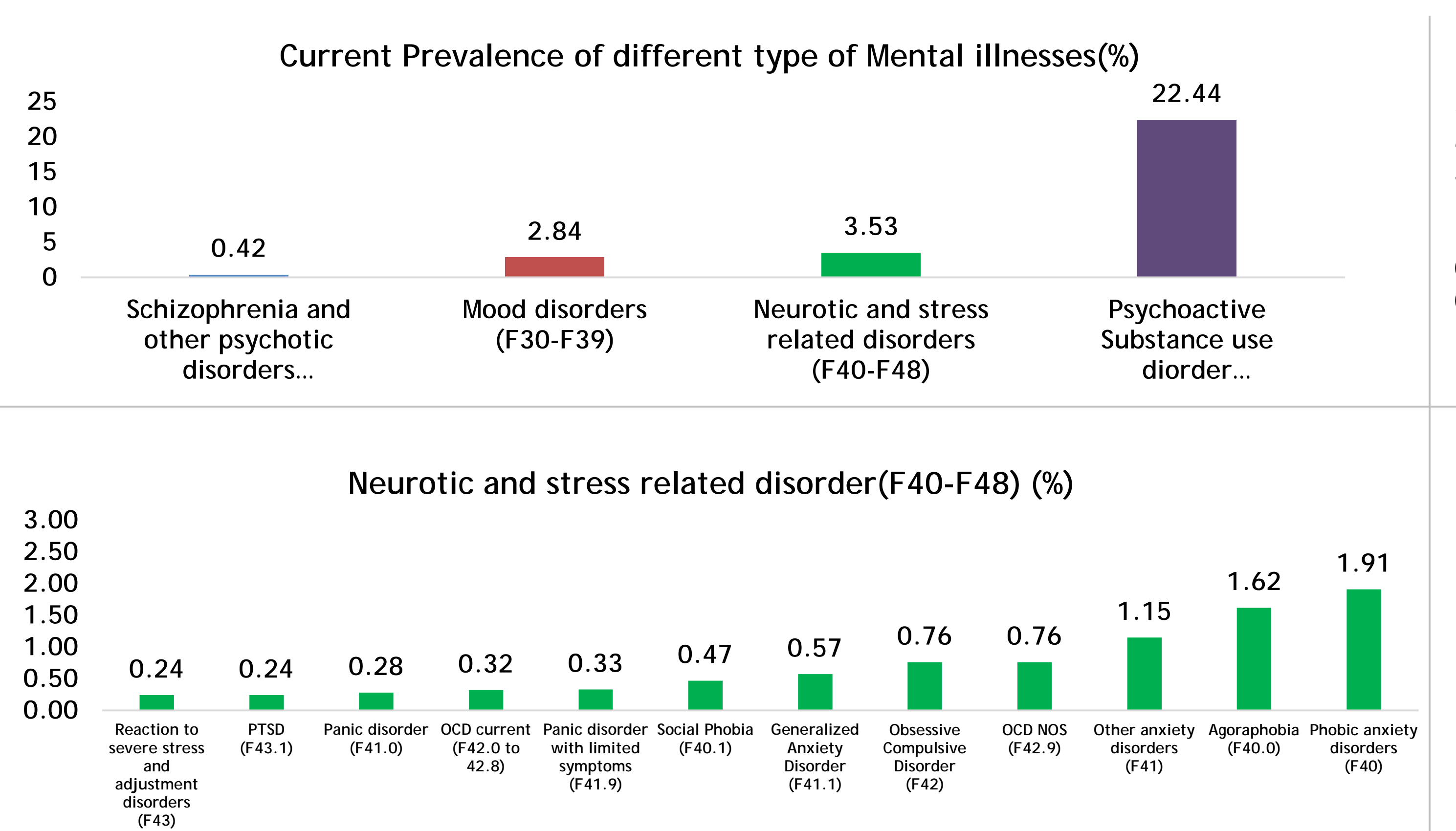


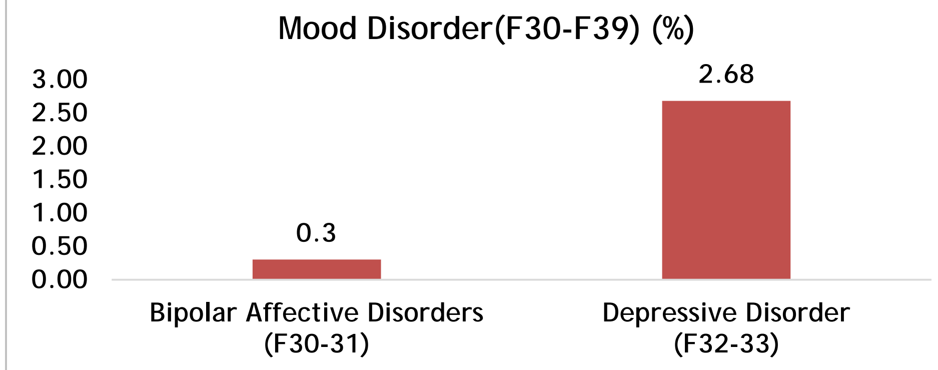


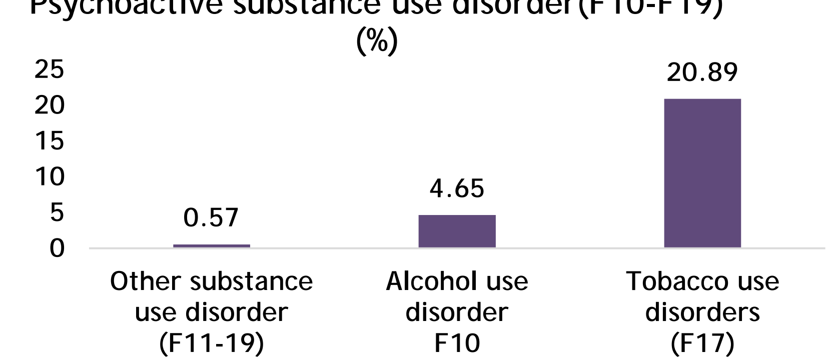


Demand: prevalence rates (%) by types of mental illness

Current weighted prevalence of Mental Illnesses as per ICD-10 DCR among adults 18+ years from the NMHS survey report 2015-16







Supply: type of facilities

- The provision of public mental health care in India is a joint responsibility of Center and State governments.
- **The mental health activities undertaken at the different levels of health care facilities in India:**

Village Level	Primary Heath Center (PHC)/Community Health center (CHC)	District Hospital	Medical colleges/Psychiatric Institutions	Community care facilities for short and long-term care
• Management of psychiatric emergencies. • Counseling for alcohol or drug abuse.	• Treatment of functional psychosis, anxiety, depressive disorders &alcohol dependence. • Management of psycho-social problems using psychosocial interventions.	• Training of medical officers and health personnel. • Support to NGOs. • Admit and provide hospital treatment for psychiatric patients including ECT treatments.	• Consultation to district psychiatrists, health center's medical officer w.r.t to "difficult" cases of psychiatric disorders. • Specialized treatments, e.g. drug dependent persons, behavior therapy. • Rehabilitation.	• Decreasing stigma of long stay in distant institutions. • Types of facilities as part of total mental health care system are : Day care centers, Short term stay/ half way homes, Vocational training centers etc.

Supply: human resources

- As per the Ministry of Health and Family Welfare there are total:
  - 3800 Psychiatrists.
  - 898 Clinical Psychologists.
  - 850 Psychiatric Social Workers.
  - 1500 Psychiatric Nurses in the country.
- Below table provide the Mental health care human resource (per 1,00,000 population) from the NMHS survey report 2015-16.

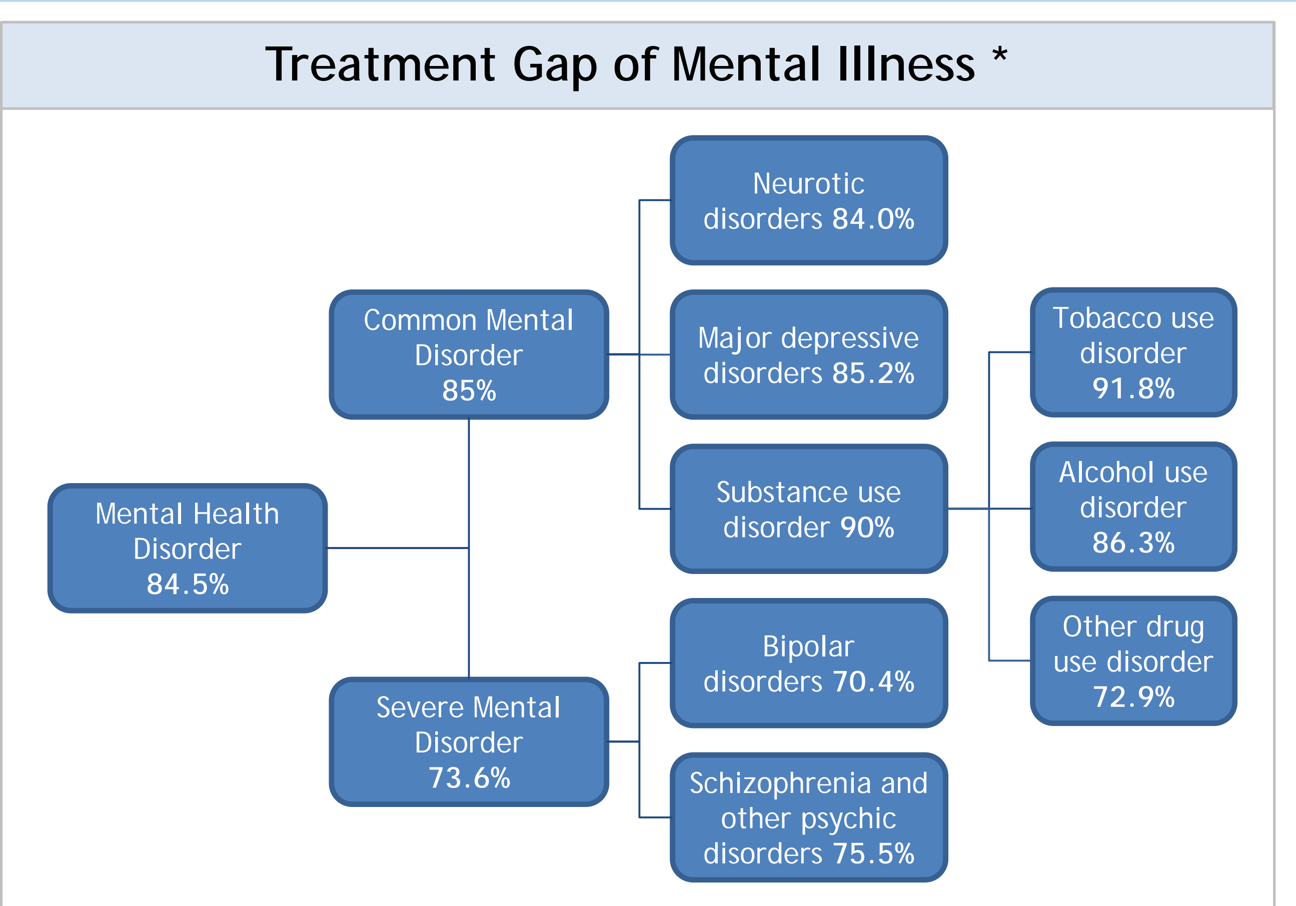
Human Resources	Number
Psychiatrists	4.64
Medical doctors trained in mental health	19.98
Clinical psychologists	1.56
Nurses trained in mental health	22.69
Nurses with DPN qualification	0.638
Psychiatric Social workers	1.32
Rehabilitation workers and Special education teachers	21.86
Professional and Paraprofessional psychosocial counsellors	68.75

Demand and Supply Gap

Refers to the difference between number of people who need care and those who receive care. The statistics is considered from the NMHS survey report 2015-16.

- At present, India spends only around 0.06% of its health budget on mental health compared to 4% spend by most developed nations.
- Multiple factors from lack of awareness to affordability of care, varies between rural and urban areas, appear to critically influence wide treatment gaps.
- Nearly 50% of persons with major depressive disorders reported difficulties in carrying out their daily activities.
- Up to 40% of the patients have to travel more than 10 km to reach the first available services at the district headquarters.

* The percentage numbers in this graph suggests that out of total people suffering from mental illness, 84.5% of them are either not on any treatment or with inadequate treatment facility.



Demand and Supply Gap

Refers to the difference between number of people who need care and those who receive care.

Mental healthcare professionals per population of 100,000 people			
Mental Health Professionals	Need*	Availability	Availability/Need
Psychiatrists	11500	3800	33%
Clinical Psychologists	17250	898	5%
Psychiatric Social Workers	23000	850	4%
Psychiatric Nurses	3000	1500	50%

Demand issues:

- Stigma and discrimination against, people with mental disorders is barrier to mental health service in India.
- Mental illness treatment is costly. Lack of affordability and insurance cover.

Supply issues:

- According to NHRC, out of 43 government mental hospital in India, only half a dozen are in 'Livable' condition.
- High variability among states and within states: mental health professions at district level varies from 0.1 to 10 per 1,00,000 people.
- Yearly Intake of mental healthcare professional across institutions is very low, ranging from 0-52 per year.
- Most districts lacks public rehabilitation workers, special education teachers etc. Most of them working in an informal setup.

International Markets

Mental health coverage in international markets

Mental health is an indivisible part of public health and significantly affects countries and their human, social and economic capital.

- We have studied following International Market :- UK,USA, Brazil, South Africa, UAE. Key Insights:-

Legislation

- USA has separate mental health care Act, "Mental Health and Addiction Equity Act 2008".
- In UK, South Africa, no separate act, covered under the public funded scheme subject to certain considerations w.r.t. country health law.
- In Brazil , no separate act, covered under the both private and public health scheme.
- UAE – No. process of getting a mental health Law in 2019.

Type of Mental Illnesses covered

- In most of the countries, the coverage is broadly defined as per
  - DSM-V (Diagnostic and statistical manual of mental disorder).
  - ICD-10 (International Classification of Diseases).
- In South Africa, there is a list of conditions called PMBs (Prescribed minimum benefits) which includes type of mental illnesses as well, require to cover in full.

Plan benefits

- Inpatient /Outpatient treatment.
- Limits on the no. of IP/DC days per policy year.
- Add-on cover for IP/OP psychiatric benefit cover up to an annual limit.
- Psychiatric emergencies, medications , appointments, diagnosis, psychotherapy sessions.
- Addiction treatment program per lifetime for substance abuse.

Mental health coverage in international markets

Mental health is an indivisible part of public health and significantly affects countries and their human, social and economic capital.

Current UW & Risk Assessment

- In most countries ,based on discretion of the Underwriter except Brazil where risk selection is prohibited under SUS – public funded health care system.
- No separate risk assessment for mental health.

Key Challenges

- Lack of data.
- Pricing difficulties.
- Risk selection not allowed.
- Aging of population.
- Rising list of mandatory procedures updated every 2 years.
- Not enough doctors and establishments to address the rising needs.

Risk Mitigation Strategy

- Strict benefit limits.
- Limiting inpatient stay with specialist case management Program.
- Uses of co-pay for psychotherapy, psychiatric hospitalizations, etc.
- Change in coding practices, might lead to misclassification.

Evolution of Mental Health

- **UK** - Limiting mental coverage, help keeping price competitive.
- **USA** – Continuous Progression over a period of time in the mental health act 2008.
- **Brazil** - In 1998, new law determine inclusion of mental health as mandatory, coverage amplified every 2 years, with new procedures entering the list.
- **South Africa** - With PMBs, requirement to fund at cost, had big impact on medical schemes in general.

Industry Survey - India

Industry Survey Results

Survey conducted among Indian Insurer for the inclusion of "Mental Illness" in health policy, the response results viewed as follows:

Mental Illness Definition

- Insurers considering defining:-
  - In new product filling.
  - As per underwriting guideline.
  - Defined list of included/excluded mental illnesses under policy/plan.

Product Design

- Expected progression in product design:-
  - Indemnity cover up to a sub-limit.
  - Standalone Mental illness products.
  - Outpatient/OPD cover for fixed no. of visit/fixed benefit amount.

Treatment Options

- Willingness to provide coverage for different treatment options - Ayurveda, Homeopathy, Unani other than Allopathy for mental illnesses.

Risk Mitigation

- Risk arising as a result of inclusion can be mitigated with the help of:-
  - Pre-existing exclusion.
  - Deductible/Co-payment.
  - Annual benefit limit.

Underwriting Process

- Material changes expected from the underwriters:-
  - Questions on mental health assessment.
  - Tele underwriting/ Interview for mental health screening.

Pricing Challenges

- Key challenges while pricing:-
  - Lack of clarity on cover.
  - Changes in consumer behavior.
  - Low policyholder awareness.

Expected Claim Cost

- The cost of claims might rise by a marginal percentage as a result of inclusion of mental illness in the health product.

Current Network

- Information of network hospitals providing treatment for mental illness turns out to be inadequate.

Co-morbid Risk

- Expected to have additional risk mitigation strategies for mental health disorder only, no change expected for existing common chronic condition.

Key Considerations

Key considerations for insurers

Product Design and Definition

- No clarity on definition likely to lead to significant variation in the interpretation and hence coverage offered across insurers

Pricing

- Difficult to quantify the impact on pricing given lack of relevant data, insufficient supply and social stigma.
- Slight rise in premium expected by covering mental illness under existing hospitalization insurance product.

Underwriting

- Guidelines specific to the mental health conditions may be required for the assessment on mental illness along with the impact of co-morbidities

Claim Processing/ Management

- High non disclosure due to low self awareness about the disease.
- Requirement for trained claim assessors and underwriters to assess the claims related to mental illness

Data Collection

- Policy changes likely to impact data collection requirements and system changes.

Reserving

- Higher reserves required to cover additional claims due to mental illnesses.
- Impact on reserves due to retrospective claims.
- Impact on products that offer medical coverage - travel, motor, workmen compensation etc.

Key considerations for insurers

Rights of People With Mental Illness

- With the provision of advance directives, patients have greater control on the preferred choice of care.
- Providers may have limited control on defining appropriate treatment

Insurance Provision

- No clarity on what can be covered within the insurance cover.
- Innovation of products.
- Potential for comprehensive insurance products with outpatient cover.

Supply Provision

- Potential for public-private partnership models.
- Adequate tie-up with network providers specialising in mental healthcare.

Admissions, Discharge and Treatment

- Deinstitutionalization not time bound for person in long-term care.
- Long-term admissions granted up to 180 days each time, if conditions of law are met.

Mental Health Review Board

- Registration, review and modification of advance directive by the Board likely to have implications on coverage offered by the insurers.

Caveats and limitations

- In carrying out our work and in preparing this research study, we have relied upon publicly available information supplemented by our knowledge and experience of the developments in the Indian health insurance sector.

- We performed no audits or independent verification of the information available to us. To the extent that there are any material errors in the information available, the results of our analysis will be affected as well.

- We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

- Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

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