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ELEVENTH REPORT

COMMITTEE ON PUBLIC UNDERTAKINGS

(2005 - 2006)

(FOURTEENTH LOK SABHA)

HEALTH INSURANCE – A HORIZONTAL STUDY

MINISTRY OF FINANCE

Presented to Lok Sabha on 09.03.2006

Laid in Rajya Sabha on 09.03.2006

LOK SABHA SECRETARIAT

NEW DELHI

March 2006 / Phalguna 1926 (S)

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19. Shri K.Chandran Pillai
20. Shri Shahid Siddiqui
21. **Vacant**
22. Shri Dinesh Trivedi

* Smt. Ambika Soni Ceased to be member of the Committee consequent upon her appointment as Union Minister w.e.f. 29.1.2006.

SECRETARIAT

1.	Shri John Joseph	Secretary
2.	Shri S. Bal Shekar	Joint Secretary
3.	Shri N C Gupta	Under Secretary
4.	Shri Paolienlal Haokip	Committee Officer

INTRODUCTION

I, the Chairman, Committee on Public Undertakings having been authorized by the Committee to present the Report on their behalf, present this Eleventh Report on " Health Insurance – a horizontal study."

2. The subject was selected for examination by the Committee on Public Undertakings (2004-2005).

3. The Committee on Public Undertakings (2005-2006) took a briefing on the subject from the representatives of Ministry of Finance, Ministry of Health and Family Welfare and the Insurance Regulatory and Development Authority (IRDA) on 6th June, 2005. The Committee also took evidence of the representatives of the five public sector insurance companies namely, Life Insurance Corporation of India (LIC), National Insurance Company Limited (NICL), Oriental Insurance Company Limited (OICL), United India Insurance Company Limited (UIICL) and New India Assurance Company Limited (NIACL) on 20 July, 2005. The Committee also called memoranda from various Non-governmental Organizations involved in community based health insurance. They further took evidence of representatives of Ministry of Finance, Ministry of Health and Family Welfare and the IRDA on 18th November, 2005.

4. The Committee on Public Undertakings (2005-2006) considered and adopted the Report at their sitting held on 2nd March, 2006. The Committee feel obliged to the Members of the Committee on Public Undertakings (2004-2005). They would also like to place on record their deep sense of appreciation for the valuable assistance rendered to them by officials of Lok Sabha Secretariat attached to the Committee.

5. The Committee wish to express their thanks to the Ministry of Finance, Ministry of Health and Family Welfare, Insurance Regulatory and Development Authority, various Non-governmental Organizations, the public sector insurance companies and some private insurance companies for placing before them the material and information they required in connection with examination of the subject. They also wish to thank in particular the representatives of the Ministries/Departments, Public Insurance Companies and the Insurance Regulatory and Development Authority who gave evidence and placed their valuable views before the Committee.

New Delhi:
2 March 2006
11 Phalguna 1927(S)

RUPCHAND PAL
CHAIRMAN,
Committee ON PUBLIC UNDERTAKINGS

CHAPTER – I

CONTEXTUAL FRAMEWORK

1.1 Introductory

1.1.1 In a welfare state like ours, public health is a responsibility of the State. The constitution underlines this fact by laying down that the state should regard "……..raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties." (Article 47 – Directive Principles of State Policy).

1.1.2 In a country like India having no social security system worth the name, appropriate Health Insurance Schemes for different sections of the society particularly the underprivileged and the poor is an urgent need of the hour.

1.1.3 Insurance penetration being very low and health insurance's share being minimal in the existing situation, the vast majority of the population are outside the existing Health Insurance System.

1.1.4 According to WHO figures (2002,), total health expenditures represent 6.1% of India's GDP, but most of this amount, representing 4.8% of GDP is the share of private expenditures and only 1.3% of GDP is public expenditure. Of the 4.8% private expenditure, 98.5% are out-of-pocket spending of users. In other words, 77.5% of total expenditure for health care costs are paid by individuals or

households (WHO, 2005) and this huge expenditure does not pass through any pooling mechanism.

1.1.5 Access to quality healthcare is an important indicator in the human development index. Access to health care in India is still low and with only less than 1% of GDP allotted to public health, there is lack of adequate health infrastructure. Health insurance is a complimentary financing mechanism for enhancing access to quality healthcare. There are some health insurance schemes issued by Four public sector general insurance companies, namely, National Insurance Company Limited (NICL), New India Assurance Company Limited (NIACL), Oriental Insurance Company Limited (OICL) and United India Insurance Company Limited (UIICL). Besides these four companies, Life Insurance Corporation(LIC) of India also offers a few health covers in a limited manner. At present, 82.44% of the entire commercial health insurance business in the country is shared between public companies, while private firms manage the rest 17.56%. Thus, the public insurance companies are in the forefront of health insurance in the country. The Committee, by selecting this subject, seeks to examine the achievements, failures, difficulties and potentials of the public sector insurers with regard to health insurance and to suggest remedies so that the potential benefits of health insurance in the country are fully realized.

1.1.6 In reply to a question about need for Health Insurance in the country the representatives of the Ministries of Finance and Health & Family Welfare, and the Insurance Regulatory and Development Authority (IRDA) said :-

Ministry of Finance:

"……In a welfare state it is the responsibility of the Government to meet the health needs of its Citizens. Health Insurance as a financial instrument can work out for people who can afford the premium. However, the families with a limited source of income cannot afford to contribute towards the premium and any amount of contribution by them will deplete their savings. Therefore, Health Insurance as a measure to meet the Health expenditure for all community will not succeed. In Europe, Africa & some Asian countries Social Health Insurance Programmes are supported by the Governments. Private Health Insurance as implemented through Insurance Companies will succeed only for the affordable sections of the society. India is not an exception to this rule and the popularity of various mediclaim insurance policies among the taxpayers is a clear example to this effect."

Ministry of Health & Family Welfare:

"….Health indicators like life expectancy and decline in crude birth and death rates have recorded significant progress over the planning era. Alongside health infrastructure has also increased tremendously to cater to the increasing needs in the country. Nevertheless, there are still differentials in the health status between regions and States and among socio-economic groups. Healthcare delivery is still to be achieved effectively in terms of access, availability and affordability among different sections of the society. In the context of a very large number of poor in the country spread across the remote areas, it would be difficult to conceive of an exclusive government mechanism to provide health services. All over the globe including the developing economies there is a continuing review of how health systems can be financed – either in terms of the way funds are collected or how they are pooled to spread risks.

Despite the massive public health infrastructure, effective utilization of this infrastructure is beset with several difficulties like inadequate doctors/medical officers and para-medical staff, shortage of medicines and absence of supporting infrastructure. Health Insurance is being conceived of as one of the mechanisms for financing healthcare. As public expenditure on health is about 15% and the rest is out of pocket expenses, the possibility of public outlays catering to the entire health needs of the population seems practically difficult. Existing public health infrastructure is reported to be not highly accessible to BPL families…"

Insurance Regulatory and Development Authority -(IRDA):

"Insurance is an alternative to self financing for risks in respect of life, health, property etc. While it is true that in a welfare state, it is the Government's responsibility to take care of the health of the nation,

particularly in respect of those below the poverty line and the senior citizens, considering the population profile India has, Health Insurance can definitely play a role in complementing the efforts of the Government. The Government as the finance provider and custodian of health services has provided less than 1% of GDP for health care. The existing public health infrastructure is able to cater to only around 20% of population and even for this segment health care is not complete, given the lack of proper amenities, shortage of supplies, shortage of doctors in rural areas, lack of critical care etc.

In this scenario, health insurance as a financing model for health care can definitely help bridge the gaps in affordability and accessibility in health care to a considerable extent."

1.1.7 Regarding the need for an alternative mechanism to finance healthcare, the Ministry of Health & Family Welfare in a background note furnished to the Committee stated :-

"Despite the impressive achievements, noticeable are the differentials in the health status between regions and States and among socio-economic groups. Effective healthcare delivery i.e. accessible, available and affordable still is to be achieved. Public infrastructure created is still inadequate in terms of the requirements. Also out of the aggregate health expenditure of 5.2% of the GDP, public expenditure on health is a mere 0.9%. Coverage or prepayment for health needs is poor. Almost two-thirds of spending is out of pocket expenses making a drain on personal finances. Studies have indicated that even consumers from the lowest income groups often pay considerable sums of money towards curative treatment, which shows that there is excessive financial burden on households despite the existing public healthcare system. As public health investments cannot be enhanced beyond a point, exploration of alternative mechanisms of financing of healthcare has become absolutely necessary."

1.1.8 Highlighting certain crucial data on health expenditure in the country and presenting a case for the promotion of health insurance, Secretary, , Ministry of Health and Family Welfare (Department of Health) stated during evidence:

"…..a well functioning health insurance system can come only if there is an overall efficient health care system. We are acutely conscious of this. Nevertheless, through you, I would like to submit a few generic data on

the subject of health expenditure in the country. This year the budget of the Department of Health and Family Welfare is slightly above Rs.10,000 crore. It sounds a good sum of money but we have to realise that this Rs.10,000 crore is only about 20 per cent of the expenditure that the States commit for health. So, that means, another Rs.40,000 crore is expended by the States. Totally, the public sector expenditure for health is about Rs.50,000 crore.

The fact is that this Rs. 50,000 crore is only 25 per cent of the overall health expenditure in the country. So, that means another Rs. 1,50,000 crore or so is spent by people. Of this, insurance premiums total upto about somewhere between Rs. 1500 crore to Rs. 1800 crore. That means, rest of the money people are spending, what is known as out of pocket expenditure. In some kind of medical distress, they are perforce spending the money…….

It is not by emphasizing improvement and investment in Government health care system only. Health care costs money every time, but these days more because of the high-tech interventions in health. Money has to be spent. The Government can double its Budget – the Central Government can double its Budget from Rs. 10,000 crore to Rs. 20,000 crore. They have also said it in their manifesto. They may even treble it. But even then you see in Rs. 2, 20,000 crore or so annual health expenditure, Rs. 30,000 crore cannot determine effectively all the issues. So, what is the answer? The answer is stimulating a whole host of health insurance products. Without risk pooling, special and large episode of health care has led to across the board impoverishment, particularly among the poor. Either they are not accessing health care and dying without health care or when they are accessing health care, they are getting impoverished and getting into rural indebtedness. It is said that seeking major health care is perhaps the major cause of rural indebtedness these days."

1.1.9 Stressing the importance given to health insurance by the Government, Shri C.S.Rao, Chairman, Insurance Regulatory and Development Authority (IRDA), stated in evidence;

"……. As has been pointed out by the Secretary (Health), this is one issue which has been engaging the attention of both the Ministry of Health and the IRDA from the time it has been created, as to how to provide adequate health cover to the people of this country. In fact, you would remember that when the IRDA Act was passed and later also we said that we would give preference to a company which is prepared to provide health cover on a stand-alone basis also.

If there are too many applications received, we will give preference to an insurance company which is prepared to provide health cover, but unfortunately we have not received so far in the last five years any application for a stand-alone health insurance company.

1.2 Development of Health Insurance in India

1.2.1 Insurance generally comprises of life and non-life (general) insurance. Health Insurance in India comes under general insurance. The development of health insurance in India therefore, has to be seen in the backdrop of the development of insurance in general.

1.2.2 Whereas the primary focus of the Committee is regarding the state of health insurance under the PSU general insurance companies, it is felt that highlighting the development of health insurance in its various forms would set the context for a comprehensive understanding of the subject. This necessitates taking into account certain developments that do not strictly come within the generally perceived notion of insurance, but nevertheless constitute vital components in the chronology of development of health insurance in India.

1.2.3 Taking into account various developments in and outside the insurance sector, a chronological chart showcasing the developments in the field of insurance, including developments specific to health insurance, with brief summaries are given below.

Chronology

YEAR	IMPORTANT DEVELOPMENTS
1912	Insurance Act, 1912 passed, setting down rules and regulations specific to insurance industry.
1923	Workman's Compensation Act passed, aims to provide workmen and/or dependents some relief in case of accidents arising out of or in the course of employment, causing death or disablement

1938	Insurance Act, 1938 passed, recognizing two categories, i.e. Life and non-life (general) insurance. Led to an insurance wing being set-up, attached to the Ministry of Finance.
1948	Employee's State Insurance (ESI) Act passed, providing protection to workers & dependents in the organized sector for sickness, maternity, death
1954	The Central Government Health Scheme started in 1954, providing health cover to employees of Central Government, MPs, Judges, Freedom Fighters and their families.
1956	Life Insurance industry nationalized and Life Insurance Corporation of India (LIC) set up subsequently.
1959	Mudaliar Committee constituted, recommended provision of long-range health insurance policy for all and strengthening Primary Health Centers.
1972	General Insurance industry nationalized; General Insurance Corporation of India came into being in 1973 with more than a hundred private companies merged into the four subsidiaries of GIC, namely; NICL, NIACL, OICL and UIICL. Before GIC came into existence, a number of private insurers offered group health cover to corporate bodies. GIC offered Limited hospitalization cover since 1981
1986	GIC introduced mediclaim insurance; modified in 1996 to allow differentials in premium for six age groups.
1999	Insurance Regulatory and Development Authority (IRDA) Act passed; opening up the insurance sector to private players allowing 26% Foreign Direct Investment in the sector.
2001	Indian Insurance Amendment Act, 2001 GIC became a re-insurer, its earlier role of co-ordination between the four subsidiaries taken over by a new body, General Insurance (Public Sector Companies) Association (GIPSA). IRDA introduced several insurance regulations including provisions for Third Party Administrators (TPA) system in health insurance.

1.2.4. As furnished by the five public insurance companies the development of health insurance is as follows:-

Early Years

1.2.5. The New India Assurance Company Limited, delving deep into the early developments of Health Insurance in their written reply, stated;

> "Health Insurance is not of recent origin. Concern for loss resulting from accident and illness can be traced to ancient civilizations. In fact, one of the earliest forms of health insurance may have been based on the ancient custom of paying the doctor while in good health and discontinuing payment during periods of illness. This custom existed in South East Asian countries including India. The development of health insurance in existing form in India is based on pattern followed in Europe and America.
>
> Health Insurance or medical insurance schemes had developed in India due to industrial relations problems between the employer and the employees. The Corporate Houses used to offer core and non-core benefits to the employees. The insurance policies were granted to large

Corporate Houses purely on an accommodation basis. The cover usually offered to the employees was in the nature of hospitalization and domiciliary treatment for dental and non-surgical eye treatment. The benefits used to be for very small amount. There was no scheme for individuals and families.

In 1981, the Apex Body of Public Sector Insurance Companies i.e. GIC designed a limited cover for individuals and families for covering their hospitalization needs. This was replaced by a mediclaim policy in the year 1986 under a market agreement to provide insurance benefits to individuals and groups under a group mediclaim policy. The scheme so introduced was modified in 1991 and 1996 in the light of experience and suggestions received from the insuring public and medical fraternity. The benefit provided under the policy was on reimbursement basis on occurrence of a major calamity in the form of accident/sickness to an insured person. Reimbursement of the expenses was allowed by insurance companies on production of the required bills given by the hospitals where the treatment was taken. This resulted into demand from policyholders, for payment to Hospitals, as it was difficult for an insured person to arrange for funds at the time of admission in the hospital. Requests were made to GIC for introducing a system whereby, payment could be made directly by the insurance company to the hospital where the treatment was taken. Insurance Companies entered into tie up with hospitals to provide such benefit whereby an insured person could collect a certificate of his eligibility from an insurance company and produce the same to the hospital for taking the treatment. The settlement of the claims was directly made with the hospitals. This tie up with hospitals failed in course of time in view of some reported cases wherein the hospital managed to get the reimbursement of claims of such insured persons who took treatment for pre-existing ailments."

1.2.6 Life Insurance Corporation of India (LIC) traced the early developments to a pre-independence legislation, the Workman's Compensation Act, 1923. Profiling the legislative and committee level efforts in the development of Health Insurance in India prior to liberalization, LIC in their written reply furnished the following details.

- "Workman's Compensation Act was passed in 1923. This Act aims to provide workmen and / or their dependants some relief in case of accidents arising out of or in the course of employment and causing either death or disablement of workmen.

- Employees' State Insurance (ESI) Act was passed in 1948. The ESI scheme is an integrated social security scheme tailored to provide social protection to workers and their dependents in the organized sector in contingencies such as sickness, maternity, death or disablement due to an employment injury or occupational hazard. The first SI hospital was established in 1952.

- Mudaliar Committee (1959-1961) recommendations. These included provision of long range health insurance policy for all and strengthening the Primary Health Centers (PHSCs)."

1.2.7 The National Insurance Company Limited (NICL), tracing the early developments of health insurance in the country since independence, stated in their written reply: -

> "The Employees State Insurance Act 1948 paved the way for introducing mandatory social insurance scheme in the formal sector. The ESIS introduced in 1952 benefits 33.4 million workers with income less than Rs.6500/- a month along with their families.
>
> The Central Govt. Health Scheme (CGHS) started in 1954 for employees of Central Government, members of Parliament, Judges, Freedom fighters and their families. This contributory scheme has 4.5 million beneficiaries.
>
> The first Mediclaim Insurance Scheme was introduced by GIC in 1986 for people not covered under the above scheme. Prior to 1986, cover against sickness and diseases were provided by extension of Personal Accident Policy. The Mediclaim Policy is a reimbursement policy i.e., the policyholder first pays the expenses for treatment and later gets reimbursement depending upon sum assured and the coverage. The Mediclaim Policies are issued to Individuals and Corporate clients/ Groups. In addition, Tailor-made Group Mediclaim Policies are issued for Corporate clients. The terms, conditions and the rates of premium are governed by a market agreement, which was binding on all the four subsidiaries of GIC.
>
> The scheme was revised in 1996 when the following changes were made in the original scheme:
>
> a) In limits removed
>
> b) No category-wise benefits- instead benefits provided under one sum insured

c) 7 days grace period was allowed for policy renewal

d) No personal accident cover

Simultaneously, other modified forms were also introduced keeping in view the requirements and affordability of different segments such as Jan Arogya Bima Policy, Critical Illness Policy, Sampoorna Arogya Bima Policy etc."

1.2.8 Under the sub-heading – 'Early years' in the development of health insurance in India, United India Insurance Company Ltd.(UIICL) in their reply stated:-

"The health insurance for general public was first started with the Mediclaim Policy that was introduced in 1986 under the guidance of the Ministry. This policy was introduced to the individuals as well as Groups that wanted to cover its members. Initially there were sub limits fixed for various heads. Later the sub limits were removed and all relevant expenses were paid.

Few Corporate Clients were enjoying Package Health & Hospitalization cover prior to nationalisation and they were allowed to continue the cover. This scheme had also been taking care of not only in-patient treatment but also the cost of Outpatient treatment with certain limits."

Post-Liberalization and current developments

1.2.9 After the Insurance Industry was opened up in 2000 for competition from private players and setting up of Insurance Regulatory and Development Authority (IRDA) through an Act in 1999, the scenario substantially changed.

1.2.10 Briefing the Committee on some of the developments in the health insurance sector after liberalization, the Chairman of IRDA stated:

"What has happened in the last few years, after opening up of the sector, is that the number of policies that have been sold and the amount of premium that is collected under health insurance has increased substantially. In 2001-02, we had about 75.33 lakh policies covering a premium amount of roughly Rs. 762 crore. By 2003-04, the number of policies has increased to 102.84 lakh and the amount of premium collected is Rs. 1,154.47 crore. So, there is more than 50 per cent increase in the premium and also the number of policies that are sold. So,

health insurance is becoming a somewhat popular scheme among the public and the insurance companies are also willing to sell this."

1.2.11 Commenting on the progress of health insurance in the post liberalization period, the National Insurance Company Limited in their written reply stated: -

"In the Post liberalisation, the Health Insurance Portfolio in India is regulated by Insurance Regulatory and Development Authority (IRDA). IRDA introduced one regulation providing for Third Party Administrator (TPA) to work independently to provide specialised services to support administration and management of health insurance product offered by Insurance Companies. The twin objectives of introduction of TPA were to contain the rising claims cost and to provide cashless treatment to the insuring public.

The share of health insurance premium as part of overall portfolio of non-life business of government owned companies is around 8%. Health Insurance as a portfolio has started showing an upward trend from the year 2000 (post IRDA). The share of health insurance between Public Sector Companies and Private Sector Companies is 90: 10. It is interesting to note that even after nearly two decades of health insurance, the population covered by health insurance is only 1% of the total population. The following table demonstrates the progress of health insurance in India:

Year	People Covered (lacs) % increase	Premiums (Rs. In Crs.)	Per Capita Premium (Rs.)
1997-98	27.87	216	773
1998-99	35.34	272	768
1999-00	48.94	380	777
2000-01	56.23	519	923
2001-02	77.84	742	953
2002-03	88.02	895	994
2003-04	109.95	1024	931

It will be observed that the real increase in health insurance portfolio has started only from the year 2000. Further, while there was a substantial increase in the per capita premium in the year 2000-01, it has remained range bound and nearly stagnant thereafter suggesting that the premium has not kept pace with medical inflation or for that matter even the general inflation. This has adversely affected the underwriting results of all the four companies underwriting health insurance.

Notwithstanding above, there still remains a huge potential for growth of health insurance due to following reasons:

a) India is one amongst the fastest growing economies where the GDP growth in the short-term is expected to hover around 6-7% for the short to medium term, the projections are at a 10% mark

b) People are spending more on healthcare. Today, a middle-level manager with a family of four, spends between Rs.8000 and Rs.12000 a year on healthcare- compared to just Rs.2,000 in the late – 1980s. Most users of healthcare have been paying from their own pocket and preferring private services to government ones.

c) The rise in literacy rate

d) The higher levels of income

e) An increased awareness through the deep penetration of electronic media.

Health insurance is turning out to be the fastest growing segment in the non-life insurance industry with an average growth of close to 40% per year in the last three years. This is more than twice the growth rate for the non-life industry. If the current trend continues for the next few years, health insurance will turn out to be the second biggest business segment after motor insurance. From bringing in less than 5% of the net premium of the non-life companies in 1998-99, mediclaim premium has grown close to 10% of the net premium income in 2001-02. Mediclaim as a product brings in substantial premium income of 35-40% within the personal lines business of any insurer. Hence, there is no doubt that the time has come for taking a very close look at this important portfolio and our company is fully alive to this changing scenario and are making all out efforts to tap the untapped segment."

1.3 Concept

1.3.1 Conceptual clarity being pertinent to any meaningful intervention, the Committee sought the comments of the concerned Ministries as well as the Public Insurance Companies on the concept of Health Insurance.

1.3.2 Elaborating on the concept of Health Insurance, Ministry of Health and Family Welfare (Department of Health), in their background note furnished to the Committee, stated as under ;-

"Health insurance is a form of insurance whose payment is contingent on the insured incurring additional expenses or losing income because of

incapacity or loss of good health. A Health Insurance Policy is a contract between an insurer and an individual or a group in which the insurer agrees to provide specified health insurance at a premium. Depending on a policy, the premium may be payable either as a lump sum amount or in installments. Health Insurance generally provides direct payment or reimbursement of expenses incurred during an illness. What would be the nature of protection would depend on the kind of policy purchased and the cost and range of protection under that policy. Health insurance could be either a personal scheme or a group scheme sponsored by an employer. Unlike life insurance where there are only two parties i.e. the insured and the insurer, in the case of health insurance there are three parties namely the insured, the insurer and the provider.

The generic features of insurance are equally applicable to the concept of health insurance. Insurance primarily rests on the principle of pooling of risk associated with the same cause i.e. health to share losses on some equitable basis."

1.3.3. On the concept of Health Insurance, the National Insurance Company Limited, stated as under :-

"'Insurance' whether it is health or any other line of insurance, is a concept of sharing financial burden. Insurance follows a simple statistical principle of "diversity" or "pooling of resources and sharing of risk". This means that from out of a given population that is Insured, those needing the financial support by way of a claim for loss is very small. Especially in the case of Health Insurance, it is less than 5% of the total population covered in its current form. This in effect means that out of the amount contributed by 100%, financial claims are paid to only 5%. This theory of diversity is an important factor in a country like India."

1.3.4 New India Assurance Company Limited, stressing on the social security aspect of health insurance, in their written note, stated;

"Basically the philosophy behind the concept of Health Insurance is to provide protection against uncertainty of illness /accident by spreading the risk based on the principle that "what is highly unpredictable for an individual is predictable for a group of individuals. Thus, insurance is a system by which Healthcare expenditure of few unfortunate individuals, who suffer from illness/injury is shared by many fortunate ones who are insured and exposed to the same risk but remain healthy."

1.3.5 Oriental Insurance Company, emphasizing the financial security aspects of health insurance, in their written note, stated;

> "Health insurance is a financial mechanism that exists to provide protection to individuals and households from hospitalization expenses incurred as a result of unexpected illness or injury. Under the mechanism, the insurer agrees to compensate or guarantees the insured person against loss by specified contingent event and provide financial coverage for which the insured party pays a premium. The case for health insurance rests on three grounds:
>
> a) Illness can not be predicted;
>
> b) Financial burden of hospitalization is high and cannot be planned;
>
> c) The proportion of people requiring hospitalization due to illness or injury in any large population is small thus enabling risk pooling. Pooling of risks, resources, and benefits is the hall mark of any insurance system
>
> Unlike in developed countries, in India, the social security system is inadequate and therefore, healthcare is more dependent on insurance."

1.3.6 Reflecting a similar view point, United India Insurance Company Limited, in their written reply, stated;

> "Health Insurance as a concept deals with coverage of expenses relating to treatment on account of illness and also following an accident. However, the different schemes/policies offer insurance for different risks under health insurance.
>
> Health insurance is basically a plan providing services or cash indemnities for medical care needed in times of illness or disability. It is effected by voluntary plans."

1.4 Forms of Health Insurance

1.4.1 Health Insurance can take various forms. It can be (i) Employer – provided, (ii) mandatory/social, (iii) voluntary or (iv) community-based, depending

upon the relationship between the insurer and the insured, and also on the type of service provider.

1.4.2 Asked to furnish in detail the various forms of health insurance, the Life Insurance Corporation of India, in their written reply, stated;

> "Health Insurance mechanism in India can be sorted into four broad groups:
>
> i) Social / mandatory insurance: the Employees' State Insurance Scheme (ESIS) provides cover for low-income employees of the organized industrial sector. The Central Government Health Schemes (CGHS) provides cover for central government employees.
>
> ii) Voluntary health insurance schemes include mediclaim, Universal Health Insurance (UHI) Scheme of private insurers. These are available mainly through insurance companies.
>
> iii) Employer-based insurance (Public and private sector companies including Defence, Railway, Security Forces, etc.) - The companies offer facilities by way of lump sum payments, reimbursement of employees' health expenditure or coverage under one of the public / private insurance plans.
>
> iv) Community – based schemes. These are provided either by Trusts, hospitals or NGOs. The schemes are set up
>
> - To provide health security to people living around healthcare facilities.
> - To minimize default in payments
> - As a regulatory requirement of insurance in rural and social sector.

1.4.3. Attempting to categorize health insurance, the National Insurance Co. Ltd. stated in their written reply:

> "Thus in the scenario of health for all there can be three types of coverage using the premium/tax mix for promoting health coverage.
>
> 1. Commercial Insurance – where the full premium is paid by the insured, but tax benefits can be offered and service tax on health premium can be waived.

2. Community Insurance – where communities as may be sponsored by the state government, local government, NGOs and other groups can be insured by means of limited contributions by the participating members and subsidy from the government targeted to this end from tax earnings.

3. Command or compulsory insurance or social security schemes, whereby through employer contribution or taxes social security schemes can be offered to high risk groups such as the aged as also the poorest and unemployed sections of the population."

1.4.4 In reply to the question on the various forms of health insurance, the three other public insurance companies furnished the various schemes in vogue under the voluntary health insurance schemes that constitute the main form of insurance promoted by the insurance companies in India.

1.4.5 Health insurance coverage under the various Schemes of health insurance in India is less than even 10% of the population. Of this, only about 10% coverage is through commercial health insurance meaning that only about 1% of the country's population is availing health insurance through insurance companies. The number of beneficiaries under the various forms of health insurance in India is given in the table below.

Form	Scheme	Beneficiaries in lacs
Social / Mandatory Schemes	The Employees State Insurance Scheme (ESIS) Central Government Health Scheme (CGHS) State Sponsored Schemes (This figure may be enhanced with the recent coverage extended by Assam Government to its undeserving population)	253. 43. 5.
Employer based Schemes	Railways Health Scheme Defense employees Ex-Serviceman Mining & Plantations (Public Sector) Employer run facilities/reimbursement schemes of private sector Employers run facilities / reimbursement Schemes of public sector	80. 66. 75. 40. 60. 80.
Commercial Schemes	Pubic Sector Non-Life Companies Private Sector non-life Companies Health Segment of Life Insurance companies	100. 8. 2.3
Community Schemes	Community health schemes by NGOs and others	30.

CHAPTER – II

INSTITUTIONS CONCERNED

2.1 GOVERNMENT

MINISTRY OF FINANCE

2.1.1 The public sector insurance companies are accountable to the Banking and Insurance Division of the Department of Economic Affairs in the Ministry of Finance except for matters of day to day administration and certain spheres of functional autonomy. The Ministry provides the policy framework within which these companies operate. Administration of Insurance Act, 1938, Life Insurance Corporation Act, 1956, General Insurance Business (Nationalisation) Act, 1972, Insurance Regulatory and Development Authority, Act, 1999, periodical review and monitoring of the performance of public sector insurance companies and appointment of the Chief Executives of the public sector insurance companies and IRDA also come under the Ministry of Finance.

2.2 INSURANCE REGULATORY & DEVELOPMENT AUTHORITY (IRDA)

2.2.1 To look into the minutes of Insurance Regulation, the Insurance Regulatory and Development Authority (IRDA) had been set up under an act of Parliament in 1999. IRDA monitors functioning of public and private sector insurers through regular reporting, undertaking inspections, conducting enquiries and investigations including audit of insurers, intermediaries, insurance intermediaries and other organisations connected with the insurance business. IRDA also regulates overall functioning of the insurance companies in private

and public sectors including investments through regulations issued by the Authority.

2.2.2 IRDA, an autonomous and statutory body, has been entrusted with duties, powers and functions as specified under Section 14 of IRDA Act, 1999. (Annexure-I).

2.3 INSURANCE COMPANIES

2.3.1 There are five public sectors insurance companies in the country today offering health insurance schemes. These companies come under two categories, i.e. Life and General Insurance. Health Insurance primarily comes under general insurance. In the life segment, Life Insurance Corporation of India (LIC) is the only public sector company. In the general insurance segment, four public companies namely National Insurance Co. Ltd., Oriental Insurance Co. Ltd., United India Insurance Co. Ltd. and New India Assurance Co. Ltd. operate.

2.3.2 Life Insurance industry was nationalized in 1956 and LIC was set up subsequently. The Committee are informed that though the core business of LIC was life insurance, it started offering health insurance as riders to its policies beginning from 1993.

2.3.3 General insurance industry in India was nationalized in 1972. Consequently, General Insurance Corporation of India was established in 1973 with the merger of more than a hundred private companies to constitute four subsidiaries of GIC, namely (i) National Insurance Co. Ltd., (ii) Oriental Insurance Co. Ltd., (iii) United India Insurance Co. Ltd. and (iv) New India Assurance Co. Ltd. GIC introduced Mediclaim Insurance Scheme in 1986 for the first time, and

since then, the four subsidiaries have been offering health insurance schemes on a voluntary basis besides other general insurance products. With the Insurance Amendment Act, 2001, GIC became a re-insurer and its four subsidiaries formed the General Insurance Public Sector Association (GIPSA) for coordination among them. These four companies, the Committee note, today have 82% of the total health insurance market amongst themselves.

2.3.4 Apart from the four Public Sector Companies, the following private sector General Insurance Companies also offer Health Insurance products in the country today.

1. Tata AIG General Insurance Co. Ltd.
2. ICICI Lombard General Insurance Co. Ltd.
3. Cholamandalam General Insurance Co. Ltd.
4. Royal Sundaram Alliance Insurance. Co. Ltd.
5. Iffco Tokyo General Insurance Co. Ltd.
6. Reliance General Insurance Co. Ltd.
7. Bajaj Allianz General Insurance Co. Ltd.
8. HDFC Chubb General Insurance Co. Ltd.

2.4 **NGOs and Self-help Groups**

2.4.1 Non-Governmental organizations and Self-help Groups or other Community-based organizations compliment formal health insurance schemes offered by the insurance companies by way of various community-based health insurance schemes.

2.4.2 These non-governmental organizations are facilitating the spread of health insurance to the rural and unprivileged segments either through arrangements with insurance companies or through effective community mobilization and aided projects.

2.4.3 The Committee have been informed that 64 such organizations (excluding two insurance companies and one TPA which was also included in the list) are either active or would like to be involved in spreading health insurance. Prominent among them include Self Employed Women's Association (SEWA) of Gujarat, DHAN Foundation and ACCORD of Tamil Nadu and Yeshaswini Trust of Karnataka among others.

2.5 THIRD PARTY ADMINISTRATORS (TPAs)

2.5.1 The Committee are informed that the institution of Third Party Administrators (TPAs) which facilitate a system of cash-less settlement of medical bills for the insured under health insurance has been introduced in India as recently as 2001. TPAs basically are professional organizations servicing health insurance policies sold by insurance companies by way of facilitating cash less treatment to insured individuals through institutional arrangements with insurance companies and networked service providers i.e. hospitals and nursing homes, etc. The TPAs are registered with and licensed by the IRDA and regulated by IRDA regulations, 2001 as amended from time to time.

2.5.2 Asked to furnish a detailed note on TPAs, the IRDA in a written note stated the following: -

> "Third Party Administration in Health Insurance was introduced in India in 2001 with the notification of IRDA (Third Party Administrators – Health Services) Regulations, 2001. The first set of companies was given licences in March, 2002. Today, there are 25 licensed Third Party Administrators (TPAs). The basic functions of TPAs are to provide cash-less facility to the insurers and process claims on behalf of the insurers. Covered medical expenses are paid by the TPAs directly to the hospital. The TPAs also serve as extended arms of the insurers and give professional advice to the insured, whenever required and / or asked. A Third Party Administrator acts a link between the insurer and the hospital.

By processing claims with due diligence, TPAs are expected to control claims costs for the insurers. In the long run, TPAs are expected to bring in greater professionalism in the health insurance industry, which would augur well for the growth of this segment of insurance business.

TPAs are licensed by the Insurance Regulatory and Development Authority. The criteria for licensing are :-

Only a company with a share capital and registered under the Companies Act, 1956 can function as a TPA.

The primary object of the company shall be to carry on business in India as a TPA in the health services and on being licensed by IRDA, the Company shall not engage itself in any other business.

The minimum paid up capital shall be Rupees One Crore in equity shares.

The company should have at least one Director who is a Doctor.

The aggregate holdings of equity shares by a foreign company shall not at any time exceed twenty-six per cent of the paid up equity capital of a Third Party Administrator.

The IRDA calls for Annual Reports from the TPAs and these are scrutinized to ascertain the adequacy of capital and the financial strength of the company. TPAs have to maintain a minimum of Rupees One Crore working capital at all times."

CHAPTER – III

PUBLIC SECTOR INSURANCE COMPANIES
AN EVALUATION OF HEALTH INSURANCE SCHEMES

3.1. Backdrop

3.1.1 The Committee examined the existing health insurance schemes run by PSU insurers.

3.1.2 Briefing the Committee on the broad contours of commercial health insurance in the country and the achievements so far as the public sector insurance companies were concerned, the Ministry of Finance, during evidence before the Committee stated: -

> "The Public Sector Insurance Companies have so far launched `Mediclaim' policy for general public; Overseas Mediclaim Insurance for those who are going abroad; Bhavishya Arogya insurance scheme, which was launched some time back; the Jan Arogya Policy for the poorer sections; and the latest policy launched is the Universal Health Insurance for the families living Below the Poverty Line (BPL).
>
> 'Overseas Mediclaim' and 'Bhavishya Arogya' schemes are also there. The 'Bhavishya Arogya' scheme was started in 1989. It is not a very popular scheme."

3.1.3 All the health insurance schemes offered by the four public sector general insurance companies in India come under the voluntary form of health insurance. These can further be categorized into two groups namely, government floated health insurance schemes and health insurance schemes offered by the insurance companies.

3.2 Government Schemes

a) Universal Health Insurance Scheme (UHIS)

3.2.1 One of the health schemes introduced by the Government is the Universal Health Insurance Scheme. While the Government announced the scheme, its launch was entrusted to the four public general insurers. Details of the scheme as per note furnished by Ministry of Finance are given in Annexure II.

3.2.2 The Universal Health Insurance Scheme has undergone a reformulation to make it an exclusive scheme for BPL segments of the population with enhanced subsidy from the Government in 2004. Explaining the broad features of this scheme, Ministry of Finance, during briefing before the Committee stated as under ;--

> "The Universal Health Insurance Scheme was launched on 14 July 2003. It is meant for individuals, a family of five and a family of seven. The premium for individuals was Rs.365; for a family of five it was Rs.548; and for a family of seven -- including the parents -- the premium was Rs.730. Initially, a subsidy of Rs.100 was given to each family belonging to the BPL group. This scheme, which was in operation for one year, that is, till 31 March 2004, was modified a little. In the modified form, the subsidy is Rs.200 to an individual; Rs.300 to a family of five; and Rs.400 to a family of seven. Therefore, an individual has to pay only Rs.165 from his pocket; a family of five has to pay Rs.248; and a family of seven has to pay Rs.330.
>
> The hospitalisation coverage in it is up to Rs. 30,000 for all members put together. It is given on a floater basis, that is, Rs. 30,000 is admissible to a family of seven; family of five or an individual as the case may be. It has a death cover due to accident for a sum of Rs. 25,000, and it has another component of reimbursement of wage-loss at the rate of Rs.50 up to 15 days. It is a flexible scheme, and add-ons could be built-in over and above all that the scheme prescribes."

3.2.3 A comparative chart showing the performance of the four public sector general insurance companies under this scheme is given below:

Chart I

Business performance of the four public sector insurance companies under Universal Health Insurance Scheme:

Year	Company	Target	Premium In Rs.Crore	Claim Incurred	Claim Ratio in %
2004-05	**NICL**		0.77	0.36	60.53
	OICL		3.31	1.16	35.14
	UIICL		5.64	5.34	95.00
	NIACL	1	0.22	0.03	13.63
TOTAL			**9.94**	**6.89**	**69.32**
2003-04	**NICL**		1.34	0.05	12.54
	OICL				
	UIICL		7.48	1.35	18.00
	NIACL	4	3.65	0.04	1.01
TOTAL			**12.47**	**1.44**	**11.55**

3.2.4 From the chart above, it is noted that the premium collected by the four companies in 2004-05 decreased to Rs.9.94 from Rs.12.47 crore in 2003-04. The performance of individual companies also deteriorated over the past year, i.e. New India Assurance Company Limited collected Rs.3.65 crore in 2003-04 and only Rs.0.22 crore in 2004-05. United India Insurance Company Limited, which collected Rs.7.48 crore in 2003-04 could manage only Rs.5.64 crore in 2004-05. However, Oriental Insurance Company Limited, which had nothing to show in 2003-04, reported a collection of Rs.3.31 crore in 2004-05.

3.2.5 While briefing the Committee on the achievements under the Universal Health Insurance Scheme, a representative of Ministry of Finance, stated: -

> "I would like to share some data about this scheme with the hon. Committee. Nearly 65,718 families were covered all over the country up to 31 March 2005. As this scheme caters to individuals, family of five, and family of seven, therefore, the number of persons covered under this scheme was 1,82,641. Last year, the average was coming to three per family, and this year also it is roughly three per family. The total premium collected by the insurance companies is Rs.2.8 crore, and claims paid up

> to 31 March 2005 are Rs.40.02 lakh. In fact, those who had bought the insurance cover say in the month of February would have the cover till next February. Therefore, the claims would keep coming. This scheme is still in operation. This Scheme was started only in the month of July 2004 after modification. Therefore, this scheme has not even been in operation for one full year.

3.2.6 The Committee note that the figures furnished by the four public insurers on the amount of premium collected and claims disbursed are in great variance with the figures quoted by the representative of the Finance Ministry.

3.2.7 Asked to explain the reason for making Universal Health Insurance Scheme exclusive to BPL segments, representatives of Ministry of Finance during evidence stated as under : -

> "Actually, the consideration really was that the scheme was not really taking off. Even earlier the subsidy was only for BPL families. What was found was that the coverage of non-BPL families was much larger than the coverage of BPL families and since the Government wanted to focus on the poorer sections, this change was made."

3.2.8 In view of the non-BPL segments' good response to the UHIS, the Committee wanted to know as to why the scheme was not made available to the poor above the BPL even as subsidy was made exclusive to the BPL segments at the enhanced rate. In reply, representative of Ministry Finance further stated: -

> "…….if it had been allowed to continue and the focus shifted as far as the subsidy is concerned and enhanced subsidy was paid only for BPL families, may be the BPL coverage also would have increased along with the coverage of non-BPL families. That point can definitely be argued."

3.2.9 Emphasizing the need for extending Universal Health Insurance Scheme to non-BPL families also, Secretary Ministry of Health and Family Welfare during evidence stated as under:-

> "…….The Universal Insurance Scheme raised hopes but now it is restricted to BPL category. The BPL category is a very narrow category. I

think the lower middle class and the near-BPL band poor are equally distressed and we have to find some mechanism. Then, the question of certifying that near-BPL is itself a gigantic task. In some urban areas, the BPL categorisation is also not complete, so, further difficulties come up. We would urge the Universal Insurance Scheme to be opened up for any citizen who wants to come forward. The subsidy could be restricted to BPL category but the insurance product should be available for a common man. We feel that, the universal insurance scheme is being propagated in different States through different departments. We would urge that in every State the Health Department should be given the task to propagate the Universal Insurance Scheme. It is because the Health Department is the biggest stakeholder in the Rural Health Insurance Scheme and the Universal Health Insurance Scheme is such a product. We also realise that we have a role to supplement the effort of the Regulatory Authority and the Department of Insurance in shape of accreditation process, costing and such other complex activities which will help in more transparent and market driven yet equitable insurance products. We will be in touch with them and under their guidance we will assist them. These are all the new activities and we should be prepared for it."

b) Swasthya Bima Policy

3.2.10 Swasthya Bima Policy was introduced in the year 2005. The scheme is meant for the poor and has been introduced for members of Self-help Groups (SHGs) and other Credit Linked Groups (CLGs). The scheme was launched only in 2005 and policy subscriptions for the same under all the four companies still remain a no-show. The premium is low but no subsidy is provided under the scheme. The general features of Swasthya Bima Policy are given in Annexure-III.

3.3 Schemes by Public Insurance Companies

a) Mediclaim Insurance Policy

3.3.1 The most popular and widely sold health scheme on offer from the four public sector general insurance companies is the Mediclaim insurance policy. The detailed features of the policy are given in Annexure – IV.

3.3.2 Briefing the Committee on the broad features of the scheme, a representative of Ministry of Finance during evidence stated as follows : -

> "The 'Mediclaim' Insurance Policy -- as was pointed out by the hon. Chairman, IRDA -- was introduced in 1986 at the instance of the Government. It provides reimbursement of medical expenses for hospitalisation and domiciliary hospitalisation, but it does not cover OPD treatment. The sum that is assured under this policy varies from Rs.15, 000 to Rs.5 lakh. It is available to the people from the age of 5 years to the age of 80 years. The children between the age of 3 months and 5 years can also be covered with some additional premium. I would also like to point out that the minimum premium is Rs. 213 per annum for the lowest sum assured, that is, Rs. 15,000 for people below 35 years of age. The highest premium is Rs. 17,156 per annum for people in the age group between 76 years and 80 years for the maximum sum assured, that is, up to Rs. 5 lakh. There is a family discount of 10 per cent, and some cumulative bonus if the previous year had been claim-free."

3.3.3 A comparative chart showing the performance of each company under Mediclaim, compiled on the basis of their written replies is given below.

CHART – II

Past three years business performance of the four public sector insurance companies - Mediclaim (Individual & Group)

Year	Company	Target Rs. Crore	Premium In Rs. Crore	Claim Incurred	Claim Ratio in %
2004-05	NICL		364.38	434.29	134.90
	OICL		249.62	294.05	117.80
	UIICL		252.08	313.59	124.40
	NIACL	440	455.39	527.59	115.85
TOTAL			**1321.17**	**1569.52**	**118.80**
2003-04	NICL		298.03	304.71	102.24
	OICL		229.53	224.07	97.62
	UIICL		234.22	251.36	107.31
	NIACL	395	366.42	307.17	83.83
TOTAL			**1128.20**	**1087.31**	**96.37**
2002-03	NICL		221.26	260.51	117.74
	OICL		204.08	157.54	77.19
	UIICL		211.07	219.63	104.05
	NIACL	350	354.41	270.12	76.21
TOTAL			**990.82**	**907.80**	**91.62**

3.3.4 From the foregoing facts, it is clear that about 85% of the health insurance business of the PSU insurance companies comes from Mediclaim alone, and with a claim ratio above 90% in 2003-04 and above 100% in 2004-05, the portfolio is loss-making for the public companies.

3.3.5 On the performance of the public insurers under the scheme, representative of Ministry of Finance, stated as under : -

> "This scheme has expanded considerably over a period of time. In 2003-2004, it had a coverage of 90 lakh persons. The insurance company had collected roughly Rs.1, 100 crore by way of premium, and had an incurred claim ratio of 94 per cent. I would like to point out that any incurred claim ratio beyond 70 per cent is a loss to the insurance company because they have to set aside some amount for their management expenses, and some amount for their agents in the form of commissions. Under the 'Mediclaim' scheme, the claim ratio is going up to 94 per cent. It means that companies are losing roughly between 20 per cent and 24 per cent."

b) Bhavishya Arogya

3.3.6 Bhavishya Arogya is an other health policy marketed by all the four public sector general insurance companies. Introduced in the year 1990, the scheme is basically meant to take care of the healthcare needs of an insured person after retirement. The detailed features of the scheme are given in Annexure-V.

3.3.7 The performances under the scheme for the past three years, of the four national general insurers based on their written replies is given below in a comparative chart.

CHART – III

Past three years business performance of the four public sector insurance companies under the scheme Bhavishya Arogya Policy

Year	Company	Target Rs. Crore	Premium In Rs. Crore	Claim Incurred	Claim Ratio in %
2004-05	NICL				
	OICL		0.12	0.01	14
	UIICL				
	NIACL				
TOTAL			**0.12**	**0.01**	**14**
2003-04	NICL				
	OICL		0.08		
	UIICL		0.021	0.018	87
	NIACL				
TOTAL			**0.101**	**0.018**	**87**
2002-03	NICL				
	OICL		0.181	0.02	
	UIICL		0.011	0.013	116
	NIACL				
TOTAL			**0.191**	**0.033**	**116**

3.3.8 The chart above clearly shows that the performance of the public insurance companies under the scheme is a disappointing one. NIC and NIAC have nothing to show, while the OIC and UIIC together collected only about Rs.19 lakhs in 2002-03 and a decreased amount of Rs.10 lakhs in 2003-04.

c) Jan Arogya Bima Policy

3.3.9 Jan Arogya Bima Policy designed to meet the needs of poorer sections of the society, was introduced in 1998. The details of the scheme are given in Annexure-VI

3.3.10 Based on the written replies of the companies concerned, a comparative chart showing the performance of each of the four public sector general insurance companies under the scheme is given below.

CHART – IV
Past three years business performance of the four public sector insurance companies under Jan Arogya Bima Policy

YEAR	COMPANY	TARGET Rs. Crore	PREMIUM IN Rs. Crore	CLAIM INCURRED	CLAIM RATIO
2004-05	NICL		1.66	1.54	88.20
	OICL		0.98	0.70	70.70
	UIICL		0.54	0.86	159.00
	NIACL	1.00	0.75	1.03	137.33
TOTAL			**3.93**	**4.13**	**105.08**
2003-04	NICL		0.23	0.33	102.03
	OICL		0.57	0.17	29.40
	UIICL		0.55	0.87	158.00
	NIACL	0.75	0.52	0.68	131.40
TOTAL			**1.87**	**2.05**	**58.74**
2002-03	NICL		1.94	1.82	96.39
	OICL		0.69	0.24	35.38
	UIICL		0.38	0.83	218.71
	NIACL	0.50	0.48	0.91	190.24
TOTAL			**3.49**	**3.82**	**109.45**

3.3.11 It is clear from the above chart that Jan Arogya, like most other health schemes under the public sector general insurance companies is also a loss-making scheme. The Committee note that there is substantial variance between the claim ratio quoted by the Ministry and those furnished by the undertakings.

3.3.12 Briefing the Committee on the general features of the scheme and the performance of the public general insurers under this scheme, representatives of Ministry of Finance stated as under:-

> The 'Jan Arogya' scheme was started in 1996, and it is meant for the poor people. It is again a hospitalisation expense coverage scheme. It is available to the people from the age of 5 years to 80 years. The sum assured is Rs.5,000 per annum per person, and the premium is between Rs.70 and Rs.140 per person depending upon the age. An additional premium is charged for children. In the year 2003-2004, nearly 4.68 lakh persons were covered under this scheme. The premium that the insurance companies had got was only Rs.1.85 crore, and the claims settled were Rs.3.81 crore. Nearly 206 per cent was the incurred claim ratio. It means that they gave almost double of what they got from the people as premium.

d) Overseas Mediclaim Policy

3.3.13 Overseas Mediclaim Policy is the health insurance product available for three categories of travelers to foreign countries such as Business & Holiday travelers, Employment and Study travelers and Corporate Frequent travelers. The period of cover is as per the actual period of stay abroad and the premium is based on considerations like age of the insured, period of stay abroad and type of plan chosen. National Insurance and New India Assurance Company Limited are the two public insurance companies offering scheme. A comparative business performance of the two companies under this scheme is given below.

Past three years business performance of National Insurance Co. Ltd. and New India Assurance Co. Ltd. under Overseas Mediclaim Policy

Year	Company	Target Rs. Crore	Premium In Rs. Crore	Claim Incurred	Claim Ratio in %
2004-05	NICL		15.68	7.32	46.68
	NIACL	30.00	24.30	22.37	92.06
TOTAL			**39.98**	**29.69**	**74.26**
2003-04	NICL		15.93	8.97	56.25
	NIACL	35.00	27.25	20.51	75.26
TOTAL			**43.18**	**29.48**	**68.27**
2002-03	NICL		16.07	5.53	34.41
	NIACL	30.00	33.66	24.75	73.52
TOTAL			**49.73**	**30.28**	**60.88**

e) Company Specific Schemes

3.3.14 Besides these, there are several other schemes of health insurance being offered by individual public insurance companies. These include Sampoorna Arogya Bima Policy and Critical Illness Insurance Policy by National Insurance Co. Ltd. (Annexure-VII), Health Plus Medical Expenses Policy, Cancer Insurance and Tertiary Care Insurance by New India Assurance Co. Ltd. (Annexure-VIII), Good Health Policy and Pravasi Bhartiya Bima Policy by Oriental Insurance Co. Ltd.(Annexure-IX), and Uni-medicare Policy, Mediguard Policy and Trauma Care by United India Insurance Co. Ltd.(Annexure-X).

3.3.15 In addition to the above schemes offered by the public sector general insurance companies, Life Insurance Corporation of India offers Jeevan Bharati Plan, Critical Illness Rider and Accidental Disability Benefit. While Jeevan Bharati Plan is specifically made for women covering illnesses specific to women, the other two come as riders to life insurance policies of the corporation. Dwelling on this aspect, the Chairman, IRDA, during evidence stated: -

> "In addition to the general insurance companies which have been traditionally in this line of business, the life insurance companies have also started an innovative practice of giving a critical illness rider on an existing

life insurance policy. Life insurance companies basically sell life insurance cover, but they also said that they would also like to sell a cover, which has got critical illness, and this cover will be triggered the moment a policyholder is afflicted by critical illness. It has nothing to do with hospitalisation and if it is established that this person had contacted a critical illness, then he would automatically be reimbursed by the life insurance companies. This has been started by the private life insurance companies and the LIC has also taken it in a big way. Now, we have two streams, which are operating. One is on the life insurance side where a critical illness rider is also available in addition to a normal life cover and there are also the general insurance companies which are selling insurance policies for the purpose of providing reimbursement for hospitalisation."

3.4 OVERALL PERFORMANCE

3.4.1 The Committee note that the health insurance portfolio has shown considerable growth both in terms of premiums and numbers of policies during the last two years under the public sector insurers. However, there has been greater growth in the private sector. The following table shows the percentage growth in gross premium collected by insurance companies during the years 2003-04 and 2004-05 under various segments of business including health.

Table 1: Percentage growth in gross premium in insurance companies in 2003-05.

Insurer	2003-04						2004-05					
	Fire	**Marine**	**Engg.**	**Motor**	**Health**	**Total**	**Fire**	Marine	**Engg.**	**Motor**	**Health**	**Total**
Public Sector	-3.33	-13.32	-4.44	13.46	**28.89**	6.56	-1.46	2.85	4.31	9.30	**17.79**	5.43
New India	-10.97	-21.90	18.79	8.06	**54.92**	3.17	2.54	-2.31	-3.71	8.23	**27.33**	4.38
National	-1.63	-13.14	-19.62	29.73	**42.36**	18.27	3.05	34.93	4.68	19.02	**26.28**	11.94
United India	4.67	-11.32	-6.46	3.87	**10.85**	3.33	-6.69	-18.57	10.42	-7.79	**5.24**	-3.77
Oriental	-1.62	-4.01	-7.03	12.28	**7.87**	1.02	-5.61	10.00	5.87	14.80	**6.85**	7.31
Private Sector	63.58	120.85	43.51	86.67	**130.32**	67.40	28.70	48.56	60.48	70.39	**114.21**	57.35
Total	6.57	-3.92	3.94	18.66	**35.13**	12.30	5.39	10.22	17.85	16.13	**27.91**	12.73

Source : Gupta & Trivedi, IRDA Journal, Aug,'05 issue.

The figures in Table 1 above indicate that while the public sector companies in 2003-04 achieved a 28.89% growth in their gross premium collection, the private companies achieved a whopping 130.32% growth. In 2004-05, the performance of the public sector companies further declined with a 17.79% growth in gross premium under health segment while that of the private sector remained above the cent percent growth rate at 114.27%. Interesting to

note though, is that the health insurance segment has shown the most growth for both sectors.

3.4.2 The Committee are informed that the health portfolio in the non-life insurance business has emerged as the third most important segment after motor and fire insurance in 2005. The following table shows the growing proportion of health segment in the general insurance business.

Table 2 : Proportion of major business segments in non-life insurance sector.

	Segment	**2002-03**	**2003-04**	**2004-05**
Public Sector	Motor	39.0	41.5	43.1
	Fire	19.6	17.8	16.6
	Health	**7.3**	**8.8**	**9.8**
	Marine (Cargo+Hull)	8.7	7.0	6.9
	Engg.	4.3	3.9	3.9
Private Sector	Motor	28.7	32.0	34.6
	Fire	32.7	32.0	26.1
	Health	**4.6**	**6.3**	**8.6**
	Marine (Cargo+Hull)	6.3	8.3	7.8
	Engg.	8.8	7.6	7.7
Combined	Motor	38.0	40.2	41.4
	Fire	20.9	19.8	18.5
	Health	**7.0**	**8.4**	**9.6**
	Marine (Cargo+Hull)	8.4	7.2	7.1
	Engg.	4.8	4.4	4.6

The figures in Table 2 above also indicate that while the health segment got a momentum jump from 4.6 to 8.6 percent under the private sector, the public sector experienced lesser growth momentum where the health portfolio grew from 7.3 percent to about 10 per cent in the 2002-05 period.

3.4.3 The Committee, while taking note of the vibrancy that health insurance business has experienced in the recent years, also note that in comparison to the private sector, the public sector companies have achieved relatively slower

growth rate. The following table provides details of the growth of the Health Insurance business in both the public and private sector.

Table 3 : Growth of health insurance across various insurers during 2003-04.

Insurer	Health premium (in Rs. Crore) 2004-05	Health premium as a %age of total non-life business 2004-05	Growth of health premium (2003/04-2004/05) (%)	Growth of total premium (2003/04-2004/05) (%)
ICICI Lombard	118.78	13.4	257.0	74.7
Bajaj Allianz	70.39	8.3	242.2	79.0
Royal Sundaram	30.02	9.1	88.8	28.5
IFFCO Tokio	28.37	5.6	73.3	56.0
Tata AIG	26.64	5.7	35.3	32.7
Cholamandalam	20.12	11.8		75.3
Reliance	7.98	4.9	2.4	0.3
HDFC Chubb	1.97	1.1		59.2
Private Sector	**304.27**	**8.6**	**148.0**	**55.3**
New India	504.28	11.9	43.9	4.5
National	364.29	9.5	26.3	11.9
United India	294.19	10.0	5.2	-3.8
Oriental	265.14	8.7	13.9	5.9
Public Sector	**1427.9**	**9.8**	**24.0**	**5.2**
Total	1732.17	9.6	36.0	12.3

From the table above, it is clear that the bulk of health insurance business is with the public sector. However, it is also clear that as far as percentage growth of health premium is concerned, the public sector's 24% compares unfavorably to the private sector's 148.0%.

3.4.4 Asked by the Committee as to why the growth percentage of Health Insurance under the Public Sector Insurance Companies lagged behind the exponential growth experienced by the private sector Insurance Companies, Oriental Insurance Company Limited in their post evidence reply stated:

> "The growth of business appears to be more with the Private Sector Companies because of their small premium base. The Private Sector Companies at the moment are grabbing the business from corporate houses by indulging in unhealthy practices. Moreover since only about 1% of the population is currently taking insurance policies we are concentrating on personal lines of insurance where there is huge potential."

3.4.5 In reply to the same question, New India Assurance Company wrote:-

> "The growth in terms of quantum of Health insurance business was 215 Crores by Four public sector companies as compared to Rs. 162 Crores by 8 Private Companies. However, in terms of percentage the growth was lower in public sector companies because of cautious approach in accepting business in view of rising claims ratio."

3.4.6 Assessing the spread of insurance cover by the four public insurers against the infrastructure at their disposal, CMD, UIICL, during his evidence before the Committee stated as under : -

> "So far as the spread of insurance is concerned, I would like to tell that our company is marketing, claim servicing through about 1100 offices functioning as one company. If all the four companies are taken together, it must be 4000 in number. Even with that large infrastructure, our company has been able to insure only about 12 lakh people. If all companies are taken together, it may be around 50 lakh or so, So, this is very small as compared to the infrastructure itself."

3.4.7 Highlighting the efforts made towards rural penetration in selling health policies, Shri M.K. Garg, CMD, United India Insurance Co. Ltd. further stated as under : -

> "Regarding expansion in rural areas and un-represented areas where we do not have our direct branches, we have now engaged the new system of corporate agents and micro offices. Now, banks, post offices and other institutions are having their presence in villages and we want to take advantage of that. So we have tied up with them to provide this type of insurance. Rural insurance as well as personal line of insurance is our area of thrust."

3.4.8 The spread of Health Insurance and the performance of individual Insurance Companies can be best assessed through the total number of persons covered under the various health insurance schemes. Based on the written replies of the four Public Sector General Insurance Companies, a table showing

the total number of persons covered under the various health policies of each of these companies for the past three years is given below.

Table showing number of persons covered under each of the various health insurance schemes offered by the four public sector general insurance companies.

YEAR	Name of policy	NICL	OICL	UIICL	NIACL	GRAND TOTAL
2002-2003	Individual Mediclaim			423000	2203776	
	Group Mediclaim			349000	882987	
	Overseas Mediclaim				88117	
	Mediclaim	2025610	2148247			
	Jan Arogya	207701	68704	70000	55791	
	Bhavishya Arogya			878		
	Universal Health Insurance Scheme			0	-	
Total		**2233311**	**2216951**	**842878**	**3230671**	**85,23,811**
2003-2004	Individual Mediclaim			602000	2317090	
	Group Mediclaim			589000	539585	
	Overseas Mediclaim				57076	
	Mediclaim	3122536	2223436			
	Jan Arogya	260230	58398	73000	75966	
	Bhavishya Arogya			955		
	Universal Health Insurance Scheme	78140	298796	561264	236490	
Total		**3460905**	**2580630**	**1826219**	**3226207**	**1,10,93,961**
2004-2005	Individual Mediclaim			626000	2705322	
	Group Mediclaim			593000	994460	
	Overseas Mediclaim				55890	
	Mediclaim	7560666	2864532			
	Jan Arogya	171603	101556	70000	67391	
	Bhavishya Arogya			1108		
	Universal Health Insurance Scheme	27709	107858	280644	15641	
Total		**7759978**	**3073946**	**1570752**	**3838704**	**1,63,43,390**

From the above table, the number of persons who availed health insurance had notably increased from 85, 23, 811 in 2002-2003 to 1, 63, 43, 390 in 2004-2005. However, 1.6 crore insured persons in a population of a billion plus people is still a very small number. Considering the fact that PSU Insurers

account for 82 percent of the total Health Insurance business in the country today, and that a large chunk of the health insured are from Corporate Groups and urban areas, much remains to be desired as far as the spread health insurance is concerned, especially so in rural areas.

CHAPTER IV

CHALLENGES / BOTTLENECKS

The Challenges and difficulties before the insurance companies in spreading health insurance in the country range from a basic lack of focus to technical and infrastructure shortcomings and to certain regulatory deficiencies. Some of the important challenges brought to the notice of the Committee are dealt in detail as follows.

4.1 LACK OF FOCUS

4.1.1 The Committee were informed that health insurance started at the instance of the Government. Briefing the Committee on the subject, Chairman, IRDA stated:

> "Basically we have today a cover which has been started sometimes in 1986 by the public sector insurance companies at the initiative of the Government of India. The Government of India wanted the health insurance to be spread in a big way and they directed the general insurance companies to go ahead and sell health covers. This health cover is for the purpose of providing reimbursement for the hospitalization of the insured. So, it started only like that and it continues to be like that."

4.1.2 The Committee note that health insurance is managed as a part of the miscellaneous portfolio by public general insurance companies. Asked to comment on the lack of focus on health insurance, Chairman, IRDA stated during evidence:

> "…….As has been pointed out by the hon. Chairman, the general insurance companies have been concentrating mostly on fire, engineering, and marine. The others are miscellaneous portfolios. The miscellaneous portfolios include health also in addition to shopkeeper's liabilities, shopkeeper's insurance, and small fire insurance for households, etc. The general approach of the general insurance companies has always been to look at these big portfolios because they are the ones that are going to

> give them the volumes as far as the premium is concerned. So, they are concentrating not on individuals but on corporate entities for purpose of obtaining business. As a result, the health insurance has not taken off for a long time. For the first time, at the instance of the Government of India, the general insurance companies started the health portfolio in the Eighties as a Mediclaim Policy. The same Mediclaim Policy is continuing in some form or the other, so far, with some minor modifications."

4.1.3 Asked whether there are separate officers looking after health insurance or whether it is the general staff looking after it, CMD, United India Insurance Company Limited stated:

> "It is general staff."

4.1.4 The Committee noted that the lack of focus on health insurance was due to the tariff pricing of some general insurance segments and the absence of stand-alone health insurance companies.

a) Tariff Regime

4.1.5 The Committee were also informed that tariff pricing of insurance for property, fire, motor, Engineering, etc., which make these portfolios profitable result in insurance companies focusing primarily on these segments to the neglect of the less profitable, non-tariff portfolio of health insurance. Further, health insurance ends up being treated as an accommodation business to grab the profitable portfolios.

4.1.6 The Committee also noted that IRDA was taking initiative to replace the tariff regime in general insurance. Asked to enlighten the Committee on the need and benefits of de-tarriffing and its implications for the health insurance business, Chairman, IRDA during evidence before Committee stated as under:-

"We have in the general insurance both tariff and non-tariff. Health insurance comes under non-tariff where the rates, as also the conditions, are prescribed by the insurance companies whereas in the case of fire, engineering and motor, the tariff is fixed by the Tariff Advisory Committee which was created under the Insurance Act. That tariff has to be charged by all the general insurance companies. So, when the private insurance companies came into existence, their anxiety was to get a major portion of this profitable portfolio of fire, engineering and others. They started concentrating on that particular element. When they started getting this element of portfolio, there were also requests from various entities saying now that you are getting a profitable portfolio from us, what is it that is being given in return for the employees of these organizations? They started giving health as a group policy more by way of an accommodation for purpose of getting a profitable portfolio. This is what has been expressed by the public sector companies; that the private sector insurance companies are trying to obtain the fire policy or engineering policy by offering health at a very cheap rate to obtain the profitable portfolio. This is what has been happening all along. That is also the reason why the insurance companies have been saying that there should be de-tarrifing. This request for de-tarrifing has come not only from the general insurance companies of the Government of India but also from all the general insurance companies on the ground that in a free market, the rates will have to be fixed by the insurance companies keeping in view the risk profile of that particular company, and we should not have a straitjacket method of evaluating the risk for all companies at the same rate. The point that is made is that if a company is taking certain precautions for preventing a fire from happening, then we should charge a lower premium than that of a factory, which is not taking all those precautions. That is not permitted in the existing tariff regime. It also leads to certain misuses like the one, which has been mentioned, of trying to provide an accommodation portfolio for the sake of getting a profitable one. Keeping these factors in view, the insurance regulatory authority after consulting all the stakeholders has indicated a road map for de-tariffing. What de-tariffing involves is that the insurance companies should develop individual skills within their organization for assessing the risk and for providing a rate for that particular risk. Today, the rate is determined by the Tariff Advisory Committee. So, any Branch Manager can write a policy by looking at the book that is available to him which has been published by the Tariff Advisory Committee. If that book is removed, then they will have to substitute that book by their judgment with regard to the risk profile of that particular company and determine at what rate they will be able to underwrite a risk. What the IRDA has said is that we can think of a de-tariffing by 31 December 2006 and within this one-year period, the insurance companies should set up within their own organizations a small group which is going to develop this expertise with regard to assessing the risk profile of these companies. We have also said that this unit, which is

going to look at the rate part of it, should not be under the control of the Manager who is in charge of the business development because the business development man is going to look at the volumes and not at the risk profile, and it should be independent and answerable to a separate entity which is going to directly report to the Managing Director. This is a major exercise. Whenever we move from tariff to non-tariff, what is likely to happen is that the rates are likely to come down in respect of the profitable portfolios. In respect of other portfolios where the rates are lower today, they are likely to go up. The classic case would be where fire, engineering rates are likely to come down. Their rates are likely to go up in the case of third party motor liability.

Therefore, once de-tariffing takes place, what is likely to happen is that we are going to have a correct assessment with regard to the amount of money that should be charged for various risks including health risks. Then, this accommodation for getting a profitable portfolio is likely to disappear. Then each risk is going to be evaluated based upon the risk profile of the particular company and proper under-writing will take place. So, to that extent, what the public sector companies have submitted before the august Committee is absolutely right. The tariff and non-tariff distinction that we have today is leading to distortions with regard to the rating of the risk in respect of certain areas. So, when this de-tariffing takes place, perhaps some of these distortions will disappear."

b) Stand-alone Health Insurance Companies.

4.1.7 Emphasizing the need for a stand-alone health insurance company so as to have more focus on health insurance, Chairman, LIC, during evidence stated:-

"What we feel is that a separate stand-alone company for promoting the Health Insurance would certainly help in giving due focus and increasing the coverage, more particularly in the rural areas. But this stand-alone company, as I have submitted earlier, can be in a joint venture form where we may have a partner, a foreign partner, who has got the expertise, experience and data. They must have the technical expertise to help us to price the product properly and to have proper understanding of the whole business."

4.1.8 Asked to comment on the desirability of stand-alone health insurance companies to enhance the spread of health insurance in the country, the Ministry of Finance in a written note submitted: -

"Stand-alone Health Insurance Company may be able to approach the issue in a better manner since the organizational structure of such a

company can be tailor made to suit the requirements of micro-health insurance needs of the low income population. The structure of the health insurance companies with low capital needs, suitable regulations by IRDA, appropriate subsidy, support from the Government, State Governments, and various implementing agencies in creation of stand-alone Health Insurance Companies needs to be worked out to the satisfaction of all."

4.1.9 In reply to the same, the IRDA in their note to the Committee commented:-

"World over, 80% of health insurance is transacted by stand-alone health insurers and the rest by life insurers. It is only in India that health insurance products are being sold by the non-life insurers. Life insurers only offer health covers by way of riders to a few life products. In India, there is a dearth of expertise in the field of health insurance. The current insurers do not look beyond administering a few standard policies which were initiated a while ago and have not built any expertise in this area. In the existing scenario of a requirement of a minimum paid up capital of Rs. 100 Crores, no company has come forward as a stand-alone health insurer. Non-life and life companies have other segments as their core business and given the profile of Health Insurance in India – absence of critical mass, high claims outgo, inadequate pricing and lack of standards on the part of the service providers, unless there is a reduction in the minimum capital requirement and an increase in FDI, there might not be any takers. It is important to attract foreign companies to this segment, as they will bring in the expertise, which is lacking in our country.

On its part, the IRDA has taken several initiatives in Health Insurance. The National Working Group on Health Insurance was formed under the chairmanship of the Chairman, IRDA. Based on its recommendations, three sub-committees- for creation of a data repository for health insurance, looking into regulatory aspects for registration of stand-alone health insurers and bringing about innovations in Health Insurance Products respectively were formed. The reports of these committees are being finalized shortly for submission to the National Working Group on Health Insurance, which will then make recommendations to the Government. It is also crucial that health care providers are regulated to bring about standards in health care delivery.

With Government and legislative support, we should be able to provide an enabling environment for stand-alone health insurers and make health insurance as a financing model for health care viable."

4.1.10 The Committee noted that Ministry of Finance, IRDA and some of the public sector companies were in favour of setting up of a stand-alone health insurance company to deal with health insurance business.

4.1.11 Emphasizing that present regulations permit stand-alone health insurance companies and that the arrangement is successful in foreign countries, the Oriental Insurance Company in their written note stated as under : -

> "IRDA Regulations permit registration of a company to deal exclusively with health insurance. Internationally, there have been companies dealing only with health insurance portfolio and this has been successful. Traditionally, the four Public Sector Insurers have been offering all varieties of general insurance covers along with health insurance covers. Even as of now, the insurers have differential schemes to cater to the needs of various segments of the society and also to suit their premium paying capacity. Unlike in international practice, premium rates are same for men and women. The policies have adequate coverage for the young and the old, the rich and the poor. But stand-alone Health Insurance Company can have same focus to address the issue."

4.1.12 Commenting on the feasibility aspect of stand-alone health insurers, United India Insurance Company dwelt on the potential benefits while expressing their concerns on its possible impact on the cost of health insurance. The Company in their written note stated : -

> "Stand-alone Health insurance companies once permitted to operate would be concentrating only on Health insurance and they could find various ways and means with the various authorities both in Government and other major sectors (NGOs and Self-Help groups) to spread the health insurance scheme. This stand-alone Health insurance companies would definitely benefit the spread amongst the public. We are not sure whether the cost of health insurance would be at the present level."

4.1.13 Commenting on the issue, the National Insurance Company opined that such a company purely devoted to selling health covers would definitely give

more focus but expressed the need for regulatory adjustments. The Company in their note stated as under : -

> "Health insurance is turning out to be the fast growing segment in non-life insurance industry with an average growth of 40% per annum in last three years. There is a huge potential. However, the reason for non-proliferation of a pure health insurance company in India is due to regulatory issues. The fact remains that a major portion of health insurance is underwritten by government owned insurers. Government owned companies have been interested all these years in traditional business like Fire, Motor, Marine etc. Health on a stand-alone business has never been tested out to be profitable. Clearly the cross subsidy of non-health products is the one that is sustaining the interest of the insurer to even market the health insurance. Hence, the first regulatory change that should be attempted to usher in pure health insurance company is to formulate guidelines for stand-alone health insurance companies.
>
> A pure health insurance can definitely devote more resources for selling of health products, which is now nearly non-existent. The current practice of health being "bought" and not "sold" is a trend that definitely needs to be reversed immediately."

4.1.14 Sharing similar views, and suggesting a tie-up between the four public sector general insurers on the one hand and the proposed stand-alone health insurer on the other in view of the infrastructure limitations such a company will face, CMD, New India Assurance Company Ltd. during his evidence before the Committee stated as under: -

> "I am in agreement with Shri Shukla that we could examine the aspect of having a company for just health insurance. However, the modalities have to be worked out so that we are able to cover the length and breadth of the country.
>
> Basically, most of the time, we are looking at the health policies to be sold to the weaker sections. We have to decide about what channel of distribution is to be used, how do we go about it if we go for a single unit company patronizing only health insurance. We have to consider the aspect how to reach the nook and corner of the country. We, the four public sector insurance companies in the general insurance, have roughly 4000 officers. But the stand-alone company will take time to have so many offices. But we can have a tie up where we can sell the product."

4.1.15 Emphasizing the view that stand-alone health insurance companies would help the promotion of health insurance, especially in rural areas, CMD Oriental Insurance Company Ltd. stated before the Committee:-

> "World-over, health is being sold by individual companies which specialize in health insurance. I also support the view of my colleagues that the stand-alone health insurance company will definitely help in reaching the insurance policies to the rural areas, which is a major concern. The policy is being sold in the cities."

4.1.16 Asked to explain as to why the public insurance companies were favoring the idea of stand-alone health insurers, and whether that amounted to an abdication of responsibility on their part, CMD, United India Insurance Company Ltd. stated as under :-

> "When we said that stand-alone health insurance company will be opened and all that, we did not mean that we want to abdicate our responsibility. We will be there in this business because we see that there is a potential for us. It is not only a social responsibility. Apart from that, it is a good business proposition also. We only see growth in these areas now. We will expand the health insurance concept. When we were saying that stand-alone health insurance company can be there, it has to be in competition or we can open our own stand-alone health insurance company also so as to reap the benefit of specialization, professionalism and also inter-branch move-ability of the staff, which in the present system is very difficult to do. Then, we can move people from here to another area and all that. So, we will concentrate upon health insurance sector to further promote and to further bring professionalism, but certainly it is our priority area. That is why, we were raising objection even to LIC entering into health insurance and saying why LIC should enter when we are there. We are not abdicating our responsibility."

4.1.17 On the viability of a stand-alone health insurance company, United India Insurance Company in their written note stated as under:-

> "Under a tariff regime for Fire and other profitable business, the fortunes of stand-alone health insurance Company may not be that bright. However, if tariffs goes, then all classes of insurance will be priced rationally and may pave way for proper pricing in health insurance products also, which

may be good for viability of stand-alone health insurance company as well as existing insurance companies.

The other advantage of stand-alone insurance company will be its focused approach from marketing to servicing. Since they will be dependent only on this business, they have to innovate fast to make the product successful and profitable."

4.1.18 Asked to furnish the status report on the various sub-groups of IRDA's Internal Working Group on health insurance, the IRDA in their a written note informed the Committee as under:-

"The Committee was formed with the objective of identifying the existing problems in the health insurance industry and to make recommendations to enable and encourage a large number of companies to participate in the growth of insurance in health financing thereby increasing health penetration in the country and to create a conducive environment for these companies to operate on a long-term basis covering a larger number of beneficiaries with appropriate products and services.

The Committee finalized its report covering the areas of Minimum Capital Requirement, Risk Based Capital Model as an alternative, Foreign Direct Investment, Healthcare provider related reforms, Health Insurance regulations and related issues.

(1) The Committee recommended a Minimum Capital Requirement of Rs. 50 crores for a stand-alone health insurance company. The Committee felt that this would not only render stand-alone health insurance viable, it will also provide sufficient entry hurdle for non-serious players to enter into the sector. Of course, evaluation of financial soundness and market reputation of the promoters would be equally important factors for consideration of a licence.

(2) The Committee also recommended adoption of a Risk Based Capital Model for stand-alone Health Insurance companies.

(3) There was also a recommendation that stand-alone health insurers be allowed to write Personal Accident covers as combined and add-on covers. Similarly, the Committee felt that stand-alone health insurance companies should also be permitted to sell overseas travel policies, since these cover the eventuality of sickness and accident while on overseas travel.

(4) The Committee recommended that the level of foreign direct investment in stand-alone health insurance ventures be permitted

upto 51%. This, the Committee felt was required in order to develop the domestic health insurance market and to provide it depth by introduction of newer products, contemporary underwriting practices, claims management techniques etc.

(5) The Committee recommended continuation of the existing practice of health insurance being written both by life and non life insurance companies. In addition to the current practice, it has suggested legislative changes to allow licensing of stand-alone health insurance companies.

(6) The Committee also recommended that agents of both life and general insurance companies should be allowed to take agency of stand-alone Health Insurance Companies.

The Working Group has also decided to set up a separate 'Rural Health' subgroup. The purpose of the subgroup is to increase the understanding of the barriers to providing health insurance to the rural poor and create a roadmap for overcoming the barriers and promoting and expanding private health insurance in the rural areas with public efforts."

4.2 LACK OF CO-ORDINATION

4.2.1 From the note furnished by Ministry of Health and Family Welfare . Committee note that the subject of Health Insurance is handled by many Ministries / Departments/ Public Sector Corporations and Private Sector companies. The Ministry of Health & Family Welfare (MOHFW) looks after the Central Government Health Scheme (CGHS), which was started in 1954. The Ministry of Labour looks after the Employees State Insurance Scheme started in 1948. The Ministry of Finance looks after the Universal Health Insurance Scheme, which was launched in 2003.

4.2.2 Asked whether the public sector companies co-ordinate amongst themselves, CMD of NIC, stated:

> "……yes; we coordinate among ourselves in all matters of interest, in all other matters. We definitely coordinate among ourselves. There is a body.
>
> We have a body called GIPSA – General Insurance Public Sector Association where we discuss this matter."

4.2.3 However, on coordination, Secretary, Ministry of Health & Family Welfare, stated as under:-

> "……we are operating in a very compartmentalized manner. Instead of collaborating and cooperating with each other quickly to deliver products, we seem to be in our cocoon."

4.3 LACK OF DATA

4.3.1 The Committee noted that the lack of vital data on morbidity across-demographic groups is coming in the way of insurers in formulating health schemes and in determining premium as per industry specific requirements.

4.3.2. Explaining the reasons as to why the company's various health covers could not be successfully promoted, Chairman of Life Insurance Corporation of India, stated: -

> "The real reason was that we did not have sufficient data to design the product, and price the same."

4.3.3 Reinforcing the above statement, CMD of National Insurance Co. Ltd. during evidence stated as under:-

> "Regarding premium calculation, I echo the views of Shri Shukla that we have not been able to evaluate, either from our sources or from outside agencies, the morbidity or other ratios or the actual premium."

4.3.4 Asked to comment on the availability of essential data on morbidity, diseases and demographic groups, the United India Insurance Co. Ltd. in their written reply stated:

"It is a fact that there is not enough data on mortality and morbidity in our country. However, this does not affect the popularity of health insurance as the insurers arrive at the premium and the coverage on the basis of the past loss experience and the average costs of treatment for various illnesses. The insurers would certainly be more equipped if data is made available for more scientific and actuarial basis of premium and sum insured and the diseases covered.

The presence of data would enable the insurers to bring out new products on health insurance for major diseases/commonly affecting diseases for the common public including the rural poor."

4.3.5 While briefing the Committee on the need and steps taken for collection of data, Chairman, IRDA stated as under -

"But the basic requirement is the collection of data on which we have already started the work. We have started collecting data with regard to not only the claims and premium but also the kind of diseases for which the payments have been made, and the age group at which people are getting affected, and then the claim amount for different hospitals. So, this information is being collected. Unless this information flows, no insurance company will be willing to take up this work because insurance business, like any other business, is to be a profitable business if it is to be run on commercial lines. Otherwise, the Government should subsidize. So, these are the two alternatives that are available."

4.3.6 In a subsequent note furnished by the Ministry of Finance the Committee were informed as under: -

"With a view to promoting and developing Health Insurance in the country, the IRDA constituted a Working Group on Health Insurance in September, 2003. The group comprises of representatives drawn from the IRDA, the Government and various stakeholders of the health insurance industry. Chairman, IRDA is Chairman of the working group.

Recognizing that a data bank on Health Insurance is the need of the hour, the Working Group first formed a Sub-group to examine issues related to data collection and pooling of information available with the Third Party Administrators and Insurers. The data sub-group's task was to decide on how the existing data would be collected, finalize data elements for collection of future data that would enable product development supported by actuarial rating and decide on who would be the custodian of the data repository as well as carry out its analysis.

The Data Sub Group proposed a plan for collection of existing data and recommended the data elements and structure for future data. It recommended that the Tariff Advisory Committee be the custodian of the data repository. The Data Sub Group also recommended the setting up of three committees to examine the following issues:

(1) Implementation of the recommendations of the Health Insurance Data Sub Group on Health Insurance data.

(2) Product innovations in health insurance and definition of 'pre-existing disease'.

(3) Regulatory issues pertaining to registration of Stand-alone Health Insurance Companies.

Accordingly, IRDA constituted three committees, to look into and make specific recommendations on the three areas.

I. **Sub-committee for Health Insurance data:**

The committee was formed with the objective of drawing up a road map for establishing a data repository under the custodianship of the Tariff Advisory Committee and evaluating the adequacy of data elements already finalized and recommend standard data elements in respect of health insurance proposals and claims. They included

(a) Sharing of currently available data in specific formats
(b) Introduction of standard data elements for insurance proposals and claims from a future date.

Briefly, the following recommendations were made by the committee:

1. Formats for collecting existing data as recommended by the sub-committee to be adopted for the years 2003/04, 2004/05 and 2005/06.
2. The existing data would be collected from the TPAs first within a specified time schedule.
3. Training of personnel from the TPAs, Insurers and TAC for using ICD classification with the help of the Government of India.
4. The committee recommended that the Tariff Advisory Committee publish aggregate information regarding claims.

Data for the years 2003/04 and 2004/05 has been received from the Third Party Administrators and are under verification.

> The IRDA, with the help of the Central Bureau of Health under the Ministry of Health has already commenced the training of TPA personnel on ICD 10 coding."

4.4 LACK OF AWARENESS

4.4.1 The Committee noted that one main hindrance to the successful promotion of various health covers by the insurers, was the lack of awareness about the need, availability and benefits of health insurance amongst a large majority of our population. Outlining the major problems being faced in the implementation of health insurance schemes, the Oriental Insurance Company Ltd., in their written reply stated:-

> "The concept of Health Insurance is still not very clear to the prospective clients. Some of them believe that once the premium is paid, all their health care is taken care of. Others believe that health insurance cover can be availed once they are diagnosed for some serious medical treatment. Most of them are unable to comprehend pre-existing diseases and feel that the once the policy is bought it should be 'all risk' cover. This misunderstanding often creates problems at the time of settlement of claims. Hence wrong messages are spread that health insurances do not really help those in need and therefore discourages people from buying the policy.
>
> Many times people who are already suffering from some ailments take the policy without disclosing material facts to derive benefit from the policy which at times is prevented by vigilant action of the claim processing authorities."

4.4.2 Echoing the above view, the CMD of United India Insurance Co. Ltd. stated in evidence before the Committee as under :-

> "As I said earlier, firstly, there is no awareness. Even if awareness is there, there is no paying capacity or the people feel that they are still healthy and nothing is going to happen to them. So, with that type of attitude in mind, they are not coming forward."

4.4.3 Responding to the issue of lack of awareness about health insurance and steps being taken by Government in this regard a representative of the Ministry of Finance stated:

> "Sir, as regards awareness creation through Government agencies, the hon. Finance Minister himself had written to all the Chief Ministers and the Secretary (Financial sector) had written to all the Chief Secretaries of the States to solicit their cooperation because medical, at the State level is under their control. But somehow, we could not get the kind of response, which we had anticipated."

4.5 POVERTY AND NEED FOR SUBSIDY

4.5.1 Lack of premium paying capacity amongst a sizable number of our population was cited as another reason coming in the way of implementation of health insurance schemes in the country. In this regard CMD of United India Insurance Co. Ltd. during the oral evidence before the Committee stated:-

> "However, paying capacity problem also exists. When people living below the poverty line are getting Rs. 1200 or Rs. 1500 only, how can they contribute even Rs. 15 or Rs. 20? They cannot spare money for health insurance. They also have alternative channels for treatment like Government hospitals or primary health centres. For major diseases, generally, they do not go anywhere. They leave it to the God, or to some quacks who are in the villages, as they cannot afford this."

4.5.2 The Committee noted that all the public insurers emphasized on the necessity of subsidizing premium for the poor and those living below the poverty line in order to extend health insurance cover to those segments. In this regard, Chairman, Life Insurance Corporation of India stated during the oral evidence;

> "As far as giving cover to the people, especially the poor and those who are living Below Poverty Line, is concerned, a subsidy from the Government would be a must."

4.5.3 On the above issue, CMD, New India Assurance Company Ltd. stated during evidence: -

> "We do have policies where the premium range starts from 50 paise per day to Rs.20/- per day. For the urban population of the tax-paying employees, there is deduction in the income tax under Section 80D. We have, from time to time, even introduced policies with the help of the Government where there is a subsidy paid by the Government of India for the weaker sections."

4.5.4 In reply to a question on the extent of subsidy provided under the various health insurance schemes, the National, Insurance Company in their note stated thus:

> "Subsidy is provided by Govt. of India only for Universal Health Insurance Scheme which is meant for BPL families only. Under this scheme the subsidy of Rs.200/- is provided for Individual, Rs.300/- is provided for a family of 2-5 members and Rs.400/- is provided for a family containing up to 7 members including parents of the insured. There is no other subsidy received from the government."

4.5.5 Replying to a question on the sustainability of subsidy for the poor, Oriental Insurance Co. Ltd. in their written reply stated:

> "Considering the economic situation of the majority of rural and poorer sections of the society, subsidization of premium is inevitable as of now. However, progressively subsidization has to be reduced and later eliminated. In the place of subsidizing the premium, Government can work for enhancing the income levels of the rural poor to such level where premium payment is not felt as a burden by them. At present, the BPL families are unable to bear the burden of this expense and hence, subsidy is essential."

4.5.6 Submitting that subsidy of premium, though vital to spread health insurance amongst the poor, needed to be supported by micro-insurance and Self-help Group involvement, United India Insurance Company, in their written reply contended:

> 'Subsidizing premium for the poor to a large extent is one way of encouraging the poor to take up insurance as well as contribute towards their health care. However, paying up insurance premium may not be a priority for the poor. Even where the public have the capacity to pay the premium, the collection of premium by the Insurance companies would be

a difficult task with the available infrastructure. Further unless the people are given a cashless facility, the confidence of the public cannot be gained and hence, the insurance penetration could be improved only through self-help groups, micro-insurance concept.

However, the subsidy would be high if it covers all the Below Poverty Line people. The fund can be created by way of contribution from Government/Hospital and other Institutions so that the premium and liability can be matched."

4.5.7 Echoing similar views and suggesting corporate involvement, New India Assurance Co. Ltd. in their written reply stated:

"The poor section of the society neither has awareness nor the capacity to pay the premium even if the Government subsidizes some portion of premium. Thus, there is a need to have schemes for these sections with participation of NGOs, SHGs, voluntary organizations & the Government. They can collaborate for creating awareness & implementing schemes for rural areas depending on specific need of each area. To begin with some corporate houses & charitable institutions may also adopt the areas."

4.6 LACK OF PROPER REGULATIONS IN HEALTH SECTOR

4.6.1 Regulatory shortcomings relating to the health sector in India is another major hindrance to a healthy growth of health insurance in the country as is reflected in the views expressed by the IRDA and the public insurers. The Committee noted that there are basically three aspects for regulation of health sector. One, there is a need to make it mandatory for all health service providers, hospitals, nursing homes, etc., to obtain registration. Secondly, a standard treatment protocol needs to be evolved for various illnesses. Third, a uniform pricing needs to be established for various treatments. Delving into these aspects, CMD, of United India Insurance Co. Ltd. during his evidence stated:

"……., a regulator in the health services sector is required. At present, there is no standardization or gradation of the hospitals for the

> fees, which they are charging, or the treatment, which they are giving. All types of nursing homes are opening everywhere. There is nothing, which can be called 'standardized'. We have witnessed that in cities they charge exorbitant prices as compared to towns and small Government hospitals. If an operation for appendix can be performed in a private or a trust hospital in Rs. 15,000, generally Private hospitals will charge Rs. 1 lakh or even more. So, that tendency will have to be curbed. Some regulator has to be there to take care of the health sector. Then, I think, there will be a healthy growth of the health insurance."

4.6.2 Giving their views on lack of proper regulations in the health sector and how far it was hindering the promotion of health insurance in India, Oriental Insurance Co. Ltd. in their written reply stated:

> "Yes, stringent norms should be prescribed for opening and operating hospital and some uniformity should be maintained in the fee structure for standard treatments. Registration, accreditation and rating of the hospitals should be made mandatory. Hospitals should be encouraged to come out with published charges for various services that they offer. Improvement in healthcare facilities goes hand in hand with improvements in health insurance sector."

4.6.3 Asked to comment on the need for stringent regulations in the health sector, Secretary, Department of Health, Ministry of Health and Family Welfare stated during evidence:

> "We also realise that we have a role to supplement the effort of the regulatory authority and the Department of Insurance in shape of accreditation process, costing and such other complex activities which will help in a more transparent and market driven yet equitable insurance product. We will be in touch with them and under their guidance we will assist them. These are all the new activities and we should be prepared for it."

4.7 LACK OF HEALTH INFRASTRUCTURE

4.7.1 Lack of adequate hospitals and other health care facilities is yet another commonly cited difficulty being faced by the insurance companies in spreading

health insurance covers. Analysing the problem the CMD of Oriental Insurance Co. Ltd. stated in his evidence as under :

> "I feel that the major area of concern seems to be the lack of health infrastructure in the rural and semi-urban areas. That problem has to be addressed so that people have facilities to go to the hospitals for treatment. Once the facilities are there, then, perhaps, sales can pick up. Otherwise, a person in a village has to go a long distance to have treatment for major illness. That is the key area, according to me."

4.7.2 To a question as to whether inadequate availability of health care infrastructure in the country, as also health personnel, was hindering the promotion of health insurance in the country, New India Assurance Co. Ltd. in their written reply stated:

> "Yes, While more than 75% population resides in rural areas the expenditure in rural areas is only 25% of total healthcare expenditure. Thus there is gross inadequacy of healthcare infrastructure in rural areas. Although there is growing awareness about health insurance in urban areas, which is evident from, the growth of business in the last 3 years but the lack of healthcare infrastructure in rural areas is bound to hinder promotion of Health insurance. Moreover poor quality & inadequate healthcare services of Government facilities compel the masses to go to private healthcare providers, which is a costly affair."

4.7.3 While briefing the Committee on why numerous initiatives taken by the Government have failed to bring about adequate health insurance cover to the poor, Chairman, IRDA, stated:

> "One of the primary reasons, according to me, is the lack of service providers. If we go to the village and try to sell a health insurance policy even at Rs. 100 or Rs. 150 to the poor person, the question that he is going to ask is: "When I fall ill, where do I go? And, who is going to look after me?" What is happening is that we are taking away this premium, and when the claim comes, the claim is settled but the money does not go to the hospitals that has provided this facility. If it is a Government hospital, it goes to the Government. On the other hand, if this money is given back to the primary health centre or the Taluk hospital where a person is treated, this money goes into a pool. The advantage is, that pool of money would be available for the doctors there to provide treatment to

those people who come with the health policies. Otherwise today, what is happening is that even if I have a health policy, if I am a poor man and I go to the hospital, the doctor may be willing to treat me, but he does not have the wherewithal; he does not have medicines; he does not have disposable if he wants to do an operation. So, he would simply say: " I am available to provide the service, go and get the following from the nearest medical shop…….".

4.7.4 Giving suggestions to address to this problem, Chairman, IRDA further stated :-

".…….My suggestion is that that amount that is paid by the insurance company should go to a pool in that particular hospital, and they can create a pool of this money. That pool should be used for treating people who are coming like this. Then people will be encouraged to purchase even at Rs. 165. Otherwise, how would he pay Rs. 165? He would still have to pay for medicines and disposable. So, that is my suggestion."

4.8 LACK OF PRODUCT VARIETY

4.8.1 One of the concerns of the Committee have been on the lack of variety of health covers to meet specific requirements of various strata of population such as the aged, youth, people with pre-existing diseases and for conditions which need no hospitalization, etc. Commenting on the lack of variety of health insurance products, Secretary, Ministry of Health & Family Welfare stated during evidence:

"Sir, to be honest, the Health Ministry feels the need for variety of health insurance products, ……It is because out of the total health expenditure in the country, only 5 per cent is through Central Budget and 15 per cent is through State Budgets. So, 80 per cent being through out-of-pocket expenditure including insurance premium, which is only about 1.5 per cent of the total out-of-pocket expenditure, we feel that instead of making people spend money under duress and in time of distress, people should be encouraged to have insurance products for saving for health needs. Now, it is all easy to say but we also note that there is growth but the growth is uneven. We are more interested initially for such products as community insurance. In other words, such products, which are not for the high-end clients, are meant for super-specialty hospitals only. The universal insurance raised hopes but now it is restricted to BPL category.

> The BPL category is a very narrow category. I think the lower middle class and the near-BPL band poor are equally distressed and we have to find some mechanism. Then, the question of certifying that near-BPL is itself a gigantic task. In some urban areas, the BPL categorization is also not complete so those difficulties come up. We would urge the universal insurance scheme to be opened up for any citizen who wants to come forward. The subsidy could be restricted to BPL category but the insurance product should be available for a common man. We feel that, the universal insurance scheme is being propagated in different States through different departments. We would urge that in every State the Health Department should be given the task to propagate the universal insurance scheme. It is because the Health Department is the biggest stakeholder in the Rural Health Insurance Scheme and the Universal Health Insurance Scheme is such a product."

4.8.2 Commenting on hindrances to promotion of health insurance in India, ICICI Lombard General Insurance Co. Ltd. in a note furnished to the Committee stated as under:-

> "As present the market does not offer much choice. Going ahead, greater customization would be required to cater to the various age / economic segments of the society to ensure greater demand."

a). Schemes for the poor

4.8.3 To a question on whether each public sector insurance company has health insurance schemes for the poor and the marginalized, the four national general insurers stated as follows: -

National Insurance Company Ltd.	Our Company is presently marketing three health insurance schemes where the target groups are the poor and marginalized. They are Jan Arogya Bima, Universal Health Insurance Scheme and Swathya Bima Policy.
New India Assurance Co. Ltd.	Yes, we have two schemes namely Swasthya Bima Policy and Jan Arogya Bima Policy.
United India Insurance Co. Ltd.	There is a scheme for the poor and the marginalized viz. Swasthya Bima Policy and Jan Arogya
Oriental Insurance Co. Ltd.	We have the Jan Arogya Bima, Universal Health and Swasthya Bima Yojna schemes where the premium is sizably lower

b). Schemes for the aged

4.8.4 Asked to brief the Committee on whether an appropriate health insurance model for senior citizens in the country had been identified, the Chairman of IRDA stated:

> "Sir, today, under the Mediclaim product, we have covered up to the age of 80. So, the senior citizens, in a way, are covered up to the age of 80, depending upon whether they are having any pre-existing illness. If a person is continuously having an insurance cover, then he is in no way affected by any disease that he may contract during the course of the insurance period, when he is covered by insurance. Courts have also said that insurance companies cannot refuse cover for next year for any disease."

4.8.5 On being prodded further to state whether efforts had been made to identify or formulate a compulsory health coverage scheme for the senior citizens in the fifty years since independence, the Chairman, IRDA stated: -

> "This issue came up for discussion in one of our sub-groups. It is an issue, which has been discussed in one of the sub-committees that we constituted under the Working Group. The suggestion made by the Working Group, at that time, was that we should try to have a common pool for senior citizens and then this pool should be supported by the Government because the insurance companies, which are also motivated substantially by commercial considerations, will not be able to sustain a policy for senior citizens on their own strength. What was suggested was to explore the possibility of having some kind of an understanding with the Government and create a separate pool for senior citizens, and whatever is the premium that is collected from the senior citizens will go into this pool. If the expenses are in excess of the amount that is already there in the pool, there should be a system of getting the reimbursement from the Government. This is what one of our sub-committees has already recommended. We are examining this aspect with regard to the senior citizens."

4.8.6 On whether the practice of bringing senior citizens under compulsory health insurance coverage, as prevalent in some developed and developing

countries, is an agreeable and feasible model for India, the Secretary, Ministry of Health stated: -

> "I have a very respectful submission. I am on the threshold of old age. So, my submission may not be taken as an impertinence of a young person. I am aware old age is already there and waiting round the corner for me. With utmost respect, I am speaking from my heart and not as a bureaucrat; I wish to say that the mother and child of this country, we are not yet able to give the assurance of a safe institutional delivery. In States like Uttar Pradesh, 700 mothers per one-lakh childbirths are dying. In Japan, it is somewhere around 4. In this context, I should not be taken out of context, this promise of modern allopathic system of an endless perfect life notwithstanding age is leading to disproportionate channeling of resources for geriatric care, that too for a high end hospitalization care, without any proportionate benefit to the quality of life. Even in USA, etc., a citizen writes that, when he is still in command of his faculties, sometimes, no hospital can take up heroic care and cause him impoverishment. There are a lot of complicated issues, and if I go on narrating them, I would sound unsympathetic to the senior citizens. I would submit very respectfully that there are unreserved equity issues in many lower age groups and metropolitan hospitals have created a myth that……."

4.8.7 Explaining the difficulty in bringing about a health insurance scheme for senior citizens and highlighting the alternative arrangements in place, the Secretary, Ministry of Health further stated: -

> "I was only saying that most of the insurers are still market-driven and they will not come forward for such a special scheme. The only insurance still available is public health infrastructure. My Minister has asked me to create special packages and facilities for senior citizens. That is also a way of insurance. If you are thinking of a private insurance package for senior citizens - my saying yes or no has no meaning but I am only saying this out of utmost respect - factually it will not happen now."

4.8.8 Taking note of the fact that most health covers offered by the public sector insurers provide standard coverage for the age group of 5 years to 80 years, and renewal of policies after 80 years are subjected to certain conditionalities, the Committee sought clarifications in this regard from the public insurers. In their written replies, they stated as follows: -

NICL	For persons above 80 years of age premium is loaded as under. Up to 85 years-15% and Over 85 years-25%
NIACL	In case of continuous renewal the premium is not loaded & policy is renewed beyond 80 years at the same rate, terms & conditions.
UIICL	There is generally loading on the premium solely on account of the age of the person. The claims experience also is taken into consideration when premium is loaded. The loading ranges from 10% to 100% depending on the claims experience. However, as mentioned earlier there is likely to be a restriction of Sum insured.
OICL	None as there is a slab system and persons from the age of 76 years onwards pay the same premium. However, in case of adverse claims history, premiums are loaded appropriately.

c). Health cover for women and children

4.8.9 Asked to state what policies exist for women and children under health insurance, United India Insurance Co. Ltd. in their written reply stated :-

> "There are two schemes/package policies that cover the women and children. They are:
>
> - **Uni Micro-health insurance scheme-**This scheme is offered as a package policy to the Women in self-help groups operating mainly in rural areas. The covers offered are Personal Accident for Rs 15,000/- and Hospitalization cover for RS 5,000/-. The insured woman has the option of choosing to cover her spouse and two children under the hospitalization scheme. The amount of RS 5000/- is floated among the family members on payment of additional premium.
>
> - **Mother Teresa Women and Children policy-** This is also a package policy offered to Women and children either of self-help groups or individuals. The policy offers three covers- Personal Accident, Personal Accident Cover for the children and also Hospitalization cover (Rs 5000/-) for the woman. The amount of RS 5000/- is floated among the family members on payment of additional premium.
>
> In the above category, few policies have been sold through Self-Help Groups."

The three other insurance companies stated to the effect that women and children are covered under all existing schemes.

d). Maternity and Out-patient cover

4.8.10 To a question as to whether existing health policies offer covers for maternity and out-patient care and the reasons if such covers were not available,

the replies of the four public insurance companies were largely similar and are substantially reflected in the written reply furnished by the New India Assurance Company Ltd. which stated:-

> "Maternity benefit is covered only under group policies on payment of 10% premium loading for the group. Out patient care is not covered under any of our existing health policies. The main reasons for not covering these benefits are lack of data for calculating actuarial premium & difficulty in checking fictitious & inflated bills. The total expenditure on outpatient treatment is too high & chances of mal-practices are also more. Moreover inclusion of these benefits would make the covers expensive & unaffordable for public at large. Presently there is no plan to introduce such scheme with above benefits."

e). Major diseases covers

4.8.11 In order to assess the availability of insurance schemes covering major diseases, all the four public sector general insurance companies were asked to furnish details. Except for Oriental Insurance Co. Ltd., which so far does not float any specific schemes for major diseases, the other three companies have one such scheme each. National Insurance Co. Ltd. has a Critical Illness Insurance Policy, New India Assurance Co. Ltd. has Tertiary Care Insurance Policy while United India Insurance Co. Ltd. has Trauma Care Policy. (as per details given in Annexures VII, VIII & X respectively).

4.8.12 On the question of making such schemes affordable to the poor and whether there was any proposal to introduce such schemes for the poor, the National Insurance Company in its written reply stated: -

> "This policy is designed for people having minimum income of Rs.1 Lac from gainful occupation. This policy is given in addition to Mediclaim policy. Since this is a benefit policy with a high Sum Insured and at a comparatively higher premium, poor people can hardly afford the premium. Should the Government come forward to bear the entire premium or subsidize, a suitable separate health insurance policy covering major diseases may be considered for the poor."

4.9 LACK OF PROFITABILITY

4.9.1 One of the challenges to the spread of health insurance is the loss proneness of this business. To make it profitable and to give some sustainability to the segment, the Committee were informed, *inter –alia*, that an adequate pool of insured and a system of re-insurance needed to be ensured.

a) Lack of adequate pool

4.9.2 Asked to comment on health insurance being a loss–making proposition, IRDA in a written note stated :-

> "…….there is absence of a critical mass instrumental in health insurance note taking off as one would have liked it to."

4.9.3 Reflecting on one of the causes of inadequate pool of insureds, Shri S.B.Chakraborti, CMD of National Insurance Co. Ltd., in evidence before the Committee, stated :-

> "Usually, we find that we are not in a position, for various reasons, to catch the people at young stage. The average age of the insured persons is above 45 years or 50 years or whatever it is. So, the very 'insurance' concept of pooling various resources from many people and serving the few is not done in this case because the 'probability' factor of people suffering is much more in the higher age group."

4.9.4 Stressing the need for an adequate pooling of resources and risks, Shri C.S.Rao, Chairman of IRDA, during the briefing stated as under:-

> "As far as insurance for the poor is concerned, basically, insurance, as was pointed out by my colleague Shri Hota, is a pooling of resources. A large number of people should pay the premium for meeting the claims of a few. We presume that out of one lakh people, who take insurance policy, may be 2000 people will claim it. If we have a large pool of resources, then the premium will come down and we will be able to do better. If a larger number of young people who are entering the job take the insurance policy, it could cover the medical expenses of others that are in

> the age group of 50 to 60 years. We have to encourage the younger sections of population to take up medical insurance scheme because it is a group, which is generally free from diseases.So, even if he acquires a disease during the course of the policy, either he is in his 40s or 50s, he will not come under the definition of pre-existing disease. So, he can continue to get the benefit of the medical insurance over a period of time. So, the challenge is to see how best we can popularize this mediclaim so that a large number of people get in."

b) Re-insurance

4.9.5 Re-insurance is a system of insuring the insurance companies against the risks they underwrite in relation to their clients, i.e. the insured. The Committee learnt that health insurance is prone to adverse claim ratios and that all the PSU general insurers were experiencing losses in their health insurance portfolios.

4.9.6 Explaining the concept of re-insurance and dwelling on its practice and prospects in India, Oriental Insurance company in their written reply stated:

> "Re-insurance means insurance of insurance. Re-insurance is arranged by the insurance company to protect themselves against catastrophic loses, which are beyond their capacity to bear. It is either taken for very big risks or for those small risks which are numerous and where the total accumulations are likely to be high. Health Insurance proposals will fall under the second category i.e. small risks, which are numerous in nature. So far the companies are sharing this business by way of re-insurance with General Insurance Corporation of India by way of compulsory cessions but there is hardly any other re-insurance on this portfolio. This possibility can be examined once the health insurance business increases. Internationally, not much re-insurance support is available for Health insurances".

4.9.7 Highlighting the present arrangement for re-insurance of health policies and the efforts being made to strengthen re-insurance arrangements for health insurance, National Insurance Co. Ltd., in their written reply stated;

> "At present, Indian Re-insurer (GIC) is to take 20.% of all the policies under Health Insurance. Health Insurance can be split into Jan Arogya, Universal Health and Mediclaim Insurance (Domestic and Overseas).

80.% of the above Health Insurance is retained within the company without any re-insurance protection for Net Retained Account.

Discussions are on with intermediaries (domestic and foreign) and overseas re-insurers for a re-insurance protection for the net retained account under Domestic Health Insurance. Since individual claims are not much, re-insurers preferred to go on annual aggregate claims basis, but loss Retention suggested by re-insurers, appears to be high which was considered not cost-effective.

However, efforts are on to have re-insurance protection for the domestic health insurance. It is worth mentioning that IRDA is in the process of collecting actuarial data from our TPAs using TAC as a Central Repository. The analysis coming out of their data can provide support to seek re-insurance for health."

4.9.8 Detailing the various benefits of re-insurance that insurance companies can avail from a reinsurer in addition to risk coverage, and outlining re-insurance prospects for health insurance in India, the Life Insurance Corporation of India in their written reply stated:

"In case of re-insurance, the insurance company, by paying premium to the reinsurer, transfers a part of the risk to the re-insurance company. In addition to the transfer of risk, other services provided by re-insurance companies include technical support in various areas like pricing, underwriting, administration, claims underwriting, etc.
Re-insurance is critical in case of products which carry substantial risk as the claims experience can be volatile or where the company does not have sufficient experience or data to be able to write such business on its own.

Availability of re-insurance at a reasonable cost can encourage insurance companies to offer health insurance products in India. Re-insurers can also help in designing innovative products. Health insurance is considered risky and the presence of re-insurers can give a lot of relief to the insurers. There are, therefore, good prospects for re-insurance in health insurance sector in India."

4.10 RURAL PENETRATION – MICRO-INSURANCE & INVOLVEMENT OF NGOS AND OTHER LOCAL INSTITUTIONS.

Rural Penetration

4.10.1 The Committee noted that lack of rural penetration was one of the biggest challenges coming in the way of spread of Health Insurance in the country. Based on the written replies of the four public general insurers, a comparative chart showing their infrastructure presence and health insurance sales in rural areas is given below:-

Company	Rural Infrastructure	% Of Health Policy Holders From Rural Areas
NICL	Branches in almost all districts in India	No ready statistics
NIACL	Majority Agents force in urban areas	2%
UIICL	No specific data provided	10%
OICL	One Branch in every district of most States	No statistics

4.10.2 In response to the Committee's comment that all the four public sector companies were concentrating only in urban and metro cities in selling health products, CMD, NICL, during evidence stated as under : -

> "One point was raised regarding our concentration. All four of us are having about 1100 to 1200 offices in each company. So, when we talk about these four companies, we are almost having 5000 offices and the concentration is not necessarily in metro centres. We are having our presence in almost, at least district headquarters if not down the level."

4.10.3 In reply to a question on why, despite having branches in every district in the country, the public general insurance companies were not doing enough business in rural areas, CMD, National Insurance Company Ltd. during evidence admitted to availability of potential market saying: -

> "…….There is, of course, tremendous potential available for personal line insurance by which we mean personal accident, medical insurance and so on……."

4.10.4 Admitting the poor penetration of health insurance covers in rural areas the CMD of Oriental Insurance Company Ltd. during evidence stated as under :-

> "Today, the problem could be in selling these policies in the rural areas and semi-urban areas. Even though we have made up a tie-up with the banks, we could not achieve the levels. They are distributing the policies. We have recruited special agents to sell these policies in the rural areas. Due to cost of distribution and the commission despite being paid, this policy is not selling well. We have devised policies especially for the BPL families with Government subsidy. We have tried selling that for the last two years. Even that has not been sold, two-thirds of it is being subsidized by the Government.

4.10.5 On the efforts to penetrate rural areas in the sale of health insurance, CMD, UIICL stated during evidence: -

> "Regarding expansion in rural areas and un-represented areas where we do not have our direct branches, we have now engaged the new system of corporate agents and micro offices. Now, banks, post offices and other institutions are having their presence in villages and we want to take advantage of that. So, we have tied up with them to provide this type of insurance. Rural insurance as well as personal line of insurance is our area of thrust."

Micro - Insurance

4.10.6 The Committee noted that the existing schemes, institutional mechanisms and regulating framework of heath insurance and the degree of governmental involvement in the sector were inadequate to facilitate the spread of health insurance to the poor and rural segments, and wanted to know the various enabling mechanisms which could facilitate the spread of health insurance to cover rural and poor segments of the population,

4.10.7 The Committee were informed that Micro-insurance basically is a poor man's insurance. Adapting the principles and practices of micro-insurance in

health covers is micro-Health insurance. The Committee were informed that micro-health Insurance sector had developed in the last few years at a fast pace and that the initial drive for this development came from NGOs. The Committee also noted that even the little interest shown by commercial insurers in the sector were largely spurred by IRDA regulations which required them to fulfill a quota of "rural" and 'social' clients.

4.10.8 On the concept of Micro-Health insurance, United India Insurance Co. Ltd., in their reply, informed the Committee as follows:-

> "Micro-health insurance is a form of health insurance, which offers limited protection at a low contribution (hence "micro"). It is aimed at poor sections of the population and designed to help them cover themselves collectively against risks."

4.10.9 In a similar vein, New India Assurance Co. Ltd. in their written reply stated:

> "Micro-health insurance refers to development & implementation of health insurance schemes for micro entrepreneurs, small farmers, landless laborers, women & low-income people through formal, semiformal & informal institutions. The role of semiformal institutions including credit societies, NGOs & Self-help groups is significant as they have immense potential in carrying the message of insurance by soliciting Health insurance & increasing the insurance penetration levels."

4.10.10 The Committee were informed that Micro-Health insurance schemes are normally routed through NGOs, Self-help Groups and associations like trade Unions, religious congregations and hospitals whose main area of activities put them in direct contact with the target groups.

4.10.11 In this regard, the National Insurance Co. Ltd., in their written reply stated:

> "Micro-health insurance is a very important mechanism in a country as large as India with a large population that cannot afford to pay for the healthcare costs. The only known initiative of the Government of India through the medium of insurance, in the recent years is the "Universal Health Insurance Policy". This initiative, while it is subsidized by the government, has not really measured upto the expectations in terms of number of lives covered. From an insurer's perspective, it is a nightmare- as originally conceived, this product had bundled three different benefits into one with near certainty of a claim on each policy. While the Government of India has reiterated its commitment to this product by upward revising the subsidy and trimming the benefits under this policy in the year two of this initiative, it is still not very popular and more importantly, there exists no mechanism amongst the insurers to sell it to the target population i.e., the rural poor. Hence, while the intentions of this micro-insurance initiative is laudable, the systemic issues have not been addressed, prior to it's seeding."

4.10.12 On the issue of routing Micro-health insurance schemes through grass root organizations, the Committee sought to be informed of any tie-up between the PSU general insurers and any NGO, Self-help Group or Community-based Organization to promote health insurance. In this regard, New India Assurance Co. Ltd. in their written reply stated:

> "We have tied up with Indore Municipal Corporation providing health insurance cover to entire population of Senior Citizens residing within Municipal limits. Each member is covered for sum insured of Rs. 20,000/- under hospitalization benefit. The Cash less services has been provided through TPA. Other municipal corporations and similar organizations willing to grant cover may also implement this scheme."

4.10.13 In reply to the same question, the three other PSU general insurance companies, namely, National Insurance Co. Ltd., Oriental Insurance Co. Ltd. and United India Insurance Co. Ltd. submitted that no such tie-up has so far been put in place. Their submissions are reproduced below:

NICL	No. However, for marketing of Universal Health Insurance Policy and Swathya Bima Policy, Underwriting Offices have been advised to liaise NGOs, Self-help Groups and Cooperatives.
OICL	Although, there is no such tie-up arrangement as on date, we are exploring the possibility of developing such tie-up with CBO/ NGO, Self-help groups and cooperatives.
UIICL	We have no formal tie-ups with NGOs and Self-Help Groups. However, few one or two NGOs have taken Group Mediclaim cover from us. We have also entered into arrangement with major bankers like Syndicate Bank, Canara Bank, Andhra Bank, State Bank of Hyderabad, State Bank of Travancore covering their Savings Bank accountholders.

4.10.14 On the issue of regulating the mechanism for promotion of Micro-health Insurance in India, Chairman, Insurance Regulatory and Development Authority (IRDA), during the briefing before the Committee stated as under :-

> "The third thing that we are trying from the IRDA side is to take the initiative, and we have taken that initiative. We have now passed, in the IRDA, a regulation called the Micro-insurance Regulations. There are a large number of micro finance institutions, which are operating in the country already. They would also like to enter the area of the micro-insurance. Today, if somebody wants to sell insurance, he should have certain qualifications to sell insurance. In the Micro-insurance Regulations, we have said, 'any NGO, any self-help Group can sell insurance provided they have an understanding with the insurance company. It is a facility that is available to the insurance company to sell its policy through these micro-insurance agents who do not require any qualification except their service records. If they have got good service records and the insurance company is comfortable with them, then they can use these micro-insurance agents for purpose of selling policies to the poorest of the poor. We went even a step further and said if a company is comfortable with them, they can also use the same agency for settling the claims. What normally happens is that if a premium is collected and taken to the insurance company, and when the amount has to be paid, he will have to wait for a long time. In the meanwhile, that man will go and incur some debt. So, what we have suggested in the Micro-insurance Regulations is that if the insurance company is comfortable with that NGO, they can allow them to settle the bills and claim the reimbursement from the insurance company."

4.10.15 Outlining potential significance of Micro-health insurance, to be operationalized through SHGs and NGOs etc. in India, the United India Insurance Co. Ltd. in their written reply submitted as under:-

> "As it would not be possible for the Govt. Machinery/Insurer to have access to the nook and corner of the country, it would be easier if the Self-help Groups /NGOS are more involved in the activities of Micro-health insurance. Hence Self-help groups and NGOs can be encouraged by the State and the Central Government."

4.10.16 Expressing similar views in their written reply Oriental Insurance Co. Ltd. submitted:

> "It will improve the health care of all the citizens of the country. This also spreads the message of insurance among those who were hitherto unaware of the same. This also tries to bring the unorganized sector under one umbrella."

4.10.17 The Committee were informed, through a position paper submitted by Federation of Indian Chambers of Commerce and Industry (FICCI) that there were many barriers in operating sustainable micro-health insurance in India. These include a prohibitive level of surplus requirement, inability of micro schemes to transfer risks to re-insurance, lack of information, almost no support in raising technical and administrative skills at micro-insurance level (and funds to finance training), and complications in ensuring ample supply of medical services of good quality at affordable cost. Also, that there were some (regulatory) pressure to limit micro insurers to the role of simple agents of commercial insurers which could severely restrict the growth of micro-health insurance.

4.10.18 Asked to state the major hurdles facing the operationalisation of Micro – health insurance in India, the United India Insurance Co. Ltd. in their written reply informed:

> "In India the number of the Non-Governmental Organizations/ Welfare Organizations is very few in number compared to the population of the country. The rural populace is not linked by any organization that would

aid/assist in collection of premium or in arranging for any assistance-medical or otherwise. Their network is not very strong nor wide and neither do these organizations have the authority required.

In the recent-past, the Self-help Groups have started evincing interest in this regard and here again the question of collection and payment of premium to the Insurance Companies is an impediment."

4.10.19 In addition, the Committee were informed that the growth in the micro sector in health insurance was inhibited by factors like lack of health care infrastructure, particularly in rural areas, lack of premium paying capacity, lack of awareness due to illiteracy, inadequate efforts to popularize the schemes by implementing agencies, and inadequate transport system among others.

4.10.20 Asked to furnish possible remedies to make Micro-health insurance a success in India, New India Assurance Company Ltd. in their written reply suggested the following.

- Government should define the goal of implementing agencies
- Creation of Healthcare Infrastructure in Rural areas
- Cashless facilities through providers
- Outpatient treatment with some minimum Co-payment
- Encouraging community-based Health insurance schemes
- Devising products according to local needs.

4.10.21 In response to the same question, the National Insurance Co. Ltd. in their written reply submitted:

"In order to make such micro- health insurance a success the following important factors need attention:

a. Coverage in respect of surgical treatment only – studies have shown that borrowing for meeting medical cost is the second important cost of rural indebtedness. Hence, any such scheme should aptly address this important need.
b. The scheme should address organized and identified groups – to eliminate impersonation
c. Active participation from the Govt. – for collection of premium or contribution per member

d. Treatment at door-step – availability of fully equipped health service providers."

4.10.22 Over and above these possible remedies, the Committee were informed that certain pre-requisites needed to be fulfilled to operationalize the concept of Micro-health insurance in the country. These include.

- Adopting formal insurance arrangements to the needs of target groups
- Upgrade non-formal insurance arrangements with companies.
- Linking formal & Non formal insurance institutions with banks & Self-help Groups
- Establishing Local Institutions to provide micro –insurance services,

4.10.23 Towards enabling micro-health insurance units to achieve the objectives of enhancing health insurance of undeserved populations, FICCI, in a position paper submitted to the Committee proposed the following four-pronged strategy:-

1) Flexible benefit package design, reflecting local priorities and ability to pay;
2) Re-insurance of micro-health insurance units;
3) Subsidies to cover part of the cost of the insurance premium and/or the re-insurance premium; and
4) Capacity building at micro-insurance level.

4.10.24 Briefing the Committee on the latest developments regarding the Micro-insurance Regulations, Chairman, IRDA stated during evidence as under:-

> "……..we have been working on this regulation for almost one-and-a-half years. It is because there are a number of suggestions that have come from NGOs, especially from 'Seva' and others. We have incorporated some of the suggestions and then finalised it. This has been notified only on the tenth of November. This has now come into force, and we are sending it to the insurance companies saying them to take advantage of this particular regulation, and to identify the appropriate

> agencies for delivering products in the rural areas. It covers not only health but also life or cattle or any small assets or even huts. They are all covered under this regulation."

4.10.25 The salient features of the Micro-insurance Regulations, 2005 are given in annexure-XI.

NGOs and Self-help Groups in Health Insurance

4.10.26 The Committee desired to know the views of the PSU insurance companies on the possible role they perceive for NGOs and Self-help Groups or other community-based organisations in the promotion of health insurance in India, and the initiatives on the part of Public insurance companies to harness the potential of these organizations. On the issue of harnessing the relative advantage the NGOs and Self-help Groups have in terms of reach and mass contact in rural areas, the Committee note that little or no effort had been made by the PSU general insurers. In reply to a question on whether any company had a tie-up with any NGO/SHG or Community-based Organization to promote health insurance in rural areas, all the PSU general insurers admitted to the absence of any formal tie-up.

4.10.27 Responding to the issue of involving self-help groups in micro-health insurance raised by the Committee, CMD, National Insurance Co. Ltd. stated during evidence as under :-

> "One issue was raised about the involvement of self-help groups for micro-insurances. There were some discussions amongst ourselves and I am not too sure but I have been told that for micro-insurance matters, there are some schemes of banks to provide marginal farmers some kind of money for various activities. If the self-help groups can also co-ordinate with them and if that particular group pays the premium on behalf of those members and deduct in installments from the members for a little bit of their personal line insurances, it is a reasonably good idea which has been

> discussed amongst us, but honestly, we have not crystallized our thought process. We are working on it."

4.10.28 In response to the Committee's observation on rural penetration and the potential of involving NGOs and Self-Help Groups in spreading health insurance, CMD, United India Insurance Co. Ltd. stated during evidence;

> "Sir, it is our thrust area. I think, alternative of self-help groups is a very viable alternative and it has to be harnessed if we have to bring in the spread. We have been talking to many self-help groups and NGOs. Earlier, they were not showing much interest and saying that 'Our area of concern is not that. We are into specific areas.' But now they have also woken up to that it is a community service, which they have to provide. I think, awareness is coming amongst them."

4.10.29 The Committee also sought the views of selected Non-governmental organizations/experts regarding the promotion of health insurance in the country. In all 14 organizations/experts responded, detailing the nature of their involvement and their views on what steps were needed to enhance health cover especially amongst the rural poor and the marginalized sections of society. From the exercise, the Committee learnt that the major thrust of these organizations' involvement is in the micro-health insurance sector, commonly known in India as Community-Based Health Insurance (CBHI). The Committee also noted that several NGOs were engaged as a vital link between insured communities and the insurance companies through various facilitative arrangements. These included pre-payment of premium in bulk and recovery of the same from the insured in easy monthly installments, provision of extra benefits like out-patient care and maternity care facilities and, in some cases, subsidization of premium or negotiating benefit packages to suit local needs in relation to insurance companies. These submissions of NGOs reflected their

commitment and enthusiasm, as also the propriety of harnessing those organisations in penetrating rural India with health covers. However, there were several handicaps faced by the NGO sector, of which mention may be made here of the lack of initiative and indifferent attitude of insurance companies, including Public Companies, in promoting health insurance through the NGO sector.

4.10.30 The comments of the Ministry of Finance and the Ministry of Health and Family welfare on these submissions of NGOs/experts were obtained. One of the major observation of the Ministries was that all NGOs may be enrolled as TPAs for implementation of Micro–Health Insurance schemes. Second, Social Health Insurance as against Private Health insurance needed to be given a serious consideration for effective implementation of Health insurance. Third, that the NGO approach to health insurance entailed considerable investment/start up costs by NGOs which required support from Government, insurance Companies and corporate sector, and also subsidies to make health insurance affordable to the poor.

4.10.31 Asked to furnish their comments on the role of NGOs and SHGs in health insurance, the future prospects of their involvement and the steps taken to enhance their role in promoting health insurance, the Oriental Insurance Co. Ltd. in their written reply submitted:

> "The Self-help groups and NGOs can help in marketing health insurance both in the rural sector and far flung areas. These groups have the unique advantage of having remote access for several reasons and they can conveniently handle insurance marketing as well.

> The presence of these Self-help Groups/ NGOs participation would help in spreading the message among the masses but would not have any direct impact on the subsidy. We are contacting such organizations for marketing Health Insurance Schemes like Universal Health, Swasthya Bima i.e. policies designed for BPLs. A referral fee of about 10% is paid to the self-help groups/ NGOs for the services rendered by them."

4.10.32 New India Assurance Co. Ltd. in their written reply on the issue highlighted the Company's efforts at involving Self-help Groups and the future prospects of utilizing this sector thus:

> "In order to involve self-help groups the company has recently launched Swasthya Bima policy as per Government directives. The SHGs can play an important role in creating awareness about health insurance & marketing this policy. In future these SHGs can be appointed as Agents for marketing & distribution of micro-insurance products."

4.10.33 Enlightening the Committee on the initiatives to facilitate the penetration of health insurance among the poor through micro-insurance, Chairman, IRDA, during the briefing stated:

> "In the Micro-insurance Regulations, we have said, 'any NGO, any self-help Group can sell insurance provided they have an understanding with the insurance company. It is a facility that is available to the insurance company to sell its policy through these micro-insurance agents who do not require any qualification except their service records. If they have got good service records and the insurance company is comfortable with them, then they can use these micro-insurance agents for purpose of selling policies to the poorest of the poor. We went even a step further and said if a company is comfortable with them, they can also use the same agency for settling the claims. What normally happens is that if a premium is collected and taken to the insurance company, and when the amount has to be paid, he will have to wait for a long time. In the meanwhile, that man will go and incur some debt. So, what we have suggested in the Micro-insurance Regulations is that if the insurance company is comfortable with that NGO, they can allow them to settle the bills and claim the reimbursement from the insurance company."

Panchayats

4.10.34 The Committee desired to be apprised of as to whether the public sector general insurance companies had explored the feasibility of promoting Health Insurance schemes through Panchayati Raj institutions or other such existing grass-root platforms. In reply, the Oriental Insurance Co. Ltd. in their written note submitted:

> "Although there is no existing tie-up with Panchayati Raj or such other democratic institutions, we will explore the possibilities of developing such contacts for spreading the message of health cover among rural masses.
>
> However, we are selling insurance through NGOs, Micro Finance Institutions, Rural Banks and Rural Co-operative Societies."

4.10.35 Responding to the same query, United India Insurance Co. Ltd., in their written reply stated:

> "We have not so far used the institutions like the Panchayati Raj. However, we would be educating the Panchayat Raj.
>
> The impediment in using the services of the Panchayati Raj and other NGOs is that there is no incentive for them to tie up with the insurer. There is difficulty in providing for agency commission for these agencies as of now. In case services of these agencies have to be utilized, it would be possible only with the active involvement of the Govt. and directions from the Govt. regarding release of any incentives."

4.10.36 Expressing the limitations for such an arrangement to materialize, New India Insurance Co. Ltd. in their reply argued:

> "Such an arrangement can be successful for covering selected surgical procedures or major diseases in network hospitals as has been experimented in self funded plan, for example "Yashaswini" Scheme in Karnataka. However for a comprehensive cover there is need to develop healthcare infrastructure in rural areas for successful marketing of these covers through Panchayati Raj institutions."

4.10.37 Stressing the need to first set in order the Panchayati Raj Institutions through close monitoring before such arrangements are put in place, National Insurance Co. Ltd. in their written reply submitted:

> "Till date our company has not made such arrangement for the promotion of health insurance schemes. We feel this type of arrangement might be useful in promoting health insurance if their activities are kept under close vigil."

4.11 CLAIMS MANAGEMENT & THIRD PARTY ADMINISTRATORS SYSTEM.

4.11.1 Efficient claims management and speedy disposal of claims is one critical factor that can lure or keep away potential customers of health insurance. The public grievances against insurance companies over claims rebuttals were brought to the notice of the Committee.

4.11.2 Asked to furnish the claims procedure and mechanism to monitor claims management, the National Insurance Company in their written reply stated:

> "After introduction of TPA, health insurance claims are settled by TPAS. In each Regional Office a TPA Monitoring Team has been constituted to oversee the functioning of TPAs including settlement of claims. The Service Level Agreement executed with the TPA is comprehensive and require the TPA to furnish periodic information to respective underwriting office with regard to settlement of claims. Details of settled claims are also provided at the time of requisition for replenishment of claim float fund. Generally TPAs seek opinion from underwriting offices for repudiation of claim.
>
> If any disputes arise in the TPA level, the claim is reviewed by our Underwriting offices then by regional Offices. The Company is also having one in-house grievance redressal department who also intervene when such disputes are referred. If the clients are not satisfied with the decision of our company, they approach the Insurance Ombudsman to resolve the dispute. The disputes are settled by the Insurance Ombudsman after hearing the two parties i.e. the client and the insurance company. However, it may be mentioned that at times reference are made to Ombudsman by the Insured even in case of rightful rejection."

4.11.3. The Committee note that the TPA system had been introduced in response to demands in the market for cash-less settlement of insurance claims. In this light, the Committee desired to be apprised of the impact of TPA system on health coverage. Highlighting one positive outcome from the introduction of TPAs, CMD Oriental Insurance Company stated during evidence: -

> "Today, we have got the TPAs who give customers a cash free service. The customers are enjoying the service. Therefore, sales are also more, but mainly in urban areas."

4.11.4 The Committee were informed that nearly cent percent of health policies sold by the four public general insurance companies are serviced by TPAs. In this context, the four public sector general insurance companies were asked to furnish a note on their experience and also the experience world over about TPAs. In reply, the New India Assurance Company submitted the following: -

> "Third party Administrators world over are skilled outfits where insurance companies outsource health insurance portfolio administration. The definition of Health insurance has changed to healthcare management. World over the definition is now called health cover plans where outpatient treatment, diagnostics, pharmacy benefits, curative services like hospitalization and old age rehabilitative care are part of coverage.
>
> The biggest market for health insurance/cover is USA where 1.8 million $ US are spent and insurance companies either use a TPA or have their health care service organizations. The goal for these companies is to provide the policyholders the best care at reasonable price. In other words they act as a watchdog to the unnecessary inflation of the medical treatment charges by healthcare service providers. This is needed to control the rising premium for the health cover.
>
> TPAs world over graduate to managed care service organizations. The TPAs have very close interaction with health service providers to check whether international standard protocols are being followed or not to treat the patients. They also graduate to the evidence based medicines and payment to providers for quality of care & outcome of treatment. Traditional insurance companies do not have such medical skills and

hence outsourcing to TPAs/MCOs. These help in monitoring accreditation of providers, standardized costing, data collection and quality of care.

In India the Third Party administrators were introduced *w.e.f.* 1st October-2002. This was done mainly with the objective of providing cashless service to the policyholders. The premium was enhanced by 6% to meet the additional cost of service rendered by TPAs/ With the help of TPAs the insurers can now develop standardized data patterns depending on type of Hospital or provider facility, educate clients about the international trends of treatment for various ailments, evaluate the economic impacts. The claims cost has gone up after introduction of TPAs & the comparison of claims cost per claim for the last five years are as below:

YEAR	No. of Claims	Amount settled	Amount per Claim
2000-01	305406	2034996000	6663
2001-02	116819	1885300000	16138
2002-03	196300	3105300000	15819
2003-04	161959	3006812000	18565
2004-05	245169	5018133622	20468

The comparison of claims cost in terms of percentage for the last 5 years is as below:

YEAR	No. of policies	Premium	Incurred Claims	Claims
2000-01	609255	239.16	161.77	67.64
2001-02	822534	269.96	238.28	88.26
2002-03	937012	354.43	270.12	76.21
2003-04	949648	366.42	307.17	83.83
2004-05	1075386	455.39	527.59	115.85

It is evident from the above figures that the cost per claim as well as the claims ratio has increased considerably after introduction of TPAs. The reasons for rise in claims cost are as under: -

- TPA concept being new in India, the TPAs have so far not been able to address the issue of price control & overcharging by Health care providers. The issues are being debated by group of TPAs with Indian Medical Council.
- There has been increase in cost of treatment including cost of medicines, diagnostic materials & medical appliances, Doctors fee etc.
- Policyholders prefer to go to best available healthcare providers, in view of availability of cash less service irrespective of sum insured.
- There is no regulator for price control of services provided by Hospitals and there is no categorization of Hospitals and

standardized charges for them. Thus overcharging by providers is inevitable.

- With limited number of Healthcare providers there is no competition as far as charges are concerned."

4.11.5 Asked to explain as to what extent the TPA system had improved service delivery and customer satisfaction, the National Insurance Company in their written reply submitted: -

> "At the initial stage we received lot of complaints from customers and service providers against the TPAs which have been reduced to some extent at present.
>
> A dispassionate review of the performance of all the TPAs show, that not all TPAs have passed the test. The purpose of inducting TPA was to provide quality service to Insured by TPA so that the Insurer can concentrate on area of competence of underwriting the risk and marketing the same. The performance of TPAs is monitored regularly and any deficiency in the service is brought to their notice for rectification. We need performing TPAs and so non-performer will be gradually wiped out.
>
> In addition, we are in the final stage of implementation of the system with regard to electronically exchange (export &import) of data with the TPAs. By implementing this system we feel, the services of TPAs could be improved considerably."

4.11.6 With the involvement of TPAs, the Committee were informed, the insurance companies are saved from the trouble of processing and settling the claims and the client is not required to settle his hospital bills which are settled by the TPA directly with the concerned medical institution. On being asked as to whether involving of TPAs benefited the companies in terms of expenditure on health insurance, CMD, National Insurance Company, stated during evidence: -

> "The benefit has been made to the customer for cash-less settlement. But the cost has gone up."

4.11.7 Admitting that the cost of health insurance as sustained by the PSU companies had gone up with the involvement of the TPAs, and narrating the

efforts to check rising costs, CMD, United India Insurance Company stated during evidence: -

> "…….cost has gone up, as everybody says. But TPA concept, which has been in India today, is at a very nascent stage. It has been brought only two or three years before as an experiment or as a facilitator to give in a better service for cashless. You can say that it has driven up the cost. But whether this cost will go up or it can be brought down, we are in that process because whatever TPAs were there, we are continuously monitoring their performance *vis-à-vis* claim ratios as well as analyzing the patterns and some of the TPAs have been churned also. They have stopped working. We have brought in new TPAs and we have just to see whether this concept works in India. Stand-alone, we cannot manage this type of facility. So, that is why, thinking that it will take some time to stabilize the things, we had introduced another alternative to the insured also that they can go in for without TPA facility also. Now, as steps have been taken that for all hospitals the gradation has been made by TPAs and even the cost has been brought down up to a level of 50 per cent. This type of monitoring is also being made where they charge differential rating and all that. I think, this should stabilize after some time."

4.11.8 While furnishing a detailed note on TPAs, the National Insurance Company touched upon the reason for a rise in premium costs affected by the involvement of TPAs stating: -

> "Service charges paid to TPAs are 5.5% of the net premium of insured persons serviced by them in North and Southern Zones and 5.4% in East and Western Zones. In addition to the service charges, the TPA shall be offered incentives based on the claims incurred on the insured persons. Accordingly, rate of premium under medi claims policy was also enhanced by 6%".

4.11.9 Contending that the increasing costs incurred by the companies in health insurance claims cannot be attributed to involvement of TPAs alone, Oriental Insurance Company in their subsequent note stated as under: -

> "The increasing trends in claims in health insurance cannot be exclusively attributed to the involvement of TPAs. Firstly, there has been a strong growth in the area of health insurance as compared to any other sector. More and more urbanites are becoming conscious of the fact that health care is quite expensive and are opting for health covers. Second is the

fact that the population, mainly urban population is becoming health conscious. Most of the illnesses, which were ignored in the past, are attracting greater attention of the people who are ready to undergo corrective treatment. Third is the fact that health care by medical institutions are no longer a service. Medical profession has now become more a profession. This is evident from the reports we often see about hospitals overcharging patients or directing them to undergo unnecessary tests and treatments. Fourthly, the costs of these treatments are on the rise. To the extent there was an increase in the cost of medical treatments and also to the extent there was an increase in general price index, the premiums have not gone up in health insurance. Fifthly, there could undeniably, be some lapses on the part of TPAs as well. These are attracting our rigorous attention. We have already called our region incharges to hold periodical meetings with TPAs on service levels and also directed them to undertake rigorous audit of the claims settled by them. Lapses on the part of these outsourced agencies will not be tolerated at all.

The concept of TPAs has been borrowed from advanced countries where this has worked well. The TPAs, with their expertise in handling medical industry, have concentrated on developing tie-ups with various hospitals and have also negotiated with them for a lower charges than the normal ones."

4.11.10 Asked as to whether complaints had been received against TPAs and what steps taken had been taken to address the same, IRDA in their note stated as under:-

"When TPAs first started functioning, there were some complaints relating to non-receipt of identity cards. Initially, these were being issued on a yearly basis. The IRDA then advised TPAs to consider issuing cards for three years at a time. This step has helped solve the problem of policyholders constantly worrying about non-receipt of cards etc. as without them they will not be in a position to obtain cashless facility. Today, we hardly have any complaints relating to non-receipt of ID cards.
Secondly, there are some complaints where TPAs have either delayed or failed to issue authorization letters to hospitals. Such cases are immediately followed up with not only the TPAs but also the insurers, as in most cases, it is the insurers who fail to provide the TPA with necessary information/clarification they are looking for.

In respect of reimbursement cases (TPAs also process claims for reimbursement of medical expenses on behalf of insurers), the complaints relate to disputes with regard to liability (almost all of them relating to

> whether or not a disease was pre-existing) or quantum (when certain expenses may have been disallowed). These have to do with policy condition and not with the functioning of the TPA per se."

4.11.11 Asked further as to whether claims related complaints had increased after the introduction of TPAs, Chairman, IRDA during evidence stated as under:-

> "Complaints are increasing and the third party administrators have been in existence for about two years now. We hope that once the company has standardized the manner in which the bill is to be processed, the complaints will come down. The real problem is this. The third party administrator is an extension of insurers. The liability is on the insurer and not on the third party administrator. If the third party administrator gets a clear mandate from the insurance company as to how to process these claims then part of these difficulties which we are facing today will get over. In fact we have told the insurance companies to give a clear mandate on how to process these bills and not leave it entirely to the judgment of the third party administrators. These complaints are coming and then the complaints are also going before the ombudsman for adjudication. Complaints are definitely there."

4.11.12 The Committee are informed that the sub-Committee to examine Product Innovations in Health Insurance and definition of 'Pre-existing disease' of the IRDA's Internal Working Group on Health Insurance have also commented on the TPA system and made recommendation as under:-

> "On Third Party Administration, the Committee felt that it is important that Insurance Companies take concrete steps to provide clear guidelines to enable TPAs to effectively manage and settle claims."

4.11.13 The Committee were informed that a private general insurance company, Bajaj Allianz, had introduced their own in-house Health Administration Team (HAT) in preference over the TPA system. Asked to comment on the TPA System, Bajaj Alianz General Insurance Company Limited in a note furnished to the Committee inter-alia stated as under:-

"In the present Indian setup how this can succeed is a matter of debate and concern. The TPA's should be able to reduce the cost to such a level that the cost of TPA to the insurer is met from that reduced cost otherwise the health care costs will shoot up. This should be along with better service say *cash less service* to the insured. Otherwise the basic purpose of introducing TPA services is defeated and it may result in just cost shifting with the TPA making business at the cost of the insured in the name of service. You don't need TPA for cash less service, service contracts are sufficient. The regulator should insist on the insurers to disclose to the public the actual premium for the insurance plan and the fees collected for the services to be offered by the TPA separately. This will help analyze and review the role of the TPA in the Indian health insurance sector vis-à-vis their cost to the society.

4.11.14 Asked to comment on the future relevance of TPA system in the light of this development, the IRDA in a note to the Committee stated as under:-

"Insurers may choose to engage or not engage TPAs for some or all health insurance products. Health Administration within the company may be preferred by some insurers for some or all products as they may prefer to do the claims servicing themselves. However, it is the cash-less facility which is the most important service offered by a TPA which benefits the insureds and this is nearly 50% of the total business handled by a TPA.

As regards stand-alone health insurers, some TPAs might, infact, want to merge with them and this would be good for these insurers as they will have the required expertise to serve the policyholders. For those stand-alone insurers who would still want to outsource administration of their policies, TPAs would continue to play the role they do now."

OBSERVATIONS / RECOMMENDATIONS

RECOMMENDATION NO. 1

STAND-ALONE HEALTH INSURANCE COMPANY

In a welfare state like India, it is the responsibility of the State to take care of the health of the nation. But the existing public health infrastructure is able to cater to only a very small section of the population. Supplementing the existing health system which needs rapid and large scale improvement and modernization, an effective Health Insurance System appropriate to the country needs to be built up as early as possible.

More and more people with some kind of health insurance should be the goal to be achieved. While Government employees and organized sector employees are covered under Central Government Health Scheme (CGHS), Employee's State Insurance Scheme (ESIS), as well as employer provided schemes like in the army, railways and several public sector undertakings efforts have been made to cover the rest of the populace with commercial health schemes. The Committee, however, note that only about 10% of the country's one billion plus population comes under all these forms of health cover and

of this, only about 10%, meaning about 1% of the population are covered under commercial health insurance.

The Committee feel that one of the primary reasons for limited spread of health insurance in the country is the lack of focus on this segment by insurance companies, especially the public sector general insurance companies who enjoyed a monopoly till recently and still continue to enjoy 82% of the market amongst themselves. Besides the above, tariff pricing of certain general insurance segments like fire, motor, engineering etc. has also adversely affected the growth of health insurance into an independent and sustainable business, forcing insurance companies to treat it as a miscellaneous portfolio and as an accommodation business for more profitable tariffed portfolios like fire and other property insurances. The Committee have been informed that a separate stand-alone company for promoting the health insurance would certainly help in giving the due focus and in increasing the coverage, more particularly in the rural areas. The Committee, however, find that the emergence of stand-alone health insurance companies is hindered by a number of hurdles.

The Committee note that the Insurance Regulatory and Development Authority has made certain

recommendations regarding stand-alone health insurance companies. The same may be scrutinized keeping in view that the public sector has been and can play a very important role in this regard. Stand-alone health insurance companies in the Public Sector with model performance can encourage the Private Sector to perform accordingly keeping in view the issue of affordability of large sections of the needy population and thus help create a conducive environment for spread of health insurance business.

Recommendation No. 2

Universal Health insurance scheme

The Committee note that Universal Health Insurance Scheme was introduced by the Government in 2003 with a subsidy component for people living below poverty line. The subsidy was subsequently enhanced in 2004 and the scheme was confined to the BPL segment of the population only, and in spite of it, the scheme failed to make much head way. In view of the fact that the coverage of non BPL families was much larger than that of the BPL families in the original version of the scheme, the Committee feel that the scheme ought to have been continued for the non-BPL families as well, so as to achieve the twin objective of making this scheme more attractive to the BPL segment and to cover a larger segment of the poor population under the health insurance. Besides the above, Committee note that another cause of limited success of Universal Health Insurance Scheme has been incomplete identification of BPL families. The Committee highly deplore the slipshod manner in which a laudable scheme like U.H.I.S has been implemented. The Committee desire that an exercise to identify BPL families should be initiated immediately and the entire exercise be completed within a specific time-frame

and the scheme should also be made applicable to lower middle class and the people who are just above the Poverty Line.

The Committee also note that in the absence of any targets set for the PSU insurers in terms of the number of covers sold, the insurance companies did not make concerted efforts to cover larger chunks of the population under health insurance schemes. The Committee desire that Government should set ambitious targets for the insurance companies and closely monitor their performance so that they strictly comply with the targets laid.

RECOMMENDATION NO. 3

LACK OF COORDINATION

The Committee note that various insurance schemes viz. the Employee's State Insurance Schemes, the Central Government Health Scheme and other Commercial Health Insurance schemes are being operated by three different Ministries viz. the Ministry of Labour, Ministry of Health & Family Welfare and Ministry of Finance respectively and there is no coordination amongst the three Ministries as also the IRDA in policy planning, programme implementation, monitoring and evaluation with regard to commercial health insurance thereby depriving the business of the much needed synergy which can evolve only through synchronization of individual efforts.

The Committee further note that the Ministry of Chemicals and Fertilizers has proposed, through the draft National Pharmaceutical Policy, to set up a new health insurance scheme – Rashtriya Swasthya Bima Yojana – for the poor which will be funded through a 2% health cess. While lauding the proposal, the Committee feel that an integrated approach involving all the above agencies needs to be evolved by the Government for the successful implementation of Health Insurance Schemes.

The Committee desire that a mechanism for regular cross-consultation and coordination among these agencies should be put in place to enhance the synchronization of efforts to promote health insurance in the country. The Committee further desire that a pilot health insurance scheme involving the Ministry of Health and Family Welfare, Ministry of Finance, IRDA and Public Sector Insurance Companies may be evolved and launched within a specific time-frame.

RECOMMENDATION NO. 4

LACK OF DATA

The Committee note that lack of adequate data on morbidity, demographic groups and diseases etc., is a major hindrance in formulating and designing new products in health insurance and thus affect the development and progress of health insurance in the country. The Committee are pleased to note that a sub-committee constituted under the IRDA's Internal Working Group on health insurance with the objective, inter-alia, `of drawing up a road map for establishing a data repository and evaluating the adequacy of data elements already finalized' has already submitted its recommendations.

The Committee desire that the recommendations made by this Committee be examined in its entirety and steps taken for their expeditious implementation.

RECOMMENDATION NO. 5

LACK OF AWARENESS

The Committee are constrained to observe that the level of public awareness about the need, availability and benefits of health insurance in the country is still very low despite the fact that public sector general insurance companies have been operating in the field of health insurance for nearly two decades, beginning from 1986. Though efforts have been made at the Finance Minister and Finance Secretary level to solicit the cooperation of State Governments in creating awareness amongst masses and about the need and importance of health insurance, they have not yielded the desired result.

The Committee desire that concerted efforts be made to create awareness about the need, availability and benefits of health insurance schemes especially in rural areas through a multi-pronged strategy involving the public insurance companies, the central Government, the state Governments and the Panchayati Raj Institutions as well as non-governmental organizations so that more and more people come forward to adopt Health Insurance schemes.

RECOMMENDATION NO. 6

LACK OF ADEQUATE HEALTH INFRASTRUCTURE

The Committee note that two factors that discourage a majority of potential customers from buying health insurance cover are (i) lack of adequate health care infrastructure, especially in rural areas where 75% of the country's population lives, and (ii) the consequent inaccessibility to health care for a majority of the population. Viewed in this context, the Committee feel that strengthening of the existing infrastructure for providing health care to the rural masses is of paramount importance. As efforts of the Government alone are not bringing the desired impact, the Committee feel that there is a need to involve the private and corporate sector in health infrastructure development and they should be provided with suitable incentives for this purpose. Further, the Committee desire that the possibility of channelising investments by public insurance companies to rural as well as urban health infrastructure be seriously examined, and necessary policy level initiatives and regulatory changes be effected to facilitate such investments.

The Committee are also aware of the severe shortage of manpower resources in the public health care system

especially in the rural areas. The Committee desire that the Ministry of Health & Family Welfare should take necessary steps to meet the huge shortfall of medical personnel and introduce stringent measures to enhance efficiency in health care delivery.

The Committee further desire that Governments of all States and Union Territories may be requested to allot land for development of health infrastructure in rural areas at concessional rates to private bodies/Self-help Groups/cooperatives etc. Soft loans from Life Insurance Corporation of India, Banks and other financial institutions should be made available to these bodies for creation of rural health infrastructure. The Committee further desire that enhanced budgetary support for health infrastructure should also be made available.

Chairman, IRDA, had suggested before the Committee, a system where by the amount that is paid by the insurance companies for treatment of the insured should go to a pool in that particular hospital and the creation of a pool of this money for treating the insured persons. The Committee desired that the suggestion should be studied in-depth and implemented to improve the availability of health service providers.

RECOMMENDATION NO. 7

LACK OF PROPER REGULATIONS IN THE HEALTH SECTOR

The Committee note that the unregulated mushrooming of health service providers across the country has resulted in escalation of health care prices, undependable and deteriorating quality of health care and rampant instances of under-treatment and over-treatment by doctors and hospitals / nursing homes. All these phenomena, besides being detrimental to the medical and financial welfare of the patients, also inhibit the healthy growth of health insurance sector. The Committee would like to emphasise the imperative need for fixation of standardized and properly graded pricing, evolution of uniform treatment protocols and health service provider should be made accountable for the successful functioning and healthy growth of health insurance sector in the country.

The Committee, therefore, desire that adequate steps be taken for evolving a comprehensive and stringent regulatory framework to ensure – (i) mandatory registration and credible accreditation of health care service providers like hospitals, nursing homes and clinics; (ii) the establishment of a standard clinical protocol for all treatments; and (iii) a systematized, standardized and

graded pricing for medical procedures. The regulatory framework should also ensure that violations of such norms be made punishable as criminal offences. Further, the feasibility of establishing a regulatory body to oversee all these aspects be explored and progress thereof reported back to this Committee within a period of not more than 6 months from the date of presentation of this report to Parliament.

RECOMMENDATION NO. 8

LACK OF PRODUCT VARIETY

The Committee have been informed that while there are a variety of products in terms of the sum insured and premium costs, there is a serious lack of variety of health insurance products in terms of flexibility to cater to the specific needs of different segments of the population. They are constrained to note that all the health schemes currently offered by the public sector general insurance companies are standard policies covering hospitalization only. The Committee are of the view that there is an imperative need to introduce long term health insurance products, covering out-patient care, maternity care, pre-existing diseases, suitable products for the aged, abandoned women, widows, physically and mentally challenged, children and the rural poor. The Committee, therefore, desire that in addition to the existing range of standard health insurance schemes, the Government and the public insurance companies should introduce a host of flexible and client-oriented health insurance schemes including long term health insurance products, maternity and out-patient covers, specific schemes for the abandoned women, widows, physically and mentally challenged and children. The Committee also desire that

feasibility of formulating a compulsory health insurance scheme for senior citizens as recommended by a sub-Committee of IRDA be examined and steps be taken with due promptitude to evolve such a scheme. Steps may also be initiated to include pre-existing diseases in all health schemes within a reasonable period after scheme initiation, incorporating in all such schemes some measure of subsidy as deemed appropriate and required to enable the less privileged sections of society to afford the schemes.

The Committee also note that covers for most major diseases are beyond the economic means of the poor. The Committee desire that the Government and public sector companies should evolve a mechanism to make such schemes affordable to the poor. The Committee recommend that one or two hospitals in each district should be earmarked for the treatment of major diseases like cancer, AIDS, organ transplants, Bypass surgery etc. and Central / State Governments should lend adequate budgetary support to these hospitals so as to enable the poor to get themselves treated.

RECOMMENDATION NO. 9

CLAIMS MANAGEMENT & THIRD PARTY ADMINISTRATOR SYSTEM

The Committee note that the Third Party Administrators system had been introduced by all public sector insurance companies to smoothen claims management and to facilitate cash-less settlement of medical bills for the insured. The Committee, however, are dismayed that a large number of complaints have been emanating from the insuring public on the procedure of claims management and claims disposal and that there are serious malpractices involved in claims disbursement by public sector insurance companies. The Committee are also constrained to observe that an additional burden has been thrust upon the insured by increasing the premium costs by 6% to meet the cost of service rendered by TPAs.

The Committee regret to note that the Third Party Administrators in the Country have been following unethical practices in collusion with health service providers and insurance companies in settlement of claims. They also lack the competence and necessary infrastructure to fulfill the role and functions expected of them. They also note that

complaints relating to claim settlements have increased considerably after the introduction of the TPA System.

In view of a plethora of complaints against TPAs and the increase in cost of premium as also claim costs, the Committee feel that a comprehensive review of TPA system is imperative. The Committee note that a sub-committee of IRDA's Internal Working Group on Health Insurance has, inter-alia, recommended that the insurance companies should take certain concrete steps to provide clear guidelines to enable TPAs to effectively manage and settle claims. The Committee desire that the above recommendation made by the sub-committee be examined in all its ramifications and implemented so as to smoothen the system of claims management and facilitate cashless settlement of medical bills of the insured within a set time-frame.

RECOMMENDATION NO. 10

RURAL PENETRATION

As more than 68 % of India's population still live in rural area, there is no denying the fact that rural penetration of health insurance need to be accorded utmost priority. The Committee, however, note with displeasure that despite having a huge network of branches in all district headquarters and huge strength of agents, the public sector insurance companies have not been able to sell health insurance into the rural and semi-urban areas in a big way. The Committee are further constrained to observe that there is no regulation requiring the insurance companies to have a certain minimum percentage of their total business to be carried out in the rural health insurance portfolio. The Committee are of the considered view that specific regulations should be introduced to make it mandatory for the insurance companies, both in the public and private sector, to have a fixed percentage of their entire business done in the rural health insurance segment with stringent penalties prescribed for failure to meet such obligations.

The Committee also recommend that appropriate incentives should be given to the Indian operators, preferably the Public Sector Insurance Undertakings, to

cater to the urgent needs of the Health Insurance Sector, particularly, in favour of the weaker sections and the Rural areas and also of the common man through innovative, attractive and purposeful schemes.

The Committee also note with concern, the lack of involvement of NGOs and other local institutions in the promotion of health insurance among the poor and in the rural segments. The Committee appreciate the initiative of the IRDA in introducing and notifying the Micro-insurance Regulations, 2005 which will facilitate the involvement of NGOs, self-help groups and micro-finance institutions in selling health cover to the rural areas. The Committee desire that the Government should take adequate steps to create awareness about the advantages under the new regulations and come up with a comprehensive action plan for capacity-building and promotion of such institutions in rural areas.

The Committee also commend the decision of the IRDA's Internal Working Group on Health Insurance to set up a separate – 'Rural Health' subgroup aimed at increased understanding of the barriers to providing health insurance to the rural poor and to create a roadmap for overcoming such barriers. The Committee desire that expeditious steps may

be taken for setting up of a separate ‘Rural Health’ subgroup.

They also desire to see the development of a host of micro-health insurance products suited to local needs by the insurance companies in a time-bound manner.

RECOMMENDATION NO. 11

LACK OF PROFITABILITY

The Committee note that most health insurance schemes offered by public sector insurance companies are loss-making primarily due to their inability to insure the younger people who are relatively free from major diseases. Besides this, the absence of proper re-insurance facility for health insurance is also adversely affecting the confidence of insurance companies to underwrite health covers on a large scale. The Committee, therefore, feel that public sector insurance companies need to take concerted steps to motivate and educate the young people to take health insurance policies in their own interest. The Committee desire that the Government and the regulator, after due consultation, prescribe viable targets of health coverage to the insurance companies, both in the public and private sector, and introduce incentives linked to their performance in fulfilling those targets.

The Committee also desire that the Government may give special attention and take time-bound action to set up a viable re-insurance mechanism for health insurance.

RECOMMENDATION NO. 12

POVERTY AND NEED FOR SUBSIDY

The Committee note that affording the premium of health insurance schemes is beyond the economic capacity of people living below the poverty line as well as for a large section of the population living just above the poverty line. The Committee also note that the only way to ensure health insurance cover for the poor is through subsidy to be provided by the Government to make the premium affordable for the poor. The only subsidized scheme at present is the Universal Health Insurance Scheme launched in 2003 and it has been confined exclusively to the BPL segments in 2004 with enhanced subsidy.

The Committee desire that subsidy for the poor and BPL segments be made available to all existing health insurance schemes and not restricted only to Universal Health Insurance Scheme. Further, the Committee desire that a system of differential subsidy for the poor and the BPL segments may be introduced across the board for health insurance schemes and service tax for providing health insurance may be abolished to increase its affordability.

New Delhi:
2 March 2006
11 Phalguna 1927(S)

RUPCHAND PAL
CHAIRMAN,
COMMITTEE ON PUBLIC UNDERTAKINGS

MINUTES OF THE 3rd SITTING OF THE COMMITTEE ON PUBLIC UNDERTAKINGS HELD ON 6 JUNE, 2005

The Committee met from 1500 hrs to 1700 hrs.

CHAIRMAN

Shri Rupchand Pal

MEMBERS
LOK SABHA

2. Shri Manoranjan Bhakta
3. Shri P. S. Gadhavi
4 Dr. Vallabhbhai Kathiria
5. Smt. Preneet Kaur
6. Shri Sushil Kumar Modi
7. Shri Shriniwas Patil
8 Shri Kashiram Rana
9. Shri Rajiv Ranjan Singh
10. Shri Parasnath Yadav
11. Shri Ram Kripal Yadav

MEMBERS
RAJYA SABHA

12. Prof. Ram Deo Bhandary
13. Shri Ajay Maroo
14. Shri Pyarimohan Mohapatra
15. Shri Jibon Roy

SECRETARIAT

1.	Shri John Joseph,	Additional Secretary
2.	Shri S. Bal Shekar,	Joint Secretary
3.	Shri J. P.Sharma,	Director
4.	Shri Ajay Kumar,	Assistant Director

REPRESENTATIVES OF MINISTRY OF HEALTH & FAMILY WELFARE

1.	Shri Prasanna Hota,	Secretary
2.	Smt. S. Jalaja,	Additional Secretary
3.	Shri Sujatha Rao,	Member Secy, NCH & Macro-economics
4.	Shri K. Ramamoorthy,	Joint Secretary
5.	Smt. Shubhra Singh,	Director

REPRESENTATIVES OF MINISTRY OF FINANCE

1. Shri G.C. Chaturvedi, JS (B&I) representing Deptt. of Eco. Affairs
2. Shri C.S. Rao, Chairman, IRDA
3. Shri Mathew Verghese, Member, IRDA

2. At the outset, the Chairman, Committee on Public Undertakings, welcomed the representatives of the Ministry of Health & Family Welfare, the Ministry of Finance and Insurance Regulatory Development Authority (IRDA). Thereafter, the representatives gave a briefing to the Committee on the concept of `Health Insurance' and various related aspects. The queries raised by the Members were also replied to by the representatives.

3. Concluding the meeting of the Committee, Hon'ble Chairman directed the Ministry of Health & Family Welfare and the Ministry of Finance to furnish written notes on certain additional points relating to the Health Insurance.

(The witnesses then withdrew)

4. A copy of the verbatim proceedings was kept.

5. The Committee decided to hold their next sitting on 20th June, 2005.

The Committee then adjourned.

MINUTES OF THE 5th SITTING OF THE COMMITTEE ON PUBLIC UNDERTAKINGS HELD ON 20 JULY, 2005

The Committee sat from 1130 hrs to 1415 hrs.

CHAIRMAN

Shri Rupchand Pal

MEMBERS
LOK SABHA

2. Shri Manoranjan Bhakta
3. Shri Gurudas Dasgupta
4. Shri P. S. Gadhavi
5. Dr. Vallabhabhai Kathiria
6. Shri Sushil Kumar Modi
7. Shri Shriniwas Patil
8. Shri Kashiram Rana
9. Shri Mohan Rawale
10. Shri Rajiv Ranjan Singh
11. Shri Bagun Sumbrui
12. Shri Ram Kripal Yadav

MEMBERS
RAJYA SABHA

13. Prof. Ram Deo Bhandary
14. Shri Ajay Maroo
15. Shri Jibon Roy
16. Shri Dinesh Trivedi

SECRETARIAT

1.	Shri S. Bal Shekar,	Joint Secretary
2.	Shri J. P.Sharma,	Director
3.	Shri S. B. Arora,	Under Secretary
4.	Shri Ajay Kumar,	Assistant Director

REPRESENTATIVES OF INSURANCE COMPANIES

1.	Shri A. K. Shukla,	Chairman,	Life Insurance Corp of India
2.	Shri R. Beri,	CMD,	New India Assurance Co. Ltd.
3.	Shri M. Ramadoss,	CMD,	Oriental Insurance Co. Ltd.
4.	Shri M. K. Garg,	CMD,	United India Insurance Co. Ltd.
5.	Shri B. Chakrabarti,	CMD,	National Insurance Co. Ltd.

3. The Committee took oral evidence of the representatives of Life Insurance Corporation of India, New India Assurance Company Ltd., Oriental Insurance Company Ltd., United India Insurance Company Ltd. and National Insurance Company Ltd. on the subject of Health Insurance. The representatives of above mentioned Insurance Companies clarified some of the queries raised by the Members and were asked to furnish written replies to queries which could not be readily answered then and there.

3. Verbatim proceedings of the meeting has been kept on record separately.

The Committee then adjourned.

MINUTES OF THE 11th SITTING OF THE COMMITTEE ON PUBLIC UNDERTAKINGS HELD ON 18th NOVEMBER, 2005

The Committee sat from 1500 hrs to 1650 hrs.

CHAIRMAN

Shri Rupchand Pal

MEMBERS
LOK SABHA

2. Shri Gurudas Dasgupta
3. Shri P. S. Gadhavi
4. Shri Suresh Kalmadi
5. Shri Sushil Kumar Modi
6. Shri Kashiram Rana
7. Shri Bagun Sumbrui

MEMBERS
RAJYA SABHA

8. Shri Pyarimohan Mohapatra
9. Shri Dinesh Trivedi

SECRETARIAT

1.	Shri S. Bal Shekar,	Joint Secretary
2.	Shri J. P. Sharma,	Director
3.	Shri N. C. Gupta,	Under Secretary

REPRESENTATIVES OF MINISTRY OF FINANCE
(DEPTT. OF ECONOMIC AFFAIRS – BANKING & INSURANCE DIVISION)

1.	Shri A. K. Jha,	Secretary
2.	Shri G.C. Chaturvedi,	Joint Secretary (B&I)

REPRESENTATIVES OF MINISTRY OF HEALTH & FAMILY WELFARE (DEPARTMENT OF HEALTH)

1.	Shri P. K. Hota,	Secretary
2.	Shri Deepak Gupta,	Additional Secretary
3.	Shri Amarjeet Sinha,	Director (Policy)
4.	Ms. Ganga Murthy,	Addl. Economic Advisor

REPRESENTATIVES OF INSURANCE REGULATORY & DEVELOPMENT AUTHORITY

1. Shri C. S. Rao, Chairman
2. Shri K. K. Srinivasan, Member

4. The Committee took oral evidence of the representatives of the Ministry of Finance (Department of Economic Affairs – Banking and Insurance Division) Ministry of Health & Family Welfare (Department of Health) and Insurance Regulatory & Development Authority in connection with examination of `Health Insurance – A Horizontal Study'.

3. Verbatim proceedings of the meeting has been kept on record separately.

The Committee then adjourned.

MINUTES OF THE 14th SITTING OF THE COMMITTEE ON PUBLIC UNDERTAKINGS HELD ON 2nd MARCH, 2006

The Committee sat from 1600 hrs to 1705 hrs.

CHAIRMAN

Shri Rupchand Pal

MEMBERS
LOK SABHA

2. Shri P.S. Gadhavi
3. Dr. Vallabhabhai Kathiria
4. Smt. Preneet Kaur
5. Shri Kashiram Rana
6 Shri Bagun Sumbrui

MEMBERS
RAJYA SABHA

7. Shri Ajay Maroo
8. Shri Pyarimohan Mohapatra
9. Shri K. Chandran Pillai

SECRETARIAT

1. Shri S. Bal Shekar, Joint Secretary
2. Shri N. C. Gupta, Under Secretary

2. The Committee considered the Draft Report on `Health Insurance – A horizontal study' and adopted the same with some modifications.

3. The Committee authorized the Chairman to finalise the Report for presentation. XXXXXXX XXXXXX XXXXXXXX XXXXXXXXX

The Committee then adjourned.

ANNEXURE-I

Powers and Functions of IRDA Under Section 14 of IRDA Act, 1999

(1) Subject to the provisions of this Act and any other law for the time being in force, the Authority shall have the duty to regulate, promote and ensure orderly growth of the insurance business and re-insurance business.

(2) Without prejudice to the generality of the provisions contained in sub-section (1), the powers and functions of the Authority shall include,

(a) issue to the applicant a certificate of registration, renew, modify, withdraw, suspend or cancel such registration;

(b) protection of the interests of the policy holders in matters concerning assigning of policy, nomination by policy holders, insurable interest, settlement of insurance claim, surrender value of policy and other terms and conditions of contracts of insurance;

(c) specifying requisite qualifications, code of conduct and practical training for intermediary or insurance intermediaries and agents;

(d) specifying the code of conduct for surveyors and loss assessors;

(e) promoting efficiency in the conduct of insurance business;

(f) promoting and regulating professional organisations connected with the insurance and re-insurance business;

(g) levying fees and other charges for carrying out the purposes of this Act;

(h) calling for information from, undertaking inspection of, conducting enquiries and investigations including audit of the insurers, intermediaries, insurance intermediaries and other organisations connected with the insurance business;

(i) control and regulation of the rates, advantages, terms and conditions that may be offered by insurers in respect

of general insurance business not so controlled and regulated by the Tariff Advisory Committee under section 64U of the Insurance Act, 1938 (4 of 1938);

(j) specifying the form and manner in which books of account shall be maintained and statement of accounts shall be rendered by insurers and other insurance intermediaries;

(k) regulating investment of funds by insurance companies;

(l) regulating maintenance of margin of solvency;

(m) adjudication of disputes between insurers and intermediaries or insurance intermediaries;

(n) supervising the functioning of the Tariff Advisory Committee;

(o) specifying the percentage of premium income of the insurer to finance schemes for promoting and regulating professional organizations referred to in clause (f);

(p) specifying the percentage of life insurance business and general insurance business to be undertaken by the insurer in the rural or social sector; and

(q) exercising such other powers as may be prescribed.

ANNEXURE – II

Features of Universal Health Insurance Scheme as furnished by Ministry of Finance.

The scheme was launched on 14.7.2003 by public sector general insurance companies. The salient features of the scheme are given below:

Eligibility

- Persons between the age of three months and 65 years are covered under the scheme.
- Individuals, head of the family and upto a maximum of three dependent children can be covered.
- Dependent parents can also be covered.

Benefit:

- Reimbursement of hospitalization expenses upto Rs. 30,000 can be availed individually or collectively by the members of the family.

- Personal accident cover of Rs. 25,000 for death of earning head of family.

- Compensation due to loss of earnings of earning member @ Rs. 50 per day, upto a maximum of 15 days.

Premium:

- For an individual, Re.1.00 per day, i.e., Rs. 365/- per annum.

- For a family of 5 (including the first 3 children), Re.1.50 per day, i.e. Rs. 548/-- per annum.

- For a family of 7 (including the first 3 children and dependent parents), Rs. 2.00 per day, i.e., Rs. 730/- per annum.

Subsidy:

-
- Premium subsidy @ Rs. 100/- per family for BPL families.

Exclusions:

- All pre-existing diseases.

Progress:

	Upto 31.3.2004	1.4.2004 to 31.5.2004
Total Coverage Premium collected (Rs. Lakhs) Rural coverage BPL families No. of claims Mount of claim (Rs. Lakhs)	416688 1932.24 198359 (47.60%) 9252 569 27.46	36000 183.30 13762 (38.23%) 2156 314 15.00

Redesigned Universal Health Insurance Scheme as announced in the Budget 2004-05:

The Redesigned UHIS was formally launched by the Hon'ble Finance Ministry at Mendhasal near Bhubansewar, Orissa on 20th September, 2004.

Eligibility :

Only BPL families

Premium:

- For an individual Rs. 165/- per annum (subsidy Rs. 200).
- For a family of 5 (including the first 3 children), Rs. 248/- (Subsidy Rs. 300).
- For a family up to seven, Rs. 330/- (Subsidy Rs. 400).

Benefits:

-
- Reimbursement of hospitalization expenses upto Rs. 30,000 can be availed individually or collectively by the members of the family.
- Personal accident cover of Rs. 25, 000 for death of earning head of family.
- Compensation due to loss of earnings of earning member @ Rs. 50 per day upto a maximum of 15 days.

Strategy for marketing the Redesigned UHIS:

The strategy for marketing the Redesigned UHIS include the following

- Implementation by the public sector general insurance companies on flagship basis in the country, i.e., by Oriental Insurance in Northern Region, United India in southern Region, National Insurance in the Eastern Region and New India in the Western Region.

- Publicity through print and electronic media in local languages.
- Coverage of BPL families with the active support of state governments, NGOs and Voluntary Organisations.
- Mobilization of additional subsidy through state governments to make the scheme affordable
- Tie-up with Third Party Administrators (TPAs) and Health service providers for cashless service.

Progress under the Redesigned UHIS (As on 31.10.2004):

The progress under the Redesigned UHIS is as follows:

Name of Company	No. of Policies	No. of Families	No. of Persons	Premium (Rs. In Lacs)
National	166	166	255	0.65
New India	2232	3000	4771	9.56
Oriental	39	1115	4595	5.35
United India	7522	9964	27106	30.19
Total	9959	14245	36727	45.75

ANNEXURE –III

Features of Swasthya Bima Policy as furnished by New India Assurance Company Limited .

SWASTHYA BIMA POLICY

Swasthya Bima Policy was introduced in the year-2005. It has been introduced for members of Self-help Groups and other Credit Linked Groups who avail loans from Banks or co-operative institutions.

Eligibility

The policy is issued in the name of groups, associations, institutions/ for the benefit of individuals in the group and persons in their family. A proposal form has to be duly completed.

Benefit:

The policy covers re-imbursement of hospitalization expenses for illness / diseases contracted or injuries sustained by the insured person, during the policy period.

The claim settlement is made through TPA to the hospitals / nursing home or the insured person. The total hospitalisation benefit is limited to Rs. 10,000/- per insured person.

The treatment should be taken in hospital / nursing home run by the **government.**

Pre and post hospitalisation expenses are not covered under the policy

The policy also provides for add on Benefits:

Transportation:

Cost of transportation of insured person to hospital is payable in upto Rs. 200/- during policy period provided the claim is admissible under the policy.

Meals:

Cost of meal for the patient not exceeding Rs. 30/- per day of hospitalisation and not exceeding Rs. 150/- during the policy period are payable. This benefit will be payable only if the claim is admissible under the policy.

Exclusions:

The exclusions are also similar to mediclaim policy.

Age Limit:

This insurance is available between the age of 15-65 years.

Premium:

The premium per individual is Rs. 120/- per annum. Service Tax is to be collected in addition.

ANNEXURE –IV

Features of Mediclaim as furnished by National Insurance Company Limited .

MEDICLAIM INSURANCE POLICY:

The policy covers reimbursement of Hospitalisation / Domiciliary Hospitalisation expenses for illness / diseases or injury sustained.

In the event of any claim becoming admissible under this scheme, the Company will pay to the Insured Person the amount of such expenses as would fall under different heads mentioned hereunder and as are reasonable and necessarily incurred by or on behalf of such Insured Person, but not exceeding the Sum Insured in aggregate in any one period of insurance stated in the policy schedule.

Reimbursement of hospitalisation expenses are allowed for :

(a) Room, Boarding Expenses as provided by the Hospital / Nursing Home.
(b) Nursing Expenses.
(c) Surgeon, Anaesthetist, Medical Practitioner, Consultant, Specialist Fees.
(d) Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines and Drugs, Diagnostic Materials and X-Ray, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemakers, Artificial limbs and cost of organs and similar expenses.

Pre-hospitalisation expenses incurred during the period upto 30 days prior to hospitalization and post hospitalization expenses Incurred during the period upto 60 days after discharge from the hospital are also covered under the policy.

This Insurance is available to persons between the age of 5 years and 80 years. Children between the age of 03 months and 05 years of age can be covered provided one or both parents are covered concurrently.

The Sum Insured under the Mediclaim Policy varies from Rs. 15,000/- to Rs. 5 Lakh wherein liability of the Company for domiciliary hospitalization are Rs. 3000/- and Rs. 65,000/- respectively.

Premium under Mediclaim policy varies according to the age of the Insured Persons as well as the Sum Insured opted by them. Thus the premium for Sum Insured of Rs. 15000/- upto 35 years age category comes to Rs. 213/- and that for Rs. 5 lakh comes to Rs. 5,151/-. Similarly premium for Rs. 15000/- for 76-80 years age category is Rs. 551/- and that for Rs. 5 lakh comes to Rs. 17,156/-

Family Discount @ 10% of the total premium is allowed under the Individual Mediclaim Policy for covering the family members comprising of Spouse, Dependant Children, and Dependant Parents. In case of Group Mediclaim Policy a maximum limit of 30% depending upon the size of the group is allowed as Group Discount.

Cumulative Bonus @ 5% of the Sum Insured for each claim free year subject to a maximum of 50% of the Sum Insured is admissible under the Individual Policy.

Cost of Health Check-up is also admissible to the Insured Persons once at the end of block of every 4 (four) Underwriting years provided there are no claim reported during the block. The cost so reimbursable shall not exceed the amount equal to 1% of the average Sum Insured during the block of four claim free underwriting years.

Income Tax Benefit is also available under Section 80D of the Income Tax Act.

In addition to the "**Individual**" and "**Group Mediclaim**" Policy our Company also issue "**Tailor made Group Mediclaim**" policy according to the need of the Clients.

Tailor made Group Mediclaim Policy

This is issued when modifications sought by groups based on their individual requirements and is very popular. Tailor-made policies are sold to Corporate groups as also to non corporate groups. A large chunk of mediclaim premium comes from tailor made group policies.

ANNEXURE –V

Features of Bhavishya Arogya Bima Policy as furnished by New India Assurance Company Limited .

BHAVISHYA AROGYA

The policy was introduced in the year 1990.It is a sort of deferred mediclaim policy. The policy provides cover similar to mediclaim policy.

Proposer can join the scheme any time between the age of 25 & 55 . He could choose retirement age between 55 and 60 years with a condition that there should be a clear gap of 4 years between the date of joining and the retirement age chosen. The policy retirement age means the age selected by the insured at the time of signing the proposal and specified in the schedule for the purpose of commencement of benefit in the policy. This age cannot be advanced. The pre retirement period means the period commencing from the date of acceptance of the proposal and ending with the policy retirement age specified in the schedule during which period the insured shall be paying instalment/single premium amount as applicable.

The basic sum insured has been fixed as Rs. 50,000/-, which can be enhanced by payment of additional premium subject to per illness limit of 40% of the sum insured. The policy also allows 5% cumulative bonus at the beginning of each claim free year after the selected date of retirement subject to maximum accumulation for 10 such claim free years in all during the entire life span of the insured person. Health check up is not required for obtaining this policy
In case, the insured dies or wishes to withdraw from the scheme either before the retirement age or after retirement age chosen, then appropriate refund of premium would be allowed subject to no claim having occurred under the policy. There is a provision of grace period of 7 days for payment of premium in the event of satisfactory reason for delay in renewal.

The scheme provides for assignment.

The policy does not have exclusion of pre-existing diseases, 30 days waiting period & first year exclusion of specified diseases as in mediclaim.

Policy can also be availed of on group basis in which case, facility of group discount is available.

ANNEXURE –VI

Features of Jan Arogya Bima Policy as furnished by New India Assurance Company Limited .

JAN AROGYA BIMA POLICY

This policy was introduced in the year-1998. It is designed to provide Hospitalization insurance to poorer sections of the society.

The coverage is along the lines of the individual mediclaim policy except that cumulative bonus and medical check up benefits are not included.The policy is available to individuals and family members by duly completing the proposal form.

The age limit is 5 to 70 years. Children between the age of 3 months and 5 years can be covered provided one or both parents are covered concurrently.

The sum insured per insured person is restricted to Rs. 5000/-.

The premium payable as per the following table

Age of the person insured	**Up to 46 years**	**46-55**	**56-65**	**66-70**
Head of the family	70	100	120	140
Spouse	70	100	120	140
Dependent child up to 25 years	50	50	50	50
For family of 2 + 1 dependent child	190	250	290	330
For family of 2 + 2 dependent children	240	300	340	380

Premium up to Rs. 10000/- qualifies for tax benefit under Section 80D of the Income Tax Act. Service tax is not applicable to the policy.

ANNEXURE –VII

Features of Sampoorna Arogya Bima Policy and Critical Illness insurance Policy as furnished by National Insurance Company Limited .

SAMPOORNA AROGYA BIMA POLICY :

As per desire of the Ministry this policy has been designed with the introduction of sub-limits on different heads of expenses incurred by the Insured.

This policy also covers reimbursement of hospitalization expenses only for illness / diseases contracted or injury sustained by the Insured Person in line with our standard Mediclaim Policy.

The scope of cover as well as other important parameters are identical to that of our standard Mediclaim Policy with some special features as stated hereunder :

1. This product is 20 to 25% cheaper than that of our standard Mediclaim Policy.
2. Sub limits have been introduced under different heads of hospitalization expenses.
3. Waiting period for pre-existing diseases coverage has been reduced from open ended period of 3 years in case of all diseases other than diseases of Heart and Circulatory Systems for which the waiting period is 5 years.
4. Hospital expenses of a few named diseases have been kept out of the policy coverage for first two years instead of first one year as existing in our Mediclaim Policy.
5. Scope of cover towards expenses incurred under day care surgeries have been widened in this new scheme.
6. Hospitalisation expenses of person donating an organ during the course of organ transplant will also be payable subject to the sub limits applicable to the Insured Person within the overall sum insured of that person.
7. Emergency ambulance charges are payable subject to a limit of Rs.1000/- in total or the actual amount whichever is less.
8. Hospitalisation treatment taken in Nepal, Bhutan will be considered under this scheme if prior approval is taken from the Company.
9. Proposal form has been simplified as details of all insured members are available in one document.
10. No tailor made policy is allowed under this health insurance policy.
11. Cumulative bonus @ 10% of the Sum Insured is allowed for each claim free year subject to a maximum of 60% of the sum insured of the current policy year.
12. Sum Insured under this policy varies from Rs. 25000/- to Rs. 5 lakh in multiples of Rs. 25000/-.
13. Domiciliary hospitalization is not covered under this policy.

Critical Illness insurance Policy

Our company is having a Critical Illness insurance Policy, which covers major diseases.
This is an exclusive benefit policy for individual in the age group of 18-60 years covering a) coronary artery disease b) cancer c) Renal failure d) Stroke e) Multiple sclerosis f) Major organ transplants g) Paralysis and blindness at extra premium.
Policy can be issued for a S.I. of Rs.3 to 25 lacs in multiples of Rs.1 lac. Rate of premium varies with the age of the insured. There is a waiting period of 90 days from the inception of the policy. The insured person needs to survive for 30 successive days after the diagnosis of critical illness in order to make his claim.

ANNEXURE –VIII

Features of Health Plus Medical Expense, cancer Insurance and Tertiary care Insurance Schemes as furnished by New India Assurance Company Limited .

(A) HEALTH PLUS MEDICAL EXPENSES POLICY – (INDIVIDUAL)

This policy was introduced in the year 2004. It covers reimbursement of only the hospitalisation expenses for illness / diseases contracted or injury sustained by the insured person. Cash less facility is not available.

In the event of any claim becoming admissible under the policy the company will pay to the insured person the amount of such expenses as are reasonably and necessarily incurred in respect thereof anywhere in India by or on behalf of such insured person but not exceeding in any one period of insurance the amounts mentioned in the Table of Benefits.

SECTION 1 – Table of Benefits:

HOSPITALIZATION BENEFITS	**LIMITS**
1. i. Room, Board & Nursing Expenses as provided by the hospital/nursing home including registration and service charges. **ii** If admitted into IC Unit All admissible claims under (i) & (ii) during the policy period	Up to 1% of SI per day Up to 2% of SI per day Up to 30% of SI per illness/injury
2. Surgeon, Anaesthetist,Medical Practitioners,Consultant, Specialists Fees	Up to 30% of SI per illness / injury
3. Emergency Ambulance charges	Up to Rs. 1000/-
4. Anaesthesia, Blood Oxygen, Operation Theatre Charges, surgical Appliances, Medicines & Drugs, diagnostic Materials and X-ray, dialysis, chemotherapy, radiotherapy, Cost of Pacemaker, artificial Limbs and any medical expenses incurred which is integral part of the operation	Up to 40% of SI per illness / injury

Note:

1) The Hospitalisation expenses incurred for treatment of any one illness under agreed package charges will be restricted to 80-% of the unutilised sum insured or actuals whichever is less, for any one illness.
2) Hospitalisation expenses of person donating an organ during the course of organ transplant will also be payable subject to the above sub limits applicable to the insured person and within the overall sum insured of the insured person
3) Hospitalisation treatment taken in Nepal & Bhutan will be considered under the policy provided prior approval has been taken from the Company
4) Expenses for Ayurvedic Medical Treatment for illness shall be restricted to 20% of Sum insured or Rs. 25000/- whichever is less

SECTION II – EXTENSION OF THE GEOGRAPHICAL LIMIT OF THE POLICY TO COVER TREATMENT ABROAD BY PAYMENT OF ADDITIONAL PREMIUM (**OPTIONAL – TO BE OPTED AT THE INCEPTION OF THE POLICY)**

This policy can be extended, to cover the expenses incurred for treatment of an insured person for one additional sum insured (excluding cumulative bonus) abroad in case the attending doctor or the hospital in India where the insured person is taking treatment has recommended that such types of treatment is not available in India and the insured person required specialized treatment,

surgery or post operative treatment abroad. The benefit can be availed of provided the insured person's claim has been admitted under section I of the policy. Non-payment of a claim under section I merely because S.I. is already utilized in earlier claim, will not prejudice a claim under Section II. The Company on written certification by the attending doctor will examine such request of the insured person in case Company's consulting doctor feels that such of treatment is not available in India, the Company shall allow the medical expenses of insured person incurred abroad. The reimbursement of such medical expenses incurred abroad shall be paid in Indian Rupees only, limited to one additional sum insured of the insured person mentioned in the policy schedule. The extension of Medical benefit will be allowed to an insured person from the date of admission in the hospital until discharge there from. No pre and post hospitalization expenses will be covered under this extension. No cumulative bonus will accrue under this extension.

EXCLUSIONS: Are similar to Mediclaim Policy except that preexisting diseases are covered after 4 claim free renewals

AGE LIMIT:
The cover is available between the age of 3 months to 70 years. Children are covered only when one or both parents are covered simultaneously. Person above the age of 45 years has to undergo medical tests as required by the company at their own expenses.

Above age of 70 years renewal will only be considered subject to insured enjoying at least 15% Cumulative Bonus and by payment of additional premium.

AGE	LOADING
71 TO 75	10%
76 TO 80	20%
81 AND ABOVE	30%

PREMIUM CHART (SECTION 1)

Sum Insured hospitalisation expenses (Rs.)	Up to 25 years	26 to 35 years	36 to 45 years	46 to 55 years	56 to 65 years	66 to 70 years
50,000/-	600	650	900	1000	1200	1300
100000/-	1000	1200	1400	1900	2250	2700
150000/-	1550	1800	2100	2800	3300	3600
200000/-	2000	2300	2600	3650	4300	5000
300000/-	2900	3200	3500	5200	6100	6800
400000/-	3280	4000	4400	6600	7700	8750
500000/-	4000	4800	5600	8550	10200	10700
800000/-	6500	8380	10450	13500	16500	17500
1000000/-	7500	10500	13000	17000	21000	22000

SECTION II – Extension of the geographical limit of the policy to cover treatment Abroad

PREMIUM

AGE	Up to 25 years	26 to 35 years	36 to 45 years	46 to 55 years	56 to 65 years	66 to 70 years
Additional sum insured equal to that under Sec I	1% of SI	1% of SI	1% of SI	1.5% of SI	1.5% of SI	2% of SI

All the insured persons covered in the Policy have to opt for this Section. The decision to avail of Section II benefit has to be taken at the inception. No variation would be allowed at renewals.

(B) CANCER MEDICAL EXPENSES INSURANCE POLICY

Two types of policies are devised for covering cancer Medical Expenses. One policy is available to members of Indian Cancer Society and another one for members of Cancer Patients Aids Association. The features of policy are given hereunder:

The insurance scheme offered to members of Indian Cancer Society came into effect from July 1985 and was modified from 1st May, 1987 as per the market requirement. The Indian Cancer Society offers different types of membership to their members such as life members, well-wisher ordinary members, corporate members etc. The memberships of the society are available only to those individuals below 70 years of the age and are not cancer patients. The membership fees of the society includes insurance premium also.

For availing the benefit of this insurance, a proposer has to fill membership form of the society and has to complete a proposal of the insurance company by giving the details asked therein. The proposal form also contains a certification by a doctor that the proposer is not suffering from cancer.

The policy covers the insured member and his/her spouse on floater basis. During the operation of this insurance, if the insured member or spouse contracts cancer, then the insurance Company will pay to the insured, cost of diagnosis, biopsy, surgery, chemotherapy, radiotherapy, hospitalisation and rehabilitation to the extent of the sum insured. The sum insured is available in multiple of Rs. 50,000/- subject to a maximum of Rs. 2 lacs. The policy allows cumulative bonus of 5% for each claim free year up to a maximum of 50%. The policy comes into operation only after a period of one month after the date of enrolment of the member, which date is taken as date of commencement of insurance. The policy is valid for 12 months and each insured member has to pay the annual membership of the society which includes premium before its expiry. The renewal insurance will have no waiting period and the policy will operate as usual from its renewal date.

Special features of the policy:

Policy stipulates that the insured member and his/her spouse, are covered under the policy however, once either of them contracts cancer, the spouse will not be entitled to any benefit under the policy. The other member is free to take fresh membership of Indian Cancer Society by completing the required formalities.

The Indian Cancer Society initially as an add on benefit provide to the insured member and his/her spouse check up for cancer only once, free of cost and subsequent check up at 50% discount. In case, entire sum insured is exhausted and insured person requires further treatment then the society allows chemotherapy treatment at discounted rates.

The policy can be extended to cover two dependent children of the insured person on payment of additional premium. Separate indemnities are granted to each child.
Policy covers only allopathic treatment.

GROUP CANCER MEDICAL EXPENSES POLICY

It is possible to grant a policy on group basis. The employer has to arrange for a well-wisher corporate membership. A group discount is also available on membership fee as well as premium amount based on mediclaim scale.

CLAIMS SETTLEMENT

Reimbursement of claims is made on quarterly basis on production of medical/hospital bills duly certified by Indian Cancer Society.

(C) Tertiary Care Insurance Policy

SALIENT FEATURES OF THE POLICY
The Policy covers reimbursement of Hospitalisation/Domiciliary Hospitalisation expenses for nine major ailments suffered by the insured person as defined hereinbelow :-

1. Nephritis of any Aetiology plus Bacterial renal failure requiring Kidney Transplantation & Dialysis
2. Cerebral or Vascular Strokes
3. Open and Close Heart Surgery (inclusive of C.A.B.G)
4. Malignancy disease which are confirmed on Histopathological report
5. Encephalitis (Viral)
6. Neuro Surgery
7. Total Replacement of joints
8. Liver disorder (Hepatitis B & C) associated with complications like Cirrhosis of liver.
9. Grievous injury including multiple fracture of long bones, head-injury leading to unconsciousness, burns of more than 40%, injury requiring artificial ventilatory support plus Vertebral Column Injury.

In the event of any claim becoming admissible under this scheme, the company will pay to the Insured Person the amount of such expenses as would fall under different heads mentioned below, and as are reasonably and necessarily incurred thereof by or on behalf of such Insured Person but not exceeding the Sum Insured in aggregate in any one period of Insurance stated in the schedule hereto.

A) Room, Boarding Expenses as provided by the hospital/nursing home which includes Registration & Admission Fees.

B) Nursing Expenses.

C) Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees

D) Anaesthesia, Blood, Oxygen, Operation Theater Charges, Surgical Appliances, Medicines & Drugs, Diagnostic Materials and X-ray, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, Artificial Limbs & Cost of Organs and similar expenses.

E) Reasonable expenses incurred for ambulance within city limits at the time of admission and discharge only.

(N.B. Company's Liability in respect of all claims admitted during the period of insurance shall not exceed the Sum Insured per person per annum to be reckoned from the date of inception of the risk as mentioned in the schedule.)

ADDITIONAL OPTIONAL COVER :
In the event of an admissible claim under Hospitalisation section of this policy, expenses not exceeding Rs. 500/- per week shall be reimbursed towards the boarding and lodging expenses in the hospital for one of the family members or next of kin who accompanies the Insured Person during the period of hospitalisation. The weekly compensation shall not be payable for more than 52 weeks in respect of any one covered major ailment/ policy period. This optional cover is subject to payment of additional premium as mentioned in the premium chart.

Hospitalisation and Operation Expenses reasonably and necessarrily incurred on person donating the organ to the insured person during the course of Organ transplant operation subject to limits available during the policy period.

PRE-EXISTING MAJOR AILMENTS (CONDITIONS) :
The pre-existing conditions in respect of major ailments are those conditions of sickness or its symptoms which existed prior to or at the time of inception of the first policy period and may lead to precipitation of a major ailment as defined in the policy. In case the renewal is effected with any break, the pre-existing condition will apply afresh as though the risk is assumed for the first time.

AGE LIMIT :
This insurance is available to persons between the age of 5 years and 75 years. Children between the age of 3 months and 5 years of age can be covered provided one or both parents are covered concurrently.

Family Discount

A discount of 10% in the total premium will be allowed comprising the insured and any one or more of the following :

i) Spouse

ii) Dependent Children (i.e. legitimate or legally adopted children)

iii) Dependent parents

PRE-MEDICAL HEALTH CHECK-UP :
Insured has to submit blood, urine test reports, ECG, Chest X-ray and such other reports alongwith the Certificate from Post-Graduate Medical practitioners stating that the Insured is free from all the nine major ailments proposed for insurance under this policy. The cost of pre-medical check-up at the time of first inception of the policy and when required because of break in renewal for more than seven days will be borne by the Insured. The family physician's certificate stating the health status of the Insured in a prescribed proforma should also accompany the proposal form.

Mediclaim policyholders of New India having Sum Insured equivalent to or higher than this policy will get 5 % Discount on Major ailments Insurance policy premium.

SUM INSURED :
Minimum Rs. 50,000 with multiples of Rs. 50,000 thereafter, with maximum Sum Insured of Rs. 5,00,000.

ANNEXURE –IX

Features of Good Health (Individual and Group) as furnished by Oriental Insurance Company Limited .

Good Health (Individual and Group)

Age – 1 month to 75 years. Child can be covered from 1 months to 21 years if parents are also covered.

Premium : on age based basis.

Sum Insured – Rs 50,000/- to 5,00,000/- in multiples of Rs 50,000/- & in multiples of Rs 1 lac upto Rs 10,00,000/-.

ANNEXURE –X

Features of Uni-Medicare, Mediguard and Trauma Care Policies as furnished by United India Company Limited .

(A) Uni-Medicare policy- Reimbursement of hospitalisation expenses following an unforeseen illness/accident or Cashless treatment at empanelled hospitals by the Third Party Administrators (TPAs). Sum Insured chosen from Rs 15,000/- to Rs 5,00,000/- at the Insured's choice and paying capacity. Limit per illness 30% of the Sum Insured. Lower premium and limits fixed for different head of account.

(B) Mediguard Policy- This policy is similar to that of the mediclaim policy but is not serviced by the Third Party Administrators. Reimbursement of expenses only and no cash less treatment offered. Premium fixed on the basis of the age and the sum insured opted for. This policy has been introduced recently.

(C) Trauma Care – There are two schemes – Scheme A and B – Scheme A covers 11 major diseases and Scheme B covers 5 major diseases viz. Major Heart diseases, Renal failure, Cancer, Renal disorders, Multiple Sclerosis, etc.

ANNEXURE –XI

Some of the salient features of the Micro-insurance Regulations, 2005 as furnished by IRDA

1.Micro-insurance Products:

Under the aforesaid regulations, the products which can be termed as Micro-insurance products are clearly defined as under:

- "**General micro-insurance product"** means any health insurance contract, any contract covering the belongings, such as, hut, livestock, tools or instruments or any personal accident contact, either on individual or groups basis, as per terms stated in Schedule-I which is furnished below:

Item	Type of Cover	Min. Amount of Cover	Max. Amount of Cover	Term of Cover Min.	Term of Cover Max.	Min. Age at entry	Max. age at entry
1	**Dwelling & contents, or livestock or Tools or implements or other named assets / or Crop insurance against all perils**	Rs.5000 per asset/cover	Rs. 30000 Per asset/cover	1 year	1 year	NA	NA
2	**Health Insurance Contract (Ind.)**	Rs.5000	Rs.30000	1 year	1 year	Insurers' discretion	
3	**Health Insurance Contract (family) (Option to avail limit for Individual/Float on family)**	Rs.10000	Rs.30000	1 year	1 year	Insurers' discretion	
4	**Personal Accident (per life/ earning member of family)**	Rs.10000	Rs.50000	1 year	1 year	5	70

- **"Life micro-insurance product"** means any term insurance contract with or without return of premium, any endowment insurance contract or health insurance contract, with or without an accident benefit rider, either on individual or group basis, as per terms stated in Schedule-II which is furnished below :

Item	Type of Cover	Min. Amount of Cover	Max. Amount of Cover	Term of Cover Min.	Term of Cover Max.	Min. Age at entry	Max. age at entry
1	**Term Insurance with or without return of premium.**	Rs.5000	Rs. 50000	5 year	15 year	18	60
	Endowment	Rs.5000	Rs.30000	5 years	15 years	18	60
2	**Health Insurance Contract (Individual)**	Rs.5000	Rs.30000	1 year	7 year	Insurers' discretion	
3	**Health Insurance Contract (family)**	Rs.10000	Rs.30000	1 year	7 year	Insurers' discretion	
4	**Accident Benefit as rider**	Rs.10000	Rs.50000	5 year	15 year	18	60

All micro-insurance products are required to be filed with the Authority under File & Use procedures and every micro-insurance product which is cleared by the Authority for the purpose of micro-insurance shall prominently carry the caption "Micro-insurance Product. The Regulations also encourage issuing of policies in the vernacular language which is simple and easily understood by the policyholders.

2. Micro-insurance Agents:

Micro-insurance carry enormous potential for transforming the lives of the rural poor as it can be an effective tool to provide health insurance, accidental insurance and as a means of social security. Recognizing the importance of Self-help Groups/NGOs/Micro Finance Institutions in empowering the rural poor, the Micro-insurance Regulations have allowed them to carry out the micro-insurance activities by becoming Micro-insurance Agents. These will be working in addition to existing network of agents, corporate agents and brokers. In terms of the Regulations,

(a) "**micro-insurance agent"** means – (i) a Non-Government Organisation (NGO); or (ii) a Self-help Groups (SHG); or (iii) a Micro-Finance Institution (MFI), who is appointed by an insurer to act as a mocro-insurance agent for distribution of micro-insurance products.

Explanation: For the purpose of these regulations:-

(I) ***Non-Government Organisation (NGO)*** means a non-profit organisation registered as a society under any law, and has been working at least for three years with marginalized groups, with proven track record, clearly stated aims and objectives, transparency, and accountability as outlined in its memorandum, rules, by-laws or regulations, as the case may be, and demonstrates involvement of committed people.

(II) ***Self-help Group (SHG)*** means any informal group consisting of ten to twenty or more persons and has been working at least for three years with marginalized groups, with proven track record, clearly stated aims and objectives, transparency, and accountability as outlined in its memorandum, rules, by-laws or regulations, as the case may be, and demonstrates involvement of committed people.

While they abide by code of conduct, relaxations were given with regard to training for micro-insurance agents.

(III) ***Micro-Finance Institution*** means any institution of entity or association registered under any law for the registration of societies or co-operative societies, as the case may be, *inter alia*, for sanctioning loan/finance to its members.

3. Tie-up between life insurer and non-life insurer:-

To enable micro-insurance to be an integral part of a country's wider insurance system and with a view to provide flexibility for distribution of the micro-insurance products, the Regulations are designed in such a way that (1) An insurer carrying on life insurance business may offer life micro-insurance products as also general micro-insurance products, and (2) An insurer carrying on general insurance business may offer general micro-insurance products as also life micro-insurance products, as provided herein.

Provided that where an insurer carrying on life insurance business offers any general micro-insurance product, he shall have a tie-up with an insurer carrying on general insurance business for this purpose, and subject to the provisions of section 64VB of the Act, the premium attributable to the general micro-insurance product may be collected from the prospect (proposer) by the insurer carrying on life insurance business, either directly or through any of the distributing entities of micro-insurance products as specified in regulation 4, and made over to the insurer carrying on general insurance business.

Provided further that in the event of any claim in regard to general micro-insurance products, the insurer carrying on life insurance business or the distributing entities of micro-insurance products, as the case may be, as may be specified in the tie-up referred to in the first proviso, shall forward the claim to the insurer carrying on general insurance business and offer all assistance for the expeditious disposal of the claim.

These provisions are equally applicable where an insurer carrying on non-life insurance business offers any life micro-insurance product as mentioned in 3(2) of the aforesaid Regulations.

4. Incentive to insurance companies:

(1) All micro-insurance policies may be reckoned for the purpose of fulfillment of social obligations by an insurer pursuant to the provisions of the Act and the regulations made there under.

(2) Where a micro-insurance policy is issued in a rural area and falls under the definition of social sector, such policy may be reckoned for both under rural and social obligations separately.