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Understanding the Opportunity Size and the Profit Pools in the Indian Health Insurance Landscape

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The India Opportunity

Despite the government initiatives around insurance and financial awareness driving greater adoption a majority of Indian healthcare spend is out of pocket. And while out of pocket spending has been gradually coming down from the 63% in FY16 to 50% now, it is still substantially above both developed and developing markets peers. [China 34%, Indonesia 27%, USA 10.7%, UK 13.5%].

To make things worse, healthcare inflation has been on a tear in India, with spending going up ~6% every year compared to a sub 1.5% increase in our peer set. The combination of high out of pocket spending and high healthcare inflation makes the average Indian, especially the folks at the bottom of the pyramid extremely vulnerable at the time of a health emergency in the family, with hospitalisation costs being one of the major drivers of pushing lower income Indians back into poverty.

The government, to its credit, has been working hard to include more people in the insurance umbrella via programs like the PM-JAY (Pradhan Mantri Jan Arogya Yojana)- with Government Health primarily focussed on the economically disadvantaged in India covering 29.7cr Indians. But the average premium for this insurance is ₹284, the coverage is thin, and the network hospital coverage is falling year on year, giving the countriest poorest a working but subpar solution.

Around 19.9cr covered via Group Health (where Corporates purchase policies for their employees & their family) which constitutes the largest share in premiums earned by the industry and 5.3cr covered via Retail Health Insurance (where people buy insurance directly for themselves or their family).

Retail Health Insurance penetration - which is where people take health insurance for themselves or their families is still extremely poor at less than 4%. As financial literacy in the country increases and digital platforms make accessing insurance products easier, this number is steadily inching up.

The combination of these factors makes the sector poised for steady growth over the next decade. The Indian Health Insurance sector has grown at a 19%+ CAGR since FY18 and is poised to grow in the high teens in the years to come driven by a growing awareness and adoption of health insurance products. At this rate of growth, the market will grow from its current size of ₹1.08tr in FY24 to 2tr+ over the next five years.

In order to best benefit from this growth, it is important to identify the areas of well moated profit pools in this industry. Over the course of this paper, we will attempt to do just that.

Decoding the Health Insurance Business model

Before we dive deeper into the sector to understand where the real profit pools lie, it would be helpful to get a brief understanding of some key terminologies in the sector.

Float: Insurance is one of the few businesses in the world, where the customer pays you on Day 1 (insurance premiums), for an payout they may or may not get over the next year (claims). This creates a surplus of funds with the insurance entity known as float - which can be invested by the entity to generate float income. This is typically invested in fixed income securities (Gsecs, Tbills, REITs, NCDs) to generate a relatively steady annual yield. This float also grows every year given that the premium base also expands making for a very important part of the insurance business.

Reinsurance: Insurance companies can at times have large tail-risk (natural calamity, pandemic etc) where a large number of people are impacted at once, leading to a large payout that can impact the solvency of the business. To protect themselves from this risk, insurance companies will often go to a reinsurer to cover such risks, in exchange for a small reinsurance premium. In India this reinsurer is the centrally controlled GICre. Insurance companies can choose a reinsurance to suit their specific need from quota share reinsurance (pro-rata claims), surplus share reinsurance (excess risk taken by reinsurer) and excess of loss reinsurance (excess risk taken by reinsurer upto a cap).
The gross premiums received less the reinsurance premium paid gives you the net written premium, which is the base used to evaluate most underwriting ratios for the business.

Combined ratio: Coming to the core underwriting business - there are two important factors to track here –

1. How efficiently you underwrite: This is tracked by the claims ratio (net claims incurred/ net premium earned). This ratio basically tests how well you are pricing your insurance premiums to cover for the claims that will come

in the year. While having a low frequency and intensity of hospitalisation in the country will generally help this ratio, a high amount of competition constraining pricing growth will hurt. For most well run health insurers this number is typically around the 65% range. However this does vary widely, with several public insurers having 100%+ claims ratios.

2. How efficiently you manage commissions and other expenses: This is tracked via expense ratio (operating expenses + commissions/ net premiums earned). Commissions paid to agents and brokers are a key part of the expense ratio, and since commissions are lower in the group & government segment vs retail, expense ratios often tend to be higher for retail focussed insurers. For most well run health insurers the expense ratio is typically around the 35% range.

The combination of these two gives you the combined ratio (claims ratio + expense ratio). This is one of the most tracked ratio in the insurance space and a good measure of both the underwriting discipline and the operating discipline of the insurer.

Understanding the key customer groups

There are three primary customer groups when it comes to insurance in India –

1. Government: This is a low value high volume client focussed on a larger social objective and the insurance here is commercially unviable. The claims ratio in the space is consistently north of 100% and is therefore primarily underwritten by public insurers , who underwrite 68% of this insurance.
(Lives covered 29.7cr, average premium ₹284)

2. Group: This is a moderate volume moderate value segment - insurance premiums are negotiated in bulk and priced aggressively given the scale advantage of the corporate making it commercially challenging for insurers. The claims ratio is on the higher end in this space as well but marginally better in 95-100% range. The underwriting here is again done primarily by public and private health insurers who together underwrite 84% of this insurance.
(Lives covered 19.9cr, average premium ₹2319)

3. Retail: This is the highest value and most commercially attractive part of the segment given the relatively low negotiating power and focus on quality coverage. Barring spikes during COVID, the claims ratio in this space is consistently closer to 70%, with well run insurers in the space doing even better. Interestingly, the renewal rates in this segment is the highest at well, in the ~85% range, with group renewals much lower at the ~75% market.

It is also the fastest growing segment amongst the three, growing at 18%+. It is also the most granular amongst the three in terms of distribution used to reach the end consumer, with individual agents constituting 73% of the total policies sold. This makes retail health the fastest growing, most sticky, most granular, and most profitable segment of the three customer groups - understandably the most commercially attractive as well. Standalone health insurers have the lion's share in this segment with 56%+ market share.
(Lives covered 5.3cr, average premium ₹6572)

The Indian competitive landscape

Firms competing in the Health Insurance space fall into broadly three categories as discussed above -
1. Public: There are four large public general insurance cos - National, New India, Oriental and United India. These players are largely focussed on government and group health, and understandably take a hit on underwriting profitability making them largely unattractive from an investment perspective.

2.Private underwriters: These are run by private businesses and have a presence across a variety of general insurance (motor od, motor tp, agri, fire, marine). The channel presence here is more broker focussed as a result of which they have a large amount of group health in the mix and relatively low retail health.

3. Standalone health insurers: These include players like Care, Niva Bupa, etc. They are largely focussed on the most profitable part of the market (retail health) which reflects positively on their claims and combined ratios as well.

The moats in health insurance

Now that we have identified that retail health is the most profitable part of the health insurance landscape and standalone health insurers are best placed to cater to this market, it helps to understand the moats in the sector that allow standalone health insurers to maintain their standing in the coveted retail health space.

1. Individual agents: Most retail health insurance policies (72.9%) in India are sold via individual agents. This is because most people prefer having a trusted professional they can fall back on in case of a health crisis where they have to make a claim. Having a strong individual agent network is therefore critical to maintain market share in the retail segment. Standalone health insurers have 11,58,294 individual agents working for them which is ~3x of private insurers at 4,17,745 and ~4x of public insurers at 3,09,748. Not only do they have a sizeable lead, they

are also growing their agent networks materially faster than competition - standalone (23% CAGR), private (18% CAGR), public (5% CAGR), thereby widening their moat further.

2. Network hospitals: A large network hospital coverage is a key decision making criteria since it gives people the option to go to the hospital of their choice and have a seamless and oftentimes cashless claims settlement process. For the insurers it is helpful because insurers often have pre-negotiated rates negotiated with the hospitals reducing their outflow. Both private and standalone hospitals have a good moat here with 483K and 152K network hospitals respectively, with public materially worse off at 37K and falling.

3. Service levels: Quick and stress free claims are also an important criteria while selecting insurers. A good ratio to measure this is the average time it takes to settle a claim. Here again SAHIs lead the pack with an average claims settlement of 9 days vs 13 for private players and 30+ days for public insurers.

The combination of these three factors make for a compelling moat with the standalone health insurers - often better distribution, better hospital coverage, and faster claims settlement to the consumer. In metrics like distribution reach, standalone health insurers lead their peers by not a percentage but a multiple, making it one of the strongest competitive edges.

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